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A Step Toward Optimizing Treatment Schedules for Continuation ECT: Response to Rasmussen

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TO THE EDITOR: We thank Dr. Rasmussen for his careful reading of our study and his speculations as to the reasons the data turned out as they did. Our a priori hypothesis was that additional ECT after the acute course would be beneficial in the ensuing 6-month period; our preplanned data analysis was a comparison of symptom severity at the primary study endpoint of 24 weeks, with power to control for a false positive rate of 5% or less. Our data showed significant difference at the primary time point, as well as a consistent benefit at all other time points.We believe that we were cautious in interpreting these results and that various biological explanations could be invoked to explain them. One-third of the patients in the Symptom-Titrated, Algorithm-Based Longitudinal ECT (STABLE) treatment arm did, in fact, receive additional ECT past the 4-week time point, and even for those who did not, there is no a priori reason to dismiss the possibility of ongoing biological benefit from tapering, rather than abruptly stopping, the acute course of ECT for the treatment of an episode of depression. We did not advocate that STABLE be considered “the standard of care for continuation ECT” at this point because considerable additional research is needed to establish optimal treatment schedules. Our data stand, however, as the accurately reported and conservatively interpreted results of a randomized clinical trial, and we disagree with characterizing our results as “inexplicable” or “fortuitous.”

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The authors’ disclosures accompany the original article.

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