**Review: short acting methylphenidate has short term efficacy in children and adolescents with attention deficit disorder**


**QUESTION:** What is the efficacy and safety of short acting methylphenidate for attention deficit disorder (ADD) in children and adolescents?

**Data sources**
Studies in any language published between 1981 and 1999 were identified by searching Medline, EMBASE/Excerpta Medica, PsycINFO, ERIC, CINAHL, HEALTHStar, Biological Abstracts, Current Contents, Dissertation Abstracts, Cochrane Library Trials Register, and Current Controlled Trials; reviewing bibliographies of included studies and pertinent reviews; and reviewing the files of content experts.

**Study selection**
Randomised placebo controlled trials were included if they assessed the effects of short acting methylphenidate in children ≤18 years of age with a primary diagnosis of ADD (based on a systematic and reproducible method). Exclusion criteria were n of 1 studies, participants with conditions that required specialised school and/or home environments (eg, mental retardation or autism), or participants receiving stimulants other than methylphenidate.

**Main results**
62 trials (n=2897) met the selection criteria. Mean sample size was 47. Median age of participants was 8.7 years (52 trials) and median percentage of boys was 88% (59 trials). 45 trials included participants with a homogeneous primary diagnosis of attention deficit hyperactivity disorder or ADD with hyperactivity (ADHD). Mean length of intervention was 3.3 weeks.

Children who received methylphenidate had reduced scores on both teacher and parent reported HI compared with those who received placebo (table). Similar results (albeit of variable and smaller magnitudes) were found for teacher reported clinical response, global indices, core features, and key externalising features; attention and emotional lability did not differ between groups. Variable and weaker results were found for parent reported clinical response, global indices, core features, and key externalising features; inattention, hyperactivity/impulsivity, and oppositional defiant behaviour did not differ between groups. Children who received methylphenidate had higher parent/self ratings of decreased appetite, insomnia, headache, and stomachache (table).

**Conclusions**
Short acting methylphenidate reduces some core and related clinical manifestations of attention deficit disorder in children and adolescents in the short term, but is associated with increased adverse events. No long term studies were found.

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**Methylphenidate v placebo in children and adolescents with attention deficit disorder***

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Standardised mean difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperactivity index (teacher reported)</td>
<td>0.78 (0.64 to 0.91)</td>
</tr>
<tr>
<td>Hyperactivity index (parent reported)</td>
<td>0.54 (0.40 to 0.67)</td>
</tr>
</tbody>
</table>

**Data**

<table>
<thead>
<tr>
<th>Decreased appetite</th>
<th>Methylphenidate</th>
<th>Placebo</th>
<th>NNH (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45%</td>
<td>14%</td>
<td>4 (3 to 6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insomnia</th>
<th>Methylphenidate</th>
<th>Placebo</th>
<th>NNH (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>48%</td>
<td>31%</td>
<td>6 (4 to 13)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Headache</th>
<th>Methylphenidate</th>
<th>Placebo</th>
<th>NNH (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18%</td>
<td>13%</td>
<td>17 (10 to 72)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stomachache</th>
<th>Methylphenidate</th>
<th>Placebo</th>
<th>NNH (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24%</td>
<td>15%</td>
<td>12 (6 to 84)</td>
</tr>
</tbody>
</table>

*Abbreviations defined in glossary; NNH and CI calculated from absolute risk difference data in article.

**COMMENTARY**

The meta-analysis by Schachter *et al* supports a robust body of literature showing the efficacy of methylphenidate for the acute treatment of ADHD disorders in children and adolescents. Given the continuing suspicion with which the diagnosis is viewed by some elements of the lay public, the results of this study are welcome.

The analysis identifies problems with the extant literature, such as generally small study sample sizes that include a preponderance of boys, the short duration of most studies, and outcome measures that may confound ADHD with externalising comorbid behaviours. Because of these limitations, the authors suggest that broad generalisations about the usefulness of methylphenidate should probably be avoided.

The results raise several issues. Firstly, the moderate effect size of 0.54 for parent reported hyperactivity appears less robust than in previous ADHD studies, which report overall effect sizes of 0.8–1.1. One explanation may be that 52 of the reviewed studies (84%) used either once daily or twice daily dosing strategies. Immediate release (IR) methylphenidate may wear off before the child returns home after school, resulting in the larger effect sizes reported by teachers. The current standard of care is 3 daily doses to help the child in the after school hours. Secondly, the results show the need for studies of longer duration. To date, 2 controlled studies have reported stimulant benefits continuing for up to 14 months. Thirdly, although children treated with methylphenidate have higher rates of medication induced side effects, it is important to compare these risks with the risks of untreated ADHD. Clearly, untreated ADHD has far greater detrimental effects on the child’s development than the side effects of stimulants. This must be appropriately framed for the child’s parents when clinicians discuss potential stimulant side effects. Finally, the role of IR stimulants will diminish given that the standard treatment is changing to long acting, once daily stimulants.

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