Letters to the editor

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Correction to quote attribution

I read the BCMD2B article, "Using the beneficence model as an ethical approach to surgical decision making: A case report," in the December issue of the *BCMJ* [2020:62;380-383,385]. Very timely and useful indeed, but I would like to point out that the dictum "first, do no harm," belongs to Hippocrates, not to Aristotle, as stated in the article.

—Miguel Lipka, MD, CCFP(EM)

The source of this famous dictum isn't at all clear. A remarkable amount of scholarship exists but none of it is yet conclusive. –ED

The lost art of physical examination

As we rush enthusiastically into the new age of virtual medicine, I am wondering what we are losing. I hear stories of patients receiving a telephoned prescription for penicillin, for a sore throat, unseen and unswabbed. Or for something that "sounds like" bronchitis. Another patient with right upper quadrant discomfort was treated with liver function tests and an ultrasound, but no examination. A tender breast lump? How about mammography plus or minus ultrasound?

I know I'm a dinosaur—a throwback to past generations of family medicine—but I foresee perils. It's not enough for the MOA at the end of the line to ask, "Do think you need an appointment?" Neither the patient nor the MOA should be held responsible to answer that question. I can only hope that most GP offices are finding better ways of dealing with this issue.

—Lorne Walton, MD
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An updated look at the 16-week window between doses of vaccines in BC for COVID-19

In accordance with new recommendations from the National Advisory Committee on Immunization, British Columbia has extended the interval between first and second doses up to 16 weeks for all currently approved COVID-19 vaccines in Canada.[1] In light of this change—developed to maximize the number of individuals receiving their first doses of the COVID-19 vaccine—we have updated our review of the literature.

Real-world data have emerged from jurisdictions that extended their gap between the first and second doses.[2,3] The United Kingdom approached vaccination with a planned 12-week dosing gap. In a UK preprint report (not yet peer reviewed), 60% to 70% protection was achieved in adults over the age of 70 after only one dose of either the Pfizer-BioNTech or Oxford-AstraZeneca vaccine.[4] This protection was sustained up to the maximum follow-up period of 56 and 41 days respectively, albeit with limited numbers at the longer durations. Protection against symptomatic disease was further increased to 85% to 90% following the second dose of Pfizer-BioNTech vaccine.[5] Among those who were symptomatic, the risk of hospitalization and death was reduced by 44% and 51% respectively, after a single dose of Pfizer-BioNTech, compared to an unvaccinated group.[4] These data are encouraging when you consider that the UK variant (VOC 202012/01) was dominant during the study period.

A single vaccine dose clearly reduces COVID-19 infection, hospitalization, and death.

There are also multiple reports confirming what was seen in clinical trials: protection begins around 2 weeks after dose 1 and is sustained thereafter for the duration studied.[5,6] Encouragingly, asymptomatic disease and viral loads also appear to be reduced after the first vaccination dose.[5] However, given that less than 4 months have passed since the vaccine was approved in any jurisdiction, longer-term data are not yet available. While there is biologic plausibility to surmise that these novel vaccines might provide months of protection like other protein-antigen based vaccines (e.g., HPV),[7,8] preprint data from Scotland show higher vaccine efficacy at day 28 to 34 compared to day 35 to 42 following a single dose of Pfizer-BioNTech or Oxford-AstraZeneca.[9] The significance of this, or whether there is a further decline in immunity beyond day 42, is not yet known.

A single vaccine dose clearly reduces COVID-19 infection, hospitalization, and death. When supplied to a wide enough population, transmission is also curtailed.[5] Although there is a lack of data to directly support a 16-week gap compared to shorter intervals, in the current setting of vaccine scarcity, it appears reasonable to accept the risk of an extended dosing interval in order to more rapidly provide protection to a greater proportion of the population. Vigilance will be key in determining whether this practice can continue safely while vaccine supply is limited; if the extended gap is found to put those waiting for dose 2 at excessive risk, then a shorter interval would need to be reconsidered.

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