

CONSENSUS DOCUMENT

CONSENSUS STATEMENT OF THE SPANISH SOCIETY OF INFECTIOUS DISEASES AND CLINICAL MICROBIOLOGY (SEIMC), SPANISH SOCIETY OF NEUROLOGY (SEN), SPANISH SOCIETY OF IMMUNOLOGY (SEI), SPANISH SOCIETY OF PEDIATRIC INFECTOLOGY (SEIP), SPANISH SOCIETY OF RHEUMATOLOGY (SER), AND SPANISH ACADEMY OF DERMATOLOGY AND VENEREOLOGY (AEDV), ON THE DIAGNOSIS, TREATMENT AND PREVENTION OF LYME BORRELIOSIS.

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FUNDING

No funding.

ACKNOWLEDGEMENTS:

All figures with exception of figure 8 (A,B) (provided by Dr. Mascaró from Hospital Clinic of Barcelona), have been provided by the the Center of Rickettsiosis and Artropod-Borne Diseases (CRETAV) from the Departament of Infectious Diseases of the Hospital Universitario San Pedro-Center of Biomedical Research of La Rioja (CIBIR).

ABSTRACT: The diagnosis of Lyme borreliosis (LB) is based on the epidemiological history, clinical manifestations and microbiological findings in the disseminated and late phases of the disease. Related to this fact, in recent years, microbiological diagnostic techniques have appeared. These ones, far from facilitating the diagnosis and, as such, the clinical-therapeutic management of patients suffering from LB, are creating confusion. In this consensus statement, different experts and representatives of Spanish Scientific Societies (Spanish Society of Infectious Diseases and Clinical Microbiology (SEIMC), Spanish Society of Neurology (SEN), Spanish Society of Immunology (SEI), Spanish Society of Pediatric Infectology (SEIP), Spanish Society of Rheumatology (SER), and Spanish Academy of Dermatology and Venereology (AEDV) review the epidemiology, clinical spectrum, diagnostic techniques available for the diagnosis of infection by *Borrelia burgdorferi* sensu lato, in addition to the therapeutic and prevention options of LB. In a consensual way, the recommendations to establish the correct clinical and microbiological diagnosis are offered together with the recommendations to support the therapeutic management and prophylaxis of the infection.

KEY WORDS

Lyme borreliosis, *Borrelia burgdorferi* sensu lato, Spain, guidelines.

ABBREVIATIONS

AAN: American Academy of Neurology

ACA: acrodermatitis chronica atrophicans

AEDV: Spanish Academy of Dermatology (AEDV)

AV-B: atrioventricular conduction blocks

BID: one doses every 12h

BmpA: *Borrelia* membrane protein A

BSK: Barbour-Stoenner-Kelly

CDC: Centers for Disease Control and Prevention

CLIA: ChemiLuminiscence ImmunoAssay

CMV: cytomegalovirus

CNS: central nervous system

CSF: cerebrospinal fluid

DbpA: decorin-binding protein A

DEBONEL: *Dermacentor*-borne-Erythema-Necrosis-Lymphadenopathy

DEET: N,N-diethyl-meta-toluamide

ECG: electrocardiogram

EFNS: European Federation of the Neurological Societies

EIA: enzyme immunoassay

ELFA: enzyme linked fluorescent assay

ELISA: enzyme-linked immunosorbent assay

EM: erythema migrans

ESCMID: European Society of Clinical Microbiology and Infectious Diseases

HIV: human immunodeficiency virus

IDSA: Infectious Diseases Society of America

IFA: indirect immunofluorescence assay

IFA: indirect immunofluorescence assay

IR3535: ethyl-3-(N-n-butyl-N-acetyl) aminopropionate

KPM: Kelly-Pettenkofer medium

LA: Lyme arthritis

LB: Lyme borreliosis

MMIA: Multiplexed Microbead ImmunoAssay

N: number of subjects

ND: not determined

NK: natural killer

OD: one doses every 24h

OLE: oil of lemon eucalyptus

Osp: outer surface protein

PCR: polymerase chain reaction

PMD: p-menthane-3,8-diol

PNS: peripheral nervous system

PTLS: post-treatment Lyme syndrome

s.l.: sensu lato

s.s.: sensu stricto

SEI: Spanish Society of Immunology

SEIP: Spanish Society of Pediatric Infectology

SEN: Spanish Society of Neurology (SEN)

SER: Spanish Society of Rheumatology

SI: stimulation index

TBD: tick-borne disease

TID: one doses every 8h

VlsE: variable lipoprotein surface-exposed protein

WB: western blot

WHO: World Health Organization

1. INTRODUCTION AND JUSTIFICATION OF THE CONSENSUS DOCUMENT

Lyme disease or Lyme borreliosis (LB) is a complex multisystemic process predominantly distributed in the northern hemisphere, transmitted by the bite of hard ticks of the *Ixodes ricinus* complex (*Ixodes ricinus*, *Ixodes persulcatus*, *Ixodes scapularis*, *Ixodes pacificus*) and caused by different genospecies of *Borrelia burgdorferi* sensu lato (here after *B. burgdorferi*)¹⁻³. In Europe, *I. ricinus* is the main vector^{2,3}.

Much of the clinical spectrum of LB, such as acrodermatitis chronica atrophicans (ACA), erythema migrans (EM) and neurological manifestations including Garin and Boujadox meningopoliradiculitis, and the so-called Banwarth's syndrome had already been described in Europe since the late XIX and early XX centuries. In addition, its bacterial etiology and tick transmission had also been suspected. This infection, however, aroused great medical and social interest as a result of the description in the US in the 70s^{4,5} and of the discovery of its etiological agent in the 80s⁶, with gradual increase in the description of patients until becoming the most frequent tick-borne disease (TBD) in the northern hemisphere⁷.

The diagnosis of LB may be easy in patients bitten by ticks, who develop the typical clinical manifestations of the infection, such as EM, in an endemic area for LB. But, sometimes, and despite the fact that there are other clinical manifestations suggestive of LB (e.g. meningoradiculitis and lymphocytic meningitis with facial nerve paralysis), these manifestations may be caused by other agents and processes, and a microbiological confirmation is required^{2,8,9}. To complicate the diagnosis, many patients do not remember the tick bite, which can often go unnoticed because it is painless and in areas not accessible to sight. In addition, clinical reports of LB include nonspecific clinical manifestations such as prolonged asthenia, myalgia, arthralgia, and lack of concentration, among others, that, taken away from the appropriate clinical-epidemiological environment, can lead to confusion and misdiagnosis.

For many years, and this is still the case for most Public Network Centres in Spain, the microbiological criteria recommended by Health Agencies and Scientific Societies competent in the subject (e.g. Centers for Disease Control and Prevention (CDC), European Society of Clinical Microbiology and Infectious Diseases (ESCMID), Infectious Diseases Society of America (IDSA) and others) have been applied¹⁰⁻¹⁹. But in recent years, 'other techniques' that have not been validated by these Agencies and Societies have appeared, leading to the diagnosis of LB in patients without clear epidemiological and clinical criteria. In the opinion of many experts, and this is reflected in most clinical guidelines and consensus documents, many of these techniques have only originated confusion, without meeting the requirements of sensitivity and specificity to establish a correct diagnosis of LB¹⁹⁻²¹.

Another problem, which adds difficulty to the diagnosis, is to differentiate an active infection from a past infection, and the high prevalence of antibodies against *B. burgdorferi* in endemic areas²². To complicate the issue, the literature includes cases of *B. burgdorferi*-infected patients who do not develop a measurable humoral immunity response, and patients with decreased levels of antibodies that may not be detected after an initial period of detection^{12,23}. The culture of *B. burgdorferi* has also been described in patients with persistent nonspecific clinical manifestations after having received adequate antimicrobial treatment for LB, although this is exceptional²⁴.

For the above-mentioned reasons and taking into account that every day it is more frequent that we are consulted by patients who have been diagnosed of LB without meeting the required clinical-epidemiological and microbiological criteria and sometimes they are subjected to prolonged treatments not based on scientific evidence, the Spanish Society of Infectious Diseases and Clinical Microbiology (SEIMC) has considered the need to update and prepare a Consensus Document with other Scientific Societies such as the Spanish Society of Neurology (SEN), Spanish Society of Pediatric Infectology (SEIP), Spanish Society of Rheumatology (SER), Spanish Society of Immunology (SEI) and Spanish Academy of Dermatology and Venereology (AEDV) involved in the diagnosis and management of the LB.

2. METHODOLOGY FOR THE EVALUATION OF THE DOCUMENT

After contacting with the different Spanish Scientific Societies and experts in the field, and with the aim already proposed of agreeing on some useful recommendations for the management of patients affected by LB, an exhaustive bibliographic search was proposed on the state of knowledge of the infection by *B. burgdorferi* s.l. and LB in PubMed. Given that the bibliographic search with the words "Lyme disease" or "Lyme borreliosis" or "*Borrelia burgdorferi*" retrieved more than 15,000 references, it was decided that each expert would narrow the field and choose the most relevant bibliographic citations taking into account previous consensus documents and other recommendations of Health Agencies and Scientific Societies and relevant abstract books of Conferences. As in Spain there are none wide and updated reviews of the topic, it was also considered interesting to carry out an exhaustive review about the epidemiology and history of LB in Spain.

Since available guidelines and consensus documents have been recently published and they can be easily consulted¹³⁻¹⁹, in our case, we have chosen to use the degree of consensus between Societies and experts' signatories of this document for the final recommendations.

3. MICROBIOLOGICAL CHARACTERISTICS OF *Borrelia burgdorferi* s.l. AND GENOSPECIES OF *Borrelia burgdorferi* PRESENT IN SPAIN

Bacteria of the genus *Borrelia*, along with the genera *Spirochaeta*, *Cristispira* and *Treponema*, fall within the Phylum XV Spirochaetes phyl nov., Class I Spirochaetia class. nov., Order I Spirochaetales and Family I Spirochaetaceae, and comprise 43 pathogenic species for birds and mammals, including humans. They have a characteristic spiral shape with size between 0.2 and 0.5 µm in diameter and between 3 and 33 µm in length. They have an external cell envelope, a cytoplasmic membrane, periplasmic flagella (from 15 to 20) and a protoplasmic cylinder. The flagella fulfill the functions of skeleton and mobility and are subproximally anchored in the bacterial body, and are located in the periplasmic space. They are Gram-negative and microaerophilic bacteria. According to the analysis of the 16S rRNA gene and other conserved genes such as the *flagelline* gene, and considering the ecological characteristics, *Borrelia* spp. are divided into two large groups, *B. burgdorferi* s.l. comprising the bacteria that cause LB, and a second large group of bacteria that cause recurrent fever²⁵.

A striking feature of *B. burgdorferi* s.l. is the small size and structure of its genome. This is composed of a linear chromosome, unusual in bacteria, of approximately 1 Mb and several plasmids, linear and circular, which vary in number up to 21. The guanine-cytosine ratio ranges from 23% to 32%. Another characteristic is the large number of lipoproteins that it expresses, and that are mostly encoded by plasmids, such as the 6 proteins in the outer envelope (OspA to OspF) and a variable expression protein called VlsE, which play an important role in the patient's immune response. There is an absence of genes that encode proteins that lead to cellular biosynthesis reactions, which limits the metabolic capacity of *B. burgdorferi* and turns these bacteria into obligated parasites that depend on their hosts for their nutritional support. However, the borrelias of this group grow in a highly enriched liquid medium called Barbour-Stoenner-Kelly (BSKII) at 30-34 °C in microaerophilic environment, dividing every 8-12 h during the logarithmic phase of their growth²⁵.

The 5S-23S rRNA intergenic space has been used to classify closely related genospecies of the *B. burgdorferi* s.l. complex (Table 1). Although the complex currently comprises 21 different genospecies, only *B. burgdorferi* sensu stricto (s.s.), *Borrelia afzelii*, *Borrelia spielmanii*, *Borrelia garinii* and *Borrelia bavariensis* are considered to be of pathogenic relevance to humans. Despite cases of LB caused by *Borrelia valaisiana*, *Borrelia lusitaniae*, and *Borrelia bissettiae* have been described, their pathogenic ability has been questioned and their description is occasional. *Borrelia mayonii* has been recently incorporated in the Americas²⁶.

There seems to be a tropism of different genospecies by different organs associated with plasmid variations. Thus, *B. afzelii* predominantly appears in dermatological manifestations such as ACA, *B. garinii* and *B. bavariensis* seem to present greater tropism by the nervous system, *B. burgdorferi* s.s. by the articular system, while *B. spielmanii* has been isolated exclusively from EM. Anyway, LB is a dynamic process with different clinical manifestations in different organs and systems, depending not only on genospecies, but also on time^{2,3}.

The concept of genospecies has generated controversy among various authors throughout history, and this has been greatly exacerbated in recent years. Some argue that genospecies are nothing more than genetic variations of the same species, while others criticize that genetic classification is not relevant in many cases from an ecological point of view. In 2014, Adeulu and Gupta proposed the reclassification of spirochaetals of the genus *Borrelia*, so that those that cause LB (*B. burgdorferi* s.l. complex) would be renamed '*Borrelia*', while those that cause recurrent fevers would continue with the name '*Borrelia*', based on the results of their analysis of genetic markers 'unique' in the species²⁷. Recently, detractors of this new classification have asked the Judicial Commission to support the rejection of the name '*Borrelia*' and all its combinations, based on the violation of several principles of the Code of International Nomenclature of Prokaryotes, such as, among others: endangering human health and patient safety by the confusion they create in the medical and scientific community and its possible consequences on medical coverage, avoid unnecessary creation of new names and that names should not be changed without sufficient justified reasons²⁸. This controversy has led to the non-adoption of the new nomenclature

in most published works since its proposal, adding more confusion to the chaos that this has caused. It is therefore imperative that an appropriate taxonomic committee be involved in resolving this debate.

Table 1: Genospecies of *Borrelia burgdorferi* sensu lato complex

Genospecies	Year	Vector	Main host	Pathogenicity for humans	Epidemiological distribution
<i>B. afzelii</i>	1994	<i>I. ricinus</i> <i>I. persulcatus</i>	Micromammals	+++	Europe, Asia
<i>B. americana</i>	2010	<i>I. ricinus</i> <i>I. minor</i>	Rodents, birds	-	USA
<i>Candidatus B. andersonii</i>	1995	<i>I. dentatus</i>	Cotton-tailed rabbit	-	USA
<i>B. bavariensis</i>	2013	<i>I. ricinus</i> <i>I. persulcatus</i>	Micromammals, birds	+++	Europe, Asia
<i>B. bissettiae</i>	2016	<i>I. pacificus</i> <i>I. spinipalpis</i> <i>I. ricinus</i>	<i>Neotoma fuscipes</i> (dusky-footed woodrat)	+	USA, Europe
<i>B. burgdorferi</i> sensu stricto	1984	<i>I. scapularis</i> <i>I. pacificus</i> <i>I. ricinus</i> <i>I. persulcatus</i>	Mammals, birds	+++	USA, Europe
<i>B. californiensis</i>	2016	<i>I. jellisoni</i> <i>I. spinipalpis</i> <i>I. pacificus</i>	<i>Dipodomys californicus</i>	-	USA
<i>B. carolinensis</i>	2011	<i>I. minor</i>	<i>Peromyscus gossypinus</i> , <i>Neotoma floridana</i>	-	USA
<i>B. chilensis</i>	2014	<i>I. stilesi</i>	<i>Oligoryzomys longicaudatus</i>	-	Chile
<i>Candidatus B. finlandensis</i>	2011				
<i>B. garinii</i>	1992	<i>I. ricinus</i> <i>I. persulcatus</i>	Birds	+++	Europe, Asia
<i>B. japonica</i>	1994/3	<i>I. ovatus</i>	Rodents	-	Japan
<i>B. kurtenbachii</i>	2014	<i>I. scapularis</i>	Rodents	-	USA & Europe
<i>B. lusitaniae</i>	1997	<i>I. ricinus</i>	Lizards	+	Europe

<i>B. mayonii</i>	2016	<i>I. scapularis</i>	Mammals	++	USA
		<i>I. pacificus</i>			
<i>B. sinica</i>	2001	<i>I. ovatus</i>	<i>Niviventer</i>	-	China
			<i>confucianus</i>		
<i>B. spielmanii</i>	2006	<i>I. ricinus</i>	Garden dormouse	+++	Europe
		<i>I. persulcatus</i>			
<i>B. tanukii</i>	1997/6	<i>I. tanuki</i>	Vole	-	Japan
<i>B. turdi</i>	1997/6	<i>I. turdus</i>	Unknown	-	Japan, Europe
<i>B. valaisiana</i>	1997	<i>I. ricinus</i>	Birds	?	Europe, Japan,
		<i>I. granulatus</i>			Taiwan, Korea
		<i>I. columnae</i>			
<i>B. yangtzensis</i>	2015	<i>I. granulatus</i>	Rodents	-	Asia

4. LYME BORRELIOSIS IN SPAIN. EPIDEMIOLOGY, DISTRIBUTION AND FEATURES OF *Ixodes ricinus*

The first confirmed LB patients in Spain date back to the 1980s when the first cases of neuroborreliosis and EM were described²⁹⁻³¹. Subsequently, other isolated cases were reported³²⁻³⁶, and small/medium series of patients, either from collaborative studies or from single centers, were published³⁷⁻⁴⁰, thus broadening the spectrum of clinical manifestations and making clear that the LB is common in Spain, affecting children and adults of both genders. Most cases have been reported in the northern half of the Iberian Peninsula.

In addition to the description of clinical cases, studies of seroprevalence of antibodies were carried out in different population groups showing that the infection is frequent in people who develop outdoor activities (hikers, hunters, fishermen, environmental workers and others) in which antibodies can be found in a high percentage. The risk of infection also increases with age. In fact, seroprevalence have ranged between 0-40% depending on the area, population and used technique^{22,41-53} (Table 2).

Table 2: Seroprevalence of *Borrelia burgdorferi* infection in humans (Spain)

Seroprevalence	Population type	N	Geographical area	Method	Cut-off value	Ref.
38%	Foresters and Rangers	42	La Rioja	IFA	≥ 1/128	41
5.8%	Healthy population	500	La Rioja	IFA	≥ 1/128	22
31%	People bitten by ticks	38				

29% 10% 1.3%	HIV infected people	72		IFA EIA WB	$\geq 1/128$	42
13.1%	Healthy population	298	Soria	IFA	$\geq 1/256$	43
16.4% 0%	Suspected LB Healthy population	354 150	Granada	WB		44
4.1%	Healthy population	98	León	IFA	$\geq 1/128$	45
25%	Forestry workers, 117; veterinarians, 52; shepherds, 18; apiculturists, 27; mushroom and truffle gatherers, 74; other outdoor activities, 14	302	Vizcaya	EIA WB	Negative control +3 SD	46
3.5%	Healthy population	1825	Madrid	IFA		47
4.4%	Patients (adults and children) admitted to the Hospital for surgical intervention not related to an infection.	203	Barcelona	EIA		48
3.7%	Suspected LB	936	Cartagena	EIA		49
4.4%	Healthy population	1429	Navarra	EIA		50
9.6% 4.3%	Suspected LB	623	Palencia, Burgos	IFA WB	≥ 256	51
13.2% 5.1% 16.2%	Healthy population Blood donors Suspected LB	1432	Asturias	EIA		52
7%	Forest rangers	100	Guadalajara	IFA IgG	≥ 256	53

Ref.: Reference; EIA: Enzimo-immuno-assay; IFA: indirect immunofluorescence assay; LB: Lyme borreliosis; N: number of subjects; WB: western blot.

However, since LB is not a notifiable disease in our country, we do not have records or reliable data on the incidence of this disease. Most patients are diagnosed by physicians in the event of an EM or suspicion of clinical manifestations with nervous system involvement.

In Europe, according to data from 2006 (latest WHO update), 85,000 cases are reported annually; these being clearly lower than the real data, as it is not a notifiable disease⁵⁴. There are other estimations between 60,000 and more than 200,000 cases per year, only in Germany⁵⁵. In Spain, there are no real incidence data.

As previously stated, the vector of the *B. burgdorferi* s.l. infection and LB in Europe is *I. ricinus*. The first prevalence studies of *B. burgdorferi* in ticks were carried out at the beginning of the 90s^{56,57} by means of immunofluorescence techniques and later, by PCR. Table 3 details the different studies carried out, showing very different prevalence depending on the area of Spain (0% to 48%), with higher prevalence when nymphs and adults are studied from the same area. So far, the genospecies *B. burgdorferi* s.s., *B. afzelii*, *B. garinii*, *B. lusitaniae*, *B. valaisiana* and *B. turdi* have been detected⁵⁶⁻⁷¹.

Table 3. Prevalence of *Borrelia burgdorferi* infection in *Ixodes ricinus* from Spain.

Year	Area	Source	Technique	N	Tick stage	% of infection	Genospecies	Ref.
1990	La Rioja	Cow	IFA		Adults	11%	ND	56
99	La Rioja Castilla y León	Cow Birds	IFA	2856	Adults Nymphs	14% 57%	ND	57
1992- 1997	Basque Country	Vegetation	PCR	5452	Adults Nymphs	5% 0.8%	<i>B. garinii</i> <i>B. burgdorferi</i> s.s. <i>B. valaisiana</i> <i>B. lusitaniae</i>	58
1997- 2002	Castilla y León	Humans	PCR	1329	Adults Nymphs	6.1% 0.9%	<i>B. lusitaniae</i> <i>B. garinii</i> <i>B. valaisiana</i>	59
1998- 2000	Basque Country	Vegetation Rodents	PCR		Adults		<i>B. burgdorferi</i> s.s. <i>B. garinii</i> <i>B. valaisiana</i> <i>B. afzelii</i>	60
2002- 2003	La Rioja	Vegetation	PCR	25	Nymphs	48%	<i>B. afzelii</i> <i>B. garinii</i> <i>B. valaisiana</i>	61
2003- 2005	Basque Country	Vegetation	PCR	288	Adults	1.7%	<i>B. afzelii</i> <i>B. garinii</i>	62
2004	Asturias	Vegetation	PCR	448	Nymphs	4%	ND	63
2009	La Rioja	Birds	PCR	181	Nymphs Larvs	10.5% 7.8%	<i>B. garinii</i> <i>B. valaisiana</i>	64

2009-2011	La Rioja	Birds	PCR	17	Nymphs	40%	<i>B. turdi</i>	65
2009-2016	La Rioja, Basque Country, Navarra, Cantabria	Vegetation	PCR	652	Nymphs	4.1%	<i>B. afzelii</i> <i>B. garinii</i> <i>B. lusitaniae</i> <i>B. valaisiana</i> <i>B. burgdorferi</i> s.s.	66
2012-2014	Asturias	Vegetation	PCR	845	Adults	6.1% 1.4%	<i>B. afzelii</i> <i>B. garinii</i> <i>B. lusitaniae</i> <i>B. valaisiana</i>	67
2014-2015	Iberian Peninsula	Dogs	PCR	147	Adults	2.7%	<i>B. afzelii</i> <i>B. garinii</i> <i>B. valaisiana</i>	68
2015	Galicia	Vegetation	PCR	1048	Adults Nymphs	24% 12.2%	<i>B. afzelii</i> <i>B. burgdorferi</i> s.s. <i>B. garinii</i> <i>B. lusitaniae</i> <i>B. valaisiana</i>	69
??	Galicia	Roe deer	PCR	3449	Adults Nymphs	0.4% 0.1%	<i>B. garinii</i> <i>B. valaisiana</i> <i>B. lusitaniae</i> <i>B. afzelii</i>	70
2015-2017	Galicia	Vegetation	PCR	1056	Adults Nymphs	14.9% 10%	<i>B. afzelii</i> <i>B. garinii</i> <i>B. lusitaniae</i> <i>B. valaisiana</i> <i>B. burgdorferi</i> s.s.	71

Ref.: Reference; IFA: indirect immunofluorescence assay; N: number of subjects; ND: not determined; PCR: polymerase chain reaction

In 1992, García-Moncó *et al.* succeeded in cultivating *B. burgdorferi* s.s and in 2000, Escudero *et al.* cultured *B. garinii*, *B. afzelii*, *B. valaisiana*, and *B. lusitaneae* from *I. ricinus*^{72,73}. In 1998, Oteo *et al.* isolated the first pathogenic *B. burgdorferi* strain in Spain, corresponding to *B. garinii* (RIOJA-1 strain), from a patient with an EM from La Rioja⁷⁴, and given the description of LB cases with clinical manifestations not-defining of LB only based on serological findings and without clear epidemiological antecedents, the “Lyme Disease Study Group of the SEIMC” established a definition of ‘endemic area’ to support the diagnosis⁷⁵.

In Spain, the number of diagnosed cases decreases from North to South with areas considered endemic, such as La Rioja, Navarra, North of Castilla y León, Asturias, Cantabria, the Basque Country and more recently, Galicia, where in the last decade a progressive increase in the number of reported cases has been observed^{20,76-78}.

As already noted, in the Iberian Peninsula, as in the rest of Europe, LB is transmitted to humans by the bite of hard ticks of the genus *Ixodes*, and specifically by *I. ricinus* (**Figures 1-3**).

This species, particularly in its nymph stage, is the one that most frequently bites people in northern Spain⁷⁹. *I. ricinus* is the tick species with the highest bacterial alpha-diversity (species richness) within the anthropophilic ticks from our environment⁸⁰. In Spain, *I. ricinus* has been described not only as vector of *B. burgdorferi* s.l. (mainly, *B. garinii* and *B. afzelii*) but also as vector of other human pathogenic microorganisms, such as *Rickettsia monacensis*⁸¹, *Rickettsia helvetica*^{64,82}, *Anaplasma phagocytophilum*^{83,84}, *Neoehrlichia mikurensis*⁸⁵, *Babesia* spp.^{86,87}, *Borrelia miyamotoi*⁸⁶ and of other bacteria species not implicated in human pathology, such as the recently cultured *Rickettsia vini*⁸⁸. Despite *I. ricinus* is the vector of the TBE virus, it has not been notified in Spain up to date^{89,90}, and only imported cases have been detected.

I. ricinus is generally distributed in temperate deciduous forests and mixed forests with shrubs, thick undergrowth and a high degree of relative humidity (>80%). In figure 1, a female *I. ricinus* can be seen waiting for a host. In figure 3 the different stages of the tick and their sizes are detailed. They prefer areas with litter cover on the ground that provide protection against drought in summer and cold in winter, creating a humid microclimate. In rainy areas, it is easy to find these ticks in coniferous forests connected with grasslands where there are extensively exploited livestock and abundant cervids that acts as dispersers and amplifiers as well as wild fauna (micromammals), which act as reservoirs⁹¹. They can also live in urban and peri-urban environments. In areas such as La Rioja or Navarra, *I. ricinus* habitually lives in areas with a minimum altitude of 400 m and a maximum of 1,200-1,300 m. However, in western areas with the influence of the Atlantic Ocean and higher humidity, *I. ricinus* can be found from sea level to 2,000 m of altitude. In southern Spain, there are also areas where there are stable populations of *I. ricinus*, such as the 'Parque de los Alcornocales' in Cadiz, and the 'Doñana National Park'^{20,92}. In the last decade, the distribution of *I. ricinus* (and the pathogens it transmits) continues to expand northwards in latitude and towards higher altitude areas throughout Europe⁹³⁻⁹⁵. The shorter and less severe winters in recent years appear to have contributed to a greater abundance of *I. ricinus*, parallel to an expansion of its reservoirs and hosts. These factors and the phenomena of contact between ticks (co-feeding) seem to be responsible for the local variations in the prevalence of the different *Borrelia* spp. (and other microorganisms) in ticks⁹⁶. *I. ricinus* are mainly active from spring to autumn, although we can find them active throughout the year depending on the factors mentioned above. Activity in spring is usually higher than in autumn (associated with higher temperature and photoperiod) with the exception of larvae, which show the opposite situation in some areas^{92,97,98}.

Other species of ticks such as *Ixodes hexagonus*, *Ixodes canisuga* and *Ixodes frontalis*, contribute to the circulation of *B. burgdorferi* in Spain^{57, 65}, although no cases of LB associated with their bites, which are rare in humans, have been reported.

5. CLINICAL MANIFESTATIONS OF LYME BORRELIOSIS

In most patients in whom *B. burgdorferi* causes disease, the clinical manifestations follow a chronological course that can be related to the pathogenesis and pathophysiological changes caused by the causative bacteria. As it is a dynamic process over time, it has been classified into different phases or stages² as detailed in table 4.

Table 4: Classification and main clinical manifestations of Lyme borreliosis

Phase	Clinical manifestations
Early localized	EM, lymphocytoma with or without lymphadenopathy
Early disseminated	EM multiple, disseminated lymphocytoma and/or early neurologic, cardiac and musculoskeletal manifestations. Ophthalmic manifestations.
Late	ACA, lymphocytoma, late neuroborreliosis, persistent or relapsing arthritis of more than 6 months

EM: Erythema migrans ACA; Acrodermatitis chronica atrophicans.

In this document, we have reviewed the state of the knowledge of LB clinical manifestations according to the organ or system affected.

5.1. Skin manifestations

The skin manifestations are the most frequent and best documented, and can appear during all phases of the infection. The first descriptions date from the end of the 19th century in Europe (*Acrodermatitis chronica atrophicans* - Buchwald 1983)⁹⁹ and the beginning of the 20th century (*Erythema chronicum migrans* - Afzelius 1909)¹⁰⁰. Later, other manifestations such as *lymphadenosis benigna cutis*, now called lymphocytoma associated with *B. burgdorferi*, were added¹⁰¹.

5.1.1. Erythema migrans (EM)

The earliest and most typical clinical marker of LB in both, North America and Europe, is EM^{102,103}. It is characterized by the development of a small erythematous macule at the point of the tick bite, which grows at the border and typically clarifies in the center, acquiring a targeted or annular appearance (**Figure 4A**), although it can also sometimes take other more atypical forms (**Figures 4B and 4C**).

If unrecognized and untreated, it can grow and become large, losing intensity in the tonality of the borders (**Figure 4B**). It appears a few days to 2-3 weeks after the bite and without treatment, it can take many weeks or months to disappear. This is the early localized phase of the infection. In some patients, the bacteria spread through the skin through the lymphatic vessels and similar lesions or satellite plaques appear, usually smaller in size, which are sometimes purpuric in appearance (**Figure 4D**). This is what we call multiple EM and corresponds to the early skin disseminated phase of the *B. burgdorferi* infection. EM is usually painless, although some patients report a certain stinging-itch in the area. The border of the lesion is usually sharp, unlike other cellulites. The clinical presentation of EM in children is similar than in adults, although EM is more commonly localized on the head or neck than in adults¹⁰⁴. A variable percentage of patients with EM have arthromyalgia, low-grade fever and conjunctivitis^{55,103,104}. The presence of fever and severe impairment of the general state, with or without other clinical manifestations or changes in blood parameters, should alert us to a possible co-infection by other agents transmitted by *I. ricinus* (in our media, *B. miyamotoi*, *A. phagocytophilum*, *N. mikurensis*, *Babesia* spp., *R. monacensis*). The differential diagnosis of EM in our environment should be made with other annular erythemas and DEBONEL (*Dermacentor-borne-Erythema-Necrosis-Lymphadenopathy*), caused by *R. slovaca* or *Ca. R. rioja*, since when this infection is located outside the head, an EM-like appears but with central necrosis¹⁰⁵ (**Figure 5**).

In travelers returning from certain US areas, it can be very difficult to distinguish between EM and southern tick-associated rash illness (STARI)¹⁰⁶. EM must be also differentiated from the skin reaction caused by the tick-bite (saliva) (**Figure 2**) and sometimes the substances used to remove the tick (liquid nitrogen) can cause a reaction that may simulate an EM (**Figure 6**). That is why we do not recommend this practice.

5.1.2. Lymphocytoma

In Central Europe, and associated with *B. afzelii* infection, and mainly in children, the so-called *Borrelia* lymphocytoma has also been described during the early localized phase, and less frequently in the disseminated phase. This rare manifestation is usually located on the earlobe, face, nipple or scrotum. It manifests as a well-located plaque or as a painless bluish-red nodule at the point of the tick-bite or at a distance that appears within weeks of contracting the infection. Microscopically, the architecture is made up of a dense lymphocytic infiltrate that must be differentiated from cutaneous lymphomas⁵⁵. Although communicated, it is a rare skin manifestation in Spain¹⁰⁷ (**Figure 7**).

5.1.3. Acrodermatitis chronica atrophicans (ACA)

ACA is another cutaneous manifestation in patients with persistent infection (late stage), overall in Central Europe and much less frequent in Spain (**Figure 8**). In a large series recently published in Slovenia, authors conclude that ACA is typically caused by *B. afzelii* (also other genospecies can be involved) and usually affects old women, although it can be diagnosed in children. Clinical presentation depends on the duration of illness and probably on the *Borrelia* genospecies causing the disease¹⁰⁸. It starts as a violaceous patch, usually located on the extensor surface of a limb. Periarticular nodules and cords can

also be present (**Figure 8**). It progresses slowly without treatment, causing a skin atrophy, which will allow see the vessels of the skin. ACA is accompanied by a polyneuropathy in up to 50% of cases^{55,109}.

These three manifestations are clearly related to an infection with *B. burgdorferi*. The relationship between infection with *B. burgdorferi* and other dermatoses, especially morphea, lichen sclerosus, and interstitial granulomatous dermatitis is still debated.

5.2. Neurologic manifestations

The involvement of the central and peripheral nervous system (CNS and PNS) in *B. burgdorferi* infection, occurs in approximately 15% of infected patients, particularly in the early disseminated phase of the infection (weeks after the tick bite) and less often in later stages (2-3% of infected patients)¹¹⁰⁻¹¹². The neurological manifestations in Europe and the US appear to be different in some aspects¹¹³⁻¹¹⁵.

Lyme Neuroborreliosis is divided between early and late manifestations (duration of signs and symptoms for more than 6 months), as well as between CNS and PNS manifestations.

5.2.1. Early neuroborreliosis: The most common manifestations of early neuroborreliosis are cranial neuropathy (particularly facial palsy), lymphocytic meningitis, and radiculoneuritis, which can occur in isolation or in combination, and these are known as the Garin-Bujadoux-Bannwarth syndrome, although unfortunately recent literature only mentions Bannwarth's syndrome. This condition occurs weeks after the appearance of the typical skin lesion (EM) or the tick bite, and is characterized by a severe, migrating radicular pain that can be accompanied by peripheral nerve paresis, often combined with uni- or bilateral (one-third of cases) facial palsy and cerebrospinal fluid (CSF) pleocytosis. Pain disappears after antibiotic treatment; however, the disorder spontaneously resolves in 5 to 6 months without therapy¹¹⁶. Patients presenting with facial palsy are commonly misdiagnosed as having Bell's palsy, and radiculitis may be mistaken for a herniated disc. The presentation in the periods of activity of *I. ricinus* as well as a history of tick exposure and a skin lesion compatible with an EM should alert to the clinicians.

Two recent retrospective studies in Denmark and Germany showed that the most common neurological disorder was radiculitis, present in 66% and 50% of patients, respectively, facial palsy in 43% and 25%, and meningitis in 10% and 6%^{113,114}. Aside from radiculitis, patients with early neuroborreliosis may also have other forms of PNS involvement, including plexopathies and a more disseminated polyneuropathy or mononeuritis multiplex. In the US and Europe, facial palsy and lymphocytic meningitis are the most common early manifestations. Headache is the main complaint in meningitis, and fever and meningismus may be mild or absent. In untreated patients, recurrent attacks of meningitis may alternate with periods of remission. CSF analysis shows a moderate (around 100 cells/mm³) lymphocytic mononuclear cell pleocytosis¹¹⁷ sometimes with atypical features, resembling lymphoma with moderate protein increase, and normal glucose contents³⁵.

Occasionally, patients may have a stroke, likely secondary to infective endarteritis, in a similar way as it occurs in syphilis or tuberculosis. A few cases of retrobulbar optic neuritis, papillitis, neuroretinitis and

ischemic optic neuropathy have been reported. Papilledema secondary to raised intracranial pressure in Lyme meningitis occurs in children, with few adult cases reported^{111,112}.

5.2.2. Late neuroborreliosis: This condition is much less common and may present as a peripheral polyneuropathy accompanying ACA, an almost exclusively European entity¹⁰⁹. The neuropathy is predominantly sensory and tends to follow the topographical distribution of the skin disease.

Late CNS involvement may appear months to years after the disease onset, and it was initially known as chronic encephalomyelitis¹¹⁸. In addition to be very uncommon (less than 2% of all Lyme neuroborreliosis), it represents a controversial entity¹¹⁹⁻¹²². It is defined as continuous disease lasting more than 6 months and its diagnosis can be only made in the presence of suggestive neurologic symptoms, CSF pleocytosis, and intrathecal *B. burgdorferi* antibody production¹²³. Patients complain of cerebral malfunctioning, particularly cognitive problems, or present spinal cord signs and symptoms, including paraparesis, ataxia, and bladder dysfunction. When there is CNS involvement, the CSF shows a lymphocytic pleocytosis (usually in hundreds of cells/mm³), increased proteins and normal glucose. More details are discussed in the diagnosis section.

5.3 Musculoskeletal manifestations

Musculoskeletal manifestations in the context of LB are frequent. In fact, its importance has been reflected in the history of LB itself, which in the first descriptions in the US was called 'Lyme arthritis' (LA)⁵. The prevalence of the joint and musculoskeletal manifestations is more frequent depending on the geographical area since the clinical spectrum is different between the American continent and Europe.

5.3.1. Arthritis

In Europe, oligoarticular arthritis and joint inflammation during the early disseminated phase seem to be less frequent than in the American continent, and in late stages, this arthritis is rarely resistant to antibiotic therapy and hardly related to autoimmune mechanisms. In the US, more than 10% of LA cases are resistant to treatment and associated to autoimmune mechanisms^{3,20,102}. In Spain, reports of the classic form of LA are rare, probably related to the fact that *B. garinii* is the most frequent genospecies causing LB in Spain. Anyway, as it occurs with the cutaneous and neurological manifestations of LB, in Spain it is more frequent to diagnose this type of manifestations in north-western regions^{20,124}. According to data from a recent study including patients who underwent serology tests and showed positive results in urban areas, the prevalence of LA was very low (6 cases out of 78 positive serologies from 574 samples)¹²⁵. In the natural history of the disease, up to 45-62% of patients with untreated EM develop LA characterized as a monoarthritis or oligoarthritis. LA can be intermittent or persistent, frequently affecting the knee joint, although it can present as an asymmetric oligoarthritis^{1-5,125}.

In a study carried out from 2010 to 2016 in France, *Borrelia* was detected in 37 out of 357 (10.4%) synovial fluids tested by PCR. Patients' median age was 36 years (range 6-78) with 61% of men and 28% patients under 18. The presentation was monoarticular in 92% and the knee was involved in 97%. Contrary to the

Borrelia genospecies distribution in European ticks, *B. burgdorferi* s.s. was the most prevalent species found in synovial fluid (54%) followed by *B. azfeli* (29%) and *B. garinii* (17%)¹²⁷. In this series, despite proper antibiotic therapy, roughly one third of patients presented persistent inflammatory synovitis and a small proportion developed systemic arthritis¹²⁷. Apart from the knee, it can also affect the shoulder, ankle, elbow, temporo-mandibular joint or wrist. The association with bursitis or inflammatory tendinopathy is usual. Less frequently, it affects more than five joints, mainly large. Inflammatory episodes, that begin acutely, can last from weeks to months, being much more frequent in untreated patients. It is common to present arthritis with clinical joint synovial fluid effusion, although the inflammation is not extremely painful except for loaded and pressured joints or in over-weighted patients¹²⁵. If the inflammation chronically persists in correctly treated patients (10%), the concept of post-infectious LA appears. It is characterized by proliferative synovitis that persists ≥ 2 months after oral antibiotics or ≥ 1 month after, at least, two weeks of intravenous antibiotics, which may lead to joint dysfunction due to cartilage erosions and joint radiological progression. It is thought to be related to persistent immune activation rather than persistent infection status and is still discuss¹²⁸. The study of synovial fluids reveals an inflammatory process with an elevation of the cell count between 10,000-25,000 cells/microL, increase of proteins, none specific, neither different from other infections.

The differential diagnosis includes all acute and chronic inflammatory processes, mainly monoarticular or oligoarticular, due to infectious agents and/or inflammatory and autoimmune diseases. Previous history of EM helps to focus the clinical picture of such arthritis and seek for LB. The serological response to *B. burgdorferi* is the main diagnostic test, but occasionally seroconversion does not occur until a few weeks later in cases of early disseminated infection. Patients with arthritis occurring in advanced stages of the disease are usually seropositive for antibodies to *B. burgdorferi*.

The outcome of patients with early LB covers from a stage of full recovery to the development of autoimmune arthritis such rheumatoid arthritis or psoriatic arthritis, within months of treatment, likely occurring in patients with unique risk factors (psoriasis), considering the infection a potential trigger to chronic stages^{129,130}. In the aforementioned French series, despite proper therapy, 34% of patients developed persistent synovitis for at least two months (median duration: 3 months, range 2-16). Among those, three patients developed systemic inflammatory oligo- or polyarthritis in previously unaffected joints with no signs of persistent infection (repeated PCR testing negative), which mandated disease-modifying anti-rheumatic drugs introduction, leading to remission¹²⁷.

Moreover, the presence of musculoskeletal manifestations of migratory type or recurrent arthralgia is very frequent in early stages (50-75%), and they are also present in patients in late stages of the infection¹⁴. They are unspecific, overlapping through the infectious disease course. Therefore, in the absence of other typical manifestations of the disease such as EM or meningoradiculitis, the presence of isolated arthralgias should not justify the investigation of LB (Consensus level: 9/9)

5.4 Cardiological manifestations

Cardiological manifestations in the context of LB can be observed in the early disseminated and late stages of infection, although their communication is much less frequent than skin, neurological or joint manifestations. This is because, in most cases, *B. burgdorferi* only causes self-limited atrioventricular conduction blocks (AV-B) that do not cause clinical manifestations or do so temporarily. According to the CDC, involvement occurs in only 1.1% of reported LB cases and it is more common in men in USA¹³¹, although a study carried out in New York city with children suffering LB without symptoms of carditis, showed electrocardiographic alterations in up to 29%, most frequently AV-B grade I¹³². In Germany, it can be found in up to 10% of patients¹³³. There are no data of prevalence in Spain, although members of this panel have observed asymptomatic AV-B in patients with early localized and disseminated forms of LB. Anyway, according to current opinion, there is acute, self-limiting Lyme carditis, and persistent Lyme carditis. Acute Lyme carditis mostly manifests as transient conduction disorders of the heart (e.g. AV-B I to III) or supraventricular and ventricular rhythm disturbances, pericarditis, myocarditis, and pancarditis in single cases that can be cause of cardiac failure and sudden death¹³⁴. Usually these patients spontaneously recover within 3 to 7 days and thus, permanent pacemakers are not needed. Other authors reported that myocarditis is relatively frequent^{135,136}.

Persistent Lyme carditis is defined as a case of chronic heart failure confirmed by positive serology and endomyocardial biopsy. Tick-bites or EM are not always reported. Seropositivity and control of its specificity by western-blot (WB) are indicative but no an etiological proof. Even histological detection of spirochetes in endomyocardial tissue or cultivation of borrelia from endomyocardial biopsy are not final etiological proofs of the respective cardiac disorder. Those findings, however, are an indication for antibiotic treatment¹³⁷.

According to the recently published American guidelines¹⁹, ECG should only be performed in patients with signs or symptoms consistent with cardiac involvement in the context of LB, including dyspnea, edema, palpitations, lightheadedness, chest pain and syncope (Consensus level: 9/9)

5.5. Other clinical manifestations

The development of other clinical manifestations accompanying the typical clinical manifestations of LB is relatively frequent.

5.5.1. Ophthalmic manifestations

Ophthalmic manifestations may occur in every stage of the disease. Conjunctivitis and episcleritis are the most frequent manifestations in early localized stage. Neuro-ophthalmic disorders and uveitis occur in the early disseminated stage, whereas keratitis, chronic intraocular inflammation and orbital myositis have been reported in the persistent stage of borreliosis¹³⁸. In some cases, these ophthalmological manifestations may also be due to a Jarisch-Herxheimer-type reaction¹³⁹. These ophthalmological manifestations are not specific of LB, and they do not require investigation of *B. burgdorferi* infection

without a clear clinical-epidemiological history or out of the context of LB, since a positive result could be equivocal.

5.5.2 Psychiatric manifestations

Although psychiatric disorders may coexist in the course of LB, there is no recommendation to request microbiological tests to determine the state of infection by *B. burgdorferi* in patients with such disorders if they do not present other clinical manifestations suggestive of LB. The same occurs in children with attention deficits¹⁹. We refer the readers to the excellent and exhaustive reviews about LB previously cited herein, which mention other manifestations that may accompany the wide spectrum of clinical manifestations of *B. burgdorferi* infection^{3,102}.

5.5.3. Congenital Lyme disease

Vertical transmission of *B. burgdorferi* is a proven fact, although there are controversies regarding the risk of transmission and effects on delivery and fetus¹⁴⁰. In 2018, Waddel *et al.* performed a systematic review of gestational LB and 59 cases were identified from 1969 to 2017¹⁴¹. Twelve cases were associated to miscarriage or fetal death; eight cases, with newborn death; and 16, with other post-delivery abnormalities, including syndactyly, respiratory distress and hyperbilirubinemia. One case described complete features of clinical and laboratory results consistent with vertical transmission of LB. They also summarized eight epidemiological studies comparing features or serology from pregnant women in endemic areas with non-Lyme pregnancies. The authors concluded that there was no association between gestational LB or surrogate measures of exposure and adverse birth outcomes. A meta-analysis of nine studies showed significantly fewer adverse birth outcomes in women treated for gestational LB compared to those who untreated during pregnancy, providing indirect evidence of association between gestational LB and adverse birth outcomes. Other risk factors investigated, such as trimester of exposure, acute vs. disseminated LB at diagnosis, and symptomatic LB vs. seropositive women with no LB symptoms during pregnancy were not significantly associated with adverse birth outcomes¹⁴¹.

5.6 Post-treatment Lyme syndrome (PTLS)

Patients diagnosed of LB and correctly treated usually have a full recovery. Anyway, persistent neurologic deficits, such as facial paralysis or persistent pain can be observed in a low percentage of treated patients. Time to recovery can be longer in patients with late stages also. These facts should not be confounded with PTLS.

PTLS has been defined as persistent symptoms without objective manifestations that persist for at least six months after conventional treatment for LB has been completed¹⁴². These patients usually refer nonspecific symptoms, such as fatigue, arthralgia, myalgia, or perceived cognitive impairment. These symptoms should not be attributed to persistent active infection. In this context, serological tests should not be used as proofs of efficacy of the treatment since despite the fact that antibody titres usually decrease after treatment, patients can remain seropositive for years and this fact does not mean active infection^{12,143}.

If these symptoms persist after adequate treatment, several controlled studies have shown that immunocompetent patients do not benefit from retreatment or prolonged treatment^{19,144-146}. In these patients, other possible causes of disease that justify the persistence of clinical manifestations should be sought (Consensus level: 9/9).

'Chronic Lyme Disease' is a term that creates great confusion and it is often used by some doctors and patients¹⁴⁷. Most Health Agencies and Scientific Societies are against the use of this term, which is commonly used to define patients with nonspecific and persistent symptoms in whom no active infection is demonstrated, and even, in many cases, they never have had *B. burgdorferi* infection confirmed with tests recommended in this and other guidelines for the diagnosis of *B. burgdorferi* infection. These patients must be differentiated from patients with clinical manifestations of the late phase of LB with evidence of *B. burgdorferi* infection, and from patients with PTLS (Consensus level: 9/9).

6. DIAGNOSIS OF *Borrelia burgdorferi* s.l. INFECTION AND LYME BORRELIOSIS

6.1. Direct diagnoses

The accurate microbiological diagnosis of *B. burgdorferi* infection and LB is based on the demonstration of the presence of the agent in different biological samples by culture and/or visualization of *B. burgdorferi* in the affected tissues. These techniques require great technical and time-consuming dedication as well as trained staff and continuous quality controls, so they are usually only available in specialized laboratories. In addition, the culture is mainly sensitive in the early phase of the disease, in which the diagnosis is based on the epidemiological history and clinical manifestations. As the infection progresses over time and other organs and systems are affected, the sensitivity decreases. There are different culture media -usually liquid-, with incubations between 30-35°C up to 12 weeks and in microaerophilia, such as the Barbour-Stoenner-Kelly (BSK) and its modifications, such as BSK-II or BSK-H, or the modified Kelly-Pettenkofer medium (KPM)¹⁴⁸⁻¹⁵⁰. However, this technique only has a high performance in skin samples (biopsies of ACA and EM)¹⁵¹, decreasing its sensitivity when performed in sterile fluids such as CSF or synovial fluid in the early disseminated phase (eg: acute meningoradiculitis and arthritis), and even more in the late stages of the disease (e.g. persistent neurological syndromes). Regarding the visualization of *B. burgdorferi* s.l., the lack of specific antibodies for the development of immunohistochemistry techniques also limits their use, although there are specific stains to demonstrate the presence of spirochetes in tissues (Warthin-Starry, modified Dieterle or modified Steiner silver stains)¹⁵²⁻¹⁵⁴. For all these reasons, the direct diagnosis is mainly based on molecular biology techniques (PCR assays in their different versions: conventional, real-time, isothermal, etc.). Their sensitivity at least overlaps with that of culture techniques¹⁵⁵. They are faster, more affordable, and also allow us know the involved genospecies. Nevertheless, molecular tests are not standardized and partial fragments of a variety of chromosomal genes, such as *fla*, *p66*, 16S rRNA or plasmid-borne genes, such as *ospA*, *ospB*, *VlsE* or the 5S/23S rRNA intergenic spacer region can be used as PCR targets. It is worth-noting that plasmid-borne genes may yield false positive results since borrelias are able to shed blebs containing plasmids that dissociate from

bacteria and may persist in tissues and body-fluids without active disease¹⁵⁶. Therefore, detection based on chromosomal genes is recommended. Since their sensitivity can be lower, the use of two target genes is recommended¹⁰. Molecular detection of *B. burgdorferi* should be also performed with appropriate samples (e.g. blood and urine are not suitable materials for diagnosis)¹⁵⁷ and in specialized laboratories. PCR assays are useful in patients with skin manifestations, especially with EM, where the sensitivity is around 70%, according to a meta-analysis conducted by Ružić-Sabljić and Cerar (2017), with a better profitability in skin biopsies from ACA patients, where the diagnostic sensitivity reaches 75%¹⁵⁸. However, molecular assays are not worthy in cases of EM since this skin manifestation is very specific and highly suggestive of LB. Synovial fluid is considered a valuable sample for the diagnosis of LA by PCR, with median sensitivity of 77.5%. It decreases up to 22.5% for CSF in neuroborreliosis, and it is 18% or even lower for blood, serum or plasma samples¹⁵⁸. A negative PCR result does not exclude the possibility of LB. The sample should be quickly processed in the laboratory under optimized conditions (4-8°C in less than 24 hours after the extraction) to obtain the highest yield for *Borrelia* detection¹⁰. Sensitivity of samples fixed in paraffin or kept for longer periods of time is reduced when compared with that of fresh or fresh/frozen specimens¹⁵⁹. The specificity of positive results must be confirmed by identification up to genospecies level to reduce contamination risks. We recommend the use of molecular diagnostic tests in cases of suspicion of neuroborreliosis with CSF, ACA with skin biopsies and LA with synovial fluids, and always performed by specialized laboratories. (Consensus level: 9/9)

6.2. Indirect diagnoses

Due to the difficulties indicated, the most common and accessible diagnostic techniques are the serological ones to demonstrate the presence of antibodies against the causative agent. In this regard, it is worth recalling the kinetics of antibody response against *B. burgdorferi*. Thus, from the bite of the infecting tick to the development of the humoral immune response, a 'window period' or 'serological silence' passes, in which the presence of antibodies is not detected in the infected individual. In patients who develop EM as the first clinical manifestation of the disease, seroconversion occurs between two and four weeks after observation^{143,160}, being those who present localized EM, without systemic involvement, the ones with the lowest seroconversion rate. A negative serological result at an early stage does not necessarily exclude the diagnosis of BL. For this reason, to demonstrate *B. burgdorferi* s.l infection, the serological test should be repeated at least four weeks later. Anyway, it should be clear that in patients with an EM it is not necessary to confirm the presence of antibodies against *B. burgdorferi* to make the diagnosis of LB. Early antimicrobial therapy may abrogate the antibody response, resulting in seronegativity, although evidence is contradictory^{143,161}.

In general, the number of *B. burgdorferi* proteins that are recognized by the immune system of the infected individual significantly increases during the course of the disease. In the early stages of infection, the first proteins to be recognized are OspC (Outer surface protein C), flagellin and BbK32 (Fibronectin-binding protein)¹⁶² that the bacterium expresses early to evade immune mechanisms. In relation to IgM and IgG antibodies produced during infection, IgM occurs in the EM phase only in half of patients in the first two to

four weeks of disease development, so 50% of them are negative to this antibody. If the patient progresses towards the appearance of a second phase of systemic involvement (e.g.: with associated myalgias and arthralgias), IgM production reaches a peak at six-eight weeks and then gradually lowers the titre after three months¹⁶³. However, there may be patients who remain IgM positive for a long time (up to ten years after the infection has passed and been correctly treated)¹⁶⁴. In addition, IgM can be positive in cases of syphilis, infection by Epstein-Barr virus, HIV, systemic lupus erythematosus and other connective diseases and immunological processes, due to cross-reaction¹⁶⁵. Cross-reactions with poorly characterized circulating antigens have also been described in some pregnant women and even in healthy individuals^{166,167}. This is due to some antigens of the bacterium may share epitopes similar to these other infectious agents and to the individual's self-antigens. The development of IgM is followed by an increase in IgG production. This response of polyclonal IgG is directed to numerous proteins of the microorganism such as the aforementioned BbK32, OspC, flagellin and VlsE (Vmp-like sequence E). Subsequently, other IgG antibodies are directed against other proteins such as p58, DbpA (Decorin-binding protein A) and BmpA (*Borrelia* membrane protein A), among others¹⁶⁸. In the late and evolved phases of the disease, normally, although not absolutely, IgM turns negative and an increase in IgG is observed compared to a greater number of antigens.

For all the above, we do not recommend giving a diagnosis of LB based on an isolated positive IgM value, except in early phases, with typical manifestations of the disease and always in an adequate epidemiological environment. Thus, support for the microbiological diagnosis of LB should preferably be performed by IgG measurement (consensus level 9/9).

The most commonly used serological methods are the enzyme immunoassay (EIA or EIA based), indirect immunofluorescence assay (IFA) and immunoblot or Western Blot (WB).

6.2.1 EIA: Different techniques use this approach. The most common is ELISA (enzyme-linked immunosorbent assay), and it can be automated, allowing the processing of a large number of samples and better standardization. Other equivalent techniques, such as ELFA (Enzyme Linked Fluorescent Assay), CLIA (ChemiLuminiscence ImmunoAssay) and MMIA (Multiplexed Microbead ImmunoAssay) have been also developed. The antigens used in all these commercially available techniques can be of four types: 1) Sonicates of the whole bacterium, obtained by culture technique; 2) Purified native antigens; 3) Recombinant antigens (OspC, OspA, BmpA, VlsE); 4) Synthetic peptides such as C6 (extracted from a region of the VlsE) or pepC10 (extracted from the OspC).

The use of sonicates of whole bacterial cells entails the presence of a high number of antigens, many of them of low specificity, which implies a high risk of generating cross-reactions¹⁶⁹⁻¹⁷¹. Some ELISA tests may use a mixture of recombinant antigens with whole cell lysates, which may increase sensitivity in the early phase of LB while maintaining specificity^{172,173}. With the emergence of new *Borrelia* spp. as human pathogens in Europe (e.g. *B. miyamotoi*) the serodiagnosis is even more difficult since ELISA and WB tests designed for the diagnosis of LB may also show cross reactions against *B. miyamotoi* antibodies due to *B. burgdorferi* and *B. miyamotoi* share proteins such as FlaB, GroEL and BmpA (P39)^{174,175}. If these

assays are also cross reactive against other *Borrelia* spp. such as *B. mayonii* is unknown. Up to our knowledge, this species belonging to the *B. burgdorferi* s.l. complex has not been found in Europe.

In addition, the sensitivity of commercial EIA based techniques varies depending on the phase of the patient's disease. Thus, in the phase of localized EM without systemic involvement, the sensitivity is around 54%, in neuroborreliosis it reaches 81%, 96% in arthritis and 97% in ACA. Specificity is generally considered between 90% and 97% in healthy controls¹⁷⁶.

6.2.2. IFA: Another option for the first step of serodiagnosis is the IFA technique. The antigens used are complete bacteria fixed on a slide, alone or in combination with immunodominant antigens, such as VlsE or OspC. Although at first this was the most used or reference technique, today it is used less often than the EIA techniques, since it is not automatable and it is subject to the observer's subjectivity (with the consequent lower reproducibility inter-laboratories)¹⁷⁷. In addition, the interpretation of results is difficult because the optimal dilution of the cut-off point is not standardized⁴⁴. For these reasons, as stated in the German laboratory guidelines¹⁷⁸, we do not consider IFA to be the most appropriate serological technique for screening (Consensus level: 9/9).

6.2.3 WB: It is used for confirmation of EIA or IFA tests. For its interpretation, qualitative criteria have been proposed (assessing as positive the infection by *B. burgdorferi* when certain bands appear)¹⁷⁹ of a quantitative type (assessing not so much the type of bands but the greater or lesser number of them)¹⁸⁰ or a combination of both¹⁸¹. The limitations, as with other serological techniques, are that the simple positivity of bands in the WB can indicate a past contact with the microorganism, an active acute infection, a persistent infection, a cross-reactivity with other microorganisms (particularly in the presence of isolated bands against the flagellin protein), or be the result of a monoclonal or polyclonal stimulation nonspecific B lymphocytes in the course of infections by lymphotropic viruses, such as the VEB. For these reasons, we repeat that the serological diagnosis should be always made under a clinical suspicion of LB and within the appropriate epidemiological context (Consensus level: 9/9).

The incorporation of the C6 peptide or the VlsE protein to the EIA techniques has been proposed in America as a unique and sufficient technique for the microbiological diagnosis or as a second confirmation test ignoring the use of a WB¹⁹. In Europe, two-tier laboratory assay strategy based on a highly sensitive screening EIA based as first step, followed by a highly specific immunoblot test (WB), as confirmation for positive or equivocal cases, continues to offer better profitability^{13,15,18,178}. These differences are due to the fact that in Europe the presence of various genospecies involved in LB (*B. garinii*, *B. afzelii*, *B. burgdorferi* s.s.) can generate antigenic polymorphisms, complicating the serodiagnosis based on ELISA C6, unlike in America, where *B. burgdorferi* s.s. is the only species involved in LB¹⁸².

Taking into account the comments and experience, in Europe the recommended serologic diagnosis of LB consists of an EIA based technique followed by WB^{13,15,18,178}. It must be mentioned that these tests must be performed only in cases of clinically suspected LB (for patients with signs indicated under the clinical case definitions) in an adequate epidemiological environment, with the exception of EM, to avoid

over-testing with the subsequent unnecessary costs¹³. This panel assumes the recommendation with a level of consensus: 9/9.

As already mentioned above, the serology results will depend on the stage of the disease. Thus, in early LB, whose only manifestation of the disease may be the presence of EM, or in the short-term acute neuroborreliosis, serology can be negative in up to 60% of patients. In these cases, with high suspicion of LB and negative serology results, it is advisable to repeat it in three or four weeks to check if there is seroconversion¹⁸. (Level of consensus: 9/9).

A properly treated LB does not preclude the subject from being reinfected after a new tick bite. In these cases, when antibodies from the first infection may continue to exist, serodiagnosis is complicated for the clinician. When we have a patient with a possible reinfection with previously positive serology, it is advisable to do a serology in the new acute phase of reinfection, repeating it three-four weeks later in order to detect any increase in the antibody titre or modifications in the pattern of WB bands, with respect to the first infection (Consensus level: 9/9).

In case of suspected neuroborreliosis, blood serology is insufficient since, even if positive, it would establish the diagnosis only in a few cases (e.g.: the development of facial paralysis in a child after a recent bite of *I. ricinus* in an endemic area with a positive serology result against *B. burgdorferi* is highly suggestive of neuroborreliosis). CSF analysis should be performed, since on rare occasions patients may show IgG antibodies in the CSF in the absence of a peripheral response. In neuroborreliosis there is a lymphocytic pleocytosis, sometimes with the presence of plasma cells, a highly suggestive finding. The spirochetal invasion of the CNS results in the local production of CXCL13, a B-cell attracting chemokine with the subsequent intrathecal production of specific antibodies. The demonstration of intrathecal antibody production is highly indicative of neuroborreliosis and relies on measuring anti-IgG *Borrelia* antibodies in both CSF and serum, and referring it to the total albumin or immunoglobulins G in both samples¹¹¹. The formula usually employed is:

Antibody Index = Concentration (U/ml) of specific IgG antibodies in CSF / Concentration (U/ml) of specific IgG antibodies in blood serum / Total concentration (mg/L) of IGG in CSF / Total concentration (mg/L) of IgG in blood serum.

An antibody index greater than 1.3 indicates positivity for intrathecal synthesis^{183,184}. In addition, the CSF can be processed for culture and molecular techniques.

6.3 Other techniques for the diagnosis of infection with *B. burgdorferi* s.l. and LB

There are other techniques that have not been approved by any scientific agency or society as valid for the diagnosis of LB and that, for this reason, are discouraged:

6.3.1. Determination of CD57+

CD57+, also called HNK-1, LEU-7 or L2, is a sulfated carbohydrate molecule, with a molecular weight between 100 and 115 kD. It has been defined as a Natural Killer (NK) lymphocyte marker, although it is only expressed in a percentage of lymphocytes and is also expressed in T lymphocytes, especially in the

senescence phase or 'exhausted lymphocytes'¹⁸⁵. Based on a study by Stricker and Winger, a low CD57+ cell count (mean 30±16 cells/ml) was associated with the controversial term chronic LB¹⁸⁶. The authors studied 73 patients with LB who started late antibiotic treatment and found an increase in the count of these cells after therapy (66±39 cells/mL). However, this study suffers from several biases, such as the low number of patients included, biases in the presentation of results, non-monitoring of expression kinetics in patients after treatment, non-validated control groups, and absence of a clear case and treatment definition. Other researchers, such as Marques *et al.* found no significant differences in CD57+ between nine patients with post-Lyme syndrome versus 12 patients cured of LB and the control group consisting of nine healthy volunteers¹⁸⁷.

The elevation or decrease of the CD57+ marker has been associated with HIV, B hepatitis, C hepatitis, measles, parvovirus 19 and cytomegalovirus (CMV) infections¹⁸⁸, and non-infectious pathologies, such as multiple sclerosis, systemic lupus erythematosus, rheumatoid arthritis, dermatomyositis, polymyositis, ankylosing spondylitis or chronic fatigue syndrome, among others. Alterations in the expression of this marker have been also detected in different types of cancer¹⁸⁹.

Based on these studies and publications, the CD57 marker does not seem a useful parameter even after antibiotic treatment or persistence of symptoms. To date, none studies have proven the usefulness of this test or its sensitivity and specificity (Consensus level: 9/9)

6.3.2. ELISPOT Interferon- γ Test (IFN- γ)

It is based on the release of IFN- γ from samples of peripheral blood leukocytes that are stimulated with antigen/s of the microorganism, in order to explore the stimulation and activation of T lymphocytes against the different *B. burgdorferi* genospecies.

Several studies have shown the elevation of IFN- γ levels in patients with early, late/evolved LB and post-Lyme syndrome. The sensitivity of this test during the early phase of the disease ranges from 36% to 69%¹⁹⁰. In another study in which this test was performed for patients who had a positive ELISA C6 test, sensitivity was increased to 83%¹⁹¹. Also, in this unique study, the decrease of this parameter was verified for patients undergoing antibiotic therapy for LB, and no other study has demonstrated the agreement between the serological tests and the concentration of IFN- γ . The specificity of the test is highly variable among studies according to the chosen population. Similarly, cross-reaction with other spirochetes and lack of reproducibility has been demonstrated¹⁹². The determination of this molecule in other samples (synovial fluid, CSF, skin biopsies, etc.) has not shown that it can be a useful diagnostic tool.

6.3.3. IFN- α

There are studies, such as that of Jacek *et al.* (2013)¹⁹³ that have shown an increase in IFN- α levels for patients with post-Lyme syndrome, which may suggest the existence of immune-mediated processes in patients with persistent symptoms, which may contribute to the immunopathology of the disease. These same authors demonstrated how treatment with beta-lactam antibiotics did not modulate the activated

immune response. As with the previous test, more studies are needed to demonstrate the clinical utility of this parameter.

Therefore, currently the ELISPOT IFN- γ test and the IFN- α should not be used in clinical practice until other research studies prove their usefulness (Consensus level: 9/9).

6.3.4. Lymphocytic proliferation test

It serves to assess the lymphoproliferative response of peripheral blood mononuclear cells against *B. burgdorferi* antigens. The results are expressed based on a Stimulation Index (SI). If the SI is greater than ten, the test is considered positive and if it is less than ten, negative. At present, no study has been able to demonstrate its clinical utility, obtaining low specificities and sensitivities, so that the diagnostic guidelines do not contemplate this test¹³. (Consensus level: 9/9)

6.3.5 CXCL-13 marker

This is an immunological marker (chemokine) that can be studied in CSF when suspected neuroborreliosis, also known by other names such as BCA-1 or B cell-attracting chemokine (B cell-attracting chemokine-1), and BLC or B lymphocyte chemoattractant. Its primary function is to attract B lymphocytes. It is expressed in high density in organs such as the spleen, lymph nodes, liver and digestive system. In relation to LB, this molecule is becoming one of the most promising diagnostic tools. Its greatest usefulness is within the diagnosis of early neuroborreliosis and several studies have demonstrated its elevation in the CSF of these patients¹⁹⁴⁻¹⁹⁶. It is detected before the antibodies in the CSF and also its concentration decreases in a short period of time once the antibiotic treatment is established, so it can also be used for monitoring it. It has a sensitivity of 89%-97% and a specificity of 96%. One of its drawbacks is that there is currently no established value as a cut-off point, with each laboratory having its own, so the interpretation can be variable inter-laboratories. Another drawback is that it can also rise in other inflammatory diseases of the CNS such as some viral meningitis, neurosyphilis, cryptococcosis or even lymphoma in CNS, which forces to discard these for a correct interpretation of this marker. This panel recommends this determination for the diagnosis and follow-up of LB with caution until there is no more data and its specificity is better known (Consensus level: 9/9)

6.3.6. There are other **markers** that are currently being evaluated, such as the determination of **CCL-19**¹⁹⁷, **apolipoprotein B-100**^{198,199} **antibody-free chains (kappa and lambda) or the determination of total IgM and albumin** in the CSF of patients with probable neuroborreliosis. However, none has shown to be more promising than CXCL-13, as the range of positivity in patients presenting with other non-Lyme neuro-inflammatory diseases is higher, leading to low specificity²¹. Techniques such as either dark-field or focus floating microscopy are not recommended for diagnostic purposes^{15,20} (Consensus level: 9/9).

7. TREATMENT:

The antimicrobial treatment of LB has not changed in recent decades and it is based on the treatment of the infection by *B. burgdorferi* depending on the stage of the disease and the organ and/or system affected^{200,201}.

To our knowledge, there are no large clinical trials with an appropriate design and enough number of patients to support the recommendations with high level of scientific evidence in some cases, so many recommendations are fundamentally based on the few clinical trials and meta-analysis studies collected in the scientific consensus recommendations published by other scientific societies^{15,17,19,55,202}. The choice of the drug will depend on the age, history of allergies, pregnancy, intolerances, or sun exposure given the possibility of photosensitivity with doxycycline. Tables 5 to 12 schematically show the drugs and recommended doses in each of the processes associated with LB.

We are aware of the controversy with the term "chronic Lyme" and its treatment^{203,204}. Since the members of this panel do not consider other LB forms than those developed in the different sections of the text, and reject the term "Chronic Lyme Disease" related to a persistent infection by *B. burgdorferi* resistant to conventional treatment, we will not make recommendations on this aspect. Anyway, all the members of this document are against carrying out prolonged treatments with antibiotics and/or their combinations in patients who suffer non-specific clinical manifestations such as asthenia, arthralgia, lack of concentration, etc., with the exceptions that appear in the text for the simple fact of having suffered a previous infection by *B. burgdorferi* s.l. (Consensus level: 9/9)

Most LB patients respond to antimicrobial treatment in a timely manner, depending on the type of clinical manifestation and/or affected organ or system, although in patients under special conditions, such as those undergoing immunosuppressor treatments, anti-TNF, hematological malignancies or in elderly patients, the response may be slower and sometimes patients have to be retreated²⁰⁵⁻²⁰⁸.

Another aspect that we want to highlight is that this panel recommends the use of doxycycline over other therapeutic options, when appropriate. Consideration should be given to the good penetration of this antibiotic into the CNS and other tissues due to the possibility of spirochete dissemination. Unlike the recently published American Guidelines, which consider the preferential treatment with intravenous beta-lactams in the treatment of neuroborreliosis¹⁹, doxycycline can also be considered as an alternative treatment to intravenous beta-lactams for the treatment of CNS infections with meningeal involvement. In fact, in Europe, doxycycline is considered the treatment of choice if there are no parenchymal complications^{15,17,209,210}. (Consensus level: 9/9)

In addition, doxycycline has the advantage of being active and of choice against other microorganisms transmitted by ticks that occasionally can co-infect the patient, such as *A. phagocytophilum*, *B. miyamotoi* and *Rickettsia* spp. that are circulating in our environment and are transmitted by *I. ricinus*. It is only recommended avoiding doxycycline in pregnancy and lactation, when the risk benefit must always be assessed^{211,212}. Regarding the use of doxycycline in children, the American Academic of Pediatrics recently wrote: 'Clinical use of tetracyclines in children younger than eight years has been limited due to the known binding to teeth and bones in young children that permanently may stain teeth. However,

doxycycline, a second-generation tetracycline, has not been shown to cause tooth staining in young children'. 'Doxycycline can be used for short durations (e.g. 21 days or less) without regarding patient age'²¹³.

Another factor to consider when prescribing an antimicrobial treatment against LB is that although treatments are generally well tolerated, depending on the phase of the disease, more than 15% of patients may experience a Jarisch-Herxheimer reaction consisting of a transient exacerbation of symptoms during the first 24 hours of treatment²⁰⁰.

7.1. Early localized phase

7.1.1. Erythema migrans

There are some randomized clinical trials comparing the efficacy of different treatments in this situation. Results may vary between those performed in Europe or in the US, because of the design and to the fact that the *Borrelia* genospecies involved may be different. Anyway, and based on these clinical trials, the treatment of choice in this situation is an oral regimen with doxycycline, amoxicillin or cefuroxime axetil²¹⁴⁻²¹⁷ as is showed in table 5. This panel, when no contraindication, preferably recommends the use of doxycycline for 10-14 days, both in children and adults (Consensus level: 9/9).

If a beta-lactam from those specified (equally effective) is chosen, it should be prolonged for a minimum of 14 days. The use of macrolides (azithromycin, clarithromycin or erythromycin) as first-line drugs is generally discouraged, leaving them as an alternative in cases where doxycycline, amoxicillin or cefuroxime cannot be used. In the case of the use of azithromycin, some authors recommended prolonging the treatment for seven days²¹⁸. In pregnant patients, the use of ceftriaxone is the recommended option²¹⁹. (Consensus level: 9/9).

Table 5: Treatment of erythema migrans in the early localized phase without other associated symptoms.

Drug	Adult dose	Child dose	Duration
Doxycycline	100 mg orally BID	4 mg/kg/day orally in two divided doses (maximum 100 mg per dose)	10 days (10-21 days)
Amoxicillin	500 mg orally TID	50 mg/kg/day orally in three divided doses	14 days (14-21 days)
Cefuroxime axetil	500 mg orally BID	30 mg/kg/day orally in two divided doses (maximum 500 mg per dose)	14 days (14-21 days)
Azithromycin	500 mg orally OD	5-10 mg/kg/day orally	5 days

		(maximum 500 mg per dose)	(5-10 days)
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BID: one doses every 12h; TID: one doses every 8h; OD: one doses every 24h.

7.1.2. Borrelial Lymphocytoma

The pattern for borrelial lymphocytoma is similar to that used in EM¹⁵, although a retrospective study of 144 adult patients treated with these guidelines has shown that 9.7% of the patients required retreatment because the lesion persisted after one month. Subsequently, it disappeared in all cases²²⁰. The recommended treatment is showed in table 6. It must be considered that there are no consensus among Societies since French guidelines recommend 14 days¹⁵ and other guidelines such as the German ones recommend 21 days⁵⁵.

The duration in days of the treatment recommended in the table should be considered according to the severity and persistence of the clinical manifestations. Most patients treated with the recommended regimen present a complete resolution of the signs and symptoms in the following 20 days, avoiding the progression to other phases of the disease. As in other infectious diseases, some patients present subjective symptoms (headache, musculoskeletal pain, arthralgia or fatigue) that can persist for weeks or months after treatment. These symptoms usually resolve spontaneously in the following months and do not require sustained or repeated antibiotic treatment, as they are not due to the persistence of the infection. However, if the appearance of other clinical manifestations (e.g.: fever) is observed despite treatment, co-infections with other tick-borne agents (*A. phagocytophilum*, *Babesia divergens*, *B. miyamotoi*) should be ruled out. (Consensus level: 9/9)

It should also be considered that infection with *B. burgdorferi* and LB do not leave permanent immunity and LB may be suffered in more than one occasion (very rare). In that case, the patient will be treated under the same recommended guidelines¹⁵. (Consensus level: 9/9)

7.2. Early disseminated phase

7.2.1. Multiple Erythema Migrans

The recommended treatment is oral doxycycline for ten to 21 days, with the same considerations made in localized EM. Prolongation of treatment for more than ten days will be based on accompanying signs and symptoms^{209,211}. The doses and duration of the treatment against multiple EM with associated flu-like symptoms and Borrelial lymphocytoma are showed in table 6.

Table 6: Treatment of multiple erythema migrans in early disseminated phase with associated flu-like symptoms and/or solitary or disseminated lymphocytoma.

Drug	Adult dose	Child dose	Duration
Doxycycline	100 mg orally BID	4 mg/kg/day orally in two divided doses (maximum 100 mg per dose)	14 days (10-21 days)
Amoxicillin	500 mg orally TID	50 mg/kg/day orally in three divided doses	14 days (14-21 days)
Cefuroxime axetil	500 mg orally BID	30 mg/kg/day orally in two divided doses (maximum 500 mg per dose)	14 days (14-21 days)
Azithromycin	500 mg orally OD	5-10 mg/kg/day orally (maximum 500 mg per dose)	7 days (5-10 days)

BID: one doses every 12h; TID: one doses every 8h; OD: one doses every 24h.

7.2.2. Early neuroborreliosis

Clinical Practice Guidelines for therapeutic management of Lyme neuroborreliosis have been recently published by the Infectious Diseases Society of America, American Academy of Neurology and American Collage of Rheumatology¹⁹, and the European Federation of the Neurology Societies (EFNS)¹²³. German and French Guidelines have been also recently published^{15,17}.

Using an intravenous beta-lactam (ceftriaxone, penicillin or cefotaxime) for the treatment of these conditions has been the classic recommendation, and this option continues to be the one recommended by the American guidelines. In Europe, the new guidelines recommend the use of oral doxycycline as long as there are no parenchymal complications at the brain or spinal level or the clinical manifestations are very severe²¹⁰.

The recommended treatment for isolated facial paralysis without signs of meningeal involvement is oral doxycycline for a minimum of 14 days and a maximum of 28 days, although a clinical trial did not show differences in the response related to the duration of treatment²²². In any case, as specified in previous paragraphs, the history of allergies, oral tolerance, pregnancy and lactation should be taken into account. The minimum duration of treatment should last at least 14 days in children and adults^{15,17}. Adjunctive corticosteroids neither improve nor impair the outcome for patients with LB peripheral facial palsy treated with doxycycline²²³. As also specified in previous paragraphs, doxycycline is the elective antibiotic

treatment for the remaining neurological manifestations of the early phase, and as an alternative, a beta-lactam by intravenous route at the doses and with the duration specified in the table 7. In case of parenchymal involvement, the recommended treatment is an intravenous beta-lactam as is showed in table 7. (Consensus level: 9/9)

Table 7: Isolated facial palsy, or involvement of other cranial nerves with or without associated meningitis or polyradiculoneuropathy without parenchymal involvement and with parenchymal involvement*.

Drug	Adult dose	Child dose	Duration
Doxycycline	100 mg orally BID	4 mg/kg/day orally in 2 divided doses (maximum 100 mg per dose)	14 days (14-28 days)
Ceftriaxone*	2 g intravenous OD	80 mg/kg/día intravenous OD (maximum 2 g/day)	14 day (14-28 days)
Cefotaxime*	2 g intravenous TID	150-200 mg/kg/day intravenous divided in 3-4 doses (maximum 6 g/day)	14 days (14-28 days)
Penicillin G*	20 million Units intravenous divided in 6 doses	200,000-400,000 U/kg/day IV divided in 6 doses (maximum 20 million/day)	14 days (14-28 day)

BID: one doses every 12h; OD: one doses every 24h; TID: one doses every 8h.

7.2.3. Carditis

Asymptomatic AV-B with a PR interval of less than 300 milliseconds observed with relative frequency in the early stages of the disease does not require antimicrobial treatment different from that of the process itself. Patients with myopericarditis or those with severe or potentially severe involvement should receive intravenous antibiotic treatment at the doses and for the duration specified in Table 8. This can be simplified to the oral route (doxycycline, amoxicillin or cefuroxime axetil) once the blockage is resolved and/or clinical improvement occurs until completing a cycle of 21-28 days¹⁹. In patients with symptomatic bradycardia that cannot be managed with drugs, the American guidelines recommend the use of temporary pacemakers¹⁹. This panel agrees with these recommendations. (Consensus level: 9/9).

Table 8: Carditis in uncomplicated patient PR <300 ms and *carditis with first degree AV-B with PR >300 ms or 2/3 degree AV block or myocarditis.

Drug	Adult dose	Child dose	Duration
Doxycycline	100 mg orally BID	4 mg/kg/day orally in two divided doses (maximum 100 mg per dose)	14 days (14-21 days)
Amoxicillin	500 mg orally TID	50 mg/kg/day orally in three divided doses	14 days (14-21 days)
Cefuroxime axetil	500 mg orally BID	30 mg/kg/day orally in two divided doses (maximum 500 mg per dose)	14 days (14-21 days)
Ceftriaxone*	2 g intravenous orally OD	80 mg/kg/day intravenous orally (maximum 2 g/day)	14 days (14-28 days)

BID: one doses every 12h; TID: one doses every 8h; OD: one doses every 24h.

Treatment of the other manifestations accompanying the early disseminated phase, such as the possibility of acute arthritis, should be carried out following the scheme in Table 7.

7.3 Late phase

7.3.1. Arthritis

In the case of arthritis, to prolong treatment with oral doxycycline, amoxicillin or cefuroxime for up to 28 days at the doses specified in table 9 is recommended. Some patients with sustained synovitis refractory to antibiotic treatment may benefit from the use of disease-modifying antirheumatic drugs, such as methotrexate or arthroscopic synovectomies^{15,17,19}.

(Consensus level: 9/9)

Table 9: Treatment of persistent arthritis.

Drug	Adult dose	Child dose*	Duration
Doxycycline	100 mg orally BID	4 mg/kg/day orally in two divided doses (maximum 100 mg per dose)	28 days
Ceftriaxone	2 g intravenous orally OD	80 mg/kg/day intravenous orally OD (maximum 2 g/day)	28 days
Amoxicillin	500 mg orally TID	50 mg/kg/day orally	28 days

BID: one doses every 12h; OD: one doses every 24h; TID: one doses every 8h.

7.3.2. Acrodermatitis chronica atrophicans (ACA)

Treatment with oral agents is recommended as showed in Table 10. Doxycycline or amoxicillin for 30 days are the recommended ones⁵⁵. When ACA is accompanied by involvement of the nervous system (usually as axonal polyneuropathy with predominant sensory symptoms), intravenous therapy with ceftriaxone or other beta-lactam should be used⁵⁵. (Consensus level: 9/9)

Table 10: Treatment of acrodermatitis chronica atrophicans with or without associated polyneuropathy.

Drug	Adult dose	Child dose*	Duration
Doxycycline	100 mg orally BID	4 mg/kg/day orally in two divided doses (maximum 100 mg per dose)	28 days
Amoxicillin	500 mg orally TID	50 mg/kg/day orally in three divided doses	28 days
Ceftriaxone	2 g intravenous orally OD	80 mg/kg/day intravenous OD (maximum 2 g/day)	28 days

BID: one doses every 12h; TID: one doses every 8h; OD: one doses every 24h.

7.3.3. Late neuroborreliosis

As detailed in the corresponding section for this phase, different neurological manifestations have been described, such as subacute encephalopathy, mononeuritis multiplex, peripheral axonal sensory neuropathy or encephalomyelitis, among others. These pictures are very rare and avoidable with effective treatment in previous stages of the disease. There are excellent manuscripts that have exhaustively reviewed their therapeutic approach. The EFNS recommends treatment of these conditions with intravenous ceftriaxone for three weeks¹²³. The same therapeutic option is recommended by the American Academy of Neurology (AAN), although they do not specify the duration of treatment²²⁴. German guidelines recommend the same scheme for two-three weeks¹⁷, while French guidelines recommend doxycycline and ceftriaxone as an alternative for three weeks¹⁵. This panel, as in the previous sections, chooses to recommend doxycycline as the first option and ceftriaxone as an alternative depending on the severity of the clinical picture and accompanying manifestations (e.g.: ACA and polyneuropathy), as showed in Table 11. As an adjunct to antimicrobial therapy, accompanying symptoms should be treated. Rehabilitation treatment and psychological support to patients are sometimes needed. (Consensus level: 9/9)

Table 11: Treatment of late neuroborreliosis.

Drug	Adult dose	Child dose	Duration
Doxycycline*	100 mg orally BID	4 mg/kg/day orally divided in two doses (maximum 100 mg per dose)	21 days (14-21days)
Ceftriaxone*	2 g intravenous OD	80 mg/kg/day intravenous OD (maximum 2 g/day)	21 days (14-21 days)

BID: one doses every 12h; OD: one doses every 24h.

* In case of coexistence of ACA, 28 days.

7.4. Post-Lyme syndrome. Chronic Lyme borreliosis.

The prescription of an adequate treatment, under the recommendations established in the text, allows the control of the infection with cure for a very high percentage of patients. For patients treated in the early phase of the disease, cure usually occurs within three weeks whereas in the late-phase of the disease, the response is usually slower. Antibiotic treatment may fail, although this situation is rare and it is usually due to problems with adherence or absorption of antibiotics rather than to the existence of antibiotic resistance of *B. burgdorferi*. For patients with the so-called post-Lyme syndrome, there is some controversy. Studies showing no effect on such symptoms after prolonging the duration of the antibiotic treatment, repeating it or carrying out cycles with antibiotics, have been carried out^{144,145,225-229}. This

approach is not recommended in any guideline. However, some authors advocate prolonging treatment in case of persistence of symptoms and evidence of coinfection by other tick-borne agents²⁰³. Anyway, the issue draws great controversy.

The members of this panel, until there is more scientific evidence, and since the persistence of *B. burgdorferi* infection after adequate treatment has not been demonstrated, are positioned not to use prolonged treatments or cycles or combinations of antibiotics in these cases. (Consensus level: 9/9).

We have often observed that prolonged treatment with doxycycline improves subjective symptoms in patients with post-Lyme disease or with other persistent inespecific symptoms of different diseases. This could be due to the inhibition effect of doxycycline metalloproteases rather than to their antimicrobial effect²³⁰.

8. PROPHYLAXIS

Prophylaxis of LB is based on pre-exposition measures to avoid the bite of the vector and post-exposition measures.

8.1. Pre-exposition measures

The best method to avoid LB is preventing tick bites. In the table 12, the general recommendations for preventing LB are showed. This implicates preventing tick exposure by avoiding tick-infested areas during the periods of *I. ricinus* activity in Spain²³¹. In case of going to the countryside, being keeping to the center of trails could minimize contact with adjacent vegetation where ticks are more abundant. The use of protective clothing that limits the contact of ticks with the body can be very effective to avoid tick attachment. It is advisable wearing light-colored clothing to detect the arthropod before attached to the skin, cap, long trousers tucked into the socks, long-sleeved shirt tucked into the trousers and do not wear sandals or open-toed shoes. It is desirable to inspect for unattached ticks on clothing because they can turn into a later tick-bite as well as washing clothes in hot water and dry clothing on high heat after outdoor activities. Bathing may also wash off unattached ticks²³¹. The use of repellents has also demonstrated the decrease of tick-bites incidence when applied to clothes and/or bare skin. A good repellent should be effective against various arthropods, no irritating after topical administration, with pleasant odor or odorless, persistent after washing and economic. Recommended repellents for the prevention of tick-bites are DEET (N,N-diethyl-meta-toluamide), picardin, ethyl-3-(N-n-butyl-N-acetyl) aminopropionate (IR3535), oil of lemon eucalyptus (OLE), p-menthane-3,8-diol (PMD), 2-undecanone, or permethrin^{19,231}. All of them can be applied to both skin and clothing, except permethrin which must be only applied to clothing due to its toxicity. When clothes are sprayed with permethrin (0.5%) or made with pretreated, permethrin-impregnated material provides high effective protection against tick-bites^{232,233}. Its use on clothing could be effective for up several weeks and even supports the washings reducing significantly tick-bites and tick-borne pathogen transmission^{232,234}. In general, efficacy and duration of repellents depends on the concentration used providing greater and/or longer periods of efficacy those products with higher concentrations²³⁵. However, DEET optimal concentration range varies from 15 to 33%. Products

containing >50% do not offer a significant increase in protection time over lower concentrations²³⁶. DEET, which is available in a wide variety of topical formulas providing up to 12 hours of protection, has been shown to be the most effective and with the broadest spectrum repellent¹⁹.

Despite these products are reasonably safe to use, many people develop certain toxicity. This fact has misguided in the use of repellents based on natural products as garlic, citronella, eucalyptus oil, geranium oil, lavender oil or Alaska yellow cedar oil (e.g., citriodiol or p-menthane-3,8-diol available on the market as a tick repellent) but there is not enough evidence and their effectiveness has to be demonstrated. The Spanish Association of Pediatrics as well as the American Academy of Pediatrics (AAP)²³⁷ and the CDC only recommend DEET for children at least two months of age, although it is desirable to be avoided as much as possible in children under two years of age²³⁸. The American Association of Pediatrics and the CDC do not recommend OLE and PMD for children <three years of age¹⁹. The contact between humans and parasitized domestic animals could increase the risk of a tick-borne disease acquisition. Thus, the most effective preventative measure arises in the use of effective long-acting acaricides in pets as permethrin, amitraz or fipronil or lindano^{239,240}.

The members of this panel assume these recommendations to avoid tick-bites (Consensus level: 9/9). Other measures based on controlling and reducing ticks and tick-infected populations to reduce the number of human tick-bites and human diseases include physical, mechanical and biological strategies and are beyond the scope of these guidelines.

Vaccines for preventing LB were developed in past and only available in USA but to date commercial vaccines are not available for humans^{241,242}. New technologies based in the new RNA vaccines developing antibodies against tick-saliva components have shown 'in vitro' activity to reduce *B. burgdorferi* infection. Educational programs could be a good tool to decrease the risk of acquiring a tick borne infectious disease increasing people confidence and likelihood to practice precautionary behaviors²⁴³.

This panel recommends education programs in schools and recreational or professional associations (hunters, mountaineers...) that instruct in the prevention of tick bites, how to recognize them and ways of extraction (Consensus level: 9/9).

Table 12: General recommendations to prevent Lyme borreliosis.

- Do not go off the trail when walking in areas where there are ticks.
- Use clothes that cover exposed areas of the body (cap, long trousers tucked into the socks, long sleeved shirt into the trousers and appropriate footwear).
- Wear light-colored clothing to detect ticks before they attach.
- Use tick repellents.
- Inspect the body after being in an outdoor area where ticks are abundant.
- Remove the tick with tweezers as soon as possible when detected.
- Take doxycycline in certain circumstances after tick-bite.
- Observe the site of the tick attachment for up to six weeks.

8.2. Post-exposition measures

If a patient is bitten by a tick, we must proceed to extract it and the use of antibiotic prophylaxis with doxycycline should be considered.

8.2.1. Tick removal

Despite wearing appropriate clothing, tick bites can occur and they are usually painless, making important to do an exhaustive exploration of the entire body in order to look for any attached ticks and remove them. Removal of the attached ticks must be done as soon as possible since it is accepted that 36-48 hours for *B. burgdorferi* transmission are needed, and the risk increases with longer attachments. Some European studies suggest the transmission of *B. burgdorferi* within 24 hours of attachment of *I. ricinus* ticks^{244,245}. The use of tweezers or forceps to remove ticks significantly decreases the risk of complications associated to the tick-bite or the infection with the microorganisms they transmit²⁴⁶. The correct extraction of ticks should be done using thin-tipped tweezers or blunt, rounded forceps introducing them between tick head and the skin to grasp the mouth parts of ticks intact, if possible, and pulling the tick straight upward with steady pressure, perpendicular to the skin²⁴⁷. Other tick removal devices have been shown being useful for removing ticks²⁴⁸⁻²⁵¹. If after the extraction any part of the tick is retained in the skin it should be advisable to perform a biopsy of the inoculation place in order to avoid a neurotoxic paralysis due to the presence of the arthropod salivary glands and the neurotoxin in the patient when the bite is close to a nerve structure²⁵². Nevertheless, last American Guidelines for the Prevention, Diagnosis and Treatment of Lyme Disease indicates that if a tick is partially removed, but detached mouthparts remain and cannot easily be removed from the skin, they should be left alone and permitted to fall out¹⁹. After removing the tick from the skin area, it should be disinfected with povidone iodine, chlorhexidine or other skin disinfectant. Ticks removed should be stored at -20°C for future analyses for the detection or isolation of the causative agent in case of the patient develops an infectious disease²⁵³. Other popular methods for removing ticks from skin as manual extraction, oil, vaseline, petroleum, lighted cigarettes, among others, are associated with an increase of complications and transmission of infectious agents^{246,247}. Taken into account the above considerations, this panel recommends not handling the tick and use forceps for the tick extraction, as is showed in **figure 9** (Consensus level: 9/9).

8.2.2. Antibiotic Prophylaxis after Tick Bite

Single-dose doxycycline, given within 72 hours of exposure, is common practice in US and has been evaluated in different clinical studies for postexposure prophylaxis of three spirochetal infections: Lyme disease, syphilis, and tick-borne relapsing fever²⁵⁴. The last Guidelines by the Infectious Diseases Society of America (IDSA) recommend prophylactic antibiotic therapy only to adults and children within 72 hours of removal if the tick bite was from an identified *Ixodes* spp., if it occurred in a highly endemic area, and if the tick was attached for ≥ 36 hours¹⁹. The preferred antibiotic regimen for the chemoprophylaxis is the administration of a single dose of oral doxycycline (200 mg for adults and 4 mg/kg up to a maximum dose of 200 mg for children) within 72 hours of tick removal over observation. In this case, it has been weighed

the likelihood of disease and the effectiveness of prophylactic doxycycline therapy to be higher than the potential risks of the antibiotic. This fact has been not extensible for European countries where it is not recommended with the argument that it will be necessary to perform 40-125 prophylaxes for preventing one borreliosis²⁵⁵, and the impact on the intestinal flora and a possible development of resistance is conceivable¹⁷. Anyway, doxycycline prophylaxis must be reconsidered in Europe. Thus, a clinical trial that would allow extending this recommendation to Europe has been recently published²⁵⁶. In this open-label, randomized, controlled trial, administering a single dose of 200 mg doxycycline within 72 h after removing an attached tick from the skin, compared to no treatment in people older than eight years resulted in a relative risk reduction of 67% (95% CI 31 - 84%). No serious adverse events were reported. Since we do not have data from Spain and considering that it is a sunny area, a reasonable option might be to consider that when the tick has been manipulated, the tick is engorged or the patient has a high level of anxiety, the prophylaxis with doxycycline could be offered (Consensus level: 9/9).

Safety of doxycycline during pregnancy has not been assessed; therefore, in the case of pregnant women, risks, benefits and uncertainties of doxycycline versus observation should be weighed²⁵⁴. In any case, after suffering a tick bite, it is advisable to instruct the patients in the possible signs and symptoms that they may develop and they should at least observe the point of the bite for at least six weeks (Consensus level: 9/9).

CONFLICTS OF INTEREST

1. **José A. Oteo** declares no conflict of interest in the writing of this article.
2. **Héctor Corominas** declares no conflict of interest in the writing of this article.
3. **Raquel Escudero** declares no conflict of interest in the writing of this article.
4. **Fernando Fariñas-Guerrero** declares no conflict of interest in the writing of this article.
5. **Juan Carlos García-Moncó** declares no conflict of interest in the writing of this article.
6. **Miguel A. Goenaga** declares no conflict of interest in the writing of this article.
7. **Sara Guillén** declares no conflict of interest in the writing of this article.
8. **José M. Mascaró** declares no conflict of interest in the writing of this article.
9. **Aránzazu Portillo** declares no conflict of interest in the writing of this article.

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FIGURES

Figure 1: Female *Ixodes ricinus* waiting on the grass.



Figure 2: Patient bitten by an adult female (A) and a nymph (B) of *Ixodes ricinus*. Note the concomitant presence of an erythema surrounding the tick caused by the local irritation of the tick saliva.

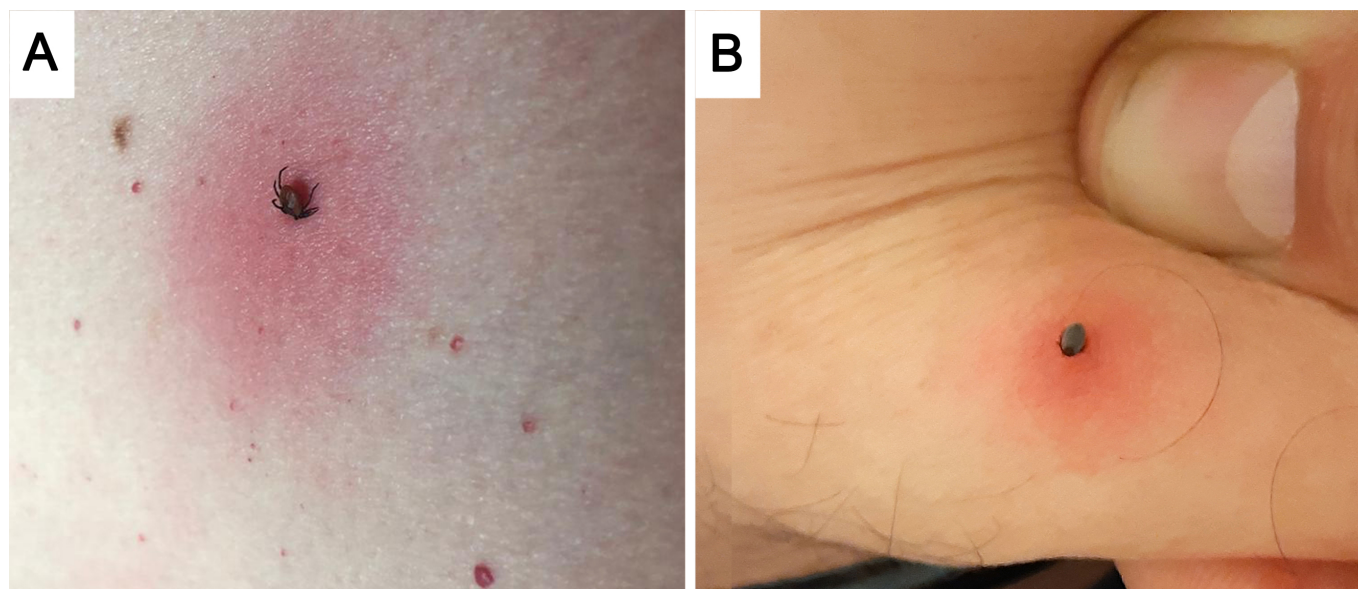


Figure 3: Different sizes and stages of *Ixodes ricinus*.

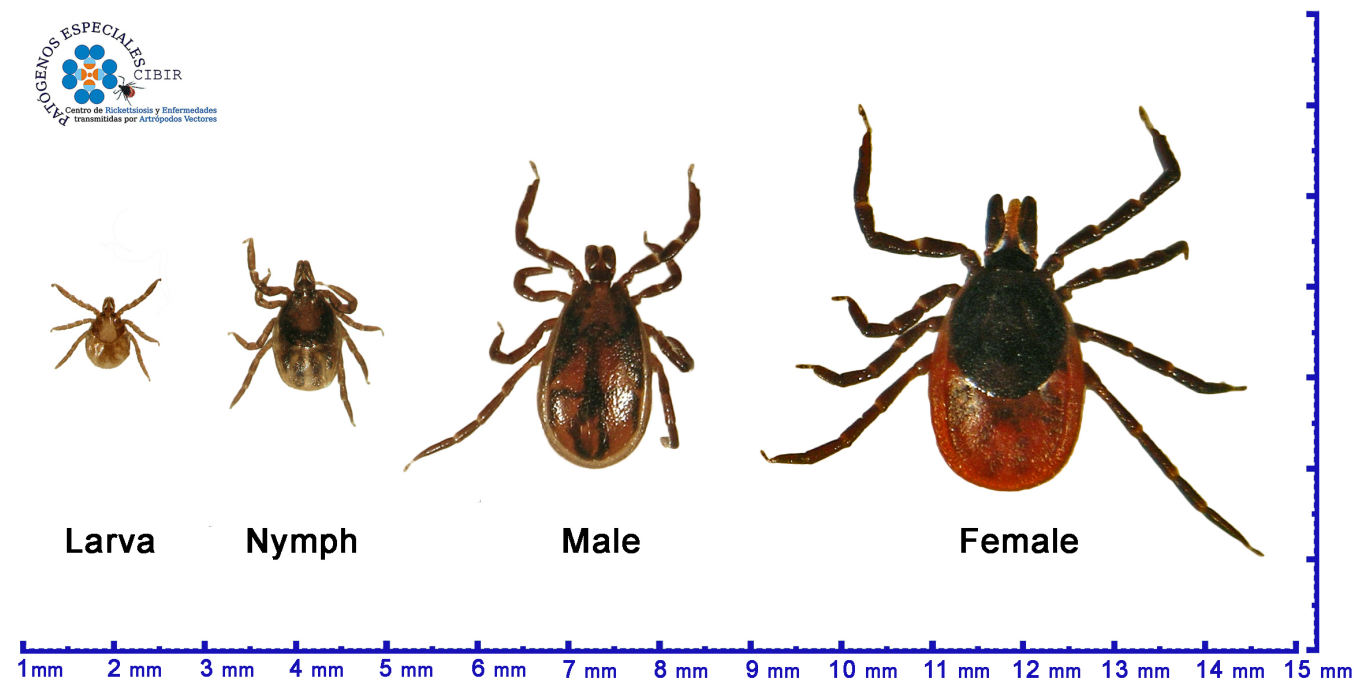


Figure 4: A) Typical erythema migrans (EM) with annular appearance on leg. B) Large EM of more than 6 weeks of evolution. C) EM without the typical annular appearance. D) EM in the early disseminated phase with satellite lesions.



Figure 5: Erythema migrans-like lesions with eschar in patients bitten by *Dermacentor marginatus* and caused by *Candidatus Rickettsia rioja* (A) and *Rickettsia slovaca* (B) (DEBONEL).

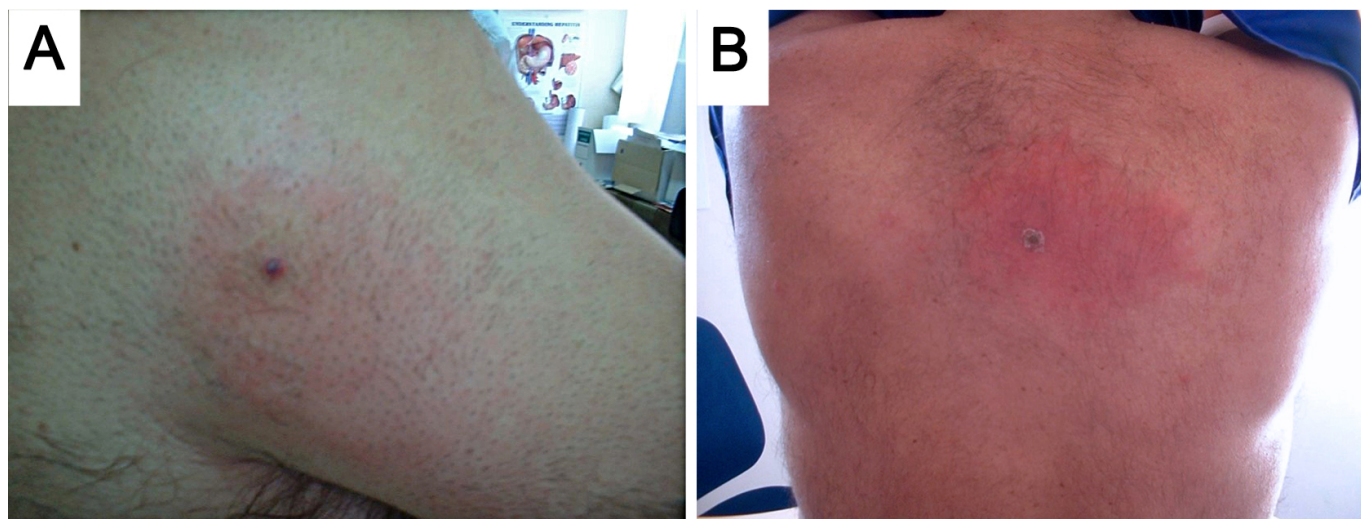


Figure 6: Erythema migrans-like lesion after removing a tick. A day before, a spray of liquid nitrogen was used to freeze the tick.



Figure 7: Borrelial lymphocytoma.



Figure 8: Acrodermatitis chronica atrophicans (ACA) affecting left hand (A) and left elbow (B) with an underlying fibrous cord on the arm. ACA affecting low extremities (C) and an arm with a fibrotic nodule (D).



Figure 9: Recommended type of forceps (A) and tick extraction using forceps (B).

