mer and late Summer-beginning of autumn[3]. The disease is characterized by chronicity, distinguishing three phases. The first, localized early infection, where the first manifestation is usually migratory erythema. The second, disseminated early infection, with neurological manifestations (neuroborreliosis) and cardiac disorders. And the third, late or persistent infection (arthritis, encephalopathy). In many cases, facial paralysis (occurring in 5% of children with Lyme disease1) may be the only neurological symptom and it may develop even in the absence of previous migratory erythema[1].

Serology allows the diagnosis of Lyme disease by the determination of IgG and IgM antibodies and the comparison of two samples separated by a three- or four-week interval[4]. The oral antibiotic regimen includes amoxicillin 50 mg/kg divided into three doses and cefuroxime acetyl 30 mg/kg per day divided into two doses, both in regimens of 14 to 21 days. Doxycycline is recommended in children from 8 years of age at doses of 4 mg/kg per day divided into two doses. For the parenteral regimen, ceftriaxone 50-75 mg/kg intravenously in single dose[5].

Since acute facial paralysis in children is a disease of good prognosis, several studies have described even better recovery rates in patients with neuroborreliosis compared to other causes[2]. Most patients diagnosed with Lyme disease do not have a history of stinging and the variety in the presentation should be suspected, even in the absence of a sting.

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Clinical practice, research, and teaching: the triad that marks emergency medicine

Asistencia, investigación y docencia: la tríada de la medicina de urgencias y emergencias

To the editor:

Excellent editorial by Llorens[1] in relation to the original article by Fernández-Guerrero et al.[2] which clearly and objectively shows the increase in the scientific production of the emergency physicians in the last five-year period. Llorens expresses that it is necessary to believe that our work is not exclusively care, and to believe that there is time for research. A great truth. However, it should be made clear, not only care doctors have to believe this, but also those responsible for emergency departments (ED). Despite having no recognized specialty in Spain, Emergency Medicine (EM) has its own entity based on specific scenarios and therefore, as emergency physicians, we have the obligation to generate evidence and specific knowledge, which will no doubt only be possible if we cement our EDs in the tripod of assistance, teaching and research, as any other hospital service. We have dignity and passion for the EM, but our supervisors, emergency coordinators and chiefs must also have these qualities. A good example of this are the initiatives such as independent clinical trials conducted exclusively in the Spanish HES[3].

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