Depression Treated by E.C.T.

SIR,—I read with interest the letter of Dr. S. Karagulla (*Journal*, March 13, p. 646) and well remember the flutter in the dovecotes of the protagonists of E.C.T. produced by her article in the *Journal of Mental Science* four years ago.[1] In the evaluation of treatment of depressive states by E.C.T. it is necessary, as she says, to have an adequate control group, and her series from 1930 to the time of introduction of E.C.T. provides that control group.

In 1941 I described the recovery, etc., rate in a series of 212 consecutive cases at the Latchmore Hospital, Ham Common, for mentally affected officers in the 1914–18 war, all of whom I saw from beginning to end of their hospital career, excepting a few remaining after October, 1919.[2] The rates were : recovered 60.4%, relieved 17.5%, not improved 19.8%, died 2.3%. These 212 were of course of different types, including schizophrenics and paralytics, who lowered the recovery rate. The material was usually good, most cases were young, many were exhaustion cases, and a good recovery rate was to be expected. Although occurring so long ago, they may be considered, like Dr. Karagulla's earlier cases, as a control group. In the annual report of the Board of Control for 1952 the number of direct admissions is given as 66,773, of whom 16,552 were discharged as recovered, about 25% ; and 29,052 were, however, discharged as relieved, about 45% ; combined rate of discharge 70%. In 1921, the recovery rate was 32.5%, and had been much the same for many years previously. In 1946 the relieved rate practically equalled that of the recovered, combined 62%, as compared with 48% just before the Mental Treatment Act of 1930.

I must say I was surprised at the low recovery rate of 1952, and can only presume there must have been a greater proportion of senile admissions. The high relieved rate, I believe, is due to the large number of voluntary admissions. I think it is generally conceded that many more comparatively mild cases are now sent to mental hospitals, although these milder cases do not necessarily have a better prognosis as regards recovery.

My impression is that the value of E.C.T. has been overrated, with the possible exceptions of involution cases, and I agree with Dr. Karagulla that a critical review of physical methods of treatment is necessary. Indeed, Mr. Harvey Jackson, in an article on leucotomy, suggests that electro-convulsive therapy has been responsible for much atrophic change, possibly arising out of repeated diffuse petechial haemorrhages.[3]—I am, etc.,

Hastings. HARVEY BAIRD.

REFERENCES

[1] *J. ment. Sci.*, 1950, **96**, 1060.
[2] Ibid., 1941, **87**, 109.
[3] Ibid., 1954, **100**, 62.

Dangers of Induced Hypotension

SIR,—It is a relief to read Dr. Harry F. Griffiths's letter (*Journal*, March 20, p. 706) giving support of the technique of induced hypotension. During the past three years I have personally employed this method using hexamethonium bromide in 250 patients, for the operations of radical mastectomy, block dissection of glands of neck, major plastic repairs, prostatectomy, vaginal hysterectomy, and colporrhaphy. No serious complications have arisen, and I have met with no catastrophes, nor delayed ill effects which might be attributed to the anaesthesia. I have been much impressed by the excellent operating conditions, by the reduction in operating time, and by the satisfactory post-operative condition of the patients.

Is it not possible that the deaths reported with induced hypotension might have been largely due to unsatisfactory anaesthetic technique associated with the induced hypotension, rather than the hypotension itself ? The following case illustrates how readily induced hypotension might have been incorrectly blamed for a post-operative hemiplegia. In December last the patient, a woman aged 63, with a B.P. of 220/120, had a wide excision of malignant melanoma of cheek, and a graft. The anaesthetic was given by a registrar and induced hypotension was not used. On the third day this patient developed a sudden hemiplegia. She came to the theatre again last week, having partially recovered from the hemiplegia, for a block dissection of malignant glands of neck. The B.P. was 215/120 and I hesitated as to the advisability of using induced hypotension, but decided in favour, and employed my usual technique. The total dose of hexamethonium bromide used was 20 mg. Conditions were satisfactory, the systolic pressure remaining between 80 and 60 throughout the operation lasting 1¼ hours. The patient was returned to the ward with a systolic B.P. of 60, and the foot of the bed slightly raised. One hour later the B.P. was 95 and it gradually returned to the previous level over three days. It is now ten days since operation and there has been an uneventful recovery.—I am, etc.,

Manchester, 3. FLORENCE FAULKNER.

Medical Needs in the Gold Coast

SIR,—The Council of the Gold Coast Branch of the British Medical Association has read with interest the recent correspondence on the medical needs in the Gold Coast. It is suggested that members of the Association wishing to come to the Gold Coast should communicate with the secretary of the local Branch, as conditions in the Gold Coast are changing daily. I would do my best to supply any information about local conditions that may be required.—I am, etc.,

P.O. Box 297, Accra. M. J. COLBOURNE,
Secretary, Gold Coast Branch.

Clergy and Doctors

SIR,—No one who has been in general practice can fail to realize that there are many problems that affect both doctors and clergy. Have we not all had patients whose complaints start from worry over some moral problem—perhaps one which they would rather disclose to us than to a clergyman ? And do not the clergy constantly hear details of illness ? There is surely overwhelming need for co-operation between us.

I would, however, suggest to the Rev. Tony Clemens (*Journal*, April 24, p. 983) that whilst co-operation must take place in the hurly-burly of parish and practice, it should not begin there. There are many difficulties to be faced—not merely those of preserving confidence—and I would suggest that the best way to begin would be by quiet thought and discussion in a small group of clergy and doctors, where difficulties could be foreseen and personal idiosyncrasies ironed out.—I am, etc.,

East Hoathly. F. GRAY.

London Medical Orchestra

SIR,—Congratulations to those who are responsible for the formation of the new London Medical Orchestra. Their inaugural concert on Saturday, April 3, showed a wonderful degree of precision, confidence, and musicianship under an evidently first-rate conductor. Not even a hint of the untidiness so noticeable in the writing of prescriptions. Without derogating the strings, I was particularly impressed with the quality of the wind playing, as it is on the whole harder to come by amateur wind players than strings. It is invigorating to meet with busy practitioners able and willing to devote leisure to so admirable a pastime—a real recreation for themselves and for us, their appreciative colleagues. I hope they enjoyed it as much as I did. I am glad to hear that they mean to aid medical charities. These will get more of my money than before. Good luck to these blenders of cures and keys.—I am, etc.,

London, W.12. R. PATRICK ROSS.