Intracranial aneurysm and HLA-DR2

Sir: We read with interest the letter from Schievink et al concerning HLA antigens and intracranial aneurysms. They commented on a study by Østergaard's group which provided some evidence in support of a genetic predisposition to intracranial aneurysms, namely an increased incidence of HLA-DR2 amongst aneurysm patients.

Dr Schievink and his colleagues could not substantiate this hypothesis when they analysed the frequency distribution of HLA-DR2 in a retrospective study of 31 cases of death associated with subarachnoid haemorrhage (SAH) following rupture of intracranial aneurysms. Quite correctly, they emphasise the selective nature of both Østergaard's data and their own and point to the need for larger studies of unselected patients to include those with ruptured and unruptured aneurysms.

We fear that there will inevitably be some selection despite implementation of the above suggestions. Referral to neurosurgical centres of patients after SAH will depend upon local policy but in general neurosurgeons will only be notified of the fittest patients. Furthermore, even patients with unruptured aneurysms will have been selected in that of necessity they will present with symptoms which justify the use of angiography needed to demonstrate their aneurysms.

In the light of the foregoing, the results of an investigation recently completed by us may be of interest. We conducted a pilot study concerning the possible implication of HLA antigens in the pathogenesis of non-haemorrhagic deterioration following aneurysm SAH. The results of this study, full publication of which is in preparation, were recently announced in a preliminary communication.

Forty patients (28 females, 12 males) of mean age 44 years (SD 13-8) who had sustained an aneurysmal SAH were followed to death or discharge. Tissue typing was performed using standard methods. The table compares the frequency of HLA-DR2 amongst controls, the total SAH study population and patients grouped according to aneurysm site. Technical difficulties precluded typing for HLA-DR2 in two patients (one male and one female). No statistical significance could be observed between the several groups (chi square with Yates's correction).

On the basis of the above, we agree with Schievink et al that the overall frequency of HLA-DR2 does not differ significantly between control groups and the aneurysmal SAH population. However, the slightly higher incidence of HLA-DR2 in those patients with anterior communicating artery aneurysms suggests that a weak genetic predisposition for the development of this type of aneurysm may exist.

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References

An implant clamp for atlanto-axial fusion

Sir: Mills et al, in a letter to the Journal describe an implant clamp for the surgical stabilisation of C1–C2 instability. The clamp is a unique device and obviously appears to render substantial stability to the spine. We, however, have several concerns regarding the utilisation of such a device. First, the Brooks and Gallie fusions, as mentioned by Mills et al, are widely accepted. They, in addition, have a low complication rate and an acceptable fusion rate. Furthermore, the sublamellar wires used with these fusions offer a minimal risk of spinal cord compression because of the small volume occupied by these wires in the capacious upper cervical spinal canal. On the other hand, the photographs accompanying the letter by Mills et al demonstrate a rather bulky device. The hooks of this device appear to be

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Creutzfeld-Jacob like syndrome due to lithium toxicity.

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