The ECT Consultation: Determining Appropriateness for ECT

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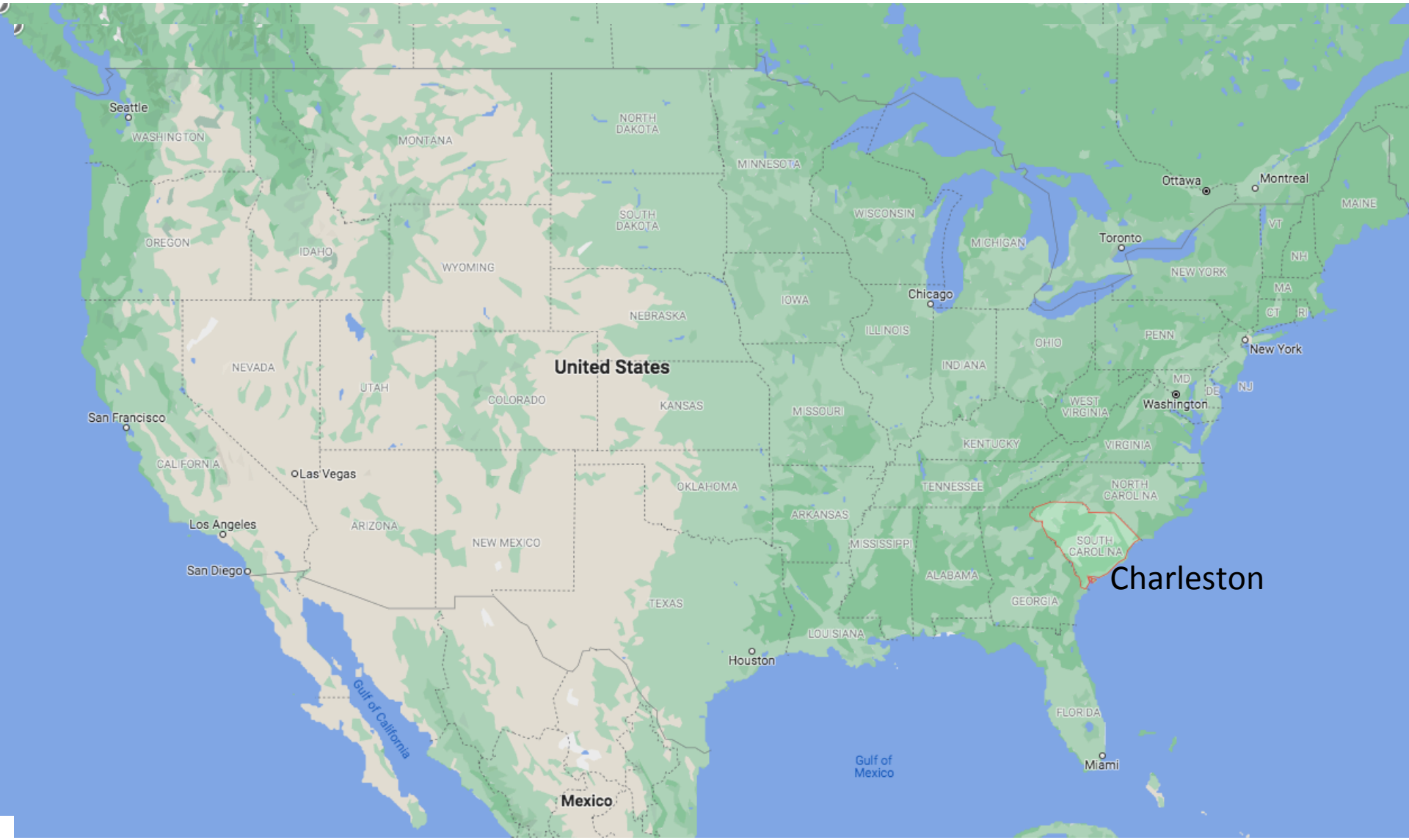
Disclosures

- NIMH (past grant support)
- UpTo Date (honoraria for writing ECT sections)
- Cambridge University Press Royalties
- Northwell Health System (honoraria for teaching ECT course)
- Psychiatric Times (honoraria for writing ECT column)
- Expert witness for ECT legal cases
- Some of the following will be opinion, not fact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Presentation Overview

- Denmark stats
- Patient selection
- The ECT Consultation
- The ECT Consultation note

Denmark vs. the USA

- Population of Denmark: 5.8 million
- Population of USA: 327 million
- (Population of California: 39.5 million)

- Psychiatrists in Denmark: 1,092 (2018)
- Psychiatrists in USA: 49,000
- (Psychiatrists in California: 5,806)

Electroconvulsive Therapy Practice in the Kingdom of Denmark

A Nationwide Register- and Questionnaire-Based Study

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Objectives: The aim of this study was to survey and describe the contemporary practice of electroconvulsive therapy (ECT) in the Kingdom of Denmark (Denmark, Greenland, and the Faroe Islands).

Methods: Data regarding number of ECTs and number of patients with different diagnoses treated with ECT were retrieved from the Danish National Patient Registry. In addition, a 45-item questionnaire was sent to all psychiatric departments practicing ECT in Denmark (n = 26), Greenland (n = 1), and the Faroe Islands (n = 1).

Results: According to the Danish National Patient Registry, a total of 21,730 ECTs were administered to 1891 unique patients in 2017. All departments responded to the survey. The psychiatric departments' attitude toward ECT was generally favorable and in accord with official guidelines. Maintenance ECT was used in all departments but one. Bilateral electrode placement was preferred. All departments used a preselected age-based dosing strategy. Involuntary ECT was performed in 96% of the psychiatric departments, but infrequently (3% of all treatments). All departments used a Thymatron (brief pulse) device, and in 71% of the departments, ECT was given in a specialized ECT unit and preanesthetic evaluation was carried out in all departments. The departments reported several different practices regarding documentation and monitoring of treatment effect, patient consent, screening for side effects (including cognitive side effects), and guidelines for the discharge of ECT patients.

Conclusions: Electroconvulsive therapy is frequently used in Denmark, Greenland, and the Faroe Islands in a relatively uniform way in adherence with clinical guidelines.

Key Words: electroconvulsive therapy (ECT), practice, survey, Denmark

(*J ECT* 2019;35: 258–263)

The Kingdom of Denmark includes Denmark, Greenland, and the Faroe Islands. Greenland and the Faeroe Islands have home rule, but are part of the Kingdom of Denmark, with the same tax-based universal health care system. Denmark has a homogeneous population of approximately 5.75 million in 2017 according to Statistics Denmark. The country is divided into 5 regions, which are responsible for the regional health care system including psychiatry. Individual regions organize their own psychiatric health services, including the practice of ECT, but the Danish Psychiatric Society has published a national clinical guideline for the administration of ECT.[5] No private hospitals or clinics in the Kingdom of Denmark administer ECT.

The aim of the present study was to survey the contemporary practice of ECT and describe the variations that exist in the homogenous public health care system in Denmark, Greenland, and the Faroe Islands.

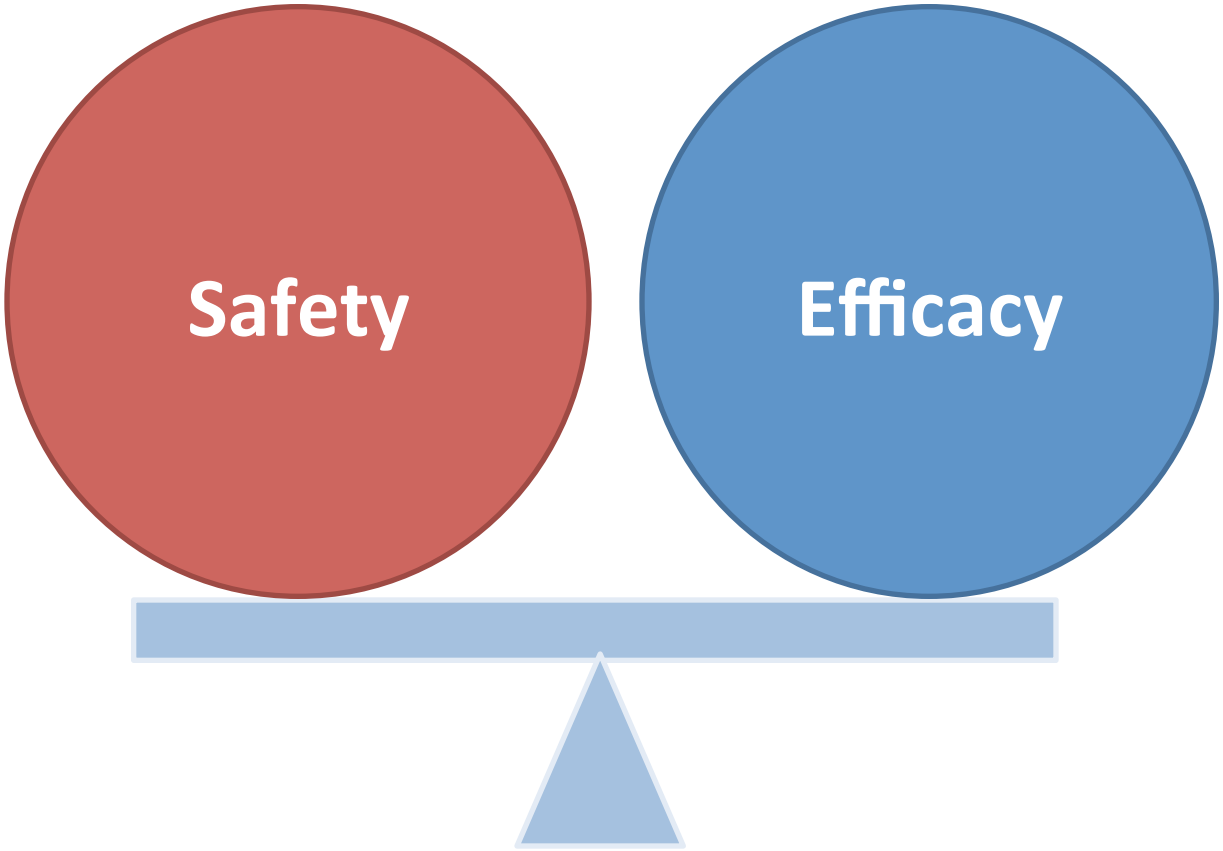
MATERIALS AND METHODS

The present study consists of 2 parts: a national register-based study and a survey of the clinical practice of ECT in the Kingdom of Denmark.

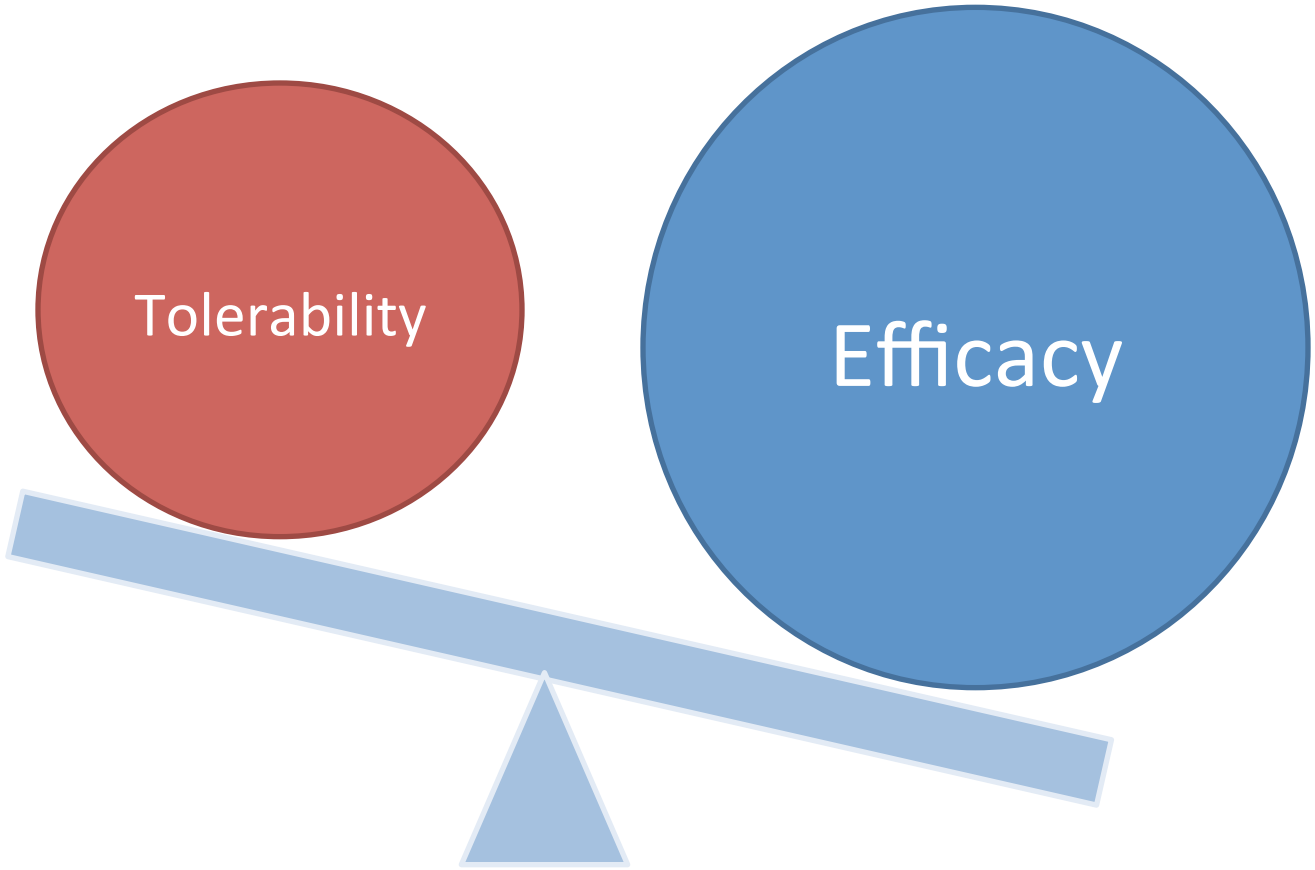
National Register–Based Study

In Denmark, it is mandatory for the psychiatric departments to register any use of ECT in the Danish National Patient Registry (DNPR).[6] We retrieved quantitative data from the DNPR regarding number of ECTs, number of patients treated with ECT, and their diagnoses at the time of ECT.

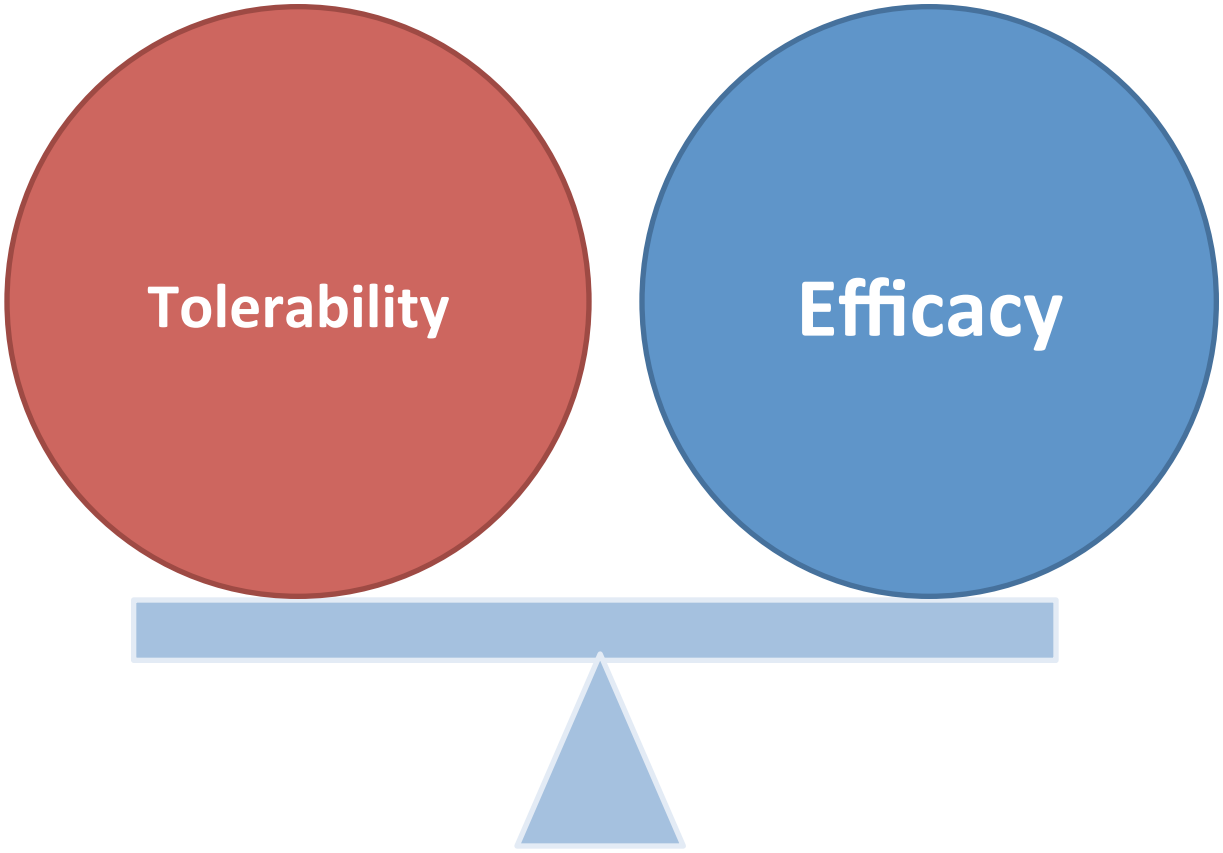
ECT



ECT



ECT (Optimized)



“All good ECT practitioners are alike; all deficient ECT practitioners are deficient in their own way…”

Do: be the best ECT practitioner you can be

Don't: be "that other guy"

“For the correctly chosen patient, ECT is like penicillin for strep.”

Experienced ECT clinician

“For the poorly chosen patient, ECT is like surgery for chronic low back pain.”

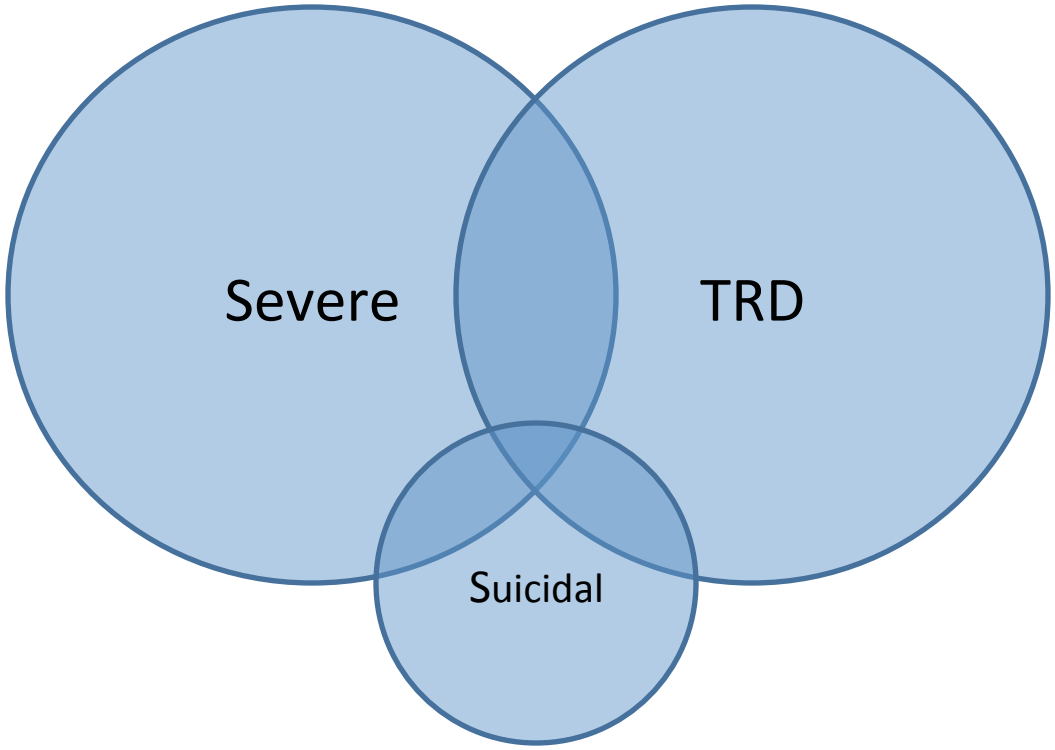
Experienced ECT clinician

Patient Selection

- Do: select patients with high integrity of Axis I mood and psychotic disorders

- Don't: be pressured into treating patients with pure personality disorders because the referring psychiatrist doesn't know what else to do

Severe Depression is **Not** Identical to TRD




The patient failed everything else, maybe it's time for ECT

When to Consider ECT

- Most practitioners bend over backwards to avoid ECT
- ECT should be prescribed sooner, rather than later, in a severe depressive episode
- The longer one waits, the longer the patient (and family) suffer
- The longer one waits, the harder the episode is to treat

Most Common Significant Other Reaction to ECT

“It was a miracle”

“Diagnosis of melancholic depression is made from observation and by eliciting information from the patient,” he said. “I don’t need a DST to confirm it, why bother? Would you not treat if the test came back negative?”

Jay Amsterdam, MD

(from an interview with Amy Lutz,HSSC 688,Final Paper

The Rise and Fall of the Dexamethasone Suppression Test: Stability, Consensus, Closure)

Patient Selection- the Optimal ECT Patient

- Severity of depression (urgency)
- Episodicity
- Heritability

(subtle difference between “appropriateness for ECT” and research “predictors”)

The ECT Consultation

- Taking the psychiatric and medical history
- Educating patient/family about ECT
- Synthesizing information-recommendation to patient/family
- Writing the ECT consultation note

The ECT Consultation

- Does the patient have an ECT-responsive illness?
- Does the patient have any medical problems that might increase risk or require modification of technique?
- Is there appropriate informed consent?

Does the patient have an ECT-responsive illness?: HPI

- Standard psychiatric interview (with special emphases)
- Can open with "When did this episode of depression begin?"
- Elicit all depressive symptoms, including:
  - Suicidal ideation/intent/acts
  - Weight loss
  - Psychotic thinking
  - Level of dysfunction/distress

Does the patient have an ECT-responsive illness?: HPI Continued

- Treatment trials in the current episode (efficacy and tolerability)
  - Medications (don't need obsessional details of every single trial)
  - other: rTMS, ketamine, psychotherapy

Does the patient have an ECT-responsive illness?

Past psychiatric History

- Prior episodes (#, type, symptoms, duration)
- Treatment trials*
- Hospitalizations
- Suicide attempts

*if prior ECT, try to get details, including electrode placement, # of treatments, response, tolerability, duration of benefit, any MECT?

Does the patient have an ECT-responsive illness?
Family Psychiatric History

- Often overlooked, but important because of:
  -heritability of severe mood disorders
  -likelihood that treatment response may be similar in family members

The report of a relative with good response to ECT is reassuring, both about the integrity of the diagnosis, and the likelihood of treatment response.

Does the patient have any medical problems that might require modifications of technique or increase the risks of the procedure?

- Medical history elicited to assess patient's risk for general anesthesia, need for additional testing/consultations
- "Do you have any medical problems?"
- "Have you ever had surgery?"
- Surgical history
  - Type of surgery, details of anesthesia (if known), any problems with anesthesia

Does the patient have any medical problems that might require modifications of technique or increase the risks of the procedure?

- Cardio-pulmonary history
  - Ask older patients if ever had a "heart attack" or chest pain
  - "Can you walk up a flight of stairs without getting winded?"

- Smoking history
  -number of pack years
  -tell not to smoke morning of procedures

- History of alcohol/drug use/abuse

Does the patient have any medical problems that might require modifications of technique or increase the risks of the procedure?

- Handedness
- Height
- Weight in kg
  - for anesthesia drug dosing
- Dental assessment
  - Decision about removal of dentures
- Allergies

Synthesizing information-recommendation to patient/family

- Give patient your assessment of diagnosis
- Provide patient with your opinion of appropriateness of ECT

Is there appropriate informed consent?

- Educate patient/significant other(s) about ECT
  - start with simple generic facts about ECT

- Educate patient/significant other(s) about potential risks and benefits
  - medical risks
  - cognitive risks

Is there appropriate informed consent?

- Educate patient about electrode placement choices
  - ask patient if they have a preference (when appropriate)
  - give your opinion

- Other technical issues, e.g. stimulus dosing

  (no consensus about what level of technical detail is appropriate)

Is there appropriate informed consent? (Restrictions/assessments)

- NPO*
  - *except possibly some medications
- Driving restriction
- Medications to stop, hold, take
- Need for pre-procedural medical or laboratory evaluation

The ECT Consultation Note

- ID, HPI, past psychiatric history,

  family psychiatric history, medical/surgical history

  – handedness, height/weight, dentition

  – allergies, current medications

  History of ETOH/drugs,

  MSE, social history, impression/plan

- No more than one page!

ECT Consultation Note:

- Patient seen in the office for ECT consultation, referred by Dr. X, in the company of her husband.
- HPI
- Past psychiatric History
- Family Psychiatric History
- Medical History (including surgical, handedness, weight, dentition)
- Current Medications
- Allergies
- Alcohol/drugs
- Cigarettes
- Social History
- Mental status examination
- Impression
- Plan (or recommendations)

ECT Consultation Note:

Impression:

Major depression, recurrent, severe. Because of the severity of the patient's current illness, and his failure to respond to multiple medication trials, ECT is a reasonable therapeutic option.

Risks of ECT, both medical and cognitive, discussed in detail.

Patient told of need to be NPO prior to each procedure, and need to refrain from driving during ECT course.

Patient told of requirements for pre-procedural medical and laboratory evaluation.

We discussed the differences between bilateral and unilateral electrode placement,

that ECT treats the current episode but does not cure the underlying illness, and that maintenance ECT may be needed in addition to ongoing medication management.

Plan:

Patient will discuss with her referring doctor whether or not she wishes to proceed with a course of outpatient ECT.

Tak!