We suggest that the hazards and limitations of current screening techniques, combined with the present ignorance about the natural course of intracranial aneurysms, make screening of first degree relatives of patients with subarachnoid haemorrhage impracticable.

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1 Bromberg JEC, Rinkel GJE, Algra A, Greebe P, van Duyn CM, Hasan D, *et al.* Subarachnoid haemorrhage in first and second degree relatives of patients with subarachnoid haemorrhage. *BMJ* 1995;311:288-9. (29 July.)
2 Maurice-Williams RS. *Subarachnoid haemorrhage.* Bristol: Wright, 1987.
3 Heiserman JE, Dean BL, Hodak JA, Flom RA, Bird CR, Drayer BP, *et al.* Neurologic complications of cerebral angiography. *AJNR* 1994;15:1401-7.
4 Huston J, Nichols DA, Luetmer PH, Goodwin JT, Meyer FB, Wiebers DO, *et al.* Blinded prospective evaluation of sensitivity of MR angiography to known intracranial aneurysms: importance of aneurysm size. *AJNR* 1994;15:1607-14.

Paper is ambiguous about number with proven aneurysm

EDITOR,—Jacoline E C Bromberg and colleagues report that the estimated relative risk of subarachnoid haemorrhage in first degree relatives of patients with subarachnoid haemorrhage compared with the general population was between 2·7 and 6·6.[1] This is similar to the 4·1-fold increased risk that colleagues and I found in first degree relatives of patients with aneurysmal subarachnoid haemorrhage in the population of Rochester, Minnesota, in the United States,[2] despite the dissimilar methods used in the two studies.

Not all subarachnoid haemorrhages are due to aneurysmal rupture, and we limited our study to patients with a proved ruptured intracranial aneurysm.[2] Bromberg and colleagues do not state how many of the 163 patients with subarachnoid haemorrhage had an aneurysm. To compare the different studies on the familial aggregation of subarachnoid haemorrhage[1-4] it would be interesting to know the proportion of patients with a proved intracranial aneurysm and the location of these aneurysms in the study population reported by Bromberg and colleagues.

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1 Bromberg JEC, Rinkel GJE, Algra A, Greebe P, van Duyn CM, Hasan D, *et al.* Subarachnoid haemorrhage in first and second degree relatives of patients with subarachnoid haemorrhage. *BMJ* 1995;311:288-9. (29 July.)
2 Schievink WI, Schaid DJ, Michels VV, Piepgras DG. Familial aneurysmal subarachnoid hemorrhage: a community-based study. *J Neurosurg* 1995;83:426-9.
3 Norrgård Ö, Ängquist KA, Fodstad H, Forsell Å, Lindberg M. Intracranial aneurysms and heredity. *Neurosurgery* 1987;20: 236-9.
4 Ronkainen A, Hernesniemi J, Ryynänen M. Familial subarachnoid hemorrhage in east Finland, 1977-1990. *Neurosurgery* 1993;33:787-97.

Authors' reply

EDITOR,—Jeremy Rowe and colleagues are under the impression that subarachnoid haemorrhage in the relatives of our patients was diagnosed on the basis of a telephone interview alone, but, as we wrote, all diagnoses were verified by a review of medical documents. Furthermore, Rowe and colleagues are not surprised at the increased risk of subarachnoid haemorrhage in first degree relatives since most neurosurgeons have encountered families with clustering of such haemorrhages. We found, however, that the increased risk in first degree relatives applies to the average patient with subarachnoid haemorrhage and is not confined to a few selected families. We agree, as we suggested in our paper, that one should not rashly screen these relatives but should study the risks and benefits. Indeed, conventional angiography is not the method of choice for screening, although in the study to which Rowe and colleagues refer the neurological complications occurred only in patients investigated for transient ischaemic attack or stroke (n=227) and not in those investigated for unruptured aneurysms (n=62) or subarachnoid haemorrhage (n=137).[1] Whether relatives should be screened with non-invasive methods such as magnetic resonance angiography should be studied prospectively; we are about to embark on such a project.

Schievink *et al* found an increased risk of subarachnoid haemorrhage in first degree relatives of the same order of magnitude as the risk that we found.[2] The design of their study differed from ours: it was community based and concerned a retrospective series of patients, and a telephone interview was performed with the patient or next of kin to find first degree relatives who might be affected. We approached all relatives personally and found that we would have missed a quarter of affected relatives if we had used only the family history obtained through the patient or next of kin. Therefore, Schievinks *et al*'s estimate of the incidence of subarachnoid haemorrhage in first degree relatives may be too low. Despite this, the similarity of the results in the two studies suggests that they can be generalised to first degree relatives of other patients with subarachnoid haemorrhage.

In reply to Wouter I Schievink's question, we can state that 123 of the 163 patients and six of the 10 relatives had a proved intracranial aneurysm. We chose not to exclude patients who did not undergo angiography because they were mainly patients in poor clinical condition. Since familial subarachnoid haemorrhage seems to carry a worse prognosis than sporadic subarachnoid haemorrhage[3] this could bias the results. Full details about the patients and the location of aneurysms will be published shortly.[4]

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1 Heiserman JE, Dean BL, Hodak JA, Flom RA, Bird CR, Drayer BP, *et al.* Neurologic complications of cerebral angiography. *AJNR* 1994;15:1401-7.
2 Schievink WI, Schaid DJ, Michels VV, Piepgras DG. Familial subarachnoid haemorrhage: a community-based study. *J Neurosurg* 1995;83:426-9.
3 Bromberg JEC, Rinkel GJE, Algra A, Limburg M, van Gijn J. Outcome in familial subarachnoid hemorrhage. *Stroke* 1995; 26:961-3.
4 Bromberg JEC, Rinkel GJE, Algra A, van Duyn CM, Greebe P, Ramos LMP, *et al.* Familial subarachnoid haemorrhage: distinctive features and patterns of inheritance. *Ann Neurol* (in press).

Career choices for generation X

EDITOR,—Clare Vaughan states that the medical career structure is rigid and outdated and that flexible career paths for general practitioners are needed, especially to allow for part time working.[1] Having worked in general medicine before moving to Orkney in 1988, I expected to find part time work in general practice, perhaps through the retainer scheme, after a career break while my children were young. Now I find myself ineligible for the retainer scheme owing to a recent European directive that requires full vocational training for participation. I cannot complete vocational training as my previous experience falls outside the time limits required. A sufficient range of accepted specialties is not available for me to undertake training locally if this experience is disregarded.

It seems that flexibility is decreasing, and I find it wasteful to be thus retired while still relatively young. I hope that the desired flexibility will materialise soon.

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1 Vaughan C. Career choices for generation X. *BMJ* 1995;311: 525-6. (26 August.)

Controversy over new data on oral contraceptives

Risk of delay was small

EDITOR,—The rapidity with which the Committee on Safety of Medicines released its advice about the risk of thromboembolism associated with oral contraceptives has caused much anger, concern, and confusion.[1] Critics of the committee maintain that (*a*) systems exist for the rapid dissemination of information to medical practitioners, (*b*) these systems could have disseminated information to medical practitioners within 12-48 hours, and (*c*) the short delay resulting from the use of these systems would have resulted in less confusion, concern, and anger. The committee seems, however, to have thought that the dangers were so great that no delay was acceptable.

How many women would have been harmed if Professor Michael Rawlins, the chairman of the committee, had delayed his announcement by 48 hours? Professor Rawlins's letter states that the maximum thromboembolic risk from oral contraceptives that do not contain desogestrol and gestodene is 10 cases per 100 000 per year. He estimates that the risk of thromboembolic events associated with desogestrol and gestodene is double this, the implication being that women taking contraceptives that contain desogestrol and gestodene have a maximum extra risk of 10 cases per 100 000 per year. This approximates to 0·5 cases per million per 48 hours.

A spokesman for the Family Planning Association has estimated that one and a half million women in Britain are taking oral contraceptives. We can therefore imagine a worst case scenario and assume that all of these 1·5 million women are taking a high risk pill. Calculations show that if Professor Rawlins had delayed his announcement by 48 hours less than one woman in Britain (0·8 at the most) would have been placed at risk of having an extra thromboembolic event. Had the delay been one week, at the most 2·8 women would have been placed at risk of having an extra thromboembolic event. Has a sledge hammer been used to crack a nut?

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1 Carnall D. Controversy rages over new contraceptive data. *BMJ* 1995;311:1117-8. (28 October.)
2 Committee on Safety of Medicines. *Combined oral contraceptives and thromboembolism.* London: CSM, 1995.

GPs were swamped by calls

EDITOR,—The way in which the Department of Health handled the information from the Committee on Safety of Medicines on the risk of thromboembolism associated with combined oral contraceptives was inept and dangerous.[1] Any