RCPsych Free Members' Webinar: Dean's Grand Rounds

Catatonia and ECT: a European perspective

Webinar Questions and Answers – Thursday 14 December 2023

The following questions were asked during the Catatonia and ECT: a European perspective event held on Thursday 14 December 2023. Some of these and many others were answered by the speakers during the conference – please watch the relevant session to see these.

Please note that not all questions that were asked are included below. We hope to add to this document as further answers become available.

Thursday 14 December	
What is the difference between the ECT and TMS in the treatment of catatonia?	There is insufficient evidence to support the use of rTMS in the treatment of catatonia (Dr Richard Braithwaite)
I would like to know why the high court got involved in this case. Thanks	This is a case in the Republic of Ireland, so the legal framework is difference in this regard to the Capacity Act/MHA of England/Uk (Dr Angela Carballedo)
Mon, Wed & Fri ECT?	3 consecutive daily sessions, followed by 3 sessions per week for the remainder (Dr Myles Doyle) NB always give at least x3/week for catatonia - there's almost no evidence for using x2/week (Dr Richard Braithwaite)
RUL or BL ECT?	This question was answered live.
During the course of the ECT while the lorazepam was being weaned off, were seizures seen?	Sometimes yes, sometimes no. Some visible…. Positive evidence on EEG throughout, but difficult to interpret given profound baseline EEG which

	normalised by time of discharge from hospital (Dr Myles Doyle)
I have a patient currently in ICU with a GCS of between 4and 6. He was admitted for sepsis and r/o stroke. MRI was not very significant. WCC and Neutrophil were slightly raised. He was on clozapine prior to hospital admission which the ward failed to administer. Now the ward is thinking of withdrawal catatonia or NMS although the psychiatry team and pharmacy do not think so. We are planning a professionals meeting and have suggested neurology input to rule out encephalopathy. We are having a professionals meeting tomorrow. Any suggestions?	If they have 3 symptoms/signs from the DSM5 list - it's catatonia - so treat it as such! (Dr Richard Braithwaite) Sudden withdrawal of clozapine can also cause catatonia and organic catatonia can also be considered (Dr Gazdag)
What antiepileptics was he given and the timing of their use? His recovery seems to have been associated with them stopping as well as ECT.	Levetiracetam and Sodium Valproate. No change in presentation prior to commencement or at point of discontinuation. Both stopped prior to ECT... (Dr Myles Doyle)
Valproate dose "homeopathic"?	Agreed. Very low dose... but no antidepressant, so was a careful watch and wait approach that continued by POA CMHT.... (Dr Myles Doyle)
Core trainee here. thank you for presentation 1. was he under Section or treated under MCA and Best interest? 2. were there any contraindications to ECT in this case? i.e. subdural hematoma etc	Was not in an approved centre (medical hospital in Ireland, where MHA does not apply - if not pre detained prior to transfer from an approved centre). Considered life threatening presentation - could have used common law, but as we knew a course would extend to 12 sessions, we sought a High Court Order to protect our patient who lacked capacity to consent (Dr Myles Doyle)
Thanks for this interesting case presentation! I have two questions: 1) What was the thinking behind a subtherapeutic dose of sodium valproate? 2) What where the examination findings that led the liaison psychiatry team towards a diagnosis of catatonia, other than abnormal movements?	The constellation of overall presentation, with a forensic revision of past psychiatric history and and day by day account was sought by our team with all members of his family. I think that the rapidity of his movements initially made it harder to define them specifically, and once within the intensive medical environment, natural consideration can be towards continuing to seek an undiagnosed medical aetiology. He did demonstrate negativism, some stereotypic movements (at best clinical judgement), and a suggestion of a brief change from a depressed stated to an elated state prior to very rapid deterioration. We committed to focusing on the overall narrative, supported by extensive medical investigations..... It was the clinical judgement at that time. Therefore, evidence-based treatment followed..... We were fully supported by family, which we appreciated greatly. The Sodium Valproate was a very low dose initiation.....It has remained at that dose under careful watch by CMHT. Not on an AD that caused prev

	swit (Dr Myles Doyle)
What was the indication of maintenance sodium valproate please?	Valproate was used for its mood stabilising properties. Thanks (Dr Angela Carballedo)
Is he compliant with sodium valproate now?	Yes. Still 200mg under his POA CMHT. (Dr Myles Doyle)
The cases I've seen like this have tended to have BPAD so important to ensure ongoing treatment for this	Yes. Agree. He's not on any antidepressant, still low dose Sodium Valproate at the discretion of his CMHT POA. He's under regular review. Also, Walter and family have put in place an Advanced Directive for ECT should he become unwell again... (Dr Myles Doyle)
Interesting case and well presented Dr Doyle . It tells us how catatonia is under diagnosed and plus as psychiatrists, we do not tend to consider ECT as early as we should be doing . Thanks	Indeed. Many thanks. (Dr Myles Doyle)
Sorry, Why Lithium was stopped please?	One episode in 2018, did well for the following 3 years, no previous history, keen to wean off and supported by his treating Psychiatrist.... (Dr Myles Doyle)
My question is for Dr Gabor- Do you have any experience of catatonia in autistic individuals especially those who also have learnign disability?	This question was answered live. The ECT center of the Department of Psychiatry and Psychotherapy at Semmelweis University is specialized to treat patients with catatonia associated to autism spectrum disorders. The catatonic symptoms of these patients show usually good response to ECT also when it is associated with learning disability. (Dr Gazdag)
According to his age and past medical history, did he present any orientation problems after ECT?	A brief delirious presentation.... quickly resolved. By time of d/c on 02/02/2023, having commenced ECT on 22/012/2023, his ACE-R scored 86. Remarkably cognitively well so quickly... (Dr Myles Doyle)
What are the common presenting symptoms and signs of catatonia in older people	This question was answered live. Most common is the retarded form, but agitated form can also occur. It is frequently associated to cognitive impairment. (Dr Gazdag)
When was venlafaxine stopped	Reduced in the acute psychiatric hospital. Discontinued in the medical hospital (Dr Myles Doyle)
Any cases of autistic catatonia during this period (2021-22)?	This question was answered live.
How long you could have continued with daily ECT before switching to 3 weekly?	3 consecutive days..... then 3 weekly (Dr Myles Doyle)
Did you use ultra-brief or brief-pulse for the ECT sessions? Did you increase the charge during the process?	There's no place for UBP in catatonia. I'd also strongly advise against RUL in the first place. (Dr Richard Braithwaite)

Do you have any thoughts on the conept of catatonia in autism. Does it normally have another underlying diagnosis? Does it respond to ECT?	This question was answered live.
Any experience of using ECT for treatment of catatonia in autistic individuals under 18 especially those who have additional learning disability?	This question was answered live.
Can any speaker please speculate on the pathophysiology of Catalonia and why/how Benzos/ECT could be working to treat the condition.	
Can you comment on the concept of "Autistic Catatonia" which I and colleagues have become aware of in recent months - and the argument that environmental/psychological interventions are more helpful than drugs/ECT which can be harmful in this group?	
Any views on ICD-11 giving Catatonia a specific illness category.	ICD-11 made a significant change in the position of catatonia accepting it as a separate diagnostic group. This step is important on the way to get rid of the kraepelian view of catatonia and to accept that these symptoms can be associated not only to psychosis, but other mental disorders, organic disorders as well as psychoactive substance use. (Dr Gazdag)
I have noted a lot of case reports of catatonia in those with Alcohol dependence. Is there a causal link?	As the new categorization in ICD-11 reflects, catatonia can also be associated to psychoactive substance use, including alcohol dependence. A possible mechanism that can explain the connection between alcohol dependence and catatonia is the downregulation of GABA-A and GABA-B receptors. (Dr Gazdag)
Should ECT be used when the cause is non psychiatric?	Yes. There is probably a common pathway. (Dr Richard Braithwaite)
Do you have any thoughts on using magnetic siezure therapy for treatment of catatonia? especially in elderly or patients with dementia?	
Is ECT safe for patient with bipolar depression and Temporal lobe epilepsy?	Yes (Dr Richard Braithwaite)
Is there a negative press about ECT in Europe as I have seen in UK and USA?	In Central-East-Europe definitely. (Dr Gazdag)
Is ECT being used less and less over the last few decades?	Certainly, in the UK, rates decreased a lot following restrictive national guidance in 2003, but has largely stabilised in the last decade. (Dr Richard Braithwaite) The same is true for Hungary. ECT utilization rate decreased from

	0.31/100,000 to 0.17/100,000 between 2002 and 2014. (Dr Gazdag)
What does lysis mean in terms of response to ect?	You can interpret this term as disappearance of catatonic symptoms in this figure (Professor Linda Van Diermen)
Our clinic doesn't have IV lorazepam, is there any rationale in trying to do a lorazapem test with oral lorazepam if patient can swallow tablets?	Yes (Dr Richard Braithwaite) In Hungary we do not have IV lorazepam thus we use IV clonazepam with similar results. (Dr Gazdag)
What are the panel's views regarding the anti-ECT campaigns that we see here in the UK, often spearheaded by prominent psychologists, and its potential impact on ECT acceptability from a patient point of view etc (even when life-saving)?	Unfortunately these anti-ECT campaigns targeting the efficacy and brain damaging effect of ECT is not based on evidences but rather false beliefs and as I see these fixed beliefs cannot be changed with rational argumentation. These campaigns can definitely decrease the acceptability of ECT. Fortunately anti-ECT forces are less active in the media in Hungary. (Dr Gazdag)
Any thoughts on treatment for patients presponsive to ECT and not able to tolerate high dose lorazepam. Currently trialling Memantine in a patient.	Memantine is worth for a try. (Dr Gazdag)
Is there any consensus on tapering on anticonvulsants/mood stabilizers while preparing for ECT?	In our ECT center we decrease the dose of the anticonvulsant medication or if we see short or insufficient seizure activity, even stop anticonvulsant for the time of ECT and restart after that. (Dr Gazdag)
If Lorazepam is not available. Can an alternate benzodiazepine be used? If so, can you give the regimens for them please.	Zolpidem! And also, others, see guideline from Rogers ea (Professor Linda Van Diermen) In Hungary we use IV clonazepam as we have no IV lorazepam. Oral alprazolam also works. (Dr Gazdag)
Thanks for the presentation. Please, what are some of the indications and contra indications for use of ECT in older children	
What has been the response by the public to the nurse led ECT service in Norway?	
in case of malignant catatonia‹, is there a specific measures to consider when ECT is indicated. is there a risk to use succinyl choline in this case?	Start ECT as early as possible. Longer waiting time increase mortality. (Dr Gazdag)
what about use of ECT in patients with suicidal attempts?	ECT has an antisuicidal effect, so it can be recommended. Nevertheless the underlying condition will define the efficacy. If it is severe personality disorder, than ECT will be less effective. (Dr Gazdag)
thank you for the presentations. I wonder what the attitude from the service users and their relatives.	They usually express better attitudes than lay public. (Dr Gazdag)

Any thoughts on the use of lithium in this situation I have seen it mentioned in some other papers. The working diagnosis have been autistic catatonia. Had full neuro work up which didn't show anything	
any comments about use of Ketamine and ECT in catatonia?	
I am a Liaison Psychiatrist and have a patient with no classical symptoms of catatonia but declined drastically in her functionality and is now bed bound for more than 12 weeks with high risk of self neglect. Unable to assess trigger or her mood due to her non-engagement. Organic causes ruled out. No response to Benzos. There is a past history of anxiety and depression. Would ECT help?	This patient seems to be immobile, negativistic, withdrawn. These symptoms can be considered as retarded catatonia. So ECT is worth for a try. (Dr Gazdag)
In terms of patients presenting with acute catatonia on an acute general ward. How can we arrange for ECT on an acute ward or ICU.	That was one of the complexities of the case and the reason for the High Court application. (Dr Angela Carballedo)
what are your thoughts on using the MST for catatonia in older patients please?	
Hi, I wouldn't ECT serve as a augmentation strategy if anti epileptics / mood stabilisers are prescribed already? Secondly, we generally increase the charge as part of the protocol.	
Would you say there's a rise in Catatonia in Autism	I personally do not see a rise in the prevalence of catatonia in autism, rather greater attention is focused on catatonic symptoms and thus recognition improved. Changes in the position of catatonia in DSM5 and ICD-11 also contributed to these changes. (Dr Gazdag)