

*Letters
- Weaver -*

November 5, 1979

Richard D. Weiner, M.D., Ph.D.
V.A. Hospital
Durham, North Carolina 27705

Dear Rich,

After a hectic few months, I have finally had the time to read the many reports and papers that have been on my desk since my holidays. Among these, was the report "ECT and Seizure Threshold" as presented at the Society of Biological Psychiatry. The paper is quite good, reflecting many more cases than I thought had been studied.

There is little that I can argue with in the data, but there are some questions inherent in the attitudes expressed. As I understand the study, it is an assessment of two aspects of induction, electrode placement and electric currents, with a number of criteria-- duration of seizure (or seizure threshold), degree of amnesia, total energy, and clinical efficacy. Others have carefully documented that electrode placement alters clinical outcome little, but does reduce the degree of amnesia and alters the type of disorganization in neuropsychological tests. But the evidence for different effects for brief stimuli is still sparse. In Weaver's recent studies, he found that his LEBS delivered less joules to the 'head', but he could not demonstrate a difference either in clinical assessments or in degree or type of amnesia. In similar fashion, the present report also fails to define such differences.

Yet, in a number of places, the implication is raised that brief stimulus treatment (MECTA) is 'better'. For example, on page 1, you combine two thoughts in one sentence: "Two modifications of ECT technique; lateralized brain stimulation via unilateral electrode placement and the use of brief pulse stimuli have made it possible to diminish the severity of side-effects . . ." Again, on page 8: "No difference in suprathreshold seizure duration on the basis of stimulus waveform was found, suggesting that not only are the seizures with brief pulse stimuli produced by lower amount of electrical energy, but also that they are equivalent in terms of potency. . ." Now, the word 'potency' is not defined; I know you mean potency to deliver a seizure, but then, could it not mean potency in clinical terms? This is compounded by the phrase (page 9, top) ". . . and thereby possibly less therapeutically potent.")

I agree that a detailed test of the MECTA machine (or other brief stimulus) is needed, but the assessment should indicate the number of patients treated, the number of missed inductions, the number of seizure

seconds, changes in depression ratings, tests of neuropsychological functions, etc. Much of this has already been done for unilateral and bilateral electrode placements, and the evidence is quite compelling. Similar assessments need be done for brief stimuli, and until these are done cleanly, the equivalent efficacy of brief stimuli and safety in side-effects will remain open questions.

Perhaps, such an assessment can be the basis of a collaborative effort, and I would urge you to work with Dick Abrams to formulate a useful protocol. I would hope that the issues (induction factors, assessment factors) will be defined carefully.

Again, my thanks for sharing these progress reports with me, and my apologies for the delay in reading.

My regards.

Sincerely yours,

Max Fink, M.D.
Professor of Psychiatry

P.S. You should know that a bill regulating the consent procedures for psychosurgery and convulsive therapy is being prepared for the Assembly of the State of New York. I have read a preliminary draft, and it is clearly modelled upon the recent California statutes. It is probable that the APA will be asked for its help by a committee in New York headed by Dr. Murray Glusman of the New York State Psychiatric Institute; and you may be hearing ~~from~~ from him or from the APA.