

EL NIÑO CON PROBLEMAS DEL RENDIMIENTO ESCOLAR

Evaluación, diagnósticos diferenciales y terapéutica

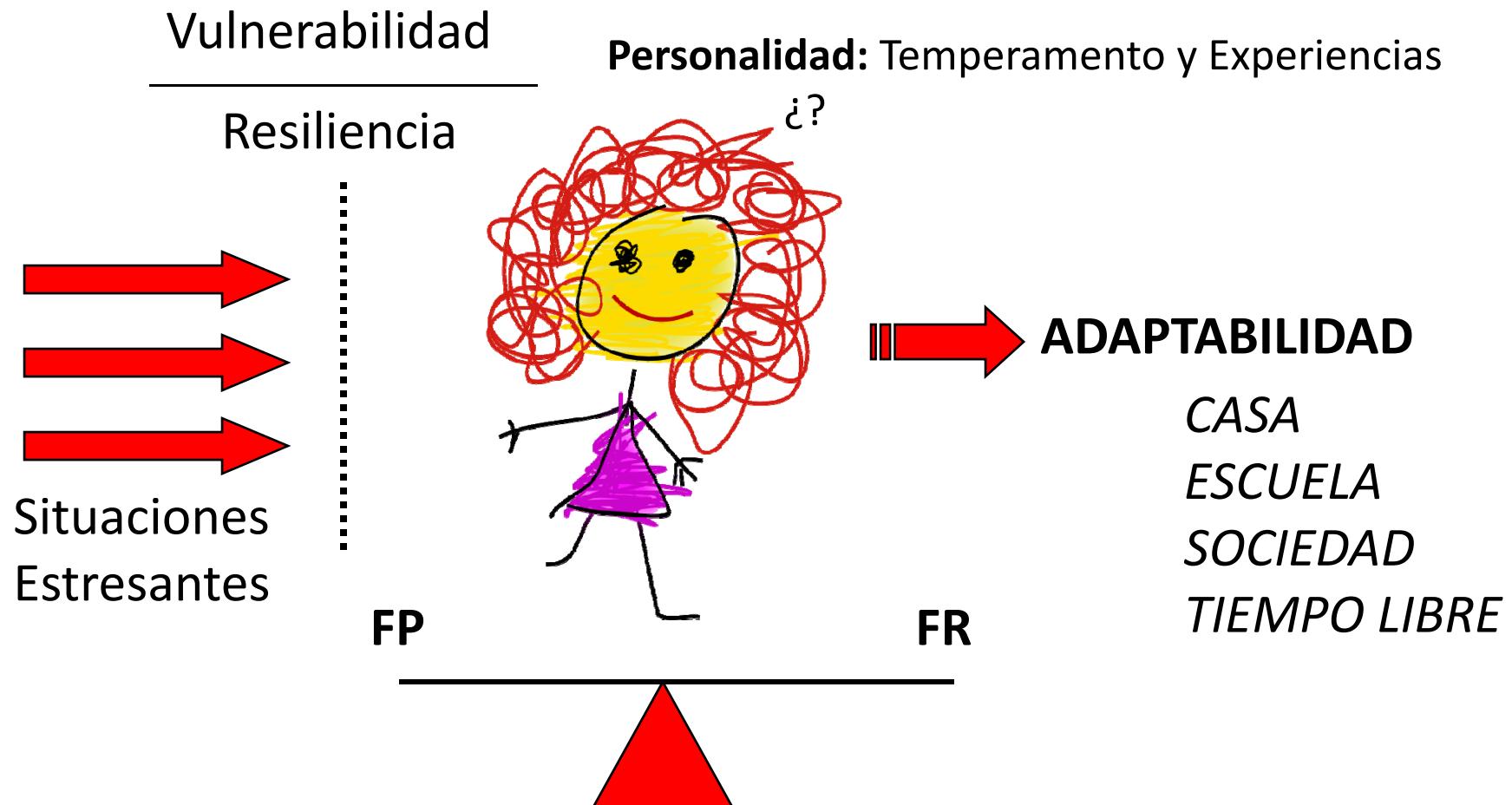
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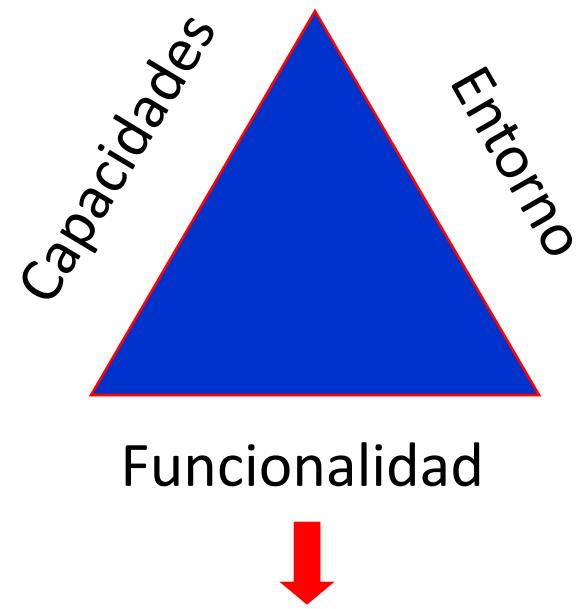
OBJETIVO DE LA PEDIATRIA

- El objetivo de la pediatría moderna es contribuir a que cada niño y adolescente alcance el óptimo funcionamiento físico, psíquico y social para que pueda desarrollar todas sus potencialidades. Dicho de otra manera, el objetivo final es favorecer el desarrollo de una persona íntegra y feliz que colabore, de acuerdo a sus capacidades, con la construcción de una sociedad mejor.

FUNCIONALIDAD



MULTIFACTORIALIDAD DEL APRENDIZAJE



RENDIMIENTO

RENDIMIENTO ESCOLAR

- La escuela es el ámbito en el cual se manifiestan más objetivamente las dificultades de adaptación que han pasado desapercibidas en otros ámbitos

FRACASO ESCOLAR

- Consulta frecuente en la práctica diaria
- Falta de formación profesional
- Desafía métodos médicos tradicionales
- La detección precoz y la intervención adecuada determinan el pronóstico.
- Consecuencias emocionales, familiares y sociales

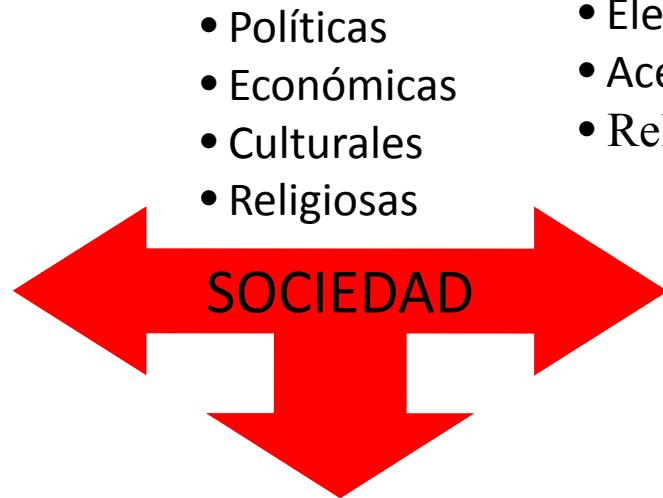
FISIOPATOLOGIA

- Disfunción familiar
- Problemas socio-económicos
- Expectativas parentales
- Habilidades académicas



FAMILIA

- Alteraciones sensoriales
- Perfil del neuro-desarrollo
- Problemas del sueño
- Temperamento
- Enfermedad crónica
- Alteración emocional
- Resiliencia
- Interés por la educación



- Procesos escolares: énfasis académico
- Elementos físicos y administrativos
- Aceptación grupal
- Relación con el docente: rótulos



ESCUELA



NIÑO

Diagnósticos a Considerar

Médicos

- Alteraciones sensoriales
- Alteraciones del sueño
- Enfermedades crónicas
- Efectos de medicación
- Epilepsia
- Intoxicación por plomo
- Déficit de hierro
- Historia de prematuridad
- Distiroidismos
- Somatizaciones

Neurodesarrollo

- Discapacidad intelectual
- Déficit de atención
- Trastornos del aprendizaje
- Trastornos del espectro autista

Salud mental

- Depresión
- Ansiedad
- Trastorno de Conducta
- Trastorno opositor desafiante
- Bipolaridad
- Adicciones
- Fobia escolar
- Trastorno estrés post-traumático
- Víctima de abuso
- Adicción digital

Familiar

- Adicciones
- Enfermedad crónica
- Maltrato
- Exposición a violencia

Antecedentes

- Complicaciones perinatales
- Antecedentes médicos
- Historia del desarrollo
- Antecedentes emocionales y conductuales
- Rendimiento, conducta y ausentismo escolares
- Evaluaciones y tratamientos previos
- Historia familiar de problemas escolares
- Factores de riesgo psicosociales

Hallazgos del Examen Físico

- Observación general: Hiperactividad, impulsividad, socialización, tics, tristeza
- Características fenotípicas
- Alteraciones de la piel: genodermatosis
- Retraso puberal en varones
- Baja talla, microcefalia o macrocefalia
- Malformaciones congénitas menores
- Signos neurológicos blandos
- Evaluación sensorial

SIGNOS NEUROLÓGICOS BLANDOS

- Disdiadococinesia, sincinesias y posturas distónicas de MMSS al caminar con los talones, se presentan con más frecuencia en niños con Déficit de Atención y Trastornos del Aprendizaje.
-

Otras evaluaciones

- Informes escolares y de terapeutas
- Cuestionarios a padres y maestros: CBCL, Conners; Vanderbilt, Jellinek (PSC) , etc.
- Semiología del cuaderno
- Pruebas proyectivas: dibujos persona, familia, árbol, dibujo libre, prueba de los 3 deseos
- Estudios de laboratorio e imágenes según factores de riesgo y evaluación médica.
- Observación escolar



Capacidades



Variante normal

Problema

Trastorno

TRASTORNOS ESPECÍFICOS DEL APRENDIZAJE

- Se caracterizan por la discrepancia entre el rendimiento académico y las capacidades cognitivas. Son consecuencia de una disfunción del SNC y no causados por alteraciones del entorno ni por otras condiciones.

TRASTORNOS ESPECÍFICOS DEL APRENDIZAJE

- Algunos niños comienzan con problemas a partir de tercer o cuarto grado cuando aumentan las exigencias académicas y la complejidad de las funciones

Aprender a leer

vs.

Leer para aprender

ETIOLOGÍA DE LOS TRASTORNOS ESPECÍFICOS DEL APRENDIZAJE

- Hereditaria
- Prematurez
- Injuria del SNC: hipoxia, infecciones, tóxicos, traumatismos
- Deprivación sociocultural en niños pequeños
- Alteraciones genéticas y cromosómicas: NF1, Fra-X, XO, XXY
- Consumo materno de alcohol, drogas, anticonvulsivos

Hallazgos que Sugieren Trastorno Específico del Aprendizaje

- Problemas con el lenguaje
- Dificultad para aprender los colores
- Desorientación espacial y lateral
- Déficit témporo-secuencial
- Problemas de la percepción viso-espacial
- Problemas de integración sensorial
- Torpeza motora y presencia de signos neurológicos blandos
- Rendimiento desigual en distintas materias o adecuado rendimiento al principio con aparición de problemas posteriormente
- Baja autoestima
- Humor cambiante, tristeza, depresión
- Evitación escolar por frustración

Asociaciones Mórbidas de los Trastornos Específicos del Aprendizaje

- Déficit de atención (20%)
- Trastorno de conducta
- Trastorno del lenguaje
- Ansiedad de separación-fobia escolar
- Depresión y baja autoestima (50%)
- Trastorno de la coordinación motora
- Trastorno opositor desafiante
- Tics

Trastorno por Déficit de Atención

- La AAP recomienda descartar TDA en todo paciente con disatención, impulsividad, hiperactividad, problemas escolares y/o de conducta.
- El diagnóstico es clínico y requiere los criterios del DSM V
- Juntar información de padres y educadores (más de un ámbito) acerca de la duración de los síntomas, edad de comienzo y compromiso funcional.
- Deben descartarse alteraciones coexistentes.
- No son necesarias otras evaluaciones.

Trastorno por Déficit de Atención

- Tipos:
 - Predominantemente disatencional
 - Predominantemente hiperactivo-impulsivo
 - Combinado
- Síntomas antes de los 12 años
- Compromiso en 2 o más ámbitos
- Disfunción académica, social u ocupacional
- Otras causas neurológicas, médicas, psicológicas y psiquiátricas como causa principal del déficit de atención han sido descartadas.

DSM-5 Criteria for ADHD

People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:

- **Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:**
 - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
 - Often has trouble holding attention on tasks or play activities.
 - Often does not seem to listen when spoken to directly.
 - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
 - Often has trouble organizing tasks and activities.
 - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
 - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
 - Is often easily distracted
 - Is often forgetful in daily activities.
- **Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:**
 - Often fidgets with or taps hands or feet, or squirms in seat.
 - Often leaves seat in situations when remaining seated is expected.
 - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
 - Often unable to play or take part in leisure activities quietly.
 - Is often "on the go" acting as if "driven by a motor".
 - Often talks excessively.
 - Often blurts out an answer before a question has been completed.
 - Often has trouble waiting his/her turn.
 - Often interrupts or intrudes on others (e.g., butts into conversations or games)

In addition, the following conditions must be met:

- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Trastornos que pueden simular TDA o exacerbarlo

- **Variantes normales:** niños superdotados, temperamento, diferencias culturales
- **Trastornos médicos:** Problemas sensoriales, ayuno, medicación, abuso de sustancias, apnea del sueño, distiroidismos, ferropenia, intoxicación por plomo, ausencias, complicaciones de enfermedades crónicas, enfermedades neurodegenerativas, prematuridad, cirugía CV, FAS, NF1, Esclerosis Tuberosa.
- **Trastornos del desarrollo:** Trastornos del Aprendizaje, TEA, síndrome de Tourette, Discapacidad Intelectual, Trastornos del lenguaje y comunicación.
- **Trastornos emocionales o conductuales:** Trastorno de Conducta, Trastorno Opositor Desafiante, Ansiedad, Depresión, Trastorno Bipolar, TOC, Trastorno de estrés postraumático, Trastorno de Adaptación, Esquizofrenia.
- **Problemas psicosociales:** Disfunción y estrés familiar. Abuso.

Comorbidades del Trastorno de Déficit de Atención

- Raramente ocurre en forma aislada
- Trastorno opositor desafiante (35,2%)
- Trastorno de conducta (25,7%)
- Trastorno de ansiedad (25,8%)
- Trastorno depresivo (18,2%)
- Trastornos del aprendizaje (40%)
- El pediatra que sospecha déficit de atención debe sospechar trastorno del aprendizaje y viceversa

CDC. Prevalence of diagnosis and medication treatment for Attention-deficit/hyperactivity disorder. US 2003. MMWR Morb Mortal Wkly Rep. 2005; 54:842-847.

Discapacidad Intelectual

- Los niños con Discapacidad Intelectual leve suelen ser detectados en los primeros años de la escuela primaria
- La mayoría tiene desarrollo motor normal y carece de dismorfias
- Considerar: Fra-X, XXY, XXX, FAS, FHS

Alteraciones Emocionales y Aprendizaje

- Aunque la mayoría de los estudiantes con trastornos emocionales tienen problemas académicos y de conducta en la escuela, los problemas emocionales son responsables primarios de sólo un pequeño porcentaje de alumnos con problemas del rendimiento escolar.

EL NIÑO CON ENFERMEDAD CRONICA

- Limitaciones físicas: motoras, sensoriales
- Disfunción neurológica: epilepsia, PC, MMC
- Dolor crónico
- Medicaciones
- Ausentismo excesivo
- Alteraciones emocionales

CAIDA DEL RENDIMIENTO ESCOLAR

- Crisis personales o familiares
- Cambio de colegio
- Adicciones
- Violencia familiar
- Enfermedades neurodegenerativas
- Enfermedades tiroideas
- Hipoacusia adquirida
- Embarazo

Ausentismo crónico

- Ansiedad de separación - beneficio secundario
- Trastornos del aprendizaje
- Enfermedades crónicas físicas o mentales
- Disfunción familiar
- Mala relación con maestros
- Trampa
- Embarazo

Evaluación psicopedagógica

- Permite determinar perfil individual del neurodesarrollo, cognitivo y emocional.
- Evalúa fortalezas y debilidades
- Intenta determinar las estrategias adecuadas para cada niño con problemas escolares.

Tratamiento Multimodal del TDA

- Terapia conductual y asistencia psico-educativa en el hogar y la escuela (Punto de partida)
- Asistencia en el aula
- Tratamiento medicamentoso

[Arch Gen Psychiatry](#). 1999 Dec;56(12):1073-86.

A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. The MTA Cooperative Group. Multimodal Treatment Study of Children with ADHD.

[No authors listed]

Abstract

BACKGROUND:

Previous studies have demonstrated the short-term efficacy of pharmacotherapy and behavior therapy for attention-deficit/hyperactivity disorder (ADHD), but no longer-term (i.e., >4 months) investigations have compared these 2 treatments or their combination.

METHODS:

A group of **579 children with ADHD Combined Type, aged 7 to 9.9 years**, were assigned to 14 months of medication management (titration followed by monthly visits); intensive behavioral treatment (parent, school, and child components, with therapist involvement gradually reduced over time); the two combined; or standard community care (treatments by community providers). Outcomes were assessed in multiple domains before and during treatment and at treatment end point (with the combined treatment and medication management groups continuing medication at all assessment points). Data were analyzed through intent-to-treat random-effects regression procedures.

RESULTS:

All 4 groups showed sizable reductions in symptoms over time, with significant differences among them in degrees of change. For most ADHD symptoms, children in the combined treatment and medication management groups showed significantly greater improvement than those given intensive behavioral treatment and community care. Combined and medication management treatments did not differ significantly on any direct comparisons, but in several instances (oppositional/aggressive symptoms, internalizing symptoms, teacher-rated social skills, parent-child relations, and reading achievement) combined treatment proved superior to intensive behavioral treatment and/or community care while medication management did not. Study medication strategies were superior to community care treatments, despite the fact that two thirds of community-treated subjects received medication during the study period.

CONCLUSIONS:

For ADHD symptoms, our carefully crafted **medication management was superior to behavioral treatment** and to routine community care that included medication. **Our combined treatment did not yield significantly greater benefits than medication management for core ADHD symptoms, but may have provided modest advantages for non-ADHD symptom and positive functioning outcomes.**

[Dev Behav Pediatr](#). 2001 Feb;22(1):60-73

Findings from the NIMH Multimodal Treatment Study of ADHD (MTA): implications and applications for primary care providers.

[Jensen PS](#)¹, [Hinshaw SP](#), [Swanson JM](#), [Greenhill LL](#), [Conners CK](#), [Arnold LE](#), [Abikoff HB](#), [Elliott G](#), [Hechtman L](#), [Hoza B](#), [March JS](#), [Newcorn JH](#), [Severe JB](#), [Vitiello B](#), [Wells K](#), [Wigal T](#).

[Author information](#)

Abstract

In 1992, the National Institute of Mental Health and 6 teams of investigators began a multisite clinical trial, the Multimodal Treatment of Attention-Deficit Hyperactivity Disorder (MTA) study. Five hundred seventy-nine children were randomly assigned to either routine community care (CC) or one of three study-delivered treatments, all lasting 14 months. The three MTA treatments-monthly medication management (usually methylphenidate) following weekly titration (MedMgt), intensive behavioral treatment (Beh), and the combination (Comb)-were designed to reflect known best practices within each treatment approach. Children were assessed at four time points in multiple outcome. **Results indicated that Comb and MedMgt interventions were substantially superior to Beh and CC interventions for attention-deficit hyperactivity disorder symptoms.** For other functioning domains (social skills, academics, parent-child relations, oppositional behavior, anxiety/depression), results suggested slight advantages of Comb over single treatments (MedMgt, Beh) and community care. High quality medication treatment characterized by careful yet adequate dosing, three times daily methylphenidate administration, monthly follow-up visits, and communication with schools conveyed substantial benefits to those children that received it. In contrast to the overall study findings that showed the largest benefits for high quality medication management (regardless of whether given in the MedMgt or Comb group), secondary analyses revealed that Comb had a significant incremental effect over MedMgt (with a small effect size for this comparison) when categorical indicators of excellent response and when composite outcome measures were used. In addition, **children with parent-defined comorbid anxiety disorders, particularly those with overlapping disruptive disorder comorbidities, showed preferential benefits to the Beh and Comb interventions.** Parental attitudes and disciplinary practices appeared to mediate improved response to the Beh and Comb interventions.

Pediatrics 2005; 115:6 e749; 10.1542/peds.2004-2560

Treatment of attention-deficit/hyperactivity disorder: overview of the evidence.

[Brown RT](#), [Amler RW](#), [Freeman WS](#), [Perrin JM](#), [Stein MT](#), [Feldman HM](#), [Pierce K](#), [Wolraich ML](#); [American Academy of Pediatrics Committee on Quality Improvement](#); [American Academy of Pediatrics Subcommittee on Attention-Deficit/Hyperactivity Disorder](#).

Abstract

The American Academy of Pediatrics' Committee on Quality Improvement, Subcommittee on Attention-Deficit/Hyperactivity Disorder, reviewed and analyzed the current literature for the purpose of developing an evidence-based clinical practice guideline for the treatment of the school-aged child with attention-deficit/hyperactivity disorder (ADHD). This review included several key reports, including an evidence review from the McMaster Evidence-Based Practice Center (supported by the Agency for Healthcare Research and Quality), a report from the Canadian Coordinating Office for Health Technology Assessment, the Multimodal Treatment for ADHD comparative clinical trial (supported by the National Institute of Mental Health), and supplemental reviews conducted by the subcommittee. These reviews provided substantial information about different treatments for ADHD and their efficacy in improving certain characteristics or outcomes for children with ADHD as well as adverse effects and benefits of multiple modes of treatment compared with single modes (eg, medication or behavior therapies alone). The reviews also compared the effects of different medications. Other evidence documents the long-term nature of ADHD in children and its classification as a chronic condition, meriting the application of general concepts of **chronic-condition management**, including an individual treatment plan with a focus on ongoing parent and child education, management, and monitoring. **The evidence strongly supports the use of stimulant medications for treating the core symptoms of children with ADHD** and, to a lesser degree, for improving functioning. Behavior therapy alone has only limited effect on symptoms or functioning of children with ADHD, although **combining behavior therapy with medication seems to improve functioning and may decrease the amount of (stimulant) medication needed**. Comparison among stimulants (mainly methylphenidate and amphetamines) did not indicate that 1 class outperformed the other.

Tratamiento Multimodal del TDA

- La combinación de terapia conductual y psicoestimulantes produce efectos similares a la medicación con respecto a los síntomas centrales del TDA. El tratamiento combinado produce mejores resultados en aquellos con problemas vinculares, ansiedad o problemas de la lectoescritura. El tratamiento combinado se asoció a mayor satisfacción de la familia y maestros

RECOMENDACIONES PARA EL TRATAMIENTO DEL TDA

- Considere el manejo de un niño con enfermedad crónica
- Establezca objetivos conjuntos con el paciente, padres, y docentes.
- Inicie tratamiento conductual y/o farmacológico
- Ante la mala evolución evalúe diagnóstico, compliance medicamentosa y asociaciones mórbidas
- Supervise la evolución y la aparición de efectos adversos

Tratamiento farmacológico del TDA

- Mejora la atención, impulsividad e hiperactividad. Efectos a corto plazo. Facilita otros tratamientos.
- Psicoestimulantes: metilfenidato (80% de efectividad), pemolina: hepatotóxico (retirado en 2005 por la FDA)
- Atomoxetina (en niños con ansiedad)
- Risperidona no mejora atención ni la impulsividad pero reduce las conductas disruptivas y agresivas. No aprobado por la FDA para tratamiento del TDA
- Otros: antidepresivos: imipramina, bupropion
- Alfa2 adrenergicos: clonidina

TRATAMIENTO CON ESTIMULANTES

- Dosis no dependiente del peso. Comenzar con dosis bajas. Variabilidad de respuesta. Drogas seguras. Pocas contraindicaciones.
- La mejor dosis es la que mejora la función con mínimos efectos adversos.
- Efectos adversos tempranos y de corta duración

ESTIMULANTES: EFECTOS ADVERSOS

- Frecuentes: ↓ apetito, dolor abdominal, cefalea, agitación, problemas para conciliar el sueño, retraimiento social, síntomas GI
- Labilidad emocional
- Taquicardia, HTA
- 15% tics motores (transitorios)
- El efecto sobre los tics es impredecible. La presencia de tics previos no es contraindicación
- Síntomas psiquiátricos: alucinaciones insectos, episodios de manía,
- Desaceleración transitoria del crecimiento. No compromiso de la talla a largo plazo
- Metilfenidato contraindicado en convulsiones no controladas, cardiopatías estructurales

[Pediatrics](#). 2003 Jan;111(1):179-85.

Does stimulant therapy of attention-deficit/hyperactivity disorder beget later substance abuse? A meta-analytic review of the literature.

[Wilens TE¹](#), [Faraone SV](#), [Biederman J](#), [Gunawardene S](#).

Abstract

OBJECTIVE:

Concerns exist that stimulant therapy of youths with attention-deficit/hyperactivity disorder (ADHD) may result in an increased risk for subsequent substance use disorders (SUD). We investigated all long-term studies in which pharmacologically treated and untreated youths with ADHD were examined for later SUD outcomes.

METHODS:

A search of all available prospective and retrospective studies of children, adolescents, and adults with ADHD that had information relating childhood exposure to stimulant therapy and later SUD outcome in adolescence or adulthood was conducted through PubMed supplemented with data from scientific presentations. Meta-analysis was used to evaluate the relationship between stimulant therapy and subsequent SUD in youths with ADHD in general while addressing specifically differential effects on alcohol use disorders or drug use disorders and the potential effects of covariates.

RESULTS:

Six studies--2 with follow-up in adolescence and 4 in young adulthood--were included and comprised 674 medicated subjects and 360 unmedicated subjects who were followed at least 4 years. The pooled estimate of the odds ratio indicated a 1.9-fold reduction in risk for SUD in youths who were treated with stimulants compared with youths who did not receive pharmacotherapy for ADHD ($z = 2.1$; 95% confidence interval for odds ratio [OR]: 1.1-3.6). We found similar reductions in risk for later drug and alcohol use disorders ($z = 1.1$). Studies that reported follow-up into adolescence showed a greater protective effect on the development of SUD (OR: 5.8) than studies that followed subjects into adulthood (OR: 1.4). Additional analyses showed that the results could not be accounted for by any single study or by publication bias.

CONCLUSION:

Our results suggest that stimulant therapy in childhood is associated with a **reduction in the risk for subsequent drug and alcohol use disorders.**

Pediatrics 2014;134:e935–e944

ADHD, stimulant treatment, and growth: a longitudinal study.

[Harstad EB¹](#), [Weaver AL²](#), [Katusic SK³](#), [Colligan RC⁴](#), [Kumar S⁵](#), [Chan E¹](#), [Voigt RG⁶](#), [Barbaresi WJ⁷](#).

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Abstract

BACKGROUND AND OBJECTIVE:

There is ongoing concern that stimulant medications may adversely affect growth. In a sample of attention-deficit/hyperactivity disorder (ADHD) cases and controls from a population-based birth cohort, we assessed growth and the association between stimulant treatment and growth.

METHODS:

Subjects included childhood ADHD cases ($N = 340$) and controls ($N = 680$) from a 1976 to 1982 birth cohort ($N = 5718$). Height and stimulant treatment information were abstracted from medical records and obtained during a prospective, adult follow-up study. For each subject, a parametric penalized spline smoothing method modeled height over time, and the corresponding height velocity was calculated as the first derivative. Peak height velocity (PHV) age and magnitude were estimated from the velocity curves. Among stimulant-treated ADHD cases, we analyzed height Z scores at the beginning, at the end, and 24 months after the end of treatment.

RESULTS:

Neither ADHD itself nor treatment with stimulants was associated with differences in magnitude of PHV or final adult height.

Among boys treated with stimulants, **there was a positive correlation between duration of stimulant usage before PHV and age at PHV** ($r = 0.21$, $P = .01$). There was no significant correlation between duration of treatment and change in height Z scores ($r = -0.08$ for beginning vs end change, $r = 0.01$ for end vs 24 months later change). Among the 59 ADHD cases treated for ≥ 3 years, there was a clinically insignificant decrease in mean Z score from beginning (0.48) to end (0.33) of treatment ($P = .06$).

CONCLUSIONS:

Our findings suggest that ADHD treatment with stimulant medication **is not associated with differences in adult height or significant changes in growth.**

Atomoxetina

- Única droga no estimulante reconocida por FDA
- Menos efectiva.
- Máximo beneficio después de varias semanas
- En niños con ansiedad como comorbidad
- Efectos adversos similares a estimulantes con excepción de los tics
- Raramente hepatotoxicidad
- Ideación suicida (raro)

Monitoreo del Tratamiento

- Peso y talla en cada consulta
- Evaluación cardiovascular clínica, pulso y TA, tolerar hasta incrementos del 5%
- Cambios del humor, conductas psiquiátricas, ideación suicida
- Remarque la importancia del tratamiento conductual y de las rutinas en cada consulta. Esto permitirá usar menos cantidad de medicación

Qué rol tiene la psicoterapia en el tratamiento del TDA?

- Los estudios han demostrado que la psicoterapia es efectiva para el tratamiento para los niños con TDA. Sin embargo el tratamiento con estimulantes es más efectivo para resolver los síntomas de déficit de atención, impulsividad e hiperactividad.
- En el estudio MTA:
 - los niños que recibieron medicación solamente o tratamiento combinado mejoraron más que los que recibieron tratamiento conductual intensivo durante 14 meses. Sin embargo existieron grandes diferencias individuales con buen rendimiento en todos los grupos.
 - El funcionamiento en la casa y el hogar fue mejor en los que recibieron el tratamiento combinado (tratamiento de las comorbilidades).

Cúal es el mejor tratamiento para mi hijo?

- No existe un mejor tratamiento para todos los niños con TDA
- La selección será individualizada y dependerá de las comorbilidades presentes y la aceptación familiar al tratamiento farmacológico.
- En niños con ansiedad, depresión y severos conflictos familiares el tratamiento combinado suele dar los mejores resultados..

Capacidades Sociales y Estimulantes

- Se pensaba que los niños con TDA sólo podían aprender a manejarse socialmente con terapias conductuales específicas. El estudio MTA determinó que pueden aprender esas habilidades por sí mismos cuando por el tratamiento estimulante pueden enfocarse.
- Los niños tratados con estimulantes (sólos o combinados con terapia conductual) mostraron mejoría de las capacidades sociales en los distintos ámbitos. Esto sugiere que los síntomas del TDA interfieren con la capacidad de aprender habilidades sociales. La medicación ayuda a incorporar estas habilidades al disminuir los síntomas centrales del TDA.

Falta de respuesta

- Evaluar diagnóstico
- Considerar asociaciones mórbidas
- Tratamiento no adecuado
- Falta de compliance con el tratamiento

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