Autism Spectrum Disorder (ASD)

Presenting Issue:

A primary care provider (PCP) reached out to WI CPCP regarding a 6-year-old female patient exhibiting aggressive outbursts at home and school. The child struggles with communication, social interactions, and tolerating changes in routine. Both the PCP and the parents are concerned about a potential autism spectrum disorder (ASD) diagnosis. The patient has been referred for neuropsychological testing, but the current waitlist is 9 months long. The PCP is seeking guidance on supporting the patient in the interim.

Consultant's Response:

Diagnostic Assessment for Autism Spectrum Disorder (ASD):

1. Comprehensive, Coordinated Assessment:
   The gold standard for diagnosing ASD involves a multidisciplinary team, including a psychologist or psychiatrist, the primary care provider, a speech therapist, an occupational therapist, and possibly a physical therapist, along with comprehensive neuropsychological testing. However, extended waitlists can make timely assessments difficult to obtain.

   In addition to CW and Aurora Health, Marshfield Clinic offers a comprehensive approach to ASD evaluation. For more information, visit Marshfield Children's Specialty Care.

   Referring to a child psychiatrist is also reasonable, as many general or adult psychiatrists may not feel comfortable diagnosing pediatric patients.

2. Referral for Psychotherapy:
   A referral for psychotherapy can support the diagnostic process and provide early intervention to address symptoms.

3. Interim Support:
   Autism Rating Scales: It may be useful for parents to complete an autism rating scale. While public access to free rating scales is limited, the AQ-Child (Ages 4-11) and AQ-Adolescent (Ages 12-15) versions serve as valid tools. This scale has high sensitivity (95%) and specificity (95%) and can help clarify areas of concern. For scoring, refer to the AQ-Child Scoring Guide; AQ-Adolescent Scoring Guide

   Early Interventions: Interventions for identified areas of concern can be initiated while awaiting formal assessment.

   School-Based Support: If symptoms are significantly affecting the child's school performance, the parents can request that the school staff conduct an autism assessment. Although "educational autism" doesn't directly align with the medical diagnosis, children who qualify through a school assessment may be eligible for appropriate accommodations via an Individualized Education Program (IEP).

4. Medication for Aggression Associated with ASD:
   Medication should not replace therapy but may be considered if aggressive outbursts are dangerous to the child or others and non-medication interventions are insufficient:

Guanfacine IR or ER (Intuniv): A trial of guanfacine (used off-label for aggression) is a reasonable first step. It tends to have fewer side effects than atypical antipsychotics and may be effective, especially for milder cases. The maximum recommended dose for ADHD is 4 mg/day, but a lower dose is typically used for addressing aggressive outbursts.

Atypical Antipsychotics: If guanfacine is not effective, risperidone or aripiprazole—FDA-approved for aggression in patients with ASD—are reasonable next steps. While these medications have a higher side effect burden, they can be highly effective. Referrals to a psychiatrist are often made at this stage. **Before starting an atypical antipsychotic:**

Monitoring: Baseline and periodic monitoring of BMI, waist circumference, HbA1c, fasting plasma glucose, and fasting lipids is essential. Refer to the ADA monitoring schedule - Recommendations for lab monitoring of atypical antipsychotics.

Involuntary Movements: Monitoring for abnormal involuntary movements at baseline and periodically throughout the medication trial should also be done. The AIMS scale can be used to monitor abnormal involuntary movements. AIMS Examination Procedure

In the studies that led to FDA approval, the dosage of risperidone was determined based on the patient's weight:

- For children weighing less than 20 kg: The starting dose was 0.25 mg/day.
- For children weighing between 20 and 45 kg: The starting dose was 0.5 mg/day, increased to 0.5 mg twice daily on day 4.

Titration Schedule:

- For children weighing less than 45 kg: The dose was increased by 0.5 mg increments based on clinical response, with a maximum dosage of 2.5 mg/day.
- For children weighing 45 kg or more: The dose increase was accelerated without specifying exact doses, with a maximum dosage of 3.5 mg/day.

Common Side Effects: Weight gain, increased appetite, drowsiness, fatigue, drooling, dizziness, constipation, tremors, and tachycardia are common. The average weight gain is 2.7 ± 2.9 kg.

Efficacy: Aggression typically improves by week 4 of treatment.

For additional information, Risperidone in the treatment of behavioral disorders associated with autism in children and adolescents.

Teaching Points:

1. The gold standard for diagnosing ASD is a multidisciplinary team approach, including neuropsychological testing. Waitlists for such assessments can be lengthy.
2. Tools like the Autism Quotient—Child or Autism Quotient—Adolescent can help clarify symptoms while waiting for a formal diagnosis.
3. Even without a definitive ASD diagnosis, interventions can still be introduced to address key symptoms.
4. Psychotropic medications can be considered for aggression if non-medication interventions fail, particularly when the aggression is causing significant functional impairment or danger to the child or others.