Anaesthesia for ECT during the COVID-19 pandemic

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The Royal College of Anaesthetists (RCoA) and the Association of Anaesthetists acknowledge that ECT is a NICE-approved treatment that is an urgent and important element of the management of some patients. These comments on the conduct of anaesthesia for ECT are made in the context of the COVID-19 pandemic.

Anaesthesia for ECT involves the administration of a hypnotic and a neuromuscular blocking drug, and therefore routinely involves manual ventilation of the lungs. Manual ventilation is currently considered by Public Health England (PHE) to be a potentially infectious aerosol-generating procedure (AGP) for COVID-19 when patients are in medium-risk or high-risk pathways as defined by the latest PHE guidance. This guidance recommends that only Standard Infection Control Precautions (SICPs) need be used in low-risk patient pathways. SICPs for an ECT treatment comprise: gloves (single use), apron (single use), fluid-resistant surgical mask (extended use possible) and consideration of the use of eye protection. Low-risk patients include:

- Asymptomatic patients with a negative PCR (antigen) test within 72 hours who have self-isolated in accordance with NICE guidance.
- Those who have recovered from COVID-19, have been asymptomatic for >72 hours and have a negative PCR.
- Patients who are tested regularly and have a negative PCR, including inpatients in areas in which COVID-19 patients are not treated.

Many patients presenting for ECT will be in a low-risk pathway, and therefore their ECT treatment can be conducted without the need for FFP3 masks, waiting for periods for aerosol clearance or recovering patients in the treatment room, i.e. with only SICPs. However, when there is concern that patients who might otherwise be classifiable as low-risk may have been mixing with other patients whose risk category is uncertain, it might be wise to consider these patients as being in a medium or high-risk pathway.

When patients presenting for ECT are in medium-risk or high-risk pathways, it will be necessary to use airborne transmission-based precautions (TBPs). We recommend that only those necessary for the performance of the procedure be present in the treatment area: the patient, a psychiatrist, a psychiatry nurse, an anaesthetist and an anaesthesia assistant. Trainees in anaesthesia and psychiatry.
may also be present. Airborne precaution PPE should be worn by all present. Treatment can proceed immediately after induction of anaesthesia, as is normal practice for ECT. After treatment, the patient can be transferred to a recovery area once invasive airway adjuncts, e.g. oral airways, have been removed. PHE guidance for medium-risk and high-risk pathway patients requires that an aerosol clearance time of five times the time taken for one air exchange in a clinical area (ACT₅) be allowed after an AGP before others who are not wearing airborne PPE can enter the treatment area. Hospitals should ensure that air exchange data for ECT treatment areas is available to allow accurate estimation of ACT₅.

ECT treatment should be considered a part of the provision of emergency services by departments of anaesthesia, and Clinical Directors should ensure that staff are made available for ECT treatments during the endemic phase of COVID-19 and during any surges in prevalence that may follow. Very occasionally, the provision of ECT treatment may require the transport of patients to treatment areas in which there are rooms that have high air exchange rates in order to facilitate treatment. Such arrangements should not be made without the involvement and support of psychiatrists.

Training in anaesthesia for remote sites is a key part of the curriculum of the FRCA examination. Trainee anaesthetists should therefore be involved in the delivery of anaesthesia for ECT provided that this has the support of the relevant School of Anaesthesia, and the trainee has been appropriately risk assessed.