Clinical Snippets January 2026

1. Measles refresher (from NZ Doctor)

- A characteristic maculopapular rash and Koplik spots are the key clinical signs of measles infection.
- Koplik spots: may appear at the end of the prodromal period; are quite specific for measles; have a "grain of salt" on a bright red background appearance.
- Maculopapular rash: appears after a prodromal period; usually appears on the face first, then descends downwards; eventually turns brown and fades; may be less apparent on people with dark skin.
- Notify Public Health immediately if there is a clinical suspicion of measles and advise the patient to isolate while awaiting test results (PCR takes up to 2-3 days). The Medical Officer of Health will guide confirmation testing.
- Measles PCR on a nasopharyngeal or throat swab is the test of choice. It is most sensitive in the prodromal period or during the first few days of rash. Sensitivity is high enough to exclude infection if negative in the first seven days after the rash appears. It is very important to include the date of onset of rash and the measles vaccination history in the clinical details on the laboratory request form. Do not send the patient to the lab!
- If measles transmission in the local community is low, then the pre-test probability of any individual patient being diagnosed with measles will be low and other diagnoses should also be considered. Parvovirus, enterovirus, adenovirus, scarlet fever and infectious mononucleosis (among other infections) may all mimic measles to some extent and should all be considered in the New Zealand setting.
- Complications of measles include: otitis media (7 to 9% cases); pneumonia (1 to 6% cases); croup; encephalitis (1 per 1,000 cases – fatal in 15%, and 1 in 3 have permanent brain damage); possible miscarriage or premature delivery in pregnant patients (frequency unknown); diarrhoea (8% cases). If referring to hospital ensure ambulance staff (if used) and ED staff are aware of potential measles. The process in the Waikato is to phone paediatric on-call registrar, arrange for immune or vaccinated family member to present to ED reception ahead of case if possible, masks for everyone, the case will then be directed to negative pressure room.
- If a high-risk close contact has presented to primary care, contact the Medical Officer of Health and follow the local process for arranging urgent post-exposure prophylaxis with immunoglobulin.
- Offer measles vaccination to people born after 1969 with unknown or no history of measles vaccination (and no contraindications).
- Further details are available on your local Health Pathways including Medical Officer of Health contact details. RNZCGP publishes updates and has developed resources to assist practices to prepare for arrival of measles cases.

2. NZ Doctor Spotlight series

Two further reports from the NZ Doctor Spotlight series using reporting from the Conporto Event Detection & Mitigation service that automatically analyses the patient's medical records and identifies if a risk of harm is likely:

A. NSAID use in CKD

(i) Background: In people with an eGFR below 45ml/min/1.73m2, NSAIDs should be avoided as their use is associated with worsening renal function, acute kidney injury, electrolyte disturbances and increased cardiovascular risk. Safer alternatives for pain management are preferred, such as paracetamol or topical NSAIDs. Māori, Pacific and Indo-Asian peoples are at higher risk of developing chronic kidney disease, with rates up to three times higher than in other populations. Advanced CKD is also more common, occurring up to five times more often. Because of this, NSAID prescribing and over-the-counter supply carry greater potential for harm in these ethnic groups.

(ii) Over two weeks in August 2025 the event detection system recorded 226,285 patient interactions across 245 practices, identifying 468 potential harm events. Of these, 51 detections were NSAIDs prescribed to patients with an eGFR <45ml/min/1.73m^2.

(iii) Before prescribing or dispensing an NSAID:

- check renal function – confirm the patient's most recent eGFR result
- avoid NSAIDs in patients with an eGFR <45ml/min/1.73m^2, unless under specialist advice
- consider alternatives for analgesia in those with CKD (eg, paracetamol, topical agents, non-pharmacological)
- review for polypharmacy risks – avoid concurrent use of an NSAID, an ACE inhibitor or angiotensin receptor blocker, and a diuretic (the "**triple whammy**").

Additionally, all patients with newly diagnosed CKD should have their medicines reviewed for nephrotoxic risk. Patients with CKD should be advised to avoid over-the-counter NSAIDs and to check with their healthcare team before using any new medicines.

B. Methotrexate without folic acid

(i) Background: Between 7 and 30% of patients discontinue methotrexate within the first year due to toxicity, and some of these cases are likely related to folate antagonism. Methotrexate toxicity includes minor adverse effects such as mouth ulcers, nausea and vomiting, and major effects such as bone marrow suppression and liver function abnormalities. Folic acid supplementation reduces the frequency and severity of these adverse effects, decreases treatment discontinuation, and may improve adherence and long-term response to therapy.

(ii) Over two weeks in September 2025, the event detection system recorded 176,334 patient interactions across 240 medical centres, with 506 new harm events identified. Among these, 15 patients were prescribed methotrexate without an accompanying folic acid prescription.

(iii) Before prescribing or dispensing methotrexate, check folic acid is also prescribed and that patients understand how to take it correctly – commonly, 5mg once weekly, taken on a different day to

methotrexate. Alternative regimens may be used in some situations. For example, if adverse effects occur, it is possible to increase folic acid to 10mg weekly. Doses above 10mg have no proven additional benefit. Continue folic acid for as long as methotrexate therapy is given as the risk of adverse effects remains throughout treatment. Encourage adherence to folic acid to support ongoing methotrexate use and reduce the risk of adverse effects. Advise patients to report early signs of toxicity, such as mouth ulcers, sore throat, bruising or nausea.

3. Disability Allowance updates

(i) New disability allowance special food information form

If a patient has extra costs for special food or diet due to their medical condition, MSD may be able to support them through the Disability Allowance. Patients can print out the new 'Disability Allowance – special food information' form to record what their extra food costs are. You will still need to complete a Disability Allowance medical certificate for your patient confirming that they have additional costs related to purchasing special foods, and that these costs are ongoing and directly related to their disability or ongoing health condition. There is a separate form for StudyLink beneficiaries.

(ii) For people who do not meet Pharmac funding criteria for continuous glucose monitors (CGMs):

The ongoing costs of CGMs can be considered in Disability Allowance (DA) for patient who meet the eligibility criteria for DA, do not meet Pharmac funding criteria (usually people with type 2 diabetes), and whose life or health would be placed at risk, or their disability aggravated if they did not receive assistance. Additional information will also be required for these requests:

- How well controlled is the patient's diabetes?
- Do you (the medical/nurse practitioner) support this request and consider the use of a CGM to be essential?
- Has there been instances when the patient's condition has been compromised despite good diabetic management, for example ongoing high blood glucose levels, hospitalisation due to very high/low glucose levels?
- The type of CGM preferred (if there is a preference). Use of the lowest cost device is encouraged (comparison table available here)

4. Cremation Regulations exemption extended

The Ministry of Health has advised work on amending the Cremation Regulations 1973 is still ongoing. In the meantime, the partial exemption from complying with Cremation Regulation 7 has been extended until 30 April 2026. Details of the exemption can be found on the Health NZ website. The exemption applies to the requirement for a medical practitioner or NP to see and identify the body after death for the purpose of completing the cremation certificate in situations when:

- the death occurs in rest homes, residential care facilities, and other long-term in-patient facilities; and
- the death is not unexpected; and

- where the medical history and current conditions of the deceased are known by a medical or nurse practitioner.

This exemption does not apply to deaths in public hospitals, hospices, private homes, or other settings and where a medical practitioner does not know the medical history of the individual. Certifying practitioners are still required to view the body of a person who dies outside of a residential care facility in order to issue a cremation certificate. Under this authorisation a medical referee must receive advice from a trusted source, who has a reasonable level of assurance of the cause of death to verify the identity of the deceased and that the deceased died of natural causes.

5. Concussion Guidelines

Australia and Aotearoa New Zealand Concussion Guidelines were published on-line in November 2025 and are worth reviewing. There is a dedicated 'toolbox' section with links to evidence-based assessment tools for various components of mTBI assessment and management. The guideline notes that *the use of a standardised tool with concussion-specific measures allows for consistent and standardised assessment, with the ability to follow and monitor the progression of recovery* and the Toolbox includes links to the Brain Injury Screening Tool (my favourite) as well as numerous other assessment resources. Ther guideline is organised into manageable sections both general and symptom specific and includes practical guidance on issues such as when is imaging indicated, return to work and sport after mTBI, and management of repeated mTBI.

6. RNZCGP position statement on 12-month prescribing

The Royal New Zealand College of General Practitioners (RNZCGP) has released a position statement on Twelve-month prescribing in general practice, ahead of amendments to the Medicines Regulations 1984 that will increase the period of supply limit from three months to 12 months, from 1st February, 2026. Clinicians are expected to use clinical judgement when making prescribing decisions, and this should include a risk/benefit assessment for each patient. The College recommends that practices adopt their own in-house policy to guide their clinicians, always consider equity and access when deciding on a prescribing period and to work collaboratively with pharmacists.

A poster and FAQ sheet for patients have also been produced to help explain the changes.

7. Resources

(i) Angina Action Plan

New Zealand Heart Foundation has available a simple Angina Action Plan which can be printed off for patients in any of English, Te Reo Māori, Samoan, Tongan, Chinese, Korean

(ii) **Birth trauma screening tool**

The UK's City University recently developed a **scale which can be used to assess for post-traumatic stress symptoms related to birth experience**. The tool (City Birth Trauma Scale) is based on DSM-5 criteria for post-traumatic stress. The tool includes a short scale involving five questions and a longer, more in-depth scale, both of which can be completed on-line and saved as a PDF or printed off for manual completion and scanning. The website includes information on scoring and interpreting the results. The tools hold great value for whānau including facilitation of accurate diagnosis of distress and guidance towards appropriate treatment and support. Support for whānau can be found on the **Birth Trauma website**.

(iii) **Online learning modules for bowel screening**

Health New Zealand, Te Whatu Ora, has announced that four new learning modules for bowel screening are now available on regional learning sites (listed on the main website). The modules are designed to give clinical staff the information needed to clearly and confidently discuss bowel screening with patients. The module content includes bowel cancer and screening, the faecal immunochemical test (FIT), culturally safe communication and advice on responding to different situations when discussing bowel screening including real-life scenarios. The modules take a total of around 75 minutes to complete and are relevant for any staff that might be involved in bowel screening discussions with patients.

(iv) **Antibiotic stewardship**

The Te Whata Kura website has been developed by a multidisciplinary team from across Aotearoa to provide nationally unified antibiotic prescribing guidance. It is accessible via web or as an app on your mobile device and is designed to promote both prudent use and equitable access to best-practice prescribing. Website information notes Te Whata Kura will provide a consistent national standard, allowing all prescribers access to the same expert advice, and enabling more informative monitoring of appropriate and inappropriate antibiotic prescribing. It comes with the disclaimer that *these are educational guidelines and do not supplant clinical judgement or Infectious Diseases/Clinical Microbiology consultation.* There is regional information on how to access infectious diseases expertise for complex cases. The guidelines are organised by where you prescribe antibiotics (community, hospital or surgical prophylaxis), adult versus child then by anatomical region.

(v) **Adult ADHD**

There is a live webinar scheduled for 7pm on 17 February 2022 run by Health Pathways Education and RNZCGP covering the changing role of primary care in diagnosing and managing adult ADHD. Topics include:

- New prescribing rules and boundaries
- Key expectations under the Clinical Principles Framework
- Practical steps for screening, referral, titration, and managing supply issues

- Training options and Health Pathways updates
- What to do if you choose not to provide comprehensive ADHD diagnostic care