CLINICAL COMMENTARY:
White-coat hypertension represents one point along the continuum of hypertension
Unfortunately, the best available clinical evidence provides an unfulfilling answer to the question posed by this Clinical Inquiry. It requires inductive reasoning and logic to derive a treatment plan from the evidence presented. Perhaps it is because the diagnosis of white-coat hypertension remains poorly defined and clinically elusive.

Nevertheless, application of the simple principle of “where there’s smoke, there’s fire” fits best here. Clinicians should be aware that white-coat hypertension represents one point along the continuum of hypertensive disease. When diagnosed, patients with white-coat hypertension should at a minimum be followed for associated morbidities and treated when systemic hypertension is identified.

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REFERENCES
evaluated to establish mean scores for affected and unaffected children. Many scales publish such normative data in commercially available manuals. Some scales have been evaluated by 1 or more independent studies to compare children with and without ADHD. Rating scales have not been evaluated as a sole tool for the diagnosis of ADHD.

The test characteristics of a particular scale depend on the cut points for a positive or negative test. The usefulness of psychological tests in discriminating normal from abnormal behavior is often reported as “effect size.” The effect size is the difference in mean scores between 2 populations divided by an estimate of the individual standard deviation. An effect size of 4.0 means that abnormal subjects and normal controls are separated 4 standard deviations and thus almost completely separated. An effect size of 1.0 shows significant overlap between the 2 populations. An effect size of 4.0 is roughly equivalent to a sensitivity and specificity of 97%. An effect size of 1.0 is roughly equal to a sensitivity and specificity of 71%.

Table 1 outlines the characteristics and effect size of several available brief ADHD-specific checklists. Typically, the gold standard was a clinical diagnostic interview, usually conducted by a clinical psychologist, as well as supporting data from schools and parents.

**RECOMMENDATIONS FROM OTHERS**

The American Academy of Pediatrics states that the use of ADHD-specific checklists is a clinical option when evaluating children for ADHD. They caution that the ADHD scales may function less well in clinicians’ offices than suggested by reported effect size and, in addition, rating scales are subject to bias and may convey a false sense of validity. They also state that it is not known if these scales provide additional information beyond a careful clinical assessment.

### TABLE

**Descriptive characteristics of abbreviated symptom checklists for ADHD**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Minutes</th>
<th># Items</th>
<th>Age</th>
<th>Effect size</th>
<th>Hyperactivity</th>
<th>Inattention</th>
<th>Impulsivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTeRS Parent Version</td>
<td>5–10</td>
<td>25</td>
<td>5–12</td>
<td>1.5</td>
<td>2.0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>ACTeRS Teacher Version</td>
<td>5–10</td>
<td>24</td>
<td>5–12</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>DSM-IV SNAP</td>
<td>5–10</td>
<td>40</td>
<td>6–12</td>
<td>3.1–5.1</td>
<td>3.5–4.2</td>
<td>4.0–5.5</td>
<td></td>
</tr>
<tr>
<td>DSM-III–R SNAP</td>
<td>5–10</td>
<td>38</td>
<td>6–12</td>
<td>3.1–5.1</td>
<td>3.5–4.2</td>
<td>4.0–5.5</td>
<td></td>
</tr>
<tr>
<td>ADHD Rating Scale-IV</td>
<td>5</td>
<td>18</td>
<td>5–18</td>
<td>1.1</td>
<td>1.2</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Conners Rating Scale, Revised (1997, Short Version)</td>
<td>5–10</td>
<td>27</td>
<td>3–17</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

Numbers reported in ranges indicate multiple studies.
ACTeRS, ADD-H Comprehensive Teacher Rating Scales; DSM, Diagnostic and Statistical Manual of Mental Disorders; SNAP, Swanson, Nolan, and Pelham; ADHD, attention deficit/hyperactivity disorder; NA, not available.
The Institute for Clinical Systems Improvement recommends use of at least 1 ADHD-specific rating scale to be administered to parents and teachers. This information should be used as part of the overall historical database for the child and should not be used as the sole criteria for diagnosis of ADHD.²

Many sources agree that ADHD-specific rating scales allow a rapid and consistent collection of information from multiple sources. However, the information they provide is necessary, but not sufficient, to make a definitive diagnosis of ADHD. In addition to assisting in diagnosis, checklists can be helpful in monitoring treatment changes once a diagnosis has been established.

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REFERENCES
8. Diagnosis and Management of Attention Deficit Hyperactivity Disorder in Primary Care for School Age Children and Adolescents. Bloomington, Minn: Institute for Clinical Systems Improvement; 2003. Available at: www.icsi.org/