Correspondence

Propofol and electroconvulsive therapy

Sir: Bentham & Callinan (*Psychiatric Bulletin*, 1994, **18**, 374) and Curran (*Psychiatric Bulletin*, 1994, **18**, 650) highlight the debate surrounding the anaesthetic propofol (Diprivan) and ECT. Several well-designed ECT studies have clearly shown that at usual doses, propofol results in seizures of shorter duration then methohexitone (Brietal). For ECT to be effective, it is assumed that seizures must be of 'adequate' duration. It is not clear at what point seizure duration becomes adequate, but figures of 20–30 seconds or greater are quoted. As propofol results in shorter seizures it seems, reasonably enough, that it is not suitable as an anaesthetic for ECT.

However, the situation is not that simple. Some studies have, while confirming that propofol results in shorter seizure duration, shown that propofol ECT seems to be as effective as methohexitone ECT in terms of outcome (Martensson *et al*, 1994; Fear *et al*, 1994). Other studies have indicated that seizure duration is not the only criterion for effective ECT. Sackeim *et al*, 1993 showed that patients receiving 'supra-threshold' stimuli in unilateral ECT showed a faster and higher response rate than those receiving only 'threshold' stimuli even though seizure durations were similar (and 'adequate') in both groups.

The College states that propofol is not a suitable anaesthetic for ECT. The manufacturer's data sheet (Zeneca Pharmaceuticals) says that it is not recommended as an anaesthetic for ECT. However they are currently reviewing the evidence and may apply for the data sheet to be amended. As long as a doubt remains about propofol and ECT I would agree with Curran that methohexitone remains the anaesthetic of choice. However I believe that it is premature to write off a useful anaesthetic like propofol. More research on the interrelationship between ECT efficacy and factors such as seizure duration, site of electrode placement, stimulus dose and anaesthetic technique is required.

FEAR, C. F., LITTLEJOHNS, C. S., ROUSE, E. *et al* (1994) Propofol anaesthesia in electroconvulsive therapy. Reduced seizure duration may not be Relevant. *British Journal of Psychiatry*, **165**, 506–509.

MARTENSSON, B., BARTFAI, A., HALLEN, B. *et al* (1994) A comparison of propofol and methohexital as anaesthetic agents for ECT: effects on seizure duration, therapeutic outcome, and memory. *Biological Psychiatry*, **35**, 179–189.

SACKEIM, H. A., PRUDIC, J., DEVANAND, D. P. *et al* (1993) Effects of stimulus intensity and electrode placement on the efficacy and cognitive effects of eletroconvulsive therapy. *New England Journal of Medicine*, **328**,839–846.

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Difficulties in acute psychiatric admissions

Sir: We were interested to read Hollander & Slater's article (*Psychiatric Bulletin*, 1994, **18**, 532–534) on difficulties in acute psychiatric admissions.

It was gratifying to see the extra work load and the "anger and frustration" caused by this being highlighted. The resulting use of leave beds, increased absconding, premature discharge or leave, and waiting lists for acutely ill patients are obviously a cause of concern and the transfer of patients between hospitals does indeed produce "suboptimal care and reduced continuity". Within Merseyside transfers are mostly from the inner city hospitals to more peripheral hospitals. That inner city patients take up peripheral hospital beds may explain the authors' finding of a uniform pressure on beds throughout their region. In support of this, a brief survey of out of area admissions to three peripheral Mersey region hospitals over a six month period showed that 143 patients from Liverpool hospitals were transferred peripherally due to no local beds being available, thus reducing the ability of peripheral hospitals to take their own local patients.

The burden of placing patients requiring acute admission often falls upon trainees during their 'on call' commitments. The shortcomings of this *ad hoc* system of junior

to junior referral between psychiatric hospitals frequently means the consultant ultimately responsible for the patient's continuing care may remain ignorant about the admission and have little input into the initial assessment. Unfortunately treatment in the peripheral hospital may be limited to the goal of 'return to sender' or an entire episode of in-patient care may by-pass the patient's own psychiatric team.

The current "perpetual crisis" in bed occupancies requires clear guidelines from senior hospital medical staff on how local urgent admissions are dealt with and placed. Benefits would be twofold; reducing the stress and tension encountered by psychiatric trainees admitting urgent cases and preventing patients passing "out of sight and out of mind" during episodes of acute psychiatric illness.

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General practitioners and lithium

Sir: Some fund-holding practices have wanted to take over the supervision of lithium prophylaxis once patients have been stabilised. I believe psychiatrists should strongly resist this.

It would be expecting a lot of GPs, each of whom has only one or two patients on lithium, to be up to date with the renal, cardiac, eletrolytic, cyetic, and post-natal contra-indications and to monitor partners and deputising doctors prescribing the 14 classes of drugs interacting with lithium. Under GP care in my psychiatric sector, three patients had no blood test for three to three and a half years, one had six blood tests in 22 years, two had lithium-induced delirium, one had a wrong diagnosis, none had regular annual thyroid or renal function tests, two had unnecessary diuretics, one becoming uraemic and the other suicidal as the lithium was stopped; NSAID prescriptions doubled a patient's serum lithium concentration and two became manic on stopping lithium unnecessarily when an antibiotic was prescribed.

In Edinburgh, general practitioners prescribed maintenance lithium, advised and reminded about blood tests by the hospital, yet the admission rate for mania increased three-fold, the drop-out rate being one per three to four patient-years (Dixon & Kendell, 1986; Marker & Mander, 1989). By contrast, in my local lithium clinic, the admission rate of manic-depressives was reduced by 70%, or by 86% taking into account Angst's finding of a naturally increasing relapse rate (Angst *et al*, 1969). The drop-out rate from all causes has been one per 35 patient-years.

Lithium alone is not enough for Coppen *et al* (1971) found that 50% needed additional antidepressants or neuroleptics during two years' follow-up. My patients took neuroleptics or antidepressants for 40% of the time they were on lithium, 61.4% requiring no admissions during 350 patient-years audited. Support from the clinic reduced suffering, admissions, tribunals, loss of productivity, and social security costs. During 350 patient-years on lithium there were no suicides or renal failure, and just two patients required thyroxine for incipient hypothyroidism.

ANGST, J., DITTRICH, A. & GROF, P. (1969) Course of endogenous affective psychosis and its modification by prophylactic administration of imipramine. *International Pharmacopsychiatry*, **2**, 1–11.

COPPEN, A. *et al* (1971) Prophylactic lithium in affective disorders. Controlled trial. *Lancet, August 7*, 275–279.

DICKSON, W. E. & KENDELL, R. S. (1986) Does maintenance lithium therapy prevent recurrence of mania under ordinary clinical conditions? *Psychological Medicine*, **16**, 521–530.

MARKER, H. R. & MANDER, A. J. (1989) Efficacy of lithium prophylaxis in clinical practice. *British Journal of Psychiatry*, **155**, 496–500.

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Some unusual legal issues

Sir: We wish to bring readers' attention to some unusual legal issues.

Miss A, aged 28, was admitted to hospital informally with a two month history of increasingly severe psychotic depression with psychomotor retardation. Her phychiatric history included long-standing poly-drug and alcohol abuse, repeated self-laceration, and a suggestion of anorexia nervosa. Refusal to remain in hospital necessitated detention under the Mental Health Act 1983.

Ten days after admission she was due to get married. She had lived with her fiancé for 18 months. The team felt that she was too depressed to give valid consent. Her partner was unable to accept she was ill and demanded her discharge, and threatened to