

Systematic review of the screening, diagnosis and management of ADHD in children with epilepsy. Consensus paper of the Task force on comorbidities of the ILAE pediatric commission

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Summary

Attention deficit hyperactivity disorder (ADHD) is a common and challenging comorbidity affecting many children with epilepsy. A working group under the International League Against Epilepsy (ILAE) Pediatric Commission identified key questions on the identification and management of ADHD in children with epilepsy. Systematic reviews of the evidence to support approaches to these questions were collated and graded using criteria from the American Academy of Neurology Practice Parameter. PRISMA requirements were followed, with PROSPERO registration (CRD42018094617).

No increased risk of ADHD in boys with epilepsy compared to girls with epilepsy was found (level A). Valproate use in pregnancy is associated with inattentiveness and hyperactivity in offspring (1 class I study), and children with intellectual and developmental disabilities are at increased risk of ADHD (level A). Impact of early seizure onset on development of ADHD was unclear (level U), but more evident with poor seizure control (level B). ADHD screening should be performed from 6 years of age, or at diagnosis, and repeated annually (level U) and reevaluated after change of antiepileptic drug (AED) (level U). Diagnosis should involve health practitioners with expert training in ADHD (level U). Use of the Strength and Difficulties Questionnaire screening tool is supported (level B). Formal cognitive testing is strongly recommended in children with epilepsy who are struggling at school (level U). Behavioral problems are more likely with polytherapy than monotherapy (level C). Valproate can exacerbate attentional issues in children with childhood absence epilepsy (level A). Methylphenidate is tolerated and effective in children with epilepsy (level B). Limited evidence supports that atomoxetine is tolerated (level C).

Multidisciplinary involvement in transition and adult ADHD clinics is essential (level U).

In conclusion whilst recommendations could be proposed for some of the study questions, this systematic review highlighted the need for more comprehensive and targeted large population prospective studies.

Key words: ADHD, Epilepsy, Children, AED, Screening tools, Methylphenidate

INTRODUCTION

Epilepsy is a “spectrum” disorder, with associated cognitive and psychiatric impairment in approximately half of patients. Attention deficit hyperactivity disorder (ADHD), defined by DSM-5 Criteria as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, is the most common comorbidity in children with epilepsy.^{1, 2} Prevalence of ADHD in children with epilepsy is reported as 30-40% in targeted studies³⁻⁵ and 12.5-15% in a non-targeted, population registry study,⁶ overall a rate 2.5 to 5.5 times higher than in otherwise healthy children without seizures. Attention problems often predate onset of seizures.^{6, 7} The predominantly inattentive type of ADHD is more prevalent in patients with epilepsy.^{5, 9, 10} A large, population-based cohort study suggested that both genetic and environmental factors contribute to this comorbidity.⁷

The impact of comorbid ADHD in people with epilepsy is significant, often associated with academic and vocational underachievement, depression and anxiety.^{8, 9} Furthermore, ADHD is under-diagnosed in children with epilepsy,¹⁰ as difficulties with attention and behavior are attributed to the epilepsy itself, or to effects of antiepileptic drugs (AEDs). Even if recognized, ADHD is frequently untreated¹⁰ compounded by the myth that stimulants may lower seizure threshold.¹¹

The purpose of this consensus paper developed by the International League Against Epilepsy (ILAE) Pediatric Commission is to provide evidence-based guidance to inform clinical practice regarding screening, diagnosis and management of ADHD in pediatric epilepsy patients.

METHODS

A Task Force on Pediatric Comorbidities was recruited by the Pediatric

Commission of the International League Against Epilepsy (ILAE). The working group identified 5 specific questions which were highly relevant to clinical care (Table 1), and for each, a group of 3-4 members reviewed the existing literature.

The systematic review was completed, for each study question using a National Library of Medicine and Embase search with focused search terms (supplemental data, Table S1). The process followed PRISMA requirements (Table S2) and was registered on PROSPERO (registration number CRD42018094617) (Table S3). The literature search was performed with a date-range spanning January 1990 to January 2018. Only papers in English were considered. Supplemental table S1 provides more detail on the specific study question related search terms and the number of studies identified. Where possible, recommendations were graded according to level of the evidence-based data according to the American Academy of Neurology Practice Parameter (supplemental data, Table S4).¹² Where there were single studies which related to the study question, the class (I, II, III, IV) of the study rather than a grade (A,B,C,U) was documented. Where consistent evidence was lacking but a recommendation remained useful, level U category was implemented, and the working group acknowledged that this was their expert opinion. Formal workshops to synthesize the literature search, and to discuss grading of evidence and “expert opinion”, were organized by the ILAE pediatric commission during the International Epilepsy Congress in Turkey 2015 and the American Epilepsy Society meeting in 2016, in addition to regular informal communications amongst each sub-question working group.

RESULTS

An executive summary is presented in Table 2. The full document reports the available data and the group agreement question by question.

1. What are the risk factors for ADHD in children and adolescents with epilepsy and when should screening begin?

What are the risk factors of ADHD in children with epilepsy?

There is a bidirectional association between epilepsy and ADHD, with ADHD occurring 2.54 times more commonly in children with epilepsy than in control children without epilepsy, and epilepsy occurring 3.94 times more in children with ADHD than in control children without ADHD.⁵

Discussion of Findings (supplemental data Table S1).

Sex. (Level A)

In the general population, ADHD is 3-7 fold more common in boys than girls.¹³ However, most studies document equal sex distributions of ADHD in children with epilepsy.¹⁴ Two studies evaluating children with new-onset epilepsy found that male sex was not predictive of higher rates of ADHD.^{14, 15} Similar findings were noted in studies of children with pre-existing epilepsy.^{4,16} In contrast, a single cross sectional study investigating the risk of ADHD in patients aged 10-19 years with focal or generalized epilepsy found a strong trend between the presence of ADHD and male sex ($p=0.06$).¹⁷ In conclusion, most studies found no increased risk in boys with epilepsy compared to girls with epilepsy.

Prenatal insults.

A single, class I, prospective observational study of children born to mothers on monotherapy AEDs during pregnancy, found that a higher level of inattentiveness and hyperactivity in children at 3 years of age with prenatal exposure to valproate, compared to carbamazepine, lamotrigine or phenytoin.¹⁸

Intellectual and Developmental Disabilities. (Level A)

Class I and II studies consistently note a higher prevalence of ADHD in children with associated intellectual and developmental disabilities. A cross-sectional survey of British children noted a higher rate of comorbid ADHD in those with complicated epilepsy, inclusive of severe learning disorders, speech or language problems.¹⁹ In children with newly-diagnosed epilepsy, significantly higher rates of school-based remedial services and neuropsychological deficits in executive function occurred in children with the additional comorbidity of ADHD.¹⁴ A study of 85 children with epilepsy, found that ADHD was present in only 20% of patients with normal cognitive function, versus 59% of those children with cognitive delays.²⁰ A prospective, community-based study of children with epilepsy, found that children with intellectual disability had a higher mean level of symptoms on both the Parent and Teacher versions of the ADHD-Rating Scale IV than those without intellectual disability.²¹ In addition, Reilly and colleagues found that developmental coordination disorder was significantly predictive of a higher risk of ADHD.²² In conclusion children with epilepsy as well as intellectual and developmental disabilities are at increased risk of ADHD.

Family history of ADHD

It is generally accepted that genetic factors play a significant role in predisposition to ADHD.²³ Only one small class III study has evaluated this association in children with epilepsy and comorbid ADHD. Sixteen mothers of children with ADHD plus epilepsy were evaluated using the ADHD Rating Scale IV, and half met criteria for ADHD.²⁴

Age at epilepsy onset. (Level U)

Although some studies show higher prevalence of ADHD amongst those with earlier age of epilepsy onset, the literature is conflicted on this topic. Alfstad and colleagues demonstrated that early onset of epilepsy increased the risk of developing psychiatric

disorders overall, although the study did not specifically address ADHD alone (class II).¹⁷ Similarly, a study of adolescents with epilepsy attending mainstream schools, noted higher rates of ADHD in those with younger age at seizure onset (class II).²⁵ A small study on children with childhood epilepsy with centrotemporal spikes (CECTS), found that children who were younger at epilepsy onset had higher prevalence of attention deficit (class II).²⁶

In contrast, Hermann and colleagues found no significant correlation between younger age at seizure onset and higher rates of ADHD (class II) in a cohort of children with newly-diagnosed epilepsy.¹⁴ Similarly, Kral and colleagues found no association between earlier age at epilepsy onset and ADHD in a retrospective cohort study of children with epilepsy (class III).²⁷

Seizure and epilepsy type. (Level U)

Several well-designed studies provide evidence that children with childhood absence epilepsy (CAE) have high rates of ADHD; however, these studies did not compare CAE to other epilepsy types.²⁸⁻³⁰ Four studies have assessed whether specific seizure types correlate with greater risk of ADHD and found no correlation.^{4, 14, 15, 27}

In contrast, one study comparing 23 children with temporal lobe epilepsy to 20 children with idiopathic generalized epilepsy found that those with temporal lobe epilepsy performed worse on tests of attentional control (class III).³¹ Another study comparing 51 children with focal seizures with altered awareness to 31 with CAE found similar prevalence of executive dysfunction in both cohorts (class II).³²

EEG Variables (Level U)

Several studies on small cohorts of children with CECTS noted a correlation between higher spike index and poorer function on measures of attention.^{26, 33} In contrast a small pilot study did not find any correlation between spike index during sleep and

severity of ADHD symptoms in children with various types of epilepsy.³⁴ A prospective study of children evaluated at seizure onset and compared to healthy siblings, found that interictal spikes were an independent risk factor of processing speed but not of attention/executive/construction impairment.³⁵ In conclusion, there is no convincing evidence for a relationship between interictal EEG changes and the severity of attention deficits.

Seizure frequency and control (Level B)

Most studies support a link between poor seizure control and higher risk of ADHD. In a prospective observational class III study of 40 children with “idiopathic or cryptogenic epilepsy”, both higher seizure frequency and polypharmacy correlated with greater risk of developing ADHD.³⁶ In a survey of children with drug resistant epilepsy attending a regional epilepsy center, higher seizure frequency was correlated with greater risk of attention and hyperactivity subscale scores on the Child Behavior Checklist (CBCL) (class III).³⁷ In a class III study of 75 children with focal epilepsy, those with seizures occurring at least weekly, were rated by their parents to have more symptoms of hyperactivity than those having less frequent seizures.³⁸ A study of adolescents with epilepsy, found a significant correlation between greater number of AEDs used and lower scores on an inattentive subscale (class III).²⁵

A single class III study reported a prevalence of ADHD of over 60% in a cohort of children with refractory epilepsy.¹⁶ While this study suggests intractability is highly correlated with ADHD, a comparison group with less severe epilepsy was lacking. Conversely, a single population-based, case-control study found no significant correlation between seizure frequency at initial diagnosis in children with newly-diagnosed epilepsy (class II).¹⁵

Based on combined study findings, but balanced by the limitation of most data being from class III studies, there is evidence to support an association between poor seizure control and increased risk of ADHD. Future studies need to examine the interaction effect of polypharmacy and seizure frequency and control, to determine if the increased risk for ADHD is related to seizure frequency and control, or the adverse effects of polypharmacy.

When to screen children with epilepsy for ADHD. (Level U; expert opinion).

There are no studies that evaluate when to screen children with epilepsy for ADHD. Based on reports that children with epilepsy are at elevated risk of ADHD at the time of presentation with their first seizure³⁹ or when epilepsy is first diagnosed,¹⁴ screening for ADHD should be performed in every child with epilepsy starting at age 6 years, or at the time of diagnosis if older than 6 years, and repeated annually. Attention should also be re-evaluated after any change of AED. Screening should not be performed within 48 hours of a seizure associated with a post-ictal state.

2. What screening tools should be used, and how should ADHD be diagnosed in children and adolescents with epilepsy?

Whilst guidelines and consensus statements for assessment of Attention Deficit Hyperactivity Disorder (ADHD) exist,^{40, 41 42 43} the ideal assessment method and how to differentiate among subtypes is not defined. The diagnosis of ADHD should involve health practitioners with expertise in ADHD, such as psychologists, child psychiatrists, child neurologists and developmental pediatricians (level U: expert opinion). Diagnosis of ADHD requires: 1) validated ADHD rating scales from parents and teachers based on Diagnostic and Statistical Manual of Mental Disorders – 4th or

5th editions (DSM-IV and -5); 2) rating scale information through parent interview; and, 3) exclusion of other causes. Rating scales permit screening to assess ADHD symptoms but no formal recommendations state using one tool over the other (supplemental file, Table S5). Measures differ in terms of normative populations, availability in languages other than English, cost, whether they assess impairment in various areas (school, home, work), screening for symptoms other than ADHD, and time required to complete.⁴⁴

Six studies met the inclusion criteria with a total of 608 participants with childhood onset epilepsy. Three were ranked as class I,^{21, 22, 45} two as class II,^{17, 46} and one as class III⁴⁷. Four of the studies^{21, 22, 45, 46} included diagnostic efficiency statistics (e.g., sensitivity, specificity), and one study reported the concordance between the screener identification of problematic behavior and a psychiatric diagnosis.¹⁷ A summary of study findings is provided in Table 3.

Three of the studies used the Strengths and Difficulties Questionnaire (SDQ),⁴⁸ with two of them reporting data on the Hyperactivity subscale—among other SDQ scores,^{22, 46} and one using the Total score only¹⁷. All studies combined both Borderline and Abnormal cut-offs on the SDQ as a positive screen for ADHD. More children screened positive on parental reporting of the Hyperactivity scale than actually had the diagnosis, compared to teachers who under-identified children who ultimately received a diagnosis of ADHD.²² Another study of similar sample size and with similar ADHD rate found the sensitivity and specificity of parental report on the SDQ hyperactivity subscale to be stronger than the Reilly *et al* UK study²² at 86.4% and 95%, respectively.⁴⁶ Borderline or abnormal SDQ total scores are highly correlated with the presence of a validated psychiatric diagnosis (93.6%), of which ADHD is the most common (31.7%).¹⁷ Overall, the SDQ had better sensitivity than

specificity, suggesting that it can be used as a screener, but that more detailed psychiatric diagnosis should follow for those identified at risk.

Two of the studies^{45, 47} used the parent (CBCL) version of the Achenbach System of Empirically Based Assessment⁴⁹. Using three rating scales found specificity for the scores above the clinical cut-offs for ADHD, namely the CBCL (85%), the teacher version of the Achenbach measure (TRF) (64%) and the Swanson, Nolan, and Pelham-IV Questionnaire (SNAP-IV) (81%).⁵⁰ There was low concordance between the information obtained from parents compared to the teachers, because the TRF results were normal for a large proportion of patients diagnosed with ADHD by the psychiatric evaluation. Hesdorffer and colleagues also used the parent version of the Achenbach System (CBCL) in their longitudinal study of cases of a community cohort of childhood onset epilepsy.^{45, 51} Sensitivity for the CBCL at the 9-year assessment was 0%, while specificity was 97%.⁴⁵ The sensitivity and specificity of the CBCL was adequate in a small sample of idiopathic epilepsy patients and comparable to the SNAP-IV, but the CBCL was a poor screener when compared against an ADHD diagnosis based on a structured interview at a 9 year follow up.

A study using the ADHD-Rating Scale IV found significantly higher scores on parent versus teacher ratings on all three subscales (total score, inattentive score, and hyperactive-impulsive score).²¹ Using the 80th percentile cutoff, sensitivity and negative predictive values were higher for parent reports but specificity and positive predictive values were higher for teacher responses.

Given the limited number of studies that met criteria, additional research is needed. Nonetheless, one class I and two class II studies support the ability of the SDQ to predict ADHD diagnosis in children with epilepsy (Level B). These three

studies had relatively larger sample sizes (>65), included a wide age range, represented diverse epilepsy types, and were from different countries. The SDQ is available at no cost in multiple (>80) languages and has ability to screen for other problems. Potential drawbacks of the SDQ include lower sensitivity for the inattentive presentation of ADHD,^{52, 53} which is often more prevalent in epilepsy populations.^{14, 16, 54} However, this weakness was not reflected in the studies reviewed here where the combined subtype was more prevalent and thus may be contributing to the strong ability of the SDQ to perform well. The low specificity of the SDQ could be a limitation; but, as a *screening* tool, that limitation can be remedied by appropriate follow up with a diagnostic interview by a qualified clinician. It is more important to over identify (false positive) on screening rather than miss children (false negative) who are at risk (level U; expert opinion). Other limitations of the SDQ, as well as other measures, may be its utility in different sub-populations who have epilepsy including children with intellectual disability^{55, 56} or of different racial and ethnic backgrounds⁵⁷. Overall very few measures evaluating children for a diagnosis of ADHD are validated (nor do they have generated scoring or cut-off norms) for populations from different ethnic or cultural backgrounds or those with intellectual disability.

Results are limited to questionnaires. There is also good rationale for using a multi-trait, multi-method approach which includes a short computerized evaluation.⁵⁸ Continuous Performance Tasks (CPTs) have high positive predictive value but poor negative predictive value meaning that a child that performs poorly is likely to have ADHD but a child who “passes”, may also still have ADHD; thus, computerized tests do not reliably differentiate children with ADHD from those without.^{59, 60} CPTs that rely on reaction time may also be a challenge as children with epilepsy have slow

processing speed which may interfere with performance rather than a primary attention problem.³⁸ Access to free cognitive functioning tools in children with epilepsy is available but these need to be assessed for sensitivity and specificity.⁶¹ One such tool is EpiTrack Junior which is a screening tool to assess attention and executive function validated in German and Austrian cohorts.⁶¹ The tool has not yet been tested for its reliability in predicting ADHD.

3. What criteria can be used to distinguish ADHD from other conditions such as absence seizures, learning disorders and other conditions that mimic ADHD?

ADHD may be misdiagnosed in children with absence epilepsy and vice versa.⁶²

Further ADHD is a common co-morbidity in children with absence seizures, occurring in 30-60% of affected cohorts.²⁸

Studies reporting the clinical aspects to make the distinction between ADHD and absence epilepsy were scarce. Three features were more suggestive of non-epileptic staring than absence seizures: (1) lack of interruption of play; (2) more commonly noted by a professional rather than a parent; and, (3) interruptible by external stimuli, such as touch.⁶³ Furthermore, hyperventilation induces an absence seizure in most children with untreated childhood absence epilepsy.⁶⁴ Comparing 17 children with CAE to 27 with ADHD, 2 items, “does not complete homework” and “does not remain on task”, were found which had a 79% sensitivity and 92% specificity for ADHD.⁶² Lee and colleagues found that commission errors (number of responses to non-targets) and response time variability was increased in children with ADHD and CAE, compared to those with CAE alone.²⁹ Differing study methodologies limited comparison. In conclusion, a distinction between ADHD and CAE should be based

on history and an EEG with hyperventilation (level U, expert opinion).

Approximately 21-33% of children with epilepsy have comorbid intellectual disability.⁶⁵⁻⁶⁷ Furthermore, even in those with normal IQ, learning disabilities are common.⁶⁸ It has already been documented that intellectual disability is correlated with higher risk of ADHD (see Section 1: Intellectual and Developmental Disabilities, above). Similarly, sleep disorders are more prevalent amongst children with epilepsy and comorbid ADHD compared to those with epilepsy alone.⁶⁹ Both learning and sleep disorders may present as staring and inattention. Formal cognitive testing should be strongly considered in children with epilepsy who are struggling at school (Level U: expert opinion). Careful screening for anxiety and depression, as well as bipolar disorder and early onset schizophrenia, and queries regarding sleep should be undertaken routinely in children with epilepsy, particularly if inattention and academic concerns are present (level U: expert opinion). Where the child neurologist is unable to exclude these disorders, psychologist or psychiatric evaluation using screening instruments should be implemented.

4. What is the recommended management of ADHD in children and adolescents with epilepsy?

Are there some precautions to consider with certain AEDs with regards to ADHD?

Sixteen studies were identified (supplemental data, Tables S1, S6 with additional references).

There were 3 class I studies.⁷⁰⁻⁷² Study populations reviewed were CAE and focal seizures treated with various AEDs.^{70, 71} The two studies reviewing ethosuximide,

lamotrigine and valproate in CAE provided strong evidence that valproate is associated with exacerbation of attentional issues in this population.^{70, 71} The other study compared levetiracetam to placebo in children with focal seizures, and showed marginal improvement in behavior, but not specifically attention in those treated with levetiracetam.⁷²

There were 2 class II studies, one assessed focal seizures and the other children with CECTS.^{73, 74} The focal seizure study reported that children on monotherapy or combined therapy with carbamazepine, oxcarbazepine or sodium valproate had no significant difference in combined processing speed and attention, as secondary outcomes, but was limited by a short study period.⁷³ The other study reviewed topiramate and carbamazepine in children with CECTS.⁷⁴ The topiramate group had a trend towards improvement in attention but worsened cognition, compared to those on carbamazepine, however the lack of significance of these findings limited further conclusions.

There were 11 class III studies. Two studies reviewed CECTS, one focal seizures, one generalized seizures, one complex seizure disorders and six all seizure types. Diverse AEDs were included with little consistency across studies limiting comparison. Polytherapy was associated with higher rate of behavioral problems. (level C). Several studies from both resource-poor and resource-equipped settings found no correlation between AEDs and behavior and attention problems. A Tanzanian based study found no evidence of behavior exacerbation with AEDs, including phenobarbital, but assessments were based solely on parental feedback and access to AEDs was limited with only 48% of the study group receiving therapy⁷⁵. This is supported by studies from resource equipped settings as well. In contrast, other studies reported that patients with CECTS on AEDs were more likely to have

social problems, aggressive behavior, and attention problems, and be anxious / depressed.⁷⁶ The study group alluded that this finding was related to ongoing seizures rather than specifically AEDs. Another study concluded that topiramate was associated with worsening in behavior in children with epilepsy aphasia syndromes at 3 months, but this was much less marked at 6 and 12 months of intervention time.⁷⁷

Should precautions be considered with specific AEDs with regard to ADHD?

(Table S7 with additional references). There was strong evidence (level A) to support the finding that valproate can exacerbate attentional issues in children with CAE. Polypharmacy is more likely to be associated with behavioral problems than monotherapy (level C). Studies are needed to elucidate whether the polytherapy itself has resulted in the behavioral problems, or the combination of polytherapy and the underlying brain problem reflects difficult-to-control epilepsy which, in turn, has resulted in the prescription of polytherapy. As such polytherapy has not been proven to cause of behavioural problems but is a marker for the complication. Data to support adverse behavioral effects from phenobarbital, whilst reported, is inconsistent and lacking good quality evidence due to small study sizes, lack of accepted behavioral screens and poor consistency in study methodologies. More studies with one epileptic syndrome comparing AEDs are necessary.

Do methylphenidate, atomoxetine or amphetamines have a worsening effect in seizure frequency? (Table S6, S7)

Exacerbation of seizures is reported in 0-18% of study populations on methylphenidate, but most are mild and transient, with no more than 5% stopping medication. Since these studies were not placebo-controlled it is not possible to

determine if the changes are related to baseline fluctuations. Seizure exacerbation rates for atomoxetine were 7-9% but again the numbers were too small to draw conclusions, and there are no data for amphetamines. Seven studies which included patients with refractory epilepsy, indicated that methylphenidate is probably safe. There was only one study which documented tolerability to atomoxetine in a complex population group, 7% had seizure exacerbation.⁷⁸ Data collected by the pharmaceutical manufacturer, found that seizures were no more prevalent in children with ADHD treated with atomoxetine than in children with ADHD without psychostimulant intervention.⁷⁹ This data did not separate out children with co-morbid epilepsy.

Are there any evidence-based treatment recommendations with respect to the management of ADHD in children and adolescent with epilepsy?

Data relating to treatment of ADHD in children and adolescents with epilepsy is limited (Table S7). There are no class I studies on efficacy and only seven class II and eight class III studies. For tolerability only nine class II and nine class III studies were identified. Most available data are on methylphenidate (n=16), with very limited data addressing amphetamines (n=1) or atomoxetine (n=2). Three studies involved adult patients. Lack of consistency in study methodology limited comparison between studies. For methylphenidate, overall there was a 65-83% improvement in ADHD symptoms of affected patients with co-morbid epilepsy, with statistical significance identified in several papers. Atomoxetine and amphetamines may be less effective, but data are too limited to draw conclusions. One adult based class III study comparing response to methylphenidate versus amphetamines found greater efficacy in the methylphenidate group.⁸⁰ Two class III and one class IV study reviewed

response to atomoxetine in a pediatric population with epilepsy and ADHD, 59% and 82% reported benefit with the remaining study reporting that 37% continued therapy but actual efficacy was not quantified.^{78, 81, 82}

In conclusion, Level B evidence supports efficacy of methylphenidate in children with epilepsy and comorbid ADHD. There is level U evidence for efficacy of atomoxetine and amphetamines. For tolerability, safety of methylphenidate in children with epilepsy (both controlled and refractory) and ADHD, is supported by Level B evidence, atomoxetine is level C and amphetamine level U.

Class I studies are needed to confirm these recommendations.

5. What is the recommended follow-up and transition of children and adolescents with ADHD and epilepsy?

- **When and how to discontinue pharmacological treatment of ADHD in children and adolescents with epilepsy**

There are no studies that focus specifically on the natural history of ADHD in children and teens with epilepsy. Thus, there is no data to inform decisions regarding need for maintenance of pharmacological treatment for ADHD in such cohorts.

However, in approximately two-thirds of cases with ADHD alone, symptoms persist into adulthood.⁸³ ADHD is often associated with other comorbidities including substance abuse and mood disorders, and lack of symptom management at this critical time in adolescence and young adulthood which may have profound consequences on academic and vocational performance, social relationships and risk-taking behavior. Furthermore, young adults with ADHD may not appreciate, and

therefore not seek care for their symptoms, or may stop stimulants as they perceive they have outgrown this disorder.⁸³

Thus, if pharmacological treatment of ADHD is beneficial and appears well tolerated, it may be continued for as long as it remains effective, but should be reviewed annually, as recommended by ADHD clinical guidelines (class IV).⁴²

- **What is the ideal management of transition of care to the adult services?**

There were no studies devoted to transition of patients with both comorbid ADHD and epilepsy. But various guidelines for transition of care for adolescents with special needs exist.⁸⁴ (Supplemental data: Table S8).

A transition working group comprising pediatric and adult health care providers and patient representatives identified seven steps to maximize a successful transition (Table S8) and highlighted psychiatric issues such as ADHD as a factor which may increase the risk of unsatisfactory transfer.⁸⁵ Another report from the Transition in Epilepsies symposium identified ADHD as a treatable disorder which may interfere with transition and successful adulthood.⁸⁶

The NICE guidelines for transition of adolescents with ADHD were established in the UK in 2008,⁴² and accepted throughout Europe (class IV), and specific recommendations are listed in Table S6. Treatment of ADHD declines sharply from childhood through young adulthood despite persistence of functional impairment. Primary care providers are less likely than pediatricians or psychiatrists to prescribe medications for ADHD.⁸³

Recommendations (Level U: expert opinion)^{83, 87} include multidisciplinary involvement in transition and adult ADHD clinics. This is essential as many patients experience challenges with housing, employment, relationships and psychosocial well-being.

CONCLUSION

This paper addresses the common and challenging clinical aspects of managing children with epilepsy and ADHD. Key study questions on common and practical issues were identified and the evidence in the literature critiqued to establish the strength of evidence to support statements and where possible to put forward recommendations (Table 2).

Despite ADHD being a common comorbidity for children with epilepsy,⁵ the analysis was limited by the lack of class I studies, consistency across study methodology and directness to the study questions. Specifically there was lack of controlled, randomized double blind studies, of large sample and follow-up, lack of specific evaluation of attention, inadequate data on impact of each AED on attention, and study cohorts of broad, phenotypic heterogeneity. Few studies used a neuropsychological battery to evaluate attention. Those studies that did use appropriate batteries (e.g, Masur *et al.*),⁷⁰ in general, used one instrument. In the case of Masur and colleagues, Continuous Performance Test (CPT) was used, which is regarded as the gold standard tool for sustained attention. Some studies used the CBCL which is based on parents' report and does not replace neuropsychological testing.

Young children with suspected ADHD should be screened for psychiatric diagnoses that might mimic ADHD in particular anxiety disorders that are co-morbid with pediatric epilepsy.

Impulsivity is one of the core features of ADHD, but this symptom is not well studied in children with co-morbid epilepsy. The most common form of ADHD in children with epilepsy is the inattentive form, with the result that there is limited data on impulsivity.⁴

The report was useful to identify where common management concepts were not supported by strong evidence base and where there are significant areas in need of a more structured and targeted research.

This report has been generated to provide a practical but evidence-based guide to challenging areas in the approach to the care of children with epilepsy who are at risk of, or affected by, the co-morbidity ADHD. The outcome of this systematic review is to demonstrate the need for better designed studies to address many of the important areas addressed.

Bullet points :

- Risk factors for ADHD in children with epilepsy include co-morbid developmental disabilities, as well as poor seizure control.
- Data support the ability of the SDQ to predict ADHD diagnosis in children with epilepsy
- Polytherapy is more associated with behavioral problems than monotherapy.
- Valproate can exacerbate attentional issues in children with CAE.
- Methylphenidate is tolerated and effective in children with epilepsy and co-morbid ADHD

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The following authors conducted the literature review, classified the evidence and wrote the narratives for their allocated questions. All authors proof read and approved the final version of the paper.

VKP, PS, KAD, EW, MLS, MO, HK and MA contributed to the question 'who is at risk of ADHD in children with epilepsy'.

MLS, MMB, LC, and PvB contributed to the question 'how to screen and how to diagnosis ADHD in children and adolescents with epilepsy'.

KAD, DD, PvB, MMB and LC contributed to the question 'how to differentiate absence seizures from ADHD and the differential diagnoses to consider before diagnosing ADHD.

MLS, KV, SA, LC, HH, VKP, MMG, JMW, EW and MMB contributed to the question 'how to manage children and adolescents with epilepsy and ADHD'.

HH, MMG, KV, EW, and MK contributed to the question on 'follow-up and transition of children and adolescents with ADHD and epilepsy'.

SA, EW and JMW compiled the final combined version of the paper.

Ethical Publication Statement

“We confirm that we have read the Journal’s position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.”

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Legends

Table 1: List of clinical practice-oriented questions about ADHD in Children and Teens with Epilepsy identified by the ILAE Pediatric Commission

Table 2: Executive summary of recommendations to study questions.

Table 3: Summary of the studies with data to assess which screening tools should be used in the diagnosis ADHD in children and adolescents with epilepsy

Supplemental files

Table S1: Systematic search process and terms for study questions.

Table S2 : PRISMA checklist

Table S3 : PROPERO registered study as registered CRD42018094617

Table S4 : Class of Evidence and Recommendation Level according to the American Academy of Neurology (AAN) uses the following definitions for the level of recommendation and classification of evidence

Table S5: Validated rating scales to assess ADHD symptoms

Table S6: Summary of the data relating to the study question “Are there some precautions to put in place with AEDs with regards to ADHD?”

Table S7: Summary of the data relating to the study question “Is there any evidence-based treatment to the management of ADHD in children and adolescent with epilepsy?”

Table S8: Summary of the data relating to the study question “What is the recommended follow-up and transition of children and adolescents with ADHD and epilepsy?”

Table 1: List of clinical practice-oriented questions about ADHD in Children and Teens with Epilepsy identified by the ILAE Pediatric Commission

- 1. What are the risk factors for ADHD in children and teens with epilepsy and when should screening begin?**
- 2. What screening tools should be used, and how should ADHD be diagnosed in children and adolescents with epilepsy?**
- 3. What criteria can be used to distinguish ADHD from other conditions such as absence seizures, learning disorders and other conditions that mimic ADHD?**
- 4. What is the recommended management of ADHD in children and adolescents with epilepsy?**
- 5. What is the recommended follow-up and transition of children and adolescents with ADHD and epilepsy?**

Table 2 : Summary of Recommendations with regard to screening, diagnosis and management of ADHD in children with epilepsy.

Study question	Recommendation	Level of recommendation	Comment
1. What are the risk factors for ADHD in children and teens with epilepsy and when should screening begin?			
What are the risk factors of ADHD in children with epilepsy?			
	There is no increased risk of ADHD in boys with epilepsy compared to girls with epilepsy.	A	
	Valproate use in pregnancy is associated with inattentiveness and hyperactivity in offspring.	Class I	Single class I study
	Children with epilepsy with comorbid intellectual and developmental disabilities are at increased risk of ADHD.	A	
	Evidence is conflicted for the impact of early seizure onset on the development of ADHD in children with epilepsy	U	Need large prospective studies
	Specific seizure types are not predictive of higher rates of ADHD	U	
	Poor seizure control is associated with increased risk of ADHD.	B	
When to screen the children with epilepsy for ADHD	Screening for ADHD should be performed from 6 years or at the time of diagnosis and repeated annually.	U	Expert opinion
	Reevaluation of attention function after any change of AED	U	Expert opinion
	Screening should not be performed within 48 hours of seizure event associate with a post ictal state	U	Expert opinion
2. What screening tools			

should be used, and how should ADHD be diagnosed in children and adolescents with epilepsy?			
	The diagnosis of ADHD should involve health practitioners who have undergone expert training in the recognition of ADHD.	U	Expert opinion
	Data support the ability of the SDQ to predict ADHD diagnosis in children with epilepsy	B	Expert opinion – research on other screening tools is needed
	It is more important to over identify (false positive) on screening rather than miss children (false negative) who are at risk	U	Expert opinion
3. What criteria can be used to distinguish ADHD from other conditions such as absence seizures, learning disorders and other conditions that mimic ADHD?			
	A distinction between ADHD and CAE should be based on history and an EEG with hyperventilation.	U	Expert opinion
	Formal cognitive testing is strongly recommended in children with epilepsy who are struggling at school.	U	Expert opinion
	Careful screening for anxiety and depression, and queries regarding sleep should be undertaken routinely in children with epilepsy, particularly if inattention and academic concerns are present.	U	Expert opinion

<p>4. What is the recommended management of ADHD in children and adolescents with epilepsy?</p>			
<p>Are there precautions to consider with certain AEDs with regards to ADHD?</p>	<p>Polytherapy is more likely to be associated with behavioral problems than monotherapy. Valproate can exacerbate attentional issues in children with CAE.</p>	<p>C A</p>	
<p>Does methylphenidate exacerbate seizures?</p>	<p>Methylphenidate is tolerated in children with epilepsy (both controlled and refractory) Limited evidence supports that atomoxetine is tolerated in children with epilepsy and ADHD. Tolerability for amphetamine in children with epilepsy is not defined.</p>	<p>B C U</p>	
<p>Is there any evidence-based treatment to the management of ADHD in children and adolescent with epilepsy?</p>	<p>Evidence supports efficacy of methylphenidate in children with epilepsy and comorbid ADHD. Limited evidence exists for the efficacy of atomoxetine and amphetamines in children with epilepsy and ADHD.</p>	<p>B U</p>	
<p>5. What is the recommended follow-up and transition of children and adolescents with ADHD and epilepsy?</p>			
	<p>Multidisciplinary involvement in transition and adult ADHD</p>	<p>U</p>	<p>Expert opinion</p>

	clinics is essential as many patients experience challenges with housing, employment, relationships and psychosocial well-being.		
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Table 3: Summary of the studies with data to assess which screening tools should be used in the diagnosis ADHD in children and adolescents with epilepsy

Study	Country	Sample	Measure	Seizure characteristics	DSM diagnosis
Reilly et al. 2014 ²²	UK-South	New onset epilepsy in the community; IQ>34; n=69; ages 5-15	SDQ Abnormal/Borderline Parent Rating on the Hyperactivity scale had 50%/75% sensitivity	1/3 had weekly seizures; 2/3 had no or less often	Consensus of psychologist, pediatrician, psychiatrist based on case notes, standardized screening and cognitive measures, and school observations. N= 28 ADHD (19 ADHD-C; 9 ADHD-I)
Reilly et al. 2017 ²¹	UK-South	Active epilepsy in the community : IQ>34, n=69, ages 5-15	ADHD-RS IV Abnormal parent total score had 86% sensitivity and 51% specificity Abnormal teacher total score had 63% sensitivity and 90% specificity	1/3 had weekly seizures; 2/3 had no or less often	Consensus of psychologist, pediatrician, psychiatrist based on case notes, standardized screening and cognitive measures, and school observations. N= 28 ADHD (19 ADHD-C; 9 ADHD-I)
Tanabe et al. 2014 ⁴⁶	Japan	Primary clinic; severely mentally or physically handicapped excluded; n=68; ages 4-17	SDQ Abnormal/Borderline Hyperactivity Parent had 86.4% sensitivity; 3 children missed and 2 of them had ADHD-I ADHD-RS was significantly correlated with SDQ Hyperactivity scale but not compared with diagnosis	76% had no seizures; 74% on 1 AED; 77% LRE; 23% generalized	Structured interview with parents and teachers, mental evaluation, and behavioral observation. N=22 (32.4%) dx with ADHD (14 ADHD-C; 8 ADHD-I)
Alfstad et al. 2016 ¹⁷	Norway but used UK norms	Consecutive patients with a hospital stay at a tertiary center; IQ<70 excluded; n=101; ages 10-19	SDQ Abnormal/Borderline Parent or Self Total Score	Range of epilepsy types (52% focal/48% generalized) and etiologies; but occipital/parietal focal epilepsy excluded; 53% on 1 AED/ 55% had no GTC in last 6 months	Kiddie-SADS-PL; neuropsychological testing; n=32 (31.7%) had ADHD

Loutfi et al. 2011 ⁴⁷	Brazil	Routine neurology clinic visit; n=30; ages 6-13 years	CBCL Attention Problems; 82% sensitivity; 85% specificity SNAP-IV cut off; 93% sensitivity; 81% specificity	Idiopathic epilepsy, well controlled	Clinical Interview; n=16 (53.3% had ADHD (7 ADHD-C; 6 ADHD-HI; 3 ADHD-I)
Hesdorffer et al. 2014 ⁴⁵	USA-Connecticut	Longitudinal study of community-based cohort of epilepsy cases over 4 years: baseline, 9 year follow up; n=163	CBCL-DSM oriented ADHD score; 0% sensitivity; 96% specificity	Median age of onset 6.8 years	Diagnostic Interview Schedule for DSM-IV (DIS-IV); n=13 (5.4%) had ADHD