

Modified ECT in times of Covid-19 pandemic: an experience from Kashmir

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The COVID-19 pandemic has evolved rapidly and is fast overwhelming worldwide health care resources, especially in developing countries where healthcare is low. In the wake of the pandemic and fears about increasing spread, routine inpatient and outpatient services were suspended in all major hospitals across India. This scenario was not different in the union territory of Kashmir when compared to other states of India. The drug de-addiction unit of our department was also converted into COVID ONLY hospital. These patients also had to be managed by the general psychiatric services, overburdening a system that already runs at total capacity.

Psychiatric services shifted to telemedicine mode wherever possible. Still, Modified Electroconvulsive therapy (M-ECT), a life-saving intervention, had to bear the brunt and was suspended in many parts of the world and India. It was done in view of decreased availability of anesthesiologists, fear of transmission from bag-mask ventilation, not to speak of the general thought process of “mental health can wait”. M-ECT is administered to patients with suicidality, refusal to feed, catatonia, treatment resistance in a variety of mental health issues, in addition to a variety of neurological problems². The uses of m-ECT are diverse, and the efficacy is generally reasonable.^{3,4} Considering the fact that the COVID-19 pandemic has also brought with itself an additional burden on mental health services in terms of exacerbation in the illness of people with pre-existing mental health issues as well as new-onset anxiety and depressive diseases in people exposed to the stress of loss of employment, loss of social contact etc., the need of the hour

is more focus on mental health and making it available to all.⁵

Our hospital, a tertiary care institute and one of only two mental health facilities available in our Union Territory, continued to deliver routine m-ECT services to our patients. This has been made possible by our focus on the importance of m-ECT as a life-saving measure and by using safety measures to reduce the spread of the virus. In coordination with the department of anesthesiology, we continued to deliver m-ECT services to our patients twice a week, which was the usual practice before the start of the pandemic.

The various safety measures employed include keeping the theatre staff to a minimum of four (a psychiatrist, anesthetist, psychiatric nurse and anesthesia assistant). Adequate ventilation was ensured. The windows in the ECT theatre were kept open. In addition, complete personal protective equipment (PPE), which included an N95 respirator, gloves, a fluid-resistant long-sleeved gown and a face shield, was provided to them-ECT staff as per WHO guidelines. Gloves were changed after every session as per 5 WHO indications for hand hygiene. The gown was changed in case of accidental contamination.

COVID testing (Polymerase Chain Reaction, PCR) of the patients was performed two days before the first m-ECT session. For the subsequent session, which was carried out two days after the first session, the patients were hospitalized in most of the cases. For the third and following

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sessions, PCR was repeated in the case of symptomatic patients only. This was done in the face of substantial logistic challenges. At the start of the epidemic, the whole Kashmir region had only one RT-PCR facility, subsequently increasing to two facilities. The introduction of rapid antigen testing in July 2020 came as a massive relief for the delivery of m-ECT services as we started doing antigen testing for the third and subsequent sessions after doing RT-PCR for the first session. This was done as a point-of-care test to minimize the burden on testing facilities and reduce costs. Rapid antigen tests have demonstrated high specificity in detecting other respiratory viruses in various meta-analyses.^{6,7} It is worthwhile to mention that no patient tested COVID positive during the four months either on RT-PCR or on the rapid antigen testing kits. A total of 30 rapid antigen tests have been carried out since April 2020.

Though we have been able to keep m-ECT services available to our patients, the number of patients able to avail of this service had seen a sharp decline relative to the period April- July 2019 and pre lockdown period (January 1 to March 24 2020) when the numbers were 72 and 35 respectively. This might be due to the lockdown imposed by authorities given the ongoing pandemic making travel difficult and partly due to people refraining from moving outside due to fear of getting affected.

We administered 112 m-ECT sessions during this period to 19 patients. The most frequent indication for administration of m-ECT sessions was non-response to pharmacotherapy (12 patients), followed by suicidality (5 patients) and refusal to feed (2 patients).

While it is essential to prioritize acute and emergency care in the current situation, mental health cannot and should not be at the cost of patients suffering other ailments. M-ECT is a vital tool in the hands of mental health professionals to

deal with emergencies and, as such, should be prioritized and made available to patients at all costs.

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