Individualized C-ECT and M-ECT

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ERFA XIV
Gjøvik May 22 2019

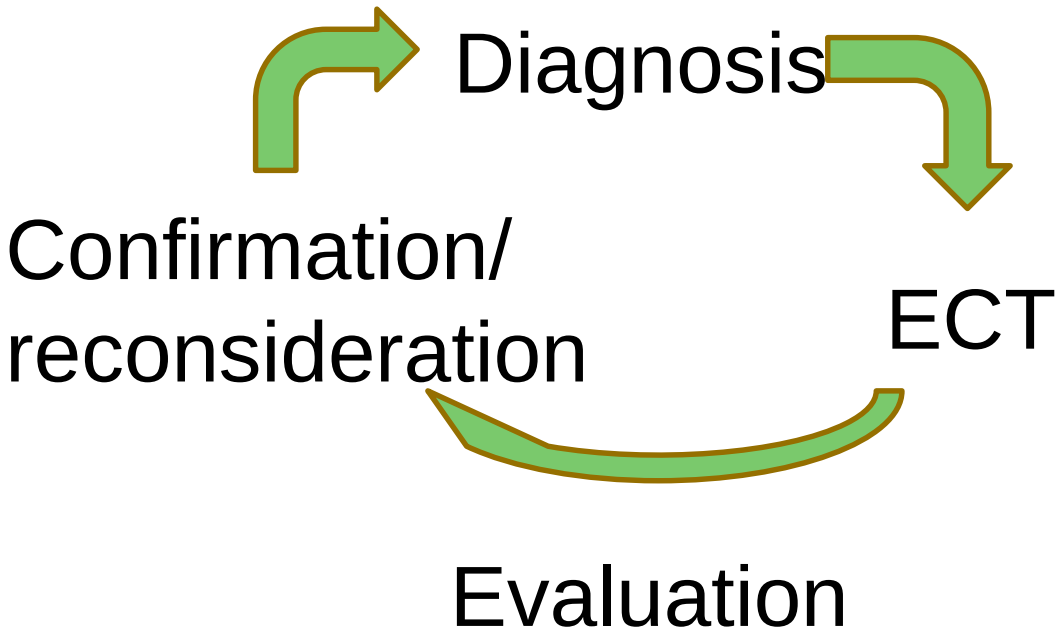
The bottom line:

ECT patients are individuals

Five patients with Major Depression, severe episode, ECT-treated

- M-74 Living in the small nothern village of his wife's family. Divorce at mother's funeral
- M-78 Belonging to strict religios cult; excluded, drinking, divorce
- M-54 Recurrant Bipolar disorder, psychosis
- M-58 Well functioning, married, clear-cut episodes of depression
- K-47 Neurotic traits, overconumption of alcohol, hip operation.

The role of ECT in the diagnostic process



”True” response – remission ?

Relapse or insufficient effect?

”True” ECT response

- Symptoms, observable retardation/agitation
- Periodic illness – free intervals
- Early observable signs
  - Staff/relatives note before patients
- Gradually increased stability
- ***Clearly observable*** improvement after 6-10 treatments
  - Confirmed by staff, relatives and patient
- Maintained improvement for ***at least*** a week
  - Depending on the number of treatments

”False” ECT-response

- ECT sometimes powerful placebo-effect
- Reduced anxiety
- Transient euforia (side-effect!)
- Short-lived relief, often less than a week
- *When going throug the patient’s file, no lastring stable improvement can be found.*

ECT-confirmed diagnosis

- ”Genuine” biological affective disorder
- Continue treatment along this line
  - Maintenance ECT
  - Litium
  - Antidepressants
  - ”Mood stabilizers”

  } Often to be combined – process!
- Psychoeducation
  - Early signs
- ECT again at signs of relapse

Unspecific, short-lived improvement

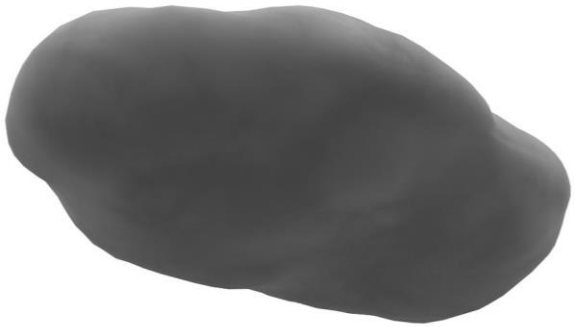
- Reevaluate diagnosis
  - Alienation, isolation, neuropsychiatr
  - Percieved shortcomings, failures, exhaustion
  - Loss of dignity/self-esteem
  - Substance abuse
  - Personality disorders
- ***Psychological focus***
- Avoid further ”medicalization”, future ECT
- *Given that treatment series was adequate*

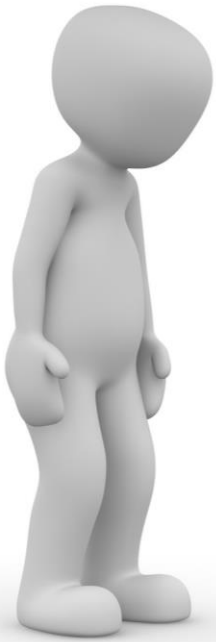

Konsten att fejka
LINA LIMAN
EN BERÄTTELSE OM AUTISM
arabiska

”Shock me sane”

ECT ur ett patientperspektiv

Lina Liman



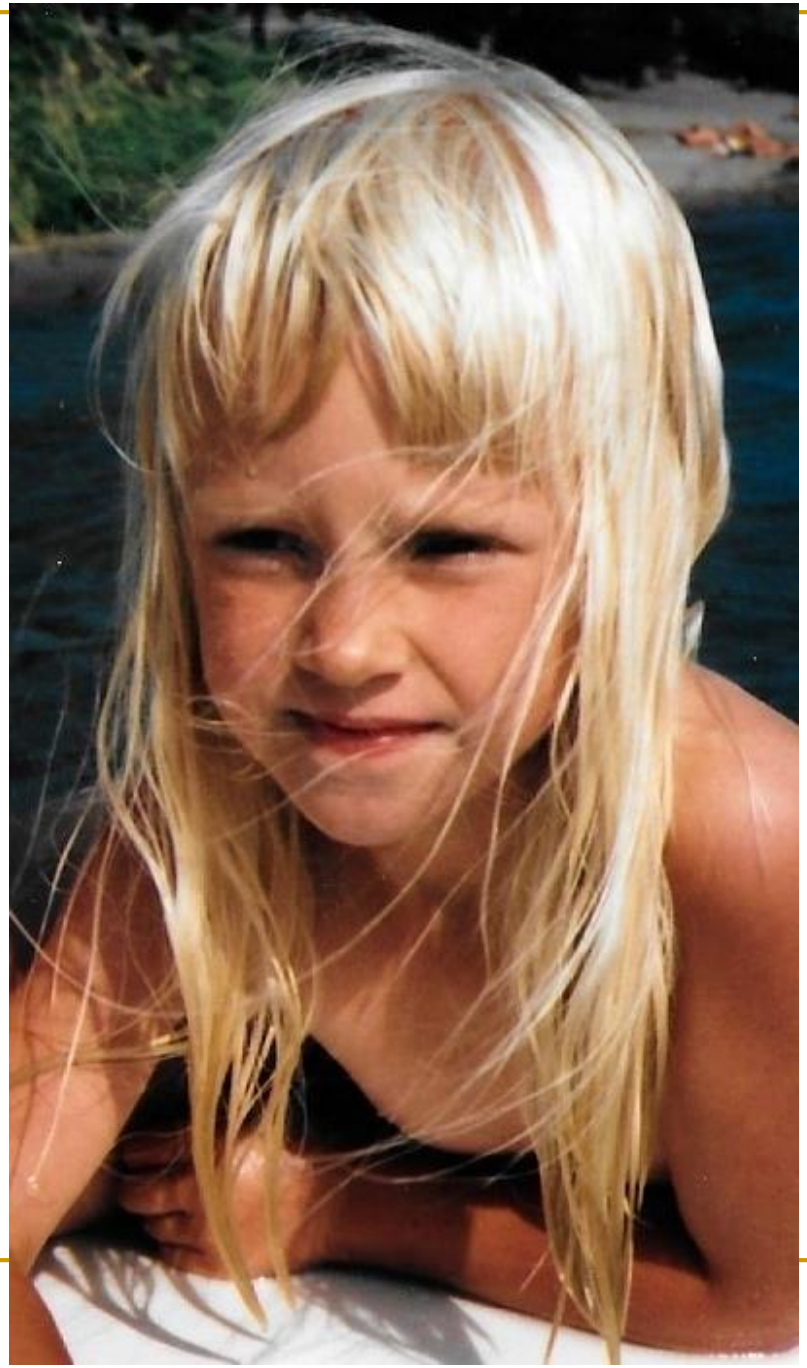


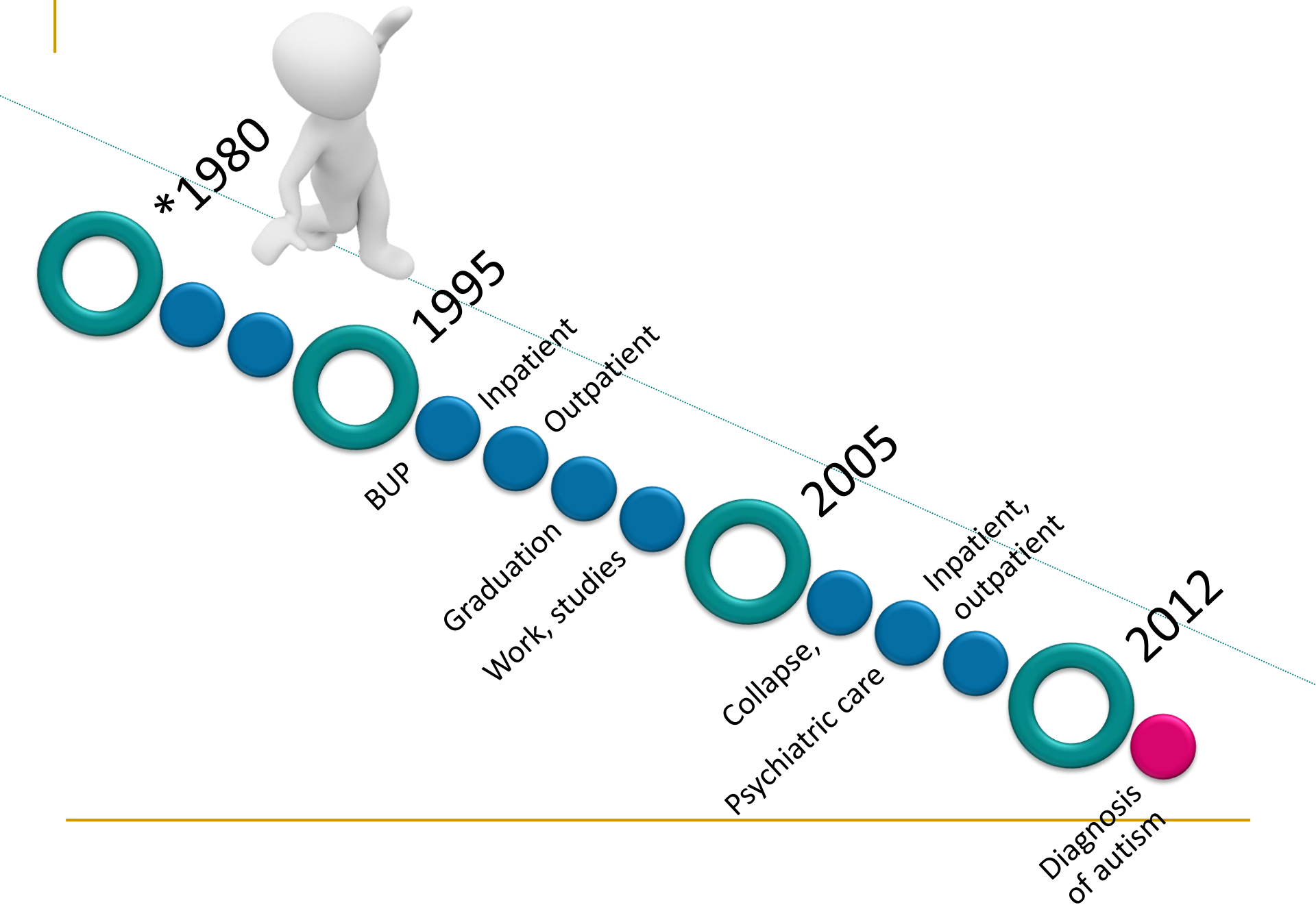
Why don't I belong?

Why can't I fit in?

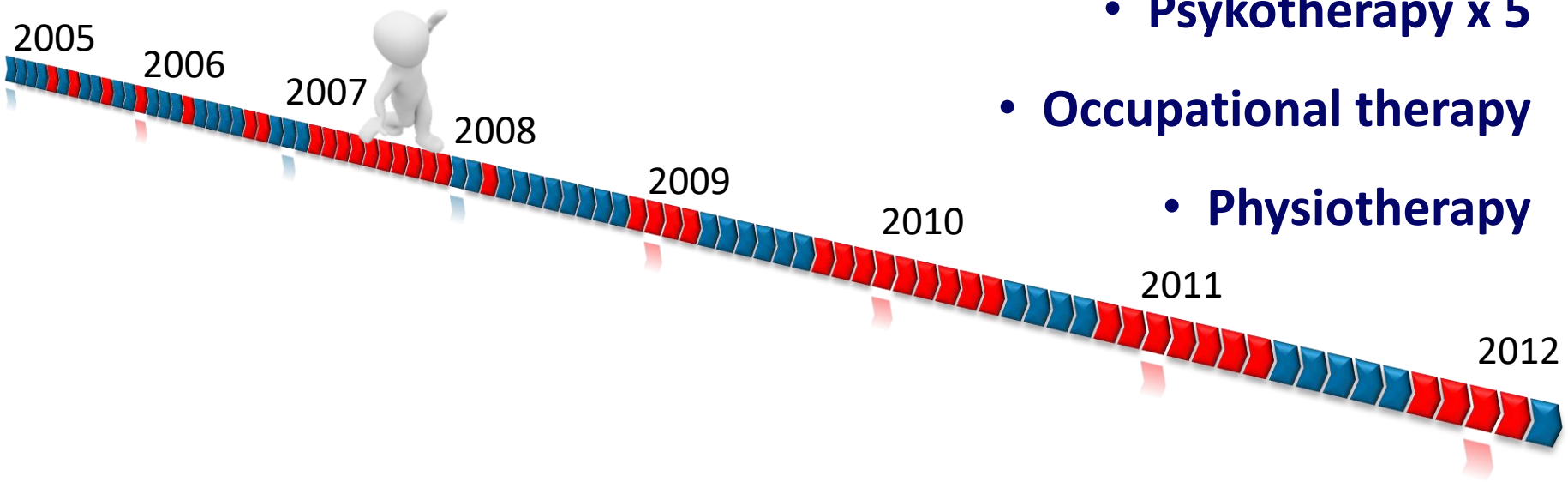
I feel so different from others.

What is wrong with me?



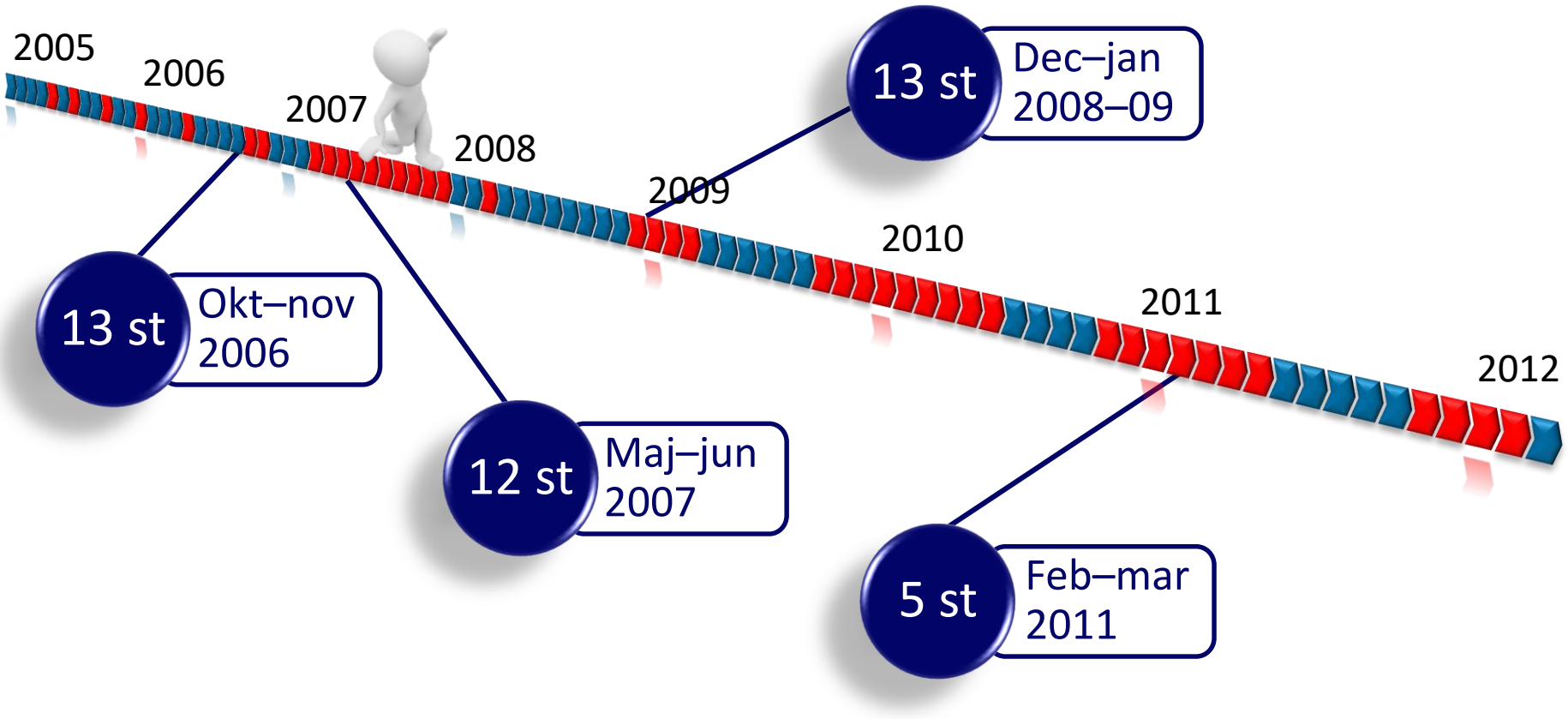

*1980
1995
BUP
Inpatient
Outpatient
Graduation
Work, studies
2005
Collapse,
Psychiatric care
Inpatient,
outpatient
2012
Diagnosis
of autism

- Drugs, many
- ECT, 4 series
- Psykotherapy x 5
- Occupational therapy
- Physiotherapy



Outpatient Inpatient

ECT series


2005
2006
2007
2008
2009
2010
2011
2012
13 st
Okt–nov
2006
12 st
Maj–jun
2007
13 st
Dec–jan
2008–09
5 st
Feb–mar
2011

No lasting improvement

Fel diagnos

Felbehandling

Bristande förståelse

Fel strategier

Utebliven förbättring

Minskad livskvalitet

Adekvat diagnos

Adekvat hjälp

Förståelse

Bättre strategier

Stabilitet

Ökad livs-kvalitet


EACH DAY I LIKE IT BETTER
AMY S. F. LUTZ
each day i like it better
AUTISM, ECT, AND THE TREATMENT OF
OUR MOST IMPAIRED CHILDREN
FOREWORD BY DIRK DHOSSCHE, MD,
AND CHARLES KELLNER, MD

American Psychiatric Association Task Force on ECT 2001*

- *”The clinical literature establishing the efficacy of ECT **in specific disorders** is among the most substantial for any medical treatment”*

*__American Psychiatric Association Task Force on Electroconvulsive Therapy. Electroconvulsive Therapy__: Recommendations for Treatment, Training, and Privileging,. 2nd ed: Washington DC: American Psychiatric Association Press; 2001.

The first challenge:

To treat the right patients

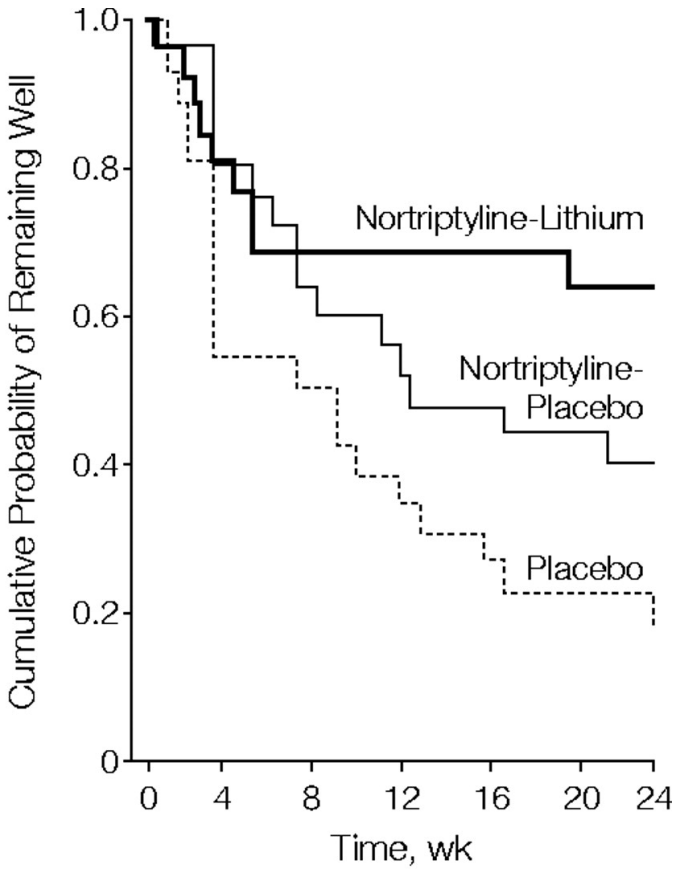
The second challenge:

To ensure and evaluate treatment efficacy

The third challenge:

To prevent relapse

Kaplan-Meier Estimates



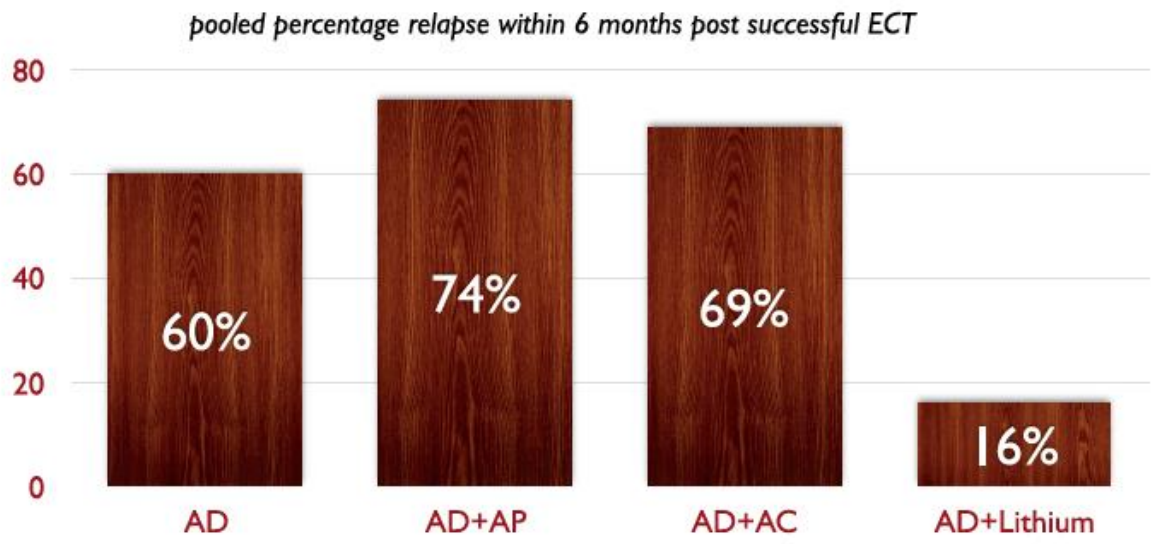
No. at Risk

Placebo	29	14	13	9	6	5	4
Nortriptyline-Placebo	27	20	15	13	12	11	10
Nortriptyline-Lithium	28	18	15	15	15	14	14

Sackeim, H. A. et al. JAMA 2001;285:1299-1307.

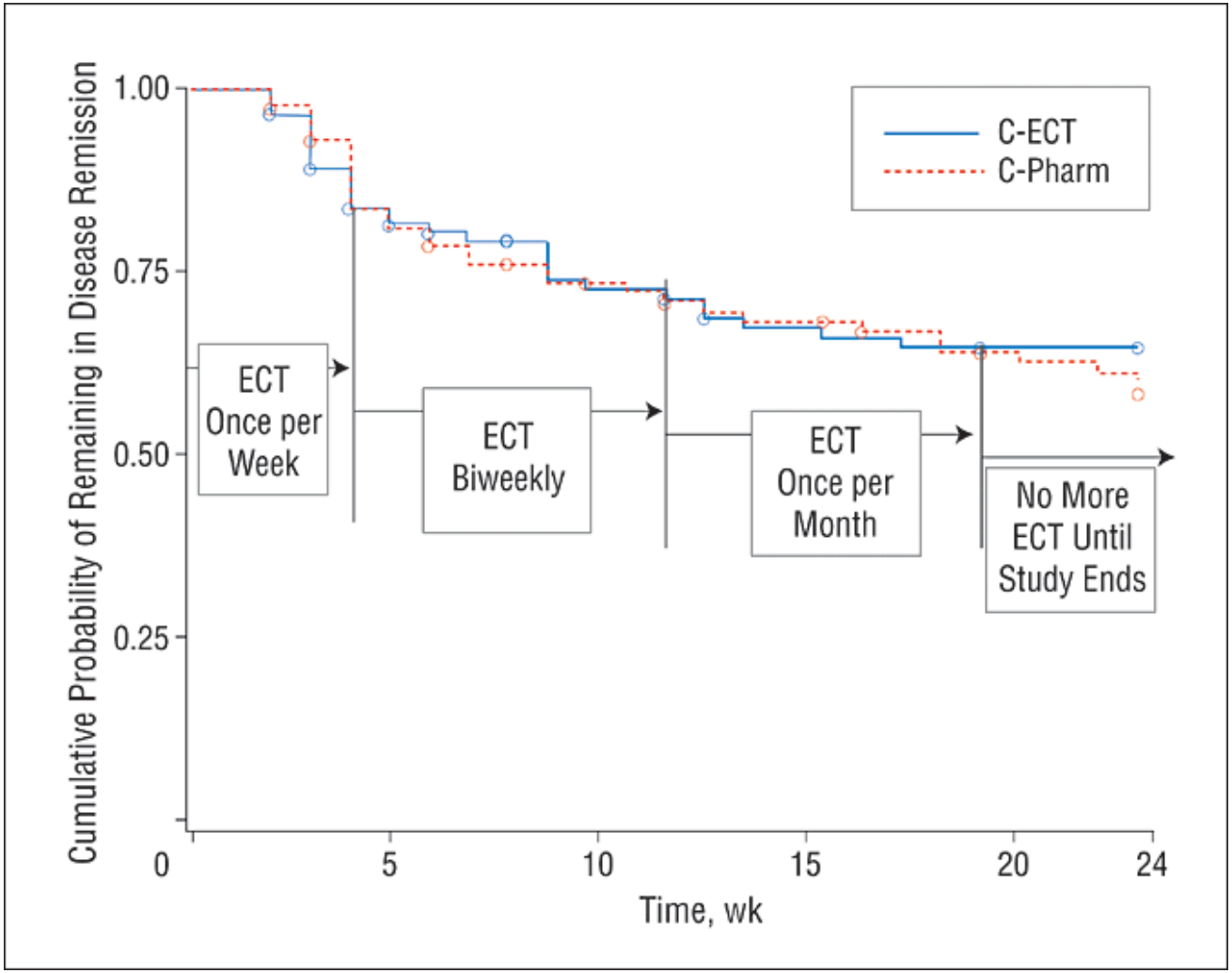
Lithium

in relapse prevention - combi-therapy



Atiku et al (2015). Improving Relapse Prevention After Successful ECT For Patients With Severe Depression: Completed Audit Cycle Involving 102 Full ECT Courses in West Sussex, UK. *J ECT* 31(1):34-6

Kaplan-Meier curves showing proportion of patients who remained in disease remission (not disease relapse) during the continuation phase (phase 2)

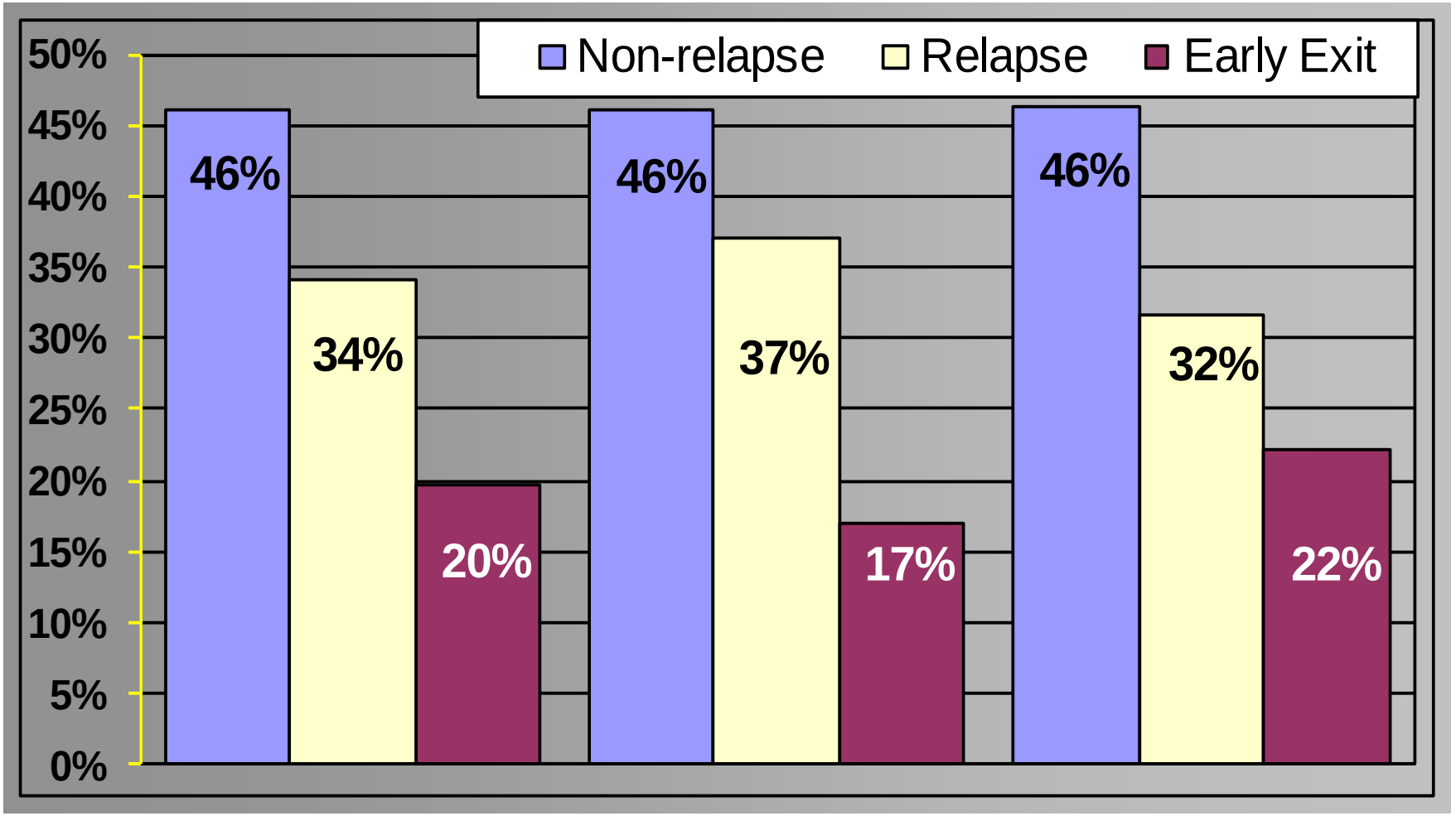


C-Pharm:
Li +
Venlafaxin

Kellner, C. H. et al. Arch Gen Psychiatry 2006;63:1337-1344.

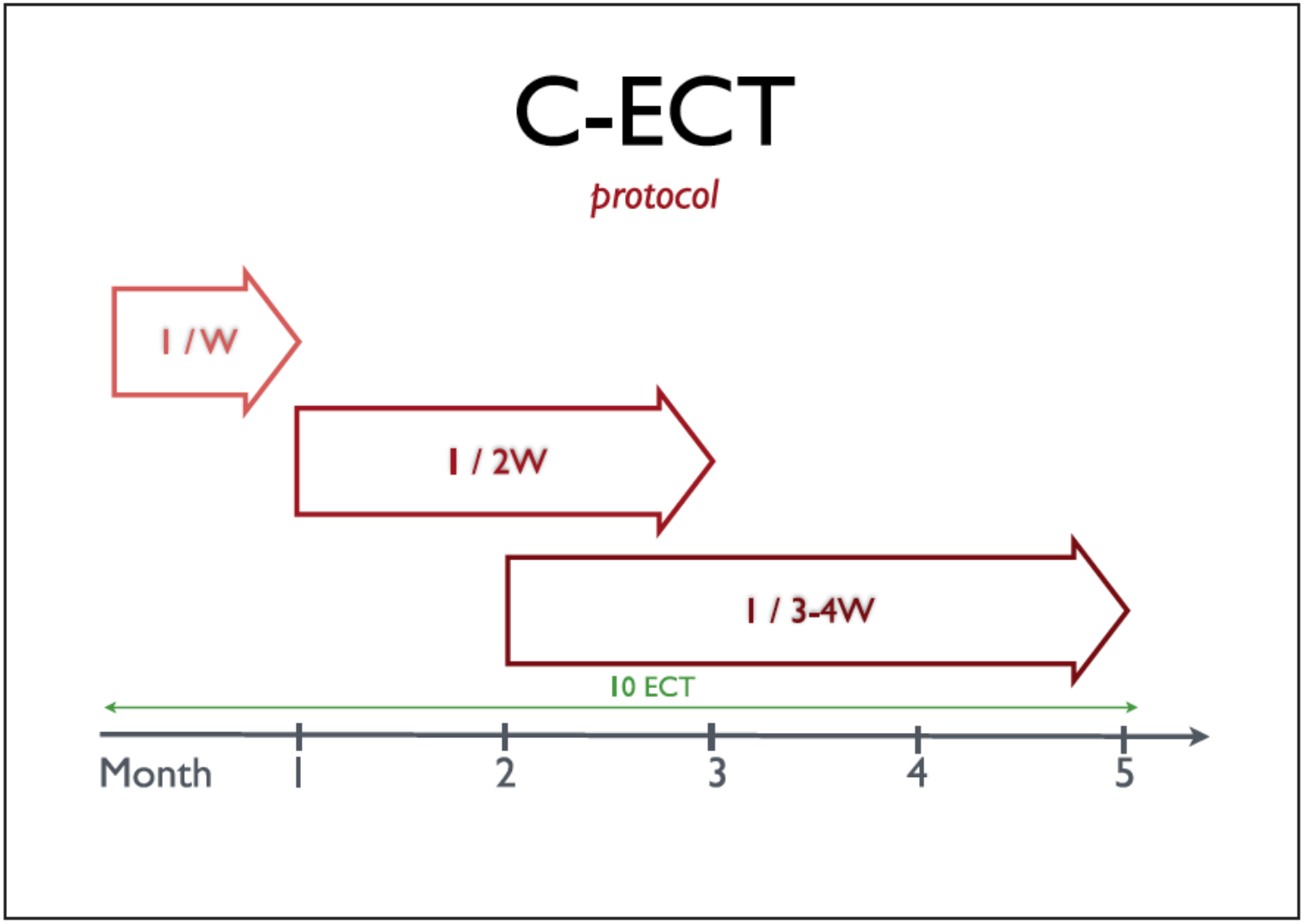
ARCHIVES OF GENERAL PSYCHIATRY

Relapse Status at 6 Months



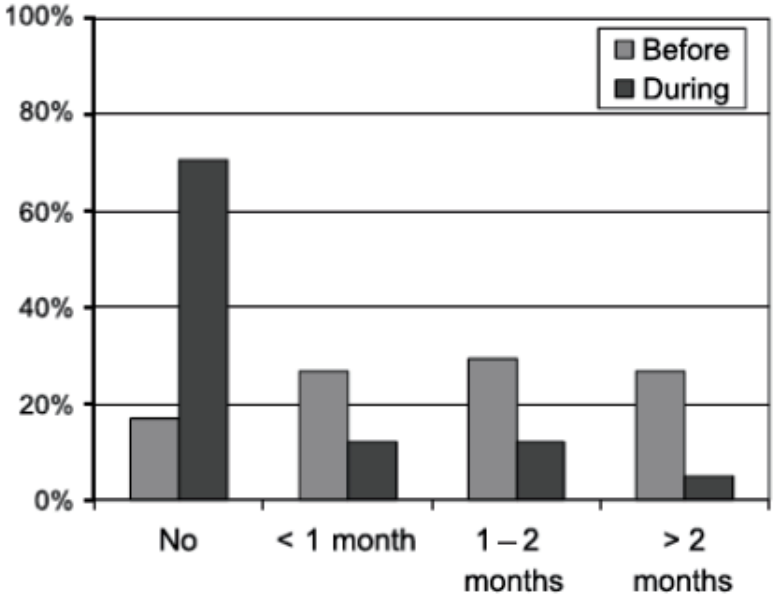
Total (n=184)	C-ECT (n=89)	p = n.s.	C-Pharm (n=95)

Typical C-ECT protocol



'Fixed'
is not good enough

Individualized continuation ECT



Percentage of patients and time spent in hospital, 3 y before and during 3 y of M-ECT + Med (N = 41)

Odeberg et al (2008). Individualized C-ECT and medication as a bridge to relapse prevention after an index course of ECT in severe mood disorders: a naturalistic 3-year cohort study *J ECT* 24, 183-190

Individualized Continuation Electroconvulsive Therapy and Medication as a Bridge to Relapse Prevention After an Index Course of Electroconvulsive Therapy in Severe Mood Disorders: A Naturalistic 3-Year Cohort Study

Håkan Odeberg, MD,† Bruce Rodriguez-Silva, MD,† Pirjo Salander, MD,† and Björn Mårtensson, MD, PhD‡*

Abstract: Electroconvulsive therapy (ECT) is recognized as an effective acute treatment for mood disorders but is associated with high risk of relapse. To minimize this risk, we introduced as a routine individually tapered continuation ECT with concomitant medication (C-ECT + Med) after an index series in January 2000. In August 2002, a chart review of all patients (n = 41) who had received C-ECT + Med for more than 4 months was carried out. Sixteen patients also participated in an extensive interview. Mean duration of administered C-ECT at follow-up was 1 year, but for most patients (63%), C-ECT had been terminated. For 49% of patients, adjustments between ECT sessions had been made due to early signs of relapse. Two weeks was the most common interval between sessions for patients with ongoing C-ECT. The frequency of lithium-treated patients had increased from 12% before index to 41% during C-ECT. However, the rated response to the drug varied.

Need for hospital care 3 years before and after the initiation of C-ECT + Med was compared in a second evaluation of the cohort. The number of patients hospitalized, number of admissions, and total days in hospital were all significantly reduced. Hospital days were reduced by 76% ($P < 0.001$). Three patients with previously cumulative years

stopped immediately after remission is achieved. This distinguishes practice of ECT from pharmacological treatment, which is normally continued for stabilization or used eventually for long-term relapse prevention once the patient has responded. To avoid relapse after ECT, psychotropic medication can be introduced during or immediately after the acute treatment series. In early studies with tricyclics alone, this strategy seemed to be rather successful, preventing relapse in approximately 80% of cases.[1,2] However, in modern studies, relapse rates of approximately 50% within 6 to 12 months—despite intensive pharmacological treatment—have repeatedly been reported, with pre-ECT medication resistance indicating even more unfavorable outcome.[3–7] In a study by Sackeim et al,[4] relapse within 1 year after index ECT was 84% on placebo, 60% on nortriptyline alone, and 39% on a combination of nortriptyline and lithium, thus establishing the latter combination as the to-date best proven pharmacological strategy for relapse prevention after acute ECT for major depression.

Continuation ECT (C-ECT) and maintenance ECT are other strategies for relapse prevention after the index series

Individualized M-ECT, C-ECT and medication

Episode of illness

Diagnostic evaluation

Long-term relapse prevention

Acute treatment (ECT)

Continuation treatment

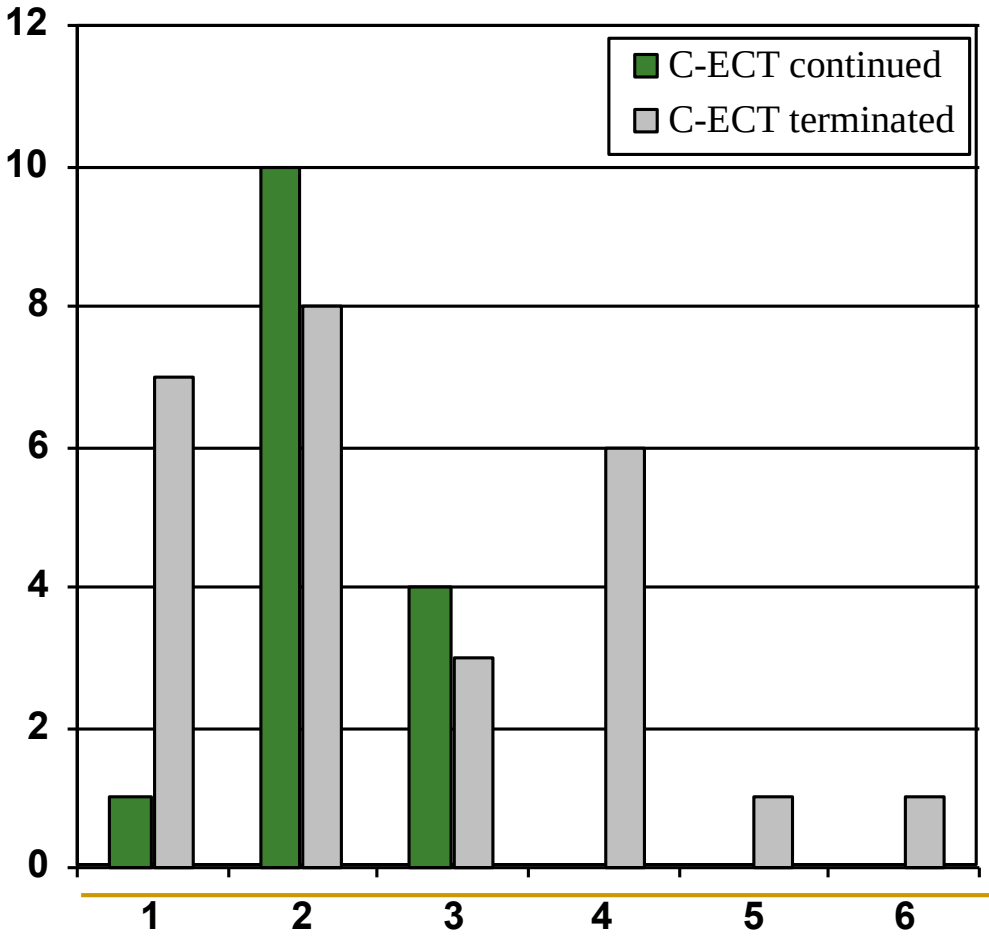
Procedure for individualized M-ECT

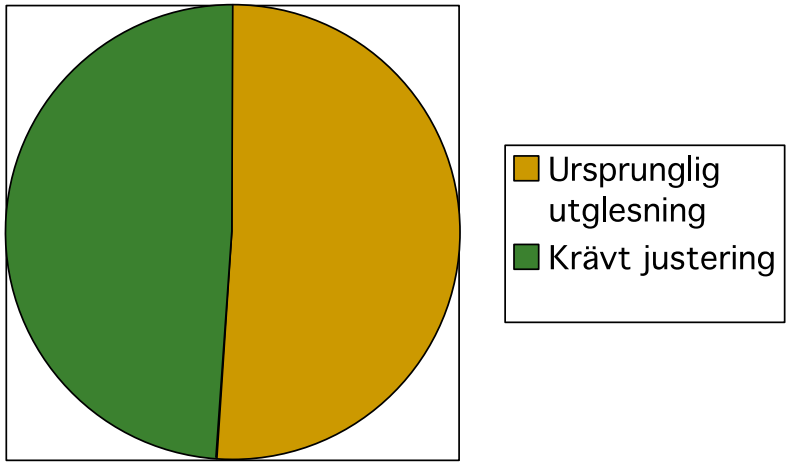
- Careful evaluation of response –
  - **Nursing role** important, pattern of response
- Aim for maximal remission
  - Relatives!
- Gradual tapering of treatments
  - Observation and documentation of response and relapse signs – **Nursing role**!
- Individually:
  - 2/w – 1/w – 1 every two, three or four weeks
  - From 1 - 6 months, rapid restart if stopped (PRIDE!)
- Continuation if needed. Availability: Nursing role!

Note:

- M-ECT only for clear ECT responders!

Treatment frequency in C/M-ECT





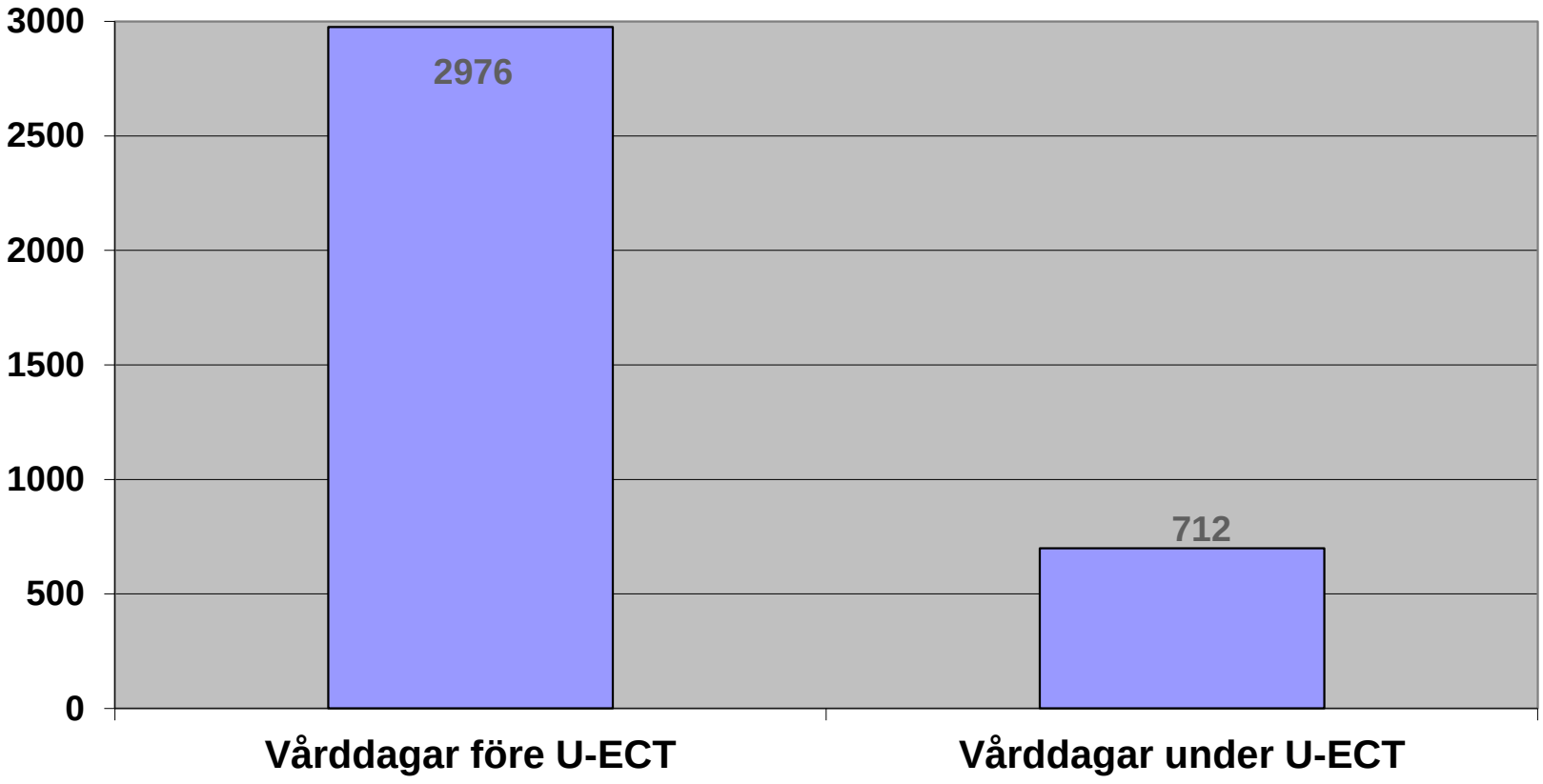
Odeberg et al, 2008

Experience during follow-up period(n=15)

	Number of patients				
	Negative		Neutral	Positive	
	-2	-1	0	+1	+2
Overall satisfaction with treatment		2	3	3	7
Comparison to previous treatments		1	3	2	7
Satisfaction with care	1		1	1	**12**
Development of memory	5	3	5	1	1
Development of close relationships			8	3	4
Life situation as a whole		1	5	6	3

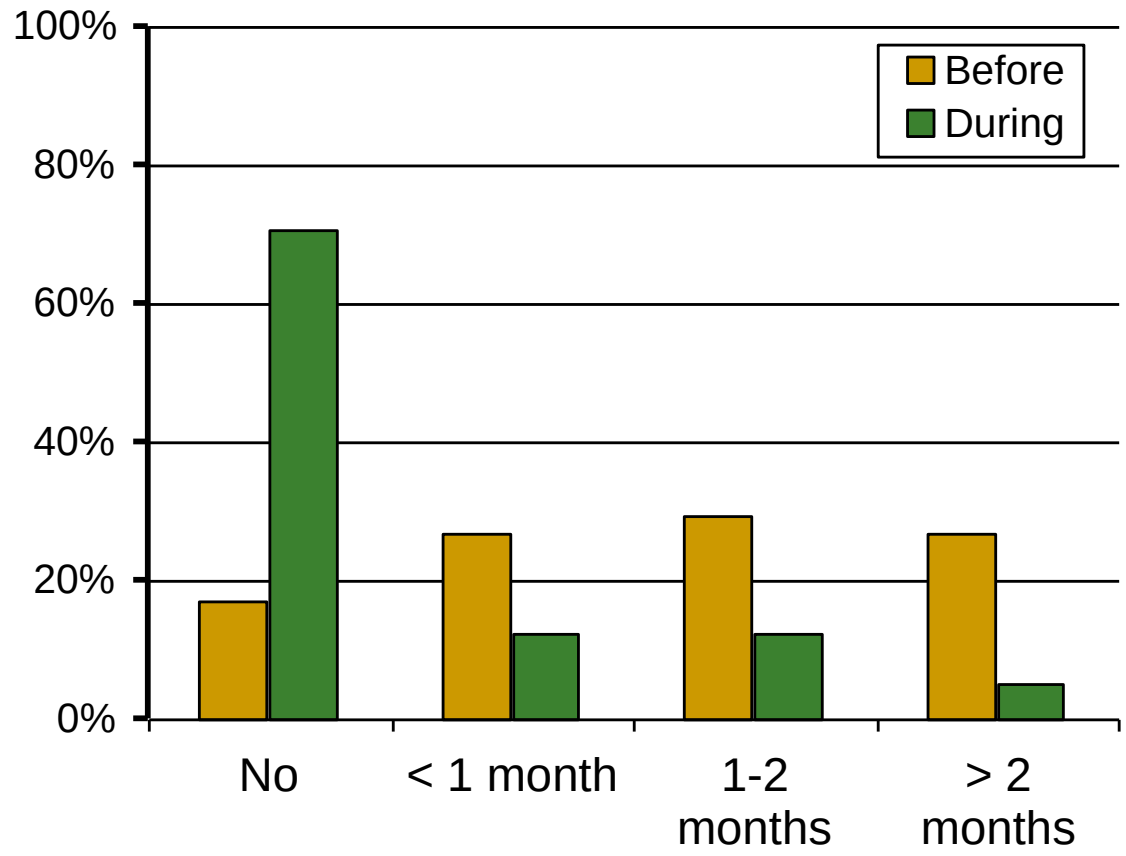
Odeberg et al 2008

Hospital days during 3 years before and after introduction of Continuation-ECT+Med. (N=41)



Håkan Odeberg och medarbetare 2005

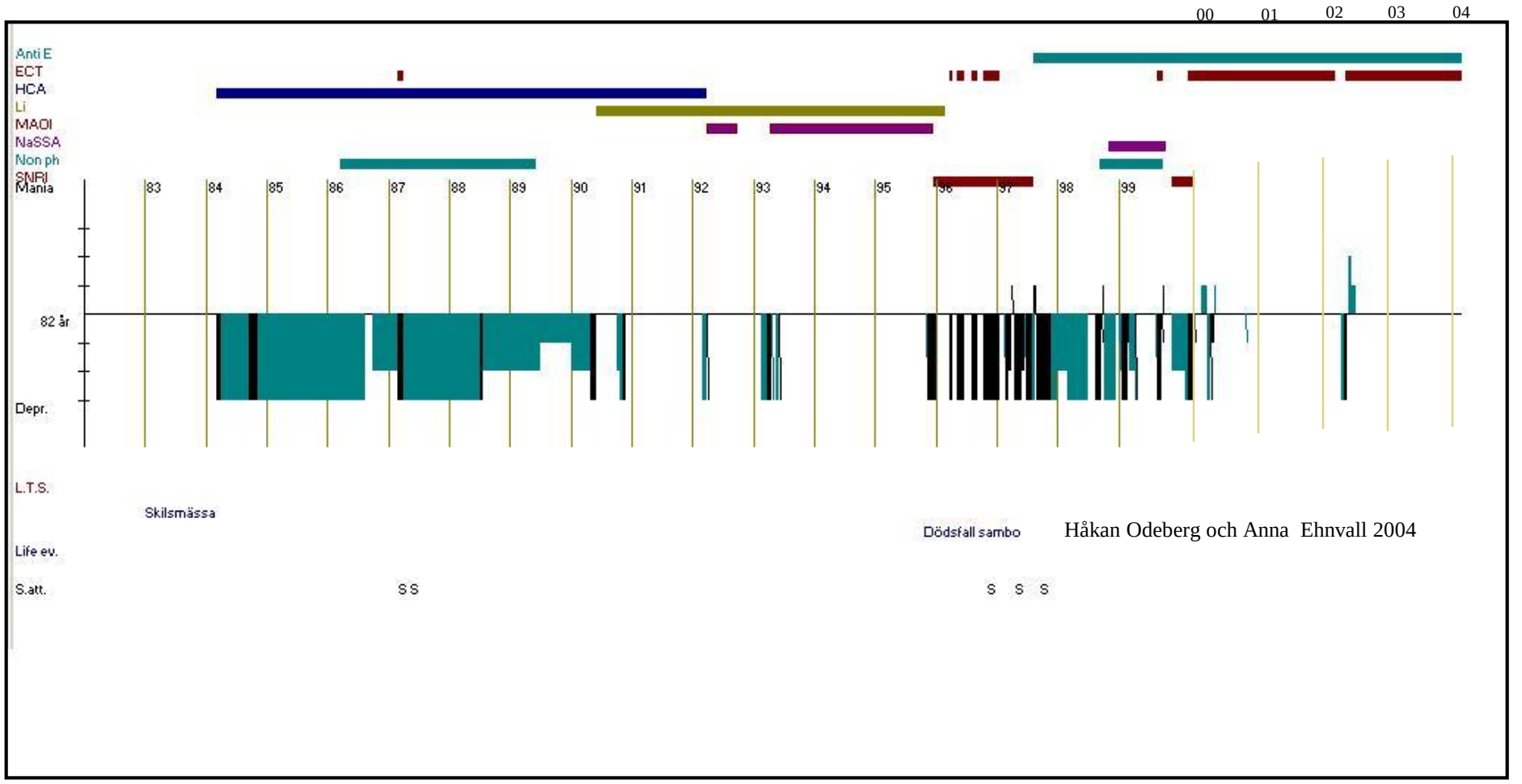
Percentage of patients with no hospital days, short term, intermediate or long-term hospitalization, three years before and during three years of integrated C-ECT and medication.



N=41

Odeberg et al, 2008

Patient 1 Woman 80 yrs



Håkan Odeberg och Anna Ehnvall 2004

Other examples

Patient	Period before	Hospital days	Period after	Hospital days
Född-47	130402-140610	182	140611-180320	0
Född-57	110103-120827	585	2013-2017	25 per år
Född-63	120507-141231	532	141229-180320	0
Född-89	140801-151020	137	151021-180327	0

Continuation; stabilizing treatment

Aim is to taper ECT, replace with medication

- Separate: Continuation - Maintenance
  - Continuation – while trying out medication
  - Maintenance – long-term profylaxis
- Continuation only to true responders
- Maintenance to carefully selected patients
  - Obvious effekt
  - Previous experience of relapse in spite of medication

Aim to space treatments as much as possible

  - 2-4 weeks interval
  - Selected patients 1-2 treatments per week
  - More often if worsened (treatment refusal!!!)

Follow up and evaluation – The art of teamwork

- Observations at each treatment session
  - Nursing role essential
    - Patient's report, activity, observations
  - Observant to any sign of worsening
    - ”Problematization” – not least about treatment!
- Contact with family
  - Comfort, alliance
- Cooperation with prescribing doctor
  - Give enough – not to widely spaced treatments.
- Long-term considerations

Too widely spaced Maintence ECT

- Gradual worsening, often delay
  - Go back in time
- Negative perception of treatment
  - ”Doesn’t help”
  - More subjective side-effects
- Problems of interpretation
  - ”ECT doesn’t work”
- Risk that the only efficient treatment available is terminated.

Always consider litium in periodic illness

Continuation ECT during the period when the dose is adjusted and efficacy established (3-6 months).

Follow up/evaluation – The bottom line

- Out-patient tapering of ECT.
  - Visits to ECT doctor
  - ECT-”rounds”
  - Cooperation ECT nurse, ECT doctor, ”regular” doctor
- Evaluation of index ECT
  - Cooperation!
  - MODE, observations (”mobile phone pictures”)
  - Continous evaluation – 3 – 6 – 10 treatments
  - Continuity, stimulus technique, seizure quality
  - If insufficient effect – rekommendation other treatments.
  - ECT NOT ”LAST RESORT“ – IMPORTANT MESSAGE
- Taper gradually ***when ECT was effective.***
  - C-ECT + medication.