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Case Study 5- ADHD

Comment on the difference in medical practice US/Canada vs Europe

Introduction

- *Many names are used to describe a wide spectrum of impairment*
 - ADD
 - ADHD
 - HKD
 - Further classification into latent classes etc.
- *For brevity, I will refer to ADHD*



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Difference between the US and Europe?



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The Worldwide prevalence of ADHD: is it an American Condition?

Faraone et.al ., World Psychiatry 2003.

- *13 studies from 1982-2001.*
- *Concluded that prevalence of behaviors in other countries that meet criteria for ADHD is in the same range as in the USA.*
- *Differences in prevalence stem from a different definition of the disorder rather than true behavioral differences.*
- *Highest prevalence in countries using DSM IV.*
- *Main difference is in the rate of diagnosis.*

Difficulties in evaluating TUES for ADHD

- ADHD label refers to heterogenous set of symptoms*
- Symptoms are dimensional, causing disagreements about diagnosis.*
- Diagnosed at different rates in different places (DSM IV vs ICD 10, parenting styles, expectations of children, access to health care).*
- People hold different- and reasonable- views about goals of psychiatry and parenting.*
- People hold different- and reasonable- views about the best way to treat ADHD.*

Source: Facts, values, and ADHD: an update on the controversies; Child and Adol. Psy Mental Health, 2009.



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ADHD prevalence in the USA



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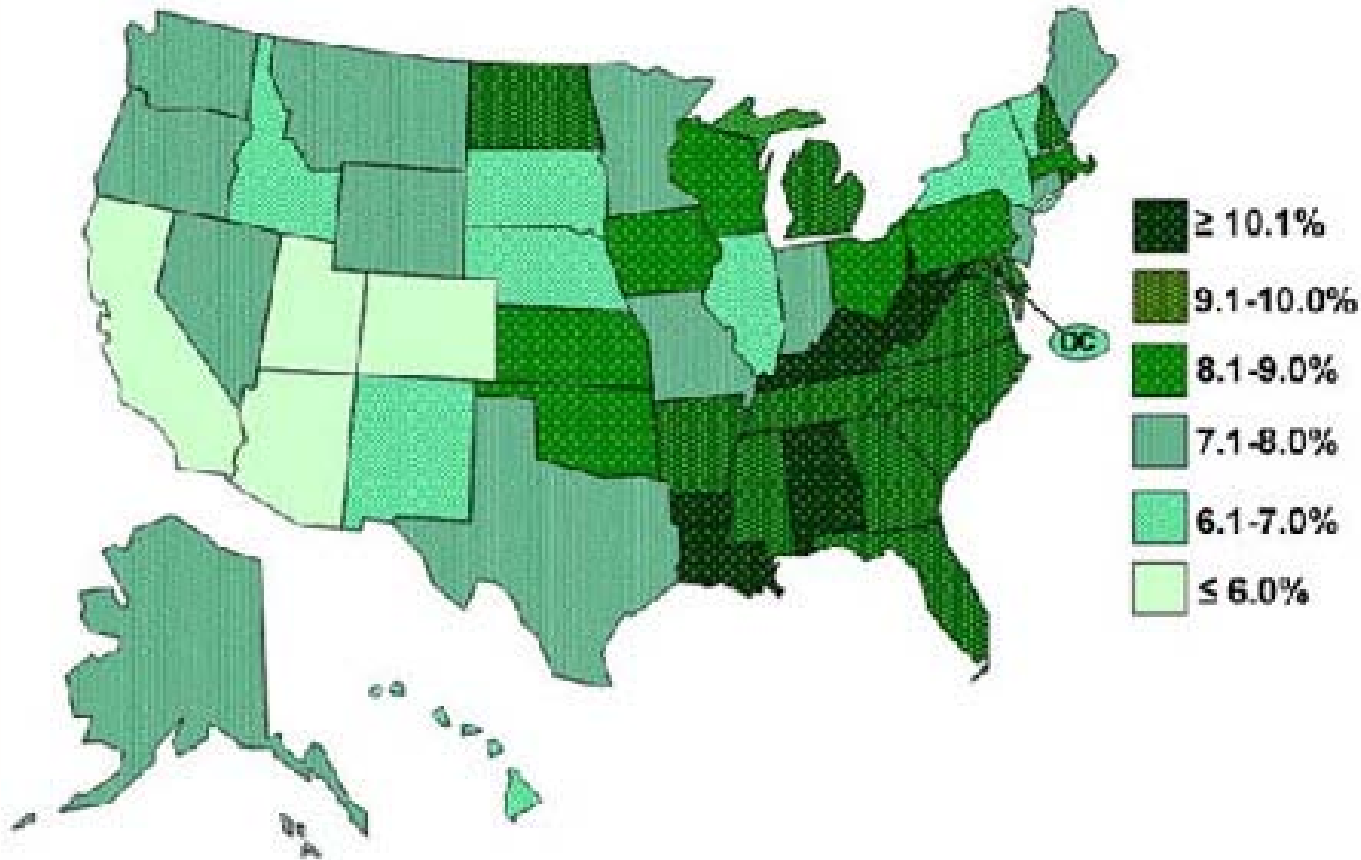


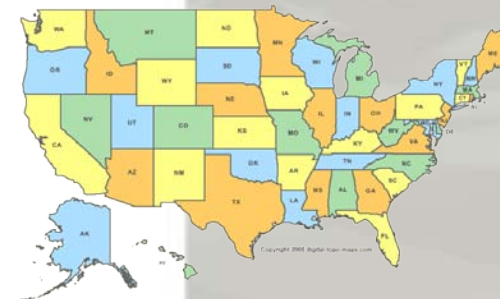
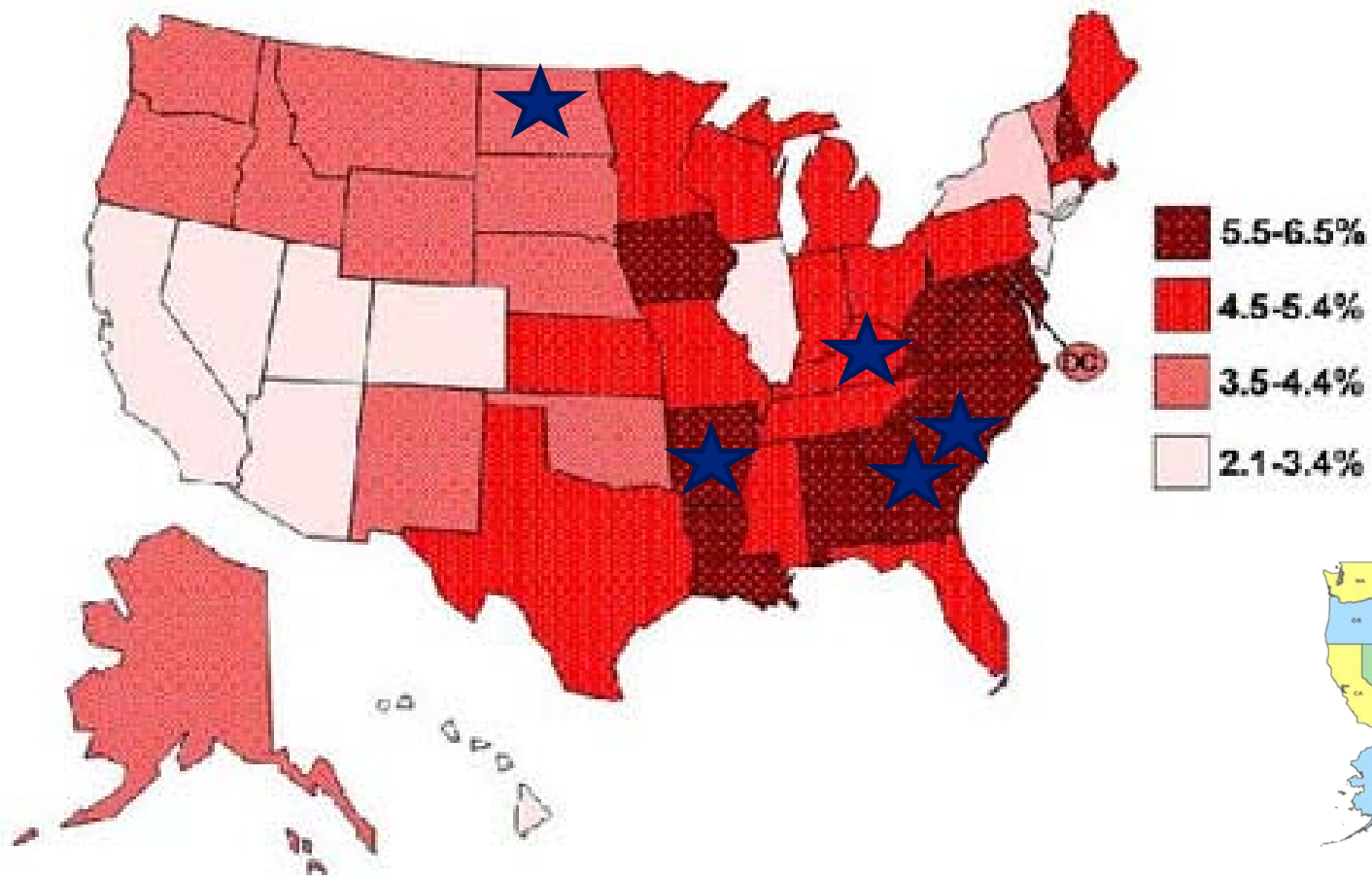
Diagram obtained from the Center for Disease Control Website:
<http://www.cdc.gov/ncbddd/adhd/prevalence.html>

Treatment of ADHD using Medication



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Differences in practice between US and Europe

- Approval rate for TUEs for stimulants to manage ADHD as of Nov 15 2009:

	USADA	European IF
Total Received	87	36
Returned for more info	33	6
Approve	31	23
Denied	4	1
No Action required	18	N/A
Pending	1	6

Conclusion: Relative harmony in terms of rates of approval between USADA and the Europe-based IFs. Any differences in clinical practice does not predict approval rates for TUEs (at least for US athletes).



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Medical Information to support the decisions of TUECs-ADHD

- *“A record of the onset of symptoms is required”*
- *“DSM IV or ICD-10 criteria.....must be met”*
- *“When ADHDappears at young age....demands a second expert opinion”*
- *Ongoing therapy requires annual review at minimum.*



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Case study #2- the 'Gold Standard'



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- *Write-up provided to you as a hand-out and contains:*
 - History of present illness, including statements from the athlete
 - Past psychiatric history
 - Medical history
 - Family psychiatric history
 - Developmental history
 - Mental status examination
 - Comment on standardized testing
 - General impression of prescribing physician
 - Diagnostics impressions
 - Recommendation
- *The application contained all of the documents cited in the write-up.*
- *However- is it realistic to expect all prescribing physicians to provide this much detail in an application? Can we agree on the minimum requirements for a “complete application”?*

Interactive Session

- *Discussion of minimal standards of an application*
- *WADA guidelines are flexible, and generally refer to the DSMIV as the standard diagnostic tool.*
- *Given this:*
 - What is the most persuasive evidence that determines if an application is approved or denied?
 - Would it be useful if such evidence was specifically stated in WADA Guidelines?



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Minimal Standards for an Application??

- Longitudinal data- to demonstrate chronic disorder. **YES/NO?**
- Symptoms across settings. **YES/NO**
- Collateral sources (Athlete AND Parent AND teacher description of symptoms) **YES/NO?**
- Athletes (and family's?) social and medical history **YES/NO?**
- Evaluation for co-morbid psychiatric disorders. **YES/NO?**
- Detailed rationale for treatment plan? **YES/NO?**



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For discussion: Optional items in TUE application?

- *Psychometric testing?*
- *Behavior rating scales?*
- *Diagnosis by psychiatrist (as opposed to general practitioner)?*
- *Second opinion?*
- *Evidence of trials with atomoxetine?*
- *Evidence of trials with behavior techniques?*



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Summary and Conclusion

- *Wrap up from interactive session, and*
 - consider areas of discord that stand in the way of mutual recognition efforts,
 - consider areas of concern with regard to diagnosis,
 - consider concerns for stimulant abuse.



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USADAs minimum standards



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- Longitudinal data- to demonstrate chronic disorder. **YES**
- Symptoms across settings. **YES-very important.**
- Collateral sources (Athlete AND Parent AND teacher description of symptoms) **YES-especially a description from the athlete about how they feel on and off of medication.**
- Athletes (and family's?) social and medical history. Helpful but not essential
- Evaluation for co-morbid psychiatric disorders. **YES-especially mood disorders**
- Detailed rationale for treatment plan? Helpful, but more important that athlete gets regular care.

Staterra as a permitted alternative

- USADA's experience is that most prescribing physicians feel atomoxetine is not effective, and they do not feel it should be used as first-line treatment.*
- Consensus of USADA TUEC is that a lack of trial of atomoxetine shall not be the basis for a denial.*



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DSM IV versus ICD 10-Risks



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- *Athletes with diagnosis of HKD according to ICD 10 may be considered to be at 'severe end' of DSM IV scale. Less likely to have denied TUE, but more likely some athletes are not diagnosed with a disorder which causes real impairment.*
- *Athletes with diagnosis of ADHD- 20 times more prevalent than HKD diagnoses. Greater potential for use of stimulants unnecessarily (although this may be value-based), and possibly abuse (easier to meet criteria).*

DSM IV versus ICD 10: 3 important differences.

- *ICD-10 more rigorous criterion for pervasiveness (full syndrome evident in two separate environments).*
- *ICD-10 defines a single disorder of inattention AND hyperactivity AND impulsiveness. DSM IV generally and/or with variety of subtypes.*
- *ICD-10 discourages multiple diagnoses (except for hyperkinetic conduct disorder). DSM IV recognizes multiple co-morbid conditions (depression, anxiety, conduct and oppositional defiant disorder, etc.)*



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