CALL FOR ABSTRACTS
VII ANNUAL SCIENTIFIC CONFERENCE ON LYME BORRELIOSIS
and other Spirochetal and Tick-borne Diseases

If you would like to present data, in poster form, please send your abstract/s to the LDF by December 31, 1993. Selected abstracts will be published in the Compendium. Abstracts should be typed within the abstract box outline. No additional pages are allowed. Please use capitol letters for the title, underline main author and include the address where research was done & the timeframe. A conference committee member will contact you regarding more information, as needed. Selections will be made by the end of February, 1994.

Category (check one):

- o Microbiology
- o Pathogenesis
- o Diagnosis
- o Clinical manifest.
- o Treatment
- o Veterinary Issues
- x Epidemiology
- o Other spirochetal, tick-borne diseases
- o Other (list) _____

CAN MS SOMETIMES BE A CHRONIC FORM OF LYME BORRELIOSIS ?

Many symptoms considered characteristic of Multiple Sclerosis [MS] are seen in some patients diagnosed with Lyme Borreliosis [LB]. The distinguishing features of an MRI used to confirm an MS diagnosis are also seen in some chronic LB patients. MS is the most common severe neurological disease of man. LB is seen with many different symptoms including many forms of neurological disease. Physicians often find it difficult to differentiate between the two diseases. Many patients are first diagnosed as having MS on the basis of MRI or symptoms and then later rediagnosed as having chronic LB. There are many dangers that can accompany this misdiagnosis. Patients who are misdiagnosed as having MS are often treated with steroids which can promote a much more rapid progression of LB than is seen in untreated patients. If patients are eventually rediagnosed as having LB and treated with antibiotics, the previous steroid treatments can sometimes interfere with the proper treatment of the LB. Fifteen years ago the treatment regimen for LB patients shifted from steroids to antibiotics enormously improving the success of the treatment..

The MRI which is often used to confirm a suspected case of MS is indistinguishable from an MRI of patients with either LB or Optic Neuritis. Optic Neuritis is most commonly seen in young women. A large majority of them will eventually develop MS. Patients with LB can also develop Optic Neuritis. Progression of LB to Optic Neuritis and of Optic Neuritis to MS is commonly seen. Their common MRI and their other inter-relationships provide evidence that LB, Optic Neuritis and MS may very well all have the same etiological agent. The etiological agent of LB is definitely a Borrelia. The etiological agent of Optic Neuritis and MS are considered by some as "unknown", but since most Optic Neuritis patients eventually develop MS it is safe to say that they may well have the same etiological agent. A neuropathologist who conducted postmortems on hundreds of MS patients over 40 years ago was able to demonstrate spirochetes in many of the MS lesions. He published -- 30 years before the same Borrelia were shown to be involved in the newly identified LB.

In Borrelia infections, the earlier in the disease that antibiotic treatments are initiated the more effective they usually are. If Optic Neuritis and MS are also Borrelia infections, they also should be treated as early as possible. Both diseases are now often treated with steroids, but much strong evidence has been published that steroids should not be used in either condition. Because of a possible or probable Borrelia etiology, the use of early antibiotic treatments of MS and Optic Neuritis patients should be considered by physicians. Some practitioners have treated many MS and Optic Neuritis patients with antibiotics with greater success than with any standard steroid treatments. This deserves close attention since the present treatments of Optic Neuritis and MS are under strong criticism because of their dangers and ineffectiveness.

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