Paediatric Cardiology

ADHD; Checklist for whether requires cardiology assessment prior to treatment

Staff relevant to:	Community Paediatrics, Children's Hospital & Primary care
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1. Introduction and Who this Guideline applies to;

Children's Cardiology acknowledge that unnecessary wait for ECG and Cardiology assessment can have a very significant impact on child's education and family relationships.

This guidance is intended to provide a decision aid to streamline the appropriate provision of ADHD medications for children and avoid unnecessary investigations and delays. There have previously been concerns about proarrhythmic effects of stimulant ADHD medications; Evidence now suggests that the risk in healthy children is likely no higher than the background level. NICE guidelines approved and apply from 2018.

2. Referral

Large population studies & meta-analyses have consistently found **no** significant increase in risk of sudden cardiac death or serious cardiovascular events in children and adolescents treated with stimulant medications (like methylphenidate or lisdexamfetamine) compared to those not treated. The absolute risk is extremely low, roughly in line with the background population risk. (NICE guidance 2018 N.G 87;1.7.5)
MHRA (UK regulator) & EMA (Europe) have repeatedly concluded that the cardiovascular risk in properly screened children is **very low**, recommending **routine pre-treatment screening** but not restricting use.

If any of the following apply, refer for a Cardiology opinion before starting medication for ADHD:

- history of congenital heart disease or previous cardiac surgery
- history of sudden death in a first-degree relative under 40 years suggesting a cardiac disease
- shortness of breath on exertion compared with peers (excluding respiratory causes)
- a murmur heard on cardiac examination
- Other signs of heart failure eg peripheral oedema / hepatomegaly
- fainting on exertion or in response to fright or noise
- palpitations that are rapid, regular and start/ stop suddenly. Fleeting occasional bumps are usually ectopics & do not need investigation. (See Palpitations Guideline)
- chest pain suggesting cardiac origin (see Chest Pain Guideline)
- Average blood pressure >95th percentile (chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://nuhp.koha-ptfs.co.uk/cgi-bin/koha/opac-retrieve-file.pl?id=9dec1787bec561da5da6b1f0f6d10352) or https://adc.bmj.com/content/92/4/298

Please utilise checklist appendix 1

3. Education and Training

None

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Audit of prior referrals vs	Current referrals		One off	

5. Supporting References

NICE 2019. Attention deficit hyperactivity disorder: diagnosis & management. NG87 (SEE https://www.nice.org.uk/guidance/ng87/chapter/Recommendations#maintenance-and-monitoring

Cardiac risk assessment before the use of stimulant medications in children and youth (Canadian Paediatric Society) Paediatr Child Health Vol 14 No 9 November 2009

The cardiovascular safety of methylphenidate. John W Jackson. BMJ 2016;353:i2874 doi:10.1136/bmj.i2874 (Published 31 May 2016) Page 1-2

Blood pressure centiles for Great Britain. Jackson LV, Thalange NKS, Cole TJ. Arch Dis Child 2007;92:298–303. doi: 10.1136/adc.2005.081216 https://adc.bmj.com/content/92/4/298

6. Key Words

Attention deficit hyperactivity disorder

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

EDI Statement

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It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

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Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Prof Frances Bu'Lock			**Executive Lead** Chief Medical Officer
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
November 2025	**1**	**UHL Paediatric Cardiology**	**New document**

7. APPENDIX 1: Referral checklist

1) Have they had previous heart surgery / are under cardiology follow-up? Y / N

2) Do they have an abnormal cardiovascular examination: eg murmur, heart failure, absent femoral pulses? Y / N

3) Do they have a first degree relative who died suddenly under the age of 40 or is known to have a high risk of doing so? Y / N

4) Do they have severe cardiac chest pain, breathlessness or syncope on exertion? Y / N

5) Do they have rapid regular palpitations that start & stop suddenly (not fleeting 'bumps' or flutters) Y / N

If the answer to all 5 questions is No, start medication.
It is safe to proceed with stimulant medication if there are;
- No personal cardiac history concern
- No concerning family history in parents or siblings
- Normal cardiac exam
- Normal BP and pulse for age

If the answer to any of questions 2 – 5) is Yes, Refer to paediatric cardiology with all relevant clinical and family details; (and ECG if possible); these children should be seeing a cardiologist anyway.

If the answer to question 1) is Yes, contact their cardiologist for advice, in writing, rather than making another new referral.

NB: If the child has elevated blood pressure >95th percentile for age or classified as hypertensive in an adult, recheck it. **If persistently elevated, also refer to paediatric hypertension team.**