Current Psychiatry

Letters

Questioning ADHD red flags

Dr. Manuel Mota-Castillo's description of "Five red flags that rule out ADHD in children" (Pearls, April, p. 56) is remarkably at variance with current research and clinical practice in the diagnosis and treatment of children with attention-deficit/hyperactivity disorder.

Mood disorders are well-known comorbidities of ADHD and, unfortunately, numerous young adults with a childhood history of ADHD do "get high on" and become addicted to cocaine and other street drugs. Further, impairing, problematic symptoms often are not noted until the second grade or later in the elementary school years, especially in children who have the inattentive type of ADHD. Absence of a history of symptoms in kindergarten certainly does not contradict a diagnosis of ADHD.

The Multimodal Treatment Study for ADHD, or MTA study, among others, found that about 40% of carefully diagnosed children with ADHD also had oppositional-defiant disorder (ODD), and that 10% to 20% had conduct disorder (CD). These are common ADHD comorbidities.

Finally, a child's response to initial medication treatment never confirms nor refutes this diagnosis. This point has been emphasized in every major publication in our field for a decade.

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I have several problems with Dr. Mota-Castillo's comments:

First, moodiness can be a part of ADHD. Also, some unfortunate children have ADHD with comorbid bipolar or mood disorders.

Second, depending on the demands of the child, the environment, and the response to the child's behavior (among other things), ADHD can appear to be intermittent.

Third, ADHD symptoms are present in kindergarten. Some kids do not get diagnosed that early, especially those with ADHD, inattentive type, but they still meet the criteria for ADHD.

Fourth, comorbidity is usually the rule with ADHD. Fifth, response to a stimulant does not make a diagnosis of ADHD. I do not have ADHD, but I would likely "think better" on a stimulant!

Finally, a follow-up appointment at 2 weeks does not confirm a diagnosis of ADHD. The diagnosis is made only after a thorough review of the child's history, a review of the pediatric record, a physical examination by the pediatrician, a clinical interview with the parents or primary caregiver, an interview and examination of the child, a review of school records, and input from current and previous teachers as well as all others who provide care for the child in structured and unstructured settings.

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Dr. Mota-Castillo responds:

Dr. Clark's letter is not surprising; his statements echo other ADHD experts and the ADHD clinics around the country. Let me clarify several misconceptions around this illness, however.

I don't blame people who follow dictates from the MTA study, considering the high academic level of the researchers involved. Still, their findings are not immune to further investigation and clinical testing. In fact, other prominent investigators such as Charles Huffine, MD, and Andres Pumariega, MD, have requested the deletion of the CD diagnosis from DSM-IV. Several others have questioned ODD as a valid entity.

I am not a famous scholar from a prestigious school, but I can point to hundreds of children previously diagnosed with ODD who became "non-oppositional" after treatment for their real conditions—either a mood, anxiety, or psychotic disorder.

Other prominent researchers, including Kay Redfield-Jamison, have refuted the assumption that all children diagnosed historically with ADHD were correctly differentiated from other disorders that may display some similar symptoms. Jamison recently cited a tragic patient outcome: A young boy was misdiagnosed with ADHD, placed on stimulants, and ultimately hanged himself.

continued on page 48