Clinical Snippets April 2025

1. Sudden sensorineural hearing loss (SSNHL)

(i) The March issue of GP Voice referred to information from the New Zealand Audiological Society (NZAS) regarding the importance of prompt assessment and treatment of Sudden Sensorineural Hearing Loss (SSNHL) given the research showing that early treatment can improve the chances of hearing recovery. The reader is referred to a 2024 article in the Australian Journal of General Practice which gives an excellent summary of the diagnosis and management of SSNHL including differentiating between conductive and sensorineural heating loss.

(ii) Key points from the article include:

- Sudden sensorineural hearing loss is an otologic emergency.
- Prompt diagnosis and initiation of treatment with high-dose corticosteroids improves patient hearing outcomes
- Do not delay treatment while awaiting investigations (ie audiogram).
- Prompt referral through to an ENT service and/or an emergency department is recommended.
- Consider adjuncts to therapy including hyperbaric oxygen therapy, audiovestibular services and/or intra-tympanic dexamethasone.

(iii) The gold standard for confirmation of SSNHL is diagnostic audiometry (urgent same day – usually community provider) but use of tuning fork tests (Weber and Rinne) is advised in the article and in our Community Health Pathways. A 512Hz tuning fork is used (cost $10-30).

(iv) There is some difference in content between the various regional Community Health Pathways so I recommend consulting your specific pathway, particularly with respect to steroid treatment. In general, the criteria for sudden sensorineural hearing loss (SSNHL) include:

- Hearing loss that is sensorineural in nature
- Hearing loss of at least 30 dB over at least three consecutive frequencies
- Hearing loss that occurs within a 72-hour period (and best outcomes are seen when the patient is treated within 72 hours of hearing loss onset).

Characteristics of SSNHL include:

- Acute onset with rapid progression of symptoms, generally within 72 hours
- Almost always unilateral hearing loss

- Patients may awaken with hearing loss or blocked feeling, with or without associated tinnitus, and occasionally vertigo
- May occur at any age but is more common in those aged in their 40s or 50s.
- Spontaneous improvement in hearing occurs in 2 out of 3 patients but recovery may not be complete. Recovery is more likely in younger age groups and in those with milder losses.
- SSNHL is commonly misdiagnosed as otitis media due to an overlap of symptoms (e.g. acute hearing loss, aural fullness, tinnitus and sometimes preceding viral infection).
- Most cases (85 to 90%) are idiopathic but consider other potential causes.

2. Goodfellow Gem – ADHD Treatment

A recent Goodfellow Unit Gem looked at a Swedish study published in JAMA which examined 2-year mortality risk in patients with a diagnosis of ADHD comparing those who received pharmacotherapy for the disorder with a similar cohort who did receive pharmacotherapy. The median age at diagnosis was 17.4 years (6-64 years). The 2-year mortality risk was lower in the initiation treatment strategy group (39.1 per 10 000 individuals) than in the non-initiation treatment strategy group (48.1 per 10 000 individuals). Among individuals diagnosed with ADHD, medication initiation was associated with significantly lower all-cause mortality, particularly for death due to unnatural causes. (e.g., unintentional injuries, suicide, and accidental poisonings). There is a chance that more safety-conscious people will get preferential access to medication but this is the best available data.

3. No more RICE?

A NZ Doctor sports medicine article published earlier this year looked at the evidence behind the age-old RICE advice we give to patients with acute soft tissue injuries. The rationale behind RICE is to use rest to prevent any further soft-tissue injury, cryotherapy (ice) to induce vasoconstriction and limit bleeding and swelling, compression to limit swelling by physical means, and elevation to reduce the effects of gravity. Cryotherapy also has an analgesic effect. However, on reviewing the medical literature the author concluded there is no evidence to support the use of cryotherapy for acute soft-tissue injuries, but if used, it should probably only be in the first few hours after injury. Do not apply ice for more than 10 to 15 minutes as there are reports of damage to underlying superficial nerves (eg, the common peroneal nerve) with prolonged application, and superficial burns if applied directly to the skin. The key points from the article were:

- Acute management of soft-tissue injuries should include protection (rather than prolonged rest), elevation, compression and education.

- Load optimisation and exercise, without exacerbating pain, are important after the first few days.
- There is no evidence to support the use of cryotherapy or anti-inflammatories.

4. NZF Update – SSRIs and venlafaxine

The March NZF Update includes reference to cautions and patient advice updated and new pre-treatment screening and monitoring sections added for SSRIs and venlafaxine.

(i) Pre-treatment screening advice is to perform an ECG in those at high risk of QT-interval prolongation. Christchurch Medicines Information Service have a handy one pager on risk factors but note they include use of two or more drugs that cause QTc prolongation independently (includes macrolide and quinolone antibiotics) and use of one or more drugs that may cause electrolyte disturbance (e.g. diuretics, β-agonists, proton pump inhibitors), bradycardia (e.g. β-blockers, donepezil) or other effects that predispose the individual to the QTc prolonging effects of another drug.

(ii) Monitoring recommendations are:

- Monitor closely for suicidality (suicidal behaviour, unusual changes in behaviour, self-harm, irritability, agitation, increased anxiety). Review patient regularly (e.g. weekly during the first month of treatment) and specifically ask about suicidal thoughts or actions, particularly at the beginning of treatment, when the dose is increased or decreased, or when the antidepressant is stopped.

- Perform an ECG in those at high risk of QT-interval prolongation 4 weeks after starting treatment, following any dose increase, and following addition of an interacting medicine. Consider stopping treatment if QT-interval is greater than 500 milliseconds or has increased by greater than 60 milliseconds.

5. Coffee and atrial fibrillation

Issue 250 of GP Research Review looked at a Swiss study examining coffee consumption and adverse cardiovascular events in patients with atrial fibrillation. The study involved over 4000 patients and at a median follow-up of 4.7 years, patients with AF who were 'daily' coffee consumers had a lower incidence rate of a major cardiovascular event (MACE) than 'not-daily' consumers (5.09 vs 7.49 per 100 person-years, respectively). Following adjustments for confounders, AF patients who consumed coffee daily had a 23% lower risk of MACE and the reduction in MACE risk was greatest for those who consumed 2-3 cups of coffee per day. Daily coffee consumers also had lower risks of all-cause mortality and hospitalisation for acute heart failure. The reviewer noted there is existing evidence that coffee consumption increases longevity in general although there

is also some evidence of the association of high coffee consumption with development of AF. However, continuing to drink coffee after diagnosis of AF does not appear to be harmful.

6. Resource – Dermnet Newsletter

I am sure most of us are aware of the Dermnet dermatology website launched in 1996 by Hamilton dermatologists Dr Amanda Oakley, Dr Mark Duffill and Dr Marius Rademaker and now described as the world's leading free dermatology resource. It is worth considering subscribing to the Dermnet newsletter which summarises content updates and new cases and provides links to professional education resources such as the Dermnet Lecture Series available on Youtube. This series is designed to cover the core medical undergraduate dermatology curriculum and is a great 'refresher' resource for practicing GPs.

7. Bits and pieces

(i) Updated guidelines for the prevention of **legionellosis** in NZ were published this month. Common sources of infection include exposure to the bacteria via compost and also spa pools, so it is worth asking about both of these potential sources when reviewing patients with possible atypical lower respiratory tract infections.

(ii) Pharmac has announced that **varenicline (Champix)** is available again from 1 April 2025. People will need to meet the funding criteria to access funded Champix, one of which is that the person is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring. Champix is a three-month course. There is a starter pack, followed by two repeats of Champix 1 mg (56-tablet pack).

(iii) Just a reminder that there is WINZ funding available for **dental treatment** for eligible clients of up to $1000 per 52-week period. The grant does not have to be paid back eligibility depends on income and asset assessment (details on the WINZ website). The grant covers immediate and essential treatment, which can include extractions, fillings for tooth restoration (not for cosmetic or for non-oral health issues), treatment of infection, and root canal treatment (except molars). It does not include regular dental check-ups, cosmetic treatment, scale and polish, and teeth cleaning (unless this treatment is required because of gum infection), cast restorations, orthodontic treatment, molar root canal treatment or dentures. The client's dentist needs to complete a Dental Treatment information form.

(iv) The Otago Medical School Hauora Māori curriculum contains a **te reo glossary** intended to alert students and staff to words that are commonly used (as reflected in the glossary levels) within the health environment in Aotearoa New Zealand. The glossary is aligned with the Aki Hauora App that is available on both android and apple devices. This is a game based app to facilitate familiarity with the glossary.

(v) Tools for Practice #386 examined the question 'does reducing **sodium intake** or substituting table salt with sodium-potassium alternatives improve cardiovascular outcomes?' The bottom line was that based on one large randomized, controlled trial in patients with hypertension/previous stroke with above average daily salt intake (eg 4.8 g/day), replacing table salt with a salt substitute may decrease mortality (from ~4.5% to ~4%) and stroke (from ~3.5% to 3%) per year. Whether reducing sodium by other means reduces mortality or cardiovascular events is unknown. The article notes that many guidelines recommend specific sodium reduction (example: <2g/day) but there is no reliable way for patients to estimate sodium consumption. According to our last national nutrition survey, adults in Aotearoa New Zealand eat on average about 8.5 g of salt a day (3.4g sodium/day).