F. Letters

February 6, 1979

Barry Maletzky, M.D.
Portland, Oregon 97202

Dear Dr. Maletzky,

Your letter of inquiry relating to our experience with the MECTA and with MMECT was referred to me foomreply. As you know, I visited Paul Blachly in Oregon in 1968 and undertook a series of confirming studies of MECT. The publications relate our experience, which was not good.

In 1976, we purchased a MECTA instrument. In our initial treatments, we were unable to achieve a grand mal seizure using maximum current intensity and settings. We called the manufacturer, returned the instrument as he requested, and it was returned to us, with the assurance that a faulty part had been replaced. We again attempted to induce seizures and could do so at the maximum settings. When we attempted to use unilateral electrodes, we were unable to achieve the higher currents needed for such inductions. Gradually, the therapists replaced the instrument and when it was no longer useful, it was shelved, where it remains today.

In the review of MECT (among other modifications of ECT) which was undertaken by the APA Task Force on Convulsive Therapy, we were unable to find systematic data which would assure us that this modification was safe or more effective than routine ECT, expecially with unilateral electrode placements. Our conclusions are cited in the Task Force report, #14 of the APA reports, dated November, 1978.

In my own review of ECT, which is in press and which will be available by the end of the month, I come to the same conclusion, that MECT indications for MECT are unclear, and further study is necessary before its role in treatment is defined." In that statement, I am being kinder than my real feelings, which are that MECT has little justification except as a research tool.

I am acquainted with your very interesting report on the relation of deizure duration to outcome in ECT, as published in the latest issue of Comprehensive Psychiatry. I have cited the report in

my review, and find your conclusions most useful. The possibility of a therapeutic window for ECT is an important concept, and is consistent with the experiences reported from my laboratory by M. A. Green, who found that the duration of seizures changed with treatment, and that thresholds usually rose. But we were unable to define a 'window', but then we didn't have the concept.

With regard to the MECTA, there is need for better instrumentation for ECT, and perhaps the unidirectional brief stimulus approach recommended by Lieberson in the 1950's and lately by Weaver is the way to go. But there seem to be inherent faults in the MECTA that need remedying before the instrument will be useful in the clinic. Similarly, the efficacy and applicability of MMECT is so far from demonstrated, that a text as to how it should be applied clinically may be premature.

I look forward to your next report on the 'therapeutic window' in ECT.

Sincerely yours,

Max Fink, M.D.

Citations:

R. Abrams. MECT: What have we learned ? in Fink, M., Kety, S., McGaugh, J. and Williams, T. (Eds.): Psychobiology of Convulsive Therapy, Washington, V.H. Winston, 1974, 79-84.

M.Fink. Convulsive Therapy: Theory and Practice. New York, Raven Press, 306 pp., 1979.

Abrams, R. and Fink, M. Clinical experience with multiple electroconvulsive treatments. Comprehensive Psychiatry 13: 115-121, 1972.