between microbiologists and clinicians is important.

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Electroacupuncture in fibromyalgia

EDITOR,—Several important issues arise from Christophe Deluze and colleagues' paper on electroacupuncture in fibromyalgia.[1] The use of electroacupuncture rather than ordinary acupuncture in this study is questionable. To treat musculoskeletal pain, manual manipulation of the needles is all that many experienced physicians consider to be necessary.[2] Indeed, excessive stimulation of the needles may exacerbate the symptoms. This and the unpleasantness of needle insertion (suggesting poor needling technique) led to an unusually high drop out rate in both the group given electroacupuncture (17%) and the controls (15%) in the study.

The authors also seem uncertain about the rationale for selecting acupuncture points; they say that they used "four common acupuncture points," but it is unclear exactly which points these were. The authors claim that "traditional acupuncture points" were used, and the hand point does seem to correspond to the Chinese acupuncture point Hegu (LI4). The leg point, however, corresponds only approximately to the Chinese acupuncture point Zusanli (ST36), the location given being inaccurate. This point should be located by using a system of proportional measurement, which allows for differences in the size of patients. The correct distance below the inferior border of the patella is not 5 cm but 3 cun, which corresponds to the width of the patient's four fingers. Needle insertion into the tender points was avoided in this study. In treating myofascial pain, however, the best results are generally considered to be obtained by inserting the needles into the points of maximum tenderness, though electrical stimulation is usually unnecessary.

Lastly, the points used in the control group cannot be regarded as suitable: electrical stimulation of needles only 2 cm from the real points is unlikely to be without some effect. The true efficacy of acupuncture may have been underestimated, and further studies of higher quality are needed.

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AUTHORS' REPLY,—Peter J Lewis believes that we used non-optimal techniques in our study. Most of the objective data on acupuncture analgesia have been obtained with electroacupuncture rather than dry needling as described in the reference that Lewis cites; therefore we prefer electroacupuncture. We chose acupuncture points that had been used in most experiments with acupuncture analgesia, as well as in the two previous clinical studies, both of which were of electroacupuncture.[1-3] The points used most often correspond to the Hegu (L14) and Zusanli (ST36) points. As most readers of the *BMJ* are not acupuncturists we found it more accurate to give the location in centimetres rather than cuns. In fact, the location of the traditional Chinese points is given in a variable manner in different acupuncture books.

Fibromyalgia is not identical with the specific myofascial pain syndrome as defined by the International Association for the Study of Pain.[4] Patients with fibromyalgia often complain of exacerbation of their symptoms when the tender points are stimulated by pressure, electric current, needling, or vibration. Insertion of needles into tender points therefore seems inappropriate for the treatment of fibromyalgia.[5]

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Another African disaster

EDITOR,—I visited Mogadishu in Somalia before the United States and UN peacekeeping forces were deployed. Anarchy prevailed. Most men sported an absurd amount of lethal weaponry, which they were fully prepared to use. Four wheel drive pick ups, crudely converted to gunships with heavy machine guns welded on, were everywhere, guarding the warlords or parked ready for hire. All outsiders required protection, so business was good for "the technicals," so named because the UN could not employ gangsters and paid them instead as technical assistants.

There were many food kitchens and supplementary feeding centres run by Unicef and the Red Cross; several were based on projects already started by local women. What they had achieved with a few weeks of supplementary feeding was remarkable. Previously there had been fighting when the food was served because of the fear that there would not be enough to go around; now there were orderly queues. In camps where previously 10-20 children had died each day death was uncommon and occurred mainly among new arrivals. In one feeding centre the room for the dead had become a Koranic school for young children.

A few hospitals remained open throughout the fighting. Digfar was run almost entirely by local Somali staff—25 doctors and nearly 100 nurses—who had not been paid for over two years. At the height of the troubles the hospital was seeing 100 cases of major trauma a day. Three non-government organisations also stayed throughout: Médecins Sans Frontières in Medina, the International Medical Corps (based in the United States) in Digfar, and SOS Children, keeping open its obstetric unit. How they managed to cope is a mystery.

The people are the only resource left. The political, economic, and social difficulties are catastrophic. With the UN peacekeeping forces now being deployed Somalia will be fed. And then what—UN trusteeship and massive international aid? The worry is that as international interest wanes and other disasters compete for attention Somalia will be allowed to slip back into starvation and anarchy. There are no short cuts or easy answers to this crisis or any of the others that curse Africa.[1,2]

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1 Wright J, Ford H. Another African disaster. *BMJ* 1992;305: 1479-80. (12 December.)
2 Black J. Second letter from Eritrea. *BMJ* 1992;305:1480-1. (12 December.)

EDITOR,—John Wright and Helen Ford describe the anguish and despair affecting many sub-Saharan African countries and made so much worse recently by drought.[1] It is extraordinary, therefore, that these desperately poor countries still owe money to (and still struggle to repay) the rich financial institutions in the North[2] at the expense of feeding or delivering health care to their own people.

Debt relief was barely discussed at the meeting of the World Bank and International Monetary Fund last September. Endless rescheduling by creditors has caused these very poor countries' debts actually to increase. Over the past 10 years the debt of sub-Saharan countries has tripled to $180bn and these countries now hand over one third of their foreign exchange earnings in debt payments. Every Zambian citizen now owes his country's creditors $1000—three times what he earns in one year.[3] Mozambique's external debt is $4·7bn, Ethiopia's $3.0bn, and Somalia's $2·1bn.

With 40 million people starving and infant mortality rising at an alarming rate, doctors must start pressurising governments and banks to stop this spiral of deprivation and environmental degradation in which the world's poorest countries are trapped. MEDACT (Medical Action For Global Security, 601 Holloway Road, London N19 4DJ), is making this important human rights issue central to its educational programme and campaign this year.

As Wright and Ford say, the overwhelming responsibility of governments is to feed and care for their own people. Unless they are allowed to do this, efforts by the medical profession to supply vaccines, drugs, or aid are futile.

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HIV transmission, travel, and Thailand

EDITOR,—Ahilya Noone and colleagues warn about the danger of HIV infection to travellers in Thailand.[1] I have just visited Thailand and met venereologists there. Since 1984 there have been constant campaigns alerting the public in Thailand to the dangers of HIV, AIDS, and sexually transmitted diseases. Though there is still a disproportionate preponderance of sexually transmitted diseases in prostitutes, labourers, and agricultural workers, since 1986 the incidence of all venereal diseases has decreased. Use of condoms has been enthusiastically advocated locally among the Thai people.

Surveillance is centred on communicable disease control based on national returns from an effective network of 96 sexually transmitted diseases clinics