J. Lesem 1992

May 9, 1992

Wilma Harrison, M.D.
Roerig Division Pfizer Inc.
235 East 42 Street
New York City 10017-5755

Dear Wilma,

Thank you for the invitation to participate in the teaching commitments of Roerig. I am delighted to do so. As you know, I am now identified with ECT and catatonia than in standard antidepressant research. My 'expertise' is rather specialized and may, or may not, fit into the Roerig teaching program.

ECT is a most effective treatment, which is offered mainly at major academic hospitals in the U.S. It is hardly available at Veterans Hospitals, state mental hospital, municipal hospitals mental health services, or the NIMH clinical center. Despite the confirmed efficacy and safety of modern ECT. Despite the reports of numerous commissions and study groups. Despite the belief by many psychopharmacologists that the drugs can do all, for all, if only their knowledge and skills were applied. [Even Don Klein, however, has begun to refer patients for ECT.]

What can be done? If you wish to support lectures or conferences on ECT, I can surely help.

Perhaps Roerig is interested in something more. Each year at the APA, the industry sponsors large lectures, with food and excellent P.R. Each year, the topics are focussed on drug treatment for mania or panic disorder or therapy resistant schizophrenia, each a topic designed to support a defined use of a specific drug. Roerig could do more. Offer a symposium on the evaluation and treatment of the severe mentally ill, with a focus on the relative efficacy, indications, and combined uses of drugs and ECT. By including ECT, you will capture a large [and growing] group of physicians who feel that their training has been deficient [it generally has] and who are now asked to use ECT [by insurers]. A symposium could be organized about a single diagnostic group [depression, bipolar disorder, psychosis] or about a problem [treatments in pregnancy, the elderly, or young adults] with a focus on guidelines for the use of drugs and ECT, in association or sequentially.

Catatonia is a second topic. A few years ago, Mickey Taylor and I wrote an argument that catatonia should be separated from schizophrenia [it is only defined as a subtype of schizophrenia in DSM-III] into a separate class in DSM-IV. The DSM-IV committee agreed, in part, and now recommend that catatonia be a modifier of four conditions.

Our interest in catatonia is based on two issues. Is catatonia a part of schizophrenia or is it something else? Considering the particular efficacy of ECT, should it not be separated from other conditions so that ECT can be used early in the treatment? Further, are catatonia and NMS similar or different disorders?

I also enclose an editorial "Pharmacotherapy and ECT" which expresses my opinion of some present lacks in the education of psychopharmacologists and clinicians about ECT.

Some specific suggestions. For lectures, the following titles are descriptive:

For whom should ECT be considered?
ECT and pharmacotherapy: Combined and sequential use.
Efficacy and safety of modified ECT.

Catatonia and NMS: Identification and treatment.
Catatonia: Not so rare and very treatable.

For the APA, a conference can be organized on the topic of catatonia, or therapy resistant depression [psychosis], or the pregnant psychotic. Each topic can be organized to be rather unique in modern APA annals.

I enclose some reprints for your review, and a copy of my 'short' c.v.

My thanks for your consideration and my best regards.

Sincerely yours,

Max Fink, M.D.
Professor of Psychiatry