(PBL) Diagnosis and Management of ADHD in Children: Sharpening our ADHD Tools

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Dr. Hamilton is a graduate of Duke University, Durham, North Carolina, and earned his medical degree at the University of Pittsburgh School of Medicine in Pennsylvania. He completed his internship and family medicine residency at Franklin Square Hospital, Baltimore, Maryland, where he served as chief resident. At the University of Cincinnati, Ohio, he completed a fellowship in faculty development and received additional training in developmental pediatrics and adolescent medicine. Prior to joining the faculty of Inspira Family Medicine Residency, he served as assistant program director at Blackstone Family Practice Residency in Virginia. Dr. Hamilton’s clinical interests include the evaluation and management of children who have attention-deficit/hyperactivity disorder (ADHD), learning difficulties, and emotional/behavioral problems. He has been published in American Family Physician and UpToDate on the topics of developmental pediatrics and emotional/behavioral problems. He obtained his Drug Abuse Treatment Act (DATA) waiver and treats individuals who have opioid use disorder.
Learning Objectives

1. Practice applying new knowledge and skills gained from Diagnosis and Management of ADHD in Children sessions, through collaborative learning with peers and expert faculty.

2. Identify strategies that foster optimal management ADHD in children within the context of professional practice.

3. Formulate an action plan to implement practice changes, aimed at improving patient care.

Associated Sessions

• Diagnosis and Management of ADHD in Children: Sharpening our ADHD Tools
PBL: Case 1: Isabelle

- Isabelle is a 12 year old (DOB 07.07.2007) girl who has been your patient since she was five. She’s always struck you as a sweet and somewhat reserved child.

- She is seeing you today (Sept. 2019) as her mother worries that Isabelle will have many of the same problem this year (7th grade) that she had in 6th grade.

- Her mother reports that Isabelle has always been a “space cadet” but this had not interfered with her school work until last year.

- Her mother thinks last year’s teachers were a “bad fit” for Izzy, but she is off to a bad start this year.
PBL: Case 1: Isabelle

• Izzy’s mother describes problems at home concerning messiness, poor organization and forgetfulness.
• She reports that last year there were problems around failure to turn in homework, difficulty following directions, difficulty sustaining focus on schoolwork.

Case 1: Isabelle

• What additional history do you want to gather?
• What is in your differential diagnosis?
Case 1: Isabelle

• Important history gathered:
  • Born 3000gms, term, uneventful pregnancy, labor and delivery.
  • Izzy has been a bit “spacy” as long as her mother can recall.
  • She's more anxious than her siblings but mother unaware of problematic anxiety.
  • Mother receives CBT for anxiety, had no history of ADHD, nor difficulties in school and received an associates degree at a nearby community college.
  • Izzy’s father was never diagnosed with ADHD but had many behavioral and academic problems, did not graduate high school and has had problems with drugs, alcohol and mood disorders.
  • Mom describes a good relationship with Izzy, but describes arguments and frustrations over organizational skills, planning, and follow-through.
  • Last year Izzy struggled with language art and social studies, did well in math.
  • She has a close group of friends and is active in cheer.

Case 1: Isabelle

• You receive completed NICQH Vanderbilt forms – both a parent (mother) and teacher form.
• What information can you gather from these forms?
• What conclusions are you willing to make and what matters remain unresolved?
Case 1: Isabella

• You discuss your impressions with Izzy’s mother and she would like a trial of treatment and Izzy seems willing.
• What do you emphasize in your discussion to her mother about treatment?
• What sort of discussion do you have with Isabelle?
• How to you begin your treatment – with what medication and at what dose and with what sort of follow-up?
• What are your short-term priorities?
• How will you monitor response to treatment?

Case 2: Fred

• Fred is 6 year old (DOB 3-12-2013) first grader whom you saw as an infant and toddler, but have not seen in a few years.
• He is accompanied by his mother who confesses that she has long had concerns about his behavior.
• Freddie is described as “been difficult to control since he could walk.”
• She describes Fred as “unable to stay still” and not taking direction well.
• His mother received reports from pre-school that he was “aggressive and bossy” with his peers and his she reports similar problems at home.
• Freddie reacts strongly to limits and his mother has grown tired from trying to control his behavior.
Case 2: Fred

- Fred is a twin, and was born at 2630 gm (5 pounds, 13 oz.) 35 weeks gestation. He had a brief stay in the NICU but an otherwise uneventful infancy.
- Fred had delayed language milestones and you sent him for early intervention at 15 months when he had few words.
- His twin has developed without struggles.
- Family history:
  - Paternal: dropped out of high school, SUD.
  - Maternal depression. Good student in HS, enjoys reading.

Case 2: Fred

- In the room Freddie is literally in constant motion, climbing, jumping and grabbing. No effective limit setting or redirection is observed although parenting is never harsh.
- You succeed in engaging him and he makes excellent eye contact as he colorfully describes his favorite video game.
- He is cheerful and interpersonally warm. He is affectionate with his mother who reciprocates affection.
Case 2: Fred

- His mother and Freddie return for follow-up with completed Vanderbilt forms.
- How do you interpret the Vanderbilt forms?
- What diagnoses do you make?
- What other diagnosis do you wish to explore?
- How do you translate findings from the Multimodal Treatment of ADHD (MTA) into a treatment strategy?

Case 3: Andrew, 16 years old

- This is the first time you’re meeting Andrew (DOB 4-25-03) who is here with his mother.
- Andrew sits sullenly, ear buds in place, as his mother describes a difficult last year of school (freshman year) where universally poor grades mandated summer school which he attended and completed.
- He suffered several suspensions last year for behavior; the worst of the behavior sounds like reactionary aggression.
- His mother describes a somewhat detached, difficult child since around age 13.
- He’s described as “thin-skinned” and quick to react negatively.
Case 3: Andrew

- Andrew’s mother reports that he was diagnosed with ADHD at age 8, and was on methylphenidate for about a year but she does not recall much about the experience.
- Andrew played football previously, but grades have precluded participation freshman year.
- He is not involved in any school sports, activities or clubs.
- She denies unprovoked aggression but endorses irritability and disagreeableness.

Case 3: Andrew

- You meet briefly with Andrew alone.
- He is a reluctant historian.
- He reports regular marijuana use, denies cigarettes, alcohol or other drugs.
- He describes all his teachers as “out to get him” and he only speaks positively of a former coach.
- He describes a group of similarly-minded friends.
- You send Andrew and his mother home with Vanderbilt forms for his mother and teacher.
Case 3: Andrew

- Prior to the follow-up visit the Vanderbilt forms arrive for your review.
- You look them over during lunch prior to his FU visit.

Case 3: Andrew

- What is your tentative list of diagnoses, and with what degree of certainty?
- You scratch out some notes to yourself in preparation for the follow-up visit (you’ve secured a 30 minute visit)
- What do you recommend to Andrew and his mother? What sort of follow-up to you arrange?
Questions