

## LETTERS

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### **A survey of psychiatrists in northwest England concerning their use of maintenance electroconvulsive therapy**

Dr. Lim's practice audit of maintenance electroconvulsive therapy (M-ECT) in the elderly (Lim, 2006) describes a group of older people treated with M-ECT in Australia but does not describe the views of Australian psychiatrists regarding the use of this form of treatment. We explored the views of psychiatrists in northwest England regarding the use of M-ECT in the 1990s: our study group was a subset of the cohort reported in Benbow *et al.* (1998), namely those respondents to a first-stage questionnaire who stated that they had used M-ECT (25%) or were prepared to consider its use (67%). A second-stage questionnaire inquired specifically about practice in relation to M-ECT, defined as the regular administration of ECT in order to minimize the likelihood of further episodes of illness, and was sent to 85 individuals of whom 77 responded, giving a response rate of 87.5%. Of these respondents, 49% stated that they had not prescribed maintenance treatment within the past 10 years; 42% estimated that they had prescribed one or two courses; 8% three to four courses and 1% five to six courses. None had prescribed more than six courses, so the experience of any one individual was relatively limited.

Indications for maintenance ECT were given as failure of prophylactic mood stabilizing drugs (75%), rapid relapse after repeated courses of ECT (75%), toxicity of mood stabilizing drugs (51%), and patient preference (27%). In response to further questions, 4% of respondents said that they would consider using M-ECT after one or two relapses, 35% after three or four relapses, 27% after five or six relapses, 10% after seven or eight relapses and 3% after more than eight relapses. A single respondent stated that they would not require any.

Some 95% of respondents stated that they would try lithium treatment before considering M-ECT and 79% would try carbamazepine first. M-ECT was reported as being used by 45% of respondents for recurrent depressive illness, by 18% for bipolar manic depressive illness, by 8% for schizoaffective illness and by 3% for schizophrenia. None reported using M-ECT for recurrent mania.

Age was not generally regarded as a contraindication: 3% of respondents stated that they would not prescribe M-ECT for people over the age of 65 years, a further 9% would not prescribe it for people aged over 80 years, and an additional 5% stated that they would not prescribe it for people aged over 90 years. Most people (73%) stated that they did not have an age limit, and 52% did not regard concurrent dementia as a contraindication to its use.

With regard to the frequency of M-ECT, 20% of respondents stated that they would prescribe M-ECT weekly, 30% fortnightly, 12% three weekly, 16%

monthly and 7% bimonthly, while 47% noted that their practice was variable. Duration of treatment also varied. 27% would continue M-ECT for less than 6 months, 43% for between 6 and 11 months, 4% for 12–17 months and 5% for longer periods, with 9% stating that treatment would be ‘continuous’. At that time, 49% of respondents stated that they used bilateral electrode placement, 25% unilateral and the remainder varied their practice.

Respondents were invited to append comments and there were some interesting points among these. One person reported that they felt “irrationally” opposed to the use of maintenance treatment. Another described how he/she had known a woman who died at the age of about 90 after receiving 642 maintenance treatments as it was the only treatment which kept her well from psychotic depression. Relatives were said to have been instrumental in advocating the use of M-ECT on three occasions. One respondent pointed out that frequency of relapse is not the only factor to take into account, but that severity and duration of illness should also be considered, as episodes which respond readily to treatment, although frequent, might be better tolerated by patients, obviating the need to consider M-ECT. Another commented that they saw little need for M-ECT as they regarded psychosocial management together with medication as “usually effective.” One person wrote that M-ECT has a “definite though uncommon” place in modern practice. Another commented that it is occasionally very effective, and one respondent suggested that psychosurgery might be a better option.

These findings are interesting, as it is likely that practice in the U.K. may have changed following publication of the National Institute for Clinical Excellence’s (NICE) guidelines on the use of ECT (NICE, 2003). In the U.K. prior to NICE’s guidelines, M-ECT was being used by 22% of respondents in Pippard and Ellam’s (1981) audit, and by 20% of old age psychiatrists in a later survey (Benbow, 1991). This survey found that 25% of psychiatrists in northwest England were using M-ECT. There were wide variations in practice with some psychiatrists requiring more episodes of illness prior to considering the use of M-ECT. The literature (Andrade and Kurinji, 2002) suggests that many people treated with M-ECT are in their later years, so it was not surprising that our group regarded neither dementia nor advanced age as contraindicating treatment. We interpreted the results as showing a remarkable consensus among respondents regarding the continuing need for M-ECT in a small population, predominantly with recurrent mood disorder, and concluded, like Dr. Lim, that there was a need for further study of the role of M-ECT. The introduction of the NICE guidance has probably led to changes in U.K. practice and it would be interesting to know what has happened to the small group of people in northwest England with relapsing severe resistant depressive illnesses, who would have been considered for treatment with M-ECT in the 1990s. Barnes (2005) states that it is likely that there are some U.K. patients who will still be prescribed “continuation” ECT, and highlights the need for documented assessment of the risks and benefits of treatment coupled with valid informed consent. However, those of us practicing in the U.K. may have to rely on our international colleagues to clarify the role of this treatment.

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### Three sisters covering the transient global amnesia spectrum

We report the case of an Italian family in which three sisters experienced transient global amnesia (TGA). Since its early description, this transitory pure memory deficit has attracted increasing interest, especially within the neurological community. In 1964 the term “TGA” was coined to identify the abrupt onset of anterograde amnesia, accompanied by repetitive queries lasting for hours and then gradually recovering, leaving an amnesic gap for the duration of the attack. Afterwards, many studies focused on TGA, and in 1990 clinical criteria were defined by Hodges and Warlow (1990). Further studies showed that meeting diagnostic criteria was a significant predictor for a better outcome than in other forms of transient amnesia, while amnesic patients who did not fulfil the TGA criteria had different outcomes. Precipitating and trigger events for TGA were identified and divided into physical and psychological factors (Inzitari *et al.*, 1997; Quinette *et al.*, 2006). Physical precipitants were found to be gardening, housework and sawing wood, contact with water and changes in body temperature occurring during hot baths or showers, or a cold swim at the swimming pool. Emotional trigger events included a major life or death event, emotional stress triggered by a gastric endoscopy, an exhausting work session, and anxiety resulting from conflicts at home or at work, health problems and money worries. Several hypotheses have been proposed for its pathogenesis such as psychogenic, venous dysfunction due to jugular venous valve incompetence, or ischemic aetiology, but the enigma of TGA still needs to be unravelled (Lewis, 1998; Akkawi *et al.*, 2001).