

key points

SELECTED BY

Dr Peter Saul

GP, Wrexham and associate GP Dean for North Wales

ADHD is the term most widely used to cover a group

of common, chronic neurodevelopmental disorders characterised by developmentally abnormal and disabling levels of restlessness and overactivity (usually combined with impulsiveness) and/or inattention. There are three subtypes of ADHD: predominantly inattentive; predominantly hyperactive-impulsive; and combined type. For a diagnosis of ADHD to be made: onset of symptoms has to occur before the age of seven, symptoms should have been present longer than 6 months and they must be causing significant impairment.

The prevalence of ADHD is at least 5%. Two-thirds of

children with ADHD continue to have symptoms in adolescence. At the age of 25, half will still have symptoms which continue to cause significant impairment. ADHD is associated with an increased rate of other disorders: mood disorders; anxiety; other behavioural disorders; autism spectrum disorders; tic disorders; specific learning difficulties; developmental co-ordination disorder and sleep disorders.

The GP has an important role in identification of possible

ADHD, and onward referral, and also in the management of ADHD post-diagnosis, particularly with respect to prescribing medication usually on a shared care basis with specialist services. It is important to ask about the core symptoms of ADHD, the age of onset and duration, and to consider the possibility of comorbidity. A report from the school is helpful. If there is a strong suspicion of ADHD, a referral should be made to the local CAMHS or paediatrician with a special interest in ADHD.

SIGN recommends behavioural training as first-line

management for parents of preschool children with symptoms of ADHD, provided by trained facilitators. Medication is recommended as first-line treatment for core symptoms of severe ADHD and for milder forms when behavioural interventions have been unsuccessful.

There are three licensed medicines in the UK for the

treatment of ADHD: the psychostimulants methylphenidate hydrochloride and dexamfetamine sulphate and the non-psychostimulant, atomoxetine. Methylphenidate and atomoxetine are licensed for use in children aged six years and above; dexamfetamine for children aged three years and above. Medication is not recommended as first-line therapy for preschool children.

Psychostimulants are recommended as the first choice

medication for core symptoms of ADHD. In the UK, in practice this is usually methylphenidate. Response to methylphenidate is assessed by means of a trial period, during which there should be close liaison with parents and with school. Arrangements for follow up and six-monthly checks of height, weight and blood pressure are necessary. Atomoxetine is recommended for core symptoms of ADHD in children where psychostimulant medication is not appropriate, not tolerated or ineffective.