

# Knowledge of Electroconvulsive Therapy for Treatment of Catatonia

**To the Editor:** We read with interest the article by Kaur and colleagues<sup>1</sup> discussing the knowledge of internists and neurologists regarding the identification and management of catatonia. Indeed, the prevalence of catatonia in acute medical and psychiatric inpatient settings is high, identification is poor and often delayed, and the differential diagnosis is quite broad.<sup>2</sup> Early recognition is of paramount importance given the high mortality rate associated with delayed diagnosis.<sup>2,3</sup> However, in addition to early and accurate diagnosis, effective early treatment is essential. Thus, while knowledge of benzodiazepines as a “first-line” intervention was assessed, we were surprised that there was no mention of electroconvulsive therapy (ECT), especially in situations where benzodiazepines may be contraindicated or inappropriate, response to pharmacotherapy is not sustained, or conditions are life-threatening. In the absence of prospective comparator intervention trials, we think that knowledge of all viable treatment options for catatonia is more essential for the clinician, irrespective of discipline, rather than an arbitrary ordering of treatments. Although response to benzodiazepines is useful in supporting the diagnosis and sometimes terminating the catatonic state regardless of etiology, more often a definitive treatment is needed. Though

used or recommended as a first-line treatment, no benzodiazepine, in fact, has US Food and Drug Administration (FDA) approval for use in catatonia. In contrast, in 2018, during a device reclassification review, the FDA recognized catatonia, among other disorders, as an approved “on-label” indication for ECT.<sup>4</sup> Numerous reports and recent reviews identify ECT as a definitive, lifesaving, and reliable intervention for catatonia, especially when benzodiazepines have failed.<sup>5–7</sup> Potential predictors of ECT response have been identified, and some evidence suggests that ECT can be considered a first-line treatment in certain cases.<sup>6–8</sup> Consequently, we think internists, neurologists, and even psychiatrists should know about the early role and benefit of ECT in catatonia treatment.

Lastly, although the authors cite a previous survey instrument used by Cooper and Roig Llesuy<sup>9</sup> as providing consistency in finding that psychiatry residents scored better than internal medicine residents on catatonia knowledge, Kaur et al<sup>1</sup> do not provide an actual copy of their new survey, nor information about its validity, making direct comparison impossible. Thus, we caution that future researchers may need to modify the Catatonia Experience, Impressions, and Applications questionnaire to ensure capture of all available treatment options.

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