MODIFIED VERSUS UNMODIFIED ECT

Sir,

Apropos the paper of Andrade et al. (April, 2000), I am surprised that the authors have tried to justify the use of unmodified ECT by showing that musculoskeletal complications are not common or serious. Tharyan et al. (1993) too have done the same. The problem is not as to whether orthopaedic complications are more or less frequent with this type of treatment. The question is whether these should at all be allowed to occur knowingly and whether in the present era of sophistication - the patients should at all be subjected to application of electrodes and current in a fully conscious state and made to convulse uncontrollably, when it is possible to avoid all these entirely? Further, there are occasions of the patient failing to convulse and having the so called ‘stunning effect’ - a very painful experience for him. There is a shrill cry in many patients during the tonic phase and the sound of convulsions during the clonic phase - all audible from out side - even to the patients waiting for their turn to receive treatment. These often frighten them and they do not willingly enter the ECT room and often have to be brought in forcibly, made to lie down and held firmly to receive the treatment. The patients often resist putting in the mouth gag and try to escape by raising their head - thus causing the electrodes slip, resulting in incomplete stimulation and stunning and so on. As against this, in modified ECT these violent happenings do not occur, the patient is much more cooperative and much less apprehensive, thus rendering the procedure smooth and peaceful. I write all this from my experience of giving both modified and unmodified ECTs over the last three decades. To me, giving unmodified ECT appears akin to performing surgery without anaesthesia - a most barbaric practice indeed!

The problem is that our ECT set ups are often utterly ill-equipped and sadly understaffed. This is the reason why most of the centres in our country - some very prestigious ones - are continuing with unmodified ECT. Even departments having establishments worth crores do not have proper facilities for modified ECT. The reason perhaps is that the work of ECT is often relegated to the junior most staff and the senior seldom bother to be there. Therefore they do not care to bring the facilities up to the optimal standards.

Another reason for not giving modified ECT is lack of the services of an anaesthetist. I feel that a psychiatrist is the best person to give anaesthesia for ECT. I have been doing it for the last 25 years without much problem. In nearly two-thirds of treatments anaesthesia was given by me and in the remaining one-third by an anaesthetist. The frequency of complications were same with both and a patient who died following ECT had been given anaesthesia by the anaesthetist (Shukla and Mishra, 1985). Pearlman et al. (1990) have reported that, in their set up, in 98.8% of ECTs, anaesthesia was given by psychiatrists and there was no mortality and minimum morbidity over a 9 year period. They further reported that the anaesthetists took more time and spent more oxygen per ECT than the psychiatrists.

I would therefore strongly recommend that ECT should always be modified and the anaesthesia should be given by the psychiatric team. Of course, for doing this, the psychiatrist must receive training in passing an endotracheal tube and in giving artificial respiration. It is a matter of giving a dignified look to the procedure and offering the patient a more humane approach and handling. Would any one of us be willing to receive unmodified ECT, should such a need arise? Certainly not - given the alternative of modified ECT. Then why should our patients?

REFERENCES

Andrade, C., Rele, K., Sutharsan, R. & Shah, N. (2000) Musculo-skeletal morbidity with unmodified ECT may be less than earlier believed. Indian Journal of Psychiatry, 42, 156-162.

Pearlman, T., Loper, M. & Tillery, L. (1990) Should psychiatrists administer...
anaesthesia for ECT? American Journal of Psychiatry, 147, 1553-1556.

Shukla, G.D. & Mishra, D.N. (1985) Death following ECT: a case report. Indian Journal of Psychiatry, 27, 95-97.

Tharyan, P., Saju, P.J., Dutta, S., John, J.K. & Kuruvilla, K. (1993) Physical morbidity with unmodified ECT: a decade of experience. Indian Journal of Psychiatry, 35, 211-214.

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