Clinical Snippets April 2026

1. Diabetes

As part of the recently released National Diabetes Roadmap Te Whatu Ora has published a notice stating they will align New Zealand's diagnostic threshold for diabetes and pre-diabetes with international standards to facilitate timely and appropriate diagnosis of diabetes and to minimize the risk of overdiagnosis of pre-diabetes.

Effective **1 July 2026** the national diagnostic thresholds for HbA1c are changing to:

- **Diabetes:** HbA1c **≥ 48 mmol/mol** (lowered from the current ≥ 50 mmol/mol).
- **Prediabetes:** HbA1c **42 – 47 mmol/mol** (previously 41 – 49 mmol/mol)
- **Normal:** HbA1c **< 42 mmol/mol.**
- **No confirmatory test required** if HbA1c **> 53 mmol/mol.**
- Confirmatory test required as soon as practical if HbA1c 48 – 52 mmol/mol eg. repeat HbA1c, fasting glucose or random glucose (if symptomatic)

It is worth keeping in mind that diabetes exists on a spectrum. Microvascular risk begins to increase above an HbA1c of 39 mmol/mol, which is the threshold used for prediabetes in some countries. At the borderline range, diabetes is not usually symptomatic.

2. Whole body scanning

An excellent article by Dr Orna McGinn in a recent issue of NZ Doctor examined the risks of consumer driven health testing including whole body scanning which is being promoted on social media and by some imaging providers. About the same time, the Canadian primary care evidence summary service Tools for Practice released their summary #410 titled Whole-Body MRI for Cancer Screening: Many findings, little benefit with the clinical question *What are the potential benefits and harms of performing whole-body MRI for cancer screening in asymptomatic adults?* The bottom line was that systematic reviews of observational studies found that 94% of patients who undergo whole-body MRI will have a radiologic abnormality and up to 30% require additional investigations. Ultimately, 1.1-1.6% will have a pathologically confirmed cancer (most commonly prostate, renal, lung, thyroid). No data on mortality exists. **Whole-body MRI for cancer screening in asymptomatic individuals should not be encouraged.** The summary notes that patients who undergo whole-body MRI have higher downstream health care costs, primarily from additional imaging and speciality consultations. The time to perform whole-body MRI depends on machine, sequences captured and protocols, but typically 60-90 minutes which is about three times as long as a body-specific MRI (eg brain or knee).

3. Sepsis

A recent NZ Doctor article on sepsis promoted the new pre-hospital and primary care sepsis screening and action tools we have discussed previously in Snippets and which are available from the NZ Sepsis website and the HQSC clinical guide. The article emphasises the four principles of screen, stratify, act immediately and use critical language, and notes that clinical judgement remains central. *The HQSC clinical guide accepts that while not every person with amber flags needs transfer to hospital, this is warranted where there is persistent whānau concern or acute functional decline, or when people lack the ability to return for assessment in the event of deterioration.* Three primary care cases are presented and there is a list of practical points:

- Build a sepsis habit. Note normal temperature does not exclude sepsis.
- Communicate clearly and transfer early [use terms such as red flag sepsis]
- Antimicrobials (prompt administration of IV ceftriaxone or other available broad spectrum antibiotic – antibiotics are first priority and while blood cultures are very helpful they can remain positive for up to 30 minutes after antibiotics are given, so can follow a dose of antibiotics if IV access is initially difficult)
- Safety netting vital if the patient is believed suitable for observation in the community
- Embed the tools locally. Add the sepsis pathways PDFs to your practice intranet, put laminated copies in triage rooms, and run a short huddle to rehearse the flags.

4. 1 May Privacy Act updates

From the April issue of GP Pulse is a reminder that the Privacy Amendment Act 2025 will introduce a new Information Privacy Principle (IPP 3A) which will come into effect on Friday 1 May. From this date, if your organisation collects personal information from third parties (i.e. not from the individual concerned) you must take reasonable steps to ensure the individual is aware. The Privacy Commission has published updated guidance on application of the principle

Essentially, under the existing principle IPP3, agencies (businesses or organisations) must already inform people when they collect their personal information from them. Under IPP3A, if an agency collects a person's personal information from someone other than the person themselves (i.e. indirectly), then that agency is required to tell the person, unless an exception applies.

If an agency has collected personal information indirectly, IPP3A requires them to take reasonable steps to make sure that the person concerned is told:

- that the information has been collected
- the purpose of the collection
- the intended recipients of the information
- the name and address of the agency that is collecting the information and the agency that holds the information
- whether the collection is authorised or required by law and which particular law
- their right to access and correct their information.

MPS has developed guidance for members on what these changes mean for clinicians and explains what your practice should think about and implement before 1 May. It is expected the majority of practice obligations under IPP3A will be met by an update of the practice's existing Privacy Statement. The Privacy Statement needs to describe the types of information collected and the purpose for which it is collected. This means that if a practice receives information from a source not explicitly mentioned in their Privacy Statement, they will not generally need to re-notify the patient, provided the information is of the same type and collected for the same purpose. The guidance gives specific advice on what the Privacy Statement should contain and discusses exceptions to IPP3A requirements and the issue of receipt of unsolicited third-party information.

5. Smartphones and kids

A study recently published in Pediatrics and reviewed in Issue 269 of GP Research Review looked at health outcomes at age 12 associated with smartphone ownership. Researchers analysed data from 10,588 participants in the Adolescent Brain Cognitive Development (ABCD) study. Compared with non-owners, 12-year-olds with smartphones had higher odds of depression, obesity, and insufficient sleep after adjustment for socioeconomic, developmental, and monitoring factors. Earlier acquisition was additionally associated with obesity and insufficient sleep. Among youth without a smartphone at 12, those who obtained one by age 13 showed increased clinical-level psychopathology and insufficient sleep even after controlling for baseline status. Findings were robust across sensitivity analyses. Overall, smartphone ownership – particularly earlier ownership – was consistently associated with adverse mental and physical health indicators in early adolescence, with implications for caregivers and policy.

6. MPS Resource

MPS has released the Safe Prescribing podcast series - a five-episode, practical, medicolegal resource designed to help you reduce risk, streamline decision-making, and feel more confident in everyday prescribing.

- Episode 1: 12-month prescriptions: What the law change means in practice, how to decide on prescription length, and strategies to minimise complaints.
- Episode 2: Prescribing by telehealth and narrow-scope clinics: The rise of telehealth brings new risks. We explore how to keep patients safe and protect yourself when consulting remotely.
- Episode 3: Prescribing by proxy: when care is shared: Shared care is now the norm. We unpack the medicolegal implications of prescribing for patients you haven't personally assessed, and how to stay aligned with Medical Council expectations.
- Episode 4: Standing orders: A clear, practical look at your obligations when using standing orders, and how to ensure you're meeting regulatory requirements.
- Episode 5: Dangerous drugs: focus on Methotrexate - Using a real case example, we highlight why methotrexate remains a high-risk medication and how to avoid the errors that lead to serious harm.

7. Spotlight Series

The NZ Doctor Spotlight series looking at prescribing data analysed using the Conporto Health Event Detection & Mitigation service has reported on several prescribing issues:

(i) **Co-prescribing of PDE5 inhibitor and nitrates**. There were 10 events over a fortnight amongst 196k interactions.

- avoid concurrent use of nitrates (this is a contraindication - concurrent use may cause potentially life-threatening hypotension and, in severe cases, can precipitate myocardial infarction).
- if nitrates must be given, allow a minimum of 24 hours after sildenafil or 48 hours after tadalafil, and consider a longer interval in anyone with factors that could raise PDE5 inhibitor levels (eg, interacting medicines)
- review patient medicine histories to identify any prescription of a nitrate (eg, glyceryl trinitrate, isosorbide mononitrate)
- counsel patients to tell emergency or ambulance staff when they last used a PDE5 inhibitor, so nitrates are avoided in acute care
- check for cardiovascular disease – ask about angina, chest pain, shortness of breath, palpitations or syncope, even if the patient is not on nitrate therapy

(ii) Prescribing of **metformin in patients with severe renal impairment**, defined as an eGFR below 15ml/min/1.73m^2. At this level of kidney function, metformin is generally contraindicated because the risk of metformin-associated lactic acidosis increases significantly. Lactic acidosis carries a high fatality rate and can be difficult to recognise early because symptoms are often non-specific. There were 5 episodes of such prescribing over a fortnight amongst 227k interactions.

- stop metformin in patients with an eGFR <15ml/min/1.73m^2
- review the most recent renal function results before issuing a new or repeat prescription or adjusting the dose
- check for episodes of acute illness (eg, dehydration, vomiting or infection) that may reduce kidney function, and consider temporarily withholding metformin
- assess for risk factors that increase susceptibility to lactic acidosis, including poorly controlled diabetes, heart failure, liver disease or alcohol misuse
- consider alternative glucose-lowering therapies more suitable for patients with severe renal impairment
- discuss sick day management and the need to pause metformin during acute illness, and reinforce the importance of regular renal monitoring

- advise patients to seek medical attention promptly if they develop symptoms such as unusual fatigue, muscle pain, abdominal discomfort, rapid breathing or nausea, as these may indicate lactic acidosis or acute kidney injury.

(iii) **First prescriptions of allopurinol at doses >200mg per day in patients with severe renal impairment**, defined as an eGFR below 30ml/min/1.73m^2. There were 9 episodes of such prescribing detected over a fortnight amongst 212k interactions.

- Allopurinol and its metabolites are renally excreted, and impaired kidney function leads to accumulation. This increases the risk of serious adverse reactions, including allopurinol hypersensitivity syndrome and drug reaction with eosinophilia and systemic symptoms (DRESS), which can be life-threatening. Renal impairment has an additive effect on genetic susceptibility to these reactions, making cautious initiation and slow titration essential.

- The New Zealand Formulary advises caution in renal impairment and suggests the following dosing for gout prophylaxis:
    - eGFR 30–60: start at 50mg once daily and increase by 50mg every four weeks, if tolerated, until target serum urate level (<0.36mmol/L) is reached
    - eGFR <30: start at 50mg every second day and increase by 50mg every four weeks, if tolerated, until target serum urate level (<0.36mmol/L) is reached.

- Before initiating allopurinol, check renal function and document baseline eGFR. Start at the lowest recommended dose and titrate slowly, monitoring serum urate and renal function. Advise patients about hypersensitivity reactions. Patients should be counselled to stop taking allopurinol at the first sign of a rash (even if mild) or if they develop other symptoms of an allergic reaction (eg, swelling of the lips or mouth, difficulty breathing, fever) and to seek urgent medical help. Consider alternative urate-lowering strategies and/or specialist input for patients with significant renal dysfunction.

8. Post Script

One of our listeners, Dr Andre Bonny from Nelson, took up the challenge to produce a Medsafe-type information sheet for alcohol (see over). Perhaps a bit light on the social harms including family and relationship damage, crime, accidents and injuries, and economic and workplace issues. From an economic perspective, a 2024 report to the Ministry of Health/Manatu Hauora included the following statistics for the 2023 year:

- $9.1b estimated total cost of alcohol harm based on disability-adjusted life years
- $4.8b associated with disability-adjusted life years from Fetal Alcohol Spectrum Disorder (FASD)
- $1.2 b associated with disability-adjusted life years from alcohol use disorder
- $281m - intimate partner violence (for alcohol use disorder alone)

- $74m - child maltreatment (for hazardous drinking alone),
- $2.1b in societal cost of road crashes where alcohol was a factor
- $4b in lost productivity associated with alcohol use, including FASD, crimes and workplace absenteeism
- $810m, predominantly in health and ACC spending

Ethanol (Ethyl Alcohol) – One Page Safety Summary (Medsafe■Style)

Overview
Ethanol is a psychoactive central nervous system depressant commonly present in alcoholic beverages and some medicinal preparations. While widely consumed socially, ethanol has no routine therapeutic indication and is associated with significant health risks, particularly when used regularly or combined with other medicines. It affects brain neurotransmitters including GABA and glutamate, leading to sedation, reduced inhibition, impaired coordination, and altered judgement.

Key Health Risks
Short■term: impaired judgement, reduced coordination, slurred speech, nausea, vomiting, slowed reaction time, injury risk.
Serious acute effects: respiratory depression, hypoglycaemia, seizures, loss of consciousness, alcohol poisoning.
Long■term: liver disease (fatty liver, hepatitis, cirrhosis), cardiovascular disease, increased cancer risk, cognitive impairment, and alcohol dependence.

Adverse Effects
Common: headache, fatigue, dehydration, sleep disturbance, mood changes.
Less common: gastric irritation, memory impairment, anxiety or depression.
Serious: severe intoxication, cardiac arrhythmias, acute pancreatitis, liver failure.

High■Risk Groups
Young people and adolescents; pregnancy (risk of Fetal Alcohol Spectrum Disorder); people with liver disease; people with mental health disorders; individuals taking sedating medicines.

Interactions With Medicines

Medicine Type	Interaction Risk
Benzodiazepines	Excess sedation, respiratory depression
Opioid pain medicines	Increased overdose risk
Sleeping medicines	Severe drowsiness and impaired breathing
Antidepressants	Increased sedation and impaired cognition
Antipsychotics	Enhanced CNS depression
Warfarin / anticoagulants	Increased bleeding risk

Dependence and Withdrawal
Regular heavy use may lead to tolerance and physical dependence. Withdrawal symptoms may include tremor, anxiety, sweating, agitation, and seizures in severe cases requiring medical supervision.

Key Safety Message
Ethanol significantly increases the risk of sedation, overdose, injury, and drug interactions, especially when combined with other central nervous system depressants.