Comorbidities Common With ADHD Diagnosis

Among children with ADHD, 80% also meet criteria for conduct, oppositional defiant, or bipolar disorder.

BY HEIDI SPLETE
Senior Writer

HOUSTON — "When I am asked whether I think [attention-deficit hyperactivity disorder] is overdiagnosed, I say that kids are underfoot now more than they used to be," Saundra Gilfillan, D.O., said at the annual meeting of the American Society for Adolescent Psychiatry.

"Did we miss ADHD before? No, the hyperactive kids wore themselves out," said Dr. Gilfillan, a child and adolescent psychiatrist at the University of Texas Southwestern Medical Center at Dallas, which cosponsored the meeting.

Comorbidities are common with ADHD: As many as 80% of children and adolescents with ADHD meet criteria for a related category disorder, particularly conduct disorder, oppositional defiant disorder, and bipolar disorder. When evaluating a child or adolescent for ADHD, consider other conditions as well.

When Dr. Gilfillan assesses children and adolescents for ADHD, with or without comorbidities, she starts by asking parents about the child's behavior as an infant.

Hyperactive children were often very active in utero and active as infants; they did not sleep well and were distracted when eating, she said. In addition, children with ADHD often skipped the crawling stage or spent very little time crawling. Dr. Gilfillan also asks whether the child or adolescent is invited to birthday parties.

"It's a very big developmental thing on the social side," and parents who recognize a "hyper," aggressive child may not want the child in their house, she noted. She also asks about emergency department visits and car accidents.

"I like to look at report cards, to see what teachers wrote about behavior," she said. Another question is who babysits. "If the grandmother won't babysit the child, then that's a problem," she said.

People do not truly outgrow ADHD; the symptoms simply evolve. Motor hyperactivity in childhood evolves into internal feelings of restlessness in adolescence and adulthood. They often have problems in classes where they have to sit or take notes, she said.

Children with ADHD who do not have comorbid conditions generally exhibit less severe symptoms. Their carelessness and inattention may lead to destructiveness and misbehavior, but it appears to be unintentional. Children with ADHD who also have conduct disorder, oppositional defiant disorder, and bipolar disorder are more likely to have social problems, to require hospitalization, and to develop other problems such as depression and anxiety. There are more specific observations on cormobidities:

► **Conduct disorder.** "I call these the thugs and 'thugettes,' " Dr. Gilfillan said. These children or teens have no respect for societal norms—they genuinely do not care about the rights of others. The majority of child-onset cases of conduct disorder are in males, but by adolescence the numbers are approximately equal. Children with conduct disorder don't always make it to the psychiatrist because they go into the legal system first.

► **Oppositional defiant disorder.** By contrast, children with oppositional defiant disorders tend to be argumentative, but usually only within their immediate network of family and friends. Some kids negotiate that way; some derive satisfaction from engaging their parents in an argument.

► **Bipolar disorder.** More than 50% of adolescents with bipolar disorder have at least one coexisting psychiatric disorder. "In many areas, to get a child some time in a psychiatric hospital, you must have a diagnosis of bipolar disorder," Dr. Gilfillan noted.

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As a result, many clinicians lead with the bipolar diagnosis because they know the child needs to spend some time in an inpatient facility, she said. Features of bipolar disorder in children and adults are similar to characteristics of ADHD. The prolonged outbursts, which she described as "affective storms," are bipolar rather than hyperactive.

Early symptoms of childhood-onset bipolar disorder include oversensitivity to sensory stimulation and night terrors as an infant, and high levels of anxiety and difficulty controlling anger as a school-aged child. Reports from family members might suggest that the child has a difficult temperament.

Treatment options for children and adolescents with ADHD and other conditions include Strattera (atomoxetine), Adderall (amphetamine mixed salts), and Concerta (methylphenidate), as well as Ritalin (methylphenidate HCl) and Dexedrine (dextroamphetamine sulfate).

Underdosing is one of the most common reasons for discontinuing medication, Dr. Gilfillan said.

Parents often are not used to titration for their children's medications, since it is not used for ear infections or urinary tract infections. Families become impatient and say that the medication is not working; they may want to switch drugs instead of increasing the dose.

"Medication can do some things, but other things must be done at the same time," she said. Nonmedication therapies for ADHD and comorbid problems include parenting classes, hobbies, sports that channel excess energy, and strategies for better academic performance.

When evaluating a child or adolescent for ADHD and other conditions, remember that "normal" is somewhere in the differential, Dr. Gilfillan cautioned.

However, if the ADHD, with or without comorbidity, goes untreated, drug and alcohol abuse are more likely later in life, she added.

Dr. Gilfillan is a consultant and member of the speakers' bureau for Pfizer, Ortho-McNeil, and Abbott, and is a member of the speakers' bureau for AstraZeneca. ■

Physician Adherence to Guidelines for ADHD Varies Widely

BY KERRI WACHTER
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WASHINGTON — It appears that there is a wide range of adherence to the American Academy of Pediatrics guidelines on attention-deficit hyperactivity disorder, Wendy Davis, M.D., said at the annual meeting of the Pediatric Academic Societies.

"While [physicians] show a high level of confidence in prescribing and monitoring stimulant medications . . . few [physicians] in our study practiced in a manner that reflected understanding and documented use of targeted outcomes. Furthermore, our physicians expressed a lack of confidence in their ability to diagnose and treat attention-deficit hyperactivity coexisting conditions," said Dr. Davis, a professor of pediatrics at the University of Vermont in Burlington.

In 2000, the AAP released clinical practice guidelines for the diagnosis and evaluation of the child with attention-deficit hyperactivity disorder (ADHD). Dr. Davis and her colleagues evaluated a group of pediatricians in Vermont for their adherence to the following selected recommendations from the guidelines:

► The clinician should recommend stimulant medication or behavior therapy as appropriate to improve targeted outcomes.

► The physician, parents, child, and school personnel should collaborate to identify targeted outcomes to guide management.

► The physician should periodically provide a systematic follow-up for the child with ADHD, and monitoring should be directed to targeted outcomes and adverse effects by obtaining specific information from parents, teachers, and the child.

► Evaluation of the child with ADHD should include assessment of possible coexisting conditions.

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A total of 22 doctors in five pediatric practices—20% of practicing pediatricians in Vermont—participated. A self-administered pediatrician confidence survey served as a baseline measure. In this survey, pediatricians were asked to rate their confidence with various aspects of the diagnosis and treatment of ADHD.

In addition, a preintervention chart audit was conducted to assess adherence to AAP guidelines on several measures. The initial chart review included charts for all 5- to 15-year-old patients with a diagnosis of ADHD after 2001—a total of 225 (75% male patients).

In the survey, 89% of pediatricians responded that they were mostly or highly confident in starting patients on stimulant medication for the treatment of ADHD.

Based on the preintervention chart audit, 92% of charts indicated stimulants had been prescribed for the treatment of ADHD.

A total of 79% of pediatricians responded that they were mostly or highly confident in adjusting stimulant medication, and 72% of charts had evidence of dosage changes after the initial prescription.

Setting targeted outcomes proved to be more of a challenge for pediatricians, with 58% responding that they were mostly or highly confident in setting these, and 38% of charts had evidence of documented targeted outcomes.

Only 37% of pediatricians were mostly or highly confident in arranging for and coordinating nonpharmacologic treatment of ADHD.

However, 68% indicated that they communicated with school personnel most or almost all of the time.

According to the chart audit, parents were involved in treatment planning and monitoring 85% of the time. In addition, 77% of the charts had evidence of consultation with school personnel.

Based on the chart audit, adverse side effects were evaluated 86% of the time, though only 71% of charts had notations of the duration of effectiveness. Only 39% of charts indicated assessment of the adequacy of medication effectiveness.

Based on the survey, only a third (32%) of pediatricians were mostly or highly confident in identifying coexisting psychiatric conditions. And only 21% were mostly or highly confident in treating ADHD coexisting conditions.

Only 32% of charts had notations of coexisting conditions, Dr. Davis, said at the meeting, also sponsored by the American Pediatric Society, the Society for Pediatric Research, the Ambulatory Pediatric Association, and the American Academy of Pediatrics. ■