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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

The geography of disease

SIR,—The intriguing paper by Dr D J P Barker and his colleagues (1 December, p 1389) on the differential prevalence of gall stones in nine towns in England and Wales provides further evidence of the considerable geographical, social, ethnic, and cultural differences which exist within the British Isles. The authors draw attention to a negative correlation between prevalence of gall stones and standardised mortality ratios for ischaemic heart disease in their nine towns. It is of interest that this negative correlation can be further subdivided, for if one compares their findings in respect of gall stones for men and women with the death rates per 100 000 for atherosclerotic and coronary disease (ICD 420) in men and women aged 45-64 a differential pattern emerges between the sexes. In men the correlation coefficient is -0.45 and is not significant whereas for women it is -0.63 and is significant at the $p < 0.05$ level.

Studies such as those by Dr Barker and his colleagues serve to remind us of the multifactorial nature of the majority of chronic conditions, and of the folly of seeking to implicate single factors in isolation as "the cause" of diseases such as coronary disease

and gall stones. Evidence is accumulating that one cannot even draw general conclusions from closely defined groups within a given local community. We have recently completed a study of cardiovascular risk factors in Nottingham teenagers (in press and unpublished observations) and have found striking differences between the patients registered with our three participating general practices. These differences include not only labile variables such as urate and lipid concentrations and

arterial pressure but inbuilt markers such as the distribution of the ABO blood groups.

Dr Barker and his colleagues are to be congratulated for reminding us that even within a small country such as ours the study of geographical differences in disease prevalence is a fascinating and worthwhile exercise.

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Epidemiology of multiple sclerosis

SIR,—We have read with interest your leading article comments (1 December, p 1386) on the subject of epidemiology of multiple sclerosis.

We agree that multiple sclerosis can be attributed to the interaction of both environment and heredity, with environment thought to exert a greater influence on the manifestation of the disease. While it cannot be denied that epidemiological studies have provided most of the information on environmental factors, most studies are based on residences to ascertain the geographical distribution of

multiple sclerosis. We wish to point out that the use of residence as a variable in the research not only is inadequate because the resultant estimate of incidence or prevalence, or both, is misleading, but it underscores the underlying importance of past environmental influences during prenatal and perinatal periods of individuals who express multiple sclerosis later in life. We have data to indicate the importance of such influences which will be published in due course. In the meantime the purpose of this letter is to demonstrate the