Letters to the Editor

Another man-made crisis in Rwanda: international community at fault

SIR—*The Lancet* has published many reports about Rwanda, urging global action to improve emergency preparedness to prevent public health disasters such as Goma (Feb 11, p 339), and has addressed (March 4, p 529) issues of economics, neutrality, coordination, inter-agency competition, accountability, leadership, and training. Thus, it is distressing that the same refugees are now facing starvation because the international community has failed to respond adequately to requests from the World Food Program in November, 1994. The table shows the monthly requirements and food delivered or on its way. The minimum shortfall will be half the need. Already 35 314 tons have been borrowed from other programmes, which will be disrupted unless replaced. Even if the population estimates are inaccurate and the refugees obtain some food by their own efforts, it is clear that they face another catastrophe—mass starvation. For survivors, the food supplies do not provide a balanced diet: we can predict scurvy, pellagra, and beri-beri. Sporadic cases of cholera and dysentery occur in every camp; with starvation and social deterioration epidemics are inevitable.

Much can go wrong when supplying enormous amounts of food, to vast numbers, in isolated places. Refugees cannot eat food in transit and food supplies take months to reach them. The available food is being distributed sporadically and unevenly so that many get nothing. Healthy hunger strikers die after about two months. In Benaco, the daily ration was reduced lately to 1300 kcal, and some got nothing. The refugees are volatile and some are used to violence. A vehicle carrying volunteers from Action International Contre la Faim was recently attacked with a grenade. The pending break in food supply will make relief work impossible.

Those who responded to the crisis incurred an obligation to maintain aid, as necessary. For months the United Nations and donor governments have known that this obligation will be shirked. Refugees will perceive our leaders' indifference to their starvation when the trucks fail to turn up and the aid workers leave. Already the reduced ration is thought a ploy to enforce repatriation. Why should they trust us? Without such trust how can we expect them to return to Rwanda, accept imposed order, or respect volunteers? Deliberate starvation is not a legitimate way to force repatriation; even so, refugees would need food until after the next harvest. Although some were indeed responsible for genocide, withholding food is not the solution; the burden falls on the weak, not the perpetrators of violence.

	Cereals	Pulses	Oil	Total food†
Requirements (ton/month)	37 714	11 577	1969	56 046
Supply				
February	5008	0	0	5438
March	9251	1315	221	11 861
April	615	7033	472	9456
May	26 549	8113	796	39 390
June	33 124	4821	1416	42 164
July	33 779	7195	144	43 423
Shortfall	117 958	40 985	8765	184 544

All figures in metric tons. †Other food supplied include salt, corn-soy-blend, sugar, and dried skim milk.

WFP=World Food Program, UNHCR=United Nations High Commission for Refugees

Table: **Projected regional supply of food to 3015 000 Rwandan refugees in camps in Rwanda, Burundi, Tanzania, and Zaire, by WFP/UNHCR for February to July, 1995**

Our governments are now cynically failing those whose plight so recently caused anguish. Will we respond again, when electorates are confronted with emaciated children and corpses, with a transient injection of aid? Why is our interest in the survival of refugees so fickle? What is the responsibility of the medical profession to the voiceless millions who starve in squalid conditions throughout the world? While Rwandan refugees starve, the west pays farmers to grow less food. We and our leaders have a collective responsibility for what is happening in central Africa. Nevertheless, who is accountable? Will they still be in charge for the next disaster? Who will address the difficulties you outline in your March 4 editorial realistically, ethically, and transparently?

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Large-cell anaplastic lymphoma-specific translocation in Hodgkin's disease

SIR—The t(2;5)(p23;q35) translocation has been associated almost exclusively with non-Hodgkin anaplastic large-cell lymphoma (ALCL); however, the characterisation of the morphological spectrum of lymphomas containing this translocation has been hampered by the difficulty of obtaining cytogenetics on these neoplasms. With the recent molecular cloning of the (2;5) translocation, reverse transcriptase (RT) PCR-based assays can now be used for the detection of the der(5)-encoded *NPM/ALK* chimeric mRNA.[1] Application of these RT-PCR assays to a series of large-cell non-Hodgkin's lymphomas has revealed the presence of this chimeric message in a substantial percentage of ALCLs, as well as occasionally in patients showing immunoblastic or diffuse large-cell morphologies.[2] Orscheschek and colleagues report (Jan 14, p 87) RT-PCR detection of the t(2;5)-derived *NPM/ALK* chimeric transcript in 11 of 13 patients with Hodgkin's disease. The detection of this chimeric message in Hodgkin's lymphoma has been interpreted to suggest that ALCL and Hodgkin's disease have a close biological relation. If correct, this would be an important finding with both clinical and biological implications.

In three independent studies, our laboratories have analysed 108 patients with Hodgkin's disease by RT-PCR analysis for the presence of the *NPM/ALK* chimeric transcript. These patients were mainly from North America and included examples of all histological subtypes (66 nodular sclerosis, 32 mixed cellularity, 7 lymphocyte

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