Am J Psy. 112: 745-6 mar 56

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CORRESPONDENCE

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instituted suit against the hospital and the private psychiatrist who treated him. This suit was defended in court and the case rested on the fact that succinylcholine chloride was not used on the first treatment. The plaintiff's attorney introduced articles on the use of succinylcholine chloride and, in spite of the fact that succinylcholine chloride was not in general use at that time and was just being introduced, a verdict of $3,000 against the psychiatrist was returned by the jury. There was a directed verdict of no negligence against the hospital since the facilities were there and could have been used by the psychiatrist if he so desired.

Now the question we can all ask is: if on April 3, 1953, when succinylcholine chloride was first being introduced and very few were using it, one of us was found guilty of negligence in not using it, what will happen in 1956 if a man does not use succinylcholine chloride and a fracture is sustained?

Dr. Kalinowsky also warns against the use of electric shock in patients on large doses of chlorpromazine and reserpine, and I have no objection to this even though at Bournewood we have treated these patients using atropine, pentothal-succinylcholine chloride routinely with no untoward effects.

I want to repeat that if succinylcholine chloride is used one should have experience with the method and should be skilled in the technique of maintaining a patent airway and oxygen under positive pressure. I agree with Dr. Kalinowsky that the routine use of succinylcholine chloride by unskilled persons will lead to fatalities, but the effort should be made to train men in the use of succinylcholine chloride and/or to use nurse-anesthetists skilled in the procedure so that the goal of routine use of succinylcholine chloride can be attained.

CHARLES SALTZMAN, M.D.,
Brookline, Mass.

ADDITIONAL REMARKS ON THE DANGER OF PREMEDICATION IN ELECTRIC CONVULSIVE THERAPY

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: The comments on my previous letter give me a welcome opportunity to amplify the points therein. To begin with the letter by Dr. Resch and his staff, it is known to me that many hospitals apply ECT during medication with chlorpromazine and reserpine without accident. The deaths reported in my letter, should have been sufficient as a warning against this combination. I am now able to report on 2 more fatalities which Bini, who introduced electric shock therapy, authorized me to mention here. Considering the fact that in almost 20 years of experimentation with and routine use of ECT, the group at the Neuropsychiatric University Hospital in Rome lost only 1 patient, the 2 deaths within a short period of medication with chlorpromazine were significant enough to discontinue a combination which has not been proven superior to the subsequent application of the 2 treatments.

The problem of premedication with succinylcholine was added in my letter as evidence that any premedication adds to the risk of ECT. This did not mean a strict rejection of succinylcholine with which I am thoroughly familiar. I am treating many selected cases with large doses of succinylcholine with the assistance of an anesthetist, and at the New York Psychiatric Institute we are trying to evaluate the usefulness of small doses given without an anesthetist. Dr. Saltzmann, like most staunch advocates of the method, tries to explain accidents with poor technique. The personal communications mentioned in my first letter came from 2 extremely competent therapists, Baumer and Baumgartl, who, as early as 1953, gave an excellent and then favorable report on succinylcholine (Nervenarzt, 24: 66, 1953), and von Baeyer, foremost electroshock therapist. Baumer described his cases as cardiac deaths and rightly points out in his letter to me that respiratory arrest, even of long duration, can always be controlled.

I wish to clarify my position in this matter. I cannot see why cardiovascular disease should be a reason to use muscle relaxants. The entire experience with ECT in patients with cardiac disease has shown that electrically induced convulsions do not increase cardiac decompensation any more than convulsions in epileptics. Recently I saw a threatening reaction with pentothal-anectine

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New York City.

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It is the consensus of our staff that there has been no increase of complications resulting from the combination of tranquilizing drugs in usual doses with ECT. In this 3-month period there has been neither deaths nor fractures.

From this experience it has been concluded that there is no contraindication to continuing the use of these tranquilizing drugs in preparing patients for electroconvulsive therapy.

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I agree with Dr. Kalinowsky that succinylcholine chloride should not be used by every psychiatrist routinely or we shall have many more deaths. However, when a person skilled in anesthetic procedure assists, when oxygen is given routinely, I believe it is a very safe procedure and it is certainly less traumatic to the cardiovascular system. The 5 deaths from unpremedicated treatment were attributed mainly to coronary episodes and cardiac conditions. I am sure that with succinylcholine chloride those deaths would not have occurred because the stress on the cardiovascular system would have been that much less. With our 17,000 treatments with succinylcholine chloride we have had no complaint of back pain and no fractures reported as compared with the 1% to 10% fractures reported when unpremedicated treatments are given.

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Dr. Kalinowsky also warns against the use of electric shock in patients on large doses of chlorpromazine and reserpine, and I have no objection to this even though at Bournewood we have treated these patients using atropine, pentothal-succinylcholine chloride routinely with no untoward effects.

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tion for muscle relaxants, aside from threatening hemorrhages in subdural hematoma, bleeding ulcers and post-operative conditions, in the prevention of fractures of the long bones. Those of the spine have no clinical significance, and court decisions like the one mentioned by Dr. Saltzmann, as well as a similar one, where a fusion operation (!) had made the backache permanent, should not influence our medical judgment. In view of the greater risk for life, we must search our conscience and be sure that no legal con-

ATARACTICS IN P

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: It seems to us that Drs. Dean's and Gahagan's interesting article (p. 661, Feb. 1946; p. 850, Apr. 1956) about ataractic drugs call for a little more clarification on the subject.

We would like to point out that the psychiatrist in private practice usually treats more neurotics than psychotics. The latter are found in mental hospitals and that is exactly where the greatest successes with ataractic or neuroplegic drugs, as they are also called, are reported.

By now, it is well established that chlorpromazine and reserpine should not be given in depressive states unless accompanied by anxiety and agitation and, in this case, the ataractic drugs should be combined with electroshock or, in some cases, with antidepressant drugs like Amphetamine, Meratran, etc. It also should be remembered that ataractic drugs should be discontinued 1-2 days before electrocoma therapy is given, in order to avoid serious complications.

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