number of deaths in this group in this semi-rural area, deaths being recorded under "other cancers." In 1980-1, however, there were three deaths from cancer of the paranasal sinuses in this practice of 10 000 patients. These were in young people living and working within four miles of each other. The possible environmental significance of this cluster is not apparent from the death returns for the area.

I suspect that the method of mapping cancer mortality described in this paper will fail to pick up clusters of rare tumours, particularly in areas of scattered population.

The environmental implications of this are important. The only accurate way of defining cancer mortality in these areas would be the use of disease indices either in general practice or in local departments of oncology.

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SIR,—The recent paper from Dr M J Gardner and others (13 March, p 784), which attempts to relate variations in cancer mortality in different areas of the UK to the distribution of environmental and occupational factors, uses an approach which appears to suffer from a number of serious limitations.

One of these, to which the authors themselves draw attention, is the occurrence of false-positive findings. Their results appear to show at least two of these, namely the incidence of pleural mesothelioma in Bexley and Gillingham. The blanket assumption of the authors that raised mortality from pleural mesothelioma is to be linked with occupational exposure to asbestos would not appear to hold true for either of these areas. Bexley is a north Kent dormitory suburb of London with little industry and is very much part of the "commuter belt." It is in no sense "centred on Barking" as the authors appear to imply, and, without some more convincing demonstration of association, the Bexley figures can only be viewed as a statistical quirk. Similarly, Gillingham appears to be an oddity in view of the apparent assumption that the high standardised mortality ratio from pleural mesothelioma is to be associated with the naval dockyard at Chatham. If the source of the problem was the shipbuilding at Chatham, one would have expected the raised SMRs primarily in Chatham itself as well as perhaps Gillingham and the other Medway towns.

Similar reservations should perhaps also be expressed about Thurrock and Canvey Island, which are centres for the petroleum industry. Asbestos exposure in these areas would be likely to have come from construction work; but if that is the significant factor at these sites, why not elsewhere?

It is suggested that the authors are in danger of not considering the implications of their findings? For example, it is easy to associate the raised incidence of nasal cancer in Rushden with the boot-and-shoe industry, but this should immediately raise the question of why only Rushden of all the boot-and-shoe centres. Again, why should Tower Hamlets have a raised SMR for nasal cancer? The association between nasal cancer and the furniture industry in the Wycombe area apparently relates to the use of certain hardwoods and not the furniture industry generally, which is quite widely scattered throughout the country.

While recognising the possible value of the type of exercise outlined in the paper from Professor Acheson and his coworkers, there is, it is suggested, a very real danger of falling into the trap of supplying answers before the proper questions have been put, with the result that facile and oversimplistic associations are likely to be made.

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Falling rate of provision of residential care for the elderly

SIR,—The paper by Emily Grundy and Professor Tom Arie (13 March, p 799) pointing out the falling rate of provision of services for the elderly reaches sad conclusions which cannot be avoided. There is no doubt that the total service available is too low in most areas because of failure of provision by the local authorities, but I think it is a mistake to suggest that a debate on the balance of care to be provided by the NHS and local authorities is an entirely separate issue.

The thinking of the 1940s was that hospital treatment and "aftercare" could be easily separated and responsibility divided accordingly. This was applied to the services for the elderly in a totally artificial way. It sidetracked the crucial issue that senile dementia is a deteriorating condition for which increasing nursing care and continuing medical supervision is required. It was a convenient manoeuvre which has led to the present problems. It passed to the local authorities a type of provision which is essentially medical in nature and more appropriate for the NHS. Of course, we do not want to add even more geriatric wards to the mental hospitals and psychiatric services or have the elderly carry any stigma that might be attached to this. Few sufferers from senile dementia require psychiatric specialist supervision on a daily basis in the long term. They can be accommodated in small continuing care units built for the purpose or in adapted premises but not in mental hospital grounds. I believe that the proposition that local authorities should provide special homes for the elderly mentally ill has set the wrong pattern—they should spend their money on the other groups whose needs do not require the level of nursing on which care needs should be judged.

Such ideas were published by the Scottish Division of the Royal College of Psychiatrists in 1977[1] and by the Joint Programme Planning Group of the Scottish Health Services Planning Council and the Advisory Council on Social Work in Scotland 1979.[2] This is not a good time to suggest an additional expense for the NHS but there is no use pretending that either realistic planning or provision will occur otherwise. Such an approach would have the advantage of basing a plan on clinical reality, emphasising the true need and removing the complexity of double responsibility. It is true that it would let the local authorities off the hook, but the hook should never have been inserted.

Mental handicap services are in a similar dilemma but it seems agreed by all concerned that a reduced NHS input is justified in this instance. Could we not rationalise the difficulties by some political-administrative trading? There are no obvious vested interests in the status quo.

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[1] Scottish Division of the Royal College of Psychiatrists. *The psychiatrist's contribution to the care of the elderly*. Edinburgh: RCPsych, 1977.
[2] Joint Planning Group of the Scottish Health Services Council and the Advisory Council on Social Work in Scotland. *Services for the elderly with mental disability in Scotland*. Edinburgh: HMSO, 1979.

Case clustering in pityriasis rosea: support for role of an infective agent

SIR,—It is surprising how epidemiology has for some become conventional and has escaped the real world. Technique has become a ritual so seductive that some practitioners expect not to be criticised as long as they obey the rules and go through the correct forms.

Pityriasis rosea is probably a disease which is caused by the communication from one patient to another of a micro-organism. Our reason for believing this is the opinion of competent skin specialists that "the course is that of a low-grade infection," the fact that sufferers frequently give a history of contact with another sufferer, and that dermatologists suffer more frequently than a comparable group of ENT specialists.

Papers such as that of Dr A G Messenger and his colleagues (6 February, p 371) strengthen our belief not at all. Our only reason for comment is to protest about the waste of time and effort that the paper represents and above all about the negative educational effect that it has. It does not in the very least add to our knowledge. It is no substitute for a proper epidemiological study in which individual cases would be examined for their direct contact, not at 0·25 km distance, with previous individual cases and in which confirmation would be sought with a proper microbiological inquiry. Moreover, the research is flawed as the authors admit their hypotheses were not formed before the inquiry started as is required by the use of statistical methods.

Medicine is not about conventions of technique, however elegant.

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**We sent this letter to the authors, who reply in the two letters below.

SIR,—We are intrigued that Dr Cameron and Dr Jones, advocates of "a proper epidemiological study," are prepared to base their criticism of our work on the outcome of a small retrospective postal survey[1] and on "the opinion of competent skin specialists that (in pityriasis rosea) ... sufferers frequently give a history of contact with another sufferer" (reference not given). Bjornberg and Hellgren[2] in their survey of 826 cases of pityriasis rosea obtained such a history in only four cases out of 108 who had been specifically questioned on this aspect. In our own study of 126 cases, in only two pairs were the pair members aware of being in contact with one another. We would submit that a history of contact between cases *is* uncommon, and it was this that led us to question whether the occasional cluster was merely coincidence. Clearly, contact tracing seemed inappropriate, and we therefore used a precise epidemiological