Clinical Snippets November 2026

1. New type 2 diabetes guidance for children and adolescents

BPAC Bulletin 158 notes the recent release of new Australian and NZ guidelines for screening, assessment and management of type 2 diabetes in children and adolescents.

(i) Key updates in the guidelines include:

- a revised screening algorithm for young people at risk of T2D which acknowledges an intergenerational diabetes epidemic in First Nations communities across Australia and Aotearoa NZ.
- recommendations on newly approved medicines and management strategies for youth-onset type 2 diabetes
- greater guidance on strategies to improve engagement of youth living with T2D and psychological health
- advice regarding emerging phenotypes of youth-onset T2D
- guidance regarding the use of continuous glucose monitoring systems in youth-onset T2D

(ii) Some of the practical points for primary care include:

- Be aware of the following risk factors for youth-onset type 2 diabetes: overweight/obesity, in-utero exposure to maternal diabetes, first-degree relative with type 2 diabetes, signs of insulin resistance (acanthosis nigricans), co-morbid conditions associated with obesity/metabolic syndrome (e.g. hypertension, dyslipidaemia), antipsychotic medicine use
- Screening for type 2 diabetes is recommended from age eight years in people of Māori or Pacific ethnicity if they have any of the above risk factors (see Figure 2 in the guideline)
- People of other high-risk ethnicities (e.g. South East Asian) should be screened from age ten years if they have overweight/obesity and at least one other risk factor
- Diagnostic criteria for youth-onset type 2 diabetes are the same as adults. See Box 2 in the guideline for details. The possibility of other forms of diabetes should be considered in discussion with paediatric/youth diabetes services.
- Following diagnosis, patients with youth-onset type 2 diabetes will typically be under the care of a specialist diabetes multidisciplinary team. This generally includes treatment, education and ongoing follow-up. Primary care is likely to be involved in ongoing medicine prescribing, monitoring for co-morbidities and the development of any complications, providing support to the patient and their family/whānau and facilitating engagement with other health services.

2. Antiretroviral meds – changes to funded access

Pharmac has announced that from 1 November 2026:

- Removal of the Special Authorities (SA) and Hospital restrictions for HIV medicines (also called antiretrovirals) to resolve issues with access raised by the health sector.
- Enabling access to two HIV medicines (emtricitabine with tenofovir disoproxil combination tablets and dolutegravir tablets) on a practitioner supply order (PSO) for **post-exposure prophylaxis (PEP) only**. This will allow immediate access for these antiretrovirals for post-exposure HIV prophylaxis (PEP) for people presenting to emergency clinics and sexual health clinics across New Zealand. The PSO must be endorsed for Post-Exposure Prophylaxis (PEP) only, supplied only by an authorised practitioner. Supply of emtricitabine with tenofovir and dolutegravir via PSO for PEP is for an **unapproved indication**. It is the responsibility of the medical practitioner or authorised prescriber to obtain informed consent at the time of supply.
- These changes are not intended to change prescribing patterns, prescriber types, or move HIV treatment management into primary care. The aim is to reduce barriers and make it simpler for people to get the treatment they need. **It does not change expectations regarding the clinical management, monitoring, or specialist involvement in the care of people living with HIV.** It remains the responsibility of the prescribing clinician to be familiar with the management of HIV, including appropriate prescribing, ongoing monitoring, and ensuring patients remain linked with specialist services.
- Useful resources for those health practitioners wishing to provide PrEP and PEP are available on your Community Health Pathways and the New Zealand Sexual Health Society website.

3. MoH clarifications

(i) **ADHD prescribing** - The RNZCGP reports in a recent edition of e-Pulse that the Ministry of Health has advised that some GPs are initiating ADHD medicines in patients aged 17 years and under. Under the Gazette notice, only paediatricians, psychiatrists or authorised nurse practitioners may initiate dexamfetamine, lisdexamfetamine or methylphenidate to this age group. GPs may continue prescribing only on written recommendation. The Ministry is asking Pharmac to clarify the Special Authority form.

(ii) **Viewing a body** - The Ministry of Health receives many enquiries from certifying health practitioners seeking clarification about whether examination of a body by audiovisual (AVL) satisfies the requirements under the Burial and Cremation Act 1964 or Cremation Regulations 1973 to examine the body, and to see and identify the deceased, for the purposes of death

and cremation certification. The Ministry's view is that the requirements under the legislation to examine the body and to see and identify the deceased contemplate the practitioner carrying out those functions in person. Accordingly, the Ministry does not consider that the use of AVL would satisfy those statutory requirements.

4. National Community Referred Radiology (CRR) changes

Te Whatu Ora has announced changes to the CRR criteria effective in most regions from this month. A key change is that community referrers can no longer request CT colonography (CTC) directly under the updated pathway. Referral is now through the FIT pathway, with secondary care determining whether colonoscopy or CTC is appropriate, in line with the National FIT for Symptomatic Patients Guidelines. The Health Pathway on *Colorectal Symptoms* is also being updated to reflect these guidelines. With the CRR there is also a new urgent (within 2 weeks) direct access CT Abdomen and Pelvis (CT AP) section with specific criteria (not yet published at the time of the podcast). Referrers should refer to their local HealthPathway (*Community Radiology Access and Funding*) for all current referral requirements.

5. Resources

(i) **Updated smoking cessation guideline and training resources** - The 2026 update reflects current evidence on behavioural support, pharmacotherapy, relapse prevention, digital tools and vaping as a smoking cessation tool. There is a dedicated pharmacotherapy module that is relevant for any health providers who discuss, recommend, supply, prescribe, dispense or support the use of stop smoking treatments.

(ii) **Digital DL9 certificate** - NZ Transport Agency | Waka Kotahi has introduced a digital medical certificate for driver licence (DL9) form through HealthLink available since September. The HealthLink website contains step by step user guides for the various PMSs, FAQs and additional information. Paper forms are still accepted currently but will be phased out over time. There has also been an update to appendix 9 of the 'Medical aspects of fitness to drive' document with new road sign recognition cards that can be used as an additional resource when assessing a patient's fitness to drive. NZTA note this is not a mandatory test. *If you think a patient seems to be forgetful or have memory loss, you can show them our sign recognition pack of common traffic signs. If they have trouble with recognising the signs or take a long time to answer, they may need further assessment. Road sign recognition pack It's important to note that performing well on this test doesn't necessarily mean a patient is fit to drive from a cognitive perspective, particularly if other aspects of their history raise concerns.*

(iii) **GLP-1 agonists and contraception** – The Faculty of Sexual & Reproductive Healthcare have produced a practical guide for patients using GLP-1 agonists and hormonal contraception.

Note that tirzepatide (Mounjaro) does require additional precautions in patients on oral contraception (either swap to an alternative (non-oral) form of contraception while on the drug or use a barrier method in addition to the oral contraceptive for four weeks after commencing the drug and for four weeks following any dose increase). This advice does not apply to other GLP-1 agonists.

6. Prescribing

Some prescribing pearls from a Medscape series Primary Care Hack include:

(i) **Mirtazapine**: Low-dose mirtazapine has a greater sedative effect than higher-dose mirtazapine. A dose ≤15 mg has high affinity for sedating histamine receptors. However, at higher doses (i.e. ≥30 mg), mirtazapine has an increased noradrenergic effect that blunts this sedative effect, and may be overstimulating in older adults. Consequently, low-dose mirtazapine can improve sleep efficiency, total sleep time, and sleep quality. This effect is most noticeable in the first few weeks of therapy.

(ii) **CCBs and losartan**: Losartan and CCBs may be preferential as antihypertensive agents in people living with gout and hypertension as they have urate-lowering properties and have been associated with a lower risk of incident gout among people with hypertension. Statins (particularly atorvastatin), fenofibrate and SGLT2 inhibitors have also demonstrated urate lowering properties. Antihypertensives known to increase urate levels include diuretics, beta-blocker, ACE inhibitors and non-losartan ARBs.

(iii) **Oral iron**: Oral iron absorption is most effective with once-daily or alternate-day dosing of supplements. Although iron supplements used to be given up to three times daily, more recent studies have shown that taking one dose each day or on alternate days can help to optimise iron absorption. Therefore, for first-line treatment of iron deficiency, a single daily tablet is recommended, taken until 3 months after iron deficiency is corrected to allow stores to be replenished. If not tolerated, consider either reducing to alternate-day dosing or switching to an alternative preparation with lower elemental iron content.

(iv) **Gliclazide in glucocorticoid-induced diabetes and hyperglycaemia:** Owing to its mechanism of action, gliclazide is preferred for the initial management of glucocorticoid-induced diabetes and hyperglycaemia. Glucocorticoids impair the function of pancreatic beta cells while sulfonylureas promote insulin release from the cells. If a person experiences glucocorticoid-induced diabetes, or glucocorticoid-induced hyperglycaemia in the context of T2D (and they are not taking insulin), a UK consensus recommends initially trialling gliclazide 40 mg od in the morning, titrated as required to a maximum of 240 mg od. Note: all people taking gliclazide should have access to SMBG, in view of hypoglycaemia risk.

8. Reading

An editorial in a recent edition of Psychological Medicine reviewed evidence on the positive effects of reading across the age groups. Reading remains valuable across adulthood; engaging with books is associated with enhanced well-being, reduced stress, and greater empathy, likely through its stimulation of emotional and social-cognitive processes. In middle-aged and older adults, cognitively stimulating activities such as reading have been linked to slower cognitive decline and a reduced risk of dementia, underscoring its potential role in healthy brain ageing. The second five books recommended in the Medscape article titled 10 Books Doctors Should Read At Least Once are:

- **A Leg to Stand On** — Oliver Sacks, 1984
  A serious accident forces Sacks to confront the temporary loss of the use of one leg and, above all, the experience of becoming a patient.
  Why read it: It is an extraordinary reflection on the relationship between doctor and patient, on vulnerability, and on the perception of one's own body.

- **The Covenant of Water** — Abraham Verghese, 2023
  A great family saga in which medicine weaves through the story of several generations, amid illness, treatment, and social change.
  Why read it: Because Verghese, a physician at Stanford School of Medicine as well as a writer, succeeds in transforming illness and the practice of medicine into narrative, recounting with great sensitivity the relationship between the body, family, and destiny.

- **What Patients Say, What Doctors Hear** — Danielle Ofri, 2017
  An essential book on clinical communication.
  Why read it: It makes it clear that listening is a medical skill.

- **The Emperor of All Maladies: A Biography of Cancer** —Siddhartha Mukherjee, 2010
  A history of cancer written like a historical novel.
  Why read it: Medical research is made up of insights, failures, and people.

- **Green Parrots: A War Surgeon's Diary** — Gino Strada, 2005
  The account of Strada's experience as a war surgeon, through the wounded he encountered in Afghanistan, Pakistan, Rwanda, and other conflict zones.
  Why read it: Because it brings medicine to the heart of war, showing the patients' pain, the doctor's responsibility, and the relationship between care, violence, and human dignity.