F. E. ~~Chain~~ Letters

March 29, 1989

John M. Ackerman, M.D.
2417 Castillo Street
Santa Barbara, California 93105

Dear Dr. Ackerman,

I am acquainted with publications describing electro-acupuncture ECT (EACT) by Dr. Xue and his coworkers in Beijing, and another by Drs. He and Zhuosan (in a separate report from Xian). Both reports appeared in CONVULSIVE THERAPY in 1985. They suggested an equivalence in efficacy between EACT and conventional ECT but greater safety for EACT. In the absence of a random assignment study with independent assessments of outcome and cognition, we remain in the dark as to the importance of these reports.

The second report, "An Investigation of Transient Absence of Brain Wave During Convulsion of EACT and ECT" seems to be an abstract. The citation is not given. From the abstract, it is not clear when in the course of the seizure, the TABW occurred. In 1966, Blachly and Gowing described the end-point of EEG-monitored seizures as 'precise' or 'imprecise'. Recent studies of the end point find that more than 2/3 of seizures end in a period of iso-electric activity, a flat EEG which may be what is described by Dr. Xue as TABW. The period of isoelectric activity in ECT varies but may be prolonged for more than a few minutes in unusual cases. Usually the duration is under 30 seconds. We are now investigating whether a precise end-point is a favorable prognostic sign (and am imprecise end-point, an unfavorable one). If I am considering the same phenomenon (TABW = isoelectric activity), then Dr. Xue's observation that 4.1% of cases with EACT had TABW while 31.4% of ECT cases had TABW, would suggest that ECT was the more favorable (effective) treatment. But such speculation needs to be examined with Dr. Xue or another practitioner of EACT.

At one time, Dr. Xue corresponded with me and I invited him to visit Stony Brook where I was prepared to let him demonstrate his technique in our unit. He was unable to accept, so I do not have any direct experience with EACT.

Like other modifications of ECT, the burden of proof of claims of efficacy or safety lies with the protagonist. I do not know how many cases would be required to define a difference between EACT and ECT, or if there is a difference. I suppose one could estimate the number of cases needed after observing EACT practice in a few model cases. In assessing differences between unilateral and bilateral electrode placements, for example, it required a few hundred cases to demonstrate a difference.

If Dr. Johnson is enthusiastic to try EACT, an open clinical trial in characteristic depressed (and delusional) cases would be of some interest. If he could verify the claims that seizures were induced with remarkably low currents; that needle electrodes were safe and effective; and that the number of treatments needed were either equal or fewer than ECT, it might justify others trying EACT.

During Dr. Xue's visit, did he demonstrate EACT? If yes, I would be pleased to talk to an American observer who may have participated in such a demonstration.

Thank you for bringing Dr. Xue's arguments to my attention. If there is more that needs discussion, you can call me most mornings at my office (516-444 2929).

Sincerely yours,

Max Fink, M.D.