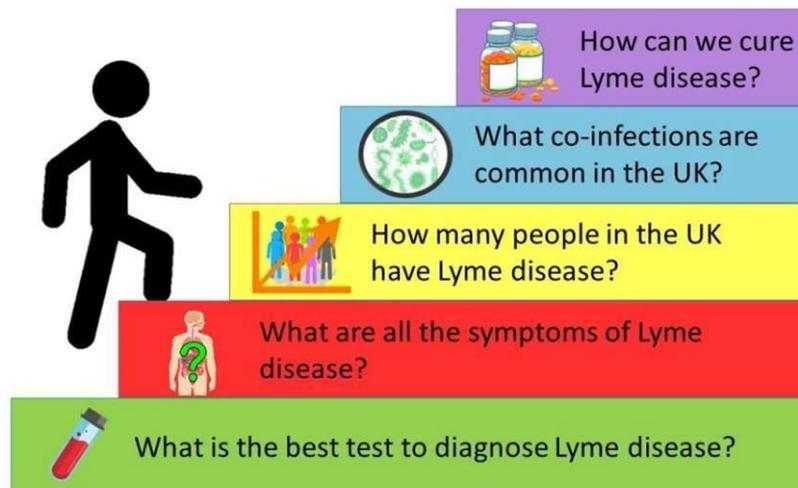


“The best intentions pave the road to hell”

William Shakespeare



Lyme borreliosis patients are sometimes given information which suggests that the provider lacks knowledge of the basic facts of the illness. The graphic above is an example of this. This picture can be found on the Caudwell LymeCo website and was included with Louise Alban’s anti-petition blurb on LDUK.

The graphic is a rough representation of the research recommendations made in the NICE draft guideline. It looks reasonable and authoritative and even appears encouraging – but it is actually none of these.

Lyme borreliosis research is littered with dubious experiments, designed and conducted by people with ulterior motives and competing interests. Those of us who have been around for long enough and who have studied the literature, know that some research into the disease has not been done and reported with the intention of adding to the pool of knowledge, but appears to be aimed at establishing and maintaining control over perceptions of the illness.

VIRAS have previously provided a comprehensive analysis of the deceptive NICE research recommendations, “[Be careful what you wish for](#)”. Here we provide a simplified version based on the graphic above.

STEP 1. 'What is the best test to diagnose Lyme disease?'

- This is a bogus question. Only direct detection of the bacteria can 'diagnose Lyme disease'. Serology (detection of antibodies produced by the immune system) as provided by Public Health England (PHE) cannot 'diagnose Lyme disease'. All credible laboratories and test kit manufacturers state that their serology tests are only intended to help doctors in making a clinical diagnosis.
- The 'best test' does not mean a 'reliable test'. E.g., the test manufacturer's own figures show that the testing provided by the PHE has sensitivity of only 41% (6 out of 10 INFECTED patients, will get false-negative test results). NICE claim that this represents 'high sensitivity' when any medical scientist would consider this 'very low sensitivity'.
- Lyme borreliosis serology can produce 500 times more false negatives than tests for HIV.
- The 'best test' according to the World Health Organisation in 1993, and further demonstrated by independent researchers in 2002, requires the use of a combination of test methods, rather than relying on just one. This means using a combination of direct detection (e.g., culture, FISH, PCR) and indirect (e.g., serology, Elispot). This approach can improve the sensitivity of tests for the infection, though it still cannot rule-out an infection.

STEP 2. "What are all the symptoms of Lyme disease?"

- This is a strange question, because it cannot be answered. There is no organ or tissue in the body that cannot be invaded by Lyme borreliosis spirochaetes. They can even invade bone.
- Therefore any conceivable symptom is possible. E.g.: a symptom reported in several cases was an auditory hallucination of hearing opera music.
- Medical authorities such as Burrascano and Horowitz have compiled lists of symptoms counting well over 100 as identified through clinical experience.
- What would actually be useful for patients and doctors, is a practical questionnaire of symptoms and risk factors like those developed by the aforementioned doctors. These might increase the chances of correctly diagnosing an infected patient, which is what actually matters.

STEP 3 "How many people in the UK have Lyme disease?"

- An answer to this question would be interesting, but there is no way to find out. What the NICE Research Recommendation actually asks is: how many people are 'seropositive' according to the tests used by PHE.
- Having 'Lyme disease' and being 'seropositive' are two completely different things.
- Research has shown that substantial numbers of blood donors are 'seropositive'. These people must NOT have Lyme disease, or else the Blood Service could be infecting people receiving transfusions.
- Research has shown that substantial numbers of infected patients are 'seronegative'.
- Epidemiologists want to know about Prevalence (how many people are infected) and Incidence (the number of new cases each year) – serology cannot provide this information.
- Therefore serology cannot even give a reliable estimate of "how many people in the UK have Lyme disease?"

STEP 4 "What co-infections are common in the UK?"

- This sounds more encouraging and is actually important, but it falls short.
- The NICE research recommendation specifies 'tick-borne' co-infections. Therefore it omits opportunistic infections (e.g. nematodes, candida and other fungal infections, mycoplasma, CPN), reactivated infections (e.g. HHV6, Epstein Barr), and an altered course of common infections (e.g. viruses causing colds, 'flu) which can be much more severe and long lasting in Lyme patients.
- NICE again specify 'seroprevalence'. It is unknown whether testing for co-infections by this method would be as unreliable for co-infections as it is for Lyme borreliosis and for similar reasons, e.g., immune suppression, pathogen mutation etc.

STEP 5 "How can we cure Lyme disease?"

- This also sounds encouraging, but is actually another bogus question.
- NICE actually specify: "What are the most clinically and cost-effective treatment options" and they do not refer to a "cure" at all.
- In the absence of an EM rash, the NICE draft guideline defines 'Lyme disease' as a positive serology blood test – which they claim is 'diagnostic'. They do not define it as 'infection with Lyme bacteria' and as already observed, these are two completely different things.
- With PHE methods, there is no way to tell when the infection is cured (the infection has been eradicated), they can only tell when a patient has become seronegative (the levels of antibodies has dropped).
- PHE's Dr Matthew Dryden, has claimed that 100% of his Lyme patients were cured. As he used short-term antibiotic treatment to achieve this result, it is safe to consider that NICE's