where we studied 123 consecutive patients with neurologic involvement and CSF anti-Borrelia antibodies.¹

In analyzing these patients, we found that a positive intrathecal anti-Borrelia AI had a diagnostic sensitivity of 75% and a specificity of 97% in Lyme neuroborreliosis.¹ We chose to include all patients with CSF anti-Borrelia antibodies and not only patients with pleocytosis and CSF antibodies for several reasons.

First, we did not want to exclude any neuroborreliosis diagnosis, second because establishing the Lyme etiology of patients with pleocytosis and anti-Borrelia antibodies in CSF is generally not a diagnostic problem, and third because pleocytosis is no longer an obligatory criterion for European diagnosis of neuroborreliosis.

Initially, in 1996, European criteria for neuroborreliosis (EUCALB criteria) included pleocytosis⁴ but it is not currently a necessary criterion for early neuroborreliosis, as mentioned on the EUCALB Web site.⁵ Moreover, several articles reported some cases in Europe for which neuroborreliosis was diagnosed without any pleocytosis.^{6,7}

Drs. Ljøstad and Mygland have some concerns about the etiologic diagnosis of the 22 of 40 patients with definite neuroborreliosis and normal CSF count. All these patients presented symptoms already described in neuroborreliosis literature. Some patients had acute delusion, cognitive impairment, or lower motor neuron syndrome; such symptoms rarely recover spontaneously, particularly the lower motor neuron syndrome.

Moreover, in our study, none of the patients have relapsed more than 2 years after the end of the antibiotic treatment. Three of the four patients with spinal radiculitis had bilateral sciatalgia without disk herniation. Such symptoms are rarely “idiopathic with spontaneous recovery” but are frequent in neuroborreliosis. A higher sensitivity of the Borrelia AI was observed when tested only on patients with pleocytosis in our study since 16

out of 18 patients (89%) with neuroborreliosis and pleocytosis had a positive AI. Specificity was not calculable because there was no other patient in our cohort with pleocytosis but patients with neuroborreliosis. The specificity was also not calculated in the study of Drs. Ljøstad and Mygland.³

Finally, we agree with Drs. Ljøstad and Mygland, who reported that the Borrelia AI is more frequently positive after 6 weeks of clinical evolution.³ In our study, the four patients with negative AI had lumbar puncture for CSF analysis between 2 to 4 weeks after the onset of symptoms.

F. Blanc, B. Jaulhac, J. de Seze, Y. Hansmann, C. Tranchant, Strasbourg Cedex, France

Disclosure: The authors report no disclosures.

Copyright © 2008 by AAN Enterprises, Inc.

1. Blanc F, Jaulhac B, Fleury M, et al. Relevance of the antibody index to diagnose Lyme neuroborreliosis among seropositive patients. *Neurology* 2007;69:953–958.
2. Hansen K, Lebech AM. Lyme neuroborreliosis: a new sensitive diagnostic assay for intrathecal synthesis of Borrelia burgdorferi-specific immunoglobulin G, A, and M. *Ann Neurol* 1991;30:197–205.
3. Ljøstad U, Skarpaas T, Mygland A. Clinical usefulness of intrathecal antibody testing in acute Lyme neuroborreliosis. *Eur J Neurol* 2007;14:873–876.
4. Stanek G, O’Connell S, Cimmino M, et al. European Union Concerted Action on Risk Assessment in Lyme Borreliosis: clinical case definitions for Lyme borreliosis. *Wien Klin Wochenschr* 1996;108:741–747.
5. Available at: http://meduni09.edis.at/eucalb/diagnosis_case-definition-outline.html
6. Dhôte R, Basse-Guerineau AL, Beaumesnil V, Christoforov B, Assous MV. Full spectrum of clinical, serological, and epidemiological features of complicated forms of Lyme borreliosis in the Paris, France, area. *Eur J Clin Microbiol Infect Dis* 2000;19:809–815.
7. Roux F, Boyer E, Jaulhac B, Dernis E, Closs-Propette F, Puechal X. Lyme meningoradiculitis: prospective evaluation of biological diagnosis methods. *Eur J Clin Microbiol Infect Dis* 2007;26:685–693.

CORRECTION

There is nothing staid about STARD: Progress in the reporting of diagnostic accuracy studies

In the editorial “There is nothing staid about STARD: Progress in the reporting of diagnostic accuracy studies” by Karen C. Johnston and Robert G. Holloway (*Neurology*® 2006;67:740–741), accompanying the article “The quality of diagnostic accuracy studies since the STARD statement: Has it improved?” by Smidt et al. (*Neurology*® 2006;67:792–797), the pre-STARD vs post-STARD comparison was stated to be significant. A correction was subsequently published (*Neurology*® 2007;68:534) stating that the data provided demonstrated a statistically insignificant difference. A third opinion has been obtained and it has been determined that the original article was statistically sound and need not have been corrected. Readers should thus refer to the original article and disregard the earlier correction.

Neurology[®]

CORRECTION

Neurology 2008;71;152

DOI 10.1212/01.wnl.0000325577.49086.b9

This information is current as of July 7, 2008

**Updated Information &
Services**

including high resolution figures, can be found at:
<http://n.neurology.org/content/71/2/152.full>

Permissions & Licensing

Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
http://www.neurology.org/about/about_the_journal#permissions

Reprints

Information about ordering reprints can be found online:
<http://n.neurology.org/subscribers/advertise>

Neurology® is the official journal of the American Academy of Neurology. Published continuously since 1951, it is now a weekly with 48 issues per year. Copyright . All rights reserved. Print ISSN: 0028-3878. Online ISSN: 1526-632X.