ADHD PRACTISE PARAMETER

IRSHAAD SHAFFEEULLAH, M.D.

A diplomate American Board of
CHILD AND ADOLESCENT
PSYCHIATRY

Similar type of idea

SPECIAL COMMUNICATION

The Texas Children's Medication Algorithm Project: Revision of the Algorithm for Pharmacotherapy of Attention-Deficit/Hyperactivity Disorder

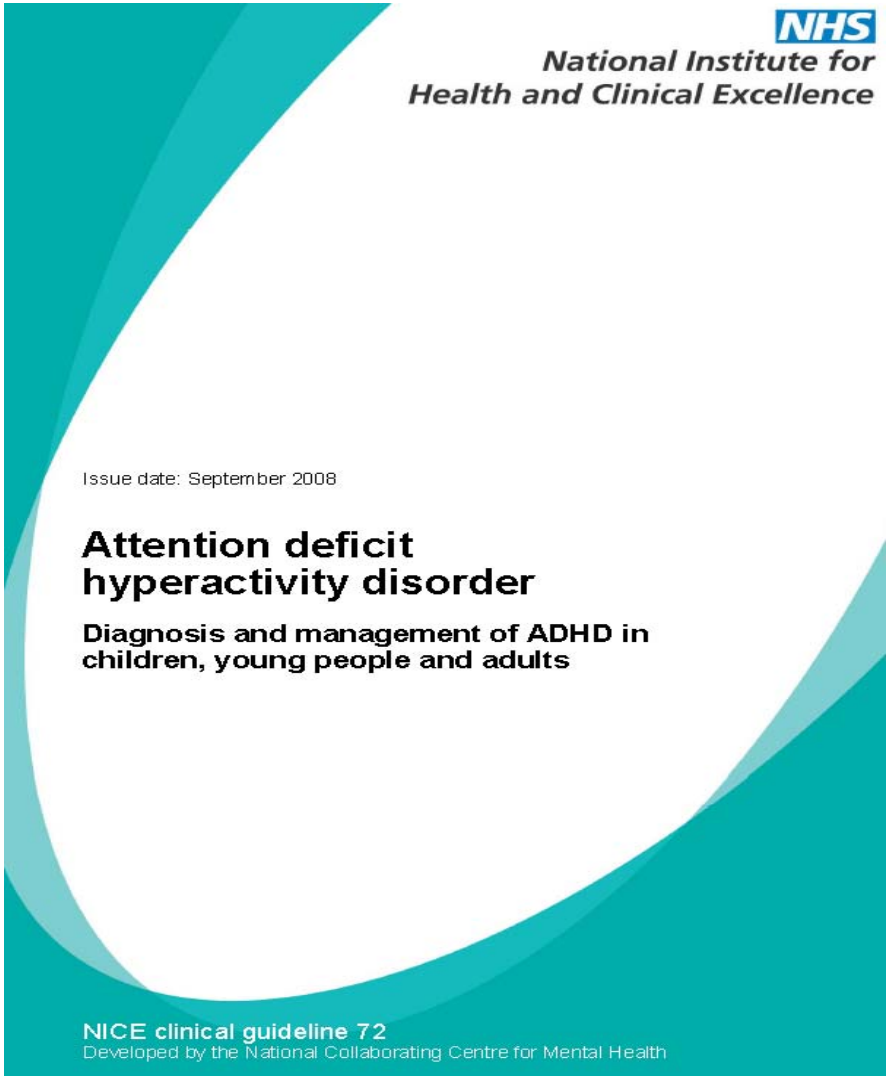
STEVEN R. PLISZKA, M.D., M. LYNN CRISMON, PHARM.D., CARROLL W. HUGHES, PH.D., C. KEITH CONNERS, PH.D., GRAHAM J. EMSLIE, M.D., PETER S. JENSEN, M.D., JAMES T. McCRACKEN, M.D., JAMES M. SWANSON, PH.D., MOLLY LOPEZ, PH.D., AND THE TEXAS CONSENSUS CONFERENCE PANEL ON PHARMACOTHERAPY OF CHILDHOOD ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Similar document

Canadian ADHD Practice Guidelines (CAP-Guidelines)

Third Edition

Similar document



AACAP document

Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/ Hyperactivity Disorder

ABSTRACT

This practice parameter describes the assessment and treatment of children and adolescents with attention-deficit/ hyperactivity disorder (ADHD) based on the current scientific evidence and clinical consensus of experts in the field. This parameter discusses the clinical evaluation for ADHD, comorbid conditions associated with ADHD, research on the etiology of the disorder, and psychopharmacological and psychosocial interventions for ADHD. *J. Am. Acad. Child Adolesc. Psychiatry*, 2007;46(7):894–921. **Key Words:** attention-deficit/hyperactivity disorder, evaluation, treatment, practice parameter.

- Neurobiological condition
- One of the best researched disorders in medicine
- Causes significant impairment
- Prevalence about 7.8 % but 4% receive treatment.
- DSM requires 6/9 SSx but adult may have impairment with fewer than 6/9 SSx.

Recommendations key

- MS – minimal standard (rigorous evidence), should be done in all cases
- CG – clinical guideline (strong evidence)
- OP – option (acceptable evidence or opinion)
- NE – not endorsed

Recommendation 1

Screening – MS

- ADHD screening-Must be part of every ptc. mental health assessment.
- Must look for whether impairment is present
- Screening must be done regardless as to the nature of the chief complaint
- Rating scales/questionnaires can be included

Recommendation 2

Evaluation - MS

- Interview parents and patients
- Get information about school functioning
- Evaluate for comorbid psychiatric d/o
- Review medical/social/family Hx
- Must have 6/9 symptoms, and know duration, severity and frequency.
- Presence of symptoms vs impairment
- DSM requires 2 settings but severe impairment in one setting needs Tx.

ADHD Recommendation 3

Lab testing/Neurology is not indicated, if Medical Hx unremarkable -NE

- Majority have no medical probs.
- Head injury, hyperthyroidism, lead exposure, exposure in utero of toxic subs.
- EEG, MRI, PET, SPECT, etc not indicated for routine w/u

ADHD Recommendation 5
Look for comorbidity - MS

- Are the ADHD like symptoms due to a comorbid disorder or secondary symptoms.
- develop a treatment plan to address each comorbid disorder
- depressive disorder occurs several years after the onset of ADHD
- Anxiety disorders have an earlier onset concurrent with the ADHD
- comorbid diagnosis of mania should be considered in ADHD patients who meets – “DIGFAST”.

Recommendation -5

- Acutely manic ADHD patients generally require mood stabilization before treatment of the ADHD.
- Some associated symptoms that do not reach level for DSM criteria may dissipate once the ADHD is successfully treated.

ADHD recommendation 6 - A Well-Thought-Out and Comprehensive Treatment Plan Should Be Developed-MS

- Psychoeducation
- treatment plan should be reviewed regularly and modified if the patient's symptoms do not respond
- Parental ADHD may interfere
- No evidence was found to support cognitive-behavioral therapy dietary modification, EEG feedback or social skills training.

Recommendation 7
use a FDA approved medication for initial treatment - MS

- Stimulants - 65-75% are responders

  - both MPH and amphetamine are equally efficacious in both the adolescent and child

  - long acting has same efficacy as short acting, but long acting have many advantage e.g. once daily dosing, etc.

  - initial treatment may use long acting.

  - adult-adolescent may need around 1.1 mg/kg/day (88+/- 22mg) – no study examine doses beyond 72 mg of concerta.

  -titrate q 1-3 weeks

Recommendation 7

- Preschoolers - 2.5 – 30 mg/day of MPH

  - higher rate of side effect esp. irritability, crabbiness, prone to crying.

  - metabolize MPH slower than school age children

  - Ritalin FDA approved 6 y/o and above (but Dexedrine 3 y/o and above)
- Atomoxetine – given bid or od. Use in ADHD + anxiety.
- Start with stimulants

Recommendation 7

- Start with Atomoxetine

  - substance abuse

  - comorbid anxiety

  - severe side effect of stimulants e.g. mood lability, severe tics.

Recommendation 8

If no response to ADHD meds, review Dx, consider ABA, use off label meds -CG

- Ascertain whether undetected affective d/o, anxiety d/o, subtle developmental problems are not the primary problem.
- Bupropion, TCA (imipramine, nortriptyline), α agonists (clonidine)
- If some response but not fully, then use FDA meds + ABA.
- Clonidine - max 0.2 mg/day (27-40kg), 0.3 mg/day (40-45 kg), 0.4 mg/day (≥ 45kg).

  - can give up to q.i.d dosing.

Recommendation 9
monitor for side effects - MS

- Most common with stimulants are;

  - appetite, wt loss (cyproheptadine)

  - insomnia (melatonin/clonidine, etc), headache

  Less common with stimulants are;

  - tics (clonidine)

  - emotional lability/irritability (“worsening” in evenings?)
- Atomoxetine; GI, sedation, decreased appetite, headache

Recommendation 9

- Don’t Tx with antipsychotics if aggressive/emotionally labile/psychotic behavior is clearly a side effect of stimulants – stop stimulants.
- Cardiovascular;

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Cardiovascular Events and Death in Children Exposed and Unexposed to ADHD Agents

Hedi Schelleman, Warren B. Bilker, Brian L. Strom, Stephen E. Kimmel, Craig Newcomb, James P. Guevara, Gregory W. Daniel, Mark J. Cziraky and Sean Hennessy

Pediatrics; originally published online May 16, 2011;
DOI: 10.1542/peds.2010-3371

CONCLUSIONS: The rate of cardiovascular events in exposed children was very low and in general no higher than that in unexposed control subjects. Because of the low number of events, we have limited ability to rule out relative increases in rate. *Pediatrics* 2011;127:1102–1110

Recommendation 10
If response is robust then no need for other treatment intervention is needed - OP

- ADHD who have positive response to medication, without comorbidity, no need for psychosocial intervention.
- So ABA no mandatory as part of the regimen

Recommendation 11.
Having less than optimal response then psychosocial intervention + meds is beneficial

- Comorbidity + psychosocial stressors benefit from psychosocial interventions
- anxiety,ODD or CD, ethnic minorities/low income,

Recommendation 12
Assess periodically - MS

- Make sure medication still effective, dose optimal, side effects.
- Assess height, weight, BP and pulse
- Look for comorbidities
- Psychoeducation
- Need for other intervention, e.g. psychosocial

Recommendation 13
Monitor weight and height - MS

- Higher dose may be more significant than a lower dose
- Most delay occurs in first 1-3 years of Tx
- Plot weight and height on a growth chart x2/year
- Final adult height may not be affected (?)
- Drug holidays

DSM 5..some proposed changes

- Although irritable outbursts are common, abrupt changes in mood lasting for days or longer are not characteristic of ADHD and will usually be a manifestation of some other distinct disorder.
- In children and young adolescents, the diagnosis should be based on information obtained from parents **and** teachers
- Examination of the patient in the clinician's office may or may not be informative
- Six (or more) of the following symptoms…. ***Note:*** for older adolescents and adults (ages 17 and older), only 4 symptoms are required….. by age 12.