Clinical Snippets October 2025

1. Suicide prevention

(i) A recent Goodfellow Gem drew attention to the NHS guidance Staying safe from suicide (2025) which includes references to NICE Guideline NG225: Self-harm: assessment, management and preventing recurrence. Of note, the NICE guideline strongly advises against the use of risk assessment tools and scales, or global risk stratification into low, medium, or high risk, to predict future suicide or repetition of self-harm or to determine who should or should not be offered treatment or be discharged.

(ii) The NHS guidance has 10 key principles:

- **relational safety**: build and maintain trusting, collaborative therapeutic relationships. These are the strongest predictor of good clinical outcomes
- **biopsychosocial approach**: address safety as part of a broad biopsychosocial approach aimed at improving overall well-being by considering biological, psychological and social aspects
- **safety assessment and formulation**: reach a shared understanding with the individual about safety and changeable factors that may affect this
- **safety management and planning**: consider the need for immediate action and work with the individual to navigate safety and the factors impacting this over time.
- **dynamic understanding**: regularly assess and adapt formulations and safety plans based on the individual's changing needs and circumstances
- **evidence-based practice**: base work on the latest research and understand population-level risk trends
- **involving others**: encourage the involvement of trusted others, where possible and as appropriate
- **inclusivity**: Ensure practices are inclusive and adaptable, particularly for marginalised and high-risk groups
- **clear communication**: use simple language tailored to the individual and don't use jargon. Use interpreters or approaches like drawing, if needed
- **continuous improvement:** regularly review and refine approaches based on outcomes and feedback

(iii) A written, prioritised list of coping strategies and/or sources of support that the person who has self-harmed can use to help alleviate a crisis. Components can include recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods. The NZ Mental Health Foundation provides an editable Personal Safety Plan which is also available as hard copy. Other suicide related resources are also available.

(iv) Community Health Pathways has sections on *Suicide Prevention in Adults* and *Suicide Prevention in young People.* The Pathways do currently include risk stratification but also emphasise the most important priorities are to engage the patient, provide hope, and look at ways to keep them safe. Hopelessness has a high correlation with eventual suicide. The Pathway also emphasises the importance of building a strong therapeutic alliance by:

- Communicating empathy and understanding for patient's extreme suffering.

- Providing reassurance that recovery is possible.
- Reinforcing the patient's help-seeking behaviour in coming to see you for treatment.

2. Ondansetron in pediatric gastroenteritis

Issue 259 of GP Research Review looked at a double blind study published in NEJM in which just over 1000 children between the ages of 6 months to <18 years with acute gastroenteritis associated vomiting whose carers were provided with 6 doses of oral ondansetron or placebo at the time of ED discharge, with instructions to use in the case of ongoing vomiting. Outcomes were measured in symptom continuation and deterioration, duration, total number of vomiting episodes and the need for further medical intervention. In the 7 days after enrolment, those prescribed ondansetron had significantly less chance of deterioration and reduced episodes of vomiting. Adverse events were balanced between study arms. Take-home message: Ondansetron is effective in reducing vomiting from gastroenteritis in those aged between 6 months and 18 years. NZFC notes acute gastroenteritis-related vomiting associated with dehydration is an indication for a single dose of ondansetron in children.

3. HIPC Rule 11

A recent issue of NZ Doctor contained an article from the office of the Privacy Commissioner on Rule 11 of the HIPC which links to last month's discussion around suicide prevention.

The question is presented: *When a patient insists that their parents not be told about what's going on in their life, but you think their mental health is at risk and parental support could lessen that threat, what should you do?* If a patient refuses consent to share their health information, but a GP believes their safety is at risk, Rule 11 of the Health Information Privacy Code may allow the doctor to act.

Rule 11 of the HIPC permits the disclosure of health information if it is necessary to prevent or lessen a serious threat to the life or health of any person, or to public health or safety (the serious threat exception). In each case, specific requirements must be met for the serious threat exception to apply. If another piece of legislation requires or allows you to share the health information in question, you should rely on that legislation rather than Rule 11. For example, if sharing is permitted by the Oranga Tamariki Act 1989 you should rely on that as your authority. You don't need to also make an assessment under Rule 11.

If no other piece of legislation applies, you need to assess the disclosure under Rule 11. There are four steps to work through.

(i) Has the person authorised you to share their health information? If yes you can release information as agreed with the person.

(ii) If you do not have authorisation, it reasonably practical to seek authorisation? For the serious threat exception to apply, you need to have reasonable grounds to believe that it is not desirable or practical to seek the individual's authorisation. If you request authorisation to disclose the information but the individual does not grant it, you must consider why the authorisation was not granted and

whether it is appropriate to proceed with the steps. If the threat is serious enough, you might find that it outweighs the need for authorisation. If it is not desirable or practicable to seek authorisation, go to step three.

(iii) Is there a serious threat to the life or health of a person?

The serious threat exception applies to serious threats to the life or health of the person whose information it is, that of any other person, or public health or safety. When considering whether there is a serious threat, you need to use your clinical judgement to assess the likelihood of the threat occurring, the seriousness of the threat and the harm that could eventuate and the imminence of the threat. If the threat does not meet the "serious threat" threshold, you cannot rely on this exception. If there is a serious threat, go to step four.

(iv) Is the disclosure to someone who can help lessen or prevent the threat?

You can only disclose health information under this exception if you are sharing the information with someone who can help lessen or prevent the threat, and only as much information as is needed to do so. For example, if you have gone through these four steps and concluded that involvement from a patient's loved one in their care would lessen the threat, you should still only share as much information as is necessary to do that.

As always, it will be crucial to document your decision-making process. It may help to record the answer to the four steps sequentially in your notes as you are deciding on the best course of action, as well as your rationale for these answers. The full guidance on this exception is available in the **resources and learning section at privacy.org.nz**.

4. Long-acting insulin

- A recent Tools for Practice from the College of Family Physicians of Canada looked at the evidence comparing once-weekly insulin icodec (Awiqli) compared to daily long-acting insulins in type 2 diabetes? The bottom line was that once-weekly insulin icodec is as effective as daily long-acting insulin (glargine or degludec) in lowering HbA1c. Safety and hypoglycemia risk appear similar, though data are limited for patients or situations at risk for hypoglycemia such as sick days or in frail patients.

- Insulin icodec is not yet approved for use in New Zealand but is approved in Australia for type 2 diabetes in adults and adult type 1 diabetes with some restrictions. Insulin icodec (Awiqli™ 700 units/mL, 2100units/pen) is an ultra-long-acting insulin. In insulin naive patients, initial recommended dosage is 70 units once per week, equivalent to 10 units daily. Maximum dose per injection 700 units. When switching from another long-acting insulin, use the equivalent total weekly dose but a one-time 50% higher loading dose may be considered. However, it may be a while before it is approved in New Zealand – it is more expensive than other long-acting insulins. Approximate costs per month for 40 units/day or 280/week: Glargine: $70; Degludec: $100; Icodec: $115 NZD equivalent.

5. Insomnia medication

The Research Review Educational Series has published an update on recent advances in the management of insomnia. Behaviour therapy is the recommended first line treatment for insomnia with hypnotics being used as adjunctive or alternative therapy. Health Pathways has a comprehensive summary of accepted insomnia management practices.

The publication reviews the various available hypnotics including dual orexin receptor antagonists (DORAs) which are a newer class of hypnotic. In December 2024, the Minister of Health consented to the distribution of the DORA lemborexant (Dayvigo®) in New Zealand for treatment of insomnia in adults. The following 'take home' messages relate to lemborexant.

- RCTs, meta-analyses and network analyses have shown lemborexant has favourable efficacy and side effect profiles compared to placebo and benzodiazepine receptor agonists. Lemborexant significantly reduced time to sleep onset and increased overall sleep time compared to placebo and zolpidem at 1 month, and compared to placebo at 6 months with these effects maintained to 12 months.
- Discontinuation of lemborexant therapy was not associated with rebound insomnia and lemborexant did not significantly impair next-day memory or driving, compared to placebo and benzodiazepine agonist receptors.
- Lemborexant was well tolerated with a TEAE (treatment emergent adverse event) rate similar to placebo. TEAEs most commonly associated with lemborexant are somnolence, headache, nightmares and/or abnormal dreams. A single retrospective study found Lemborexant was associated with a lower rate of falls in hospitalised patients compared to benzodiazepine receptor agonists.
- Information on dosing and precautions is available in NZ Formulary and the Medsafe data sheet. The drug is not currently subsidised and is an unapproved medicine (s29). The Better Sleep Clinic website has a page dedicated to comparing the various medications used in insomnia management which might be a useful resource for patients. The cost of a four week supply of Lemborexant in NZ (Pharmacy Direct) is $113 for the 5mg tab and $143 for the 10mg tab.
- There is a recent Goodfellow Gem briefly summarising relevant prescribing data

6. Triple therapy for COPD

A recent NZ Doctor article on triple therapy for COPD includes the following take home points:

- For mild COPD, monotherapy with a bronchodilator is usually adequate; start a regular LAMA early; if symptoms increase, add a LABA.
- An eosinophil count $\geq 0.3\times10^9$/L helps identify people with frequent exacerbations who are most likely to respond to an ICS.
- If an ICS is indicated, it should be part of triple therapy (ICS + LAMA + LABA not ICS + LABA).

- Strongly recommend vaccinations (encourage the unfunded vaccines, especially pneumococcal) and pulmonary rehabilitation (refresher course every two to three years).
- The debate around the benefits and risks of therapy for COPD involves the place of inhaled corticosteroids. When we had limited inhaled therapy options for COPD, many people with COPD were initiated on an ICS + LABA combination. Subsequently, different phenotypes of COPD have been identified, and those with frequent exacerbations (two or more exacerbations in 12 months) have been shown to have fewer exacerbations when on an ICS. Those without frequent exacerbations derive no benefit but are at increased risk of adverse effects from ICS therapy, such as pneumonia.

- Resources:
    - Trelegy Special Authority form
    - 2025 GOLD COPD guidelines

7. Resource – iron studies and anaemia

A recent Research Review Educations Series titled What the ferritin? Is well worth an hour of CME. It covers the basics of iron metabolism and then the various blood test used to asses iron status. There is a very helpful table to aid distinguishing iron deficiency from anaemia of chronic disease and an acute phase reaction, and algorithms aiding differentiation of absolute versus functional iron deficiency. The importance of investigating an underlying cause of absolute or functional iron deficiency is emphasised. Take home messages include:

- Low serum iron is not a reliable indicator of depleted iron stores (diurnal variation and inter-individual variation, sensitive to recent iron intake, acute and chronic illness.
- Low transferrin saturation (TSAT) with low ferritin is consistent with iron deficiency (ID). High TSAT with high ferritin indicates iron overload. TSAT alone is not a reliable marker of iron status.
- A normal or raised serum ferritin level does not necessarily exclude ID; it is important to distinguish between absolute and functional ID, especially in patients with inflammation or chronic disease. However, serum ferritin is a sensitive and specific test for ID. Low ferritin levels are highly specific for ID; high ferritin levels do not necessarily indicate iron overload.
- The reticulocyte haemoglobin equivalent RET-He test is a rapid, inexpensive indicator of ID in chronic disease.
- If patients are started on oral iron replacement therapy, they should be checked at 6 weeks to ensure the medication is being tolerated and that haemoglobin levels are increasing. Patients who receive IV iron replacement therapy should have a full blood count at 2–3 months post-infusion to check for haemoglobin normalisation.

8. Follow-ups

(i) Adult ADHD management: MyHealthHub has hosted a webinar ADHD in Adults – the Primary Care Perspective by Auckland psychiatrist Dr Sidesh Phaldessai. The hour-long webinar is eligible for PD points and explores explore the diagnosis, referral, management and long-term care of adult ADHD. Dr Phaldessai is also hosting an online Adult ADHD GP Masterclass which is a series of six webinars 7.30pm-8.30pm every Wednesday from 22 October until 26 November 2025 covering all aspects of adult ADHD diagnosis and management. It is RNZCGP endorsed (12 CME points) and if you are unable to attend on the given date and time - the webinar will be recorded and you can access it later.

(ii) Further to a discussion in the last Snippets regarding medications that can affect the QTc interval, Christchurch Medicines Information Service have recently published a succinct 2-page bulletin on the issue including predisposing risk factors, culprit drugs and drug interactions and how best to manage the risk. There are links to the CredibleMeds website which enables you to search individual medications and categorises them as:

- Known Risk of Torsade de Pointes (TdP) - These drugs prolong the QT interval AND are clearly associated with a known risk of TdP, even when taken as recommended.
- Possible Risk of TdP - These drugs can cause QT prolongation BUT currently lack evidence for a risk of TdP when taken as recommended.
- Conditional Risk of TdP - These drugs are associated with TdP BUT only under certain conditions of their use (e.g. excessive dose, in patients with conditions such as hypokalemia, or when taken with interacting drugs) OR by creating conditions that facilitate or induce TdP (e.g. by inhibiting metabolism of a QT-prolonging drug or by causing an electrolyte disturbance that induces TdP).
- Drugs to Avoid in Congenital Long QT Syndrome (cLQTS) - These drugs pose a high risk of TdP for patients with cLQTS and include all those in the above three categories (KR, PR & CR) PLUS additional drugs that do not prolong the QT interval per se but which have a Special Risk (SR) because of their other actions.