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TEAM ADHD UPDATES

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A Clinical Newsletter

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## Team ADHD Faculty Featured this Issue:

Andrew J. Cutler, MD
*Chief Medical Officer*
*Neuroscience Education Institute*
*Clinical Associate Professor of Psychiatry*
*SUNY Upstate Medical University*
*Bradenton, FL*

Dr Cutler is board certified in both Internal Medicine and Psychiatry, additionally he is a Certified Physician Investigator (CPI) from the Association of Clinical Research Professionals (ACRP), and is a Fellow of the American Psychiatric Association (APA). He has been conducting psychopharmacology research for 26 years, including ADHD studies for over 20 years. Dr. Cutler has been Principal Investigator on over 400 clinical trials, and has authored over 100 scientific papers and presented over 300 posters at scientific meetings around the world. His passion for ADHD research is fueled by his desire to further a greater understanding of the specific needs and corresponding potential of ADHD patients.

## HIGHLIGHTS FROM A RECENT ADHD PRESENTATION BY DR. ANDREW J. CUTLER

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### Comorbid Complex ADHD

Comorbid complex ADHD is very common. Studies show that up to **75**% of individuals with ADHD have at least one psychiatric condition, and **80**% of those individuals have more than one comorbidity. But why do people with ADHD have comorbidities? It's possible that one disorder is a precursor to the other (evolving over time), it could be a risk factor for developing the other, or the disorders may have a common genetic basis. The impact of ADHD may lead to the development of some comorbid disorders (such as depression and anxiety), making them secondary conditions. The comorbidity profile can change throughout the individual's life span. In children and adolescents, studies have shown a high incidence of oppositional defiant disorder (ODD), which decreases in adulthood.

### Comorbid Complex ADHD Throughout the Life Span

The cumulative burden of comorbid complex ADHD evolves and accumulates throughout the life span. For example, although ODD is the most common comorbidity in children, conduct disorder and anxiety are also seen, with the impact of these, along with ADHD, resulting in low self-esteem in this age group.

Moving from childhood into adolescence and adulthood, ODD and conduct disorder decrease, but criminal behaviors may start to show, with antisocial personality disorder becoming more common. Additionally, learning delays in childhood may develop into complex learning difficulties in adolescence and adulthood. With this progression, people often become demoralized and frustrated, resulting in a lack of motivation and a tendency toward underachievement. Substance abuse also may come into play.

### Diagnosis of ADHD and Comorbidities

The presence of comorbidities in different age groups can complicate the diagnosis of ADHD, as symptoms of these comorbidities often overlap with symptoms of ADHD.

- First, it's important to establish the diagnosis, by confirming that the individual meets DSM-5 criteria for ADHD.
- Then you should rule out alternative explanations for the symptoms.
- Finally, it's important to assess for comorbid conditions, which may affect the treatment of ADHD, as well as the diagnosis.

## Hot Topics in ADHD

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## ADHD Patient Resource Corner

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# Hot Topics in ADHD

*This issue's Hot Topics are provided by Frank A. Lopez, MD, Director of the Children's Developmental Center, Winter Park, Florida. Dr. Lopez has provided a topline summary of the recent (2019) ADHD Guideline Updates from the American Academy of Pediatrics (AAP).*

## 2019 AAP Guideline Updates: ADHD

### Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

*Wolraich ML, Hagan JF Jr, Allan C, et al; AAP Subcommittee on Children and Adolescents with Attention-Deficit/Hyperactive Disorder.*

**Attention-deficit/hyperactivity disorder has been described as the most common neurobehavioral diagnosis in children, and it can and does impact a child's academic performance, and general health. The American Academy of Pediatrics first published clinical recommendations for the diagnosis and evaluation of this condition in 2000. Recommendations for treatment followed in 2001, 2011, and, most recently on September 30, 2019.**

**did you know** *Along with the 2019 AAP guideline publication, Wolraich ML, et al published a brief historic perspective on the ADHD Diagnosis and Treatment Guidelines (Wolraich ML, et al.* Pediatrics. *2019;144(4):e20191682).*

**The essential difference in the recent guideline is greater emphasis on working with schools to develop individual student plans in Key Action Statements (KAS) 5b and 5c; and the addition of KAS-7, which address the importance of the diagnosis and treatment of comorbid ADHD.**

#### SUMMARY OF KEY ACTION STATEMENTS RELATED TO DIAGNOSIS

- KAS-1: The primary care clinician should initiate an evaluation for ADHD for any child ages 4 to 18 years who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (Grade B, strong recommendation).
- KAS-2: To make the diagnosis of ADHD, the primary care clinician should determine whether or not the Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria have been met, including documentation of impairment in more than one major setting by obtaining information primarily from reports from parents, guardians, teachers, and other school or and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (Grade B, strong recommendation).
- KAS-3: When evaluating a child for ADHD, the primary care clinician should include assessments for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety depression, oppositional defiant and conduct disorders), developmental (eg, learning and language disorders), or physical conditions (eg, tics, sleep apnea) (Grade B, strong recommendation).
- KAS-4: The primary care clinician should recognize that ADHD is a chronic condition and consider children and adolescents with ADHD as children and youth with special health care needs, following the principles of the chronic care model and the medical home (Grade B, strong recommendation).

**did you know** *The 2019 AAP guideline for management of ADHD includes an updated Process of Care algorithm to assist in implementing these guidelines (available in the guideline supplement; http://pediatrics.aappublications.org/content/suppl/2019/ 09/18/peds. 2019-2528.DCSupplemental). The algorithm focus on the care team, including the family, and has adopted the initial psychosocial assessment and mental health update described by the AAP Mental Health Initiative (http://www.aap.org/mentalhealth).*

# Hot Topics in ADHD

## RECOMMENDATIONS FOR TREATMENT OF CHILDREN AND YOUTH WITH ADHD VARY DEPENDING ON THE PATIENT'S AGE

- KAS-5a: For preschool-aged children (4-5 years of age), the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (Grade A, strong recommendation).
  - Prescribe methylphenidate if behavioral interventions do not provide significant improvement and there is moderate to severe continued disturbance in the child's ability to function. (Grade B, strong recommendation).
  - In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risk of starting medication at an early age against the harm of delaying the diagnosis and treatment of ADHD.
- KAS-5b: For elementary school and middle school-aged children (6-11 years), the primary care clinician should prescribe FDA-approved medications for ADHD along with evidence-based parent- and/or teacher-administered behavior therapy (preferably both). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine, in that order. The school environment program replacement is a part of any treatment plan (Grade A, strong recommendation for medications, training, and behavior treatments with the family and school).
- KAS-5c: For adolescents 12 to 18 years of age, the primary care clinician should prescribe FDA-approved medications for ADHD with the consent of the adolescent, and may prescribe behavioral therapy as treatment for ADHD if available (Grade A, strong recommendation for medications, training, and behavioral treatments with the family and school).
- KAS-6: Primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse events (Grade B, strong recommendation).

## A NEW KEY ACTION STATEMENT WAS ADDED IN 2019

- KAS-7: If trained for or experienced in diagnosing comorbid conditions, the primary care clinician may diagnose and initiate treatment for such conditions (Grade C, recommendation).
  - If the primary care clinician is not trained or experienced in making the diagnosis or initiating treatment, the patient should be referred to an appropriate subspecialist to make the diagnosis or initiate treatment.

**The effect of comorbid conditions on ADHD treatment can be variable. For some individuals, treatment of ADHD as described in KAS-5a-c may resolve or improve the comorbid conditions, such as coexisting aggression, oppositional defiance, depression, or anxiety. The comorbid condition, however, may require treatment in addition to the ADHD treatment.**

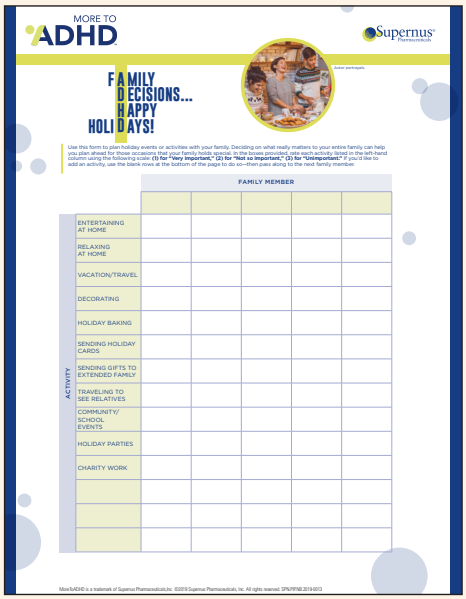
**The previous approach to treating ADHD has evolved from treating the most impactful condition first, to recognizing that, in many cases, treating ADHD is as important as treating the comorbid conditions—a co-treatment approach. For serious comorbid conditions (eg, suicidal ideation, severe temper outbursts, substance use disorder, mood disorders such as major depressive disorder, bipolar disorder, anxiety), however, ADHD should be treated after the serious comorbid condition has been addressed.**

**did you know**

*During the guideline update, several systemic barriers that restrict or hamper a clinician's ability to adopt the recommendations were identified. The Guideline Subcommittee identified major barriers and presented recommendations to address those barriers in the guideline supplement (http://pediatrics.aappublications.org/content/suppl/2019/09/18/peds.2019-2528.DCSupplemental).*

# ADHD Patient Resource Corner

***To download this resource or provide support for your patients interested in learning more about ADHD, go to: MoreToADHD.com***




**Holiday ADHD Checklist**

This form may be helpful to families planning holiday events and for prioritizing related activities.

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## References


Wolraich ML, Hagan JF, Allan C, et al. AAP subcommittee on children and adolescents with attention-deficit/hyperactive disorder. Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Pediatrics*. 2019;144(4):e20192528.

Wolraich ML, Chan E, Froehlich T, et al. ADHD diagnosis and treatment guidelines: a historical perspective. *Pediatrics*. 2019;144(4):e20191682.


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