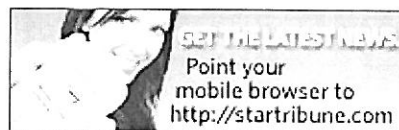


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Elizaeth Maloney: We've much to learn about Lyme disease

Assertions in a recent article were based on unreliable evidence.

By ELIZABETH MALONEY

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The April 12 article about the resolution passed by the Minnesota Board of Medical Practice ("Activists and doctors divided over Lyme disease treatment") brought many questions to mind, including: "When did the Star Tribune morph into Fox News?" The article used buzzwords and themes known to inflame physicians, and it misled readers regarding the professional credentials and capabilities of physicians who recognize that persistent/chronic Lyme exists.

I am a family physician who has spent the last several years researching and developing educational materials and programs on Lyme disease; my current course for primary care physicians is accredited for six continuing medical education credits by the American Academy of Family Physicians.

Lyme disease is a relatively new illness. Our scientific understanding of it continues to

evolve, yet basic questions remain unanswered. For example, we lack reliable diagnostic tests and tests of cures. Until we can separate the infected from the noninfected and the cured from the uncured, arguments over diagnostic and treatment approaches will continue.

This is especially true when it comes to the medical management of patients who remain ill after receiving commonly prescribed courses of antibiotics. Persistent infection has been demonstrated in multiple animal models and human case reports, and two schools of thought have developed.

The Infectious Diseases Society of America (IDSA) takes a narrow view, offering limited treatment options. The International Lyme and Associated Diseases Society takes a broad view, believing that doctors can best determine who should be treated and in what manner.

The IDSA is concerned about the "overuse" of antibiotic treatment in patients with persistent symptoms. It states that the evidence doesn't support additional antibiotics and recommends against retreatment. The conclusions are based on the results of four retreatment trials funded by the National Institutes of Health. However,

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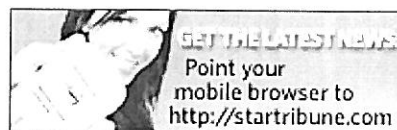
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a careful reexamination of that evidence found that two of the studies were so improperly designed that they should be ignored. The other two demonstrated one patient type that benefited from additional treatment.

Thus, while the IDSA's viewpoint was emphasized in the April 12 article, it isn't scientifically valid. This may surprise the many physicians who follow the IDSA guidelines on Lyme disease. But science and medicine are supposed to be based on the facts, not on majority rule, and the evidence clearly demonstrates that retreatment helps some patients.

What we don't know is who else should be offered additional antibiotic treatment and what form that treatment should take. Studies to answer these questions have yet to be done, but today's patients can't wait for tomorrow's research.

Until we have answers, doctors caring for patients must do so to the best of their ability. Practice guidelines may present a reasonable starting point, but recommendations made on a generalized basis should never be substituted for the clinical judgment of the doctor treating an individual patient. Treatment decisions

should be based on the health, financial and quality-of-life costs associated with ongoing, untreated Lyme disease, as well as on the risks associated with treatment. All medical treatments carry risks; in general, the risks of carefully managed antibiotic treatment are low.

The argument over treatment recently came before the Minnesota Board of Medical Practice. In March, the board passed a resolution placing a five-year moratorium on investigations based on third-party complaints concerning the prescription of long-term antibiotics. While the board was reportedly reluctant to pass its resolution, I applaud its leadership. The moratorium preserves the board's authority and buys time for additional scientific information to come to light. I'm confident we will learn much in the five years the board set aside.

The tone and material of the April 12 article may move papers and search engines, but it doesn't serve the public or medical communities. To my medical colleagues, let me suggest this: Rather than waste energy on what divides us from our patients and each other, let's put rhetoric aside and go after the real adversary, Lyme disease.

Elizabeth Maloney, of Wyoming, Minn., is a

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