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# PUBLIC HEALTH ALERT

Investigating Lyme Disease & Chronic Illness in the U.S.A.

## Insights into Lyme Disease Treatment: Ginger Savely, DNP

### Book Excerpt

*Insights Into Lyme Disease Treatment: 13 Lyme-Literate Healthcare Practitioners Share Their Healing Strategies*

By **Connie Strasheim**

Available from  
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### Chapter 4: Ginger Savely, DNP Part 1 of 3

About this article:

The following is an excerpt from the book, *Insights Into Lyme Disease Treatment: 13 Lyme-Literate Health Care Practitioners Share Their Healing Strategies*, by Connie Strasheim. The book is 443 pages and retails for \$39.95; it is available from BioMed Publishing Group by calling 530.573.0190 or online at [www.LymeBook.com](http://www.LymeBook.com). The book is based on interviews with 13 Lyme-Literate health care practitioners. Each doctor is given their own chapter in which to explain their Lyme disease treatments. This chapter focuses on the treatments of Ginger Savely, DNP, of San Francisco, CA. Note: This book excerpt will be broken up into multiple issues of Public Health Alert due to space con-

straints, so be sure to pick up the next few issues of the Public Health Alert!

### Ginger Savely, DNP: Biography

Dr. Ginger Savely is originally from Maryland but has lived in Austin, TX since 1979. In 2005, she opened her practice in San Francisco and currently resides there two weeks per month. She has Bachelor's degrees in Psychology, Music and Nursing. She graduated number one in her Bachelor's in Nursing program at U.T. Austin and was awarded the Outstanding Graduating Senior Award. Dr. Savely holds Master's degrees in Educational Philosophy and Nursing (specifically, the Family Nurse Practitioner program at U.T. Austin). She received her doctorate degree in nursing practice from Case Western Reserve University. She also holds advanced certification as a menopause clinician and as a master psychopharmacologist. She is fluent in Italian and conversant in French and Spanish.

Before entering the medical field, Dr. Savely worked for ten years as a per-

forming singer/keyboardist/songwriter. She also worked for fifteen years as a Lamaze childbirth instructor.

Prior to treating tick-borne diseases, Dr. Savely had a special interest in fibromyalgia and chronic fatigue syndrome and gave professional presentations on these topics, including co-presentation of original research at the 1996 chronic fatigue syndrome conference in San Francisco.

In 1999, Dr. Savely started to gain expertise in the diagnosis and treatment of tick-borne diseases. She is now recognized as one of the top Lyme disease specialists in the country and patients come to her San Francisco office from all over the United States. Dr. Savely is an active member of ILADS (International Lyme and Associated Diseases Society). She also serves on the advisory boards of both the California Lyme Disease Association and the Charles E. Holman Foundation for Morgellons Research.

### Healing Philosophy

It is unlikely that any

treatment for Lyme disease can completely eradicate the pathogens responsible for tick-borne infections.

Unfortunately, the pathogens have too many survival techniques. Instead, the goal should be to control the infections by reducing the body's bacterial/parasitic load and by strengthening the immune system so that it can take over the job of keeping the infections under control.

Antibiotics are the essential cornerstone of treatment but are not all that is required to get well. In order to facilitate the body's ability to heal, those with Lyme must do everything possible to strengthen their immune systems.

Getting one's health back is a full-time job. The chronically ill need to become aware of how everything affects their health, including their environment, diet, habits and attitude. Even once the infections are under control, those with Lyme will need to live the rest of their lives making healthy lifestyle choices so that their immune systems will remain strong and able to keep the "bugs" at bay.

# SPECIAL REPORT

## Treatments for Infections Borrelia

When treating Lyme disease, I see two types of patients. While each type may have symptoms of the other, overall, patients resemble one type more than the other. These two types are: 1) patients with primarily musculoskeletal symptoms which resemble syndromes such as fibromyalgia and 2) patients with primarily neurological symptoms that resemble syndromes such as chronic fatigue syndrome or Multiple Sclerosis. I call those with musculoskeletal symptoms the "pain" people. I do an exam during my patients' first visit to determine which type they are, and to what degree. For example, I look for affected reflexes; are they hyper or hypo? Also, I test their pupil reaction to light, and perform balance and other neurologic tests.

For treatment of the musculoskeletal patients, I tend to start with oral antibiotics, such as high dose doxycycline, a combination of clarithromycin and cefdinir, or a combination of Ketek and high dose amoxicillin.

For the neurological patients, if I see that they have a lot of neurological signs and symptoms, the first thing that I will do, if they are not allergic to penicillin, is give them Bicillin (penicillin G) injections. I prefer Bicillin to intravenous therapy because it is less expensive, less risky and requires less intervention. Rocephin (ceftriaxone) is another good medication that can also be given in shots but it has a short half-life so patients must receive injections often, which can be painful. Because Bicillin has a

longer half-life, it can be given only once or twice per week. I prescribe Bicillin LA (and it must be the LA form), 1.2 ml, or 2.4 ml intramuscularly every three to four days, depending upon how aggressive patients want to be with their treatment. I find Bicillin to work really well, and it's good to try first, before intravenous antibiotics, because some patients get just as beneficial an effect with the shots as with an IV.

If I then pair up Bicillin injections with Ketek, and pulse Flagyl (metronidazole), two weeks on, two weeks off, I find this to be my best "killer" combination for my patients. So for neurological types, my protocol is basically one or two oral medications, along with Bicillin injections.

Of course, everyone with Lyme disease has neurological symptoms to some degree, but in some people they are more pronounced than others, especially in those with MS-like symptoms, early-onset dementia, Parkinson's or fulminate psychosis.

I would actually give intravenous antibiotics to every Lyme patient, if it weren't for the expense and inconvenience. Intravenous treatments work better and faster, no matter what kind of Lyme disease patients have. Unfortunately, though, we (the patient and I) have to consider a lot of things in treatment, including cost.

## Babesia

When it comes to Lyme co-infections, I will sometimes treat my patients' Babesia right off the bat with the tried and true combina-

tion of Mepron (atovaquone) and Zithromax (azithromycin) or Biaxin, along with Flagyl. This combination of remedies integrates two different Babesia treatment approaches and also kills Borrelia. However, I use this three-drug protocol only if patients can tolerate it. Not everyone can tolerate Flagyl early on in their treatment.

In addition, I include artemisinin at a dose of 800-900 mg (300 mg, three times per day) in the antibiotic protocol. I find that using high doses of artemisinin makes a huge difference in treatment outcomes. In the past, I used lower doses of this herb but over the years have realized that it's important to use higher doses and to pulse it, four days on, three days off. It's an important part of the treatment protocol for Babesia.

When patients' insurance plans won't cover payment for Zithromax, I will prescribe Biaxin, or Ketek. The unfortunate thing about medicine these days is that patients' health care choices often have to do with finances; with what their insurance plans will cover or what they can afford. It's a sad state of affairs.

While Mepron, Zithromax and artemisinin are often an effective combination for some types of Babesia, they don't always get rid of Babesia duncani, or Babesia WA-1, as it is sometimes called. Babesia WA-1 is extremely hard to get rid of. I don't always see patients improve with the aforementioned combination of antibiotics, even after months of use. With Babesia microti, I have found that patients can sometimes get well in as little as four to six months of treat-

ment, but Babesia duncani is an entirely different matter.

Patients with this strain can often treat until kingdom come; indeed, after two years of treatment, some witness no change in symptoms. So I have to try other combinations of medications for patients with Babesia duncani, such as Lariam (mefloquine) and plaquenil, or chloroquine and primaquine. The drawback of the latter medications, however, is that they aren't well tolerated by patients so they aren't usually used as the first line of defense against the infection. I also use Malarone, and sometimes that works when Mepron doesn't, but we (in the medical community) don't know why, since Malarone, like Mepron, is atovaquone, but with proguanil added to it. But treatment usually means trying different things to see what works. Practitioners sometimes have to run through the mill of options. My approach is to start with the medication that has the best combination of being both effective and well tolerated, although sometimes the most effective drug is the one that is the least well tolerated, which means I sometimes end up leaving the most effective one for later.

## Bartonella

Take Bartonella, for instance. I used to start patients on a quinolone antibiotic such as ciprofloxacin or Levaquin (levofloxacin) to treat this infection, and wait before giving them the rifampin and doxycycline, because the latter two are not as easily tolerated as the former two. But the longer I treat Bartonella, the more I tend to

lean towards using the least tolerated and most effective medications first, because I often end up using them anyway, when the others just don't work well enough. So for the treatment of Bartonella, rifampin and doxycycline generally work the best, in my experience. Note that patients in different geographical locations may respond better to different antibiotics.

Bartonella requires treatment for a minimum of four months, but some patients need to take antibiotics for much longer than that. In general, Bartonella is easier to treat than Babesia microti, but not necessarily easier than Babesia duncani.

If there's one thing that I have learned from treating Lyme patients for so many years, it is that the more antibiotics that they are able to take and tolerate, the better off they will be. It's important to flood the system with antibiotics. Therefore, intravenous therapy, if tolerated, would be my first choice of treatment for patients, because it's the best way to get the most antibiotics into the body at the fastest rate. Intramuscular antibiotics would be my second choice, and oral antibiotics, third. That said, if patients have a cast iron gut, it may be possible for them to take five to six antibiotics at once, and in this case, oral dosing may be just as effective as intramuscular or intravenous dosing.

I think that you can tell how long a practitioner has been treating Lyme disease by how aggressive their treatment is. The newbies tend to be wimpy. Those who have been treating this disease a long time, like Drs. Burrascano and Jones, will

give up to five or six antibiotics at once. The longer that I have been doing this, the more aggressive I have become with my treatments, too. Dr. Jones tells me, however, that I should use the term "appropriate" instead of "aggressive", when referring to treatments! So I keep adding antibiotics into patients' protocols as long as they can tolerate them, and I find that this approach works better.

Interestingly enough, on several occasions, I have found that after my patients have been on two antibiotics, and I switch them to two new ones, instead of just taking the new antibiotics, they accidentally take all four—the former two plus the new two. They then come back a month later and say, "Wow, I am so much better! This was the best month I ever had!" They got confused in their protocol, but taking the extra antibiotics actually resulted in them taking giant leaps forward in their healing.

But then again, there are so many factors that come into play when it comes to healing, and as a practitioner, you can't just say, "This is what you have to do," because everyone's needs are different.

So what should patients be able to tolerate in terms of antibiotic doses? Well, this is one of the biggest controversies in the world of Lyme. There are two camps of practitioners in the Lyme disease world. First, the "ramping up" camp, and then the "blast 'em hard" camp. The "ramping up" camp believes in slowly increasing antibiotic doses and the number of medications that patients take over time, so that they can avoid horren-

dous Herxheimer reactions. The concern with this approach to treatment is that the bugs get a warning of sorts from the lower dose antibiotics and can then hide from subsequent treatments. Conversely, the advantage of hitting the bugs hard right off the bat is that they are caught by surprise. The downside of the "blast 'em" approach is that patients get stronger Herxheimer reactions. So deciding upon which approach to take can be a tough decision for practitioners. In my practice, I tend to start out with the latter one. However, if I notice that my patients' Herxheimer reactions are so severe that their ability to heal is being hampered by the creation of a cytokine storm that could be damaging the body, then I will back off on their dosing. As a practitioner, you can't know in advance which patients are going to be more intolerant of treatments. About 10% of my patients don't Herx at all! I wish all of them could be this way, but unfortunately, that's not the way it is. Others Herx so badly that they think they are going to die. So initially, I try to hit the bugs hard first, to see if my patients can weather the storm, while supporting them the best that I can along the way.

Treating Mold, Candida and Environmental Toxins  
I treat my patients' Candida towards the end of their treatment regimen, because the antibiotics for Lyme cause yeast, so there's no point in treating for yeast as long as patients are taking antibiotics. When I do treat them for yeast, I also treat them for mold, using Cholestyramine (as advocated by Dr. Ritchie

Shoemaker, M.D.) to bind the mold's biotoxins. I think that mold is a huge problem for Lyme disease patients, too. For some, it may even be the main reason why they got sick, and is the reason why they stay sick. Recent work by Dr. Ritchie Shoemaker has also shown that Lyme patients who are continually exposed to environmental mold will not get well.

To be continued in the next PHA issue!

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