

The Practice of Electroconvulsive Therapy

Recommendations for Treatment, Training, and Privileging

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effective seizures may be difficult to induce (Boylan et al. 2000; Coffey et al. 1995a; Sackeim et al. 1987b). Especially when treated with bilateral ECT, some elderly patients may have seizure thresholds that exceed the maximum output of current-generation ECT devices in the United States (Krystal et al. 2000; Lisanby et al. 1996; Sackeim 1991). In the context of an elevated seizure threshold, the clinician should consider reducing or withdrawing sedative/hypnotic or other anticonvulsant agents (including benzodiazepines), replacing prophylactic lidocaine with another antiarrhythmic medication (Devanand and Sackeim 1988; Hood and Mecca 1983), minimizing doses of barbiturate anesthesia, and ensuring adequate ventilation. In addition, because of altered metabolism in the elderly, dosages of all medications used with ECT may need to be reduced.

In the recent past, preadministration of intravenous caffeine was used to augment ECT in the context of short seizures (Calev et al. 1993; Coffey et al. 1987d, 1990; Hinkle et al. 1987; Shapira et al. 1985, 1987). However, although pretreatment with caffeine lengthens the duration of evoked seizures, it does not appear to reduce seizure threshold (Fochtmann 1994; McCall et al. 1993). Because seizure duration per se is not related to the efficacy of ECT (Nobler et al. 1993; Sackeim et al. 1991), the rationale for using caffeine or related agents (Swartz and Lewis 1991) as an augmentation strategy is questionable. In addition, caffeine augmentation of ECT has been associated in rare cases with cardiovascular (Acevedo and Smith 1988; Beale et al. 1994c; Jaffe et al. 1990b) and perhaps other (Enns et al. 1996) adverse effects.

Elderly patients may be at greater risk for more persistent confusion and greater memory deficits during and after ECT treatment. Various retrospective studies have indicated that patient age and medical status are predictors of the development of persistent confusion during the ECT course (Alexopoulos et al. 1984; Burke et al. 1985, 1987; Fraser and Glass 1978, 1980; Gaspar and Samarasinghe 1982; Kramer 1987a; Miller et al. 1986; Tomac et al. 1997). Older patients and those with compromised medical status are at highest risk for prolonged confusion. Relative to younger patients, Zervas et al. (1993) found that older patients with depression had more severe anterograde and retrograde amnesia immediately following the end of the ECT course, with some of these differences persisting at 1-month follow-up. Unfortunately, in this work, a cutoff of 65 years was used for the oldest patients in the sample. Sobin et al. (1995) examined the relationship between preexisting cog-