Clinical Snippets – October 2022

1. Heavy Menstrual Bleeding

A Research Review educational article on Heavy Menstrual Bleeding was published last month. This includes helpful management algorithms and advice and is well worth downloading for easy reference.

Take home messages include:

- HMB is an under-diagnosed and under-treated condition occurring in approximately one in four women of reproductive age; ask all women of reproductive age about their periods.
- Māori and Pacific women have higher rates of endometrial cancer and worse outcomes compared to other ethnic groups. One review of social and cultural beliefs concluded that norms and practices in Pacific Island communities make it hard for some women to manage menstrual health with dignity due to the association of menstruation with taboos and shame. This highlights the importance of proactively asking Pacific women about their periods whilst remembering to be culturally sensitive to any beliefs they may have towards investigation and treatment.
- Most patients with HMB can be effectively managed in primary care. For all patients with HMB, discuss the impact the condition is having and their goals of treatment. Ask to perform a pelvic examination and test for iron deficiency and anaemia.
- In patients with HMB and risk factors for endometrial cancer, prompt investigation (including a pipelle biopsy) is recommended, particularly in women of Māori or Pacific ethnicity
- A pelvic ultrasound performed on day 5-10 of the menstrual cycle is the first-line investigation for patients with suspected structural uterine abnormalities
- Patients with HMB need to understand the benefits and risks of their treatment options to enable them to make the best choice
- A LNG-IUD (MIRENA®) is the first-line treatment for HMB once underlying pathology has been excluded; this should be offered to all patients, where clinically appropriate
- Referral for consideration of surgical options is appropriate at patient' request, when pathology is identified or when medical treatment fails

A recent Tools for Practice compared levonorgestrel intrauterine systems for heavy menstrual bleeding compared with standard oral treatments (NSAID, TXA. COC and progestagen only pills)

The review concluded: Compared to other treatments (example oral contraceptives), blood loss with an IUD is reduced ~80% versus 25%, more women with an IUD are satisfied (75% versus 60%), and more remain on treatment at 2 years (64% versus 38%).

2. Case of the month

(i) A patient in his mid-50s presented with a five-month history of a left submandibular lump which he felt may be slowly growing. Examination unremarkable other than a firm painless 3cm lump in the submandibular region diagnosed as possible reactive lymph node and patient advised to return if it persisted beyond another three months or grew. Returned in four months as lump unchanged. Noted to have likely dental infection/poor dental hygiene treated with antibiotics and lump attributed to this. Similar return advice provided. Patient reviewed in another medical centre six months later because the lump had grown further – immediately referred and diagnosed with adenoid cystic carcinoma with pulmonary metastases.

(ii) HealthPathways section 'Neck Lumps in Adults' refers to the MoH neck lump 'HSCAN' criteria as:

Unexplained neck or salivary mass and 1 or more of:

- mass larger than 1 cm and persisting longer than 3 weeks.
- mass is increasing in size.
- previous head and neck cancer including skin cancer.
- facial palsy.
- any new unexplained upper respiratory tract symptoms, e.g. hoarseness, dysphagia, throat or ear pain, blocked nose or ear.

(iii) Management advice includes:

- If a lump is likely to have an infective cause, treat with broad spectrum antibiotics. Recheck in 1 to 2 weeks for resolution, although complete disappearance may take a couple of months.
- If lump is suspicious, as well as arranging FNA, request ORL assessment.
- If FNA result is not consistent with clinical findings, discuss with pathologist or await specialist opinion.
- A reactive node on FNA can be observed for 1 to 2 months. If it does not settle, consider a repeat FNA or request ORL assessment.

(iv) There are several Mercy Ascot Learning Modules on neck lumps and related topics that are a useful refresher on the subject.

3. Fever in children under 2 months of age

A recent Research Review speakers series on management of fever in children include reference to the 2022 Starship Hospital guidance on management of fever in children under two months of age. Recommendations are summarised as:

- Fever in the guideline is defined as temperature of $\geq$ 38° C rectally, in the hospital or in the community. Aural temperature can be unreliable in this age group.
- Risk of serious bacterial infection is stratified by age – highest under 21 days, intermediate in the 21-28-day group and decreases progressively in the older age groups.
- Refer all unwell infants

- Refer well infants <28 days - clinical appearance cannot be relied upon to "rule out" invasive bacterial infections and septic screen is required
- Well appearing 29 to 60 days - clean urine sample as a minimum; observation +/- other investigations. Techniques for obtaining a clean catch urine sample in neonates and infants are described in the Starship Hospital guidance on urinary tract infection.

4. End of life care

A recent GP Pulse included an opinion piece on the inequitable state of palliative care in New Zealand, largely due to under-resourcing and lack of central planning. The report noted a recent case of a woman in her 90s is an all-too-common scenario. Her daughter had set up her home to care for her mother until she died, as was her wish. Sadly, towards the end she developed some pain and required morphine. There were no doctors available at that time of night to make a house call, so she had to go to the Emergency Department to have it administered. She died in an ED cubicle a while later – not at all what she and her family had hoped for.

For GPs wanting to take a more active and proactive role in end of life care of their patients, the Ministry of Health resource Te Ara Whakapiri Toolkit is worth downloading and gives very practical advice on proactive assessment and planning to ensure the patient's needs are established and met, recognising the dying patient and specific symptom control strategies.

5. Update from the National Cervical Screening Programme

From July, 2023, the primary method for cervical screening will test for human papillomavirus (HPV), the cause of over 95% of cervical cancers. Self-testing will be an option for everyone.

- Participants can choose how to have their screening test performed - they can opt for:
    - Self-testing using a swab, in a location of their choice (including at home)
    - A clinician to take the HPV test using a swab
    - A clinician to take a liquid-based cytology sample (using a speculum) which can be used for HPV testing, and cytology if required
- Clinical oversight is required in order to explain the test, manage results and arrange follow up. The NCSP website notes: When HPV primary screening is introduced it is likely participants will still access their health care provider for the cervical screening, even when undertaking self-testing. The Ministry of Health will be looking at ways to make screening even more accessible in the future, which may include a future approach of a national mail-out of self-testing kits, if they are found to work safely and well for participants.
- A GP Pulse article further defines clinical oversight for self-testing as: for every self-test sample, there is a health professional who signs the laboratory request form and who is responsible for:
    - providing advice and obtaining informed consent
    - providing the test kit to the participant/coordinating getting it back (tests won't be sent out centrally)

    - ensuring the correct lab request information is provided on the request form and that the request form is signed by them
    - ensuring the participant is told of the test result and the result is followed up and the next steps/referrals are completed as needed

- Protocols to manage results will be formalised before the programme starts, based on this guidance:

    - HPV not detected -> five-year screening interval.
    - HPV 16/18 detected -> option of returning to primary care for a cytology sample or direct referral to colposcopy, where cytology will be taken.
    - HPV other (non 16/18) detected -> Cytology sample required: Normal / Low-grade cytology -> repeat HPV Test in 12 months; High-grade cytology – referral to colposcopy

- In the meantime, the key message is “keep screening”. We don’t want anyone holding off on screening until HPV Primary Screening becomes available next year because the time lag will make a difference for some people - cytology screening needs to continue while we prepare for the new programme.

6. Out of interest…

Spironolactone and binge drinking: A group of American researchers found that spironolactone reduced binge drinking in mice and reduced self-administration of alcohol in rats without adversely affecting food or water intake or causing motor or coordination problems. They then retrospectively analysed electronic health records of patients drawn from the United States Veterans Affairs healthcare system to explore potential changes in alcohol use after spironolactone treatment was initiated for other conditions and found a significant link between spironolactone treatment and reduction in self-reported alcohol consumption, with the largest effects observed among those who reported hazardous/heavy episodic alcohol use prior to starting spironolactone treatment. The action may relate to spironolactone’s mineralocorticoid blocking effect on the amygdala.