



## Comparing fast-acting interventions for treatment-resistant depression: An explorative study of accelerated HF-rTMS *versus* intranasal esketamine

Dear Editor,

Treatment-resistant depression (TRD), the non-response to two different antidepressant classes during a major depressive episode, is a severe clinical condition in almost 30% of depressed patients, carrying substantial direct and indirect financial burdens on the healthcare system [1]. Accelerated rTMS (arTMS) protocols are novel approaches that exert a comparable antidepressant efficacy without significantly compromising the safety and tolerability associated with the standard rTMS regimen [2,3]. arTMS also ensures the potential for rapid antidepressant action, observable within the initial post-treatment weeks [4]. This qualifies arTMS as a rapid therapeutic intervention for TRD, comparable to glutamatergic modulators like intranasal esketamine (ESK-NS), an N-methyl-D-aspartate (NMDA) receptor antagonist [5], approved as the first therapeutic agent for TRD by FDA and EMA [6].

A direct comparison between these two treatment protocols is currently missing. Hence, this study aimed to compare (a) the effectiveness and the speed of antidepressant action and (b) the safety and tolerability of arTMS and ESK-NS in treating TRD.

In a multicentric, observational, retrospective study, we studied 59 patients with TRD (women/men,  $n = 32/n = 27$ ; age,  $54.61 \pm 11.32$ ) who consecutively underwent either a one-week, high-frequency rTMS protocol (ReModula: four daily sessions of HF-rTMS over the left DLPFC for five consecutive days) or a three-month ESK-NS therapy (biweekly administrations in the first month; weekly in the second month; bimonthly in the third month). Study design and administration procedures of arTMS and ESK-NS are fully detailed in supplementary materials. Treatment assignment (arTMS:  $n = 30$ ; ESK-NS:  $n = 29$ ) was determined based on the clinician's judgment. The depression severity was assessed with the total score of the Montgomery-Åsberg Depression Rating Scale (MADRS) at baseline (T0), one month (T1), and three months (T2) after the initiation of treatment.

Sociodemographic and clinical characteristics did not differ between treatment groups at T0 (see supplementary materials), except for a longer duration of the current episode among those patients treated with arTMS (months,  $19.57 \pm 13.42$  vs.  $12.03 \pm 9.47$ ;  $t_{57} = 2.484$ ,  $p = 0.016$ ).

rm-ANCOVA (within-factor: "time"; between-factors: "gender", "protocol"; covariate: age, duration of the current episode, number of failed antidepressant trials in the current episode) showed a significant "time"  $\times$  "protocol" interaction effect ( $F_{2,104} = 3.814$ ,  $p = 0.025$ ,  $\eta_p^2 = 0.068$ ) on MADRS score, with Mauchly's test of sphericity not significant ( $W = 0.893$ ,  $\chi_2^2 = 5.794$ ,  $p = 0.055$ ). As shown in Fig. 1A, the MADRS scores between the two groups:

a) did not differ at baseline ( $p = 0.307$ );

- b) decreased significantly and separately at T1 (arTMS, T0 vs. T1:  $p < 0.001$ ,  $d = 1.709$ ; ESK-NS, T0 vs. T1:  $p < 0.001$ ,  $d = 1.361$ ) and T2 (arTMS, T0 vs. T2:  $p < 0.001$ ,  $d = 1.822$ ; arTMS, T1 vs. T2:  $p = 0.989$ ,  $d = 0.218$ ; ESK-NS, T0 vs. T2:  $p < 0.001$ ,  $d = 2.338$ ; ESK-NS, T1 vs. T2:  $p < 0.001$ ,  $d = 1.042$ );
- c) significantly differed at T1 ( $p = 0.048$ ), with a higher MADRS decrease ( $d = 0.864$ ) in the arTMS group, but did not at T2 ( $p = 1.000$ ).

As shown in the upper panels of Fig. 1B, the response rates (RRs) ( $\geq 50\%$  decrease of MADRS total score) were significantly higher in arTMS than ESK-NS at T1 (respectively,  $n = 15/50\%$  vs.  $n = 5/17.24\%$ :  $\chi_1^2 = 7.062$ ,  $p = 0.008$ ), but not at T2 ( $n = 18/60\%$  vs.  $n = 20/68.97\%$ :  $\chi_1^2 = 0.517$ ,  $p = 0.472$ ). The remission rates (MADRS total score  $< 10$ ) did not differ between groups at T1 and T2 (T1,  $n = 5/16.67\%$  vs.  $n = 1/3.45\%$ :  $\chi_1^2 = 2.820$ ,  $p = 0.093$ ; T2,  $n = 12/40\%$  vs.  $n = 10/34.48\%$ :  $\chi_1^2 = 0.192$ ,  $p = 0.661$ ), as depicted in lower panels of Fig. 1B.

Regarding safety and tolerability, eight patients (26.66%) from the arTMS group and 24 (82.75%) from the ESK-NS group reported treatment-related side effects (trSEs). The most frequent arTMS trSEs were transient post-stimulation headache (13.33%) and scalp discomfort at the stimulation site (10%). Additionally, one participant encountered a mid-episode of agitation throughout the stimulation session, which was transient and didn't require any specific intervention. The most prevalent ESK-NS trSEs were: temporary sedation (55.17%), transient dissociative symptoms (34.5%), short-lived hypertension (10%), and brief agitation (6.89%).

Our findings revealed that arTMS had a more rapid effect, yielding higher RRs at the one-month follow-up than ESK-NS. arTMS accelerated response aligns with previous research, suggesting that faster protocols can shorten treatment duration, maintaining comparable efficacy [2]. Simultaneously, they potentially lead to a swifter response than standard protocols [4]. Besides, the RRs for arTMS and ESK-NS were consistent with existing literature, which reports three-month RRs of 60% for arTMS and 62.06% for ESK-NS among patients with TRD [6,7]. In terms of safety and tolerability, both treatments were found to be safe, with minor and transient trSEs. Notably, arTMS demonstrate lower trSEs incidence, potentially offering a more tolerable treatment option. However, the incidence of ESK-NS trSEs is consistent with real-world settings [6]. Interestingly, neither treatment induced manic switches, confirming their safety [6,8,9].

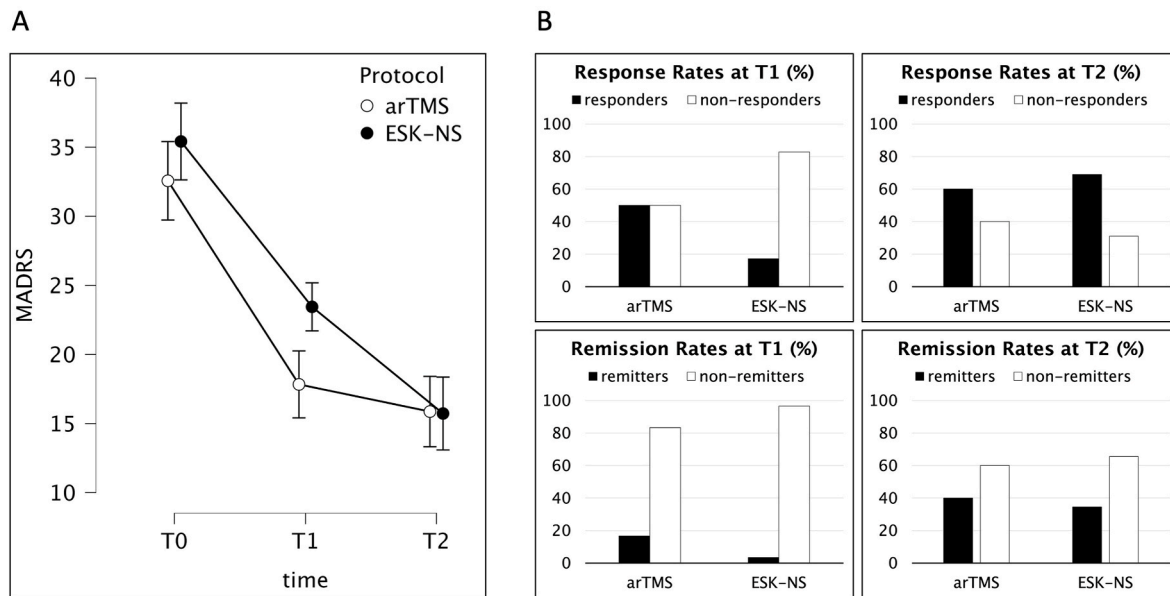
Several limitations should be considered. Firstly, the retrospective and naturalistic nature of the study did not allow for treatment randomization or the use of blinded assessors. However, the study's design is also a strength since it is more representative of real-world conditions, unlike RCTs which often involve only pre-screened

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**Fig. 1.** (A) Means (circles) and 95% confidence intervals (vertical bars) of Montgomery–Åsberg Depression Rating Scale (MADRS) scores in the accelerated rTMS (arTMS) and intranasal esketamine (ESK-NS) protocol groups at baseline (T0), after one month (T1), and after three months (T2) from the treatment beginning. (B) Percentages of the response rates ( $\geq 50\%$  decrease of MADRS total score) at T1 (left upper panel) and T2 (right upper panel) and remission rates (MADRS total score  $< 10$ ) at T1 (left lower panel) and T2 (right lower panel) in the arTMS and ESK-NS protocol groups.

subjects. Secondly, the limited sample size of both treatment groups highlights the need for more extensive cohort studies for validation.

The findings from this explorative research should be replicated, especially through randomized prospective studies.

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#### Declaration of competing interest

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#### Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.brs.2023.06.003>.

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Mauro Pettoruso  
 Department of Neurosciences, Imaging and Clinical Sciences, Università  
 Degli Studi G. D'Annunzio, Chieti, Italy  
 Department of Mental Health, ASL 2 Abruzzo Lanciano-Vasto-Chieti, Chieti,  
 Italy

Giacomo d'Andrea\*, Francesco Di Carlo  
 Department of Neurosciences, Imaging and Clinical Sciences, Università  
 Degli Studi G. D'Annunzio, Chieti, Italy

Luisa De Risio  
 Department of Mental Health and Addiction, ASL Roma 5, Rome, Italy

Francesca Zoratto  
 Centre for Behavioural Sciences and Mental Health, Istituto Superiore di  
 Sanità, Viale Regina Elena 299, 00161, Rome, Italy  
 Unit of Cognitive Primatology, Institute of Cognitive Sciences and  
 Technologies, National Research Council of Italy, Via Ulisse Aldrovandi 16/  
 b, 00197, Rome, Italy

Andrea Miuli  
Department of Mental Health, ASL 2 Abruzzo Lanciano-Vasto-Chieti, Chieti,  
Italy

Beatrice Benatti, Matteo Vismara  
Department of Biomedical and Clinical Sciences Luigi Sacco and Aldo  
Ravelli Center for Neurotechnology and Brain Therapeutic, University of  
Milan, Milano, Italy

Enrico Pompili, Giuseppe Nicolò  
Department of Mental Health and Addiction, ASL Roma 5, Rome, Italy

Cinzia Niolu, Alberto Siracusano  
Department of Systems Medicine, University of Rome Tor Vergata, Rome,  
Italy

Stefano S. Sensi  
Department of Neurosciences, Imaging and Clinical Sciences, Università  
Degli Studi G. D'Annunzio, Chieti, Italy

Bernardo Dell'Osso  
Department of Biomedical and Clinical Sciences Luigi Sacco and Aldo  
Ravelli Center for Neurotechnology and Brain Therapeutic, University of  
Milan, Milano, Italy

Giorgio Di Lorenzo  
Department of Systems Medicine, University of Rome Tor Vergata, Rome,  
Italy  
IRCCS Fondazione Santa Lucia, Rome, Italy

Giovanni Martinotti  
Department of Neurosciences, Imaging and Clinical Sciences, Università  
Degli Studi G. D'Annunzio, Chieti, Italy  
Department of Mental Health, ASL 2 Abruzzo Lanciano-Vasto-Chieti, Chieti,  
Italy  
Psychopharmacology, Drug Misuse and Novel Psychoactive Substances  
Research Unit, School of Life and Medical Sciences, University of  
Hertfordshire, Hatfield, AL10 9AB, UK

\* Corresponding author. Department of Neurosciences, Imaging and  
Clinical Sciences, Università degli Studi G. D'Annunzio, Via dei Vestini,  
66100, Chieti, Italy.

E-mail address: [giacomo.dandrea1993@gmail.com](mailto:giacomo.dandrea1993@gmail.com) (G. d'Andrea).