significant outcomes following standardized treatment protocols. However, in naturalistic settings physicians adapt treatment protocols to individual clinical considerations achieving better outcomes. These varied therapeutic strategies may inform other physicians in designing improved treatment paradigms. In the current design, we present a review of response and remission rates to dTMS in MDD patients.

**Methods:** 39 patients (25% male) with chronic MDD, ages 24–84 years (mean = 46.85), previously failing 1–8 medication regimens (mean = 4.23) received dTMS using H-coil technology. Symptom severity was assessed using PHQ-9 scores at baseline and every 5 treatments subsequently. Patients received an acute phase dTMS treatment (20 sessions), after which 8 patients discontinued. 31 patients received further maintenance treatment (10 sessions). dTMS efficacy was evaluated using Repeated Measure ANOVA to contrast baseline, acute and maintenance paradigms. Response (≤10 or ≥50% from baseline) and remission (≤5) were calculated.

**Results:** A significant treatment effect (p = 0.000) of symptom severity was observed in both paradigms. Post-acute symptom severity average score, decreased 59 percent (Means = 19.12 vs. 9.15) with 28 patients responding and 17 remitting (7 responders including 3 remitters didn’t begin maintenance). Additionally, post-maintenance average scores, decreased 8 percent more (Means = 19.12 vs. 6.50) with 30 patients responding and 17 remitting.

**Conclusion:** These results suggest that, both acute and maintenance dTMS treatment paradigms are effective in treatment of MDD symptom severity. However, extending the treatment paradigm from 20 to 30 sessions proves significantly beneficial.

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