index ranges (90 and 98, respectively). The response by both patients warranted additional i.v. anaesthetic prior to application of the electrical stimulus. Fortunately, neither of the patients reported awareness of the procedural events.

Consequently, we no longer use bispectral index monitoring alone to assess pre-ictal anaesthetic depth in patients receiving ECT.

Moreover, Zand and colleagues recently reported that the BIS was not a reliable monitor of anaesthetic depth during Caesarean section and that BIS values lower than previously recommended are needed to avoid isolated extremity responses. They suggest, for a sensitivity of 100%, that the BIS value should be lower than 27 to ensure that all patients are truly unconscious.

**Declaration of interest**

None declared.

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1. Soehle M, Kayser S, Ellerkamm RK, Schlaepfer TE. Bilateral bispectral index monitoring during and after electroconvulsive therapy compared with magnetic seizure therapy for treatment-resistant depression. Br J Anaesth 2014; 112: 695 – 702


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**Reliability of bispectral index analysis in patients undergoing Caesarean section**

Editor—We read with interest the article by Zand and colleagues entitled ‘Survey on the adequacy of depth of anaesthesia with bispectral index and isolated forearm technique in elective Caesarean section under general anaesthesia with sevoflurane’. They conclude that bispectral index analysis (BIS) is not a reliable method for monitoring depth of anaesthesia in Caesarean section and that lower than previously recommended values are needed to avoid isolated forearm technique test responses during laryngoscopy, intubation, and skin incision. We do not feel that this conclusion is representative of our practice in the UK, where usual doses of thiopental are higher, at 5 – 7 mg kg⁻¹.² ³

The other issue raised is the reliability of BIS in the first 2 min of induction due to a lag time in the speed of onset of BIS monitoring,⁴ in addition to the delay in neurone receptor dynamics.⁵ The time delay of descending (induction) and ascending (awakening) recordings of electroencephalogram index calculation can take 14 – 155 s, so we cannot draw any conclusion of real-time awareness at times such as during rapid sequence induction and endotracheal intubation. Finally, in our view, BIS could be very useful in situations such as postpartum haemorrhage, where uterine atony may be decreased by the reduction of the concentration of volatile agent.⁶

**Declaration of interest**

None declared.

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**Avoiding awareness in Caesarean sections under general anaesthesia**

Editor—The recent paper by Zand and colleagues was of interest to us (a group of British anaesthetic trainees) because routine Caesarean sections are rarely performed under general anaesthesia in our practice.¹² As such, we would find this medical device assessment difficult to perform. Nonetheless, these results have the potential to impact our practice. Inclusion of the patient characteristics and indication for the procedure would help us to transfer these findings to our clinical context.