Study the efficacy of repetitive transcranial magnetic stimulation on a sample of resistant schizophrenic patients with positive and negative symptoms

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Study the efficacy of repetitive transcranial magnetic stimulation on a sample of resistant schizophrenic patients with positive and negative symptoms

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ABSTRACT

Background: Transcranial magnetic stimulation one of the tools that may help schizophrenic patients.

Aim of The Work: To Examine the validation of rTMS in treatment positive and negative symptoms of refractory schizophrenic patients.

Patients and Methods: The study included 40 resistance schizophrenic patients separated into two groups: Group A: 20 patients received 15 sessions of r-TMS for 3 weeks, With five daily sessions with a two day break, Group B: 20 patients were randomly (one every one patients) chosen for sham stimulation. The Positive and Negative Syndrome Scale was used to examine all patients before and after the intervention. Department of Psychiatry, Faculty of Medicine, Al-Azhar University, Cairo

Results: The mean age of all studied patients was 30.4 ± 5.5 years. 22 were males (55%) and 18 females (45%). The mean BMI of all studied patients was 28.7 ± 3.01 (kg/m²). The mean duration of disease was 11.45 ± 6.3 months. The mean age of onset was 18.9 ± 2.4 years. There were 9 patients (22.5%) with positive family history. Active rTMS was accompanied by significant improvement in total PANSS degree, PANSS positive degree, PANSS negative degree and general psychopathology degree. The sham (placebo group) did not show any significant changes in schizophrenic symptoms (negative nor positive).

Conclusion: Dual mode distribution rTMS stimulation of left DLPFC and left TPC could significantly improve schizophrenic patients with positive and negative symptoms.

Keywords: Resistant Schizophrenia; positive symptoms; negative symptoms; Transcranial Magnetic Stimulation.

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INTRODUCTION

Schizophrenia has been described as a disease of brain connection, which is thought to constitute the pathophysiology of this sickness.

Schizophrenia starts early in life and consequently reasons significant and long term disabilities. This requires continuous medical care, as well as rehabilitation and support services. The financial costs of the sickness in the United States have been estimated to be greater than the expenses for all cancers combined.

Auditory hallucinations (AH) are one of the most common symptoms of schizophrenia, affecting 70–80% of patients. They have been related to anatomical and/or physiological brain abnormalities in this disorder. Changes in the integrity of white matter in the left arcuate fascicle and inter hemispheric projections through the corpus callosum, for example, were linked to AH in schizophrenia patients in the structural domain.

Antipsychotics are efficacy in many cases, but they can also cause a lot of side effects like weight gain, sedation, increase serum prolactin, tardive dyskinesia and other movement disorders. Furthermore, around 25% to 30% of patients recognized with schizophrenia not respond to antipsychotic medication.

Repetitive Transcranial Magnetic Stimulation (rTMS) is a non-operative brain activation approach that has been found to be beneficial in the treatment of neuropsychiatric diseases including resistant depression, OCD, Neuropathic pain, autism, and migraine, among others.

Few studies have lately tried it for the management of schizophrenia, with varying results.

PATIENTS AND METHODS

This study was a Randomized interventional study conducted in Department of Psychiatry, Faculty of Medicine, Al-Azhar University

The study included forty patients who were schizophrenic according to standard of Diagnostic and Statistical Manual of Mental Disorders (DSM 5), which inclusive positive symptoms like hallucinations, delusions, and negative symptoms like poverty of motivation and lack of interest. Patients were selected randomly from the outpatient
Twenty patients were treated by actual r-TMS and same number were subjected to sham stimulation as a group.

We utilized a Magstimrapid2 TMS machine (Magstim Ltd, Whitland, Wales) and a figure-of-eight coil to supply the r-TMS (diameter of each wing 70mm, peak magnetic field 2.2T). At the outset, we used the vision of movement to determine each patient’s motor threshold. Motor threshold is defined as the less exciting stimulation able to causing an apparent finger movement by the abductor policies braves in at least 5 of 10 primary motor cortex stimulations\textsuperscript{10}.

We used the International 10–20 technique used for EEG to identify the stimulation areas, naming the left dorsolateral prefrontal cortex (DLPFC) as F3 and the left TemporoParietal Cortex as the midway between T3 and P3. All patients had 15 r-TMS treatments over the course of three weeks, with five daily sessions separated by a two-day rest period. Each session had 40 trains that ran every 30 seconds: 20 trains of ten Hz r-TMS with a 3-s duration to the left DLPFC and 20 trains of one Hz r-TMS with a 30-s duration to the left TPC.

This approach included activating the left DLPFC with high-frequency energizing and the left TPC with low-frequency energizing\textsuperscript{10}.

The sham stimulation will be identically localized, with the coil oriented 90 degrees far from the skull. This approach produces intracerebral voltage around One third that of active TMS energizing while reproducing sound and a few body sensations (e.g. vibration and contraction of scalp muscles) that resemble active stimulation\textsuperscript{9}.

Statistical analysis:

Version 18.0 of the Statistical Program for the Social Sciences (SPSS) was utilized to analyze the data. Quantitative data were expressed as mean standard deviation (MSD), while qualitative data was expressed as frequency and percentage No ( percent ), and the two were compared using the scholar t-test. To compare nonparametric data, the Chi-square test was used. P- values were calculated using a statistical significance of P 0.05.

RESULTS

Baseline characteristics:

As regard description of demographic and laboratory data, the average age of all studied patients was 30.4 ± 5.5 years with least age of 21 years and most age of 42 years. 22 were males (55%) and 18 females (45%). The mean BMI of all studied patients was 28.7 ± 3.01 (kg/m²). The mean duration of disease was 11.45 ± 6.3 months. The mean age of onset was 18.9 ± 2.4 years. There were 20 smokers (50%). There were 9 patients (22.5%) with positive family history. 22 of studied patients were from rural (55%) and 18 from urban (45%).

There was no statistical significant difference (p-value > 0.05) between studied groups as regard demographic data (age, sex, duration, onset age, smoking, family history and residence). The baseline
total PANSS grade of patients in the active rTMS group (78.4±16) and the placebo (sham) group (76.4± 12.2) was not significantly different (p-value > 0.05).

Efficacy of rTMS

Our study results showed that active rTMS had a significant impact in total PANSS degree, PANSS positive degree, PANSS negative degree and general psychopathology.

Among patients of active rTMS group, the total PANSS score was 78.35±16 and after treatment it became 51.8±12.8 with highly statistical significant difference. The score of positive symptoms was 18.05±4.4 before treatment and 13.5±6.08 after treatment. The negative symptoms were 26.05±6.16 and became 15.55±5.18 with highly statistical significant difference; the general psychopathology score was 34.25±15.22 and became 22.75±9.54.

Among patients of sham rTMS group, the total PANSS score was 76.4±12.2 and after treatment it became 73.9±12.5. The score of positive symptoms was 19.2±5.5 before treatment and 17.9±4.9 after treatment. The negative symptoms were 24.2±7.0 and became 23.60±6.8; the general psychopathology score was 33.1±6.8 and became 32.4±6.5, the difference was not significant in all patients (50%), and one "severe" patient (12.5%).

In female patients with hand pain (n = 36), Kellegren Lawrence class was mild (grade II) in eight patients (22.2%), moderate (grade III) in 21 patients (58.3%) and severe (grade IV) in seven patients (19.4%). There were morphological changes in four "mild" patients (11.1%), 13 "moderate" patients (36.1%) and four "severe" patients (11.1%). There was low capillary density in 5 "mild" patients (13.9%), 17 "moderate" patients (47.2%) and 5 "severe" patients (13.9%).

So, there were about 41 patients (73.2%) with low capillary density in all studied patients.

<table>
<thead>
<tr>
<th>Studied patients (N = 40)</th>
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<tbody>
<tr>
<td><strong>Age (years)</strong></td>
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<tr>
<td>Min – Max</td>
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<tr>
<td><strong>Sex</strong></td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<tr>
<td><strong>BMI (kg/m²)</strong></td>
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<tr>
<td>Min – Max</td>
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<tr>
<td><strong>Duration of disease (months)</strong></td>
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<tr>
<td>Min – Max</td>
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<tr>
<td><strong>Age of onset (years)</strong></td>
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<tr>
<td>Min – Max</td>
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<tr>
<td><strong>Smoking</strong></td>
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<tr>
<td>No</td>
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<tr>
<td>Smoker</td>
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<td><strong>Family history</strong></td>
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<tr>
<td>Negative</td>
</tr>
<tr>
<td>Positive</td>
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<tr>
<td><strong>Residence</strong></td>
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<tr>
<td>Rural</td>
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<td>Urban</td>
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<tr>
<th>(Pre rTMS)</th>
<th>Cases (N = 20)</th>
<th>Sham (N = 20)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General psychopathology</strong></td>
<td>Mean</td>
<td>34.3</td>
<td>33.1</td>
</tr>
<tr>
<td>±SD</td>
<td>15.2</td>
<td>6.8</td>
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<tr>
<td><strong>Negative symptoms</strong></td>
<td>Mean</td>
<td>26.1</td>
<td>24.2</td>
</tr>
<tr>
<td>±SD</td>
<td>6.2</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td><strong>Positive symptoms</strong></td>
<td>Mean</td>
<td>18.1</td>
<td>19.2</td>
</tr>
<tr>
<td>±SD</td>
<td>4.4</td>
<td>5.5</td>
<td></td>
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<tr>
<td><strong>Total PANSS</strong></td>
<td>Mean</td>
<td>78.4</td>
<td>76.4</td>
</tr>
<tr>
<td>±SD</td>
<td>16.0</td>
<td>12.2</td>
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Table 1: Description of demographic data in studied groups

Table 2: comparison between studied groups as regard Pre rTMS Clinical assessment.

This table shows no statistical significant difference (p-value > 0.05) between studied groups as regard Pre rTMS Clinical assessment (General psychopathology, negative symptoms, positive symptoms and total PANSS).
(Cases group) | Pre (N = 20) | Post (N = 20) | P-value
--- | --- | --- | ---
**General psychopathology**<br>Mean | 34.25 | 22.75 | 0.007 S<br>±SD | 15.22 | 9.54
**Negative symptoms**<br>Mean | 26.05 | 15.55 | < 0.001 HS<br>±SD | 6.16 | 5.18
**Positive symptoms**<br>Mean | 18.05 | 13.50 | 0.01 S<br>±SD | 4.43 | 6.08
**Total PANSS**<br>Mean | 78.35 | 51.80 | < 0.001 HS<br>±SD | 16.04 | 12.83

Table 3: Comparison of Pre and post active rTMS Clinical assessment in Cases group.

This table shows statistical significant difference (p-value < 0.001) between Pre and post active rTMS Clinical assessment in Cases group.

(Sham group) | Pre (N = 20) | Post (N = 20) | P-value
--- | --- | --- | ---
**General psychopathology**<br>Mean | 33.1 | 32.4 | 0.759 NS<br>±SD | 6.8 | 6.5
**Negative symptoms**<br>Mean | 24.2 | 23.6 | 0.767 NS<br>±SD | 7.0 | 6.8
**Positive symptoms**<br>Mean | 19.2 | 17.9 | 0.452 NS<br>±SD | 5.5 | 4.9
**Total PANSS**<br>Mean | 76.4 | 73.9 | 0.518 NS<br>±SD | 12.2 | 12.5

Table 4: Comparison of Pre and post active rTMS Clinical assessment in Sham group.

This table shows no statistical significant difference (p-value > 0.05) between Pre and post sham rTMS Clinical assessment.

**DISCUSSION**

Our study outcomes confirmed that active rTMS was linked with significant improvement in total PANSS degree, PANSS positive degree, PANSS negative degree and general psychopathology degree.

In agreement with the current study, Oh and Kim used the identical r-TMS protocol as the present study and they found that r-TMS was effective in decreasing the total degree of PANSS and degree of the positive and negative subscale.11

Results obtained in this study were resemble with Foulet et al. who conducted a double-blind study of ten patients with treatment resistant auditory hallucinations.12

In a current meta-analysis by He et al. who did thirteen studies for evaluation, and similarly detected a modest impact for 1-Hz rTMS on auditory hallucinations in schizophrenic patients.13

In contrast to our results, Fitzgerald et al. found no difference in therapeutic effect in the domains between the real and sham groups of twenty patients complaining from modest to sharp resistant negative symptoms.14

Similarly, Saba et al. used TMS for 10 days to treat eighteen schizophrenia patients with persistent auditory hallucinations. There were no beneficial between the impact and placebo groups, according to the researchers.15

In 2011, a number of randomized experiments utilizing fMRI to determine TMS treatment location
did not show any improvement in the intensity of auditory hallucinations.16

In agreement with this study, a sham-controlled trial was performed by Hajak et al. on twenty schizophrenia patients who obtained high frequency TMS to the left dorsolateral prefrontal cortex over ten days. Functional neuroimaging was done at the conclusion of the research; there was a significant decrease in negative and depressed symptoms, but no changes in neuroimaging were reported.17

In another recent study from our locality, by Nagy et al. who led to a Randomized interventional research on forty patients with schizophrenia. There was statistical significance differences between active and sham group as regarding PANSS Negative subdomain scale, used prior and after the rTMS sessions (P value= 0.001 ).18

In contrast to our results, numerous different clinical studies haven't supported validation of rTMS in the management of negative symptoms of schizophrenic patients.

A meta-analysis conducted through Freitas et al comprising eight high frequency (10 Hz) stimulus studies practice to the left dorsolateral prefrontal part of the cortex in schizophrenia patients with seen an impact length of 0.58.19

Another meta-analysis looked at seven high-frequency controlled trials on schizophrenia patients’ left dorsolateral prefrontal cortex and found an effect size of 0.63. TMS effect sizes range from 0.27 to 0.63, which is positive; given that effect sizes for neuroleptic drug therapy of bad symptoms range from 0.17 to 0.21.20

CONCLUSION

Dual mode distribution to rTMS energizing of both left DLPFC and left TPC could be significantly improve positive and negative symptoms in resistant schizophrenic patients.

REFERENCES


