

The Other Victims of COVID-19 *The Value of Electroconvulsive Therapy*

Dear Sir,

The COVID-19 pandemic has prompted dramatic adjustments to the practice of medicine. Regarding electroconvulsive therapy (ECT), its availability has been limited because of a variety of factors, including (a) the implementation of more time-consuming protocols because of the aerosol-generating nature of the procedure, (b) risk of patient infection because of exposure to a health care setting, and (c) reassignment of health care professionals to other higher-priority positions during the pandemic. Consequently, many patients have seen their ECT schedules altered, either in terms of frequency reduction or in terms of discontinuation of the therapy.¹⁻³

In our hospital, as of the third Monday of June 2020, 4 of our 29 acutely hospitalized psychiatric patients had relapsed coinciding with changes in their ECT schedule due to the COVID-19 crisis. Three were receiving care at our acute psychiatric ward, and the fourth was home hospitalized. None of them had suspected or confirmed severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, but the reduction in availability of ECT during the pandemic forced a decrease in frequency or complete interruption of their ECT schedules. We describe their cases hereinafter.

CASE 1

A 39-year-old woman with resistant, multipisodic schizophrenia relapsed while being hospitalized in a subacute psychiatric facility after discontinuation of weekly ECT maintenance therapy. Medication adjustments and daily psychiatric supervision were insufficient for stabilization, and the patient was finally admitted to our acute inpatient unit, where ECT is available, as opposed to the subacute facility. We implemented tri-weekly ECT sessions, and the patient recovered slowly, being then readmitted to the subacute unit with continuation of weekly ECT sessions.

CASE 2

The second case was a 51-year-old woman with rapid cycling bipolar disorder type I

whose twice-a-month maintenance ECT was paused temporarily, and afterward, she refused to restart the treatment. She soon presented with a severe mixed episode that required acute hospitalization. Because the patient kept rejecting ECT, we intensified psychopharmacological therapy, which eventually controlled the symptoms and the patient could be discharged home.

CASE 3

The third case was a 72-year-old woman with resistant, multipisodic schizophrenia who was receiving treatment with clozapine and long-term weekly maintenance ECT whose schedule was reduced to every 2 weeks. A month afterward, she developed catatonia, being admitted to our acute inpatient unit for ECT intensification. After 3 weeks of twice-a-week ECT, the patient was back to normal, and we discharged her home with weekly ECT sessions.

CASE 4

A 72-year-old man with recurrent major depressive disorder relapsed—with a depressive episode with psychotic symptoms—after his once-monthly ECT schedule was discontinued. He was admitted to home hospitalization, and ECT was restarted, initially twice a week for 2 weeks and then weekly, achieving a rapid improvement, which allowed us to discharge him within 5 weeks. We maintained weekly ECT afterward to ensure full remission.

DISCUSSION

We report 4 simultaneous cases in which ECT schedule adjustments due to the COVID-19 pandemic coincided with—and probably favored—psychiatric relapse, which was severe enough to require hospitalization. From March 14, 2020, to May 1, 2020, our hospital reduced its ECT activity up to 75% (from 40 weekly sessions to 10) because of anesthetists' relocation, shortage of materials, and time-demanding proper implementation of the SaRS-CoV-2 safety protocol. Also, since then, all patients have been required to have a negative nasopharyngeal swab for SARS-CoV-2 performed 24 to 48 hours before each session. As of the end of June 2020, we are progressively increasing our activity, having reached up to 60% of the usual number of ECT sessions. For this quantitative readjustment, we established the following prioritization criteria of patients: catatonia or severe persistent agitation unresponsive to medication, and maintenance ECT with a history

of either relapse when discontinued or severe clinical features, including catatonia, suicidal attempts, or other violence. Currently, we have intensified the communication between patients, families, and therapists to maximize the early detection of relapse. Cases 1, 2, and 4 were not prioritized because they had no history of the mentioned severe clinical features, and besides, they were on their first maintenance ECT course; case 3 did meet these features and was considered intermediate priority, so we proceeded to a frequency adjustment but not a discontinuation.

Electroconvulsive therapy is a safe, effective therapy for severe mental illness. In many patients, acute ECT requires continuation and/or maintenance therapy for sustained benefit, consistently with the chronic, episodic nature of the conditions it is prescribed for. Decisions on ECT frequency reduction or termination are necessarily individualized and, often, empirically modulated.⁴ The COVID-19 pandemic has required forced adjustments on ECT schedules, leading to nonclinical, availability-related changes on the patients' frequency or maintenance of the procedure. In any case, prioritization of individuals has undoubtedly been kept under strict clinical reasoning.¹ Nonetheless, these adjustments may have led to a worsening of preexisting psychiatric illness, which is probably the case of the 4 patients we report. None of them had neither been subjected to recent major psychopharmacological changes nor suffered from significant stressful life events apart from the lockdown situation, of which we cannot discard a contribution to their clinical worsening. In fact, one of them (case 1) was actually hospitalized in a subacute unit when she relapsed, which guaranteed she was adherent to medication—that is to say, including unsuccessful adjustments—and under strict professional supervision.

As a matter of fact, our patients are “collateral victims” of SARS-CoV-2. None of them acquired the infection, but all suffered indirect health consequences serious enough for requiring hospitalization. Unfortunately, these collateral victims of the COVID-19 pandemic emerge not only from the deterioration of standard health care, which has affected—and is still affecting—millions of people worldwide. The impact of lockdown, the traumatic experiences of those close to COVID-19 cases, and the consequences of the emergent social and economic crisis, among others, will inexorably leave behind countless other victims.⁵

This case series highlights the value of ECT as an effective, timely critical therapy for severe mental disorders. Thorough benefit-risk assessment is always needed when deciding about frequency changes or discontinuation of ECT; things as they are, it seems to be no different in these overwhelmingly transformed times of COVID-19.

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This research did not receive any specific funding. The authors do not report any financial or other relationship relevant to the subject of this article. Some of them, however, do report conflicts of interest not related to this research. M.S.V. has received financial support for education and training from Janssen-Cilag and Lundbeck. J.G.B. has received financial support for traveling and educational activities from Adamed, Italfarmaco, Lundbeck, and Janssen. I.P. has received continuing medical education–related honoraria or consulting fees from ADAMED, Janssen-Cilag, and Lundbeck. M.V.R. has received research grants from Eli Lilly & Company and has served as a speaker for Abbott, Bristol-Myers Squibb, GlaxoSmithKline, Janssen-Cilag, and Lundbeck. M.B. has been a consultant for, received grant/research support and honoraria from, been on the speakers/advisory board of, and received honoraria from talks and/or consultancy of Adamed, Angelini, Ferrer, Janssen-Cilag, Lundbeck, Otsuka, Neuraxpharm, Pfizer and Sanofi.

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Electroconvulsive Therapy Administered During the COVID-19 Pandemic

To the Editor:

Electroconvulsive therapy (ECT) has been the criterion standard treatment for patients with psychiatric disorders who have failed to respond to pharmacological therapy or those who are noncompliant with medication and/or suicidal.¹ The coronavirus disease 2019 (COVID-19) pandemic has disrupted mental health care all over the world since January 2020, and it has also affected the practice of ECT with guidelines being developed for the ECT procedure, ECT anesthesia, and ECT administration.² There has also been a reluctance to proceed with nonemergency ECT during the pandemic when it is otherwise indicated, and a number of patients in the middle of ECT courses were disrupted because of the onset of the pandemic.³ There has been a concern about the potential risk to patients from cross-contamination within ECT departments, risk to staff from aerosol-generating procedures during ECT, and the redeployment of ECT teams, all contributing to limiting patient's access to treatment.⁴

We work in a tertiary general hospital in Mumbai, India, and many patients who receive ECT in our center are elderly, have medical problems such as diabetes and hypertension, and come from diverse parts of Mumbai city where COVID-19 infection rates may vary. The patients coming to our center are from the lower strata of society; have poor oral hygiene, poor general self-care, and overcrowding in their houses; live in slum dwellings; and do not follow social distancing or hand sanitization as per the recommendations.

We present herewith details of patients receiving ECT during the lockdown period in Mumbai, that is, between March 23, 2020, and June 8, 2020 (both days inclusive). There were many patients wherein an ECT course had been started, and they would have suffered if the course was abandoned midway. The psychiatry resident doctors and consultants involved in ECT received training in precautions from the microbiology and anesthesia departments and thus felt confident to administer ECT under protection.

In all, 168 ECTs were administered to 33 patients during the lockdown period. There were 16 male and 17 female patients. Of the 168 ECTs administered, 112 treatments were given on an inpatient basis to a total of 23 patients, whereas the rest were administered the same on an outpatient basis. Of the 33 patients, 12 new patients started their ECT course during the lockdown, whereas the others were receiving ECT prior and continued their course into the lockdown. The number of ECTs given to single patient ranged from 1 to 14. Majority of the patients (n = 24 [74.7%]) suffered from schizophrenia, whereas others suffered from depression and bipolar disorder. The indications for ECT were suicidality, aggression, noncompliance with medication, and past favorable response to ECT. Of patients who were receiving ECT prior to the lockdown, 2 patients backed out of completing the ECT course, citing fear of contracting COVID infection. It is important to mention that none of the nursing staff, ECT staff, doctors, and patients developed COVID during the entire period.

A departmental decision was made to restrict the ECT staff down to only 4 ECT practitioners, 2 anesthetists who would remain unchanged, and 2 nursing staff and 3 ancillary male staff to reduce the number of staff for ECT. There was a dedicated staff and resident doctor who would have the role of screening new ECT patients and conducting COVID-19 screening, taking temperature prior to letting the patient into the ECT room. All relatives accompanying the patient had to wear a mask and remain with the patient post-ECT as well. The ECT room had a single entrance, and access of other staff to the ECT room was totally restricted. These changes required a serious and conscientious effort on the part of the staff and the resident doctors adjusted to all the changes. The department had a discussion on complete sanitization of the ECT room. The ECT room was sanitized at the start and end of the day's ECT. On average, 9 to 10 ECTs were given in a day. All ECT staff and doctors were requested to be vigilant of their movements so that they did not get in contact with