# 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