

Alprostadi (Prostaglandin E₁) – Standard Concentration

Newborn use only

2025

Alert	1 microgram = 1000 nanograms. Always consult with paediatric cardiologist prior to commencing alprostadi. Prostin VR preparation contains ethanol.
Indication	1. Temporary maintenance of ductus arteriosus patency in duct -dependent congenital heart disease (CHD). 2. Add on medication for unresponsive pulmonary hypertension in congenital diaphragmatic hernia (CDH).
Action	Relaxes the ductus arteriosus in early postnatal life and supports its patency.
Drug Type	Prostaglandin E ₁ or PGE ₁
Trade Name	Prostin VR.
Presentation	Ampoules (sterile solution) 500 microgram/mL, 1 mL
Dose	Always consult with paediatric cardiologist prior to commencing alprostadi. Starting Dose 10 nanogram/kg/minute (range: 5 to 50 nanogram/kg/minute).¹⁻⁵ A higher starting dose >10 nanogram/kg/minute is required in hypoxic and haemodynamically unstable infants with CHD.^{5,6} Measures are required for the management of apnoea and hypotension at higher doses. Maintenance Dose 3-20 nanogram/kg/minute. Aim to administer the lowest dose that safely maintains ductal patency.¹⁻⁴ Dose can be increased to a maximum dose of 50 nanogram/kg/minute if there is no clinical or echocardiographic response. Very rarely paediatric cardiologist may suggest a short trial of up to 100 nanogram/kg/minute.
Dose adjustment	Therapeutic hypothermia: No information. ECMO: Higher doses may be required. Renal impairment: No dose adjustment. Hepatic impairment: No dose adjustment.
Maximum dose	Higher doses ≥ 50 nanogram/kg/minute may be needed to resuscitate infants with poor perfusion and oxygenation ('grey baby') and with ductal closure in suspected duct-dependent CHD.
Route	IV
Preparation	IV infusion Note: Refer to <u>Appendix</u> for tables to assist with concentration selection. Weight suggestions for infusion concentrations below are a guide only. Clinicians may choose infusion concentration different to the suggested based on expected dose and the corresponding 24-hour fluid volumes. 20mL Syringe 1 microgram/mL (1000 nanogram/mL) infusion (suggested weight <1 kg) Draw up 0.2 mL (100 micrograms) of alprostadi and add 9.8 mL of glucose 5% or sodium chloride 0.9% to make a 10 mL solution (10 microgram/mL). Further dilute: Draw up 2 mL of this solution (20 microgram) and add 18 mL of glucose 5% or sodium chloride 0.9% to make a final volume of 20 mL. 10 nanogram/kg/min = 0.6 mL/kg/hour. 2 microgram/mL (2000 nanogram/mL) infusion (suggested weight 1 to 2 kg) Draw up 0.2 mL (100 micrograms) of alprostadi and add 9.8 mL of glucose 5% or sodium chloride 0.9% to make a 10 mL solution (10 microgram/mL). Further dilute: Draw up 4 mL of this solution (40 microgram) and add 16 mL of glucose 5% or sodium chloride 0.9% to make a final volume of 20 mL. 10 nanogram/kg/min = 0.3 mL/kg/hour. 5 microgram/mL (5000 nanogram/mL) infusion (suggested weight >2 to 3.5 kg)

	Draw up 0.2 mL (100 micrograms) of alprostadi and add 19.8 mL of glucose 5% or sodium chloride 0.9% to make a final volume 20 mL. 10 nanogram/kg/min = 0.12 mL/kg/hour. 10 microgram/mL (10000 nanogram/mL) infusion (suggested for higher doses of 50 nanogram/kg/minute or weight >3.5kg) Draw up 0.4 mL (200 micrograms) of alprostadi and add 19.6 mL of glucose 5% or sodium chloride 0.9% to make a final volume 20 mL. 10 nanogram/kg/min = 0.06 mL/kg/hour. 50mL Syringe 1 microgram/mL (1000 nanogram/mL) infusion (suggested weight <1kg) Draw up 0.2 mL (100 micrograms) of alprostadi and add 9.8 mL of glucose 5% or sodium chloride 0.9% to make a 10 mL solution (10 microgram/mL). Further dilute: Draw up 5 mL of this solution (50 microgram) and add 45 mL of glucose 5% or sodium chloride 0.9% to make a final volume of 50 mL. 10 nanogram/kg/min = 0.6 mL/kg/hour. 2 microgram/mL (2000 nanogram/mL) infusion (suggested weight 1 to 2 kg) Draw up 0.2 mL (100 micrograms) of alprostadi and add 9.8 mL of glucose 5% or sodium chloride 0.9% to make a 10 mL solution (10 microgram/mL). Further dilute: Draw up 10 mL of this solution (100 microgram) and add 40 mL of glucose 5% or sodium chloride 0.9% to make a final volume of 50 mL. 10 nanogram/kg/min = 0.3 mL/kg/hour. 5 microgram/mL (5000 nanogram/mL) infusion (suggested weight >2 to 3.5 kg) Draw up 0.5 mL (250 micrograms) of alprostadi and add 49.5 mL of glucose 5% or sodium chloride 0.9% to make a final volume 50 mL. 10 nanogram/kg/min = 0.12 mL/kg/hour. 10 microgram/mL (10000 nanogram/mL) infusion (suggested for higher doses of 50 nanogram/kg/minute or weight >3.5kg) Draw up 1 mL (500 micrograms) of alprostadi and add 49 mL of glucose 5% or sodium chloride 0.9% to make a final volume 50 mL. 10 nanogram/kg/min = 0.06 mL/kg/hour.
Administration	Ensure administration is via a vein that has a good blood flow. This can be achieved by peripheral cannula if the limb is adequately perfused or via UVC. ²⁴
Monitoring	Continuous pulse oximetry, heart rate, ECG and blood pressure monitoring. Assess urine output and peripheral perfusion frequently.
Contraindications	Cyanotic neonates with persistent foetal circulation. ²³ Neonates with total anomalous pulmonary venous return below the diaphragm. ²³ Neonates with polysplenia or asplenia in whom pulmonary atresia is combined with anomalous pulmonary venous return which may be obstructed. ²³
Precautions	Ensure adequate cardiorespiratory monitoring and cardiorespiratory resuscitation equipment available for immediate use if necessary. Apnoea is frequent. Commencement of alprostadi ≤ 20 nanogram/kg/minute and low maintenance dose reduces apnoea incidence. Titrate to infant's response (increased oxygenation, echo findings and side effects) - Aim is to be on the lowest dose that safely maintains the ductal patency. Hyperosmolar – infuse at concentrations < 20 microgram/mL. Neonates with total anomalous pulmonary venous return below the diaphragm – may precipitate pulmonary oedema because of increased pulmonary blood flow.
Drug Interactions	Concomitant administration with heparin may result in an increased risk of bleeding.

Adverse Reactions	Apnoea is frequent. Commencement of alprostadi ≤ 20 nanogram/kg/minute and low maintenance dose reduces apnoea incidence. Methylxanthines (caffeine or aminophylline) may be used to prevent or treat apnoea.^{7,8} May lower blood pressure by relaxing the vascular smooth muscle and can elevate body temperature. Abdominal distension, bradycardia, enterocolitis, vomiting and skin rash.^{4,9} Skeletal changes and hypertrophic pyloric stenosis have been reported.^{10,11,12} Extravasation may cause tissue necrosis. Flushing – higher incidence with intra-arterial compared with intravenous administration
Overdose	No antidote is available; treatment is symptomatic and supportive. Support respiratory and cardiac function. Monitor pulmonary function, vital signs, ECG and pulse oximetry, and fluid and electrolyte status in patients with significant diarrhoea.²³ Contact the Poisons Information Centre on 13 11 26 (Australia) for information on the management of overdose.
Compatibility	Fluids: Glucose 5%, glucose 10%,²⁵ sodium chloride 0.9%. Y-site: Adrenaline, Amiodarone, Amino acid solutions, ampicillin, caffeine citrate, calcium gluconate, cefazolin, cefotaxime, chlorothiazide, dobutamine, dopamine, epinephrine, fentanyl citrate, flecainide acetate, furosemide (frusemide), gentamicin sulfate, heparin sodium, methylprednisolone sodium succinate, midazolam hydrochloride, milrinone lactate (only at milrinone concentrations of 0.5 mg/mL in glucose 5%), morphine hydrochloride, pantoprazole sodium, pentoxifylline, potassium chloride, sodium nitroprusside, tobramycin sulfate, vancomycin hydrochloride, vecuronium bromide. Uncertain compatibility: Dexmedetomidine, noradrenaline hydrochloride, norepinephrine hydrochloride, SMOFlipid (Alprostadi 20 mcg/mL in D5W approaches the incompatibility threshold with SMOFlipid)
Incompatibility	Fluids: No information Y-site: insulin human regular, levofloxacin, milrinone lactate at concentrations 200 microgram/mL.
Stability	Diluted solution: Stable for up to 24 hours.
Storage	Ampoule: Store at 2 to 8°C. Do not freeze.
Excipients	Ethanol
Special Comments	Do not use if cloudy (crystallised) or hazy. Undiluted solution (500 microgram/mL) is hyperosmolar. Dilute before administration to a concentration of 20 microgram/mL or less.
Evidence	Background The incidence of critical congenital heart disease (CCHD) is estimated to be approximately 1.7 in 1000 live births.² Maintaining duct patency to optimise the balance of pulmonary and systemic blood flow is the cornerstone strategy in the stabilisation and early clinical care of infants with CCHD. Due to its ability to stimulate endothelium and keep ductus arteriosus open, alprostadi is used in the management of infants awaiting definitive surgical intervention of the CCHD. Efficacy Ductal-dependent congenital heart defects There are no randomised controlled trials. Cohort studies report a low starting dose of 10 nanogram/kg/min highly effective in hemodynamically stable infants with an antenatally known duct dependent congenital heart disease when started early and before constriction of the ductus arteriosus. A higher starting dose may be required in infants who have a constricting or closed ductus arteriosus and are hemodynamically unstable and hypoxic.³⁻⁶ Level III-3 studies report maintenance of oxygenation and ductal patency with doses of alprostadi 3 to 20 nanogram/kg/minute.^{1-4, 13, 14} Level III-3 studies report lower rates of apnoea with alprostadi ≤ 20 nanogram/kg/minute.^{1,13} Use of methylxanthines reduced the incidence of apnoea in newborn infants with ductal-dependent congenital heart disease receiving alprostadi.^{7,8} Infants on alprostadi infusions who are intubated for transport have higher rates of complications compared to non-intubated infants.¹⁵ (LOE III-3, GOR C) In infants undergoing balloon atrial septostomy, rapid withdrawal of alprostadi infusion may be associated with hypoxaemia.¹⁶

	Pulmonary hypertension Alprostadi may have beneficial effects in infants with congenital diaphragmatic hernia (CDH) who have unresponsive severe pulmonary hypertension with restrictive ductus arteriosus and suboptimal right ventricle function.¹⁷⁻¹⁹ In a retrospective study, alprostadi was administered to 18 infants with CDH and acute life-threatening pulmonary hypertension who had impaired cardio-respiratory status despite inhaled nitric oxide with or without prostacyclin and sildenafil. All infants were mechanically ventilated and had a bidirectional exclusively right to left high maximum blood flow velocity (> 150 cm/sec) through the ductus arteriosus. Alprostadi was infused via a central catheter at an initial rate of 25 ng/kg/min. The infusion rate was titrated up or down based on the ductal blood flow velocity (target: 100 cm/sec). The authors reported reduction in the median FiO₂ from 0.80 to 0.35 to keep the preductal saturation between 88 to 96% within 6 hours after PGE₁ commencement.¹⁷ Pharmacokinetics Metabolism of PGE₁ is an oxygen-dependent process, occurring in the pulmonary vascular bed and reduced in patients with pulmonary hypertension.²⁰ There is an increased volume of distribution in patients on ECMO requiring increased infusion rates to maintain ductal patency.¹⁰ (LOE IV, GOR C) Safety Reported complications include apnoea (19%), abdominal distension (16%), bradycardia (13%), enterocolitis (6.5%), hypotension (6.5%), vomiting (5%), fever (1.6%) and skin rash (1.6%).^{9, 14} (LOE III-3) With prolonged use, skeletal changes and hypertrophic pyloric stenosis have been reported.^{10-12,21} Caffeine and apnoea: In a small, randomised control trial (n=42) aminophylline significantly reduced apnoea and the need for endotracheal intubation in infants receiving alprostadi at low doses (10 to 30 nanogram/kg/min).⁷ However, no difference was noted in the incidence of apnoea when caffeine was used prophylactically at higher dose of alprostadi (40-50 nanogram/kg/min) in a retrospective study involving 64 infants.⁸ In a study from New South Wales Australia, apnoea was more likely to occur in non-ventilated infants when alprostadi infusion rate was ≥15 nanogram/kg/minute compared with <15 nanogram/kg/minute, and many infants were transported safely without the need for mechanical ventilation and methylxanthine.¹³
Practice points	
References	- Huang FK, Lin CC, Huang TC, Weng KP, Liu PY, Chen YY, Wang HP, Ger LP, Hsieh KS. Reappraisal of the prostaglandin E₁ dose for early newborns with patent ductus arteriosus-dependent pulmonary circulation. <i>Pediatrics and neonatology</i>. 2013;54:102-6. - Strobel AM, Lu le N. The Critically Ill Infant with Congenital Heart Disease. <i>Emergency medicine clinics of North America</i>. 2015;33:501-18. - Vari D, Xiao W, Behere S, et al. Low-dose prostaglandin E₁ is safe and effective for critical congenital heart disease: is it time to revisit the dosing guidelines? <i>Cardiol Young</i>. 2021 Jan;31(1):63-70. - Yucel IK, Cevik A, Bulut MO, Dedeoglu R, Demir IH, Erdem A, Celebi A. Efficacy of very low-dose prostaglandin E₁ in duct-dependent congenital heart disease. <i>Cardiology in the young</i>. 2015;25:56-62 - Haughey BS, Elliott MR, Wiggin JY, et al. Standardizing Prostaglandin Initiation in Prenatally Diagnosed Ductal-Dependent Neonates; A Quality Initiative. <i>Pediatr Cardiol</i>. 2023 Aug;44(6):1327-1332. - Naiyananon F, Dissaneevate S, Thatrimontrichai A, et al. Predictors of high maintenance prostaglandin E₁ doses in neonates with critical congenital heart disease-ductal-dependent pulmonary circulation during preoperative care. <i>Pediatr Neonatol</i>. 2024 Feb 1: S1875-9572(24)00011-1. - Lim DS, Kulik TJ, Kim DW, Charpie JR, Crowley DC, Maher KO. Aminophylline for the prevention of apnea during prostaglandin E₁ infusion. <i>Pediatrics</i>. 2003;112:e27-9. - Higgins KL, Buck ML. Caffeine Citrate for the Prevention of Apnea Associated with Alprostadi Infusions. <i>J Pediatr Pharmacol Ther</i>. 2020;25(3):235-240. - Ofek Shlomai N, Lazarovitz G, Koplewitz B, et al. Cumulative Dose of Prostaglandin E₁ Determines Gastrointestinal Adverse Effects in Term and Near-Term Neonates Awaiting Cardiac Surgery: A Retrospective Cohort Study. <i>Children (Basel)</i>. 2023 Sep 19;10(9):1572. - Watt K, Li JS, Benjamin DK, Jr., Cohen-Wolkowicz M. Pediatric cardiovascular drug dosing in critically ill children and extracorporeal membrane oxygenation. <i>Journal of cardiovascular pharmacology</i>. 2011; 58:126-32.

11. Kaufman MB, El-Chaar GM. Bone and tissue changes following prostaglandin therapy in neonates. The Annals of pharmacotherapy. 1996; 30:269-74, 77.
12. Perme T, Mali S, Vidmar I, et al Prolonged prostaglandin E₁ therapy in a neonate with pulmonary atresia and ventricular septal defect and the development of antral foveolar hyperplasia and hypertrophic pyloric stenosis. Upsala journal of medical sciences. 2013; 118:138-42.
13. Carmo KA, Barr P, West M, Hopper NW, White JP, Badawi N. Transporting newborn infants with suspected duct dependent congenital heart disease on low-dose prostaglandin E₁ without routine mechanical ventilation. Arch disease child Fetal and neonatal edition. 2007;92:F117-9.
14. Lucron H, Chipaux M, Bosser G, Le Tacon S, Lethor JP, Feillet F, Burger G, Monin P, Marcon F. Complications of prostaglandin E₁ treatment of congenital heart disease in paediatric medical intensive care. Arch des maladies du coeur et des vaisseaux. 2005;98:524-30.
15. Meckler GD, Lowe C. To intubate or not to intubate? Transporting infants on prostaglandin E₁. Pediatrics. 2009;123:e25-30.
16. Finan E, Mak W, Bismilla Z, McNamara PJ. Early discontinuation of intravenous prostaglandin E₁ after balloon atrial septostomy is associated with an increased risk of rebound hypoxemia. Journal of perinatology : official journal of the California Perinatal Association. 2008;28:341-6.
17. Le Duc K, Mur S, Sharma D, et al. Center for Rare Disease «Congenital Diaphragmatic Hernia». Prostaglandin E₁ in infants with congenital diaphragmatic hernia (CDH) and life-threatening pulmonary hypertension. J Pediatr Surg. 2020 Sep;55(9):1872-1878.
18. Fortas F, Di Nardo M, Yousef N, et al. Life-threatening PPHN refractory to nitric oxide: proposal for a rational therapeutic algorithm. Eur J Pediatr. 2021 Aug;180(8):2379-2387.
19. Hari Gopal S, Patel N, Fernandes CJ. Use of Prostaglandin E₁ in the Management of Congenital Diaphragmatic Hernia-A Review. Front Pediatr. 2022 Jul 1; 10:911588.
20. Arai K. [The intrapulmonary metabolism of prostaglandin E₁ in patients with pulmonary hypertension]. Masui The Japanese journal of anesthesiology. 1995;44:536-41.
21. Soyer T, Yalcin S, Bozkaya D, Yigit S, Tanyel FC. Transient hypertrophic pyloric stenosis due to prostoglandin infusion. Journal of perinatology : official journal of the California Perinatal Association. 2014;34:800-1.
22. Merative™ Micromedex® Complete IV Compatibility (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: Aug/27/2024).
23. Australian Product Information Prostine VR (Alprostodil). Available from: <https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2010-PI-05405-3&d=20240911172310101>. Accessed 12th September 2024.
24. Seigel A, Legge N, Hughes G, Carmo KB. Umbilical venous catheterisation: emergency central venous access which saves lives in coarctation of the aorta. BMJ Case Reports CP. 2021 Nov 1;14(11):e245789.
25. Palmero D, Chavan E, Berger-Gryllaki M, Tolsa JF, Di Paolo ER, Pannatier A, Henry H, Sadeghipour F. Stability of prostaglandin E₁ solutions stored in polypropylene syringes for continuous intravenous administration to newborns. European Journal of Hospital Pharmacy. 2018 Oct 1;25(e2):e109-14.

Appendix

Infusion tables to assist concentration selection

Table 1: Infusion rates when using alprostadi concentration 1 microgram/mL
(Suggested weight <1kg)

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	Approximate nanogram/kg/minute									
0.5	3.3	6.7	10	13	17	20	23	27	30	33
1	1.7	3.3	5	6.7	8.3	10	12	13	15	17
1.5	1.1	2.2	3.3	4.4	5.6	6.7	7.8	8.9	10	11
2	0.8	1.7	2.5	3.3	4.2	5	5.8	6.7	7.5	8.3
2.5	0.7	1.3	2.0	2.7	3.3	4.0	4.7	5.3	6	6.7
3	0.6	1.1	1.7	2.2	2.8	3.3	3.9	4.4	5	5.6
3.5	0.5	1.0	1.4	1.9	2.4	2.9	3.3	3.8	4.3	4.8
4	0.4	0.8	1.3	1.7	2.1	2.5	2.9	3.3	3.8	4.2

4.5	0.4	0.7	1.1	1.5	1.9	2.2	2.6	3.0	3.3	3.7
5	0.3	0.7	1.0	1.3	1.7	2.0	2.3	2.7	3.0	3.3

Table 2: Infusion rates when using alprostadi concentration **2 microgram/mL**
(Suggested weight 1-2 kg)

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	Approximate nanogram/kg/minute									
0.5	6.7	13	20	27	33	40	47	53	60	67
1	3.3	6.7	10	13	17	20	23	27	30	33
1.5	2.2	4.4	6.7	8.9	11	13	16	18	20	22
2	1.7	3.3	5	6.7	8.3	10	12	13	15	17
2.5	1.3	2.7	4.0	5.3	6.7	8	9.3	11	12	13
3	1.1	2.2	3.3	4.4	5.6	6.7	7.8	8.9	10	11
3.5	1.0	1.9	2.9	3.8	4.8	5.7	6.7	7.6	8.6	9.5
4	0.8	1.7	2.5	3.3	4.2	5	5.8	6.7	7.5	8.3
4.5	0.7	1.5	2.2	3.0	3.7	4.4	5.2	5.9	6.7	7.4
5	0.7	1.3	2.0	2.7	3.3	4.0	4.7	5.3	6	6.7

Table 3: Infusion rates when using alprostadi concentration **5 microgram/mL**
(Suggested weight >2 to 3.5 kg)

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	Approximate nanogram/kg/minute									
0.5	16.7	33	50	67	83	100	117	133	150	167
1	8.3	17	25	33	42	50	58	67	75	83
1.5	5.6	11	17	22	28	33	39	44	50	56
2	4.2	8.3	13	17	21	25	29	33	38	42
2.5	3.3	6.7	10	13	17	20	23	27	30	33
3	2.8	5.6	8.3	11	14	17	19	22	25	28
3.5	2.4	4.8	7.1	9.5	12	14	17	19	21	24
4	2.1	4.2	6.3	8.3	10	13	15	17	19	21
4.5	1.9	3.7	5.6	7.4	9	11	13	15	17	19
5	1.7	3.3	5	6.7	8	10	12	13	15	17

Table 4: Infusion rates when using alprostadi concentration **10 microgram/mL**
(Suggested for higher doses of 50 nanogram/kg/minute or weight >3.5 kg)

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	Approximate nanogram/kg/minute									
0.5	33	67	100	133	167	200	233	267	300	333
1	17	33	50	67	83	100	117	133	150	167
1.5	11	22	33	44	56	67	78	89	100	111
2	8.3	17	25	33	42	50	58	67	75	83
2.5	6.7	13	20	27	33	40	47	53	60	67
3	5.6	11	17	22	28	33	39	44	50	56
3.5	4.8	9.5	14	19	24	29	33	38	43	48
4	4.2	8.3	13	17	21	25	29	33	38	42
4.5	3.7	7.4	11	15	19	22	26	30	33	37

	5	3.3	6.7	10	13	17	20	23	27	30	33
$\text{Dose (nanogram/kg/min)} = \frac{\text{Rate (mL/hr)} \times \text{Concentration (microgram/mL)} \times 1000}{\text{Weight (kg)} \times 60}$ $\text{Rate (mL/hr)} = \frac{60 \times \text{Dose (nanogram/kg/min)} \times \text{Weight (kg)}}{\text{Concentration (microgram/mL)} \times 1000}$											

VERSION/NUMBER	DATE
Original 1.0	22/08/2025
REVIEW	22/08/2030

This standard concentration formulary has been developed by the ANMF standard concentration working group. The working group (in alphabetical order): Mohammad Irfan Azeem, Susanah Brew, Cindy Chen, Michelle Jenkins, Kerrie Knox, Rebecca O'Grady

Authors Contribution

Current version	Nilkant Phad, Srinivas Bolisetty
Evidence Review	Nilkant Phad, David Osborn (original version)
Expert review	Kathryn Carmo, Hiroko Asakai, Amber Seigel
Nursing Review	Renae Gengaroli
Pharmacy Review	Mohammad Irfan Azeem, Kerrie Knox, Rebecca O'Grady, Michelle Jenkins
ANMF Group contributors	Bhavesht Mehta, Rebecca Barzegar, Cindy Chen, Thao Tran, Celia Cunha Brites, Susannah Brew, Bryony Malloy, Samantha Hassall, Jutta van den Boom, Amber Seigel, Tiffany Kwan, Charles Tian, Amy Porter, Trong Tran, Dianne Lee
Final editing	Nilkant Phad
Electronic version	Thao Tran, Cindy Chen, Ian Callander
Facilitator	Srinivas Bolisetty