

those with severe dementia may not have been recognised. Although BPSD were not associated with severity of dementia assessed by the FAST,² we notice a possible difference between those of stages 3–5 (mean total BEHAVE-AD score over admission: 2.4) and the more severe stages (means 3.6, 3.4 and 3.7, respectively, for stages 6a–c, 6d–e and 7a–f).

We agree the BEHAVE-AD scale has shortcomings; for example, it misses apathy and disinhibition.³ Our choice was pragmatic, based on ease of administration and available staff time. The Neuropsychiatric Inventory has more detailed items on agitation and aggression, but we also used the Cohen–Mansfield Agitation Inventory to characterise agitated behaviour (details available from the authors on request) and wished to avoid duplicating data collection. We would like to highlight that most of our cohort did not come from residential or nursing care; 67% were admitted from their own home (Table 2).¹

Although admission is overall a negative experience, the precipitating illness may require hospital treatment. We had no data on BPSD prior to admission or how they would have evolved in another setting. Teasing out which elements of the admission have the strongest influence on poor outcomes, or whether the physical illness causing the admission produces negative effects, would require further investigation. Unfortunately, the answers to these questions will be complex and methodologically challenging to define properly.

There is recent evidence that improving the hospital environment for people with dementia is worthwhile.⁴ We hope our paper provides information to inform more effective interventions.

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More data on speed of remission with ECT in geriatric depression

We appreciate the important contribution of Spaans *et al*¹ to the evidence that electroconvulsive therapy (ECT) is a rapidly acting treatment in geriatric depression. Their data are a reminder that, despite the recent excitement about other neuromodulation modalities for the treatment of depression, ECT remains a standard and vital treatment for our most seriously ill patients, particularly those in the geriatric age group. We would like to add data about the speed of ECT remission in geriatric depression from the ongoing National Institute of Mental Health (NIMH)-supported multicentre trial, Prolonging Remission in Depressed Elderly (PRIDE, ClinicalTrials.gov Identifier: NCT01028508).

Our group has just completed enrolment of 237 patients in phase 1 of a trial in which patients with unipolar depression over 60 years of age receive a course of ultra-brief pulse right unilateral ECT augmented with venlafaxine. (Phase 2 of the trial is random

allocation to venlafaxine plus lithium or venlafaxine plus lithium plus flexible maintenance ECT. This phase of the trial will be completed in the next 3 months.) The cohort of 133 remitters in phase 1 required a mean of 7.3 (s.d. = 3.1) ECT sessions to reach remission, defined as a Hamilton Rating Scale for Depression (HRSD-24) score of ≤ 10 on two consecutive occasions (personal communication, R. Knapp). Because ECT was administered three times a week in our study, seven treatments approximate 2.5 weeks until remission, a time comparable to that reported by Spaans *et al*.

In our previous study, comparing the efficacy of the three standard electrode placements in ECT,² the mean number of ECT sessions needed to achieve remission in patients over 60 years of age was also consistently low: bi-temporal (5.5, s.d. = 2.2, $n = 19$), bi-frontal (5.4, s.d. = 2.1, $n = 11$), right unilateral brief pulse (5.1, s.d. = 2.1, $n = 19$). Speed of response takes on added importance when patients are urgently ill and present with severe suicidal urges, agitation, psychosis, or malnutrition from profound depression. Because of its unsurpassed efficacy and now better-documented speed of response in geriatric depression, ECT should no longer be relegated to last place in treatment algorithms for severe depression.³ Finally, it should be noted that in both Spaans *et al* and the PRIDE study, newer techniques allow practitioners to prescribe ECT in a form that is more tolerable for patients than in the past.⁴

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Authors' reply: We agree that the superior efficacy and faster onset of action of ECT compared with other treatment modalities warrants the earlier application of ECT in the treatment of elderly patients suffering from severe depression. The growing evidence of superior efficacy in the subgroup of elderly patients¹ suggests the existence of distinctive subgroups with individual, clinical, cognitive and genetic parameters predicting response or non-response, as well as the emergence of side-effects. An exploratory study on clinical and cognitive profiles that predict early and complete remission with a Clinical Global Impression of Severity of 1 within 2 weeks of treatment has been submitted for publication. Brief pulse treatment, older age, shorter duration of the current depressive episode and psychosis predicted fast remission, but also a lower executive function at baseline as measured with letter