

ISEN International Society for ECT and Neurostimulation

April 2, 2020

RE: COVID-19 and ECT

Dear ISEN members and others in the ECT profession:

The COVID-19 pandemic has led to growing concern among ISEN members and other ECT professionals about how best to provide ECT services during the crisis. This letter, from the ISEN Executive Committee, addresses a number of issues and provides suggestions about practice adaptations.

Our ISEN listserv has seen an explosion of questions and solicitations for advice on how to manage ECT patients, keep our ECT services active, and address infection control during this pandemic. We are aware that many ECT programs are in danger of closing now because of COVID-19, but we also know that many are persevering, at least a limited basis. We provide suggestions for all of us to consider during this crisis, but acknowledge that this is not an official guideline or list of mandatory policies, as every site will face varied challenges depending on penetrance of the virus, local resources, staffing models, and regulatory policies. All of us need to collaborate with our anesthesiology, infection prevention, nursing, and administrative colleagues to ensure we conform with local standards and hospital needs.

IMPORTANCE of ECT FOR OUR PATIENTS

All of us know that ECT is a vital treatment for our patients, but for some it is absolutely critical. Despite the fact that many of us have been asked to stop ECT altogether, many have been able to explain the importance of ECT to our medical colleagues and hospital administrators by describing clinical need clearly. A reduction of caseload is often required or mandated, and we face difficult triage decisions as good stewards of preserving resources and manpower. When considering ECT for patients while in this pandemic, we need to decide whether ECT is elective, urgent/essential, or an emergency.

1. **Elective ECT:** Patients who have chronic or treatment resistant depression without active suicidal ideation or dangerousness. ECT could be delayed for a number of weeks or months. Other patients may be more stable long term maintenance ECT patients, and may be candidates for further taper or holding ECT with medication and/or psychotherapy management
2. **Urgent or Essential:** Patients at risk for rapid decline leading to hospitalization, suicide risk, poor po intake or self-care. Often these are the acutely ill index outpatients or inpatients OR the continuation/maintenance outpatients in whom illness is expected to relapse quickly if not continued. In addition to risk of suicidal ideation and clinical

worsening, patients in this classification may require ER visits and hospitalizations that would increase infection exposures for the patient and others if not treated with ECT.

3. **Emergency:** Patients are at grave risk of harm due to severity of illness. These patients will likely be inpatients and may have severe psychotic depression, medical frailty, lethal catatonia, neuroleptic malignant syndrome, or manic delirium.

REDUCING ECT CASELOAD

As the number of patients with COVID-19 cases overwhelm hospitals, clinicians may need to reduce ECT caseloads to much lower numbers. This may be important to reduce risk of spreading illness amongst patients, hospital staff, and the general public. Also, many of us are facing Personal Protection Equipment (PPE) shortages, and this is a concern for many hospitals. To reduce ECT cases:

1. The ECT team needs to classify each patient and triage
2. Maintenance ECT cases: stable patients could stop or move out to longer intervals
3. Index/acute course patients: Most ECT clinicians may want to continue a typical 3x/week schedule to stabilize patients and discharge as quickly as possible. As an alternative, these patients could transition to a 2x/week schedule thus reducing the number of ECT sessions during peak medical COVID-19 caseload in the hospital
4. Slowdown or temporarily halt ECT consultations for stable elective patients.
5. Consider holding ECT, if possible, for potentially fragile or at risk patients such as the elderly with medical illnesses, patients with pulmonary issues, etc.

COVID-19 SCREENING

Screening for COVID-19 symptoms prior to administering ECT is important to reduce exposure risk. ECT nurses and physicians should develop a screening process. The screening of patients and family members should occur before and during arrival for ECT. Patients should be provided instructions to call prior to coming for ECT if they experience any active concerning symptoms. The following screening questions can be considered. Every institution will likely have their own recommendations, and the screening process should be discussed with local infection prevention experts and adapted to your ECT program.

Screening questions

- Have you been tested for COVID-19 within the past month? If yes, have you been advised the outcome of the test result?
- Have you travelled overseas or out of state in the last 21 days?
- Have you had contact with someone with COVID-19, in the last 14 days?
- Have you been advised by a health professional (Public Health / Infectious Diseases) to self-quarantine for 14 days due to contact with someone who has COVID-19?
- Have you been in a group of more than 10 individuals in the last 14 days?

AND

- Have you experienced any flu-like / respiratory symptoms over the past 2 weeks?
- Do you or anyone in your immediate house hold have or have you had cough, fever / difficulty breathing, sore throat, muscle aches, over the past two weeks?

INFECTION CONTROL and ECT TREATMENT ROOM

A major risk for infection is that ECT involves ventilation with a bag and mask procedure with the potential to aerosolize respiratory droplets. Currently, many hospitals have even recommended intubation for all surgery / procedure cases to reduce risk of aerosolizing droplets. Even if proper screening is done before ECT, some patients could be asymptomatic carriers. For those of us who are able to conduct ECT during this pandemic, we have likely experienced a wide-array of recommendations from our anesthesiology and infection prevention colleagues. These recommendations are coming at a dizzying pace and may change daily. As COVID-19 infections spread quickly in various areas, health care systems are taxed to the extreme and become quite reactive to shortages of PPE, manpower, and need for new work flows to prevent infections/exposures. The following strategies for maintaining a safe treatment room environment have emerged in the past two weeks. **Note:** we are not providing absolute guidelines, but describe what is currently being done in many ECT programs. It is extremely important for you to work together with your local anesthesiology and infection prevention teams.

1. It appears appropriate to avoid ECT for any COVID-19 positive patient or patient under investigation (PUI) for COVID-19 unless there is imminent risk for the patient. If a COVID-19 positive or PUI patient requires ECT, the issue of intubating may be raised by the anesthesia team and risks/benefits should be reviewed. The need for a negative pressure room may also be suggested or required by some programs for COVID-19 positive patients.
2. Should ECT patients be intubated at this time? The possibility of intubating ALL ECT patients has arisen in some places as hospitals may consider masked ventilation potentially more dangerous than intubation. However, it appears from a number of communications that intubation right now during this pandemic is not necessarily routine. There are also options other than bag-and-mask and intubation. ECT physicians should discuss with the anesthesia team the risks of intubating patients and be mindful that intubation may prolong a short procedure, induce gagging and coughing, and increase the amount of potentially contaminated equipment in the room. Again, the risks and benefits of intubation, if recommended, should be discussed with the anesthesia and infection prevention teams as local practices and policies may vary.
3. Common PPE appears to now include: gown, mask, eye shield, head covering, and gloves. N95 masks are considered mandatory at some but not all locations, and even then, not necessarily for all team members in the treatment room (e.g. only for those in close proximity of the ventilation procedure) With shortages of N95s, some places are allowing the use of a mask for the entire treatment day while covering with a different surgical mask each treatment. Some hospitals are looking to sterilize N95s and other equipment with UV light and heat as well. In this crisis, PPE and its use should include thorough communication among anesthesia, infection prevention, and ECT team members. Finally, all in the treatment room using PPE should be consistent and abide local standards and protocols to avoid the spread of COVID-19.
4. Reduce number of team members in the room to limit exposure and preserve PPE. Only essential team members should be present during this crisis. Unfortunately, this means excluding trainees such as resident physicians and students.
5. Programs that do a combination of inpatient and outpatient ECT or treat patients from multiple sites should consider 'batching' cases to avoid cross contamination. For example, a program may administer ECT to all outpatients first in the day before finishing with inpatients, or vice versa, depending on the relative infection risk.

6. Access to testing for COVID-19 remains variable and limited in many countries, but if and when testing becomes more readily available and quick, then pre-procedure testing may be an option to consider to reduce risk of infection and use of PPE.

STAFFING PLAN

It is important for all us to consider how we manage our respective ECT teams. Any of us could be exposed to COVID-19 or become infected, and we may need to be quarantined for several weeks. If you are in an area in crisis already or potentially facing crisis levels of COVID-19 infections in your area, a thoughtful plan will allow you to continue providing ECT to those in need. The following are some ideas to assist all of us:

1. Create a master list of MDs, RNs, and support team members who provide ECT care.
2. For scheduling: consider having the treatment room ECT physician and/or anesthesia team be consistent for longer stretches of time to limit exposures to others, eg. Same ECT physician for 1 or 2 weeks in a row.
3. Design a schedule for 2-3 months during your expected COVID-19 peak
4. Create a list of back-ups and contingencies in the event you are sick or absent.

We hope this letter assists you with suggestions on doing ECT during this COVID-19 crisis. Again, these suggestions are not official guidelines, but rather items to consider implementing, reviewing, and discussing with your local hospital experts in anesthesia and infection prevention. Undoubtedly, there will be other excellent ideas for us to share with each other, and we encourage the use of the ISEN listserv to do so.

Finally, we encourage you to continue advocating for patients by providing ECT where possible for appropriate candidates. During this pandemic, many and varied challenges will be faced, but if we all stay steadfast, collaborative, and creative in our work places, ECT will remain available for our most vulnerable patients.

Sincerely,

ISEN EXECUTIVE COMMITTEE