NZGP Podcast Shownotes - November 2025

1. NZ Doctor prescribing Spotlight series

NZ Doctor have been publishing a Spotlight series of snapshot reports using hazard detection data from the Conporto Event Detection & Mitigation service that automatically analyses the patient's medical records and identifies if a risk of harm is likely.

(i) The first report looked at sodium valproate prescribing in women of childbearing potential without documented history of hysterectomy. Sodium valproate is contraindicated in girls and women of childbearing potential, unless other treatments are ineffective or not tolerated, and effective contraception is in place. It should not be prescribed in pregnancy for epilepsy unless no alternatives exist, or in pregnancy at all for bipolar disorder. Between 14 and 27 April 2025, 187,608 patient interactions were captured and a total of 474 new harm events were detected across 307 medical centres. Over these two weeks, 56 females aged 10–59 years were identified as being prescribed sodium valproate without a history of hysterectomy recorded in their notes. Of these, 29 women did not have any history of epilepsy. ACC have developed a resource on benefits and risks of anti-seizure medicine prescribing for healthcare professionals to discuss with anyone who could get pregnant.

(ii) A second report run between 19 May and 1 June 2025 focussed on the "triple whammy" combination – the concurrent use of an NSAID, an ACE inhibitor or angiotensin II receptor blocker, and a diuretic in patients with impaired renal function (eGFR <60). This combination significantly increases the risk of AKI, especially in patients with impaired renal function, but can also cause harm in those with previously normal renal function. Māori, Pacific peoples and older adults are particularly vulnerable due to higher rates of chronic kidney disease, heart disease and multimorbidity. Over the observation period there were 191,140 patient interactions a total of 491 new harm events were detected across 299 medical centres. Over these two weeks, 57 patients with impaired renal function prescribed all three components of the triple whammy. The event detection system indicates the combination has been newly initiated in patients with renal impairment. It is important to note that only prescribed NSAIDs are captured – patients may also be taking over-the-counter NSAIDs, which are not recorded and could further increase risk. Advice is to avoid prescribing the triple whammy combination in patients with already impaired renal function and educate patients with impaired renal function of the potential risk of OTC NSAIDs.

(iii) Another report run between 16 and 29 June 2025 looked at co-prescribing of macrolide antibiotics (particularly erythromycin or clarithromycin) with simvastatin, a known high-risk interaction that is contraindicated. Macrolides strongly inhibit cytochrome P450 3A4, the enzyme that metabolises simvastatin. This can lead to a 10-fold increase in simvastatin exposure and four-fold increase in atorvastatin exposure, significantly raising the risk of myopathy and rhabdomyolysis. Risk increases with age ≥65 years, higher statin doses and concurrent medicines (eg, azole antifungals, ciclosporin) or comorbidities such as diabetes or renal impairment. Over the observation period there were 209,108 patient interactions across 295 medical centres, with 517 new harm events identified. Among these, 25 patients were prescribed a macrolide antibiotic while also taking simvastatin. Advice: Before prescribing or dispensing a macrolide antibiotic check for concurrent statin use, particularly simvastatin or atorvastatin. If a macrolide cannot be avoided, one of the following is recommended:

- Temporarily withhold simvastatin or atorvastatin during the course of macrolide treatment.
- Consider using a statin not metabolised by CYP3A4, such as pravastatin or rosuvastatin.
- Select a macrolide with a lower interaction risk, such as roxithromycin, with caution – warn patients to promptly report symptoms of myopathy, such as muscle pain or weakness.

2. Carotid artery POCUS

Issue 261 of GP Research Review includes review of a cross-sectional study published in BMC Primary Care investigating the sensitivity and specificity of POCUS for identifying carotid atherosclerosis in primary care, and the prevalence of carotid atherosclerosis in apparently healthy individuals with high or very high cardiovascular disease risk. A total of 199 participants aged 40–69 years with high or very high calculated CVD risk and no prior treatment with antilipemic drugs underwent POCUS of the carotid arteries. The prevalence of carotid atherosclerosis was 69.5%, with higher rates in males and older patients. The sensitivity and specificity of POCUS for detecting carotid atherosclerosis were 96.4% and 90.0%, respectively. The reviewer's take home message was that using POCUS in primary care can significantly improve early cardiovascular disease risk assessment and prevention and is another effective point-of-care procedure that can be accurately undertaken in general practice. I note all family medicine practitioners taking part in the study took part in a 5-step individual carotid artery POCUS course, which took from 2 to 6 months (depending on prior ultrasonographic experience of the practitioner).

3. Insomnia study

The same issue of GP Research Review summarised the randomised controlled DREAMING study from the Netherlands published in the British Journal of General Practice which aimed to asses the effectiveness of low-dose mirtazapine (7.5-15mg) and amitriptyline (10-20mg) in patients with insomnia disorder. Insomnia Severity Index (ISI) scores were assessed at baseline and again at 6, 12, 20, and 52 weeks. The conclusions: Compared with placebo, low-dose mirtazapine provided a statistically significant and clinically relevant reduction of insomnia severity at 6 weeks, but not at later time points. Low-dose amitriptyline resulted in a statistically significant but not clinically relevant reduction at 6 weeks. The results do not support the prescription of low-dose amitriptyline and mirtazapine for several months in patients with insomnia disorder in general practice. Based on the results, GPs may consider prescribing off-label low-dose mirtazapine for a period of about 6 weeks in cases where non-pharmacological treatment is insufficient. BPAC has excellent resources on management of insomnia.

4. Sepsis

HQSC has released the Clinical Guide to Sepsis management in New Zealand. There is a section on sepsis management outside the acute hospital setting together with tables of red and amber assessment criteria. Take home points include relevant to primary care include:

(i) Refer all people with suspected sepsis outside acute hospital settings for emergency medical care by the most appropriate means of transport (usually via ambulance) if:

• they meet any high-risk (RED FLAG) criteria (see relevant tables) or

• there is a concern that the person would be unable to return with new or worsening symptoms

• one or more moderate- to high-risk criteria are present and there is increased concern for sepsis and/or lack of improvement after a period of observation.

(ii) If a definitive diagnosis is not reached, or the person cannot be treated safely outside an acute hospital setting, refer them urgently for care.

(iii) For people with infection who do not have any high or moderate- to high-risk criteria who are being treated for infection, provide information about sepsis symptoms and how to access medical care if they are concerned (use dedicated written patient resources).

5. SA updates

Pharmac has announced the requirement for some Special Authority renewals is to be removed from some products from 1st December, 2025. New patients will still require an initial Special Authority application. Pharmac states they we will work with Health New Zealand to extend the expiry dates for people with an existing Special Authority approval for these products.

The affected products include:

- Insulin pumps and continuous glucose monitors (interoperable and standalone) for type 1 diabetes
- Long-acting muscarinic antagonists with long-acting beta$_2$-agonists (LAMA/LABA inhalers) for respiratory conditions
- Febuxostat for gout
- Budesonide capsules for Crohn's disease and microscopic colitis
- Epoetin alfa for chronic renal failure

6. Alzheimer's Disease advances

(i) A recent NZ Doctor article noted that new blood tests for biomarkers of Alzheimer disease pathology can allow earlier diagnosis and improve its accuracy. Biomarkers such as p-tau217 are being used to assist diagnosis in countries like the US, Japan, the UK, and China, and have shown "good agreement" with PET imaging, CSF biomarkers, and postmortem diagnosis, the experts say. The diagnostic accuracy of these blood tests sits at 90–95 per cent, well above the 60–70 per cent with a purely clinical approach, and they can reduce the need for CSF biomarkers and PET scans by approximately 80–90 per cent. Results are being validated in primary care and real-world settings overseas although the tests are not yet available in New Zealand.

(ii) Their uptake is expected to grow with a rise in the availability of new disease-modifying treatments for Alzheimer disease. These expensive anti-amyloid monoclonal antibodies require biomarker-based diagnosis to identify possible candidates for treatment, and their use is controversial due to their modest effectiveness, frequent IV infusion regimen, and serious potential side effects that require regular monitoring with MRIs. They are not licensed in New Zealand, but they are in clinical use or available in a growing number of territories, including the UK, EU, US and China. Donanemab and Lecanemab have been licensed in Australia this year but are not subsidised. Donanemab currently costs approximately $A 4700 per infusion every four weeks over the 18-month treatment course.

(iii) Advances in diagnosis and management of Alzheimer's disease are discussed in a recently published three-part on-line Lancet series if you are interested in more detail. In the meantime, your local Health Pathways has a section on Cognitive Impairment that includes available assessment, management and support services advice.

7. Interesting bits from Research Review

(i) A New Zealand study NZ comparing NT-proBNP levels in Pacific peoples, Māori, and NZ Europeans with heart failure found that after adjustment for ethnicity, age, sex, body mass index, estimated glomerular filtration rate, ejection fraction and presence of AF, while levels in European and Māori were not statistically different, For each decade of life over 60 years, plasma NT-proBNP levels in patients with HF were a mean 67% lower in Pacific peoples than in aged-matched NZ Europeans suggesting we might have to use different normal ranges according to ethnicity.

(ii) A US study looking at varenicline (Champix) for youth nicotine vaping cessation used the standard smoking cessation varenicline regime or placebo with either text messaging support or weekly counselling plus text messaging support in a 12 week trial. Continuous abstinence rates in the last month of treatment were 51%(V) vs 14%(P) and at 6-month follow-up 28%(V) vs 7%(P). Results were similar for the text only versus text + counselling groups. Treatment-emergent adverse events did not differ significantly between groups. Conclusion: Varenicline, when added to brief cessation counselling, is well tolerated and promotes nicotine vaping cessation compared with placebo in youth with addiction to vaped nicotine. Note this would be off-label prescribing in NZ and NZF includes a warning to monitoring for neuropsychiatric adverse effects including suicidality in patients prescribed varenicline.

(iii) A multicentre, double-blind randomised controlled trial from China published in JAMA Internal Medicine compared vitamin K2 (185mcg nocte) with placebo for management of nocturnal leg cramps. The medication was taken every day for eight weeks and those in the K2 arm experienced a significantly lower number of weekly nocturnal leg cramps versus placebo with significantly greater reductions in cramp severity and duration. There were no reported adverse events. Vitamin K2 is readily available over the counter or on-line. There is a possible interaction between Vitamin K2 and warfarin with potential to decrease the INR.