

It is illegal to post this copyrighted PDF on any website.

Consensus Recommendations for rTMS in Depression: Not Entirely Correct!

To the Editor: The recently published consensus recommendations¹ on use of transcranial magnetic stimulation (TMS) for treating depression are very thorough and the most comprehensive recommendations published to date. However, there were several points that should not be accepted into guidelines.

First, there is no evidence that adding pharmacotherapy to TMS improves response and remission rates. A study of active TMS + placebo medication, active TMS + active medication, sham TMS + active medication, and sham TMS + placebo medication has not been done yet.

Second, the article states (in the section Evidence Basis for Antidepressant Efficacy) that 21% of subjects in the H1-coil multicenter trial² failed 3 or more medications in the current trial (second-stratum group). In fact, 41.5% of the patients failed 3 or more medications in the current episode.²

Third, in the same section, the article compares the H-coil second-stratum group to Sequenced Treatment Alternatives to Relieve Depression (STAR*D) steps/levels 3 and 4, while in fact only level 4 is comparable to the H1-coil second-stratum group (patients in both failed 3 or more medications in the current episode). Moreover, the 28.9% remission rate in the second-stratum group with the H1-coil occurred in the context of a double-blind antidepressant-free study, while the 13% remission rate for STAR*D step 4 was in an open-label study, a design in which patients typically have higher response and remission rates.³

Fourth, there is no evidence for any role of a physical examination component to evaluate the medical safety of rTMS. Every clinical trial for TMS included a physical examination component at baseline and endpoint, and none reported any significant findings. While our colleagues in primary care are eliminating more and more screening physical examination components that lack evidence, we should not add physical examinations to the treatment of depression patients.

Fifth, informed consent is a process and not a form, and the process should not differ between pharmacologic or TMS treatments. The potential for serious side effects from medications is much greater than from TMS, and there is no need for a consent form for medications or TMS separate from a general consent for treatment. Rather, there should be documentation of a risk-benefit conversation with the individual patient. There are advantages to an informed consent form, in that it simplifies the documentation, but there is no advantage to signing a consent form a second time for a second treatment course.

Sixth, confirmation or redetermination of the motor threshold (MT) in patients on medications should probably be done by the operators on a daily basis. The most likely cause of a TMS-induced seizure is a change in cortical excitability, measured as the resting MT. The most likely culprit for MT changes is medication (a change in intake, absorption, or metabolism).

Seventh, patients with implanted vagal nerve stimulation devices (or other conductive metal in the neck) can be treated with rTMS with no safety concerns.^{4,5} Regardless of the coil, there is no magnetic field or induced electrical field that reaches the neck.^{6,7}

REFERENCES

1. McClintock SM, Reti IM, Carpenter LL, et al; National Network of Depression Centers rTMS Task Group, American Psychiatric Association Council of Research Task Force on Novel Biomarkers and Treatments. Consensus recommendations for the clinical application of repetitive transcranial magnetic stimulation (rTMS) in the treatment of depression. *J Clin Psychiatry*. 2018;79(1):16cs10905.
2. Levkovitz Y, Isserles M, Padberg F, et al. Efficacy and safety of deep transcranial magnetic stimulation for major depression: a prospective multicenter randomized controlled trial. *World Psychiatry*. 2015;14(1):64–73.
3. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. *Am J Psychiatry*. 2006;163(11):1905–1917.
4. Philip NS, Carpenter SL, Carpenter LL. Safe use of repetitive transcranial magnetic stimulation in patients with implanted vagus nerve stimulators. *Brain Stimul*. 2014;7(4):608–612.
5. Sperling W, Kornhuber J, Wiltfang J, et al. Combined VNS-rTMS treatment in a patient with therapy resistant depression. *Pharmacopsychiatry*. 2007;40(1):39–40.
6. Roth Y, Amir A, Levkovitz Y, et al. Three-dimensional distribution of the electric field induced in the brain by transcranial magnetic stimulation using figure-8 and deep H-coils. *J Clin Neurophysiol*. 2007;24(1):31–38.
7. Lu M, Ueno S. Comparison of the induced fields using different coil configurations during deep transcranial magnetic stimulation. *PLoS One*. 2017;12(6):e0178422.

Aron Tendler, MD^{a,b}
aron.tendler@gmail.com
Roman Gersner, PhD^b

^aAdvanced Mental Health Care Inc., Royal Palm Beach, Florida

^bBrainsway Ltd., Jerusalem, Israel

Potential conflicts of interest: Drs Tendler and Gersner have a financial interest in Brainsway Ltd., the manufacturer of the H1-coil.

Funding/support: None.

Role of the sponsor: None.

J Clin Psychiatry 2018;79(1):171r11851

To cite: Tendler A, Gersner R. Consensus recommendations for rTMS in depression: not entirely correct! *J Clin Psychiatry*. 2018;79(1):171r11851.

To share: <https://doi.org/10.4088/JCP.171r11851>

© Copyright 2018 Physicians Postgraduate Press, Inc.

You are prohibited from making this PDF publicly available.

It is illegal to post this copyrighted PDF on any website.

Dr McClintock and Colleagues Reply

To the Editor: We appreciate the interest of Drs Tendler and Gersner in our recent consensus recommendations for the clinical application of repetitive transcranial magnetic stimulation (rTMS) in the treatment of depression.¹ They raise 7 points about the consensus recommendations. Regarding their first point about combining rTMS with medication, we clarify that while published data suggest that the combination of rTMS and current pharmacotherapy is safe,² there is no randomized controlled evidence at present that the combination, relative to rTMS alone, would confer greater response and remission rates.

Regarding their second and third points about the antidepressant treatment resistance level that characterized the sample in the industry-sponsored H1-coil randomized controlled clinical trial,³ we note that Table 1 in the published report by Levkovitz et al indicated that 21.8% and 20.7% of participants in the active deep-TMS and sham groups, respectively, failed 3 or more medications.³ Drs Tendler and Gersner suggest that participants from the Levkovitz et al³ study were comparable to patients treated in step 4 of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study.⁴ While open-label and randomized controlled clinical trials may generate different clinical outcomes, we maintain that the Levkovitz et al³ study sample may be comparable to STAR*D patients in either step 3 or step 4 since many patients in step 1 of the STAR*D study (n = 3,057) had received prior treatment for their current depressive episode before entering the study.⁵

Regarding the fourth point, Drs Tendler and Gersner object to the recommendation for physical examination in rTMS patient care. However, the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients With Major Depressive Disorder⁶ indicated that pretreatment evaluation should include identification of medical disorders that may contribute to the patient's presentation or complicate care. Moreover, the APA Practice Guideline⁶ further recommended coordination of care between the psychiatrist and other health professionals, such as a primary care provider, who may be performing physical examinations. Thus, we recommend that a targeted physical examination (either newly conducted or previously conducted and documented in the medical record) be a component of the pre-rTMS treatment evaluation to provide the prescribing clinician with, in addition to the medical history, sufficient knowledge to make informed medical decisions and ensure medical safety and necessity of rTMS.^{7,8}

We agree with their fifth point that informed consent is a process and not a form, and we recommend that the informed consent process be documented, which includes the written informed consent form. Moreover, informed consent is part of standard clinical care,⁹ and we clarify that reobtaining consent is necessary when there has been a change in treatment protocol, risks, or benefits related to rTMS antidepressant treatment.¹⁰

In their sixth point, Drs Tendler and Gersner note that the patient's motor threshold should be assessed on a daily basis. We disagree with daily checking of the motor threshold, as there is only 1 study of this¹¹ and otherwise little evidence to suggest that the motor threshold is unstable over a standard rTMS treatment course (eg, 4–6 weeks). Rather, we recommend that the motor threshold be established before starting rTMS and rechecked if there has been a clinical event or change in medication that could alter the seizure threshold.

To their seventh point, we disagree that “patients with implanted vagal nerve stimulation devices... can be treated with rTMS with no safety concerns.” While it is generally safe to use rTMS in patients treated with VNS as long as the TMS coil is not activated near the implanted VNS device and leads,^{12,13} we recommend caution given the limited safety data and coordination with clinicians experienced

in the application of VNS therapy to review contraindications to rTMS and/or to monitor the functioning of the VNS device.

It has been almost a decade since the US Food and Drug Administration cleared rTMS for the treatment of depression in adults. Over that time period, the clinical use of rTMS has increased, and, as the letter by Drs Tendler and Gersner points out, the practice of rTMS is in clear need of consensus guidelines to standardize quality, evidence based, clinical care. We appreciate the comments by Drs Tendler and Gersner as they highlight a number of practical issues that clinicians may have with varying standards of care, and we hope our consensus recommendations will serve as a vehicle to advance and inform these discussions.

REFERENCES

1. McClintock SM, Reti IM, Carpenter LL, et al; National Network of Depression Centers rTMS Task Group, American Psychiatric Association Council of Research Task Force on Novel Biomarkers and Treatments. Consensus recommendations for the clinical application of repetitive transcranial magnetic stimulation (rTMS) in the treatment of depression. *J Clin Psychiatry*. 2018;79(1):16cs10905.
2. Carpenter LL, Aaronson ST, Clarke GN, et al. rTMS with a two-coil array: safety and efficacy for treatment resistant major depressive disorder. *Brain Stimul*. 2017;10(5):926–933.
3. Levkovitz Y, Isserles M, Padberg F, et al. Efficacy and safety of deep transcranial magnetic stimulation for major depression: a prospective multicenter randomized controlled trial. *World Psychiatry*. 2015;14(1):64–73.
4. Rush AJ, Trivedi JH, Wisniewski SR, et al. Bupropion-SR, sertraline, or venlafaxine-XR after failure of SSRIs for depression. *N Engl J Med*. 2006;354(12):1231–1242.
5. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: A STAR*D report. *Am J Psychiatry*. 2006;163(11):1905–1917.
6. Gelenberg AJ, Freeman MP, Markowitz JC, et al; Work Group on Major Depressive Disorder. *Practice Guideline for the Treatment of Patients With Major Depressive Disorder*. 3rd ed. Arlington, VA: American Psychiatric Association; 2010.
7. Azzam PN, Gopalan P, Brown JR, et al. Physical examination for the academic psychiatrist: primer and common clinical scenarios. *Acad Psychiatry*. 2016;40(2):321–327.
8. Garden G. Physical examination in psychiatric practice. *Adv Psychiatr Treat*. 2005;11(2):142–149.
9. Grady C. Enduring and emerging challenges of informed consent. *N Engl J Med*. 2015;372(9):855–862.
10. Miller FG, Colloca L. The placebo phenomenon and medical ethics: rethinking the relationship between informed consent and risk-benefit assessment. *Theor Med Bioeth*. 2011;32(4):229–243.
11. Zarkowski P, Navarro R, Pavlicova M, et al. The effect of daily prefrontal repetitive transcranial magnetic stimulation over several weeks on resting motor threshold. *Brain Stimul*. 2009;2(3):163–167.
12. Rossi S, Hallett M, Rossini P, et al; The Safety of TMS Consensus Group. Safety, ethical considerations, and application guidelines for the use of transcranial magnetic stimulation in clinical practice and research. *Clin Neurophysiol*. 2009;120(12):2008–2039.
13. Phillips NS, Carpenter SL, Carpenter LL. Safe use of repetitive transcranial magnetic stimulation in patients with implanted vagus nerve stimulators. *Brain Stimul*. 2014;7(4):608–612.

Shawn M. McClintock, PhD, MSCS^{a,b}
shawn.mcclintock@utsouthwestern.edu

Irving M. Reti, MBBS^c

Linda L. Carpenter, MD^d

William M. McDonald, MD^e

Marc Dubin, MD, PhD^f

Stephan F. Taylor, MD^g

Ian A. Cook, MD^h

John O'Reardon, MDⁱ

Mustafa M. Husain, MD^{a,b}

Christopher Wall, MD^j

Andrew Krystal, MD^{b,k}

Shirlene Sampson, MD^l

Oscar Morales, MD^m

Brent G. Nelson, MDⁿ

Mark S. George, MD^{o,p}

Sarah H. Lisanby, MD^b

You are prohibited from making this PDF publicly available.

It is illegal to post this copyrighted PDF on any website.

^aDepartment of Psychiatry, UT Southwestern Medical Center, Dallas, Texas

^bDivision of Brain Stimulation and Neurophysiology, Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, North Carolina

^cDepartment of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine, Baltimore, Maryland

^dButler Hospital, Brown Department of Psychiatry and Human Behavior, Providence, Rhode Island

^eDepartment of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, Georgia

^fDepartment of Psychiatry, Weill Cornell Medical College, White Plains, New York

^gDepartment of Psychiatry, University of Michigan, Ann Arbor, Michigan

^hSemel Institute for Neuroscience and Human Behavior, Departments of Psychiatry and Behavioral Sciences and of Bioengineering, University of California at Los Angeles, Los Angeles, California

ⁱDepartment of Psychiatry and Behavioral Sciences, Rowan University School of Medicine, Stratford, New Jersey

^jPrairieCare, Rochester, Minnesota

^kDepartment of Psychiatry, University of California San Francisco School of Medicine, San Francisco, California

^lDepartment of Psychiatry and Psychology, Mayo Clinic, Rochester, Minnesota

^mPsychiatric Neurotherapeutics Program, McLean Hospital, Harvard Medical School, Boston, Massachusetts

ⁿDepartment of Psychiatry, University of Minnesota, St Louis Park, Minnesota

^oDepartment of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina

^pRalph H. Johnson VA Medical Center, Charleston, Charleston, South Carolina

Potential conflicts of interest: The authors' disclosures accompany the original article.

Funding/support: None.

J Clin Psychiatry 2018;79(1):171r11851a

To cite: McClintock SM, Reti IM, Carpenter LL, et al. Dr McClintock and colleagues reply. *J Clin Psychiatry*. 2018;79(1):171r11851a.

To share: <https://doi.org/10.4088/JCP.171r11851a>

© Copyright 2018 Physicians Postgraduate Press, Inc.

You are prohibited from making this PDF publicly available.