Letters to the Editor

Comment on Late-Onset ADHD Reconsidered With Comprehensive Repeated Assessments Between Ages 10 and 25

TO THE EDITOR: We read with great interest the article by Sibley et al. (1), published in the February 2018 issue of the *Journal*, examining symptoms of attention deficit hyperactivity disorder (ADHD) longitudinally in a cohort without a baseline childhood diagnosis.

The authors identified cases of possible late-onset ADHD via screening and then used an iterative process to rule out nontrue cases. The overwhelming majority did not have true late-onset adult ADHD but had childhood symptoms persisting into adulthood, or they did not have ADHD (rather, they had cognitive impairment due to heavy substance use or other psychiatric morbidities).

These U.S. findings accord closely with our experience in U.K. adult ADHD clinics. We have not observed a single case of true adult-onset ADHD. The authors' findings (1) support the need for specialist assessment by experienced ADHD clinicians. Screening instruments are blunt tools, potentially helpful for initial gate-keeping but not for confirming or refuting an ADHD diagnosis or for teasing apart nuanced differences from or overlap with other disorders.

Sibley and colleagues identified two adults with late-onset ADHD where the diagnosis may have been valid (i.e., there was an absence of childhood symptoms, and symptoms were not due to heavy substance use or other identified mental disorders). We wonder whether these uncommon cases may reflect organic pathology, such as cognitive dysfunction from thyroid disease or traumatic brain injury (diffuse axonal injury can give normal results on a brain scan) or other psychiatric disorders (e.g., impulse control disorders or gambling disorder, which are not typically screened for).

In the United Kingdom, there is a lack of National Health Service resourcing for adult ADHD. As Sibley et al. acknowledge, decades of research support ADHD as a chronic neurodevelopmental condition that often persists into adulthood (1). Recent DSM changes allow for the diagnosis of some high-functioning adult cases. The lack of resource provision in the United Kingdom is extremely unfortunate given ADHD's high prevalence, coupled with the existence of clinically effective, cost-effective treatments. ADHD treatment may reduce criminality and driving accidents (2, 3). For those with ADHD treated appropriately, patients often report profound benefits for everyday functioning.

REFERENCES

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The Importance of Scrutinizing Emergent ADHD Symptoms in Adults: Response to Chamberlain and Müller

TO THE EDITOR: The authors of our recent article on late-onset attention deficit hyperactivity disorder (ADHD), part of the Multimodal Treatment Study of Children with ADHD, enjoyed reading the letter to the editor from Chamberlain and Müller and thank them for sharing their clinical observations from the United Kingdom. We agree that screening tools are blunt assessments and that adult ADHD diagnoses require very careful and detailed clinical assessments by specialists.

As the authors point out, investigating childhood ADHD symptoms and disentangling the causal roles of substance abuse and other mental disorders are just the tip of the iceberg. There are many other sources of cognitive dysfunction that might lead to false positive symptom endorsement on an ADHD checklist. These include diseases that influence cognition, neurological disorders, brain injuries, stress responses, unhealthy lifestyles (i.e., sleep, diet, physical activity), extremely taxing environmental demands (e.g., working multiple jobs while raising children alone), deprivation, and