June 10, 1993

Dr. John Little
H&CS
Lakeside Hospital
Gillies Street
PO Box 63 Ballarat 3353
Victoria, Australia

Dear Dr. little,

It is not clear why you sent the proposed guidelines for ECT to me. The best U.S guidelines are those proposed by theAmerican Psychiatric Association Task Force in its 1990 report *Electroconvulsive Therapy: Recommendations for Treatment, Training and Privileging* (APA Press, Washington D.C.) or the 1992 text written by Richard Abrams (*Electroconvulsive Therapy*, Oxford University Press, 1992). Both contain the present consensus in the U.S. regarding all the questions you summarize in your report.

I attach some specific comments on your document, which may be idiosyncratic with me and my team.

There is no experience to warrant or justify any specific decisions regarding pulse width or frequency in treatment efficacy. Swartz makes claims about duration, arguing that some brief pulse trains at 4 to 8 seconds are more efficient (more effective?) than the short trains of the MECTA. There is evidence that total energy (mC) is a factor in efficacy when unilateral electrode placement is used. For my part, we are dedicated to the THYMATRON device which allows changes in energy and duration. When we use the MECTA device, we use the SR-2 as the more facile of the MECTA devices.

In the U.S., it is no longer acceptable to undertake ECT without EEG monitoring; we would no more think of unmonitored ECT than we would think of unmodified (no anesthetic) ECT.

I have not been to Australia, and would probably be pleased to come if the arrangements were suitable.

Much of what I know about modern ECT comes from articles in *Convulsive Therapy,* the quarterly journal now in its ninth year of publication. I do not think you know it in Australia -- perhaps you could subscribe and educate your peers.

Sincerely yours,

Max Fink, M.D.
Editor

Electroconvulsive Therapy: A Medical Guide

page 1: In discussing theories, why not cite the neurohumoral and the GABA-ergic hypotheses? These are detailed in *Convulsive Therapy* (vol 5, #3, September 1989).

page 2: Why is catatonia cited among both psychiatric and non-psychiatric reasons for ECT? And what makes the non-psychiatric 'controversial'. For catatonia, if benzodiazepines are not effective in a few days, ECT is clearly justified even in catatonia secondary to systemic disorders (lupus, typhoid, NMS).

The contraindications are not consistent with the APA discussion. We no longer accept any absolute contraindication. We now approach each case with a risk/benefit analysis, and if ECT is commanded by the psychiatric conditon, no systemic condition is seen as a contraindication.

page 3: ECT was not the first effective treatment for mental illness; it was believed to be effective for dementia praecox and that was its novelty.

Inanition and manic delirium are conditions that should be added to the list.

We would not accept the statement that the anesthetist decides whether a patient is fit for ECT. That is the psychiatrist's decision; the anesthetist is to do his best with what is given to him, much as he has to do with traumatic or non-elective surgery. (When ECT is compelled by a patient's illness, it is not elective.)

page 4: It is too sanguine to say that permanent brain damage does not occur. At times, as a result of poor techinique, a prolonged seizure is not recognized, an airway is not maintained and a permanent dementia ensues. You can say that 'permanent structural brain damage does not occur **under usual treatment schedules'**.

page 5: A common problem is post-seizure agitation or delirium.

For consent for ECT, we usually insist that a 'significant other' to the patient consent as well as the patient.

page 7: I believe fractures occurred in T10, not T5.

Pre-oxygenation does not reduce the seizure threshold unless you have evidence not in our literature.

The efficacy/ energy relationships are restricted to unilateral electrode placements.

Brief pulse currents produce less cognitive impairment than alternating currents.

page 9: I cannot believe you mean 2780 amperes -- perhaps milliamperes? Any reference to the electric chair in an ECT document is pejorative. Delete it.

page 10. AT this late date, you cannot be serious in stating that the observer can tell when a seizure starts or ends in ECT when patients are effectively paralyzed and asleep. In our studies in 1980-81, we showed that cuff monitoring and EEG monitoring were essential. By 1987-90, we became convinced that EEG monitoring was essential, mainly as a protection against missing a prolonged seizure.