TRATAMIENTO DEL TDAH EN ADULTOS:

Medicina basada en pruebas

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de Salud Mental

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- **Introducción.**
- **Guías europeas TDAH adultos.**
- **Tratamiento farmacológico y psicológico.**
- **Conclusiones**

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- **Conclusiones**

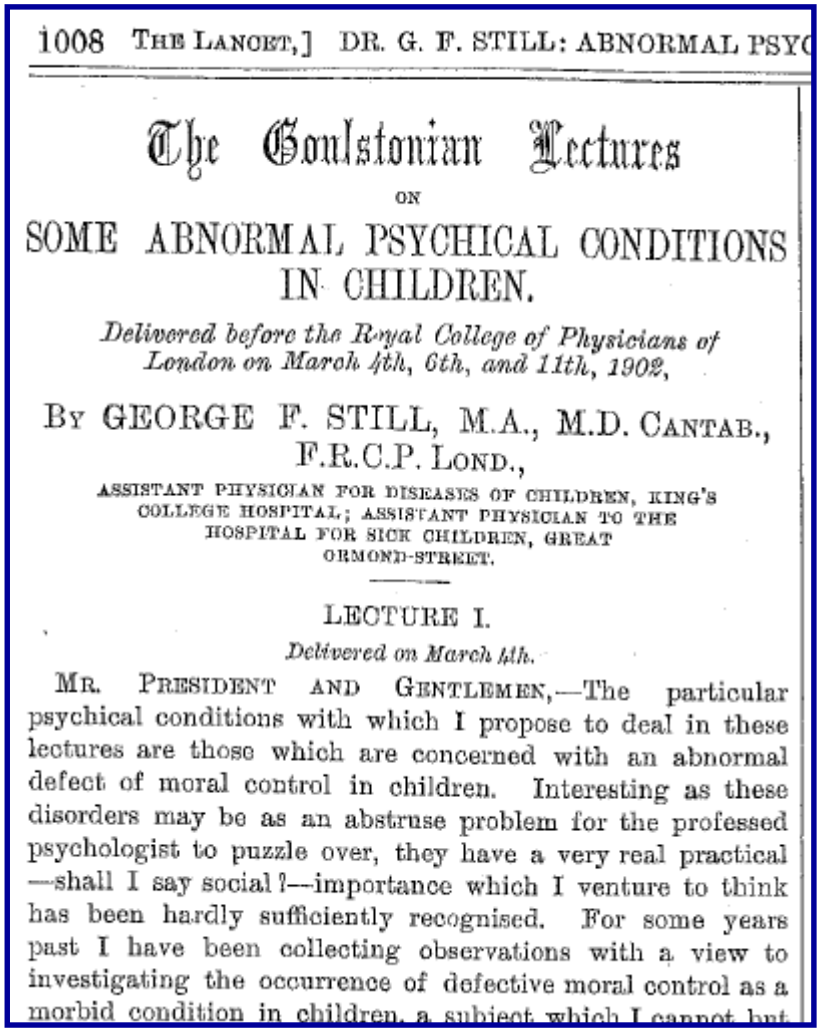
CONFLICTOS DE INTERÉS
Dr. Ramos-Quiroga

- **Janssen:** ponencias, consultor, becas
- **Lilly:** ponencias, consultor, becas
- **Laboratorios Rubio:** consultor, becas
- **Shire:** ponente, consultor, becas
- **Fundación Alicia Koplowitz:** becas
- **Instituto Carlos III:** becas, panel expertos
- **Institut Català de la Salut:** estatutario


El médico en casa
Comprender el
TDAH en adultos
Trastorno por déficit de atención con hiperactividad en adultos
Qué es y sus causas
Síntomas, diagnóstico y tratamiento
Vivir con TDAH
El futuro del TDAH
Dr. Josep Antoni Ramos-Quiroga
Lda. Rosa Bosch
Dr. Miguel Casas
Amat
editorial

DR. GEORGE STILL

1902



1008 THE LANCET,] DR. G. F. STILL: ABNORMAL PSYC

The Goulstonian Lectures

ON

SOME ABNORMAL PSYCHICAL CONDITIONS IN CHILDREN.

Delivered before the Royal College of Physicians of London on March 4th, 6th, and 11th, 1902,

BY GEORGE F. STILL, M.A., M.D. CANTAB., F.R.C.P. LOND.,

ASSISTANT PHYSICIAN FOR DISEASES OF CHILDREN, KING'S COLLEGE HOSPITAL; ASSISTANT PHYSICIAN TO THE HOSPITAL FOR SICK CHILDREN, GREAT ORMOND-STREET.

LECTURE I.

Delivered on March 4th.

MR. PRESIDENT AND GENTLEMEN,—The particular psychical conditions with which I propose to deal in these lectures are those which are concerned with an abnormal defect of moral control in children. Interesting as these disorders may be as an abstruse problem for the professed psychologist to puzzle over, they have a very real practical —shall I say social?—importance which I venture to think has been hardly sufficiently recognised. For some years past I have been collecting observations with a view to investigating the occurrence of defective moral control as a morbid condition in children, a subject which I cannot but

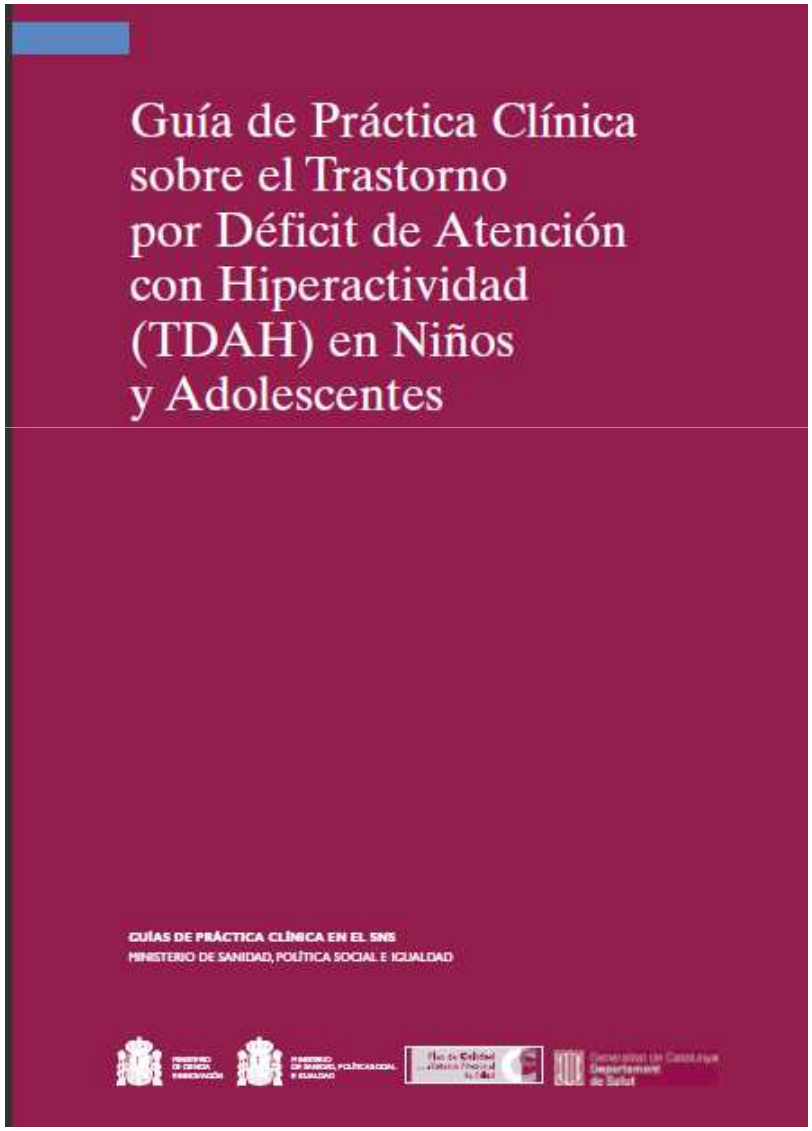
MANEJO DEL TDAH

MEDICINA BASADA EN PRUEBAS:

- **Las decisiones corresponden a un uso racional, explícito, juicioso y actualizado de los mejores datos objetivos aplicados al tratamiento de cada paciente.**

- **El objetivo primordial de la MBP es el de que la actividad médica cotidiana se fundamente en datos científicos y no en suposiciones o creencias.**

MEDICINA BASADA EN PRUEBAS



¿...PERO PODREMOS APLICARLA?

¿…PERO PODREMOS APLICARLA?

SITUACIÓN EN EUROPA

- **“NO” se dispone de ningún fármaco con indicación para el tratamiento de adultos con TDAH en la UE (excepto Alemania, para MTF pellets).**

- **Existen entre 10 y 20 millones de adultos con TDAH en la UE huérfanos de tratamiento.**

INVESTIGACIÓN EN EUROPA

- **European Network Adult ADHD.**

- **International Consortium Adult ADHD and Substance Abuse (ICASA).**

- **International Multicenter persistent ADHD Collaboration (IMpACT).**

SITUACIÓN EUROPEA

BJPsych | The British Journal of Psychiatry (2009)
194, 273–277. doi: 10.1192/bjp.bp.107.045245

Attention-deficit hyperactivity disorder: treatment discontinuation in adolescents and young adults

Suzanne McCarthy, Philip Asherson, David Coghill, Chris Hollis, Macey Murray, Laura Potts, Kapil Sayal, Ruwan de Soysa, Eric Taylor, Tim Williams and Ian C. K. Wong

SITUACIÓN EUROPEA

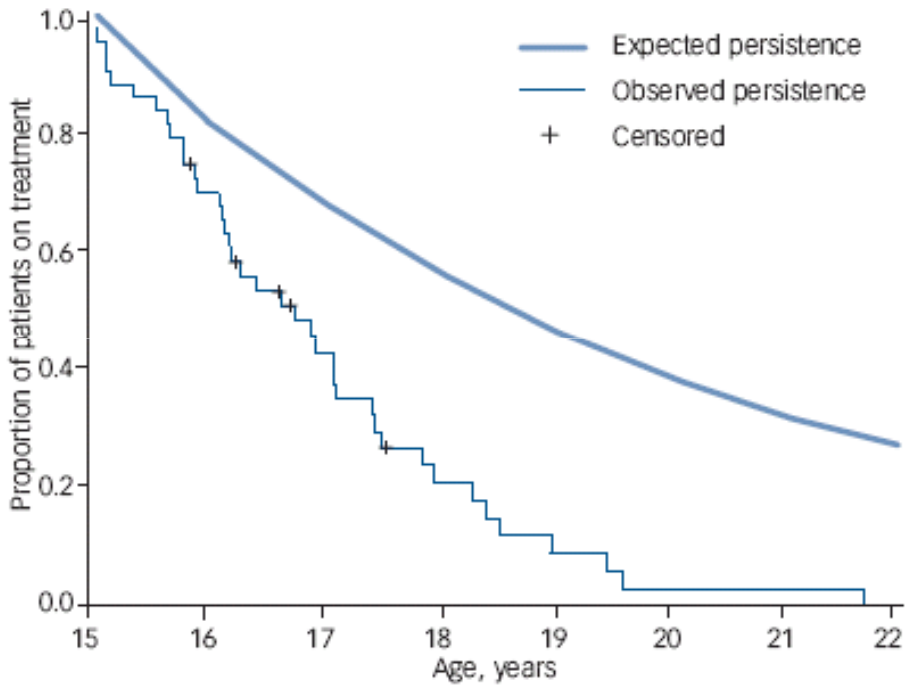


Fig. 2 Proportion of patients aged 15 years in 1999 remaining in treatment for each 1-year change in age (n=44) (expected persistence 83%).

BJPsych The British Journal of Psychiatry (2009) 194, 273–277. doi: 10.1192/bjp.bp.107.045245

SITUACIÓN EUROPEA

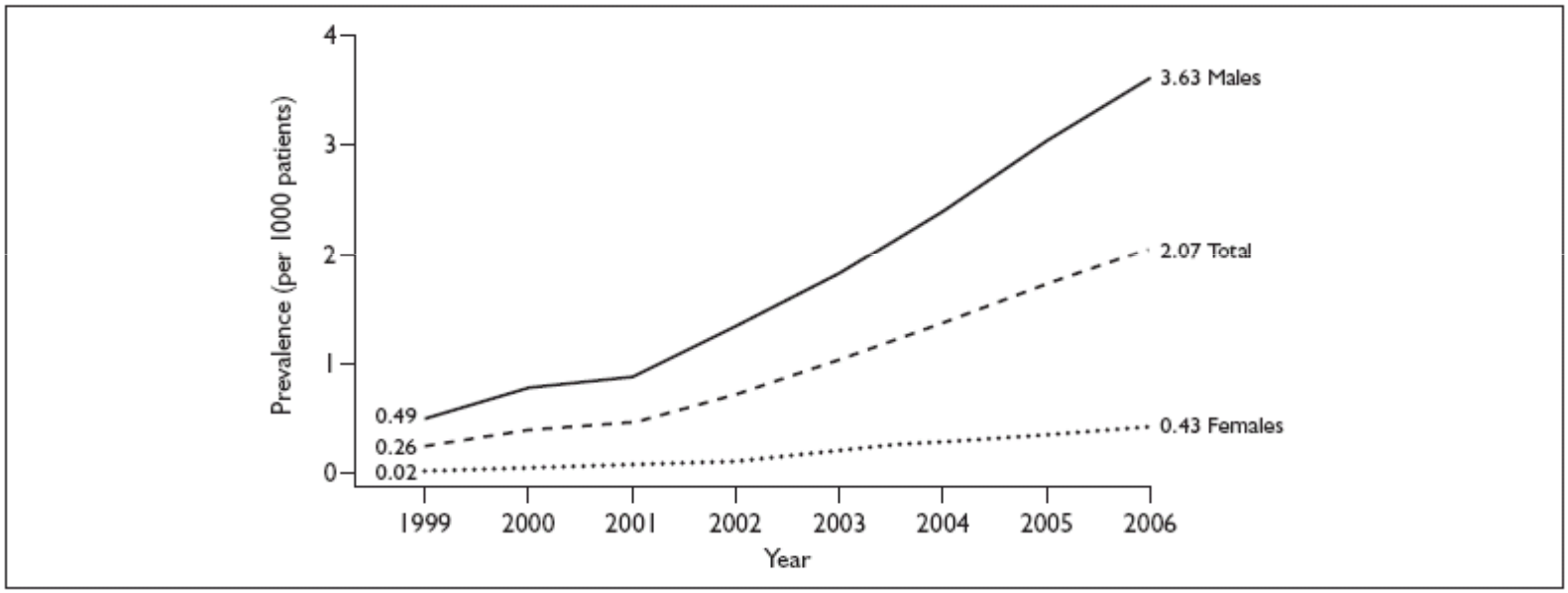


FIGURE 5 *Prevalence of prescribing of methylphenidate, dexamfetamine and atomoxetine to patients aged 15–21 years from 1999 to 2006.*

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GUÍAS EUROPEAS TDAH ADULTOS

- **British Association for Psychopharmacology (2007).**
- **National Institute for Health and Clinical Excellence (NICE, 2008).**
- **European Consensus (2010).**

British Association for Psychopharmacology (2007)

Table 1 Categories of evidence and strength of recommendations

Categories of evidence for causal relationships and treatment	
Ia:	Evidence from meta-analysis of randomized controlled trials
Ib:	Evidence from at least one randomized controlled trial
IIa:	Evidence from at least one controlled study without randomization
IIb:	Evidence from at least one other type of quasi-experimental study
III:	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies
IV:	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities
Categories of evidence for observational relationships	
I:	Evidence from large, representative population samples
II:	Evidence from small, well-designed, but not necessarily representative samples
III:	Evidence from non-representative surveys, case reports
IV:	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities
Strength of recommendation	
A	Directly based on category I evidence
B	Directly based on category II evidence or extrapolated from category I evidence
C	Directly based on category III evidence or extrapolated from category II evidence
D	Directly based on category IV evidence or extrapolated from category III evidence
S	Standard of clinical care

European Consensus: The European Network Adult ADHD (2010)

Kooij *et al. BMC Psychiatry* 2010, **10**:67
http://www.biomedcentral.com/1471-244X/10/67

REVIEW Open Access

European consensus statement on diagnosis and treatment of adult ADHD: The European Network Adult ADHD

Sandra JJ Kooij[1*], Susanne Bejerot[2], Andrew Blackwell[3], Herve Caci[4], Miquel Casas-Brugué[5], Pieter J Carpentier[6], Dan Edvinsson[7], John Fayyad[8], Karin Foeken[9], Michael Fitzgerald[10], Veronique Gaillac[11], Ylva Ginsberg[12], Chantal Henry[13], Johanna Krause[14], Michael B Lensing[15], Iris Manor[16], Helmut Niederhofer[17], Carlos Nunes-Filipe[18], Martin D Ohlmeier[19], Pierre Oswald[20], Stefano Pallanti[21], Artemios Pehlivanidis[22], Josep A Ramos-Quiroga[23], Maria Rastam[24], Doris Ryffel-Rawak[25], Steven Stes[26], Philip Asherson[27]

BMC Psychiatry 2010; 10-67

European Consensus: The European Network Adult ADHD (2010)

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- **European Network Adult ADHD:**

  40 profesionales, 18 países.

- **Reuniones de consenso:**

  3 entre 2003 y 2009.

- **Revisión de la evidencia.**

BMC Psychiatry 2010; 10-67

European Consensus: The European Network Adult ADHD (2010)

Kooij *et al. BMC Psychiatry* 2010, **10**:67
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- **Los síntomas del TDAH pueden ser tratados efectivamente en adultos.**
- **La ausencia de tratamiento en adultos con TDAH: alto impacto funcional.**
- **Tratamiento multimodal: farmacológico, psicoeducación, TCC, coaching y TF.**

BMC Psychiatry 2010; 10-67

European Consensus: The European Network Adult ADHD (2010)

Kooij et al. BMC Psychiatry 2010, 10:67
http://www.biomedcentral.com/1471-244X/10/67

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- **Primer paso:**

  PSICOEDUCACIÓN

- **Fármaco de elección:**

  METILFENIDATO o AMF.

- **Fármaco de segunda línea:**

  ATOMOXETINA

- **Otros:**

  BUPROPION, CLONIDINA, DESIMIPRAMINA, GUANFACINA, MODAFINILO.

BMC Psychiatry 2010; 10-67

European Consensus: The European Network Adult ADHD (2010)

Kooij et al. BMC Psychiatry 2010, 10:67
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- **Ajustar las dosis de metilfenidato de forma individual.**
- **Metifenidato de liberación prolongada mejora la adherencia al tratamiento.**
- **Combinaciones de metilfenidato de liberación prolongada y liberación inmediata.**

BMC Psychiatry 2010; 10-67

European Consensus: The European Network Adult ADHD (2010)

Kooij *et al. BMC Psychiatry* 2010, **10**:67
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- **Fobia social, TUS o inestabilidad emocional.**
- **Tratamiento de la comorbilidad: antidepresivos o eutimizantes.**
- **Los suplementos dietéticos no han demostrado eficacia en el tratamiento de los adultos con TDAH.**

BMC Psychiatry 2010; 10-67

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METILFENIDATO EN ADULTOS

ORIGINAL RESEARCH ARTICLE

CNS Drugs 2011; 25 (2): 157-169
1172-7047/11/0002-0157/$49.95/0

Efficacy of Methylphenidate for Adults with Attention-Deficit Hyperactivity Disorder

A Meta-Regression Analysis

Xavier Castells,[1,2] *Josep Antoni Ramos-Quiroga*,[1,3] *David Rigau*,[4] *Rosa Bosch*,[1] *Mariana Nogueira*,[1] *Xavier Vidal*[5] and *Miguel Casas*[1,3]

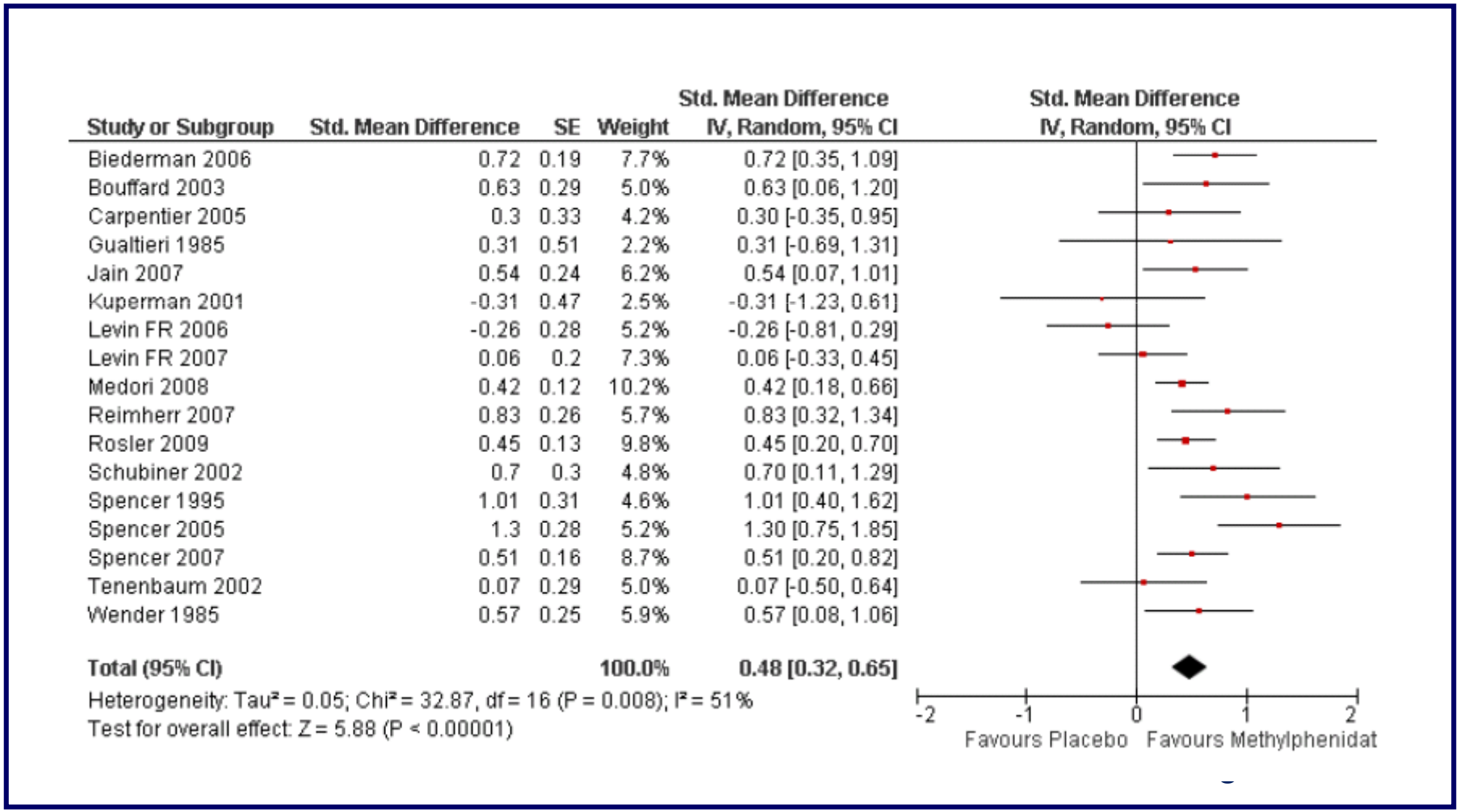
CNS Drugs 2011

METILFENIDATO EN ADULTOS

Reference	N of patients	Drug release formulation	Dose (mg/d)	Dose regime	Intervention length (d)	Diagnostic system	Comorbid SUD[1]	Design	Rater	Jadad score
Biederman 2006	149	Non-continuous	80.9	Flexible	42	DSM IV	N	P	Inv	4
Boufard 2003[2]	38	Non-continuous	45.0	Fixed	28	DSM-IV	N	CO	Pat	3
Carpentier 2003	25	Non-continuous	45.0	Fixed	28	DSM-IV	Y	CO	Inv	3
Gualtieri 1985	8	Non-continuous	48.7[3]	Fixed	5	DSM-III	N	CO	Pat	3
Jain 2007	50	Non-continuous	56.8[3]	Flexible	35-77	DSM-IV	N	CO	Pat	3
Kuperman 2001[4]	37	Non-continuous	NR	Flexible	49	DSM-IV	N	P	Pat	3
Levin 2006	98	Continuous	60.0[5]	Flexible	70	DSM IV + Utah	Y	P	Pat	4
Levin 2007	106	Continuous	50.0[5]	Flexible	91	DSM-IV	Y	P	Inv	3
Medori 2008	402	Non-continuous	42	Fixed	35	DSM-IV	N	P	Inv	3
Reimherr 2007	43	Non-continuous	64.0	Flexible	28	DSM-IV + Utah	N	CO	Inv	3
Rösler 2009	359	Non-continuous	41. 2	Flexible	196	DSM-IV	N	P	Inv	3
Schubiner 2002	48	Non-continuous	78.8	Flexible	84	DSM-IV	Y	P	Pat	2
Spencer 1995	25	Non-continuous	66.5	Flexible	21	DSM-III-R	N	CO	Inv	3
Spencer 2005	146	Non-continuous	82.0	Flexible	42	DSM-IV	N	P	Inv	3
Spencer 2007[4]	221	Non-continuous	29.8	Fixed	35	DSM-IV	N	P	Inv	3
Tenenbaum 2002[6]	24	Non-continuous	45.0	Fixed	21	DSM-IV	N	CO	Pat	4
Wender 1985	37[7]	Non-continuous	43.2	Flexible	14	Utah	N	CO	Inv	3

[1] The presence of comorbid SUD was an inclusion criterion.
[2] SMD was calculated by averaging two patient-rated ADHD symptoms scales.
[3] Dose was reported in the article as mg/kg/d and patients weight was not available. Daily dose was estimated assuming that patients weight was 81.2 Kg.
[4] SMD was calculated from change from baseline scores.
[5] Dose was calculated from the dose range during the last week of assessment.
[6] SMD was calculated by averaging four patient-reported ADHD symptoms scales.

METILFENIDATO EN ADULTOS



Study or Subgroup	Std. Mean Difference	SE	Weight	Std. Mean Difference IV, Random, 95% CI
Biederman 2006	0.72	0.19	7.7%	0.72 [0.35, 1.09]
Bouffard 2003	0.63	0.29	5.0%	0.63 [0.06, 1.20]
Carpentier 2005	0.3	0.33	4.2%	0.30 [-0.35, 0.95]
Gualtieri 1985	0.31	0.51	2.2%	0.31 [-0.69, 1.31]
Jain 2007	0.54	0.24	6.2%	0.54 [0.07, 1.01]
Kuperman 2001	-0.31	0.47	2.5%	-0.31 [-1.23, 0.61]
Levin FR 2006	-0.26	0.28	5.2%	-0.26 [-0.81, 0.29]
Levin FR 2007	0.06	0.2	7.3%	0.06 [-0.33, 0.45]
Medori 2008	0.42	0.12	10.2%	0.42 [0.18, 0.66]
Reimherr 2007	0.83	0.26	5.7%	0.83 [0.32, 1.34]
Rosler 2009	0.45	0.13	9.8%	0.45 [0.20, 0.70]
Schubiner 2002	0.7	0.3	4.8%	0.70 [0.11, 1.29]
Spencer 1995	1.01	0.31	4.6%	1.01 [0.40, 1.62]
Spencer 2005	1.3	0.28	5.2%	1.30 [0.75, 1.85]
Spencer 2007	0.51	0.16	8.7%	0.51 [0.20, 0.82]
Tenenbaum 2002	0.07	0.29	5.0%	0.07 [-0.50, 0.64]
Wender 1985	0.57	0.25	5.9%	0.57 [0.08, 1.06]
Total (95% CI)			**100.0%**	**0.48 [0.32, 0.65]**

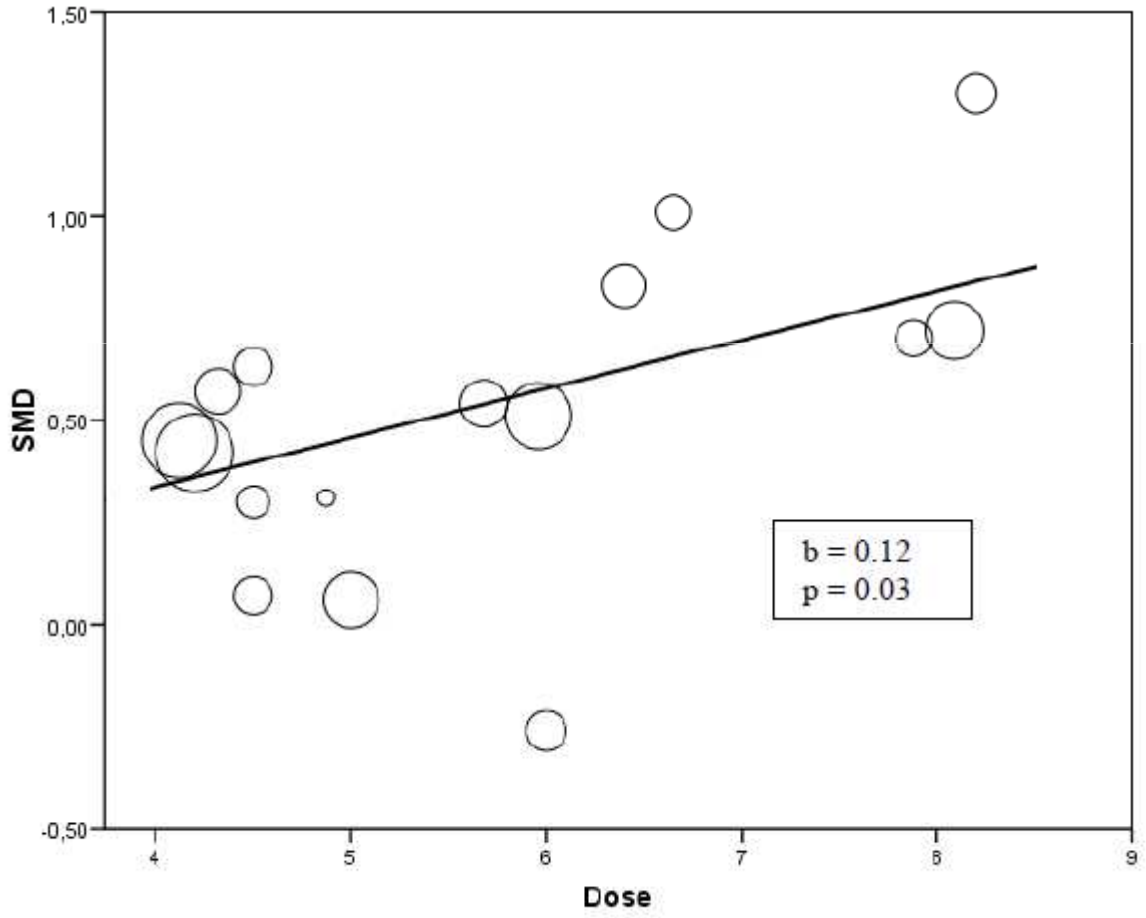
Heterogeneity: Tau² = 0.05; Chi² = 32.87, df = 16 (P = 0.008); I² = 51%

Test for overall effect: Z = 5.88 (P < 0.00001)

METILFENIDATO EN ADULTOS

	SMD [95%CI][1]	t [2]	p [2]	Residual heterogeneity
Dose[3]	0.12 [0.01, 0.23]	2.42	0.030	I^2 = 28.4 %
Formulation				I^2 = 28.5 %
Non-continuous release	0.55 [0.40, 0.70]			
Continuous release	-0.10 [-0.60, 0.40]	-2.68	0.017	
Dose regime				I^2 = 48.9 %
Fixed	0.40 [0.07, 0.73]	-0.77	0.454	
Flexible	0.55 [0.30, 0.79]			
Treatment length	-0.12 [-0.53, 0.28]	-0.65	0.528	I^2 = 51.8 %
Comorbid SUD				I^2 = 40.7 %
Yes	0.18 [-0.22, 0.58]	-1.85	0.084	
No	0.57 [0.38, 0.76]			
Study design				I^2 = 50.0 %
Parallel	0.45 [0.19, 0.71]	-0.53	0.601	
Cross-over	0.55 [0.24, 0.87]			
Rater				I^2 = 44.8 %
Patient	0.28 [-0.04, 0.61]	-1.66	0.118	
Investigator	0.59 [0.37, 0.81]			
Clinical trial reporting quality				I^2 = 50.3 %
Jadad ≥ 3	0.48 [0.28, 0.69]	-0.51	0.619	
Jadad < 3	0.70 [-0.19, 1.59]			

METILFENIDATO EN ADULTOS



METILFENIDATO EN ADULTOS

	Primary analysis			
	SMD [95%CI][1]	t [2]	p [2]	Residual heterogeneity
Model 1				$I^2 < 0.01$ %
Constant	0.56 [0.43, 0.68]	9.73	< 0.0001	
Dose[3]	0.12 [0.03, 0.20]	2.96	0.011	
Continuous release	-0.67 [-1.12, -0.23]	-3.26	0.006	
Model 2				$I^2 < 0.01$ %
Constant	0.57 [0.44, 0.70]	9.58	< 0.0001	
Dose[3]	0.13 [0.04, 0.21]	3.25	0.006	
Comorbid SUD	-0.46 [-0.81, -0.11]	-2.86	0.014	
Model 3				$I^2 < 0.01$ %
Constant	0.57 [0.44, 0.70]	9.57	< 0.0001	
Dose[3]	0.12 [0.03, 0.21]	3.04	0.010	
Continuous release	-0.52 [-1.17, 0.14]	-1.73	0.110	
Comorbid SUD	-0.17 [-0.68, 0.34]	-0.72	0.488	

Table 3: Multivariate moderator analysis of the efficacy of methylphenidate for adult ADHD. All analyses include dose, and, in the model 1 (top) also the type of formulation, in the model 2 (middle) the presence of comorbid SUD and both in the model 3 (bottom).

MTF SÍNTOMAS EMOCIONALES

The World Journal of Biological Psychiatry, 2010; 11: 709–718

ORIGINAL INVESTIGATION

Twenty-four-week treatment with extended release methylphenidate improves emotional symptoms in adult ADHD

MICHAEL RÖSLER[1], WOLFGANG RETZ[1], ROLAND FISCHER[2], CLAUDIA OSE[3], BARBARA ALM[4], JÜRGEN DECKERT[5], ALEXANDRA PHILIPSEN[6], SABINE HERPERTZ[7] & RICHARD AMMER[2]

MTF SÍNTOMAS EMOCIONALES

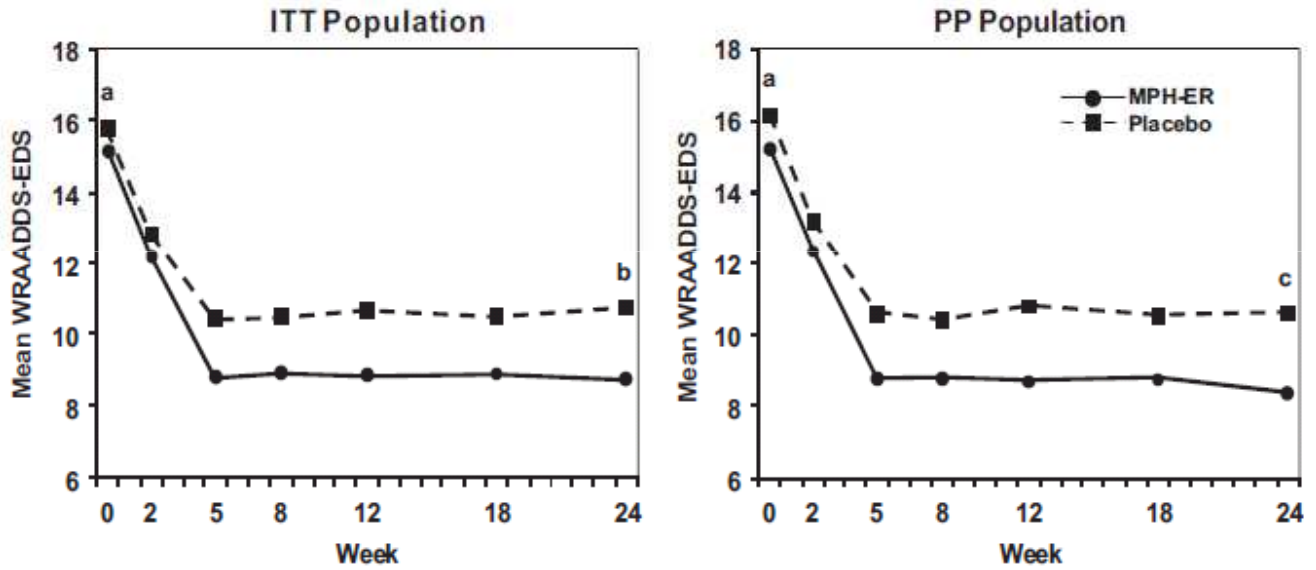


Figure 1. Mean score of the WRAADDS Emotional Dysregulation Scale (WRAADDS-EDS) during the 24-week observation period. The difference between MPH-treated persons and placebo group is significant from week 5 onwards. a=Not significant, bP=0.0009, cP=0.0013. ITT population: N=241 (MPH), N=118 (placebo). PP population: N=179 (MPH), N=85 (placebo).

DOSIS METILFENIDATO OROS

ORIGINAL CONTRIBUTION

Eficacia y seguridad de metilfenidato OROS en adultos con trastorno por déficit de atención/hiperactividad

Un estudio de escalada de dosis, aleatorizado, controlado con placebo, doble ciego, de grupos paralelos

Lenard A. Adler, MD,† Brenda Zimmerman, MS,‡ H. Lynn Starr, MD,§ Steve Silber, MD,|| Joseph Palumbo, MD,|| Camille Orman, PhD,|| y Thomas Spencer, MD¶#*

(*J Clin Psychopharmacol* 2009;29: 239-247)

DOSIS METILFENIDATO OROS

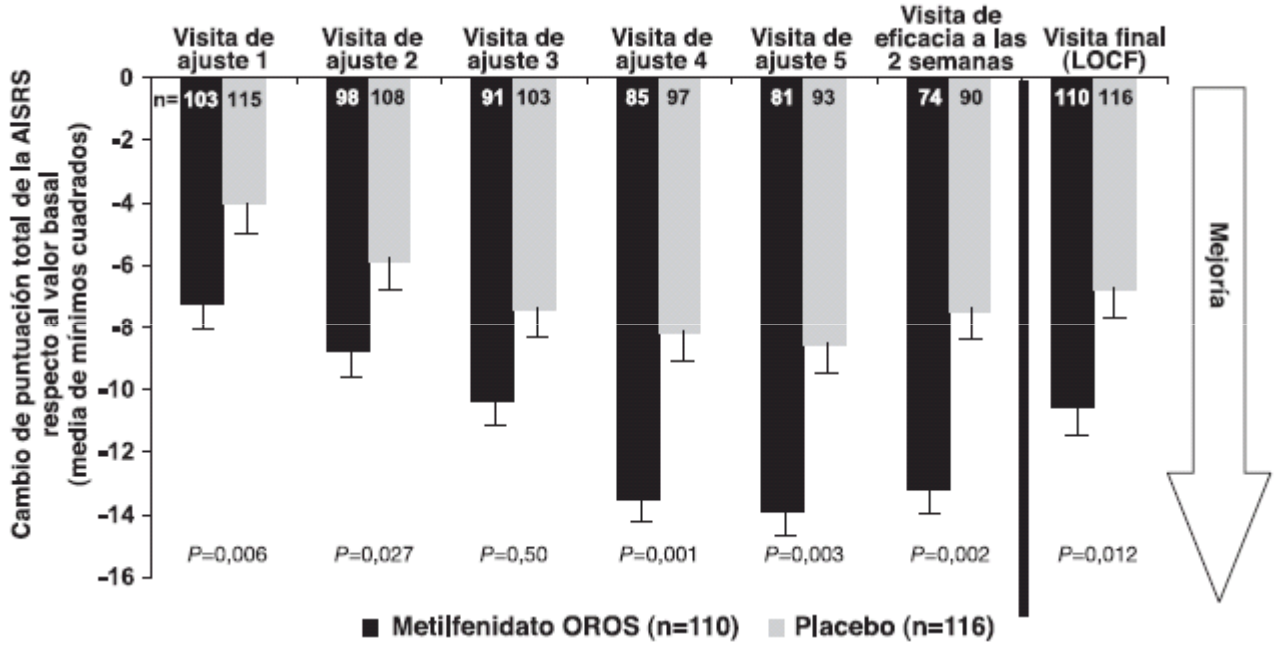


FIGURA 1. Cambio de la puntuación total de la escala Adult ADHD Investigator Symptom Report Scale respecto al valor basal, en cada visita y en la visita final (media de mínimos cuadrados ± EEM): población de análisis ITT para metilfenidato OROS frente a placebo. La puntuación total de la Adult ADHD Investigator Symptom Report Scale va de 0 a 54 y las puntuaciones más altas indican un TDAH más grave. El cambio respecto al valor basal es el valor de la visita menos el valor basal. Valor de p basado en la prueba de diferencia significativa entre los tratamientos según un modelo de ANCOVA con el cambio respecto al valor basal como variable dependiente, los grupos de centros y el tratamiento (metilfenidato OROS frente a placebo) como factores, y el valor basal como covariable. Valor de p nominal sin ajuste para pruebas múltiples.

DOSIS METILFENIDATO OROS

TABLA 2. Acontecimientos adversos registrados con frecuencia (en ≥5% de los pacientes tratados con metilfenidato OROS o con placebo)

Término MedDRA preferido	Metilfenidato OROS (n = 110), n (%)	Placebo (n = 116), n (%)
Algún acontecimiento adverso	93 (84,5)	74 (63,8)
Disminución del apetito	28 (25,5)	7 (6,0)
Cefalea	28 (25,5)	16 (13,8)
Sequedad de boca	22 (20,0)	6 (5,2)
Ansiedad	18 (16,4)	4 (3,4)
Náuseas	14 (12,7)	3 (2,6)
Aumento de presión arterial	11 (10,0)	6 (5,2)
Insomnio	10 (9,1)	6 (5,2)
Aumento de frecuencia cardiaca	8 (7,3)	5 (4,3)
Insomnio inicial	8 (7,3)	4 (3,4)
Bruxismo	7 (6,4)	1 (0,9)
Irritabilidad	7 (6,4)	2 (1,7)
Tensión muscular	7 (6,4)	0 (0,0)
Diarrea	4 (3,6)	6 (5,2)
Somnolencia	3 (2,7)	8 (6,9)

MTF OROS: SEGURIDAD

Neuropsychiatric Disease and Treatment

Dovepress
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Open Access Full Text Article

ORIGINAL RESEARCH

Safety and tolerability of flexible dosages of prolonged-release OROS methylphenidate in adults with attention-deficit/hyperactivity disorder

This article was published in the following Dove Press journal:
Neuropsychiatric Disease and Treatment
24 August 2009
Number of times this article has been viewed

Jan K Buitelaar[1]
J Antoni Ramos-Quiroga[2]
Miguel Casas[2]
J J Sandra Kooij[3]
Asko Niemelä[4]
Eric Konofal[5]
Joachim Dejonckheere[6]
Bradford H Challis[7]
Rossella Medori[8]

Abstract: The osmotic release oral system (OROS) methylphenidate formulation is a prolonged-release medication for the treatment of attention-deficit/hyperactivity disorder (ADHD) in children, adolescents, and adults. We conducted a seven-week open-label extension of a double-blind study to assess the safety and tolerability of OROS methylphenidate in a flexible dose regimen (18–90 mg daily) for the treatment of adults diagnosed with ADHD (N = 370). Medication was adjusted to optimize efficacy and tolerability for each patient. Adverse events, vital signs, and laboratory parameters were assessed. Most patients (337; 91%) completed the seven-week treatment and the final dispensed dose was 18 mg (8%), 36 mg (29%), 54 mg (34%), 72 mg (20%), or 90 mg (9%). Adverse events were reported in 253 (68%) patients and most were mild or moderate in severity; most frequently reported included headache (17%),

MTF OROS: SEGURIDAD

Table 4 Adverse events by daily dose at final treatment visit

Adverse event, n (%)	Daily dosage of OROS methylphenidate (N = 370)				
	18 mg	36 mg	54 mg	72 mg	90 mg
Headache	2 (9.5)	2 (2.4)	4 (3.6)	5 (7.7)	1 (3.1)
Decreased appetite	0	0	1 (0.9)	1 (1.5)	2 (6.3)
Insomnia	1 (4.8)	1 (1.2)	4 (3.6)	1 (1.5)	1 (3.1)
Nausea	0	1 (1.2)	1 (0.9)	0	0
Nasopharyngitis	1 (4.8)	6 (7.3)	3 (2.7)	3 (4.6)	1 (3.1)
Restlessness	1 (4.8)	1 (1.2)	1 (0.9)	2 (3.1)	0
Dry mouth	1 (4.8)	0	0	0	1 (3.1)
Fatigue	0	1 (1.2)	0	0	0
Dizziness	1 (4.8)	0	0	1 (1.5)	0
Anxiety	1 (4.8)	2 (2.4)	0	0	0
Palpitations	1 (4.8)	1 (1.2)	0	1 (1.5)	0
Depressed mood	0	0	2 (1.8)	2 (3.1)	1 (3.1)
Tachycardia	0	1 (1.2)	1 (0.9)	1 (1.5)	0
Nervousness	1 (4.8)	0	0	0	0
Influenza	0	0	0	1 (1.5)	0
Disturbance in attention	0	0	0	1 (1.5)	1 (3.1)

MTF SEGURIDAD

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

ADHD Drugs and Serious Cardiovascular Events in Children and Young Adults

William O. Cooper, M.D., M.P.H., Laurel A. Habel, Ph.D.,
Colin M. Sox, M.D., K. Arnold Chan, M.D., Sc.D., Patrick G. Arbogast, Ph.D.,
T. Craig Cheetham, Pharm.D., Katherine T. Murray, M.D.,
Virginia P. Quinn, Ph.D., M.P.H., C. Michael Stein, M.B., Ch.B.,
S. Todd Callahan, M.D., M.P.H., Bruce H. Fireman, M.A.,
Frank A. Fish, M.D., Howard S. Kirshner, M.D., Anne O'Duffy, M.D.,
Frederick A. Connell, M.D., M.P.H., and Wayne A. Ray, Ph.D.

NEJM, Nov 1, 2011

MTF SEGURIDAD

Retrospective cohort study

1.200.438 children and young adults (2-24)
2.579.104 persons-year of follow-up
373.667 persons-year of current use ADHD drugs

Serious cardiovascular events

RESULTS

Cohort members had 81 serious cardiovascular events (3.1 per 100,000 person-years). Current users of ADHD drugs were not at increased risk for serious cardiovascular events (adjusted hazard ratio, 0.75; 95% confidence interval [CI], 0.31 to 1.85). Risk was not increased for any of the individual end points, or for current users as compared with former users (adjusted hazard ratio, 0.70; 95% CI, 0.29 to 1.72). Alternative analyses addressing several study assumptions also showed no significant association between the use of an ADHD drug and the risk of a study end point.

NEJM, Nov 1, 2011

MTF SEGURIDAD

Retrospective cohort study

1.200.438 children and young adults (2-24)
2.579.104 persons-year of follow-up
373.667 persons-year of current use ADHD drugs

Serious cardiovascular events

CONCLUSIONS

This large study showed no evidence that current use of an ADHD drug was associated with an increased risk of serious cardiovascular events, although the upper limit of the 95% confidence interval indicated that a doubling of the risk could not be ruled out. However, the absolute magnitude of such an increased risk would be low. (Funded by the Agency for Healthcare Research and Quality and the Food and Drug Administration.)

NEJM, Nov 1, 2011

ALCOHOL Y METILFENIDATO

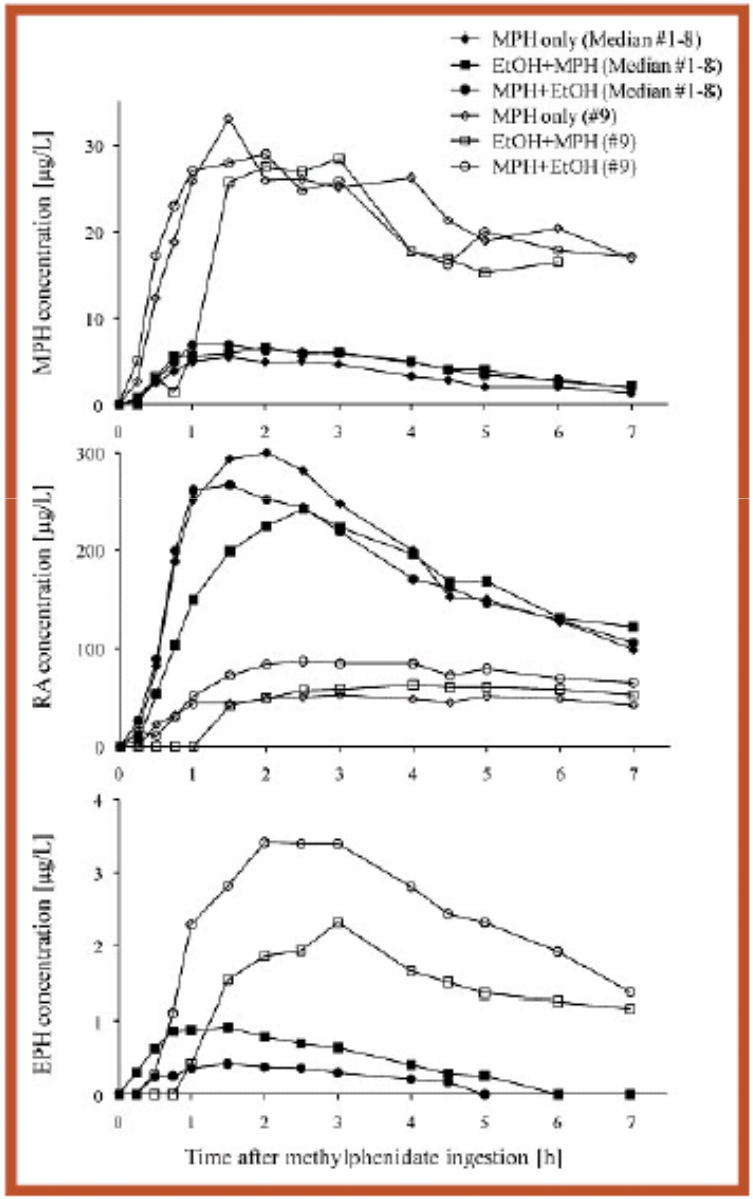
Influence of ethanol on the pharmacokinetics of methylphenidate's metabolites ritalinic acid and ethylphenidate

Michaela Koehm, Gerold F. Kauert, Stefan W. Toennes

Institute of Forensic Toxicology, University of Frankfurt, Frankfurt/Main, Germany

Correspondence to: Dr. Stefan W. Toennes, Institute of Forensic Toxicology, University of Frankfurt, Kennedyallee 104, 60596 Frankfurt/Main, Germany; e-mail: toennes@em.uni-frankfurt.de

ALCOHOL Y METILFENIDATO



TRATAMIENTO ABUSO ANFETAMINAS

Drug and Alcohol Dependence 108 (2010) 130–133

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Short communication

Sustained release methylphenidate for the treatment of ADHD in amphetamine abusers: A pilot study☆

Maija Konstenius[a,*], Nitya Jayaram-Lindström[a], Olof Beck[b], Johan Franck[a]

[a] Division of Psychiatry, Department of Clinical Neuroscience, Karolinska Institutet, 17176 Stockholm, Sweden
[b] Division of Clinical Pharmacology, Department of Medicine, Karolinska Institutet, 17176 Stockholm, Sweden

TRATAMIENTO ABUSO ANFETAMINAS

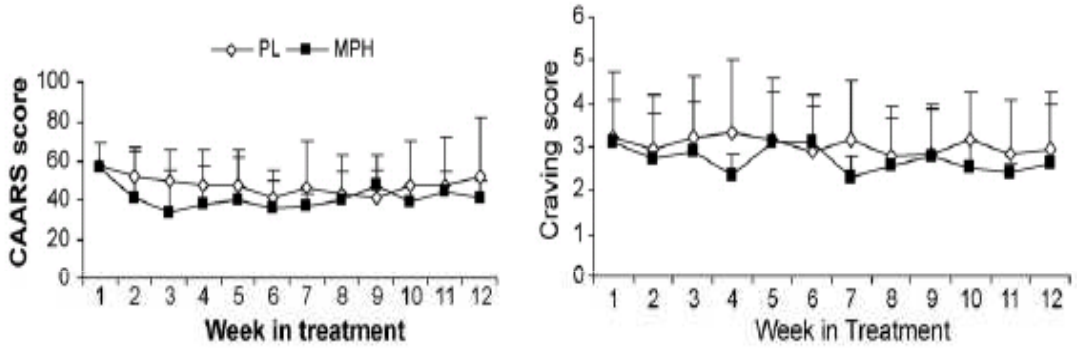


Fig. 1. The effects of methylphenidate (MPH) and placebo (PL) treatment as reflected in the Conners' adult ADHD self-report rating scale (CAARS) and a visual analog craving scale (maximum = 7) as a function of weeks in treatment.

MTF OROS Y NICOTINA

Drug and Alcohol Dependence 110 (2010) 156–159

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Short communication

OROS-methylphenidate or placebo for adult smokers with attention deficit hyperactivity disorder: Racial/ethnic differences☆

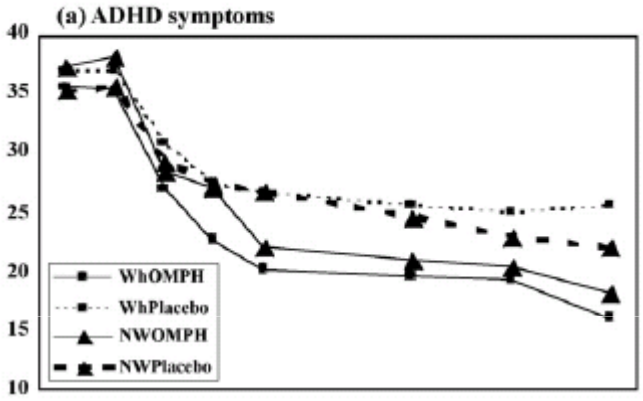
Lirio S. Covey[a,*], Mei-Chen Hu[b], Theresa Winhusen[c], Judith Weissman[d], Ivan Berlin[e], Edward V. Nunes[a]

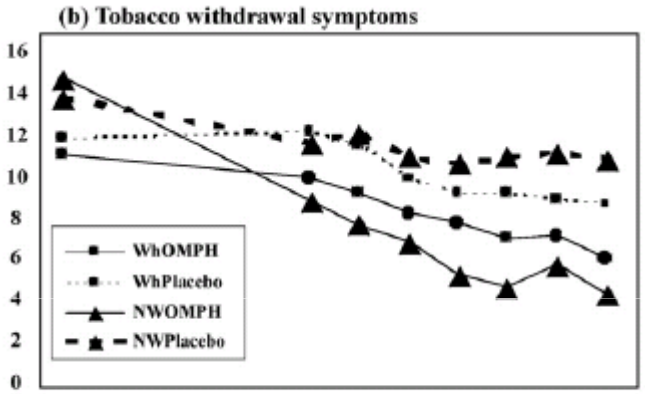
Winhusen TM et al. 2010

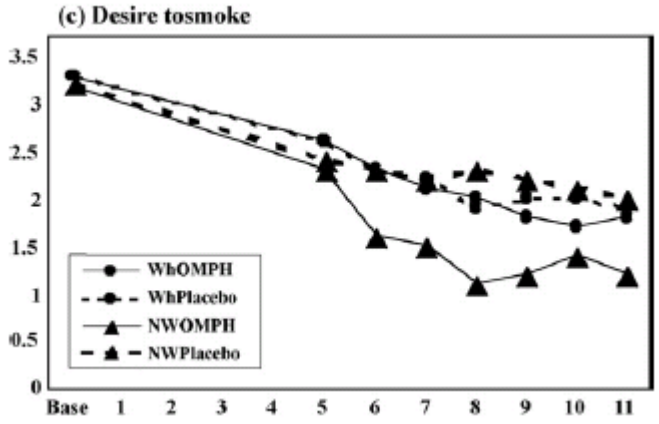
Impact of attention-deficit/hyperactivity disorder (ADHD) treatment on smoking cessation intervention in ADHD smokers: a randomized, double-blind, placebo-controlled trial.

J Clin Psychiatry. 2010 May 18. [Epub ahead of print]

MTF OROS Y NICOTINA







AMFETAMINAS EN ADULTOS

G0028 Amphetamines for Attention Deficit Hyperactivity Disorder (ADHD) in adults

Amphetamines for Attention Deficit Hyperactivity Disorder (ADHD) in adults

Review information

Review No

G0028

Authors

Xavier Castells[1], Josep Antoni Ramos-Quiroga[2], Rosa Bosch[2], Mariana Nogueira[2], Miguel Casas[2]

[1]Unit of Clinical Pharmacology, Department of Medical Sciences, Faculty of Medicine, Universitat de Girona, Girona, Spain

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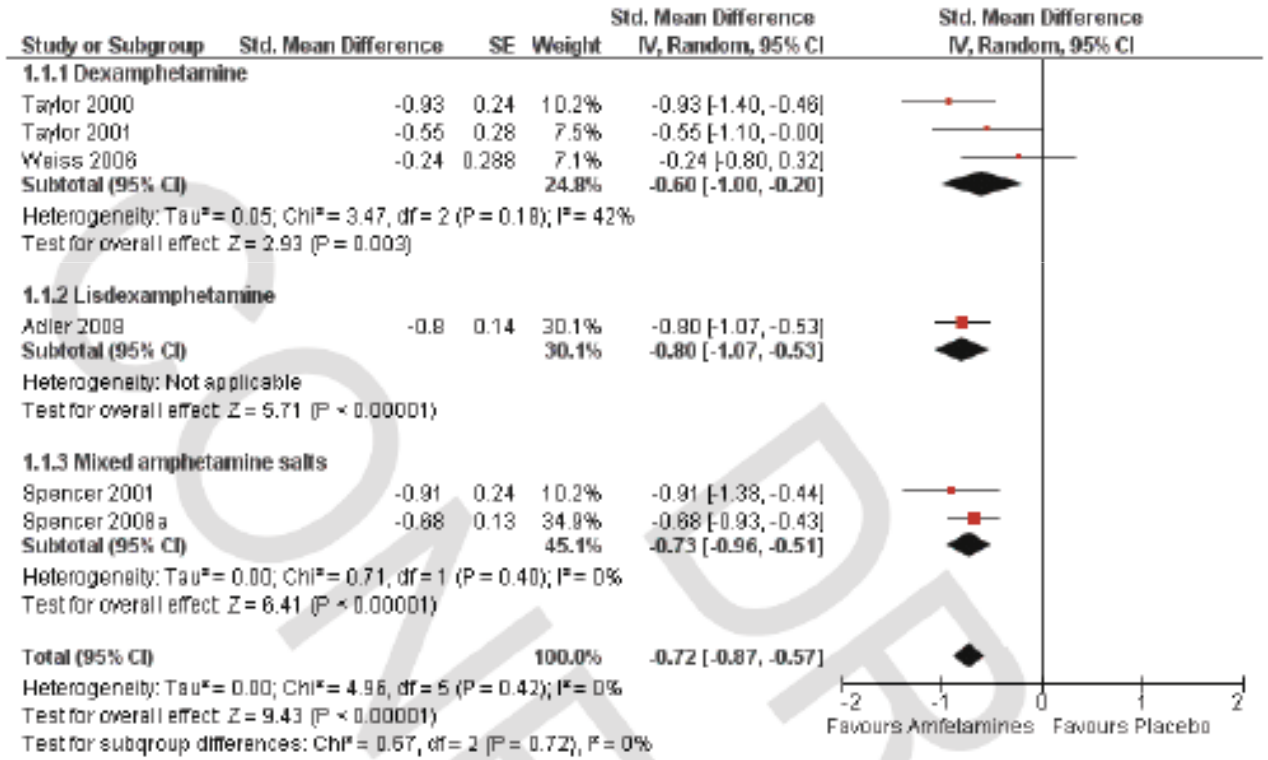
Citation example: Castells X, Ramos-Quiroga JAntoni, Bosch R, Nogueira M, Casas M. Amphetamines for Attention Deficit Hyperactivity Disorder (ADHD) in adults. Cochrane Database of Systematic Reviews 2009 , Issue 2 . Art. No.: CD007813. DOI: 10.1002/14651858.CD007813 .

Cochrane Database 2011

AMFETAMINAS EN ADULTOS

G0028 Amphetamines for Attention Deficit Hyperactivity Disorder (ADHD) in adults



Caption

Forest plot of comparison: 1 Amphetamine derivatives vs. placebo for adult ADHD, outcome: 1.1 ADHD symptom severity.

Cochrane Database 2011

LISDEXAMFETAMINA

Wigal *et al. Behavioral and Brain Functions* 2010, **6**:34
http://www.behavioralandbrainfunctions.com/content/6/1/34

BEHAVIORAL AND BRAIN FUNCTIONS

RESEARCH Open Access

Randomized, double-blind, placebo-controlled, crossover study of the efficacy and safety of lisdexamfetamine dimesylate in adults with attention-deficit/hyperactivity disorder: novel findings using a simulated adult workplace environment design

Timothy Wigal*[1], Matthew Brams[2], Maria Gasior[3], Joseph Gao[4], Liza Squires[3], John Giblin[5] for 316 Study Group

RESULTADOS

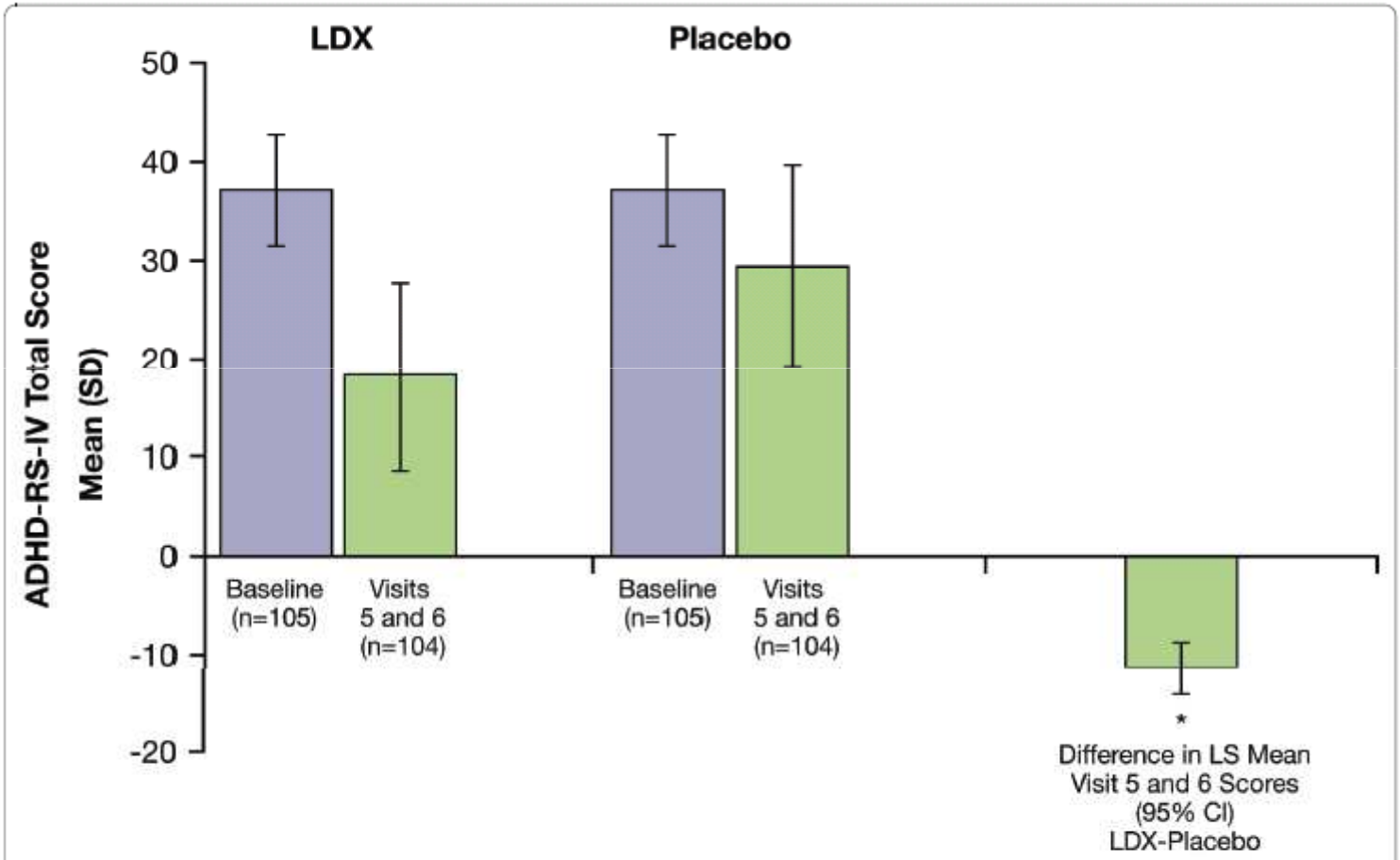


Figure 4 ADHD-RS-IV total scores at baseline and visit 5/6 and difference in LS mean (95% CI) between LDX and placebo during the double-blind crossover phase. (ADHD-RS-IV = Attention-Deficit/Hyperactivity Disorder Rating Scale IV; CI = confidence interval; LDX = lisdexamfetamine dimesylate; LS = least squares). * $P < .0001$ LDX vs placebo.

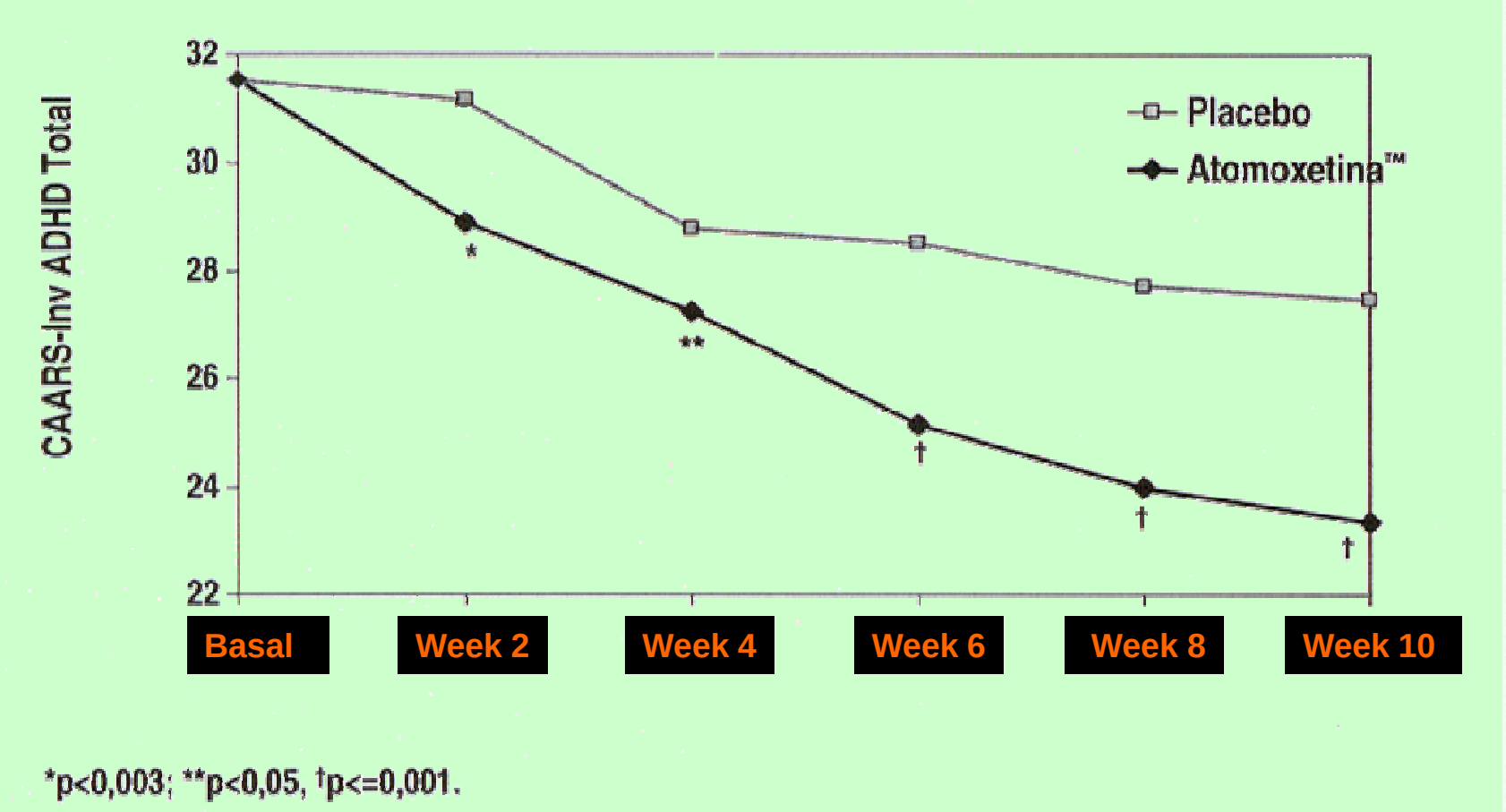
ATOMOXETINA EN ADULTOS

Atomoxetine in Adults with ADHD: Two Randomized, Placebo-Controlled Studies

David Michelson, Lenard Adler, Thomas Spencer, Frederick W. Reimherr, Scott A. West, Albert J. Allen, Douglas Kelsey, Joachim Wernicke, Anthony Dietrich, and Denái Milton

Biol Psychiatry 2003;53:112-120

ATOMOXETINA



(Michelson D. et al., 2003)

ATOMOXETINA

RESEARCH

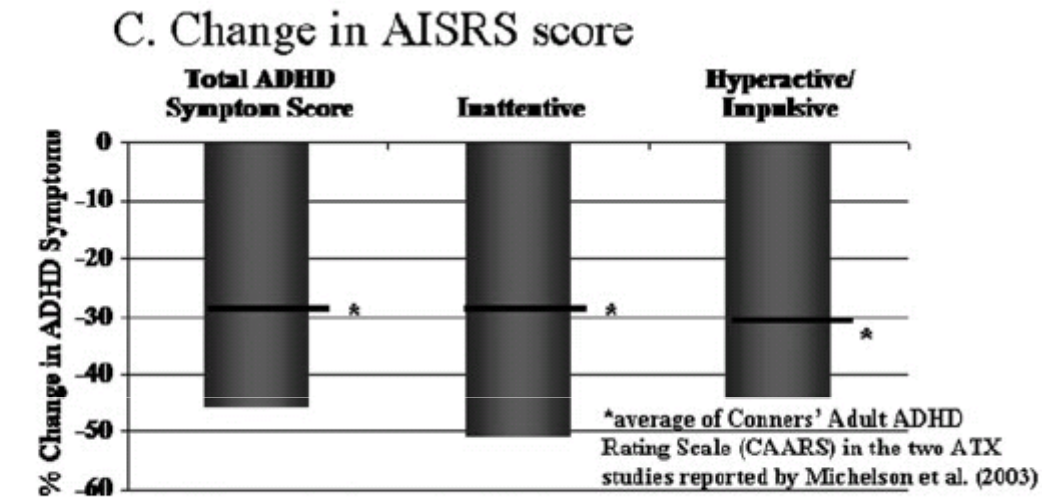
CNS Neuroscience & Therapeutics

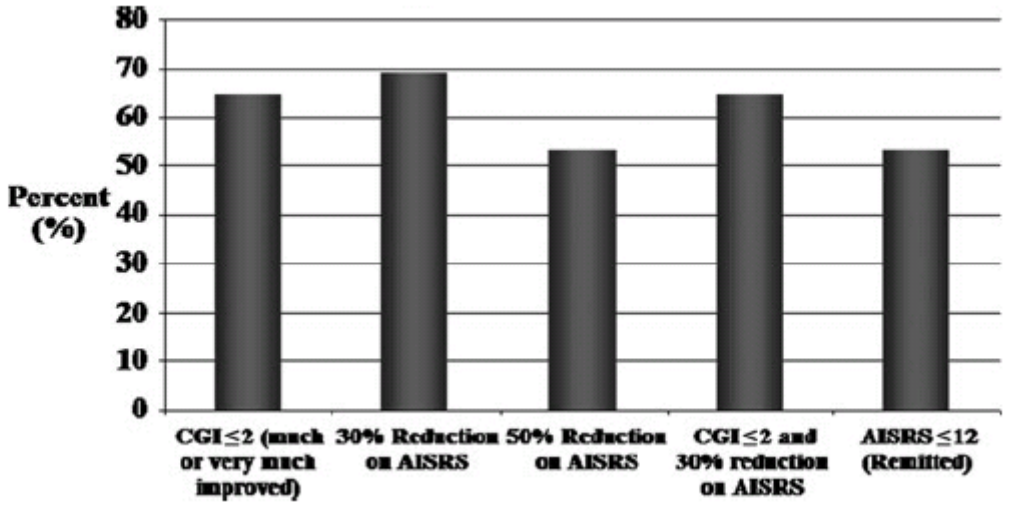
Atomoxetine in the Treatment of Adults with Subthreshold and/or Late Onset Attention-Deficit Hyperactivity Disorder-Not Otherwise Specified (ADHD-NOS): A Prospective Open-Label 6-Week Study

Craig Surman, Paul Hammerness, Carter Petty, Robert Doyle, Nicole Chu, Nitzah Gebhard, Courtney Williams & Joseph Biederman

Massachusetts General Hospital, Clinical and Research Program in Pediatric Psychopharmacology and Adult ADHD, and Harvard Medical School, Boston, MA, USA

RESULTADOS


C. Change in AISRS score
Total ADHD Symptom Score
Inattentive
Hyperactive/ Impulsive
% Change in ADHD Symptoms
0
-10
-20
-30
-40
-50
-60
*
*
*
*average of Conners' Adult ADHD Rating Scale (CAARS) in the two ATX studies reported by Michelson et al. (2003)


Percent (%)
80
70
60
50
40
30
20
10
0
CGI≤2 (much or very much improved)
30% Reduction on AISRS
50% Reduction on AISRS
CGI≤2 and 30% reduction on AISRS
AISRS≤12 (Remitted)

FUNCIÓN CARDIACA

Table 4 Measures of cardiac functioning (mean ± SD)

	Baseline	Endpoint	Test statistic	*P*-value
Systolic BP	122.8 ± 15.0	122.1 ± 13.5	$t_{(44)} = 0.33$	0.74
Diastolic BP	72.3 ± 9.8	75.6 ± 9.0	$t_{(44)} = -3.24$	0.002
Heart rate	74.2 ± 11.0	83.3 ± 13.1	$t_{(44)} = -5.66$	<0.001
PR interval	155.7 ± 18.2	151.0 ± 17.9	$t_{(43)} = 2.27$	0.03
QRS interval	90.6 ± 12.0	89.8 ± 11.7	$t_{(44)} = 1.26$	0.21
QT interval	388.8 ± 28.4	376.0 ± 28.2	$t_{(44)} = 4.11$	<0.001
QTC interval	409.7 ± 14.7	411.9 ± 15.2	$t_{(44)} = -1.25$	0.22

EFECTOS SECUNDARIOS

Adverse effects	N (%)	N persisting[a] (%)
Dry mouth	26 (58)	12 (46)
Gastrointestinal	22 (49)	5 (23)
Insomnia	22 (49)	4 (18)
Tired/fatigued	22 (49)	2 (9)
Headache	17 (38)	6 (35)
Decreased appetite	15 (33)	1 (7)
Warmth/flushing/sweating	13 (29)	4 (31)
Colds/allergies/infections	11 (24)	0
Lightheaded/dizzy	10 (22)	0
Musculoskeletal discomfort	9 (20)	2 (22)
Tension/jitteriness	9 (20)	2 (22)
Mood change	7 (16)	0
Sexual function	7 (16)	3 (43)
Urinary hesitancy	6 (13)	5 (83)
Neurologic	5 (11)	0
Vision/ocular	5 (11)	0
Feeling cold	4 (9)	1 (25)
Injury	4 (9)	0
Muscle twitch/tremor	4 (9)	1 (25)
Impaired concentration	3 (7)	0
Palpitations	3 (7)	2 (67)
Tingling sensation	3 (7)	1 (33)
Vivid dreams	3 (7)	0
Anxiety	2 (4)	0
Bad taste	2 (4)	1 (50)
Chest discomfort	2 (4)	0
Skin changes	2 (4)	0
Increased appetite	1 (2)	1 (100)
Paresthesia	1 (2)	0
Shortness of breath	1 (2)	0
Urinary incontinence	1 (2)	1 (100)

TRATAMIENTOS COGNITIVO-CONDUCTUALES

ORIGINAL CONTRIBUTION

Cognitive Behavioral Therapy vs Relaxation With Educational Support for Medication-Treated Adults With ADHD and Persistent Symptoms

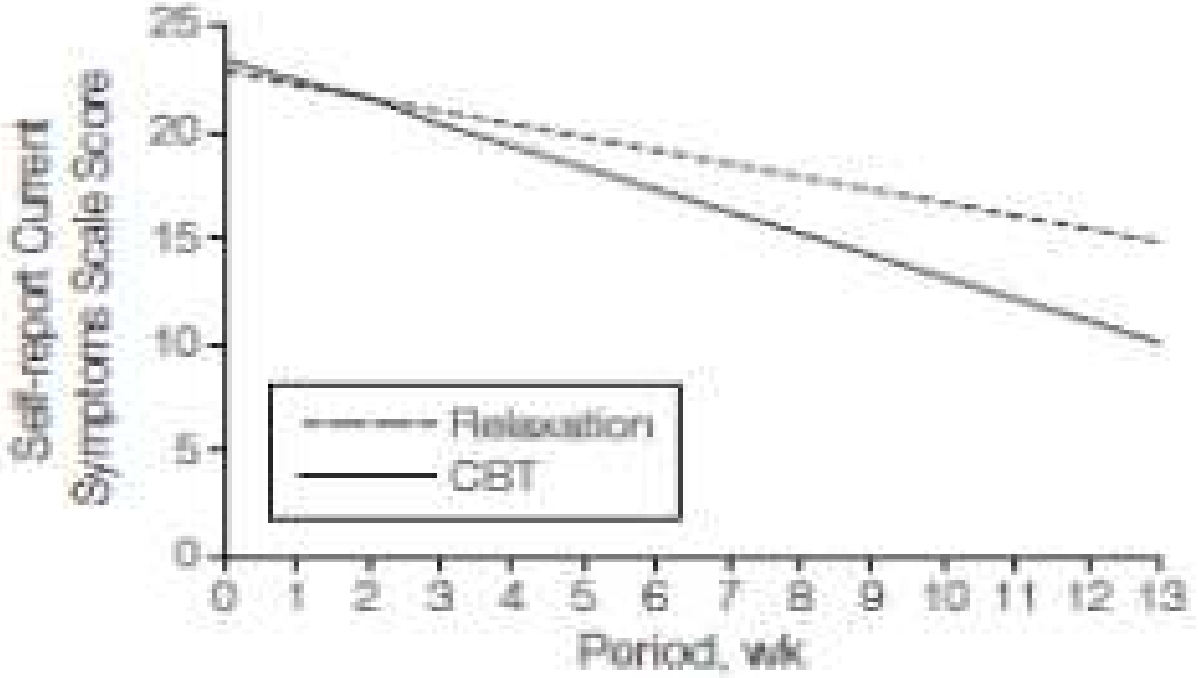
A Randomized Controlled Trial

Steven A. Safren, PhD, ABPP
Susan Sprich, PhD
Matthew J. Mimiaga, ScD, MPH
Craig Surman, MD
Laura Knouse, PhD
Meghan Groves
Michael W. Otto, PhD

JAMA. 2010;304(8):875-880

TRATAMIENTOS COGNITIVO-CONDUCTUALES

RESULTADOS



CBT indicates cognitive behavioral therapy. On the x-axis, the 0 time point indicates baseline and 13 weeks indicates posttreatment.

TRATAMIENTOS COGNITIVO-CONDUCTUALES

RESULTADOS: PRE Y POS-TRATAMIENTO

Table 2. Unadjusted Baseline and Posttreatment Outcome Scores[a]

	Cognitive Behavioral Therapy		Relaxation With Education	
	Baseline	Posttreatment	Baseline	Posttreatment
ADHD rating scale	(n=43) 26.44 (8.48)	(n=41) 14.46 (8.46)	(n=43) 25.33 (8.21)	(n=37) 19.19 (9.71)
CGI for severity	(n=43) 4.74 (0.85)	(n=41) 3.20 (1.19)	(n=43) 4.63 (0.85)	(n=37) 3.73 (1.31)
Self-report on CSS	(n=41) 24.73 (8.72)	(n=38) 11.84 (7.16)	(n=40) 26.40 (9.48)	(n=34) 19.12 (11.21)

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; CGI, Clinical Global Impression; CSS, Current Symptoms Scale.

[a]Values are expressed as mean (SD).

TRATAMIENTOS COGNITIVO-CONDUCTUALES

RESULTADOS: 6 y 12 MESES SEGUIMIENTO

Table 3. Unadjusted 6- and 12-Month Follow-up Scores[a]

	Cognitive Behavioral Therapy		Relaxation With Education	
	6-mo Follow-up	12-mo Follow-up	6-mo Follow-up	12-mo Follow-up
ADHD rating scale	(n=37) 13.51 (7.70)	(n=38) 13.39 (8.49)	(n=30) 16.20 (9.81)	(n=32) 16.97 (10.72)
CGI for severity	(n=37) 3.05 (1.31)	(n=38) 3.21 (1.24)	(n=30) 3.43 (1.19)	(n=32) 3.69 (1.26)
Self-report on CSS	(n=34) 11.97 (6.05)	(n=36) 13.58 (9.14)	(n=27) 15.52 (11.75)	(n=29) 16.10 (9.18)

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; CGI, Clinical Global Impression Scale; CSS, Current Symptoms Scale.

[a] Values are expressed as mean (SD).

TERAPIA META-COGNITIVA

Article

Efficacy of Meta-Cognitive Therapy for Adult ADHD

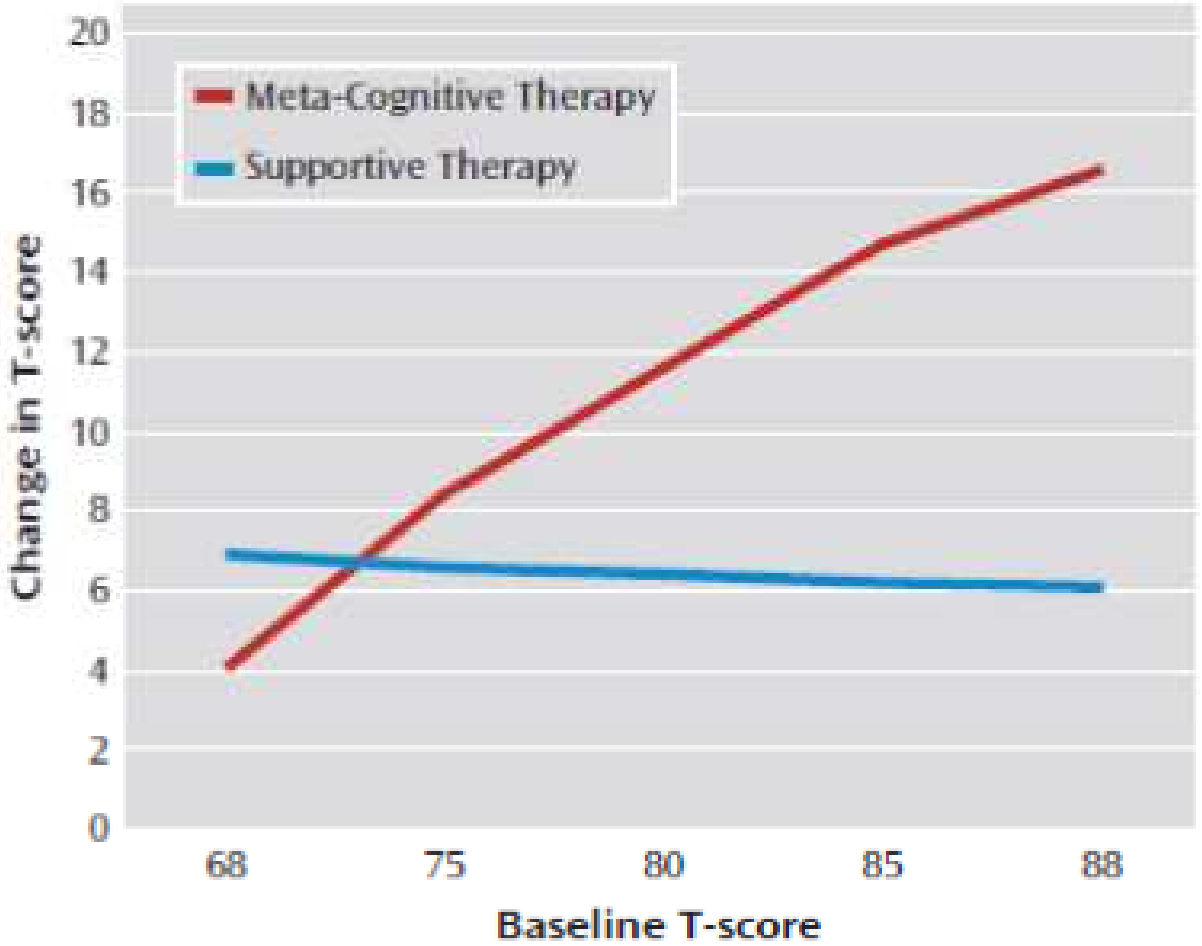
Objective: The authors investigated the efficacy of a 12-week manualized meta-cognitive therapy group intervention designed to enhance time management, organization, and planning in adults with attention deficit hyperactivity disorder (ADHD).

Mary V. Solanto, Ph.D.
David J. Marks, Ph.D.
Jeanette Wasserstein, Ph.D.
Katherine Mitchell, Psy.D.
Howard Abikoff, Ph.D.
Jose Ma. J. Alvir, Dr.P.H.
Michele D. Kofman, Ph.D.

(Am J Psychiatry 2010; 167:958–968)

TERAPIA META-COGNITIVA

RESULTADOS



REMISIÓN EN TDAH

REVIEW ARTICLE

CNS Drugs 2010; 24 (12): 1-20
1172-7047/10/0012-0001/$49.95/0

Achieving Remission as a Routine Goal of Pharmacotherapy in Attention-Deficit Hyperactivity Disorder

J. Antoni Ramos-Quiroga[1,2] and *Miguel Casas*[1,2]

1 Department of Psychiatry, Hospital Universitari Vall d'Hebron, Barcelona, Spain
2 Department of Psychiatry and Legal Medicine, Universitat Autònoma de Barcelona, Barcelona, Spain

CNS Drugs 2010

CRITERIOS DE REMISIÓN

Table I. Definitions of remission of attention-deficit hyperactivity disorder (ADHD) in children in clinical trials using specific interventions

Scale utilized	Description of scale	Remission criteria utilized	Studies (year)
SNAP-IV-18	First 18 items on a 90-item scale assessing inattention and hyperactivity; items are rated from 0 = not at all, to 3 = very much	Mean score ≤1 (not at all or just a little)[31,40,41] or ≤1 on each item[42]	Steele et al.[40] (2006) Swanson et al.[31] (2001) Greenhill et al.[41] (2006) Weiss et al.[42] (2004)
ADHD-RS-IV	18 items assessing inattention and hyperactivity; items are rated from 0 = not at all, to 3 = very much	Total score ≤18 (never, rarely or sometimes ill)[43]; score ≤9 on the inattentive subscale;[43] ≥40% reduction from baseline in total score[44]	Stein et al.[43] (2003) Bangs et al.[44] (2008)
CGI-S	Single-item clinician assessment of the severity of ADHD symptoms; severity of impairment is rated from 1 = not at all ill, to 7 = maximal, profound impairment	Score ≤2 (not at all or minimally ill)[22,43,45]	Stein et al.[43] (2003) Michelson et al.[22] (2002) Hong et al.[45] (2008)
CGI-S plus RCI	Patients were classified as normalized when they achieved a significant ($p < 0.05$) RCI, indicating reliable symptoms improvement	Score ≤2 or ≤3 on CGI-S plus significant RCI score[43]	Stein et al.[43] (2003)
CGI-ADHD-S	Single-item rating based on clinician's total experience of ADHD patients; severity is rated from 1 = normal, not at all ill, to 7 = among the most extremely ill subjects	Score of 1 or 2 (normal or minimally ill)[23]	Kelsey et al.[23] (2004)
K-ARS	18 items assessing DSM-IV criteria for inattention and hyperactivity; items are rated on a 4-point scale from 0 = not at all, to 3 = very frequent	Score ≤18 on the K-ARS (not ill or slightly ill); for the ADHD inattentive subtype, a score ≤9 on the inattentive subscales of the K-ARS[45]	Hong et al.[45] (2008)

ADHD-RS-IV = ADHD Rating Scale, version IV[27]; **CGI-ADHD-S** = Clinical Global Impression-ADHD-Severity scale[46]; **CGI-S** = Clinical Global Impression of Severity scale[46]; **K-ARS** = Korean ADHD Rating Scale[47]; **RCI** = Reliable Change Index[48]; **SNAP-IV-18** = first 18 items on the Swanson, Nolan and Pelham, version IV rating scale[26].

ÍNDICE

- **Introducción.**
- **Guías europeas TDAH adultos.**
- **Tratamiento farmacológico.**
- **Conclusiones**

CONCLUSIONES

- **Se dispone de evidencia científica en el tratamiento del TDAH en adultos: ECACP, metaanálisis, y tres guías europeas.**

- **Tratamiento farmacológico de primera elección: METILFENIDATO EN TODAS LAS GUÍAS.**

- **Se dispone de otras opciones, como ATOMOXETINA y LISDEXAMFETAMINA...**

CONCLUSIONES

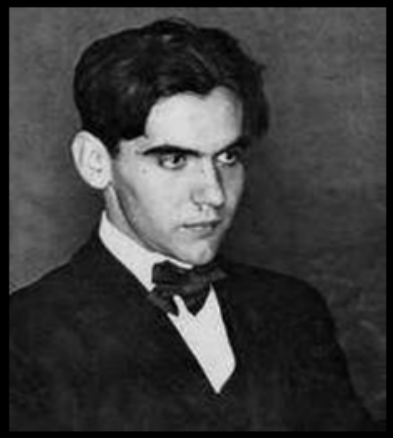
- **Se necesitan más estudios a largo plazo en adultos.**
- **Definir mejor cuando hay que retirar el tratamiento.**
- **Se necesitan más estudios que comparen eficacia y seguridad entre distintos fármacos en adultos.**
- **Se necesitan estudios que comparen tratamientos psicológicos entre si y también con fármacos en adultos.**

- **SE NECESITA ESCUCHAR Y LEER MÁS….. !!!!**

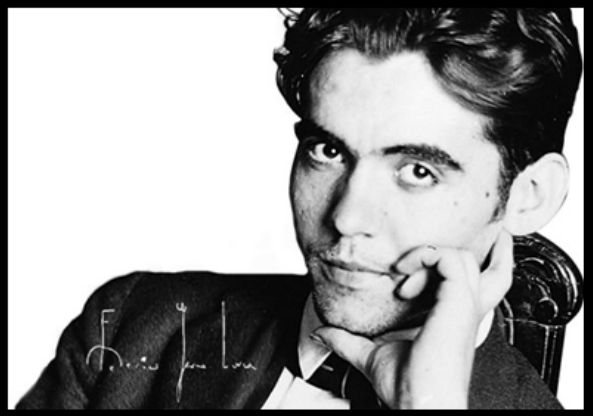
Discurso de Federico García Lorca al inaugurar la biblioteca de su pueblo con plena vigencia 80 años después.

Medio pan y un libro

Medio pan y un libro.
Alocución de Federico García Lorca al pueblo de Fuente Vaqueros (Granada) en septiembre de 1931:

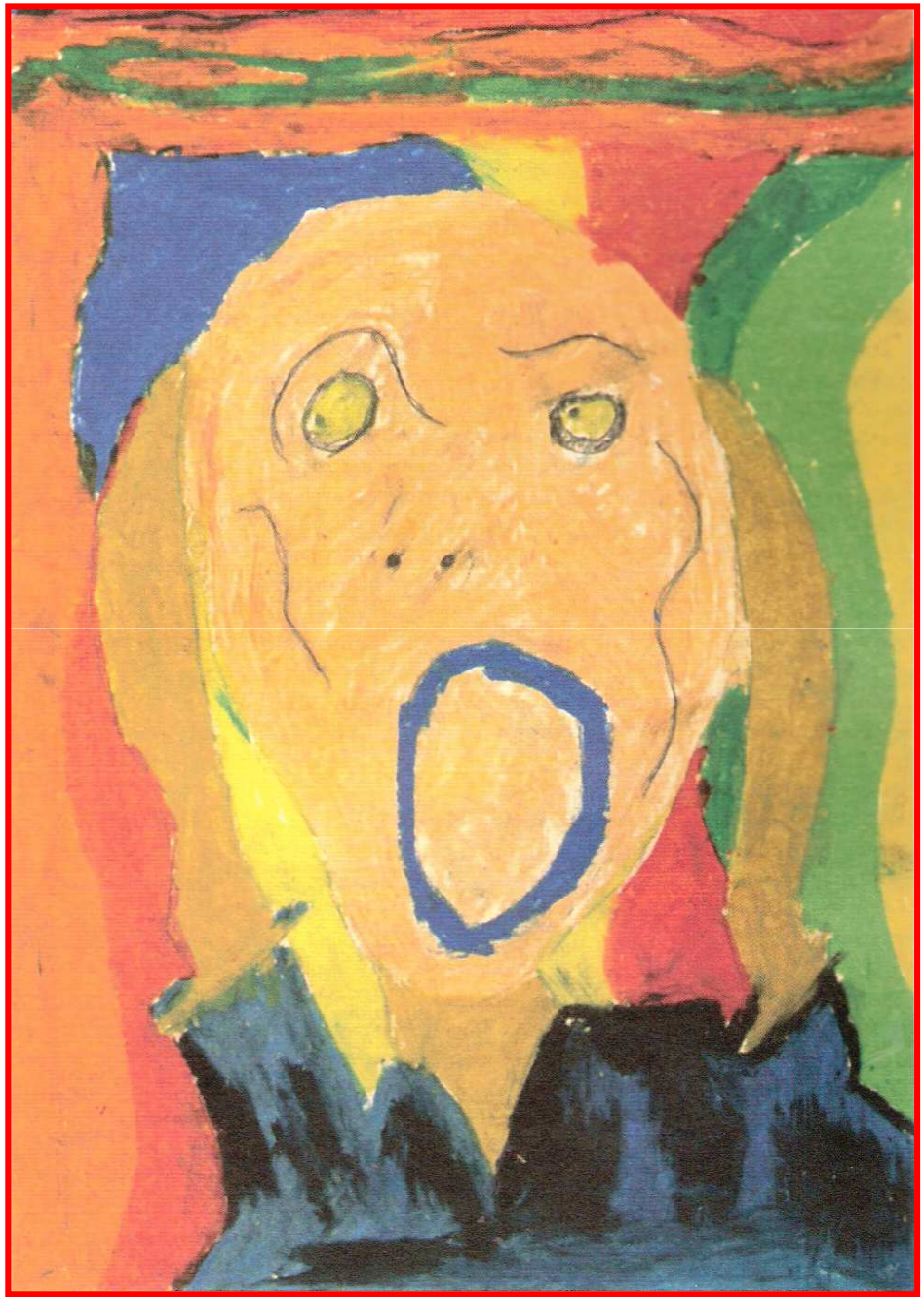


"No sólo de pan vive el hombre. Yo, si tuviera hambre y estuviera desvalido en la calle no pediría un pan; sino que pediría medio pan y un libro. Y yo ataco desde aquí violentamente a los que solamente hablan de reivindicaciones económicas sin nombrar jamás las reivindicaciones culturales que es lo que los pueblos piden a gritos. Bien está que todos los hombres coman, pero que todos los hombres sepan. Que gocen todos los frutos del espíritu humano porque lo contrario es convertirlos en máquinas al servicio de Estado, es convertirlos en esclavos de una terrible organización social.



(A PUNTO DE CUMPLIRSE 80 AÑOS DE AQUEL DISCURSO, CUALQUIER SEMEJANZA CON LA ACTUALIDAD, NO ES PURA COINCIDENCIA)

Federico García Lorca al pueblo de Fuente Vaqueros (Granada) en septiembre de 1931:

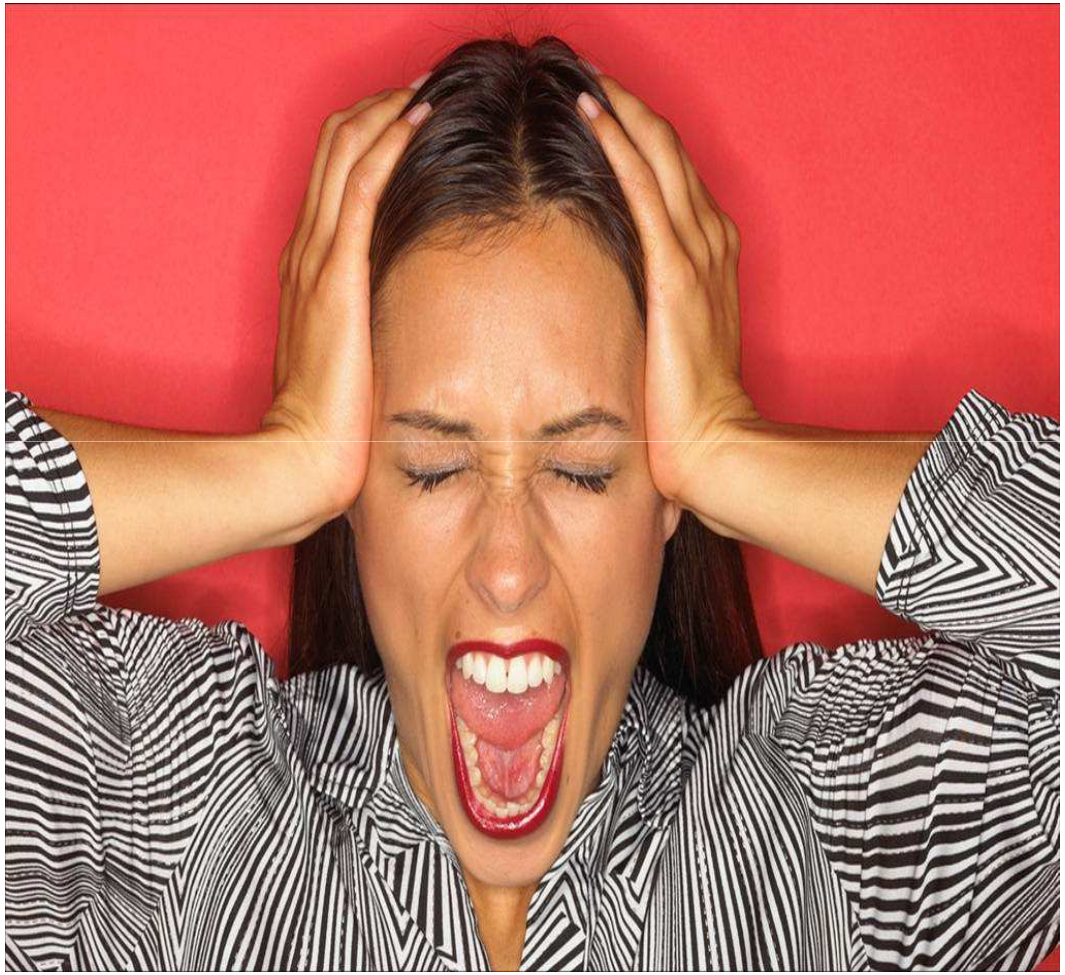


El trastorn de les oportunitats….

The Scream: My life with ADHD

Darcy Easton, aged 11

British Journal of Psychiatry 2006, 188, A22



El trastorn de les oportunitats….

The Scream:
My life with ADHD

TRATAMIENTO DEL TDAH EN ADULTOS:

Medicina basada en pruebas

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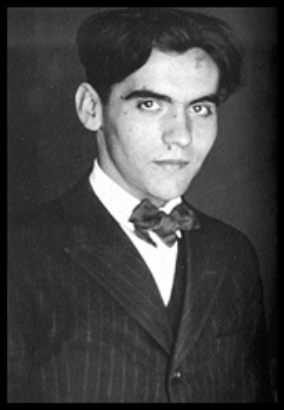
"Cuando alguien va al teatro, a un concierto o a una fiesta de cualquier índole que sea, si la fiesta es de su agrado, recuerda inmediatamente y lamenta que las personas que él quiere no se encuentren allí. «Lo que le gustaría esto a mi hermana, a mi padre», piensa, y no goza ya del espectáculo sino a través de una leve melancolía. Ésta es la melancolía que yo siento, no por la gente de mi casa, que sería pequeño y ruin, sino por todas las criaturas que por falta de medios y por desgracia suya no gozan del supremo bien de la belleza que es vida y es bondad y es serenidad y es pasión.

"Por eso no tengo nunca un libro, porque regalo cuantos compro, que son infinitos, y por eso estoy aquí honrado y contento de inaugurar esta biblioteca del pueblo, la primera seguramente en toda la provincia de Granada.

"Yo tengo mucha más lástima de un hombre que quiere saber y no puede, que de un hambriento. Porque un hambriento puede calmar su hambre fácilmente con un pedazo de pan o con unas frutas, pero un hombre que tiene ansia de saber y no tiene medios, sufre una terrible agonía porque son libros, libros, muchos libros los que necesita y ¿dónde están esos libros?



"¡Libros! ¡Libros! Hace aquí una palabra mágica que equivale a decir: «amor, amor», y que debían los pueblos pedir como piden pan o como anhelan la lluvia para sus sementeras. Cuando el insigne escritor ruso Fedor Dostoyevsky, padre de la revolución rusa mucho más que Lenin, estaba prisionero en la Siberia, alejado del mundo, entre cuatro paredes y cercado por desoladas llanuras de nieve infinita; y pedía socorro en carta a su lejana familia, sólo decía: «¡Enviadme libros, libros, muchos libros para que mi alma no muera!». Tenía frío y no pedía fuego, tenía terrible sed y no pedía agua: pedía libros, es decir, horizontes, es decir, escaleras para subir la cumbre del espíritu y del corazón. Porque la agonía física, biológica, natural, de un cuerpo por hambre, sed o frío, dura poco, muy poco, pero la agonía del alma insatisfecha dura toda la vida.

"Ya ha dicho el gran Menéndez Pidal, uno de los sabios más verdaderos de Europa, que el lema de la República debe ser: «Cultura». Cultura porque sólo a través de ella se pueden resolver los problemas en que hoy se debate el pueblo lleno de fe, pero falto de luz".