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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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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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, Schievink *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 haemorrhage³ this could bias the results. Full details about the patients and the location of aneurysms will be published shortly.⁴

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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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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 desogestrel and gestodene is 10 cases per 100 000 per year. He estimates that the risk of thromboembolic events associated with desogestrel and gestodene is double this, the implication being that women taking contraceptives that contain desogestrel 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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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

possible theoretical benefit from saving a very few women from thromboembolism will have been swept away by the fact that a huge number of women, panicked by the media hype, will have stopped taking their pill immediately. Any scare about oral contraceptives causes a higher morbidity from pregnancy or terminations than it saves. This does not take into account the appreciable extra stress caused to general practitioners, primary care nurses, and receptionists faced with one and a half million extra consultations in one and a half days. There is also no way of measuring how many really urgent consultations were displaced by the clamour of the pill taking population.

The whole exercise was made infinitely worse because we knew nothing about it. My colleagues and I had no chance to discuss a strategy as a practice or to arrange extra counselling clinics. At the end of my "morning" surgery at 110 pm the first women started to telephone in, or came to reception, in tears. They had listened to the news at 1 pm. By the time we had received a fax from the Committee on Safety of Medicines at 340 pm (when we were all out on visits) 60 out of a possible 350 patients had already contacted us. Our patients could not believe that we did not even know which pills had been affected.

We have tried extremely hard over the years to encourage our population to ask for information. With a national decision of this magnitude, it was an error at the highest level that general practitioners were not given the full details of the studies so that our patients could make up their own minds. The concept of evidence based medicine has been accepted for many years in primary care but not, it seems, in government. There seems to be one standard of expectations for the medical profession to have a rational approach to resources, priorities, good quality information, and communication with our patients and a different one for the Department of Health.

A constructive critical response from the whole of the medical profession is needed to stop this happening again.

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Perception of risk is affected by presentation

EDITOR,—T Fahey and colleagues advise that informed clinical and health policy decisions should be made on the basis of full understanding of the limitations of the data presented, and they show how members of health authorities were influenced more by relative risk than by other presentations of the same data.¹ This may apply to the general public too. If that is so, the public relations disaster of the Committee on Safety of Medicines' release of conclusions from unpublished data on the risk of thromboembolism with certain combined oral contraceptives might have been avoided if the data had been presented in a form showing the difference in the percentage of event free women (table).² This would have alarmed women less and allowed a more measured

*Risk of venous thromboembolism with combined oral contraceptives**

	Oral contraceptives containing gestodene or desogestrel	Other combined oral contraceptives
Absolute (excess) risk per 100 000 per year	15	7.5
Relative risk	2.0	1.0
% Of women free of thrombosis	99.985	99.993

*Based on data given by Committee on Safety of Medicines.²

determination of policy when the results of the relevant studies are published.

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Screening for diabetic retinopathy

Adequate programme would save money

EDITOR,—Bob Ryder's editorial on screening for diabetic retinopathy notes the potential cost of litigation if those at risk are not screened adequately but fails to mention the more certain savings that may result from a comprehensive screening service.¹ Even when non-insulin dependent diabetes alone was considered an American computer model that compared the efficacy of treating macular oedema and neovascularisation with the federal costs of blindness calculated savings of \$247.9m (£165.3m) and 53 986 person years of sight.² These figures assumed only a (current) 60% uptake of services.

Perhaps more worrying is not the exact mechanisms of screening but the consequences of failure to screen. In a study of the diabetic patients in the Avon region who were registered as blind only a quarter had been screened once or more and half had not been screened although they were known to be diabetic.³ The other quarter had been diagnosed as diabetic only after presenting to an ophthalmologist with visual symptoms.

The American computer model predicted savings of \$472.1m (£314.7m) and 94 304 person years of sight if all of the population with non-insulin dependent diabetes were to be screened, which translated into savings of \$975 (£650) per person enrolled into the screening programme in the United States. Although allowance must be made for some differences in costs between the United States and Britain, the need for vigorous screening speaks for itself.

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Services are still patchy in Britain

EDITOR,—Bob Ryder emphasises the need for a screening test of adequate sensitivity and specificity in programmes to detect diabetic retinopathy,¹ but this is only part of the problem. For a screening programme to be effective, high population coverage is needed, prompted by an accurate call and recall system. This is far from the case with diabetes. Studies suggest that fewer than half of people known to have diabetes, whether they are cared for by hospitals or in general practice, have an annual examination of their fundi.^{2,3} Several studies have shown that when attendance for screening is prompted (to either a hospital or a screener based in the community) coverage of over 70% can be achieved.^{2,4}

Present services for detecting diabetic eye

disease are patchy, and there is a strong case for a national programme.⁵ We have recently been funded by the Department of Health to examine the current provision and organisation of screening. This will include a national survey and detailed examination of the performance of different systems in delivering high rates of coverage. The study is coordinated by an intercollege group, which includes representatives from the Royal College of Physicians, the Royal College of General Practitioners, and the Faculty of Ophthalmology of the Royal College of Surgeons. We hope that our results will contribute to the development of a policy for the detection of diabetic retinopathy that not only uses appropriate tests but includes the other essential attributes of an effective programme.

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GPs in south London have direct access to screening service

EDITOR,—Bob Ryder encourages those engaged in screening for diabetic retinopathy to use both of the two main methods of retinal examination: direct ophthalmoscopy and retinal photography.¹ Photography has the advantage of providing a permanent record so that progression of retinopathy can readily be monitored, and if Polaroid prints are used they can be shown to the patient to indicate the importance of the eye test. Ophthalmoscopy can detect smaller lesions, can be used to check the peripheral retina, and can be useful when lens opacities blur the photographs.

Current strategy in the provision of health care for diabetic patients has seen a shift to primary care, with general practitioners and practice nurses delivering the care that was formerly the sole province of the hospital diabetic clinic. In response to this shift St Thomas's, Guy's, and King's College Hospitals now provide general practitioners with direct access to an eye screening service for patients who receive the rest of their care from their practice. These diabetic eye complication screening clinics, sited in each hospital, provide a standard set of screening tests for large numbers of people with diabetes in south London.² Polaroid photography of the fundus and direct ophthalmoscopy after mydriasis, as recommended by Ryder, are combined with measurement of the intraocular pressure and visual acuity. The results are reviewed by the consultant ophthalmologist responsible for treating retinopathy, who decides whether an ophthalmic referral is required or whether mild retinopathy can be monitored safely at further visits to the clinic to conserve the resources of the eye department. Linking screening with treatment in this way is invaluable in reducing visual loss due to diabetes; identifying the retinopathy without making a timely referral is not enough.

The advantages of centralising screening are that