Photography for Anorexia Nervosa

SIR: May I add to the comments by Byrne (*Journal*, December 1988, **153**, 848)? I have also found the use of visual recording of the physique of anorexic subjects to be of value both in documenting progress and as an adjunct to therapy. In particular, I have found confidential video-recording of the subject's physical presentation has been useful. Often, the appearance of parts of the body not easily viewed, such as the back and buttocks, has prompted anorexic subjects to comment spontaneously about the degree of emaciation that is present, when they tolerate viewing equally emaciated parts of their bodies that they can view more frequently. I look forward to the results of Byrne's prospective study.

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ECT mythology?

SIR: Several points made by Russell (*Journal*, December 1988, **153**, 850) concerning the effectiveness of pulse-type ECT stimuli, are in need of clarification.

Dr Russell mentions recovery rates of over 90%, with small numbers of treatments using sine-wave ECT apparatus, but no quotes of specific references were given. The majority of research performed during the era of the sine-wave equipment is unlikely to have included standardised depression scales, and must, hence, be viewed cautiously. Abrahams *et al* (1983) found an 81% success rate of six bilateral ECT treatments with pulse-wave machines, which demonstrates the high level of efficacy of the method.

Certainly there is evidence to suggest the decreased effectiveness of unilateral ECT with the newer machines, and also an increased vulnerability to sabotage by inexperienced operators, with the lower currents involved. However, these factors seem to play little part in bilateral treatments.

Addressing the subject of side-effects, a study by Weiner *et al* (1986) reported a considerably increased level of cognitive impairment, following treatments with sine-wave equipment, when compared with pulsed bilateral ECT.

Now that it has been demonstrated that fits in excess of 32 seconds bestow the maximum benefit, I feel that the way forward is by the accurate measurement of ECT-induced seizures, with EEG monitoring equipment, so that seizures of optimum length can be more easily induced. I feel that this approach has mconsiderably more merit than relying on anecdotal successes of the past.

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Manic Features During a Course of ECT

SIR: The development of manic symptoms or a complete manic syndrome in patients receiving antidepressent medication is well recorded and the clinician's response, reduction in medication with the additional prescription of major tranquillisers, is probably uniform. The management of manic features developing during the course of the ECT is, I suspect, less uniform. In training I encountered at least two patients who developed manic symptoms during a course of ECT which was, as a consequence, stopped. Thereafter the patients (both with major affective disorders) appeared to take a rather chronic course. My practice as a consultant has been to carry on a course of ECT if manic symptoms develop, on the basis that mania itself can be treated with ECT and the development of these symptoms suggests only that the affective disorder has been modified rather than fully treated. I cannot find much help in the literature on these alternative courses, and would be interested to know readers' views and experience in this area.

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Philosophy for trainees

SIR: I recently had to prepare a journal club, and I selected Yorke's incisive article entitled "A defect in training" (*Journal*, February 1988, **152**, 159–163). His article led me to Benjamin's letter on the mind–body problem (*Journal*, July 1988, **153**, 124) in which he introduced the need for some sort of

https://doi.org/10.1192/S0007125000175099 Published online by Cambridge University Press