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More data on speed of remission with ECT in geriatric depression

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We appreciate the important contribution of Spaans *et al*[1] to the evidence that electroconvulsive therapy (ECT) is a rapidly acting treatment in geriatric depression. Their data are a reminder that, despite the recent excitement about other neuromodulation modalities for the treatment of depression, ECT remains a standard and vital treatment for our most seriously ill patients, particularly those in the geriatric age group. We would like to

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add data about the speed of ECT remission in geriatric depression from the ongoing National Institute of Mental Health (NIMH)-supported multicentre trial, Prolonging Remission in Depressed Elderly (PRIDE, ClinicalTrials.gov Identifier: NCT01028508).

Our group has just completed enrolment of 237 patients in phase 1 of a trial in which patients with unipolar depression over 60 years of age receive a course of ultra-brief pulse right unilateral ECT augmented with venlafaxine. (Phase 2 of the trial is random allocation to venlafaxine plus lithium or venlafaxine plus lithium plus flexible maintenance ECT. This phase of the trial will be completed in the next 3 months.) The cohort of 133 remitters in phase 1 required a mean of 7.3 (s.d.= 3.1) ECT sessions to reach remission, defined as a Hamilton Rating Scale for Depression (HRSD-24) score of ⩽10 on two consecutive occasions (personal communication, R. Knapp). Because ECT was administered three times a week in our study, seven treatments approximate 2.5 weeks until remission, a time comparable to that reported by Spaans *et al*.

In our previous study, comparing the efficacy of the three standard electrode placements in ECT,[2] the mean number of ECT sessions needed to achieve remission in patients over 60 years of age was also consistently low: bi-temporal (5.5, s.d.= 2.2, n= 19), bi-frontal (5.4, s.d.=2.1, n= 11), right unilateral brief pulse (5.1, s.d.=2.1, n= 19). Speed of response takes on added importance when patients are urgently ill and present with severe suicidal urges, agitation, psychosis, or malnutrition from profound depression. Because of its unsurpassed efficacy and now better-documented speed of response in geriatric depression, ECT should no longer be relegated to last place in treatment algorithms for severe depression.[3] Finally, it should be noted that in both Spaans *et al* and the PRIDE study, newer techniques allow practitioners to prescribe ECT in a form that is more tolerable for patients than in the past.[4]

References

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