ADHD-medisinering

Emnekurs BUP, Juni 2024

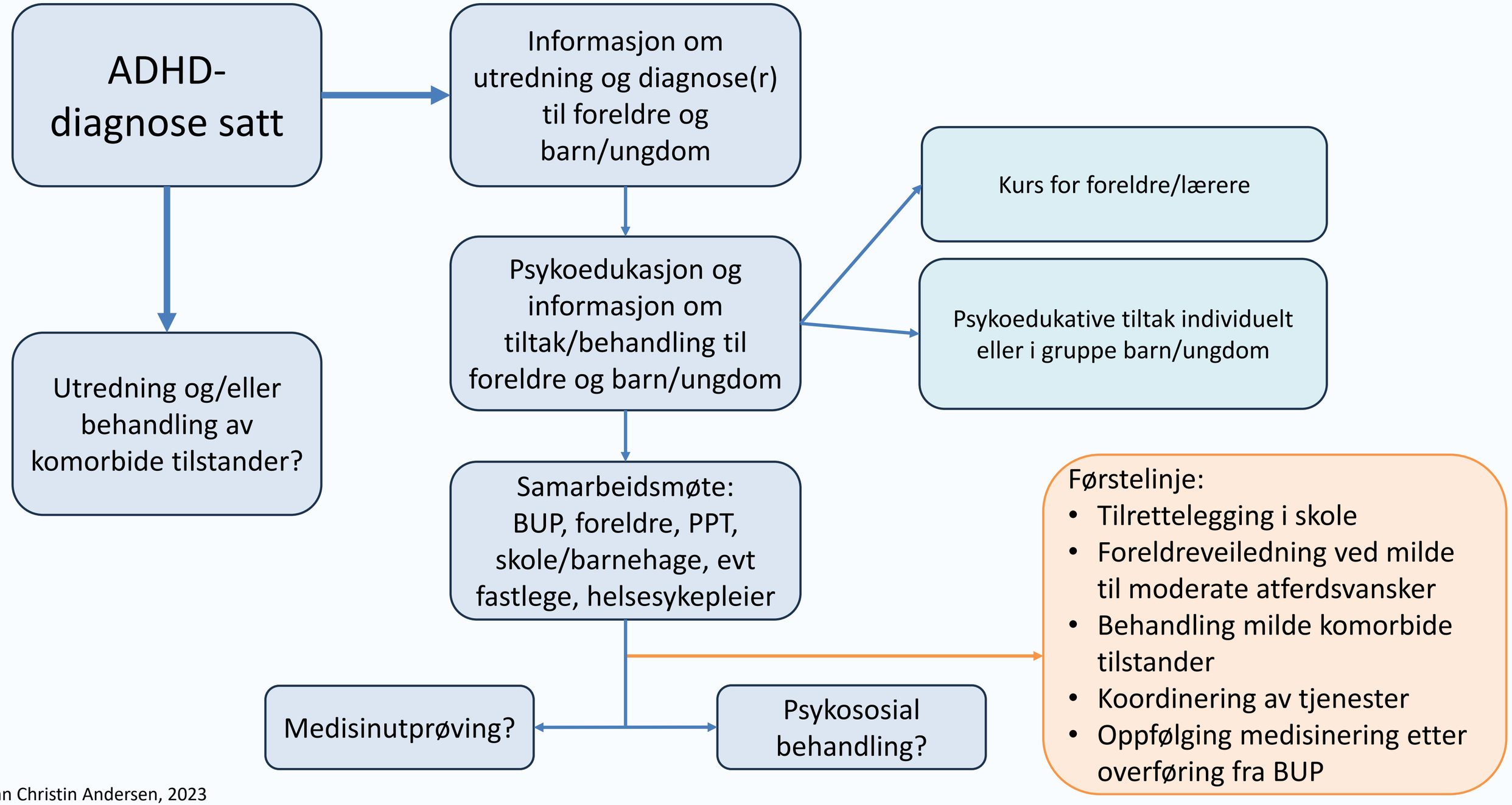
Ann Christin Andersen

Barne- og ungdomspsykiater, Phd, Overlege BUP Volda

Førsteamanuensis, RKBU/NTNU

HELSE MØRE OG ROMSDAL
På lag med deg for helsa di

NTNU | Institutt for psykisk helse
Regionalt kunnskapssenter for barn og unge – psykisk helse og barnevern



Ann Christin Andersen, 2023

Hva vet vi om ADHD-medisinering av barn og unge? :

- ADHD-medisiner, særlig sentralstimulerande, har vist solid evidens for positiv effekt på kjernesymptomer, *i alle fall på kort sikt*
- Få langtidsstudier men evidens for positive langtidseffekter på en rekke utfallsmål i naturalistiske studier
- Ofte ikke nok for å normalisere funksjon
- «Prøve å feile» for å finne riktig behandling til den enkelte
- Obs samtidige vansker
- Bivirkninger og compliance en kjempeutfordring, men anbefaling om langtidsbehandling når medikamenter tolereres og gir positiv effekt
- OBS: Toleranseutvikling? Medikamentferier!

EXPERT OPINION ON PHARMACOTHERAPY
2023, VOL. 24, NO. 4, 425–434
https://doi.org/10.1080/14656566.2023.2169604

Taylor & Francis
Taylor & Francis Group

REVIEW

Evidence-based prescribing of medications for ADHD: where are we in 2023?

Samuele Cortese [a,b,c,d]

[a]Centre for Innovation in Mental Health, School of Psychology, Faculty of Environmental and Life Sciences, University of Southampton, Southampton, UK; [b]Solent NHS Trust, Southampton, UK; [c]Hassenfeld Children's Hospital at NYU Langone, New York University Child Study Center, New York, New York, USA; [d]Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, Nottingham, UK

ABSTRACT

Introduction: A large number of randomized controlled trials (RCTs) and observational studies on the pharmacotherapy of ADHD are available.

Areas covered: Based on a search in PubMed and PsycInfo (up to 15 September 2022), this review addresses to which extent this body of research is currently able to inform routine prescribing practice, in terms of the choice of medication, titration strategy, augmentation treatments, and use of alternative, non-approved treatments.

Expert opinion: A growing body of evidence is informing prescribers on some, but certainly not all, aspects related to the pharmacological treatment of ADHD in the daily clinical practice, with important weaknesses/gaps that need to be addressed. First, evidence synthesis of RCTs is not able to inform decision-making at the individual patient level. Second, the maximum safe and effective doses, possibly beyond those currently recommended, are not well understood. Third, evidence from RCTs on augmenting strategies is still limited. Fourth, no novel agents with the same or higher effect size of stimulants, in terms of efficacy, but with better tolerability and lower abuse potential, have been found. Implementation of precision psychiatry approaches and stratification of patients in future RCTs will be key to, respectively, individualize the treatment strategies and test etiopathophysiology-based agents.

ARTICLE HISTORY

Received 02 October 2022
Accepted 13 January 2023

KEYWORDS

ADHD; pharmacotherapy; meta-analysis; randomized controlled trials; precision psychiatry

Tips: Artikkel fra «European ADHD Guidelines Group» som oppsummerer dei vanligste bivirkninger ved ADHD-medisinering, og råd for handtering basert på empirisk, fagfellevurderte studier.

Omtaler bl.a.:

- Appetitt og veksthemming
- Kardiovaskulære bivirkninger
- Søvn
- Tics
- Misbruk
- Kramper (og komorbid epilepsi)
- Suicidalitet
- Psykotiske symptomer

God artikkel å slå opp i når aktuelt!

NTNU | Institutt for psykisk helse
Regionalt kunnskapssenter for barn og unge – psykisk helse og barnevern

HELSE MØRE OG ROMSDAL
På lag med deg for helsa di

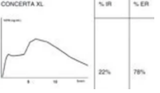
THE JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY
ACAMH
Journal of Child Psychology and Psychiatry 54:3 (2013), pp 227–246 doi:10.1111/jcpp.12036

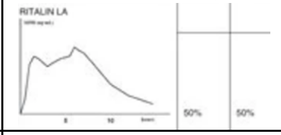
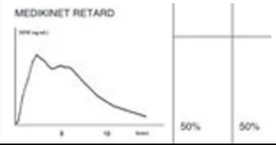
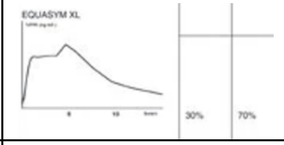
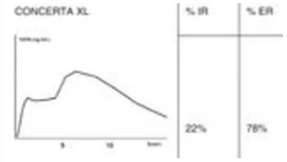
Practitioner Review: Current best practice in the management of adverse events during treatment with ADHD medications in children and adolescents

Samuele Cortese,[1,2,3,*] Martin Holtmann,[4,*] Tobias Banaschewski,[5] Jan Buitelaar,[6] David Coghill,[7] Marina Danckaerts,[8] Ralf W. Dittmann,[5] John Graham,[9] Eric Taylor,[10] Joseph Sergeant,[11] on behalf of the European ADHD Guidelines Group†

[1]Phyllis Green and Randolph Cowen Institute for Pediatric Neuroscience, Child Study Center of the NYU Langone Medical Center, New York, NY, USA; [2]UMR_S INSERMU 930, CNRS ERL 3106, François-Rabelais University, Child Psychiatry Centre, University Hospital, Tours, France; [3]Department of Life Sciences and Reproduction, Verona University, Italy; [4]LWL-University Hospital for Child and Adolescent Psychiatry, Psychotherapy and Psychosomatics of the Ruhr University Bochum, Hamm, Germany; [5]Department of Child and Adolescent Psychiatry and Psychotherapy, Central Institute of Mental Health, Medical Faculty Mannheim/ Heidelberg University, Mannheim, Germany; [6]Department of Cognitive Neuroscience, Radboud University Nijmegen Medical Centre, and Karakter Child and Adolescent Psychiatry University Centre, Nijmegen, the Netherlands; [7]Division of Neuroscience, Medical Research Institute, University of Dundee, Ninewells Hospital and Medical School, Dundee, UK; [8]Department of Child and Adolescent Psychiatry, University Hospitals Leuven, KU Leuven, Belgium; [9]Child and Adolescent Psychiatry, The Centre for Child Health, Dundee, UK; [10]Department of Child and Adolescent Psychiatry, Kings College London Institute of Psychiatry, UK; [11]Vrije Universiteit, Amsterdam, the Netherlands

Background: Medication is an important element of therapeutic strategies for ADHD. While medications for ADHD are generally well-tolerated, there are common, although less severe, as well as rare but severe adverse events AEs during treatment with ADHD drugs. The aim of this review is to provide evidence- and expert-based guidance concerning the management of (AEs) with medications for ADHD. **Methods:** For ease of use by practitioners and clinicians, the article is organized in a simple question and answer format regarding the prevalence and management of the most common AEs. Answers were based on empirical evidence from studies (preferably meta-analyses or systematic reviews) retrieved in PubMed, Ovid, EMBASE and Web of Knowledge through 30 June 2012. When no empirical evidence was available, expert consensus of the members of the European ADHD Guidelines Group is provided. The evidence-level of the management recommendations was based on the SIGN grading system. **Results:** The review covers monitoring and management strategies of loss of appetite and growth delay, cardiovascular risks, sleep disturbance, tics, substance misuse/abuse, seizures, suicidal thoughts/behaviours and psychotic symptoms. **Conclusion:** Most AEs during treatment with drugs for ADHD are manageable and most of the times it is not necessary to stop medication, so that patients with ADHD may continue to benefit from the effectiveness of pharmacological treatment. **Keywords:** ADHD, medication, adverse events, management, recommendations, European.



Sentralstimulerande:					
	FORM	**STYRKE**	**DOSERING**	**VIRKNING**	**Misbruks-fare**
Metylfenidat:	Ritalin tbl	10mg		2-4 timer	Høy
	Ritalin kapsler	10, 20, 30, 40 og 60 mg	0,8-1,2 mg/kg/døgn. Max 60 mg/døgn	Release 50:50, virketid 6-8 timer 	Medium
	Medikinet tbl	5, 10 og 20 mg		2-4 timer	Høy
	Medikinet kapsler	5, 10, 20, 30, 40, 50 og 60 mg	0,8-1,2 mg/kg/døgn. Max 60 mg/døgn	Release 50:50, virketid 6-8 timer 	Medium
	Equasym depot (kapsler)	10, 20 og 30 mg	0,8-1,2 mg/kg/døgn. Max 60 mg/døgn	Release 30:70, virketid 6-8 timer 	Medium
	Concerta, depottbl	18, 27, 36 og 54 mg	0,8-1,2 mg/kg/døgn. Max 54 mg/døgn barn og 72 mg/døgn ungdom	Release 20:80, virketid 8-12 timer 	Medium
Lisdexamphetamine:	Elvanse	Kapsler 20, 30,40,50 mg	Dose titreres etter effekt/bivirkn. Maks 70 mg/døgn	Virketid 10-13 timer. Pro-drug dexamphetamin. (Aduvanz for voksne, synonymt? Doser til 70 mg)	Medium*
	Balidax	Kapsler 20,30,40,50,60,70 mg	Dose titreres etter effekt/bivirkn. Maks 70 mg/døgn	Virketid 10-13 timer. Pro-drug dexamphetamin.	Medium*
Dexamphetamin	Attentin	Tbl 5, 10, 20 mg	Doseres 1-2 ganger daglig. Titrering dose. Max 20 mg/døgn	Virketid 4-6 timer **Omtrentlig omregning Lisdeksamfetamin til deksamfetamin dose: Lisdex dose : 3,4** (Dvs 20 mg Elvanse tilsvarer 5,9 mg Attentin)	Høy

Ikkje-sentralstimulerande:					
	FORM	**STYRKE**	**DOSERING**	**VIRKNING**	**Misbruks-fare**
Atomoksetin (selektiv hemmer pre-synaptisk NA transportprot)	Atomkosetin, kapsler	10, 18, 25, 40, 60, 80 og 100 mg (NB SKAL IKKE DELES!)	0,5-1,2 mg per kg/døgn. Max 1,2 mg/kg.	24 timer	Lav
	Strattera, mikstur	4 mg/ml	0,5-1,2 mg per kg/døgn. Max 1,2 mg/kg.	24 timer	Lav
Guanfacin (Selektiv alfa-2A-adrenerg agonist)	Intuniv	1, 2, 3 og 4 mg	Vedlikehold 0,05-0,12 mg/kg/døgn. Max 4 mg inntil 12 år, max 7 mg ved vekt >58,5 kg	24 timer. OBS Hypotensjon og bradychardi, tett oppfølging i opptrapping. Eget overvåkningskjema i felleskatalogen.	Lav

Etter overføring til fastlegen:

- Fortsette å monitorere effekt og bivirkninger:

  Høgde, Vekt, Puls og Blodtrykk minst halvårlig

- Dosejustering ofte nødvendig ved vekst
- Problem m matlyst/vekt/vekst: medikamentfrie dager/ferier? Seponere?
- Toleranseutvikling: Medikamentferie? Skifte av preparat?
- Motstand/Compliance: Samarbeid og motivasjonsarbeid!
- Over en uke medisinfri: Trapp opp dose via et par trinn ved reoppstart
- Obs Guanfacin: må trappes rolig ned med kontroll BT ved seponering.
- Skifte innenfor metylfenidater for å oppnå annen virketid stort sett uproblematisk. Skifte mellom preparatgrupper: Ny vurdering på BUP

Takk for oppmerksomheten!

ann.c.andersen@ntnu.no

Illustrasjoner: Adobestock, photostock og private