in the program we described.[1] Even if a case of VL and HIV coinfection was missed by DAT, the diagnostic algorithm used in Ethiopia would still identify it, because in the case of a negative DAT result, but persisting signs and symptoms of VL, a splenic aspiration is indicated. DAT is used as a first-line test to reduce the number of tissue aspirates required for screening clinically suspicious cases.

The results from European studies cannot be extrapolated to African VL, because the patient characteristics are quite different. For example, in the study by Pintado and colleagues,[2] which Subhash Arya and Nirmala Agarwal refer to, patients were mainly injection drug users who were profoundly immunocompromised. An evaluation of DAT in Ethiopian patients with VL (with and without HIV infection) concluded that in contrast to the observations made in Europe, DAT in Ethiopia remains reasonably sensitive in diagnosing VL during HIV coinfection.[3] These findings are confirmed by unpublished data from the Médecins Sans Frontières miltefosine study in Kafta Humera Woreda, which show that DAT titres in cases of HIV coinfection did not differ from those in cases where there was no coinfection, that is, there was no shift in the mean and distribution of DAT titres.

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Are FASD guidelines practical and sustainable?

Christine Loock and associates[1] recommend that children with suspected fetal alcohol spectrum disorder (FASD) undergo a "comprehensive, multidisciplinary assessment." The assessment outlined in recommendation 3.1 of the supplement presenting Canadian guidelines on diagnosis of FASD[2] is comprehensive but is neither justified by evidence nor sustainable within existing resources. If the prevalence of this disorder is around 1%, as suggested,[2] more than 400 such children per year would need assessment in Alberta alone.

On the basis of data in the 2004 annual reports of the Alberta Children's Hospital and the Glenrose Rehabilitation Hospital, and allowing for the fact that children are also seen in other regional assessment centres, I estimate that approximately 800 preschool children are now seen annually by our tertiary developmental assessment centres, so this would add another 50% to their workload. A small number of children with FASD are assessed by our local tertiary-level team each year, but the guideline implies that children currently being seen by family doctors, general pediatricians or subspecialists (e.g., developmental pediatricians, clinical geneticists, child psychiatrists), in conjunction with early intervention workers, school psychologists, community speech-language pathologists and others, are receiving inadequate diagnosis. This is a very important issue, given that our provincial education ministry provides extra funding to school districts for children with a diagnosis of FASD; one risk of these guidelines is that none of these children will meet the diagnostic criteria for funding.

The "tertiary bias" of the guideline is further illustrated by recommendation 1.4: among the "appropriate professionals" not mentioned (for children with other developmental disabilities) are colleagues from family medicine or general pediatrics. Even subspecialists such as myself often function in a community-based role. While access to the full multidisciplinary team is essential for some of the children I see, I believe that the diagnostic assessment I provide is quite appropriate for many children within a more limited scope (i.e., working collaboratively with community practitioners).

I suggest that children with a confirmed history of exposure to alcohol and relevant developmental, behavioural and phenotypic findings should receive a diagnosis within the spectrum of FASD by anyone competent to do so, including an experienced primary care physician. Children for whom there is genuine doubt about the diagnosis should be referred for further assessment by an appropriate multidisciplinary team.

Recommendations for more complex diagnostic processes require clear evidence concerning cost and benefit, sensitivity and specificity, and validity and reliability.

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[The authors respond:]

The FASD guidelines[1] and accompanying article[2] should not be interpreted as implying a "tertiary bias," as suggested by Keith Goulden. On the contrary, trained and functional FASD diagnostic teams have recently been established in smaller communities throughout Canada and are providing excellent service outside of tertiary care facilities, often without a subspecialist's direct involvement.

According to the diagnostic process outlined in the guidelines, any physician "specifically trained in FASD diagnosis" can be a member of the team. Such multidisciplinary di-