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Summary

Schizophrenia and related psychoses CHAPTER 1 maintained their symptomatic improvement or improved further. Another small retrospective study of ECT augmentation of clozapine reported an acute response (defined as improvement rated on the Clinical Global Impression Improvement scale)¹⁹ in around three-quarters of the patient sample, and three-quarters of the responders remained out of hospital over a 1-year follow-up period.²⁰ In a randomised, single-blind study,² participants with clozapine-refractory schizophrenia either continued solely on their clozapine treatment or had it augmented with a course of bilateral ECT. After 8 weeks, a predefined response criterion (which included a 40% or greater reduction in the psychotic symptom subscale of the Brief Psychiatric Rating Scale)²¹ was met by half the participants receiving clozapine plus ECT but none of the group on clozapine alone. When the non-responders from the clozapine-alone group crossed over to an 8-week, open trial of ECT, nearly half met the response criterion. A 2016 systematic review and meta-analysis²² looking specifically at ECT augmentation of clozapine treatment found a paucity of controlled studies, although the authors acknowledged the methodological challenges of such investigations. They concluded that ECT may be an effective augmentation strategy for schizophrenia that has failed to respond to clozapine monotherapy, but that further research was required to determine the place of such a strategy in any TRS treatment algorithm. A subsequent meta-analysis of RCTs addressing ECT augmentation for clozapine-resistant schizophrenia noted the lack of studies with sham ECT as a control, but reached the conclusion that such a treatment strategy was effective and relatively safe.²³ In 2021, Chakrabarti⁹ reinforced the point that such meta-analyses were based on limited and low-quality evidence and only addressed the short-term efficacy of ECT augmentation. Counter to the relatively encouraging conclusions of these meta-analyses, in a more recent, 10-week RCT²⁴ involving 40 participants with clozapine-resistant schizophrenia, augmentation with real ECT was not found to be superior to sham treatment in terms of symptom response. The primary outcome was a 50% reduction in PANSS total score, but this was achieved for only one participant (in the real ECT group). There is some provisional evidence that maintenance ECT may be effective when combined with clozapine.²⁵

Adverse effects Although ECT augmentation of continuing antipsychotic medication appears to be generally well tolerated, adverse effects such as transient retrograde and anterograde amnesia, drowsiness, headaches and nausea have been reported for a minority of cases^{3,12,13,24,26} and there are reports of an increase in blood pressure after ECT and prolonged seizures.¹ The cognitive adverse effects are generally considered to be mild and transient.^{20,23,27}

Summary While the evidence remains rather inconclusive, it tends to support ECT augmentation of antipsychotic treatment, particularly clozapine, as a potentially efficacious and relatively safe augmentation strategy in TRS.^{7,28–30} However, further, well-controlled trials are required to establish the clinical benefit-risk balance of such a treatment strategy in both the short and long term.

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