Map showing distribution of significant leukaemia incidence ratios (incidence ratio >1.0 ; $p < 0.05$) at ages 0-14 in 143 electoral wards in West Berkshire and Basingstoke and North Hampshire District Health Authorities. Figures are numbers of cases. Bold outlines indicate urban areas. (● = Atomic Weapons Research Establishment, Aldermaston, ■ = Royal Ordnance Factory, Burghfield, and ▲ = United Kingdom Atomic Energy Authority's Establishment, Harwell.)

ignores all other nuclear sites. The more extensive analysis of data from the Office of Population Censuses and Surveys by Dr Paula Cook-Mozaffari (in press) provides a geographically more complete but very different picture. Selecting only the sites with an excess incidence from the full set is bound to give a biased average for the selected group.

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AUTHORS' REPLY—Though there have been no systematic studies of the completeness of cancer registration in Britain, the Childhood Cancer Research Group estimated that during 1971-6 91% to 95% of all childhood leukaemias in Britain were registered in the national scheme.¹ Reliable data for more recent years are not available, and the studies quoted by Dr Harte do not provide sufficient information for assessing the completeness of childhood cancer registration.

Dr Wade suggests that the excess incidence of childhood leukaemia around the nuclear establishments in our study was confined to the area around the Royal Ordnance Factory at Burghfield and that this might be explained by differences in disease frequency in urban and rural areas. Our analyses were designed to test the specific hypothesis that the incidence of leukaemia was increased in children living in the vicinity of the nuclear establishments in the study area. We had no prior hypothesis concerning any individual establishment, but we did note that the relative excess around the Atomic Weapons Research Establishment at Aldermaston was of a similar magnitude to that around the Royal Ordnance Factory at Burghfield.

The figure shows the leukaemia incidence ratios for 1972-85 in children aged 0-4 years living within 10 km of the United Kingdom Atomic Energy Authority's Establishment at Harwell, the Atomic Weapons Research Establishment at Aldermaston, and the Royal Ordnance Factory at Burghfield and within 10 km of both the establishment at Aldermaston and that at Burghfield. Most of the

Map showing leukaemia incidence ratios (observed/expected cases) at ages 0-4 in the West Berkshire and Basingstoke and North Hampshire District Health Authorities. Circles of radius 10 km are drawn around each nuclear establishment. (● = Atomic Weapons Research Establishment, Aldermaston, ■ = Royal Ordnance Factory, Burghfield, and ▲ = United Kingdom Atomic Energy Authority's Establishment, Harwell.)

population, and thus most of the children with leukaemia, live in the urban area of Reading. In the remaining, largely rural, areas the population is smaller and there are correspondingly fewer children with leukaemia. The incidence ratio is, however, not highest in the urban area of Reading, and there are no significant differences between the incidence ratios shown in the figure. Finally, the data presented by Cook-Mozaffari *et al* are not at variance with ours.²⁻⁴

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Irritable bowel syndrome as a cause of chronic pain in women attending a gynaecology clinic

SIR,—Mr Patrick Hogston suggests that 60% of women with "unexplained pelvic pain" in his study had the irritable bowel syndrome (11 April, p 934). We find it hard to equate the findings of this study with our own.

Research among patients attending the pelvic pain clinic at the Samaritan Hospital does not as a rule show symptoms attributable to the bowel. All new patients attending the clinic are questioned directly, and in the past six months only five patients out of 130 have had symptoms suggestive of the irritable bowel syndrome, while in a study conducted in 1985 and 1986 only three of 35

women had such symptoms (unpublished findings). Mr Hogston's study relied solely on a questionnaire to make the diagnosis. Few clinical details of the patients are given with regard to their reproductive history and use of contraceptives. The only investigation reported to have been done was laparoscopy. Though some clinicians may find that the Manning questionnaire provides enough evidence to diagnose this condition, such an approach takes no account of recent work on pelvic pain in women.¹

Dyspareunia was reported in 41 of 50 patients. The author describes this as an association of the irritable bowel syndrome, attributing it to a "tender colon" while quoting from a paper describing a multitude of symptoms, including nocturia, frequency, an unpleasant taste in the mouth, and a constant feeling of tiredness. Surely all one can really conclude from this report is that women with pain report many symptoms. To conclude that dyspareunia is a further manifestation of the irritable bowel syndrome is not justified.

Finally, there is another explanation for chronic pelvic pain in women of childbearing age; 80% of such women have been shown to have dilated pelvic veins and pelvic congestion.² This study was based on the firm evidence of pelvic phlebograms comparing normal subjects with patients with pelvic pain. A further study of the symptoms of these patients showed that their pain was aggravated by long periods of standing, during and after sexual intercourse, and in the premenstrual period (unpublished findings).

We believe that labelling patients as having disease on the basis of a questionnaire alone is likely to result in a misleading diagnosis. The conclusion on such scant evidence that the irritable bowel syndrome is the major cause of pain in women with normal findings at laparoscopy simply further muddies the waters of this difficult subject.

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Pinch skin grafting or porcine dermis in venous ulcers

SIR,—Mr K R Poskitt and colleagues (14 March, p 674) are to be congratulated on their study of pinch skin grafting as there are very few randomised clinical trials on the management of venous ulcers. In particular, they show what can be achieved with experienced team care and relate some useful facts on healing rates.

The finding, however, that human skin is a better dressing for most ulcers than pig skin is hardly surprising. Nevertheless, before we all rush to use pinch grafts there are three points that are not clearly brought out in the discussion. Firstly, there seems to be a very wide variation in the healing rates in the pinch graft group, which suggests that not all pinch grafts take equally well on the same ulcer. Secondly, nearly a third of the patients in the pinch graft group required further grafts at around three to five weeks, yet there is nothing to show for this in the results. Thirdly, successful pinch grafts might be expected to maintain a high healing rate for the very reasons proposed by the authors—namely, length of epithelial margins and production of epithelial growth factors—yet the percentage reduction in ulcer size