TE WAIORA Nelson Marlborough Health

DHB Office
Braemar Campus

Private Bag 18
Nelson, New Zealand

29 April 2022

[redacted]

Response to a request for official information

[redacted]

Thank you for your request for official information as received 7 December 2021 by Nelson Marlborough Health (NMH)[1], followed by the necessary extension of time 25 January 2022 and notice of decision 16 February 2022, where you seek the following information.

NMH Frame of reference: We interpret the term "Spike Protein" in your request is used interchangeably to refer to either the COVID-19 disease or the COVID-19 vaccine and, where applicable, we have responded under *'COVID-19 disease'* and *'COVID-19 vaccine'* (all vaccinations administered and entered into the national COVID Immunisation Register).

1. ***The number of Spike Protein (Covid or Pfizer Vax injury) cases reported each day in Nelson and Marlborough from 1 April 2021. Please report as Covid, Vax or both with whatever criteria and information you can provide including age, sex, symptoms etc.***

NMH response:

COVID-19 disease
There have been 26 cases of COVID-19 in Nelson Marlborough from 1 April 2021 to 15 December 2021.
Gender: 73% were male, 27% female.

COVID-19 vaccine
The total number of adverse vaccine reactions reported in the COVID Immunisation Register from 1 April 2021 to 6 December 2021 is 779. Of these, 650 were classified by the reporting clinician as Mild, 122 as Moderate, and 7 as Severe. Three were from AstraZeneca (average adverse reaction rate 2.61%), the remainder from Pfizer (average adverse reaction rate 0.30%).
- 50.2% of reactions were primarily dizziness or faintness
- 9.9% were primarily numbness or tingling
- 6.6% were primarily nausea.

23 hospital visits were coded as COVID-19 vaccine related. Of these, 8 resulted in admission to hospital.

Please also note that the Centre for Adverse Reactions Monitoring (CARM) website provides extensive breakdown of all reported adverse events that may be attributed to the COVID-19 vaccines that occur beyond the immediate post-vaccination period in order to monitor for safety signals.

[1] Nelson Marlborough District Health Board

2. ***The dates of admission and discharge of each Spike Protein / Covid/ Vax injury case to Nelson and Marlborough hospital. Please include so far as possible the dates in hospital and dates of transfer between ED, ICU, Ward 9 etc and where possible whether the admission was attributed to Covid or to the PfizerVax or both and;***

NMH response:

COVID-19 disease
Due to low numbers (<3 individuals) this information is withheld under section 9(2) of the Act to *'protect the privacy of natural persons, including that of deceased natural persons'.* In the circumstances, the withholding of that information is not outweighed by other considerations which render it desirable, in the public interest, to make that information available.

COVID-19 vaccine
Case 1: Admitted 22/04/2021, discharged 23/04/2021
Case 2: Admitted 15/06/2021, discharged 17/06/2021
Case 3: Admitted 10/08/2021, discharged 11/08/2021
Case 4: Admitted 17/08/2021, discharged 18/08/2021
Case 5: Admitted 31/08/2021, discharged 03/09/2021
Case 6: Admitted 31/08/2021, discharged 02/09/2021
Case 7: Admitted 13/09/2021, discharged 15/09/2021
Case 8: Admitted 30/11/2021, discharged 01/12/2021

3. ***For each SpikeProtein (whether Covid or PfizerVax) admission to any NMDHB facility, the symptoms and time between first diagnosis and/ or most recent PfizerVax***

NMH response:

COVID-19 disease
Due to low numbers (<3 individuals) this information is withheld under section 9(2) of the Act to *'protect the privacy of natural persons, including that of deceased natural persons'.* In the circumstances, the withholding of that information is not outweighed by other considerations which render it desirable, in the public interest, to make that information available.

COVID-19 vaccine
Admitted patients were diagnosed between 0 – 4 days of their most recent COVID-19 vaccination, and were classified with one of the following conditions-

- Other complications following immunisation, not elsewhere classified
- Anaphylaxis and anaphylactic shock due to adverse effect of correct drug or medicament properly administered
- Gastric ulcer, chronic or unspecified with haemorrhage
- Diseases of the circulatory system in pregnancy, childbirth and the puerperium
- Other and unspecified abnormalities of heart beat

4. ***The number of Spike Protein (Covid or PfizerVax) deaths in Nelson and Marlborough***

NMH response:
COVID-19 disease
Due to low numbers (<3 individuals) this information is withheld under section 9(2) of the Act to *'protect the privacy of natural persons, including that of deceased natural persons'.* In the circumstances, the withholding of that information is not outweighed by other considerations which render it desirable, in the public interest, to make that information available.

COVID-19 vaccine
Nil.

5. ***Any NMDHB treatment protocols for treating Covid and or Spike Protein / PfizerVax injuries***

NMH response:

COVID-19 vaccine
Please see attached NMH Guideline *Anaphylaxis – Emergency Management.*

6. ***The blood testing and any other test protocols for suspected or possible Spike Protein injuries and the criteria for using different tests including D-dimer test on recent strokes, heart attack, blood clots etc especially if patients have recently received the PfizerVax.***

NMH response:
COVID-19 disease
We follow national protocols and guidance on the management of the disease.

COVID-19 vaccine
Investigations will be directly related to the clinical syndrome with which the patient presents for assessment. No specific tests will assist in the analysis for any role of recent vaccination in the clinical presentation.

7. ***Any information about incidence of admissions for clotting, bleeding or other harm that may be attributed to the Spike Protein since February 2021.***

NMH response:
Please refer to our response to Question 3.

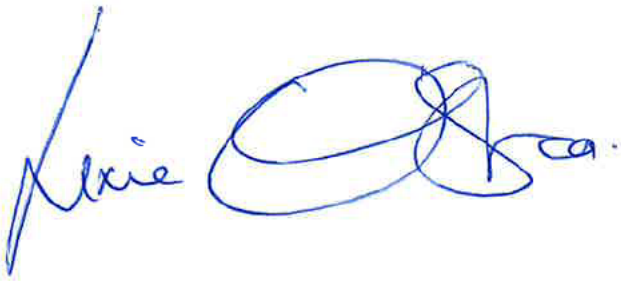
8. ***Any reports from health care staff, coroners, funeral directors, retirement villages etc of any changes in incidence of any of the above.***

NMH response:
NMH does not collect information from funeral directors and Coroners; Coronial Services of New Zealand prepares information about coronial cases. Any patient related information from healthcare staff or retirement villages is not held in a form that is readily retrievable from Patient management System and, under section 18(f), *'the information requested cannot be made available without substantial collation and research'*. It would take a significant amount of time and resources to extract and manually review individual patient files to collate any such information.

This response has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone 0800 802 602. If you have any questions about this decision please feel free to email our OIA Coordinator OIArequest@nmdhb.govt.nz

I trust that this information meets your requirements. NMH, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released. If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider.

Yours sincerely



Lexie O'Shea
Chief Executive

Encl: NMH Guideline: *Anaphylaxis – Emergency Management*

Nelson Marlborough District Health Board

Emergency Departments – NMDHB

Anaphylaxis – Emergency Management

Adapted from Australasian Society for Clinical Immunology and Allergy's (ASCIA's) Anaphylaxis Management Wall Chart 2011

Clinical features	Any acute onset of hypotension or bronchospasm or upper airway obstruction where anaphylaxis is considered possible, even if typical skin features are not present	**OR**	Any acute onset illness with typical skin features (urticarial rash or erythema/flushing, and/or angioedema)	**PLUS**	Involvement of respiratory and/or cardiovascular and/or persistent severe gastrointestinal symptoms

1 Immediate action

- Remove allergen (if still present)
- Call for assistance
- Lay patient flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.

2 Give INTRAMUSCULAR ADRENALINE into mid-lateral thigh without delay

Adrenaline Dose Chart (1:1000 ampoules)

Age (years)	Weight (kg)	Adrenaline volume 1:1000
<1	5 –10	0.05–0.1 mL
1–2	10	0.1 mL
2–3	15	0.15 mL
4–6	20	0.2 mL
7–10	30	0.3 mL
10–12	40	0.4 mL
>12	>50	0.5 mL

Autoinjectors

An adrenaline autoinjector (EpiPen or Anapen) may be used instead of an adrenaline ampoule and syringe.

For children 10–20 kg (aged ~1–5 years), EpiPen Junior or Anapen Junior should be used.

Repeat doses every 5 minutes as needed

If multiple doses required or a severe reaction, consider adrenaline infusion

3 Supportive management

When skills and equipment available:

- Monitor pulse, blood pressure, respiratory rate, pulse oximetry
- Give high flow oxygen and airway support if needed
- Obtain intravenous access in adults and in hypotensive children
- If hypotensive, give intravenous normal saline (20 mL/kg rapidly) and consider additional wide bore intravenous access

For additional measures see below

4 Additional measures

Adrenaline infusion

If inadequate response or deterioration, start an intravenous adrenaline infusion as follows:
Give only in liaison with an emergency medicine/medical/paediatric SMO

- Mix 1 mL of 1:1000 adrenaline in 1000 mL of normal saline
- Start infusion at ~5 mL/kg/hour (~0.1 microgram/kg/minute) ** See NMDHB ED Adrenaline Infusion Guideline
- Titrate rate according to response
- Monitor continuously

CAUTION – Intravenous boluses of adrenaline are not recommended due to risk of cardiac arrhythmia

If the adrenaline infusion is ineffective, consider:

For upper airway obstruction

- Nebulised adrenaline (5 mL i.e. 5 ampoules of 1:1000)
- Consider intubation if skills and equipment are available

PTO

For persistent wheeze

- Bronchodilators: Salbutamol 6 –12 puffs of 100 microgram using a spacer OR 5 mg salbutamol by nebuliser
- Oral prednisone 1 mg/kg (maximum 50 mg) or intravenous hydrocortisone 5 mg/kg (maximum 200 mg)

For persistent hypotension/shock

- Give normal saline (maximum 50 mL/kg in the first 30 min)
- In patients with cardiogenic shock (especially if taking beta blockers) consider an intravenous glucagon bolus of 1–2 mg in adults (in children: 20–30 microgram/kg up to 1 mg). This may be repeated or followed by an infusion of 1–2 mg/hour in adults
- In adults, selective vasoconstrictors metaraminol (2–10 mg) or vasopressin (10–40 units) only after advice from an emergency medicine/physician

5 Observation

Prolonged and biphasic reactions may occur

Observe patient for up to 4 hours after last dose of adrenaline

Observe longer (overnight) if patient:

- had a severe reaction (hypotension or hypoxia) or
- required repeated doses of adrenaline or
- has a history of asthma or protracted anaphylaxis or
- has other concomitant illness or
- lives alone or is remote from medical care

6 Follow-up treatment

Antihistamines

Antihistamines have no role in treating respiratory or cardiovascular symptoms of anaphylaxis. Oral non-sedating antihistamines may be given to treat itch and urticaria. Injectable promethazine should not be used in anaphylaxis as it can worsen hypotension and cause muscle necrosis.

Corticosteroids

The role of corticosteroids is unknown. It is reasonable to prescribe a 2 day course of oral steroid (e.g. prednisone 1 mg/kg, maximum 50 mg daily) to reduce the risk of symptom recurrence after a severe reaction or a reaction with marked or persistent wheeze.

Adrenaline autoinjector

Prescribe an autoinjector. Train the patient in autoinjector use and give them an ASCIA Action Plan for Anaphylaxis (see Australasian Society of Clinical Immunology and Allergy website www.allergy.org.au)

Paediatric patients should be referred to the Public Health nurse

Referral

Adults: Refer patients back to GP for follow up and further investigation as necessary

Paeds: Refer to Paeds OPD for definite anaphylaxis (if not admitted)

References:

Australasian Society for Clinical Immunology and Allergy's (ASCIA's) Anaphylaxis Management wall chart 2011, Australian Prescriber, August 2011, Vol 34 No 4

Brown SGA. Anaphylaxis: Clinical concepts and research priorities. EMA 2006; 18:155-169

Endorsed by the Australasian Society of Clinical Immunology and Allergy, the Royal Australasian College of Physicians, the Royal Australian College of General Practitioners, the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Radiologists, the Internal Medicine Society of Australia and New Zealand, and the Australian Dental Association

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Date for Review	Position: Emergency Physician	