Clinical Snippets September 2024

1. Deprescribing

- I have recently looked at complaint where a 76-year-old patient had been taking high dose statins and aspirin for many years for primary prevention of CVD (current estimated 5-year risk 16%). After a medication review, the GP stopped his aspirin and reduced his statin dose and he suffered a stroke about six months later.

- While it is reasonably clear cut that the risk of using aspirin for primary prevention of CVD in this age group is outweighed by the potential risks (NZ guidelines state: *In patients aged over 70 years the balance of benefits and harms of aspirin is not clear and therefore use is not recommended for primary CVD prevention alone*), there is little consensus on using statins for primary prevention of cardiovascular diseases (CVDs) and all-cause mortality in adults aged 75 years or older due to the underrepresentation of this population in randomized controlled trials.

- A recent study in the Annals of Internal Medicine aimed to evaluate the long-term effects and safety of statins for primary prevention of CVD in adults older than 75 years. In both the age groups 75-84 and 85+, initiating statin therapy was associated with lower incidence of CVD and all-cause mortality, even among the older population aged 85 years or older. In addition, statin use did not increase the risk of adverse events, such as myopathies and liver dysfunction.

- European guidelines on management of dyslipidaemias (2019) currently recommend treatment with statins for primary prevention according to the level of risk in older patients ≤ 75years, and initiation of statins in older people ≥ 75 years may be considered if at high risk or above. The NZ guidelines take a similar approach: *for healthy people over 75 years with few co-morbidities and an estimated life expectancy of more than 5 years, we recommend estimating their 5-year CVD risk using the NZ Primary Prevention equations and discussing the same management options as for people under 75 years of age.*

- There are a few studies that look specifically at the effect of withdrawing statins or de-escalating therapy in older age - a 2021 study found that discontinuing therapy with statins was associated with a significantly increased risk of hospital admission for heart failure and any cardiovascular outcome, death from any cause, and emergency admission for any cause. Another 2021 study published in JAMA noted statin discontinuation was associated with a higher rate of cardiovascular events than statin continuation among older people receiving long-term statin treatment, but more definitive evidence is needed.

- Deprescribing resources

    - HQSC link to resources
    - The Comprehensive Geriatric Assessment site (CGA) has links to version 3 of the STOP-START tool which gives very useful on information to consider when stopping or starting medication in the elderly
    - Stopping medicines in older people: the flip side of the prescribing equation (BPAC)

2. Fever in children

BPAC have recently updated their resource on identifying the risk of serious illness in children with fever. Practice points include:

- Measure and document temperature (taken in the axilla or using an infrared tympanic thermometer), heart rate, respiratory rate and capillary refill time. If the child's respiratory rate is elevated for their age or there is increased work of breathing, measure oxygen saturation. If the heart rate or capillary refill time is abnormal, measure blood pressure. (There are links to an HQSC video on how to accurately measure blood pressure).
- In children aged six months and over, elevated temperature alone is a poor predictor of the risk of serious illness and evaluation of all vital signs is essential
- Many children will have fever, but no obvious identifiable cause, and it can be difficult in younger children to distinguish between a life-threatening bacterial infection and a self-limiting viral illness that can be managed in the community; prioritise clinical judgment and experience
- The publication contains a useful table of moderate to high risk and high-risk features to consider (including age specific vital sign ranges) and advice depending on features observed
- Put protective measures in place so that if the child were to deteriorate at home or if symptoms persist, further health care will be sought. This may include information on warning symptoms and signs and instructions on what to do if the child's condition deteriorates, and an arrangement for follow-up, either in person or via phone. Do not underestimate the importance of clinical judgement and experience when assessing young children with fever. Also consider the level of concern of the parent/caregiver.
- The Goodfellow Unit also has a 30-minute course Could this be sepsis released in January this year which contains useful reminders on how paediatric sepsis can present.

3. Pain management

The August NZF changes include an update on sections related to pain management including a new guidance section on Opioid choice (where you can find a variety of conversion tables) and a section on Complex regional pain syndrome emphasising the importance of early diagnosis using the Budapest criteria, and early referral to specialist pain services and physiotherapy. There are additional updates in the following sections:

- Pharmacological treatment for acute pain
- Non-opioid analgesics
- Opioid analgesics
- Other analgesics and adjuvants
- Pain management of common specific conditions

5. Enduring Power of Attorney

The Goodfellow Unit has published a webinar on EPOAs (35 mins) which is worth a listen. I regularly see complaints regarding EPOAs including assessments for activation, failure to communicate with an activated attorney or communicating with an attorney without patient consent when the EPOA has not been activated.

Take home messages from the presentation include:

- Familiarize yourself with the PPPR Act (Protection of Personal and Property Rights Act 1988)
- There must be a trigger to assess capacity
- Capacity assessments are complicated and take time
- The act states what info must be included in an activation certificate
- Seek advice from Geriatricians, Psychogeriatricians and Lawyers as needed

6. Microalbuminuria

A recent Goodfellow Unit Gem looked at the role of ACE/ARBs in patients with microalbuminuria.

- To preserve kidney function, proteinuria should be targeted as actively as hypertension, to lower UACR (urinary albumin-creatinine ratio) as much as possible, ideally <50 mg/mmol with ACE inhibitors/ARBs (ARBs preferred as fewer cases of cough and the dose increased to maximum to attain the proteinuria goal).

- Candesartan is preferred unless there is gout, whereas Losartan has the additional benefit of lowering uric acid. ACE inhibitors and ARBs have an anti-proteinuria effect over and above that achieved by lowering blood pressure alone. Other BP meds can do it but need at least a 20 mmHg drop to achieve the same protection. Titrate to maximum tolerated dose to achieve maximal anti-proteinuric effects.

- When there is no microalbuminuria, low doses of different medications are considered optimal for lowering blood pressure with minimal adverse effects.

A Goodfellow Unit short course (30 minutes) on pharmacological management of CKD was published in July this year.

7. Rongoa Māori

Issue 110 of Māori Health Research Review included comment on Te Matahouroa: a feasibility trial combining Rongoā Māori and Western medicine in a surgical outpatient setting - recently published in the NZMJ. The trial involved six patients (diagnoses of various cancers) who met with both a Rongoā Māori practitioner and a Western trained surgeon during three 45-minute appointments over a 6-month period. Patient whānau were welcome and kai was provided. The study notes benefit to the participants across multiple themes presented as extracts from qualitative interviews. Barriers and facilitating factors are discussed. This would be very useful reading for anyone contemplating increasing the use of Rongoā Māori as part of their Māori health practice plan.

Additional resources for Rongoā Māori include:

- A 2008 BPAC article
- ACC Rongoā Māori Services including links to ACC registered practitioners via Healthpoint
- A 2022 article Adapting Traditional Healing Values and Beliefs into Therapeutic Cultural Environments for Health and Well-Being giving excellent background into the principles of Rongoā Māori and adapting these principles into our current environment

8. Male CVD patients and sex

Issue 13 of GP Practice Review refers to recent guidelines from the Princeton Consensus Conference that describe best practice on the evaluation and management of male patients with CVD and erectile dysfunction. Many males with CVD, either overt or undiagnosed, experience erectile dysfunction. In addition, erectile dysfunction is associated with an increased risk of CV events, even among males without established CVD. The guidance includes:

When consulting with male patients with confirmed erectile dysfunction and **known** CVD, the following steps are recommended:

1. Assess the patient's exercise ability relative to their age.

2. Categorise the risk of a CV event during sexual activity as low, intermediate or indeterminate, or high risk, as guided by a patient-reported description of lifestyle, i.e. sedentary versus active.

The exertion of sexual activity between couples in a longstanding relationship equates to approximately 2 to 3 METS, which is equivalent to walking 1 mile on a flat surface in 20 minutes or climbing 2 flights of stairs in 10 seconds. Younger couples may expend 5 to 6 METS while engaging in more intense sexual activity (equivalent to approximately 4 minutes of standard Bruce Protocol Treadmill Test).

3. Patients with intermediate or indeterminate risk may require exercise stress testing; achieving 5-6 metabolic equivalents of task (METS) in 4 minutes without ischemia suggests the patient has sufficient exercise tolerance to perform sexual activity with a low level of risk.

4. Low-risk patients can receive therapy for erectile dysfunction. If the patient is being prescribed nitrates, assess their current need for therapy and where appropriate, consider deprescribing nitrates and determine if a PDE-5 inhibitor (the ' afils' can be safely initiated.

5. High-risk patients are those with unstable CVD and these patients require referral to a cardiologist for specialist assessment.

The guideline provides several algorithms and tables to assist in the assessment and risk stratification of patients. The possibility of using non-PDE5 inhibitor therapies is also discussed as is the safety and efficacy of PDE-5 inhibitors in female patients.

9. What keeps me up at night…

I have recently looked at case of delayed diagnosis/delayed management of Charcot neuro-arthropathy (Charcot foot).

- It is most commonly associated with diabetes although is uncommon with an annual incidence in diabetics of 0.12 – 0.3%. It usually presents acutely, commonly as a red, hot, swollen foot, possibly following minor trauma. However, acute attacks may also be more subtle and may be associated with minimal symptoms. The affected foot may be several degrees warmer than the contralateral foot. The erythema may resolve with elevation of the affected extremity. Pain is variable but typically not prominent and is generally less than might be expected from the clinical and radiologic appearance of the affected joint[1].

- In early acute disease CBC and inflammatory markers may be normal in the absence of concurrent infection and plain X-rays (preferably weight-bearing) may be normal or nonspecific in showing only soft tissue swelling, loss of joint space, or osteopenia. However, as the condition progresses in the absence of treatment, X-rays show bony changes such as fracture, subluxation/dislocation, and bony debris.

- Management of diabetic neuroarthropathy is focused on strategies to avoid unprotected weightbearing on the affected foot. Health Pathways lists suspected Charcot neuroarthropathy as a diabetic foot 'red flag' with acute orthopaedic referral recommended if the diagnosis is suspected.

- A retrospective audit presented in a 2017 NZMJ by Waitemata DHB showed the median time from symptom onset to diagnosis was 17 weeks. Symptoms at presentation were: oedema (49%), warmth (73%), erythema (17%), swelling (90%) and pain (60%). Concomitant ulcers were present in 32%, deformities 83%, osteomyelitis 2% and septic arthritis 2%.

- Uptodate states: Acute diabetic neuroarthropathy should be suspected in any patient with diabetic neuropathy who presents with a unilateral, warm, swollen, erythematous foot (without alternate explanation). A high index of clinical suspicion is important to diagnose diabetic neuroarthropathy early. A delay in diagnosis is very common and can result in progression of diabetic neuroarthropathy and an increased risk of complications. Without treatment, progression can be rapid, and irreversible damage can occur within six months or less

10. New IUD

Pharmac have announced the **Choice TT380 Standard** copper IUD is no longer being produced and existing stock expire on 30 September 2024 with the product to be delisted from 1 October 2024. From 1 September 2024 a replacement product, **TCu 380 Plus Normal**, is listed. The main difference is the in-situ life for this product is **5 years, compared to the 10 years of Choice TT380 Standard product**. Further information on the products is available in the manufacturer data sheet.

[1] Martin E. Diabetic neuroarthropathy. Uptodate. www.uptodate.com Accessed 25 August 2024