



Other advantages to aerobic exercise

Persistent inflammation, as revealed by increased levels of inflammatory biomarkers, is associated with several chronic disorders, as highlighted by Barbara Nicklas and colleagues.¹ Accordingly, current guidelines recommend 30 minutes or more of daily, moderate-intensity physical exercise.² However, little is known about the effects of vigorous aerobic training on inflammation, and debate continues regarding the intensity of physical activity required to achieve the most favourable health benefits.¹

To investigate the association between vigorous aerobic training and inflammation, we analyzed the concentration of high-sensitivity C-reactive protein (hs-CRP) in sedentary healthy controls, amateur road cyclists and professional road cyclists, matched for age and sex. All subjects were in a fasted state, and the athletes had rested for 24–48 h since their last training session. The hs-CRP was measured by the reference assay using the Behring Nephelometer (Dade Behring GmbH, Marburg, Germany). No significant differences could be observed in the median concentration of hs-CRP between sedentary controls (0.67 mg/L), amateur cyclists (0.54 mg/L, $p = 0.85$) and professional cyclists (0.59 mg/L, $p = 0.99$), nor between professional and amateur athletes.³ We also measured levels of hs-CRP in members of the na-

tional Italian cross-country ski team and found similar levels (0.55 mg/L, $p = 0.32$) (unpublished data). The percentage of subjects with hs-CRP levels above the 3.0 mg/L high-risk threshold was comparable and not statistically different among groups.

These data suggest that healthy individuals subjected to vigorous aerobic training are not likely to develop persistent proinflammatory reactions and the advantageous metabolic changes induced by exercise training might be safely used as preventive or therapeutic measures in patients with chronic disorders.

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Pharmaceutical advertising

I found it extremely disturbing that the May 24 issue of *CMAJ* came bundled with a 4-page advertisement from Berlex for their newly launched oral contraceptive pill.

The advert was thinly veiled as an educational document, complete with a stamp of approval from the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the name of a professor who does not have the word “author” anywhere near his name.

Advertisements within your journal

are a necessary evil; shameless adverts masquerading as continuing medical education (CME) documents are not.

After all the efforts invested by *CMAJ* on issues of social justice, medical ethics and intellectual property rights, to prostitute your publication on behalf of a pharmaceutical company is heartbreaking. It only provides more evidence that physicians on the whole are completely incapable of navigating the muddy waters of conflict of interest.

I found it paradoxical that the editorial at the front of the same *CMAJ* issue says, “The public expects physicians to advocate for their individual and collective well-being.”¹

Unfortunately, the actions of *CMAJ* and the SOGC reinforce the notion that physicians today would rather advocate for the highest bidder.

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The SOGC stands by its conference highlight bundled with the May 24 issue of *CMAJ*. This highlight was authored by a writer at the SOGC and presented a report of interest from our international CME meeting. It detailed a conference given by one of our members, which was recorded on an audiotape to ensure the accuracy of the quotes. A full final review was performed by an obstetrician/gynecologist at the SOGC. The report is fully referenced and deals with many important issues concerning the use of oral contraception. The latter third deals with a new oral contraceptive, the first to be introduced in 7 years, and again reports fully referenced data.

New products are a reality in the

practice of medicine, and the SOGC finds it important to disseminate this information to our members. Better for health professionals to receive medical updates from a specialty society rather than directly from industry itself or, worse, direct-to-consumer advertising from industry. The article was independently produced with no input or review from industry. Its dissemination was provided by an unrestricted educational grant. The fact that this article sheds a positive light on a new product does not indicate a conflict of interest. What we at the SOGC advocate for is up-to-date accurate dissemination of information to our members, and this document accomplishes this.

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Well-water maintenance

We congratulate Erica Weir for having recently drawn attention to well-water maintenance.¹ 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.^{2,3} 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,^{4,5} 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.⁶ Nevertheless, pathogen testing is extremely useful for outbreak investigation.⁷

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HIV/AIDS and leishmaniasis coinfection in Ethiopia

Aranka Anema and Koert Ritmeijer¹ 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.² 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