



The Hong Kong Society of Child Neurology and Developmental Paediatrics

## Annual Scientific Meeting 2014

1 – 3 November 2014 · Hong Kong

### “Paediatric Neuropsychopharmacology”



PROGRAMME BOOK



The Hong Kong Society of  
Child Neurology and Developmental Paediatrics

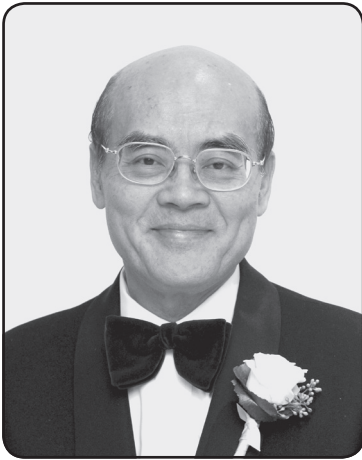
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## WELCOME MESSAGE



The Annual Scientific Meeting of the Hong Kong Society of Child Neurology and Developmental Paediatrics is an important event for the child healthcare professionals in Hong Kong because this is the occasion we host our multidisciplinary scientific meeting with the objectives to enhance cross-pollination (knowledge exchange and skill sharing) amongst experts in the arena of neuro-sciences with active participation of doctors (child neurologists, developmental behavioural paediatricians, general paediatricians, adult neurologists, neuro-surgeons, psychiatrists, radiologists, pathologists, public health specialists and others), nurses, allied health professionals, psychologists, social workers, special school teachers and other members in the transdisciplinary team. Over the past years, we have hosted meetings with themes covering Child Neurology (CN) and Developmental Behavioral Paediatrics (DBP) with great successes. We are proud to present the meeting this year at the celebration of the 20<sup>th</sup> Anniversary Celebration of our Society.

The Annual Scientific Meeting this year is on Paediatric Neuropsychopharmacology and our Course Director Professor Paramala J Santosh M.D., Ph.D., MRC Psych is the Head of the Centre for Interventional Paediatric Psychopharmacology (CIPP) at the Maudsley Hospital and Honorary Reader of the Institute of Child Health and Institute of Psychiatry, London, United Kingdom. He is a world expert in the area of child psychiatry and neuro-pharmacology and a scholar with immense experience in medication trials in children and adolescents with ADHD, Conduct Disorder and Autism Spectrum Disorder, as well as a professional active in measurement and health outcome research, acquired brain injury and metabolic syndromes and a clinician with extensive publications in the medical literature.

Our ASM this year will last for three days from 1<sup>st</sup> to 3<sup>rd</sup> November 2014 in Hong Kong. The whole programme consisting of series of lectures, seminars, workshops and keynote speeches by the Course Director coupled with contributions from local experts in the various specialties will promise all attendants a full and comprehensive coverage of the subject.

I would like to take this opportunity to thank Kwong Wah Hospital and the Hospital Authority for providing us with the meeting venues and the following key figures for contributing to the success of this Annual Scientific Meeting: Dr. Catherine Lam, Dr. Tsui Kwing Wan, Dr. Mario Chak, Dr. Stephenie Liu, Dr. Theresa Wong and others in the Organizing Committee as well as all speakers at the Meeting. Wyeth Hong Kong Limited is to be commended for their support via an Educational Grant as well as to Ms. Sigourney Liu and her effective team at MIMS (Hong Kong) Limited for their efficient organization of this Meeting. Most important of all, I would like to thank all members for their support and all registrants for their active participation which are always vital for the success of this Meeting. For all your support, I say thank you and I look forward to having your continual support for all future activities of our Society. I wish you all a fruitful and enjoyable Annual Scientific Meeting 2014!

**Dr. Chan Chok Wan**

*President*

*The Hong Kong Society of Child Neurology and Developmental Paediatrics*



## COUNCIL MEMBERS



### The Hong Kong Society of Child Neurology and Developmental Paediatrics (2012 – 2014)

President:	Dr. Chok-wan Chan
Vice President:	Dr. Catherine Chi-chin Lam
Honorary Secretary:	Dr. Stephenie Ka-yee Liu
Honorary Treasurer:	Dr. Theresa Yee-ling Wong
Council Members:	Dr. Wai-kwong Chak Dr. Florence Mun-yau Lee Dr. Tim Kam-tim Liu Dr. Kwing-wan Tsui Dr. Sam Chak-ming Yeung
Co-opted Council Members:	Dr. Josephine Shuk-ching Chong Dr. Chin-pang Chow Dr. Wing-cheong Lee

## ORGANIZING COMMITTEE

Members:	Dr. Wai-kwong Chak Dr. Catherine Lam Dr. Stephenie Liu Dr. Kwing-wan Tsui Dr. Theresa Wong
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## COURSE DIRECTOR



Dr Paramala Santosh is a Child and Adolescent Psychiatrist and has a long-standing interest in developmental psychopharmacology, neuropsychiatry and psychopathology, and the use of information technology and wearable technology to improve health delivery. He is recognised as an international expert in Autism Spectrum Disorders (ASD) and ADHD, and Paediatric Psychopharmacology. He re-analysed data from the Multimodal Treatment Study of ADHD (MTA) using a European perspective, and assisted in improving European guidelines. He is recognised as an expert in the field of assessment and management of complex multiple co-occurring developmental disorders. He developed and leads the Centre for Interventional Paediatric Psychopharmacology (CIPP), which has both clinical and research arms. He has conducted research into the overlap of Autism and ADHD, Bipolar Disorder and Autism, Bipolar Disorder and ADHD, and Childhood Dementias in the context of neurodegenerative disorders such as Hunter's, Hurler's, Sanfillippo syndrome, Gaucher Disease, Batten's disease etc. He has also been

involved in developing computerized assessment tools such as the HealthTracker™ and non-pharmacological interventions in the management of complex co-morbidity. He currently holds multiple large EU FP7 and NIHR grants and is a Visiting Reader at the Institute of Psychiatry, Psychology & Neurosciences, King's College London and is the Coordinator of the Suicidality: Treatment Occurring in Paediatrics (STOP) Programme. He is regularly an invited speaker at multiple national and international conferences and has published widely.

Dr Santosh had his basic medical training in India, and obtained his MD in Psychiatry from the Post-Graduate Institute of Medical Science and Research (PGIMER), Chandigarh, India. He subsequently completed his Psychiatry training at Guy's Hospital. After specialisation in Child and Adolescent Psychiatry from the Maudsley Hospital, London, he became a Consultant in 2002 at the Maudsley and Guy's Hospitals and then in 2004 moved to Great Ormond Street Hospital for Children, London, to set up the Centre for Interventional Paediatric Psychopharmacology (CIPP). CIPP is involved in assessing and managing children and adolescents with severe and complex treatment-resistant neuropsychiatric disorders, childhood bipolar disorders, childhood dementias, epilepsy related psychiatric comorbidity, post-head injury syndromes and children with severe physical illness or serious psychotropic induced side-effects. In February 2012, the CIPP moved to the Maudsley Hospital, London. He is a Visiting Reader at the Institute of Psychiatry, Psychology and Neurosciences, King's College London and continues his focus on translational research.



# FACULTY MEMBERS

Name	Affiliation
Dr. Mario Chak	Associate Consultant Department of Paediatrics and Adolescent Medicine Tuen Mun Hospital, Hong Kong
Dr. Chok-wan Chan	Specialist in Paediatrics Private Practice, Hong Kong
Dr. Catherine Lam	Consultant Paediatrician Child Assessment Service Department of Health, Hong Kong
Dr. Stephenie Liu	Senior Medical Officer Child Assessment Service Department of Health, Hong Kong
Dr. Flora Mo	Associate Consultant Psychiatrist Alice Ho Miu Ling Nethersole Hospital, Hong Kong
Dr. Venus Tam	Associate Consultant Department of Psychiatry (Child and Adolescent Psychiatry) Castle Peak Hospital, Hong Kong
Dr. Lucia Tsang	Clinical Psychologist, Child Assessment Service Department of Health, Hong Kong
Dr. Kwing-wan Tsui	Senior Medical Officer Department of Paediatrics and Adolescent Medicine Alice Ho Miu Ling Nethersole Hospital, Hong Kong
Dr. Theresa Wong	Specialist in Paediatrics Private Practice, Hong Kong
Ms. Dominique Yeung	Clinical Pharmacist, Department of Pharmacy Queen Mary Hospital, Hong Kong
Dr. Sam Yeung	Specialist in Paediatrics Private Practice, Hong Kong



# SCIENTIFIC PROGRAMME

Date: 1 November 2014 (Saturday)

Venue: Lecture Theatre, 10/F., Yu Chun Keung Memorial Medical Centre, Kwong Wah Hospital, Yaumatei, Kowloon

13:00 – 14:00 Registration and Light Buffet Lunch

14:00 – 15:00 **Seminar I** (Chairpersons: Dr. Chok-wan Chan and Dr. Stephenie Liu)  
Pharmacological Management of Neuropsychiatric Disorders in Children with Acquired Brain Injury and Dementia

*Professor Paramala Santosh, UK*

15:00 – 15:30 **Local Presentation I** (Chairpersons: Dr. Chok-wan Chan and Dr. Stephenie Liu)  
Traumatic Brain Injury: a Six-year Journey for a Teenager with Multiple Sequelae

*Dr. Lucia Tsang, DH*

15:30 – 16:00 Coffee Break

16:00 – 17:00 **Seminar II** (Chairpersons: Dr. Chok-wan Chan and Dr. Stephenie Liu)  
Neurobehavioural Problems in Children with Epilepsy and Antiepileptic Medication

*Professor Paramala Santosh, UK*

Date: 2 November 2014 (Sunday)

Venue: Lecture Theatre, 10/F., Yu Chun Keung Memorial Medical Centre, Kwong Wah Hospital, Yaumatei, Kowloon

09:30 – 10:00 Registration

10:00 – 11:00 **Seminar III** (Chairpersons: Dr. Catherine Lam and Dr. Sam Yeung)  
Pharmacological Management in Children with Autism and Intellectual Disability

*Professor Paramala Santosh, UK*

11:00 – 11:30 **Local Presentation II** (Chairpersons: Dr. Catherine Lam and Dr. Sam Yeung)  
Neuropsychiatric Problems in Temporal Lobe Epilepsy

*Dr. Mario Chak, TMH*  
*Dr. Venus Tam, CPH*

11:30 – 12:00 **Local Presentation III** (Chairpersons: Dr. Catherine Lam and Dr. Sam Yeung)  
Pharmacology of Common Psychotropic Drugs Used in Children

*Ms. Dominique Yeung, QMH*

12:00 – 13:30 Light Buffet Lunch

13:30 – 14:30 **Seminar IV** (Chairpersons: Dr. Mario Chak and Dr. Kwing-wan Tsui)  
Pharmacotherapy of ADHD – an Update

*Professor Paramala Santosh, UK*





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14:30 – 15:00 **Local Presentation IV** (Chairpersons: Dr. Mario Chak and Dr. Kwing-wan Tsui)  
Management of Challenging Behaviours in Child Psychiatric Setting

*Dr. Flora Mo, AHMLNH*

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15:00 – 15:30 Coffee Break

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15:30 – 16:30 **Seminar V** (Chairpersons: Dr. Mario Chak and Dr. Kwing-wan Tsui)  
Pharmacological Management in Child and Adolescent Anxiety and Depression

*Professor Paramala Santosh, UK*

Date: 3 November 2014 (Monday)

Venue: Pearl Ballroom, 2/F., Eaton, Hong Kong, Jordan, Kowloon

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18:30 – 19:00 Registration

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19:00 – 20:00 **Keynote Lecture** (Chairpersons: Dr. Chok-wan Chan and Dr. Theresa Wong)  
Collaborative Working between Paediatrics and Child Psychiatry - Service Models and Harnessing  
Technology for Management of Common Child and Adolescent Mental Health Problems

*Professor Paramala Santosh, UK*

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20:00 – 22:00 Chinese Banquet

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## ACADEMIC ACCREDITATIONS

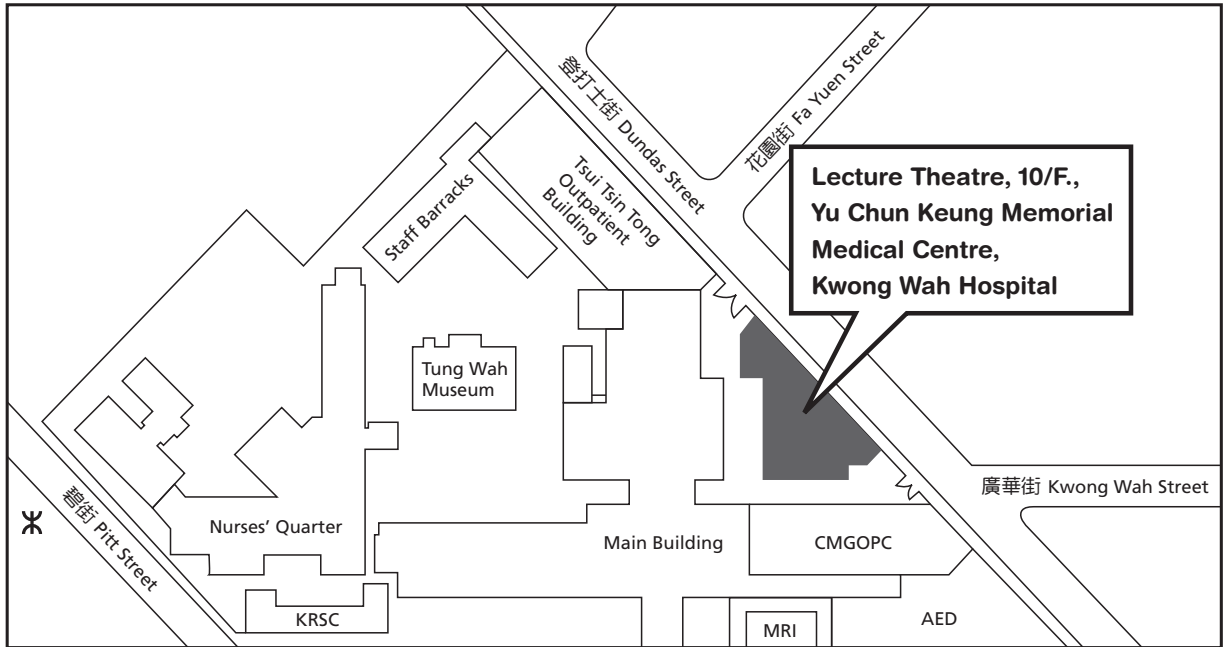
College / Association	1 Nov	2 Nov	3 Nov
Hong Kong College of Paediatricians (Category A)	3	6	1
Hong Kong College of Psychiatrists	TBA	TBA	TBA
Hong Kong College of Family Physicians (Category 5.2)	3	5	1
Hong Kong College of Physicians	1	2	0.5
Hong Kong Occupational Therapists Association	1.5	2.5	0.5
Hong Kong Physiotherapy Association	3	5	1
MCHK Programme	3	5	1



# VENUES

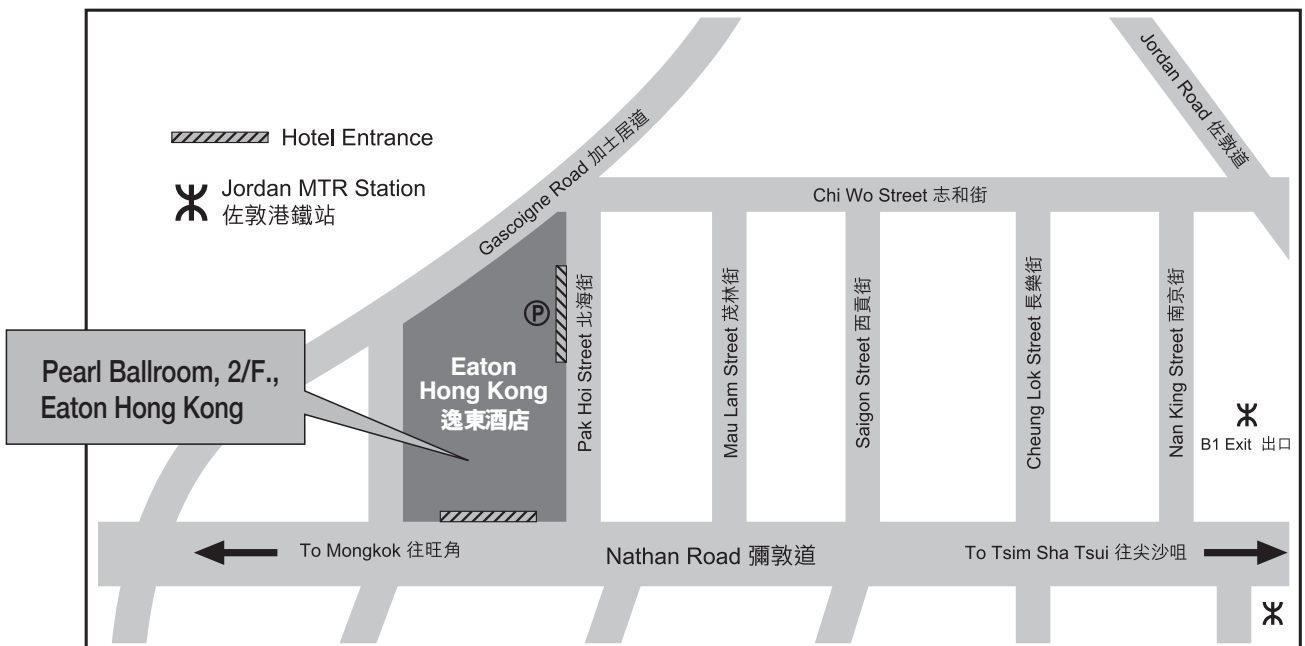
## KWONG WAH HOSPITAL 廣華醫院

1 - 2 NOVEMBER 2014



## EATON, HONG KONG 香港逸東酒店

3 NOVEMBER 2014





# SEMINAR I

## Pharmacological Management of Neuropsychiatric Disorders in Children with Acquired Brain Injury and Dementia

**Professor Paramala Santosh**

*Visiting Reader, Developmental Neuropsychiatry & Psychopharmacology, Department of Child and Adolescent Psychiatry, King's College London*

*Head and Consultant Child & Adolescent Psychiatrist, Centre for Interventional Paediatric Psychopharmacology (CIPP), Child and Adolescent Mental Health Services, Maudsley Hospital, London, United Kingdom*

The focus of pharmacotherapy is two-fold, i) to alleviate or reduce specific symptoms or behaviours, such as the features of ADHD, aggression, anxiety, depression, mood lability, withdrawal, repetitive stereotyped, obsessions and compulsions and occasionally psychotic or catatonic symptoms and ii) to provide possible neuroprotection. Often, the presentations in ABI revolve around delirium, depression, anxiety and post-traumatic stress disorders, while symptoms in childhood dementia often show symptoms of ADHD, oppositional and defiant behaviour, aggression, disinhibition and mood lability, alongside multi-organ involvement. Conditions that occur commonly in people with both ABI and dementia that may be associated with behavioural disturbance are epilepsy, autonomic storms, pain associated with muscular spasms and dystonia, reflux and gastritis, constipation, bed-sores, ill-fitting splints or braces should be treated appropriately before psychotropics are considered.

The target symptoms for treatment should be selected carefully and measured before the start of treatment so that response can be monitored accurately. Before psychotropic medication is considered, a full history should be taken, including an account of any medication used in the past, together with the response, the past medical history and detailed family history. Careful note should be taken of any individual or family history of medical problems that might increase the risk of prescribing specific drugs. Symptoms such as inattention, impulsivity, hyperactivity, tics, obsessions and psychosis may respond largely to medication alone. Symptoms such as aggression, rituals, self-injury, anxiety and depression are likely to require both medication and other forms of management. Psychological interventions such as modified CBT can be helpful in children with good cognitive ability and communication in ABI and in early stages of dementia. Symptoms that are unlikely to respond to medication and need specific remediation include skill deficits in academic or social domains. Low-dose 5HT-1A partial agonists, serotonergic drugs, partial dopamine agonists, melatonin etc are being investigated for its neuroprotective effects.





# LOCAL PRESENTATION I

## Traumatic Brain Injury: a Six-year Journey for a Teenager with Multiple Sequelae

**Dr. Lucia Tsang**

*Clinical Psychologist, Child Assessment Service, Department of Health, Hong Kong*

Traumatic brain injury may bring along significant impact on one's sensory, motor, neurocognitive, behavioural, emotional and social functioning. This group of patients is reported to have higher incidence of psychological and psychiatric disorders. These impairments may be temporary or persistent, focal or pervasive, causing partial or total functional disability that can be debilitating to one's daily coping and to his/her family at large.

The prognostic factors such as age at injury, nature and severity of the insult, neuronal plasticity, premorbid functioning, course of rehabilitation, and psychosocial factors are said to affect the outcome of traumatic brain injury.

A teenager, who underwent a severe traumatic brain injury at the age of 13, will be reviewed along the context of the above theoretical framework. His premorbid functioning, the series of longitudinal follow-ups on his sensory, motor, language, neurocognitive functions and the emergence of somatic complaints, mood disorder, social difficulties, post-traumatic stress disorder, hallucination and seizure attacks would be discussed.



## SEMINAR II

### Neurobehavioural Problems in Children with Epilepsy and Antiepileptic Medication

**Professor Paramala Santosh**

*Visiting Reader, Developmental Neuropsychiatry & Psychopharmacology, Department of Child and Adolescent Psychiatry, King's College London*

*Head and Consultant Child & Adolescent Psychiatrist, Centre for Interventional Paediatric Psychopharmacology (CIPP), Child and Adolescent Mental Health Services, Maudsley Hospital, London, United Kingdom*

There are few studies on epilepsy and psychopathology in people with intellectual disability (mental retardation) despite epilepsy prevalence rates that are thirty times higher than in the general population. One-third of patients with epilepsy and intellectual disability meet criteria for possible psychiatric disorder, particularly mood and anxiety disorders; twice the comparison rates for intellectual disability alone. Certain seizure phenomena (greater seizure severity, more seizures in past month, lesser tendency to loss of consciousness during seizures) are particular risk factors for psychiatric disorder. Psychiatric disorder is least likely when seizures are well controlled, and loss of consciousness in seizures may be protective of emotional well-being (possibly a biological effect of seizures on mood, or patients being less aware of the seizure, or too tired to manifest distress).

Disruptive behavioural problem levels are variable and have even been reported to be lower than population norms in some studies. Behavioural problems appear to be less epilepsy specific and more predicted by intellectual and sensory impairment. Side effects of AEDs should be assessed because they may contribute to behaviour problems.

Anti-epileptic drugs (AEDs) continue to be the mainstay of epilepsy treatment, but the benefits of seizure control need to be weighed carefully against possible adverse effects, which can include behavioral problems and psychiatric disorders. The most commonly reported psychiatric adverse effects of AEDs are non-specific behavioral problems. The associations between AEDs and psychosis, depression and behavioral changes will be discussed. The concept of forced normalization will be discussed. Depression seems to be linked with AEDs potentiating GABAergic neurotransmission in patients with limbic system abnormalities such as hippocampal sclerosis. Psychoses have been described as associated with several of the new AEDs, and they are often seen in a setting in which previously refractory patients suddenly become seizure-free. In general terms, the use of AEDs in monotherapy, adopting slow titration schedules and low doses when possible, can significantly reduce the occurrence of behavioral adverse effects. A previous history of psychiatric disorder or a familial predisposition are important risk factors and should be always considered when choosing the appropriate AED. Several factors are implicated and the risk is likely to be linked to the severity of epilepsy, polytherapy, rapid titration and high dosages of the drugs. There is increasing evidence that good clinical management can decrease the risk of psychiatric adverse effects of AEDs: knowing which drugs are most likely to be implicated, starting with low doses and escalating slowly, and identifying those patients who will require close monitoring because of clinical risk factors, including a history of psychiatric disorders, febrile seizures or hippocampal sclerosis, should decrease the occurrence of such adverse effects in the future.





## SEMINAR III

### Pharmacological Management in Children with Autism and Intellectual Disability

**Professor Paramala Santosh**

*Visiting Reader, Developmental Neuropsychiatry & Psychopharmacology, Department of Child and Adolescent Psychiatry, King's College London*

*Head and Consultant Child & Adolescent Psychiatrist, Centre for Interventional Paediatric Psychopharmacology (CIPP), Child and Adolescent Mental Health Services, Maudsley Hospital, London, United Kingdom*

Autism Spectrum Disorder (ASD) can present with a variety of neuropsychiatric, emotional and behavioural problems. Neurochemical and functional imaging studies have identified abnormalities in neurotransmitters and brain structure. Children and adults with ASD and accompanying psychiatric symptomatology require a multidisciplinary/multimodal management approach, of which medication can be an important part. There is a remarkable lack of diagnostic instruments that have been adapted to assess co-occurring disorders specifically in people with ASD. The Centre for Interventional Paediatric Psychopharmacology (CIPP) identifies and diagnoses each co-occurring condition in ASD, by ensuring that the 'core' domain of the disorder is present, e.g. obsessions for diagnosing obsessive-compulsive disorder (OCD); symptoms reach 'thresholds' used in classificatory systems and are developmentally inappropriate; symptoms are NOT 'double counted' (e.g., hyperactivity in ADHD and for hypomania); each disorder produces additional impairment and checking that onset and course of the disorders are not indistinguishable and identical; and using multiple sources of information to ascertain the above criteria.

Medication can reduce the impact on interfering symptoms, improving the lives of individuals with autism spectrum disorder (ASD) and their families. Although there are no widely-accepted medications for treating the core symptoms of ASD, clinical trials have provided evidence for efficacy and tolerability of medication used for treating comorbid psychiatric conditions. A number of these have a good evidence base, including stimulant medication for the features of Attention Deficit Hyperactivity Disorder and Risperidone and Aripiprazole for improving challenging behaviour. Serotonergic agents are not useful in managing the repetitive behaviours inherent to ASD and should only be used if the child has significant Depression, Anxiety Disorders or Obsessive Compulsive Disorder. Treatment with psychopharmacological agents should only be undertaken after a careful assessment to ensure that any psychiatric symptoms are not the result of underlying physical disorders and to determine which symptoms should be targeted. The aim is to choose and adjust medication that achieves maximum benefit with minimum adverse effects.



# LOCAL PRESENTATION II

## Neuropsychiatric Problems in Temporal Lobe Epilepsy

**Dr. Mario Chak**

*Associate Consultant, Department of Paediatrics and Adolescent Medicine, Tuen Mun Hospital, Hong Kong*

**Dr. Venus Tam**

*Associate Consultant, Department of Psychiatry (Child and Adolescent Psychiatry), Castle Peak Hospital, Hong Kong*

Epilepsy is the most common neurological disorder in pediatric populations. Overseas epidemiological studies showed that there is high prevalence of psychopathology in children with epilepsy. Early psychiatric referral, assessment and treatment are beneficial to both patients and their caregivers.

Among different types of epilepsy, temporal lobe epilepsy (TLE) is one of the commonest causes of treatment-resistant epilepsy. Some patients may be benefited from surgeries if the foci of seizure are well demarcated. The Department of Neurosurgery, Pediatrics and Child & Adolescent Psychiatry of Tuen Mun Hospital (TMH) had collaborated since 2005 to perform surgeries for cases with refractory temporal lobe epilepsy. There were altogether fourteen case notes with TLE surgeries done between 2005 and 2014 achieved for the current study in order to assess the psychiatric co-morbidities in patients undergoing surgeries for refractory TLE. The demographic data, clinical information of epilepsy, neuroimaging results and psychiatric symptoms were revealed and summarized. It showed that there is high prevalence of psychiatric symptoms in patients with refractory TLE, though the symptoms may not be sufficient for a formal psychiatric diagnosis. The most common ones are anxiety and depressive symptoms. Some patients also have other psychiatric co-morbidities such as attention-deficit/ hyperactivity disorder (ADHD). This reflected that multi-disciplinary coordination in treatment of TLE is very important.





# LOCAL PRESENTATION III

## Pharmacology of Common Psychotropic Drugs Used in Children

**Ms. Dominique Yeung**

*Clinical Pharmacist, Department of Pharmacy, Queen Mary Hospital, Hong Kong*

ADHD is one of the most commonly diagnosed childhood psychiatric disorders. Having a child with ADHD creates a significant amount of stress among caregivers and teachers. Finding the best pharmacologic agent to treat and manage symptoms is important for this patient population. Methylphenidate is the first line of drug for ADHD. Onset of action can range from 15 to 120 minutes, and duration ranges from 3 -12 hours, depending on the formulation. Selection of an agent will depend on these characteristics.

### **Antidepressants**

There are four main antidepressant drug classes. Tricyclic antidepressants and monoamine oxidase inhibitors are not recommended for use in pediatrics because of their adverse effect profile and toxicity in overdose. Most studies have evaluated selective serotonin reuptake inhibitors (SSRIs) for the treatment of pediatric depression. Only fluoxetine and escitalopram have FDA approval indication for treatment of depression in pediatrics but other SSRIs are also used commonly. Medication related adverse effects typically occur shortly after therapy initiation whereas symptom improvement is often not observed until at least 2-4 weeks of treatment at a therapeutic dose.

### **Atypical antipsychotic agents**

The need for effective therapeutic interventions for youths with a variety of neuropsychiatric conditions has led to the increasing prescription of atypical antipsychotic agents. This has occurred despite the fact that only several atypical antipsychotic agents received FDA approval indications for use in individuals less than 18 years of age. Each agent blocks, to varying degrees, dopamine D2 receptors (the putative mechanism of their antipsychotic activity). However, each agent has additional distinct receptor binding profiles in the central nervous system. As a result of these differences, the safety, tolerability, or efficacy of a given compound may not be the same for another atypical antipsychotic agent and these medications are not interchangeable.





# SEMINAR IV

## Pharmacotherapy of ADHD – an Update

**Professor Paramala Santosh**

*Visiting Reader, Developmental Neuropsychiatry & Psychopharmacology, Department of Child and Adolescent Psychiatry, King's College London*

*Head and Consultant Child & Adolescent Psychiatrist, Centre for Interventional Paediatric Psychopharmacology (CIPP), Child and Adolescent Mental Health Services, Maudsley Hospital, London, United Kingdom*

Attention Deficit Hyperactivity Disorder (ADHD) is a heterogeneous behavioural syndrome characterised by maladaptive levels of hyperactivity, impulsivity and inattention. ADHD is a common disorder and prevalence varies depending on the classificatory system used. The NICE Guideline on ADHD draws together systematic reviews and expert opinion to produce clinical practice recommendations covering diagnosis, behavioural and pharmacological treatment and organisation of services for children and adults. The key practice recommendations and the challenges for implementing the guideline in routine clinical practice will be discussed. Some of the key recommendations of the NICE guideline are that ADHD should only be diagnosed by specialists in secondary care, that parent training/education should be used as first-line management in those with moderate ADHD but medication may be offered as first-line treatment for severe ADHD, alongside other management strategies. Methylphenidate, atomoxetine and dexamfetamine are recommended, within their licensed indications, as options for the management of ADHD. Decide which drug treatment to use based on: comorbidities (for example, tics, Tourette syndrome, epilepsy), their different adverse effects, potential problems with compliance (for example, modified release/once daily formulations to avoid taking medication at school), potential for drug diversion and misuse, preferences of the child or young person and their parent or carer. The findings from the Multimodal Treatment study of ADHD (MTA) will be discussed in detail to illustrate what can be done to optimize care.

Consider methylphenidate for ADHD without significant comorbidity and for ADHD with comorbid conduct disorder; methylphenidate or atomoxetine in the presence of tics, Tourette syndrome, or anxiety disorder. Try atomoxetine in those with stimulant misuse or risk of stimulant diversion, if methylphenidate has been tried and has been ineffective at the maximum tolerated dose, or the child or young person is intolerant to low or moderate doses of methylphenidate. Initial treatment should begin with low doses and titration with methylphenidate may be with either immediate- or modified-release preparations.

Modified-release methylphenidate may be preferred to increase adherence and if there are concerns about diversion or substance misuse. Dose should be titrated against symptoms and adverse effects for 4-6 weeks for methylphenidate and dexamfetamine (or lisdexamfetamine). Guanfacine can be used as an adjunct. Titration may require 8 to 10 weeks to obtain optimal effects on atomoxetine. Following an adequate treatment response, drug treatment should be continued for as long as clinically effective and reviewed annually. Drug holidays are not routinely recommended.





# LOCAL PRESENTATION IV

## Management of Challenging Behaviours in Child Psychiatric Setting

**Dr. Flora Mo**

*Associate Consultant, Department of Psychiatry, Alice Ho Miu Ling Nethersole Hospital, Hong Kong*

Challenging behaviour is more common in individuals with learning disabilities. Those with physical, emotional and communication difficulties would also show behavior that is difficult to manage. There are many types of behaviour that would be described as challenging including physical and verbal aggression, self-injurious behavior, stereotyped behaviour, inappropriate sexual behaviour, stealing, smearing and urination and non-compliant behaviour etc.

Such behaviour is often caused by many factors. The assessment of which involved thorough observation and the reporting by people who are taking care of these children including parents, teachers and other professionals. The management includes combination of multidisciplinary approaches with address to the physical, social and psychological needs of the patient. There is also a role of medication in some situations. In this talk local experience of managing such condition would be shared with illustration using clinical scenarios.

  
2 NOV



## SEMINAR V

### Pharmacological Management in Child and Adolescent Anxiety and Depression

**Professor Paramala Santosh**

*Visiting Reader, Developmental Neuropsychiatry & Psychopharmacology, Department of Child and Adolescent Psychiatry, King's College London*

*Head and Consultant Child & Adolescent Psychiatrist, Centre for Interventional Paediatric Psychopharmacology (CIPP), Child and Adolescent Mental Health Services, Maudsley Hospital, London, United Kingdom*

Like other medical conditions, anxiety disorders tend to be chronic unless properly treated. Most kids find that they need professional guidance to successfully manage and overcome their anxiety. Several scientifically proven and effective treatment options are available for children with anxiety disorders. The two treatments that most help children are cognitive-behavioral therapy and medication. Medications such as Selective serotonin reuptake inhibitors (SSRIs) can be useful in the treatment of anxiety disorders and are often used in conjunction with therapy. SSRIs are currently the medications of choice for the treatment of childhood and adult anxiety disorders. The U.S. Food and Drug Administration (FDA) have also approved the use of some SSRIs for the treatment of pediatric obsessive-compulsive disorder. Other types of medications, such as tricyclic antidepressants and benzodiazepines, are less commonly used to treat children. A combination of CBT and an antidepressant works better for children aged 7-17 than either treatment alone. Medication can be a short-term or long-term treatment option, depending on how severe the child's symptoms are and how he or she responds to treatment.

Management of depression in children and adolescents again warrant psychological therapy such as CBT or interpersonal therapy (IPT) in mild to moderate cases and SSRIs added to those with severe depression. The findings from the Treatment of Adolescent Depression (TADS) will be discussed in detail. The FDA issued a warning in October 2004 that antidepressant medications, including SSRIs, may increase suicidal thoughts and behavior in a small number of children and adolescents. However, the FDA has not prohibited or removed these medications, and no suicides were reported in the studies that led to the warning. The findings from the Suicidality: Treatment Occurring in Paediatrics (STOP) will also be discussed including practical management of self-harm will be discussed. SSRIs are generally tolerated with few side effects. The most commonly reported physical side effects include headache, stomachache or nausea, and difficulty sleeping.





# KEYNOTE LECTURE

## Collaborative Working between Paediatrics and Child Psychiatry - Service Models and Harnessing Technology for Management of Common Child and Adolescent Mental Health Problems

**Professor Paramala Santosh**

*Visiting Reader, Developmental Neuropsychiatry & Psychopharmacology , Department of Child and Adolescent Psychiatry, King's College London*

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In this age of medical specialization, one needs to be looking to improving co-working between Paediatrics (behavioural, general, developmental) and Child Psychiatry. Different countries use different service delivery models based on their health care set-up. The different models and ways to improve healthcare delivery using technology will be discussed.

The web-based health assessment and monitoring platform that we developed called HealthTracker™ will be discussed and demonstrated. Animated cartoons are used to obtain information about psychopathology, side-effects and quality of life from children as young as 5 years. The platform also obtains information from parents, clinicians and teachers and can be used to effectively utilize the limited clinical time available. This platform can also be used to triage cases that need to be seen by paediatrics or child psychiatrists. Effective use of technology (web-based, conference calls, mHealth) can improve quality of care provided in a cost-effective manner. Children often prefer the newer technologies to communicate their distress rather than face-to-face meetings. The HealthTracker™ has been used in monitoring complex symptoms such as suicidality across Europe (STOP project), transitions from adolescent to adult mental health (MILESTONE project) and will be discussed as exemplars. It is possible to set-up alerts, and aspires for personalized medicine using technology in coordinated care of children with various problems including emotional and behavioural problems. This talk will provide a forum for discussing how the local system of provision of care for this group of children can be optimized.



# PAST ANNUAL SCIENTIFIC MEETINGS

Since the inauguration of our Society in 1994, Annual Scientific Meetings were held each year:

**2013**

**Date:** 2 – 4 November 2013

**Theme:** Paediatric Neurometabolic Disorders

**Course Director:** Professor Marc Patterson, Australia

**Keynote Lecture:** Universal Newborn Screening for Metabolic Disorders

**2012**

**Date:** 16 – 19 November 2012

**Theme:** Augmentative and Alternative Communication

**Course Director:** Dr. John Costello, USA

**Keynote Lecture:** Breaking the Silence for Children with Complex Communication Difficulties

**2011**

**Date:** 18 – 21 November 2011

**Theme:** Paediatric Neuro-Radiology

**Course Director:** Professor Paul Griffiths, UK

**Keynote Lecture:** An Approach to Imaging Children with Cerebral Palsy

**2010**

**Date:** 26 – 29 November 2010

**Theme:** Neuro-Immunology

**Course Director:** Professor Russell Dale, Australia

**Keynote Lecture:** Auto-antibodies in Paediatric Neurology

**2009**

**Date:** 13 – 16 November 2009

**Theme:** Autism Spectrum Disorders: Updates on Management

**Course Director:** Professor Lonnie Zwaigenbaum, Canada

**Keynote Lecture:** Complementary and Alternative Medicine in Autism Spectrum Disorders: Public Forum

**2008**

**Date:** 21 – 24 November 2008

**Theme:** Neuro-Genetics

**Course Director:** Professor Alan Percy, USA

**Keynote Lecture:** Exploring the Neurogenetics of Mental Retardation

**2007**

**Date:** 16 – 19 November 2007

**Theme:** Energy Crisis of Nervous System

**Course Director:** Dr. Ingrid Tein, Canada

**Keynote Lecture:** Approach to the Diagnosis and Management of Muscle Cramps, Exercise Intolerance and Recurrent Childhood Myoglobinuria

**2006**

**Date:** 10 – 13 November 2006

**Theme:** Attention Deficit Hyperactivity Disorder

**Course Director:** Professor Drake Duane, USA

**Keynote Lecture:** Treatment of ADHD: Medical Behavioural and Educational and Prognosis

**2005**

**Date:** 11 – 14 November 2005

**Theme:** Neuromuscular Disorders of Infancy, Childhood and Adolescence

**Course Director:** Professor Royden Jones, USA

**Keynote Lecture:** Childhood Neuromuscular Disorder from the Perspective of Adult Neurology



**2004**

**Date:** 19 – 22 November 2004

**Theme:** Paediatric Rehabilitation

**Speaker:** Dr. Chok-wan Chan

**Keynote Lecture:** Evolution of Developmental Paediatrics in Hong Kong

**Course Director:** Professor Robert Armstrong, Canada

**Keynote Lecture:** Developmental Paediatrics in the 21<sup>st</sup> Century

**2003**

**Date:** 19 – 22 September 2003

**Theme:** Paediatric Neurocritical Care

**Course Director:** Dr. Robert Tasker, UK

**Keynote Lecture:** Head Injury and Neuroscience – Inside Fragile Minds

**2002**

**Date:** 8 – 11 March 2002

**Theme:** Paediatric Neuro-Ophthalmology

**Course Director:** Professor David Taylor, UK

**Keynote Lecture:** The Apparently Blind Child

**2000**

**Date:** 8 – 11 December 2000

**Theme:** Language Development, Learning Disorders and Brain Plasticity:  
Research and Clinical Implications

**Course Director:** Professor Albert Galaburda, USA

**Keynote Lecture:** Language Development, Learning Disorders and Brain Plasticity:  
Research and Clinical Implications

**1999**

**Date:** 20 – 22 November 1999

**Theme:** Paediatric Neuro-Epidemiology

**Course Director:** Dr. C. M. Verity, UK

**Keynote Lecture:** What Happens to Children who Suffer with Febrile Convulsions

**1998**

**Date:** 14 – 16 July 1998

**Theme:** Paediatric Epilepsy

**Course Director:** Professor Brian Neville, UK

**Keynote Lecture:** Epilepsy: A Potential Reversible Cause of Developmental Disability

**1997**

**Date:** 11 – 13 November 1997

**Theme:** Neonatal Neurology

**Course Director:** Professor Alan Hill, Canada

**Keynote Lecture:** Brain Injury in Premature Newborn – An Overview

**1996**

**Date:** 29 October – 1 November 1996

**Theme:** Paediatric Neurorehabilitation

**Course Director:** Professor Joe Watt, Canada

**Keynote Lecture:** Recent Advances in Paediatric Neurorehabilitation

**1995**

**Date:** 14 – 16 November 1995

**Theme:** Neurometabolic Diseases

**Course Director:** Professor Kenneth Swaiman, USA

**Keynote Lecture:** Update on Neurometabolic Diseases in Childhood





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