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## Lyme Disease in Urban Areas, Chicago

**To the Editor:** Lyme disease is a multisystem illness caused by infection with the tickborne spirochete *Borrelia burgdorferi*. Most infections in the United States occur in the Northeast and upper Midwest, and the midwestern focus now includes Illinois (1,2). Previously, the greatest risk of contracting Lyme disease in the Midwest was confined to the northernmost states (Wisconsin and Minnesota) and did not encroach into heavily populated areas around the city of Chicago. However, we showed recently that *B. burgdorferi*-infected *Ixodes scapularis* ticks were recovered from sites in Cook and DuPage counties (3), but the percentages of infected ticks were low ( $\leq 5\%$ ). Since that time, however, reports of Lyme disease in Cook County have been reviewed and individual *I. scapularis* tick submissions from Lake County, north of Chicago, have been

received. We therefore surveyed new areas north of Chicago (closest was <1 mile from the city limits; farthest was  $\approx 25$  miles from the city limits) and examined additional ticks for infection with *B. burgdorferi*.

From December 2006 to May 2007, we collected 172 adult *I. scapularis* ticks from sites to the north and northwest of Chicago (Figure). Adult ticks were collected because nymphal ticks are more difficult to obtain, and the infection rate in adult ticks is similar (1). The tick midguts were removed aseptically, inoculated into tubes containing 1 mL of modified Barbour-Stoenner-Kelly medium (4), incubated at 35°C, and examined for spirochetes for up to 3 weeks. Spirochetes were recovered from 21 (32%) of 65 ticks and 40 (37%) of 107 ticks collected from sites in Cook and Lake counties, respectively. In addition, PCR using primers specific for outer surface protein A (5) confirmed that the spirochetes were *B. burgdorferi*.

The findings demonstrate that the midwestern endemic focus of

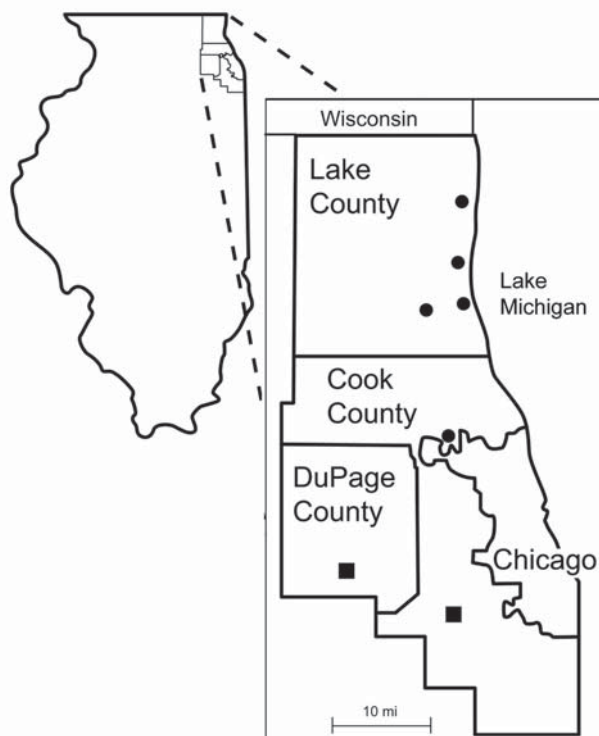


Figure. Sites surrounding Chicago from which *Borrelia burgdorferi*-infected *Ixodes scapularis* ticks were recovered in 2005–2006 (■) and 2006–2007 (●).

*B. burgdorferi*-infected *I. scapularis* now includes northern Cook and Lake counties. More importantly, the high percentage of *B. burgdorferi*-infected ticks in this region confirms a newly recognized significant risk of Lyme disease in suburban areas adjacent to Chicago (population  $\approx$ 7 million). Recently, the Infectious Diseases Society of America recommended that clinicians consider prescribing a single prophylactic dose of doxycycline (200 mg) when patients have received tick bites in areas where the percentage of *B. burgdorferi*-infected *I. scapularis* exceeds 20% (6,7). The high percentage of infected adult ticks identified in this survey highlights the need for physicians in the Chicago area to become familiar with this recommendation, especially considering the high likelihood that nymphal *I. scapularis* ticks are similarly infected (1). Moreover, confirmation of the increasing risk of contracting Lyme disease near metropolitan Chicago should provide impetus for more comprehensive studies to completely define the risk of this potentially serious illness.

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## Oral Versus IV Treatment for Catheter-related Bloodstream Infections

**To the Editor:** I read with interest the article by Halton and Graves on the economics of catheter-related blood stream infections (1). The most important determinants of infection in a temporary central venous catheter (CVC) are location and duration (2). Also important are aseptic CVC insertion and maintenance. Reducing the economic effects of CVCs is important, but I believe clinicians should use oral antimicrobial agents more often in place of intravenous (IV) antimicrobial therapy.

The economic and clinical benefits of using oral versus intravenous antimicrobial therapy are considerable. Oral therapy has important advantages over intravenous therapy administered via CVCs. Clinical advantages of oral antimicrobial therapy include the elimination of phlebitis CVC line infections. At equivalent doses, acquisition costs of oral agents are less than intravenous counterparts. Healthcare institutions charge IV administration fees per antimicrobial intravenous dose. Administrative cost for intravenous antimicrobial agents is US \$10/dose. Intravenous antimicrobial administration costs are eliminated when drugs are administered orally. In hospitalized patients, oral antimicrobial therapy results in a decreased hospital length of stay with its attendant economic implications.

Oral therapy for serious systemic infections should be with high bioavailability drugs, i.e.,  $\geq$ 90%, which results in essentially the same serum/tissue levels as if when administered by IV. Because all parenteral antimicrobial agents do not have an oral formulation, clinicians should select an equivalent oral agent with the same spectrum as its parenteral counterpart

