Clinical Snippets August 2024

1. Diverticulitis

A recent Tools for Practice from the College of Family Physicians of Canada looked at the question: Do antibiotics change clinical outcomes for patients with acute uncomplicated diverticulitis? The bottom line based on current evidence is that for non-septic immunocompetent patients with acute uncomplicated diverticulitis, antibiotics do not alter early complication or recurrence rates.

This approach is emphasised in a 2023 BPAC article on diverticular disease which contains detailed diagnostic and management advice including the following practice points:

- Patients with red flag symptoms indicative of complicated diverticulitis, e.g. abscess, perforation, obstruction or fistula, significant immune suppression or relevant uncontrolled co-morbidities likely to worsen their condition, e.g. diabetes, liver or renal disease, require referral to secondary care (where a CT scan can be performed to confirm the diagnosis)

- For patients with less severe symptoms, a clinical diagnosis of uncomplicated diverticulitis can be made after reasonable exclusion of other causes, and conservative treatment initiated in the community, including paracetamol (NSAIDs or weak opioids can be considered if no contraindications). Patients should be ideally followed up in 48 hours, or earlier depending on their clinical condition.

- Antibiotics are no longer routinely recommended for most patients with suspected acute uncomplicated diverticulitis; oral antibiotics may be considered for some patients who are at higher risk of complications (e.g. due to co-morbidities), but who do not meet criteria for secondary care referral. Antibiotics can also be considered for patients managed conservatively who do not show improvement within 48 hours of their first presentation.

- While conventional advice has recommended short-term diet modification for patients with acute uncomplicated diverticulitis, i.e. two to three days of clear liquids before slowly reintroducing dietary fibre, there is a lack of clinical evidence to support this. If tolerated, an unmodified diet may be more appropriate. It is now accepted that obstruction in acute diverticulitis is rare and diets high in nuts, seeds and corn do not increase this risk of developing diverticulitis, suggesting there are other mechanisms involved.

2a. New Free Resources available through Healthpathways.

- Health New Zealand Te Whatu Ora has provided all Healthpathways users with access to two free "evidence-based medicine" tools - BMJ Best Practice, and EBSCO Dynamed.
- Just follow the links on your Health Pathways home page to sign up for your free profiles and have a look around.
- Both sites give access to up to the minute evidence-based guidance and information on a huge range of medical topics, medical calculators, clinical updates and medical news. Each have different flavours and styles.

As an example there was reference in a recent GPs for GPs Facebook post to changes in recommendations for first line drug therapy for patients with persistent restless legs syndrome (RLS). The BMJ Best Practice site takes a practical approach through diagnosis and what tests to order to treatment algorithms with recommendations changing depending on severity of RLS (intermittent, chronic, refractory) and pregnancy status. For non-pregnant patients with chronic RLS gabapentinoids (e.g., pregabalin, gabapentin) are the first-line pharmacological option with dopamine agonists now regarded as second line.

2b. WINZ Resource

WINZ have produced a downloadable one-page summary of main and supplementary financial benefits available to eligible patients which may be of assistance when advising patients in need.

3. Type 2 diabetes

A UK-based cohort study recently published in the BMJ and reviewed in Issue 13 of GP Practice Review found that, the GLP-1 receptor agonist-SGLT-2 inhibitor combination was associated with a lower risk of major adverse cardiovascular events and serious renal events compared with either drug class alone. The reviewer noted the study provides evidence that after initiating lifestyle change and pharmacotherapy with metformin and either a SGLT-2 inhibitor or a GLP-1 receptor agonist, stepping up to triple therapy by adding either a SGLT-2 inhibitor or a GLP-1 receptor agonist is an effective method of intensifying treatment to reduce cardiovascular risk and potentially improve renal outcomes. However, in New Zealand this would require patients to self- fund at least one of these medicines with Pharmac special authority criteria as they currently stand.

Related to this - Pharmac's procurement process for continuous glucose monitoring (CGM) devices, insulin pumps and insulin pump consumables is progressing but it appears funding for these products will be limited to those with type 1 diabetes. The Aotearoa Diabetes Collective has created a useful guide with templates for letters to support WINZ Disability Allowance applications for CGM and empagliflozin (for those already prescribed a GLP1 receptor agonist) for people living with type 2 diabetes.

4. COVID-19 technology support changes

Health New Zealand Te Whatu Ora have provided an update on two COVID-19 technology products that are being decommissioned from 1 August 2024.

- **GP notifications**: The technology supporting notifications to GPs is being decommissioned and you will no longer receive notifications of self-reported RAT results. This change aligns COVID-19 with other 'point of care' tests where patients self-test and proactively contact their healthcare provider for treatment if needed. The text message that a person receives when they self-report a positive RAT result has been updated and they are taken through a questionnaire to assess if they are eligible for antiviral medicines. If they are unwell or if it appears they're eligible they are recommended to contact their healthcare provider or a participating community pharmacy. The GP will not be aware of a self-reported RAT result, so will not contact them.

- **COVID-19 Clinical Care Module (CCCM)**: The CCCM will be decommissioned. GPs should continue to report COVID-19 cases via Healthlink as COVID remains a notifiable disease and this test result will automatically flow through to the Notifiable Disease Management System.

5. Perinatal depression

A Recent issue of NZ Doctor contained an excellent article on management of perinatal depression. Important practice points included:

- Antidepressants are not risk free. However, given the adverse outcomes associated with uncontrolled depression for both the birthing parent and their baby, most antidepressants have a favourable risk–benefit ratio for moderate to severe depression during pregnancy and breastfeeding.

- Routine discontinuation or switching of antidepressants during pregnancy and breastfeeding is discouraged without consideration and discussion of the specific risks (including the risks of relapse) and benefits for that individual. If the decision is made to discontinue, the antidepressant should be slowly tapered, not stopped abruptly.

- If the patient has not had antidepressants before, selective serotonin reuptake inhibitors (SSRIs) are generally recommended for first-line treatment with Sertraline being the preferred SSRI in pregnancy. It is thought to have the lowest placental transfer of any SSRI and may have the lowest risk of neonatal persistent pulmonary hypertension. Additionally, if breastfeeding is desired, it has low infant exposure via milk.

- Escitalopram or citalopram are also relatively safe in pregnancy and breastfeeding and are reasonable alternatives. Fluoxetine, while having a reasonable safety profile during pregnancy, is least preferred during breastfeeding as it has a long half-life and may accumulate in milk. Paroxetine may have an increased risk of congenital heart defects, although this has not been conclusively proven. Paroxetine also has an increased risk of neonatal adaptation syndrome (NAS) compared with other SSRIs. For these reasons, some guidelines recommend avoiding paroxetine during pregnancy, if possible, although it has low infant exposure via milk for those who wish to breastfeed.

The article reviews use of all classes of antidepressants and current evidence base for risks versus benefits. There are links to a variety of support and self-help resources including:

- **Perinatal Anxiety & Depression Aotearoa** provides screening tools, factsheets on antenatal and postnatal anxiety and depression, and locally available support services and helplines
- **Mothers Helpers** offers support for mothers with antenatal and postnatal anxiety and depression, including an online perinatal depression recovery course
- **Healthify** has information on perinatal depression and anxiety, how it is treated, and a list of available support services
- **Beating the Blues** provides free online cognitive behavioural therapy
- **Just a Thought** offers two free specialised online perinatal CBT courses
- **Tuku Iho** is a bilingual app that focuses on te ao Māori maternal and tamariki wellbeing

The article also includes links to two sites that provide consumer-oriented information on risks and benefits of various drugs that may be used in pregnancy:

- Organization of Teratology Information Specialists (US) MothertoBaby factsheets
- UK Teratology Information Service, Best Use of Medicine in Pregnancy leaflets

6. Patient information sheets available from bpac^{nz}

The following information sheets are especially designed to support primary care consultations, and can be downloaded and printed, or the link sent to patients via text or email.

- Advice if you are prescribed an antibiotic
- Advice if your child is prescribed an antibiotic
- Information for managing seasonal viral illness ("Cold & Flu")
- Information for managing at home with COVID-19

7. HPV priority group funding

Funding for HPV screening and follow-up priority groups has been extended until 30th June, 2025. Details of the process are available on the Heath NZ Te Whatu Ora website and includes two algorithms aimed at simplifying determination of eligibility for funding.

8. Weird but wonderful

Preliminary studies have shown a significant decrease in severity of obstructive sleep apnea (OSA) with the use of a combination of atomoxetine and oxybutynin, with patients having moderate pharyngeal collapsibility during sleep (a higher proportion of hypopneas to apnea and mild degree of oxygen desaturation) more likely to respond. A 2022 study evaluated the efficacy and safety of atomoxetine 80 mg and oxybutynin 5 mg in the treatment of OSA confirming findings of previous studies. The most common adverse events (insomnia (12%) and nausea) were consistent with the expected profile of the individual drugs. A 2024 study adding acetazolamide to the combination found no increase in efficacy with this addition.

9. Why I don't sleep at night…

I have recently reviewed the case of an older child assessed in primary care after running in to a barrier pipe (waist level) with subsequent abdominal pain. There were no findings of an acute abdomen and the child was discharged after responding to simple analgaesia but collapsed and died at home about 36hrs later. Post-mortem findings revealed a jejeunal rupture. Children are more vulnerable to blunt abdominal injury than adults because they have relatively compact torsos with smaller anterior-posterior diameters, which provide a smaller area over which the force of injury can be dissipated; larger viscera, especially liver and spleen, which extend below the costal margin; and less overlying fat,

and weaker abdominal musculature to cushion intra-abdominal structures. Uptodate[1] notes that repeated, serial examinations are necessary in children with abdominal trauma because serious intra-abdominal injury (IAI) may not be apparent upon the initial examination. Abdominal tenderness may be especially difficult to determine in young children who are frightened and cannot clearly communicate and in older children who are uncooperative or neurologically impaired. The message is to have a high index of suspicion for possible IAI in children presenting with blunt force abdominal trauma.

Coincidentally, Issue 28 of Child Health Research Review reviewed the recently published Pediatric Emergency Care Applied Research Network (PECARN) prediction rules to reduce inappropriate use of computed tomography (CT) in children with abdominal or head trauma. The rules were validated with a high degree of accuracy: the intra-abdominal injury rule had a sensitivity of 100.0% and a negative predictive value (NPV) of 100.0% but has not been validated for use in primary care and given presence of abdominal pain is a 'not very low risk' criterion I'm not sure how practical it would be.

[1] Saladino R et Conti K. Pediatric blunt abdominal trauma: Initial evaluation and stabilization. Uptodate. www.uptodate.com Accessed 1 August 2024