

However, the akathisia seen in this patient was probably not due to the anticholinergic property of the drug. As noted in our report, the patient also developed marked akathisia while being treated with doxepin. This time the akathisia was not associated with confusion. Further, the akathisia was ameliorated by treatment with benztropine mesylate, an anticholinergic drug, suggesting that the akathisia was not due to an anticholinergic effect.

Since the time we wrote our initial report we have seen other patients taking estrogens who developed akathisia when placed on a regimen of tricyclic drugs. The mechanism underlying this interaction remains speculative.

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### ECT in Pregnancy

SIR: The question of whether to administer ECT during pregnancy is of great practical importance. The article "Case Report of ECT During High-Risk Pregnancy" by Michael G. Wise, M.D., et al. (January 1984 issue) could easily deprive such patients of the necessary ECT. In 40 years of experience I have seen numerous pregnant women receive ECT without danger to mother or child. These cases included patients treated before muscle relaxants were available, and the patients had strong muscular contractions and cyanosis. The absence of any complication is not surprising in view of the fact that childbirth in idiopathic epilepsy also is not complicated by spontaneous seizures.

The requirement that an obstetrician be present to monitor fetal heartbeats would make ECT for pregnant women in psychiatric hospitals without obstetrical departments impossible. Even in general hospitals the unnecessary cost of obstetrical assistance would limit the use of ECT, which, in view of the contraindications of psychotropic drugs in pregnancy, is of the utmost importance.

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### Dr. Wise Replies

SIR: I certainly share Dr. Kalinowsky's concern regarding "unnecessary costs" in medical care. However, I disagree that obstetrical assistance or consultation for pregnant patients undergoing ECT represents unnecessary cost. The argument that ECT is completely safe when used during pregnancy, as Dr. Kalinowsky seems to suggest, rests on two assumptions. The first is that case reports collected over many years (1) fail to show any additional risk for the mother and fetus when ECT is used during pregnancy. The second is the belief that women with idiopathic epilepsy have no increase in fetal abnormalities or complications, therefore indicating that maternal seizures are safe for the fetus. We would take issue with both of these conclusions. The case reports in the literature of ECT during pregnancy are helpful. When we contemplated using ECT in a high-risk pregnant patient, we used the clinical experience found in these case reports as a foundation for our treatment. However, several cautions need to be raised. There are no controlled studies using ECT during pregnancy. Little is known regarding the physiologic effects of ECT on either the uterus or the fetus.

Case reports with a good outcome are more likely to be published. Finally, the total number of cases reported in the literature (approximately 320) is insufficient to measure a small or even moderate increase in maternal or fetal mortality or morbidity. The second issue is whether mothers with idiopathic epilepsy have the same rate of birth abnormalities as the general population. Epileptic pregnant women have a greater prevalence of maternal complications, more complications during delivery, and a 2 to 3 times greater risk of congenital malformations in their babies (2). Whether this greater rate of birth abnormalities is due to maternal genetics, anticonvulsant drugs, or maternal seizures is a point of current controversy.

When the entire question of ECT during pregnancy is examined, I agree with Remick and Maurice (3), who recommended that an obstetrician should be a member of the treatment team. As these authors pointed out, external fetal monitoring is an extremely safe procedure and should be offered to mothers undergoing ECT therapy. I agree. If patients undergoing ECT have other obstetrical conditions placing them at high risk, an obstetrician is an essential member of the treatment team. In view of the present medical-legal climate (obstetrics ranks number one nationally for litigation), it behooves physicians taking care of patients requiring ECT to use every method available to ensure the safety of the procedure.

We would also disagree with Dr. Kalinowsky's statement that psychotropic drugs are contraindicated in pregnancy. Rather, we would prefer the statement that they are relatively contraindicated. If indeed necessary, psychotropic drugs can be used during pregnancy. According to the new Food and Drug Administration classification of drugs (4) in pregnancy, most of the psychotropic drugs used would be classified as category C or D. Obviously, all drugs should be used in pregnancy with extreme caution, with the patient's informed consent, and only when absolutely necessary (5).

Finally, since Dr. Kalinowsky has seen numerous pregnant women treated with ECT without documented sequelae to either the mother or child, I encourage him to publish his data. His experience would certainly be useful to both practicing psychiatrists and obstetricians.

### REFERENCES

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### Recent Alcohol Abstinence and the Dexamethasone Suppression Test

SIR: In stating that we "did not . . . adequately screen patients for affective disease, hepatic dysfunction, and alcohol withdrawal," Charles A. Dackis, M.D., and associates