Response to Growth Hormone in Attention Deficit Hyperactivity Disorder: Effects of Methylphenidate and Pemoline Therapy

Jayashree K. Rao, MD*; Joanne R. Julius, MS‡; Timothy J. Breen, PhD‡; and Sandra L. Blethen, MD, PhD‡

ABSTRACT. Objective. To determine whether treatment of attention deficit hyperactivity disorder (ADHD) with methylphenidate hydrochloride or pemoline diminishes the response to growth hormone (GH) therapy in patients with idiopathic GH deficiency (IGHD) or idiopathic short stature (ISS).

Methods. The National Cooperative Growth Study database was used to identify patients between 3 and 20 years of age with IGHD or ISS and those within these groups who were treated with methylphenidate or pemoline for ADHD. Their growth in response to GH treatment (change in height standard deviation score [SDS]) was compared with that of patients with IGHD or ISS who were not treated for ADHD, by using a stepwise multiple regression analysis.

Results. In the IGHD cohort, there were 184 patients who were being treated for ADHD and 2313 who were not. In the ISS cohort there were 117 patients who were being treated for ADHD and 1283 who were not. There was a higher percentage of males being treated for ADHD in both cohorts. In the IGHD cohort, the change in height SDS was positively associated with the number of years of GH treatment, parents’ heights, body mass index, and GH injection schedule, and was negatively associated with height SDS at the initiation of GH therapy, age, and maximum stimulated GH level. The use of methylphenidate or pemoline had a negative effect on the change in height SDS, but the magnitude of the effect was small. Similar effects were noted in the ISS cohort, but body mass index and the use of methylphenidate or pemoline had no effect on the change in height SDS.

Conclusions. Concurrent ADHD therapy is associated with a slight decrease in the change in height SDS during GH treatment in patients with IGHD but not in those with ISS. Even in IGHD, the magnitude of the effect is small and should not deter the use of such concurrent therapy.

Statistics

Descriptive data are reported as mean ± SD for continuous variables and as percentages for categorical variables. Height SD scores (SDS) were calculated as follows: SDS = (height – mean height of normal persons of the same age and sex)/(SD of height of normal persons of the same age and sex). Height and weight standards were obtained from data collected by the National Center for Health Statistics. Differences in the mean values between the ADHD and comparison groups were tested by using Student’s t tests and differences in the proportions were tested by using χ² tests.

The response to GH therapy was defined as the change in height SDS from the time that GH therapy was initiated to the time of the most recent height measurement or the height measurement when treatment was discontinued, whichever oc-
curred first. This definition of response (as opposed to yearly growth rates) avoids problems associated with annualizing growth data for intervals different from 12 months and makes it possible to use data from all patients (including dropouts) in the analysis, thereby eliminating concerns about possible patient-selection bias. Multiple stepwise regression analysis was used for determining the relative influence of the following variables on the change in height SDS: age at enrollment, sex, height SDS at enrollment, body mass index (BMI), mother’s height SDS, father’s height SDS, maximum stimulated GH level (5.9 ± 2.4 μg/L), BMI (kg/m²), bone age deficit, y, maternal height SDS, paternal height SDS, and methylphenidate or pemoline therapy.

A result was considered statistically significant if the P value was < .05. All statistical analyses were performed by using the Statistical Analysis System (SAS version 6.11, SAS Institute Inc, Cary, NC).

RESULTS

We identified a total of 3897 patients who met the entry criteria, 301 of whom also had been treated with methylphenidate or pemoline for ADHD. The comparison groups consisted of 184 patients with ADHD and 2313 patients with IGHD and of 117 patients with ADHD and ISS and 1283 patients with ISS.

### TABLE 2. Factors With a Significant Effect on the Response to GH Therapy

<table>
<thead>
<tr>
<th>Enrollment Characteristics</th>
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<tbody>
<tr>
<td><strong>IGHD Cohort</strong></td>
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<tr>
<td>There were small but significant differences between the ADHD–IGHD group and the IGHD group in several variables that have been shown to predict the response to GH therapy. These were height SDS at enrollment (−2.8 ± 0.7 vs −3.0 ± 0.9; P &lt; .01), maximum stimulated GH level (5.9 ± 2.4 vs 5.6 ± 2.7 μg/L; P &lt; .01), BMI (15.7 ± 2.1 vs 16.5 ± 2.9 kg/m²; P &lt; .001), and GH injection schedule (cumulative weighted average ≥4 times a week, 85% vs 77%; P &lt; .05). Other predictive variables, including age at enrollment, parental heights, and weekly GH dose, that have been shown previously to be important were not different between the two groups. Male sex was preponderant in both groups and was significantly greater in the ADHD–IGHD group (88% vs 73%; P &lt; .01). The bone age deficit was significantly less in the ADHD–IGHD group (2.2 ± 1.3 vs 2.0 ± 1.0 years; P &lt; .05). Sex and bone age, however, have not had important predictive power in other analyses of the response to GH therapy.</td>
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<tr>
<td><strong>ISS Cohort</strong></td>
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<td>There were fewer significant differences between the ADHD–ISS and ISS groups. These were male preponderance (85% vs 75%; P &lt; .05), BMI (15.4 ± 1.6 vs 15.9 ± 2.0 kg/m²; P &lt; .01), and father’s height SDS (−0.9 ± 1.3 vs −0.7 ± 1.3; P &lt; .05). All other variables, eg, height SDS, age at enrollment, age at onset of puberty, GH injection schedule, bone age deficit, and mother’s height SDS, were similar between the two groups.</td>
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<tr>
<td><strong>Response to GH</strong></td>
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<td>The factors that had a significant effect on the response to GH therapy are shown in Table 2.</td>
</tr>
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<table>
<thead>
<tr>
<th><strong>TABLE 1. Patient Characteristics</strong></th>
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<tr>
<td><strong>ADHD–IGHD</strong></td>
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<tr>
<td>(n = 184)</td>
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<tr>
<td>Male sex, number (%)</td>
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<tr>
<td>Entered puberty during treatment, number (%)</td>
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<tr>
<td>GH injected ≥4 times a week, number (%)</td>
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<tr>
<td>Age at enrollment, y</td>
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<tr>
<td>Height SDS</td>
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<tr>
<td>Maximum stimulated GH level, μg/L</td>
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<tr>
<td>BMI (kg/m²)</td>
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<tr>
<td>Bone age deficit, y</td>
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<tr>
<td>Maternal height SDS</td>
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<tr>
<td>Paternal height SDS</td>
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<tr>
<td>Years of GH therapy</td>
</tr>
<tr>
<td>Change in height SDS</td>
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</tbody>
</table>

* P < .05; ** P < .01; *** P < .001.

Comparisons are between ADHD–IGHD and IGHD or between ADHD–ISS and ISS, as appropriate.
BMI. It was negatively associated with height SDS and age at NCGS enrollment and maximum stimulated GH level. Sex and change in pubertal status during GH therapy did not affect the change in height SDS. Treatment with methylphenidate or pemoline had a negative effect on the change in height SDS, but the magnitude of the effect was small and the magnitude of the difference in the change in height SDS between the ADHD–IGHD and the IGHD groups decreased with time (Fig 1).

**ISS Cohort**

The change in height SDS was positively associated with (in order of decreasing predictive importance) duration of GH therapy, GH injection schedule, mother's height SDS, and father's height SDS. It was negatively associated with age at enrollment, height SDS, and maximum stimulated GH level. BMI, sex, and change in pubertal status during GH treatment did not affect the change in height SDS. Therapy with methylphenidate or pemoline did not have a significant negative effect on the change in height SDS (Fig 2).

**DISCUSSION**

The variables shown to be important predictors of the change in height SDS in the patients with IGHD (longer duration of GH therapy, height SDS when GH therapy was initiated, parental heights, BMI, degree of GH deficiency, and GH injection schedule) also have been reported as significant predictors of the growth rate during the first year of GH treatment in other studies in children with IGHD.10–16 Because the patients who were treated with methylphenidate or pemoline were different from the other patients with IGHD in several variables that have been shown to predict the response to GH treatment, we used a stepwise multiple regression to determine the effect of treatment with methylphenidate or pemoline on the response to GH therapy. We found that treatment with these agents had a negative effect on the change in height SDS in the IGHD cohort but not in the ISS cohort. The magnitude of this effect in the IGHD cohort was small, contributing only $-0.17$ SD over an average of 3 years of treatment with GH. Furthermore, examination of the slopes of the regression lines indicates that the effect may decrease with time.

Because the nature of the neurochemical changes associated with ADHD and their effects on the hypothalamic–pituitary–insulin-like growth factor I axis are not well understood,17 the role, if any, of ADHD or its treatment with methylphenidate or pemoline in the short stature often associated with this disorder is not clear. By confining our study to patients with IGHD and ISS who were treated with GH, we isolated one part of the growth axis, namely,
the response to GH, from possible effects on the hypothalamic–pituitary axis.

From the point of view of the physician who provides care to children with ADHD, the message is clearer. Therapy with methylphenidate or pemoline has no demonstrative effect on the response to GH therapy in children with ISS. The small negative effect of these agents on the response to GH therapy in patients with IGHD should not deter clinicians from using them in children with IGHD when they are medically indicated.

REFERENCES


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