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Electroconvulsive Therapy Is Helpful for Patients With Obsessive-Compulsive Disorder–Related Disorders: A Response to dos Santos-Ribeiro et al

To the Editor: dos Santos-Ribeiro and colleagues¹ have done a great service to systematically compile the cases in the literature of patients with obsessive-compulsive disorder (OCD) and related disorders treated with electroconvulsive therapy (ECT). They found a positive response in over 70% of the cases, providing sufficient, even compelling, evidence to include ECT among the treatment options for severe and treatment-resistant patients, even in the absence of randomized controlled trials (RCTs).

The authors' call for RCTs in these severe disease conditions may never be fulfilled. Ethical concerns about enrolling patients with life-threatening symptoms, often minors and those with limited ability to provide informed consent, into complex clinical trials are major stumbling blocks, not to mention the costs of adequately powered trials and the pharmaceutical industry's lack of interest in ECT. The authors emphasize the profound bodily injury of some patients with OCD and related disorders. It is unconscionable to suggest that patients in dire situations plod through clinical trials when similar patients have benefitted from ECT. The review by dos Santos-Ribeiro et al¹ encourages clinicians to consider ECT when faced with treating such severely ill patients.

Many of the case reports describe remarkable improvements in symptoms (particularly self-injury), with dramatic increases in quality of life for patients and families. The authors' implied critique, that ECT is not curative of the underlying illness but rather its benefits are temporary (without maintenance treatment), is a familiar trope. The expectation that a single course of ECT has life-long benefits is unrealistic. In its standard use for mood disorders, an acute course of ECT treats the current episode of illness; maintenance ECT can prevent future episodes. In chronic and continuous illnesses such as schizophrenia, Parkinson disease, or OCD,² ECT has significant effects on current symptoms (psychosis, motor dysfunction, obsessive thinking), but benefits typically wear off in weeks or months and are reinforced with maintenance treatments. ECT is a treatment, not a cure; the analogies of the need for repeated doses of insulin to treat diabetes, ongoing dialysis to treat renal failure, or repeated courses of antibiotic to treat recurrent bouts of pneumonia are applicable. It is anomalous to hold ECT to a different standard and a disservice to patients.

The authors¹ lament the absence of a scale that captures pertinent symptoms in OCD and related disorders across diagnoses and is useful for assessment of diagnosis, severity, and ECT efficacy. They note that catatonia is often present (but unrecognized) in tic disorders, Tourette's disorder, autism spectrum disorders, self-injurious behaviors, and other OCD and related disorders. A standardized catatonia assessment, including the use of a catatonia rating scale, may provide such a transdiagnostic measure in

both research and clinical practice, strengthening the case for recommending ECT.^{3,4} Catatonia scales exist for adult, pediatric, and autistic patients.^{5,6}

The review highlights the need for further research of OCD and related disorders and the use of ECT (and maintenance ECT) in these conditions. Unlike the authors, we do not find that their review shows the glass half empty because RCTs are lacking; rather, it emphasizes the glass as half full, inviting increased use of ECT in these conditions.

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dos Santos-Ribeiro and Colleagues Reply

To the Editor: We would like to thank Kellner and colleagues¹ for their insightful comments on our review² of the utility of electroconvulsive therapy (ECT) in obsessive-compulsive-related disorders (OCDs). In our search, we were unable to find any randomized controlled trial (RCT) in any broadly defined OCDs and suggest that treatment provision would benefit from confirmatory RCTs that support ECT use in these cases, particularly in patients with severe tic disorders and self-injurious behavior. Kellner and colleagues¹ suggest that RCTs would be challenging in this scenario given the particularities of these samples, most notably inability to consent and increased severity. However, we are convinced that there may be reasons for greater optimism.

First, most clinicians with expertise in OCDs would most likely agree that the greatest majority of patients with DSM-5 OCDs and Tourette's disorder (including self-injurious tics) are capable of providing consent, with the possible exception of people with psychosis or severe cognitive impairment.³ Thus, the view that these patients are intrinsically unable to understand and agree with participation in an RCT may simply not hold true. Inability to provide consent may be relevant in children and autism spectrum samples though, which represent a minority of patients of broadly defined OCDs in our review. However, even in severe neuropsychiatric illnesses for which consent and life-threatening severity are similar problems (eg, catatonia), other researchers have already recognized the need to perform high-quality RCTs to validate ECT use.⁴

Second, one must not ignore the increasing literature showing therapeutic alternatives for treatment-resistant OCDs,⁵ which could provide active (and effective) treatment control arms for OCD participants randomized not to receive ECT in RCTs. Furthermore, a related omission has already proved relevant for the ECT literature. In our previous systematic review,⁶ the alleged efficacy of ECT in OCD (the "prototypical OCD") was overrepresented in patients who initially were not adequately treated with the best-available treatments for OCD. This finding highlights the importance of investigating the efficacy of ECT versus other treatments in OCDs. A recently published RCT⁷ on γ-knife surgery in treatment-refractory OCD also showed that it is possible to enroll very severe and refractory OCD subjects for this sort of study within very strict ethical limits.

In conclusion, it seems appropriate to ask how and not if a RCT of ECT in OCDs should be performed.⁸ We believe that any ethically designed RCT in OCDs would need to include the selection of proper patients (eg, participants who are able to consent), the adoption of conventional treatment arms (thus providing adequate treatment for all enrolled patients), and early termination, including the administration of rescue therapies if required. Ideally, the number of ECT sessions proposed and their respective doses need to be weighed against the risks of repeated exposures to anesthetic procedures, their potential complications,

and other side effects. Further, in transdiagnostic trials, validated scales that are used across the whole spectrum of OCDs, and not simply a few disorders, would need to be adopted. From the point of view of patients and their families, it is critical to have access to a treatment that is known to be effective and safe.

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