ECT for OCD?

A CASE PRESENTATION

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- AR is a 73 y/o Pakistani lady
- Known to MH services since 1984
  - Obsessive compulsive disorder ICD-10 F42
  - Recurrent depressive disorder ICD-10 F33

- PMHx
  - Stroke 1996
  - Hypercholesterolemia
  - Hypothyroidism
  - Osteoarthritis of her knees

- FHx
  - Nil psychiatric

BACKGROUND I

BACKGROUND II

- Personal & Social hx
  - Born in Pakistan as an only child
  - Described a pleasant childhood and school experiences
  - Married when she was 18 and moved with her husband to London
  - Worked for a year in a manufacturing company before stopping work to have a family
  - 4 children, one of whom has a intellectual disability
  - She lives with 3 of her children in a privately owned home
  - She became a widow in 1964 aged 29
  - She receives a widows and credit pension

PSYCH Hx 1984-2002

1984:
First admission
Informal
Psychosocial stressors
'Nervous breakdown'

OCD symptomology:
Difficult to feel 'satisfied' in tasks
Doesn't feel she can 'finish activities'
Mainly in form of washing, checking & counting
- washing hands
- tightening bottle tops
- checking light switches

2002:
Father died
- Severe OCD
- Suicidality

Initially NHS Rx but t/f to Priory

Priory:
ECT X8 for 'depression'
Improvement after 2 sessions
8 sessions 'my mum is back'
Asymptomatic for 10yrs

PSYCH Hx 2010 - 2015

GP re-refers to CMHT 2010 due to relapse
Intrusive thoughts & behaviour initiation for anxiety reduction
Hours consumed by counting & checking
Unable to leave the house
Venlafaxine increased & Risperidone added

MAY 2013
CHECKING LOCKS & TAPS
CHANGE TO CLOMIPRAMINE 100MG

→

Oct 2013
IMPROVEMENT SINCE CHANGE
FOCUS ON PSYCHOLOGY

→

JAN 2014
DETERIORATION
CLOMIPRAMINE INC TO 150MG

→

FEB 2014
LITTLE CHANGE
RISPERIDONE 2MG ADDED

→

MAY 2014
SOME BENEFIT
RISPERIDONE INC TO 3MG

→

JAN 2015
IMPROVEMENTS STABILISED
D/C ON CLOMIPRAMINE & RISPERIDONE

- June 2015 – daughter admitted to hospital (psychosis) → clomipramine inc to 100mg BD
- Sept 2015 – comorbid depressive Sx & suicidality

"OCD is getting me"

Fear of contamination and dirt

Compulsions driven by fear of harm to daughters

washing hands for 40mins

repeating phrases over & over

Avoiding baths as taking hours

Washed face 30 times

Not eating

Not sleeping

Wanting to stab her abdomen

2015

Wanting to take an OD

- LAS called by family at 2am
- Admitted informally to MH unit – ch lorazepam
- Family pushing for ECT but told by all professionals – not indicated
- D/C'ed with push to prioritise cognitive & behavioural input
- Oct 2015 – little progress. OCD 'all she can do'. Not engaging in psychology

2015

- As you are aware, she and her family are very keen on ECT. They told me that this has helped in the past when she was given it. I discussed today the evidence that supports ECT in OCD, which is very poor. There is no suggestion from the guidelines that this is one of the treatments which help. On balance of risk and benefit, I do not feel that I would be able to prescribe ECT, as there are also the complications of general anaesthesia to contend with. I explained to the family my very difficult situation as it would actually be much easier for me to offer them ECT even though I do not think it would work, other than as a placebo, but this would be unethical in my view
- My view would be that the most important lines of treatment are psychological interventions, medication and finding alternative activities to occupy her time
- Referral made to National OCD service

CLINIC LETTER TO GP

The first question the family had for me today was whether she should have another
cour ... ECT which they thought had helped her last time. I explained that her
de ... were secondary to her OCD. Furthermore ECT is not a
tr ...

I was shown a letter from Dr and I understand that there is a possible referral being made to our service at the Maudsley Hospital. I do not think she would be suitable for our residential unit as there are no nursing staff and she would not be sufficiently able to self-care. It is possible we could assess and treat her as an out-patient but it would be tricky because we would have to arrange an interpreter for this because I do not have any Urdu/Punjabi speaking therapist.

OCD SPECIALIST

- April 2016 – improvement with the increase of fluvoxamine, therefore further increased to 300mg
- August 2016 –again deterioration; thoughts to cut her throat again but denies intent
- Feb 2017 – Managing with behaviours through psychological methods, but still distressed by OCD symptomology; further requests for ECT declined

- March 2017 – family pursue TMS privately
- April 2017 – “Unfortunately, after 15 sessions of TMS, they have not noticed any differences”
  - 45 minutes on left lobe at '60'
  - 15 minutes on right lobe at '55'
- Try place the machine on top of head for last 5 sessions

PROGRESS...?

- August – Sept 2017 Patient admitted to the Priory & underwent ECT
  - (indication = depressive illness)
- Standard two sessions weekly - nine sessions in total
- Family and her have found that it has "profoundly helped"
- However this has come at a financial cost to the family; they re-mortgaged the family home with the treatment costing £50,000
- D/C'ed with fluoxetine 40mg, lithium 400mg nocte and 1mg risperidone ON to CMHT f/u

DESPERATION

- March 2018 - relapse in her illness
- Very preoccupied by intrusive thoughts, engaging almost continuously in compulsive rituals such as checking switches and handles, folding tissues, rubbing her nose
- Feels she has "lost all hope" and is at "rock bottom"
- Family are struggling to manage care needs- "it is beyond us"
- Admitted to hospital July 2018
- Y-BOCS 32/40
- Changed to venlafaxine

"AT EXACTLY THE 6 MONTH MARK"

- 2/52 - quiet on ward, requires prompting. Carrying out rituals before taking meds - food is normally cold by the time she eats. Sleeping ok. At times difficulty with giving medication. Appears low in mood

- 3/52 - continues to take >2hours to finish meals. Very slow, needs assistance with personal hygiene. Isolates. Doing everything but sad. Always replies that she is ‘not very well’

- 4/52 Sleeping well, no real change in presentation on ward. Continues to be very ritualistic. Eating and drinking well. OCD is getting worse and she is became aggressive toward staff and shouting

- 5/52 Y-BOCS continues to be severe (score = 35)

Obsessive-compulsive disorder:

Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder

National Clinical Practice Guideline Number 31

developed by

National Collaborating Centre for Mental Health

commissioned by the

National Institute for Health and Clinical Excellence

published by
The British Psychological Society and
The Royal College of Psychiatrists

8.2.2 Current practice

People with severe OCD may occasionally receive ECT and it has been recommended by the Expert Consensus Guideline for OCD for treatment refractory patients who may also be depressed only if they have not responded to three or more trials of SRIs nor to CBT (March *et al.*, 1997). There are no current recommendations for ECT for OCD in the UK. The practice of ECT for other conditions, namely depressive illness, schizophrenia, mania, and catatonia, is discussed in detail in the NICE Technology Appraisal No. 59.

8.2.3 Studies considered

A total of nine papers were found specifically addressing ECT for OCD from 1973–2003: one descriptive paper, five single case reports (two of which are letters), one letter describing three cases, one open trial, and one retrospective review of 32 cases treated over a 20-year period.

8.2.4 Descriptive review

There are four case reports describing a successful outcome for ECT as a treatment for OCD (Casey & Davis, 1994; Husain *et al.*, 1993; Mellman & Gorman, 1984; Thomas & Kellner, 2003). The case reports are generally of poor quality and lack methodological rigour. A further case report described the onset of mania following the use of ECT with OCD and treatment was discontinued (Chung *et al.*, 2001). Three cases of successful outcome following ECT for OCD are described in a letter (Beale *et al.*, 1995) although the absence of outcome measures precludes any firm conclusions regarding outcome.

Khanna and colleagues (1988a) conducted an open trial with nine subjects, all of whom met DSM-III criteria for OCD (American Psychiatric Association, 1980). Measures of OCD symptoms were administered at pre-treatment, during and post-ECT. Monthly follow-up assessments were conducted for 6 months. The authors reported that all subjects returned to pre-trial state within 6 months. The largest study (Maletzky *et al.*, 1994) is a retrospective review of 32 patients with OCD (19 of whom were described as non-depressed). All subjects had previously received trials of CBT and pharmacotherapy with little or no effect. Subjects were evaluated on the Maudsley Obsessive Compulsive Inventory (MOCI) and two depression scales at pre- and post-treatment and at 6- and 12-month follow-ups. The results indicated that the non-depressed group improved on measures of OCD symptoms at 12-month follow-up, but depression scores deteriorated substantially. Overall, 18 of 32 (56%) maintained some improvement at 12-month follow-up. These results have to be treated with extreme caution as all of the subjects also received active treatment such as medication during the 1-year follow-up so any improvement cannot be attributed solely to ECT.

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Electroconvulsive therapy for obsessive-compulsive disorder: a systematic review.

Fontenelle LF[1], Coutinho ES, Lins-Martins NM, Fitzgerald PB, Fujiwara H, Yücel M.

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Abstract

OBJECTIVE: Surgical therapies for treatment-refractory obsessive-compulsive disorder (OCD), such as deep brain stimulation or psychosurgery, remain unattainable for many patients. Despite the long-held view that electroconvulsive therapy (ECT) is an ineffective treatment for OCD, there is no systematic review to support or refute this claim, which is the basis of the current review.

DATA SOURCES: A systematic search of MEDLINE, Web of Science, Scopus, and LILACS databases was conducted on December 22, 2013, using the terms obsessive-compulsive disorder and electroconvulsive therapy. Reference lists, specific journals, and clinical trial registries were also scrutinized. No date or language limitation was imposed on the search.

STUDY SELECTION: After irrelevant and redundant records from the 500 identified titles were excluded, the 50 articles reporting the acute treatment effects of ECT in OCD and related constructs (involving a total of 279 patients) were analyzed for this study.

DATA EXTRACTION: The relevant sociodemographic, clinical, and outcome data of individual cases were extracted. Data from individual cases were used to compare the characteristics of responders versus nonresponders to ECT.

RESULTS: Most selected records were case reports/series; there were no randomized controlled trials. A positive response was reported in 60.4% of the 265 cases in which individual responses to ECT were available. ECT responders exhibited a significantly later onset of OCD symptoms ($P = .003$), were more frequently nondepressed ($P = .009$), more commonly reported being treated with ECT for severe OCD ($P = .01$), and received a fewer number of ECT sessions ($P = .03$). ECT responders were also less frequently previously treated with adequate trials of serotonin reuptake inhibitors ($P = .05$) and cognitive-behavioral therapy ($P = .005$).

CONCLUSIONS: Although 60% of the reported cases reviewed exhibited some form of a positive response to ECT, it cannot be stated that this provides evidence that ECT is indeed effective for OCD.

- 07.09.18 – 16.10.18 underwent 10 sessions ECT
- Treatment 3 - brighter, more engaged
- At treatment 4 – having home leave
- 5 - feeling better in her mood. More able to concentrate and motivate
- 8 – 50% improvement in OCD, much brighter in mood, more alert, more engaged in what is happened around her and more consistent in her presentation
- 10 - significantly brighter and more engaged today than the team have ever seen her. Speech much more spontaneous. Improvement in objective cognition
- YBOCS at end of treatment 4/40 – D/C'ed with Venlafaxine & Lithium

ECT Rx

Thank you