Why Hesitate? Let's Vaccinate!

Webinar Q&A – January 26, 2021

Q: Do you delay the 2nd dose if a patient gets COVID after first dose?

Peter: With other vaccines the key is not to take the booster too early - taken later the boost is actually better.

Q: How effective is the Pfizer vaccine against the new variants given that Moderna seems to be slightly less effective for the South African variant?

Peter: Pfizer has not released tests on SA version yet.

Q: How concerning is the delay in second dose for developing effective immunity? What is the absolute longest time interval before it is considered useless?

Noah: NACI says 42d is fine. Consensus of immunologists is that waiting even longer is totally fine. The trouble is that you don't get full protection likely until you have both.

Peter: In Israel they have had good protection after the first shot... they will be releasing more data weekly on their vaccine program.

Q: Does the mRNA vaccine, after injected, go into every cell in the body or just the immune cells?

Peter: Good question - not sure... I have looked and there is no clear data of where it goes.

Q: After testing positive for COVID how long should you wait before getting the vaccine?

Lynora: Different agencies have different suggestions - I have seen 3-6 months usually based at least partially on existing reinfection data showing it is rare within 3-6 months (and rare overall so far). Immunity resulting from infection is basically unknown, likely > 1 year, possibly longer.

Lynora: 3 months is minimum recommendation WHO says 6 months (reinfection is rare overall, particularly in that the period)

Noah: Immunity from infection may wane by 3M so a person with prior infection should be vaccinated before that time when possible.

Q: Can you please give an update on J&J's vaccine? One dose should have better uptake.

Peter: It is a human adenovirus, so we need to see if the results are like the Oxford one – in other words not flat line. We will have data in the next week or so.

Q: I thought that it was determined that Bell's palsy was not an AE from the vaccine and that it is simply occurring at the normal rate in the large study populations?

Peter: The rate is no more than background, which is 1 in 10000 but it has been making the social media rounds… nurses posting videos of their face so we need to explain that it could be from the shot, but 80% get better... patients don't mind if it will go away.

David: It is very low but in Pfizer and Moderna trials, it happened more commonly in vaccinated people than in people who got placebo.

Q: How long is the effectiveness/protection of each, the Pfizer and Moderna vaccine?

Peter: Not sure so they are tracking original patients in the trial for 2 years so we will know over time. They will be checking antibody levels.

Q: Please comment about colchicine as a potential treatment. Can you speak about the colchicine study from Montreal group? Is there any information on doses of colchicine used etc. for which benefit was noted?

Peter: It blocks inflammasomes and protects against the bad cytokine storm, but not to be used to prevent COVID.

Noah: I would avoid making off label prescribing based on press releases alone.

Q: At what point in vaccination of population will masks be able to be removed?

Peter: Good question – my guess is when we hit herd immunity – so 60-70% and when cases drop – non vaccinated still will need to mask because asymptomatic carriers could still infect them.

Q: Are any vaccines grown in placental cells? One of my patients who is Catholic told me she could not take the vaccine if it is grown in placental cells.

Noah: You should tell her the Pope recommended the vaccine. The mRNA vaccines do not have any fetal cells nor are they grown in placental cells. The CEP website has info on religious considerations.

Q: Which faith leaders have given approval for COVID vaccines?

Noah: Nearly all. There are statements from the Pope, Muslim leaders, Jewish, etc etc

Q: Now that the interval may be longer between first and second dose, is it still important not to have any other vaccines in between? Like Shingrix/Prevnar etc. Or Prolia etc. Is it OK to have 2 weeks after the first dose? When is the optimal time?

Noah: Recommendation is no other vaccine within 2 weeks.

Q: You reviewed that side effects are common, especially after the second dose. What can we recommend for symptom management? Is it safe to use NSAIDs? Or is acetaminophen preferred?

Noah: Great question. All people should get an 'after care' sheet. Yes NSAIDs and Tylenol are fine! Sore arm is very common. Other things less so. An after care document is on MOH website right now and I think CEP also.

Q: What are the chances of infecting others with COVID-19 if you are vaccinated and come into contact with the disease? Does the vaccine afford you any protection from infecting others?

Noah: All other vaccines do so people are optimistic, but we do NOT have proof of this yet, so recommendations are to continue public health guidance.

Q: Can someone with history of GBS get the mRNA vaccines?

Noah: You can always consult a neurologist, but I would lean to yes, vaccinate. Connection between GBS and vaccines is uncertain. Viral infections are more likely to flare GBS than a vaccine, statistically.

Q: How do you advise/counsel patients when they ask about long-term risks of the vaccine when it only been around less than a year?

Peter: Most side effects of all vaccines happen in the first 6 weeks, but they will track all patients for 2 years – to be certain.

Q: What do you recommend for pregnant women or women planning to become pregnant with regards to vaccination (especially for front line health care workers).

Noah: They should get the vaccination.

Peter: If they are at high risk then it makes sense. Also, we have real world data collection happening as well. Every day more and more pregnant patients are vaccinated, so we have real world data.

Q: Is there any study of whether the COVID-19 vaccine can trigger an autoimmune response?

Noah: This is a theoretical concern that has not been seen in any of the data to date.

Q: What if someone got Pfizer as a first dose and Moderna as a second is there a interaction

Noah: No, but that should not happen.

Q: Could you comment on the issue of vaccine pause post first dose Pfizer vaccine if the second dose not available before 42d interim window?

Peter: No fear as the data looks good out to 90 days – you are still protected. Still use mask and distance of course.

Q: For the Oxford vaccine, if a patient has had exposure to the adenovirus and developed immunity to it, would that make the vaccine ineffective in that patient? Isn't the adenovirus a common "cold" virus?

Noah: This is a different type of adenovirus, from chimps, humans would not have seen that.

Q: None of the vaccines are interchangeable. Wondering why Pfizer and Moderna cannot be interchanged?

Noah: We just know nothing about this.

Q: If two patients are vaccinated, must they still isolate from one another or can they bubble once they've had the vaccine?

Noah: This is a great question. Recommendations are still to follow public health guidance, but I believe this will evolve.

Q: You mention 6 weeks to see risk, but If mRNA vaccines are a new type of vaccine, how can we compare to older vaccines in terms of risks and long term side effect concerns?

Noah: Because the mRNA and the spike protein are long long gone. They are gone within minutes to hours. All that is left is the immune response/memory just like with other vaccines.

Q: What about patients who are undergoing chemotherapy? Can they have the vaccine during chemo treatment?

Noah: It is likely they will have a limited response.

Q: There was news about the death of a doctor in the US after COVID-19 vaccination by developing thrombocytopenia, what could be the reason for this?

Noah: This is a reason to monitor. There have been no other signals of ITP but ongoing surveillance is needed.

Q: Do we need the COVID vaccine every year or only once? Does vaccination confer protection past 6-9 months or will we need a vaccine annually?

Lynora: Duration of protection is not yet known (trials started last summer) some think it may be long lived, but a booster could potentially be required. Also, virus changes may warrant revaccination.

David: Unknowable…we have only been giving vaccines for a few months in trials.

Q: What are the recommendations surrounding asymptomatic transmission post-vaccination?

Noah: Right now the recommendation is to continue following public health guidance until we know more.

Q: Where can we find the data and/or what is the evidence that supports a booster dose at 42 days instead of the 21-28 days.

Noah: In addition to what Peter said, there is a recommendation and justification on the NACI website.

Q: How does the rate of side effects from covid vaccine compare with the rate of side effects with other vaccines?

Noah: Less than 4hingrix.

Q: How soon will there be COVID-19 vaccine for kids, especially those involved in contact sports, i.e. hockey?

Noah: We may have results by summer for kids.

Q: Can you comment on vaccine hesitancy in populations that have deep-rooted distrust of the healthcare system?

Noah: This is a really important point. Hesitancy and lack of trust are readily understood from a structural/systemic point of view. It is important to partner, legitimately partner, with different communities through trusted sources.

Q: How long alcohol should be avoided after receiving two doses of Pfizer vaccine to maximize the efficacy?

Noah: There is no interaction to my knowledge.

Q: With regard to patients who are immunocompromised (whether through disease, meds, inherited immunoglobulin deficiency disorders, HIV etc etc), have autoimmune disorders, or have multiple risk factors (eg hypertension and DM and obesity etc), yet are under 80 and 65 years old, how can we advocate to have their vaccine prioritization raised?

Noah: The detailed prioritization framework will come out and by the time spring comes around, there will not likely be a need to prioritize because we will have lots of vaccine (I hope).

Q: If there were to be choices, what would be the best choice of vaccine for people who are immunocompromised and/or have autoimmune disorders?

David: I don't think we know enough to answer this question yet. The Pfizer and Moderna vaccines contain lipid… so VERY immunogenic. That can cut both ways in someone with autoimmune disease, but what we do know is that people who are immune compromised are at markedly greater risk of death if they get COVID, so vaccination is probably safer than non-vaccination.

Q: We could not give high dose flu vaccine to the needy – how do we expect to have vaccine for all who want it?

Noah: Canada has ordered many more vaccines than the number of Canadians. They are coming. We will eventually have more than we need.

Q: What are the dosages of colchicine and Olumiant for a patient who is tested positive for COVID-19? Can one take both together? If not, which drug is the first choice?

Lynora: Colchicine is also in the RECOVERY trial in the UK so I'd likely await confirmatory data before changing practice. No janus kinase inhibitor has been approved for use without an antiviral and I don't think data is supportive yet (Lynora)

Q: I talked to a patient who had her second dose of Pfizer and she developed swelling in the axilla of that side. Also, her neck lymph nodes were swollen on that side. She did have breast reduction surgery prior. So, is it lymphatic response?

Lynora: Lymphadenopathy has been seen as part of the vaccine immune response so I would agree that likely. In that case it should resolve over a week (or 2)

Q: Would you give the second dose after anaphylaxis to dose one?

Lynora: Anaphylaxis is a contraindication. If the reaction was unclear I'd consider referring though.

Q: Do the mRNA vaccines induce T-cell immunity?

Lynora: There is evidence they induce t-cell immunity - the degree of additional protection is unclear.

Q: Noah: why does MTX need to be stopped for the flu shot and not this vaccine?

Noah: I mean, we have no data here. The recommendations are generic. I think these patients need counselling and discussion of options.