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 electro-

acupuncture.^{1,3} The points used most often correspond to the Hegu (LI4) 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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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 North² 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

in 73 provinces. For instance, at the central sexually transmitted diseases centre at Bangrak Hospital, Bangkok, there were separate clinics for female and male sex workers, with adequate laboratory facilities for all the diagnostic modalities for HIV and sexually transmitted diseases.

The number of people attending sexually transmitted diseases clinics fell from 1103813 in 1987 to 877146 in 1991, and the number with venereal diseases (defined as syphilis, gonorrhoea, chancroid, and lymphogranuloma venereum) fell from 410406 to 182024. The table shows the incidence of various diseases in 1987 and 1991.

Incidence of sexually transmitted diseases per 1000 population in Thailand, 1987 and 1991

	1987	1991
Syphilis	0.41	0.22
Gonorrhoea	4.36	1.64
Chancroid	0.85	0.22
Lymphogranuloma venereum	0.37	0.12
Non-gonococcal genital infection	1.7	1.01
Total	7.69	3.21

Genital ulcer disease is an important factor in the spread of HIV. In Thailand in 1991 the falling incidence of chancroid approached that of herpes genitalis for the first time, reaching 0.22/1000 compared with an incidence of herpes genitalis of 0.18/1000. In December 1991 the prevalence of HIV infection in different groups remained high: intravenous drug users 34%, brothel sex workers (local users) 22%, higher class (tourist) sex workers 5.5%, male patients of sexually transmitted diseases clinics 5.6%, pregnant women 0.67%, blood donors 0.8%.

Thailand is, as Fred Lenihan points out, making an enormous effort to combat these infections.² Recommendations have been made (Chavalit Mangkalaviraj, personal communication) that information given to travellers and epidemiological data should be exchanged internationally and that study tours for health staff in interested countries should be set up.

I thank Dr Anupong Chitwarakorn, Office for Communicable Disease Control, Bangkok, for supplying me with epidemiological information.

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- 2 Lenihan F. Thailand tries again to tackle AIDS. *BMJ* 1992;305:1385. (5 December.)

EDITOR,—Ahilya Noone and colleagues point out the need for travellers to receive appropriate information on safer sexual behaviour.¹ A four week campaign, jointly organised by Greater Glasgow and Argyll and Clyde Health Boards, was run in the international departure lounge of Glasgow airport in July and August last year. During peak periods of departures of chartered aircraft to Mediterranean destinations a small team of sessional workers was in the lounge. Departing travellers were encouraged to complete a prize crossword on beermats, whose clues related to transmission of HIV and safer sex. On completion the crosswords were placed in a "treasure chest," part of a large and colourful photomontage prominently displayed in the lounge. A prize draw was held regularly, and winners were awarded specially designed T shirts. Participants were also offered free condoms and information about HIV and about health while abroad.

During the four weeks an estimated 66000 people passed through the lounge when the team was present. About 10500 crosswords were completed, almost all correctly. About 30% of

respondents were under 21, 36% were 21-30, and 34% over 30; 52% were female. Around 2500 T shirts were given out, and nearly 6000 people took condoms and information leaflets. The campaign provoked great interest and virtually no adverse comment. In a separate survey most respondents correctly understood the aim of the campaign and thought that it was appropriate in such a venue.

The positive reaction to the campaign suggests that airport departure lounges are ideal locations for conveying information about safer sex. There is a captive audience, most of whom can understand the relevance of the message, and many are prepared to participate as they await their flight.

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National standard for entry into general practice

EDITOR,—The working party set up to make recommendations on a national standard of entry into general practice¹ seems to have been unaware of European Community directive 86/457/EEC. This is mostly concerned with current standards of training in general practice in the health services of member states. Article 11, however, states that suitable proposals should be brought forward by 1997 for appropriate training for every general medical practitioner in order to satisfy the specific requirements of general medical practice. Informal contact with officials in Brussels through diplomatic sources has indicated that this is intended to apply to all practitioners, in public or private practice, in any form of primary health care. In other words, vocational training in general practice will become the minimum standard for practice of any form of medicine other than specialist practice, or training for such. Therefore proposals to fail people in general practice training will, if the directive is implemented, be tantamount to striking people off the medical register, and the idea of a subprincipal grade may actually be illegal after 1997.

I am also concerned about the working party's proposals for other reasons. Firstly, it seems unreasonable, against nature, and misogynistic to suggest to a young woman that she will have to wait until her late 20s to complete her minimum training and then be able to start a family. Secondly, I find it impossible to accept that general practice is a specialty. Something that is general by definition cannot be a specialty. The alternative term of family practitioner is not acceptable either. I practise as a ship's doctor. I am certainly a general practitioner, but I am not a family practitioner. One problem with the Royal College of General Practitioners is that it seems to equate general practice exclusively with being an NHS general practitioner. There are other forms of general practice.

History indicates that general practice is not so demanding that unqualified people cannot pass themselves off as principals for many years and get away with it. I wonder how many years unqualified people could pass themselves off as consultant thoracic surgeons, for example, without detection. Pretending that general practice is something that it is not runs the risk of people remarking on the emperor's new suit of clothes. I would therefore ask for a sense of proportion over the future of general practice, along with some breadth of vision

and tolerance for alternative types of general practice. I do not want to have to found a Royal College of Ships' Surgeons to carry on practising my brand of general practice.

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Risk stratification for open heart surgery

EDITOR,—If operative mortality is to be of any use as an indicator of quality in cardiac surgery a system of risk stratification must be in place. The purpose of our paper was simply to show that the Parsonnet system can be applied easily and effectively to cardiac surgical practice in Britain.¹ That we found a lower mortality than expected is not relevant to the paper's message. I wish to reassure Andrew Allan and Andrew T Forsyth² that our trial was indeed prospective.

David J Spiegelhalter suggests that the Parsonnet system overstates risk.³ Whether or not that is the case, the system remains an excellent method of stratifying patients into well defined risk groups. Kenneth M Taylor and Peter K H Walton mention other methods of risk stratification such as PANECAN (the pan-European cardiovascular network) and bayesian analysis.⁴ For such methods to gain widespread acceptability they must be comparable to the Parsonnet system in ease of implementation. I look forward to the day when a statistically perfect model is available for assessing the quality of cardiac surgical care. In the meantime, however, widespread implementation of the Parsonnet system would represent a great improvement in the audit of cardiac surgery over crude mortality figures.

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Laser treatment of port wine stains

EDITOR,—M J C Van Gemert and colleagues echo the opinion of most of those who use laser treatment for port wine stain malformations that pulsed tunable dye lasers with a wavelength of 577 or 585 nm are the best choice for treating children.¹ Their suggestion that pulsed dye laser treatment should be offered as first line treatment for port wine stain malformations whenever possible, however, is controversial with respect to adult patients and ignores the complex nature of these lesions and their treatment with lasers.

Although many port wine stains in adults can be effectively treated with a pulsed dye laser, this may not be the most effective treatment and a considerable proportion of lesions do not respond. Port wine stains are heterogeneous, and responses to different lasers vary considerably.

My experience suggests that many lesions that are macular and blanch on direct pressure respond more favourably to pulsed dye lasers than to alternatives such as copper vapour lasers,² although in many cases responses are similar. Lesions that do not blanch on pressure (which are often dark in