Clinical Snippets December 2025

1. Restless leg syndrome in adults

(i) Best Practice Bulletin 127 commented on an updated international guideline from the American Academy of Sleep Medicine published earlier this year that has recommended a new treatment hierarchy for managing patients with severe symptoms of restless legs syndrome. One of the most significant changes is that dopamine agonists, previously first line for patients with severe symptoms, are no longer recommended due to concerns with augmentation syndrome (worsening of restless legs symptoms over time). The importance of iron supplementation in people with low ferritin levels is also strongly emphasised.

(ii) Good practice statements include:

- The first step in the management of RLS should be addressing exacerbating factors, such as alcohol, caffeine, antihistaminergic, serotonergic, antidopaminergic medications, and untreated obstructive sleep apnoea.

- In all patients with clinically significant RLS, clinicians should regularly test serum iron studies including ferritin and transferrin saturation (calculated from iron and total iron binding capacity). Testing should ideally be administered in the morning avoiding all iron-containing supplements and foods at least 24 hours prior to testing. Consensus guidelines, suggest supplementation of iron in adults with oral or IV iron if serum ferritin ≤ 75 mcg/L or transferrin saturation < 20%, and only with IV iron if serum ferritin is between 75 and 100 mcg/L. Note that Special Authority criteria for funded access to IV iron supplementation in New Zealand requires a diagnosis of anaemia and a serum ferritin level ≤ 20 mcg/L (or a serum ferritin level between 20 – 50 mcg/L and CRP ≥ 5 mg/L), therefore people with restless legs syndrome may not qualify.

- RLS is common in pregnancy; prescribers should consider the pregnancy-specific safety profile of each treatment being considered.

(iii) gabapentin and pregabalin are now regarded as first line pharmacological treatment for adult RLS (off-label use in NZ) with dipyridamole and low dose opioids conditionally recommended as second line agents. There are conditional suggestions against the standard use of dopamine agonists (ropinirole, pramipexole) with the qualifying remark: [the drug] *may be used to treat RLS in patients who place a higher value on the reduction of restless legs symptoms with short-term use and a lower value on adverse effects with long-term use (particularly augmentation).* [Note potential adverse effect of impulse control disorders also]. There are also conditional suggestions against the use of bupropion, carbamazepine, clonazepam, valproate and valerian. Health Pathways acknowledges the new guidance with the RLS pathway to be updated as resource allows.

2. Pregabalin prescribing

A recent NZ Doctor article looked at prescribing of pregabalin in neuropathic pain. This was presented as a case study and comment from various health providers.

- There is reference to the 'black box' warning which notes the drug *poses risks of misuse, abuse and dependence which can lead to overdose and death especially when used concomitantly with opioids and other CNS depressants.*
- Dosing is renal function dependent.
- Withdrawal symptoms are common and can occur even when stopping relatively low doses of pregabalin. NZF notes that, dose reduction should be individualised as tolerated; a suggested regimen is to reduce the daily dose of pregabalin at a maximum rate of 50–100mg every week, but the tapering rate may need to be considerably slower, e.g. smaller dose reductions over a longer time. Gradual withdrawal allows for monitoring, and appropriate management of withdrawal symptoms. In those taking high doses for long periods of time, complete withdrawal may take several weeks or months.
- Pregabalin use in the first trimester of pregnancy may cause major birth defects in the unborn child. Pregabalin should not be used during pregnancy unless the benefit to the mother clearly outweighs the potential risk to the fetus. Women of childbearing potential must use effective contraception during treatment – ideally long-acting reversible contraception (LARC) is preferred; alternatively, two complementary forms of contraception including condoms should be used.

Comments from a specialist pain physician regarding issues experienced in her practice include:

- lack of informed decision-making – patients unaware of the indication, mechanism and 'off label' nature of the gabapentinoid use, potential side effects and difficulty weaning in future
- not having been advised of the potential risks to a developing pregnancy, and thus not using effective contraception
- cognitive impacts – including one older gentleman who was unable to complete the crossword in his daily paper as he usually could, and a young woman who had a near-miss car accident with her children in the car
- mood effects – including low mood and new-onset suicidal ideation
- discontinuation syndrome – many of my patients have experienced severe symptoms (eg, mood destabilisation, insomnia, suicidality) when trying to wean from gabapentinoids, and I have had two who needed to do so slowly over a year.

3. Ryeqo

(i) The drug company Gedeon Richter Australia has announced registration in July 2025 of their product Ryeqo for the treatment of endometriosis symptoms, including endometriosis pain, for adult women of reproductive age who have previously tried medical or surgical treatment for their endometriosis. It was initially approved in October 2023 for the treatment of moderate-to-severe symptoms of uterine fibroids in adult women of reproductive age.

(ii) Ryeqo is an oral treatment which contains the combination of a GnRH (gonadotropin-releasing hormone) receptor antagonist, relugolix 40mg, and a hormone add-back therapy, estradiol 1mg and norethisterone acetate, 0.5mg in a single, once-daily tablet. The main component, Relugolix works by reducing the hormone oestrogen that drives endometriosis symptoms including pain, whilst the estradiol and norethisterone acetate add-back therapy components help to maintain hormonal balance.

(iii) Ryeqo is not currently funded on the Pharmaceutical Schedule – patients will need to pay for the medicine (around $NZ250 per month) and any associated healthcare professional fees.

(iv) A comprehensive prescribing summary, including recommendations regarding informed consent and monitoring, has been developed by Cheshire and Merseyside NHS and although this reflects current prescribing restrictions in the UK, it provides an excellent overview of use of the drug. Medsafe have published Consumer and Health Professional prescribing data sheets.

3. Nortriptyline reminder

Health Pathways recommends nortriptyline as a first-line pain modifying agent in management of chronic non-malignant pain and I often see it prescribed appropriately for this indication. However, I have also received several complaints relating to adverse reactions (often stated by the complainant to be serotonin syndrome) occurring at what appear to be fairly modest doses of the drug although often in combination with other serotonergic medications such as tramadol. Health Pathways incudes the following advice with respect to prescribing of nortriptyline for chronic non-malignant pain:

- Best taken as a single evening dose 3 to 4 hours before bed.
- Start at 10 to 25 mg.
- Due to variations in CYP2D6 enzyme and metabolism of nortriptyline, there is a lot of individual variation in dose response.
- **Nortriptyline needs to be titrated, guided by measurement of plasma level after at least 10 days on a new dose.**
- Aim for a trough (late afternoon) plasma of between 200 to 400 nmol/L.
- Trial for at least 6 weeks at a therapeutic level.
- Typical effective dose is 50 to 75 mg, but some patients will require either much smaller or much higher doses.

4. Signs in ACS

Issue 262 of GP Research Review reported on a recently published meta-analysis evaluating the diagnostic accuracy that 13 symptoms and signs had in patients with suspected acute coronary syndrome (ACS) and acute myocardial infarction (AMI). The results suggested that the included symptoms and signs had limited utility for the detection of both conditions. The symptoms with the highest diagnostic accuracy for ACS were an absence of chest wall tenderness (diagnostic OR 7.73) and pain radiating to the right arm (OR 3.9). The most accurate symptoms for AMI were sweating, pain radiating to the right arm, absence of chest wall tenderness and pain radiating to both arms. Chest pain on exercise was also important in ACS. The reviewer's take-home message was *Symptoms have*

limited value in diagnosis of AMI and ACS, and objective testing remains essential for accurate diagnosis.

While we are on diagnosis of chest pain it is important to remember spontaneous coronary artery dissection (SCAD) as a cause of ACS. SCAD is often underdiagnosed, partly because it occurs in younger individuals (average age 51yrs, 80-90% female) without typical cardiovascular risk factors and clinicians may fail to consider ACS in a young female. It is the cause of around a third of heart attacks in women under 50 and half of all heart attacks in pregnancy and the post-partum period. The majority of patients (around 70%) present with non-ST-segment elevation myocardial infarction (NSTEMI), while 30% have ST-segment elevation MI (STEMI), with chest discomfort reported by around 90% of the subjects. Less common symptoms included nausea, vomiting, light headedness, and dyspnoea. I have also seen a recent case where a middle-aged woman without traditional CV risk factors presented with shortness of breath and chest tightness on exertion and was found to have 95% stenosis of her left main coronary artery due to radiotherapy she had undertaken several years previously for left sided breast cancer.

5. HQSC Cultural Resource:

To support the 2023 publication RN frailty care guide 'Guide for health professionals caring for kaumātua' HQSC has developed a series of short videos on cultural considerations when caring for kaumātua (Māori older adults) and their whānau in aged residential care and other health settings. The series covers key concepts of Māori identity, whanaungatanga (relationships), mana and manaakitanga (dignity and respect), tapu, noa and whakamā (sacredness, balance, and shame), and holistic care. Each video encourages reflection and offers practical ways to weave tikanga Māori into everyday care [2-3 minutes each].

- An introduction to caring for kaumātua https://youtu.be/m7lctQ2RHKk
- Māori identity and strength-based approaches https://youtu.be/KW1af0D7dvs
- Whanaungatanga and Whānau https://youtu.be/GBPFq2W31Ds
- Mana and Manaakitanga https://youtu.be/nuOu48i_CTU
- Tapu and noa, whakamā https://youtu.be/jrn142QCcEk
- Holistic care https://youtu.be/CVbUYpWdeWA

6. Reminder: Staff checks

- A recently published investigation by the Ombudsman launched found Health NZ had not been following the proper vetting processes required by law for nine years.
- It is a requirement in the Children's Act 2014 for all non-core children's workers to have passed an appropriate check to work with children, and this check requires updating every three years.
- Details relating to the legislation requirements and checking process can be found on the Te Whatu Ora website.

7. Resources

(i) STI Patient Info

The Sexually Transmitted Infections Education Foundation has a series of patient pamphlets available, which cover a range of topics related to herpes and human papillomavirus. Topics include HPV vaccination, cervical screening and results, HPV and throat cancer, and breaking down herpes myths. These resources are available electronically (**herpes.org.nz** and **hpv.org.nz**) and hard copies can be ordered and posted out free to general practices and sexual health clinics.

(ii) Herpes guidelines

STIEF and the New Zealand Herpes Foundation have also published updated clinical guidelines for the management of genital herpes in Aotearoa. Access them for free online (**guidelines.stief.org.nz**). The guidelines include genital herpes management flowcharts for clinicians covering first episodes, recurrent genital herpes and herpes in pregnancy. There is also key information to provide to patients at the time of diagnosis. [A reminder that dosing of acyclovir and valaciclovir is renal function dependent – important to avoid neurotoxicity associated with elevated serum levels, particularly in the elderly being treated for shingles]

(iii) Cyber security guide for primary care

Health New Zealand, Te Whatu Ora, has published guidance on managing cyber security incidents for primary care organisations. *Strengthen Your Digital Defence: A Guide to Cyber Security Incident Response for New Zealand Primary Health Sector* is one of several resources developed to help healthcare organisations prepare for and respond to worst-case cyber security incidents. This includes reducing cyber security risks, preparing for future incidents, responding to a cyber security incident and how to recover and return to normal operations in the aftermath. The guide is intended as an educational tool and does not contain exhaustive advice; it should not replace any legal, technical or professional cyber security advice your organisation already has.

(iv) Miscarriage Matters website

The Miscarriage Matters website presents the organisation's mission as *To improve the experience of miscarriage in New Zealand by empowering people with information, advocacy and support. To do this by raising awareness, connecting existing services, providing information, delivering care packages, supporting midwives (and other maternity carers), supporting research, and advocating for positive change.* There are extensive written resources on all aspects of miscarriage and miscarriage support (including a FAQ section), and a pamphlet that can be ordered by practices to provide to women following a miscarriage. The organisation also makes and delivers personal Care Packages for women in Canterbury, the West Coast, North Shore (Auckland), South Auckland and Wellington who experience miscarriage.