

Re: No prolonged antibiotic therapy for disease attributed to borreliosis

I have previously commented on an editorial review of a publication from the Netherlands on the topic of borreliosis treatment (1). In issue 16/2016 of the Journal of the Norwegian Medical Association, a response was given by Randi Eikeland at the Norwegian National Advisory Unit on Tick-Borne Diseases (2). I agree, of course, that patients who have no documented or likely borrelia infection should not receive prolonged antibiotic treatment, nor should they receive short-term treatment. My point is that the study reviewed does not necessarily lead to the conclusion that a two-week course of antibiotics for Lyme borreliosis will always suffice.

If we interpret the title's formulation «symptoms attributed to Lyme disease» to mean that in reality, Lyme borreliosis is not involved, but rather various symptoms that the patients would like to attribute to this cause, there is hardly any disagreement between Eikeland and myself. I persist in my claim that the Dutch article includes patients who cannot reasonably be thought to have active Lyme borreliosis. In my first article I pointed out the absence of serological confirmation. In all three groups, the median duration of symptoms exceeded two years. In the groups, altogether 32, 36 and 41 % (!) respectively had no IgG in their *Borrelia burgdorferi* serology after all this time. When considering that approximately 90 % of the patients also suffered from arthralgia or other musculoskeletal symptoms that normally result in a reliable IgG response, it is obvious that the investigators ought not to be «certain that the person had an active borrelia infection as the reason for their chronic symptoms,» as claimed by Eikeland (3).

In the *Läkartidningen*, the *NEJM* article has been editorially assessed and commented upon under the heading *Längre tid med*

antibiotika förbättrade inte borreliasymtom [Longer periods of antibiotic treatment failed to improve symptoms of borreliosis] (4). Most readers will take this to mean that in general, Lyme borreliosis does not require treatment in excess of two weeks. I have received comments from Norwegian doctors expressing the same concern. This is not in line with recommendations from competent quarters, and will entail poor treatment of several categories of borreliosis. Suffice it to mention conditions such as acrodermatitis chronica atrophicans, late-diagnosis neuroborreliosis and arthritis, all of which ought to be treated for four weeks. Norwegian recommendations indicate the same (5).

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References

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