Early Diagnosis Is Central to New ADHD Guidelines

BY DOUG BRUNK
San Diego Bureau

The American Academy of Child and Adolescent Psychiatry has released an updated version of its 10-year-old practice parameter for the assessment and treatment of children and adolescents with attention-deficit hyperactivity disorder.

An underlying theme of the parameter, released last month, is the recognition that the diagnosis and treatment of ADHD are "in the mainstream of American medicine and American psychiatry," lead author Dr. Steven R. Pliszka said in an interview.

"ADHD is an international phenomenon now. It's no different from screening for asthma or diabetes or treating those conditions," he added.

"We have an equal degree of evidence of the biological causes and effective treatments," said Dr. Pliszka, chief of adolescent psychiatry at the University of Texas, San Antonio. "We want everyone to recognize that and go forward and help their patients."

In a process that began in late 2004, Dr. Pliszka and his associates assembled 13 recommendations based on a review of nearly 5,000 references related to the diagnosis and treatment of ADHD that were generated between 1996 and 2006. These included references from the 1997 version of the practice parameter, as well as those that appeared in the scientific medical literature, in book chapters, or at scientific meetings.

Two chief developments drove the need to update the parameter, Dr. Pliszka said. One is the proliferation of new treatments for ADHD that have emerged in the last 5-10 years.

Another is what he called "a growth of genetics and neuroimaging studies that are starting to point the way to the underlying causes and brain features of the disorder."

One recommendation in the 44-page document that differs from the 1997 version is based in part on results from the National Institute of Mental Health–sponsored multimodal treatment study of children with ADHD, which examined different treatment options for the disorder (Arch. Gen. Psychiatry 1999;56:1073-86). It concluded that careful medication management alone was superior to behavioral therapy and to routine community care that included medication.

"While there's debate about exactly how to interpret that study, I think for the child who just has ADHD and no other complicating condition, medication treatment appears to be most effective by itself," Dr. Pliszka said.

In contrast, if the child has ADHD in combination with other problems like learning disabilities, behavior disorders, or depression, then he or she needs a combined approach: the medication and some type of psychosocial intervention, he noted.

"We don't recommend behavioral intervention alone except in milder cases or in cases where the diagnosis is in question," said Dr. Pliszka.

Other recommendations address medications used for ADHD. They conclude that stimulant medications are usually the best first-line treatment options.

The current stimulants on the market "tend to be equally efficacious, and it's largely a matter of family and physician preference as to which one you use," Dr. Pliszka said.

The nonstimulant atomoxetine (Strattera) may be considered as a first-line treatment "in certain situations like co-occurring anxiety and tics," he said.

Dr. Martin T. Stein, a developmental-behavioral pediatrician at Rady Children's Hospital in San Diego who was not involved in assembling the recommendations, called the new practice parameter a valuable reference for child psychiatrists and general pediatricians alike.

"I think it's quite good," Dr. Stein, who is also a professor of pediatrics at the University of California, San Diego, said in an interview. "There are so many areas where psychiatric practice and pediatric practice overlap and complement each other in this document." Any physician who treats children could read this and find it quite valuable for practice, he said.

The document notes that there may be a place in ADHD treatment for medications not approved by the Food and Drug Administration, but which have demonstrated efficacy in some studies. These include bupropion, tricyclic antidepressants, and α–agonists.

"These should only be tried if the ones in the approved group have failed," Dr. Pliszka said.

The document also addresses concerns about the potential for rare side effects from stimulant use, including aggression and mood lability.

"In controlled trials, there is no evidence that the stimulants produce these [side effects] in numbers greater than in the placebo groups," Dr. Pliszka said. "We acknowledge that they've been reported in post-marketing studies and that physicians should be alert to them, but there's not any undue concern. They shouldn't be a reason that people would shy away from using the medication."

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DR. PLISZKA

As for concerns about possible cardiovascular side effects based on reports of sudden deaths in people taking certain agents used in ADHD treatment, Dr. Pliszka and his associates concluded in the document that the rates of sudden death of children on ADHD medications "do not appear to exceed the base rate of sudden death in the general population."

In the interview, Dr. Pliszka emphasized that he and his associates "do not view cardiovascular side effects as a risk of the stimulants. The one group to be cautious with are those people that already have some pre-existing heart disease."

He predicted that neuroimaging is going to lead ADHD research efforts in the future, but emphasized that, at this time, neuroimaging "shouldn't be used commercially to diagnose ADHD. The diagnosis is still made by the efforts of the physician talking to the family, talking to the child, and gathering data about behavior."

Dr. Pliszka disclosed that he receives or has received research support, acted as a consultant, and/or serves on a speakers' bureau for Shire Pharmaceuticals Group, McNeil Pediatrics, and Eli Lilly & Co. ■

To access the document, click on "practice parameters" from AACAP's home Web page at www.aacap.org.

EXPERT COMMENTARY

Go With Experience for ADHD

Sometimes, going with experience is the best approach, and this seems to be the case in most cases of attention-deficit hyperactivity disorder. Stimulant medication is the first line of pharmacological treatment for children with ADHD.

BY MARTIN T. STEIN, M.D.

Amphetamines have been around since the 1950s and methylphenidate since the 1960s, and these stimulants have more than 200 studies attesting to their safety and efficacy.

The research indicates that 70% of patients will respond to amphetamine treatment with improvement, 70% of patients will respond to methylphenidate, and 50% of those who do not respond to one will respond to the other.

Thus, the newest drug for ADHD, atomoxetine, should not be used routinely as a first-line agent.

Atomoxetine (Strattera) became available in the United States in 2003 and was approved based on several randomized, controlled trials and safety studies. It was the first new medication for ADHD approved in more than 30 years and the first nonstimulant medication for treating patients with ADHD.

But although atomoxetine has some advantages, it is not the first drug that a physician should reach for in most new patients. The other drugs work and there is just too much experience with them to ignore.

In one study in which researchers compared methylphenidate treatment with atomoxetine, both drugs produced similar improvements in the core ADHD symptoms over 10 weeks of treatment (J. Am. Acad. Child Adolesc. Psychiatry 2002;41:776-84).

But atomoxetine might cause drowsiness or fatigue early in treatment. Because it is similar to stimulants, it might also cause anorexia, weight loss, headaches, abdominal pain, and mild (usually clinically insignificant) elevation of blood pressure and pulse.

In 2005, Eli Lilly & Co., atomoxetine's maker, agreed to add a black box warning to the label noting uncommon reports (0.4%) of suicidal ideation in children taking the drug. There have been no reports of successful suicides associated with atomoxetine.

Therefore, there needs to be more post-marketing clinical experience with atomoxetine before it can be considered a first-line agent. Atomoxetine's advantages include that it might be associated with less emergence or exacerbation of tics, less interference with sleep, and a beneficial effect on patients with coexisting anxiety.

Given the long track record of the alternatives, atomoxetine should be reserved for those patients with ADHD who fail treatment with stimulants or have intolerable side effects, patients for whom there is concern about abuse or the parent is opposed to the use of "a stimulant," patients who experience significant sleep disturbance, and perhaps, patients with a coexisting tic or anxiety disorder.

Patients who do begin atomoxetine should be started on a dosage of 0.5 mg/kg per day for the first 3-5 days and then titrated up to 1.2-1.4 mg/kg per day. Atomoxetine can be given in a single daily dose or twice daily. Fatigue and nausea generally are less likely when the medication is taken in the evening. Beneficial effects on core ADHD symptoms are usually seen after 2-6 weeks on the medication. ■

DR. STEIN is a professor of pediatrics at the University of California, San Diego, and the Rady Children's Hospital in San Diego. He also cochaired an American Academy of Pediatrics subcommittee that issued treatment guidelines on attention-deficit hyperactivity disorder and is a consultant to Eli Lilly. These comments were made at an AAP conference in Vail, Colo.

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