AAP Releases Guideline on Diagnosis, Evaluation, and Treatment of ADHD

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Guideline source: American Academy of Pediatrics

Evidence rating system used? Yes

Literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? No

Published source: *Pediatrics*, November 2011

Available at: http://pediatrics.aappublications.org/content/128/5/1007.ful

Endorsed by the AAFP, May 2012. http://www.aafp.org/online/en/home/clinical/clinicalrecs/endorsedguidelines.htm

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A collection of Practice Guidelines published in *AFP* is available at http://www.aafp.org/afp/practguide.

The American Academy of Pediatrics (AAP) first published guidelines on the diagnosis and evaluation of attention-deficit/hyperactivity disorder (ADHD) in 2000, with recommendations for treatment published in 2001. Based on new data collected since then, the AAP released new guidelines in 2011, which were endorsed by the American Academy of Family Physicians in 2012.

Evaluation

ADHD often goes undiagnosed; therefore, an evaluation for ADHD should be performed in patients four to 18 years of age who present in the primary care setting with academic or behavior problems and who display inattention, hyperactivity, or impulsivity. When making an ADHD diagnosis, clinicians should ensure that all criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV), text revision, are met and that all other causes are ruled out. It should be noted that although DSM-IV criteria can be used in preschool-aged children (four to five years of age), the subtypes may not be valid. If patients have behaviors that do not meet DSM-IV criteria, the *Diagnostic and Statistical Manual for Primary Care* can provide guidance.

Information should be collected from the patient's parents, teachers, and other mental health care professionals. Because most adolescents (12 to 18 years of age) have more than one teacher, and because many times parents have less opportunity to observe behavior in adolescents, it may be more difficult to get this information in this population. Clinicians should, however, attempt to get information from at least two teachers, and from other persons who interact with the adolescent (e.g., coaches, counselors).

Evaluation for ADHD should include assessment for coexisting conditions and problems, such as anxiety, depressive disorders, learning disorders, tics, and sleep apnea. Adolescents with newly diagnosed ADHD should be assessed for substance abuse; when possible, substance abuse should be treated before initiating treatment for ADHD.

Treatment

ADHD should be considered a chronic condition, and the care of patients with ADHD should follow the principles of the chronic care model and the medical home.

Preschool-aged children with ADHD should receive behavioral therapy administered by a parent or teacher. Initially prescribing behavioral therapy alone is supported by strong overall evidence and by a study that found that many preschool-aged children with moderate to severe dysfunction had improved symptoms with behavioral therapy alone. If significant improvement is not observed with behavioral therapy and the patient continues to experience moderate to severe functional disturbances, methylphenidate (Ritalin) can be prescribed. If behavioral therapy is not available, the risks of

prescribing medications in younger patients should be weighed against the harms of waiting to start treatment. Although medications are not contraindicated in this population, only one good-quality multisite study of medication use in children four to five years of age has been done. It is also thought that medications could possibly affect growth in these children.

Medications, preferably combined with behavioral therapy, should be prescribed in elementary school–aged children (six to 11 years of age). Evidence for the use of stimulants is strong, and evidence for the use of atomoxetine (Strattera), extended-release guanfacine (Intuniv), and extended-release clonidine (Kapvay) is sufficient, but not as strong as for stimulants.

Medications, preferably combined with behavioral therapy, should be prescribed in adolescents, assuming the patient agrees with taking medication. Diversion of medication is a concern in adolescents; therefore, the clinician should be alert for indications of misuse and diversion, and should contemplate prescribing medications with less or no potential for abuse. In this population, it also is important that clinicians provide medication to control symptoms while driving (e.g., longer-acting medication; late afternoon, short-acting medication).

Although behavioral therapy does not require a specific diagnosis, patients with symptoms that do not meet DSM-IV criteria for ADHD should not receive medication. In patients who are prescribed medication, the dosage should be titrated to maximize benefit and minimize adverse effects. ■

Answers to This Issue's CME Quiz

Q1. B
Q2. A, B, C
Q3. B
Q4. A, B, C, D
Q5. B
Q6. B
Q7. C

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