CORRESPONDENCE

May be because cases of gull dependence are usually not brought for consultation to the psychiatrists. It has been our experience that there is usually an increase in the symptomatic abuse of this product in psychotic disorders and episodes of depressive illness. This report is an effort to bring to the notice of researchers in the field of psychiatry and related fields, the endemic abuse of this substance - a hitherto unrecognized but widely prevalent problem.

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PHYSICAL MORBIDITY AND UNMODIFIED ECT

Sir,

We read with interest the article by Drs. Tharyan et al (Journal, Oct 1993). It is a commendable attempt at documenting the experience with unmodified ECT in a center that has been compelled to use the same under severe resource constraints. It offers a useful body of information to other psychiatrists, in a similar predicament, who have no choice but to make the best of a bad situation, conscious of the limits of safety. The authors, however, have deflected the debate by telescoping into their discussion issues of desirability and comparability vis-a-vis the currently accepted standard of modified ECT. It appears that in their anxiety to legitimize unmodified ECT and reassure themselves, they have exceeded the limits of valid inference.

They observed that unmodified ECT in a selected population (after screening out those requiring modified ECT) is not very unsafe except for fractures in about 0.8% of patients. Although they recorded one death with cardiac arrest, the authors comment that the treatment is safer than modified ECT. This remark we opine is without sufficient basis. First, the two ECT comparisons were not strictly random. Second, by virtue of screening some patients for only modified ECT, this group is different from the larger unmodified ECT group. As can be seen by their data, the upper age range in the modified ECT group was 70 years whereas it was 50 years for the unmodified ECT group. Third, the modification procedures are not clearly described, eg., the dose of atropine if used should have been given.

The authors have not made a data-based case to justify the implication that "the recommendation to routinely give only modified ECT requires further review". The debate needs to be addressed with truly comparable data, on both morbidity and acceptability of the two procedures. Meanwhile, psychiatrists owe to their patients to advocate and strive to offer them the best current standards of care including modified ECT.

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THARYAN ET AL REPLY

Sir,

We appreciate the interest shown by Gangadhar & Janakiramaiah in our paper on unmodified ECT, the main aim of which was to stimulate a debate on the routine use of modified ECT in this country, given the paucity of anaesthetic and resuscitative facilities in many centers where ECT is administered. However, their comments on the validity of our inference appear based primarily on the assumption that the patients in our study treated with modified ECT were older and less physically fit than those treated with unmodified ECT.

The first assumption is erroneous as the data in Table 1 of our paper clearly states that the upper age range of 70 years and 59 years pertain to patients treated with unmodified ECT, who experienced myalgia or fractures respectively, and not to patients given modified ECT. The difference in the mean ages of patients in the two treatment groups was not significant. The second assumption is partly true in the observation that patients in our series treated with modified ECT had a higher prevalence of pre-existing musculo-skeletal complications; however, as highlighted in our paper, unmodified ECT was
given uneventfully to patients with a variety of coexisting cardiac, respiratory, metabolic and neurological disorders. Thus, though not randomly allocated, a selection bias would not explain the higher cardiac morbidity in patients treated with modified ECT.

The modification procedure we follow consists of hyperventilation with 100% oxygen prior to and after the stimulus, the use of hypnotic doses of thiopentone in the range of 100-300 mgs, muscle relaxation with 25-30 mgs of succinylcholine chloride (0.5 mgs/kg body weight), monitoring of seizure duration by the cuff method, and maintenance of a patent airway. Atropine is given as premedication for both modified as well as unmodified ECT in a standard dose of 0.6 mgs intramuscularly, 30 minutes prior to treatment; though this dose may be considered inadequate to prevent vagally stimulated arrhythmias (Allen et al, 1982), there is still a lack of evidence regarding the efficacy and need for routine anticholinergic premedication (American Psychiatric Association, 1990).

The focus of our study was on whether modified ECT is routinely indicated and our findings of less than 1% physical morbidity when unmodified ECT is administered by a trained team suggest that from a clinical standpoint, modification of ECT is indicated primarily in the event of coexisting musculoskeletal disorders (2% of our cases). The change from unmodified to modified ECT in the west occurred largely due to socio-political and medico-legal reasons, but despite changes in technique, public attitudes to ECT have changed but little (Fox, 1993). The mortality of ECT actually increased sharply when modified ECT came into general use in the early 1950's and was largely attributable to ill-equipped psychiatrists assuming the role of anesthetists (Maclay, 1953). Modern ECT in the west is undoubtedly safe but is performed in well equipped settings under the supervision of anesthetists and involves a small number of patients at each session.

This is far removed from the conditions under which ECT is administered in many centers in this country. Until data on the frequency of complications on modified ECT are made available from centers where it is routinely administered, and especially where psychiatrists are solely responsible for anesthesia, it remains unclear what would be considered "the best current standards of care" with reference to ECT in the Indian context.

Our study remains the only attempt to provide data relevant to this issue and we reiterate our conclusion that the recommendation to routinely modify ECT is premature and requires further review.

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