Learning Assessment
& Neurocare Centre
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All enquiries & correspondence to:
48-50 Springfield Road
Horsham
West Sussex
RH12 2PD
Tel: +44 (0)1403 240002
Fax: +44 (0)1403 260900
Email: info@lanc.uk.com
www.lanc.uk.com
Also consulting at:
Harley House
London W1G 8PP

Risperidone in Comorbid ADHD and ODD/CD

To the Editor:

I would like to add our clinic's experience in the use if risperidone to that of Demb and Nguyen (1999). Although little has been written about its use in children, leaving clinicians somewhat unsupported, many clinicians managing children and adolescents with complex attention-deficit/hyperactivity disorder (ADHD) find it a very effective medication.

Our clinical specialises in the assessment and management of children and adolescents with ADHD and related conditions; we receive national and international referrals. We have found risperidone particularly useful in children with ADHD, comorbid with oppositional defiant disorder and conduct disorder (ODD/CD) of early onset. Some may have coexisting bipolar disorder.

We have been using Risperidone since 1003-combining it with methylphenidate or dextroamphenatmine-when a psychostimulant to treat the core symptoms, plus the addition of clondine or nortrptyline, plus psychosocial strategies, has not been effective in helping the ADD/CD symptoms.

Our recent audit data show that 38% of the 2,400 children assess had combined ADHD with ODD or CD; about half of these cases were of early onset. With appropriate medication in this early-onset group it was possible to obtain a very good response in 92%. Seventy-three percent of the total group needed a second medication to obtain this result. Clonidine was the medication most used. When clonidine failed, Risperidone was generally used.

Thirty children were treated with Risperidone. The ages ranged from 6 to 21 years. Twenty-eight had the diagnosis of combined ADHD, and 2 had inattentive plus impulsive ADHD. All had early-onset of ODD/CD as well. Twenty-nine of the 30 may have met the criteria for bipolar disorder, 50% had associated learning difficulties, 1 had associated Asperger's syndrome, and 3 had significant tics or Tourette's disorder in addition to ADHD.

The time interval between making the diagnosis and the institution of Risperidone treatment was between 0 months and 6 years, in most cases between4 and 24 months. In the interim other strategies had been tried. For example, clonidine had been previously used in the 28 of the 30 children. Only 2, because of the severity og their problems, were started directly on Risperidone.

The daily dosage used was between 0.5mg and 6mg. The doses did not appear to be related to age or weight, but to individual response. Fifty percent of the children required a twice-daily dosage, whereas in 12 children once daily was sufficient and 3 children required a three-time-daily regimen.

Results show that 20 (67%) of the 30 children showed a very significiant improvement in symptoms. Five of the 20 showed a moderate improvement and in 5 the Risperidone was stopped, either because of no improvement (in 2) or excessive weight gain (in 3). The most common side effect was excessive weight gain, occurring in 10 patients. Vomiting and drowsiness occurred in 1 patient each, 1 patient experienced withfrawal dyskinesia, but reinstitution of Risperidone and slower withdrawal produced no recurrence. The higher incidence of dyskinetic side effects reported by Demb and Nguyen was not shown in series.

All patients were requested to have liver function tests. These were undertaken in 15 patients and all had normal results.

The maximum period of treatment so far is 4 years. The impression is that most children have an ongoing need for Risperidone and discontinuation of Risperidone results in a recrudescene of symptoms.

These preliminary audit data show that Risperidone may have place in the management of children with ADHD with associated severe early-onset ODD/CD, when other treatments have proved unsuccessful. It is associated with very significant improvements in a high percentage of this difficult-to-treat population. Excessive weight gain has been the main side effect, and concerns about a high incidence of dyskinesia have so far not been substriated. The dosage of Risperidone used is generally less than that suggested for schizophrenia. Further controlled studies are necessary. Untreated, this group of children and adolescents have an extremely high incidence of long-term educational, psychiatric, amd antisocial morbidity, and any risks associated with the use of Risperidone need to be balanced against the poor prognosis of the untreated disorder in this group.

Geoffrey D. Kewley, FRCP
Learning Assessment and Neurocare Centre
West Sussex, England