

Roanoke Response 2005: Standard of care for Lyme is under dispute

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Thursday, October 27, 2005

Standard of care for Lyme is under dispute
Leila Zackrison, M.D.

Zackrison is a doctor in Alexandria.

Jen McCaffery's article on my hearing before the Virginia Board of Medicine was accurate but incomplete ("Shining a light on Lyme disease," Oct. 11).

As McCaffery stated, the charges of improper patient care stemmed from a very acrimonious debate within the medical community over how to treat patients suffering from Lyme disease.

At issue is the standard of care followed by most physicians (Centers for Disease Control guidelines), which is based on eradicating the Lyme spirochete during the disease's acute phase, and consists of less than a four-week course of antibiotics. This standard is successful if the diagnosis is made almost immediately after infection and if the patient is otherwise strong and healthy.

Prior to medical school, I earned a master's degree in biochemistry, and learned how to apply its research techniques to the knowledge provided by medical training and subsequent clinical observation.

Thus, I, and a minority of like-minded colleagues, have observed that if the infection occurs in patients already suffering from other diseases, the acute phase of Lyme (and other tick-borne diseases) can be masked by other symptoms or misdiagnosed and treated as something else, often under the label of fibromyalgia, chronic fatigue syndrome or similar diagnoses which share the same symptoms as Lyme.

The spirochetes, which never read the CDC guidelines anyway, remain in the patient's body, entering a longer-lasting or chronic phase.

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Their life-cycle is longer than four weeks, and they prefer to hide in places that have low blood flow and thus are difficult to reach even with "adequate" antibiotics. It stands to reason that four-week antibiotic treatment is incapable of eradicating a six-week or longer life-cycle bacterium. Most internists in Northern Virginia and nationwide refuse to accept the fact Lyme exists in a chronic phase.

The damage caused by the complaint against me was extensive: many weeks of intense preparation for the hearing, a significant amount of lost income, declining physician-originated referrals (though patient-originated referrals are very robust), lawyer's fees, not seeing many patients who needed my type of specialized care and, worst of all, the unnecessary fear and anxiety my patients experienced over the possibility of losing the best doctor that they have ever seen.

As demonstrated in the hearing, none of the three patients were harmed. In fact, one is still under my care.

Even the Board of Medicine's expert witness concluded his comments by stating that the basis of this complaint should best be dealt with by debate and research within the medical community, not by a disciplinary hearing.

I was exonerated because it was clear during the hearing that I know what I am doing, I am a capable diagnostician and I have a higher rate of success with immuno-compromised patients — especially with Lyme patients — than do those physicians who insist on using the standard of care for non-standard infections and patients with complex presentations who do not fit any standard but their own.

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