Avoid Potential Mistakes in Managing ADHD

Watch out for comorbidities such as learning disabilities, ODD, conduct disorder, depression.

BY DAMIAN McNAMARA
Miami Bureau

MIAMI BEACH — To avoid mistakes in the management of a child with attention-deficit/hyperactivity disorder, consider the patient's receptive language age, comorbidities such as depression, and medication to protect a young child when a parent is very intolerant of the child's behavior, Dr. David O. Childers recommended.

Attention-deficit/hyperactivity disorder (ADHD) is complex and not a stand-alone diagnosis, said Dr. Childers, a neurodevelopmental pediatrician. Look for a grouping of social, behavioral, and attention issues, as well as immaturity of fine and gross motor skills, judgment, and/or learning.

Errors in stimulant dosing, untreated insomnia, and missing ADHD inattentive type in an adolescent are other pitfalls to avoid, Dr. Childers said at the annual Masters of Pediatrics conference sponsored by the University of Miami.

Begin with assessment of receptive language age. "Our receptive language defines our behavior. We all have conversations in our heads. If the conversation in your head is at the 3-year-old level, your behavior will be like a 3-year-old," said Dr. Childers, who serves as chief of the section of developmental pediatrics, University of Florida College of Medicine in Jacksonville.

Medications make a difference, he said, "But they are a Band-Aid approach—they do not make the problem go away."

Dr. Childers outlined the following possible mistakes in management of ADHD:

► **Mistake 1: Automatic prescription of stimulants for a hyperactive 3-year-old.** A physician might want to dose "the hyperactive child who is jumping off the chair and up on the exam table … but is it the right thing to do?" Dr. Childers asked. The medication will allow the young child to focus their attention where they want to, and "a 3-year-old is nothing but a walking 'id.' They want it, they want it, they want it now," he said, whether it's a toy or their own personal needs met.

► **Mistake 2: Not dosing a young child for protection.** A possible exception to the first mistake is the scenario of a "really, really hyperactive 3-year-old with a really intolerant parent. There is a subset of children who have a desperate need for protection," he said. "Sometimes the stimulant is important at this age" in such cases.

► **Mistake 3: Inappropriate initial dosing.** There can be, for example, a 5-year-old who is extremely emotional, a zombie, or absolutely intolerable after starting a particular medication. "I get a lot of these referrals," Dr. Childers said.

A prescription of 5 mg of methylphenidate is 2.5 mg of the L isomer and 2.5 mg D isomer, or 2.5 mg total of active isomer.

"Part of the problem is we start frequently with the mixed amphetamine salts 5 mg," he said. This is 5 mg of active isomer. "So starting them on mixed salts is double the dose [we give with methylphenidate]. This is not the ideal [starting] dose for the average 4- to 6-year-old. I'm not saying you're not going to get there, anyway, but do you want to start there?"

► **Mistake 4: Confusing the first effective dose with an ideal dose.** "We find a dose that is effective, and we leave it there. We make the mistake of settling for lowest effective dose, not the best dose," Dr. Childers said. Parents in this situation might say, "He tried the medicine—it didn't work" or "The medicine worked for a little while, but then his body got used to it."

► **Mistake 5: Neglecting comorbidities.** "This is where some people start to make mistakes," he noted. ADHD might be primary, and it might be secondary. Learning disabilities, oppositional defiant disorder, conduct disorder, anxiety, depression, encopresis/enuresis, and poor self-esteem are among possible comorbidities.

Parents will ask, "What did you do to my kid? He is crying all day, upset all the time since starting the medication."

"Many times I diagnose childhood depression," Dr. Childers said. "Childhood depression can look like ADHD in many cases." ADHD incidence is 6%-10%, childhood depression incidence is 10%, and they can be comorbid. "You think it's hard to talk to a parent about putting a child on a stimulant, try to talk to them about putting a child on Prozac."

► **Mistake 6: Not detecting drug diversion.** "ADHD is inherited. It is one of the most heritable conditions we know of," Dr. Childers said. "You find a child with ADHD, the likelihood you'll find a parent with ADHD is 0.8."

He added that there are exceptions, but sometimes "my goal is to see how fast I can make the diagnosis in the parent."

Keep in mind that maybe the child is not the only one who sees the value of the medication. "Parents can divert." A drug-seeking parent might say, "I need to change my child from the long-acting to the short-acting." Long-acting agents, in general, have much less abuse potential. In contrast, short-acting stimulants can be divided, and there can be enough to get a child through school and a parent through work.

► **Mistake 7: Confusing ADHD with an undiagnosed learning disability.** Learning disabilities are more common, with an incidence of 15%-20%, compared with 6%-10% for ADHD, he said.

The physician might, for example, see a young boy who got all As and Bs in school, and, then all of sudden, starts getting Ds in third grade. It could be a learning disability arising at a time when children have to read to learn. Or it could manifest later, such as an inattentive 13- or 14-year-old girl who sits quietly in the back of class and just makes passing grades.

"Be careful of what you call it before you diagnose it," Dr. Childers said. "Once you label the kid as 'ADHD,' the school will not be looking for anything else."

One person attending the meeting said sometimes a school asks the physician to treat the child for ADHD on a trial basis. "Parents have told me that the child is not allowed back in school without a prescription for Ritalin," Dr. Childers said. "I write a letter to school saying they need to make the diagnosis of a learning disability first. It's a war, and difficult if you don't have access to testing."

The Federal Individuals with Disability Education Act (IDEA) requires schools to test for a learning disability at the parent's request, he added.

► **Mistake 8: Undiagnosed ADHD in an adolescent.** Sometimes it is easy to miss the adolescent with ADHD, inattentive subtype, Dr. Childers said. "We get so programmatic in our approach that the differential list of problems in adolescence doesn't place ADHD high on the index of suspicion." He added, "Just because ADHD was not diagnosed in childhood doesn't mean it is not there."

► **Mistake 9: Insufficient dosing.** "Rebound and insomnia is not subtle," Dr. Childers said. "I use a booster dose. The problem isn't the medicine; the problem is the medicine wearing off." If a stimulant wears off at 4 p.m. and bedtime is at 8 p.m., a small dose in the evening "can make a huge difference. Kids will be more stable and be able to fall asleep."

It is important to note whether the insomnia predated the stimulant use. Get a basal sleep history, Dr. Childers advised. Also recommend proper sleep hygiene. "My first question is: Is there a TV in the bedroom? The answer is always yes, and I ask them "Why?" They can't answer it." Remove the television forever, and give the child a bath and warm milk before bedtime, he said. "That is enough for most kids."

► **Mistake 10: Overdiagnosis of bipolar disorder.** More and more parents are coming in and saying, "My teacher, aunt, therapist, neighbor, etc. said my child has 'bipolar disorder,' " Dr. Childers remarked.

The adult prevalence of bipolar disorder is 1%-1.6%, according to a National Alliance of Mental Illness Fact Sheet, January 2004. "It's not a curable illness. Bipolar is a lifelong diagnosis. So how can 7% of children have bipolar disorder?"

A much more common diagnosis is a combination of ADHD and oppositional defiant disorder (ODD) versus bipolar disorder, Dr. Childers said. "The one big difference I always look for is a trigger to the behavior. If a parent says, 'Every time I tell him no, he has a tantrum,' it is unlikely it's bipolar disorder, and more often it's ODD."

Dr. Childers said he tells parents that they should have three goals for their child that appropriate management of ADHD can help to achieve: a happy childhood, a successful academic experience, and out the door and independent by age 18.

Dr. Childers had no relevant financial disclosures. ■

Ask 10 Questions Before Prescribing Stimulants for ADHD

BY MARY ELLEN SCHNEIDER
New York Bureau

NEW YORK — Before starting a child on stimulants to treat attention-deficit/hyperactivity disorder, consider asking some extra questions to confirm the diagnosis and family history, Dr. Laurence L. Greenhill said at a psychopharmacology update sponsored by the American Academy of Child and Adolescent Psychiatry.

Dr. Greenhill, director of child and adolescent psychiatry at the New York State Psychiatric Institute at Columbia University, New York, presented a 10-item checklist for physicians to use as a guide before initiating stimulant therapy in children and adolescents:

► Is the diagnosis of ADHD accurate?

► Is there a history of simple tics, chronic motor tics, or Tourette syndrome? This is important to document but doesn't necessarily change the course of treatment, he said.

► Does the patient have comorbidities?

► Does the child have a history of cardiovascular problems? In May 2006, the Food and Drug Administration directed manufacturers of ADHD medications to revise their labeling to reflect concerns about adverse cardiovascular events. Since the FDA began its deliberations on this issue, there has been growing public awareness about the possible risk of cardiovascular complications, Dr. Greenhill said.

► Is there a family history of sudden death when young, stroke under age 40 years, or malignant hypertension? Also, does the child have a history of seeing a cardiologist or having chest pain with shortness of breath? All of these questions can serve as screening questions and should be documented in the chart, Dr. Greenhill said. "If they're all negative, most cardiologists I know don't want to see [these patients] for referrals," he said.

► Is there substance abuse at home?

► Has there been a normal physical exam by a pediatrician in the past year?

► Is there a record of baseline height, weight, pulse, and blood pressure?

► What are the specific targets of treatment?

► Is the quantified ADHD severity moderate to severe?

Dr. Greenhill disclosed financial relationships with Best Practice LLC, Sepracor Inc., Eli Lilly & Co., Pfizer Inc., Johnson & Johnson, Otsuka America Inc., and McNeil Pediatrics, a division of McNeil-PPC Inc. ■