To: "Wyatt, Richard J." <WYATTR@dirpc.nimh.nih.gov>
Subject: **Re: Your advice is needed.**
Date sent: **Tue, 13 May 1997 20:32:01**

Dear Richard,
It is difficult to answer the generic questions about a patient in un-named country. I would hesitate to recommend ECT for anyone I cared for in some countries, and would not hesitate at all in others.
So -- what country are we talking about?

Specifics -- as best as I can answer:

1. ECT is an appropriate treatment for paranoid and/or delusional psychoes of any etiology, especially if they have failed to respond to available treatments.
The ability to 'mask ECT' could be done easily with standard sedative medications, but would it not be easier to have the patient sent to the US for treatment here?

2. The number of treatments, device to be used, settings are each questions which cannot be answered generically. Again, if you name the country I can try to get you the name of an 'expert' who can advise. [In the US, two devices are in common use -- the MECTA SR-2 and the THYMATRON DGx -- both are essentially the same in energy output but like two cars, they differe materially in 'bells and whistles', and each therapist seems to have a preference. I use both equally well.

3. There is good evidence for the synergy of neuroleptics and ECT. Such is documented for CPZ, fluphenazine, thiothixene, and clozapine. The few cases with haloperidol are marked by conflict. There are no

data on olanzapine or risperidone.

The only other medications which have to be carefully considered are: benzodiazepines [and other anticonvulsants] which seem to mitigate the effects of ECT; theophylline and caffeine [which increase the hazard of prolonged seizures]. There are other interactions which need to be considered -- see the special number of CONVULSIVE THERAPY 1993; 9: #4 237-352.

4. Memory difficulties are largely in te hands of the therapist. In US hands today, the short term effects may be severe, but the long term effects minimal to unmeasurable.

5. Response to ECT is quite uniform, achieving 80-90% in the least able hands. [ECT is remarkably safe and effective even when badly administered.]. The duration of response, however, depends on therapist skill. For example, I treat all my patients over 4 months, and sustain some in ambulatory ECT if the illness has been recurrent or severe. Continuation ECT varies from weekly initially to longer intervals of 2-4 weeks late in the course.

Again, the family needs to put their faith in a skilled therapist.

I plan to be at San Diego beginning Wednesday evening [I have a debate Thursday afternoon at SBP]* and will return next Wednesday. If the family trusts you enough to e-mail me, I will answer confidently.

Sorry about the California Philip May data. Such a lovely idea for a follow-up.

I hope this is helpful.

Max

* The debate is with the Germans Franzek and Beckmann -- they find catatonia to be a subtype of schizophrenia, and they have very interesting genetic and family data to support the Kraepelin-Leonhard views. Taylor and I, on the other hand, see catatonia as a syndrome most often associated with mania and depression or with neurotoxic syndromes and only occasionally in schizophrenia It should be a good debate. They have good data and good points but so do we,

Max