

without complete remission, in treatment with 75 mg/day Imipramine, 150 mg/day Quetiapine and 15 mg/day Mirtazapine, while the outpatient department decided against maintaining ECT-ketamine.

Ketamine is an anaesthetic that is an antagonist of N-methyl-D-aspartate (NMDA) receptors; it is involved in the glutamatergic route and is of growing interest in the physiopathology of depression.⁵ Treatment with ketamine has been shown to have a swift antidepressive response, although its use is controversial and data on this in the literature are contradictory.^{6–8} A study conducted with 90 subjects with TRD showed faster and more sustained improvement in depressive symptoms, increasing cognitive protection and the duration of convulsion in those patients treated with anaesthetic doses of ketamine (0.8 mg/kg) and ECT.⁹ Nevertheless, there is a notable lack of evidence on its safety and efficacy in elderly patients, who are a group especially susceptible to TRD.

We believe that in our progress towards an increasingly personalised and technical psychiatry,¹⁰ ketamine may be a valid alternative to the use of conventional anaesthetics, giving a longer avct, which could play an important role in improving observed antidepressive efficacy. These results, together with the reported cognitive protection⁹—which was not evaluated in our subjects—mean that it is a desirable option for elderly patients, although more evidence is required to evaluate its effectiveness and safety in this age group.

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Adriana Fortea^{a,*}, Laura Espinosa^a, Clara Oliveras^a, Pol Bruguera^a, Antoni Benabarre^{a,b,c,d}

^a Servicio de Psiquiatría y Psicología, Instituto Clínico de Neurociencias, Hospital Clínic de Barcelona, Barcelona, Spain

^b Servicio de Psiquiatría y Psicología, Programa de Trastornos Bipolares, Instituto Clínico de Neurociencias, Hospital Clínic de Barcelona, Barcelona, Spain

^c Institut d'Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), Barcelona, Spain

^d Facultat de Medicina, Universitat de Barcelona, Barcelona, Spain

* Corresponding author.

E-mail address: fortea@clinic.cat (A. Fortea).
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Should the laryngeal mask airway play a role in electroconvulsive therapy?[☆]



¿Debería desempeñar un papel la mascarilla laríngea en la terapia electroconvulsiva?

Dear Editor,

We read with interest the article by Buj-Alvarez et al.¹ describing the use of a laryngeal mask airway (LMA) during

electroconvulsive therapy (ECT) to facilitate hyperventilation and would like to share our experience. While there is a place for the LMA during ECT (primarily as a rescue device as part of the American society of anesthesiologists difficult airway algorithm in patients who cannot be ventilated) we feel that for a number of reasons routine use is not necessary and may actually be detrimental.

The pilot study described in the article compared two groups of patients, one ventilated with an LMA and one with a face mask, but it is not clear if the face mask group was ventilated with any assistive devices such as an oral airway. Since it is not possible to accurately measure the end tidal CO₂ when ventilating with a face mask it is also unclear how the authors were able to determine that the results of this study were related to a difference in the degree of hyperventilation achieved by the two different methods of ventilation. Minute ventilation can be used as a proxy for quantifying the degree of hyperventilation in the facemask

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group, but even then one must assume that at a rate of 20 liters per minute of ventilation a more than adequate level of hyperventilation has been reached since I cannot be accurately measured. We have been able to achieve an acceptable degree of hyperventilation using only a simple bag-valve-mask device and the occasional soft oral airway.

Laryngeal mask airways work very well to maintain a patent airway in most patients but require some skill and time to place. They work best when the patient is spontaneously breathing and may not allow for adequate ventilation with positive pressure if not seated correctly. If an appropriate bite block is not available for use with an LMA, the device must be removed and then quickly replaced. Any difficulty with placement can cause a delay in post stimulus hyperventilation and increases the potential for oropharyngeal injury. Because of this some choose to leave the LMA in place and protect the teeth in each side with a modified bite block. It is not clear which strategy the authors chose to follow in the study and we would be interested to know if they encountered any difficulties similar to the ones described above.

For these reasons we believe a device such as an LMA could be used with an appropriate bite block not as a routine strategy but for specific patients such as those who are difficult to achieve an acceptable degree of hypoxapnia due to difficulties with ventilation for any reason, but not as a first line choice. For a procedure that only requires a brief period of anesthesia it seems unnecessary to routinely use

an expensive and somewhat invasive device such as the LMA, especially when the same results can be achieved by an experienced anesthesiologist without one.

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Ethan O. Bryson^{a,*}, Adriana P. Hermida^b,
Charles H. Kellner^c

^a *Departments of Anesthesiology and Psychiatry, The Icahn School of Medicine at Mount Sinai, New York, NY, United States*

^b *Department of Psychiatry, Emory University School of Medicine, Atlanta, GA, United States*

^c *Department of Psychiatry, The Icahn School of Medicine at Mount Sinai, New York, NY, United States*

* Corresponding author.

E-mail address: ethan.bryson@mountsinai.org

(E.O. Bryson).

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