and duration and comparability of history taking procedures for evaluating past asbestos exposure; study of the significance of (para-)occupational exposure situations.

14. Study of the age and sex standardized incidence of malignant tumours in the general population according to areas of living-working: urban-rural, industrialisation in general, presence of asbestos industries, presence of dockyards and harbours, presence of asbestos mines and presence of other potential asbestos emitting sources.

A general remark on the feasibility of epidemiological studies appears to be appropriate. The question is whether an epidemiological approach can be found, that delineates the contributory role of asbestos and other mineral fibres to induction of malignant tumours. With retrospective techniques, it has been possible to establish past exposure to asbestos in most cases of mesothelioma. It is probable that with more complete history taking only a relatively small number of mesothelioma patients will remain having no (para-) occupational exposure. How we can regard this remaining group is still unclear. A logical assumption is that this group contains:

a) not recognized (para-)occupational or neighbourhood exposure,
b) cases due to true environmental exposure,
c) cases due to other pollutants (mineral fibres?),
d) cases not related to asbestos or other pollutants.

To study this, one would need fairly large numbers of cases, one would also like to compare large communities, and one would like to know the "normal" fibre burden of the lung. At present the number of mesothelioma cases in, for example, the Netherlands may be too small to study an urbanization effect. So, the question can only be solved, it seems, by waiting until higher numbers become available, or by performing a rigidly coordinated international study.

Within the EEC, mesothelioma registration sometimes appears to be related to the social insurance system and reports only occupationally related cases, which have to be financially compensated. Such a system will underreport the total prevalence.

As for bronchial cancer, the perspectives may be brighter. There is still a clear urban-rural gradient in most countries; this gradient is diminishing however, at least in the UK and in the Netherlands. Still if we could

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