

## Appendix 2



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### **Preliminary Evidence of Prevalence of Chronic Borreliosis/Lyme Disease in Australian General Practice.**

From the 1<sup>st</sup> July 2013 to the end of October 2014 I participated in a roster of General Practitioners providing Saturday morning consultations for patients from a group practice who wished to be seen. Borreliosis/Lyme Disease, Chronic Fatigue syndrome and my regular patients from my special interest practice were, as far as possible, excluded, and asked to attend during the weekday normal hours.

In those 15 or so months I saw 103 essentially random General Practice patients.

**Patient 1.** 31 year old male, unwell with various problems with cognition, energy and pain since a tick bite in Western Australia March 2012. Unfit for work.

I was the 4<sup>th</sup> GP in the practice he had seen.

He had clear symptoms for the co-infections Babesia and Bartonella.

Testing showed positive Elispot results for Borrelia, Yersinia, Chlamydomphila pneumoniae and Chlamydia trachomatis.

PCR for DNA of Borrelia in his urine was equivocal. Immunoblot for Borrelia was negative though the p41 band of IgG was positive.

Currently returned to full work capacity on herbal medicines and a strict diet, avoiding aggravating foods.

**Patient 2.** 26 year old male. An ex soldier who had spent time in Afghanistan and medically discharged with Post Traumatic Stress Disorder (PTSD). Had become fatigued and aching while in Victoria at Puckapunyal, training in the bush in the vicinity of sick kangaroos which had what he referred to as an illness they called “wobbly head”. He was somewhat better and functional during his tour of Afghanistan while on Doxycycline (as prophylactic for Malaria). On return to Australia and ceasing Doxycycline he became increasingly unwell and unfit to work, eventually being discharged with a diagnosis of PTSD. On review of his symptoms it seemed to me the PTSD diagnosis was probably inappropriate as several key symptoms were missing, and some symptoms he had were not in the PTSD range. He qualified indeed for a diagnosis of ME/CFS on the 2003 Canadian Clinical criteria.

Testing showed a positive Borrelia Immunoblot

IgM p100 and p39, IgG Positive p41 ,Equivocal p100.

Borrelia Elispot Positive.

Serology Q fever positive.

Raised IgG for Chlamydomphila pneumoniae

Symptoms typical for co-infection with Bartonella.  
Still unfit for work, unable to afford treatment

**Patient 3.** 41 year old male. Fatigued, anxious and only partly able to work. Unwell to some extent for years. Very limited exercise capacity.  
CD 57 count was 50 (usually indicative of Borrelia infection: the range of CD57 is ordinarily 60-354 – according to a small study of 10 healthy patients presented by Ginger Savely at ILADS conference Boston 2013, and 60-360 in 1000 random patients measured by LabCorp in the USA when establishing normal ranges for CD57)  
PCR for DNA of Borreila in his urine was equivocal.  
Strong clinical indications for Bartonella (especially including anxiety state).  
All other Borrelia tests negative.  
Following treatment for Bartonella and then Borrelia, his exercise capacity has become normal (a keen cyclist) and work and study capacity have become normal.

**Patient 4.** 13 year old boy with sero-negative arthritis of one knee and fatigue.  
CD57 count was 60.  
He did not proceed to the recommended Borrelia tests, but 6 months later he presented to another GP in the same practice with striae on his back far more florid than a case reported in [“Case Reports in Paediatrics”](#) or another case in a [CDC paper on Bartonellosis](#) depicting typical striae of Bartonella infection.

**Patient 5.** 55 year old woman. Fatigued and cognitive problems for many years.  
Itchy skin condition for a couple of years.  
Symptoms typical of Babesia and Bartonella.  
CD 57 count of 20.  
Borrelia tests all negative.

**Patient 6.** 49 year old male. No fatigue or depression.  
Recurring Erythema Migrans rashes for some time (pathognomonic of Borreliosis in endemic areas of the world).  
Declined to be tested as he felt well, and on account of the expense involved.

**Patients 7 & 8.** Two women in their fifties with long established Fibromyalgia. No inclination to be tested.

**In my practice I have found over 80% of Fibromyalgia patients have a positive Borrelia test, and a further 15% have an equivocal test for a total of 95%.**

**This amounts to between 2% and 8% of random general practice presentations.**

As Borreliosis causes so much disability and morbidity, this high prevalence is an inducement for some systematic large scale research by clinicians and health economists.