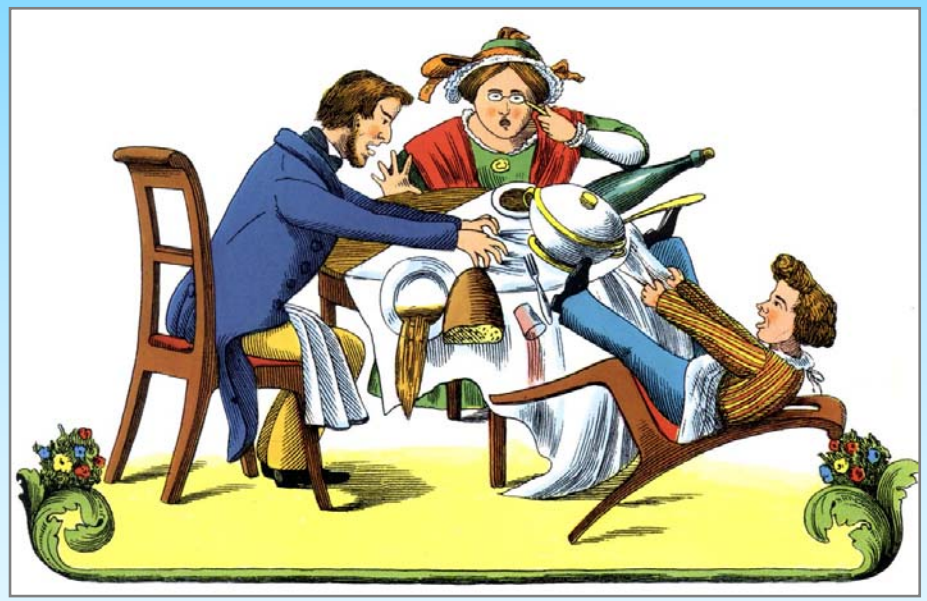
Statuskonferenz ADHS, 08.12.-09.12.2014, Berlin

Leitlinien zur Diagnostik und Therapie von Kindern und Jugendlichen



Tobias Banaschewski

Klinik für Psychiatrie und Psychotherapie des Kindes- und Jugendalters, Zentralinstitut für Seelische Gesundheit, Mannheim

Potentielle Interessenkonflikte

- Mitglied in Advisory Boards / Beratende Tätigkeit BMS, Desitin, Lilly, Medice, Shire, Viforpharma
- Vortragshonorare / Kongressreisen
  Janssen-Cilag, Lilly, Medice, Novartis, Shire, Viforpharma
- Forschungsförderung
  EU, DFG & BMBF

Leitlinien

- … sind systematisch entwickelte Aussagen, die den gegenwärtigen Erkenntnisstand wiedergeben, um die Entscheidungsfindung von Ärzten und Patienten für eine angemessene Versorgung bei spezifischen Gesundheitsproblemen zu unterstützen
- … sind als „Handlungs- und Entscheidungskorridore“ zu verstehen, von denen in begründeten Fällen abgewichen werden kann oder sogar muss

LL - Hilfen für die individuelle Entscheidungsfindung

AWMF-Regelwerk „Leitlinien“. 2012

Methodische Qualität von Leitlinien
Stufen-Klassifikation der AWMF

Methodischer Hintergrund von Leitlinien:
S-Klassifikation

S3	**Evidenz- und konsensbasierte Leitlinie**	Repräsentatives Gremium, Systematische Recherche, Auswahl, Bewertung der Literatur, Strukturierte Konsensfindung
S2e	**Evidenzbasierte Leitlinie**	Systematische Recherche, Auswahl, Bewertung der Literatur
S2k	**Konsensbasierte Leitlinie**	Repräsentatives Gremium, Strukturierte Konsensfindung
S1	**Handlungs-empfehlungen von Expertengruppen**	Konsensfindung in einem informellem Verfahren

SYSTEMATIK

AWMF-Regelwerk „Leitlinien“. 2012

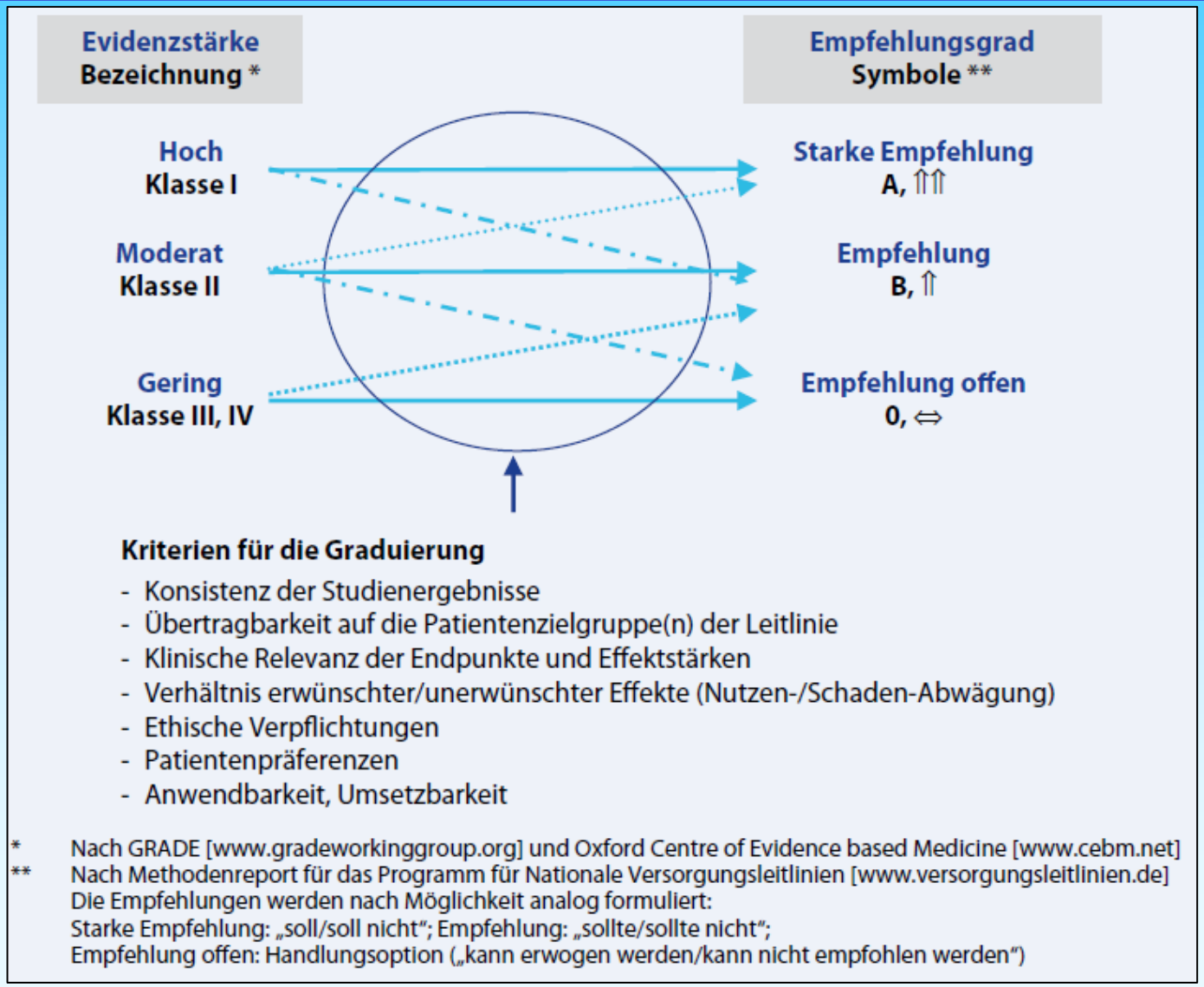
Klassifizierung der Evidenzgrade

Oxford Centre for Evidence-based Medicine

Grad	Studien Therapie/Prävention, Ätiologie / Nebenwirkungen
1a	Systematischer Review (mit Homogenität von RCTs)
1b	Einzelner RCT (mit engem Konfidenzintervall)
1c	Alle-oder-Keiner-Fallserie
2a	Systematischer Review (mit Homogenität von Kohortenstudien)
2b	Einzelne gut geplante Kohortenstudie oder RCT minderer Qualität
2c	Outcome-Studien; Ökologische Studien
3a	Systematischer Review (mit Homogenität von Fall-Kontrollstudien)
3b	Einzelne Fall-Kontroll-Studie
4	Fallserien oder Kohorten- / Fall-Kontrollstudien minderer Qualität
5	Expertenmeinung ohne explizite Bewertung der Evidenz oder basierend auf physiologischer oder experimenteller Forschung

Phillips et al., 2001

Von der Evidenz zur Empfehlung



Kriterien für die Graduierung

- Konsistenz der Studienergebnisse
- Übertragbarkeit auf die Patientenzielgruppe(n) der Leitlinie
- Klinische Relevanz der Endpunkte und Effektstärken
- Verhältnis erwünschter/unerwünschter Effekte (Nutzen-/Schaden-Abwägung)
- Ethische Verpflichtungen
- Patientenpräferenzen
- Anwendbarkeit, Umsetzbarkeit

* Nach GRADE [www.gradeworkinggroup.org] und Oxford Centre of Evidence based Medicine [www.cebm.net]
** Nach Methodenreport für das Programm für Nationale Versorgungsleitlinien [www.versorgungsleitlinien.de]
Die Empfehlungen werden nach Möglichkeit analog formuliert:
Starke Empfehlung: „soll/soll nicht"; Empfehlung: „sollte/sollte nicht";
Empfehlung offen: Handlungsoption („kann erwogen werden/kann nicht empfohlen werden")

Muche-Borowski & Kopp, 2011

Nationale und internationale ADHS – Leitlinien (Kinder- und Jugendliche)

- American Academy of Pediatrics - Guidelines (2000, 2001)
- American Academy of Child and Adolescent Psychiatry - Practice Parameter (2002, 2007)
- Canadian ADHD Resource Alliance (2010)
- EUNETHYDIS - European Guidelines (1998, 2004, 2006, 2010)
- National Institute for Clinical Excellence (2000, 2008)
- Scottish Intercollegiate Guidelines Network (2009)
- Leitlinien der Deutschen Gesellschaft für Kinder- und Jugendpsychiatrie und Psychotherapie (2000, 2007)
- Leitlinie der Arbeitsgemeinschaft ADHS der Kinder- und Jugendärzte (2002)

Systematic review of national and international guidelines on attention-deficit hyperactivity disorder

Miguel Seixas[1,2], Margaret Weiss[3] and Ulrich Müller[1,2,4]

Journal of Psychopharmacology
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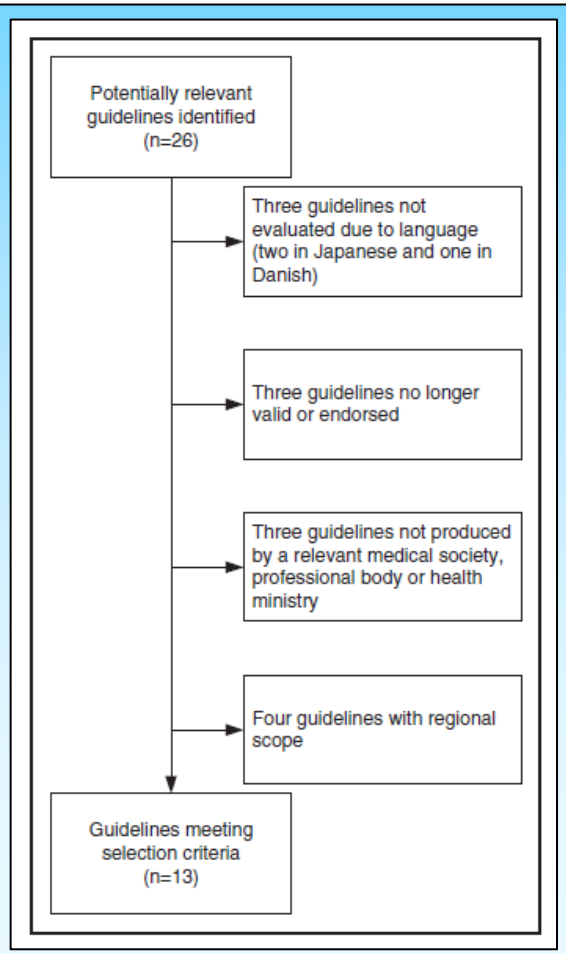

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Table 1. Overview of national and international ADHD guidelines

Association	AAP (2000[a], 2001[b])	NZ (2001)	DGPPN (2003)	ESCAP (2004[c], 2006[d])	BAP (2006)	DGKJP (2007)	AACAP (2002[e], 2007[f])	NICE (2008)	SIGN (2009)	CADDRA (2011)
Authors	Perris & Stein et al	Tuohy et al	Ebert et al	Taylor et al[c]; Banaschewski et al[d]	Nutt et al	Döpfner et al	Greenhill et al[e]; Pliszka et al[f]	Taylor et al	Forbes et al	Weiss et al
Date of publication	May 2000[a]; Oct 2001[b]	Jul 2001	Oct 2003	Jul 2004[c]; May 2006[d]	Nov 2006	Nov 2006	Feb 2002[e]; Jul 2007[f]	Sep 2008	Oct 2009	Jan 2011
Previous version	-	-	-	Dec 1998	-	1999; 2003	1997	Mar 2006	Jun 2001*	2006; 2008
Origin	USA	New Zealand	Germany	Europe	UK	Germany	USA	UK	UK (Scotland)	Canada
Source	www	www	Journal	Journal	www	www; book	www	www, book	www	www
Target group	Primary care clinicians	Health professionals	Physicians	CAMH, Paeds	GP, Paeds, CAMH, Psych	CAMH	Clinicians, CAMH, Psych	Clinicians	Health professionals	Physicians
Grading of evidence	Yes	No	Yes	Yes	Yes	Yes (inconsistent)	Yes	Yes	Yes	Yes
Funding	Unclear	Unclear	Self-funded; no individual disclosures	Unclear	Pharma	Unclear	Unclear; individual disclosures	Public funding	Public funding	Self-funded; with individual disclosures
Diagnosis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Treatment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
C&A	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes
Adult	No	No	Yes (adults only)	Yes (drug treatment only, Banaschewski et al)	Yes	No	Yes (Greenhill et al)	Yes	No	Yes

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Diagnostik

Association	AAP (2000, 2001)	NZ (2001)	DGPPN (2003)	ESCAP (2004, 2006)	BAP (2006)	AACAP (2002, 2007)	DGKJP (2007)	NICE (2008)	SIGN (2009)	CADDRA (2011)
Diagnostic criteria	DSM-IV	DSM-IV	ICD-10; DSM-IV; Wender-Utah criteria	ICD-10; DSM-IV	DSM-IV; ICD-10	DSM-IV; ICD-10	ICD-10; DSM-IV	DSM-IV; ICD-10	DSM-IV; ICD-10	DSM-IV
ADHD specialist	0	+	0	+	+	0	0	+	+	+
Screening	+	–	0	0	+	+	0	–	0	+
Screening for comorbidities	+	+	+	+	+	+	+	+	+	+
Psychiatric interview	Patient, parents, school, informants	Patient, parents, school, informants, observation	Parents, informants	Patient, parents, school	Patient, informants	Patient, parents, school	Patient, parents, school	Patient, informants	Patient, parents, school	Patient, parents, school, informants
Questionnaires and rating scales	Optional (CPRS-R, CTRS-R, SSQ-R); not recommended for diagnosis (CBCL-R, TRF, DSMD-total scale, CPRS-R-Global Problem Index, CTRS-R-Global Problem Index)	CPRS-R; CTRS-R; ACTeRS; SNAP-IV	DSM-IV symptom checklist; CPRS; WURS; BADDS	C-GAS; axis 6 of the MAS; CBCL; CCC; CPRS-R; CTRS-R; DBD; HSQ-R; SSQ-R; IOWA-CTRS; RBPC; Rutter Scales; SNAP-IV; SDQ; TRF; YSR; NIMH DISC-IV; PACS	WURS; ASRS; BADDS; BSOPA-SC; ASRS-V1.1; ADHDRS-IV; Canadian Consensus Screening Checklist	WPRS; WURS; CAARS; APRS; ADHDRS-IV; BADDS; CBCL; CPRS-R; CTRS-R; CASS-L; HSQ-R; SSQ-R; IOWA CTRS; SNAP-IV; SKAMP; VADPRS; VADTRS; CAP	not specified	Conners' rating scales, CAADID, SDQ, C-GAS	+	CAAT
Neuropsychological assessment	0	Not routinely; continuous performance tests potentially useful.	0	+	Not for diagnosis; recommended to inform management	–	0	0	0	Psychoeducational assessment and psychological testing
Physical examination	+	+	+	+	+	+	+	+	+	+
Other investigations	Blood lead levels, thyroid function, brain imaging, EEG and continuous performance tests not routinely recommended	EEG, heavy metal tests, thyroid function tests, other blood tests and organ imaging tests not recommended routinely. Personality tests not recommended	EEG; thyroid function tests; CT/MRI	Not routinely	0	Thyroid function tests, serum lead levels, EEG, head MRI, SPECT, PET - all not routinely recommended	Thyroid function tests; EEG	ECG if clinical/historical indications	Blood analysis, EEG and brain imaging if necessary to exclude underlying medical problem	Polysomnography, EEG and brain imaging may be indicated

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Pharmakotherapie

Association	AAP (2000,2001)	NZ (2001)	DGPPN (2003)	ESCAP (2004,2006)	BAP (2006)	AACAP (2002,2007)	DGKJP (2007)	NICE (2008)	SIGN (2009)	CADDRA (2011)
MPH	1st	1st	1st	1st	1st	1st	1st	1st	1st	+
MPH MR	1st	+	0	+	1st	1st	1st	1st	1st	1st
Dexamphetamine	1st	1st	+	+	1st	1st	+	+, 1st in C&A	1st	1st
Mixed amphetamine salts	1st	0	+	+	0	1st	+	0	0	1st
Lisdexamphetamine	0	0	0	0	0	0	0	0	0	1st
Atomoxetine	0	0	+	+	1st	1st	1st	+, 1st in C&A	+	1st
Bupropion	Outside scope	0	+	0	+	+	+	+	+	+
Clonidine	Outside scope	0	0	+	+	+	+	+	+	0
Guanfacine	0	0	0	+	+	+	+	0	0	0
Modafinil	0	0	0	0	+	0	0	+	-	+
Pemoline	-	0	0	+	-	-	0	0	0	0
TCA	Outside scope	+	+	+	+	+	+	+	+	+
Pre-treatment safety measures	0	+	0	0	0	+	+	+	+	+
Explicit dose	+	+	0	+	0	+	+	+	For some agents only	+
Titration	Outside scope	+	0	+	0	+	+	+	+	+
Monitoring	+	+	+	+	+	+	+	+	+	+
Adverse effects	+	+	0	+	+	+	+	+	+	+
Contra-indications	+	0	0	+	0	+	+	+	0	+
Cost considerations	0	0	0	+	+	0	+	+	0	+
Drug holidays	0	0	0	Only if growth retardation	0	+	+	-, exceptions permitted	0	-, exceptions permitted

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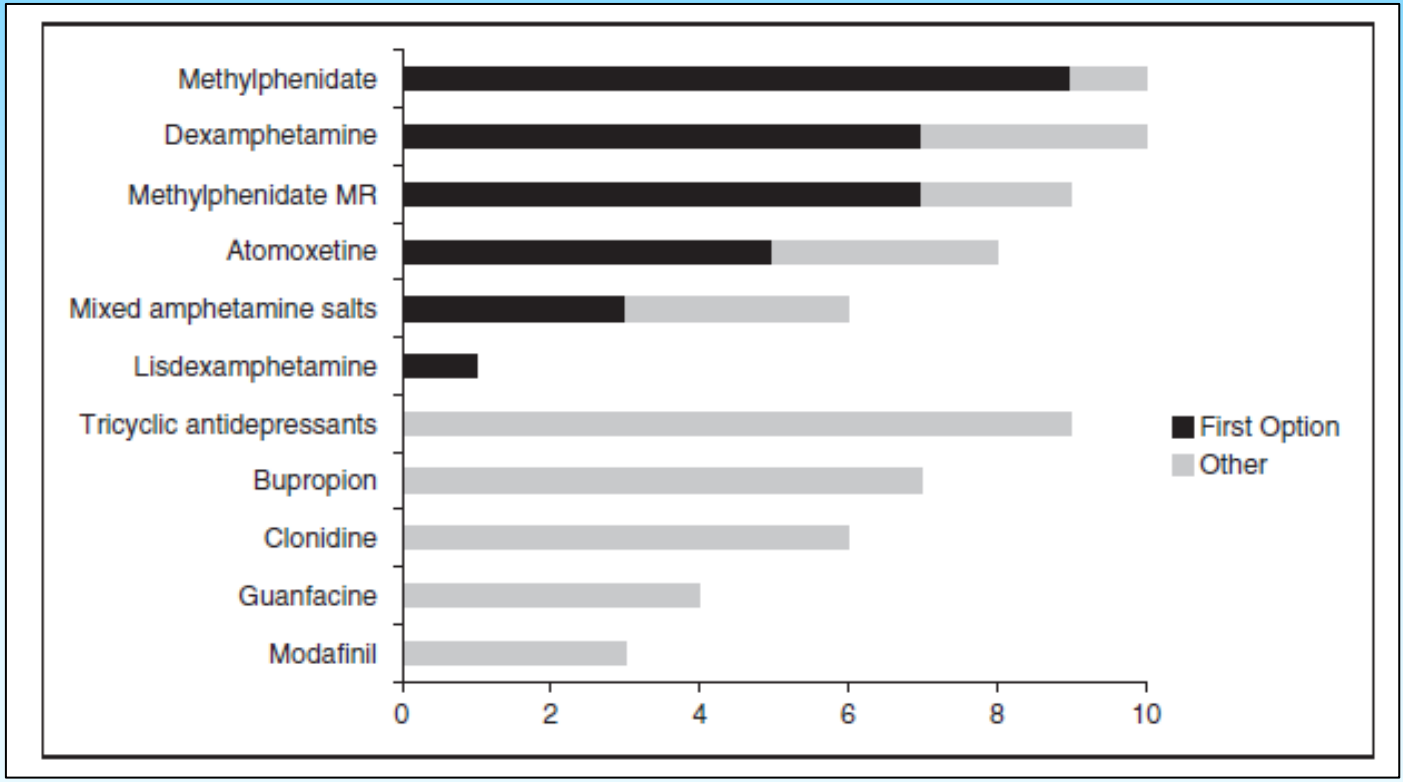
Pharmakotherapie



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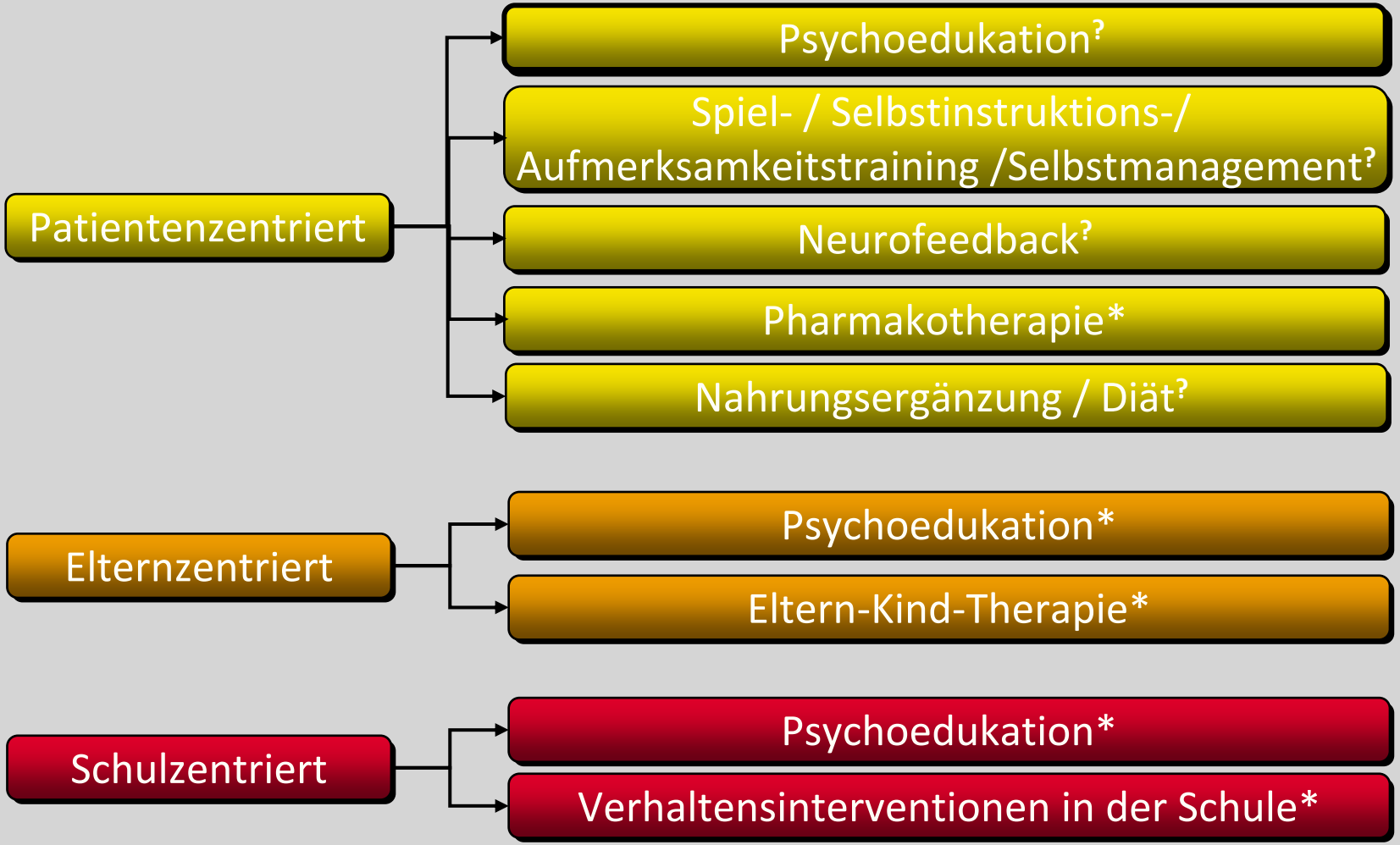
Nichtpharmakologische Therapieoptionen

Association	AAP (2000, 2001)	NZ (2001)	DGPPN (2003)	ESCAP (2004, 2006)	BAP (2006)	AACAP (2002, 2007)	DGKJP (2007)	NICE (2008)	SIGN (2009)	CADDRA (2011)
Individual interventions	0	0	+	+	0	0	+	+	0	+
Group interventions	0	+	+	+	0	0	+	+	0	0
Family-based interventions	0	0	0	+	0	0	+	+	+	+
School-based interventions	+	0	0	+	+	0	+	+	+	+
Occupational interventions	0	0	0	0	+	0	0	0	0	+
Behavioural parent training	+	0	0	+	0	0	+	+	+	+
Behavioural management	0	+	0	+	0	0	+	+	0	+
Psychoeduation	+	0	+	+	+	+	+	+	+	+
Family therapy	0	0	0	0	0	0	+	0	0	+
Social skills training	0	0	0	+	0	-	0	+	0	+
Cognitive therapy	-	0	0	0	0	0	+	0	0	0
CBT	-	0	0	+	0	-	+	+	0	+
Supportive therapy	0	0	0	+	+	0	0	0	0	+
Self-help	0	0	0	+	0	0	+	+	+	+
Counselling	0	0	0	0	0	0	0	0	0	+
Cognitive remediation	0	0	0	Academic skills	0	0	+	0	0	Academic skills
Carer support	+	+	0	+	0	0	0	0	+	+
Other therapies	Play therapy not recommended	Dietary interventions supervised by dietitian and at parents' request. Optometric vision training, sensory integrative training, chiropractic manipulation, tinted lenses, megavitamins, herbal remedies and biofeedback not recommended (-)	0	Elimination and restriction diets not routinely recommended (-)	0	Dietary modification and EEG biofeedback not recommended (-)	Dietary modification, biofeedback	Elimination and restriction diets not recommended; fatty acid supplements not routinely recommended (-)	Avoidance of case-specific food additives (+); omega-3 and omega-6 fatty acid supplements, iron supplements, zinc supplements, antioxidants, Bach flower remedies, homeopathy, massage therapy and neurofeedback (all -)	Anger management; interpersonal therapy; expressive arts therapy; play therapy.
Multimodal interventions	+	0	+	+	0	+	+	+	+	+

Multiple guidelines for the diagnosis and management of ADHD

- All guidelines emphasise the importance of a patient-centered, multimodal treatment approach
  - All recommend incorporating psychological, behavioral and educational interventions

Bausteine der multimodalen Therapie



* gut etabliert
? fraglich

Döpfner, Frölich & Lehmkuhl (2013). *Aufmerksamkeitsdefizit- / Hyperaktivitätsstörung (ADHS) Leitfaden Kinder und Jugendpsychotherapie, Band 1.* Göttingen: Hogrefe.

Multiple guidelines for the diagnosis and management of ADHD

- All guidelines emphasise the importance of a patient-centered, multimodal treatment approach
  - All recommend incorporating psychological, behavioral and educational interventions
- Differences in the treatment of ADHD between Europe and North America include:
  - the emphasis placed on non-pharmacological interventions
  - the range of available medications
  - the severity of symptoms and impairment required to initiate medication

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Methodische Qualität AGREE-Score

Guideline	AAP (2000)	AAP (2001)	NZ (2001)	AACAP (2002)	DGPPN (2003)	ESCAP (2004)	ESCAP (2006)	BAP (2006)	DGKJP (2007)	AACAP (2007)	NICE (2008)	SIGN (2009)	CADDRA (2011)
Scope and purpose (maximum score 12)	11	8	11	7	5	3	8	8	4	4	12	11	10
Stakeholder involvement (maximum score 16)	8	9	13	4	7	5	5	7	5	4	13	10	9
Rigour of development (maximum score 28)	20	22	19	15	11	14	21	17	9	16	27	23	19
Clarity and presentation (maximum score 16)	15	12	14	12	12	12	12	14	12	16	16	14	16
Applicability (maximum score 12)	3	5	3	3	3	5	5	5	4	3	11	12	6
Editorial independence (maximum score 8)	2	2	2	3	2	5	6	8	2	5	8	8	8
Total score (maximum score 92)	59 (64%)	58 (63%)	62 (67%)	44 (48%)	40 (43%)	44 (48%)	57 (62%)	59 (64%)	36 (39%)	48 (52%)	87 (95%)	78 (85%)	68 (74%)

Europäische Leitlinien

Eur Child Adolesc Psychiatry [Suppl 1]
13:I/7–I/30 (2004) DOI 10.1007/s00787-004-1002-x

ORIGINAL CONTRIBUTION

Eric Taylor
Manfred Döpfner
Joseph Sergeant
Philip Asherson
Tobias Banaschewski
Jan Buitelaar
David Coghill
Marina Danckaerts
Aribert Rothenberger
Edmund Sonuga-Barke
Hans-Christoph Steinhausen
Alessandro Zuddas

European clinical guidelines for hyperkinetic disorder – first upgrade

Eur Child Adolesc Psychiatry
DOI 10.1007/s00787-010-0140-6

ORIGINAL CONTRIBUTION

European guidelines on managing adverse effects of medication for ADHD

J. Graham · T. Banaschewski · J. Buitelaar · D. Coghill · M. Danckaerts · R. W. Dittmann · M. Döpfner · R. Hamilton · C. Hollis · M. Holtmann · M. Hulpke-Wette · M. Lecendreux · E. Rosenthal · A. Rothenberger · P. Santosh · J. Sergeant · E. Simonoff · E. Sonuga-Barke · I. C. K. Wong · A. Zuddas · H.-C. Steinhausen · E. Taylor · (for the European Guidelines Group)

Received: 24 March 2010 / Accepted: 6 October 2010

Eur Child Adolesc Psychiatry (2006)
xx:1–20 DOI 10.1007/s00787-006-0549-0

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Edmund J.S. Sonuga-Barke
Eric Taylor

Long-acting medications for the hyperkinetic disorders

A systematic review and European treatment guideline

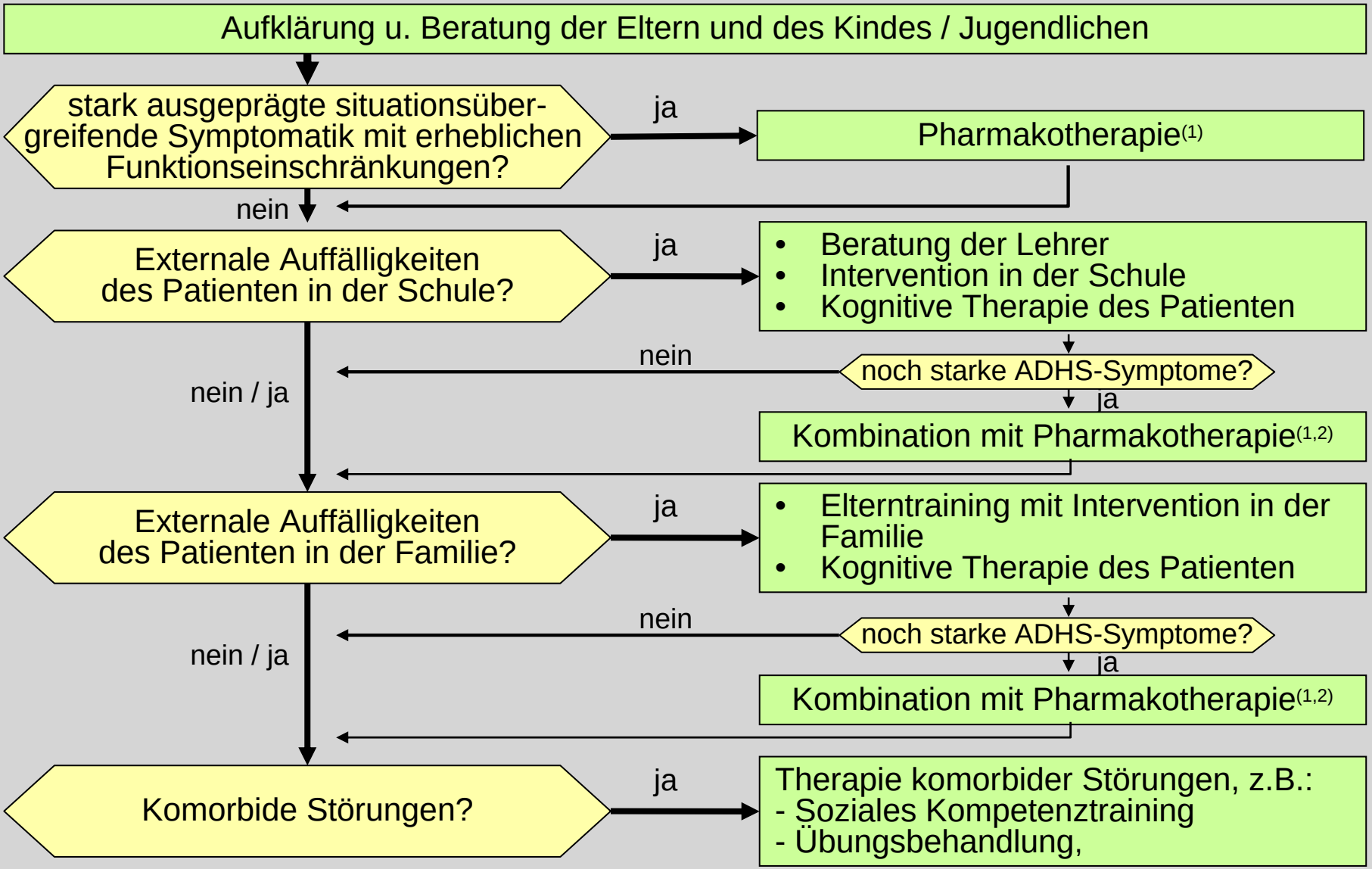
THE JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY
Journal of Child Psychology and Psychiatry *:* (2013), pp **–** doi:10.1111/jcpp.12036

Practitioner Review: Current best practice in the management of AEs 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] and 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

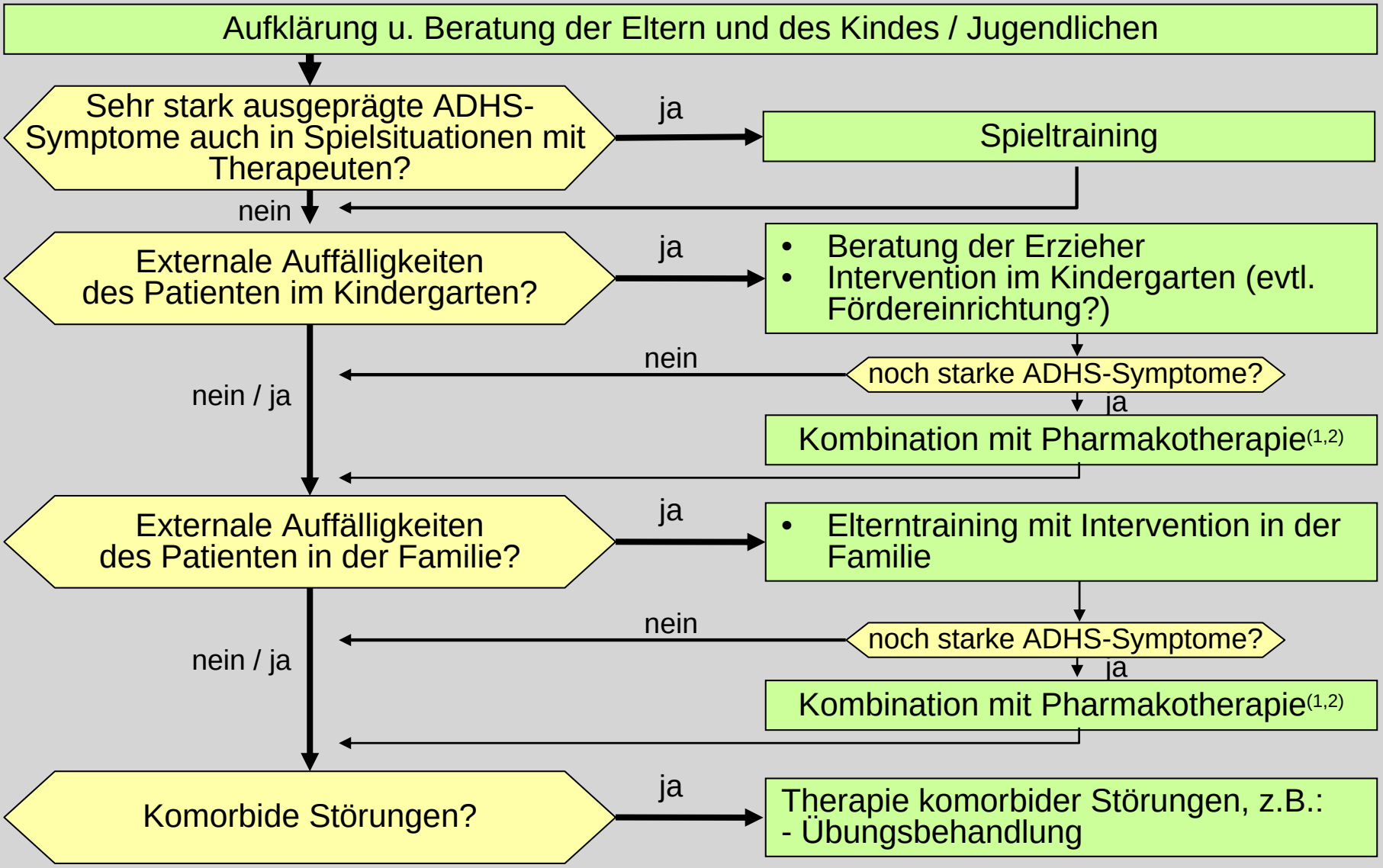
Behandlungsalgorithmus : ADHS-Schulalter



Soweit keine Kontraindikation vorliegt; 2) Wenn ADHS-Symptomatik nicht auf familiären Kontext beschränkt ist

deutsch: DGKJPP (2004); europäisch: Taylor et al. (2004); modifiziert
Taylor, Doepfner, Sergeant, et al. (2004). Clinical guidelines for hyperkinetic disorder- first upgrade. *European Child & Adolescent Psychiatry, 13*, I/7 - I/30

Behandlungsalgorithmus : ADHS-Vorschulalter



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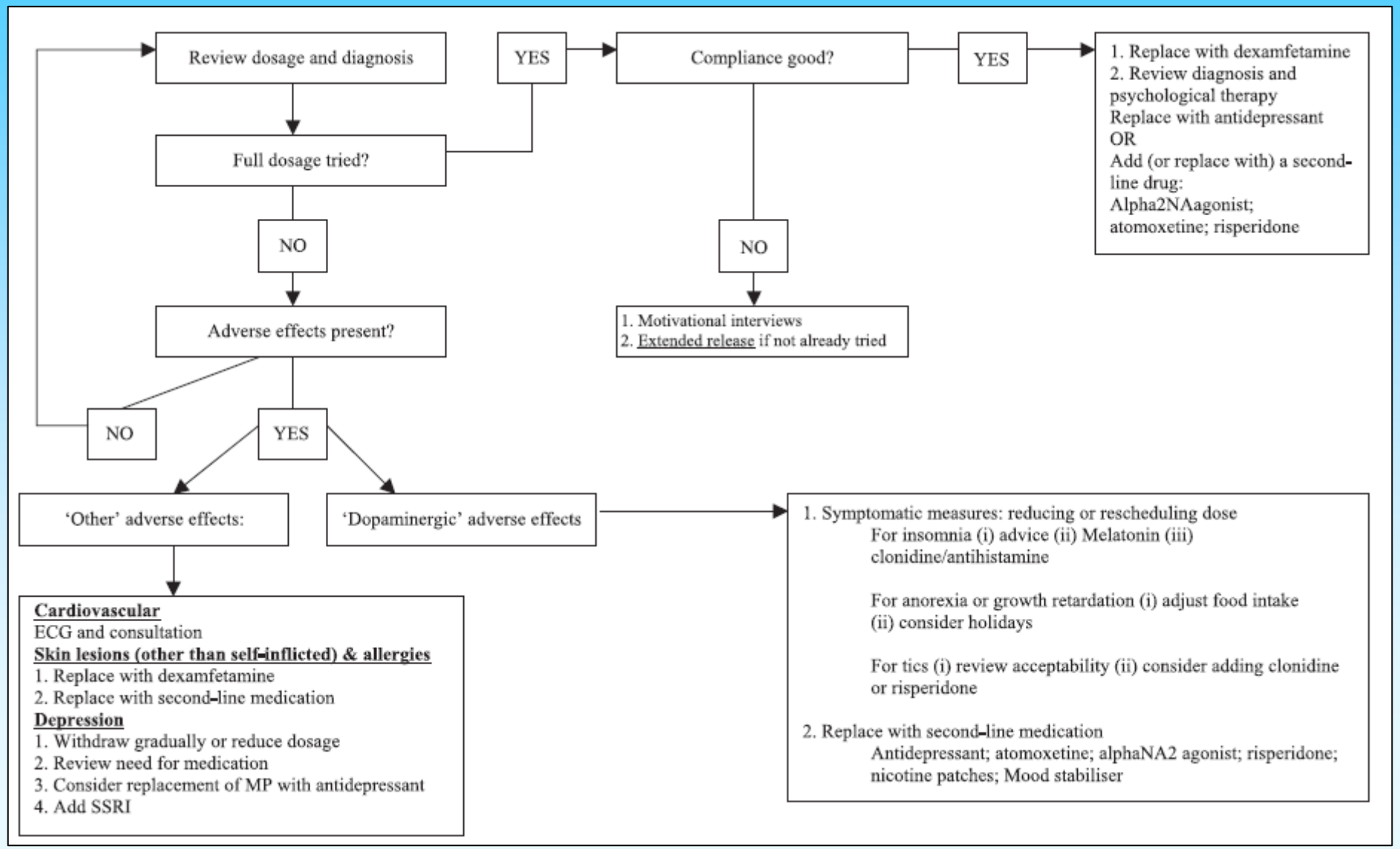
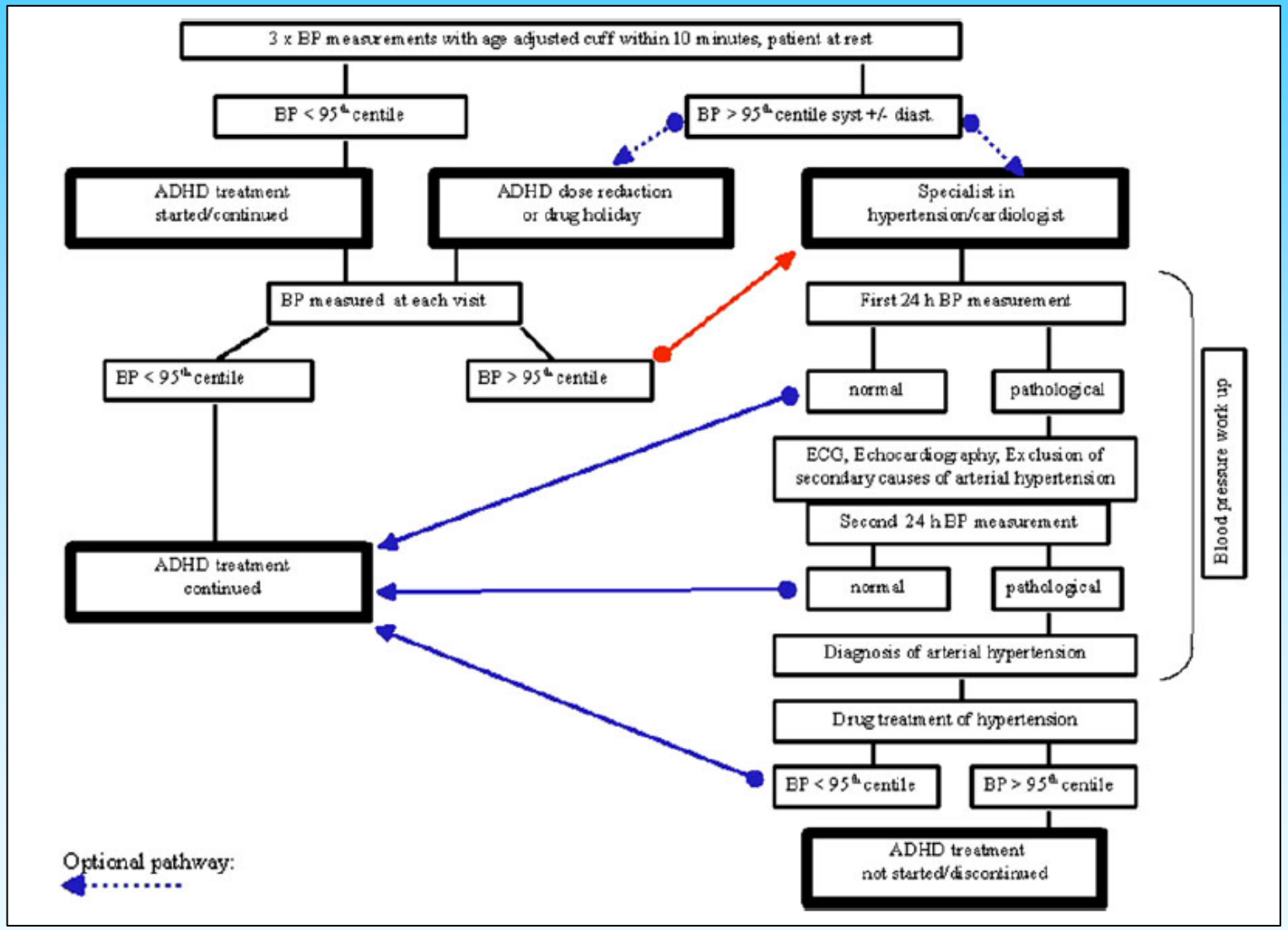
Döpfner, Frölich & Lehmkuhl (2013). *Aufmerksamkeitsdefizit- / Hyperaktivitätsstörung (ADHS) Leitfaden Kinder und Jugendpsychotherapie, Band 1.* Göttingen: Hogrefe.

EUNETHYDIS Leitlinien

Empfehlungen bei Nichtansprechen auf MPH



Medikamentöse Therapie
Monitoring & Management von Blutdruck



Graham et al., 2011

NICE Guidelines

Diagnosis of ADHD

- Diagnosis should only be made by a specialist psychiatrist, paediatrician or other healthcare professional with training and expertise in the diagnosis of ADHD.
- Diagnosis should be based on:
  - a full clinical and psychosocial assessment. Discuss behaviour and symptoms in the different domains and settings of the person's everyday life
  - a full developmental and psychiatric history, and
  - observer reports and an assessment of mental state.
- Diagnosis should be made when symptoms of hyperactivity/impulsivity and/or inattention:
  - meet the criteria in DSM-IV or ICD-10 (hyperkinetic disorder), **and**
  - are associated with at least moderate psychological, social and/or educational or occupational impairment based on interview and/or observation in multiple settings, **and**
  - are pervasive, occurring in at least two settings.
- As part of the diagnostic process, include an assessment of needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people also include an assessment of the parents' or carer's mental health.
- Do not diagnose ADHD based on rating scales or observational data alone. However, rating scales[2] are valuable adjuncts, and observations (for example, at school) are useful if there is doubt about symptoms.
- ADHD should be considered in all age groups. Adjust symptom criteria for age-appropriate changes in behaviour.
- Take into account children or young people's views when determining the clinical significance of impairment.

NICE Guidelines

Pre-school children

- Drug treatment is not recommended.
- Offer parents or carers referral to a parent-training/education programme as first-line treatment (see page 22) if they have not attended one, or if it has been only partially effective.
- If treatment is effective, before discharge from secondary care:
  - review the child with their parents or carers and siblings for residual coexisting conditions and develop a treatment plan for these if necessary
  - monitor for recurrence of ADHD symptoms and associated impairment after the child starts school.
- If treatment is ineffective consider referral to tertiary services.

NICE Guidelines

School-age children and young people with moderate ADHD and moderate impairment

- Drug treatment is not indicated as first-line treatment.
- Offer parents or carers referral to a group parent-training/education programme (see page 22) on its own or with other group treatment (cognitive behavioural therapy [CBT] and/or social skills training) for the child or young person.
- Consider individual psychological interventions (such as CBT or social skills training) for older adolescents.
- Where ADHD is present with a learning disability, offer referral to an individual or group parent-training/education programme according to the preference of the child or young person and the parents or carers.
- If treatment is effective, before discharge from secondary care, review the child or young person with their parents or carers and siblings for residual problems such as anxiety, aggression or learning difficulties. Develop a treatment plan for these if necessary.
- Reserve drug treatment for children and young people with:
  - moderate impairment where non-drug interventions have been refused
  - persisting significant impairment following a parent-training/education programme or group psychological treatment.

NICE Guidelines

School-age children and young people with severe ADHD (hyperkinetic disorder) and severe impairment

- Offer drug treatment as first-line treatment (see below). Also offer the parents a group-based parent-training/education programme (see page 22).
- If drug treatment is not accepted, advise parents or carers and the child or young person of the benefits and superiority of drug treatment. If drug treatment is still not accepted offer a group parent-training/education programme.
- If group parent-training/education is effective for those who refused drug treatment:
  - assess for coexisting conditions
  - develop a longer-term care plan.
- If group parent-training/education is ineffective for those who refused drug treatment:
  - discuss drug treatment again, or other psychological treatment (group CBT and/or social skills training)
  - highlight the benefits and superiority of drug treatment in severe ADHD.

S3- Leitlinie ADHS

Anmeldende Fachgesellschaft(en):	Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie (DGKJP) → Visitenkarte Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V. (DGPPN) → Visitenkarte Deutsche Gesellschaft für Sozialpädiatrie und Jugendmedizin e.V. (DGSPJ) → Visitenkarte
Beteiligung weiterer AWMF-Gesellschaften:	Deutsche Gesellschaft für Kinder- und Jugendmedizin e.V. (DGKJ) → Visitenkarte Gesellschaft für Neuropädiatrie (GNP) → Visitenkarte Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM) → Visitenkarte
Beteiligung weiterer Fachgesellschaften/Organisationen:	Arbeitsgemeinschaft Niedergelassener Neuropädiater (AGNNP) Berufsverband der Kinder- und Jugendärzte e. V. (BVKJ) Berufsverband für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie in Deutschland e. V., BKJPP Bundesarbeitsgemeinschaft der Leitenden Klinikärzte für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie e. V., BAG zentrales adhs-netz ADHS Deutschland e.V AdS e.V. Deutscher Verband der Ergotherapeuten (DVE) e.V. Fachgruppe Klinische Psychologie und Psychotherapie der DGP e.V. Berufsverband Deutscher Psychologinnen und Psychologen (BDP) Berufsverband der Kinder- und Jugendlichenpsychotherapeutinnen und Kinder- und Jugendlichenpsychotherapeuten e.V. (BKJ) Bundesverband der Vertragspsychotherapeuten e.V. (bvvp) Deutscher Fachverband für Verhaltenstherapie e. V. Vereinigung Analytischer Kinder- und Jugendlichen-Psychotherapeuten in Deutschland (VAKJP) Berufsverband Deutscher Nervenärzte (BVDN) Berufsverband deutscher Psychiater (BVDP) Berufs- und Fachverband Heilpädagogik e. V., BHP Bundespsychotherapeutenkammer Bundesärztekammer, BÄK Arzneimittelkommission der deutschen Ärzteschaft (AkdÄ)

S3- Leitlinie ADHS

Planung und Organisation

Begründung für die Auswahl des Leitlinienthemas

Zielorientierung der Leitlinie

Stufenklassifikation (S1, S2e, S2k, S3)

Zusammensetzung der Leitliniengruppe: Beteiligung von Interessengruppen

Erarbeitung eines Projektablaufplans

Erarbeitung eines Finanzierungskonzepts

Formulierung von klinisch relevanten Fragestellungen

Erklärung von und Umgang mit Interessenkonflikten

Anmeldung

Anmeldung beim AWMF-Leitlinienregister

Leitlinienentwicklung

Konstituierende Treffen

Systematische Evidenzbasierung

Recherche, Auswahl und methodische Bewertung bereits vorhandener Leitlinien und deren Aufbereitung

Recherche, Auswahl und methodische Bewertung von Literatur und deren Aufbereitung

Strukturierte Konsensfindung

Redaktion

Klarheit und Gestaltung

Externe Begutachtung

Gesamtverabschiedung

Langversion, Kurzversion, Patientenversion, Leitlinien-Report

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Langversion, Kurzversion, Patientenversion, Leitlinien-Report

Alpha-2 Agonists for Attention-Deficit/ Hyperactivity Disorder in Youth: A Systematic Review and Meta-Analysis of Monotherapy and Add-On Trials to Stimulant Therapy

Tomoya Hirota, MD, Shimon Schwartz, MD, Christoph U. Correll, MD

			Relative Risk				Risk Difference		NNT/NNH			
Outcome/Treatment	Trials	Patients	RR	95% CI	I^2%	*p*	RD	95% CI	NNT/H	95% CI	I^2%	*P*
Fatigue												
Clonidine	1	62	2.19	0.62 to 7.69	NE	.22	–	–	–	–	–	–
Clonidine XR	1	230	10.86	1.49 to 79.04	NE	**.02**	0.13	0.07 to 0.19	NNH: 8	5 to 15	NE	**<.0001**
Clonidine total	2	292	4.16	0.77 to 22.51	54	.10	–	–	–	–	–	–
Guanfacine	0	–	–	–	–	–	–	–	–	–	–	–
Guanfacine XR	3	881	3.21	1.62 to 6.36	0	**.0008**	0.09	0.03 to 0.15	NNH: 11	7 to 34	60	**.002**
Guanfacine total	3	881	3.21	1.62 to 6.36	0	**.0008**	0.09	0.03 to 0.15	NNH: 11	7 to 34	60	**.002**
α-2 Agonists total	6	1,173	3.28	1.85 to 5.83	0	**<.0001**	0.10	0.06 to 0.14	NNH: 10	8 to 17	36	**<.00001**
Sedation												
Clonidine	0	–	–	–	–	–	–	–	–	–	–	–
Clonidine XR	0	–	–	–	–	–	–	–	–	–	–	–
Clonidine total	0	–	–	–	–	–	–	–	–	–	–	–
Guanfacine	0	–	–	–	–	–	–	–	–	–	–	–
Guanfacine XR	4	1,059	2.43	1.06 to 5.58	35	**.04**	0.06	0.01 to 0.11	NNH: 17	10 to 100	64	**.02**
Guanfacine total	4	1,059	2.43	1.06 to 5.58	35	**.04**	0.06	0.01 to 0.11	NNH: 17	10 to 100	64	**.02**
α-2 Agonists total	4	1,059	2.43	1.06 to 5.58	35	**.04**	0.06	0.01 to 0.11	NNH: 17	10 to 100	64	**.02**
Somnolence												
Clonidine	2	147	2.87	0.88 to 9.40	59	.08	–	–	–	–	–	–
Clonidine XR	1	230	5.33	2.22 to 12.77	NE	**.0002**	0.28	0.19 to 0.38	NNH: 4	3 to 6	NE	**<.00001**
Clonidine total	3	377	3.53	1.48 to 8.42	60	**.005**	0.28	0.20 to 0.35	NNH: 4	3 to 5	0	**<.00001**
Guanfacine	0	–	–	–	–	–	–	–	–	–	–	–
Guanfacine XR	4	1,059	4.01	1.62 to 9.93	81	**.003**	0.27	0.14 to 0.40	NNH: 4	3 to 8	86	**<.0001**
Guanfacine total	4	1,059	4.01	1.62 to 9.93	81	**.003**	0.27	0.14 to 0.40	NNH: 4	3 to 8	86	**<.0001**
α-2 Agonists total	7	1,436	3.75	2.08 to 6.74	72	**<.0001**	0.27	0.19 to 0.36	NNH: 4	3 to 6	74	**<.00001**

Note: Boldface p values indicate p < .05. NE = not estimable; NNH = number-needed-to-harm; NNT = number-needed-to-treat; NS = nonsignificant.

JAACAP, 2014

Disparities between guidelines and clinical practice

Only 14% of participants consciously adhered to published clinical practice guidelines

Decisions Regarding ADHD Management (DRAMa) thematic analysis of UK and Belgian child psychiatrists' experiences and attitudes to the assessment, diagnosis and treatment of ADHD[1]

Clinicians demonstrate considerable ambivalence in diagnosing and treating ADHD

Based on interviews with US ADHD clinicians[2]

1. Kovschoff et al. *Eur Child Adolesc Psychiatry* 2012; 21:87–99; 2. Rafalovich *Sociol Health Ill* 2005; 27:305–323

Treatment outcomes differ in clinical trials and clinical practice

- Many clinical trials are short-term
- Clinical trial inclusion and exclusion criteria lead to homogenous clinical trial populations
  - Patients with comorbid conditions often excluded
- Patients in clinical trials tend to receive more support than in standard clinical practice
  - Treatment adherence actively encouraged and carefully monitored

The MTA study demonstrated significantly greater improvements in ADHD symptoms during 14 months of medication management than community care – even though the latter group usually received a medication of known efficacy[1]

1. The MTA Cooperative Group *Arch Gen Psychiatry* 1999; 21:87–99

Vielen Dank für

Ihre Aufmerksamkeit !