Clinical Snippets July 2025

1. Kawasaki disease

- Issue 33 of Child Health Research Review reported a recently published study on the increasing incidence of Kawasaki disease and associated coronary aneurysm in Aotearoa New Zealand. The study was undertaken in the Auckland region and revealed an overall incidence (per 100,000 per year under age 5 years) of 20.4 – highest in Asian (43.9) and Pacific (17.7) populations with little difference between NZ European (10.1) and Māori (8.3) populations. Around 17% of children developed coronary artery aneurysm and this was more common in children under 1 year and Pacific children.

- Starship Hospital has accessible guidelines on KD diagnosis and management which are worth reviewing. The guidance notes that 85% of children with KD are under 5 years old, but it can occur in older children and adolescents. The most concerning complication is the development of CAA, which occurs in 20-25% of cases without treatment. Prompt treatment with IVIG reduces the risk of aneurysm. However, rates of coronary artery aneurysms, even with treatment, are increasing worldwide, with some studies reporting 30% of infants who have been treated with IVIG still developing a coronary artery aneurysm.

- Diagnostic criteria include presence of fever for ≥5 days with core clinical features of truncal and limb rash which can present variably (maculopapular, scarlatiniform, erythema-multiforme like), conjunctival injection without exudate, mucositis with dry cracking lips and strawberry tongue, swelling and erythema of the extremities followed by peeling, and lymphadenopathy – usually cervical and unilateral. These signs are no necessarily present all at once and some may appear while others disappear. Children with KD are often unusually irritable, out of proportion to the other signs exhibited. They may also have a range of other non-specific symptoms and signs including abdominal pain, diarrhoea, dysuria and joint pain.

- The illness may be classified as complete or incomplete KD depending on the number of core clinical features present and supplementary lab/echocardiograph data. Prompt recognition and treatment is required to reduce the risk of coronary aneurysm, and the disease should also be considered in infants with isolated fever for 7 days in the absence of other core features.

2. Weaning antidepressants

- A recent Goodfellow Unit Gem introduced the RELEASE (REdressing Long-tErm Antidepressant uSE) resources which have been officially recognised by The Royal Australian College of General Practitioners. The resources include tapering plans for 15 of the most commonly prescribed antidepressants, including 'slower', 'even slower' and 'faster' tapering plans for most antidepressants

- The tapering plans provide step-by-step instructions for slowly reducing antidepressant doses and information on how to access the mini doses used in tapering and include a brief intervention to prompt and support a discussion with people who have been taking antidepressants for longer than 12 months. There are also printable information sheets and videos for patients to access.

- There is also a 2024 webinar on de-prescribing antidepressants and managing withdrawal available on the Goodfellow Unit website.

3. Firearms and GP phone number

- A recent RNZCGP e-Pulse noted The Arms Act Amendment 2020 change requires firearms licence applicants to provide the contact details of their health practitioner. The Firearms Safety Authority's license application form asks for 'Health Practitioner contact details'. There are two fields to fill in for a mobile phone number or alternative contact such as the practice's telephone number.

- Firearms licence applicants are only required to provide one of those options. Mobile phone number is not necessary – the practice number is sufficient. Unfortunately, the current on-line registration form identifies the GP Mobile as a required field and Te Tari Pūreke (The Firearms Safety Authority) note work is underway as follows:

    - The existing mobile phone field on the digital form will be hidden.
    - The alternative phone field will be renamed to "Health practice phone number."
    - They will engage their vendor to update the downloadable PDF form to have the mobile phone number field removed from the form.

- In the meantime, they will remove the red asterisk from the mobile phone field in the digital form and update the grey italic instruction text beneath the mobile phone field label, to clarify that users only need to supply the practice number. Further

information for health practitioners regarding their responsibilities under the Arms Act is available on the Te Tari Pūreke website.

4. Pediatric wrist buckle fractures

- The Canadian College of Family Physicians Tools for Practice #390 looked at the evidence around immobilization of pediatric buckle (torus) fractures of the wrist. The bottom line was that children with buckle fractures treated with a soft bandage, a rigid splint, or a cast all heal with minimal complications and similar functional outcomes and satisfaction at ~4-6 weeks. Pain is similar at all time points though casting results in slight reduction on the first day.

- The authors noted that NICE (UK) guidelines recommend soft bandage for buckle fractures, but no Canadian guidelines have been published. Home management with family physician follow-up as needed results in similar outcomes to scheduled family physician follow-up. Importantly, greenstick fractures (cortex is fractured on one side and buckled on the other) generally require rigid immobilization.

5. Carer Support

- The Carer Support Subsidy for people with disabilities is funded by Disability Support Services. Carer Support is available for 'full-time Carers'. A full-time Carer is the person who provides more than 4 hours per day unpaid care, for example, the wife of a husband who has dementia. The number of hours or days that Carer Support is funded for depends on their needs and those of the person they care for.

- The Carer Support Subsidy is accessed by having a needs assessment from a Health NZ Needs Assessment Service Coordination (NASC) service, and GP, Mental Health Clinician or Specialist can support access to a Carer Support Subsidy by completing a Carer Support Registration Form. Paid family and whānau carers may also be eligible for Carer Support and will be advised of this by their NASC.

- Use of the subsidy is governed by the Te Whatu Ora Carer Support Subsidy Purchasing Guidelines. Examples of potentially eligible claims include: A contribution to the costs of substitute caring whilst the full-time carer takes a break (up to $80 per day); Expenses that are a necessary part of supporting the disabled person while the full-time carer takes a break; One-off purchases of: Tablet devices. Noise cancelling headphones. Sensory items (such as fidget spinners etc.) Weighted blankets.

- You cannot claim for: Purchases of items as a form of delivering respite, except those listed above. Self-care services such as massages, pedicures and other appearance or therapeutic care that are not for the direct benefit of the disabled person. All expenses that are not a necessary part of supporting the disabled person while the full-time Carer is taking a break. Gifts and other forms of recognition for support provided voluntarily. Travel related costs for disabled people, whānau, and/or persons providing support, including: Accommodation; Overseas and domestic travel; Food.

6. Mirena update

- A couple of years ago we reported that Mirena had been approved in the UK for up to eight years for contraception. The Mirena levonorgestrel intrauterine system is now approved in New Zealand for up to eight years for contraception. The Mirena data sheet has been updated to reflect this. No changes have been made to the licensed duration of use for other indications (heavy menstrual bleeding, endometrial protection in patients taking oestrogen replacement treatment); this remains at up to five years.

- N.B. The manufacturer states that for heavy menstrual bleeding (idiopathic menorrhagia), if symptoms have not returned after five years of use, continued use of Mirena may be considered but it should be removed or replaced after eight years at the latest. For endometrial protection during oestrogen replacement treatment, Mirena should be removed or replaced after five years.

- For further information on long-acting contraceptives, there is an excellent 2021 BPAC article available. Note also Pharmac has announced that from 1 August 2025, Mirena and Jaydess IUDs will be available on a Practitioners Supply Order (PSO), allowing doctors and nurses to provide them directly during appointments. Pharmac is also increasing the number of Jadelle contraceptive implants available on PSO.

- Up to 25 Mirena IUDs, 10 Jaydess IUDs and 20 Jadelle paired implants can be ordered per PSO.

7. Pharmac update eformoterol/budesonide inhalers

- Pharmac has announced that from 1 August 2025, people using the 100/6 and 200/6 budesonide with eformoterol inhalers will be able to receive three-months supply all at once, reducing the need for multiple pharmacy visits. These inhalers will also be available on a Practitioners Supply Order (PSO) (one of each per PSO). This means

doctors and nurses will be able to keep it in their clinic for emergency use, teaching and demonstrations. They will also be able to give it to people if accessing a pharmacy isn't practical.

- The currently funded brands of budesonide with eformoterol combination inhalers are Symbicort Turbuhaler, DuoResp Spiromax (dry powder inhalers) and Vannair (metered dose inhaler). Changes relate to the 100/6 and 200/6 budesonide/eformoterol inhalers because these strengths are used in AIR and SMART therapies per the NZ adolescent and adult asthma guidelines.

8. Resources

- Functional Neurological Disorder Aotearoa website: Contains a wealth of educational and local practical information for sufferers of FND and includes useful information for health professionals on supporting patients with FND.

- Health Apps page on Healthify - The NZ Health App Library, funded by Health New Zealand | Te Whatu Ora, is made up of apps that have been reviewed by experts, so patients can access reputable and reliable app-based information and support on a variety of conditions. The library is searchable alphabetically and by category, with New Zealand based apps easily identifiable.

- Christchurch Medicines Information Service has produced a guidance sheet on swapping patients from Saxenda (liraglutide) to Wegovy (semaglutide). Semaglutide generally leads to greater weight loss than liraglutide, but may also cause more gastrointestinal (GI) adverse effects (primarily nausea, vomiting and diarrhoea). When switching from liraglutide to semaglutide, a conservative approach is generally recommended, starting with comparatively lower doses of semaglutide, to help reduce the risk of GI adverse effects during the transition. No wash-out period is required; semaglutide can be started the day after stopping liraglutide.

- Another resource for clinical guidance and queries is Open Evidence which aims to "tame the medical information firehose. We built OpenEvidence to aggregate, synthesize, and visualize clinically relevant evidence in understandable, accessible formats that can be used to make more evidenced-based decisions and improve patient outcomes". Partners include the JAMA journal network, NEJM and the Mayo Clinic Platform. Registration is free (you need to upload a copy of your APC) and you can keep a record of your question history if you need it for MOPS

9. That's interesting

Issue 254 of GP Research Review contained comment on some interesting papers:

(i) Penicillin allergy testing with direct oral challenge in primary care - researchers from Michigan developed a protocol for a direct oral penicillin challenge using amoxicillin in patients identified as having a very low-risk penicillin allergy using the PEN-FAST allergy decision rule. All 49 patients had a successful negative direct oral challenge (500mg amoxicillin PO and observed for one hour with telephone follow-up at one week and one month), and all had their penicillin allergy removed from electronic health records.

(ii) A cross-sectional study on accuracy of urine dipstick for the diagnosis of urinary tract infection in febrile infants aged 2 to 6 months concluded that urine dipstick testing had greater sensitivity and specificity than urine microscopy, at a white blood cell cut point of ≥7 cells per high-power field (sensitivity 90.2% vs. 83.9%, respectively; specificity 92.6% vs. 87.0%). The study involved 9387 febrile infants who underwent a catheterised urine culture, and 11% of these infants were found to have a UTI. The most common pathogen was Escherichia coli (88.4%). The reviewer's take-home message: dipstick is accurate, but don't forget to send the urine off for culture for a definitive diagnosis!

(iii) A meta-analysis looking at the effects of vitamin D supplementation on diabetic foot ulcer healing found that wound healing and reduction in wound area were significantly improved in patients taking vitamin D supplementation as compared to the placebo-treated controls. Vitamin D is known to improve glucose metabolism and insulin indexes, as well as having a positive effect on inflammation and this was also confirmed in the trials. Take-home message: vitamin D supplementation is worth a try in patients with lower leg diabetic wounds.

9. IgNobel contender?

Also from Issue 254 of GP Research review was comment on a study published in the BMJ looking at the effect of laughter exercise versus 0.1% sodium hyaluronic acid on ocular surface discomfort in dry eye disease. Patients (229) with symptomatic dry eye disease were randomly assigned to either laughter exercise (n=149) or artificial tears (n=150) 0.1% sodium hyaluronic acid eyedrops) four times each day for 8 weeks. In the laugher exercise group, patients were required to repeat "Hee hee hee, hah hah hah, cheese cheese cheese, cheek cheek cheek, hah hah hah hah hah hah" 30 times during every 5-min session. At 8 weeks, laughter exercise was found to be non-inferior to eye drops with regard to the primary outcome (mean change in the ocular surface disease index). Laughter exercise also achieved greater efficacy in improving non-invasive tear break-up time. The reviewer commented: We already know that laughter is beneficial for mental health as well as other health parameters (improved immune function, reduced cortisol levels, etc.), but now we see that it is as effective

as lubricating eye drops at improving dry eye symptoms. There is without a doubt some truth to the centuries-old saying that “laughter is the best medicine”.