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## Well-water maintenance

We congratulate Erica Weir for having recently drawn attention to well-water maintenance.<sup>1</sup> We have some additional information to help physicians interpret the results of reports on well-water quality.

Although we agree with the list of potential contaminants of well water presented by Weir in Box 1, it is worth mentioning that routine monitoring of water microbiological quality entails the detection of the nonpathogenic coliforms, the total and thermotolerant (fecal) coliforms. Nonpathogenic *Escherichia coli* are the most common coliform in human and animal feces and they are recognized as the best index of recent fecal contamination of surface water and groundwater.<sup>2,3</sup> In the presence of thermotolerant (fecal) coliforms or *E. coli*, a boil-water advisory is advisable until the water is treated and disinfected.

Total coliforms, which might be present in the general environment (in soil and plants) without fecal contamination, are usually considered as an indicator of the vulnerability of groundwa-

ter to microbiological contamination. If total coliforms are detected, a boil-water advisory is usually not recommended but inspection of the well and more frequent analysis of the water for *E. coli* is advisable.

Nonpathogenic intestinal enterococci (a subgroup of fecal streptococci) appear to survive longer in the environment than *E. coli* and are being proposed as microbiological indicators of groundwater quality. They are also considered to be an index of fecal contamination,<sup>4,5</sup> although they are not totally specific to animal or human feces.

Pathogens are rarely measured in drinking water because they are expensive to detect and detection methods have not yet been standardized.<sup>6</sup> Nevertheless, pathogen testing is extremely useful for outbreak investigation.<sup>7</sup>

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## HIV/AIDS and leishmaniasis coinfection in Ethiopia

Aranka Anema and Koert Ritmeijer<sup>1</sup> describe their practical and effective strategy for treating visceral leishmaniasis (VL) in patients coinfecting with HIV/AIDS in Ethiopia. Relying on low serologic titres of  $\leq 1:400$  to exclude VL is problematic, because titres of  $\leq 1:400$  might well be the result of patients with leishmaniasis having a grossly inadequate serologic response.

Coinfection with HIV and VL is documented to be associated with a poor serologic response. In Spain, among 120 patients with VL, including 80 coinfecting with HIV, the serologic response was significantly lower among those coinfecting with HIV.<sup>2</sup> An identical scenario in Kafta Humera Woreda would lead to an underdiagnosis of VL and spoil the utility of an efficient decentralized diagnostic and therapeutic service.

It would be worthwhile to investigate at least some of those with serological titres of  $\leq 1:400$  for *Leishmania donovani* in their tissue aspirates. If costs are prohibitive in Ethiopia, then maybe the international community could help with this assay.

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The direct agglutination test (DAT) is not the only diagnostic test used