those contracting with acute services, while moving towards uniformity across the UK.

A training video should confine itself to established facts or clearly identify 'grey' areas. To imply that propofol should not (ever) be used in ECT is wrong. More accurate is that propofol reduces seizure duration and that the clinical consequences of this is unknown. Hypertensive patients for example *might* benefit from propofol?

The video demonstrated electrode positioning at a point 2 cm perpendicular to the mid point between the angle of the eye and the external auditory meatus. I suspect the "two centimetres" quoted should have been two inches as four centimetres is nearer the existing recommendations.

The technique of 'hyperoxygenation' referred to as a fit provocation technique may act by inducing *hypoxia* – or at least that is one considered mechanism to explain the EEG response to hyperventilation through cerebral vasoconstriction. It is stated as being "harmless" in the video, but many EEG departments consider it potentially hazardous in the elderly or those with vascular insufficiency.

The emphasis on stated consultant sessional input is good, as is the idea that fewer junior doctors at a time ought be on an ECT rota. But surely it is not so inappropriate for GP trainees to participate in ECT administration?

While fit threshold is higher in men, and higher in older people as stated, it is also higher with dehydration (relevant when patients are not drinking). Fit threshold is stated as being higher for bilateral ECT, and yet higher energy levels are often needed for unilateral ECT as (presumably) more energy is lost through short circuiting.

The TEST facility on the ECTRON series 5, according to a communication from ECTRON, is a guide only. They say that failure of the test light to flash before administration is *not* a cause for concern because of some patients having a very high static impedance, but much lower dynamic impedance.

I am pleased to see the College taking a lead in modern forms of communication. The finished product, with audience participation is a good use of 55 minutes. As the video says however, it must supplement hands on training and the contents of the new handbook, and not "stand alone".

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## *Reply*

DEAR SIRS

We were aware that in producing a 55-minute video which includes quite a lot of technical detail there would be some points which caused debate. Several of the points that Dr Littlejohns raises will be addressed in the accompanying teaching manual. Unfortunately, this has been delayed because of an evaporation of secretarial support at the College. There clearly is one mistake. The 2 cms that Dr Littlejohns referred to should be 2 inches or its metric equivalent. This was a mistake that I made in the original filming. We did a subsequent take with the correct distance inserted but it is clear that the incorrect version has been edited into the final tape. We will amend this in subsequent versions.

C. P. FREEMAN
*Chairman*
*Special Committee on ECT*

## *The responsibility for the care of young brain-damaged people*

DEAR SIRS

I have never succeeded in getting a reliable answer to "*Who, precisely, is responsible for the medical care of people in their 40s and 50s with cranio-cerebral pathology expressed as organic mental disorders?*"

I have seen several of these patients passed, most distressingly for patients and carers alike, between general psychiatrists and old age psychiatrists, and felt troubled at the lack of definite assignment of their care to a specific branch of psychiatry. While acknowledging the difficulty of the undertaking, I would request help to resolve the question of which psychiatrists are responsible for the young brain-damaged, whatever the aetiology.

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## *Reply*

DEAR SIRS

Old age services do not routinely accept a responsibility for patients of all ages who are suffering from acquired brain damage. It is increasingly common for patients suffering from dementia in the presenium to be managed by local old age services; this is a matter of local agreement and for agreement over individual cases. There is widespread support for the idea of Sub Regional Units/Services for patients and families where dementia presents in this age group.

A working group chaired by Professor McClelland considered this issue and the wider context of services for the younger patients with acquired, often traumatic, brain damage and published their recommendations in the *Psychiatric Bulletin* (1991, **15**, 513–518).

DAVID JOLLY
*Chairman*
*Old Age Section*