correct in stating that the British Psycho-Analytical Society has withdrawn from UKSCP.

It is sad that they chose to leave before their proposals could be discussed. We would welcome them back into UKSCP. For the time being, a place on the forthcoming Registration Board is available for them.

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Seizure duration and clinical efficacy in patients receiving ECT

DEAR SIRS

I read with interest the article by Dr Joyce, 'Short duration induced seizures and therapeutic outcome at electroconvulsive therapy applications' (*Psychiatric Bulletin*, July 1992, **16**, 408–410). The conclusion gives the misleading impression that the psychiatrist/anaesthetist only needs to be aware of the effects of benzodiazepines and propofol in relation to reductions of seizure duration in patients receiving ECT.

A seizure duration of 25s (Cronholm & Ottosson, 1960) and a cumulative seizure duration of 210s (Maletzky, 1978) are both considered to be central to the therapeutic efficacy of ECT. Many factors are known to affect the duration of seizure and these must also be given consideration, in addition to the effects of psychoactive and anaesthetic drugs. No mention is made of these in Dr Joyce's article. Seizure threshold increases (and seizure duration decreases) with increasing age and the cumulative number of treatments. Seizure thresholds are also higher in men and in those receiving bilateral ECT (Sackheim *et al* 1987). In addition, the seizure threshold is also influenced by a large number of different drugs including diazepam and propofol, and also drugs as diverse as caffeine and propranolol.

Greater awareness of these factors by junior psychiatrists, who are mainly responsible for administering ECT, is long overdue. Individual seizures that are unduly short will result in the total number of ECTs having to be increased to reach the necessary cumulative seizure duration for therapeutic efficacy. If individual seizure durations are of adequate length this will have three major benefits. First, it will reduce the cost of treatment by reducing to a minimum the number of ECT treatments required and secondly it would be possible to treat more patients with the available resources. Finally, but most importantly, it would lessen the anaesthetic risk to the patient by minimising the number of anaesthetics.

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References

CRONHOLM, B. & OTTOSSON, J. (1960) Experimental studies of the therapeutic action of electro-convulsive therapy in endogenous depression. *Acta Psychiatrica Scandinavica*, suppl., **146**, 60–101.

MALETSKY, B. M. (1978) Seizure duration and clinical effect in electroconvulsive therapy. *Comparative Psychiatry*, **19**, 541–550.

SACKEIM, H. A., DECINA, P., PROHOVNIK, I. & MALITZ, S. (1987) Seizure threshold in electroconvulsive therapy: effects of sex, age and electrode placement, and number of treatments. *Archives of General Psychiatry*, **44**, 355–360.

DEAR SIRS

I am grateful to you for giving me the opportunity to comment on Dr Curran's letter.

Dr Curran rightly points to some of the many factors known to affect seizure duration and threshold, and possibly also the efficacy of ECT. How convenient it would be if there were simple measures to indicate that particular applications of ECT were "adequate"! Unfortunately, crude and simple measures such as the adoption of a 25 second minimum seizure length and/or a cumulative seizure time of 210 seconds have insufficient empirical evidence to support their use, nor are they at all closely related to the clinical outcome of treatment. For example, near threshold unilateral ECT reliably induces bilateral seizures which tend to be more prolonged than those resulting from bilateral suprathreshold stimulation yet have less therapeutic efficacy. Short seizures, lasting less than about 15 seconds, should always prompt review of possible causes, importantly but not only drugs, anaesthetic agents and dosages, but it must not be assumed that longer seizures are necessarily adequate nor that short seizures cannot be efficacious.

There is no substitute for careful clinical assessment of the patient and the treatment process throughout the treatment and for close involvement of experienced psychiatrists and anaesthetists, specifically trained in ECT, in administering the treatment and in training and supervising others in giving it; it is no longer possible to justify having "junior psychiatrists ... mainly responsible for administering ECT."

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