Clinical Snippets September 2025

1. Malnutrition

A recent issue of NZ Doctor reviewed detection and management of adult malnutrition (Malnutrition Awareness Week ran from 8-12 September), noting it can be difficult to detect and is often overlooked in primary care.

(i) Key risk factors include:

- older age (especially 75+)
- chronic conditions (eg, chronic obstructive pulmonary disease, heart failure, cancer, inflammatory bowel disease, liver disease, dementia)
- polypharmacy and medication side effects
- poor appetite or early satiety
- chewing or swallowing difficulties
- living alone, poverty or reduced mobility, especially in older adults
- recent hospital admissions or unexplained weight loss.

(ii) Start with the basics – ask patients:

- Have you lost weight without trying in the last three to six months?
- Have you been eating less than usual?
- Have you noticed your clothes or belts fitting more loosely?

(iii) Routinely document:

- weight and height so it is easy to see if weight has changed over time
- changes in appetite, energy or function
- illness or social factors affecting food intake (eg, living situation, money to buy food).

(iv) Use a validated screening tool

- Malnutrition Universal Screening Tool (MUST) assesses BMI, unplanned weight loss and acute disease effect, and is available online. It categorises risk as low, medium or high.
- MNA-SF is designed for older adults (65+) and includes six questions on appetite, mobility, recent illness, weight loss and BMI. It can be completed by health professional or patients

(v) Refer to a registered dietitian if the patient is:

- identified as being at high risk of malnutrition (using a validated screening tool)
- experiencing unintentional weight loss of greater than 5 per cent in three to six months
- eating poorly due to illness, nausea, swallowing issues, poor dentition or depression
- recently discharged from hospital after a nutrition-impacting condition
- living with a long-term condition that affects eating or nutrient absorption
- unable to meet nutritional needs with food alone.

Do not wait for laboratory results. Malnutrition is a clinical diagnosis, and blood tests are not required to refer.

(vi) Health Pathways have a dedicated section *Weight and Nutrition in Older Adults*

2. Breast Screening Extension

Te Whatu Ora has announced an extension to the national breast screening programme.

(i) Extending the age for breast screening across New Zealand in **year one will only apply to 2 age groups: 70 and 74-year-olds** (except for the pilot district of Nelson and Marlborough which started 1 October 2024)

As of 1 October 2025:

- Women who turn 70 on or **after** 1 October 2025 are eligible for free mammograms every 2 years (from their last screen) until aged 75. Note: some women may have screened at 69 and won't be due again at 70
- Women who are 70 to 74 **before** 1 October 2025 are eligible for one final screen at age 74, if booked before turning 75

(ii) Extending the age (to include all women up to the age of 74) will be fully in place by the end of 2029. This phased approach will enable breast screening and cancer treatment services to progressively meet the additional demand.

(iii) Women aged 70 and 74 will be automatically identified through the new online breast screening system called Te Puna . A BreastScreen Aotearoa provider will then send them a personalised link to enrol/re-enrol and to book a mammogram. This is a shift away from an opt-in to an opt-out enrolment approach.

(iv) Design and construction work for three additional fixed locations is expected to be ready in time for the age extension national rollout, and another two in 2026. Mammography, ultrasound machines and three additional mammography semi-trailers are also on order. Additional funding for treatment costs related to the age extension are planned.

(v) The Te Puna website notes GPs and primary care professionals are encouraged to talk with their patients aged 45 to 69 (and women aged 70 and 74 from 1 October 2025) to enrol/re-enrol and to book a mammogram when they receive their secure personalised link. GPs are also requested to keep referring their patients aged 45 – 69 years (plus women aged 70 and 74 from 1 October 2025*) through current processes to ensure all eligible women are invited.

3. Serum oestradiol

The BMS Tool for Clinicians, released in July 2025 by the British Menopause Society (BMS), provides guidance on measuring serum estradiol in the menopause transition, emphasizing that a single estradiol level is not sufficient to gauge menopause hormone therapy (MHT) effectiveness or manage symptoms. Some points from the 13-page document summarised in GP Notebook include:

- there is uncertainty about the significance of a single serum estradiol level both in relation to symptom management and in managing long-term health consequences of the menopause, such as osteoporosis and cardiovascular disease. There is variation of measured serum estradiol for any dose of HRT in any given individual.
- in the perimenopause it is not possible to distinguish between endogenous and exogenous estradiol through serum estradiol testing

- there is poor correlation between serum estradiol and symptom management with significant inter-individual clinical response to the same dose of estradiol containing HRT
- there is no value in checking serum estradiol if a patient is taking oral estradiol, as a significant percentage is metabolised to the weaker estrone which does not cause a reduction in FSH levels. The ratio of estradiol and estrone change after the menopause, so there is significantly more estrone
- there is no value in measuring a serum estradiol in women taking combined hormonal contraception
- there is no known threshold for serum estradiol and prevention of loss of bone density or prevention of osteoporotic related fractures
- there is no evidence regarding the optimum HRT monitoring strategy for women with premature ovarian insufficiency (POI) although it is stated that monitoring serum estradiol may be useful in monitoring women with female hypogonadism including POI, but a holistic approach is necessary to ensure adequate treatment
- during the menopause transition there is an overall decline in estradiol, but in the perimenopause, estradiol can fluctuate erratically and dramatically including supraphysiological levels at times.

4. Equity focus – anticoagulant monitoring

Issue 116 of Maori Health Review examined a recent NZMJ article on anticoagulation management and poor clinical outcomes in tamariki and rangatahi with rheumatic heart disease following mechanical valve replacement surgery in Counties Manukau

- This was an observational study conducted in the Counties Manukau region between 2016 and 2021. A total of 53 individuals were included, of whom 19% were Māori and 81% were Pacific peoples. Median age at time of first mechanical valve surgery was 15 years (range 4-23 years), and the median duration of anticoagulation was 4 years (range 0.5-18 years). Monitoring was most commonly carried out via the community laboratory service and general practitioner.

- Overall, 38 individuals had at least one anticoagulation-related hospitalisation. Reasons for the 80 anticoagulation-related hospitalisation events were subtherapeutic INR without clinical complication (52%), supratherapeutic INR without clinical complication (15%), haemorrhage (14%), stroke (9%), other thromboembolic event (6%), and prosthetic valve thrombosis (4%). Five deaths occurred over the study period.

- The authors concluded that urgent efforts are required to improve services for anticoagulation monitoring and management in young adults following mechanical valve surgery for rheumatic heart disease. What are the barriers to optimum INR management in this group and how might they be best addressed?

5. Prostate cancer screening and DRE

Best Practice Bulletin 128 includes an interesting Practice Focus on the question *Prostate cancer screening - to DRE or not to DRE?*

- Prostate cancer is the most common cancer in males in New Zealand, and the second most common cause of cancer-related mortality. Performing a digital rectal examination (DRE) for prostate cancer screening is often considered best practice in New Zealand, alongside PSA testing. However, recommendations vary between international guidelines.

- An article published in the British Journal of General Practice (BJGP) last year questioned the value of DRE in prostate cancer screening and raised concerns about the procedure representing a barrier to males seeking care for prostate-related issues. The British Association of Urological Surgeons in association with Prostate Cancer UK, has since issued a statement (June, 2025), that DRE is no longer considered a useful screening test for prostate cancer. There have been no changes to the recommendations in New Zealand at this stage.

- The statement states evidence shows that fear of rectal exams is the greatest barrier to men taking action by talking to their GP about the PSA blood test. Different research from Prostate Cancer UK found that in a group of more than 2,000 men, 60% were concerned about having a rectal exam. Of those, 37% would not speak to a GP about prostate worries because they feared the DRE. Even worse, Black men — who have twice the risk of getting prostate cancer and dying from it — report that they feel an even greater stigma about rectal exams.

- My favourite AI source states DRE is not recommended as a primary screening test for prostate cancer due to its poor diagnostic accuracy and limited impact on cancer-related morbidity or mortality. Systematic reviews and meta-analyses demonstrate that DRE has low sensitivity (approximately 51%) and specificity (approximately 59%) for prostate cancer detection, and its positive predictive value is particularly poor in men with low or normal PSA levels.

6. Release of 16 optimal cancer care pathways

The Cancer Control Agency | Te Aho o Te Kahu has published 16 Optimal Cancer Care Pathways (OCCPs) for eight solid tumours and eight blood cancers that affect people in Aotearoa New Zealand.

The OCCPs are pathways that describe contemporary best practice for the delivery of optimal cancer care by tumour type. Each OCCP has been designed in partnership with the sector:

- With the needs of the person and their whānau (family) at the heart
- To reflect the best service capabilities available in New Zealand
- To provide a national expectation of equitable, high-quality, timely, and evidence-based cancer prevention and care for all New Zealanders.

7. FIT Symptomatic Pathway

- The implementation of the FIT for Symptomatic clinical pathway in the Waikato District went live last month. The pathway is a new model of care for patients referred from primary care with bowel symptoms. Patients will be triaged and graded by a clinician as usual, and will be graded for urgent colonoscopy, non-urgent colonoscopy, to be seen in clinic, or declined. Some of the patients graded as non-urgent will be sent a FIT test kit as part of the triage process. Patients who are triaged as urgent or not suitable for the FIT test will proceed to colonoscopy or clinic without the requirement to complete the FIT test.

- Patients with a negative FIT result, unless otherwise stated at the initial triage by the grader, will be returned to primary care without being offered a colonoscopy. They will receive a discharge letter advising them that if their symptoms become more severe or persist for more than six weeks, they are to make another appointment promptly with their GP/ health care provider.

- Within the FIT for Symptomatic Register, patients will be flagged if they have been sent a bowel screening kit or are due to be sent one in the next 30 days. Within the FIT for Symptomatic pathway there are patient touch points to support the patient to return the FIT KIT if a result is not received.

- The National Bowel Screening Programme FIT threshold for a positive test result is ≥200ng Hb/ml buffer while the threshold for the FIT for Symptomatic clinical pathway is ≥50ng Hb/ml. When tested on the New Zealand population the diagnostic accuracy was comparable to previous studies in the UK. Using a threshold of 50ng Hb/ml buffer the sensitivity was 91% and the specificity was 83%. The negative predictive value is 99.6% for a threshold of ≤50ng Hb/mL buffer with the number needed to scope to identify one bowel cancer if the FIT threshold is ≤50ng Hb/mL buffer being 280.

- Criteria for referral of symptomatic patients for colonoscopy remain the same. The pathway FAQ sheet notes the following:

    - You need to advise the patient that they are being referred for a bowel assessment and they may be offered a FIT test.
    - Provide them with the patient information sheet that will be available on HealthPathways and on HealthEd (various languages and print sizes), confirm their address and identify any support needs on referral.
    - Please also advise the patient that if they receive a negative FIT result but continue to have persistent symptoms to return to you, their GP or nurse practitioner.
    - Please consider if the practice needs to actively contact a FIT negative patient at six weeks (having received a discharged letter). There are many barriers to symptom presentation and being advised you don't need a colonoscopy may subtly add to these.

8. Oral iron tablets

- Pharmac has announced a supply issue affecting ferrous sulfate 325 mg modified-release tablets (Ferrograd) due to a change in manufacturer and price. Ferrograd tabs are expected to go out of stock in early September and no alternative equivalent brand is available. No new patients can be prescribed ferrous sulfate tablets from 1st September, 2025, and this formulation will be delisted from the Pharmaceutical Schedule on 1st March, 2026.

- Ferrous fumarate 200 mg (Ferro-tab) is an alternative oral iron supplement although it is an immediate-release formulation and lower elemental iron dose than Ferrograd, and some patients may require dosing up to three times daily, as opposed to once daily with Ferrograd (see NZF for dosing instructions). However, ferrous fumarate may be better tolerated by some patients.

9. Standing orders for adrenaline for authorised vaccinators

- A recent statement from the Immunisation Advisory Centre confirms that while there has been no change to the Medicines Regulations 1984, authorised vaccinators administering adrenaline for post-vaccination anaphylaxis require a prescription or a Standing Order.

- Vaccinator authorisation is enabled under the Medicines Regulations 1984 (44A), which does not include authorisation to administer adrenaline. Previously, administration of adrenaline by authorised vaccinators was understood to have been covered by vaccinator authorisation.

- Adrenaline is not a prescription medicine; however, it is a restricted (pharmacist-only) medicine and its administration by non-prescribing registered healthcare professionals (other than pharmacists) requires a prescription or a Standing Order.

- An adrenaline Standing Order template and supporting FAQs are available on Health New Zealand's Prevention-Immunisation Dropbox. Links with additional resources below:
    - HNZ Dropbox – Standing Order template and supporting FAQs
    - Standing Order Guidelines, Ministry of Health, 2016 v2
    - Medicines (Standing Order) Regulations 2002
    - IMAC management of anaphylaxis factsheet
    - HealthPathways