Letters to the Editor

Pharmacologic Treatment for Older Children with ADHD

Original Article: Right Care for Children: Top Five Do's and Don'ts

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To the Editor: The article on right care for children described nonpharmacologic therapy as the preferred initial intervention for children with attention-deficit/hyperactivity disorder (ADHD). This recommendation requires modification. Although behavior therapy is the evidence-based preferred initial therapy for children four to five years of age, this is not the case for children ages six to 11 years.

The American Academy of Pediatrics (AAP) recommended in its 2011 guideline that when treating children ages six to 11 years with ADHD, "the primary care clinician should prescribe U.S. Food and Drug Administration–approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation.)"[1] The authors of the right care for children article cited the MTA Cooperative Group study as supporting evidence for their recommendation; however, that study actually demonstrated the superiority of treatment with methylphenidate (Ritalin) over behavior therapy.[2]

Preferring initial behavior therapy over medical therapy is unambiguously evidence-based and recommended by the AAP for children ages four to five years.[1,3] The AAP assigned a lower evidence rating to the addition of behavior therapy or its use in the absence of medical therapy for older children.

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References

1. Wolraich M, Brown L, Brown RT, et al. Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Pediatrics*. 2011;128(5):1007-1022.
2. The MTA Cooperative Group. Multimodal treatment study of children with ADHD: a 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Arch Gen Psychiatry*. 1999;56(12):1073-1086.
3. Charach A, Carson P, Fox S, et al. Interventions for preschool children at high risk for ADHD: a comparative effectiveness review. *Pediatrics*. 2013;131(5):e1584-e1604.

In Reply: We appreciate the thoughtful comments by Dr. Hamilton. As noted, the AAP recommends behavior therapy and/or medication for the treatment of ADHD for children ages six to 11 years.[1] This guideline leaves treatment options open to the clinician and recommends shared decision-making, which we support. We appropriately acknowledge the evidence that pharmacologic agents improve symptoms of ADHD in older children.[1] However, we stand by our original recommendation because a more nuanced perspective is required when addressing functional impairments.

Commonly used stimulants have well-described adverse effects.[2] First-line behavior therapy is a medication-sparing intervention for patients who respond to behavior therapy alone. Most studies of ADHD treatment randomize patients by intervention, then measure symptoms. Although that is helpful in comparing static interventions, this is not how clinicians manage ADHD in daily practice. A 2014 study randomized children to start with stimulant therapy or behavior therapy. Uniquely, patients with persistent symptoms underwent a second randomization to either increased intensity of the initial therapy or addition of the opposite intervention. Regardless of the additional therapies, the

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children initially randomized to behavior therapy had lower rates of rule violations at school and discipline outside the classroom.[3] This study better simulates the iterative process of treating ADHD and demonstrates the potential impact of front-line behavior therapy.

We have serious concerns about the misdiagnosis and overdiagnosis of ADHD. When children are inappropriately diagnosed, they are exposed to unnecessary side effects and stigma. As stimulant prescribing has increased, so have reports of abuse and overdose.[4] In a 2018 study, children born the month prior to the cut-off date to start kindergarten were significantly more likely to be diagnosed with ADHD than those born the month after the cut-off.[5] In schools with a September 1 kindergarten cut-off, children born in August had a 33% higher relative risk of an ADHD diagnosis than children born in September. These results bring into question the accuracy of the diagnostic process for ADHD.

Finally, we would like to draw attention to potential concerns regarding conflicts of interest and professional guidelines. Several members of the AAP guideline committee received compensation from large pharmaceutical companies who produce Adderall XR, Vyvanse, Strattera, Quillivant XR, etc.[1] We appreciate the importance of academic-industry relationships; however, the negative impact of financial conflicts on guideline development is well described.[6]

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References

1. Wolraich M, Brown L, Brown RT, et al.; Subcommitee on Attention-Deficit/Hyperactivity Disorder; Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Pediatrics*. 2011;128(5):1007-1022.
2. Pelham WE, Burrows-MacLean L, Gnagy EM, et al. A dose-ranging study of behavioral and pharmacological treatment in social settings for children with ADHD. *J Abnorm Child Psychol*. 2014;42(6):1019-1031.
3. Pelham WE Jr., Fabiano GA, Waxmonsky JG, et al. Treatment sequencing for childhood ADHD: a multiple-randomization study of adaptive medication and behavioral interventions. *J Clin Child Adolesc Psychol*. 2016;45(4):396-415.
4. King SA, Casavant MJ, Spiller HA, et al. Pediatric ADHD medication exposures reported to US poison control centers. *Pediatrics*. 2018;141(6):20173872.
5. Layton TJ, Barnett ML, Hicks TR, et al. Attention deficit–hyperactivity disorder and month of school enrollment. *N Engl J Med*. 2018;379(22):2122-2130.
6. Lenzer J, Hoffman J, Furberg CD, et al. Ensuring the integrity of clinical practice guidelines: a tool for protecting patients [published correction appears in *BMJ*. 2014;348:f1335]. *BMJ*. 2013;347:f5535. ■