Referential


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Accuracy of Recommendations in the Infectious Diseases Society of America Clinical Practice Guidelines for Lyme Disease

To the Editor—I read with interest the recently revised Infectious Diseases Society of America guidelines for the diagnosis and management of Lyme disease [1]. Several significant inaccuracies were noted.

The statement was made that “there is no convincing biologic evidence for the existence of symptomatic chronic B. burgdorferi infection among patients after receipt of recommended treatment regimens for Lyme disease” [1, p. 1094]. This is clearly contradicted in a report by Phillips et al. [2], in which Borrelia burgdorferi bacteremia was confirmed using fluorescent antibody immunoelectron microscopy in 91% of 47 symptomatic patients who had experienced relapse after receiving oral and intravenous antibiotic therapy. This research was, in fact, cited by Klempern et al. [3] in the “Laboratory Studies” section of their report; however, the actual point of the article seems to have been missed—namely, that organisms may persist despite “standard therapy.” Persistent or relapsing symptoms may therefore, be due to active infection rather than to slow resolution of inflammation, and this may be the basis for some of the panel’s observations that a second course of treatment may be needed for some patients.

Second, the guidelines state that “there is no convincing evidence in North America for the persistence of B. burgdorferi in the skin of humans after treatment with antibiotic regimens known to be active against B. burgdorferi in vitro” [1, p. 1117]. Although reported from Europe, the findings of Hunfeld et al. [4], in which repeat skin biopsy cultures were still positive after treatment, suggest that the same phenomenon could be observed in North America, particularly because the in vitro sensitivities that they observed did not indicate resistance on the basis of increasing MICs.

Third, the statement is made that “because of a lack of biologic plausibility, lack of efficacy, [and] absence of supporting data… the following are not recommended for treatment of patients with any manifestation of Lyme disease:… benzathine penicillin G…and others” [1; p. 1094]. This is contradicted by Dr. Steere’s own data [5, 6], in which benzathine penicillin G was used successfully in the treatment of established arthritis. Although the success rate appeared to be modest (35%), therapy with benzathine penicillin was clearly more effective than placebo, which was associated with no improvement (P < .02). Therefore, some patients may respond to this treatment. Whether this therapy can be applied to other extra-articular manifestations of Lyme disease should be studied.

Fourth, the specific recommendations regarding the use of oral doxycycline omitted the important issue of reduced bioavailability when the drug is coadministered with free calcium. This could explain the apparent “failure” of tetracycline treatment in some patients who were not advised to restrict calcium intake for several hours before and after the drug’s administration.

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Concerns Regarding the Infectious Diseases Society of America Lyme Disease Clinical Practice Guidelines

To the Editor—The Canadian Lyme