

· 世界全科医学工作研究 ·

【编者按】中国全科医学杂志与澳大利亚 Monash 大学和 Melbourne 大学的全科医学专家和心理学专家在 2012 年伊始共同推出“全科医学中的心理健康病案研究”学术专栏，该专栏由澳大利亚的几位专家轮流撰写，以介绍社区常见的心理问题及其解决方法为主要内容，获得了读者的广泛好评。今年本刊将继续该学术专栏的登载，以推动我国社区心理学服务的能力建设，并带动社区心理学研究的深入。与此同时，由几位澳大利亚教授合作撰写的著作《全科医学中的精神病学》正在由中国全科医学杂志社与国内外专家合作进行翻译，期望不久在中国出版。希望通过本学术专栏和翻译名著等工作，让中国的全科医学在心理健康服务方面迈上新的台阶。在此衷心感谢担任本栏目翻译点评工作的本刊编委、澳大利亚 Monash 大学杨辉教授对中国全科医学发展给予的帮助和支持！

全科医学中的心理健康病案研究（十九） ——儿童的心理健

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【关键词】 注意缺损多动障碍；儿童期；心理健康；全科医学

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与成人相比，儿童（特别是男孩）通常表现得比较松散、任性和忙乱（活跃）。如果与儿童相应年龄的生长发育的期望值相比，有些儿童过分和持续地表现出这些行为，并对他的社交生活和学习造成损害，那么就存在神经发育的问题，称为注意缺损多动障碍（attention deficit hyperactivity disorder, ADHD）^[1]。由于各国在诊断标准上的差别，加上文化和社会因素的影响，对注意缺损多动障碍患病率的估计差别很大，如欧洲 6~12 岁儿童的患病率为 1.5%，而美国为 5%^[1]；中国各研究报告的估计范围更大，波动在 1%~14%^[2]；香港报告的患病率为 6%^[3]。在中国，大多数有这种障碍的儿童易被漏诊，没有得到及时治疗。即便是得到治疗，大多也只采用中药。此外，儿童心理障碍诊断率低还受到“污名”现象的影响^[2]。注意缺损多动障碍在男孩中的流行率是女孩的 2 倍。

全科医生在评估和管理儿童心理健康中扮演着核心的角色，因为全科医生了解儿童的家庭、社会和文化环境。全科医生可以评估儿童的行为发育是否正常，并可以把儿童转诊给儿科专家或精神病学专家。而且，全科医生还可以随访和监测对儿童的治疗过程，并帮助儿童家庭与当地的支持性服务建立联系，协调家长与儿童学校的合作^[4]。

1 病史

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注：Grant Blashki、Fiona Judd 的作者简介见 2012 年第 1A 期，Leon Piterman 的作者简介见 2012 年第 2A 期，见中国全科医学杂志官方网站（http://www.chinagp.net）；文后附英文来稿原文

安东尼是一个 8 岁的男孩。父母是中国人，最近在澳大利亚做生意和读学位。安东尼在当地上小学。在课堂上，他一会儿也坐不住，经常干扰老师上课，跑出教室，不停地碰其他孩子的头，每项功课都不能完成。他是一个很容易相处的孩子，只不过不能坚持与其他孩子做好游戏。他的书写有困难，不过英语说得还很流利。安东尼在家的时候也是一刻都停不下来，不能专注游戏，不能安静坐下来吃饭，不能坐下来看电视。他不能完整地做好一件事，比如不能穿好衣服。他不能安静下来去睡觉，而且每天早上醒得很早。只要是他醒着，就根本停不下来。他会经常打断父母与来访者的交谈。安东尼的父母很疼爱他，不过由于他一贯的要求行为和很差的学校表现，父母也很生气和沮丧。最近，安东尼开始不准备去上学，推说自己肚子疼。父母送他去学校的时候，他会感到很痛苦；不过一旦父母离开，他也能在学校待下去。你询问孩子父母关于家族史方面的问题，发现孩子的叔叔和堂哥（即叔叔的儿子）有学习困难、强迫性反社会行为、就业不稳定等问题。

2 发育史

母亲在怀安东尼的过程中，孕期是正常的。母亲在孕期曾经抽很多烟，不过现在已经戒烟了。安东尼是足月产，不过属于急产（1.5 h）。安东尼生下来时皮肤深紫色，需要清理呼吸道和给氧。生下 1 min 时阿普加评分为 2 分，5 min 时为 6 分。与其他孩子相比，安东尼的体质量和身高均偏低（第 5 个百分位）。他是一个焦躁不安和不停运动的婴儿，很难安静下来吃奶，睡眠也不好。他 12 个月开始走路，不过精细运动能力和动手能力发育比较晚。到目前为止，他还没有明确的用手偏好。对安东尼的发育评估结果证实，他的各种能力发育属于正常偏下，且短期听力记忆能力和精细运动能力发育迟滞。

3 躯体检查

在整个看病过程中, 安东尼不停地在搬弄各种玩具, 但没有完成过任何一项游戏活动, 比如组装起玩具火车的轨道。他经常用一些毫不相干的理由打断父母的谈话, 不过态度是友善的, 而且能保持很好的目光接触。你让他画一个小人儿, 在画画的过程中他很容易分心, 窗外轻微的声音就能让他停下来。他需要不断的鼓励才能画好小人儿。他画的小人儿很潦草, 缺乏很多细节, 明显低于他这个年龄段孩子的画画能力。在画画的时候, 他握笔的动作比较笨拙。你让他在画上写上自己的名字, 并写一句简单的话。他写出来的字母大小, 间隔不一, 遗漏一些词, 而且有拼写错误。躯体检查结果证实, 他的生命体征正常。腹部检查和神经学检查均没有异常发现。

4 提问

- 4.1 最可能做出什么心理学诊断?
- 4.2 你考虑哪些心理学和神经发育的问题和鉴别诊断?
- 4.3 应该考虑做哪些进一步的评估和辅助检查?
- 4.4 什么原因造成注意缺损多动障碍?
- 4.5 应该考虑哪些非药物的干预措施?
- 4.6 哪些医学管理措施适合安东尼这样的孩子?

5 解答

5.1 心理学诊断 可能的诊断, 按照国际疾病分类标准 (ICD-10) 的诊断是“多动性障碍” (hyperkinetic disorder), 或者按照美国精神疾病诊断标准 (DSM-IV) 诊断为“注意缺损多动障碍-注意缺损和多动综合型”^[1,4-5]。他在几个方面发育异常: 缺乏注意力、活动过度、容易冲动、混乱。

这些症状严重地影响了他在学校的学习、社交互动、娱乐和家庭生活。这些症状在7岁前发作, 已经持续了6个多月, 并具有弥漫性 (在各种场合发生)。

5.2 心理学和神经发育的鉴别诊断 注意缺损多动障碍的孩子通常有各种相关的认知、情感和行为问题。按照 ICD-10 的诊断标准, 最常见的问题包括: (1) 特定的学习技能障碍 (比如阅读、拼写和计算技能), 或者精细功能障碍, 或言语和语言障碍; (2) 品行障碍, 比如对立违抗性障碍; (3) 儿童情感障碍, 比如离别障碍、惊恐障碍、社交焦虑障碍, 并可能有躯体化症状; (4) 心境障碍, 比如抑郁发作; (5) 抽动障碍; (6) 非器质性睡眠障碍; (7) 弥漫性发育障碍, 如儿童孤独症; (8) 精神发育迟滞, 如智力残疾。

对于安东尼的病例, 全科医生应该考虑手写、阅读和精细运动能力 (动手操作和握住铅笔所必须具备的), 以及语言 (短期听力记忆问题) 方面的特定的发育障碍。他不能保持自己按照别人的口头指令做事情, 并有随境转移的情况, 即经常不明白在课堂要做什么, 而且做事情杂乱无章。

全科医生还应该考虑他有离别障碍和社交焦虑问题, 他有拒学现象, 并以肚子疼作为躯体化症状。安东尼对上学的焦虑可能有很多潜在原因, 包括越来越明显的学习困难和社交困难, 以及因为各种行为和学习成绩差所遭受的老师和父母的批评。

5.3 进一步的评估和辅助检查 对于安东尼的肚子疼, 可能需要进一步的检查, 以便在把症状归因为焦虑之前, 能排除器

官方面的原因。在做这方面检查时, 全科医生要采用最简单的措施, 让家长得到安慰。要让家长知道他的肚子疼与他的上学焦虑有关系。医生可以根据孩子的临床表现, 安排一些简单的实验室检查, 比如粪便镜检和培养检查, 或者腹部 X 线检查。

学校报告中提到的信息会非常有帮助。对孩子的认知评估, 比如智力测验和学习能力测验, 可以帮助全科医生更深入地了解这个孩子。如果怀疑有遗传性的障碍, 则可以安排更专业的检查, 比如脑电图扫描、染色体分析等。

5.4 造成注意缺损多动障碍的原因 对于某些注意缺损多动障碍的儿童来说, 是脑部损伤 (如胎儿酒精综合征)、或获得性脑损伤、或遗传性疾病 (如 X 染色体脆折症) 造成的症状。对于另外一些儿童来说, 他们的症状是生物学 (如遗传和家族影响因素)、心理学 (如短期听力记忆发育迟滞) 和社会学方面因素 (如家庭矛盾和父母教养问题) 的互动结果。大多数患儿还同时存在其他发育和行为问题, 如焦虑、拒学、对抗和挑衅行为, 抽搐; 抑郁和焦躁不安; 学习困难 (包括拼写、阅读和算术困难), 以及协调和语言问题^[1,4-5]。

具体对安东尼的案例来说, 这个孩子的注意缺损多动障碍的可能原因, 一部分是母亲在孕产期吸烟造成的脑部影响, 另一部分是急产和围生期缺氧造成的。还有部分原因可能是父母遗传因素的影响, 因为家族史中发现有人有学习困难和行为问题。

随着儿童期的成熟, 注意缺损多动障碍的症状通常会改善。大多数孩子进入成人期后不再符合注意缺损多动障碍的诊断条件, 不过可能终生仍持续某些症状性障碍^[4-5]。在成人期继发的心理健康和行为问题包括社交关系困难、就业困难、酒精和物质滥用^[4-5]。青春期出现的品行障碍可能发展成为犯罪行为 and 人格障碍; 焦虑可能发展成为强迫障碍, 青春期易患抑郁, 而易冲动性则可能造成自杀行为。如果不能获得可靠的儿童期发育信息, 则可能很难进行注意缺损多动障碍与成人的双相障碍的鉴别诊断。

5.5 非药物干预措施 一个很有帮助的措施是对家长进行教育, 让家长了解孩子的心理问题, 并给家长提供管理困难行为的专业建议。医生可以给家长提供网上的教育资料, 也可以给家长提供书面的教育手册^[5]。在学校, 老师可以采用专门的教育技术来帮助这些孩子, 比如把某个任务分解成很多简单的步骤, 让孩子逐步地完成; 改变学校和教室的环境, 减少让孩子分心的影响因素; 多鼓励孩子, 对孩子取得的小进步给予及时的表扬等。

可以让孩子使用“核对清单”, 帮助孩子更好地管理自己的活动, 比如“穿衣服的清单”、“准备书包的清单”。还可以采用清晰的“每日活动表”, 帮助孩子安排每天的活动。

如果具有适应证 (如焦虑), 可以给孩子提供心理学治疗。可以采用放松练习的方法, 或让孩子接受参与社交技能的培训^[5]。

目前还没有充分的证据表明改变饮食的措施对孩子的帮助。有些成瘾性的食物 (如酒石黄, 一种黄色的人工色素) 可能会刺激孩子不好的行为^[5]。

5.6 医学管理措施 有大量的证据表明, 中枢兴奋性药

物^[4-5] (如利他灵和硫酸右旋苯丙胺) 可以在三年内减弱注意缺损多动障碍的症状, 改善学习, 克服孩子的家庭和社交问题。到目前为止, 还没有发现这类药物的长期效果。中枢兴奋性药物是短效的 (2~6 h), 通常每天服用2~3次。不过晚上不要服药, 以免影响孩子的睡眠。这些药物的常见不良反应包括抑制食欲 (以及青春期成熟迟滞)、头痛、焦虑和烦躁不安、抽搐、出现失眠 (不过失眠也是注意缺损多动障碍的一个症状)。很少出现的不良反应有心悸和血压轻微升高, 因此需要在临床上进行监测; 还有很少的患者出现精神病性症状的不良反应。

药物治疗计划应该由专家提出, 不过全科医生可以每周对孩子进行监测, 观察药物的治疗反应。一旦出现了稳定的药物作用, 全科医生可以改成每个月监测一次。需要注意的是, 某些儿童甚至家长可能会非法地使用这类药物。

全科医生对孩子的监测应该包括血压、脉搏、身高、体质量、睡眠、食欲、抽搐情况、心境等。如果需要在10个小时内保持稳定的药物浓度, 或服药依从性和服药管理上有问题, 那么可以使用缓释的中枢兴奋剂。二线的治疗药物包括托莫西汀、丙咪嗪、可乐定。目前认为神经松弛剂 (如利培酮) 对缓解症状的效果不明确, 不过如果孩子出现进攻行为或不稳定心境, 可以由专家决定是否使用这种药物。对于全科医生来

说, 一个最好的监测方法是采用“症状核查清单”对患儿的治疗反应进行监测。

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· World General Practice/Family Medicine ·

[Introduction of the Column] The Journal presents the Column of Case Studies of Mental Health in General Practice, with academic support from Australian experts in general practice, psychology and psychiatry from Monash University and the University of Melbourne. The Column's purpose is to respond to the increasing needs of mental health services in China. Through study and analysis of mental health cases, we hope to improve understanding of mental illnesses in Chinese primary health settings, and to build capacity amongst community health professionals in managing mental illnesses in general practice. Patient-centred whole-person approach in general practice is the best way to maintain and improve the physical and mental health of residents. Our hope is that these case studies will lead new wave of general practice and mental health development both in practice and research. A number of Australian experts from the disciplines of general practice, mental health and psychiatry will contribute to the Column. A/Professor Blashki, Professor Judd and Professor Piterman are authors of General Practice Psychiatry. The Journal cases are helping to prepare for the translation and publication of a Chinese version of the book in China. We believe Chinese mental health in primary health care will reach new heights under this international cooperation.

Case Studies of Mental Health in General Practice (19)

—Childhood Mental Health

Bruce Tonge, Leon Piterman, Fiona Judd, Grant Blashki, Hui Yang

[Key words] Attention deficit hyperactivity disorder; Childhood; Mental health; General practice

Compared to adults, children, particularly boys, are often

relatively inattentive, impulsive and busy (hyperactive). If these behaviours are much more excessive and pervasive than expected in a child of the same developmental age, and cause impairment in the child's social life and learning, then the child has the neurodevelopmental condition of Attention Deficit Hyperactivity Disorder (ADHD)^[1]. Prevalence estimates vary because of differing diagnos-

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tic criteria and cultural and social factors from about 1.5% of 6 – 12 year olds in Europe, to 5% in the USA^[1]. In China, estimates vary widely from 1% – 14%^[2] and about 6% in Hong Kong^[3]. There are only several hundred specialist clinicians available in mainland China with expertise in ADHD therefore the condition is greatly underdiagnosed and undertreated, usually with herbal remedies. Under diagnosis might also be influenced by the stigma associated with mental illness in children^[2]. ADHD is twice as common in boys.

The General Practitioner plays a central role in assessment and management because they understand the family, social and cultural environment of the child. The GP can assess whether the behaviour is developmentally excessive, and if services are available, refer on for assessment to a specialist paediatrician or psychiatrist. The GP can then follow up and monitor treatment and link the family into local support services and liaise with the school^[4].

1. History

Anthony L is the 8 year old son of Chinese parents currently living in Australia for business and study reasons. Anthony attends a local primary school. In class he cannot sit still, interrupts the teacher, runs out of the room, keeps touching other children on the head and is unable to complete any schoolwork. He is friendly but cannot persist in games. He has difficulty writing and reading even though he speaks English well. At home he is constantly moving. He is unable to focus on a game, sit still to eat a meal, or watch the TV. He cannot complete tasks such as dressing himself. He has difficulty settling to sleep but is then up early and does not stop all day. He interrupts the conversation of his parents and visitors. His parents love him but are upset and stressed by his constant demanding behaviour and school failure. Recently he has been refusing to get ready for school, complaining of stomach pains and is distressed when his parents take him to school but he does settle quickly after they leave him. On questioning regarding Anthony's family history it was discovered that a paternal uncle and young adult male cousin have a history of learning difficulties, impulsive antisocial behaviour and unstable employment.

2. Developmental history

The pregnancy was normal although Anthony's mother smoked cigarettes heavily, a habit she has now ceased. Delivery was at full term but labour was precipitous (1.5 hours). Anthony was born blue requiring suction and oxygen with Apgar score of 2 at one minute and 6 at five minutes. Anthony has remained relatively small for his weight and height (5th percentile). He was an irritable and restless baby who had difficulty settling to breast feeding and slept poorly. He walked at 12 months but was delayed in the development of his fine motor skills and handedness. He still does not have a clear hand preference. A developmental assessment revealed a scatter of abilities in the low normal range but with delay in short term auditory memory and fine motor skills.

3. Examination

Throughout the consultation, Anthony was on the move from one toy to another without completing an activity such as assembling a toy train track. He often interrupted his parents with irrelevant comments but was friendly and made good eye contact. When asked to draw a person he was easily distracted for example by a faint

noise outside the room. He needed prompting to complete the drawing which lacked detail and was immature for a child his age. When asked to draw a person he used a clumsy pencil grasp. When asked to write his name and a simple sentence, the letters were uneven in size and spacing with some omission and the spelling was incorrect.

On physical examination his vital signs were normal, including abdominal and neurological examination, which were both unremarkable.

4. Questions

- 4.1 Question 1: What is the most likely psychological diagnosis?
- 4.2 Question 2: What are the associated psychological or neurodevelopmental problems and differential diagnoses to consider?
- 4.3 Question 3: What further assessment and investigations should be considered?
- 4.4 Question 4: What causes ADHD?
- 4.5 Question 5: What non – pharmacological intervention should be considered?
- 4.6 Question 6: What medical management would be the appropriate for Anthony?

5. Answers

- 5.1 Answer 1: What is the most likely psychological diagnosis?

The likely diagnosis is Hyperkinetic Disorder (ICD – 10) or ADHD (DSM – IV) of the combined inattentive hyperactive type^[1,4-5]. He has developmentally excessive: inattention, hyperactivity, impulsiveness and disorganisation.

These symptoms severely interfere with his school work, social interactions, play and family life. The symptoms commenced before the age of seven, have persisted for more than six months, and are pervasive (occur in more than one setting).

- 5.2 Answer 2: What are the associated psychological or neurodevelopmental problems and differential diagnoses to consider?

Children with ADHD often have a range of other associated cognitive and emotional and behavioural problems. The most frequent of these which can be diagnosed according to the ICD – 10 are: (1) Specific developmental disorders of scholastic skills (for example with reading, spelling or arithmetic) or Motor Function or Speech and Language. (2) Conduct Disorders, such as Oppositional Defiant Disorder. (3) Emotional Disorders of childhood such as Separation, Phobic or Social Anxiety Disorder perhaps with somatic symptoms. (4) Mood Disorder such as a Depressive episode. (5) Tic Disorders. (6) Non – Organic Sleep Disorders. (7) Pervasive Developmental Disorder such as Childhood Autism. (8) Mental Retardation (Intellectual Disability).

For Anthony the GP should consider Specific Developmental Disorders with hand writing, reading, fine – motor skills (necessary to manipulate and hold a pencil) and language (short term auditory memory problems). He is unable to retain and work on verbal instructions which together with his distractibility mean that he often does not know what he is meant to be doing in class and is disorganised.

The GP should also consider Separation and Social Anxiety Disorders with school refusal and somatic symptoms of stomach pain. There are multiple underlying reasons for Anthony's anxiety about going to school including his increasing learning and social difficulties as well as the criticism of his behaviour and school failure

by the teacher and his parents.

5.3 Answer 3: What further assessment and investigations should be considered? The abdominal pain may need to be further investigated to rule out an organic cause prior to attributing the symptom to anxiety. The GP would investigate this pain at a simple level given that this situation specific in order to reassure the parents that the pain is related to his anxiety about going to school, and depending on the clinical presentation some simple tests such as a stool micro and culture or an abdominal x-ray may be warranted.

School report findings can be very helpful. Cognitive assessment for example IQ and learning ability tests may help get a more in depth picture of the child. Specialised tests such as EEG brain scan or even a Chromosome analysis maybe useful if a genetic disorder is suspected.

5.4 Answer 4: What causes ADHD? For some children with ADHD, the symptoms are the result of a specific brain disorder due to a condition such as Foetal Alcohol Syndrome or an acquired brain injury, or a genetic disorder such as Fragile X Syndrome. For most children, ADHD will be the result of an interaction of biological (genetic and familial influences), psychological (e.g. delay in the development of short term auditory memory) and social (family conflict and parenting difficulties) factors. Most children with ADHD also have other developmental and behavioural problems such as anxiety and school refusal, oppositional and defiant behaviour, tics, depression and irritability, learning difficulties (spelling, reading, numeracy) and problems with coordination and speech^[1,4-5].

In Anthony's case, the development of ADHD may be due in part to the neonatal effects on his brain of maternal tobacco use and a precipitous delivery and perinatal hypoxia. There may also be some paternal genetic influences given the family history of learning and behaviour problems.

Symptoms of ADHD usually improve as children mature. The majority will not qualify for a diagnosis of ADHD when they reach adulthood but many will still continue to have some symptomatic impairment in their daily life^[4-5]. Subsequent mental health and behavioural problems in adult life include difficulties with relationships, employment, and alcohol and substance abuse^[4-5]. The emergence of Conduct Disorder in adolescence can develop into criminal behaviour and Personality Disorder. Associated anxiety might develop into Obsessive Compulsive Disorder. Depression is an increasing risk during adolescence and suicidal behaviour can be a consequence of impulsiveness. If a reliable childhood developmental history is unavailable then differentiating ADHD from Bipolar Mood Disorder in adults can be difficult.

5.5 Answer 5: What non-pharmacological intervention should be considered? Parent education about the condition and advice on managing difficult behaviour, perhaps using an online or printed parenting programme can be helpful^[5]. Special educational techniques at school such as breaking tasks into simple steps, modifying the environment to reduce distractions and rewarding small achievements are helpful. The use of written checklists to help the child to be better organised can be very helpful, for example lists to guide dressing and school bag packing, and a clear timetable for daily ac-

tivities. Psychological treatment for the associated anxiety might be indicated such as the use of relaxation exercises and participation in a social skills training group^[5]. There is insufficient evidence on the benefits of diets to recommend their use, although some food additives such as tartrazine (yellow colouring) can adversely stimulate behaviour^[5].

5.6 Answer 6: What medical management would be the appropriate for Anthony? There is extensive evidence that stimulant drugs^[4-5] (methylphenidate and dexamphetamine sulfate) reduce symptoms of ADHD, improve learning, family and social problems for up to three years. To date there is no clear evidence of longer term benefits. Stimulant drugs are short acting (2-6 hours) and are usually given 2-3 times a day but not in the evening to avoid disturbing sleep. Common side effects include appetite suppression (with delay in pubertal maturation), headaches, anxiety and irritability, tics and initial insomnia (but this is also a symptom of ADHD). More rarely palpitations and minor increases in blood pressure (which need monitoring) and psychotic symptoms might occur.

Drug treatments should be initiated by a specialist but can be monitored weekly by the GP until a therapeutic response is established, then monthly. Occasionally illegal use of the drug by child or parent might occur.

The GP should monitor blood pressure, pulse, height, weight, sleep, appetite, tics and mood. Slow release forms of stimulant drugs might also be available if a more even level of medication is required over ten hours or if compliance and administration of the drug by the teacher is a problem. Second line drug treatments include atomoxetine or perhaps imipramine or clonidine. Neuroleptics such as risperidone have no clear benefit on symptoms of ADHD but might be used by a specialist for aggression or unstable mood. The use of a symptom checklist is the best way to monitor response to treatment.

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