



Guidelines for the Pharmacological Management of Attention Deficit Hyperactivity Disorder (ADHD) in Children, Young People and Adults

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Target Audience:

This guideline must be read and understood by all staff involved in the management of service users with ADHD



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Guidelines for the Pharmacological Management of Attention Deficit Hyperactivity Disorder (ADHD) in Children, Young People and Adults

1. Introduction

These guidelines are for the pharmacological management of ADHD in children, young people and adults in Hertfordshire Partnership University NHS Foundation Trust (HPFT) services.

ADHD is a common neurodevelopmental disorder characterised by inappropriate levels of activity and impulsivity and an impaired ability to sustain attention.¹ Those affected have difficulty regulating their activities to conform to expected norms, and often fail to achieve their potential. Many have comorbid difficulties such as developmental delays, specific learning problems and other emotional and behavioural disorders. Severe ADHD may be diagnosed as hyperkinetic disorder, which is characterised by a more severe disturbance with significant hyperactivity.²

Although ADHD begins in childhood, research has shown that it can continue through to adulthood for some. Approximately 15% of children with ADHD retain the diagnosis by age 25. A much larger proportion (65%) are in partial remission, with persistence of some symptoms associated with continued impairment. In adults, social and occupational problems can be caused by difficulties in concentrating, paying attention to detail and completing tasks, together with impulsivity and an inability to plan ahead. Moreover, ADHD is commonly associated with mental health, addiction or behavioural problems.³

The NICE ADHD guidelines (CG72)⁴ state that a diagnosis of ADHD in children, young people and adults should only be made by a paediatrician, specialist psychiatrist, or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD. For a diagnosis of ADHD, based on a complete history and evaluation of the patient, symptoms of hyperactivity/impulsivity and/or inattention should:

- > meet the diagnostic criteria in DSM-IV or ICD-10 (hyperkinetic disorder), and
- be associated with at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
- be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings

2. Purpose and Scope

To provide guidance on the safe and effective prescribing of medication to children, young people and adults diagnosed with ADHD within HPFT.

The following reference sources should also be consulted alongside these guidelines:

- <u>NICE CG 72</u>: Attention deficit hyperactivity disorder. Diagnosis and management
- <u>NICE TAG 98</u>: Methylphenidate, atomoxetine and dexamfetamine for attention deficit hyperactivity disorder (ADHD) in children and adolescents
- <u>British Association for Psychopharmacology</u>: Evidence-based guidelines for the pharmacological management of attention-deficit hyperactivity disorder (2014)
- The Maudsley Prescribing Guidelines in Psychiatry
- BNF
- BNF for children

3. Treatment for school-age children, young people and adults with ADHD⁴

A diagnosis of ADHD based on either DSM-IV or ICD-10 criteria must be present and documented, prior to commencing pharmacological treatment. Such treatment should be initiated by an appropriately qualified specialist with expertise in ADHD and must not be initiated if the diagnosis is uncertain, or benefit unlikely. Pharmacological treatment should always form part of a comprehensive treatment plan that includes psychological, behavioural, educational and occupational interventions.

Continued prescribing and monitoring may be performed by general practitioners, under shared care arrangements (see ADHD Shared Care Protocol).

Drug therapy is not recommended for pre-school children and parent-training/education programmes are the first-line treatment.

For school-age children and young people with moderate impairment, parent-training/education programmes are usually the first-line treatment. CBT and/or social skills training may also be offered. Pharmacological treatment is NOT indicated as the first-line treatment in this group and should be reserved for those:

- > with severe symptoms and impairment
- > with moderate levels of impairment who have refused non-drug interventions
- whose symptoms have not responded sufficiently to parent-training/education programmes or group psychological treatment

For adults with either moderate or severe impairment, drug therapy should be the first-line treatment unless the person would prefer a psychological approach. Drug treatment should only be started under the guidance of a psychiatrist, nurse prescriber specialising in ADHD, or other clinical prescriber with training in the diagnosis and management of ADHD. CBT may also be considered. Clinicians are supported in prescribing for adults with ADHD by the NICE CG 72⁴ and BAP (British Association of Psychopharmacology) guidelines⁶.

4. Transition to adult services⁴

Young people with ADHD receiving treatment and care from CAMHS or paediatric services should normally be transferred to adult services if they continue to have significant symptoms of ADHD. A young person should be re-assessed at school leaving age to establish the need for continuing treatment in to adulthood. Transition should be planned in advance by both referring and receiving services. A lack of treatment during the transitional period typically results in increased morbidity in adulthood.

During the transition to adult services, a formal meeting involving CAMHS and/or paediatrics and adult psychiatric services should be considered, and full information provided to the young person about adult services. The young person, and when appropriate the parent or carer, should be involved in the planning.

5. Choice of drug therapy

In children and young people for whom drug treatment is appropriate, NICE recommends methylphenidate, atomoxetine and dexamfetamine as options, within their licensed indications. The decision about which product to prescribe should be based on specific criteria, such as the presence of comorbid conditions (see General Treatment Principles below and Table 1). Methylphenidate is generally the first-line choice, followed by atomoxetine.^{1,5}

Following a decision to start drug treatment in adults with ADHD, methylphenidate should normally be tried first. Atomoxetine or dexamfetamine should be considered in adults unresponsive or intolerant to an adequate trial of methylphenidate (this should usually be about six weeks). Caution should be exercised when prescribing dexamfetamine to those likely to be at risk of stimulant misuse or diversion.⁴

NICE TA98 and CG72 both pre-date the availability of lisdexamfetamine dimesylate and licensed guanfacine in the UK. Their place in therapy is indicated in Table 1 below.

The <u>'Choice and Medication'</u> website has a number of <u>Handy Charts</u> which may help the prescriber and patient and / or his or her parent or guardian to decide which medication is the most suitable.

When discussing treatment options with an adult, child, young person and/or his or her parent or guardian, written information should be provided along with information about how to access further information if needed. Patient information leaflets are available from the <u>Choice and Medication</u> website.

*Antipsychotics are not recommended for the treatment of ADHD in children, young people and adults.

6. Patient monitoring^{4,5,6,7}

Baseline assessment

Prior to commencing pharmacological treatment for ADHD, children, young people and adults should have a full pre-treatment assessment, which should include the following:

- Full mental health and social assessment.
- Full history and physical examination, including:
 - assessment of history of exercise syncope, undue breathlessness and other cardiovascular symptoms
 - heart rate and blood pressure plotted on a centile chart for children and young people; <u>Blood Pressure Charts</u> (Also refer to Appendix 1 & 2: Blood Pressure Table – Boys & Girls)
 - height and weight plotted on a growth chart for children and young people; <u>RCPCH Girls</u> <u>Growth Chart 2-18 years</u> and <u>RCPCH Boys Growth Chart 2-18 years</u> Weight only for adults plotted on a weight/BMI chart <u>Height / Weight Chart - NHS Choices</u>
 - family history of cardiac disease and examination of the cardiovascular system if deemed appropriate
- An electrocardiogram (ECG) if there is a past medical or family history of serious cardiac disease, a history of sudden death in young family members, or abnormal findings on cardiac examination. Further specialist cardiac evaluation should be considered in such cases.
- Risk assessment for substance misuse and drug diversion in young people and adults.
- For girls of child-bearing potential, it is important to discuss contraception and the risks of pregnancy, and to consider the safety of prescribing medication in pregnancy.
- Prior to prescribing guanfacine, in addition to the monitoring above, it is necessary to conduct a baseline evaluation to identify patients at increased risk of somnolence and sedation, hypotension and bradycardia, QT-prolongation arrhythmia and weight increase/risk of obesity.

On-going monitoring

Height

- Measure every 6 months in children and young people and plot on a growth chart (see above under 'Baseline assessment' for links to growth charts). This must be reviewed by the healthcare professional responsible for treatment.
- If growth is significantly affected by drug treatment (i.e. the child or young person has not met the height expected for their age), the option of a planned break in treatment over school holidays should be considered to allow 'catch-up' growth to occur.

Weight

- Measure 3 and 6 months after commencement of drug treatment and every 6 months thereafter in children, young people and adults. Plot weight on the relevant growth/weight chart for children, young people and adults (see above under 'Baseline assessment' for links to growth/weight charts). This must be reviewed by the healthcare professional responsible for treatment.
- If there is evidence of weight loss associated with drug treatment for ADHD consider the following strategies to reduce weight loss or manage decreased weight gain:
 - take medication either with or after food, rather than before meals
 - recommend additional meals or snacks early in the morning or late in the evening when the stimulant effects of certain medicines have worn off
 - obtain dietary advice
 - encourage consumption of high-calorie foods of good nutritional value

- > consider changing the medication if weight loss persists
- Patients treated with guanfacine may show an increase in their weight, therefore monitoring of weight should be done on a 3-monthly basis for the first year of treatment and 6-monthly monitoring thereafter.

Strategies to reduce weight gain, or manage increased weight gain must be discussed with the patient and or parent/carer(s).

Heart rate and blood pressure (refer to Appendix 1 & 2)

- Monitor and record (on a centile chart for children and young people) before and after each dose change and routinely every 3 months. (See above under 'Baseline assessment' for links to centile charts).
- For people who have sustained resting tachycardia, arrhythmias or a systolic blood pressure greater than the 95th percentile (or a clinically significant increase) measured on two occasions should have their dose reduced and be referred to a paediatrician or adult physician.

Psychiatric disorders

 Development of *de novo* or worsening of pre-existing psychiatric disorders should be monitored at every adjustment of dose and then at least every 6 months and at every visit with the specialist or GP.

Risk of diversion, misuse and abuse

 Patients should be monitored for the risk of diversion, misuse and abuse of CNS stimulants such as methylphenidate, dexamphetamine and lisdexamphetamine. For children and young people prescribed stimulant drugs, monitor for changes in the potential for drug misuse and diversion, which may come with changes in circumstances and age.

7. General treatment principles⁴

Prescribers should have good knowledge of the medicines used for the treatment of ADHD and their different preparations, including their pharmacokinetic profiles, thus allowing treatment to be tailored effectively for an individual (refer to BNF and relevant Summary of Product Characteristics - SPCs).

Prescribers must be familiar with Controlled Drug (CD) legislation governing the prescription and supply of stimulant drugs which have a misuse potential and risk of diversion.

During titration, the dose should be gradually increased until there is adequate control of symptoms and behaviour and improvement in education and/or relationships and side-effects are tolerable.

Effects and side-effects of drug treatment must be routinely monitored and recorded in the relevant electronic patient record (EPR). A dose reduction should be considered if side-effects become troublesome.

If there is a choice of more than one appropriate drug, the product with the lowest cost (taking into account the cost per dose and number of daily doses) should be prescribed.

Following an adequate response, drug treatment for ADHD should be continued for as long as it is clinically effective. This should be reviewed annually.

NICE recommends when deciding to treat children or young people with drugs, professionals should consider:

- Methylphenidate for ADHD without significant comorbidity
- Methylphenidate for ADHD with comorbid conduct disorder
- Methylphenidate or atomoxetine when tics, Tourette syndrome, anxiety disorder, stimulant misuse or risk of stimulant diversion are present

- Atomoxetine if methylphenidate has been tried and has been ineffective at the maximum tolerated dose, or the child or young person is intolerant to low or moderate doses
- In consultation with a specialist, dexamfetamine may be considered in children and young people whose ADHD is unresponsive to a maximum tolerated dose of methylphenidate or atomoxetine

Dose titration should be slower if tics or seizures are present. Also, monitor for emergence or worsening of tics at every dose adjustment. If stimulant drug related tics emerge, reduce dose of the stimulant drug, consider changing to atomoxetine, or stop drug treatment.

If seizures are exacerbated in a child or young person with epilepsy, or de novo seizures emerge following initiation of methylphenidate or atomoxetine, discontinue the drug immediately. Dexamfetamine may be considered as an alternative in consultation with a specialist.

Following an adequate treatment response, NICE advise that drug treatment be continued for as long as it remains clinically effective. The need for continued drug treatment should be reviewed at least annually. This should involve a comprehensive assessment of clinical need, benefits and side effects. The effect of missed doses, planned dose reductions and brief periods of no treatment should be evaluated. NICE state that drug holidays, although not routinely recommended, may be considered.

 TABLE 1: ADHD Medication – Dosing Guidance, Formulation(s) and Additional Prescribing Information (Adapted from NICE CG 72 Guidance)^{4,5,7,8,9,10,11}

	Dosing Guidance	Formulation(s)	Additional Prescribing Information
	CHILDREN 6 – 17 YEARS:	IR formulations:	 Methylphenidate is indicated as part of a
	Immediate release (IR) formulations	Ritalin® 10mg	comprehensive treatment programme for ADHD in
(First-line:	5mg once or twice daily (breakfast and	Medikinet® 5mg,	children 6 years of age and over when remedial
children and	lunch), increasing daily dose by weekly	10mg and 20mg	measures alone prove insufficient
adults)	increments of 5-10mg. Licensed max.	tablets	 Begin with low doses and titrate dose against
	dose 60mg daily	(preferable during	symptoms and side-effects over 4-6 weeks, until dose
CNS Stimulant		initial dose	optimisation is achieved
Schedule 2 CD	Modified release (MR) formulations	titration,	 MR formulations may be preferred over IR
	Concerta XL 18mg once daily in the	particularly if	formulations for the following reasons:
	morning, increased in steps of 18mg	flexible dose	- improving adherence
	every 1 week, then adjusted according	regime required)	 reducing stigma (no dose during school hours)
	to response. Licensed max. dose 54mg		 avoiding problems associated with storing and
	daily	MR	administering CDs at school
		formulations*:	 diminished rebound symptoms and addressing
	Delmosart XL 18mg once daily in the	Concerta XL®	impairment later in the day
	morning, increased in steps of 18mg	(18mg, 27mg,	 concerns re: misuse or diversion
	every 1 week, then adjusted according	36mg and 54mg	 The different types of products are not
	to response. Licensed max. dose 54mg	tablets)	interchangeable and the BNF recommends
	daily	Delmosart® XL	prescribing by brand name to avoid the risk of
		(18mg, 27mg,	destabilisation from different release characteristics of
	Matoride XL 18mg once daily in the	36mg and 54mg	the XL products dispensed generically
	morning, increased in steps of 18mg	tablets)	In children and young people in whom
	every 1 week, then adjusted according	Matoride XL®	methylphenidate has been tried and has been
	to response. Licensed max. dose 54mg	(18mg, 36mg and	ineffective at the maximum tolerated dose, or the
	daily	54mg tablets)	individual is intolerant to low or moderate doses of
		Xenidate XL	this drug, consider atomoxetine
	Xenidate XL 18mg once daily in the	(18mg, 27mg,	• In adults unresponsive or intolerant to an adequate
	morning, increased in steps of 18mg	36mg and 54mg	trial of methylphenidate (approximately 6 weeks),
	every 1 week, then adjusted according	tablets)	atomoxetine, dexamfetamine or lisdexamfetamine
	to response. Licensed max. dose 54mg	Equasym XL®	should be considered
	daily	(10mg, 20mg and	Common adverse effects include insomnia,
		30mg capsules)	nervousness, headache, decreased appetite,
		Medikinet XL®	abdominal pain and other gastrointestinal symptoms
		(10mg, 20mg,	and cardiovascular effects such as tachycardia,

	Equasym XL 10mg once daily in the morning, before breakfast, increased at weekly intervals if necessary. Licensed max. dose 60mg daily Medikinet XL 10mg once daily in the morning, with breakfast, adjusted at weekly intervals according to response. Licensed max. dose 60mg daily <u>ADULTS:</u> (unlicensed for initiation in adults) Begin with low doses (5 mg three times daily for IR formulations or the equivalent MR dose) Increase dose according to response up to a maximum of 100 mg/day Higher doses than the licensed maximum daily doses only to be given under the direction of a specialist	30mg and 40mg capsules) *MR preparations should be prescribed by BRAND to ensure correct formulation is dispensed		palpitations and minor increases in blood pressure. For full details refer to relevant SPC Associated with a worsening of pre-existing anxiety, agitation or tension and also with the onset or exacerbation of motor and verbal tics; monitor regularly
ATOMOXETINE (Second-line: children and	<u>CHILDREN</u> Child 6-17 years up to 70 kg body weight: initially 0.5mg/kg/day_Increase	Strattera®10mg, 18mg, 25mg, 40mg, 60mg,	•	Atomoxetine is indicated for the treatment of ADHD in children of 6 years and older, in adolescents and in adults as part of a comprehensive treatment
adults)	dose after 7 days according to response, to a maintenance dose of	80mg, 100mg capsules	•	programme and under specialist supervision Offer a single daily dose, or 2 divided doses to
(Selective	approximately 1.2mg/kg/day			minimise side-effects
noradrenaline	*High daily doses to be given under the	Strattera®	-	Where a satisfactory clinical response is not achieved
reuptake inhibitor)	direction of a specialist; maximum	4mg/1ml oral		when taken as a single daily dose, the individual may
	(Doses above 100mg/day not	free		doses in the morning and late afternoon, or early
	licensed)			evening
			•	Consider in individuals unresponsive or intolerant to
	Child 6-17 years over 70 kg body		_	an adequate trial of methylphenidate
	weight: use a total starting dose of		-	disorder, stimulant misuse or risk of stimulant
	40mg/day. Increase dose after 7 days			diversion are present
	according to response up to a		-	Consider if psychotic symptoms emerge after starting
	maintenance dose of 80mg/day.			treatment with a stimulant drug

DEXAMFETAMIN E (Preferred third- line: children) (Second-line: adults) (CNS stimulant) Schedule 2 CD	CHILDREN Child aged 6-17 years: initially 2.5mg two or three times daily, increased according to response by 5mg at weekly intervals, increasing to a maximum of 20mg/day. Up to 40mg/day may occasionally be required ADULTS (unlicensed in adults) Begin with low doses of 5 mg twice daily. Increase dose weekly according to response, up to a maximum of 60 mg/day. Offer divided doses, usually between 2 and 4 times daily	5mg tablets 1mg/ml oral solution	•	Dexamfetamine is indicated for children with refractory hyperkinetic states Begin with low doses and titrate dose against symptoms and side-effects over 4-6 weeks, until dose optimisation is achieved Consider if ADHD is unresponsive to maximum tolerated dose of methylphenidate or atomoxetine in refractory hyperkinetic states Common adverse effects include insomnia, nervousness, headache, decreased appetite, abdominal pain and other gastrointestinal symptoms and cardiovascular effects such as tachycardia, palpitations and minor increases in blood pressure. For full details refer to relevant SPC
LISDEXAMFETAM INE (Alternative third- line: children) (Second-line: adults) (CNS stimulant) Schedule 2 CD	CHILDREN Child 6-17 years: Initially 30mg once daily in the morning, increased in steps of 20mg every 1 week if required. Maximum dose 70mg/day ADULTS (licensed in adults) Initially 30mg once daily in the morning, increased in steps of 20mg every 1 week if required. Maximum dose 70mg/day	Elvanse® 20mg, 30mg, 40mg, 50mg, 60mg and 70mg capsules Elvanse Adult® 30mg, 50mg and 70mg capsules	•	Elvanse is indicated as part of a comprehensive treatment programme for ADHD in children aged 6 years and over when response to previous methylphenidate treatment is considered clinically inadequate Consider if ADHD is unresponsive to maximum tolerated dose of methylphenidate, atomoxetine and the preferred third-line drug, dexamfetamine Elvanse Adult is indicated as part of a comprehensive treatment programme for ADHD in adults 25mg of lisdexamfetamine is the molecular equivalent to 10mg of dexamfetamine Discontinue if response is insufficient after 1 month Common adverse effects include insomnia, nervousness, headache, decreased appetite, abdominal pain and other gastrointestinal symptoms and cardiovascular effects such as tachycardia, palpitations and minor increases in blood pressure. For full details refer to relevant SPC
(Fourth-line:	Initial dose of 1mg daily, given either in	2mg, 3mg or 4mg		children and adolescents 6-17 years old for whom

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children only)	the morning or the evening, titrated	prolonged release		stimulants are not suitable, not tolerated, or have
· · · · · · · · · · · · · · · · · · ·	according to response in increments of	tablets		been shown to be ineffective. Guanfacine must be
(Selective alpha	not more than 1mg a week to a			used as a part of a comprehensive ADHD treatment
2A-adrenergic	maximum of 4mg daily in children aged			programme, typically including psychological.
receptor agonist)	6–12 years and up to 7mg daily.			educational and social measures
	depending on body weight, in		-	Prior to prescribing, it is necessary to conduct a
Prescribing to	adolescents aged 13–17 years			baseline evaluation to identify patients at increased
remain in	corresponding to a usual dose range of			risk of somnolence and sedation, hypotension and
secondary care	0.05-0.12mg/kg/day			bradycardia OT-prolongation arrhythmia and weight
Scoondary care	0.00 0.12mg/kg/ddy			increase /risk of obesity. This evaluation should
				address a patient's cardiovascular status including
				blood pressure and heart rate. documenting
				comprehensive history of concomitant medications
				past and present co-morbid medical and psychiatric
				disorders or symptoms, family history of sudden
				cardiac/unexplained death and accurate recording of
				pre-treatment height and weight on a growth chart
			-	Careful dose titration and monitoring is necessary at
				the start of treatment with quanfacine since clinical
				improvement and risks for several clinically significant
				adverse reactions (syncope, hypotension
				bradycardia, somnolence and sedation) are dose and
				exposure related. Patients should be advised that
				somnolence and sedation can occur, particularly early
				in treatment or with dose increases. If somolence
				and sedation are judged to be clinically concerning or
				persistent, a dose decrease or discontinuation should
				be considered
			-	When stopping guanfacine, the dose must be tapered
				with decrements of no more than 1 mg every 3 to 7
				days, and blood pressure and pulse should be
				monitored in order to minimise potential withdrawal
				effects, in particular increases in blood pressure and
				heart rate.

8. Comparative cost of ADHD Drug Treatment (Drug Tariff & eBNF – Jan 2017)

Drug and dose range	Annual Cost				
Methylphenidate IR 5-60mg daily	£39.39 - £425.88				
Methylphenidate M/R (Concerta XL) 18-54mg daily	£405.47 - £957.06				
Methylphenidate M/R (Equasym XL) 10-60mg daily	^{mg} £325 - £910				
Methylphenidate M/R (Medikinet XL) 10-60mg daily	£325 - £875.16				
Atomoxetine 10-80mg daily	£690.17 - £920.27				
Atomoxetine Liquid 10-80mg daily	£340 -£2125				
Dexamfetamine 5-20mg daily	£321.75 - £1287				
Lisdexamfetamine 30-70mg daily	£757.12 - £1081.08				
Guanfacine 1-7mg daily	£728 - £1841.84				

9. Duration, discontinuation and continuity of treatment⁴

Following an adequate treatment response, drug treatment for ADHD should be continued for as long as it remains clinically effective. This should be reviewed at least annually.

Drug holidays are not routinely recommended for children and young people, however consideration should be given to finding the best pattern of use together with the individual and their parent or carer; this may include periods without drug treatment.

For adults, an individual treatment approach is important and the need for adapting patterns of use must be reviewed at least annually, including the effect of drug treatment on co-existing conditions and mood changes.

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Blood Pressure Table – Boys (Appendix 1)

(Diagnosis, Evaluation and Treatment of High Blood Pressure in Children and Adolescents; US Dept. Health and Human Services; Revised May 2005)

Age	BP		5	systolic	BP (m	mHg)		Diastolic BP (mmHg)							
(Year)	Percentile		←F	Percent	ile of H	leight -	→			←P	ercent	ile of H	leight -	→	
	Ļ	5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
1	50th	80	81	83	85	87	88	89	34	35	36	37	38	39	39
	90th	94	95	97	99	100	102	103	49	50	51	52	53	53	54
	95th	98	99	101	103	104	106	106	54	54	55	56	57	58	58
	99th	105	106	108	110	112	113	114	61	62	63	64	65	66	66
2	50th	84	85	87	88	90	92	92	39	40	41	42	43	44	44
	90th	97	99	100	102	104	105	106	54	55	56	57	58	58	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
	99th	109	110	111	113	115	117	117	66	67	68	69	70	71	71
3	50th	86	87	89	91	93	94	95	44	44	45	46	47	48	48
	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	110	112	113	63	63	64	65	66	67	67
	99th	111	112	114	116	118	119	120	71	71	72	73	74	75	75
4	50th	88	89	91	93	95	96	97	47	48	49	50	51	51	52
	90th	102	103	105	107	109	110	111	62	63	64	65	66	66	67
	95th	106	107	109	111	112	114	115	66	67	68	69	70	71	71
	99th	113	114	116	118	120	121	122	74	75	76	77	78	78	79
5	50th	90	91	93	95	96	98	98	50	51	52	53	54	55	55
	90th	104	105	106	108	110	111	112	65	66	67	68	69	69	70
	95th	108	109	110	112	114	115	116	69	70	71	72	73	74	74
	99th	115	116	118	120	121	123	123	77	78	79	80	81	81	82
6	50th	91	92	94	96	98	99	100	53	53	54	55	56	57	57
	90th	105	106	108	110	111	113	113	68	68	69	70	71	72	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
	99th	116	117	119	121	123	124	125	80	80	81	82	83	84	84
7	50th	92	94	95	97	99	100	101	55	55	56	57	58	59	59
	90th	106	107	109	111	113	114	115	70	70	71	72	73	74	74
	95th	110	111	113	115	117	118	119	74	74	75	76	77	78	78
	99th	117	118	120	122	124	125	126	82	82	83	84	85	86	86
8	50th	94	95	97	99	100	102	102	56	57	58	59	60	60	61
	90th	107	109	110	112	114	115	116	71	72	72	73	74	75	76
	95th	111	112	114	116	118	119	120	75	76	77	78	79	79	80
	99th	119	120	122	123	125	127	127	83	84	85	86	87	87	88
9	50th	95	96	98	100	102	103	104	57	58	59	60	61	61	62
	90th	109	110	112	114	115	117	118	72	73	74	75	76	76	77
	95th	113	114	116	118	119	121	121	76	77	78	79	80	81	81
	99th	120	121	123	125	127	128	129	84	85	86	87	88	88	89
10	50th	97	98	100	102	103	105	106	58	59	60	61	61	62	63
	90th	111	112	114	115	117	119	119	73	73	74	75	76	77	78
	95th	115	116	117	119	121	122	123	77	78	79	80	81	81	82
	99th	122	123	125	127	128	130	130	85	86	86	88	88	89	90

Blood Pressure Levels for Boys by Age and Height Percentile*

Age	BP		5	Systolic	BP (m	mHg)		Diastolic BP (mmHg)								
(Year)	Percentile ↓		←F	Percent	ile of H	leight -	→			←P	Percent	ile of H	leight -	→		
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th	
11	50th	99	100	102	104	105	107	107	59	59	60	61	62	63	63	
	90th	113	114	115	117	119	120	121	74	74	75	76	77	78	78	
	95th	117	118	119	121	123	124	125	78	78	79	80	81	82	82	
	99th	124	125	127	129	130	132	132	86	86	87	88	89	90	90	
12	50th	101	102	104	106	108	109	110	59	60	61	62	63	63	64	
	90th	115	116	118	120	121	123	123	74	75	75	76	77	78	79	
	95th	119	120	122	123	125	127	127	78	79	80	81	82	82	83	
	99th	126	127	129	131	133	134	135	86	87	88	89	90	90	91	
13	50th	104	105	106	108	110	111	112	60	60	61	62	63	64	64	
	90th	117	118	120	122	124	125	126	75	75	76	77	78	79	79	
	95th	121	122	124	126	128	129	130	79	79	80	81	82	83	83	
	99th	128	130	131	133	135	136	137	87	87	88	89	90	91	91	
14	50th	106	107	109	111	113	114	115	60	61	62	63	64	65	65	
	90th	120	121	123	125	126	128	128	75	76	77	78	79	79	80	
	95th	124	125	127	128	130	132	132	80	80	81	82	83	84	84	
	99th	131	132	134	136	138	139	140	87	88	89	90	91	92	92	
15	50th	109	110	112	113	115	117	117	61	62	63	64	65	66	66	
	90th	122	124	125	127	129	130	131	76	77	78	79	80	80	81	
	95th	126	127	129	131	133	134	135	81	81	82	83	84	85	85	
	99th	134	135	136	138	140	142	142	88	89	90	91	92	93	93	
16	50th	111	112	114	116	118	119	120	63	63	64	65	66	67	67	
	90th	125	126	128	130	131	133	134	78	78	79	80	81	82	82	
	95th	129	130	132	134	135	137	137	82	83	83	84	85	86	87	
	99th	136	137	139	141	143	144	145	90	90	91	92	93	94	94	
17	50th	114	115	116	118	120	121	122	65	66	66	67	68	69	70	
	90th	127	128	130	132	134	135	136	80	80	81	82	83	84	84	
	95th	131	132	134	136	138	139	140	84	85	86	87	87	88	89	
	99th	139	140	141	143	145	146	147	92	93	93	94	95	96	97	

Blood Pressure Table – Girls (Appendix 2)

(Diagnosis, Evaluation and Treatment of High Blood Pressure in Children and Adolescents; US Dept. Health and Human Services; Revised May 2005)

Ane	RP		Diastolic BP (mmHg)												
(Year)	Percentile		←F	Percent	ile of H	leight -	→			←P	ercent	ile of H	eight -	→	
	Ļ	5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
1	50th	83	84	85	86	88	89	90	38	39	39	40	41	41	42
	90th	97	97	98	100	101	102	103	52	53	53	54	55	55	56
	95th	100	101	102	104	105	106	107	56	57	57	58	59	59	60
	99th	108	108	109	111	112	113	114	64	64	65	65	66	67	67
2	50th	85	85	87	88	89	91	91	43	44	44	45	46	46	47
	90th	98	99	100	101	103	104	105	57	58	58	59	60	61	61
	95th	102	103	104	105	107	108	109	61	62	62	63	64	65	65
	99th	109	110	111	112	114	115	116	69	69	70	70	71	72	72
3	50th	86	87	88	89	91	92	93	47	48	48	49	50	50	51
	90th	100	100	102	103	104	106	106	61	62	62	63	64	64	65
	95th	104	104	105	107	108	109	110	65	66	66	67	68	68	69
	99th	111	111	113	114	115	116	117	73	73	74	74	75	76	76
4	50th	88	88	90	91	92	94	94	50	50	51	52	52	53	54
	90th	101	102	103	104	106	107	108	64	64	65	66	67	67	68
	95th	105	106	107	108	110	111	112	68	68	69	70	71	71	72
	99th	112	113	114	115	117	118	119	76	76	76	77	78	79	79
5	50th	89	90	91	93	94	95	96	52	53	53	54	55	55	56
	90th	103	103	105	106	107	109	109	66	67	67	68	69	69	70
	95th	107	107	108	110	111	112	113	70	71	71	72	73	73	74
	99th	114	114	116	117	118	120	120	78	78	79	79	80	81	81
6	50th	91	92	93	94	96	97	98	54	54	55	56	56	57	58
	90th	104	105	106	108	109	110	111	68	68	69	70	70	71	72
	95th	108	109	110	111	113	114	115	72	72	73	74	74	75	76
	99th	115	116	117	119	120	121	122	80	80	80	81	82	83	83
7	50th	93	93	95	96	97	99	99	55	56	56	57	58	58	59
	90th	106	107	108	109	111	112	113	69	70	70	71	72	72	73
	95th	110	111	112	113	115	116	116	73	74	74	75	76	76	77
	99th	117	118	119	120	122	123	124	81	81	82	82	83	84	84
8	50th	95	95	96	98	99	100	101	57	57	57	58	59	60	60
	90th	108	109	110	111	113	114	114	71	71	71	72	73	74	74
	95th	112	112	114	115	116	118	118	75	75	75	76	77	78	78
	99th	119	120	121	122	123	125	125	82	82	83	83	84	85	86
9	50th	96	97	98	100	101	102	103	58	58	58	59	60	61	61
	90th	110	110	112	113	114	116	116	72	72	72	73	74	75	75
	95th	114	114	115	117	118	119	120	76	76	76	77	78	79	79
	99th	121	121	123	124	125	127	127	83	83	84	84	85	86	87
10	50th	98	99	100	102	103	104	105	59	59	59	60	61	62	62
	90th	112	112	114	115	116	118	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
	99th	123	123	125	126	127	129	129	84	84	85	86	86	87	88

Blood Pressure Levels for Girls by Age and Height Percentile*

Ane	BP	Systolic BP (mmHg)									Diastolic BP (mmHg)							
(Year)	Percentile		←P	ercent	ile of H	leight -	→				←P	ercenti	le of H	leight -	→			
	Ļ	5th	10th	25th	50th	75th	90th	95th		5th	10th	25th	50th	75th	90th	95th		
11	50th	100	101	102	103	105	106	107		60	60	60	61	62	63	63		
	90th	114	114	116	117	118	119	120		74	74	74	75	76	77	77		
	95th	118	118	119	121	122	123	124		78	78	78	79	80	81	81		
	99th	125	125	126	128	129	130	131		85	85	86	87	87	88	89		
12	50th	102	103	104	105	107	108	109		61	61	61	62	63	64	64		
	90th	116	116	117	119	120	121	122		75	75	75	76	77	78	78		
	95th	119	120	121	123	124	125	126		79	79	79	80	81	82	82		
	99th	127	127	128	130	131	132	133		86	86	87	88	88	89	90		
13	50th	104	105	106	107	109	110	110		62	62	62	63	64	65	65		
	90th	117	118	119	121	122	123	124		76	76	76	77	78	79	79		
	95th	121	122	123	124	126	127	128		80	80	80	81	82	83	83		
	99th	128	129	130	132	133	134	135		87	87	88	89	89	90	91		
14	50th	106	106	107	109	110	111	112		63	63	63	64	65	66	66		
	90th	119	120	121	122	124	125	125		77	77	77	78	79	80	80		
	95th	123	123	125	126	127	129	129		81	81	81	82	83	84	84		
	99th	130	131	132	133	135	136	136		88	88	89	90	90	91	92		
15	50th	107	108	109	110	111	113	113		64	64	64	65	66	67	67		
	90th	120	121	122	123	125	126	127		78	78	78	79	80	81	81		
	95th	124	125	126	127	129	130	131		82	82	82	83	84	85	85		
	99th	131	132	133	134	136	137	138		89	89	90	91	91	92	93		
16	50th	108	108	110	111	112	114	114		64	64	65	66	66	67	68		
	90th	121	122	123	124	126	127	128		78	78	79	80	81	81	82		
	95th	125	126	127	128	130	131	132		82	82	83	84	85	85	86		
	99th	132	133	134	135	137	138	139		90	90	90	91	92	93	93		
17	50th	108	109	110	111	113	114	115		64	65	65	66	67	67	68		
	90th	122	122	123	125	126	127	128		78	79	79	80	81	81	82		
	95th	125	126	127	129	130	131	132		82	83	83	84	85	85	86		
	99th	133	133	134	136	137	138	139		90	90	91	91	92	93	93		