Clinical Snippets January 2025

1. New prostate cancer care pathway

Te Aho o Te Kaho (Cancer Control Agency) have recently published *Optimal cancer care pathway for people with prostate cancer* (OCCP - publication not yet available on their website). The pathway extends from preventative health measures through to palliative and end of life care as it relates to prostate cancer. There are some (mostly subtle) variations from current Community Health Pathways (CHP) guidance and these changes will be incorporated into the pathway in the future.

- **Screening Recommendations**
  The CHP emphasizes shared decision-making for prostate cancer screening in men aged 50–70 years, and those over 40 years with a family history of prostate cancer or carrying BRCA2 mutations. The OCCP focuses on PSA testing for men aged 50–69 years and recommends screening for higher-risk groups such as positive family history, Māori or African descent (from age 45 years) and known BRCA2 carriers (from age 40 years). It advises against PSA testing in asymptomatic men older than 75 years or those with a life expectancy of less than 10 years.

- **PSA Thresholds and Management**
  Thresholds for referral based on PSA levels differ slightly between the two guidelines. The CHP and OCCP suggest a PSA level above 4 µg/L for men younger than 70 years and above 20 µg/L for men older than 76 years as markers for referral to urology. For men aged 71-75 years the OCCP recommends a referral threshold PSA level of 6.5 ug/L compared with the current CHP recommendation of 10 ug/L. Both pathways agree that a PSA level above 50 µg/L warrants immediate referral for a high suspicion of cancer.

- **Repeat Testing and Diagnostic Pathway**
  Both guidelines recognize the importance of excluding transient causes of PSA elevation, such as urinary tract infections or recent ejaculation, before testing. However, the OCCP specifically recommends repeat PSA testing in six weeks to confirm an elevated result, whereas the CHP allows a window of 6–12 weeks for repeat testing. The OCCP also advocates for using adjunct diagnostic tools, such as MRI and PSA kinetics (density and velocity), to guide biopsy decisions. This is a key distinction, as the HealthPathways guidance primarily relies on PSA and digital rectal examination (DRE) findings.

- **Role of Digital Rectal Examination**
  The Community HealthPathways considers DRE as part of the screening process but allows for PSA testing alone if men decline DRE. In contrast, the OCCP strongly emphasizes the importance of DRE, noting that abnormal findings may warrant referral even if PSA levels are normal.

- **Management and Follow-Up**
  Both pathways provide guidance on active surveillance for low-risk cancers. The OCCP formalizes this process with regular PSA monitoring intervals based on risk level, while the Community HealthPathways recommends annual PSA and DRE for men with a family history or other high-risk factors.

2. FIT testing and colorectal symptoms

- Current Health Pathways on investigation of patients with colorectal symptoms note that use of faecal occult blood test (FOBT) and immunochemical faecal blood test (iFOBT) are not recommended outside of the National Bowel Screening Programme although the Canterbury version notes that patients satisfying the criteria for direct access colonoscopy or CT colonography may be asked to provide a faecal sample for FIT testing.

- This variation relates to research being undertaken in the region with a study published in NZMJ towards the end of last year concluding that FIT based prioritisation of patients referred with symptoms concerning for CRC is feasible and reduces time to CRC diagnosis. Participants (over 700) were 50 years or older (40 years or older for Maori) with colorectal symptoms satisfying non-urgent criteria for colonoscopy. Depending on fHB concentration, patients were then triaged to either urgent colonoscopy, non-urgent colonoscopy or CT colonography. Overall, 17.1% of the 715 patients returning a sample had FIT positivity ≥10mcg/g, and 2.2% of patients (n=15) were diagnosed with colorectal cancer. FIT detected colorectal cancer with sensitivity and specificity of 80.0% and 84.3%, respectively. The median time to diagnosis was 25 days, which the authors note is a reduction from what is currently seen in NZ due to long wait times for colonoscopy.

- The authors comment also that informal feedback regarding the pathway has been universally positive, albeit with some criticism that general practitioners cannot yet request the test directly. *Nevertheless, we anticipate with enthusiasm a national directive on the use of FIT in patients presenting with colorectal symptoms, a work in progress under the supervision of the national bowel cancer working group, which we hope will revolutionise the assessment, referral and triage of these cases, and help obtain the greatest benefit from our colonoscopy resource.*

3. Infrequent zoledronate from early menopause

- Another New Zealand based study recently published in NEJM looked at the effect of infrequent administration of zoledronate in preventing vertebral fractures in early post-menopausal women. The study was a 10-year, prospective, double-blind, randomized, placebo-controlled trial involving early postmenopausal women (50 to 60 years of age) with bone mineral density T scores lower than 0 and higher than −2.5 (scores of −1 or higher typically indicate normal bone mineral density) at the lumbar spine, femoral neck, or hip.

- Participants were randomly assigned to receive an infusion of zoledronate at a dose of 5 mg at baseline and at 5 years (zoledronate–zoledronate group), zoledronate at a dose of 5 mg at baseline and placebo at 5 years (zoledronate–placebo group), or placebo at both baseline and 5 years (placebo–placebo group). Spinal X-rays were obtained at baseline, 5 years, and 10 years. The primary end point was morphometric vertebral fracture defined as at least a 20% change in vertebral height from that seen on the baseline radiograph. Secondary end points were fragility fracture, any fracture, and major osteoporotic fracture.

- Of 1054 women with a mean age of 56.0 years at baseline, 1003 (95.2%) completed 10 years of follow-up. A new vertebral fracture occurred in 6.3% in the zoledronate–zoledronate group, in 6.6% in the zoledronate–placebo group, and in 11.1% in the placebo–placebo group. The relative risk of fragility fracture, any fracture, and major osteoporotic fracture was 0.72 (95% CI, 0.55 to 0.93), 0.70 (95% CI, 0.56 to 0.88), and 0.60 (95% CI, 0.42 to 0.86), respectively, when zoledronate–zoledronate was compared with placebo–placebo and 0.79 (95% CI, 0.61 to 1.02), 0.77 (95% CI, 0.62 to 0.97), and 0.71 (95% CI, 0.51 to 0.99), respectively, when zoledronate–placebo was compared with placebo–placebo.

- The researchers concluded: *Ten years after trial initiation, zoledronate administered at baseline and 5 years was effective in preventing morphometric vertebral fracture in early postmenopausal women.*

4. Isotretinoin prescribing reminder

A recent issue of RNZCGP Pulse included a letter from Te Whatu Ora regarding isotretinoin prescribing. This followed a coronial case relating to death by suicide of a young patient taking isotretinoin. Prescribing advice includes:

- Please refamiliarise yourself with the appropriate use of isotretinoin. Local information can also be found at Community HealthPathways, bpacnz, and New Zealand Formulary.

- Allow sufficient time to discuss the benefits and risks of isotretinoin and other treatment options with the patient (and their whānau/caregiver where appropriate). Although not every patient will experience adverse effects, every patient should know about them and what to do if they occur. We recommend discussing both common and potentially serious but rarer adverse effects and the pre-treatment screening and monitoring required to manage these risks.

- Document discussions and decisions. Please ensure that your records accurately reflect the information that was discussed/provided during the informed consent process. We recommend providing written information to supplement discussions. Printable patient information is available online from several trusted sources such as Healthify.

- Schedule follow-up appointments to monitor treatment effect and adverse effects. Regular follow-up is needed for all patients taking isotretinoin to ensure the treatment is working as intended and is being tolerated with no unacceptable adverse effects.

- Psychiatric adverse effects have been reported in people treated with isotretinoin. Successful treatment of acne can improve psychological wellbeing. However, serious mood and behavioural disorders have been reported in some patients taking isotretinoin. While a causal association has not been definitively established, mental health should be assessed before prescribing isotretinoin and during treatment.

- Isotretinoin is highly teratogenic. Isotretinoin is contraindicated in people who are pregnant or people at risk of becoming pregnant due to the rate of severe birth defects (25-40%) even with a short duration of exposure. Patients must be able to comply with the necessary

contraceptive measures and pregnancy must be excluded before starting treatment and, periodically during treatment.

- Isotretinoin can cause liver function and lipid abnormalities. These effects are common (up to 25% of patients) and while usually mild, rare cases of hepatitis and pancreatitis have been reported. Serum lipids and hepatic function should be checked prior to starting isotretinoin and periodically during treatment.

5. Plug for This Way Up

In this time of constrained mental health resources this is a reminder of the This Way Up resources summarised in a recent newsletter to primary care health providers. Of note is a new on-line education and CBT programme designed for patients with health anxiety issues described as being suitable for patients who:

- tend to worry a lot about their health and the possibility of having or developing an illness
- check their body frequently for signs and symptoms of disease or illness
- feel compelled to research their symptoms or try to avoid health-related information or content entirely
- seem to be stuck in the way they feel and would love to learn how to get out of this cycle
- are ready and willing to learn new skills to change the way they feel

This is one of many on-line CBT programmes the site offers for a variety of psychological issues, all evidence based. The programmes are offered at no charge to the patient if prescribed by you (provider registration required) and this facilitates patient support and monitoring.

6. Equity in H Pylori testing

- The January issue of Helicobacter includes a New Zealand study on ethnic inequity in the current approach to H. pylori testing and treatment in Aotearoa New Zealand. There are up to sixfold differences in gastric cancer mortality by ethnicity in this country, and H. pylori is the major modifiable risk factor.
- The study design was a retrospective cohort analysis of linked administrative health data. Laboratory testing data and pharmacy dispensing were linked to the Northern region health user population dataset (1.9 million) from 2015 to 2018 with an individual's first test for H. pylori investigated. Ethnic differences in rates of H. pylori testing, infection, treatment, and retesting, adjusted for age, sex, and calendar year were analysed.
- Ethnic inequities were present across the clinical pathway. Compared to sole-European, testing rates were lowest in Māori (OR 0.69) and Pacific (OR 0.81) and highest in Middle-Eastern/Latin-American/African (MELAA) (OR 2.21) and Asian (OR 2.02). Positivity rates were highest in MELAA (RR 2.96, 39%) and Pacific (RR 2.84, 38%) followed by Asian (RR 1.93, 26%) and Māori (RR 1.71, 23%). Treatment rates were similar for Asian (HR 1.05), MELAA (HR 1.03), and Māori

(HR 0.98) compared to sole-European but lower in Pacific (HR 0.90). Māori and Pacific were half as likely to be retested as sole-European.

- The investigators concluded: Despite the higher prevalence of H. pylori and gastric cancer, Māori and Pacific are relatively underserved with lower rates of testing and treatment than sole-European. Improved guidelines and the consistent application of these along with an equity-focused test and treat program are likely to be particularly beneficial for Māori and Pacific in addressing inequities.

- The local Health Pathways (Dyspepsia and Reflux) notes gastric cancer tends to occur a decade earlier in Māori or Pacific people, or immigrants from high-risk countries (defined as East Asia, Central and South America, Southern and Eastern Europe, the Caribbean, Middle Eastern, Latin American, African (MELAA)). Recommended investigations include H pylori testing noting the faecal antigen test is the only test available in primary care and recommendation:
    - Advise the patient to only do the test when they have:
        - had no antibiotics for at least 1 month before the test
        - had no omeprazole or pantoprazole (PPIs) for at least 1 week before the test (even better 2 weeks)

- For further information see the 2022 BPAC article *H pylori: who to test and how to treat*.

7. Resources and brief updates

- BPAC Peer Group discussion points on drug misuse, best preceded by review of an earlier BPAC article on unintentional misuse of prescription medicines.

- One pager from Manatu Hauora summarising practical aspects of use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (The Mental Health Act). Further online training on application of the Act is available on the Te Pou website.

- Avoiding triple whammy handout from Healthify. Consider supplying to all patients on an ACE/ARB (including valsartan)and diuretic.

- BPAC Best Practice bulletin 112 refers to availability of a new guide: Continence management for people with dementia mate wareware published by researchers from the University of Auckland. The two-part guide provides practical information and advice for people with dementia mate wareware and their carers about how to navigate through the system, e.g. how to access disability support services, allied health professionals or specialist community support groups, and possible solutions to commonly encountered continence problems, e.g. locating, accessing and using public toilets, personal continence products.

- A Pharmac press release last month notes that consultation is currently underway regarding a proposal to increase patient access to ADHD medications. To quote the release: *The Ministry of Health is proposing to change the approval notices for these medicines, so that more doctors and nurse practitioners are able to prescribe them… Pharmac is proposing to change its Special Authority criteria for ADHD medicines to align with the changes the Ministry of Health is making. This will mean more doctors and nurse practitioners will be able to submit Special Authority applications for people starting funded ADHD stimulant medicines…If this proposal*

is approved, the Ministry of Health will change the approval notices on 1 July 2025. Pharmac will update its Special Authority Criteria at the same time. There is an **ADHD update: Assessment, management, and care pathways** webinar day being run by the Goodfellow Unit on Saturday 22 February 2025 (registration required, cost $320).