ADHD

Discussion Date: **2002**
Discussion Moderator: **Cliff O'Callahan, MD**

Questions:
1. Are there better ways to schedule a work-up for a child with behavior suggestive of ADHD?
2. Are there tools that are helpful in the evaluative process?
3. How are providers distinguishing between ADHD and FAS or PTSD etc?
4. Blind trials being used?
5. Favorite stimulants or other medicines.
6. Teens and adults coming for consults on ADHD!

Discussion:
1. Variability in scheduling. Some use a RN case manager as first pass to discuss need for visit and send a pack with questionnaires. Then it looks like many folk do two 30-40 minute visits (some do an initial 60 minute visit). Some have the first visit with parents only.

2. Variety in tools used with Connors, ACTeRS, ANSER forms all used. Mention was made of the Vanderbilt NICHQ forms. They are now (4/2004) the standard forms in the NICHQ and AAP ADHD toolkits and are available free or bought as a whole packet. Most require school records in addition to teachers filling out standard forms. For those without access to psychologists etc, some use additional screening forms like the Achenbach, Child Behavior Checklist, and Youth Self Report.

3. Some have access to FAS multidisciplinary clinics, others only wish. Variability in access to psychologists and psychiatrists exist, compounded by distance to "accessible" providers. Most believe that a LARGE proportion of our "ADHD" children and youth are ARND.

4. Only a couple people seem to do blind trials (placebo vs stimulant) or open trials of various stimulants.

5. Some still use Ritalin but most seem to be using long acting formulations and getting them on their formularies! (The original discussion was before the advent of Strattera). Concerta, Adderall often cited.

6. Not many of us pediatricians doing older teen and adult ADHD evals, but diagnosis of children has led some parents to go in search of evaluations for themselves.

Addendum from 4/2004: It was a great discussion and will be good to repeat after folk have had some time to work with all the newer long acting stimulant formulations and Strattera. The most significant update is the ADHD toolkit available through the AAP. It is not perfect but is a great start, easy to teach residents, and provides some uniformity throughout the country. The big weakness for Native children is the very shallow provider eval form that does not push us strongly enough to consider co-morbidities like ARND, FAS, ODD, PTSD, reactive attachment disorder etc.