

Distinguishing between adult ADHD and mild cognitive impairment

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There is considerable overlap between symptoms of adult attention-deficit/hyperactivity disorder (ADHD) and mild cognitive impairment (MCI), including problems with sustained attention or concentration, anterograde memory, and executive functioning. Differentiating these clinical syndromes based on symptomatic presentation alone can be difficult, but considering the following factors can help you make a more informed diagnosis:

Neurodevelopmental disorder history.

DSM-IV-TR stipulates onset for some ADHD symptoms by age 7, although a DSM-5 Work Group is considering symptom onset as late as age 12.¹ Initial onset or a dramatic worsening of longstanding ADHD symptoms in middle-age or older adults is atypical for this neurodevelopmental disorder.

Detailed self-diagnosed symptoms.

Patients with ADHD usually can give a satisfactory history of their symptoms. Patients with MCI often are less able to provide a useful history because they have prominent difficulties with anterograde memory, which may be associated with emerging anosognosia.

Educational learning difficulties.

Patients with ADHD frequently have comorbid learning difficulties and substance abuse disorders, which are uncommon in MCI.

Rating scales.

When in doubt, use rating scales to assess for ADHD.² Ask your patient to complete the rating scale based on how he or she remembers behaving in

elementary through middle school, most of their adult life after age 20, and since symptom onset. Obtain collateral ratings from a reliable informant based on his or her knowledge of the patient's long-term behavioral functioning.

Worsening symptoms. The typical ADHD patient will have a "positive" screen for symptoms, but will report fewer and less severe symptoms from childhood or adolescence through young adulthood and into middle and older age. Suspect MCI when your patient or an informant reports a clear worsening of symptoms in recent months or years despite a lack of evidence of a significant intervening psychiatric disorder.

Psychopharmacotherapy. Patients with MCI usually do not benefit from medications for ADHD. Patients with ADHD often report improvement in at least some of their symptoms with psychopharmacologic treatment.

When your patient's history, rating scale assessment, and medication trials do not allow you to make a confident differential diagnosis, consider referring him or her for psychological or neuropsychological testing.

There can be overlap in psychometric test findings of middle-age and older adults with a history of ADHD and those who may have MCI. Still, MCI patients' cognitive difficulties usually are more concerning and dramatic, including problems with spontaneous recall as well as "recognition memory."

When findings from psychometric testing are equivocal because of possible co-



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occurrence, retesting in 12 to 18 months usually will help you make a reliable differential diagnosis. Specifically, progression of cognitive dysfunction—including evidence of worsening anterograde memory—is common in MCI but not in ADHD.

Current symptoms of major depressive disorder may further “muddy the waters.” However, parameters such as response to adequate medication trials, progression of

cognitive dysfunction, and worsening of test-based cognitive or neuropsychological deficits over time can be useful in reaching a satisfactory differential diagnosis.

References

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Worsening anterograde memory is common in MCI but not in ADHD



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