DEFINITION OF ADHD

- Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that shows itself as a persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development and is inconsistent with age.

ETIOLOGY/ABNORMALITIES

Abnormal/diagnostic studies:
- PET scan - Brain areas that control attention use less glucose
- MRI – Decreased brain volume
- EEG – slow waves
- Some specific gene correlation
Biologic factors influence neurotransmitters with strong genetic evidence.

Positive for ADHD in the family, 1st degree relative 25% chance of disorder vs. 5% in the general population.

Sugar/food allergies connection remains:
- NIMH says food allergies/sugar may account for 5% of children with the diagnosis (very young). (e.g., MSG, Red dye, etc.)

- DMS-V
- Prevalence: Population surveys suggest that ADHD occurs in most cultures at a rate of
  - 5% of children (male/female 2:1)
  - 2.5% Adults (male/female 1.6:1)

  Know this and you know the stats
  Just be aware that there are a lot of other numbers out there

The American Psychiatric Association states in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) that 5% of children have ADHD. However, studies in the US have estimated higher rates in community samples.

The percent of children estimated to have ADHD has changed over time. A historical view provides the necessary context to understand changes in what we know about ADHD, including estimates of the rates of ADHD across time, changes in diagnostic criteria, and medication treatment.
Recent surveys asked parents whether their child received an ADHD diagnosis from a health care provider. The results show that:

- Approximately 11% of children 4-17 years of age (6.4 Million) have been diagnosed with ADHD as of 2011.
- The percentage of children with an ADHD diagnosis continues to increase, from 7.8% in 2003 to 9.5% in 2007, and to 11.1% in 2011.
- Rates of ADHD diagnosis increased an average of 3% per year from 1997 to 2006 and an average of approximately 5% per year from 2003-2007.
- Boys (13.2%) were more likely than girls (5.6%) to have ever been diagnosed with ADHD.
- Prevalence of ADHD diagnosis varied substantially by state, from a low of 5.6% in Nevada to a high of 18.7% in Kentucky.

Remember people are not statistics.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER - DSM-V

CHANGES FROM DSM – IV
ADULT CRITERIA FOR THE FIRST TIME
### Attention DHD

6 of 9 in children / 5 in adults

<table>
<thead>
<tr>
<th>Mnemonic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mistakes</td>
</tr>
<tr>
<td>2. Poor attention</td>
</tr>
<tr>
<td>3. Poor listening</td>
</tr>
<tr>
<td>4. Fails to finish</td>
</tr>
<tr>
<td>5. Poor organization</td>
</tr>
<tr>
<td>6. Avoids complex paperwork</td>
</tr>
<tr>
<td>7. Loses things</td>
</tr>
<tr>
<td>8. Distracted</td>
</tr>
<tr>
<td>9. Forgetful</td>
</tr>
</tbody>
</table>

### Attention Diagnostic Check List

<table>
<thead>
<tr>
<th>Symptoms of inattention persisting ≥ 6 months in ≥ 2 settings (6 children, 5 adults)</th>
<th>Work or School</th>
<th>Home</th>
<th>Social Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Careless mistakes/lack of attention to details</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of sustained attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Listening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to follow through on tasks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often avoids tasks requiring sustained mental effort</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losing things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily distracted by extraneous stimuli or unrelated thoughts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forgetful in daily activities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ADD Hyperactivity

6 of 9 children / 5 adults

<table>
<thead>
<tr>
<th>Mnemonic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Squirms in seat</td>
</tr>
<tr>
<td>2. Leaves seat</td>
</tr>
<tr>
<td>3. Runs/restless</td>
</tr>
<tr>
<td>4. Quiet</td>
</tr>
<tr>
<td>5. On the go</td>
</tr>
<tr>
<td>6. Talks a lot</td>
</tr>
<tr>
<td>7. Blurts out answers</td>
</tr>
<tr>
<td>8. Waiting</td>
</tr>
<tr>
<td>9. Interrupts/intrudes</td>
</tr>
</tbody>
</table>
HYPERACTIVITY DIAGNOSTIC CHECK LIST

<table>
<thead>
<tr>
<th>Symptoms of hyperactivity/impulsivity persisting ≥ 6 months in ≥ 2 settings (6 children, 5 adults)</th>
<th>Work or School</th>
<th>Home</th>
<th>Social Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidgeting/squirming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaving their seat when remaining seated is expected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive running/climbing, or feel restless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty with quiet activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“On the go”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive talking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurting out answers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to wait turn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusive</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BACK-UP CHECK LISTS

If you lose examples (secondary to ADHD) there are 2 simple check lists you can use. www.CDC.gov/adhd for parents. Vyvanse patient self report (kids, adults with examples)

DSM-V
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER DIAGNOSTIC CRITERIA

Note: Prompt words in BOLD Caps. Possible Adult e.g.s are underlined.

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. Inattention: Six in kids (or more) and five in Adults of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:
NOTE: The symptoms are NOT solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

1. Often fails to give close attention to details or makes careless MISTAKES in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate.)

2. Often has difficulty sustaining ATTENTION in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading.)

3. Often does NOT seem to LISTEN when spoken to directly (e.g., mind seems elsewhere even in the absence of any obvious distraction).

4. Often does not follow through on instructions and FAILS TO FINISH schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).

5. Often has DIFFICULTY ORGANIZING tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

6. Often AVOIDS, dislikes, or is reluctant to engage in tasks that require SUSTAINED MENTAL EFFORT (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing, lengthy papers).

7. Often LOSES THINGS necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).

8. Is often easily DISTRACTED by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).

9. Is often FORGETFUL in daily activities (e.g., doing chores, running errands; for older adolescents and adults returning calls, paying bills, keeping appointments).
B. Hyperactivity and impulsivity: Six (or 5 in Adults) at least 6 months social and academic/occupational activities: NOTE: Not secondary to defiant behavior or a lack of understanding.

1. Often fidgets with or taps hands or feet or SQUIRMS IN SEAT.
2. Often LEAVES SEAT in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that required remaining in place).
3. Often RUNS about or climbs in situations where it is inappropriate (Note: In adolescents or adults, may be limited to feeling RESTLESS.)
4. Often unable to play or engage in leisure activities QUIETLY.
5. Is often ON THE GO, acting as if “Driven by a motor” (e.g., is unable to be comfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
6. Often TALKS excessively.
7. Often BLURTS OUT AN ANSWER before a question has been completed (e.g., completes people’s sentences; cannot wait for their turn in a conversation.)
8. Often has DIFFICULTY WAITING his or her turn (e.g., while waiting in line.)
9. Often INTERRUPTS or INTRUDES on others (e.g., butts into conversations, games, or activities; may start using others people’s things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).
**DSM - V**

**HYPERACTIVITY**

C. Several symptoms present prior to age 12.*

D. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

E. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

F. The symptoms do **NOT** occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, Anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

* The rationale for 12. research found no difference between before 12 vs. 7 in terms of course, severity, outcome, or treatment response.

**DSM-V Change –** Look back for symptoms before 12. However, be aware when diagnosing adults for 1st time that adult recall of childhood symptoms is unreliable, obtain ancillary information.

* Change to age 12 as the cut-off is likely to lead to an increase in ADHD diagnosis.

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**DSM - V**

- Specify whether:
  314.01 (F90.2) Combined presentation: If both Criterion A1 (Inattention) and Criterion A2 (Hyperactivity-Impulsivity) are met for the past 6 months.
  314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (Hyperactivity-Impulsivity) is not met for the past 6 months.
  314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met but Criterion A1 (inattention) is not met for the past 6 months.

- Note: Current severity. Some feel that this change has “loosened” criteria in that neither mild or moderate would have met criteria for ADHD in DSM-IV and this could increase diagnosis of ADHD.

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**DSM-V**

**OTHER SPECIFIED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER**

- 314.01 (F90.8)
  - This category applies to presentations in which symptoms characteristic of attention-deficit/hyperactivity disorder that cause clinically significant distress or impairment in social, occupational or other important areas of functioning predominate but do NOT meet the full criteria for attention-deficit/hyperactivity disorder or any of the disorders in the neuro-developmental disorders diagnostic class. The other specified attention-deficit/hyperactivity disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for attention-deficit/hyperactivity disorder or any specific neurodevelopmental disorder. This is done by recording “other specified attention-deficit hyperactivity disorder followed by the specific reason” (e.g., “with insufficient inattention symptoms”).
DMS-V
UNSPECIFIED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

× 314.01 (F90.9)
+ This category applies to presentations in which symptoms characteristic of attention-deficit/hyperactivity disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do NOT meet the full criteria for attention-deficit/hyperactivity disorder or any of the disorders in the neuro-developmental disorders diagnostic class. The unspecified attention-deficient/hyperactivity disorder category is used in situations in which the clinician chooses NOT to specify the reason that the criteria are not met for attention-deficit/hyperactivity disorder or for a specific neurodevelopmental disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.

Note: DSM-IV did have an "Not otherwise specified" (NOS) and simply stated Do not meet criteria.

COURSE/PROGNOSIS

× Course:
+ Difficult diagnosis <4, may be normal kid stuff
+ Most are identified in elementary school
+ Peer neglect with poor attention
+ Peer rejection with hyperactivity
+ Symptoms may be minimal with one-on-one or video games
+ Meet ADA criteria, qualify for an IEP
+ Stable through early adolescent
+ Hyperactivity lessens, but restless, impulsivity, inattention persists

PROGNOSIS/COMORBIDITY

× Kids:
+ Less academic achievement
+ Family discord
+ 50% ADHD kids have ODP
+ 25% ADHD kids with conduct disorder, OJA
+ Most with DMDD have ADHD
+ * New DSM-V Diagnosis– Disruptive mood dysregulation disorder diagnosis; lower numbers of kids with bipolar diagnosis. Hallmark temper tantrums/rage. No mania/depression.
+ New DSM-V – ADHD can co-occur with autism
COURSE/PROGNOSIS/COMORBIDITY

- Adult:
  - Less stable employment
  - Interpersonal conflicts
  - Substance use*
  - Accidents
  - Seen as lazy or irresponsible
  - Antisocial or other P.D. can co-occur prison
  - * DSM-V no longer uses substance abuse or dependence. Rationale the substance changes and reduce stigma. (More “neutral”, less “negative” connotation)

ADHD         TREATMENT

W. John Mallgren, D. O.

ADHD

My “Focus” will be on kids, criteria for diagnosis <12 years (V), (from 7 in IV)
1 in 10 boys, hyper
1 in 30 girls, inattentive
Can go from a problem child to student of the month.
You don’t want to take the “boy/girl” out of them.
**CARDIAC CONCERN**

- 2006 FDA – R/O heart disease (structural), hypertrophic cardio myopathy can manifest as HTN, syncope, chest pain, arrhythmias (these symptoms in a kid, cardiology consult)
- Black Box
- Recent studies demonstrate
  - No increased CV events in young to adolescents
    - JAMA, Dec 2011
    - New England Journal of Medicine, 2011:365

**MEDICATION**

- Start with stimulants
  - Don’t use to make diagnosis, but they sure can confirm it
  - Ritalin (FDA>6) or Amphetamines (FDA>3) (Vyvanse>6)
  - About = in effect
  - I feel less amphetamines in circulation the better (they are prohibited in Japan & S. Korea) so consider starting with Ritalin
  - Ritalin less “abusable” than amphetamines

**RITALIN**

- Depending on age trial short acting (5, 10mg am & noon) or Concerta 18 / Metadate CD 10 m.g.
- If do well go to higher dose long-acting. (e.g. Ritalin SR 20, Concerta to 72mg, Metadate CD, others)
- Will get effect 30’-1h after take it
- Big s.e., weight loss
- Push doses to s.e. to get full benefit
- Duration short 4h, SR 8hr, XR 12hr (4,8,12)
- Mechanism Dopamine Reuptake Inhibitor (DRI) & Norepinephrine (NE)
- Dextro (focalin) increase affinity N.E. (reason why it works better for some)
**AMPHETAMINES**

- With amphetamine, can start with Vyvanse 10mg or child Adderall 5 bid
- No set dosing strategy on stimulants
- The table shows aggressive titration for Vyvanse (q wk). Doesn’t work for how we are set-up
- Monitor weight
- Mechanism of action
  - Dopamine release & DRI
  - NE
- New Diversion check
  - If kid on Amphetamine, we now do medication compliance with UA to detect in kids; if neg-a conversation

---

**NON-STIMULANTS**

- **Strattera, > 6 years**
  - NRI
  - Titrated dose, check epocrates
  - Warnings – SI/behavior, med guide to parents.
  - Can’t use with SZ/eating disorder
  - Now priapism along with stimulants
- **Wellbutrin (XL)**
  - Avg kids 3-6mg/kg (e.g. 100 lb. = 45kg x 5mg/kg = 227mg) = 3, 75mg
  - Can’t use with seizure or eating disorder
  - Can increase anger

---

**NON-STIMULANTS (CONT.)**

- **Alpha Agonists**
  - ? On mono TX effectiveness
  - Clonidine/Kapvay
    - Decreased hyper/aggression & for sleep
      (1/2-1 bid/tid & up .3 for sleep), Kapvay 0.1-0.4, bid
    - Guaifencin
      - Tenex 0.5-4mg
      - Another mg/kg thing, check epocrates is bid, qid
      - Intuv 1-4mg, q.d, a.m. or p.m.
- **TCA's**
  - Imipramine – start 25 h.s., 50mg <12, 75mg>12, takes time
  - Get an EKG 1st
ADHD IN ADULTS

- ADHD In Adults - 1/3 to 1/2 persist?
- Reports of over diagnosis
- E.g. get a counselor with a 4 point M.S., without meds (not for preventing falling asleep or energy)
- E.g. propriety self diagnosis assessment: (Vyvanse web site)
  - Put thing off = inattention
  - Impatient = hyperactive
  - Can't wait their turn = impulsivity
  Ergo, everyone has ADHD

SUGGESTIONS, TX ADHD ADULTS

- Wellbutrin XL 450 (a derivative of tenuate)
- Not use with seizures, eating disorders
- Strattera to 100mg
  4-6 wks +, at target dose
- TCA – imipramine 50-100mg, EKG 1st
- C IV – if use scheduled, consider 1st
- Provigil – 200-400mg
- Nuvigil – 50-250mg
- If II, Start with Ritalin
- If amphetamine, try to use Vyvanse

METHYL-PHENIDATE COMPARISON CHART

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Dosage</th>
<th>Dosage Strengths</th>
<th>Duration (hours)</th>
<th>Dosage form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylphenidate</td>
<td>Ritalin</td>
<td>Start 5mg bid</td>
<td>5mg, 10mg, 20mg</td>
<td>3-6 short</td>
<td>Tablets (can cut)</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Metadate ER</td>
<td>Start 10mg a.m.</td>
<td>10mg, 20mg</td>
<td>6-8 Intermediate</td>
<td>Tablets</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Concerta</td>
<td>Start 18mg p.o.</td>
<td>18mg, 36mg, 54mg</td>
<td>10-12 Long</td>
<td>Tablets</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Quillivant XR</td>
<td>20-60mg</td>
<td>25mg/ml</td>
<td>12 hr Suspension</td>
<td></td>
</tr>
</tbody>
</table>
## METHYL-PHENIDATE COMPARISON CHART

### CONT.

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Dosing</th>
<th>Dosage Strengths</th>
<th>Duration (hours)</th>
<th>Dosage Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexmethylphenidate</td>
<td>Focalin</td>
<td>Start 2.5mg bid FDA - max 50mg Off Label - 100mg</td>
<td>2.5-5mg, 10mg</td>
<td>4-6 Short</td>
<td>Tablets (can cut)</td>
</tr>
<tr>
<td>Dexmethylphenidate</td>
<td>Focalin XR</td>
<td>Start 5mg a.m. FDA 10mg Off Label 30mg</td>
<td>5mg, 10mg, 20mg</td>
<td>6-10 Long</td>
<td>Capsules (Sprinkles)</td>
</tr>
</tbody>
</table>

## AMPHETAMINE CHART

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Dosing</th>
<th>Dosage Strengths</th>
<th>Duration (hours)</th>
<th>Dosage Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed Amphetamine salts</td>
<td>Adderall</td>
<td>Change to XR is 1:1</td>
<td>3-5 – 2.5 q d &gt;6 Initially 5mg q4-d FDA - 40 Off Label-60mg</td>
<td>5mg, 7.5mg, 10mg, 15mg, 30mg</td>
<td>4-6</td>
</tr>
<tr>
<td>Mixed Amphetamine salts</td>
<td>Adderall XR</td>
<td>Initially &gt;6 - 10mg qd FDA - 50mg max Off Label 60mg/day</td>
<td>5mg, 10mg, 15mg, 20mg, 30mg</td>
<td>8-12</td>
<td>Capsules (Sprinkles)</td>
</tr>
<tr>
<td>L-dexamfetamine Dimesylate (A prodrug)</td>
<td>Vyvanse*</td>
<td>*New indication for binge eating disorder</td>
<td>Start daily dose: 20mg FDA Max-70</td>
<td>10mg, 20mg, 30mg, 40mg, 50mg, 60mg, 70mg</td>
<td>10-12</td>
</tr>
</tbody>
</table>

## SIDE EFFECTS

1. Cardiac (rare) but #1
2. Decreased appetite / Weight Loss
3. Tics
4. Stunted growth
5. Tummy aches
6. Insomnia
7. Psychiatric problems (agitation, psychosis, etc.)
8. Consider anything reported as treatment emergent side effect (idiosyncratic)
There are many monitoring forms, e.g. (Proprietary):
- Vanderbilt Parent Scale
- Connors Teacher rating scale
- Parents, Patient, teacher “input” focusing on behavior/grades
- Sample on the next 4 pages

* Worsening in only one setting: R/O family discord, bullying

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**SAMPLE WEEKLY ADHD MONITORING FORM**

Child’s Name__________ Date: __________
Teacher(s)____________________________

Teacher: Please answer the items below on your observations of this child during the past week. Note that for items 1-12 high scores indicate problems while for items 13-15, low scores indicate problems.

1. Fidgets with hands or feet & squirms in seat
2. Difficulty remaining seated
3. Difficulty awaiting turn
4. Always “up and on the go” or acts as if “driven by a motor”
5. Talks excessively
6. Interrupts or intrudes on others
7. Easily distracted
8. Fails to finish assigned tasks
9. Difficulty sustaining attention
10. Careless or messy work
11. Does not seem to listen when spoken to
12. Difficulty following directions
ADHD FORM CONTINUED

<table>
<thead>
<tr>
<th>13. Follows class rules</th>
<th>Not at all</th>
<th>Just a little</th>
<th>Often</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Gets along with peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Seems happy and in a good mood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Indicate how the behaviors rated on the other side compared during the morning and afternoon times during the prior week by checking of the other choices below.
(Note: If you only have this child in class during morning or afternoon this does not apply)

- Morning better than afternoon
- No clear difference
- Afternoon better than morning

17. Indicate the approximate percentage of assigned class work that this child completed during the past week:

0% 20% 40% 60% 80% 100%

18. The general quality of work completed by this child this week was:

- Very poor
- Poor
- Satisfactory
- Good
- Very good

19. If the quality of this child’s work varied significantly between subjects, please indicate this below.

20. Did this child turn in all assigned homework? If not, please indicate the assignments that were missing.

21. Please include any other comments or observations that you believe are important.

SUMMARY

1. 5% of kids 2:1 male/female
2. 2.5% Adults 1.6:1 male/female
3. No agreed way to diagnosis
4. Check list of mnemonic devices
5. In the end, same criteria for adults
6. Trial medication not used to make diagnosis; can confirm in 30 minutes
7. Changes in DMS-V have led to concerns RE: ADHD being over diagnosed

* Self report (rating scales, different sources, clinical evaluation)
SUMMARY (CONT.)

8. Medication Table at hand
9. No agreed method of treatment
10. Younger low-dose, short acting
12. Stimulants are generally well tolerated in kids
13. May need bolus/booster short acting p.m.
14. Ritalin may work, not cause side effect, when amphetamines do or vise versa

SUMMARY (CONT.)

15. Monitor via behavior/grades, rating scores
16. Helps behavior as much or more than attention
17. Watch weight, growth thing, q 6 mon (rare, parental anxiety)
18. Monitor for tics
19. Can do week-end, holiday summer-off meds
20. Are many non-stimulant options
21. CBT other therapies can treat with or with-out meds.

WHY TREAT

- Easy
- Fun
- Rewarding
- Does a lot of good