Brit. J. Psychiat. (1969), 115, 629–31

Correspondence

UNILATERAL E.C.T.

DEAR SIR,

I agree with Dr. Levy (*Journal*, January 1969, p. 121) that unilateral E.C.T. is a method of treatment that 'would repay further systematic and objective study'. We need to know much more about it: e.g. how often it should best be given; if or how it may be given to left-handed and ambidextrous patients; if it is as effective as bilateral E.C.T. in the treatment of conditions other than depression. Reports of investigations published so far have thrown little light on these questions. However, I would also like to echo the views of Dr. Cannicott and Dr. Armin (*Journal*, November 1968, p. 1483) that unilateral is as effective as bilateral E.C.T. in relieving depression, and that unilateral E.C.T. is much less upsetting to the patient, causing earlier and more comfortable recovery and fewer side-effects after each treatment. The most recent reports (1, 2, 3) on this subject in this Journal all offer evidence in support of these points. When one also bears in mind that the risk of more lasting memory impairment may be reduced by unilateral electrode placement over the non-dominant hemisphere, a useful case can be made for preferring this technique. After a double-blind trial at this hospital (4), unilateral E.C.T. is now our treatment of choice for right-handed depressed patients.

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PUERPERAL PSYCHOSIS AND THERAPEUTIC ABORTION

DEAR SIR,

I was interested in Dr. Protheroe's article (*Journal*, January 1969, p. 9) and was impressed by the information he has managed to extract from his retrospective enquiry. Although he states that his own findings do not 'have much relevance to the question of termination of pregnancy' (p. 28) he does not hesitate to reject my statement that 'there are no psychiatric grounds for termination of pregnancy'. He calls this a 'general prejudgement'. Yet, while conceding that a second puerperal schizophrenic illness cannot be predicted, he regards the results of his 1947–61 survey, which showed the risk as being one in five, as being sufficient grounds for seriously considering termination.

An important result of Dr. Protheroe's enquiry is his confirmation that the prognosis of puerperal psychosis has continued to improve, and to give point to this he divided his patients into two groups: 1927–41 and 1942–61. It would have been even more helpful if he had subdivided the second group into two: 1942–53 and 1954–61, in order to assess the contribution of tranquillizers, though there have been other advances in treatment which are less easily defined. These include trained staff, a better appreciation of relevant social factors, and the provision of better facilities in terms of social support and rehabilitation.

I wish to point out that my statement in my paper on abortion (Sim, 1963) was not a 'prejudgement' as Dr. Protheroe claims, but a conclusion based on a personal study of a very large series of puerperal psychoses as well as on a retrospective study of admissions to several mental hospitals. It was also based on the supervision and treatment of a number of schizophrenic women who became pregnant. These studies have continued, and, to date, my original conclusions have been reinforced.

I find myself in general agreement with Ekblad (1955), who pointed out that the greater degree of psychiatric handicap the greater the psychiatric risks of abortion. I can assure Dr. Protheroe that very serious consideration is given to the decision not to abort in these cases, for I accept the responsibility of supervising them during and after their pregnancy and, if necessary, undertaking their treatment.

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