NKR1_PICO10_Atomoxetine versus Methylphenidat

Characteristics of studies

Characteristics of included studies

Bedard 2015

Methods	**Study design:** Randomized controlled trial **Study grouping:** Crossover
Participants	**Baseline Characteristics** Overall ● *Age*: 10.5 ● *% male*: 74 ● *No. of patients receiving medication*: 36 **Included criteria:** All youth had a DSM-IV diagnosisof ADHD, any subtype, and participated in a larger crossovertrial to evaluate comparative efficacy/tolerability and predic-tors of response to MPH and ATX. **Excluded criteria:** Exclusionary criteria were:WISC-IV full-scale IQ below 75, non-English speaking parentor child, neurological dysfunction, systemic medical illness,uncorrected sensory impairments, and history of psychosis orbipolar disorder. Other comorbidity was permitted providedADHD was the primary disorder and the comorbid conditiondid not require medication treatment **Pretreatment:** Approximately two thirds were male and the majority had either Combined or Inattentive TypeADHD
Interventions	**Intervention Characteristics** Atomoxetin ● *Description*: Methylphenidat: 18 mg, 36 mg, 54 mg, 72 mg ● *Length of treatment* : 4-6weeks MPH ● *Description*: Atomoxetine: 0.5 mg/kg,1.0 mg/kg, 1.4 mg/kg, 1.8 mg/kg ● *Length of treatment* : 4-6 weeks
Outcomes	*ADHD kernesymptomer, lærerbedømt, Change, SD* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, observatør/kliniker bedømt, Final. SD* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, observatør/kliniker bedømt, Change SD* ● **Outcome type**: ContinuousOutcome *Ikke alvorlige bivirkninger-totalt. n* ● **Outcome type**: DichotomousOutcome *ADHD kernesymptomer, forældre, change, SD* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældre, Final, SD* ● **Outcome type**: ContinuousOutcome *Frafald pga. bivirkninger, n* ● **Outcome type**: DichotomousOutcome *Gastrointestinale bivirkninger, n* ● **Outcome type**: DichotomousOutcome *Søvnforstyrrelse, n* ● **Outcome type**: DichotomousOutcome
Notes	**Sponsorship source:** This project was funded in part by grants from theNIMH (R01 MH070935, R01 MH70564, DSIR 84-CTM)and the National Center for Research Resources and theNational Center for Advancing Translational Sciences ofthe NIH (UL1TR000067), and through a CanadianInstitutes of Health Research Fellowship to A.-C.V.B.Study medication was provided by Eli Lilly and Co. andOrtho-McNeil-Janssen **Country:** USA **Setting:** Patients recruited from NYC and chicago **Comments:** Clinicaltrials.gov: NCT00183391 **Authors name:** Anne-Claude V. Bédard **Institution:** Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York, NY **Email:** ac.bedard@mssm.edu **Address:** Department of Psychiatry, Icahn School of Medicine at Mount Sinai, Box 1230,One Gustave L. Levy Place, New York, NY 10029, USA

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Judgement Comment: The study is randomized. Not mentioned how it is done
Allocation concealment (selection bias)	Low risk	Quote: "Two capsules of OROS MPH or matching placebo and either two or three capsules of ATX (determined by the child's weight) or matching placebo were administered each morning."

Blinding of participants and personnel (performance bias)	Unclear risk	Judgement Comment: Nothing mentioned
Blinding of outcome assessment (detection bias)	Low risk	Quote: "Weekly ratings of ADHD symp- toms and severity of impairment were obtained during a parent interview by blind raters who were trained research assistants, graduate students, or postdoctoral fellows using the ADHD-RS (DuPaul et al., 1998), which was used to track changes in frequency and severity of symptoms during treatment, and aid in clinical decision making."
Incomplete outcome data (attrition bias)	Low risk	Judgement Comment: Dropout has been reported
Selective reporting (reporting bias)	High risk	Judgement Comment: No. of outcomes mentioned in the study do not match study protocol
Other bias	Low risk	Judgement Comment: No other apparent sources of bias

Cetin 2015

Methods	
Participants	
Interventions	
Outcomes	
Notes	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	High risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
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Other bias	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Garg 2014

Methods	
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Interventions	
Outcomes	
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Kemner 2005

Methods	
Participants	
Interventions	
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Kratochvil 2002

Methods	
Participants	
Interventions	
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Newcorn 2008

Methods	
Participants	
Interventions	
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Sangal 2006

Methods	**Study design:** Randomized controlled trial **Study grouping:** Crossover
Participants	**Included criteria:** atients were 6 to 14 years old at study entry. They were diag-nosed with ADHD using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV™) criteria1 as well as severity criteria. Diagnosis was assessed by the investigator's clinical evaluation and by the administration of several modules of the Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version structured interview. In addition, patients had an ADHD Rating Scale-IV-Parent Version: Investigator-Administered and Scored (ADHD RS)16 score at least 1.0 standard deviation above normative values for age and sex for either the inattentive or hyperactive/impulsive subscore, or for the combined score. All patients scored at least 80 on the Wechsler Intelligence Scale for Children®-3rdedition. **Excluded criteria:** Im-portant exclusion criteria included serious medical illness, a his-tory of symptoms suggestive of a primary sleep disorder—such as obstructive sleep apnea (OSA) (e.g., habitual snoring), periodic limb movement disorder (PLMD, eg, kicking movements during sleep), or insufficient sleep syndrome (e.g., voluntary sleep re-striction resulting in sleep duration habitually significantly short-er than expected age norms)—that could potentially result in a daytime symptom constellation similar to ADHD, and abnormal laboratory values or electrocardiogram (ECG) readings. Patients agreed not to use caffeinated beverages during the duration of the study. **Pretreatment:** None detected
Interventions	**Intervention Characteristics** Intervention ● *Description*: Atomoxetine, twice daily with placebo given as noontime dose. Flexdose 0.5 increased to between 1.0 and 1.8 mg/kg per day Control ● *Description*: Atomoxetine. Flexdose 0.5 increased to between 1.0 and 1.8 mg/kg per day
Outcomes	*Frafald EoT* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported *Abdominal pain* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported *Insomnia* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported
Notes	**Sponsorship source:** This was an industry supported study sponsored by Eli Lilly. The data were analyzed by statisticians at Eli Lilly, including Dr. Sutton, one of the authors. The manuscript was written as a combined effort of all authors. Dr. Sangal has received research support from Eli Lilly, Merck, Organon, Cephalon, and Novartis. Dr. Owens has received research support from Cephalon, Sanofi-Aventis, Johnson Johnson, Sepracor, and Eli Lilly; is a member of the speakers' bureau for Eli Lilly; is a consultant for Cephalon; and is an advisory board member for Cephalon, Pfizer, and Eli Lilly. Drs. Sutton, Allen, Schuh, and Kelsey are employees of Eli Lilly. **Country:** USA **Setting:** Two sleep disorders centers in the United States; 1 in a private-practice setting and 1 in a hospital setting **Authors name:** Kory J. Schuh **Institution:** Clinical Neurophysiology Services, PC, Troy, M **Email:** kschuh@lilly.com **Address:** Kory J. Schuh, PhD, Eli Lilly and Company, Lilly Corporate Center DC 4135 Indianapolis IN 46285

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Judgement Comment: Only described as 'randomized', no details.
Allocation concealment (selection bias)	Unclear risk	Judgement Comment: Only described as 'randomized', no details.
Blinding of participants and personnel (performance bias)	Low risk	Judgement Comment: Described as double-blind. Both groups get three doses a day. Placebo given as the third dose in the atomoxetine twice a day group.
Blinding of outcome assessment (detection bias)	Low risk	Judgement Comment: Described as double-blind. Both groups get three doses a day. Placebo given as the third dose in the atomoxetine twice a day group
Incomplete outcome data (attrition bias)	Low risk	Judgement Comment: Analyzed in total for adverse events: 79 out of 85.
Selective reporting (reporting bias)	Low risk	Judgement Comment: None detected
Other bias	Low risk	Judgement Comment: None detected

Schulz 2012

Methods	
Participants	
Interventions	
Outcomes	
Notes	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

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Other bias	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Shang 2015

Methods	
Participants	
Interventions	
Outcomes	
Notes	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

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Allocation concealment (selection bias)	High risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
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Starr 2005

Methods	
Participants	
Interventions	
Outcomes	
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Stein 2015

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	Abstract
Interventions	**Intervention Characteristics** Intervention 1 ● *Description*: Methylphenidat ● *Length of treatment* : 3-7 weeks Control ● *Description*: Atomoxetine ● *Length of treatment* : 3-7 weeks
Outcomes	*Søvnforstyrrelser* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Direction**: Lower is better ● **Data value**: Endpoint
Notes	**Sponsorship source:** **Country:** USA **Setting:** **Comments:** **Authors name:** M. Stein **Institution:** **Email:** **Address:**

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Judgement Comment: Abstract
Allocation concealment (selection bias)	Unclear risk	Judgement Comment: Abstract
Blinding of participants and personnel (performance bias)	Unclear risk	Judgement Comment: Abstract
Blinding of outcome assessment (detection bias)	Unclear risk	Judgement Comment: Abstract
Incomplete outcome data (attrition bias)	Unclear risk	Judgement Comment: Abstract
Selective reporting (reporting bias)	Unclear risk	Judgement Comment: Abstract
Other bias	Unclear risk	Judgement Comment: Abstract

Su 2016

Methods	
Participants	
Interventions	
Outcomes	
Notes	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Allocation concealment (selection bias)	Unclear risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials.

		Journal of clinical and experimental neuropsychology, pp.1-12.
Blinding of participants and personnel (performance bias)	High risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Blinding of outcome assessment (detection bias)	High risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Incomplete outcome data (attrition bias)	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Selective reporting (reporting bias)	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Other bias	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Wang 2007

Methods	
Participants	
Interventions	
Outcomes	
Notes	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Risk of bias table

Bias	Authors' judgement	Support for judgement
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Blinding of outcome assessment (detection bias)	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Incomplete outcome data (attrition bias)	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Selective reporting (reporting bias)	Unclear risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Other bias	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Yildiz 2011

Methods	
Participants	
Interventions	
Outcomes	
Notes	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
Allocation concealment (selection bias)	High risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.
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Other bias	Low risk	See Liu, Q., Zhang, H., Fang, Q. and Qin, L., 2017. Comparative efficacy and safety of methylphenidate and atomoxetine for attention-deficit hyperactivity disorder in children and adolescents: meta-analysis based on head-to-head trials. *Journal of clinical and experimental neuropsychology*, pp.1-12.

Zhu 2017

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Intervention 1 ● *Age*: 9.75 ● *% male*: 70.7 ● *No. of patients receiving medication*: Control ● *Age*: 9.92 ● *% male*: 78 ● *No. of patients receiving medication* **Included criteria:** Inclusion criteria: patients who aged from six to fourteen and conformed to the ADHD diagnos-tic criteria of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). And the scores ofCGI-ADHD-S of these patients were all higher than 4 points. The informed consent of the children's guard-ians was obtained. **Excluded criteria:** Exclusion criteria: patients who had the psychiatric disorders of mental retardation, autism, schizophrenia, pervasive developmental disorder and so on; patients who didn't respond to methylphenidate treat-ments previously; and those who had serious physical diseases in heart, lung and other organs **Pretreatment:** There was no difference between the two groups at baseline
Interventions	**Intervention Characteristics** Intervention 1 ● *Description*: Methyldphenidat:he initial dose of methylphenidate group was 0.2 mg/kg per day, and then gradually increased to 0.5 mg/kg. The drugs should be taken after breakfast every day. ● *Length of treatment* : 8 weeks Control

	● *Description*: Atomoxetine: The initial dose of atomox-etine group was 0.5 mg/kg per day then gradu-ally increased to 1.2 mg/kg according to the children's condition and tolerance. The maxi-mum daily dose was no more than 1.4 mg. Both groups were treated continuously for eight weeks. Finally, the average dose of atomox-etine and methylphenidate were 1.32 mg/kg and 0.55 mg/kg per day respectively ● *Length of treatment* : 8 weeks
Outcomes	*ADHD kernesymptomer, lærerbedømt, Change, SD* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, observatør/kliniker bedømt, Final. SD* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, observatør/kliniker bedømt, Change SD* ● **Outcome type**: ContinuousOutcome *Ikke alvorlige bivirkninger-totalt. n* ● **Outcome type**: DichotomousOutcome *ADHD kernesymptomer, forældre, change, SD* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældre, Final, SD* ● **Outcome type**: ContinuousOutcome *Frafald pga. bivirkninger, n* ● **Outcome type**: DichotomousOutcome *Gastrointestinale bivirkninger, n* ● **Outcome type**: DichotomousOutcome *Søvnforstyrrelse, n* ● **Outcome type**: DichotomousOutcome
Notes	**Sponsorship source:** **Country:** China **Setting:** **Comments:** **Authors name:** Xia Zhu **Institution:** Department of Pediatrics **Email:** Tel: +86-0539-2212102 **Address:** Department of Pediatrics, Linyi Central Hospital, No.17 Jiankang Road, Yishui, Linyi 276400, Shandong, China.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Judgement Comment: Nothing mentioned
Allocation concealment (selection bias)	Unclear risk	Quote: "The randomized single-blind parallel controlled method was adopted in this research. All children and their patients didn't know the grouping and types of therapeutic drugs. The" Judgement Comment: Described that allocation was unknown, but not how concealment was achieved.
Blinding of participants and personnel (performance bias)	Low risk	Quote: "All children and their patients didn't know the grouping and types of therapeutic drugs."
Blinding of outcome assessment (detection bias)	High risk	Quote: "The randomized single-blind parallel controlled method was adopted in this research." Judgement Comment: Only patients and parents were blinded.
Incomplete outcome data (attrition bias)	Low risk	Judgement Comment: Dropouts have been accounted for
Selective reporting (reporting bias)	Low risk	Judgement Comment: No other apparent sources of bias
Other bias	Low risk	Judgement Comment: No other apparent sources of bias

Footnotes

Summary of findings tables

Data and analyses

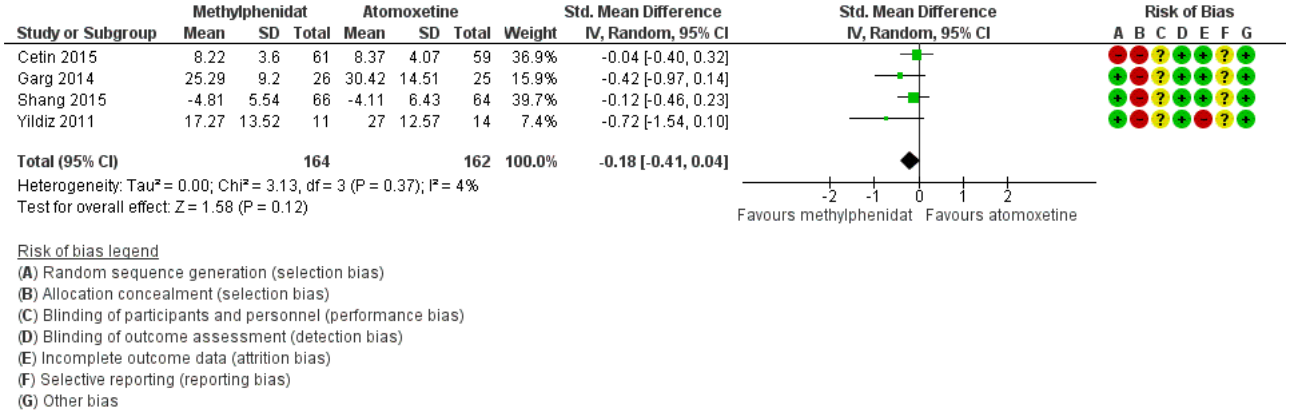
1 Methylphenidat versus Atomoxetine

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 ADHD core symptoms, teacher-rated	4	326	Std. Mean Difference (IV, Random, 95% CI)	-0.18 [-0.41, 0.04]
1.3 ADHD core symptoms, observer-rated	8	2878	Std. Mean Difference (IV, Random, 95% CI)	-0.22 [-0.39, -0.05]
1.5 ADHD core symptoms, parent-rated. Change	7	1257	Std. Mean Difference (IV, Random, 95% CI)	-0.18 [-0.32, -0.04]
1.8 Quality of life	1	386	Mean Difference (IV, Fixed, 95% CI)	2.40 [-0.06, 4.86]

1.9 Weight loss	3	369	Risk Ratio (M-H, Random, 95% CI)	0.94 [0.47, 1.87]
1.15 Appetitforstyrrelser/anorexi	12	3326	Risk Ratio (M-H, Random, 95% CI)	1.04 [0.85, 1.26]
1.16 Severe adeverse events	2	1649	Risk Ratio (M-H, Random, 95% CI)	1.54 [0.15, 16.11]
1.17 Dropout due to adverse events	13	3099	Risk Ratio (M-H, Random, 95% CI)	0.84 [0.63, 1.12]
1.20 Insomnia	13	3556	Risk Ratio (M-H, Random, 95% CI)	2.24 [1.72, 2.92]

Figures

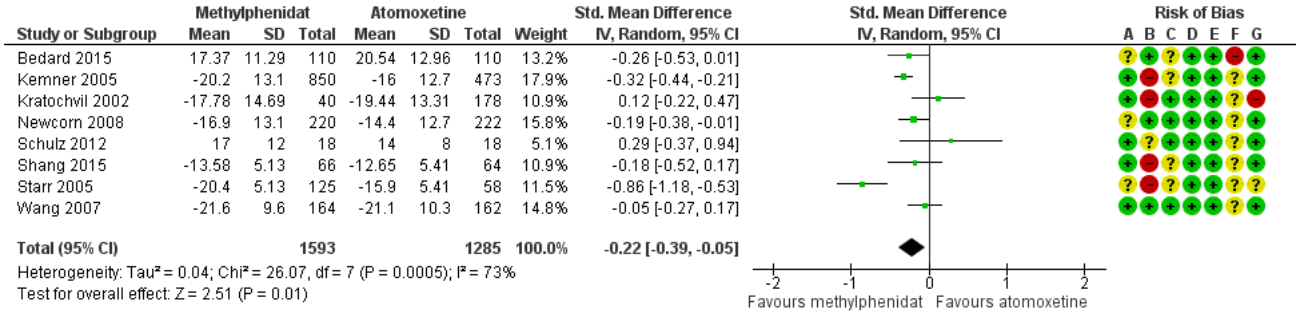
Figure 1 (Analysis 1.1)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.1 ADHD core symptoms, teacher-rated.

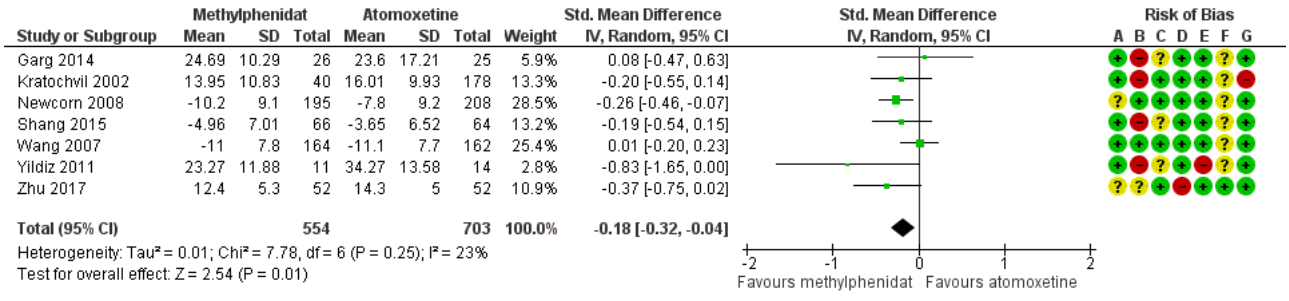
Figure 2 (Analysis 1.3)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.3 ADHD core symptoms, observer-rated.

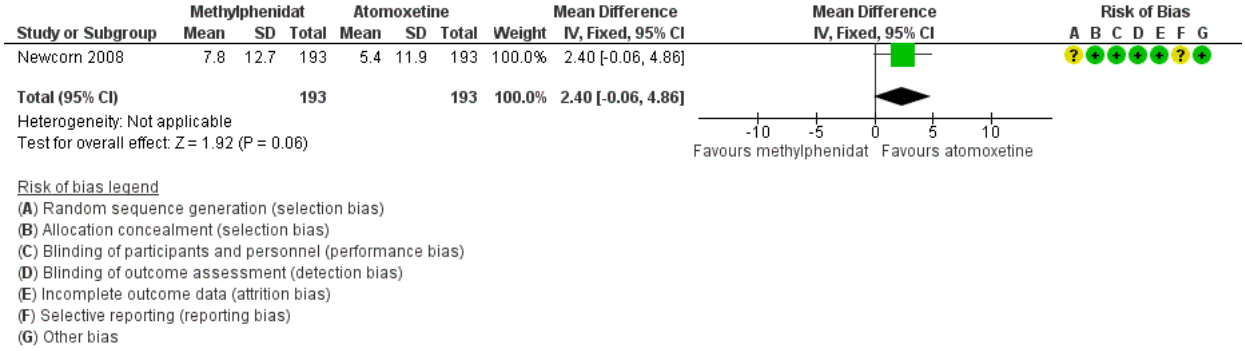
Figure 3 (Analysis 1.5)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.5 ADHD core symptoms, parent-rated. Change.

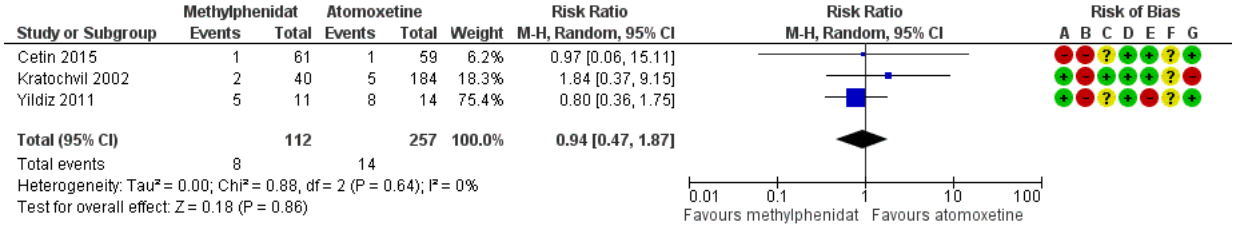
Figure 4 (Analysis 1.8)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.8 Quality of life.

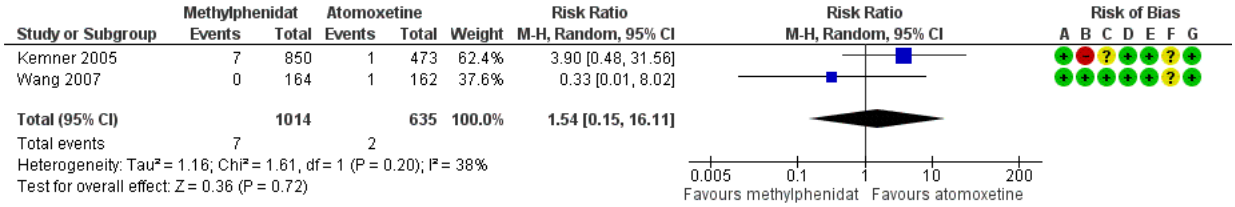
Figure 6 (Analysis 1.9)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.9 Weight loss.

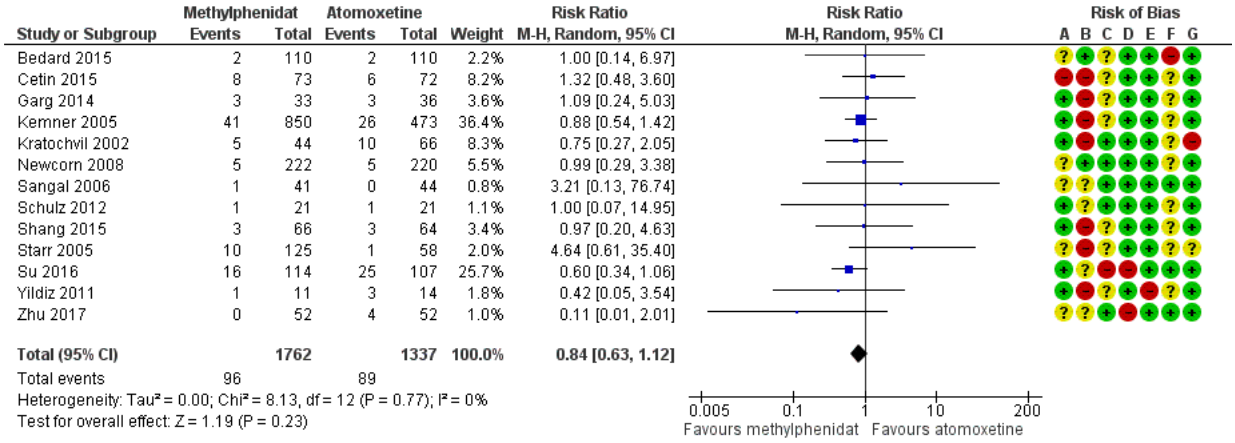
Figure 7 (Analysis 1.16)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.16 Severe adeverse events.

Figure 8 (Analysis 1.17)



Risk of bias legend
(A) Random sequence generation (selection bias)
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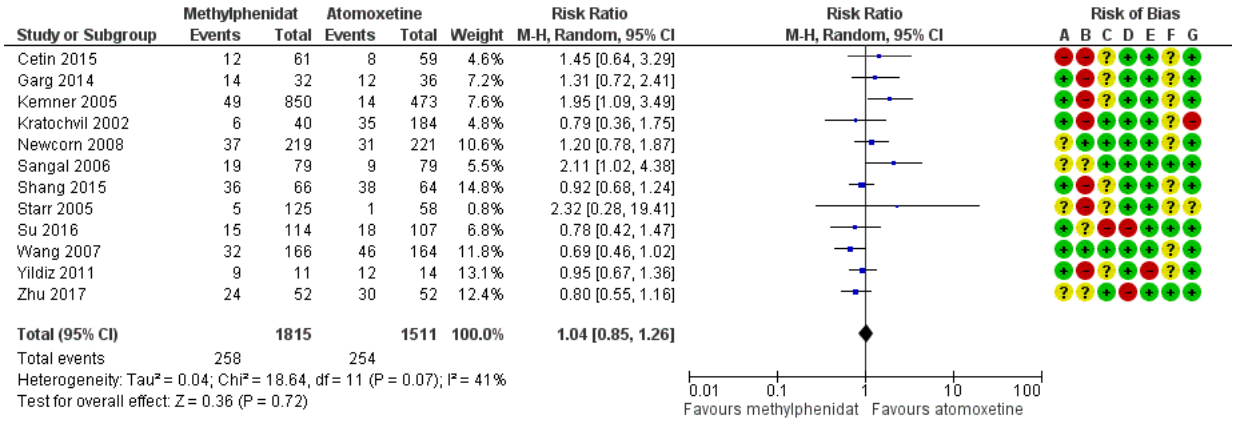
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.17 Dropout due to adverse events.

Figure 9 (Analysis 1.15)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
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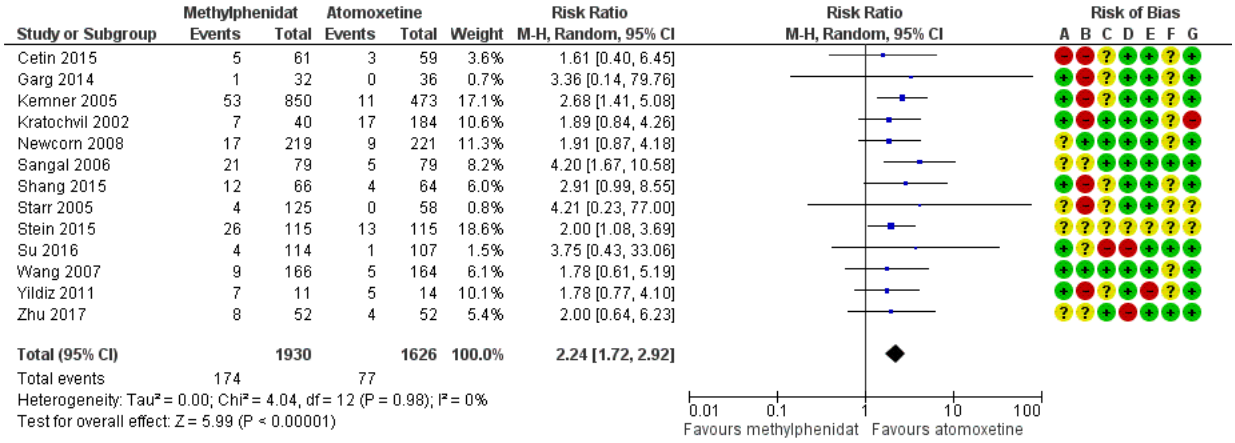
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.15 Appetitforstyrrelser/anorexi.

Figure 10 (Analysis 1.20)



Risk of bias legend
(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)
(**F**) Selective reporting (reporting bias)
(**G**) Other bias

Forest plot of comparison: 1 Methylphenidat versus Atomoxetine, outcome: 1.20 Insomnia.