

News

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COVID-19 vaccine registry for pregnant and breastfeeding individuals in Canada

While COVID-19 clinical trials with pregnant and breastfeeding individuals are now underway, initial trials did not include these populations, and the risks and benefits of COVID-19 immunization for pregnant and breastfeeding people remain largely unknown. To fill the knowledge gap, UBC researchers have launched a COVID-19 vaccine registry and survey across Canada to collect real-time data on the impact of immunization on pregnant and breastfeeding individuals.

Working with researchers across the country, and with support from the Canadian Institutes of Health Research (CIHR) and the Public Health Agency of Canada (PHAC), a UBC team is leading the national surveillance project, called CANCOVID-Preg. The project will provide those who are pregnant and breastfeeding, health care providers, the PHAC, National Advisory Committee on Immunization (NACI), and provincial vaccine advisory committees with Canadian data on safety and effectiveness to guide decisions and recommendations. It will also address unknowns surrounding COVID-19 vaccination in pregnancy and lactation, such as the immune response generated and whether or not immunity is transferred to infants.

Experts in the field, including the Society of Obstetricians and Gynaecologists of Canada and NACI, recommend individuals be offered the COVID-19 vaccine anytime during pregnancy or while breastfeeding.

The project is funded by the PHAC through the Vaccine Surveillance Reference Group and the COVID-19 Immunity Task Force. It is being conducted in partnership with vaccine surveillance efforts across Canada, including

CANVAS (<https://canvas-covid.ca>), a national web-based platform monitoring vaccine safety across all populations.

How to take part

People who are currently pregnant or breastfeeding are invited to register to take part in the vaccine study. Participants do not have to have received a COVID-19 vaccine, nor do they have to intend to receive the vaccine. To participate in the registry and survey, visit <https://covered.med.ubc.ca>.

For additional information about pregnancy and COVID-19, interim reports from the CANCOVID-Preg study can be found at <https://ridprogram.med.ubc.ca/canCOVID-preg>.

Limitations of infrared thermography make skin-surface temperature scans an unreliable COVID-19 detection tool

Used to generate a heat map of infrared radiation emitted by heat sources, such as body temperature, infrared thermography (IRT) scans have become the go-to for mass detection of illnesses such as COVID-19. The limitations of this technology are revealed in research findings recently published in the *Journal of Medical Imaging*.

Led by Dr Babak Shadgan, a researcher at the Vancouver Coastal Health Research Institute, the study concluded that IRT relies too heavily on detecting high fever, which is only one of several symptoms of an active and well-developed COVID-19 infection. Underlying health conditions, stress, pregnancy, certain medications, and other environmental factors, such as temperature and humidity, can also alter someone's surface body temperature. He notes that this can result in a false positive or false negative IRT reading.

Shadgan's research reviewed 17 published studies on the effectiveness of IRT screening at airports around the world between 2002 and 2021. He found that the noncontact thermometer's ability to detect SARS, dengue fever, swine flu, Ebola, and COVID-19 varied significantly. However, Shadgan admits that until a better rapid, non-invasive, affordable detection method becomes available, IRT will likely continue to be part of the disease detection toolkit.

He suggests that IRT can continue to be used if there is no other option, but that its results should not be relied upon exclusively. IRT is only really effective at detecting individuals who are symptomatic with a high fever. It does not detect asymptomatic individuals or infected individuals with only a slight rise in body temperature.

IRT has sometimes been paired with pulse oximetry to improve disease detection, which uses a fingertip sensor to detect oxygen saturation in a person's bloodstream. Oxygen levels below 95% are found among people with pneumonia—another symptom of a severe COVID-19 infection.

Core body temperature is also a more accurate indicator of a COVID-19 infection, notes Shadgan. The limitations of present screening tools do, however, pose a challenge. To address this, Shadgan is developing a novel biosensor to take COVID-19 disease detection further. The noninvasive, simple-to-use, accurate biosensing device could be used for regular and routine COVID-19 screening and early diagnosis. Individuals with underlying health conditions, such as heart or liver disease, immune deficiency, diabetes, or cancer, could use the biosensor on a regular basis to check if they have COVID-19 symptoms.

The study, "Review of the efficacy of infrared thermography for screening infectious diseases

with applications to COVID-19,” is available at www.ncbi.nlm.nih.gov/pmc/articles/PMC7995646.

Planning a birth after C-section made simpler

My Next Birth is a personalized online interactive patient decision aid now being used throughout BC to help people who have previously had a C-section make better-informed decisions about navigating their next pregnancy and birth. Over 75% of people in BC who have had a C-section are good candidates for a vaginal birth after cesarean, but families often have to wait until the next pregnancy to start discussing options with their care team. People want to learn about their options for their next birth sooner. Researchers conducted a series of qualitative studies and surveys in BC and found that families and care teams needed more support when exchanging information.¹⁻⁴ Families wanted to know what the reasons were for their first C-section. Was it from something unexpected that happened during labor? Is this

something that might happen again in the future? What are the options for their next birth?

The program helps them think about their preferences and jot down their questions, and it provides tailored information specific to their values and needs. It also factors in where they live in BC so they can consider what resources are available locally. After they work through the website, they receive a personalized summary to guide conversations and questions with their health care team.

The program also provides tools for health care teams, including a decision support algorithm that walks the care provider through the patient’s journey and a list of conversation prompts to guide discussions after a C-section. The hope is that the program can be a support for families to be active participants in their care.

Dr Sarah Munro, an assistant professor in obstetrics and gynecology, developed the program with her team at UBC in partnership with Perinatal Services BC, provincial health authorities, the Ministry of Health, as well as patient partners. For more information, visit www.perinatalservicesbc.ca/health-professionals/professional-resources/birth-after-caesarean.

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LETTERS

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reports are the substrate from which larger, more generalizable studies can be justified. Some of the information may have not been new to people who work extensively in the field of addictions. However, the article was published in a general medical journal for physicians who may not have extensive experience in the field. By engaging with a person with lived experience, we were able to share his unique experiences and perspectives, which may inform areas of future research and strategies to improve health care for vulnerable populations.

We used the name “John Doe” to protect the identity of the individual. We had the information to provide much more context, but given the word count limitations of the article, the need to protect John Doe’s identity, and the fact that we were publishing in a general medical journal, we focused on reporting his observations and opinions of the illicit drug trade rather than more personal characteristics.

As for what qualified John Doe as a reliable source, he was convicted in a court of law for distribution of crystal methamphetamine and fentanyl in the Downtown Eastside during the COVID-19 pandemic. Since this was the topic of the case report, we believe that qualified him to speak about the topic. His account was consistent with external data points, such as court records and collateral sources, where available. Further, there are many examples of the experience of people who use drugs in the medical literature but very few examples of people who sell drugs. The goal of the article was to highlight the lived experience of someone who sold drugs, not people who use drugs, during a unique time in history such as the COVID-19 pandemic.

There was no pre-existing relationship between the physician interviewer and John Doe. In a forensic evaluation, the forensic psychiatrist is to maintain neutrality and objectivity in their

assessment of all patients. The forensic evaluation is done voluntarily, and before the evaluation can begin, it must be determined that the patient has the capacity to consent. During the forensic evaluation, John Doe raised the topic of illicit drug trade in the Downtown Eastside during the COVID-19 pandemic. He was then asked whether he wanted to share his insights for a case report. His participation was completely voluntary, and he was assessed to have the capacity to consent to the case report. As reported in our article, written informed consent was obtained from him. He voluntarily agreed to share his information because, in his words, “I want to provide information that hopefully can prevent overdoses and save someone’s life. I think it’ll be useful for the medical community.”

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