Clinical Snippets February 2026

1. Dengue Fever

(i) At the end of January 2026 Te Whatu Ora released an alert noting there is an ongoing dengue outbreak in the Pacific, particularly affecting the Cook Islands, with continued transmission in Samoa, American Samoa, Kiribati, Nauru, and Tuvalu. To date, 86 confirmed and probable dengue cases have been reported in New Zealand, most associated with recent travel to the Cook Islands. There is a Health Pathway section on dengue that includes the following advice:

(ii) Consider dengue fever if the patient has recently travelled overseas to a country where there is a risk of dengue or a known outbreak. Infection may be asymptomatic. In patients with symptoms, clinical presentation can range from a mild febrile illness to a life-threatening shock syndrome. Symptoms include: sudden onset of high fever although that not all patients present with fever; Severe headache and retro-orbital pain; Myalgia or arthralgia; Rash, which may be itchy or hypersensitive; Anorexia with foul or metallic taste; Nausea and diarrhoea; Abnormal bruising and bleeding.

(iii) Severe dengue often presents after a few days of being mildly unwell with symptoms including: significant bleeding (gums, nose, GI, vaginal) and bruising/petechiae; hypotension causing dizziness; abdominal swelling (ascites); SOB (pleural effusion); persistent vomiting; impaired cognition and level of consciousness. Severe disease is more likely with recurrent dengue, age <1 year and >65yrs; pregnancy; patients with chronic comorbidities or who are immunocompromised. Increasing haematocrit, rapid decrease in platelet count, AST or ALT > 3 times ULN and fall in albumen are all warning features of impending severe dengue.

(iv) Fever usually lasts 2-7 days and if the fever has been present for more than 3 days, the critical phase may occur at any time. In a patient presenting with positive travel history and history consistent with dengue examine the patient noting the potential signs of severe dengue discussed and consider alternative diagnoses. Appropriate testing includes Dengue NS1 Ag (day 1-9 of illness), CBC and LFTs with other investigations as indicated by your differential diagnosis. Write the date of onset of symptoms and note any recent overseas travel on pathology request to enable the laboratory to run correct confirmatory tests.

(v) If suspected severe or impending severe dengue fever resuscitate as required and refer to hospital. Refer also if there is a rise in haematocrit 20% or more above baseline or a platelet count less than 50,000 in adults or 100,000 in children. Seek paediatric medicine advice for any child in whom you suspect the diagnosis. Notify Public Health if dengue is confirmed on testing (no isolation required while awaiting the result) or immediately in suspected cases where there is no history of international travel (may mean the Aedes mosquito has penetrated the NZ border).

(vi) There is no specific management other than supportive care (paracetamol – avoid NSAIDs/aspirin), fluid replacement, bed rest), patient education (English and Samoan) regarding warning symptoms, and regular review depending on the patient's risk factors for

severe disease and initial assessment findings. Check platelets and haematocrit from the third day of the illness until 1 to 2 days after the fever subsides (frequency depending on results and risk of severe disease).

2. Monitoring for psychostimulants

With the recent changes in restrictions on psychostimulant prescribing, I note the following recommendations in NZ Formulary regarding pre-treatment screening and monitoring during treatment.

(i) Pre-treatment screening

Before starting a psychostimulant medicine, a physical health assessment should be undertaken including psychiatric and medical history, current medicines, height and weight, and a cardiovascular assessment (including heart rate and blood pressure). A 24-hour ECG and cardiology referral is recommended if the person has a history of congenital heart disease or cardiac surgery, a history of sudden cardiac death in a first-degree relative under 40 years, shortness of breath or fainting on exertion, palpitations, chest pain, or heart murmur. Baseline symptoms and level of functioning should be recorded.

(ii) The following monitoring has been suggested by the New Zealand Clinical Principles Framework for Attention Deficit Hyperactivity Disorder Ministry of Health, 2025. Follow-up is likely to be more frequent (usually weekly), early on in treatment and during titration, and will settle over time to longer intervals of months. Individual requirements for monitoring will vary (depending on how well the ADHD core symptoms are managed and co-existing conditions) and more frequent monitoring may be necessary.

During treatment

- A review to monitor progress and adverse effects (using standardised assessment scales) should be conducted two to four weeks after initiating treatment or changing the dose. Thereafter, symptoms, level of functioning, and adverse effects should be regularly assessed and recorded at least every 6 months or at each dose change.
- An additional clinical follow-up for cardiac and mental health review after 6–12 months.
- An annual review of medication efficacy and tolerability, including weight, heart rate and blood pressure checks (more frequently if there are dose changes)
- Review the need for continuing medication every two to four years (see Treatment duration below).

Undertake reviews more frequently if there are any concerns and refer to a specialist if needed.

3. Statin side effects

A recent BMJ news article commented on a meta-analysis of double blind RCTs examining adverse effects attributed to statins published earlier this month. The study analysed 19 trials involving 123 940 participants that compared statins with placebo, with a median follow-up of 4.5 years. Findings include:

- For 62 of the possible side effects listed in package leaflets, the study found similar numbers of reports among people taking statins and those taking the placebo.

- Statin therapy was associated with a significant excess risk for four of 66 prespecified outcomes: abnormal liver transaminases, other liver function test abnormalities, urinary composition alteration, and oedema and the absolute annual excesses for each of these outcomes was below 0.1%.

- The study did not look at muscle symptoms or diabetes, as the same team had previously examined those two potential side effects, finding that statin therapy caused muscle symptoms in only 1% of people during the first year of treatment, with no excess thereafter and that statins can cause a small increase in blood sugar concentrations, the majority occurring in people with glycaemic markers already close to the diagnostic threshold for diabetes at the time of starting statins.

- Comment in the BMJ article includes: *In an era of social media driven debate, this study strengthens the evidence base needed to counter misleading claims about drug harms, communicate actual risk clearly, and prevent avoidable discontinuation or non-use of statins among patients who would benefit.*

4. Cardiometabolic issues with antidepressants

Goodfellow Gem #254 summarised a 2025 systematic review in *The Lancet* on the cardiometabolic issues with antidepressants.

There were a few surprises:

- None caused significant QT interval issues.
- Systolic blood pressure went up with amitriptyline, fluoxetine, imipramine and venlafaxine, and down with nortriptyline.
- Weight loss was observed with bupropion, citalopram, fluoxetine, moclobemide, paroxetine, sertraline and venlafaxine.
- Weight gain was found with amitriptyline (1.6kg relative to placebo) and mirtazapine (0.87kg).
- Heart rate (beats per minute) increased by 13.77 with nortriptyline, 9.74 with clomipramine, 9.44 with imipramine and 9.25 with amitriptyline

5. Chronic Kidney Disease

I regularly see complaints regarding management of CKD, usually related to the patient being unaware they have ever had abnormal renal function tests, and around inadequate testing (including ACR which is important in staging) and monitoring.

The Chronic Kidney Disease Health Pathway has been aligned nationally across most New Zealand HealthPathways regions, supporting the work of the Renal National Clinical Network. There are quick links on the right of the Health Pathways Chronic Kidney Disease webpage providing access to a one-page Chronic Kidney Disease Quick Guide and At Home Sick Day Advice. The Pathway contains advice on diagnosing, modifying reversible causes, maximising lifestyle efforts, modifying disease progression and cardiovascular risk, and when and how to escalate for further support. There is an hour long webinar recording available. You will also find the recording in the 'for health professionals' section at the bottom of the CKD pathway.

BPAC has previously published a comprehensive article on identifying and managing CKD together with an easy to follow detection and diagnosis algorithm.

6. Adult sinusitis update

Issue 22 of GP Practice Review looks at an updated Clinical Practice Guideline for adult sinusitis update published by The American Academy of Otolaryngology/Head and Neck Surgery Foundation. The guideline contains the following key recommendations:

1. Acute bacterial rhinosinusitis (ABRS) should be distinguished from acute rhinosinusitis due to other causes. ABRS should be diagnosed when

- symptoms or signs of acute rhinosinusitis (purulent nasal drainage accompanied by nasal obstruction, facial pain-pressure-fullness, or both) persist without improvement for ≥10 days beyond the onset of upper respiratory symptoms, or
- symptoms or signs of acute rhinosinusitis worsen within 10 days after an initial improvement (strong recommendation).

2. Radiologic imaging should not be obtained for patients meeting the diagnostic criteria for ABRS, unless a complication or alternative diagnosis is suspected.

3. Analgesics, topical intranasal steroids, and/or nasal saline irrigation may be recommended for symptomatic relief of viral rhinosinusitis.

4. Watchful waiting without antibiotics should be offered for adults with uncomplicated ABRS with assurances of follow-up.

5. If a decision is made to treat ABRS with antibiotics, amoxicillin for seven days is the first-line therapy for most adults. [Te Whata Kura suggests 1000mg amoxicillin TDS for 5 days]

7. Resources

(i) **Sepsis:** One-page algorithms for recognition and initial treatment of sepsis have been published by Sepsis Trust NZ, Te Whatu Ora and HQSC. Separate community algorithms, which are being incorporated into Health Pathways, are available for

- Non-pregnant adults 12 years and older
- People who are pregnant and up to six-weeks post-partum
- Children aged 11 years and under

(ii) **Methylphenidate prescribing (NZF)**

- Comparison of methylphenidate preparations for a summary of the different preparations including the advantages and disadvantages of each.
- Approximate dose equivalence between methylphenidate preparations table may be used as a general guide if switching between preparations.

(iii) **12-month prescribing aid**

An Auckland GP Dr Ryo Eguchi, has a website clinicpro.co.nz with tools he has developed including a 12-month prescribing aid in the form of an e-algorithm that facilitates a logical approach to choice of prescribing interval for patients. There are also links to additional useful 12-month prescribing resources.

8. That's interesting

An interesting article published in Issues in Mental health Nursing was titled **… 5, 6, 7, 8: The Many and Interrelated Benefits of Line Dancing – A Scoping Review.** The authors note *Line dancing has been the subject of many studies, with research focusing on particular areas of health and the impact line dancing can have in these areas.* The authors findings indicate that line dancing enhances physical health by improving balance, coordination, and cardiovascular fitness. In relation to mental health, it contributes to reduced depression and anxiety symptoms. Socially, line dancing fosters community engagement and friendships. Cognitively, participants experience improvements in memory and executive functions. The authors conclude *This review highlights the health benefits of line dancing, with evidence suggesting that line dancing is an effective health intervention with benefits for physical, mental, social, and cognitive health across various age groups… line dancing can be considered an effective, adaptable and accessible intervention that could be promoted to patients of all ages and abilities.*