**Dr Phalen’s ADHD Dogma**

**ADHD DIAGNOSIS. ADHD IS A DIAGNOSIS OF EXCLUSION.** Thus, you must account for myriad other conditions that can result in ADHD-like symptoms. This is why you MUST get input from multiple sources and read page 2 of the NICHQ Vanderbilt Assessment Scale, especially looking for symptoms of anxiety or depression and for impact on daily function. Remember to use CPT code 96110 (multiple counts!).

1. **Problems ONLY** at home suggest parent-child conflict (common = ICD-10 code Z62.82x) or teacher denial (uncommon).
   - Refer to PROXIMA Program
   - Any Baby Can of San Antonio: www.AnyBabyCanSA.org

2. **Problems ONLY** at school suggest teacher-student conflict (uncommon), bullying, learning disability, intellectual disability, or (rarely) parents in denial of ADHD or overcompensating for child’s deficits. To rule out latter two, ask if child completes homework independently and how much time is spent on homework. Write brief medical statement to school stating that ADHD is unlikely and that you request formal psychoeducational testing to rule out a specific learning disability or intellectual disability. Under the Individuals with Disabilities Education Act (IDEA) of 2004, public schools are required to do so.

3. **No impact on daily function** and/or child does well academically. This child does not have a disorder. He/she has subthreshold symptoms. Monitor and re-evaluate as needed.

**ADHD TREATMENT PLAN.**

1. **Make SURE** it’s ADHD before you treat! Be wary of patients new to your panel.
2. **THERAPY.** Behavioral therapy directed at the child, especially a younger child, has limited benefit. Parenting skills training is effective. See 1., above.
3. **START WITH STIMULANTS ALWAYS.** Parents often buy into hyperbole of the alleged benefit or superiority of non-stimulants or the newest drug on the market. Reassure them that methylphenidate is one of the oldest, most studied drugs in all of pediatrics and has been used safely and effectively since the 1930s. Tell them that Concerta® and Ritalin® are different formulations of the same drug—methylphenidate; most will not know this! If you cannot convince them that methylphenidate does not cause children to develop cloven hooves, grow a tail, and sprout horns you may then offer dextroamphetamine (Dexedrine®). Both are > 80% effective in reducing core ADHD symptoms in children who are correctly diagnosed.
4. **START LOW, REGARDLESS OF AGE.** Many clinicians do not buy into this philosophy. The algorithms do not require this. However, too many times developmental pediatricians see children who “fail” Concerta® and Adderall® XR only to respond to lower doses of their short-acting cousins. This is because some children are overly sensitive to these medications, tolerate higher doses only after building up to them, or have ADHD-inattentive type and require lower doses to begin with. This is especially true in children who have developmental disabilities (e.g., global developmental delay/intellectual disability, autism spectrum disorder). I generally start with Ritalin® or Dexedrine® 2.5 to 5 mg per dose QAM, Q noon, and (if needed for homework or to prevent parental insanity) ~ 1500, with the lower dose for kids < 6 years old. The afternoon dose is usually lower than the AM and noon doses. TID dosing prepares the family for transition later to an extended-release formulation.
5. **GO SLOW.** Increase by 2.5 to 5 mg per dose every 5 to 7 days **UNTIL ONE OF THREE THINGS OCCURS:**
   - Core ADHD symptoms are significantly reduced and child has minimal or tolerable side effects. STOP. This is the “right dose”.
   - Intolerable side effects occur and do not resolve after 7 days. TERMINATE trial and switch to another drug.
   - LexiComp® MAXIMUM DOSE is reached with NO BENEFIT. TERMINATE trial and switch to another drug. Most providers do not follow this last step and terminate drug trials prematurely, resulting in multiple “failed” drugs. Remember, stimulant dosing IS NOT BASED ON WEIGHT OR AGE, PERIOD. You must increase to maximal dosing before declaring a failure.
6. **Stimulants are like eyeglasses and are only effective when on board.** The goal of Rx treatment is to “take the edge off”, not to create a zombie, a robot, or a perfect child. Be realistic.
7. If first stimulant fails or causes intolerable side effects, switch to the other stimulant line (e.g., switch from Ritalin® to Dexedrine®) and follows Steps 4 and 5 again.
8. If a stimulant works well and causes significant side effects, consider switching to one a newer drug (e.g., from Ritalin®/Concerta® to Focalin®/Focalin XR®; from Dexedrine®/Adderall® to Vyvanse®).

9. If second stimulant truly fails at maximal dosing without side effects, reconsider the diagnosis. If you feel that ADHD remains the best diagnosis, then follow The Texas Children’s Medication Algorithm (Pliszka 2006) to pursue second-line (alpha agonists) and third-line drugs (Strattera®).

10. If the child fails multiple drug trials, you must reconsider the diagnosis and should probably consult developmental pediatrics. If developmental pediatrics is not available, consult child psychiatry.

11. If child can’t or won’t swallow tablets/capsules, consider:
   a. Metadate® CD or Ritalin® LA (methylphenidate): open capsule and sprinkle contents onto applesauce or pudding
   b. Liquid: Quillivant® XR (methylphenidate), Dyanavel® XR (amphetamine)
   c. Chewable: QuilliChew™ ER (methylphenidate)
   d. Oral-dissolving tablet: Adzenys XR-ODT™ (amphetamine)

12. **STIMULANT MAINTENANCE PLAN.** Your goal is to have the child on the **LOWEST EFFECTIVE DOSE.**
   a. **DRUG HOLIDAYS.** There is no scientific evidence to support the use of drug holidays. However, many parents opt to do this to observe child in his/her natural state, allow child to eat better on weekends, or if symptoms at home are more tolerable than at school. I generally offer it to parents and allow them to decide. You may NOT do this with Strattera®.
   b. **EXTENDED-RELEASE FORMULATIONS.** Once you find a short-acting stimulant that is effective and causes minimal or no side effects, consider switching to the extended release version of the same drug.
      - For methylphenidate, switch from Ritalin® to Concerta®. You’ll need a higher dose of Concerta® than the Ritalin® total (e.g., Ritalin® 30 mg = Concerta® 36 mg not 27 mg)
      - For amphetamine, switch from Dexedrine® to Adderall® XR. For some patients, the latter is associated with significant emotional lability!
      - BENEFITS: Smoother drug delivery, less likely to experience afternoon “rebound” as dose wears off, privacy at school by avoiding trip to nurse, improved compliance, no diversion.
      - RISKS: More likely to have appetite suppression (especially at lunchtime) and may interfere with sleep at night. To circumvent these, ensure child has a high-protein breakfast (e.g., peanut butter, cheese, eggs) and give dose right before breakfast.
   c. **BEHAVIORAL PROBLEMS.** If patient has maladaptive, externalizing behaviors while taking an ADHD Rx, you must know WHEN these symptoms occur: EITHER:
      - While Rx is on board:
         o Too low a dose (symptoms were present before and remain unchanged): you need to INCREASE dose. See Step 5, above.
         o Environmental trigger. A new or worsening psychosocial stressor causes the child to act out. You must ask about marital problems, parent-child problems, military deployments, and other stressors in the home.
         o Rx side effect (symptoms are new—NEVER had these symptoms before): DECREASE to lowest effective dose or SWITCH Rx
      - After Rx wears off: symptoms occur to a LESSER degree while the Rx is on board and INCREASE as it wears off. This means that the Rx, regardless of formulation is not acting long enough
         o If on sustained-release Rx (e.g, Metadate CD®, Concerta®), give it later in AM
         o Consider SWITCHING to a longer acting version of same Rx (e.g., Ritalin® → Concerta®
         o Consider BID or TID dosing of the current Rx (e.g., regular Adderall® BID)*
         o Consider adding a “booster” dose of Rx (e.g., Concerta® in AM + Ritalin® at 3 pm)*

*NOTE: The latter two are off-label approaches and typically not covered by civilian insurance plans.

13. **DO NOT WORRY ABOUT “UNMASKING” bipolar mood disorder or an anxiety disorder.** The chances of doing so are real but rare. The Vanderbilt can help detect some of this. Regardless, if the kid has one of these disorders, they will emerge regardless.

14. **When in doubt “phone a friend”**. Never hesitate to contact me at direct (back line): 210-644-7907 or James.Phalen@uhs-sa.com. I welcome curbside consults and enjoy questions from the field.

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