

originate from outside the region. This is notably the case for patients with Huntington's chorea, particularly before the initiation of the pre-symptomatic test service in 1986 diminished the customary tendency to concealment of the disease.

Permanent and terminal care was most frequently provided by mental hospitals. Because of the difficulty of nursing and disturbance to other patients, private nursing homes rarely admitted affected patients; except homes run by charities who specialised in Huntington's chorea and necessarily took patients from a wide area. Patients here were therefore frequently outside the health region of their homes from which they were distant, as they were from relatives. Those patients in this situation in the Oxford health region would be notified to Oxford Record Linkage on any admission to an Oxford regional hospital. The surmise that these Huntington patients form a group domiciled outside the Oxford Region who had little or no contact with a responsible family is strongly supported by Shiwach's discovering their paucity of relatives (Shiwach, 1992). Of such patients only those whose domicile can be confirmed to be within the Oxford Region should be included.

Incidentally Shiwach's statement that Watt & Seller's study (1993) "relied entirely on the (Medical genetics) Department's case-notes for the Huntington Disease patients" is not correct. It is true that all the affected patients were referred to the Medical Genetics Department but many other sources of information (e.g. mental hospitals, general hospitals, nursing homes, neurologists, psychiatrists, general practitioners, social workers, other genetic departments *et al*) were contacted, checked and used as sources of information to eliminate or include subjects.

In his criticism of Watt & Seller's (1993) population figure Shiwach has overlooked the fact that the prevalence he reported was for 1985 whereas Watt & Seller's was for 1988 for which the figure estimated by the Office of Population and Census Services (1994) is 2.512 million.

The two independently calculated prevalence figures of Huntington's chorea for an area where previous estimates vary from 25.0 to 99.5 per million are, three years apart, sufficiently close to support the view that they approach an ideally true figure and are reliable.

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D. C. WATT

75 Wykeham Way
Haddenham
Buckinghamshire

Anaesthetic technique in the practice of ECT

STR: Methohexitone shortens seizure duration compared with electroconvulsive therapy (ECT) given without anaesthesia (Ayd, 1961), yet is an ultra-short-acting intravenous anaesthetic drug, the plasma concentration falling rapidly because of its redistribution into body tissues other than brain (Corssen *et al*, 1988). Recovery of consciousness after a single bolus injection is prompt, suggesting that the concentration of methohexitone in the brain also falls rapidly after injection. If the seizure-shortening property of methohexitone is related to its concentration in the brain and this concentration is falling rapidly after induction, then the time between its intravenous injection and electrical stimulation may influence the length of cerebral seizure activity.

Twenty-two patients (average age 57 years) took part in the study to test the hypothesis that prolongation of the time between induction and electrical stimulation leads to longer cerebral seizure activity. All patients received bilateral ECT for the treatment of a primary depressive illness and all received concomitant psychotropic drug treatment that was standard. Electrical stimulation was given with a prototype of the Ectron Series 5A ECT machine at a dose 75 millicoulombs above the seizure threshold, which had been established empirically at the start of the ECT course. The time from the start of the injection of methohexitone to the start of electrical stimulation was taken as the delay and ventilation was maintained by an anaesthetic circuit that would not reduce alveolar pCO₂. The convulsion was timed from the end of electrical stimulation using the cuff technique (Addersley & Hamilton, 1953).

The index treatment was usually the sixth and the average delay was 110 (range 68-176) seconds; at the subsequent treatment this was increased by approximately one minute to 173 seconds. The average length of convulsion at the index treatment was 25.8 seconds, and was 33.2 seconds at the subsequent treatment. The average increase in

convulsion length was 7.4 seconds (95% CI, 3.7 to 11.1 seconds) or 34% (95% CI, 17 to 51%).

The present findings support the hypothesis and hence the supposition that the anticonvulsant as well as anaesthetic effects of methohexitone decline rapidly after bolus injection. The implications for the practice and theory of ECT require further investigation, but the findings ought to re-emphasise how important anaesthetic technique is in the practice of ECT. An increased delay between induction and electrical stimulation may be of value in some patients as a technique for seizure augmentation, that is, when a patient fails to have an adequate convulsion after stimulation with the maximum output of an ECT machine.

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I. P. COLLINS
I. F. SCOTT

Royal Edinburgh Hospital
Edinburgh EH10 5HF

Counselling and community psychiatric nurses

SIR: There is an urgent need for studies of the efficacy of counselling in primary medical care, and a need to establish the most effective deployment of community psychiatric nurses (CPNs). While Gournay & Brooking's study (*BJP*, February 1994, **164**, 231–238) was welcome, few conclusions can be drawn from the results due to a design failure.

The data for the two samples of patients who were randomised differently were merged at the six month follow-up point. This is inappropriate as the patients who were kept on a waiting list before entering counselling had received less therapy at follow-up. Controlled trials in general practice are difficult to do (Tognoni *et al*, 1991) and careful piloting is required before embarking on a large investigation (King *et al*, 1994).

The figures given in the paper are confusing. According to the flow diagram 106 patients were randomised to CPN care, whereas in the text this number becomes 92. Whether drop out occurred from CPN care, from the research assessments or both is not clear. It is stated that 50% of patients randomised to CPN care dropped out. We realise it is difficult to measure GP care, however,

only 55% of patients randomised to the GP completed the third research assessment. No intention to treat analysis appears to have been carried out, even when the data for the practice consultation rates for all patients entering the trial must have been available. No attempt was made to determine the type of intervention carried out by the CPNs.

Despite these limitations, Gournay & Brooking (1994) conclude that CPNs are ineffective as counsellors in general practice and would be more appropriately deployed in the care of the severely mentally ill. We sympathise with the difficulties of conducting good controlled research of brief psychotherapies in general practice. Unfortunately these data simply do not bear out the authors' sweeping conclusions.

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K. FRIEDLI
M. KING

Royal Free Hospital School of Medicine
London NW3 2PF

AUTHOR'S REPLY: We are grateful to Friedli & King for drawing attention to the apparent discrepancies in the text. The flow diagram shows 106 randomised to CPN care and the figure in the text of 92 refers to the number of patients who actually took up the offer of this intervention. We can confirm that 50% of patients who commenced CPN intervention dropped out.

With regard to our comparison of patients receiving CPN interventions and patients attending their GP, we only used patients who had been assigned to immediate CPN intervention in this analysis – we omitted the group of eight patients who were still in CPN treatment after a period on the waiting list. Thus, our comparison involved patients allocated to exactly the same conditions of treatment. Friedli & King are incorrect in their assumptions, (a) that there was no intention to treat analysis carried out; or (b) that we made no attempt to determine the type of interventions carried out by CPNs. We videotaped a selection of assessment interviews and collected a considerable amount of other data – including CPNs' intention for treatment. The results of some of these data are reported elsewhere (Gournay *et al*, 1993), and further analyses of the process data are being carried out. It must be