after the convulsion, a severe sympathetic discharge is produced, which is what is responsible for the tachycardia and postictal arterial hypertension.

Various factors of clinical risk related with the development of asystole have been studied, among which the following are included: non-geriatric adults (age <65 years), males, no relevant cardiological history, normal BMI, use of anticholinergics in previous ECTs, resting heart rate <60 bpm, use of pre-ECT beta-blockers as prophylaxis to prevent severe post-ECT high blood pressure, use of monoamine oxidase inhibitors (MAOIs), post-ECT bradycardia in previous treatments and subconvulsive stimuli.

There have been cases of asystole in patients treated previously with ECT with no presentation of any incidence. For that reason, the absence of prior complications does not guarantee that they will not appear in the future.

Characteristics of the ECT itself have also been analyzed. A lower incidence of asystole has been observed following unilateral administration of maximum charge with short 2-s pulses as compared to that of 4 s.[4] In another observational study,[5] the placement of the electrodes and the development of bradycardia and asystole were analyzed. The authors concluded that the patients treated with electrodes in bifrontal placement showed fewer changes in heart rhythm than those treated with a unilateral placement. However, it could not be concluded that unilateral or bitemporal placement in presence of premedication with atropine was more dangerous compared with the bifrontal.

In the case presented here, we can see that the treatment administered was short pulse right unilateral at 70%–80% of the maximum charge dosage in 1 and 4 ms. The patient received treatment with atropine due to low basal heart rates, except for the day in which she presented the asystole; no atropine was administered that day because she presented tachycardia before the ECT. The administration of 0.5 mg of atropine as a prophylaxis prevented further episodes of asystole.

There are very few clinical studies. This, together with the fact that the majority of the literature related to post-ECT asystole are clinical cases, makes it difficult to define factors of risk linked to this complication, which is potentially fatal even though it is rare. The majority of authors conclude that prophylactic administration of atropine, between 0.5 and 0.8 mg, is usually effective in avoiding the development of asystole, along with close monitoring of heart rate during ECT.

Conflict of interests

The authors have no conflicts of interest to declare.

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SERP: A growing society and with an European horizon☆

SERP: una Sociedad en crecimiento y con horizonte europeo

To the Editor,

As has been commented in another publication,[1] the Spanish Society of Psychiatric Residents (*SERP, Sociedad Española de Residentes de Psiquiatría* in Spanish) was created in September 2015 with very limited material and human resources, but with great enthusiasm about achieving an objective for which it was worthwhile fighting: to improve the training of the residents in psychiatry in Spain.

Since then, our small group of residents from all over Spain have worked with the utmost commitment to provide the format and content of our society. Backed by a growing number of members, the first executive board set the bases for an institution that hopes to be representative and useful for all the present and future Spanish residents in psychiatry. The support of many of our mentors in our hospitals, that of relatives and friends that have wanted to collaborate in one way or another, and the institutional support of the great national scientific societies and of other associations has been crucial in this process.

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The recent past has been marked by great milestones in our growth. On 2 March 2016, the ''1st Encounter of Residents in Psychiatry'' in our country was held in Vitoria-Gasteiz (during the ''24th Course on Updates in Psychiatry''), with notable and enthusiastic participation and an excellent scientific level. This Encounter was a wonderful occasion for residents from all over Spain to get to know each other and to learn about aspects of research led by the hands of young, well-known professionals. It also demonstrated the ability that we residents have to join together to achieve greater protagonism and to organise our training, backing one another up to acquire greater knowledge in matters that can be relegated to the background in the day-to-day teaching reality at many hospitals.

Turning to another event, during 12–15 March, a small group of SERP members enjoyed memorable sessions in the ''24th European Congress of Psychiatry'' in Madrid. Besides learning from great international experts in the symposiums and keynote presentations, the congress offered the opportunity for the first elective general assembly; the assembly participants, including delegates for members from places far away from Madrid, renewed the executive board. In Madrid we were able to get to know more residents from all parts of Spain, and to infuse them with our enthusiasm so they would join in the project. Another highly important aspect was the contact that we made there with numerous residents in psychiatry from the most diverse points of the continent. Many of these residents are managers or are part of the European Federation of Psychiatric Trainees (EFPT, http://www.efpt.eu), which presented at that time a summary of its projects in favour of cohesion and improvement in training of residents from Europe. All of them were very interested in including Spain in the Federation, and have backed our efforts; of course, we have a lot to learn from these colleagues and we should also share, little by little, our knowledge, experience and the energy that characterises us as Spaniards. We are currently observing members of the Federation, but we will soon have the possibility of joining as full members; in any case, the European perspective is a founding aspect of our Society: continuing to look to Europe and to let ourselves be seen by Europe is one of our main goals, which was strengthened in this month.

The fact that our handbook for future residents is receiving widespread diffusion is a source of pride for us. This handbook stands as an innovation in the medical environment in our country and is helping many recently licensed medical residents to make a decision for a post in psychiatry in Spanish hospitals. Once again, and above all in these coming weeks of final decision and first steps in the speciality, the SERP is wide open to support all of those who chose this path.

We are a Society made up of individuals with ever-growing experience, and there has been room in these initial steps for small errors and points open for improvement. We are committed to learning from the successes and from the mistakes, and we plan to listen to all suggestions and constructive criticism to do so.

At present, the SERP is keeping its hopes alive and fresh. The executive board elected has already held its first official meeting and we have numerous short-, medium- and long-term projects, as we will be announcing. We wish to thank all of those that have supported us and support us in this endeavour again. We will continue working every day to make our ideal more effective.

You can find further information about our Society and receive help from our team through our website: http://www.serpsiquiatria.org

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Are we considering the QTc interval of our patients?☆

¿Estamos considerando el intervalo QTc de nuestros pacientes?

To the Editor,

Long QT syndrome (LQTS) is a heart alteration caused by a lengthening of the repolarization phase of the ventricular action potential.[1] Prolonged QT interval corrected for heart rate (QTc) has been shown to be a prognostic indicator for the development of a special form of malignant ventricular tachyarrhythmia (torsades de pointes or point torsion), which involves risk of sudden death.[2] There is no single cut-off point from which the appearance of risk of cardiovascular events is clear; however, values above 450–500 ms are considered as high risk for such events.[2–4]

We know that several psychoactive agents (antipsychotic drugs, antidepressants and lithium) produce prolongation of QTc. Some of these, such as tricyclic antidepressants, do so as a class effect,[1,3] while others, such as intravenous haloperidol, are known due to very extensive documentation. We also know that specific clinical–epidemiological characteristics act as factors of risk for this prolongation (advanced age, female sex, polypharmacy).[5]

What is true is that in the case of citalopram and escitalopram, the alerts published by regulatory agencies in 2011 caused some alarm (perhaps to an excessive degree) that could lead to prescription attitudes closer to that of defensive medicine, as was indicated in the special article, ''Citalopram, escitalopram and long QT: Alert or alarm?''; and it seems only sensible (and is sufficiently based on the evidence) to limit the alarm with both drugs to patients with a history of seizures or to cases of poisoning, with the article authors recommending the need for an electrocardiogram (ECG) only for patients of advanced age.[1] We consider the URL indicated in that same article, linked to the American Medical Association, which keeps an up-to-date list by risk groups with respect to the ability of all drugs to prolong QT: http://www.azcert.org/medical-pros/drug-lists/drug-lists.cfm.

Other authors believe that performing an ECG before and after administering any psychoactive drug that can lengthen this interval (monitoring the QTc interval) is a recommendation that might be considered beneficial in general terms, independently of other factors such as patient age.[2,5] The World Health Organisation sets a similar position, as a recommendation, with respect to the use of antipsychotic drugs, indicating that in some countries this recommendation becomes obligatory (as in the case of haloperidol), having an impact on recording family history of sudden death and personal, non-filial history of seizures.[6]

We authors consequently believe that it is essential to carry out this control measure in the case of drugs such as intravenous haloperidol and sertindole. Furthermore, we feel that it is useful to reflect upon the use of the technical procedures that we have available (in this case, performing an ECG in other clinical situations that involve drugs that prolong the QTc interval) as an indispensable task required by ethics, following on from the recent remarks by Lolas-Stepke published in the same journal.[7] This is especially so considering how attainable, humane and accessible it is to perform an electrocardiogram, with it even being feasible to coordinate with primary healthcare to do so, a coordination that we also understand facilitates joint assumption of healthcare responsibilities to the benefit of the shared objective: efficient and comprehensive healthcare for the patient.

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