
Patients with Lyme borreliosis are failing to receive treatment

OPINIONS

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Is Lyme borreliosis correctly diagnosed and treated?

After contact with a number of patients I can state that not infrequently, patients with suspected Lyme borreliosis with no pathological findings in cerebrospinal fluid are told that they do not have Lyme neuroborreliosis, nor any other form of Lyme borreliosis that can be treated with antibiotics. Complex disease pictures are generally involved, with muscular and joint pain, fatigue, and often memory and concentration impairment. In the article by Roaldsnes and colleagues in the Journal of the Norwegian Medical Association, a total of 110 patients assessed for possible Lyme neuroborreliosis had 'non-specific neurological symptoms' such as prolonged fatigue, concentration problems and myalgia [\(1\)](#). Only one patient was diagnosed with possible Lyme neuroborreliosis. Altogether 27 % had high levels of borrelia-IgG serum antibodies. No mention is made of the fact that it would also have been relevant to consider alternative disease courses of Lyme borreliosis. Many of the patients had suffered symptoms for more than one year, and it is difficult to read the article in any other way than this: that if a patient has had these symptoms for such a prolonged period, Lyme borreliosis is not a relevant diagnosis. The same message is repeated in an editorial, which concludes that patients who do not fulfil the diagnostic requirements for active Lyme neuroborreliosis, irrespective of antibody level or anamnesis, should not be 'incorrectly treated with antibiotics' [\(2\)](#).

A prolonged disease picture that includes fatigue, myalgia and elevated borrelia-IgG serum antibody levels does not constitute a non-disease. Some neurologists deny the existence of musculoskeletal borreliosis. However, the term is used by Allen Steere, the 'father' of Lyme borreliosis [\(3\)](#). If they are left untreated, it is impossible to know whether these are patients who would profit from standard, targeted antibiotic therapy. I

have seen many of these patients, and I believe that they should be treated. In my experience, their symptoms often recede slowly, without this being an indication for especially long-term antibiotic therapy. The improvement is most likely associated with normalisation of cytokines and elimination of borrelia-specific immune complexes over time. Unfortunately we currently have no tests available that enable monitoring of these markers during convalescence. Population studies of borrelia seropositivity ought not to be used to adopt a position that is opposed to treatment in clinically suspected cases with positive serology (4). Nevertheless, consideration of another disease course than Lyme neuroborreliosis appears to be excluded (1). Unfortunately, an article from the Netherlands is also included as support for this position (2, 5). I have previously commented on the critical weaknesses of this study (6).

It is a serious matter that due to a lack of follow-up here in Norway, we encourage medical tourism to centres abroad where, based on current knowledge, treatment programmes are unjustifiable from the standpoint of infectious disease medicine, or based on a desire to reduce antibiotic use. Clinical manifestations of Lyme borreliosis vary widely (3). Based on my long experience with a large number of Lyme borreliosis cases, I believe that each patient must be assessed individually. By failing to do this, we do many patients an injustice.

LITERATURE

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