Clinical Snippets July 2026

1. Prescriber Update

The latest issue of Prescriber Update includes the following useful updates:

(i) Undesirable effects of opioids

Opioid data sheets are being updated to include the following potential adverse effects of opioid therapy, particularly long-term high dose treatment:

- Suppression of the hypothalamic-pituitary- adrenal (HPA) axis occasionally causing reversible adrenal insufficiency requiring monitoring and glucocorticoid replacement therapy. Symptoms include fatigue, dizziness, nausea, vomiting and low blood pressure. Opioids can also cause hyperprolactinaemia in males and females.
- Suppression of the hypothalamic-pituitary-gonadal (HPG) axis leading to low testosterone and oestrogen levels. Clinical symptoms such as reduced libido (both sexes), erectile dysfunction and menstrual irregularities can then occur.
- Sphincter of Oddi spasm which can cause increased biliary pressure, increasing the risk of biliary tract symptoms and pancreatitis. Administer opioids with caution and with appropriate monitoring in patients with pancreatitis and diseases of the biliary tract.
- Oesophageal dysfunction which manifests as oesophageal symptoms (most commonly dysphagia but also heartburn, regurgitation and non-cardiac chest pain) along with abnormal oesophageal motility following long-term opioid use.
- A 2022 BPAC article covers opioid prescribing in primary care and has some editable resources including a pain management plan and example opioid contract.

(ii) Insulin autoimmune syndrome

- Insulin autoimmune syndrome (IAS) is characterised by recurrent hypoglycaemic episodes, increased serum insulin and the presence of insulin autoantibodies. It usually occurs without exogenous insulin treatment.
- Medicines are a primary trigger of IAS in about half of cases. Medicines and active metabolites that contain a sulfhydryl group (-SH) or thiol group (R-SH) have been associated with IAS. Examples include carbimazole, clopidogrel and captopril.
- Other triggers include viral infections (eg, measles, mumps, rubella, varicella zoster) and haematological conditions (eg, multiple myeloma).
- IAS is a self-limiting condition that typically resolves within a few months. Management may include stopping the causative medicine and supportive treatment, such as dietary modifications (eg, small frequent meals with low carbohydrate content) to reduce the risk of hypoglycaemia.

2. Latest coffee update

Issue 270 of GP Research Review reviewed a study published recently in JAMA exploring whether coffee and tea intake were associated with long-term cognitive function and dementia risk. This was a prospective cohort study following 131,821 participants across the Nurses' Health Study and the Health Professionals Follow-up Study who did not have dementia, Parkinson's disease or cancer at baseline. Data on diet were collected via questionnaires every 2–4 years. Across up to 43 years of follow-up (median 36.8 years), those in the highest quartile of caffeinated coffee consumption had a significantly lower risk of dementia compared to those in the lowest quintile, after adjustments for confounders (141 vs. 330 cases per 100,000 person-years; HR 0.82) as well as a lower rate of subjective cognitive decline (7.8% vs. 9.5%). In the Nurses' Health Study, those in the highest quartile of caffeinated coffee consumption had higher objective cognitive performance scores. The associations were similar for higher intakes of tea, although decaffeinated coffee consumption was not associated with improved cognitive performance or reduced dementia risk. Benefits were non-linear and most evident at about 2–3 cups of coffee or 1–2 cups of tea daily. So another reason to keep supporting your local coffee roaster! Reference: JAMA. 2026;335(11):961–74

3. Gout -treating to target

A study recently published in JAMA Intern Med. looked at the impact of treat-to-target urate-lowering treatment and cardiovascular outcomes in patients with gout. This was a primary care cohort study (UK) of more than 109,000 new urate-lowering treatment users with up to five years follow-up. Achieving a serum urate target below 0.36 mmol/L with therapy was associated with a modest but meaningful cardiovascular benefit with patients who reached the target within 12 months having higher event-free survival and a lower risk of MACE (major adverse cardiac event) with improved 5-year event-free survival and fewer gout flares. Benefits were most pronounced for patients at high/very high cardiovascular risk, and for those who achieved a serum urate level <0.3 mmol/L. BPAC published an excellent comprehensive article on all aspects of gout management last year that is well worth a review.

4. MSD update

MSD update: Telehealth consultations and expiry dates for Work and Income certificates

- The Ministry of Social Development has recently seen examples where a Work and Income client has booked an appointment with a telehealth provider to have an interim Work Capacity Medical Certificate (WCMC) completed until they can be seen by their own GP/practice. This process often incurs an additional cost for the patient.

- Work and Income can provide discretionary benefit extensions for clients if they have a good and sufficient reason for being unable to provide a medical certificate prior to their benefit expiry date. An example of this is where the earliest possible GP appointment is after their current WCMC expires. The extension can be for up to four weeks.

- In the scenario noted above, the client can contact their own GP practice and ask for written confirmation indicating the date and time of their next booked appointment – this can be in the form of a printout from reception. Work and Income can then put an extension in place until the patient is seen, negating the need for the client to seek an interim certificate from another provider.

5. Testosterone for women

The CFPC Tools for Practice #408 examined evidence around the question *Can testosterone improve sexual function in pre or post-menopausal women?* The bottom line was in post-menopausal women with hypoactive sexual desire disorder (mostly on estrogen therapy), testosterone improves the number of satisfying sexual events by ~1 more per month over placebo at 12-52 weeks. Absence of benefit in premenopausal women may be due to small study sizes. Versus placebo, testosterone increases risk of acne (7.2% versus 5%) and hirsutism (12% versus 8%). Current guidance was summarised as:

- May consider off-label testosterone for hypoactive sexual desire disorder after addressing other causes.
- Testosterone gel 1%: One-half pump daily to posterior calf.
- Levels not recommended for diagnosis. If treatment initiated, total testosterone levels at baseline, 3-6 weeks and every 6 months (target ≤2.8nmol/L).
- Onset: 1-3 months. Discontinue if no benefit at 6 months.

6. Deprescribing PPIs

A recent Research Review Educational Series examines in some detail the rationale for and process involved in stepping down and stopping proton pump inhibitors. The review outlines best practices for PPI stewardship, including when and how to deprescribe PPIs. It highlights two deprescribing strategies and explains how alginate/antacid combinations can reduce breakthrough symptoms. Practice points include:

- PPI therapy should be reviewed routinely to confirm ongoing clinical necessity
- In the absence of a long-term indication, a trial of PPI de-prescribing is recommended

- Most patients with a long-term indication for PPI therapy who have twice daily dosing should be considered for a step down to once daily dosing
- Patients with long-term indications (eg Barret's oesophagus) should not be considered for PPI de-prescribing
- Patients who undergo PPI de-prescribing should be advised that they may experience transient upper GI symptoms due to rebound acid hypersecretion
- Consider dose taper or abruptly stopping PPI therapy when de-prescribing
- Decision to de-prescribe a PPI should be based solely on the lack of indication for continued PPI therapy, rather than concern for PPI-associated adverse events

BPAC has some resources to aid PPI deprescribing; a PPI Audit tool and an earlier article on de-prescribing PPIs in older people.

7. Ozempic mouth

A Medscape article published last month summarised information about Ozempic mouth and how to treat it. Ozempic mouth symptoms (related to use of GLP-1 inhibitors – possibly more common with semaglutide) include dry mouth (most common symptom), bad "sulfur" breath and a metallic/bitter taste in the mouth, tooth sensitivity and increased risk of tooth decay and gum disease. Symptoms are driven by delayed gastric emptying, reflux, vomiting in up to 24% of GLP-1 inhibitor users, and decreased saliva production. Delayed gastric emptying may drive sulfur burps via bacterial overgrowth/fermentation. Good oral hygiene is important with twice-daily brushing for 2 minutes each time and flossing at least once a day recommended as well as regular dental review. Additional symptom control measures include:

(i) Dry Mouth

- Advise patients to drink plenty of water or herbal tea without sugar.
- Stimulate saliva production with sugar-free gum or pastilles containing xylitol, a sugar alcohol shown to prevent tooth decay. The act of chewing gum itself increases saliva production.
- Recommend over-the-counter oral moisturizing rinses, sprays, gels, or lozenges.
- In severe cases, consider prescribing pilocarpine to boost saliva production.

(ii) Changes in Taste Perception

- Suggest smaller, more frequent meals to better tolerate the effects.
- Consider dietitian counselling to maintain a balanced diet.
- Monitor the patient closely because altered taste perception can lead quickly to nutritional deficiencies.

(iii) Reflux and Vomiting

- Encourage patients to replenish fluids consistently and eat smaller, more frequent meals.
- Suggest sugar-free antacids.
- Help patients identify trigger foods or behaviours to avoid — they might include certain acidic or fatty foods or smoking.
- Advise against brushing teeth right after vomiting when tooth enamel is softened and vulnerable to mineral loss. Instead, have them swish with water immediately and wait at least 30 minutes to brush.
- Recommend using toothpaste formulated for sensitive teeth.
- Consider modifying the medication dose to reduce vomiting.

(iv) Sulfur Burps and Halitosis

- Advise the use of a fluoride-containing antibacterial toothpaste, preferably with zinc, to help neutralize sulfur compounds and kill odor-causing bacteria.
- Recommend tongue scraping and flossing at least once a day.
- Recommend a fluoride-containing mouth rinse.

8. Study of the month

A recent Medscape Impact Factor commentary reviewed an Australian study published in JAMA Network Open titled *Regular Flatulence Patterns Among Community-Dwelling Individuals in Australia.* Flatulence patterns in 6416 individuals aged older than 14 years broadly representing the Australian population were recorded using a purpose-designed mobile phone application (Chart Your Fart). Consenting participants were instructed to enter each passage as close as possible to its discharge over at least 2 weekdays and 1 weekend day. Time of event could be retrospectively edited. The app was designed to make recording simple and discreet. The primary outcome considered was total flatus per day (fls/d) with 360192 outputs recorded.

Key findings included:

- Mean self-reported flatus frequency: ~5/day
- Men reported more flatus than women; reporting bias possible.
- Peak flatus frequency occurred in ages 26–45; lowest in 14–25 years.
- Flatus rate ↑ through day, peaking pre-bedtime; lowest early morning.

Authors note limitations of this study include failing to quantify emissions made while asleep due to reliance on self-report. Devices inserted into the anus to capture intestinal gas provide rigorous observation of flatulence production, but production is unlikely to be perfectly correlated with output, given conscious control over release and associated sociocultural

standards. Furthermore, perception of excess relies on patient self-report. Nonetheless, self-report may also partially explain the observed gender differences. Greater efficiency in expulsion could also confound frequency data, with large variation in individual volume previously observed (33-125 mL/flatus).

