MODIFYING ECT WITH A SAFE, SIMPLE AND ECONOMICAL TECHNIQUE

DEAR SIR,

I have developed a safe, simple and economical technique for modifying ECTs and have so far given 3698 ECTs to 569 patients, modifying them by minimum doses of iv diazepam (av. dose 8 mg); suxamethonium (av. dose 15 mg) and *voluntary hyperventilation* by the patients for about 150 seconds preceding ECT. This entirely dispensed with artificial insufflation.

I have found this technique simple, safe, satisfactory, economic and superior to the standard technique of modifying ECTs with thiopentone, suxamethonium and artificial insufflation which I had been using previously for over 20,000 ECTs. The muscle-relaxant action of diazepam enabled a considerable reduction of suxamethonium doses. This and the important property of diazepam of inducing consistent amnesia and anxiolysis eliminated the side-effects of painful muscle twitchings caused by suxamethonium and thus reduced the duration of apnoea induced by it. The average duration of apnoea was about 130 seconds, without evidence of cyanosis or hypoxia. The anticonvulsant action of diazepam was countered by voluntary hyperventilation which is physiologically well known to reduce the convulsive threshold. No major or noteworthy side-effects were recorded.

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NO LUNG CANCER IN SCHIZOPHRENICS?

DEAR SIR,

I have been working in psychiatric hospitals for nearly 35 years. One of the most striking features of long-stay patients, of whom the greater proportion have been patients suffering from schizophrenic illnesses, is the amount they smoke (mainly cigarettes whether factory or 'home-made').

I am struck by the fact that I cannot recall a single case of a chronic schizophrenic patient (male or female) dying of bronchial carcinoma. This must surely be below the 'normal' expectations.

I have discussed this observation with a number of colleagues who have confirmed that they too cannot recall bronchial carcinoma occurring in a patient suffering from schizophrenia. If my own experience is typical then surely there must be some important findings (chemical or other) present in patients with chronic schizophrenic illness not present in non psychotic members of the community. I have discussed my observation with Sir Denis Hill but would very much like to learn of the experiences of colleagues, especially those who have looked after long stay patients for a considerable time.

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DEPOT INJECTIONS AND TARDIVE DYSKINESIA

DEAR SIR,

If the incidence of tardive dyskinesia among the patients already receiving depot fluphenazine at the start of Dr Gibson's study (*Journal*, October 1978, **132,** 361–5) was 7 per cent, this figure was reached after a mean of 4.4 years of depot fluphenazine treatment, in addition to the previous oral therapy. Yet the increase in incidence in the next two years was 5.6 per cent and 6.1 per cent respectively—a sudden acceleration coincident with the study. The increase for the third year of follow-up seems to be slowing down again at 3.3 per cent.

Asnis (*Diseases of the Nervous System*, 1977, **38,** 856–9) has drawn attention to the importance of hysterical identification in the development of dyskinetic symptoms by some patients who notice the special interest and attention given to those with tardive dyskinesias. Dr Gibson refers to the close involvement of the community nurses in his study, so that although the patients were not in hospital mechanisms related to suggestion may still have been operative. The rise and subsequent fall in the rate of appearance of new cases is also in keeping with the epidemiology of hysterical conditions (Penrose, *On the Objective Study of Crowd Behaviour*, 1952, London: H. K. Lewis).

Finally, this may help to explain the apparent anomaly of concomitant parkinsonism and tardive dyskinesia observed in four patients.

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