Clinical Snippets March 2026

1. UTI in children

BPAC have published an update on managing urinary tract infection in children. For rapid reference there is a B-Quick summary available that includes a useful dipstick interpretation algorithm. Some relevant points include:

(i) Symptoms

- UTI symptoms in young children may be non-specific, e.g. fever, irritability, poor feeding, vomiting
- Older children may report urinary symptoms, e.g. frequent or painful urination, changes to urine colour or smell, abdominal or back pain
- Suprapubic or flank tenderness, palpable bladder or stool in the bowel, abdominal distension, dehydration and/or fever may be present on physical examination

(ii) Red flags for paediatric advice or referral

- Seek paediatric advice for children with a suspected upper UTI, i.e. with UTI symptoms accompanied by fever ≥ 38°C and/or loin or flank pain/tenderness
- Acute paediatric referral is indicated for children:
    - Aged under three months
    - With symptoms or signs of significant systemic illness or sepsis
    - With complicating factors, e.g. an abdominal or bladder mass, impaired renal function, anatomic urinary tract abnormalities, previous renal surgery/implants

(iii) Urinalysis

- Urinalysis is indicated for all children with a suspected UTI. Mid-stream or clean catch urine samples are preferred. The full article and Starship guidelines describe various methods to facilitate sample collection including the Quick wee method, bladder percussion and the Perez reflex
- Urine dipstick testing can support the diagnosis. However, urine microscopy, culture and sensitivity analysis is required to confirm a UTI and determine microbial sensitivity.
- In children aged over three months, a UTI is unlikely with a negative dipstick test result for both leukocyte esterase and nitrite; consider alternative diagnoses
- In children aged three months to three years, a positive dipstick test result for either leukocyte esterase or nitrite is sufficient to initiate empiric antibiotic treatment and send the sample for microscopy, culture and sensitivity analysis

(iv) Treatment

- Initiate oral empiric antibiotic treatment while awaiting laboratory urinalysis results. Review antibiotic choice once results are available. If symptoms are not improving and the pathogen is resistant to the empiric choice, select an alternative. Seek paediatric advice if symptoms do not respond to appropriate antibiotic treatment within 48 hours

- Order of preference for empiric treatment (three-day course standard, up to seven days may be considered in children with more severe symptoms but no red flags for secondary care referral) is cefalexin then nitrofurantoin (can be compounded into a suspension) then if bacteria are known to be sensitive amoxiclav then co-trimoxazole.

(v) Follow-up: Request a renal ultrasound (ideally to be performed six weeks after presentation) for:

- Children aged < 12 months with their first UTI
- Children of any age with an atypical UTI who have not previously been investigated with a renal ultrasound
    - Poor response to antibiotics after 48 hours
    - Poor urine flow/suspected urinary obstruction
    - Abdominal or bladder mass
    - Raised creatinine
    - Hypertension
    - Infection with a non-*E. coli* organism
- Children of any age with recurrent UTI (≥ 2 culture-proven UTIs within one year, or ≥ 3 if the symptoms were only mild) who have not previously been investigated with a renal ultrasound

2. Prescriber Update

Some updates from the March Prescriber Update include:

(i) **Gynaecomastia**

- Has been reported in association with a wide range of medicines (27 listed as a representation) including omeprazole, digoxin, spironolactone, amlodipine, most statins, isotretinoin, methotrexate, antipsychotics, sertraline, fluoxitene, methyphenidate. Atomoxetine is currently on the reporting list.
- Onset can be delayed – gynaecomastia can develop weeks to years after starting treatment or adjusting the dose. Dose reduction or discontinuation of the suspect medicine may lead to improvement, particularly when gynaecomastia is identified early. Persistence beyond 12 months may be less likely to resolve without intervention.
- Consider a medicine-related cause in male patients presenting with breast enlargement or other breast tissue changes.

(ii) **Fournier gangrene**

- Fournier gangrene (necrotising fasciitis) is a rapidly progressive infection affecting the soft tissue and fascia of the perineal, perianal or genital areas.
- Fournier gangrene has been known to occur in patients treated with empagliflozin for type 2 diabetes mellitus and is now known to occur with the use of empagliflozin in patients who do not have type 2 diabetes mellitus (eg when used in heart failure).

(iii) **Zoledronic acid in the elderly**

- Elderly patients receiving zoledronic acid infusions are at higher risk of adverse reactions and may experience more severe adverse reactions or find them more disabling than younger people. In particular, acute phase reactions are noted as a cause of concern including fever, joint pain and swelling, myalgia, influenza-like illness and gastrointestinal symptoms (abdominal pain, vomiting and diarrhoea). These usually occur within the first three days after zoledronic administration. Ocular inflammation, such as uveitis, can rarely occur and requires prompt ophthalmologist review. Administering paracetamol shortly after the zoledronic acid infusion may reduce symptoms (some clinicians recommend a dose 60 mins prior to the infusion and regular administration for up to three days post-infusion).

- Consider the following prior to the zoledronic infusion:

    - Inform the patient that acute phase reactions are common and usually resolve in a few days. However, patients should seek medical attention if symptoms are serious or prolonged.
    - Ensure the patient is adequately hydrated and measure their serum creatinine. Maintain adequate hydration following the infusion.
    - Treat pre-existing hypocalcaemia with adequate intake of calcium and vitamin D.

(iv) GLP-1 receptor agonists

GLP-1 receptor agonists can cause altered skin sensations.

- Semaglutide (Wegovy) is associated with dysaesthesia, paraesthesia, hyperaesthesia, burning sensation, allodynia and sensitive skin.
- Tirzepatide (Mounjaro) is associated with dysaesthesia.
- Consider GLP-1 receptor agonists as a possible cause in patients presenting with altered skin sensations.

NB Healthcare professionals and consumers are encouraged to report any suspected acute persistent visual loss associated with use of GLP-1 receptor agonists per Medsafe monitoring communication in January 2026. Cases of retinal vein occlusion and non-arteritic anterior ischaemic optic neuropathy (NAION) have been described in patients taking GLP-1 receptor agonists although the significance of this association is yet to be determined.

3. In other news…

(i) **Coffee**: The DECAF randomised clinical trial is a study of 200 patients with persistent AF and baseline coffee intake of 7 cups per week in which patients were randomly assigned in a 1:1 ratio to either regular caffeinated coffee consumption or complete abstinence from coffee and caffeine for 6 months following successful cardioversion. The consumption group was encouraged to drink at least one cup daily, while the abstinence group avoided all caffeinated and decaffeinated coffee and other

caffeine products. In the primary analysis, AF or flutter recurrence occurred in 47% of the coffee group versus 64% of the abstinence group, with a 17% absolute difference.

(ii) **Paracetamol**: Two recent analyses of reviews and metanalyses regarding prenatal paracetamol exposure and child neurodevelopment, one published in the BMJ and another in The Lancet, have both concluded that current evidence does not indicate a clinically important increase in the likelihood of autism spectrum disorder, ADHD, or intellectual disability in children of pregnant individuals who use paracetamol as directed. This is in contrast to the Trump administration proclamation in September last year. The BMJ authors note *Any apparent effect observed after in utero exposure to paracetamol on autism and ADHD in childhood might be driven by familial genetic and environmental factors and unmeasured confounders*.

(iii) **Morphine**: Issue 239 of Respiratory Research Review included comment on the Morphine for chronic breathlessness (MABEL) trial undertaken in the UK with results published in The Lancet late last year. Adults with chronic breathlessness due to cardiorespiratory conditions were randomised to receive oral long-acting morphine 5–10mg twice daily with a laxative (evaluable n=73) or placebo (evaluable n=67) for 56 days. At 28 days, 88% in the active arm and 99% in the placebo arm had regime adherence of >90%. However, there was no significant difference between morphine versus placebo for the primary outcome of worst breathlessness at day 28 or at other time points. There was improved cough at day 56 favouring morphine. There were more adverse events in the morphine arm than in the placebo arm. The authors concluded *we did not show a benefit of morphine for our primary outcome of breathlessness. However, secondary outcome findings taken together (some evidence of benefit [eg, cough, physical activity], some evidence of no difference [eg, morphine-related neurocognitive or respiratory harms], and newer insights into morphine-related harms [eg, morphine withdrawal, persistence of constipation despite resolution of nausea and vomiting]) alongside acceptable tolerability indicate that further research is needed to fully understand the role of morphine in people living with chronic breathlessness*.

4. Equity focus

(i) Issue 118 of Maori Health Research Review examined a recently published observational study on CVD risk assessment by ethnicity in Aotearoa New Zealand. People aged 25-74 years living in New Zealand on 31 March 2018 who were eligible for CVD risk assessment (n = 1,476,747) were analysed. Between 1 April 2018 and 31 March 2023, 67.1% of men and 65.5% of women had CVD risk assessments undertaken. After adjustment for socioeconomic deprivation and residential district, the odds of CVD risk assessment when compared with Europeans was lower in Māori men with diabetes (aOR 0.77) and without diabetes (aOR 0.73), and in Maori women with diabetes (0.93) and without diabetes (0.89). The odds of CVD risk assessment was also lower in Pacific men (aOR 0.86 [95% CI 0.78-0.94] with diabetes (aOR 0.86) and without diabetes (aOR 0.72) and Pacific women without diabetes (aOR 0.95) compared with Europeans. The reviewer notes *With CVD being a leading cause of avoidable premature death for Māori, this study has importantly quantified an often-invisible step in the CVD prevention continuum. Targeted strategies that redress equity in the wider determinants, in system design and in clinical practice, rather than simply increase screening overall, are needed*.

(ii) Goodfellow Gem #253 summarised a recent NZMJ study looking at cancers potentially attributable to excess body weight in Aotearoa New Zealand from 2019 to 2023. The authors express concern that excess body weight (EBW) contributes to many cancers in New Zealand and compounds health inequities, with higher proportions of EBW-attributable cancers within Māori and Pacific populations. Pacific peoples had the highest population attributable fraction (11.8%), and this was highest among Pacific females (16.1%). Māori also had a higher PAF (6.9%) than European/other (4.5%). The cancers most commonly attributable to EBW were colorectal cancer, followed by uterine cancer and breast cancer among postmenopausal females. The authors conclude *A pro-equity, anti-stigmatising approach to prevention, early detection and treatment of EBW is important. Ultimately, sustained reductions in EBW-attributable cancers will depend on preventing EBW.*

5. Recent releases

(i) The Medical Council of New Zealand has recently published Guidance on using artificial intelligence in patient care. It is important to review the statement in its entirety but some clauses include:

- AI is not a substitute for your clinical judgement, and you remain responsible for all your clinical decisions and actions. AI can make mistakes or reflect bias and may produce inaccurate or fabricated information. Therefore, as far as is reasonably practicable, you should check the accuracy of any AI output and confirm it is appropriate for the individual patient before using it for patient care or including it in patient records.

- Patients should know when AI is being used in their care. For low-risk AI, this can be explained in a simple statement that describes how AI is used in their care and how their data is protected. For high-risk AI that influences clinical decisions, you must explicitly inform the patient.

- There are some specific situations where you need to obtain informed consent for the use of AI, including when:
    - using an AI tool to record the consultation, such as a transcription tool (scribe)
    - the patient's personal details are shared outside of the primary medical record or used for AI training in a way that could identify them
    - the AI technology plays a significant role in diagnosis, treatment or delivery of care.

In these situations, let the patient know how their care will be affected if they decide against the use of AI. Always document in the patient's records whether informed consent was obtained.

(ii) **GP2GP:** Some recent reporting in NZ Doctor highlighted potential good news on the horizon for those concerned with clinical notes transfer between practices.

- PMS providers Medtech and Valentia Technologies say testing and rollout of an upgraded GP2GP patient file-transfer system is underway.

- Medtech expects the upgrade to be available to its customers by the end of June, while Valentia says its rollout to Indici users could be completed by May.

(iii) **Meningococcal disease**: The reporting earlier this month of two cases of meningococcal disease in tertiary students in Dunedin has led to a reminder from IMAC that now is a good time to check meningococcal immunisation status for school and university students.

- The vaccinations Bexsero (B strain) and the quadrivalent MenQuadfi (A,C,W and Y strains) are recommended and funded for those aged 13-25 years inclusive who are entering within the next three months, or are in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences or prisons. Funding covers individuals who turn 13 years of age while living in boarding school hostels.

- IMAC notes that the MeNZB vaccine used in NZ from 2004 to 2011 targeted one type of meningococcal group B disease. Those who received MeNZB are no longer expected to have protection against this type of group B disease. IMAC provides an FAQ resource on meningococcal vaccines including information on co-administration and duration of effectiveness.

(iv) **Season 2 of The Pitt** was released in NZ in January (Neon) and a Medscape emergency medicine article has several doctors rating the accuracy of the clinical presentations or procedures dominating each episode. These include:

- A hilar flip during an emergency clamshell thoracotomy to stop a catastrophic lung haemorrhage (realistic)
- Hypokalaemic periodic paralysis masquerading as traumatic paraplegia (zebra)
- Intrarectal manipulation for a coccygeal fracture (without anaesthetic!)
- Management of medication related priapism (OK except for the gentle massage and no 3-way stopcock (for phenylephrine injection and aspiration)