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Electric shock treatment medicine

Before undergoing Electroconvulsive Therapy (ECT), your healthcare provider will thoroughly explain the procedure, its effects, and potential risks. They'll also assess your overall health and ensure you don't have conditions that may make ECT unsuitable for you. Several tests may be conducted prior to ECT, including blood and urine work, imaging studies like X-rays and CT scans, and an electrocardiogram (ECG) to evaluate heart function. Certain medical conditions can render someone ineligible for ECT. These "contraindications" are evaluated on a case-by-case basis and may be adjusted to accommodate individual needs. Examples of contraindications include recent heart problems, brain tumors, or severe lung diseases like COPD. To prepare for ECT, you'll need to fast from food and liquids for several hours before the procedure. Your healthcare provider may also ask you to remove certain items, such as jewelry or medical devices, to minimize risks. In terms of medications, your healthcare provider may advise you to stop or adjust certain medications to ensure safe treatment with ECT. During the procedure, multiple healthcare providers will work together under anesthesia and other preparations, including muscle relaxants and IV injections. The goal is to safely induce a controlled seizure while minimizing discomfort. Electrical Convulsive Therapy (ECT) Involves Placement of Electrodes Against the Skin. A healthcare provider will then place electrodes on your head, depending on your specific needs and to minimize side effects. There are three different placement methods: right unilateral, bifrontal, and bitemporal. Every year, many deaths occur due to electrocution, which is significantly more common than fatalities from lightning strikes. The majority of these cases are connected to work-related injuries. Several factors determine whether an individual might suffer from electrical injuries, including the type and amount of current, as well as the path it takes through the body. Low-voltage electricity typically does not cause significant harm, but exposure to high-voltage electricity can result in severe tissue damage. When assisting someone who has been electrocuted by a high voltage, it's crucial to exercise extreme caution to avoid becoming another victim of electrical shock. If a high-voltage line has fallen to the ground, especially in wet conditions or if it comes into contact with water, there may be a ring of current spreading out from the tip of the line. The safest course of action is to call emergency services or activate your area's emergency response system. The power will be shut off by the electric company. However, individuals who have fallen or suffered severe injuries should not be moved until medical professionals arrive, as they may have serious neck injuries. Children are particularly susceptible to low-voltage electrical shocks due to household appliances and outlets. Lightning strikes are relatively rare but cause an average of 47 deaths annually in the U.S. Although there are millions of lightning strikes on Earth daily, few people are directly affected by them. Lightning can lead to cardiac or respiratory arrest, as well as neurologic injuries and severe muscle contractions triggered by electricity. Burns from electrical shocks can be severe and potentially life-threatening, requiring immediate medical attention. Other possible injuries include spinal cord damage, internal organ injuries, broken bones, and cardiac arrest. The severity of the burn and the presence of other symptoms such as shortness of breath, chest pain, or abdominal pain should be evaluated to determine the extent of the electric shock. In children, electrical mouth burns may appear as a burn on the lip with a red or dark, charred appearance. Individuals who have experienced an electric shock should be examined for entry and exit marks to assess the severity of the injury. It is essential to seek medical care immediately if there are signs of cardiac arrest, high-voltage shocks (over 500 volts), or if the individual is unsure about the voltage exposure. Medical attention may be necessary within five years of a tetanus booster shot, particularly for burns that do not heal well or those with increasing redness, soreness, or drainage. Pregnant women who have experienced an electric shock should also seek medical care promptly. The doctor's primary concern is to determine if there are any significant unseen injuries, such as muscle, heart, or brain damage. Treatment of electric shock depends on the severity of the burns and the nature of other injuries found. Minor burns may be treated with topical antibiotic ointment and dressings, while more severe burns may require surgery to clean wounds or skin grafting. Broken bones may require splinting, casting, or surgery to stabilize the bones, and internal injuries may require observation or surgery. Electric Shock Prevention and Safety Measures As age increases, the risk of electrical injury shifts from power cords to high-power systems. Children under 12 are more susceptible to cord-related injuries, while older teens and adults face risks from exploring electrical equipment. Key preventive measures include: - Regularly inspecting power cords and extension cords - Replacing damaged or exposed wires - Limiting extension cord use and ensuring proper rating - Using outlet covers for infants and updating old outlets to grounded systems - Avoiding water near electrical sources Adults can reduce risk through common sense, such as turning off power before working on systems. Caution is essential during thunderstorms, with safe shelters sought in sturdy buildings or crouched low and away from metal objects. Recovery from electric shock depends on the severity of injuries, particularly the percentage of body surface area burned. Infection is a leading cause of death in electrical injury patients, while brain damage may result in long-term health issues. Electrical injuries can range from a mild sensation to life-threatening cardiac arrest and death. People who experience electrical shocks or injuries may also suffer second-degree burns, confusion, weakness, and hearing loss. According to the CDC, lightning strikes are another cause of electrical injuries. In contrast, Electroconvulsive Therapy (ECT) is a psychiatric treatment that uses electrical current to induce seizures in patients with severe mental disorders. ECT is often used when other treatments fail, particularly for conditions like major depressive disorder, mania, and catatonia. While ECT carries some physical risks similar to brief general anesthesia, its effects are typically short-lived, causing confusion and temporary memory loss. ECT Treatment Origins Ugo Cerletti pioneered electroconvulsive therapy (ECT) which had been utilised by G.B.C. Duchenne for treating various mental disorders in the mid-19th century. The use of ECT became widespread in British asylums during the second half of the 19th century, and its popularity continued into the 20th century with Hungarian neuropsychiatrist Ladislav J. Meduna introducing convulsive therapy in 1934. Cerletti's development of ECT was largely influenced by his observation of animals being given electric shocks to induce seizures. He later experimented on humans, developing a successful treatment for schizophrenia and other mental disorders. The technique involved delivering electric shocks to the head, resulting in induced convulsions. The positive side effect of retrograde amnesia, where patients experienced memory loss after treatment, helped alleviate concerns about the procedure. The introduction of ECT led to the decline of metrazol therapy, which was deemed less safe and effective. The treatment gained international recognition, with the first ECT device being patented in the 1940s. Cerletti's work paved the way for the widespread adoption of ECT, despite controversy surrounding its use during the 1960s. Today, the Sapienza Museum of the History of Medicine in Rome houses an original prototype of Cerletti's ECT apparatus. ECT Evolution Over Time The introduction of unilateral electrode placement and brief pulse current significantly impacted ECT procedures. Initially, equipment was not widely adopted due to its novelty. In the 1940s and early 1950s, unmodified ECT was commonly used, resulting in full-scale convulsions and a risk of long bone fractures. Psychiatrists experimented with curare to modify these effects, but succinamethonium, a safer alternative, led to more widespread adoption of modified ECT. The use of muscle relaxants and short-acting anesthetics improved patient safety. The therapeutic role of electroconvulsive therapy (ECT) has been reevaluated in recent years. The American Psychiatric Association released task force reports in 1990, 2001, and subsequent updates that emphasized the importance of informed consent and the expanded role of ECT in modern medicine. By 2017, insurance companies covered ECT for severe mental illness cases, and media coverage improved, leading to increased availability at regional medical centers. Despite a decline in use due to antidepressants, ECT saw a resurgence with advancements in technology and techniques. Modern shock voltage uses shorter durations of 0.5 milliseconds compared to conventional brief pulses. Studies suggest that ECT works by temporarily disrupting neural pathways, followed by augmented neuroplasticity and rewiring. It is used with informed consent for treatment-resistant major depressive disorder, bipolar depression, catatonia, prolonged mania, and conditions requiring a rapid response due to severity. Autism in adults with intellectual disability has been treated using ECT, although findings are inconclusive. For major depressive disorder, ECT is typically reserved as a last resort or in emergency situations like imminent suicide. Studies have shown that both unipolar and bipolar depression respond equally well to ECT, with remission rates of 50.9% for unipolar and 53.2% for bipolar depression. A meta-analysis found ECT superior to simulated ECT, placebo, antidepressants, tricyclics, and monoamine oxidase inhibitors in terms of efficacy. In a systematic review published by the UK ECT Review Group in 2003, ECT was compared to placebo and antidepressant drugs, highlighting its effectiveness as a treatment option. ECT demonstrated significant efficacy in treating depression, with a large effect size compared to placebo and antidepressant drugs. In clinical trials, ECT relieved depression by reducing the Hamilton Rating Scale score by approximately 15 points, outperforming rTMS by 6 points. Response rates for treatment-resistant major depressive disorder ranged from 60-80%, with a remission rate of 50-60%. Additionally, ECT reduced symptoms, induced remission, and lowered the risk of suicide, re-hospitalization, and relapse. In schizophrenia, response rates were 40-70%. The follow-up strategy for ECT varied, often transitioning to maintenance ECT or pharmacotherapy. Without a bridge to maintenance, abrupt cessation led to high relapse rates. Maintenance therapy was not scheduled but typically initiated weekly with extended intervals. Combining ECT with antidepressants reduced relapse rates by half within 12 months and improved outcomes. Maintenance ECT can safely continue indefinitely, while lithium also demonstrated effectiveness in reducing relapse risk, especially in younger patients. ECT's utility extends to severe catatonic schizophrenia exacerbations, as well as stimulant-induced psychosis. There are case reports indicating improved psychotic symptoms through ECT. While ECT carries risks, the general consensus states there are no absolute health contraindications. Common adverse effects include confusion, memory loss, muscle soreness, headache, jaw soreness, nausea, and fatigue, which typically resolve with treatment. To minimize side effects, low doses of benzodiazepines or anesthetics can be used. However, certain conditions such as cardiovascular instability, recent stroke, or solid brain tumors increase the risk of adverse effects. ECT is highly effective in adolescents for several psychiatric disorders, with few and relatively benign side effects. The mortality rate associated with ECT is low, but cognitive impairment can occur, particularly retrograde amnesia, which may be incomplete or persistent in some cases. ECT has not been found to increase the risk of dementia or cause structural brain damage despite considerable controversy over its effects on brain tissue with many mental health associations concluding there is no evidence it causes such damage as stated by the US Surgeon General. The therapy involves delivering electrical stimuli to the brain, which can lead to side effects such as memory loss and increased risk of cardiac events. According to a 2019 review, major adverse cardiac events occur at a rate of approximately 1 in 39 patients or 1 in 200-500 procedures. The risk of death is considered low, with cardiovascular complications being the primary cause in about 30% of cases. Electroconvulsive therapy devices are used worldwide, and the placement of electrodes, as well as the dose and duration of stimulation, varies on a per-patient basis. Unilateral ECT involves placing both electrodes on one side of the head, which may reduce cognitive effects but is less effective at lower doses. Bilateral ECT places electrodes on opposite sides of the head, with bitemporal placement being the most common method. The electrical stimulus levels used in ECT are above an individual's seizure threshold, typically around 1.5 times for bilateral and up to 12 times for unilateral treatment. The seizure threshold is determined through trial and error, with some psychiatrists using dose titration and others estimating thresholds based on age, sex, and other factors. Patients may receive short-acting anesthetics like methohexital or propofol before treatment, as well as muscle relaxants like succinamethonium. In some countries, ECT is used without anesthesia, but this practice has been abolished in several nations due to concerns over safety. During electroconvulsive therapy (ECT), patients' EEG, ECG, and blood oxygen levels are closely monitored.[2]:1182 Typically, ECT is administered three times a week on alternate days for two to four weeks.[2]:1182-1183 Neuroimaging before treatment may be useful for detecting intracranial pressure or mass; however, this is not always necessary due to the low prevalence of these conditions in patients needing ECT.[95] The decision to discontinue psychiatric medications prior to treatment or maintain them varies.[2]:1185 Certain drugs that can cause toxicity when combined with ECT, such as lithium, are discontinued, and benzodiazepines that increase the seizure threshold are either discontinued or adjusted accordingly.[2]:1185, 1187A 2009 RCT suggests that concurrent use of some antidepressants may improve ECT efficacy.[38] Treatment usually consists of 6-12 sessions over 2-4 weeks, but this can vary depending on individual circumstances.[38] It is also recommended not to exceed three treatments per week.[38] For depression, treatment may be stopped if there is no improvement within the first six sessions.[98] In the US, the medical team performing ECT typically includes a psychiatrist, anesthetist, ECT nurse or assistant, and recovery nurses.[5]:109 Medical trainees may assist under the direct supervision of credentialed attending physicians and staff.[5]:110 Modern ECT devices deliver brief-pulse currents, which are thought to cause fewer cognitive effects than sine-wave currents used in the past.[2] A minority of US psychiatrists still use sine-wave stimuli,[83] but this is no longer the case in the UK or Ireland as of March 2025.[86] The electrical stimulus used in ECT typically consists of 800 milliamps and up to several hundred watts, with a duration of one to six seconds.[87] The current flows externally to the patient's head, resulting in approximately 800 milliamperes of direct current passing between the electrodes for a duration of 100 milliseconds to 6 seconds.[citation needed] Brain changes following electroconvulsive therapy (ECT) include increased gray matter volume in the frontolimbic areas, such as the hippocampus and amygdala, and enhanced white matter tracts in the frontal and temporal lobes.[35] Additionally, ECT has been linked to increased monoamine neurotransmitters and neurogenesis in the dentate gyrus. Changes in sleep architecture due to induced seizures may also contribute to its mechanism of action.[192] By 2001, approximately one million people worldwide were receiving ECT annually, with varying usage rates across countries, hospitals, and psychiatrists.[2]:26] Women account for around 70% of ECT patients, possibly due to their higher likelihood of being diagnosed with depression. Older and wealthier individuals are also more likely to undergo the treatment, whereas ethnic minorities tend to be underrepresented in ECT statistics.[105][106] In Sweden, the ECT rate remained relatively stable between 1975 and 2013, with around 41 patients per 100,000 inhabitants receiving treatment each year. ECT gained popularity in the US during the 1940s as a means to improve mood in individuals with severe depression, replacing lobotomies which reduced patients to a more submissive state. A survey from the late 1980s estimated that around 100,000 people received ECT annually, though accurate statistics are difficult to obtain due to varying reporting laws across states.[109][110] In some US states, such as Texas, ECT was used in about one third of psychiatric facilities and administered to approximately 1,650 individuals annually during the mid-1990s. Since then, usage has slightly decreased, with around 1,500 people aged 16 to 97 receiving treatment in 2000-01.[105] Private psychiatric hospitals tend to use ECT more frequently than public ones, and minority patients are underrepresented in the statistics. A typical course of ECT consists of 6-12 treatments, given three times a week in the US and twice a week in the UK, with some patients receiving continuation or maintenance therapy at intervals ranging from weekly to monthly.[2] ECT practices vary across institutions, with no national certification standards or required training, except in certain local options. In the UK, use declined from 50,000 in 1980 to 12,000 in 2002, mostly in psychiatric hospitals. Most patients are women and elderly, with mood disorders being most common diagnoses. Guidelines recommend ECT for severe symptoms after treatment failure, especially in life-threatening conditions like depression or catatonia. However, adherence is not universal, and some clinics fail to meet minimum standards. A voluntary accreditation scheme has improved compliance, and the Mental Health Act 2007 provides protections for patients, allowing them to decline ECT unless necessary for their survival. ECT was introduced in China in the early 1950s, with almost all procedures now conducted under anesthesia, totaling around 150,000 treatments annually. ECT remains a controversial topic due to its complex history and varying opinions within the medical community. While it has been used effectively to treat schizophrenia and mood disorders, including bipolar disorder, in Chinese literature, some establishments continue to use it as a form of "conversion therapy", despite being banned in 2009. Alleged internet addiction and unruliness in adolescents have also been treated with ECT, although the practice is no longer widely accepted. Public opinion and surveys suggest that many are skeptical about ECT's efficacy and ethics. The FDA has raised concerns about its safety and long-term effects, citing memory loss as a significant issue. In contrast, the World Health Organization advises that ECT should only be used with informed consent from patients or their guardians. In the US, there is a strong emphasis on patient autonomy, with doctors required to inform patients of treatment options, risks, and benefits. The use of ECT is seen as a potentially life-saving treatment, although it is typically reserved for cases where other treatments have failed. Many patients undergoing electroconvulsive therapy (ECT) feel that they are not adequately informed about the procedure's nature and potential effects. According to a 2005 review, only half of patients reported receiving sufficient information about ECT, with some even feeling pressured into consent without fully understanding the treatment. A study published in the British Journal of Psychiatry found that around 45-55% of patients felt they were given an adequate explanation of ECT, while others did not feel they had freely chosen the treatment despite signing a consent form. Involuntary ECT procedures vary across countries and jurisdictions, with some states requiring judicial orders and formal hearings before forced treatment can be administered. However, in many cases, ECT is used as a last resort when patients are deemed to be a threat to themselves or others, often without their full understanding or consent. In England and Wales, the Mental Health Act 1983 was amended in 2007 to require that detained patients who had more favorable opinions of ECT than the general public, indicating potential variations in understanding and views on this treatment method. Electroconvulsive therapy has been used throughout history to treat various mental illnesses. Despite its benefits, critics argue that ECT was often employed without proper justification and with severe consequences for the patients. The case of Ernest Hemingway is a notable example where he underwent ECT treatment for depression but ultimately lost the battle against his illness. Several individuals have shared their personal experiences with ECT, including Robert Pirsig, who was diagnosed with paranoid schizophrenia and underwent numerous sessions of electroconvulsive therapy. Thomas Eagleton, a former US Senator, received similar treatment for depression, which led to his removal from the Democratic ticket in the 1972 Presidential Election. Other notable figures such as Sherwin B. Nuland, an American surgeon and author, and David Foster Wallace, the renowned author, also underwent ECT treatments. In contrast, New Zealand author Janet Frame experienced both insulin coma therapy and ECT without anesthesia or muscle relaxants, writing about her ordeal in her autobiography. In recent years, there have been efforts to address the misuse of electroshock conversion treatment, including a landmark case in 2024 where a Chinese transgender woman was awarded compensation for being subjected to this treatment against her will. The use of ECT has also been depicted in various forms of fiction, highlighting both its potential benefits and risks. Electroconvulsive therapy remains a topic of debate among medical professionals and historians, with some arguing that it can be an effective treatment when used properly, while others claim that its application is often misguided and leads to severe consequences for patients. Despite these criticisms, ECT continues to be employed in various parts of the world to treat mental illnesses. The portrayal of ECT in literature and film has sparked conversations about its efficacy and ethics. The experiences of individuals who have undergone this treatment serve as a reminder of the complexities surrounding mental health treatments and the need for careful consideration when applying them. Studies on ECT have shown mixed results, with some indicating improved patient outcomes and others highlighting potential risks. Between 2003 and 2005, around 2,000 people in England and Wales were treated with ECT without their consent under the Mental Health Act. Regulators have expressed worries that psychiatrists are too readily assuming patients have capacity to consent, and that there is a lack of independent advocacy. In Scotland, the Mental Health (Care and Treatment) (Scotland) Act 2003 gives patients with capacity the right to refuse ECT. The use of ECT devices in the US predates medical device regulation by the Food and Drug Administration, leading to ongoing debates about safety and efficacy. The FDA's retrospective review of medical devices led to ECT being initially classified as a Class III device in 1976. In 2014, the American Psychiatric Association petitioned for reclassification to Class II due to its medium-risk status when used to treat specific conditions like catatonia or major depressive disorder. This proposal was successful in 2018, when the FDA reclassified ECT devices as Class II for these uses. However, some countries have stricter regulations; for example, Western Australia heavily restricted ECT after a bill passed in 2014, and children under 14 are prohibited from receiving ECT there, with a \$15,000 fine for performing it on them. Mental health facilities often use ECT as a treatment of last resort for conditions like chronic depression, mania, catatonia, or schizophrenia. Patients must undergo testing such as an EKG and lab tests, as well as a physical and neurological exam, before being considered for ECT. Certain medications or conditions may disqualify them from the procedure. Informed consent is also required. In the United States, ECT is performed under general anesthesia by trained health professionals with experience in ECT administration, along with a specifically trained anesthesiologist. A survey of 379 Australians found that more than 60% had some knowledge about ECT and were generally opposed to its use on depressed individuals with psychosocial issues, children, or involuntary patients. Public perceptions of ECT were more negative, with some believing it was used for punishment purposes. However, a sample of medical students and psychiatry trainees in the UK found that they had more favorable opinions of ECT than the general public, indicating potential variations in understanding and views on this treatment method. Electroconvulsive therapy has been used throughout history to treat various mental illnesses. Despite its benefits, critics argue that ECT was often employed without proper justification and with severe consequences for the patients. The case of Ernest Hemingway is a notable example where he underwent ECT treatment for depression but ultimately lost the battle against his illness. 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