Quick recovery of orientation after magnetic seizure therapy for major depressive disorder

George Kirov, Klaus P. Ebmeier, Allan I. F. Scott, Maria Atkins, Najeeb Khalid, Lucy Carrick, Andrew Stanfield, Ronan E. O’Carroll, Mustafa M. Husain and Sarah H. Lisanby

Background
Magnetic seizure therapy, in which seizures are elicited with a high-frequency magnetic field, is under development as a new treatment for major depressive disorder. Its use may be justified if it produces the antidepressant effects of electroconvulsive therapy (ECT), coupled with limited cognitive side-effects.

Aims
To evaluate the usefulness of a new 100 Hz magnetic seizure therapy device.

Method
We induced seizures with 100 Hz magnetic transcranial stimulation in 11 patients with major depressive disorder during one session of a regular course of ECT. Recovery times after seizures induced by magnetic seizure therapy and ECT were compared.

Results
Seizures could be elicited in 10 of the 11 patients. Stimulation over the vertex produced tonic–clonic activity on 9 out of 11 occasions. Stimulation over the prefrontal midpoint elicited seizures on 3 out of 7 occasions.

The mean duration of magnetically induced seizures was 31.3 s, ranging from 10 to 86 s. All patients had an exceptionally quick recovery of orientation: mean of 7 min 12 s (s.d.=2 min 7 s, range 4 min 20 s to 9 min 41 s). The recovery times were on average 15 min 35 s shorter with magnetic seizure therapy than with ECT in the same patients (paired-samples t-test: P < 0.0001). Patients reported feeling less confused after magnetic seizure therapy. Side-effects were confined to myoclonic movements, associated with the use of etomidate.

Conclusions
The new 100 Hz magnetic stimulator elicits seizures in the majority of patients when administered over the vertex. Magnetic seizure therapy was associated with shorter recovery times and less confusion following treatment. Subsequent work will be required to assess the safety and effectiveness of magnetic seizure therapy in the treatment of depression.

Declaration of interest
None. Funding detailed in Acknowledgements.
Method

Patients

Eleven patients diagnosed with treatment-resistant major depressive episodes in the context of either recurrent major depression or schizoaffective disorders according to DSM–IV criteria, who had been referred for ECT, were enrolled in this pilot study. Demographic details are presented in Table 1. Patients were treated in Whitchurch Hospital, Cardiff, Wales, and the Royal Edinburgh Hospital, Scotland. Eight of the patients were already receiving ECT, and one of their regular (twice weekly sessions) was substituted with magnetic seizure therapy. The remaining three patients received magnetic seizure therapy before ECT: two of these continued with ECT, the third decided against it. Local research ethics committee approval was obtained at both centres and patients gave written informed consent following the approved protocols. In accordance with usual clinical practice of ECT delivery in the UK, antidepressant medication was not stopped during the treatment. Every patient received at least one antidepressant, six were also taking one or more antipsychotics, and two patients (patients 5 and 10 in the table) were also taking sodium valproate.

Magnetic seizure therapy

We used two custom-built Magstim Theta devices (Magstim Ltd, Whitland, Carmarthenshire, Wales). This stimulator is capable of producing 100 Hz magnetic stimuli at 1.2 T (at the centre of the coil) with a biphasic waveform with a pulse width of 340–400 μs for up to 10 s duration (i.e. a maximum of 1000 pulses). We used a round coil with an 80 mm average diameter (47 mm inside diameter, 115 mm outside diameter). For positioning of the coil we used standard 10–20 electroencephalogram (EEG) positions.

Anaesthesia

For anaesthesia we used intravenous etomidate (0.15–0.3 mg/kg) as it does not cause an increase in the seizure threshold and might even reduce it. Muscle relaxation was achieved with intravenous succinylcholine; since patients recover more quickly from magnetic seizure therapy the dose was generally lower than that routinely used in ECT (0.5–1.0 mg/kg).

Seizure monitoring

Seizure duration during magnetic seizure therapy was measured from the start of stimulation to the termination of the observed seizure. Electroencephalogram seizure expression was monitored via bilateral fronto-mastoid EEG using magnetic resonance image-compatible plastic electrodes to prevent electrode heating during therapy.

Orientation assessment

Recovery of orientation after magnetic seizure therapy/ECT was assessed by asking the patient for their name, date of birth, age, place and day of the week. The point of orientation recovery was defined as the time when a patient was able to recall four of these five items.

Table 1: Treatment settings, duration of seizures and recovery of orientation during ECT and magnetic seizure therapy

<table>
<thead>
<tr>
<th>Patient</th>
<th>Gender, age (years), setting</th>
<th>Electroconvulsive therapy</th>
<th>Magnetic seizure therapy*</th>
<th>Seizure monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Seizure threshold, mC</td>
<td>Pulses, n</td>
<td>Position of coil</td>
</tr>
<tr>
<td>1</td>
<td>Female, 35, C</td>
<td>126 BL</td>
<td>250</td>
<td>Vertex</td>
</tr>
<tr>
<td>2</td>
<td>Male, 21, C</td>
<td>80 BL</td>
<td>500</td>
<td>Vertex</td>
</tr>
<tr>
<td>3</td>
<td>Female, 41, C</td>
<td>841 BL</td>
<td>250</td>
<td>Vertex</td>
</tr>
<tr>
<td></td>
<td></td>
<td>500</td>
<td>500</td>
<td>Vertex</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1000</td>
<td>1000^b</td>
<td>Frontal</td>
</tr>
<tr>
<td>4</td>
<td>Female, 47, E</td>
<td>80 BL</td>
<td>1000</td>
<td>Frontal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1000^b</td>
<td>1000</td>
<td>Frontal</td>
</tr>
<tr>
<td>5</td>
<td>Female, 56, E</td>
<td>170 BL</td>
<td>1000</td>
<td>Frontal</td>
</tr>
<tr>
<td>6</td>
<td>Female, 28, E</td>
<td>80 BL</td>
<td>1000</td>
<td>Frontal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1000^b</td>
<td>1000</td>
<td>Frontal</td>
</tr>
<tr>
<td>7</td>
<td>Female, 48, E</td>
<td>204 BL</td>
<td>1000</td>
<td>Frontal</td>
</tr>
<tr>
<td>8</td>
<td>Male, 39, C</td>
<td>No ECT</td>
<td>600</td>
<td>Frontal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>600^b</td>
<td>600</td>
<td>Frontal</td>
</tr>
<tr>
<td>9</td>
<td>Male, 28, C</td>
<td>80 UL</td>
<td>600</td>
<td>Frontal</td>
</tr>
<tr>
<td>10</td>
<td>Female, 70, C</td>
<td>80 UL</td>
<td>600</td>
<td>Frontal</td>
</tr>
<tr>
<td>11</td>
<td>Female, 56, E</td>
<td>46 UL</td>
<td>1000</td>
<td>Vertex</td>
</tr>
</tbody>
</table>

BL, bilateral; C, Cardiff; E, Edinburgh; ECT, electroconvulsive therapy; EEG, electroencephalogram; NA, not applicable; UL, unilateral.

a. The duration of magnetic seizure therapy seizures is given from the time of start of magnetic stimulation.

b. Patients 3 and 8 had magnetic seizure therapy on two separate days.
Results

The first treatment session with the new device took place in Cardiff in June 2006. The patient was a 35-year-old woman, who had already received five bi-temporal ECT treatments, administered at 195.8 mC. For magnetic seizure therapy, the coil was positioned over the vertex (Cz). Stimulation with 250 pulses produced no seizure. She was restimulated 52 s later with 500 pulses and had a visible motor seizure of 25 s; EEG duration was about 21 s, but the end-point was difficult to estimate as there was no post-ictal suppression (EEG trace available from the authors on request).

Orientation was recovered after 4 min 36 s. Immediately upon awakening, the patient achieved a Mini-Mental State Examination score of 27/30 points. On the next day, the patient’s score was at the pre-ECT level of 30 points. A battery of further cognitive tests that included tests for verbal and visual memory, verbal fluency and executive speed was also administered and no relevant changes in performance from baseline were found (results not presented).

We have since treated 10 further patients. In order to explore optimal parameters of stimulation for this new procedure, we applied different numbers of pulses and changed the positioning of the coil between Cz and Fz. The results for each patient and the corresponding settings for their ECTs are presented in Table 1.

Seizures were elicited in 10 of the 11 patients. The one who did not fit was stimulated with only 600 pulses. Vertex stimulation appeared to be more effective in inducing seizure activity (Table 1; see patients 3, 4, 6 and 8). The mean duration of successful seizures was 31.3 s, range 9.5–86 s.

Orientation was recovered much faster after magnetic seizure therapy than after ECT. The mean time to recovery after successful seizures was 7 min 12 s (s.d. =2 min 7 s, range 4 min 20 s to 9 min 41 s). We compared these results with the recovery times of the same patients during their nearest ECT session(s) taking care that the order of ECT and magnetic seizure therapy sessions used for the calculation was approximately balanced. The mean recovery time after ECT was 26 min 35 s. When the recovery times of the nine patients who had both ECT and magnetic seizure therapy were compared in a paired-samples t-test, magnetic seizure therapy was shown to result in 15 min 35 s quicker recovery, and despite the small numbers, this result was highly significant at P < 0.0001.

Patients uniformly commented that they felt less confused after magnetic seizure therapy. Side-effects of 100 Hz magnetic seizure therapy were restricted to the usual myotonic movements observed after etomidate anaesthesia. No serious immediate adverse events resulted from the use of magnetic seizure therapy.

Discussion

We report the first use of a new magnetic seizure therapy device capable of sustaining maximum stimulator output for 10 s at 100 Hz (1000 pulses). We treated 11 patients with a total of 18 stimulations. To explore the range of seizure thresholds, we used a different number of pulses and two positions of the coil: over vertex (Cz) or pre-frontally (Fz). Seizures were elicited in 10 of the 11 patients. The one who did not fit received only 600 pulses over the vertex. This was a 70-year-old woman who was on valproate; both her age and anticonvulsant medication could account for the difficulty to elicit a seizure. Eight more patients received stimulation over the vertex of between 250 and 1000 pulses. One of these patients (our first patient) did not have a seizure when we used 250 pulses, but she fitted when restimulated at 500 pulses. These findings correspond to the previous observations that the mean seizure threshold with 50 Hz magnetic seizure therapy was at 268 or 320 pulses.12,14

Position of stimulation coil

We also tested whether stimulation at 100 Hz was capable of inducing seizures over the prefrontal cortex, which had been difficult to achieve at lower frequencies.9,12,13 We attempted seven prefrontal cortex stimulations in six patients. Of those, three were successful (one at 500 and two at 1000 pulses) and four were not successful (one at 500, one at 600, and two at 1000 pulses). Patients who did not fit with prefrontal stimulation fitted when stimulated over the vertex (Table 1). We conclude that even at the maximum setting of the machine, some patients will only fit if the coil is positioned over the vertex (i.e. closest to the motor cortex, which has a lower seizure threshold than the prefrontal or precentral cortices).

Seizure duration and recovery

We measured seizure duration during magnetic seizure therapy starting from the onset of stimulation. This is because we observed that the seizures in magnetic seizure therapy start during the stimulation train. In contrast, in ECT the convulsion typically does not start during electrical stimulation and a latent phase is usually seen immediately after stimulation.21

The mean duration of successful magnetic seizure therapy seizures was 31.3 s, range 10–86 s. Four patients had short seizures of 10, 18, 15 and 11 s (Table 1), which would not be considered therapeutic if evoked by ECT. Two of these patients were stimulated with only 600 pulses, raising the possibility that they may have had adequate seizures if stimulated at the maximum duration output (10 s) of the device.

In line with previous results,21 the recovery of orientation after magnetic seizure therapy was much faster than after ECT. Despite the small sample size, this difference was highly statistically significant and, more importantly, clinically meaningful. The ability to combine antidepressant efficacy with low neurocognitive adverse effects would be invaluable for patients who require neurostimulation therapies.22 All patients felt less confused after magnetic seizure therapy. Many patients felt as if they had received no treatment and remembered details of what had happened immediately prior to the therapy. For instance, patients were able to continue conversations after recovery that had begun just prior to therapy.

EEG changes during seizures

It has been noted that the EEG after magnetic seizure therapy differs markedly from that after ECT, with a lower amplitude and relative absence of post-ictal suppression.12,14 We confirmed these differences after stimulation at 100 Hz. Electroencephalogram traces during ECT showed high amplitude, synchronised EEG activity and clear post-ictal suppression which were markedly different from the EEG recorded after magnetic seizure therapy (traces available on request from the authors). The observed differences between ECT and magnetic seizure therapy ictal expression on EEG could be due to the more focal stimulation achieved with magnetic seizure therapy, which spares deeper brain regions such as the hippocampus that may be implicated in the cognitive side-effects of ECT.25 Differences in patterns of seizure expression might also explain the much faster recovery after magnetic seizure therapy. Another explanation for differences in ictal EEG expression between magnetic seizure therapy and ECT may stem from the fact that we were not recording EEG from directly under the magnetic coil, where the induced currents and seizure expression should be at its strongest. Specifically,
our scalp EEG recordings were collected from bilateral prefrontal cortex, whereas the most effective coil placement was over the vertex. We have since observed that placing the electrodes over the motor cortex during magnetic seizure therapy produces clearer seizure activity, confirming our impression that these seizures are more localised (S. H. Lisanby, personal communication, 2008).

Outlook

Limitations of this work include the small sample size, open design and non-randomised nature. Nevertheless, this initial pilot study found that magnetic seizure therapy delivered with the new Magstim Theta device was well-tolerated and reliably produced seizures in the majority of patients, while resulting in much less post-ictal confusion. These encouraging initial results beg the question of the efficacy of this new investigational intervention for severe major depression. Previous open studies using 40 Hz and 50 Hz magnetic seizure therapy6,14 showed promising results, although magnetic seizure therapy did not reach the effect size of optimal ECT. The ability to provide higher-dosage seizures relative to seizure threshold may narrow the gap in efficacy. This will be tested in the context of new trials now underway using the 100 Hz device to assess the effectiveness and safety of high-dose magnetic seizure therapy relative to ECT.

References

Quick recovery of orientation after magnetic seizure therapy for major depressive disorder
George Kirov, Klaus P. Ebmeier, Allan I. F. Scott, Maria Atkins, Najeeb Khalid, Lucy Carrick, Andrew Stanfield, Ronan E. O’Carroll, Mustafa M. Husain and Sarah H. Lisanby
Access the most recent version at DOI: 10.1192/bjp.bp.107.044362

References
This article cites 17 articles, 1 of which you can access for free at: http://bjp.rcpsych.org/content/193/2/152#BIBL

Reprints/permissions
To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at http://bjp.rcpsych.org/letters/submit/bjprcpsych;193/2/152

Downloaded from http://bjp.rcpsych.org/ on November 7, 2016
Published by The Royal College of Psychiatrists