Clinical Snippets October 2026

1. AUB Pathway

- The Health Pathways section on abnormal uterine bleeding has been recently updated with some significant changes including indications for and timing of endometrial sampling as part of the investigation process, and new analysis on the role of endometrial thickness in determining management. There is a webinar available with panel discussion of practical application of the pathway.

- The key take-home messages for assessing and managing AUB include:
    - Proactively ask about periods and bleeding impact in a whānau-centred, culturally appropriate way.
    - Treat the bleeding and iron deficiency as a core part of AUB care.
    - Use risk-based assessment for endometrial cancer; do not rely on ultrasound findings.
    - Be aware that endometrial sampling may be indicated despite 'normal' endometrial thickness on USS.

- Rates of endometrial cancer incidence are increasing, particularly among younger women, with Māori and Pacific Peoples experiencing a disproportionate burden of disease. The updated guideline reflects an equity-focused redesign of care, supporting earlier recognition, timely investigation, and appropriate management of AUB in primary care to reduce reliance on delayed secondary care assessment.

- A key change is the move from ultrasound-led decision-making to a risk-based approach. Ultrasound and endometrial sampling are now separately indicated investigations, with key decisions guided by clinical risk factors rather than endometrial thickness. Endometrial sampling may be appropriate even when ultrasound findings are reported as normal if risk factors for endometrial hyperplasia or cancer are present. Risk factors include excess oestrogen exposure (such as obesity, PCOS, or chronic anovulation), diabetes, increasing age, relevant family history, and iron-deficiency anaemia. For Māori and Pacific Peoples, investigation to exclude endometrial cancer or hyperplasia should be considered early, including at or soon after first presentation with AUB. Age informs decision-making, but age alone does not determine the need for endometrial sampling.

- Management should begin at the initial consultation alongside appropriate investigation, and may include medical management of bleeding, active treatment of iron deficiency, discussion of longer-term options (including LNG-IUS where

appropriate), and planned follow-up or referral. Treating symptoms does not replace further investigation when clinically indicated.

- Clinicians should refer to their local HealthPathways site and PHO for current information on access, referral criteria, and training opportunities for LNG-IUS insertion and endometrial sampling.

2. Prescriber Update

Medsafe September Prescriber Update included the following practical points:

(i) **Rosuvastatin dosing:**

- The usual starting dose of rosuvastatin for hypercholesterolemia is 5-10 mg regardless of prior history of statin use. If necessary, the dose can be increased after 4 weeks of treatment. The usual maximum dose is 20 mg per day.
- As with all statins, rosuvastatin can cause skeletal muscle toxicity, and the risk of rhabdomyolysis increases with higher rosuvastatin doses. Be aware of other risk factors for skeletal muscle toxicity with rosuvastatin and recommended dose modifications. Risk factors include Asian ethnicity, severe renal or hepatic impairment, some medications (ticagrelor, ciclosporin, some protease inhibitors)
- Advise patients to promptly report unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.
- Only use the 40 mg dose in patients who have not responded to the 20 mg dose, ie, who still have severe hypercholesterolaemia and are at high cardiovascular risk. The 40 mg dose is contraindicated in some patients.
- Note that from 1 October 2026 Pharmac has removed the SA criteria for rosuvastatin although previous self-funding patients with repeats owing on a prescription written prior to 1 October 2026 will need a new prescription before they can access the funding for rosuvastatin.

(ii) **Prednisone-induced thyrotoxic periodic paralysis**

- In patients with hyperthyroidism, sudden intracellular shifts of potassium can cause thyrotoxic periodic paralysis (TPP). Attacks usually occur a few hours after ingesting a high carbohydrate meal or strenuous exercise.
- Prednisone can induce hypokalaemia. Therefore, suspect TPP in hyperthyroid patients treated with prednisone who present with signs or symptoms of muscle weakness.

(iii) **Ocular adverse effects of stimulant medicines for ADHD**

- Ocular adverse effects, including increased intraocular pressure (IOP), glaucoma, and dry eye, have been reported with use of stimulant medicines for attention deficit hyperactivity disorder (ADHD).
- Patients with a history of increased IOP or glaucoma, or who are at risk for acute angle-closure glaucoma require careful assessment before starting treatment and ongoing monitoring during treatment.
- Advise patients to promptly report visual disturbances or other changes in vision.

(iv) **Alpha-gal syndrome:** An emerging cause of hypersensitivity reactions to medicines

- Alpha-gal syndrome (AGS) is a tick-associated IgE-mediated allergy to alpha-galactose that may cause hypersensitivity reactions to some biological medicines including monoclonal antibodies (some of the 'imabs').
- Alpha-gal is a carbohydrate found in the tissues of most non-primate mammals, and in the gut and saliva of ticks. Sensitisation occurs following bites from certain tick species, although the tick species associated with AGS varies geographically
- Consider AGS in patients with unexplained hypersensitivity reactions, particularly if they have a history of tick bites or a history of delayed allergic reactions following consumption of mammalian products eg. beef, pork, lamb, gelatin or milk
- Clinical manifestations of AGS range from urticaria, angioedema and gastrointestinal symptoms, to severe anaphylaxis and unlike most food allergies, reactions associated with AGS are typically delayed, occurring 2 to 6 hours after exposure.

3. Arms Act 2026

- From 23 September 2026 the Arms Act 2026 came into effect with day-to-day responsibility for the firearms regulatory system shifting from Te Tari Pureke (Firearms Safety Authority) to Firearms Safety and Education New Zealand (FSE). This means you will be interacting with the new regulator, but in all other respects very little is changing for health practitioners. As previously, you must consider notifying FSE as soon as practicable if you have reason to believe:
    - your patient is a firearms licence holder (or you have reason to believe they are a licence holder); and
    - you consider the patient's health condition may impact their safety or the safety of the public, if they continue to use or possess firearms.

- You need to provide the grounds on which your opinion is based and whether you believe the licence holder poses an immediate or imminent danger of self-harm or

harm to others. Any decisions, and the reasons for them, should be carefully documented in the patient's clinical record, in case they need to be referred to later. As long as they act in good faith, health practitioners are not liable to criminal, civil, or disciplinary proceedings by disclosing personal information while performing any of the notifications under the Act. Instructions on how to perform the notification and a link to the updated Health Practitioner Reporting form are available on the FSE website.

- Note it is FSE's responsibility to notify the applicant's health practitioner when a firearms licence has been issued or when a licence holder notifies FSE that they have changed their health practitioner. However, do not assume your patient is not a firearms licence holder, just because you have not received a notification from Firearms Safety and Education New Zealand. The licence holder may choose to nominate someone other than their registered GP as their health practitioner when applying for a firearms licence. A patient might also change health practitioner without notifying FSE.

- FSE suggests you include firearms licence holder information in the patient's social history on the Patient Management System (PMS), which can be transferred as part of the medical record. You will receive notification from Firearms Safety and Education New Zealand when a patient is issued with a new licence, or their licence is renewed (licenses can last for up to 10 years); or an existing licence holder nominates you as their health practitioner. If you have received a notification from FSE regarding a person who is **not** your patient, please let them know by completing the Health Practitioner Reporting form.

4. Quick bites

(i) PCV13 and flu vaccine coadministration reminder

A reminder from IMAC that parents and caregivers should be informed of the small risk of febrile convulsions in concomitant delivery of PCV13 and influenza vaccines in children aged 6 months to under 5 years. If the child has a history of febrile convulsions, separation of two days between vaccines is recommended.

(ii) **Immunisation Handbook Update**

Version 3 of the 2026 Immunisation Handbook has been published. Updates include:

- Pre-vaccination screening guidance: Changed definition of unwell with fever (in relation to pre-vaccination screening) to be 38.5°C or over (from 38°C) – this is to

reduce the number of children turned away for vaccination, and to align with Australia and the UK.

- Polio: Updated catch-up guidance to accept any fractional inactivated polio vaccine (fIPV) doses administered overseas as equivalent to IPV doses.
- Hepatitis B: Section added about infants who are close contacts with hepatitis B-infected household members, and extended recommendation for serology testing of those infants given a birth dose of HepB. Details of serology testing and managing results are in the Handbook.

(iii) **New guide: Primary care providers supporting sensitive claims**

ACC has created a new quick guide to help primary care providers support kiritaki who have experienced sexual abuse or assault. It outlines who can lodge a sensitive claim, key claiming requirements, what information to include on the ACC45, and the support available through the ACC Sensitive Claims Service.

(iv) **Sepsis resource**

Sepsis Trust NZ has released new patient information adult and paediatric 'signs of sepsis' cards for use in patients with infections or at risk of sepsis being managed in the community. The cards have been endorsed by RNZCGP and RNZCUC. Cards can be ordered from Sepsis Trust. A recently recorded webinar Unmasking Paediatric Sepsis is available on the Health Hub website. The webinar provides an update on paediatric sepsis assessment and management, including the recently introduced paediatric sepsis pathway for use across primary and secondary care. There is a review of key signs and symptoms, red flags for deterioration, initial management priorities, and when escalation of care is required.

(v) **Private bowel screening**

The Bowel Cancer NZ website includes a section on private bowel screening options for those not eligible for the national screening programme. There are links to two FIT kit providers Allevia and True Proactive . Cost is around $150 and website information refers to a positive result not necessarily entitling the patient to follow-up in the public system. There is also a link to IGENZ which provides a stool DNA test that identifies specific epigenetic methylation markers associated with colorectal cancer. The test claims 88% sensitivity, (12% false negative rate) and 92% specificity (8% false positive rate). It has a sensitivity of 46% for detecting advanced adenoma and exhibits better sensitivity for detecting both colorectal cancer and advanced adenoma when compared with FIT testing. Cost is $265 and kits can be ordered from the IGENZ website and CareHQ.

(vi) Ivermectin cream for RPPP

A recent Research Review dermatology educational series publication on topical treatment of rosacea noted that first-line treatment options for the rosacea phenotype of papules and pustules (RPPP) include topical ivermectin 1% cream (Soolantra) recently approved by Medsafe, metronidazole 0.75% cream, and azelaic acid 20% cream. Ivermectin 1% cream demonstrates greater efficacy than metronidazole 0.75% cream in treating RPPP, especially in severe cases and is associated with longer remission periods after treatment cessation compared with metronidazole 0.75% cream. Ivermectin 1% cream is applied once daily, a regimen often preferred by patients over twice daily topical treatments. Multiple studies have shown that ivermectin 1% cream is safe and effective for the long-term management of RPPP, with evidence supporting use for at least one year. Cost for a 30g tube (prescription required) seems to be around $70 – 90.

5. Leisure

A recent Medscape article listed '10 books doctors should read at least once' and the justification for the choice. The first five a represented below with the remaining five to wait until November Snippets.

1. **When Breath Becomes Air — Paul Kalanithi, 2016**

A young neurosurgeon discovers he has an incurable cancer and switches sides in the doctor-patient relationship: from caregiver to patient. Perhaps the most important book of recent years on the theme of a doctor's professional identity.

Why read it: It teaches what it means to care when a cure is not possible.

2. **The Man Who Mistook His Wife for a Hat — Oliver Sacks, 1985**

Every patient is a person first and foremost, even before being a medical case.

Why read it: Medicine without humanity becomes nothing more than classification. For many, it will serve as a reminder of the reasons behind their choice of this profession.

3. **Being Mortal: Medicine and What Matters in the End — Atul Gawande, 2016**

One of the most important works on the relationship between modern medicine and its limits.

Why read it: The success of medicine isn't always about prolonging life but about helping a person live according to their own values.

4. **Do No Harm: Stories of Life, Death, and Brain Surgery — Henry Marsh, 2014**

A neurosurgeon reflects on the mistakes, uncertainties, and difficult decisions that shape his work, offering a powerful lesson in humility.

Why read it: A doctor is not someone who never makes mistakes but someone who recognizes the weight of their own choices.

5. **The Death of Ivan Ilyich — Leo Tolstoy, 1886**

In this short novel by the great Russian writer, published in 1886, the description of the progression of illness becomes a tool for exploring the fear of death and the human need to find meaning in existence.

Why read it: Many doctors consider it more instructive than numerous textbooks**.**