

ECT Dilemma: Should We Start This Treatment Earlier?

Alessandra Cappai^{1*}
Shubulade Smith¹

¹South London and Maudsley NHS Foundation Trust, London

Introduction

Patients with HIV-infection are at increased risk of psychiatric illnesses [1], including psychosis [2,3]. Psychiatric symptoms in HIV-positive subjects may be more severe than in the general population and include catatonic symptoms [4]. Evidence shows that ECT should be the first line treatment for catatonia if pharmacotherapy with benzodiazepines has failed [5]. However, critics of ECT still describe this procedure as “barbaric” and ineffective [6]. Such views may impact practice and hinder the timely initiation of a potentially life-saving treatment. We present a case report of catatonia in an HIV-positive subject unrelated to infectious processes which was effectively treated with ECT.

Case Report

Ben, a 31-year-old man HIV-positive, was admitted to our Medium Secure Unit from prison having been charged with arson with intent to endanger life in October 2015.

Ben had been diagnosed with HIV during routine check-up in 2005. He had used drugs in a social context, mainly crystal methamphetamine.

Ben was unknown to mental health services prior to being brought to A&E by his mother one day before his index-offence. This had been precipitated by weeks of abnormal behavior, with suspiciousness and veiled threats towards her. Ben’s behavior had progressively deteriorated and he had become unreliable and irritable. Due to his behavior, he was dismissed from work and had to move out from his shared apartment due to a fight with another resident. Of note Ben had been sexually assaulted earlier in 2015.

In February 2016, Ben was transferred from prison to unit due to concerns about his mental health. On admission, he presented as mute with no eye contact and no response to verbal commands. He was observed to be staring at fixed points, or lying in uncomfortable-looking positions. A catatonic-state was diagnosed, but disputed by many staff.

Due to complete uncooperativeness, he had to be restrained to provide blood tests, which indicated a mild lymphocytosis with normal CRP, in keeping with the chronic inflammatory process of progressive HIV. He also tested positive for syphilis. MRI and LP showed normal results.

Given the possible catatonic presentation, Ben was treated with i.m. lorazepam, to which he responded rapidly and started interacting with staff and enquiring ‘what is that stuff you gave me? I’ve got so much more energy’. However, within a few hours, he returned to a catatonic-like state.

SOAD (second opinion appointed doctor) approval for ECT was considered and discussed with Ben’s mother and the clinical team. Both

Article Information

Article Type: Case Report

Article Number: SJASR197

Received Date: 11 October, 2018

Accepted Date: 09 November, 2018

Published Date: 16 November, 2018

***Corresponding author:** Dr. Alessandra Cappai, Consultant Forensic Psychiatrist, South London and Maudsley NHS Foundation, London. Tel: +07411027510; Email: [alessandra.cappai\(at\)nhs.net](mailto:alessandra.cappai(at)nhs.net)

Citation: Cappai A, Smith S (2018) ECT Dilemma: Should We Start This Treatment Earlier?. Sch J Appl Sci Res. Vol. 1, Issu: 8 (43-45).

Copyright: © 2018 Cappai A. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

felt very uneasy, refused the use of ECT and thought other options should be tried first, despite SOAD approval.

After two weeks of no improvement, ongoing catatonia interspersed with evidence of suspiciousness, poor memory (he couldn't remember his index offence or the faces and names of staff) and continuous refusal of oral medication, an oral/i.m. olanzapine regime was started (administering daily i.m. dose of olanzapine if not taken orally).

Lorazepam was administered meanwhile and following each administration, Ben was observed interacting well with staff, attending to his personal hygiene and eating the food provided. He allowed his physical observations to be done and took oral medication. Due to his response to lorazepam, the idea of emergency ECT under S62 was put to one side.

At this point some members of the team, due to his "on-off" presentation following lorazepam administrations, became convinced that Ben was actually "choosing" to shut down at times, and that his presentation was due to an emerging personality disorder. This idea, coupled with the fact that many team members still considered it a barbaric procedure, contributed to a strong and vociferous opposition to ECT.

Due to continued concerns about ECT and repeated injections, olanzapine depot was introduced but its effects were, as expected, not immediate.

Further deterioration and refusal of any oral intake led to a regime of daily i.m. lorazepam which resulted in a rapid but short-lived improvement. Ben became able to divulge his mental state including suicidal thoughts and communicated to staff that he was hearing an authoritarian judgmental voice, commanding him to self-harm. He described at times feeling like he "froze" as though he was paralyzed and had to fight for any simple movement, to "get started".

As Ben became able to communicate more, staff accepted that his symptoms were not manufactured and they come around to the idea that he might be catatonic after all. His lack of improvement meant that his mother also began to accept that he was catatonic. This understanding was crucial to staff and Ben's mother ceasing to oppose ECT.

Following the first session of ECT, Ben's level of activity appeared increased and longer lived than with lorazepam.

As ECT sessions continued, Ben's oral intake increased, his paranoia lessened and his interaction with staff and ward and occupational activities improved. All his oral medications were gradually re-started and in May his olanzapine depot was switched to oral medication as he became fully compliant. At this point he was able to take up psychological therapy too. His mental state continued to steadily improve up until full remission of symptoms in July 2016. Ben required 5 ECT sessions in total.

Discussion

Ben developed catatonia despite his HIV infection being well controlled. A background of recent life stressors and illicit substance use may have contributed to the progress of his depressive psychosis and the prolonged period

with no treatment in prison, most likely contributed to his catatonic symptoms. In keeping with catatonia, his symptoms responded well to i.m. lorazepam, however the improvements were short-lived. Complete and sustained remission of his catatonic psychosis only occurred with the use of ECT.

ECT is the treatment of choice for catatonia. Early intervention with ECT should be encouraged to avoid undue deterioration of the patient's physical condition in those with catatonic states [5,7-10]. However, evidence suggests that the commencement of ECT is often procrastinated⁹ and thus it may be underused [5,10].

Several issues need to be acknowledged regarding the use of ECT. First of all, probably related to the fact that it has been used inappropriately in the past, including as a torture, there is a collective view that the practice of ECT is horrid and barbaric. Negative representations of ECT in the media and in films such as in "One flew over the Cuckoo's nest" have contributed to the increased stigma around ECT. In addition, ECT is indeed associated with some side effects, for example short memory loss, which can be particularly worrying for recipients. However, according to the evidence this side effect is only short-lived [11-13].

Inaccurate representation, exaggeration of its side effects and concerns about overuse and inappropriate use may increase the apprehension and stigma around ECT and result in reluctance for ECT to be used when it is appropriate and necessary to do so. This may contribute to individuals affected by treatable mental illness being held back from appropriate treatment and timely recovery [11], with obvious ethical and economic impact. Of note, most patients have a positive response and attitude towards ECT [12]. In Ben's case, even though a catatonic state was suggested early into his admission, ECT treatment was resisted by the team and his relatives. This was primarily due to the stigma around ECT, which was seen as a very cruel, barbaric option. Our view is that the stigma surrounding ECT is so profound that staff preferred to believe that that Ben was "choosing to switch-on-and-off" which made some staff dispute he was actually catatonic.

Catatonia is a complex condition, rare in young people and in Western countries, where it may therefore be difficult to recognize or may be misdiagnosed by inexperienced staff. Early detection is the key to starting a life-saving treatment such as ECT in a timely manner.

When in hospital, catatonia was suspected and diagnosed in our patient, but the idea of the best treatment i.e. ECT, was rejected because his relatives and many staff felt uneasy about this procedure, resulting in him remaining unwell possibly for longer than necessary. This indicates that more training and education about ECT is required. Many staff had no knowledge of ECT other than what they had learned from the media or films. ECT use is rarer than before and this is most likely related to earlier treatment of severe mental health problems. It is imperative, however, that when ECT is appropriate, it should be used to reduce the longer-term risk to patients' outcomes. Disclosure of scientific evidence, including its side effects, and guidelines on ECT should

form part of the essential training for staff working on psychiatric wards. This is required to reduce the stigma and misinformation around the use of ECT, allowing patients to receive the best available treatment for their condition.

Our study suggests and confirms previous evidence that ECT should be considered in the early stages of treatment and it may be safer than antipsychotic therapy in HIV-positive patients. Patients should be treated with the best evidence-based treatment regardless of individual preconceptions and sensibilities.

References

1. Bing EG, Burnam MA, Longshore D (2001) Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. *Arch Gen Psychiatry* 58: 721-728.
2. Nebhinani N and Mattoo SK (2013) Psychotic Disorders with HIV Infection: A Review. *German Journal of Psychiatry* 16: 43-48.
3. Sewell DD, Jeste DV, Atkinson JH, Clother J(1994) HIV-associated psychosis: a study of 20 cases. San Diego HIV Neurobehavioral Research Center Group. *Am J Psychiatry* 151: 237-42.
4. Volkow ND, Harper A, Munnisteri D (1987) AIDS and catatonia. *J Neurol Neuro Psychiatry* 50: 104.
5. Sienaert P (2011) What we have learned about electroconvulsive therapy and its relevance for the practicing psychiatrist. *Can J Psychiatry* 56: 5-12.
6. Reed J (2013) Why are we still using electroconvulsive therapy? BBC Newsnight, 2013; Davis N and Duncan P; "Electroconvulsive therapy on the rise again in England" *The Guardian* 2017; Pemberton M "Dr Max the Mind Doctor: Barbaric? Electric shocks can save lives and are an invaluable weapon in the arsenal to fight depression" *Daily Mail*, 2017.
7. Hriso E, Kuhn T, Masdeu JC (1991) Extrapyramidal symptoms due to dopamine-blocking agents in patients with AIDS encephalopathy. *Am J Psychiatry* 148: 1558-1561.
8. McDaniel JS, Brown L, Cournos F, et al. (2000) Practice guideline for the treatment of patients with HIV/AIDS. *Am J Psychiatry* 157: 1-62.
9. Arshad M, Arham A Z, Arif M, et al. (2007) Awareness and perceptions of electroconvulsive therapy among psychiatric patients: a cross-sectional survey from teaching hospitals in Karachi, Pakistan. *BMC Psychiatry* 7:27.
10. Luchini F, Medda P, Giorgi Mariani M, et al. (2015) Electroconvulsive therapy in catatonic patients: Efficacy and predictors of response. *World J Psychiatry* 5: 182-192.
11. Choy MM, Farber KG, Kellner CH (2017) Electroconvulsive Therapy (ECT) in the News: Balance Leads to Bias. *J ECT* 33: 1-2.
12. Maguire S, Rea SM, Convery P (2016) Electroconvulsive Therapy - What do patients think of their treatment? *Ulster Med J* 85: 182-186.
13. Cohen D, Taieb O, Flament M, et al. (2000) Absence of cognitive impairment at long-term follow-up in adolescents treated with ECT for severe mood disorder. *Am J Psychiatry* 157: 460-462.