The hyperactive child

History

- Core symptoms * of lack of concentration / disorganized excessive levels of activity / impulsive behaviour
- Family history is important

Examination

- centiles
- measure head size
- neurological assessment
- formally assess vision and hearing if any issues re either

Investigations

- laboratory tests are not required
- NO indication to do blood tests , EEG or neuro-imaging

Treatment

- individual school intervention programme
- parental support ++
- methylphenidate + dexamphetamine reduce core symptoms and improve QOL
- Beware adverse effects of stimulants
- Atomoxetine if stimulants not working or tolerated

Diagnostic criteria

- core symptoms*
- onset < 7 yo
- Persistent > 6 months
- present in more than one setting
- Causing significant functional impairment
- Not better accounted for by other mental disorder

Co-morbidity

- Very common
- educational under-achievement(1/3)
- Oppositional defiant behaviour
- anti-social behaviour
- Risk of injury up
- anxiety + mood disorders
- adverse effect on family life
- Substance abuse

Referral for specialist opinion

All cases of **suspected** ADHD who meet diagnostic criteria should be referred to either CAMHS or paediatric service

Evidence Base

- Behavioural training is recommended for parents of pre-schoolers with ADHD (B)
- School aged childen with ADHD should receive stimulant medication (A)

References

The management of attention deficit and hyperkinetic disorders in children and young people **SIGN 112 2009**

TAKE HOME MESSAGES

ADHD affects 1- 5% of children
Specialist referral required
If pre-school -try behavioual parent training
If school aged - try behavioural approaches in addition to stimulant medication for core symptoms
Behavioural treatments if co-morbidity

Complementary therapies

Avoid food/drinks with artificial preservatives
No evidence for homeopathy or massage therapy

This algorithm has been produced by the National Paediatric and Neonatology Clinical Programmes. It is aimed at medical, nursing and allied health professionals working in both primary and emergency care settings.

Amendments following suggestions of QIP committee of ICGP . Secondary care denoted in PINK

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