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特集

学術シンポジウム《日中医学交流会議2025・中国青島》

― 感染症の臨床的展望 ―

Prospect of Clinical Infectious Diseases

Keynote Lecture

"Challenge and Prospectives in Management of Major and/or Emerging Infectious Diseases in China"

王 福生
中国科学院院士

Symposium Sessions

- Session Ⅰ　Antiretroviral therapy and eradication research
  （HIV エイズ／HIV 的治疗和病毒清除）
- Session Ⅱ　Antimicrobial resistance and current strategies
  （AMR 薬剤耐性／细菌耐药）
- Session Ⅲ　Managing EBV-related disease spectrum
  （EBV 感染症／EBV 感染相关疾病的管理）
- Session Ⅳ　Research progress on the cure of hepatitis B
  （B 型肝炎／乙肝治愈研究进展）



漢方製剤にとって「良質」とは何か。その答えのひとつが「均質」である、とツムラは考えます。自然由来がゆえに、ひとつひとつに個性がある生薬。漢方製剤にとって、その成分のばらつきを抑え、一定に保つことが「良質」である。そう考える私たちは、栽培から製造にいたるすべてのプロセスで、自然由来の成分のばらつきを抑える技術を追求。これからもあるべき「ツムラ品質」を進化させ続けます。現代を生きる人々の健やかな毎日のために。自然と健康を科学する、漢方のツムラです。

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2021年4月制作 審

《特集》

学術シンポジウム
《日中医学交流会議 2025・中国青島》

感染症の臨床的展望



本誌は、2025 年 9 月 6 日に中国・山東省青島市で開催した学術シンポジウムの内容を纏めました。ご一読いただけましたら幸甚に存じます。

本期刊载了 2025 年 9 月 6 日于中国山东省青岛市举行的学术研讨会的有关内容。敬请诸位一读为盼。

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日中医学交流会議2025・中国青島
プログラム

開催日時｜2025年9月6日（土）
開 催 地｜中国・山東省青島市（ウィンダムグランド青島）
主　　催｜公益財団法人日中医学協会、中華医学会

開会式

（本誌 p.4をご参照ください）

司　　会｜梁　春琦　中華医学会副秘書長
歓迎挨拶｜周　明堅　中華医学会副会長
　　小川秀興　日中医学協会会長

基調講演

（本誌 p.10をご参照ください）

“Challenge and Prospectives in Management of Major and/or Emerging Infectious Diseases in China”

演　　者｜王　福生　中国科学院院士、中華医学会感染病学分科会次期主任委員、中国人民解放軍総医院第五医学センター感染症医学部主任
座　　長｜張　文宏　復旦大学附属華山病院感染科主任、中華医学会感染病学分科会副主任委員

学術シンポジウム「感染症の臨床的展望」

（本誌 p.16をご参照ください）

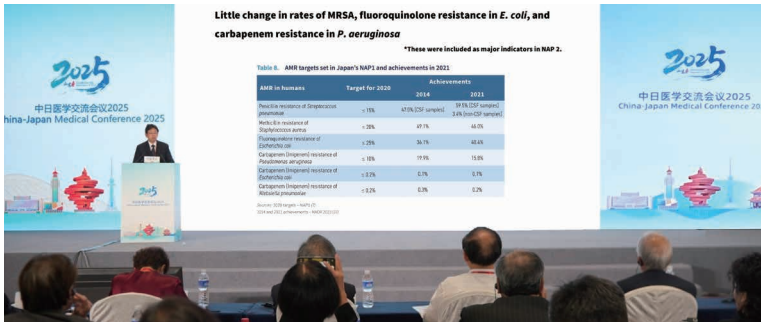
Session Ⅰ｜Antiretroviral therapy and eradication research（HIV エイズ）
Session Ⅱ｜Antimicrobial resistance and current strategies（AMR 薬剤耐性）
Session Ⅲ｜Managing EBV-related disease spectrum（EBV 感染症）
Session Ⅳ｜Research progress on the cure of hepatitis B（B 型肝炎）

感染症治療に関する「青島宣言」

（本誌 p.3をご参照ください）

情報交換会

司　　会｜梁　春琦　中華医学会副秘書長
挨　　拶｜周　明堅　中華医学会副会長
　　跡見　裕　日中医学協会理事長
乾杯挨拶｜王　福生　中国科学院院士、中華医学会感染病学分科会次期主任委員、中国人民解放軍総医院第五医学センター感染症医学部主任





日中医学交流会議2025・中国青島
青島宣言

日中両国の専門家による感染症治療に関する「青島宣言」（日中共同声明）が採択されました。

1.

感染症は人類の健康を脅かす地球規模の課題であり、アジアの重要な隣国である日本と中国は、重大な感染症、新興・再興感染症、薬剤耐性菌の拡散などの感染症分野で共通の課題に直面している一方で、それぞれ固有の強みを有している。両国の専門家は、技術の相互共有や共同研究を通じて、地域の感染症予防・制御能力と公衆衛生安全保障を共同で向上させていくことを目指す。

2.

重大な感染症の治療には、感染症専門医による長期的かつ標準化された管理が不可欠であり、加えて多領域の専門家による包括的な介入も必要であるため、感染症の管理モデルの転換を段階的に進めていくべきである。一方、免疫療法、中和抗体、低分子核酸医薬品などの新規治療法がこれらの疾患の根治に向けて新たな進展を遂げている。これらの管理と治療の分野においても、日中両国は研究協力の強化と推進を図る。

3.

細菌の薬剤耐性監視は国際的にも戦略的な意義を有し、地域間の協力が極めて重要である。薬剤耐性メカニズムの研究、薬剤耐性スペクトラムのサーベイランス、抗生物質の適正使用、ならびに新規抗菌薬の研究開発に関して、日中両国はあらゆる分野・多様なルートにおいて協力体制を更に強化し、薬剤耐性菌の制御に向けて共同で取り組む。

4.

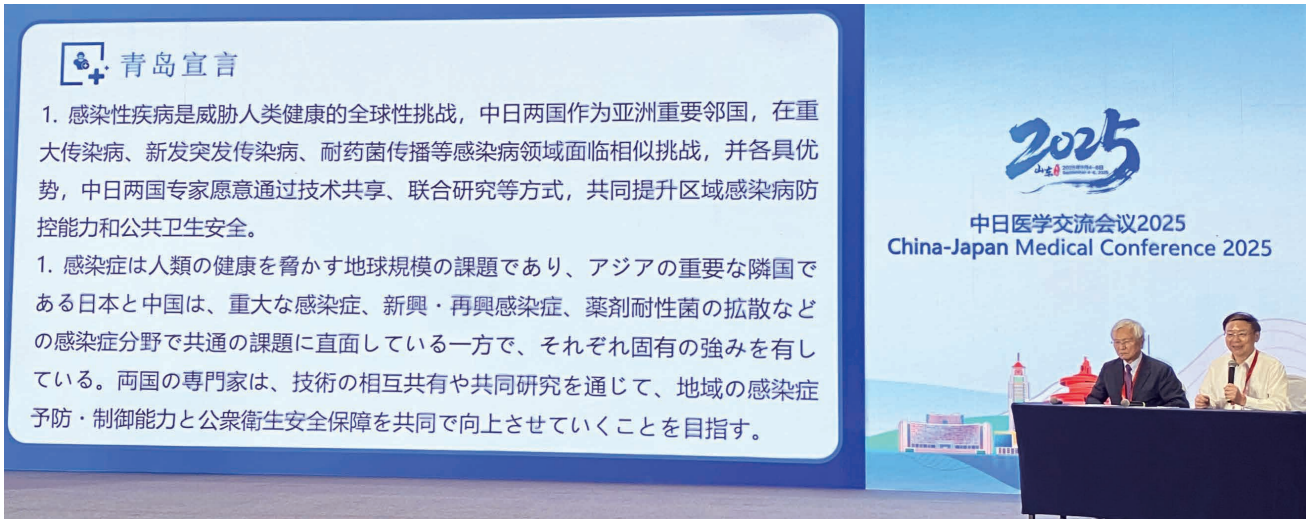
新興・再興感染症のサーベイランスと早期警戒体制においても、日中両国はプラットフォームの共有と早期警戒能力の強化を進めて、潜在的な感染症の脅威に共同で対応する。

5.

日中両国は、今後も政府主導および省庁間連携を継続し、医療機関および学術機関間の連携と交流を強化するとともに、関連学会による定期的な交流会議の開催や、より深い協力関係の構築を促進して、長期的な協力体制を構築する。

6.

感染症の予防と治療の統合的推進において、日中両国は、「予防は治療に勝る」との原則にもとづき、国民への健康教育の普及や、重点的なハイリスク群に対する予防措置の実践と研究をさらに強化する。あわせて、ワクチンの研究開発や公衆衛生分野においても、連携して防御体制の最適化を図り、地域の公衆衛生水準の向上を推進する。





開会挨拶

中華医学会副会長 | 周　明堅

爽やかな秋晴れのこの佳き季節に、青島にお集まりいただいた中日両国の医学界の皆さまと共に、「中日医学交流会議 2025」の開幕を迎えられますことを大変光栄に存じます。ここに、中華医学会を代表し、遠路お越しくださいました医学界の皆さま、専門家・研究者の皆さまに、心より歓迎申し上げます。また、長年にわたり、中日両国国民の健康福祉と友好協力の促進に尽力されてきた各界の友人の皆さまに、改めて深い敬意と感謝の意を表します。

1978 年に中華医学会と日中医学協会が協力関係を築いて以来、40 年以上にわたり、私たちは共通の使命を胸に、民間交流を通じて、慢性疾患の予防・治療、がん診療、消化器疾患、泌尿器疾患などさまざまな分野において、実効性の高い実務的協力を展開してまいりました。1992 年には両会が初めて共同で学術会議を開催し、深い協力の礎を築くことができました。さらに、2018 年の北京会議、2019 年の東京会議を経て、交流の成果は一層深化し、両国医学界の対話と協働のための重要な架け橋となりました。

現在、世界の医学界は、感染症がもたらす公衆衛生上の課題、加速する高齢化、慢性疾患対策への負荷の増大といった共通の難題に直面しています。本会議は「感染症の臨床的展望」をテーマに、HIV 治療とウイルス抑制、細菌耐性対策、EB ウイルス感染関連疾患の診療の進展、B 型肝炎の臨床治療研究という 4 つの重要課題に焦点を当てています。中日両国の第一線で活躍される専門家が英知を結集し、解決策を共に検討することで、知見と経験の共有が一層深まり、臨床技術の革新と広範な応用が促進されることを期待しています。

世界保健機関（WHO）は近年、エビデンスに基づくガイドラインの策定や感染管理基準の普及などの施策を通じ、世界的な感染症対策体制の強化を継続的に進めています。中日両国はこの分野で豊富な経験を蓄積しており、互いに学び合う価値があります。本日の討議は、単なる技術交流にとどまらず、患者の予後改善や感染リスク低減という社会的責任も担う重要なものです。国情は異なりますが、「人々の健康を中心に据える」という共通の目標は揺らぐことはありません。

中華医学会と日中医学協会は、民間の学術団体として医学の進歩を促し、人々の福祉を高めるという重要な使命を担っています。今後、協力の幅をさらに広げ、その在り方を革新し、より開放的で包摂的な学術交流のプラットフォームを構築することで、医学の知恵が両国の人々により確実に行き渡るよう努めてまいります。

最後に、本会議の成功と実り多い成果を心よりお祈り申し上げます。日本からお越しの皆さまの中国でのご滞在が充実したものとなり、健やかに過ごされますことを願っております。中日医学界の友情が松柏のごとく末永く続き、人類の健康という偉業に新たな章を共に刻んでいくことができますよう祈念いたします。



開会挨拶

日中医学協会会長 | 小川秀興

本日は「日中医学交流会議 2025 青島」にご参加いただき、誠にありがとうございます。

長きにわたり本会議の再開を待ち望んでまいりましたが、新型コロナウイルス感染症の世界的流行により、私たちは実に 6 年もの間、対面での交流を中断せざるを得ませんでした。そのような困難を乗り越え、本日こうして再び日中両国の医療者が一堂に会し、直接顔を合わせて議論を交わすことができますことは、私どもにとって大きな喜びであるとともに、未来への確かな希望を象徴するものであります。

日中医学協会と中華医学会は、これまで長年にわたり、両国が共有する医療課題に真摯に向き合い、協力して医学研究を推進し、国際社会への貢献を目指してまいりました。その中核を担ってきたのが、この「日中医学交流会議」であり、両国の医療者が互いの知見を持ち寄り、学び合い、信頼を育む場として重要な役割を果たしてきました。今回の再開は、単なる会議の復活にとどまらず、両国の医学交流が新たな段階へと進むための大きな節目であると感じております。

本年の主題は「感染症の臨床的展望」であり、HIV/エイズ、AMR（薬剤耐性）、EBウイルス感染症、B型肝炎治療という 4 つの重要領域に焦点を当てております。感染症は国境を越えて人々の健康と社会の安定を脅かす、現代における最も重大な課題の一つです。特にこれらの領域は、日中両国が共通して直面する公衆衛生上の喫緊のテーマであり、臨床現場の対応力向上と国際的な知見の共有が強く求められております。本会議を通じて、両国の専門家が最新の研究成果と臨床経験を持ち寄り、互いに学び合うことで、より実践的かつ持続可能な医療連携の基盤が築かれることを期待しております。

さらに、本会議の再開は、新型コロナウイルス感染症のパンデミックを経て、両国の医学交流が新たな価値観と視点を獲得したことを示すものでもあります。感染症対策における国際協力の重要性は、この数年間で私たちが改めて認識するに至ったことであり、今後は研究・教育・臨床の各分野において、より多層的かつ継続的な連携が求められます。青島での議論が、次世代の医療者育成や共同研究の深化につながり、日中両国がアジア、さらには世界の公衆衛生向上に寄与する礎となることを強く願っております。また、今回の対面交流を契機として、オンラインでは得難い信頼関係の構築や、長期的な協働の芽が育まれることを大いに期待しております。

最後に、本会議の開催にあたり多大なるご尽力を賜りました関係各位に深く感謝を申し上げますとともに、ご参加の皆様にとって実り多き議論と交流の場となりますことを心より祈念申し上げ、開会の挨拶といたします。

中日医学交流会议2025・中国青岛
内 容 安 排

日　　期　2025年9月6日（周六）
地　　点　中国青岛（青岛银沙滩温德姆至尊酒店）
主　　办　公益财团法人日中医学协会、中华医学会

开幕式

（请参看本期刊 p. 8）

主　　持　梁春琦　中华医学会副秘书长
致　　辞　周明坚　中华医学会副会长
　　小川秀兴　日中医学协会会长

基调演讲

（请参看本期刊 p. 10）

“Challenge and Prospectives in Management of Major and/or Emerging Infectious Diseases in China”

演 讲 者　王福生　中国科学院院士、中华医学会感染病学分会候任主任委员、解放军第五医学中心感染病医学部主任
主　　持　张文宏　复旦大学附属华山医院感染科主任、中华医学会感染病学分会副主任委员

专题讲座“感染性疾病的临床前景”

（请参看本期刊 p. 16）

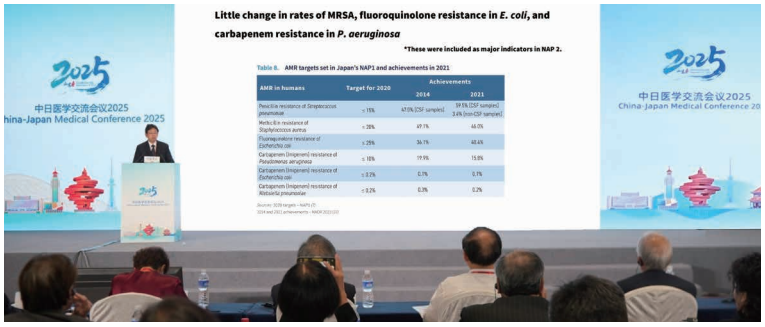
Session Ⅰ　Antiretroviral therapy and eradication research（HIV的治疗和病毒清除）
Session Ⅱ　Antimicrobial resistance and current strategies（细菌耐药）
Session Ⅲ　Managing EBV-related disease spectrum（EBV感染相关疾病的管理）
Session Ⅳ　Research progress on the cure of hepatitis B（乙肝治愈研究进展）

关于感染性疾病治疗的“青岛宣言”

（请参看本期刊 p. 7）

信息交流会

主　　持　梁春琦　中华医学会副秘书长
致　　辞　周明坚　中华医学会副会长
　　跡见裕　日中医学协会理事长
干杯致辞　王福生　中国科学院院士、中华医学会感染病学分会候任主任委员、解放军第五医学中心感染病医学部主任





中日医学交流会议2025・中国青岛
青岛宣言

在本次大会通过了中日两国专家关于感染性疾病治疗的“青岛宣言”（中日联合声明）。

1.

感染性疾病是威胁人类健康的全球性挑战，中日两国作为亚洲重要邻国，在重大传染病、新发突发传染病、耐药菌传播等感染病领域面临相似挑战，并各具优势，中日两国专家愿意通过技术共享、联合研究等方式，共同提升区域感染病防控能力和公共卫生安全。

2.

重大传染性疾病的治疗需要感染病专科的长期规范管理，也需要多学科的广泛参与，应逐步建立传染性疾病管理模式的转变。同时，免疫治疗、中和抗体、小核酸药物等新型疗法正在这些疾病的治愈方向上取得新进展。在这些管理与治疗方面，中日两国将加强和推进研究合作。

3.

细菌耐药监控具有全球战略性意义，区域合作意义深远。针对耐药机制研究、耐药谱监测、抗生素合理应用及新型抗菌药物研发，中日双方将进一步建立全方位多渠道合作，共同推进遏制细菌耐药行动。

4.

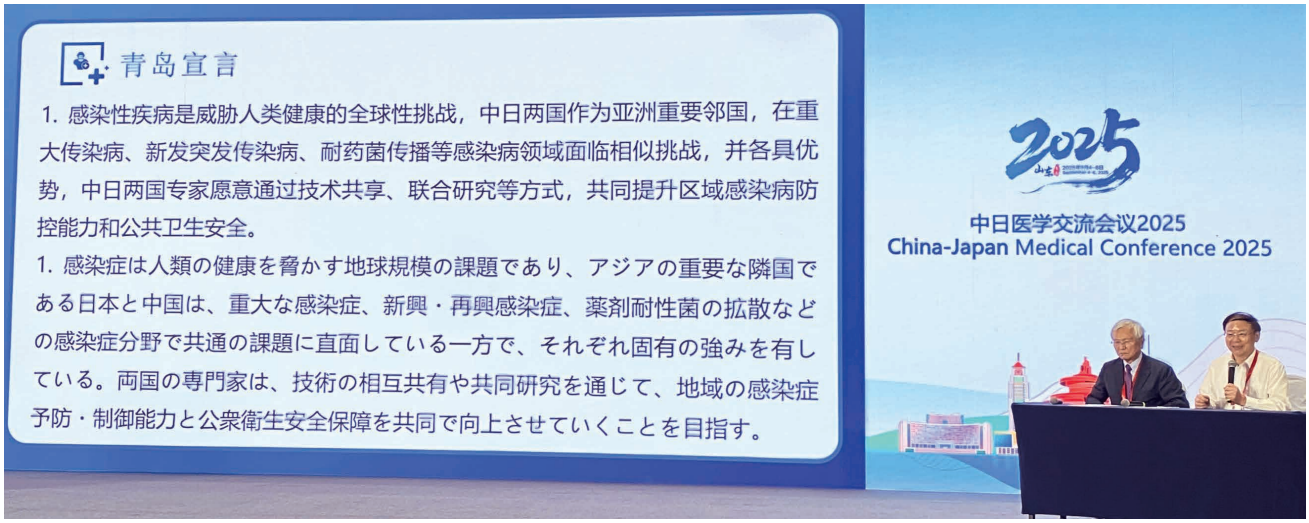
在新发突发传染病监测预警方面，中日双方也将加强平台共享及预警能力建设，共同应对潜在传染病威胁。

5.

中日双方将继续政府主导和跨部门合作，加强医疗及学术机构的联合与互动，推动相关学会举办定期交流会议及更深入的合作，形成长效机制。

6.

传染病防治结合，预防胜于治疗，应进一步加强民众健康教育普及和重点高危人群防范的实践和研究。同时，在疫苗研发和公共卫生领域，中日双方也将携手优化防控体系，推动区域公共卫生的进步。





开幕致辞

中华医学会副会长 | 周明坚

在这秋高气爽的美好时节，能与中日两国医学界同仁相聚青岛，共同开启“中日医学交流会议 2025”的序幕，我倍感荣幸。在此，我谨代表中华医学会，向远道而来的医学界同仁、专家学者致以最热烈的欢迎！对长期以来致力于促进中日两国人民健康福祉与友好合作的各界友人，表示诚挚的问候和衷心的感谢！

自 1978 年中华医学会与日中医学协会建立合作关系以来，四十余年间，我们始终秉持共同使命，通过民间渠道在慢病防治、癌症诊疗、消化系统疾病、泌尿系统疾病等领域开展了卓有成效的务实合作。1992 年，两会首次联合主办学术会议，奠定了双方深度合作的基石。此后，2018 年北京会议与 2019 年东京会议进一步深化了交流成果，为两国医学界的沟通协作搭建了重要桥梁。

当前，全球医学界正面临传染病带来的公共卫生挑战、人口老龄化加速、慢性病防控压力加剧等共同课题。本次会议以“感染性疾病的临床前景”为主题，聚焦艾滋病治疗与病毒清除、细菌耐药性防控策略、EB病毒感染相关疾病诊疗进展、乙肝临床治愈研究四大议题，汇聚两国顶尖专家智慧，共谋解决方案。我们期待通过思想碰撞与经验共享，推动临床技术的创新突破与普惠应用。

世界卫生组织（WHO）近年来通过制定循证指南、推广感染控制标准等举措，持续强化全球感染防控体系建设。中日两国在此领域积累了丰富经验，值得相互借鉴。今日的研讨不仅关乎技术交流，更承载着改善患者预后、降低感染风险的社会责任。尽管国情有别，但我们共同追求“以人民健康为中心”的目标始终一致。

作为民间学术团体，中华医学会与日中医学协会肩负着促进医学进步、增进民生福祉的重要使命。未来，我们愿进一步拓展合作维度，创新合作模式，构建更开放、包容的学术交流平台，让医学智慧更好惠及两国人民。

最后，衷心祝愿本次会议取得丰硕成果！祝各位日本同仁在华期间生活愉快、身体健康！愿中日医学界的友谊如松柏长青，为人类健康事业续写华章！



开幕致辞

日中医学协会会长 | 小川秀兴

衷心感谢大家出席今天的“日中医学交流会议2025年·青岛”。

长期以来我们一直期盼本次交流会议的重新召开，但由于新冠肺炎疫情在全球范围内的流行，我们迫不得已中断了线下交流长达六年的时间。如今克服重重困难，两国医务工作者再次齐聚一堂，得以面对面进行交流讨论，这不仅是令我们倍感欣喜之事，也是象征着通向未来的坚定希望的盛事。

多年来，日中医学协会与中华医学会始终真诚面对两国共同的医疗课题，携手推动医学研究的发展，并将为国际社会作出贡献作为目标。其中为此发挥核心作用的，正是这一“日中医学交流会议”。它为两国医务工作者提供了汇聚知识、互学互鉴、增进信任的重要平台。本次会议的重启，不仅是活动本身的恢复，更是两国医学交流迈向新阶段的重要里程碑。

今年的主题为“感染性疾病的临床展望”，重点关注 HIV/艾滋病、AMR（细菌耐药）、EB 病毒感染以及乙型肝炎治疗这四个重要领域。感染性疾病跨越国界，对人类健康与社会稳定构成威胁，是当今最严峻的挑战之一。尤其在上述领域，日中两国面临着共同而紧迫的公共卫生课题，亟需提升临床应对能力并加强国际知见的共享。我们期望通过本次会议，两国专家能够交流最新研究成果与临床经验，互相学习，共同构筑更具实践性与可持续性的医疗合作基础。

此外，本次会议的重启也表明，经历新冠肺炎疫情之后，两国医学交流已获得新的价值观与视角。过去数年中，我们再次深刻认识到国际合作在感染病防控中的重要性。今后在研究、教育、临床等各领域，更加多层次、持续性的合作将不可或缺。

我们热切地希望，青岛的讨论能够促进下一代医务人才的培养与共同研究的深化，为日中两国乃至亚洲、世界公共卫生水平的提升奠定坚实的基础。同时，也衷心期待借此次线下交流之机，能够构建出线上交流难以获得的信任关系，并孕育出长期合作的契机。

最后，谨向为本次会议的举办付出巨大努力的各位相关人士致以深深的谢意，并衷心祝愿各位参会者在此收获丰硕的讨论成果与交流体验，谨此作为我的大会开幕致辞。

Keynote Lecture

Speaker



王 福生

Fusheng WANG

M.D., Ph.D.

Academician of Chinese Academy of Science, Director of Department of Infectious Diseases, The Fifth Medical Center of Chinese PLA General Hospital

Education

1996-1998	Department of Medical Oncology at Mount Sinai Medical School, New York University in United States
1989-1992	Beijing Institute of Radiation Medicine（Ph.D.）
1984-1987	Beijing Institute of Epidemiology and Microbiology（M.S.）
1979-1984	Bengbu Medical School, China（M.D.）

Work Experience

1992-	Director of both National Clinical Research Center for Infectious Diseases and the Department of Infectious Diseases, The Fifth Medical Center of Chinese PLA General Hospital

Other Commitment

Academician of the Chinese Academy of Sciences

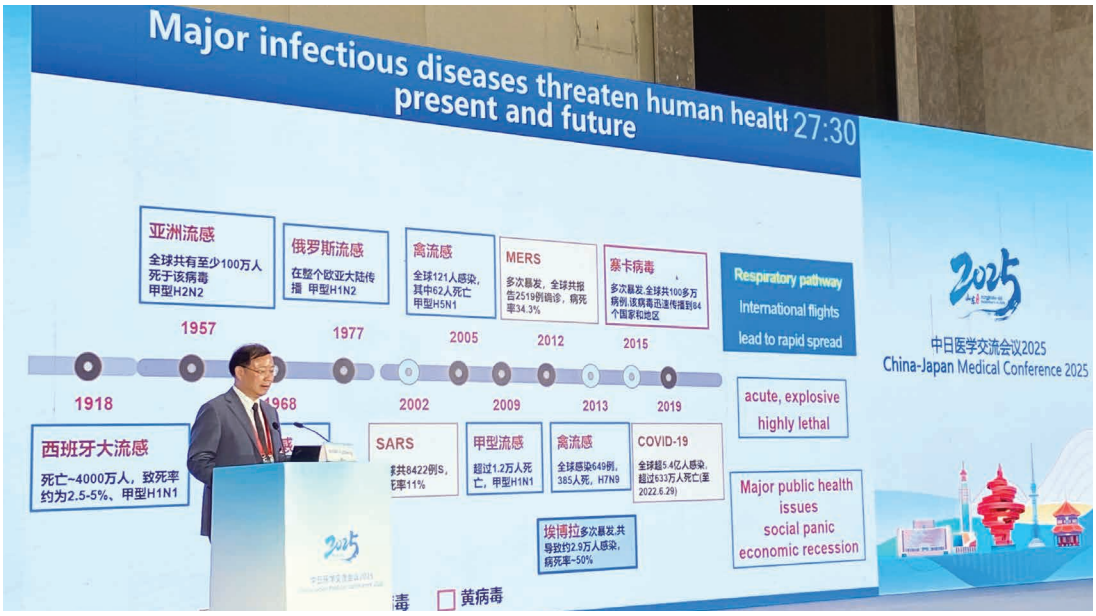
President-Elect, Chinese Society of Infectious Diseases, Chinese Medical Association

Awards and Honor

2015 Second Prizes of National Science and Technology Progress

2011 Second Prizes of National Science and Technology Progress

2006 Second Prizes of National Science and Technology Progress



Keynote Lecture

Challenge and Prospectives in Management of Major and/or Emerging Infectious Diseases in China

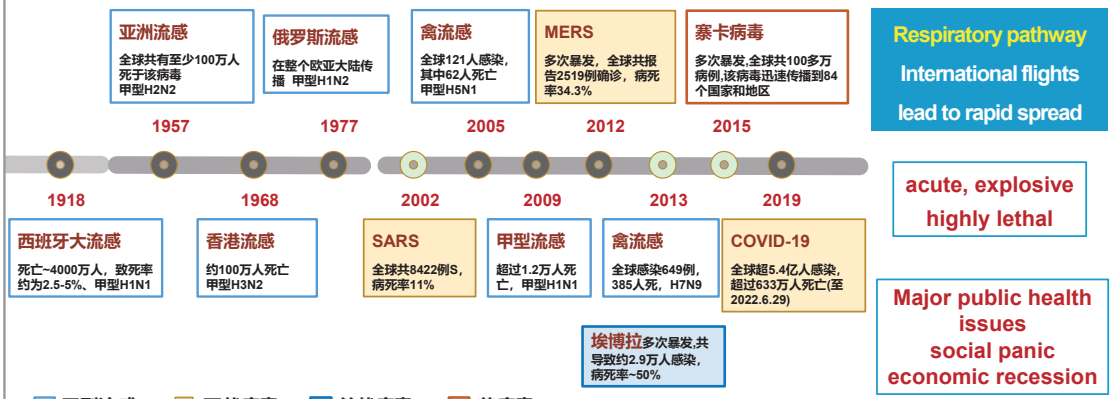
Fusheng WANG

Over the past seven decades, China has made remarkable progress in prevention and control system for major and emerging infectious diseases, and concurrently established a modern public health framework centered on prevention, which are characterized with the large number of talents with modern science and technology, support of legal system as well as the multi-sector collaborations. Since the 1978 reform and opening-up era, China has achieved many milestones in expanded immunization programs, legal system refinement, and breakthroughs in vaccine development. Notably, in the 21 century, China has demonstrated to be with robust scientific mobilization capacity and rapid response mechanisms during outbreaks of emerging infectious disease such as H7N9, Ebola, and COVID-19, which has also shaped a distinctive Chinese model of epidemic control and transitioning from a "follower" to a "global leader" in this field. Concurrently, the scientists and physicians in China have made pioneering advances in basic research and clinical translation studies for chronic infectious diseases including HIV/AIDS and chronic hepatitis B, accelerating progress toward functional cure of some chronic viral diseases. Here, we summarize the historical trajectory, key achievements, and facing challenges in management and control of major infectious diseases over the past 70 years, highlight the critical importance of building efficient, adaptive and sustainable systems for future global public health security in China.



Major infectious diseases threaten human health: present and future

Major sudden outbreaks of infectious diseases in the past century have mostly been caused by infections of influenza A virus and coronavirus



1. Before the establishment of the PRC （~1949）

At that time, infectious diseases were rampant and the most important disease threatening people's health

- Infectious diseases affected **140 million** population.
- **Two million** people died of infectious diseases.
- Average life expectancy of Chinese in 1949 was **35 y**

Low economic level/Poor medical conditions (lack of medical care and drugs) /Low level of technology/War factors

Father of Chlamydia： FF TANG

- Chlamydia trachomatis was isolated for the first time in 1955, and later the incidence of trachoma was reduced from 95% to ＜10%.



- Rabies vaccine, diphtheria vaccine and typhus vaccine were available in China.
- In 1961, China successfully eliminated smallpox 16 years earlier than the world.





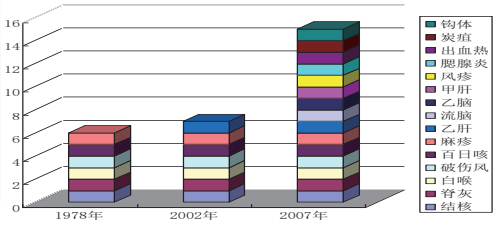


3. The period of reform and opening up (1978~2002)

The National Vaccination Program

Year	Vaccine number
1978	6 kinds (measles, whooping cough, tetanus, diphtheria, polio, tuberculosis)
2002	7 kinds (adding hepatitis B)
2007	15 kinds (adding leptospirosis, anthrax, hemorrhagic fever, mumps, rubella, hepatitis A, epidemic encephalitis B, meningitis)





SARS Taught Us A Lesson





World

Total infected person: > 8000

Death: 916

China

China mainland: 5327

Death: 349

Mortality : 6.55%

Economic loss: RMB 93.3 billion (0.8% of GDP in 2003)

Significant Improvements in Laboratory Capacity in China CDC

Leading the global laboratory network

- Confirming difficult specimens
- Providing reference and standard
- Technical support
- Research cooperation

WHO Reference laboratory In China

Reference laboratories

- Flu laboratory
- JE laboratory
- Polio laboratory
- Measles laboratory

Significant achievements have been made in the prevention and control of infectious diseases (1949-2012)

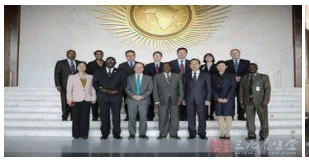
The average life expectancy has increased from 35 in 1949 to 75.2 in 2012

国家/地区	1820	1900	1950	1960	1970	1980	1999	2010	2012
China	-	24	35	36.32	61.74	66.86	71	74.83	75.2
USA	39	47	68	69.77	70.81	73.66	77	78.11	78.49
Global average	26	31	49	50.24	58.63	62.57	66	66.26	67.59

- From 1970 to 2013, the incidence rate of infectious diseases dropped 14.8 times, and the mortality rate dropped 16.3 times
- Infectious diseases eliminated in China: smallpox (1980), poliomyelitis (2000), lymphatic filariasis (2008), neonatal tetanus (2012)
- Infectious diseases that is close to be eliminated in China : leprosy, malaria, measles, rubella, schistosomiasis, rabies

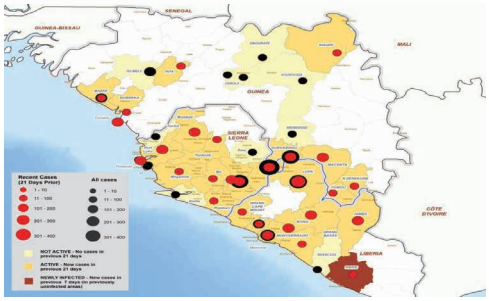
Disease control experts help African countries establish public health systems

- "Building a community with a shared future for mankind," proposed by Chinese leader, is a manifestation of Chinese wisdom and a Chinese approach to contributing to world peace and human progress.
- Since 2004, China has sent over 200 disease control experts to African countries to help establish public health systems.



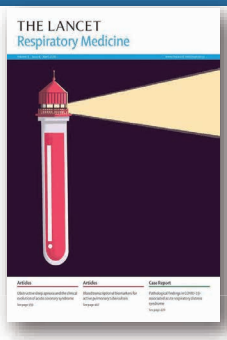


Ebola Outbreak

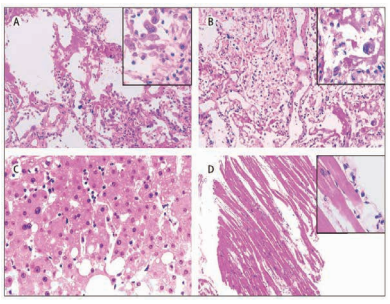


Public health emergency of international concern (WHO, 8 Aug,2014)

Pathological results of the world's first death case of COVID-19







Our findings provide scientific basis for clinical treatment, pathogenesis, and drug research

1. **Revealed the typical pathological features of ARDS in the lungs**
2. **Discovered that immune damage was an important factor** **nearly 10000 cites**
3. **Proposed the concept of clinical immunotherapy and hormone therapy**

How to Build an Outstanding Department of Infectious Diseases?

培养优秀的临床医学科学家
(Physician scientist)

- Clinical Proficiency
- Knowledge Acquisition
- Awareness of Advanced Frontiers



- Innovation Capability
- Individuality
- Team Spirit

Academic Collaboration Capacity

Sun Tzu said: The good fighter takes his stand upon the invincibility of his position, and does not miss the moment for defeating the enemy.

Other Emerging and Major Infectious Diseases

- Transmission, diagnosis, treatment, prognosis, and prevention of **dengue fever?**
- Transmission, diagnosis, treatment, prognosis, and prevention of **fever with thrombocytopenia syndrome?**
- Transmission, diagnosis, treatment, prognosis, and prevention of **Crimean-Congo hemorrhagic fever?**
- Transmission, diagnosis, treatment, prognosis, and prevention of **Disease X?**

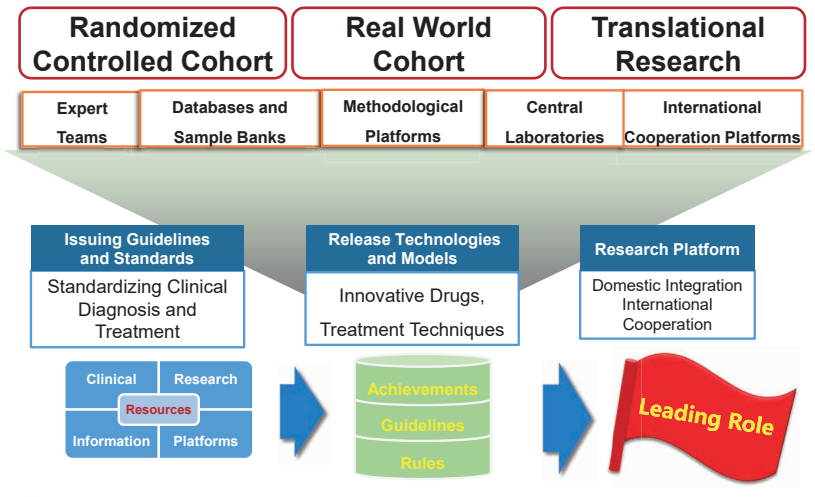
Urgent Needs:

Early diagnosis

Effective vaccines and therapeutics

Consensus on clinical treatment strategies or expert guidelines

Create a First-Class Clinical Discipline of Infectious Diseases



Symposium

Prospect of Clinical Infectious Diseases

Session I　HIV: Antiretroviral therapy and eradication research

Chairperson



唐小平
Xiaoping TANG
M.D., Ph.D.

Director of Institute of Infectious Diseases, Guangzhou Medical University

Speaker



李 太生
Taisheng LI
M.D., Ph.D.

Director of Department of Infectious Diseases, Peking Union Medical College Hospital, Chinese Academy of Medical Sciences



木内 英
Ei KINAI
M.D., Ph.D.

Professor of Department of Laboratory Medicine, Tokyo Medical University

Session Ⅱ　Antimicrobial resistance and current strategies

Chairperson



寧 琴
Qin NING
M.D., Ph.D.

Director of Institute & Department of Infectious Diseases, Tongji Hospital, Tongji Medical College, Huazhong University of Science and Technology



大曲 貴夫
Norio OHMAGARI
M.D., M.Sc., Ph.D.

Director of Japan Institute for Health Security, Department of Infectious Disease Clinical Policy, Bureau of Health Security and Management

Speaker



王 明貴
Minggui WANG
M.D.

Director of Institute of Antibiotics, Huashan Hospital, Fudan University



大曲 貴夫
Norio OHMAGARI
M.D., M.Sc., Ph.D.

Director of Japan Institute for Health Security, Department of Infectious Disease Clinical Policy, Bureau of Health Security and Management

Session Ⅲ　Managing EBV-related disease spectrum

Chairperson



孟慶華
Qinghua MENG
M.D., Ph.D.

Professor of Department of Hepatology, Beijing Youan Hospital, Capital Medical Univeristy



金兼 弘和
Hirokazu KANEGANE
M.D., Ph.D.

Professor of Department of Child Health and Development, Graduate School of Medical and Dental Sciences, Institute of Science Tokyo

Speaker



張 文宏
Wenhong ZHANG
M.D., Ph.D.

Director of National Medical Center for Infectious Diseases；Director of Department of Infectious Diseases, Huashan Hospital



新井 文子
Ayako ARAI
M.D., Ph.D.

Professor and Chair of Department of Hematology and Oncology St. Marianna University School of Medicine

Session Ⅳ　Research progress on the cure of hepatitis B

Chairperson



唐 紅
Hong TANG
M.D.

Honorary Director of Center of Infectious Diseases, West China Hospital of Sichuan University

Speaker



侯 金林
Jinlin HOU
M.D.

Professor and Chairman of Institute of Hepatology, Nanfang Hospital, Southern Medical University



田中 靖人
Yasuhito TANAKA
M.D., Ph.D.

Chief Professor of Department of Gastroenterology and Hepatology, Faculty of Life Sciences Kumamoto University

Symposium：Prospect of Clinical Infectious Diseases

Session Ⅰ
HIV: Antiretroviral therapy and eradication research

Speaker



李太生

Taisheng LI

M.D., Ph.D.

Director, Departement of Infectious Diseases, Peking Union Medical College Hospital（PUMCH）, Chinese Academy of Medical Sciences

Education

1995-1999 Ph.D., Immunology, Ecole Pratique Haute Etudes, Paris, France

1979-1984 M.D., Guangzhou SUN Ye-xian Medical University, Guangdong, China

Work Experience

2004- Professor, Department of Medicine and Department of Infectious Diseases, PUMCH, Beijing

2001- Director, PUMCH AIDS Center for Diagnosis and Treatment, Beijing

1999-2004 Associate Professor, Department of Medicine and Department of Infectious Diseases, PUMCH, Beijing

1995-1999 Research Scientist, Lab d'Immunol. Cell, URA CNRS 7627, Hôpital Pitié-Salpétrière, Paris

1993-1995 Visiting Scholar, Department of Infectious Diseases, Pitie-Salpetriere Hospital, Paris

1990-1993 Lecturer, Department of Interne Medicine, PUMCH

1990-1993 Attending Physician, Department of Infectious Diseases, PUMCH, Beijing

1984-1990 Resident Doctor, Department of Internal Medicine, PUMCH

Other Commitment

President, Chinese Society of Infectious Diseases, Chinese Medical Association

Tenured Professor, Peking Union Medical College, Bejing

Special-Term Professor,Tsinghua University Medical College, Bejing

Awards and Honor

National Advanced Worker in 2020

Wu Jieping Medical Innovation Award in 2018

The 17th Wu Jieping-Paul Janssen Medical &Pharmaceutical Award in 2016

Prix Mémorial Christine et Pierre Sévilla,National Academy of Medicine of France in 2016

First-Class Award for Science and Technology Progress of the Ministry of Education in 2015

National High-Level Leading Talent Program in 2014

Session Ⅰ HIV: Antiretroviral therapy and eradication research

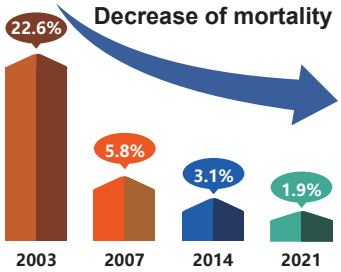
New Challenges in HIV/AIDS Diagnosis and Treatment: Insights from the 2024 Edition of the Chinese Guidelines for HIV/AIDS

Taisheng LI

The introduction of the National Free Antiretroviral Therapy Program (NFATP) in 2003 by the China National Center for AIDS/STD Control and Prevention has led to dramatic increases in antiretroviral therapy (ART) coverage among HIV-infected Chinese patients. Despite limitations in the number of available free antiretroviral drugs, the overall mortality associated with HIV/AIDS has dropped from 39.3 per 100 person-years in 2002 to 3.1 in 2014. The talk summarizes the challenges, responses, and achievements of antiretroviral therapy (ART) in China over the past 20 years. Continuous optimization of the Chinese National Guidelines for HIV/AIDS Diagnosis and Treatment has been guided by data from serial domestic multi-center studies aimed at evaluating efficacy and toxicity of available ART regimens among Chinese patients with HIV, with the goal of maximizing adherence, access, and efficacy. In addition, increasing attention has been focused on the importance of continuity in the HIV care cascade to promote linkage to care, and address the multidisciplinary chronic care needs HIV/AIDS patients on lifelong ART. As the number of patients receiving long-term ART continues to grow, the focus of HIV/AIDS treatment has gradually transitioned from urgent care to the management of non-AIDS-related chronic complications and control of chronic inflammation.

Progress in HIV Clinical Treatment in China

- 1985: First AIDS case reported in China.
- 1993: ZDV and DDC introduced for antiretroviral therapy domestically.
- 1995: First national standard (Diagnostic Criteria and Management Principles for HIV/AIDS).
- 2003: Nationwide implementation of free HIV treatment.
- 2005: First Chinese Guidelines for HIV/AIDS Diagnosis and Treatment.
- 2006: Optimized domestic ART regimens promoted clinically.
- 2009: Second-line regimens adopted in China.
- 2016: Nationwide rollout of the “test-and-treat” strategy.
- 2018: Comprehensive care and whole-course management proposed and implemented.

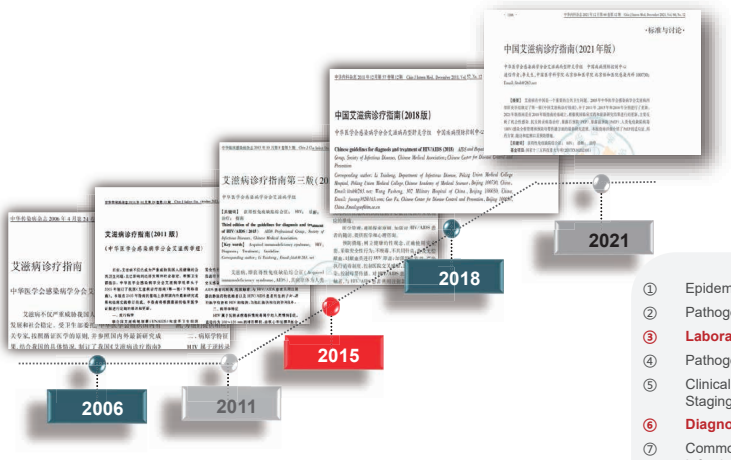


Mortality
Declined from **22.6 per 100 person-years (2003)** to **1.9 per 100 person-years (2024)**

Context-Appropriate ART: Developing the “China Model”

Serious Practical Challenges	Evolution of “China Model”
2001 HIV epidemic, concentrated mortality, lack of effective treatment measures.	**2006 Initial establishment** Introduction of effective domestic generic regimens that reduced large-scale mortality.
2002-2005 Early drugs associated with severe toxicity and high treatment-failure rates.	**2010 Refinement** Improved efficacy, affordability, and safety, further lowering mortality and transmission.
2005-2018 Rising incidence of multi-organ/multi-system complications; frequent failure of immune reconstitution	**2018 Development** Creation of a comprehensive HIV care system and proposal of new immune reconstitution strategies.

From Evidence to Practice: Develop China’s Regimens and Guidelines



The 2024 Guideline

① Epidemiology
② Pathogenic Features
③ **Laboratory Tests**
④ Pathogenesis
⑤ Clinical Presentation and Staging
⑥ **Diagnostic Criteria**
⑦ Common Opportunistic Infections
⑧ **ART**
⑨ Immune Reconstitution Inflammatory Syndrome (IRIS)
⑩ **Incomplete Immune Reconstitution**
⑪ AIDS-associated Neoplasms
⑫ Prevention of Mother-to-child Transmission and reproductive Options for HIV-serodiscordant Couples
⑬ HIV Exposure Management and Prophylaxis
⑭ **Whole-course Management of HIV Infection**

Key Update 1: Early Diagnosis

- Measure HIV viral load at initial diagnosis for all patients.
- When feasible, perform baseline resistance testing before starting ART.

Nucleic acid supplementary test:

- Use either qualitative or quantitative HIV-1 nucleic acid tests; qualitative testing is recommended first-line for supplementary testing.
- HIV-1 RNA quantification:
  - Below detection limit → report "below LOD."
  - >1,000 cps/mL → report the measured value.
  - Above LOD but ≤1,000 cps/mL → repeat sampling and retest.

HIV nucleic acid testing is valuable in acute/window periods and in advanced disease.

PUMCH outpatient cohort (2006–2022): among 136 first-diagnosed acute HIV infections, <2% had VL <1,000 copies/mL.

HIV antibody testing		Viral load (cps/mL)	Patients (n, %)	Note
ELISA	WB			
+	+	+	99(72.8%)	-
+	-/+-	+	27(19.9%)	WB retesting (+)
-	-	+	3(2.2%)	WB&ELISA retesting (+)
+	+	VL 1000-5000	5(3.7%)	-
+	+-	VL<1000	2(1.5%)	WB retesting (+)

Key Update 2: Initial regimens for treatment-naïve adults/adolescents (principles)

Recommended regimens	
2NRTIs	Third class of drugs:
TDF+3TC (FTC) TAF/FTC	+ NNRTIs: EFV[a]、RPV[b] Or +PIs: LPV/r、DRV/c Or +INSTIs: DTG、RAL
Single-tablet regimen	
TAF/FTC/BIC* TAF/FTC/EVG/c* ABC[c]/3TC/DTG* DOR/3TC/TDF ANV/3TC/TDF 3TC/TDF/EFV(400 mg)	
DTG/3TC[d], or DTG+3TC[d]	
Alternative regimens	
AZT (ABC) +3TC FTC/TAF	+NNRTIs: EFV/NVP/RPV/DOR/ANV; Or +PIs: LPV/r、DRV/c; Or +INSTIs: DTG、RAL
TDF+3TC (FTC)	+NNRTIs: NVP[e]
TDF+Avudine	+NNRTIs: EFV

a) EFV not recommended for patients with viral loads >5×10^5 copies/mL.

b) RPV only used in patients with viral load <10^5 copies/mL and CD4+ T lymphocyte count >200/μL.

c) ABC only used in patients negative for HLA-B5701.

d) DTG + 3TC and DTG/3TC are used in patients tested negative for HBsAg with viral load <5×10^5 copies/mL.

e) For patients with baseline CD4+ T lymphocyte counts >250/μL, regimens containing NVP should be avoided where possible; for patients co-infected with HCV, regimens containing NVP should be avoided.

EFV 400mg Qd to reduce side effects and to increase patient adherence

	2021	2022	2023	2024	In total
Patients on EFV*	918158	797792	536347	636858	
Price of 600mg EFV (yuan/day)	2.50	2.50	2.50	2.50	
Price of 600mg EFV (yuan/year)	912.26	912.26	912.26	912.26	
Price of 400mg EFV (yuan/day)	2.07	2.07	2.10	2.18	
Price of 400mg EFV (yuan/year)	753.77	753.77	766.50	794.63	
Cost saving (yuan/year)	146 million	126 million	78 million	75 million	425 million

*Based on Procurement data from the National Government Procurement Network (China)

4-year cumulative savings:
425 million yuan

Global benefit

- EFV remains widely used in China and in many low- and middle-income countries
- Dose-reduction yields substantial national and global savings

Key Update 3: Defining Low-Level Viremia (LLV)

Updated definitions in the 2024 guideline:

Viral blip: After achieving virologic suppression, a single detectable HIV RNA measurement followed by a return to virological suppression.

LLV: Two consecutive detectable HIV RNA measurements 50–200 cps/mL.

Management recommendations:

Blips: Generally not associated with subsequent failure.

LLV: May be associated with later failure, serious non-AIDS events, or mortality → evaluate adherence, tolerability, adverse effects, and DDIs;

- Regimen change usually not required
- Monitor HIV RNA every 3 months.

Chinese guidelines for the diagnosis and treatment of human immunodeficiency virus infection/acquired immunodeficiency syndrome (2024 edition). Chinese Medical Journal 2024:137(22):2654-2680.

Key Update 4: INR Diagnostic Criteria & Rationale

2024 Guideline

■ **Diagnostic criteria (2024):** after **≥4 years of ART** and **>3 years** with plasma HIV RNA **below LOD**, **CD4+ <350/μL** persists; **exclude** other causes of low CD4.

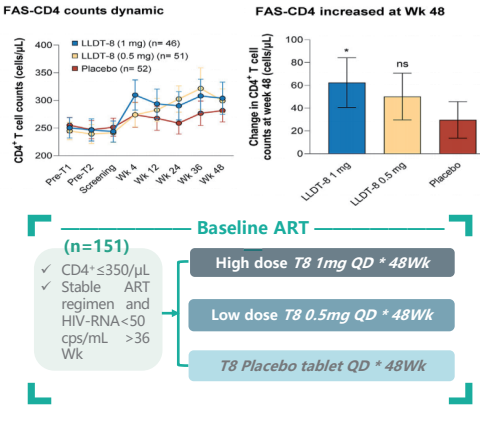
Why 4 years?

After ≈4 years of ART, CD4 recovery slows markedly.

If **CD4 <350/μL** at year 4, the **average increase** during years **5–8** is only **~20/μL per year**.

INR Therapy: Hydroxy-triptolide (T8), Phase II Study

2019~2022



T8 In INR (Median 6 year on ART):

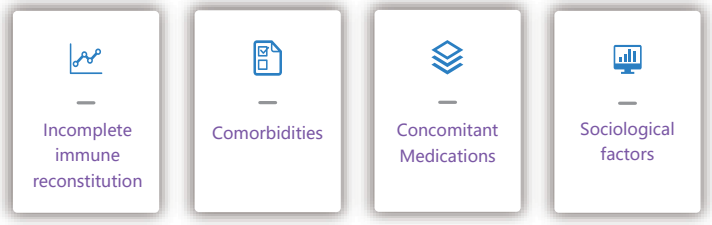
- **CD4⁺ T-cell counts increased significantly from baseline after T8 treatment.**
- Week 48: High-dose T8 group showed greater CD4⁺ gains vs. placebo.
- ≥50/μL CD4⁺ increase at Week 48: Higher proportion in T8 arms vs. placebo.
- Older INR patients (>45 years): High-dose T8 achieved consistent CD4⁺ improvement across all visits.

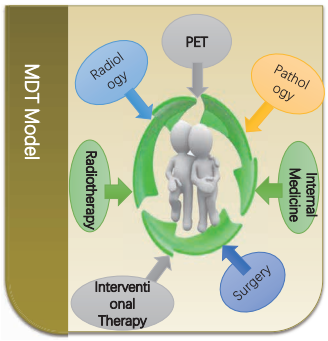
Cao W, et al. Lancet Reg Health West Pac. 2023 Mar 15;34:100724

Key Update 5: HIV Vulnerable Populations

Definition: any of the following —

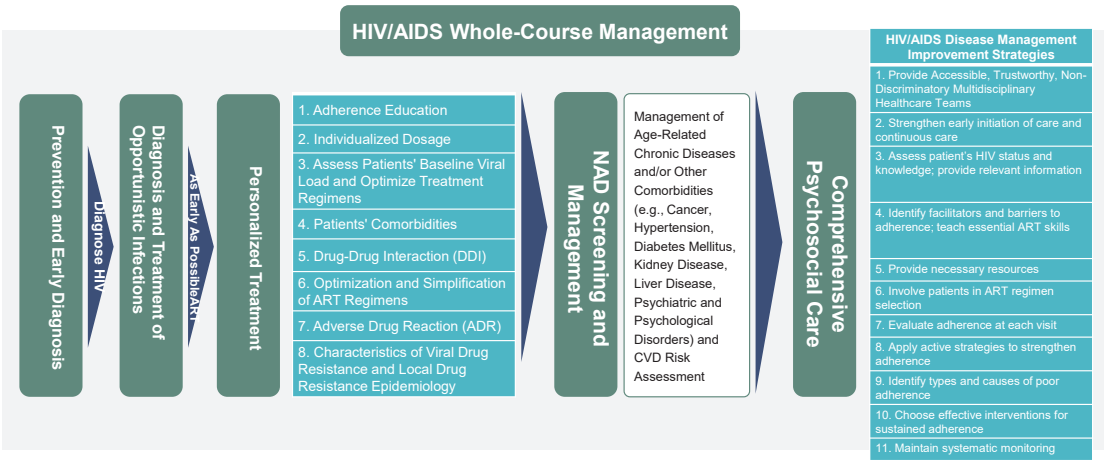
- Elderly patients over 50 years old;
- Pediatric patients, pregnant women;
- Late presenters;
- Patients with multiple comorbidities;
- Patients with severe immunosuppression (e.g., CD4⁺ <50/μL);
- Incomplete immune reconstitution after ART.





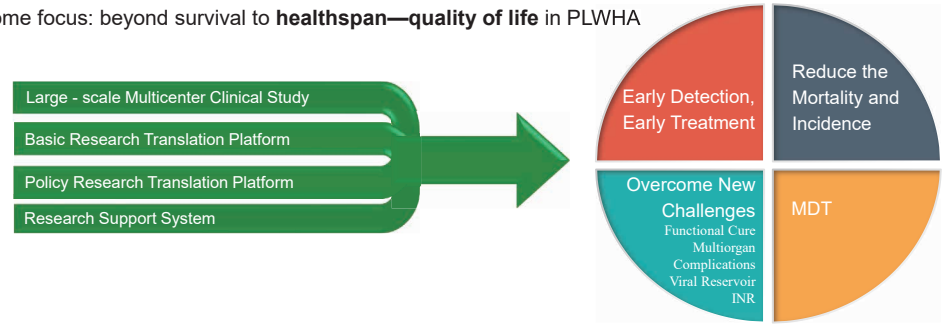
MDT Collaboration for HIV Vulnerable Populations

Key Update 6: Enriching Content on Whole-Course Management



Vision 2030: A Patient-Centered, Whole-Course HIV Care Paradigm

- Tremendous progress has been made in ART over the past 30+ years
- HIV has now become a chronic disease with long-term survival potential, yet it requires **whole-course management**
- Directions for antiviral drug research and development: **long-acting efficacy, safety, and new targets**
- Clinical limitations of ART: **controlling chronic inflammation towards clinical cure**
- Outcome focus: beyond survival to **healthspan—quality of life** in PLWHA



Symposium : Prospect of Clinical Infectious Diseases

Session Ⅰ
HIV: Antiretroviral therapy and eradication research

Speaker

木内　英

Ei KINAI

M.D., Ph.D.

Professor, Department of Laboratory Medicine,
Tokyo Medical University



Education

2009-	Ph.D., Keio University, Graduate school of medicine
1993-1999	M.D., Chiba University, School of Medicine

Work Experience

2019-	Department of Laboratory Medicine, Tokyo Medical University
2010-2018	AIDS Clinical Center, National Center of Global Health and Medicine
2003-2010	Department of Hematology, Ogikubo Hospital
1999-2001	Department of Pediatrics, Keio University Hospital

Other Commitment

The International AIDS Society

The Infectious Disease Society of America

The International Society of Thrombosis and Haemostasis

The Japanese Association for Infectious Diseases

The Japanese Association for AIDS Research

The Japanese Society of Thrombosis and Haemostasis

Japan Pediatric Society

Session Ⅰ HIV: Antiretroviral therapy and eradication research

Current Status and Challenges in HIV Treatment in Japan

Ei KINAI

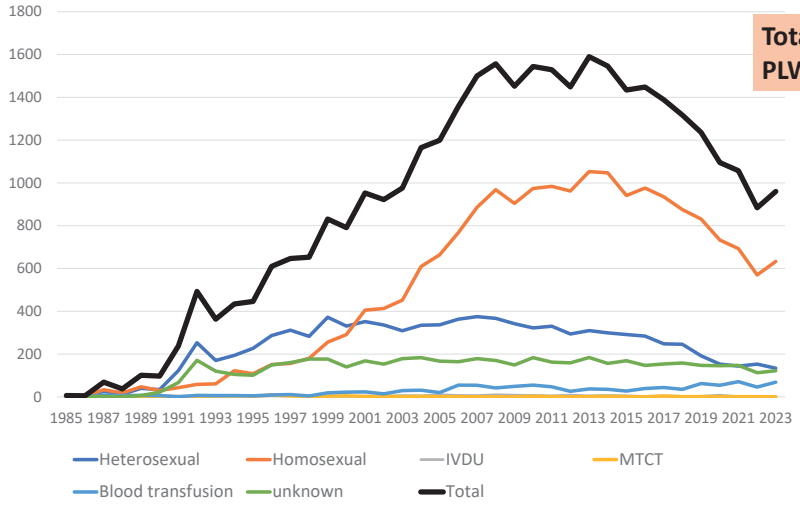
At the end of 2023, the cumulative number of people living with HIV (PLWH) in Japan was 35,381, including 10,849 with AIDS. The annual number of new cases gradually declined, and in 2023, 960 new HIV/AIDS cases were reported.The majority of initial antiretroviral therapy (ART) regimens in Japan utilize second-generation integrase strand transfer inhibitors (INSTIs), predominantly TAF/FTC/BIC.

However, new challenges have become evident. In Japan, a substantial proportion of PLWH have hepatitis B virus (HBV) coinfection, with a low rate of seroconversion and low response to vaccination. Given that, shifting to regimens without anti-HBV agents needs careful consideration. In addition, age-related comorbidities—such as renal dysfunction, decreased bone mineral density, cardiovascular disease, weight gain, and neurocognitive impairment—have emerged as new clinical challenges in PLWH. At present, our focuses in clinical management are shifted from HIV suppression or viral resistance to long-term comorbidities.

UNAIDS has established the "95-95-95" targets as a global framework for HIV elimination. Status of Japan of the target are diagnosis rate of 85.6%, ART initiation rate of 82.8%, and a viral suppression rate of 99.1%. Despite high viral suppression rate, Japan lags in both diagnosis and treatment initiation rates. Our survey revealed that of 706 untreated HIVpositive individuals, 304 (43.1%) had progressed to advanced HIV disease, and only 8.2% initiated ART within two weeks of diagnosis.

In conclusion, while current HIV treatment has become highly potent and safe, HBV coinfection and age-related comorbidities became the new challenges in Japan. To align with global HIV elimination targets, urgent efforts are needed to expand access to test and prevention.

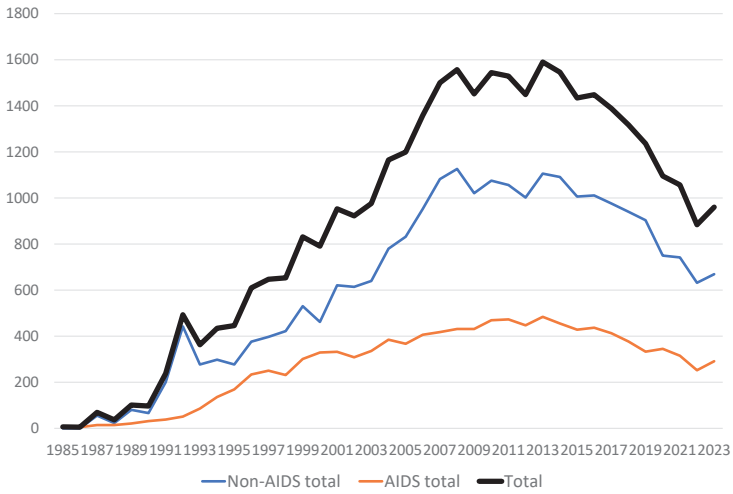
Trends in HIV new infection in Japan: by transmission route



Total number of PLWH: 35,381

National AIDS Surveillance, 2023

Trends in HIV new infection in Japan: by AIDS-defined illness

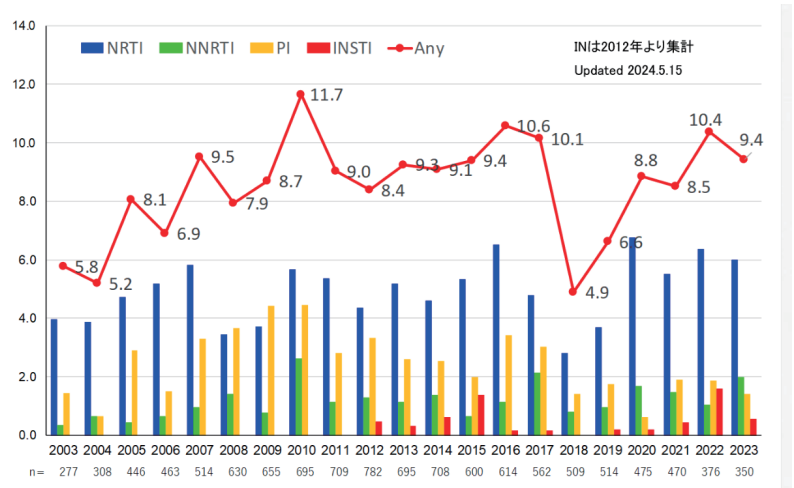


Total number of non-AIDS: 24,532

Total number of AIDS: 10,849

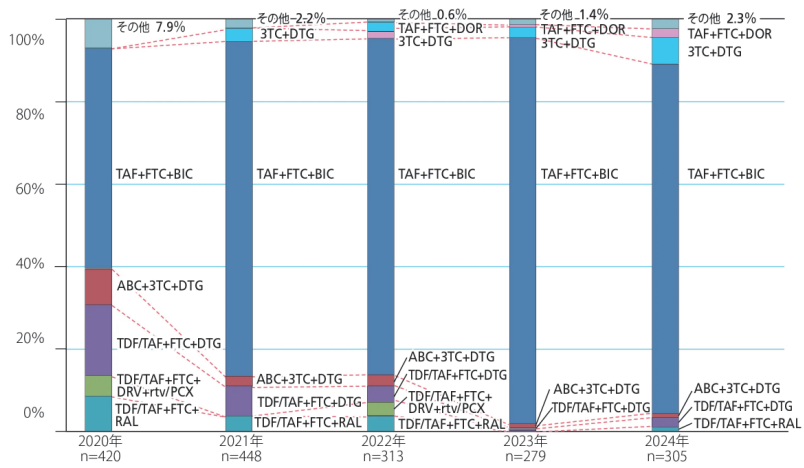
National AIDS Surveillance, 2023

Drug resistance in naive Japanese PLWH



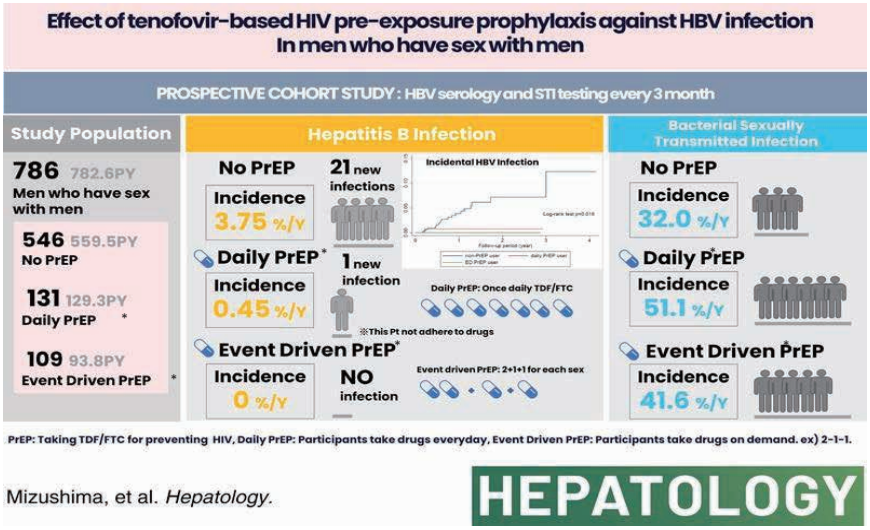
Japan Institute for Health Security: Durg resistance HIV information center; Accessed on Aug.11

Antiretroviral therapy for naive PLWH in Japan



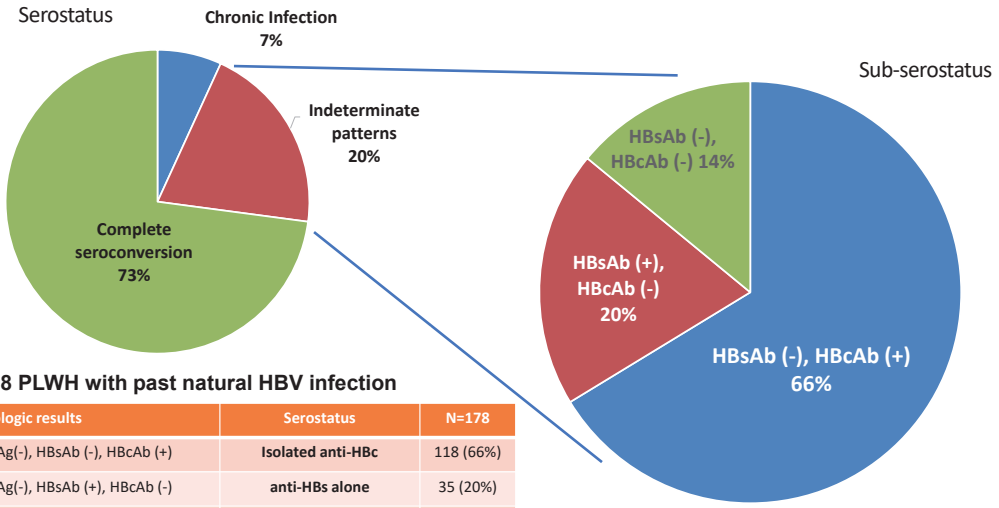
Japanese Guidelines for antiretroviral therapy, 2024

HBV is endemic in Japanese MSM



Hepatology. 2023 Mar 27. doi: 10.1097/HEP.0000000000000384. Online ahead of print.

HBV serostatus post-infection



878 PLWH with past natural HBV infection

Serologic results	Serostatus	N=178
HBsAg(-), HBsAb (-), HBcAb (+)	Isolated anti-HBc	118 (66%)
HBsAg(-), HBsAb (+), HBcAb (-)	anti-HBs alone	35 (20%)
HBsAg(-), HBsAb (-), HBcAb (-)	Lost anti-HBs/anti-HBc	25 (14%)

IAS 2025 EP0095, Jul. 13-17, 2025, Kigali, Rwanda

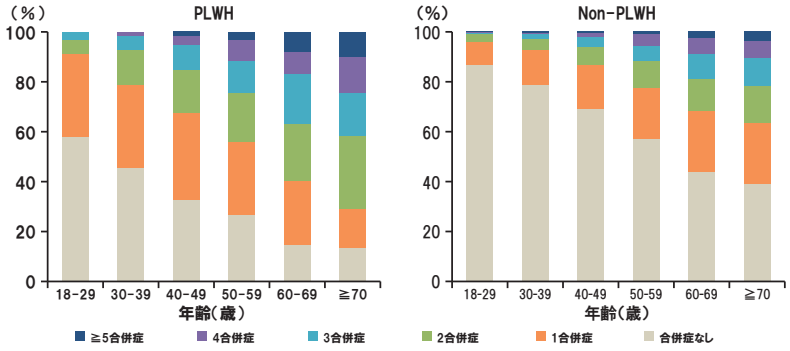
Interpretation of indeterminate HBV serostatus

Clinical Interpretation	All indeterminate status (n=178)	Isolated anti-HBc (n=118)	Anti-HBs alone (n=35)	Lost anti-HBs/anti-HBc (n=25)
Weak HBV immunity, Total, n (%)	**61 (34.3)**	**47 (39.8)**	**3 (8.6)**	**11 (44.0)**
Chronic infection, n (%)	2 (1.1)	0 (0.0)	0 (0.0)	2 (8.0)
Viral rebound	5 (2.8)	4 (3.4)	0 (0.0)	1 (4.0)
Non-seroconversion, n (%)	12 (6.7)	11 (9.3)	0 (0.0)	1 (4.0)
Weak/unstable seroconversion, n (%)	15 (8.4)	12 (10.2)	0 (0.0)	3 (12.5)
Early loss of anti-HBs, n (%)	9 (5.1)	7 (5.0)	0 (0.0)	2 (8.0)
Late seroconversion, n (%)	18 (10.1)	13 (11.0)	3 (8.6)	2 (8.0)
Robust HBV immunity, Total, n (%)	**32 (18.0)**	**1 (0.8)**	**28 (80.0)**	**3 (12.0)**
Sustained seroconversion, n (%)	23 (12.9)	0 (0.0)	23 (65.7)	0 (0.0)
Post-exposure anti-HBs elevation, n (%)	9 (5.1)	1 (0.8)	5 (14.3)	3 (12.0)
Resolved infection, n (%)	**0 (0.0)**	**0 (0.0)**	**0 (0.0)**	**0 (0.0)**
Unknown, n (%)	85 (47.8)	70 (59.3)	4 (11.4)	11 (44.0)

IAS 2025 EP0095, Jul. 13-17, 2025, Kigali, Rwanda

Multimorbidities by age in Japanese PLWH

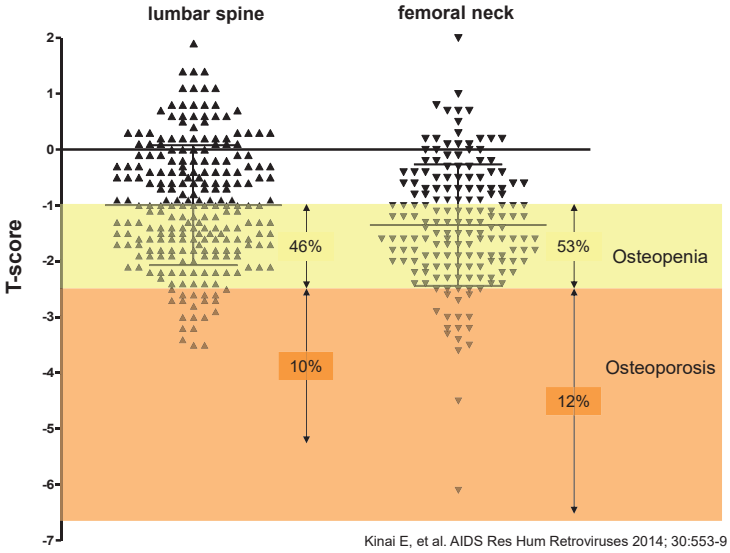
● Prevalence of multimorbidities is higher in PLWH than in non-PLWH.



RTG19SS0017-0521

Ruzicka DJ et al. *J Infect Chemother* 2019; 25 (2): 89-95

Bone mineral density in Japanese PLWH

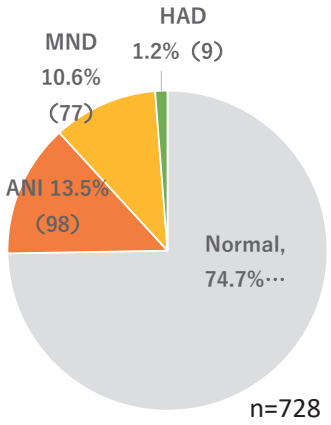


Kinai E, et al. AIDS Res Hum Retroviruses 2014; 30:553-9

HIV-associated neurocognitive disorders (HAND) in Japan

HAND 25.3%

FC	N (%)
Normal	544（74.7%）
ANI	98（13.5%）
MND	77（10.6%）
HAD	9（1.2%）
Total	728



Kinai E, et al, J Neurovirol, 2017; doi: 10.1007/s13365-017-0580-6.

Weight gain by ART is tentative/minimal

US OPERA cohort

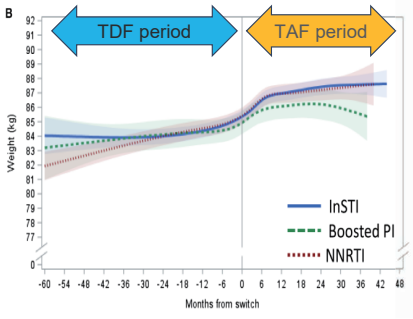
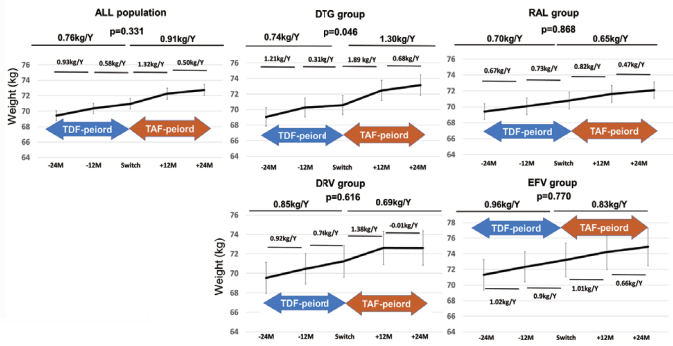


Figure.1

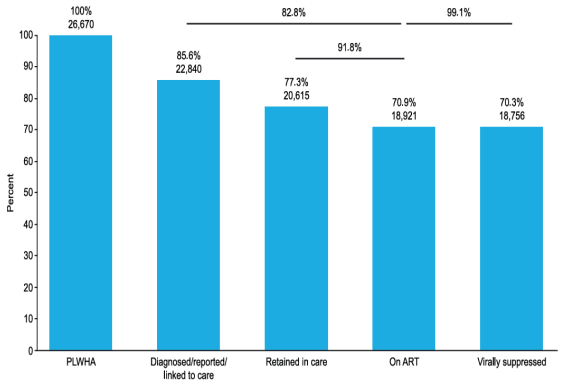
Weight change in Japanese PLWH who switched from TDF to TAF

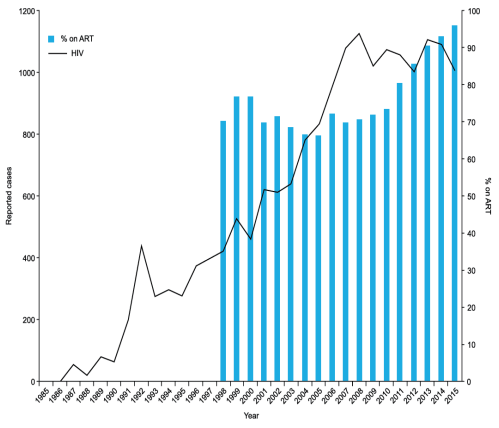


No deference of weight change between TDF vs. TAF period.
Weight continuously increase in any class of ART

1. Mallon PW, et al. : J Int AIDS Soc 2021 ; 24(4) : e25702.
2. Sekiya R, et al. : J Infect Chemother 2022.

UNAIDS 95-95-95 HIV targets in Japan





Iwamoto A, PLoS ONE 2017;12(3);e0174360

Symposium：Prospect of Clinical Infectious Diseases

Session Ⅱ
Antimicrobial resistance and current strategies

Speaker

王 明貴

Minggui WANG

M.D.

Director, Institute of Antibiotics, Huashan Hospital, Fudan University



Education

1990-1995	Shanghai Medical University（M.D.）
1982-1987	Zhejiang Medical University（B.S.）

Work Experience

2015-	Director Institute of Antibiotics, Huashan Hospital, Fudan University
2004-2015	Deputy Director Institute of Antibiotics, Huashan Hospital, Fudan University
2005-	Professor Institute of Antibiotics, Huashan Hospital, Fudan University
2003-	Chief-in-Physician Institute of Antibiotics, Huashan Hospital, Fudan University
2001-2003	Postdoctoral fellow Massachusetts General Hospital, Harvard Medical School
1997-2003	Vice Professor Institute of Antibiotics, Huashan Hospital, Fudan University
1995-1997	Visiting Physician Institute of Antibiotics, Huashan Hospital, Fudan University
1987-1990	Residency Zhejiang Jinyun Hospital

Other Commitment

President, Chinese Society of Bacterial Infection and Resistance, Chinese Medical Association

Member of the Standing Committee, Chinese Society of Infectious Diseases, Chinese Medical Association

President Elect, Committee of Society of Infectious Diseases, China Medicine Education Association

Vice President, Committee of Medical Mycology Society, China Medicine Education Association

Session Ⅱ Antimicrobial resistance and current strategies

Antimicrobial Resistance and Current Strategies in China

Minggui WANG

Antimicrobial resistance (AMR) is a global problem to public health. The prevalence of AMR among common clinical isolates, such as MRSA, VRE, CRKP, CRAB, and CRPA, shows a big difference among different regions, even among neighboring countries like in China, Japan and Korea. Therefore, communications among experts from different countries are necessary for exchanging experience for rational antimicrobial use and antimicrobial stewardship, and approaches for tackling AMR in clinical practice.

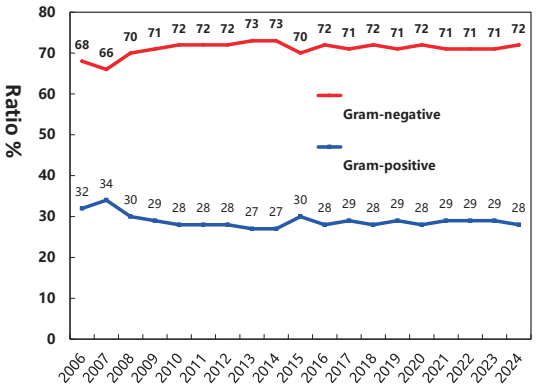
Antimicrobial resistance surveillance systems have been well established in China. For clinical isolates collected in China, the ratio of gram-negative bacilli to gram-positive cocci is approximately 7 to 3. Generally, gram-negative bacilli have a higher antimicrobial resistance profile. The prevalence of extended-spectrum β-lactamases in Escherichia coli is as high as approximately 50%. Acinetobacter baumannii-calcoaceticus complex has a carbapenem resistance rate of over 60%. The prevalence of VRE is low, and the prevalence of MRSA and CRPA showed decreasing trends. The prevalence of CRKP showed a remarkable increasing trend from 2.9% (imipenem resistance) in 2005 to 25.0% in 2018, and then slightly decreased to 22.6% in 2024.

A series of joint efforts have been made between multi-disciplinary professionals and government administrators for curbing AMR. In 2016, 14 ministries of China led by the National Health Commission jointly released the National Action Plan for Antibacterial resistance Containment, and updated the Action Plan for AMR Containment in 2022.

Much more Gram-negative bacilli than Gram-positive cocci in clinical isolates in China

% Gram-positive：Gram-negative ≈ 3:7

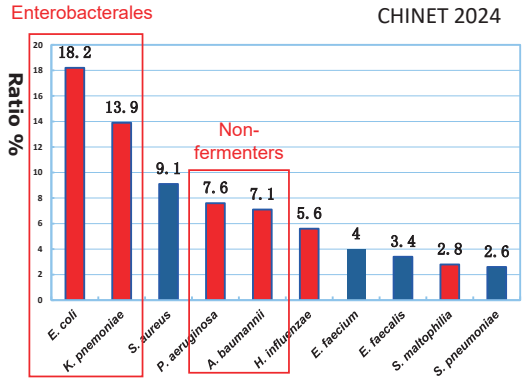
http://www.chinets.com



TOP 10 isolates

Gram-positive：Gram-negative = 4:6

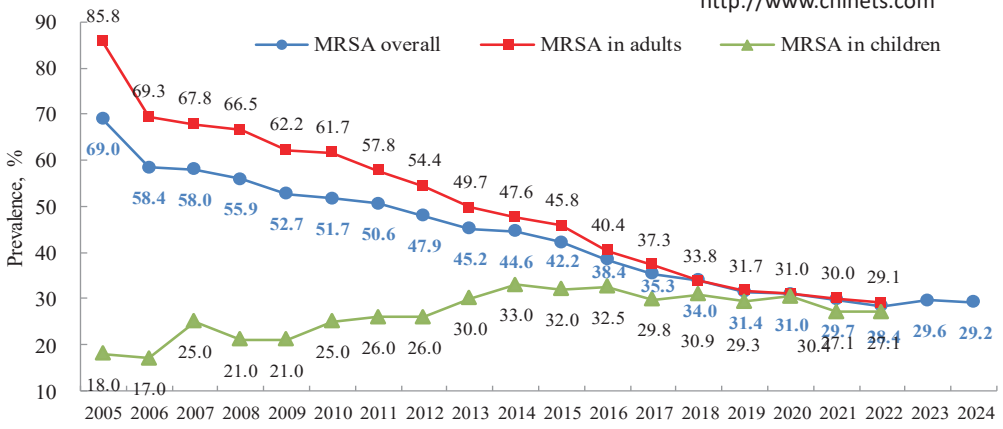
CHINET 2024



Qin X, JAC Antimicrob Resist 2024; 6(2): dlae052

Decreasing prevalence of methicillin-resistant *S. aureus* (MRSA)

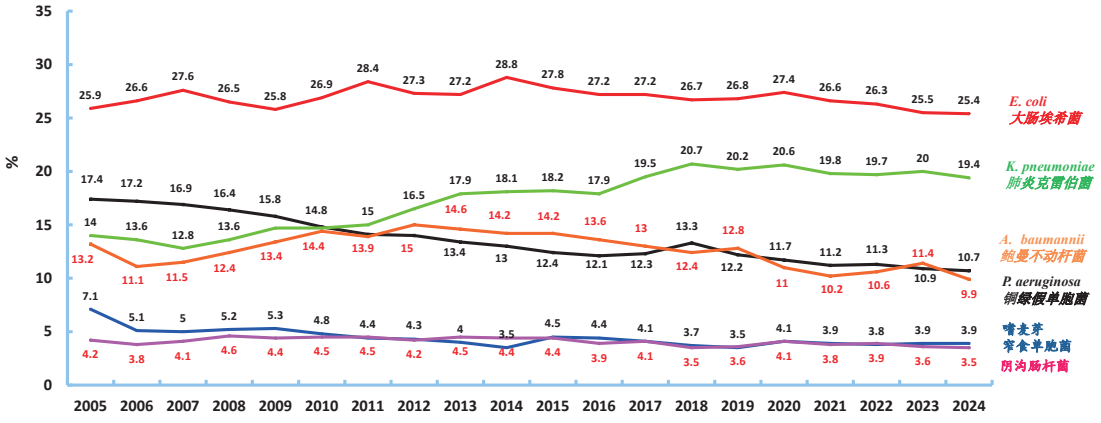
http://www.chinets.com



Qin X, JAC Antimicrob Resist 2024; 6(2): dlae052

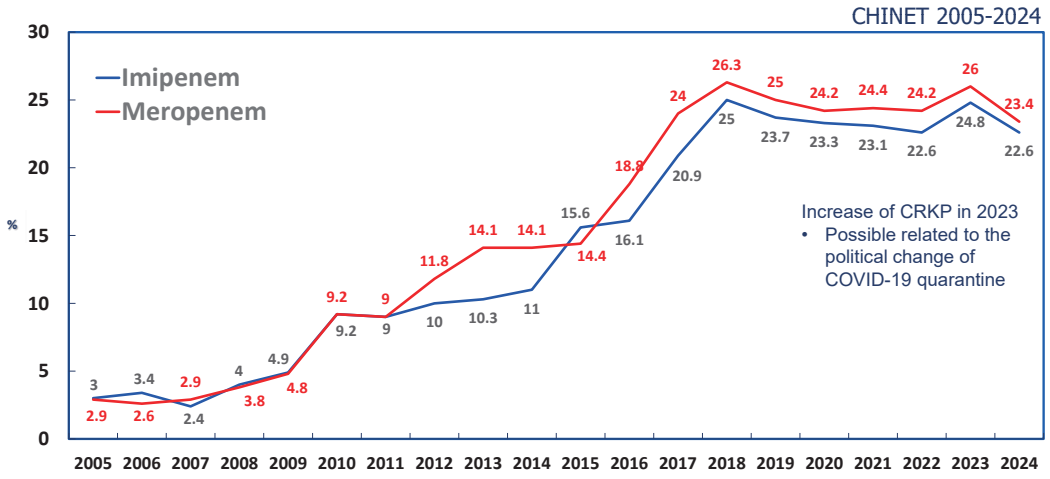
Proportion of the top four gram-negative pathogens:

Accounting for 65% of all Gram-negatives



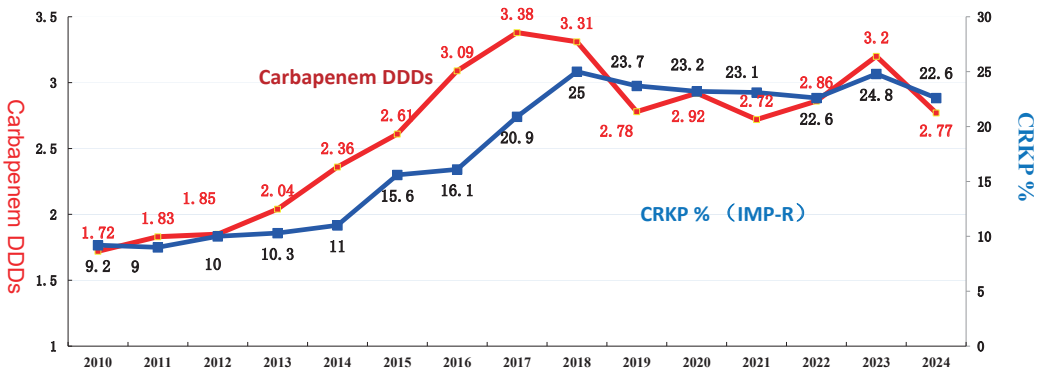
http://www.chinets.com

Increasing trends of carbapenem-resistant *K. pneumoniae* (CRKP)



Intensive clinical use of antimicrobials are related the increasing of antimicrobial resistance

The Association between the carbapenem DDD and CRKP prevalence



DDD, defined daily dose

Note: Definition of one DDD of meropenem adjusted from 2g to 3g since 2019

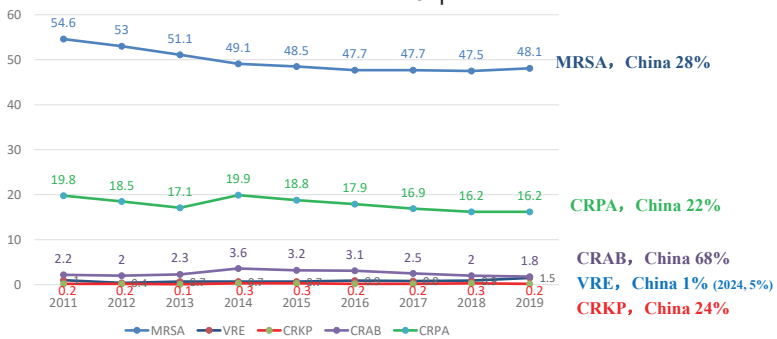
Extremely low prevalence of AMR in Japan: CRAB 1.8%, CRKP 0.2%



40th Annual Meeting of the Japanese Society for Infection Prevention and Control
July 11, 2025, Yokohama, Japan

Of five AMR data, four are lower than that in China

Prevalence of AMR in Japan



Nippon AMR One Health Report (NAOR) 2020. https: //www.mhlw.go.jp/content/10900000/000885373.pdf

Communications among experts from different countries are necessary for exchanging experience for rational antimicrobial use and antimicrobial stewardship, and approaches for tackling AMR in clinical practice

National Action Plan to contain antibacterial resistance（2016-2020）
Co-released by 14 ministries in 2016


国家卫生计生委医政医管局

主站首页 | 首页 | 机构设置 | 公文 | 工作动态

关于印发遏制细菌耐药国家行动计划（2016-2020年）的通知

国卫医发〔2016〕43号

各省、自治区、直辖市及新疆生产建设兵团卫生计生委（卫生局）、发展改革委、教育厅（教委、教育局）、科技厅（委、局）、工业和信息化主管部门、财政厅（局）、国土资源厅（局）、环境保护厅（局）、农业（农牧、农村经济、畜牧兽医）厅（委、局）、文化厅（局）、新闻出版广电局、食品药品监督管理局、中医药管理局，解放军各大单位卫生部门，

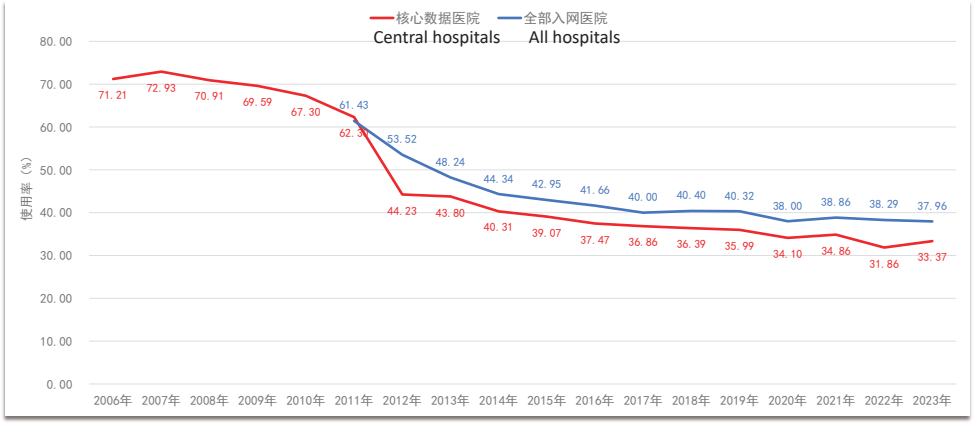
为积极应对细菌耐药带来的挑战，提高抗菌药物科学管理水平，遏制细菌耐药发展与蔓延，维护人民群众身体健康，促进经济社会协调发展，国家卫生计生委等14部门联合制定了《遏制细菌耐药国家行动计划（2016-2020年）》（以下简称《行动计划》），可从国家卫生计生委医政医管栏目下载）。现印发你们，请结合各地、各部门的工作实际认真组织实施，切实落实各项政策和保障措施，保证《行动计划》目标如期实现。

国家卫生计生委　国家发展改革委
教育部　科技部
工业和信息化部　财政部
国土资源部　环境保护部
农业部　文化部
新闻出版广电总局　食品药品监管总局
国家中医药管理局　中央军委后勤保障部卫生局
2016年8月5日

- National Health and Family Planning Commission
- Development and Reform Commission
- Ministry of Education
- of Science
- of Industry and Information
- of Land Resources
- of Environment Protection
- of Agriculture
- of Culture
- Bureau of Food and Drug Administration
- of Chinese Traditional Medicines
- Central Military Commission of Logistics

全国抗菌药物临床应用监测网

Decreasing trend of antimicrobial use in hospitalized patients in China (DDD)

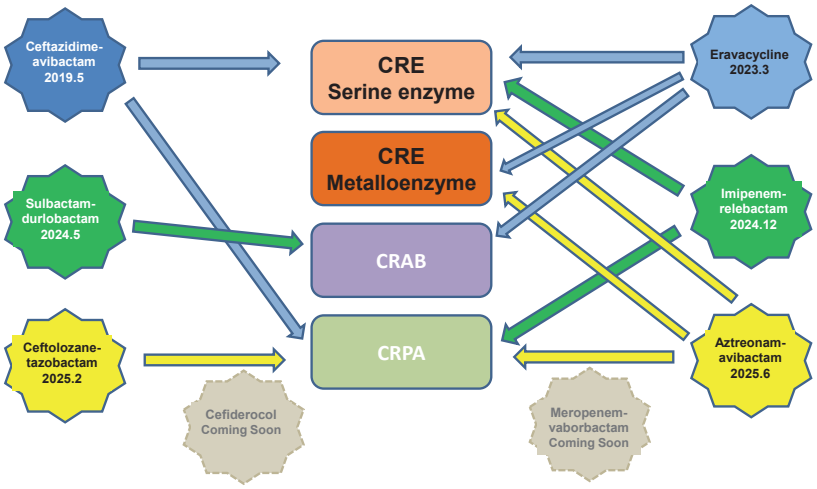


New antimicrobials developed in China

- **Etimicin: a new aminoglycoside antibiotic**
- **Antofloxacin (2009): a new quinolone**
- **Nemonoxacin (2016): a new non-fluorinated quinolone, active against MRSA**
- **Contezolid (2021): a new Oxazolidinone, less hematological toxicity**

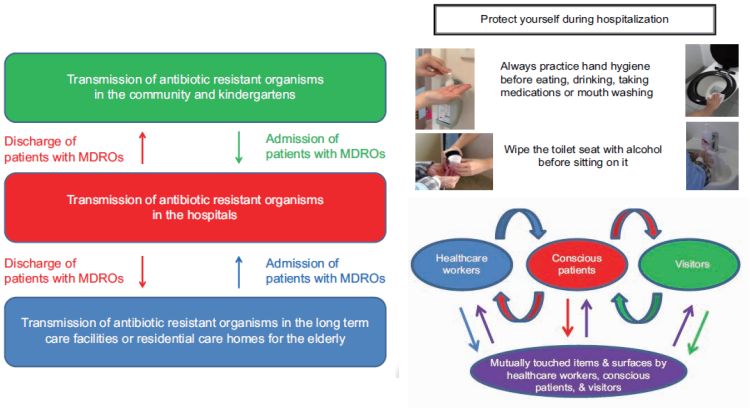
New antimicrobial	Antimicrobial activity	Ongoing Clinical trial
Meropenem-FL-058	FL-058 is a new beta-lactamase inhibitor, Active against CROs producing KPC and metallo-beta-lactamases	Phase III clinical trial for cUTI
HRS-8427	A new siderophore cephalosporin, Active against CRE, CRAB and CRPA	Phase III clinical trial for cUTI

Several new antimicrobials active against CRO launched in recent two years in China



Infection control in Chinese hospitals

Each tier 3 hospital has a Infection Control Unit with 3-5 staff



Cheng VC et al. Emerg Microbes Infect 2015; 4: e8

Continuing Medical Education:

Four training programs for professionals related to management of ID and rational use of antimicrobials

- 培元计划 Antibacterial and Antifungal ID Specialist Training Program
  - 培养感染病临床医师
  - 2015.07.28启动，上海
- 培英计划 ID Clinical Pharmacologist Training Program
  - 培养感染病专业临床药师
  - 2017.11.01启动，广州
- 培微计划 Clinical Microbiologist Training Program
  - 培养临床微生物专业人员
  - 2018.03.24启动，北京
- SHIP--中国感控医师研修项目
  Infection Control Physician Training Program
  - 培养感控医师
  - 2015启动，上海



Symposium：Prospect of Clinical Infectious Diseases

Session Ⅱ
Antimicrobial resistance and current strategies

Speaker



大曲　貴夫

Norio OHMAGARI

M.D., M.Sc., Ph.D.

Director, Japan Institute for Health Security, Department of Infectious Disease Clinical Policy, Bureau of Health Security and Management

Education

2015-	Doctor of Philosophy in Clinical Infectious Diseases Aichi Medical University, Japan
2013-	Master of Science in Infectious Diseases London School of Hygiene & Tropical Medicine, UK
1991-1997	Bachelor of Medicine Saga Medical School, Japan

Work Experience

2025-	Director, Department of Infectious Disease Clinical Policy,Bureau of Health Security and Management Specially Appointed Deputy Hospital Director Director, Disease Control and Prevention Center, National Center for Global Health and Medicine Japan Institute for Health Security
2023-2025	Deputy Director General, National Center for Global Health and Medicine Hospital, Tokyo, Japan
2017-	Director, AMR Clinical Reference Center Director, WHO Collaborating Center for Prevention, Preparedness and Response to Emerging Infectious Diseases National Center for Global Health and Medicine Hospital, Tokyo, Japan
2012-	Director, Disease Control and Prevention Center National Center for Global Health and Medicine Hospital, Tokyo, Japan
2011-2012	Vice-Director, Disease Control and Prevention Center National Center for Global Health and Medicine Hospital, Tokyo, Japan
2007-2011	Chief, Division of Infectious Diseases Shizuoka Cancer Center Hospital Shizuoka, Japan
2002-2004	Clinical fellow, Division of Infectious Diseases,The University of Texas-Houston Medical School, Houston, TX
2001-2001	Staff physician Aita Memorial Hospital, Ibaraki, Japan
2000-2001	Clinical fellow, Division of Pulmonary Medicine, St. Luke's International Hospital, Tokyo, Japan
2000-2000	Clinical fellow Division of Infectious Diseases, St. Luke's International Hospital, Tokyo, Japan
2000-2000	Chief medical resident, St. Luke's International Hospital, Tokyo, Japan
1997-1999	Medical resident, St. Luke's International Hospital, Tokyo, Japan

Other Commitment

Infectious Diseases Society of America
America Society for Microbiology
Society for Hospital Epidemiology of America
Japanese Association for Infectious Diseases
Japanese Society of Chemotherapy
Japanese Society of Internal Medicine
Japanese Respiratory Society

Session Ⅱ Antimicrobial resistance and current strategies

Implementation and Review of AMR National Action Plans: Japan

Norio OHMAGARI

Since the 2016 launch of Japan's National AMR Action Plan, significant strides have been made in public awareness, stewardship, and surveillance. A revised plan for 2023–2027 reflects outcomes from interventions, including sustained reductions in oral antibiotic use and enhanced stewardship guidance via MHLW's manual and compensation incentives. Nonetheless, injectable antibiotic use has slightly increased, and rising fluoroquinoloneresistant E. coli continues to challenge efforts.

One Health initiatives have expanded: environmental surveillance reveals persistence of resistant pathogens and resistance genes in wastewater and rivers. Veterinary guidelines for companion animals have been strengthened, aligning with broader goals of reducing antimicrobial application in agriculture and livestock sectors.

Globally, AMR remains an escalating public health crisis. WHO data indicate nearly 5 million deaths associated with AMR annually, with projections of 39 million more between 2025–2050 unless action is taken. In September 2024, UN member states adopted a declaration targeting a 10 % reduction in AMR-related deaths by 2030. May 2025's WHO assembly agreed to update the Global Action Plan by 2026, reinforcing multisectoral One Health strategies.

New threats have surfaced: conflict zones such as Ukraine and Gaza are incubators for hypervirulent, multidrugresistant pathogens, with initial cases now reaching Japan. Calls for urgent action are echoed globally, with leading health figures warning of up to 40 million AMR fatalities over 25 years if antibiotic misuse persists.

To meet these challenges, Japan must integrate its AMR plan with UHC goals, strengthen One Health governance, continue environmental and veterinary monitoring, and invest in R&D via initiatives like CARBX and GARDP under international frameworks.

AMR is no longer a niche medical issue—it demands multisectoral collaboration, sustained investment, and global solidarity.

The Daybreak

- AMR first came to the attention of policy-makers and health-care professionals in Japan in the 1980s when rates of isolation of MRSA started to rise.
- The government of Japan responded to public pressure to increase patient safety by establishing new laws governing medical practice and infection prevention and control (IPC) measures in hospitals.

Table 2. Guidelines relevant to AMR published before the development of NAP1

Title	Date	Developed by
Guidelines for prevention of hospital infection *(18)*	1990	The Japanese Society for Infection Prevention and Control
Guidelines for healthcare-associated infection control measures for small- and medium-sized hospitals and clinics *(19)*	2006	MHLW
The manual for anti-MRSA antibiotic use *(20)*	2008	Japanese Association for Infectious Diseases
Nosocomial infection control in medical institutions *(21)*	2011	MHLW
Guidelines for prevention of nosocomial infection during general dental care *(22)*	2014	MHLW
Recommendations for measures against drug-resistant bacteria *(23)*	2015	MHLW

Source: National Center for Global Health and Medicine (NCGM) 2024

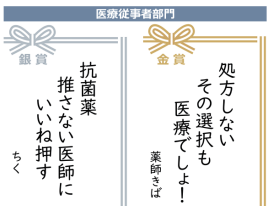
First National Action Plan on Antimicrobial Resistance 2016–2020 (NAP1)

- Formulated by a **multisectoral AMR steering committee**
- **One Health approach**
- **Six areas**: (1)Public Awareness and Education; (2) Surveillance and Monitoring; (3) IPC; (4) Appropriate Use of Antimicrobials; (5) Research and Development; and (6) International Cooperation
- **Numerical targets** for 2020 for AMR rates and for antimicrobial use (AMU)
- Progress was described in the **Annual Nippon AMR One Health Reports (NAORs)**

1. Public awareness and education

1. **Awareness-raising activities to improve public knowledge and understanding of AMR**
2. **AMR education and training for health-care providers**

Promoting Short Poet: Haiku



Anime Poster in Community Pharmacy



Media Campaign



2. Surveillance and monitoring

Additional surveillance systems set up as part of NAP1 implementation

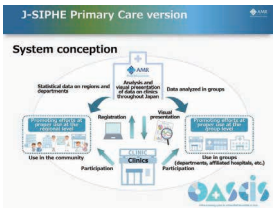
Japan Antimicrobial Resistant Bacterial Surveillance (JARBS)

薬剤耐性研究センター
耐性菌ナショナル・サーベイランス
JARBS
Japan Antimicrobial Resistant Bacterial Surveillance

Japan Surveillance for Infection Prevention and Healthcare Epidemiology: J-SIPHE

J-SIPHE
感染対策連携共通プラットフォーム

J-SIPHE for clinics (OASCIS)



2. Surveillance and monitoring

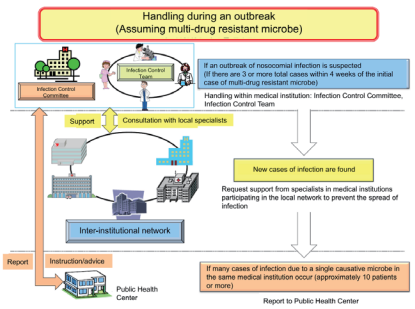
Nippon AMR One Health Report (NAOR) 2023

May 17, 2024

The AMR One Health Surveillance Committee

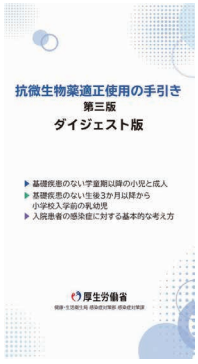
3. IPC

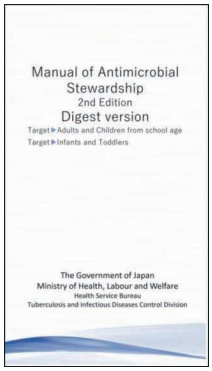
- As a result of **successive revisions in the medical fee incentives for implementing and strengthening IPC measures**, the importance of IPC in controlling the emergence and spread of AMR pathogens and other HAIs has been increasingly recognized.
- **Many larger hospitals have HAI control committees and contribute to regional infection control networks established to support IPC in small- and medium-sized health-care facilities.**
- **Awareness of personal IPC measures such as hand hygiene and wearing of personal protective equipment also rose during the COVID-19 pandemic.**



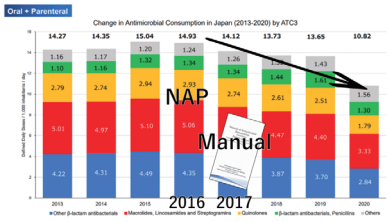
4. Appropriate use of antimicrobials

1. **Governance: multidisciplinary AMS teams**
2. **Introduction of Guidelines and AMS premiums**





Consumption of antimicrobials are decreasing



https://amrcrc.ncgm.go.jp/surveillance/010/Eng/1_All_Ages_2013-2020.pdf

5. Research and development

Policies implemented by government agencies to promote R&D:

- The Japanese Initiative for Progress of Research on Infectious Disease for Global Epidemics
- AMED Infectious Disease Drug Discovery Industry-Academia-Government Liaison Committee
- Priority infectious diseases list by MHLW , including AMR infections
- Push–pull mechanisms, expressed as Strategy 5.6 in NAP2
- MHLW has collaborated with other stakeholders to develop a list of key pharmaceuticals (including antimicrobials) to target with efforts to ensure stable in Japan

6. International cooperation

Activities to fulfil our responsibilities in the international community to combat AMR

- Meetings of health ministers of the G7 and Group of 20 (G20) countries
- Co-hosted the Tokyo Meeting of Health Ministers on Antimicrobial Resistance in Asia withthe WHO Regional Office for the Western Pacific and WHO Regional Office for South-East Asia in 2016 during which the **Asia-Pacific One Health Initiative on AMR (ASPIRE)** was launched.
- Japan hasorganized the **Tokyo AMR One Health Conference** six times since 2017 to promote measures against AMR in the Asia Pacific region through the ASPIRE initiative.
- Japan hosts two AMR-related WHO collaborating centres, both designated in 2021.
- GHIT Fund
- Representation by AMED in JPIAMR and GloPID-R
- Participation in Global Antimicrobial Resistance Research and Development Hub
- ARO Alliance for Southeast and East Asia (ARISE)

Total AMU almost achieved the numerical target sent by NAP1

Table 9. AMU targets set in NAP1 and achievements in 2021

AMU in humans (measured as defined daily dose per 1000 inhabitants per day, based on sales volume)	**Target set in NAP 1** (reduction from 2013 level)	**Achievement in 2021**
Total AMU	Reduce by 33%	32.7% reduction
Oral cephalosporins, quinolones, and macrolides	Reduce by 50%	46.0%, 47.7%, 43.7% reduction respectively
Intravenous antimicrobials	Reduce by 20%	1.1% reduction

Source: NAOR 2023 *(37)*

Little change in rates of MRSA, fluoroquinolone resistance in *E. coli*, and carbapenem resistance in *P. aeruginosa*

***These were included as major indicators in NAP 2.**

Table 8. AMR targets set in Japan's NAP1 and achievements in 2021

AMR in humans	**Target for 2020**	**Achievements**	
		2014	**2021**
Penicillin resistance of *Streptococcus pneumoniae*	≤ 15%	47.0% (CSF samples)	59.5% (CSF samples) 3.4% (non-CSF samples)
Methicillin resistance of *Staphylococcus aureus*	≤ 20%	49.1%	46.0%
Fluoroquinolone resistance of *Escherichia coli*	≤ 25%	36.1%	40.4%
Carbapenem (Imipenem) resistance of *Pseudomonas aeruginosa*	≤ 10%	19.9%	15.8%
Carbapenem (Imipenem) resistance of *Escherichia coli*	≤ 0.2%	0.1%	0.1%
Carbapenem (Imipenem) resistance of *Klebsiella pneumoniae*	≤ 0.2%	0.3%	0.2%

Sources: 2020 targets – NAP1 *(7)*
2014 and 2021 achievements – NAOR 2023 *(37)*

Development of National Action Plan on AMR 2 (NAP2)

- MHLW developed a draft of NAP2. This was reviewed by the Subcommittee on AMR, the Cabinet Secretariat and other relevant ministries and agencies, and approved by the Council of Ministers in April 2023.
- NAP2 built on the framework of NAP1, retaining the same overall structure and **six areas of focus, and emphasizing the One Health approach** to linking analysis and **use of data for action** across sectors and with international findings.
- Discussions considered **the association between interventions and indicators to determine whether candidate indicators truly reflected the outcome of actions implemented**.

Symposium：Prospect of Clinical Infectious Diseases

Session Ⅲ
Managing EBV-related disease spectrum

Speaker

張 文宏

Wenhong ZHANG

M.D., Ph.D.

Director of National Medical Center for Infectious Diseases;
Director of Department of Infectious Diseases, Huashan Hospital, Fudan University



Education

1997-2001	Ph.D. in Infectious Diseases, Fudan University
1993-1996	Master's Degree, Graduate School of Shanghai Medical University
1987-1993	Bachelor's Degree, Shanghai Medical University

Work Experience

2023-	Dean, Institute of Infectious Diseases and Health, Fudan University
2021-	Director, National Center for Infectious Diseases
2019-	Chair, Department of Internal Medicine, Fudan University Clinical Medical College
2012-	Director, Department of Infectious Diseases, Huashan Hospital, Fudan University
2006-2012	Deputy Director, Department of Infectious Diseases, Huashan Hospital, Fudan University
2003-2004	Postdoctoral Fellow, Harvard Medical School, USA
1996-	Huashan Hospital, Fudan University

Other Commitment

Vice President, Chinese Society of Infectious Diseases, Chinese Medical Association

Vice President of Internal Medicine Branch of the Chinese Medical Doctor Association

Vice President of Infectious Diseases Branch of the Chinese Medical Doctor Association

Awards and Honor

Special Prize of Shanghai Science and Technology Popularization Award,2023

First Prize of Shanghai Science and Technology Progress Award, 2021

National Innovation Award, 2020

Session Ⅲ Managing EBV-related disease spectrum

Natural History of EBV Infection and Current Management for EBV-Associated Diseases

Wenhong ZHANG

EBV infection is an event experienced by nearly every individual, with over 95% of the global population infected. In immunocompetent individuals, EBV infection progresses through three main phases: primary infection and lytic replication, latency, and lytic reactivation. Most individuals experience an asymptomatic phase or mild upper respiratory infection during childhood, while a minority present with infectious mononucleosis（IM）.

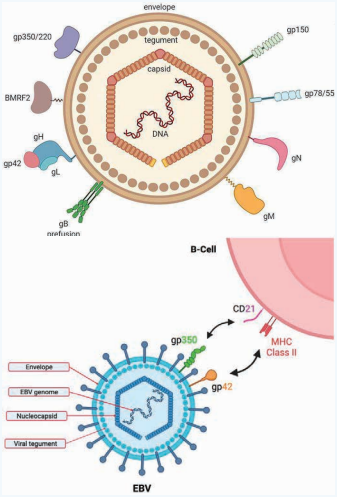
Primary EBV infection initially targets naïve B cells and establishes latent infection. Most infected individuals remain in this latent phase without health-threatening clinical manifestations. However, when host immunity is compromised, EBV can reactivate into the lytic phase, triggering specific diseases. EBV-associated diseases pose a serious threat to human health. An imbalance between the host's immune response and EBV replication can lead to various EBV-positive lymphoproliferative disorders involving B, T, and NK cells.

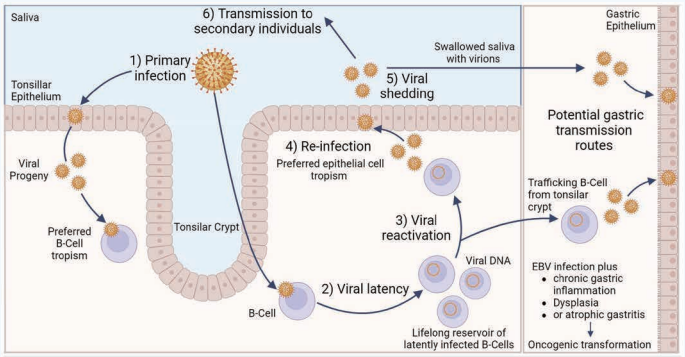
Within the EBV infection spectrum, Chronic Active Epstein-Barr Virus Disease（CAEBV）represents a critical intermediate stage between benign outcomes and disease progression. CAEBV is a lymphoproliferative disorder characterized by EBV infection of T or natural killer（NK）cells, presenting with persistent or recurrent IM-like symptoms. It bridges the gap between natural viral control and severe progressive diseases, including hemophagocytic lymphohistiocytosis（HLH）, multiple organ failure, and progression to leukemia/lymphoma, often carrying a poor prognosis. Recent multidisciplinary research has advanced treatment in this field.

For advanced CAEBV, allogeneic hematopoietic stem cell transplantation（allo-HSCT）remains the only potentially curative treatment. In contrast, non-transplant treatment options—including cytotoxic chemotherapy, immunotherapy, and cell therapy—lack consistent, sustained efficacy. While these approaches can temporarily alleviate symptoms by controlling inflammation and reducing EBV-infected lymphocyte burden, most patients experience relapse and disease progression. Here we focuses on understanding CAEBV's natural history and immune pathogenesis to identify methods for achieving durable disease control. In clinical practice, various immunotherapies, including PD-1 inhibitors, have demonstrated safety and efficacy in CAEBV. Cell-based therapies such as Epstein-Barr virus-specific cytotoxic T lymphocytes（EBV-CTLs）, chimeric antigen receptor T cells（CAR-T）, and T cell receptor-engineered T cells（TCR-T）have also shown unique advantages. These approaches have reported benefits in symptom improvement and EBV load reduction in CAEBV patients and show promise in clinical trials.

Despite the range of available treatments, patient prognosis remains suboptimal. Given the absence of a universal non-transplant regimen, the most practical current strategy involves developing more personalized treatment plans based on a deeper understanding of the disease mechanisms and stage.

01 EBV infection: Three main phases

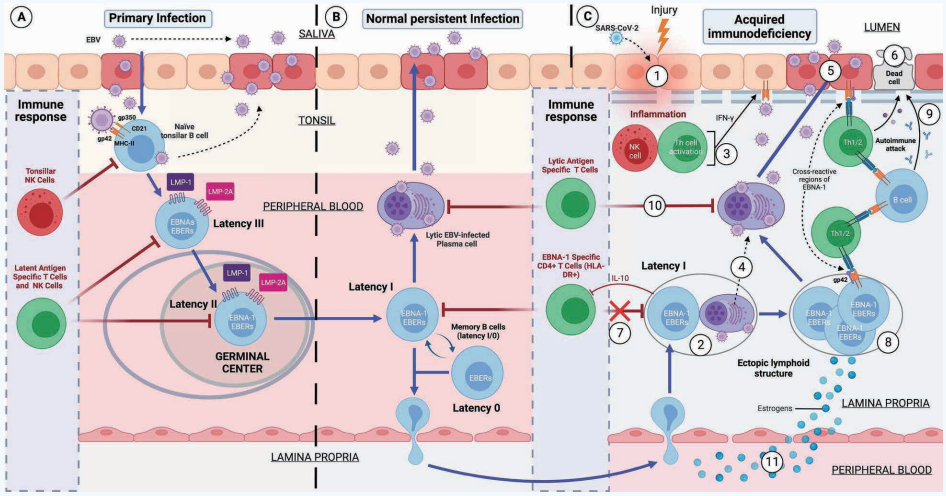




- In immunocompetent individuals, EBV infection progresses through three main phases: primary infection and lytic replication, latency, and lytic reactivation.
- Primary EBV infection initially targets naïve B cells and establishes latent infection.

Front Microbiol.2021 Jun 22:12:701611.
Life (Basel).2023 Feb 14;13(2):521.
Front Immunol.2024 Mar 26:15:1358511.

01 EBV infection — lifelong latent — reactivation



- When host immunity is compromised, EBV can reactivate into the lytic phase.

J Transl Med. 2023 Sep 17;21(1):633.

02 Expert consensus from Chinese Medical Association

国家传染病医学中心 National Medical Center for Infectious Diseases　华山医院 HUASHAN HOSPITAL

Expert consensus on diagnosis and treatment of chronic active Epstein–Barr virus disease (2025 edition)

Lymphocyte Group of Hematology Branch of the Chinese Medical Association　Hematology Group of Pediatrics Branch of the Chinese Medical Association
Infectious Disease Branch of the Chinese Medical Association　Wang Zhao　Wang Tianyou　Wang Guiqiang
Authors Info & Affiliations

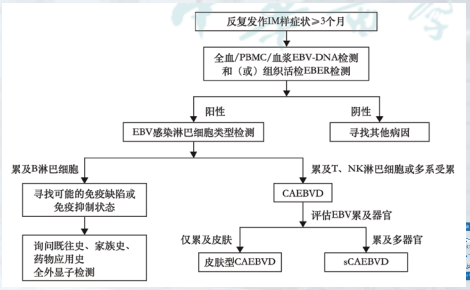
Published: 2025-04-29 · DOI: 10.3760/cma.j.cn112137-20241229-02956

➢ Diagnostic Criteria :

(meet all of the following four conditions simultaneously)

1. Persistent or recurrent symptoms similar to infectious mononucleosis have occurred for more than three months;
2. The number of EBV genomes in peripheral blood and/or affected tissues increases;
3. EBV-infected cells in peripheral blood and/or affected tissues are T cells or NK cells, or multiple lines;
4. Exclude other chronic diseases that may cause similar symptoms.

➢ Diagnostic Process:



02 Differences in PBMCs EBV-DNA between acute and chronic EBV infections


Contents lists available at ScienceDirect

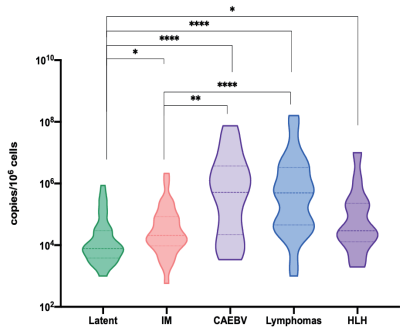
Journal of Infection

journal homepage: www.elsevier.com/locate/jinf

Clinical application of Epstein-Barr virus DNA loads in Epstein-Barr virus-associated diseases: A cohort study

Shenglei Yu[a,b,1], Qingluan Yang[a,1], Jing Wu[a,b], Mengqi Zhu[a,b], Jingwen Ai[a,b], Haocheng Zhang[a,b], Bin Xu[a,b], Lingyun Shao[a,b,c,*], Wenhong Zhang[a,b,c,d,e,*]

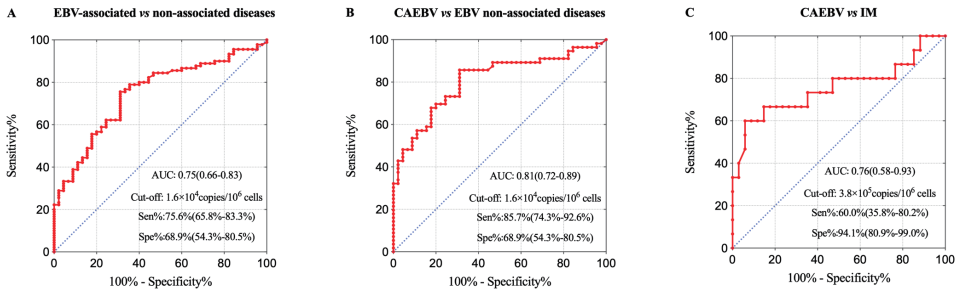
Group	EBV DNA load copies/10^6 cells
IM	2.1×10^4(9.5×10^3-8.5×10^4)
CAEBV	5.2×10^5(2.3×10^4-3.7×10^6)
Lymphomas	5.0×10^5(4.5×10^4-3.3×10^6)
EBV-HLH	2.9×10^4(1.3×10^4-2.3×10^5)



EBV T/NK-LPD shows significant differences from IM, but there are no significant differences among CAEBV, Lymphomas, and HLH.

J Infect. 2021 Jan;82(1):105-111.

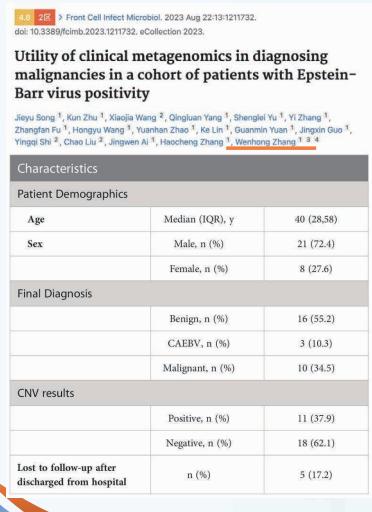
02 Diagnostic efficacy of EBV DNA in PBMCs



EBV DNA cutoff： 1.6×10^4 copies/10^6 cells

J Infect. 2021 Jan;82(1):105-111.

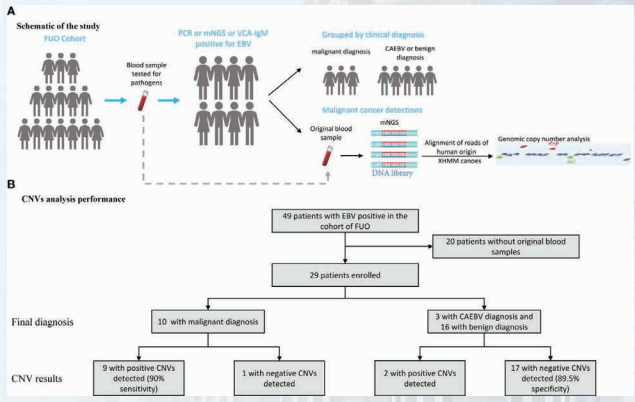
02 Utility of clinical metagenomics in diagnosing EBV-related malignancies


Front Cell Infect Microbiol. 2023 Aug 22:13:1211732.
doi: 10.3389/fcimb.2023.1211732. eCollection 2023.

Utility of clinical metagenomics in diagnosing malignancies in a cohort of patients with Epstein-Barr virus positivity

Jieyu Song[1], Kun Zhu[1], Xiaojia Wang[2], Qingluan Yang[1], Shenglei Yu[1], Yi Zhang[1], Zhangfan Fu[1], Hongyu Wang[1], Yuanhan Zhao[1], Ke Lin[1], Guanmin Yuan[1], Jingxin Guo[1], Yingqi Shi[2], Chao Liu[2], Jingwen Ai[3], Haocheng Zhang[1], Wenhong Zhang[1,2,4]

Characteristics		
Patient Demographics		
Age	Median (IQR), y	40 (28,58)
Sex	Male, n (%)	21 (72.4)
	Female, n (%)	8 (27.6)
Final Diagnosis		
	Benign, n (%)	16 (55.2)
	CAEBV, n (%)	3 (10.3)
	Malignant, n (%)	10 (34.5)
CNV results		
	Positive, n (%)	11 (37.9)
	Negative, n (%)	18 (62.1)
Lost to follow-up after discharged from hospital	n (%)	5 (17.2)



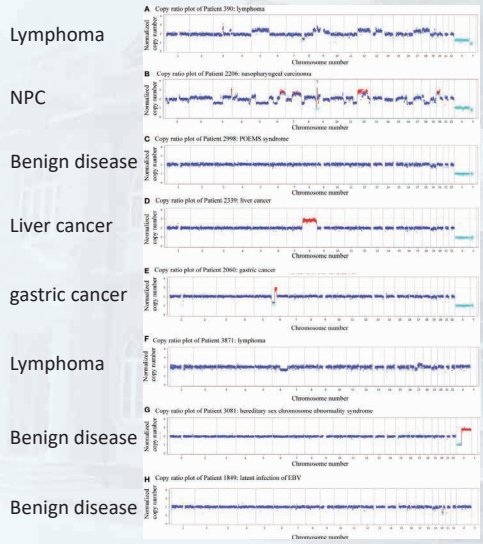
Schematic of the Copy Number Variations (CNVs) Test and Its Overall Performance

02 mNGS assist in identifying malignancies in EBV-related diseases

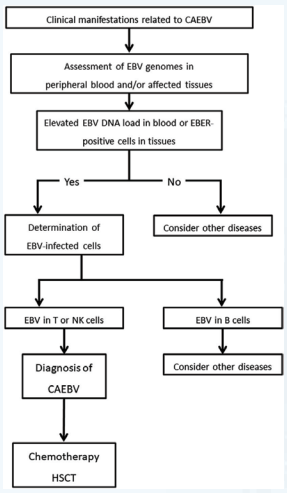
- CNV analysis suggested neoplasms: in 9/10 patients.
- CNV analysis suggested benign: in 17/19 patients.

CNV analysis for the identification for tumors:
- Sensitivity: 90%
- Specificity: 89.5%

The application of mNGS could assist in the identification of infection and malignancies in EBV-related diseases



03 HSCT is considered the only curative treatment for CAEBV



- **Hematopoietic Stem Cell Transplantation (HSCT):** is considered the only curative treatment for CAEBV. In an analysis of 80 cases, the 15-year OS rate for patients with CAEBV treated using HSCT was 60.6%, whereas that for patients who did not undergo HSCT was 25.7%.

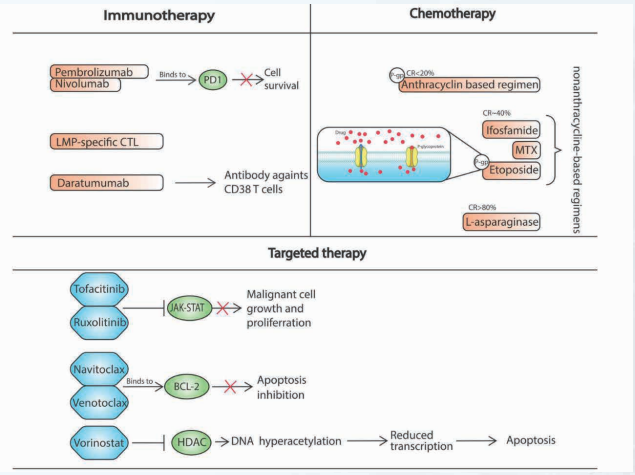
Treatment:

- **Step 1: Cooling immunochemotherapy with prednisolone, cyclosporine A, and etoposide;**
- **Step 2: Cytoreduction with modified CHOP or ESCAP;**
- **Step 3: Reconstruction using RIC for HSCT.**

The 3-year OS rate after planned HSCT for patients with CAEBV treated using this strategy (n = 63) was 87%, whereas that for patients with uncontrolled active disease was 17%.

International Journal of Hematology(2023)118: 568-576

03 Non-transplant treatment options



- **Targeted therapy :**
  - JAK Inhibitor
- **Chemotherapy/Cytotoxic Drugs:**
  - DEP-L protocol;
  - CHOP-like protocol.
- **Immunotherapy or Cell Therapy:**
  - PD-1 monoclonal antibody;
  - EBV-CTL, CAR-T, TCR-T;
  - Histone deacetylase inhibitor, CD38 Ab

Rev Med Virol [J], 32: e2328.

03 Transplantation benefits adult EBV-HLH patients

国家传染病医学中心 National Medical Center for Infectious Diseases　华山医院 HUASHAN HOSPITAL

Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) in Adult Patients with Epstein-Barr Virus-Associated Hemophagocytic Lymphohistiocytosis (EBV-HLH)

Background

- The efficacy of allogeneic HSCT in adult patients with EBV-HLH remains controversial

Patients and Methods

- A population of 356 adult patients with EBV-HLH treated with allogeneic HSCT or chemotherapy

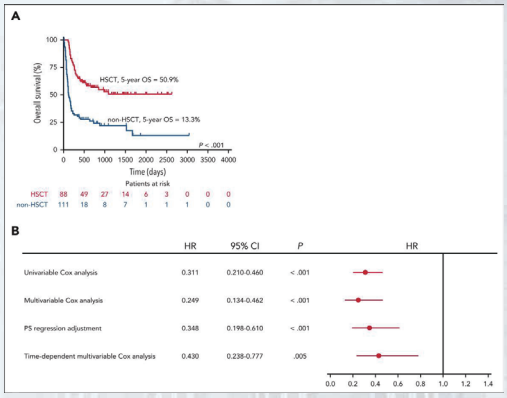
Outcomes

Prognostic prediction model

Conclusions: Allogeneic hematopoietic stem cell transplantation (HSCT) was associated with improved survival in adult patients with EBV-HLH. The prognostic prediction models established in this study may facilitate more informed treatment decision-making for EBV-HLH.

Yao et al. DOI: 10.1182/blood.2023023287

blood Visual Abstract



The data from the Chinese team revealed that the 5-year survival rate after transplantation was only around 50%

Blood. 2024 Nov 14;144(20):2107-2120.

03 Umbilical Cord Blood Transplantation (UCBT) for Children with CAEBV

国家传染病医学中心 National Medical Center for Infectious Diseases　华山医院 HUASHAN HOSPITAL

Clinical Outcome of UCBT for Children With CAEBV: A Retrospective Analysis of a Single Center

Zhiyu Fu[1,#], Biyun Li[1,#], Yujie Chai[1], Xifeng Guo[1], Xinghua Chen[2], Lei Zhang[1], Jiao Chen[1], Dao Wang[1,*]

[1] *Department of Pediatrics, The First Affiliated Hospital of Zhengzhou University, Zhengzhou, China*
[2] *Department of Pediatrics, Zhengzhou People's Hospital, Zhengzhou, China*

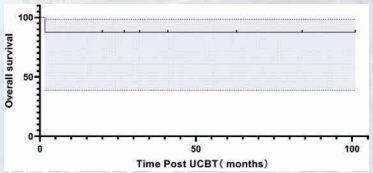
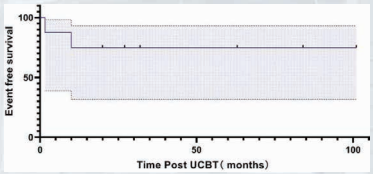


Table 3
Engraftment, Chimerism, and Survival of 8 CAEBV Patients With UCBT

NO	Time of UCBT	Interval Diagnosis-UCBT (months)	ANC≥0.5 × 10^9/L (days)	PLT≥20 × 10^9/L (days)	EBV Reactivation	CMV[b] Reactivation	Other Infection	Other Complications	aGVHD	cGVHD	Survival
1	2021	3	16	23	No	No	HC[a]	No	I	No	Alive
2	2019	13	20	30	No	Yes	HC	No	No	No	Alive
3	2017	5	39	53	No	No	HC/fungal	VOD[c]	II	Mild	Alive
4	2021	14	35	47	No	No	No	No	IV	No	Alive
5	2022	5	18	32	No	Yes	No	No	No	No	Alive
6	2016	9	13	35	No	No	No	VOD	I	No	Alive
7	2022	4	15	31	No	No	No	No	II	No	Alive
8	2021	2	14	44	No	No	No	TMA[d]	III	No	Dead

[a] HC: hemorrhagic cystitis.
[b] CMV: cytomegalovirus.
[c] VOD: hepaticveno-occlusive disease.
[d] TMA: thromboticmicroangiopathy.



8 patients ; follow-up 4 years

Conclusion

- ✓ Individuals with intact immunity go through three stages: "acute infection → latency → reactivation". When the immune balance is disrupted, the virus reactivates, which can trigger LPD.
- ✓ The immune mechanism of CAEBV is not yet fully understood.
- ✓ Currently, the only effective treatment is allo-HSCT; non-transplantation approaches (chemotherapy, immunotherapy/cellular therapy) are still being explored.
- ✓ In-depth analysis immune mechanism of CAEBV, and the formulation of individualized precise strategies, are urgent tasks for improving prognosis.

国家传染病医学中心 National Medical Center for Infectious Diseases　华山医院 HUASHAN HOSPITAL

Symposium : Prospect of Clinical Infectious Diseases

Session Ⅲ
Managing EBV-related disease spectrum

Speaker

新井 文子

Ayako ARAI

M.D., Ph.D.

Professor and Chair, Department of Hematology and Oncology
St. Marianna University School of Medicine



Education

1996-2000 Master's and Ph.D., Graduate School of Medical and Dental Science, Tokyo Medical and Dental University

1982-1988 School of Medicine, Niigata University

Work Experience

2019- Professor, Director and Chairperson, Division of Hematology & Oncology, St. Marianna University School of Medicine

2024- Visiting Lecturer, Hematology, Department of Internal Medicine, Institute of Science Tokyo Hospital

2022-2023 Visiting Lecturer, Hematology, Department of Internal Medicine, Division of Clinical Medicine, Tokyo Medical and Dental University

2019-2022 Professor, Department of Hematological Therapeutics, Graduate School of Medical and Dental Sciences, Tokyo Medical and Dental University

2017-2019 Associate Professor, Department of Laboratory Molecular Genetics of Haematology, Graduate School of Medical and Dental Sciences, Tokyo Medical and Dental University

2008-2017 Lecturer, Department of Hematology, Graduate School of Medical and Dental Sciences Tokyo Medical and Dental University

2001-2008 Lecturer and Assistant Professor, Department of Hematology, Graduate School of Medical and Dental Sciences Tokyo Medical and Dental University

1993-1993 Clinical Fellow, Department of Hematology, Tokyo Metropolitan Cancer and Infectious Disease Center Komagome Hospital

1991-1993 Senior Resident, The First department of Internal Medicine, Medical Hospital of Tokyo Medical and Dental University

1989-1991 Clinical Fellow, Internal Medicine, Emergency Care Center, Tokyo Metropolitan Bokutoh Hospital

1988-1989 Junior resident
The 1st department of Internal Medicine Medical Hospital of Tokyo Medical and Dental University

Other Commitment

The Japanese Society of Internal Medicine

Councilor, the Japanese Society of Hematology (JSH)
Councilor, Japanese Cancer Association

Councilor and Board Certified Member, the Japan Society for Hematopoietic Cell Transplantation

Japanese Society of Medical Oncology
The Molecular Biology Society of Japan（MBSJ）
Japanese Society of Laboratory Medicine Japan Society for Medical Education
American Society of Hematology（ASH）
European Hematology Association（EHA）

Awards and Honor

Dr. Nobuo Aoki Award, 2019

Japan Leukemia Research Fund Award, 2011

Ouchi Award, Medical Hospital of Tokyo Medical and Dental University, 2004

Session Ⅲ Managing EBV-related disease spectrum

Managing the Spectrum of EBV-Associated Hematologic Diseases Focusing on T- and NK-Cell Neoplasms in East Asia

Ayako ARAI

This lecture will begin with an overview of Epstein-Barr virus (EBV)-positive hematologic malignancies, based on the most recent "WHO Classification of Haematolymphoid Tumours", 5th edition. EBV is implicated in a broad spectrum of lymphoid neoplasms, among which several EBV-positive T- and NK-cell neoplasms—particularly systemic chronic active EBV disease (sCAEBV), extranodal NK/T-cell lymphoma (ENKL), and aggressive NK-cell leukemia—are notably prevalent in East Asia and exhibit distinct clinical features.

The presentation will highlight their clinical characteristics, diagnostic challenges, and treatment strategies. Advances in flow cytometry and EBV-DNA quantification have significantly improved the detection of infected lymphocyte subsets and enabled more accurate diagnosis.

In Japan, a recent nationwide study of over 100 sCAEBV cases identified key prognostic factors associated with overall survival and disease progression, providing a basis for improved clinical risk stratification. Allogeneic hematopoietic stem cell transplantation (allo-HSCT) remains the only curative treatment for sCAEBV, and pre-transplant disease control is often required. Our investigator-initiated clinical trial of ruxolitinib, a JAK1/2 inhibitor, demonstrated effective suppression of disease activity and systemic inflammation, facilitating safer transition to transplant, even though it does not eliminate EBV-infected cells.

By integrating updated disease classification, prognostic insights, and novel pre-transplant interventions, this lecture aims to enhance the understanding and clinical management of EBV-associated T/NK-cell neoplasms, particularly in East Asian populations where these disorders are more commonly observed.

Clinical Question

- Why are EBV-positive T- or NK-cell lymphomas more common in Asia?
- Can EBV cause T-cell and NK-cell lymphomas?

EBV-associated lymphoid neoplasms in WHO, 5th edition

- B-cell type
  - **Lymphomatoid granulomatosis (LYG)**
  - **EBV-positive DLBCL**
    - EBV+ DLBCL, NOS
    - DLBCL associated with chronic inflammation
    - Fibrin-associated DLBCL
  - **Plasmablastic lymphoma**
  - **Burkitt lymphoma**
  - **Hodgkin lymphoma**
- T,NK-cell type
  - **EBV-positive T- and NK-cell lymphomas**
    - EBV-positive nodal T- and NK-cell lymphoma
    - Extranodal NK/T-cell lymphoma
  - **EBV-positive T- and NK-cell lymphoid proliferations and lymphomas of childhood**
    - Chronic active EBV diseases (CAEBV)
      - Cutaneous CAEBV
        - Severe mosquito bite allergy
        - Hydroa Vacciniforme
      - Systemic CAEBV
- Lymphoid proliferations and lymphomas associated with immune deficiency and dysregulation

CAEBV: a unique model to study EBV-driven lymphomagenesis in T/NK cells

Today's Agenda

- What is CAEBV？
- How does CAEBV develop?
- Our challenges to solve CAEBV issues

Chronic active Epstein-Barr virus disease (CAEBV)

was first reported as sustained infectious mononucleosis (IM)

J Infect Dis 1988, *157*, 405-412

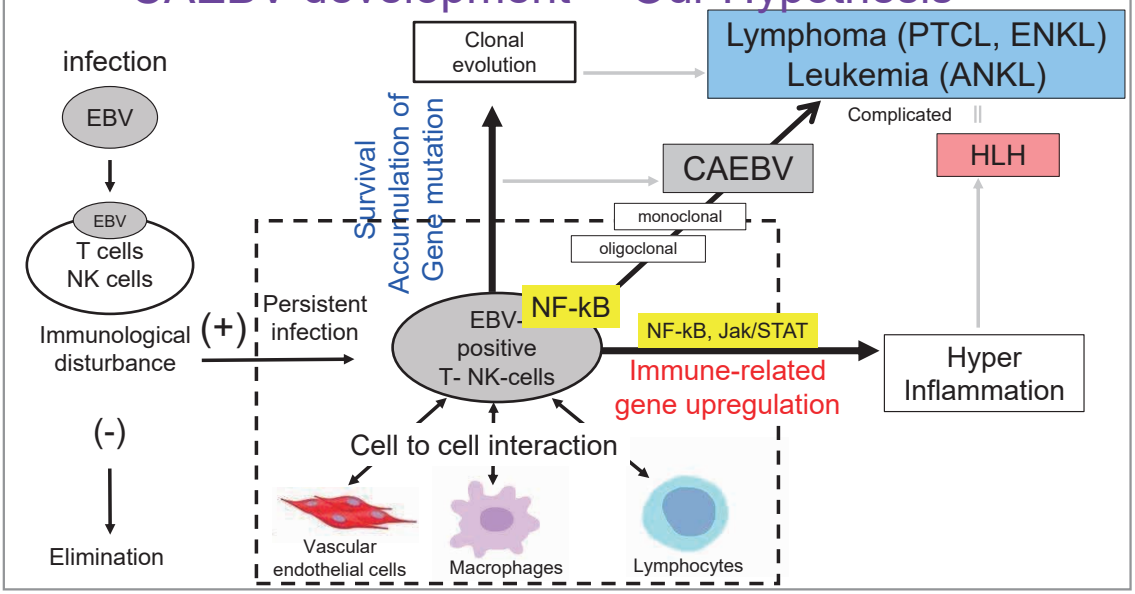
- A condition of persistent or recurrent inflammation accompanied by clonally proliferating EBV-infected T- or NK-cells
- reported mainly in Japan, China and other East Asian countries
- average incidence in Japan: 30/year
- WHO 5th defined CAEBV as an EBV+ neoplasm and set 3 subtypes
  - Systemic CAEBV: CAEBV with systemic inflammation, fever, liver dysfunction, lymphadenopathy, vasculitis etc.
  - Hydroa Vacciniforme Lymphoproliferative disorder
  - Severe Mosquito Bite Allergy

Diagnostic Criteria of CABEV

1. Systemic inflammation **persisting for more than 3 M**
2. **Increased EBV-DNA in blood**
3. EBV infection in T cells or NK cells
4. Exclusion of other known diseases

★ Immunodeficiency, autoimmune disorders, lymphoma, Other infectious disease etc.

CAEBV development — Our Hypothesis —



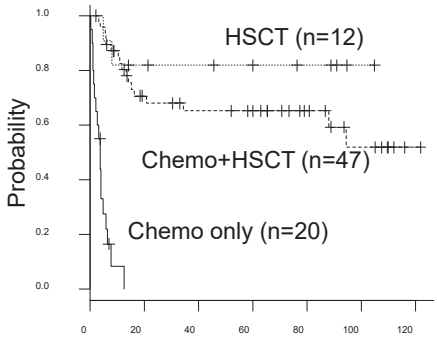
Issues in CAEBV

1. Difficulty in Diagnosis
   - Limited awareness among physicians
   - Difficulty in Proving EBV Infection of T and NK Cells
2. No Curative Drug; Only HCT Offers a Cure

Clinical issues of CAEBV
No curative medical treatment

according to the nationwide survey Japan 2020

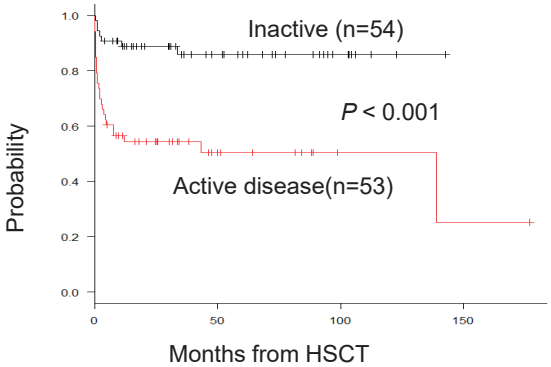
- In NO patient
  with spontaneous remission,
  EBV-infected cells were
  eradicated after chemotherapies



Yonese et.al blood adv, 2020

Inflammation (disease activity) is associated with the prognosis of allo-transplantation

The Results of TRUMP* data analyses



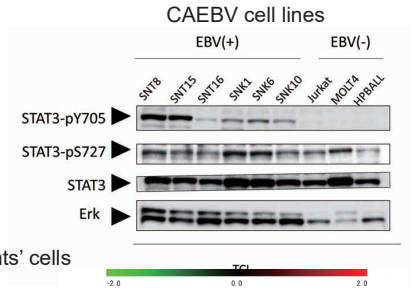
*Japanese registry of HSCT
Disease activity
- Fever
- ALT ↑
- Progressive skin lesion
- Uveitis
- Vasculitis

Yamamoto et.al Am J H.
97(6):780-790

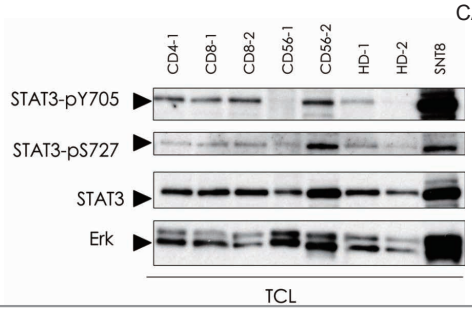
- Must resolve disease activities before allo-HSCT

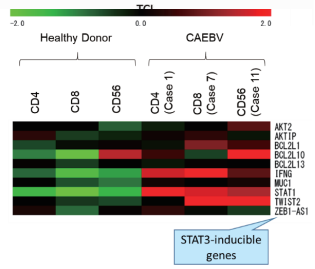
Constitutive activation of STAT3 in CAEBV

STAT3 is
- a transcription factor
- mediating survival signals
- inducing cytokine production and mediating the downstream signals of their receptors
- constitutively activated in neoplastic cells



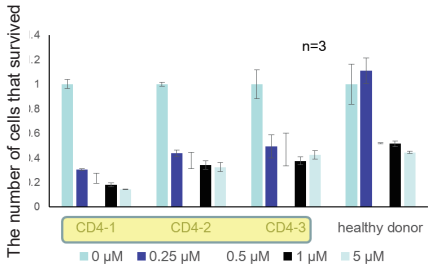
CAEBV patients' cells

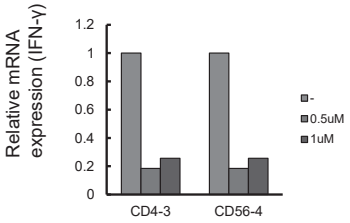




Onozawa et.al Oncotarget. 2018;9:31077-31089.

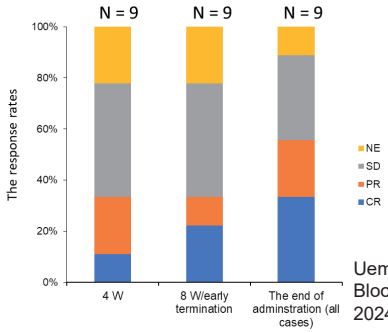
The effects of a Jak inhibitor ruxolitinib on CAEBV





Onozawa et.al Oncotarget. 2018;9:31077-31089.

An investigator-initiated clinical trial
- "Evaluating Oral JAK1/2 Inhibitor Ruxolitinib in Chronic Active Epstein-Barr Virus Infection" (UMIN# 000035121)
- Phase II Open-Label Study
- PI: Ayako Arai



Uemura et.al
Blood neoplasia
2024 Nov 2;2(1):100053.

Summary

EBV can drive lymphomagenesis in T and NK cells.
CAEBV gives us a unique window into this transformation.

Understanding CAEBV and establishing standard care will benefit all EBV-positive T/NK-cell neoplasms.

Symposium：Prospect of Clinical Infectious Diseases

Session Ⅳ
Research progress on the cure of hepatitis B

Speaker

侯 金林

Jinlin HOU

M.D.

Professor and Chairman of Institute of Hepatology, Department of Infectious Diseases, Institute of Hepatology, Nanfang Hospital, Southern Medical University



Education

1999-2000	Insititute of Hepatology,University College London, UK
1993-1995	St' Marry Hospital, Imperial College, UK
1984-1989	Master, First Medical University, Guangzhou, China
1979-1984	M.D., Fourth Medical University, Xi'an, China

Work Experience

2018-	Chairman, Institute of Hepatology, Guangdong, China
2001-	Director, Department of Infectious Diseases, Nanfang Hospital, Southern Medical University
1995-	Full professor, Department of Infectious Diseases, Institute of Hepatology, Nanfang Hospital, Southern Medical University

Other Commitment

President, Asian Pacific Association for the Study of the Liver（APASL）（2017）

President, Chinese Society of Infectious Diseases, Chinese Medical Association（2013-2016）

Vice President of The Chinese Hepatitis Prevention and Control Foundation（2015）

Awards and Honor

Research Grant（Principal Investigator, National Key Technology R&D Program, Hepatitis B therapy）

National Outstanding Youth Fund 2003

Research Grant（Principal Investigator, National Key Technology R&D Program, Hepatitis B biomarker and treatment）

Session Ⅳ Research progress on the cure of hepatitis B

New Progress on Functional Cure Therapies for Hepatitis B

Jinlin HOU

Viral hepatitis caused by HBV remains a critical global public health challenge, characterized by high prevalence and significant morbidity and mortality. The definition of HBV functional cure (FC) is clearly defined and continuously refined: the latest research identifies it as serological clearance of hepatitis B surface antigen (HBsAg) with serum HBV DNA below detectable limits, 24 weeks after treatment cessation.

Current standard treatments like nucleos (t) ide analogs have inherent limitations in achieving FC, highlighting the urgent need for novel therapeutic strategies.

Recent advancements focus on RNA-targeting modalities (siRNAs and ASOs) and immunomodulatory approaches. ASOs such as bepirovirsen and AB-137 act through dual mechanisms: they hybridize with HBV RNA to recruit RNases for viral transcript cleavage, inhibiting protein synthesis, while some activate TLR8-mediated immune responses to enhance infected cell clearance. Clinical trials show significant reductions in HBsAg and HBV DNA.

SiRNAs target HBV mRNA via RNA interference, degrading viral transcripts to halt protein production. With effective hepatocyte delivery, they achieve broad-genotype suppression, reducing viral load and HBsAg in early studies.

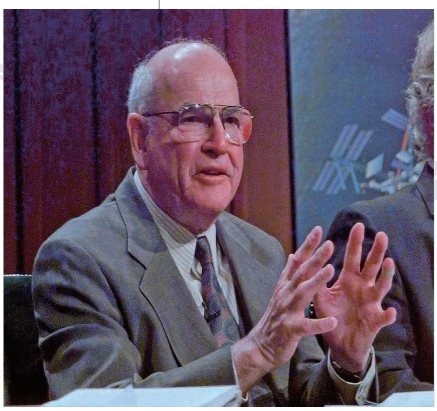
Immunomodulatory therapies are pivotal: therapeutic vaccines break immune tolerance via recombinant proteins/peptides, activating humoral and cellular immunity. Immune checkpoint inhibitors block PD-1/PD-L1 pathways, and TCRT HBsAg reverses T-cell suppression to amplify antiviral activity.

Successful implementation would mitigate transmission, curtail liver disease progression, and alleviate healthcare burdens. Despite challenges like HBsAg reoccurrence and long-term monitoring requirements, overcoming these is critical to establishing these therapies as cornerstones of global HBV elimination.

60 Years of HBsAg Discovery

Baruch Blumberg
first discovered HBsAg

1965



From the discovery of HBsAg to its clearance

1965

The First Discovery of Hepatitis B

Baruch Blumberg
first discovered HBsAg



Primary Prevention

The First Hepatitis B Vaccine Heptavax in 1981



1994

The Era of Antiviral Therapy for Hepatitis B

- Interferon-α
- Entecavir
- Tenofovir Disoproxil Fumarate
- Tenofovir Alafenamide Fumarate

New Heights in Primary Prevention

- Advancing the Global Blocking of HBV Mother-to-Child Transmission
- HBV Mother-to-Child Transmission Rate: 0.2%
- Yin.. Hou. Nat Med. 2024



2024

New Strategies and New Models for HCC Screening

Fan/Hou. J Hepatol. 2020;
Fan/Hou. J Hepatol 2023

The New Era of Hepatitis B Cure

- siRNA Combination Therapies Bring New Hope for Hepatitis B Cure
- Hou et al. N Engl J Med.2024
- Bepi Phase 3 Clinical Trial Ongoing



Specifically, what do we mean by functional cure?

Undetectable HBV DNA[1]

AND

Undetectable HBsAg[1]

SUSTAINED FOR

At least 24 weeks following cessation of all treatment[1]

Viral suppression versus functional cure[2]

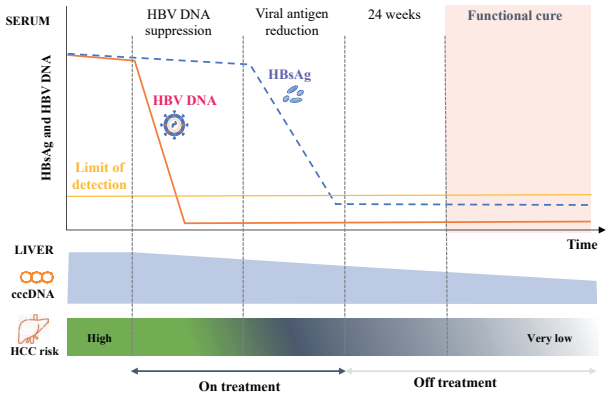
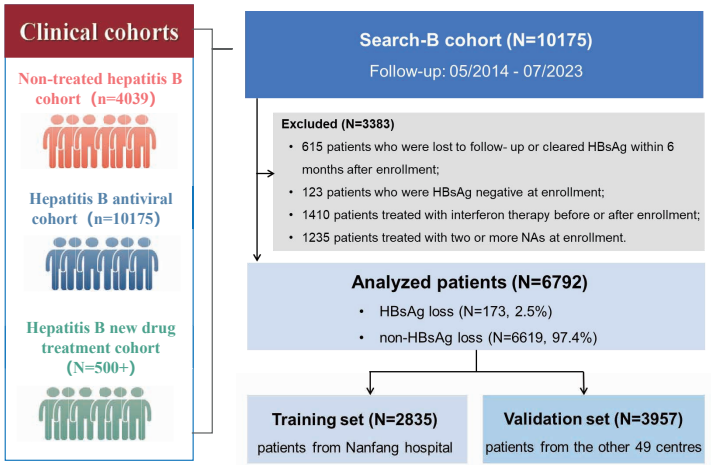


Figure recreated with permission from the Massachusetts Medical Society.[2]
cccDNA, covalently closed circular DNA; HBsAg, hepatitis B surface antigen; HBV, hepatitis B virus; HCC, hepatocellular carcinoma.

1. Ghany MG, et al. *J Hepatol* 2023;79:1254–1269; 2. Janssen H and Sonneveld MJ. *N Engl J Med* 2024;391:2163-2168; 3. Marcellin P, et al. *Liver Int* 2019;39:1868–1875; 4. Lok, ASF. *Gut Liver* 2024;18:593–601;
5. Hanan N, et al. EASL 2023. Poster SAT-158; 6. You H, et al. *J Clin Transl Hepatol* 2023;11:1425–1442.

A new digital model of HBsAg trajectory during long-term treatment in patients with chronic hepatitis B



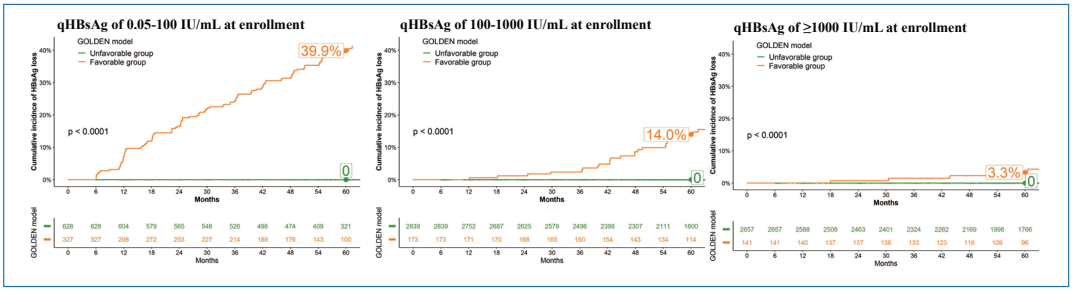
Patient selection flow chart

- All patients were not treated with interferon and had at least two qHBsAg results with a six-month interval.
- A total of 6,792 patients were included in the analysis, and the incidence of HBsAg seroconversion was 2.5%.
- There were 2,835 patients in the training set and 3,957 patients in the validation set.

Fan R et al. GUT. 2024

The stable discriminatory ability of GOLDEN model

- **Among patients with qHBsAg levels of 0.05-100, 100-1000, and ≥1000 IU/mL at enrollment, the GOLDEN model performed consistently discrimination ability.**



Fan R et al. GUT. 2024

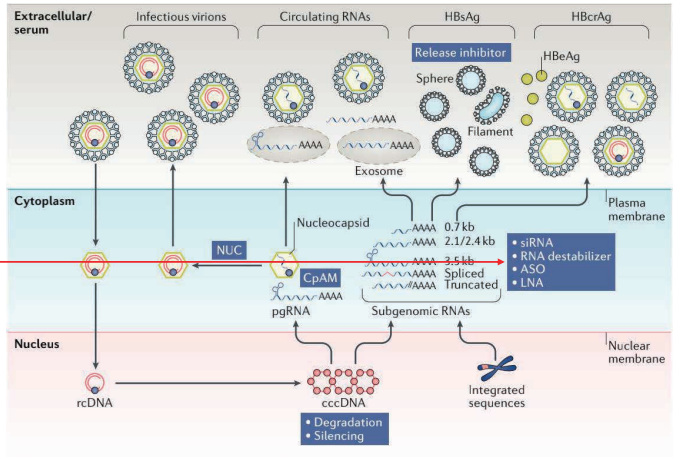
Novel treatment strategies for FC

Antiviral drugs

- **Prevent HBV entry**
- **Direct targeting of cccDNA**
- **Control of viral gene expression**
  - **Transcription**
  - **Post-transcriptional**
- **Capsid assembly**
- **HBsAg release**

Immunoregulation

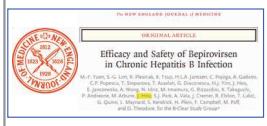
- **Innate immunity**
- **Adaptive immunity**



ASO, antisense oligonucleotide; CpAM, core protein allosteric modulator; LNA, locked nucleic acid; siRNA, small interfering RNA. From Testoni, B., Levrero, M. & Zoulim, F. Challenges to a cure for HBV infection. *Semin. Liver Dis.* **37**(3), 213–242, www.thieme.com (reprinted by permission)[88].

Fanning G C, Zoulim F, Hou J, et al. Nat Rev Drug Discov . 2019

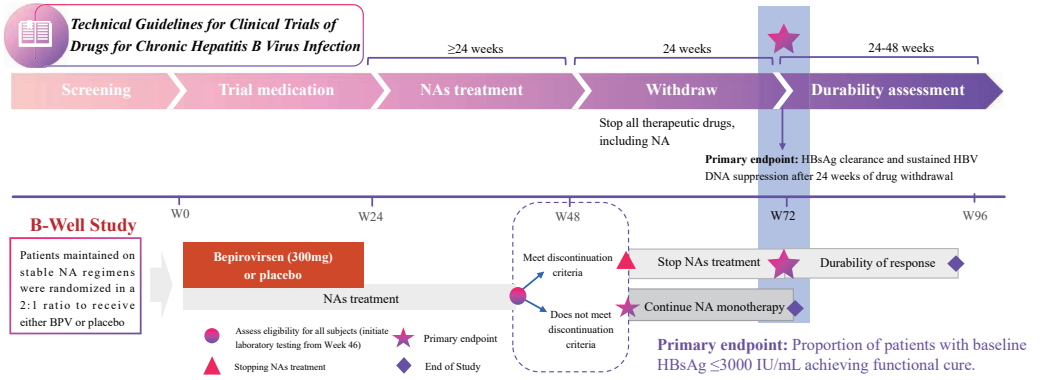
Bepirovirsen IIb trial: nearly 30% achieve HBsAg seroconversion at EOT



In Group 1 (Arm 1) receiving a 300mg dose for 24 weeks:

- **At the end of treatment, 28% (patients treated with NAs) and 29% (patients not treated with NAs) achieved HBsAg < LLOQ and HBV DNA < LLOQ;**
- **At 24 weeks after treatment completion (Post-treatment Week 24), 9% (patients treated with NAs) and 10% (patients not treated with NAs) achieved the primary endpoint (functional cure);**
- **At 24 weeks after treatment completion (Post-treatment Week 24), 16% (patients treated with NAs) and 25% (patients not treated with NAs) of patients with baseline HBsAg < 1000 IU/mL achieved the primary endpoint.**

HBsAg-Specific Trials: The first phase III trial designed for functional cure



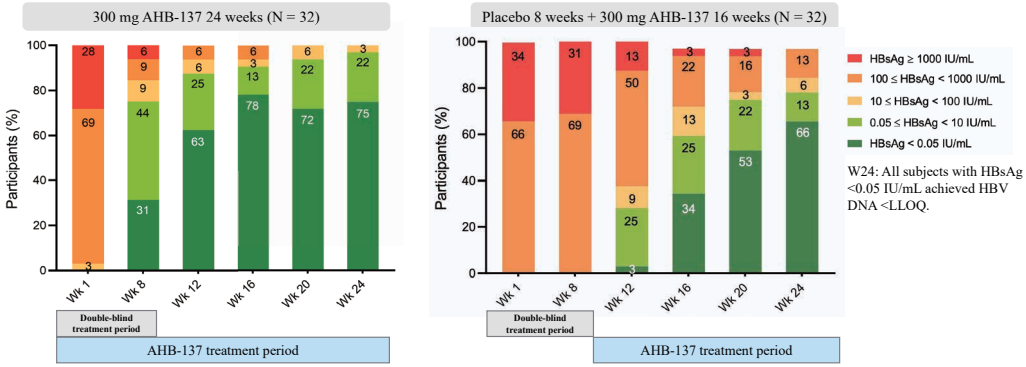
The B-Well study aligns with the NMPA CDE's study design requirements for finite-course therapeutics.

National Medical Products Administration Center for Drug Evaluation. Technical Guidelines for Clinical Trials of Drugs for Chronic Hepatitis B Virus Infection. April 2023.
; ClinicalTrials. NCT05630807; ClinicalTrials. NCT05630820.

Phase IIb clinical study results: HBsAg clearance rate at EOT

➢ **The results of the Phase IIb study reproduced the clinical efficacy of the 300 mg dose administered for 24 weeks in Phase IIa; the 300 mg dose for 24 weeks was more effective than the 300 mg dose for 16 weeks in terms of efficacy**

- **Among subjects receiving AHB-137 300 mg (with baseline HBsAg 100–3000 IU/mL), 75% achieved the primary endpoint at 24 weeks of treatment, which was higher than that in the 16-week treatment group (AHB-137 300 mg, 66%); at the end of treatment, 97% of subjects had HBsAg < 10 IU/mL.**



W24: All subjects with HBsAg <0.05 IU/mL achieved HBV DNA <LLOQ.

$ Primary endpoint: Proportion of subjects achieving a complete response at 24 weeks of treatment; Complete response (CR): serum HBsAg <LOD (0.05 IU/mL) and HBV DNA <LLOQ, with or without anti-HBs presence.

Gao Y.H.et al., 2025 EASL , late breaker poster LBP-014 .

Piranga study: the first in HBV treatment to adopt a platform study design

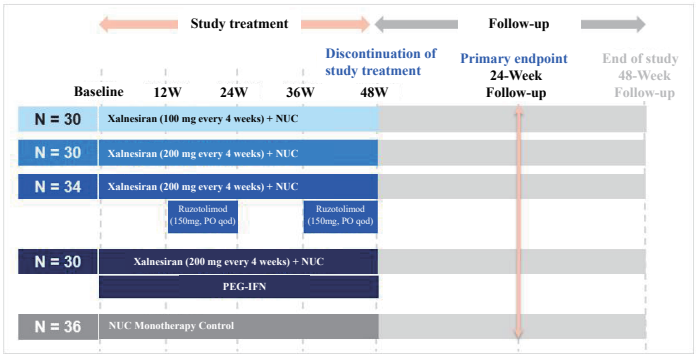
- **The Piranga study is the first in hepatitis B treatment to adopt a platform study design, enabling head-to-head comparisons of multiple new hepatitis B drugs introduced successively into the study (with a total of 9 treatment combinations).**

Participants

- Hepatitis B virus infection for >6 months
- Ongoing nucleos(t)ide analog (NUC) therapy for >12 months, with maintained treatment during the study
- HBV DNA below the lower limit of quantification (LLOQ)
- ALT <1.5 × ULN (upper limit of normal)
- Absence of cirrhosis

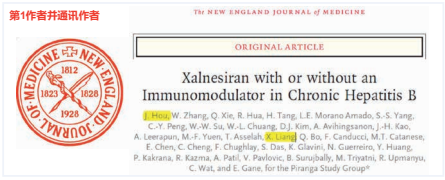
Primary endpoint

HBsAg seroclearance rate (cure rate) at 24 weeks post-treatment



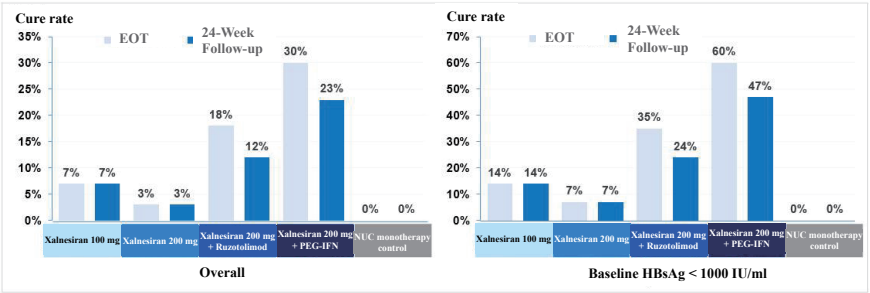
JL Hou et al. N Engl J Med 2024;391:2098-2109

Piranga study: platform study design



New strategy for HBV cure:

- **The rate exceeded 30% with siRNA + immunomodulators**
- **Monotherapy falls short in delivering the final push**



JL Hou et al. N Engl J Med 2024;391:2098-2109

Small nucleic acid drugs, represented by ASOs and siRNA, demonstrate relatively rapid research progress

- Small nucleic acid drugs (oligonucleotides) are single- or double-stranded nucleotides approximately 20mer in length, capable of modulating gene expression and demonstrating significant therapeutic potential for various diseases [1-2]
- **Currently approved and investigational nucleic acid therapeutics are predominantly represented by ASOs and siRNA [2-3]**

The difference between ASO and SiRNA

	ASO [1]	siRNA [1]	
structure	Single-stranded DNA with RNA fragments on both sides	ribotide	Single chain ASO may reduce costs and simplify delivery process [2]
Ideal length	15-25 nucleotides	21 nucleotides	
Entering the cell way	No carrier is required to enter the liver cells	**It needs to bind to the carrier to be absorbed by the liver cells** (like GalNAc)	Most siRNAs currently in clinical development are coupled with GalNAc to achieve hepatocyte-targeted delivery [3]
store up	In the cytoplasm	In the inner body	siRNA compartmentalization leads to higher doses required to achieve desired effects [4]
Frequency of administration	More frequently, weekly or every two weeks	Low frequency (once a month)	The compartmentalization of siRNA can act as a mechanism of sustained release [4]
Targeting mRNA binding	It can be combined with the target individually	**RISC-siRNA complexes need to be formed**	
The main gene The silence mechanism	By RNase H cutting the target RNA	The target RNA is cleaved by Ago protein	RNase H functions in both the nucleus and cytoplasm, enabling it to target intranuclear transcripts that are not susceptible to siRNA action [5]

1.Hui RW, et al.*Clin Mol Hepatol* 2022;28(3):408; 2. Watts JK, et al.*J Pathol* 2012;226(2):365–379; 3. van den Berg F, et al.*Viruses 2020;12(8):851; 4. Corey DR, et al.Nucleic Acid Ther* 2022;32(1):8–13; 5. Roberts TC, et al. *Nat Rev Drug Discov* 2020;19(10):673–694 .
ASO, antisense oligonucleotide; DNA, deoxyribonucleic acid; GalNac, N-acetylgalactosamine; RISC, mRNA, messenger RNA; RNA-induced silencing complex; RNA, ribonucleic acid; RNase H, ribonuclease H; siRNA, small-interfering RNA.

Symposium：Prospect of Clinical Infectious Diseases

Session Ⅳ Research progress on the cure of hepatitis B

Speaker

田中　靖人

Yasuhito TANAKA

M.D., Ph.D.

Chief Professor, Department of Gastroenterology and Hepatology



Education

1999-2001	Visiting Fellowship at National Institutes of Health, Japan
1997-2001	Graduate School of Medical Medicine at Nagoya City University, Japan
1985-1991	Medical School at Nagoya City University, Japan

Work Experience

2020-	Professor, Department of Gastroenterology and Hepatology, Kumamoto University Deputy Dean, Faculty of Life Science, Deputy Hospital Director and Director, Liver Center, Director, Endoscopy Center, Kumamoto University Hospital
2009-2020	Professor and Director, Department of Virology & Liver unit, Nagoya City University Graduate School of Medical Sciences. Director, Liver Disease Unit, Nagoya City University Hospital
2006-2009	Associate professor at Department of Clinical Molecular Informative Medicine, Nagoya City University Graduate School of Medical Sciences.
2002-2006	Lecturer at Department of Clinical Molecular Informative Medicine, Nagoya City University Graduate School of Medical Sciences.
2001-2002	Assistant professor at Department of Clinical Molecular Informative Medicine, Nagoya City University Graduate School of Medical Sciences.
1993-1996	Gastroenterologist, Nagoya Second Red Cross Hospital
1991-1993	Clinical Resident, Nagoya City University Hospital

Other Commitment

The Japanese Society of Internal Medicine

The Japan Society of Hepatology

Japanese Society of Laboratory Medicine

The Japanese Society of Gastroenterology

The Japanese Association for Antiviral Therapy

Japan Liver Cancer Association

The Japan Digestive Disease Week

The Japan Gastroenterological Endoscopy Society

Awards and Honor

2025 Academic Award by The Japanese Society of Gastroenterology

2024 Oda Award by The Japan Society of Hepatology Award

2024 APASL 2024 Kyoto Investigator Award,

2023 Minister of Education, Culture, Sports, Science, and Technology Prize: Novel Hepatic Fibrosis Testing Method

2004 AASLD-APASL Joint Workshop Award, 2007 APASL Presidential Award

Session Ⅳ Research progress on the cure of hepatitis B

A First-in-Class Oral Small Molecule Therapy for the Functional Cure of Hepatitis B

Yasuhito TANAKA

Chronic hepatitis B virus (HBV) infection remains a major global health challenge, as HBV cannot be eradicated once established in hepatocytes. While nucleos (t) ide analogues (NAs) effectively suppress viral DNA replication, they exert minimal impact on hepatitis B surface antigen(HBsAg), the key marker of viral persistence. Achieving a functional cure—defined by sustained HBsAg loss—requires innovative therapeutics that directly target viral RNA and protein production. Although small interfering RNAs (siRNAs) and antisense oligonucleotides (ASOs) have demonstrated promising HBsAg-lowering activity, their injectable route of administration limits accessibility and adherence, particularly in resource-limited settings.

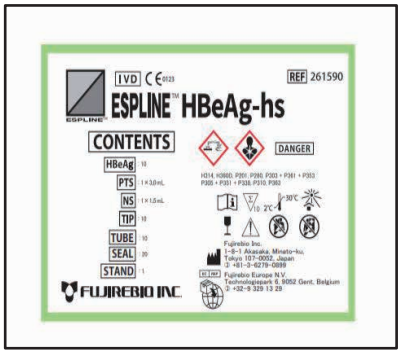
To overcome these challenges, we developed SAG-524, a first-in-class oral small molecule capable of reducing both HBsAg and HBV DNA. A high-throughput screen of 30,000 compounds using HepG2.2.15 and HBV-infected human hepatocytes (PXB cells) identified SAG-524 as a potent RNA destabilizer with low cytotoxicity and broad genotype coverage. Mechanistic studies revealed that SAG-524 destabilizes HBV RNA—including pregenomic RNA and PreS/S mRNA—by inhibiting PAPD5, an RNA poly (A) polymerase critical for HBV RNA stability.

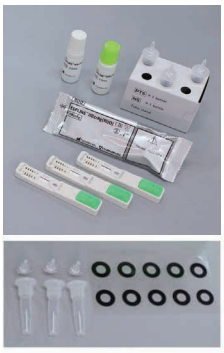
In vivo studies in humanized chimeric liver mice (PXB mice) confirmed significant reductions in serum HBsAg and HBV DNA with oral SAG-524, and combination therapy with entecavir (ETV) further enhanced antiviral efficacy, including reductions in covalently closed circular DNA (cccDNA). Preclinical safety studies in mice and monkeys showed no significant toxicity at doses up to 1,000 mg/kg/day.

SAG-524 represents a promising therapeutic candidate for achieving a functional cure of chronic hepatitis B through an innovative oral mechanism of RNA destabilization.

CE-IVDR approved HBcrAg-RDT assay

(Currently know as HBeAg-hs: highly sensitive)





CE-IVDR (as HBeAg-hs) approved on April, 2025

We are pursuing WHO Prequalification (WHO-PQ) certification.

Comparison of HBeAg reagent sensitivity

Product	Manufacturer	Platform	LoD (PEI U/ml)
HBeAg Rapid Test (RUO)	Biopanda Reagents	RDT	2.6
OneStep (Rapid test) (RUO)	AMS UK Ltd.	RDT	2.5-3
Monolisa HBe Ag-Ab PLUS (CE0459)	Biorad	ELISA	0.64
HBe Ag&Ab – ELISA (CE0318)	Dia.Pro Diagnostic Bioprobes	ELISA	0.25
Vidas HBe/Anti-HBe (CE0459)	BioMérieux	Automated assay	0.25
Elecsys HBeAg (CE0123)	Roche	Automated assay	≤0.3
Architect HBeAg (CE0088)	Abbott	Automated assay	< 0.5
ESPLINE HBeAg-hs (HBcrAg-RDT)	**FujiRebio Inc.**	**RDT**	**0.25**

ESPLINE HBeAg-hs (HBcrAg-RDT) is 10 times higher sensitivity than existing HBeAg-RDTs and has a sensitivity comparable to that of CE-IVDR-certified automated EIA assays.

EIA: enzyme immunoassay
PEI:Paul Erlich Institute (PEI) standard
Source of information: IFU of each reagent, data for serum or plasma

Performance of HBcrAg-RDT to diagnose high HBV DNA levels ≥ 200,000 IU/mL in Asia/Africa





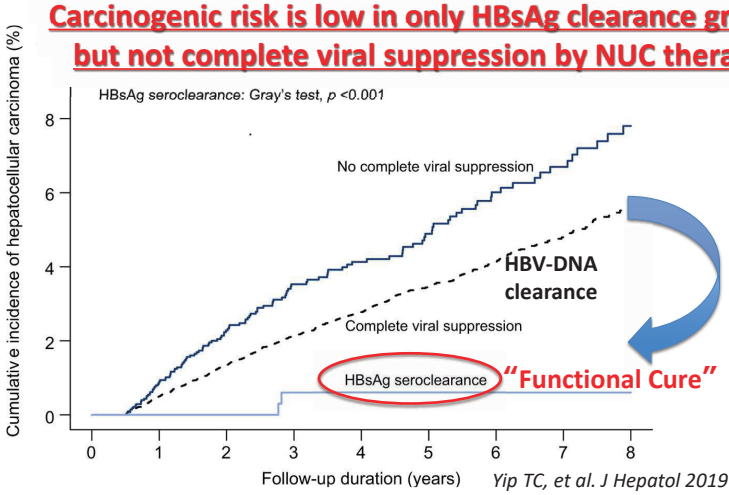
	Cambodia	Cameroon	Burkina Faso	Overall
HBcrAg-RDT	n=1194 (plasma)	n=501 (plasma)	n=269 (capillary blood)	N=1964
Sensitivity	94.0%	90.9%	89.7%	**93.1%**
Specificity	95.2%	92.7%	93.9%	**94.3%**
AUROC (95% CI)	0.946	0.918	0.918	0.937

HBeAg	n=1194 (plasma, RDT)	n=501 (serum, ELISA)	n=217 (serum, CLIA)	n=229 (capillary, RDT)	N=1912
Sensitivity	65.4%	88.6%	90.3%	71.9%	**71.2%**
Specificity	98.4%	96.1%	96.2%	98.5%	**97.5%**
AUROC (95% CI)	0.819	0.924	0.933	0.852	0.843
p-value (vs the AUROC of HBcrAg-RDT)	< 0.0001	0.7886	0.7331	0.0490	< 0.0001

Vincent JP, Tanaka Y et al., Lancet Gastroenterol Hepatol 2025

HBsAg seroclearance further reduces hepatocellular carcinoma risk after complete viral suppression with nucleos(t)ide analogues

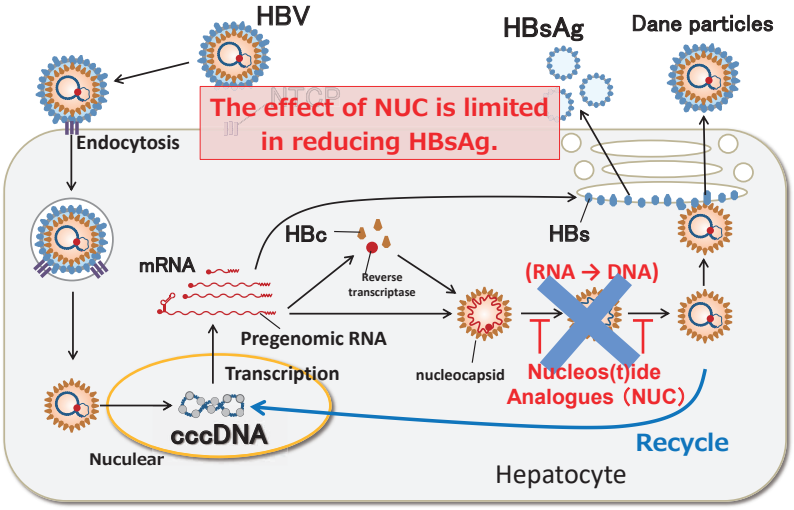
Carcinogenic risk is low in only HBsAg clearance group, but not complete viral suppression by NUC therapy



Yip TC, et al. J Hepatol 2019

Annual HBsAg clearance rate is quite low, < 2%

HBV life cycle and nucleos(t)ide analogues (NUC)

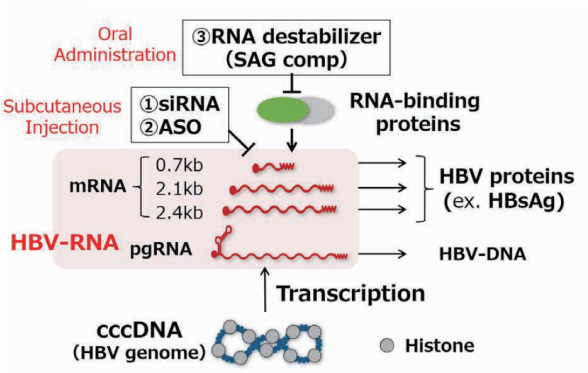


It is difficult to achieve "Functional Cure" with NUC alone, the current first-line drugs.

The Development of the novel anti-HBV Agents

Modified from Y Tanaka, Naika 2018 and Watanabe T, et al. microorganism 2021

HBV RNA-targeting therapeutic approaches



Tanaka Y. Global Health & Medicine, 2024

① Small interfering RNA (siRNA)
- Double-stranded RNA (dsRNA)
- RNA degradation via **AGO2 / RISC**
- Act on mRNA in the cytoplasm.

②Antisense oligonucleotide (ASO)
- Sulfur-modified single-stranded DNA.
- Form DNA/RNA hybrids, degradation via **RNase H.**
- act on mRNA and miRNA in both the nucleus and the cytoplasm.

③RNA-binding protein inhibitor (RNA destabilizer)
- Suppresses HBV replication by targeting host RNA-binding protein.

These HBV RNA-targeting approaches have the potential to strongly suppress HBsAg expression. （これらのHBV RNA標的化アプローチは、HBsAgの発現を強力に抑制する）

Research and Development Concepts for Novel Anti-HBV Drugs

Discovery and optimization of novel compounds with anti-HBV activity

熊本大学 Kumamoto University

Novel MoA that reduces HBsAg, which is difficult to achieve with existing drugs.

Oral — Good oral adherence

Reduction of HBsAg

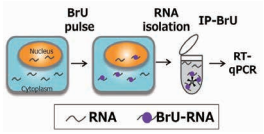
Safety — Safety studies using large animal models

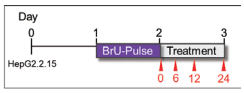
(AMED: Tanaka Y, modified)

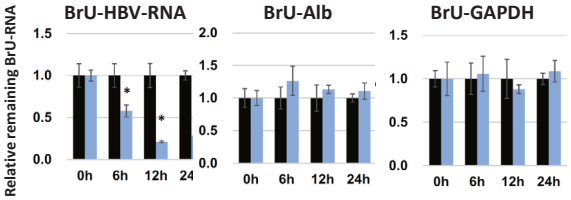
SAG-524 selectively destabilized HBV-RNAs.

BRIC assay RNA degradation kinetics

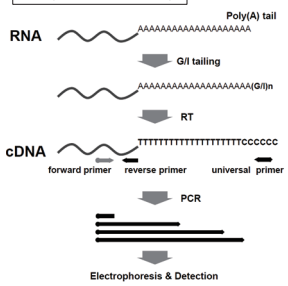
＊BRIC-assay : 5-Bromouridine IP chase assay

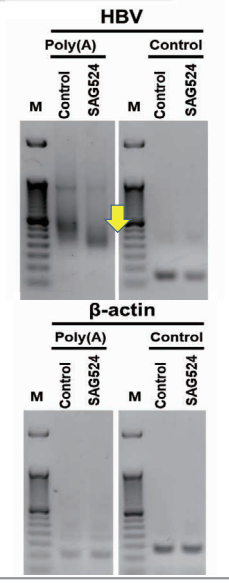






Poly(A) tail assay



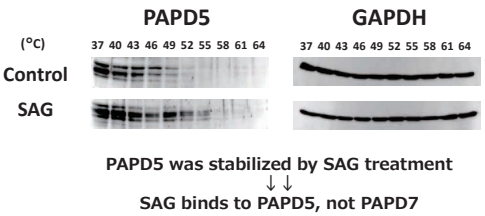


SAG-524 shortened the poly(A) tails of HBV-RNA.

SAG-524 specifically destabilized HBV-RNA.

(Watanabe T, Tanaka Y, et al. J Gastroenterol 2024)

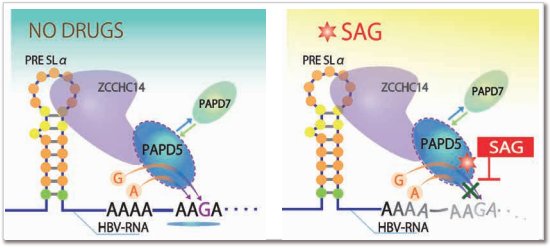
SAG-524 Exerts its Anti-HBV Effects by Targeting PAPD5

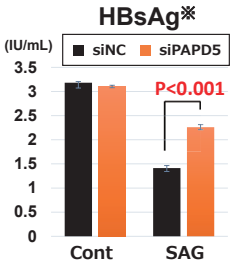


PAPD5 was stabilized by SAG treatment

↓↓

SAG binds to PAPD5, not PAPD7





SAG reduced HBsAg levels, but the effect is attenuated by siPAPD5

↓↓

SAG acts via PAPD5

(Watanabe T, Tanaka Y, et al. J Gastroenterol 2024)

SAG-524- Highly effective in HBV Animal Models

熊本大学 Kumamoto University

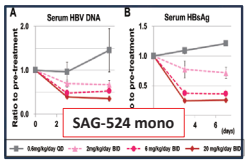


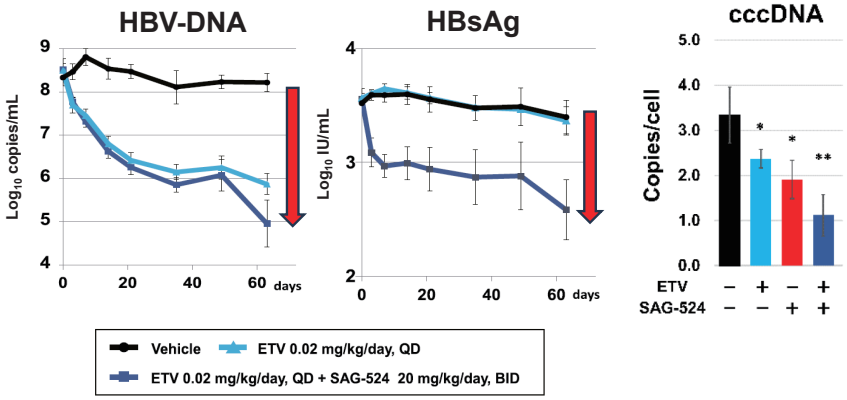
HBV-infected PXB mice

⇩

ETV p.o.

± SAG-524 p.o.



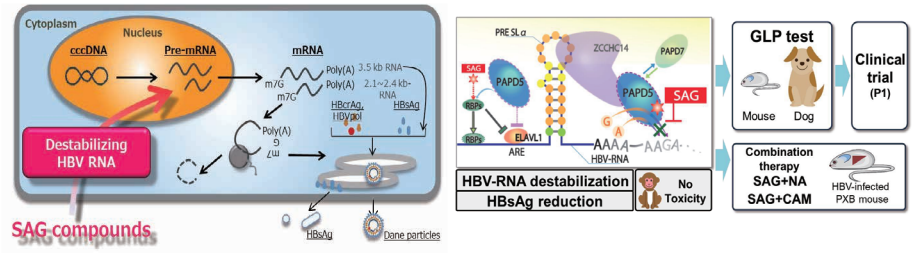


Addition of SAG to ETV markedly reduced both HBsAg and HBV-DNA in the serum of HBV-infected PXB mice

(Watanabe T, Tanaka Y, et al. J Gastroenterol 2024)

Summary

SAG-cmp is an oral small molecule that destabilizes HBV RNA by targeting RNA-binding proteins like PAPD5.



- ✓ **Degradating HBV RNA from cccDNA, suppresses viral transcription, and reducing HBsAg, HBV DNA (RNA) and HBcrAg.**
- ✓ **Complementing existing therapies and showing potential synergy with NAs, IFN-α, or CAMs.**
- ✓ **Advancing to clinical development with strong preclinical data, no observed toxicity (even 13-weeks repeated study in monkey), and AMED support.**

(Watanabe T, Tanaka Y, et al. J Gastroenterol 2024)

Prof. Yasuhito Tanaka, M.D., Ph.D.,
Kumamoto University
E-mail: ytanaka@kumamoto-u.ac.jp

Prospects of Combination Strategies for HBV cure

Supplier elimination	+	*Replication inhibition*	+	*HBsAg reduction*	+	*Immune stimulation*
・Targeting cccDNA/integrated HBV genome		• Entry inhibitors • NUC • CAM		• siRNA/ASO • NAP/STOP **・RNA destabilizer**		• TLR7/8 agonists • Anti-PD-1/anti-PD-L1 • B/T cell vaccines • IFN
				one or multiple?		Optimal use?

Patient factors	
Low HBsAg	High HBsAg

pre-treatment stratification

Timing of treatment	
Concurrent	Sequential

Modified from Grace LH, et al. *Journal of Hepatology* 2022,76;1249–1262

日中医学交流会議開催一覧

開催年	テーマ	開催都市
2025	感染症の臨床的展望	青島
2019	がん治療の現況と近未来	東京
2018	生活習慣病：日中における現状と対策・・・国家レベルとしての取り組み	北京
2016	日中両国の医学医療領域における先進課題	東京
2015	日本医療の国際展開と中国における日中医学協会の役割	東京
2012	中国医療衛生改革の現状および展望（講演：陳嘯宏中国衛生部副部長）	東京
2011	日中両国における高齢化社会と医療：認知症の早期発見と介入	東京
2010	胃腸と健康：消化管炎症、発がんへの細菌の関与	東京
2009	環境と健康：環境因子と疾病の変遷	東京
2008	インフルエンザ：日中における新型インフルエンザ流行対策の現状と展望	東京
2007	放射線治療の現状と展望	東京
2006	メタボリックシンドローム：日中における現状と取り組み	東京
2005	インフルエンザ／エイズ（講演：陳嘯宏中国衛生部副部長）	東京
2004	中国の病院の現状と未来（講演：黄潔夫中国衛生部副部長）	東京
2003	SARS の治療と予防（講演：劉暁勤中日友好医院副院長）	東京・大阪
2000	中国予防医学の現状と未来（講演：殷大奎中国衛生部副部長）	東京
1999	中国の医療分野における行政改革（講演：王隴徳中国衛生部副部長）	東京
1998	中国の薬務行政の管理と製薬事業（講演：彭玉中国衛生部副部長）	東京・大阪
1997	感染症と心臓外科（講演：殷大奎中国衛生部副部長）	東京
1995	日中医学学術交流の過去・現在・未来	東京
1994	中国と日本の中西医結合（講演：張文康中国衛生部副部長）	仙台・東京
1993	日中医学交流の現状と将来（講演：顧英奇中国衛生部副部長）	東京
1991	中国の老年病の現状と課題（講演：顧英奇中国衛生部副部長）	東京
1990	中国の環境衛生（講演：何界生中国衛生部副部長）	東京
1988	中国の医学研究体制（講演：顧英奇中国衛生部副部長）	東京
1987	中国の医学教育・研究体制の現況（講演：陳敏章中国衛生部長）	東京・仙台・大阪

※中国衛生部（現；中国国家衛生健康委員会）：日本の厚生労働省に相当する機関

日中医学交流会议召开一览表

年	题目	召开城市
2025	感染性疾病的临床前景	青岛
2019	癌症治疗的现状与近期未来	东京
2018	慢性病：日中现状和对策……国家级别的对策	北京
2016	中日两国医学医疗领域中的高端课题	东京
2015	日本医疗在国际上的推广与日中医学协会在中国的作用	东京
2012	中国医疗卫生改革的现状与展望（讲演：陈啸宏中国卫生部副部长）	东京
2011	中日两国的老龄化社会与医疗：痴呆症的早期发现与介入	东京
2010	胃肠与健康：消化道炎症与细菌在致癌方面的影响	东京
2009	环境与健康：环境因子与疾病的变迁	东京
2008	流行性感冒：日中新型流感流行对策的现状与展望	东京
2007	放射线治疗的现状与展望	东京
2006	代谢综合症：在日中两国的现状与对策	东京
2005	流行性感冒 /AIDS（讲演：陈啸宏中国卫生部副部长）	东京
2004	中国医院的现状和未来（讲演：黄洁夫中国卫生部副部长）	东京
2003	SARS 的治疗与预防（讲演：刘晓勤中日友好医院副院长）	东京 / 大阪
2000	中国预防医学的现状与未来（讲演：殷大奎中国卫生部副部长）	东京
1999	中国医疗领域行政改革（讲演：王陇德中国卫生部副部长）	东京
1998	中国药务行政管理与制药事业（讲演：彭玉中国卫生部副部长）	东京 / 大阪
1997	感染症与心脏外科（讲演：殷大奎中国卫生部副部长）	东京
1995	日中医学学术交流的过去现在未来	东京
1994	中日两国的中西医结合（讲演：张文康中国卫生部副部长）	仙台 / 东京
1993	中日医学交流的现状与将来（讲演：顾英奇中国卫生部副部长）	东京
1991	中国老年病现状与课题（讲演：顾英奇中国卫生部副部长）	东京
1990	中国环境卫生（讲演：何界生中国卫生部副部长）	东京
1988	中国医学研究体制（讲演：顾英奇中国卫生部副部长）	东京
1987	中国医学教育及研究体制现状（讲演：陈敏章中国卫生部长）	东京 / 仙台 / 大阪

※中国卫生部（现中国国家卫生健康委员会），相当于日本的厚生劳动省。

あとがき

日中医学交流会議は、本協会が財団設立当初より、ほぼ毎年継続して開催してきた学術シンポジウムです。広報委員会は、そのシンポジウムの内容を記録する業務を担い、『日中医学』において特集を組んでまいりました。本号では、これまでと同様に、2025年に中国・山東省青島市で開催された《日中医学交流会議2025》の内容を特集としてまとめました。

今回の交流会議のテーマは「感染症の臨床的展望」です。2025年9月に中華医学会感染症病学分科会が青島市内のホテルを会場として開催されたことにあわせ、9月6日に同ホテル内にて本交流会議が開催されました。

まず開会式では、中華医学会の周明堅副会長および当協会の小川秀興会長よりご挨拶がありました。続いて、次期中華医学会感染症病学分科会長である王福生先生より、中国における主要感染症および新興感染症対策について基調講演が行われました。

さらに、日中両国の感染症専門家によるシンポジウムが開催されました。シンポジウムでは4つの感染症をテーマとし、HIV治療については李太生先生と木内英先生に、薬剤耐性菌については王明貴先生と大曲貴夫先生に、EBV感染症については張文宏先生と新井文子先生に、B型肝炎については侯金林先生と田中靖人先生にご講演いただきました。中国の専門家からも活発な質疑・コメントが寄せられ、大変充実した内容となりました。

なお、本誌への掲載につきましては、誌面の都合上、演者のご了解を得たうえで、プロフィール、講演要旨および発表スライドの一部の掲載とさせていただきました。『日中医学』では、これまで日本語と中国語の両言語で記事を掲載しておりますが、本協会が主催する講演会などの講演報告については英語で掲載しております。

交流会議の最後には青島共同宣言が採択され、「両国の専門家は、技術の相互共有や共同研究を通じて、地域の感染症予防・制御能力および公衆衛生安全保障を共同で向上させていくことを目指す」ことが確認されました。

青島での対面交流を通じて再確認された強固な信頼関係が、今後、より多層的かつ継続的な連携へと発展し、人類の健康福祉の向上に貢献し続けることを切に願っております。

最後に、本特集の編纂にあたり、ご多忙の中ご協力を賜りました演者の先生方、ならびに関係各位に心より御礼申し上げます。

本次“中日医学交流会议2025青岛”能够邀请到诸多人士出席并圆满召开，在此由衷地感谢大家的支持与帮助。交流会议上中日两国专家就《青岛共同宣言》达成共识，其中确认“中日两国专家愿意通过技术共享、联合研究等方式，共同提升区域感染病防控能力和公共卫生安全。”

（緒方　剛　広報委員会委員長）

維持会員へのご入会について

当協会の趣旨にご賛同くださる方（法人を含む）に会員としてご入会いただいております。ご入会についての詳細は、当協会ホームページをご覧ください。オンラインでもご入会いただけます。

日本語　https://www.jpcnma.or.jp/entry/

中国語　https://www.jpcnma.or.jp/zh/entry/

2025年12月～2026年2月の新入会員のご芳名を記して感謝いたします。（五十音順　敬称略）

新入会員

石島旨章、近藤　豊、張新昭
陳佳玉、寺尾泰久、楊浩勇

ご寄附のお願い

当協会が、公益事業の充実を図り、日中医学交流をさらに発展させていくために、皆様の温かいご支援をお願いいたします。ご寄附についての詳細は、当協会ホームページをご覧ください。

日本語　https://www.jpcnma.or.jp/contribution/

中国語　https://www.jpcnma.or.jp/zh/contribution/

次号予定

特集《日中医学協会財団設立40年のあゆみと展望》

中国語

特辑《日中医学协会财团成立40周年的历程与展望》

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日中笹川医学奨学金制度第48期研究者募集のお知らせ

日中笹川医学奨学金制度は、日本財団、日中医学協会、中国国家衛生健康委員会が協力し、1986年から実施している奨学金制度です。

2026年は以下の要領で、第48期＜学位取得コース＞＜ポストドクターコース＞＜共同研究コース＞の研究者を募集いたします。

学位取得コース

中国の医療関係者の日本の博士学位取得を支援します。

1. 対象者

中国の以下の機関の正規在籍者であること。

1）中国各省、自治区、直轄市の衛生健康委員会及びその直属の医療、研究、予防衛生、保健衛生等の機関
2）各直轄市の区レベルの医療衛生機関
3）各省の市レベルの医療、研究、予防衛生、保健衛生等の機関
4）大学、医学専門学校（医学、薬学及び日本語専攻）
5）国家衛生健康委員会の直属機関または連携機関
6）各部隊の関連機関
7）国務院の部、委、局の直属の医薬衛生機関
8）合資または民営の三級甲病院（先進医療提供病院）及びその附属研究機関
9）国家市場監督管理総局直属の医薬衛生機関

2. 募集人数　10名

3. 助成期間　2027年4月から3年間
（4月初旬に日本に入国すること）

4. 留学機関　日本国内の大学

5. 奨学金の内容

1）日本滞在中の生活費及び宿舎費
……月額10万円（研究者に支給）
2）学費……年額70万円を上限（受入機関に支給）
※日本－中国間の往復国際航空運賃、海外旅行傷害保険料、面接試験参加旅費、訪日前の語学研修参加費（宿舎費・交通費を含む）、訪日前説明会参加費は、中国所属機関が負担する。

6. 応募の要件（次のすべての要件を満たしていること）

1）1987年4月1日以降に出生した者。
2）中国教育部承認の学部（本科）卒業者、修士課程修了者及び博士課程在学生。日本の大学院博士課程在学中の中国籍研究者も応募可とする（留学期間終了後に中国への帰国を条件とする）。
3）専門論文、著書、研究業績等を有する者。
4）IELTS 6.0点、TOEFL-iBT 80点（TOEFL-PBT 550点）以上の英語力、または日本語能力試験N2以上を有する者。英語と日本語の両方の条件を満たす者を優先して選抜する。
5）日本において研究を行うことを希望し、研究の目的が明確で、研究活動を支障なく行うことができ、中国の医療水準の向上に貢献する意志のある者。
6）応募時に日本の指導教官から受け入れ同意書を得ている者。

7. 選考方法

専門家による選考委員会において、面接試験（専門、語学力）を行い、合格者10名を決定する。合格者は、特別な理由がない限り、辞退することはできない。

8. 応募方法

1）募集締切　2026年8月14日（当日消印有効）
2）提出書類
①　所属機関推薦書（指定用紙）

② 申請書類一式（指定用紙）

※申請書類には、英文論文リスト（指定用紙）、日本の指導教官の受け入れ同意書（指定用紙）を含みます。

※指定用紙等は、笹川医学奨学金制度弁公室ホームページ（https://www.sskw.net/）からダウンロードしてください。

※提出書類に不備や不足があった場合は、審査の対象から外しますので、ご注意ください。

ポストドクターコース

中国のポストドクターの日本での研究活動を支援します。

1. 対象者

中国の以下の機関の正規在籍者であること。

1）中国各省、自治区、直轄市の衛生健康委員会及びその直属の医療、研究、予防衛生、保健衛生等の機関
2）各直轄市の区レベルの医療衛生機関
3）各省の市レベルの医療、研究、予防衛生、保健衛生等の機関
4）大学、医学専門学校（医学、薬学及び日本語専攻）
5）国家衛生健康委員会の直属機関または連携機関
6）各部隊の関連機関
7）国務院の部、委、局の直属の医薬衛生機関
8）合資または民営の三級甲病院（先進医療提供病院）及びその附属研究機関
9）国家市場監督管理総局直属の医薬衛生機関

2. 募集人数　10名

3. 助成期間　2027年4月から2年間（4月初旬に日本に入国すること）

4. 研究場所　日本国内の大学・病院・研究所等

5. 奨学金の内容

1）日本滞在中の生活費及び宿舎費
　　‥‥月額15万円（研究者に支給）
2）研究費‥‥年額120万円を上限（受入機関に支給）

※日本－中国間の往復国際航空運賃、海外旅行傷害保険料、面接試験参加旅費、訪日前の語学研修参加費（宿舎費・交通費を含む）、訪日前説明会参加費は、中国所属機関が負担する。

6. 応募の要件（次のすべての要件を満たしていること）

1）1987年4月1日以降に出生した者。
2）中国教育部が認定した博士学位（中国国外で取得したものを含む）を有する者。博士学位を有する日本在留中国籍研究者も応募可とする（留学期間終了後に中国への帰国を条件とする）。
3）専門論文、著書、研究業績等を有する者。
　応募時に研究テーマと直近5年間の研究業績を提出すること。直近5年間に発表した論文のインパクトファクター（IF）が累計で10点以上、または筆頭著者（first author）或いは責任著者（co-responding author）として発表した論文のインパクトファクター（IF）が5点以上であること。
4）IELTS 6.0点、TOEFL-iBT 80点（TOEFL-PBT 550点）以上の英語力、または日本語能力試験N2以上を有する者。英語と日本語の両方の条件を満たす者を優先して選抜する。
5）日本において研究を行うことを希望し、研究の目的が明確で、研究活動を支障なく行うことができ、中国の医療水準の向上に貢献する意志のある者。
6）応募時に日本の指導教官から受け入れ同意書を得ている者。

7. 選考方法

専門家による選考委員会において、書類選考合格者に対して面接試験（専門、語学力）を行い、合格者10名を決定する。合格者は、特別な理由がない限り、辞退することはできない。

8. 応募方法

1）募集締切　2026年8月14日（当日消印有効）
2）提出書類
　① 所属機関推薦書（指定用紙）

② 申請書類一式（指定用紙）

※申請書類には、英文論文リスト（指定用紙）、日本の指導教官の受け入れ同意書（指定用紙）を含みます。

※指定用紙等は、笹川医学奨学金制度弁公室ホームページ（https://www.sskw.net/）からダウンロードしてください。

※提出書類に不備や不足があった場合は、審査の対象から外しますので、ご注意ください。

共同研究コース

中国の医療関係者が、日本の医療関係者と行う共同研究活動を支援します。

1. 対象者

中国の以下の機関の正規在籍者であること。

1）中国各省、自治区、直轄市の衛生健康委員会及びその直属の医療、研究、予防衛生、保健衛生等の機関
2）各直轄市の区レベルの医療衛生機関
3）各省の市レベルの医療、研究、予防衛生、保健衛生等の機関
4）大学、医学専門学校（医学、薬学及び日本語専攻）
5）国家衛生健康委員会の直属機関または連携機関
6）各部隊の関連機関
7）国務院の部、委、局の直属の医薬衛生機関
8）合資または民営の三級甲病院（先進医療提供病院）及びその附属研究機関
9）国家市場監督管理総局直属の医薬衛生機関

2. 募集人数　10チームまたは10名

※申請者は共同研究の遂行に必要な研究チームメンバーを登録し、研究チームとして申請することができる。但し、研究チームメンバーの登録は2名までとし、全員が申請者の中国所属機関・部署の正規在籍者または博士課程在籍者でなければならない。

3. 助成期間　最長6か月間

※2027年4月1日以降に日本に入国すること。日本で開催する共同研究者集会への参加のため、2027年9月は日本に滞在すること。

4. 研究場所　日本国内の大学・病院・研究所等

5. 奨学金の内容

1）日本滞在中の生活費及び宿舎費
……月額25万円（研究者に支給）
2）研究費……月額10万円（受入機関に支給）

※日本－中国間の往復国際航空運賃、海外旅行傷害保険料、訪日前の語学研修参加費（宿舎費・交通費を含む）、訪日前説明会参加費は、中国所属機関が負担する。

6. 応募の要件（次のすべての要件を満たしていること）

1）1977年4月1日以降に出生した者。但し、以下の①～⑥のいずれかを満たす者は、特に優秀な者とみなし、1967年4月1日以降に出生した者も応募可とする。
　① 国家傑出青年科学基金獲得者
　② 長江学者（中国教育部が選抜したトップクラスの研究者）
　③ 国家級科学技術成果二等奨以上受賞者
　④ 各専門領域のリーダー
　⑤ 直近5年間に発表した論文のインパクトファクター（IF）が累計で15点以上である者
　⑥ IFが8点以上の論文を発表したことのある者
2）教授であること。但し、以下の①～⑥のいずれかを満たしている准教授、講師は、特に優秀な者とみなし、応募可とする。
　① 国家傑出青年科学基金獲得者
　② 長江学者（中国教育部が選抜したトップクラスの研究者）
　③ 国家級科学技術成果二等奨以上受賞者
　④ 各専門領域のリーダー
　⑤ 直近5年間に発表した論文のインパクトファクター（IF）が累計で30点以上である者
　⑥ 筆頭著者（first author）或いは責任著者（co-responding author）として発表した論文のインパクトファクター（IF）が10点

以上である者

3）直近５年間に専門論文、著書、研究業績等を有する者。

4）共同研究者と英語または日本語で支障なくコミュニケーションをとることができ、かつ英語で論文発表ができる語学力を有する者。IELTS 6.0 点、TOEFL-iBT 80 点（TOEFL-PBT 550 点）以上の英語力、または日本語能力試験 N2 以上を有する者を優先して選抜する。

5）研究の目的が明確で、研究活動を支障なく行うことができ、中国の医療水準の向上に貢献する意志のある者。

6）日本と共同研究を実施中またはこれから実施する予定で、応募時に日本の機関（共同研究者）から共同研究同意書を得ている者。既に共同研究を実施したことがあり、または実施中の者を優先して選抜する。

7）中国所属機関から出国の同意を得ている者。

7. 選考方法

専門家による選考委員会において、提出書類に基づき書類選考を行い（必要に応じて面接を行い）、合格者を決定する。合格者は、特別な理由がない限り、辞退することはできない。

8. 応募方法

1）募集締切　　2026 年 8 月 14 日（当日消印有効）

2）提出書類

① 所属機関推薦書（指定用紙）

② 申請書類一式（指定用紙）

※申請書類には、英文論文リスト（指定用紙）、日本の機関（共同研究者）の共同研究同意書（指定用紙）を含みます。

※指定用紙等は、笹川医学奨学金制度弁公室ホームページ（https://www.sskw.net/）からダウンロードしてください。

※提出書類に不備や不足があった場合は、審査の対象から外しますので、ご注意ください。

【書類提出先・お問い合わせ】

■書類提出先・申請書類に関するお問い合わせ

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住所：100082　北京市西直門北大街聯慧路 101 号
　　西晴公寓 C 座 0248 室
ＴＥＬ：010-62256266；携帯電話 15901208067
Ｆ ａ ｘ：010-62256266
E-mail：sc1000 @ vip.163.com
ＵＲＬ：www.sskw.net

■本奨学金制度に関するお問い合わせ

【日本】公益財団法人 日中医学協会
　　岡田、李、金
ＴＥＬ：03-5829-9123
E-mail：iryo @ jpcnma.or.jp

【中国】笹川医学奨学金制度弁公室
　　李忠金、呉久利
ＴＥＬ：010-62256266；携帯電話 15901208067
E-mail：sc1000 @ vip.163.com

日中笹川医学奖学金项目第48期研究员选拔工作的通知

中日笹川医学奖学金项目开始于 1986 年，在日本财团、日中医学协会以及中国国家卫生健康委员会共同合作下开展至今。

2026 年度第 48 期＜攻读博士学位型＞＜博士后研究型＞＜共同研究型＞的招生选拔内容如下。

攻读博士学位型

为希望在日本攻读博士学位的中国医疗相关人员提供支持。

1．选拔范围

申请人员须为以下单位的正式工作人员：

（一）各省（区、市）卫生健康委及直属医疗、科研、预防、保健等单位；
（二）各直辖市的区级医疗卫生机构；
（三）地市级医疗、科研、预防、保健等单位；
（四）高等院校、医学专科学校（医学、药学及日语专业）；
（五）国家卫生健康委直属和联系单位；
（六）部队有关单位；
（七）有关部、委、局直属的医药卫生机构；
（八）合资、民营的三甲医院及其附属科研机构；
（九）国家市场监督管理总局直属的医药卫生机构。

2．选拔人数　10 名

3．资助时间　自 2027 年 4 月开始 3 年（于 2027 年 4 月初赴日）

4．留学单位　日本的大学

5．奖学金内容

（一）在日期间的生活费和住宿费
……10 万日元 / 月（支付给本人）
（二）学费……70 万日元 / 年　为上限（支付给接收大学）

※ 往返日本一次的国际间旅费、海外旅行伤害保险、面试所产生差旅费、出国前的语言培训费（含住宿和交通）、出国前说明会等由派出单位承担。

6．申请人条件（须满足如下所有条件）

（一）1987 年 4 月 1 日以后出生。
（二）中国教育部承认的本科毕业生、硕士毕业生及在读博士生；在日本相关大学博士课程在读的中国籍研究人员（以学成回国为前提条件）。
（三）拥有专业论文、论著、专利等科研成果。
（四）英语 IELTS 6.0、TOEFL-iBT 80（TOEFL-PBT 550）以上或日语能力考试（JLPT）N2 级以上者，同时满足以上两个条件者优先选拔。
（五）有赴日本研究的愿望，研究目的明确，能顺利开展研究活动，愿为提高中国医疗水平做出贡献。
（六）报名时已取得日方指导老师的同意接收函。

7．选拔方法

由项目专家评审委员会对申请人进行面试（专业和外语），最终确定 10 名人选。被录取后，无特殊情况不得放弃。

博士后研究型

为希望在日本医学卫生领域从事博士后研究的中国医疗相关人员提供支持。

1．选拔范围

申请人员须为以下单位的正式工作人员：

（一）各省（区、市）卫生健康委及直属医疗、科研、预防、保健等单位；
（二）各直辖市的区级医疗卫生机构；
（三）地市级医疗、科研、预防、保健等单位；
（四）高等院校、医学专科学校（医学、药学及日语专业）；
（五）国家卫生健康委直属和联系单位；
（六）部队有关单位；
（七）有关部、委、局直属的医药卫生机构；
（八）合资、民营的三甲医院及其附属科研机构；
（九）国家市场监督管理总局直属的医药卫生机构。

2．选拔人数　10 名

3．资助时间　自 2027 年 4 月开始 2 年（于 2027 年 4 月初赴日）

4．留学单位　日本的大学、医院、研究所等

5．奖学金内容

（一）在日期间的生活费和住宿费

···· 15 万日元 / 月（支付给本人）

（二）科研费···· 120 万日元 / 年　为上限（支付给接收单位）

※往返日本一次的国际间旅费、海外旅行伤害保险、面试所产生差旅费、出国前的语言培训费（含住宿和交通）、出国前说明会等由派出单位承担。

6．申请人条件（须满足如下所有条件）

（一）1987 年 4 月 1 日以后出生。

（二）有中国教育部承认的博士学位（含在国外获得的学位）；在日本相关大学或研究机构获得博士学位的中国籍研究者（以学成回国为前提条件）。

（三）近五年内拥有专业论文、论著、专利等科研成果（近 5 年内发表论文的影响因子累计达 10 分以上或以第一作者或通讯作者身份发表论文的影响因子在 5 分以上者等）。

（四）英语 IELTS 6.0、TOEFL-iBT 80（TOEFL-PBT 550）以上或日语能力考试（JLPT）N2 级以上者，同时满足以上两个条件者优先选拔。

（五）有赴日本研究的愿望，研究目的和目标明确，能顺利开展研究活动，愿为提高中国医疗水平作出贡献。

（六）报名时已取得日方指导老师的同意接收函。

7．选拔方法

由项目专家评审委员会对申报材料进行评审合格后的申请人接受面试（专业和外语），最终确定 10 名人选。被录取后，无特殊情况不得放弃。

共同研究型

为的中国医疗相关人员与日方研究人员或研究机构开展的共同研究活动提供支持。

1．选拔范围

申请人员须为以下单位的正式工作人员：

（一）各省（区、市）卫生健康委及直属医疗、科研、预防、保健等单位；

（二）各直辖市的区级医疗卫生机构；

（三）地市级医疗、科研、预防、保健等单位；

（四）高等院校、医学专科学校（医学、药学及日语专业）；

（五）国家卫生健康委直属和联系单位；

（六）部队有关单位；

（七）有关部、委、局直属的医药卫生机构；

（八）合资、民营的三甲医院及其附属科研机构；

（九）国家市场监督管理总局直属的医药卫生机构。

2．选拔人数　10 个团队（或 10 人）

※申请人可以团队形式进行申请，团队申请时，团队成员须登记备案。团队成员必须是申请人所在单位、所在科室人员（须是正式员工或在读博士），且备案人数最多不超过 2 人。

3．资助时间　6 个月以内

※须于 2027 年 4 月以后抵达日本。2027 年 9 月必须在日本境内，以便出席此时在日本举行的共同研究型研究员交流会。

4．研究单位　日本的大学、医院及研究所等

5．奖学金内容

（一）在日期间的生活费和住宿费

···· 25 万日元 / 月（支付给研究员）

（二）科研费···· 10 万日元 / 月（支付给接收单位）

※往返日本一次的国际间旅费、海外旅行伤害保险、出国前的语言培训费（含住宿和交通）、出国前说明会等由派出单位承担。

6．申请人条件（须满足如下所有条件）

（一）1977 年 4 月 1 日以后出生，特别优秀者年龄可适当放宽至 1967 年 4 月 1 日以后出生人员（国家杰出青年科学基金获得者、长江学者、国家级科技成果奖二等奖以上获得者、学科带头人、近 5 年发表论文的影响因子累计达 15 分以上或单篇论文影响因子在 8 分以上者，同等条件下可优先录取）。

（二）职称：教授。特别优秀者可放宽至副教授、讲师（国家杰出青年科学基金获得者、长江学者、国家级科技成果奖二等奖以上获得者、学科带头人、近 5 年内发表论文的影响因子累计达 30 分以上、以第一作者或通讯作者身份发表论文的影响因子在 10 分以上者等）。

（三）近五年内拥有专业论文、论著、专利等科研成果。

（四）可使用英语或日语与日方共同研究教授及合作伙伴顺畅地进行交流和沟通，并具备发表英文论文或日文论文的水平。英语 IELTS 6.0、TOEFL-iBT 80（TOEFL-PBT 550）以上或日语能力考试（JLPT）N2 级以上者，同时满足以上两个条件者优先选拔。

（五）研究目的明确，能顺利开展研究活动，愿为提高中国医疗水平作出贡献。

（六）正在或将要与日方开展共同研究者，报名时取得日方接收单位（合作者）的同意函。已经与日方研究人员有过合作研究或正在进行合作研究的，优先选拔。

（七）所在单位同意派出。

7．选拔方法

由项目专家评审委员会对申报材料进行专业评审（必要时将安排面试）并最终确定 10 个团队（或 10 人）。被录取后，无特殊情况不可放弃。

■申请方法及报送要求

请申请人阅读《国家卫生健康委办公厅关于开展 2026 年第 47 期中日笹川医学奖学金项目人员选派工作的通知》后，自行通过各种渠道了解研究专业，联系日本的合作研究者和单位，按照申请表中的“申请须知”填写推荐表和申请表，取得日方导师（或合作者）的同意接收函后，准备申请所需相关材料。

申请人请于 2026 年 8 月 14 日前将全套纸质材料邮寄到中日笹川医学奖学金项目办公室，同时将所有提交材料的 PDF 版发送邮件至 sc1000@vip.163.com。

申请书、推荐表请从 https://www.sskw.net下载。

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■联系人：笹川医学奖学金项目办公室　　李忠金、吴久利

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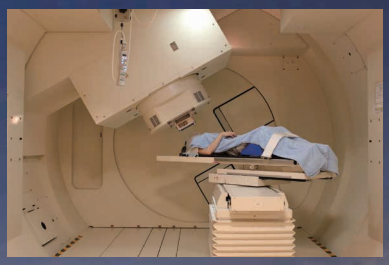
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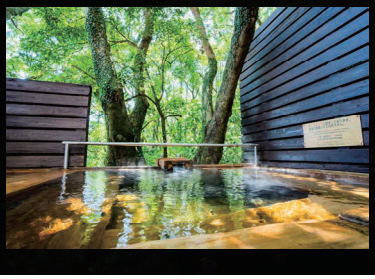
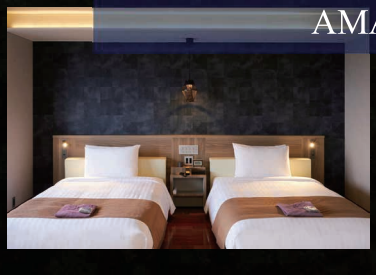
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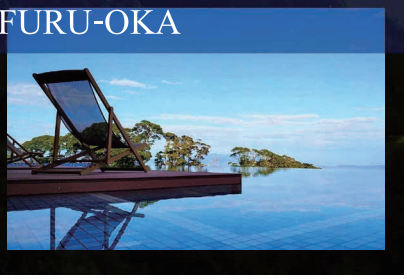


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健康づくりは活血と補腎から

人生100時代

中医学で考える健康増進のキーワード

活血（かっけつ）

血の巡り、血管力

体の隅々まで栄養を運ぶ血は、
元気で長生きのためには特に重要。
血管だけでなく、血液の量や質、
流れる力が健全であることも
大切です。

補腎（ほじん）

脳と骨の充実、足腰の充実

中医学でいう「腎」は生命力を
つかさどるといわれます。
免疫力や自然治癒力、骨の強さや
脳の機能などを支えるために、腎の働き
を補うことが大切です。

未病先防（みびょうせんぼう）

※未病先防…病気になる手前で対応し発症を未然に防ぐこと



中医学では男性は40歳頃から、女性は35歳頃から老化が始まると考えています。このため、若いうちからの健康対策が大切で、「活血」と「補腎」は元気で長生きのためのキーワードといえます。少しでも心や体の不調や健康の不安を感じていたら「未病」の段階からケアすることをおすすめします。

※同じ悩みでも原因や体質により対処法は異なります。

イスクラ 婦宝当帰膠（ふほうとうきこう）B

トウキ、センキュウ、オウギなど9種類の
動物性・植物性生薬を配合。

〈効能・効果〉
更年期障害による下記疾患：
冷え症、貧血、生理不順、
生理痛、腹痛、腰痛、肩こり、
頭痛、めまい、のぼせ、耳鳴り



第2類医薬品 ●300mL･300mL×2

イスクラ 冠元顆粒（かんげんかりゅう）

タンジン、コウカなど6種類の
理気活血の植物性生薬を配合。

〈効能・効果〉
中年以降または
高血圧傾向の
あるものの次の諸症：
頭痛、頭重、肩こり、
めまい、動悸



第2類医薬品 ●45包・90包

イスクラ 双料杞菊顆粒（そうりょうこぎくかりゅう）

六味丸にキクカ、クコシを加えた
8種類の植物性生薬を配合。

〈効能・効果〉体力中等度以下で、疲れやすく胃腸障害がなく、尿量減少又は多尿で、ときに手足のほてりや口渇があるものの次の諸症：
かすみ目、つかれ目、
のぼせ、頭重、めまい、
排尿困難、頻尿、
むくみ、視力低下



第2類医薬品 ●45包・90包

健康づくりのご相談はパンダマークの薬局薬店で
日本中医薬研究会
https://chuiyaku.or.jp/

確かな品質の中成薬を、一人ひとり適したカタチで。
イスクラ産業株式会社
https://www.iskra.co.jp/

イスクラ産業の製品は、症状・体質などをご相談のうえご購入ください。インターネット等による通信販売は行っておりませんのでご了承ください。

服薬コンプライアンス向上を目指して

クラシエの漢方

粒が小さい細粒剤

クラシエ KB2 スティック



1日2回[※1]の漢方





飲みやすさに配慮した
スティック包装

湯剤を目指した抽出方法を選択

85.4%の方が



1日2回製剤が良い[※3]

と回答[1)]

生薬の配合量と種類に着目





こだわりの品質

賦形剤を少なくしエキスの含有率を高めた製剤[※2]



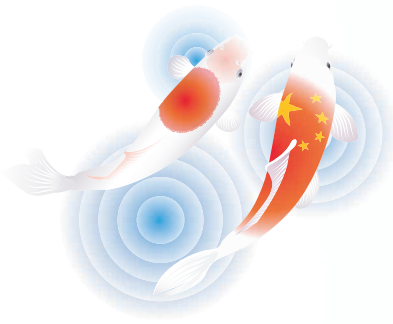
暮らしに寄り添う漢方へ。

※1 通常、成人1日量を2~3回に分割し、食前又は食間に経口投与する。なお、年齢、体重、症状により適宜増減する。※2 厚生労働省:医療用漢方エキス製剤の取り扱いについて(厚生省薬務局審査課長通知,薬審2第120号,1985)以前以後を比較。※3「1日2回のほうがよい」「どちらかといえば1日2回のほうがよい」と回答した方の合計。※4 旧品は飲み口が50mm、現行品は24.3mm。

1) 一般生活者を対象としたインターネット調査(n=103)　調査時期:2023年12月
調査会社:株式会社インテージヘルスケア　調査本体:クラシエ薬品株式会社

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〈受付時間〉10:00~17:00(土、日、祝日、弊社休業日を除く)

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