February 17, 1996

Ms. Sarah Lentz
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Dear Ms. Lentz,

Thank you for the opportunity to read you report on ECT and pregnancy. It is quite good, but as an Editor, I have some suggestions to improve the history and the practice.

In the history, the introduction of electrical inductions by Cerletti and Bini was a modification of an established treatment, that of Metrazole convulsive therapy. The induction of seizures with camphor and then pentylenetetrazol [Metrazole] was introduced by Ladislas Meduna in 1934, highlighted in an international conference in Muensingen, Switzerland in 1937, accepted throughout the world as a treatment [see the supplement to the *Am J Psychiatry* 1938]. These events preceded and were surely the stimulus to the Italians [Bini attended the 1937 meeting]. It would be better to state that the introduction of convulsive therapy by Meduna was the innovation that altered psychiatric practice. He deserves the credit.

The charge of overuse and inappropriate treatment of ECT is incorrect. All treatments that are perceived as successful and safe are 'overused' as practitioners seek to extend and define the indications. Think of the present enthusiasm for fluoxetine or the newer alleged psychotropics; or the extensive overuse of coronary artery bypass surgery; or of caesarian deliveries. The canard should not be repeated and this section should be deleted.

Further, ECT like other somatic treatments in use in the 1950s, was replaced by medications, but its renewed interest [in contrast to psychosurgery and insulin coma] was occasioned by the failures of pharmacotherapy. Despite the enthusiasm of the public and the blandishments of the pharmaceutical representatives, many patients fail modern drug therapies and are later successful with ECT.

In your suggestions about ECT in pregnancy, there are a few that are more dangerous than you consider. Vaginal examination is not only not necessary but a dangerous procedure during pregnancy and should not only not be recommended, but enjoined unless compelled by signs or symptoms that warrant such an examination. There is nothing about the examination that would alter or affect ECT, if ECT is compelled by the patient's mental state.

Anticholinergic medication as part of the ECT procedure is acceptable and useful. External fetal monitoring during the procedure has been done, and remarkably, the fetal heart rate is unaffected by the procedure. There is no justification for such monitoring as a routine procedure because the expense is excessive and the information yield *nil.*

In patients in the second half of pregnancy, intubation is part of the standard of anesthetic care, and it is routine for all our cases. The use of antacids is optional and our anesthesiologists no longer find it useful.

I am puzzled by the CME credit questions 2 and 3. ECT is indicated during pregnancy because the patient is so psychotic as to require hospital care and is exhibiting either suicidality, mania, inanition, or command delusions which threaten the life of the mother or the fetus. The emphasis on diagnosis does not reflect the compelling indication for ECT, that is behavior which puts patient or others at risk.It is not the diagnosis that is the indication; many mentally ill mothers carry to term without medication or treatment.

Question 3 is ambiguous. Each of the modifications of procedure are relevant to the care of pregnant patients.

Aside from these quibbles, I commend you on your report. We are now a main center for treating pregnant psychotic patients and treat at least one a month. Two are in treatment now, one for severe depression and suicidality and one who was in manic delirium. The first is continuing in ambulatory treatments and cares for her other child; the second has just had the delirium erased and is still being treated for mania and psychosis.

Good luck in your career.

Sincerely yours,

Max Fink, M.D.
Professor of Psychiatry
and Neurology