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earls

William W. Dodson, MD, on

Reduce appetite suppression, insomnia in ADHD treatment

Appetite suppression and insomnia—both common, dose-related side effects of psychostimulants—can jeopardize treatment adherence for patients with attention-deficit/hyperactivity disorder (ADHD). The following strategies can minimize these effects.

First, wait and see

For most patients, the optimal psychostimulant dosage produces few or no side effects. Those that occur are usually minor, transient, and disappear as patients develop tolerance within days of starting medication.

The two most commonly used stimulants—methylphenidate and amphetamine—cause similar side effects.¹ No evidence suggests either is more effective or less tolerable than the other.

Fine-tune psychostimulants to the lowest dosage that produces maximum benefit and minimum side effects. If side effects persist beyond 7 to 10 days, the dosage is probably too high or the patient is taking another stimulating medication. Before you attribute insomnia or appetite suppression to psychostimulants, ask the patient if he or she is using a decongestant, caffeine, diet pills, systemic corticosteroids, systemic albuterol, or theophylline.

Counteracting appetite suppression

Approximately one-third of adult and pediatric ADHD patients report appetite suppression at therapeutic psychostimulant dosages, but in most patients this effect is transient or clinically

insignificant. If a child taking psychostimulants is not eating or gaining weight appropriately:

- suggest that parents plan mealtimes before the patient's next dose or give high-calorie snacks throughout the day. (This strategy, although recommended by the American Academy of Pediatrics, can be cumbersome and has limited long-term efficacy.)
- switch from amphetamine to methylphenidate or vice versa.
- add the antihistamine cyproheptadine, 4 mg, with morning and evening meals
- add mirtazapine, one-half of a 15-mg tablet at bedtime to stimulate appetite and initiate sleep.

If none of these interventions work, recommend drug holidays from ADHD medications as a last resort when impairment is lowest, such as during weekends, holidays, or summers.

Curbing insomnia

About 20% of prepubertal children and 75% to 80% of adults have difficulty falling asleep while taking ADHD medications.² For many patients it is not the medications but the mental and physical restlessness of ADHD that disturbs sleep. Take a careful baseline sleep history before start-

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ing psychostimulants to help you determine later if they are causing insomnia.

Avoid benzodiazepines, which may promote tolerance and dependence. I discourage using any hypnotic to treat insomnia that occurs as a side effect. Also avoid antihistamines (Benedryl, trazodone) that may leave the patient sedated the next day.

Try a trial nap. After fine-tuning the psychostimulant to the lowest optimal dosage, ask the patient to test his ability to sleep while on that dose by taking an afternoon nap. Most patients discover they can sleep well, proving to both patient and doctor that ADHD medications usually help sleep initiation or are sleep-neutral. A successful nap can ease a patient's fear that her medication will keep her awake.

Even the longest extended-release psychostimulant formulations do not last the 14 to 16 hours of a typical waking day. This no-risk trial nap reassures patients that they can take supplemental doses as prescribed to assist them through even the longest workdays, without fear of sleep disruption.

Time-release formulations smooth the abrupt kinetics and rebound activation seen with immediate-release psychostimulants. But for patients tak-

ing immediate-release formulations, reducing the day's last dose or taking the last dose earlier can often prevent medication-associated insomnia.

If insomnia persists, try:

- melatonin, 0.5 to 1.0 mg, at bedtime, 1 hour before bedtime, at sunset, or 6 hours before anticipated bedtime. I try to mimic the natural release of melatonin triggered by sunset, but no definitive data prove the most effective dosing time.
- alpha agonists such as clonidine, 0.1 to 0.2 mg at bedtime, or guanfacine, 1 to 2 mg at bedtime. These agents have proven efficacy for treating hyperactivity and sleep disturbances without causing tolerance but may be associated with nightmares in some children.³
- mirtazapine, one-half of a 15-mg tablet at bedtime.

References

1. Greenhill LL, Abikoff HB, Arnold LE, et al. Medication treatment strategies in the MTA study: relevance to clinicians and researchers. *J Am Acad Child Adolesc Psychiatry* 1996;35(10):1304-13.
2. Corkum P, Tannock R, Moldofsky H. Sleep disturbances in children with attention deficit/hyperactivity disorder. *J Am Acad Child Adolesc Psychiatry* 1998;37:637-46.
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