February 6, 1997

Lee C. Miller, M.D.
Northwood Office Center, Suite 9
2201 Forest Hills Drive
Harrisburg PA 17112

Dear Dr. Miller,

You inquire about a 39-year old man with a 'life-long' depression who has been sensitive to the side-effects of medications and is considered a treatment failure to psychotherapy and medications. He began ECT on September 6, 1996, showing improvement after 6-8 treatments '*and then curiously the gains seemed to recede*.' Treatments continued and then '*switched over to maintenance treatments*.' Treatments have had to be given weekly, and any attempts at lengthening the interval between treatments is followed '*by a drop in mood*' [and presumably a request to continue].

1. The benefits of ECT usually persist after the course has ended. But some patient's benefits are limited to a few days after each treatment and it was for such patients that continuation therapy, either medication or ECT, has been recommended.

How to explain it? The benefits of ECT arise from our ability to stimulate the hypothalamic-pituitary axis to liberate, in greater quantities over a persistent period, of those hormones [labeled by me as '*antidepressin*'] which regulate mood. In some patients, ECT 'jump-starts' the process and further stimulation is not required. In others, the change is transient and repeated stimulation is required. The best analogy is our experience with insulin -- in some patients, diabetes can be controlled by diet; in others, oral agents; and yet others, daily and mullti-daily dosing of insulin is necessary.

To get around it -- treat more intensively and hope to get the system working again. At times, we have re-admitted patients to hospital and given a new course.

2. 'Indefinite' courses of treatment are occasionally required. At UH we have records of patients with 40, 140, and 180 treatments over periods as long as 10 years. In some, the period between treatments was lengthened by concurrent treatments -- lithium and then lorazepam in one case, clozapine in another.

Given these facts, I have no concern about continuation treatment. I would, however, do the following.

a. Assess by careful inquiry to the family whether unprescribed medications are being taken out of your ken. Specifically, alcohol, benzodiazepines, or even barbiturates muck up a treatment series. I would surely enquire what is meant by *'a small dose of Xanax at bedtime'*. Self-restraint is not a feature in benzodiazepine use.

b. I would next entertain a series of treatment trials -- lithium at levels of 0.4-0.6 mEq/l; lorazepam at 0.5mg bid; and if well tolerated, lorazepam at 1mg tid.

c. Perhaps, an independent consultation as to diagnosis is warranted. If the underlying pathology is that of a dysthymic disorder [a lifelong atypical depression] or an Axis II character pathology, perhaps the best course is to forego ECT before any damage is done. Prolonged courses of ECT are the basis for legal suits, the plaintiffs arguing that the treatments incapacited their ability to survive and work in society and their claims for damages achieve credibility with insurers and juries.

Your question is interesting. I will be out of the country until February 26. If you want to discuss this further, try me late afternoons at the numbers above.

Sincerely yours,

Max Fink, M.D.