If you have questions or concerns, contact your primary care physician or dermatologist, Dr. James Young. Our ConvenientCare clinic is also open for urgent care after hours.

Get the facts get rid of the fear

Written by Board Certified Dermatologist
James W. Young, DO, FAOCD

The diagnosis of Lyme Disease may inspire indifference in some, and fearful panic in others. Since first described in 1975, it has achieved some notoriety. Since information is the best weapon to dispel unnecessary fear, read on to be armed with the facts and not be frightened by rumor or misinformation.

The vector - or biting insect - for Lyme Disease (LD) is the deer tick, "Ixodes dammini." The disease is an infection caused by "Borrelia burgdorferi," a type of bacterium called a spirochete (spyro-keet), which was isolated in 1982. LD in the U.S. occurs primarily in the Northeast, Midwest, and West with infections occurring almost exclusively between May and November. More than 80% of cases occur in June, July and August.

The characteristic early rash or lesion of LD is called "erythema migrans" (EM). Clinical symptoms begin with EM and an acute flu-like illness (body aches, low grade fever, malaise). The rash occurs in at least 75% of adults, but is much less common in children. Some call this skin lesion a "bulls-eye" rash because of its appearance.

Only 20 - 30% of patients will actually recall a tick bite. Many patients will notice a small red spot or bump at the site, most commonly in the thigh, groin or armpit areas. Three to 30 days later (the average is 7 days), there is a gradual expansion of redness. The advancing edge is usually blue-red, warm and has no scale (unlike tinea corporis or ringworm, a fungus). Centrally, the lesion will usually clear as it grows, leaving a ring. There may be firmness, blisters, or a scab. Half of patients with EM complain of burning; however, itching, pain or localized hair loss are rare.

One fourth of patients will have multiple lesions. Without treatment, lesions will fade in about four weeks. It is possible, however, for the spots to remain for months.

Left untreated, late complications (late-Lyme) include arthritis (10% of patients, usually knees); cardiac involvement (usually young men); or neurological problems. A late sequel on the skin is acrodermatitis chronica atrophicans (ACA), which is paper-thin skin on the backs of the hands and feet that spreads inward.

The good news is that excellent treatment is available when given

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within the first few weeks of infection. Early treatment with antibiotics is straightforward and almost always results in a full cure. Treatment typically lasts in the 14 to 30 day range. Oral therapy for EM is usually sufficient; however, more aggressive treatment regimens such as IV antibiotics are needed for cardiac, neurological, or arthritic involvement. Tragically, half of the patients who have suffered from late-Lyme and develop arthritis will not respond to antibiotics and may become disabled.

Blood tests to diagnose Lyme Disease are notoriously unreliable. Identifying EM early is still the most sensitive evidence of early infection.

Your best weapon is to always inspect for ticks after returning from an outdoor activity. The tick needs to be attached for 24 hours to transmit the disease to the bloodstream. Nymphs (smaller or immature ticks) my be hard to see.

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For more information or to schedule an appointment please call 605-665-1722.