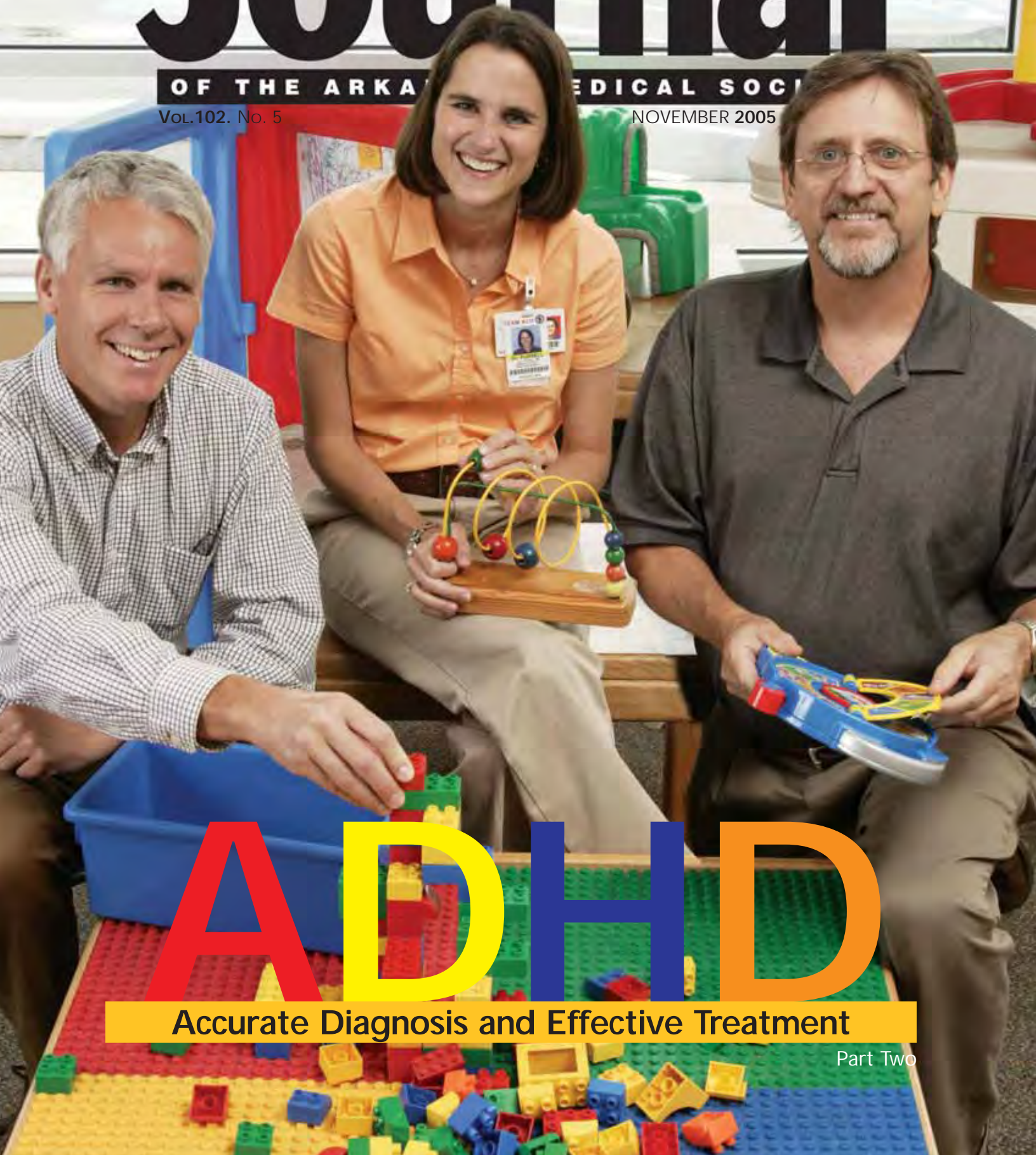


THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 102, No. 5

NOVEMBER 2005



ADHD

Accurate Diagnosis and Effective Treatment

Part Two

THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Winner of the ASAE Excellence in Communications Award

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Although a relatively common syndrome, there are many challenges to diagnosis and treatment of symptoms of Fibromyalgia. This thorough study by Dr. Bruce Safman of Arkansas Specialty Care Centers, is an effort to improve the likelihood of successful treatment and ultimately, improved quality of life for this grateful patient population.

Meet our Members

Michelle W. Eckert, MD, FACS

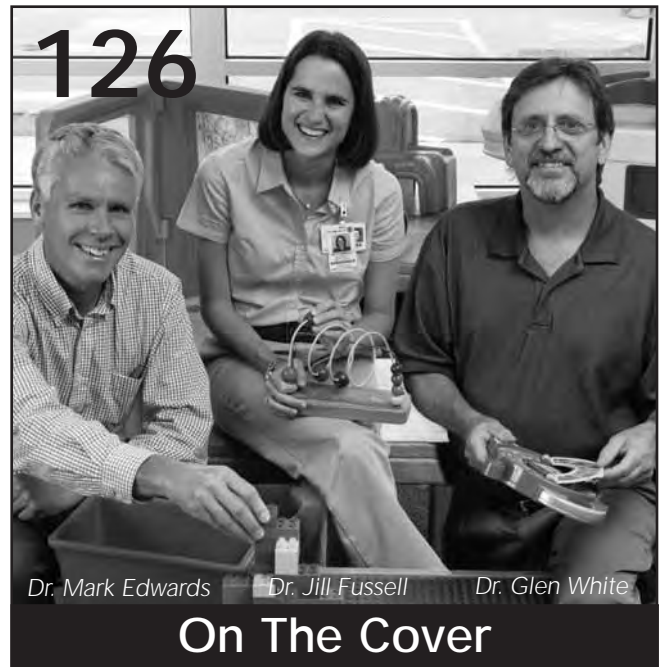


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We hope you enjoyed part one of our two-part series on ADHD, which focused on the severity of the disorder and on the experiences of an Arkansas patient's family. Part two takes an informative look at recommended ADHD evaluation, diagnosis and treatment guidelines.

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ADHD Part Two

Accurate Diagnosis and Effective Treatment

Part one of this two-part series considered ADHD from the perspective of a Little Rock family dealing with the disorder. In part two, we investigate – for health care providers and parents – the recommended evaluation, diagnosis and treatment options for ADHD in children and adolescents. Answers come from three area doctors – Dr. Glen White, Dr. Jill Fussell and Dr. Mark Edwards – all trained in the area of behavioral development and disorders.

Details for Diagnosis

When dealing with a possible case of ADHD, area experts agree that a detailed evaluation is critical to an accurate diagnosis. Jill Fussell, MD, earned her fellowship in developmental / behavioral pediatrics. She is an assistant professor of pediatrics at UAMS and course director for the residents' rotation in developmental pediatrics. Dr. Fussell said, "There is no single test that assures the diagnosis of ADHD, but there are specific guidelines available that if followed correctly, make a misdiagnosis less likely to occur." She relies on the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition – Text Revision (DSM-IV), published by the American Psychiatric Association in 2000.

DSM-IV spells out nine symptoms of inattentive ADHD and nine symptoms of hyperactive / impulsive ADHD; it indicates that at least six from each list of symptoms be present in order to meet diagnostic criteria. "The patient must

not only exhibit symptoms," said Dr. Fussell, "but also exhibit them in a way that is excessive and inappropriate for age and gender." Even more than that, DSM-IV requires that symptoms be present in at least two settings, usually home and school.

In addition to the required number of symptoms present, age is an important and required criterion. According to DSM-IV, ADHD presents early. It states that symptoms must manifest before age seven for a diagnosis. Even if the patient is evaluated and diagnosed later than age seven, the physician must be able to identify a history of symptoms from very early years. Dr. Fussell concluded, "If there aren't enough symptoms, or if symptoms don't occur in more than one setting, or if symptoms don't date back to early life, or if they're not inappropriate for age and gender, then they are likely better explained by another diagnosis.

"That's my concern about misdiagnosis. If physicians aren't following DSM-IV to the letter, they might not be ruling out better explanations before assuming it's ADHD. ADHD is not the only explanation for inattentiveness or distractibility. My job is to make sure that I can't come up with a better explanation first. Diagnosing ADHD is a last resort."

Primary Care Versus Specialty

With so many things to consider during an evaluation, can a primary care physician (PCP) or general practitioner – as opposed to a specialist – do what's necessary to diagnose ADHD?

The American Academy of Pediatrics (AAP) provides many resources for clinicians on the standards of diagnosis and treatment of ADHD (aap.org). However, AAP also mentions the possibility of referral to a sub-specialist if certain concerns are present (mental retardation, development or learning problems, anxiety or depression, or possible presence of seizures — to name a few). Also, AAP stresses that for an accurate diagnosis, pediatricians must gather information from parents and other caregivers, which would include the child's classroom teacher or another school professional.

According to Mark Edwards, PhD, it takes a lot of time to assess for ADHD, which may itself be a reason for referral. Dr. Edwards works for UAMS, primarily out of the James L. Dennis Development Center (DDC), an interdisciplinary clinic that takes on some of the state's worst behavioral cases. From DDC, Dr. Edwards conducts various training activities and research related to kids with behavioral problems. "The physician needs to recognize when referrals are a good idea. ADHD crosses so many disciplines that all of us need to be sensitive to that," said Dr. Edwards. "There are a variety of things that could look like ADHD, or co-exist with it, that you would want to rule in or out. The danger is that if you get the diagnosis wrong, you could delay effective treatment."

Aside from whether parents go to their child's pediatrician or to a specialist for an evaluation, Edwards encourages them to learn as much as they can

about the process. He recommends parents read Peter S. Jensen, MD's "Making the System Work for Your Child with ADHD," or information from organizations like Children and Adults with Attention-Deficit / Hyperactivity Disorder or the National Institutes of Health. "Parents need to be good consumers about the type of evaluation their child will need. It can't be done in 15 minutes," said Edwards. "It's fair game to ask the physician, 'In addition to talking to me, what else are you going to use in your evaluation?'"

Drugs or Behavioral Intervention

Dr. Edwards and Dr. Fussell, as well as Dr. Glen White, a psychologist and director of training for the UAMS Clinical Psychology Internship Program, all clearly stress that of the many treatments being recommended for ADHD, only a few are heavily supported by research. "If you get on the Internet, there are all sorts of herbal and other kinds of interventions," said Dr. Edwards. "We typically don't recommend those because they're controversial, and we're not sure they work. We try to only promote those interventions that are thought to be effective."

Of all the remedies being propagated, are medications – particularly stimulants – the best treatment for ADHD in children and adolescents? The answer, though surely a disappointment to those who openly condemn such medication for our children, seems to be a definite yes. "The research done on ADHD treatment continues to make one thing very clear," said Dr. White. "The single most effective treatment for kids with ADHD remains stimulant medication."

That's not the end of the story, however. Dr. Edwards, Dr. White and Dr. Fussell each emphasize that there's more to it than simply putting an ADHD child or adolescent on stimulant drugs. "Medications – specifically the stimulants methylphenidates and amphetamines – are the only treatments that address the underlying problems of ADHD," said Dr. Edwards.

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"Effectiveness of medications is without dispute. However, medication is controversial, brings with it side effects and rarely solves everything."

All three doctors express respect for the same recent study sponsored by the National Institute of Mental Health (NIMH) entitled *The Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder* (MTA Study). Dr. Fussell notes that the MTA Study is considered a *clean* study because it is not sponsored by pharmaceutical companies or other groups that might benefit from its results. The study indicates that the patient, family and those in association with the patient report the most satisfaction from a combination of medication and behavioral interventions.

Treatment Challenges

Both medication and behavioral intervention can be a challenge to all involved. "With medication, titration is a huge issue," said Dr. Edwards. "As a non-physician, I'm speaking about patients I see whose medications aren't adjusted properly. With stimulants, there's no formula for dosage. Sometimes, if physicians aren't comfortable with the use of medications, they'll give up too quickly. They'll be reluctant, for example, to try the next dose level up, which might be the very dose that the patient would do well on."

Dr. Fussell, a physician, agrees that there's a need for patience and attention to detail when it comes to medicine. "Different doctors have more or less of a comfort level for titrating doses of stimulant medications. If they will just start low and monitor side effects, they can likely adjust to the right level for each patient," she said. "The good news is that there are so many choices for us now that parents and patients don't have to tolerate side effects to get the positive effect of medication."

Behavioral intervention amounts to changing circumstances, or conditions, of the situation in which the

patient exhibits symptoms. Making sure the child is getting what he or she needs at school and / or training parents to become "experts" on ADHD could also be considered behavioral intervention. Dr. Edwards points out things that can be done in the classroom: better communication between parents and teachers, seating the child close to the teaching area, breaking up work into smaller units and other positive adjustments to the learning environment.

"The behavioral side of treatment is sometimes a challenge," said Dr. Fussell. "Parents may not have access to help from their child's school, and they may not have access to behavioral treatment centers. At the very least, physicians should arm parents with books and support organizations to contact. We don't just hand the prescription over and say, 'this is the fix.' We're always recommending a combined approach to treatment."

Fussell also stresses that families who fear the stigma of ADHD and / or its associated medication should talk to a physician about their concerns. "To treat ADHD from strictly a behavioral intervention approach is surely an option, and it's up to the families to choose their treatment," she said. "They don't have to choose medicine; however, we would not continue to use medications if we didn't see more positive than negative from them."


Holly Mathisen, who was quoted in part one of this series, has dealt with her son Hill's ADHD for eight years. Hill takes medicine, and has also had behavioral interventions over the years. For her family, a combined approach of medication, intervention and good parenting is the key to her son's maturity about his disorder. "I would say that while my husband and I think he needs the AdderallXR to function at a normal level, we are also very hands-on parents – listening, watching, observing him," said Mathisen. "We strongly believe that this kind of parenting is key to helping an ADHD child."

Treatment over time and age

Symptoms and treatment preferences change as children progress into adolescence and adulthood. Dr. Fussell reports that hyperactive and impulsive symptoms seem to be less prominent over time and less likely to remain into adulthood. On the other hand, inattentive symptoms seem to persist more into adolescence and adulthood. "If there are still symptoms into adulthood that are causing impaired functioning, treatment is still appropriate," said Dr. Fussell.

Functional impairment changes over time and must be periodically reviewed. "Functional impairment is dependent upon your job in life at a particular age. If inattentiveness or hyperactivity interferes with that job, that's functionally-impairing ADHD," said Dr. Fussell. "For school-aged children, their 'function' is to go to school, pay attention, complete assignments and develop friendships. For adolescents, it's maintaining relationships, following rules and resisting temptations to participate in impulsive, risk-taking behaviors. For adults, it might be reporting on time to work, remembering to pick up groceries and being reliable for their families."

So, length of treatment may or may not last into adulthood. Hill hopes to end his medication treatment for he plans to someday join the U.S. Marine Corps. Such a path, according to his research, cannot include ADHD medication. For Hill, and for anyone living with ADHD, it really depends on ability to function. Dr. Edwards recommends good communication with your physician and, as a rule-of-thumb, a period of withdrawal once per year. Edwards said, "This is not a life-threatening disorder; however, treatment does enhance performance."

Our thanks to Holly and Hill Mathisen, Dr. Glen White, Dr. Mark Edwards, Dr. Jill Fussell, Susan Jeeter and the many other invaluable sources who made this informative series possible. For more information about dealing with ADHD, visit www.chadd.org or www.nih.gov and see the following page of resources. 

ADHD Resources

Websites:

ADD Consultants:

<http://www.addconsults.com/>

Focus on ADD:

<http://www.focusonadd.com/>

Center for Disease Control (CDC) – ADHD Section:

<http://www.cdc.gov/ncbddd/adhd/default.htm>

American Academy of Child and Adolescent Psychiatry:

<http://www.aacap.org/>

Attention Deficit Disorder Association:

<http://www.add.org/>

Comprehensive Treatment for Attention Deficit Disorder:

<http://ctadd.net>

The Incredible Years (Model Program):

www.incredibleyears.com

ADD Coaches:

Edie Bradbury, ADHD Coach

Springdale

Fee: \$200.00 / month or by

agreement

Contact: Edie Bradbury is not individually endorsed by the Arkansas Medical Society.

Powrcoach@aol.com, or 479-263-9723

Support Groups:

Jacksonville

Greater Little Rock Area CHADD

Liz Heller

501-688-0093 or 501-837-3323

Personal email: lheller@aol.com

Chapter email: lrchadd@aol.com

Fort Smith

National Educational Campaign on Attention Deficit Disorders (NECADD)

Sharyn Floyd

501-783-7646

Mountain Home

Mountain Home, AR CHADD

870-424-3306

Jonesboro

Northeast Arkansas CHADD

870-935-9397

Little Rock

Anchorpoint Psychological Services

Mike Parker, PhD Licensed Psychologist

501-312-9900

Suggested Reading for Parents and Children:

Galvin, M.

Otto Learns about his Medication.

New York: Magination Press. 1988.

Moss, D.

Shelly the Hyperactive Turtle.

Rockville, MD: Woodbine House. 1989.

Nadeau, K., and Dixon, E.

Learning to Slow Down and Pay Attention.

Annandale, VA: Chesapeake Psychological Publications. 1993.

Quinn, P., and Stern, J.

Putting on the Brakes: Young People's Guide

to Understanding Attention Deficit Hyperactivity Disorder.

New York: Magination Press. 1991.

Bain, L. A.

Parent's Guide to Attention

Deficit Disorders.

New York: Dell Publishing. 1991.

Barkley, R.A.

Taking charge of AD/HD: The complete, authoritative guide for parents.

New York: Guilford. 1995.

Dendy, C.

Teenagers with ADD: A parents' guide.

Bethesda, MD: Woodbine House. 1995.

Barkley, R.A., & Murphy, K.R.

Attention-deficit hyperactivity disorder: A clinical workbook. (2nd ed.).

New York: Guilford. 1998.

Suggested Reading for Professionals:

Barkley, R.A.

Defiant children: A clinician's manual for parent training.

New York: Guilford. 1987.

Barkley, R.A., & Murphy, K.R.

Attention-deficit hyperactivity disorder: A clinical workbook. (2nd ed.).

New York: Guilford. 1998.

Chamberlain, P. & Patterson, G.R.

Discipline and child compliance in parenting. In M.

Bornstein (Ed.), *Handbook of parenting: Vol. 4.*

Applied and practical parenting. (pp. 205–225).

Mahwah, NJ: Lawrence Erlbaum Associates. 1995.

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For more information, call (800) 262-3211 ext. 4761, or register online at www.ama-assn.org/go/omss today.



Michelle W. Eckert, MD, FACS

Female. This one word is just one of many adjectives describing Michelle Eckert, MD. Other described terms could easily include *trained, skilled, and dedicated*. Dr. Eckert is the first female surgeon in Pine Bluff; this fact is neither a hindrance to her ability to serve her patients nor a factor in how her colleagues and patients perceive her. If anything, she has learned it's a plus. "Although there are more women in medicine these days and even in surgery, a woman surgeon in a rural area is still new. My female patients are excited to see a 'lady surgeon,' as they call me," said Dr. Eckert. "The surgeons here in Pine Bluff and the medicine docs of the area have been very supportive. It is a big compliment to them that I am thought of as a surgeon and not singled out because I'm a girl."

Her childhood in Bogalusa, Louisiana, influenced her choice to pursue medicine and ultimately, to become a surgeon. "My grandmother had a dairy farm. For a while, I wanted to be a veterinarian," said Dr. Eckert, who later leaned toward medicine. "Also, there was only one surgeon in Bogalusa. Most people had to go to New Orleans to have surgery. My grandmother had Hodgkin's Lymphoma. Of her doctors, I was most impressed with the surgeon. During medical school, surgery appealed to me, so that is what I decided to do."

Another huge influence on her life has been her college sweetheart and husband of ten years, Commander John L. Eckert, PhD, who is with the U.S. Public Health Service. "With him, I am able to do all that I do. I love him for that," said Dr. Eckert.

After surgical training, Dr. Eckert put her skills to work for patients in Pine Bluff, Arkansas. She's in private practice there, and is associated with South Arkansas Surgical Associates. Her work as a general surgeon includes thoracic, vascular, endocrine, breast, laparoscopic and trauma surgery and other types of

general surgery. "Of the areas I deal with, laparoscopic surgery is very rewarding. Laparoscopy has revolutionized the way we think about gallbladder, appendix and hernia surgery," said Dr. Eckert. "The healing process is much easier on patients. The procedures themselves are easy to do, and the visualization is fantastic."

Dr. Eckert works daily to provide excellent surgical care and to educate patients about preventive measures. "It's a fair assessment that if people took better care of themselves, a lot of medicine and surgery could be avoided," she said. "If people took better care of their diabetes and hypertension, they hopefully could avoid kidney failure and dialysis. If you do not play with firearms, you are less likely to incur a firearm injury. I love what I do, but if someone told me that I would never have to take care of another gunshot wound or stab wound, I would not cry."

In her younger days, Dr. Eckert lived for hobbies like band, writing and reading. Since moving to Pine Bluff in 2000, she's developed a love for things outdoors. "My practice partner took me duck hunting during my first winter here," said Dr. Eckert. "I loved being out in the woods, listening for the ducks, watching the dogs work. I decided that if I was going to hunt with the boys, I'd better learn to shoot."

She sure enough learned to shoot! Currently, Dr. Eckert is the 2004 Ladies Arkansas State Champion in Skeet 410- and 28-gauge shotgun event, the 2004 Reserve Ladies Arkansas State Champion in Skeet 12- and 20-gauge shotgun

event, and the 2005 Reserve Ladies Arkansas State Champion in Sporting Clay 28-gauge shotgun event. "I found that I loved shooting the targets," she said. "There is something therapeutic about breaking small, orange targets into a million pieces. I get to improve my eye / hand coordination and meet all kinds of people not in the medical field. It also helps me relate to so many of my patients who hunt."

A colleague once told Dr. Eckert about a conversation he had overheard in a hunting store," she said. "He overheard one man (speaking about me) say, 'if she can operate as well as she can shoot, I'll let her be my surgeon.'"

This sharp-shooting, female surgeon loved hearing that story. Who would have thought that her hobby would prove to be one of the best testaments

to her skill as a surgeon? "I hope to continue to enjoy the sport and maybe even one day shoot my pager at 30 yards!" **AMS**

