

## Lyme Wars: Lyme Disease Expert Critical of New Treatment Guidelines

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Mount Kisco, NY (OPENPRESS) November 28, 2006 -- A nationally-recognized expert in the study and treatment of patients with Lyme Disease, Dr. Daniel Cameron, a New York internist, epidemiologist and medical author, is criticizing the recently-released Lyme treatment guidelines published by the Infectious Diseases Society of America (IDSA). He is not alone. Other professional medical organizations and the Lyme Disease Association are vehemently questioning the new guidelines, and, the Connecticut Attorney General has taken unprecedented legal action.

Cameron says, "The guidelines are based on flawed assumptions. The guidelines recommend against treating Lyme disease patients more than once, possibly leaving them chronically ill."

"The clinical assessment, treatment, and prevention of Lyme disease, human granulocytic anaplasmosis, and babesiosis: Clinical practice guidelines by the Infectious Diseases Society of America (IDSA)," is co-authored by Dr. Gary Wormser, chief of the division of infectious diseases at Westchester Medical Center and the affiliated New York Medical College in Valhalla, NY. The last IDSA guidelines were published in 2000.

During his two decades in the Northeast, Cameron has seen Lyme as a growing epidemic locally and throughout the US. He has seen the number of patients needing long-term treatment steadily increasing.

"It's amazing to me that Dr. Wormser and I can be seeing patients from the same pool of people and have a totally different take on this disease. I am truly concerned for the people of Westchester if someone associated with the region's academic medical center is turning their backs on the realities and complications of Lyme disease and other tick-borne illnesses," says Cameron.

The International Lyme and Associated Diseases Society (ILADS), of which Cameron is a board member, has called for a retraction of the guidelines. Cameron is the lead author of ILADS' "Evidence-based guidelines for the management of Lyme disease," published in 2004.

Seen as another accepted standard of care for tick-borne disease, the ILADS guidelines call for long-term treatment with antibiotic therapies for persistent Lyme disease or co-infection complications. According to ILADS, Lyme disease testing is more often than not inaccurate and it is up to the doctor to make a clinical diagnosis. A clinical diagnosis is one based on the physician's evaluation of the patient, his symptoms, and knowledge of the disease.

The IDSA, on the other hand, says Lyme must be diagnosed by a visible rash and/or common two-tiered blood tests, is easily treated with standard 21 to 28 days of antibiotics, and even questions the existence of chronic Lyme disease. Earlier guidelines and the CDC stated that Lyme disease is a "clinical diagnosis," supported by lab testing. The new IDSA guidelines do an about face.

Cameron reminds his colleagues, "There is no test to measure the disease infecting a patient, only a measure of antibody response which can be compromised by the action of the bacteria itself."

Cameron has just published a paper refuting assumptions by one of the quoted references in the IDSA guidelines, and has had another Lyme-related study accepted and about to be published by another peer-reviewed journal.

In "Generalizability in two clinical trials of Lyme disease" in the current issue of *Epidemiologic Perspectives & Innovations*. Cameron's "Analytic Perspective" takes aim at a commonly-cited study on long-course treatment of patients with Lyme disease. Simply known as "Klempner, et al. trials," published in the *New England Journal of Medicine* in 2001, this small study has been generalized in medical literature and certainly by insurance companies to be the be-all proof that 12 weeks of antibiotics for sick patients does not help. Cameron pulls apart the science of the study, and makes it clear that the study is not useful when dealing with a broader population.

His concern, like that of many of his colleagues, is that Guidelines published by America's large professional organizations are often seen by the medical community at large, by insurers and the Centers for Disease Control (CDC) of the National Institutes of Health (NIH), as the final word on treatment. And the wording in this one leaves very little room for the clinical diagnosis of the disease.

"The IDSA guidelines do not offer an answer for the thousands of individuals with Lyme disease left with a poor quality of life after their 21 to 30 days of treatment," says Cameron. "How can we, as scientists and physicians, turn our backs on all the things we do not yet know about this complex emerging disease and its long-term affects on individuals and our communities?"

Even if the blood tests were 100 percent accurate they cannot be performed on a patient for four to six weeks after onset - which may cause a treatment delay and its possible consequences. That is another issue tackled in Cameron's work. His next article to be published has been accepted by the *Journal of Evaluation in Clinical Practice*.

"Consequences of Treatment Delay in Lyme Disease," a research letter, discusses "the poor outcome after treatment delay (of 4 wks to 8 yrs in his study group) supports the hypothesis that treatment delay is a major risk factor for developing chronic Lyme disease."

Again, this study flies in the face of the IDSA guidelines.

Lyme Disease is America's most common and fastest growing vector-borne disease. The spiral-shaped bacteria, *Borrelia burgdorferi* (Bb), which causes Lyme Disease, can be spread by the bite of ticks carried by birds, deer, house pets and rodents. It can be transmitted through human blood and from mother to child in utero. According to the CDC, "Typical symptoms include fever, headache, fatigue, and a characteristic skin rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system. Lyme disease is diagnosed based on symptoms, physical findings (e.g., rash), and the possibility

of exposure to infected ticks; laboratory testing is helpful in the later stages of disease." (cdc.gov)

(It should be noted that human granulocytic anaplasmosis (HGA) was formerly known as human granulocytic ehrlichiosis (HGE) or its common name, ehrlichiosis.)

**Dr. Cameron is a member of the IDSA and ILADS, and is an attending physician at Northern Westchester Hospital, Mount Kisco, NY.**

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