Clinical oesophagostomiasis suspected on the basis of ultrasound diagnosis should always be treated with albendazole before resorting to invasive exploratory surgery. (This thesis)

The lack of correlation at an individual level between ultrasound and stool diagnostic tests for *Oesophagostomum bifurcum* is to be expected, because ultrasound observes the tissue-living juvenile stages of *O. bifurcum*, whereas stool cultures detect the presence of a later stage of the infection, lumen-dwelling egg-laying adults. (This thesis)

Non-treatment of subclinical oesophagostomiasis is inexcusable, on the basis of its appreciable development into serious disease, the ease and reliability of its detection, and the simplicity, safety, cheapness and effectiveness of its management with albendazole. (This thesis)

Albendazole not only kills the lumen-dwelling *O. bifurcum* adults, but also the tissue-dwelling disease-causing larvae. (This thesis)

Unless disease processes are forced into succinctly-labelled diagnostic boxes, there is no management and no prognosis.

It is generally accepted that intervention should be based on morbidity caused by parasitic infections rather than on prevalence. This then implies that for monitoring morbidity markers should be used and not prevalence markers.

The fact that in Africa disease perception is not only severity related but strongly culturally and financially dependent, illustrates that the difference between subclinical and clinical pathology is one of awareness and priority.

Using PCR to distinguish between the type of *Entamoeba* cysts carried by an infected individual - whether potentially invasive *Entamoeba histolytica* or non-invasive *E. dispar* - is cost-effective.

Development is inhibited in a society where people cannot be individuals.

On a quiet African night the exuberant music of the moon is much louder than the busy, bustle of electrified European life.

Passing to the left is far more agreeable than passing to the right: it encourages the shaking of hands.

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