Table 1 Prevalence of psychiatric disorders in schoolchildren from four Brazilian regions (n=1,676)

Child psychiatric disorders	Overall sample (n=1,623)	Southeast Caeté (n=434)	Center Goianira (n=406)	Northeast Itaitinga (n=382)	North Rio Preto da Eva (n=401)	p
Any psychiatric disorder	13.1 (11.4-14.7)	14.5 (11.3-18.2)	18.5 (14.8-22.6)	6.8 (4.5-9.8)	12.0 (9.0-15.6)	<0.01
Any anxiety disorder	7.2 (6.0-8.8)	7.8 (5.5-10.8)	9.4 (6.7-12.6)	4.2 (2.4-6.7)	7.2 (4.9-10.2)	0.12
Separation anxiety disorder	1.3 (0.8-2.0)	2.3 (1.1-4.2)	1.5 (0.5-3.2)	0.8 (0.2-2.3)	0.7 (0.2-2.2)	0.15
Specific phobia	3.8 (2.9-4.9)	3.7 (2.1-5.9)	5.2 (3.2-7.8)	2.4 (1.1-4.4)	3.7 (2.1-6.1)	0.23
Social phobia	2.0 (1.4-2.8)	2.5 (1.3-4.5)	3.0 (1.5-5.1)	1.0 (0.3-2.7)	1.2 (0.4-2.9)	0.27
Posttraumatic stress disorder	0.3 (0.1-0.7)	0.5 (0.1-1.7)	0.2 (0.0-1.4)	0.0 (N/A)	0.5 (0.1-1.8)	0.57
Obsessive-compulsive disorder	0.6 (0.3-1.1)	0.2 (0.0-1.3)	0.2 (0.0-1.4)	0.8 (0.2-2.3)	1.0 (0.3-2.5)	0.38
Generalized anxiety disorder	0.4 (0.1-0.8)	0.5 (0.1-1.7)	0.7 (0.2-2.1)	0.0 (N/A)	0.2 (0.0-1.4)	0.37
Any depressive disorder	0.5 (0.2-1.0)	0.9 (0.3-2.3)	0.7 (0.2-2.1)	0.3 (0.0-1.4)	0.0 (N/A)	0.21
Major depression	0.2 (0.0-0.5)	0.5 (0.1-1.7)	0.2 (0.0-1.4)	0.0 (N/A)	0.0 (N/A)	0.34
Dysthymia	0.1 (0.0-0.4)	0.2 (0.0-1.3)	0.0 (N/A)	0.0 (N/A)	0.0 (N/A)	0.43
Any ADHD	4.5 (3.5-5.6)	4.6 (2.8-7.0)	8.1 (5.7-11.2)	1.0 (0.3-2.7)	4.0 (2.3-6.4)	<0.001
Any oppositional/conduct disorder	2.3 (1.6-3.1)	2.8 (1.4-4.8)	4.4 (2.6-6.9)	1.0 (0.3-2.7)	0.7 (0.2-2.2)	<0.001
Oppositional defiant disorder	1.7 (1.0-2.7)	2.5 (1.3-4.5)	3.4 (1.9-5.7)	0.3 (0.0-1.4)	0.5 (0.1-1.8)	<0.01
Conduct disorder	0.6 (0.3-1.1)	0.2 (0.0-1.3)	1.0 (0.3-2.5)	0.8 (0.2-2.3)	0.2 (0.0-1.4)	0.16
Any disruptive disorder*	5.8 (4.7-7.0)	6.2 (4.1-8.9)	9.9 (7.1-13.2)	2.1 (0.9-4.1)	4.7 (2.9-7.3)	<0.001
Other disorders†	1.5 (0.9-2.2)	2.3 (1.1-4.2)	1.5 (0.5-3.2)	1.0 (0.3-2.7)	1.2 (0.4-2.9)	0.04

Data presented as % (95%CI).
ADHD = attention deficit hyperactivity disorder; N/A = not applicable due to 0.0% prevalence.
* Any disruptive disorder: any oppositional/conduct disorder and/or any ADHD.
† Other disorders: substance abuse, tic disorders, eating disorders, and/or psychotic disorders.

The next challenge is to translate evidence into action, scaling up services and human resources to deal appropriately with regional morbidity.

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Psychotic syndrome secondary to meningioma treated with a low dose of olanzapine

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In November 2010, a 60-year-old woman presented for psychiatric evaluation. Her only words were: "It was not my fault." She remained silent for the rest of the interview, with a suspicious look. Her husband added that she had been very

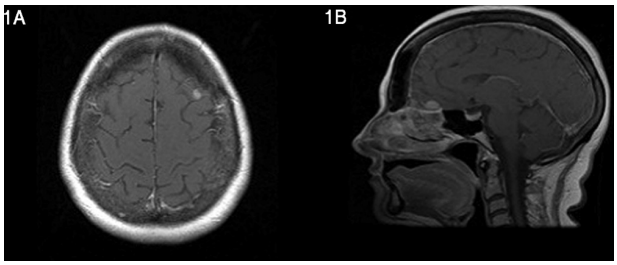


Figure 1 A) Small meningioma in the left frontal high convexity. B) At 1 year, a new meningioma was visible in the cribriform plate of the ethmoid.

agitated, sleepless, and exhibiting signs of memory loss over the previous 2 months.

She had no history of alcohol or other drug abuse, and no prior psychiatric history. Blood tests, serologies, drug screening, and electroencephalography (EEG) showed no abnormalities.

The patient had been on citalopram 20 mg/day for 1 month as prescribed by her geriatrician. We decided to switch her medication to quetiapine 50 mg/day, and requested a head computed tomography (CT) scan and advice from the neurology service.

After 2 weeks, the patient was more communicative and said that her husband had been filming her at home. Head CT showed no abnormalities, and she was discharged from the neurology service. However, we insisted that a magnetic resonance imaging (MRI) scan of the brain should be performed and increased the dose of quetiapine to 100 mg/day.

At 1-month follow-up, the patient was asymptomatic and asked: "How could I believe that my husband wanted to harm me?" MRI showed a small meningioma in the left frontal high convexity (Figure 1A) and she was referred for neurosurgical evaluation, but the neurosurgeon recommended watchful waiting.

The patient returned after 1 year, still on regular quetiapine therapy (100 mg/day). Although well, she complained of headaches and memory lapses. There were no signs or symptoms of intracranial hypertension. Blood tests, serologies, and EEG remained normal. Nevertheless, we requested another MRI scan, which showed enlargement of the frontal meningioma and emergence of a new tumor in the cribriform plate of the ethmoid (Figure 1B). Two weeks later, the patient came to evaluation in a very agitated state, asking why we had "posted what she had told us on Facebook." After a 30-day course of olanzapine 5 mg/day, the patient improved substantially. Olanzapine was well tolerated and the patient did not experience adverse effects. When last seen in August 2014, she was well and remained on olanzapine 5 mg/day.

Meningiomas are benign neoplasms of the central nervous system, highly prevalent among elderly women.[1] Benign cerebral tumors such as these may not cause any symptoms other than psychiatric manifestations until they are quite large. Analyses of correlation between peritumoral edema and coexistence of psychiatric symptoms have indicated that the underlying pathophysiological mechanism is likely related to disruptions in intracerebral pathways rather than with a mass effect of meningioma on intracranial pressure.[2] Indeed, headache, papilledema, and focal neurological signs often arise only when the meningioma has reached an advanced stage. Often, the correct diagnosis is established only after intracranial hypertension has caused irreversible cerebral damage.[2,3]

Meningiomas can cause delusions, especially when located in the cerebral convexities.[2,4] Based on the case reported herein, a low dose of olanzapine seems to be safe and effective for the treatment of such clinical presentations.

When an older adult with no history of mental illness develops psychiatric symptoms, other medical conditions should be considered in the differential diagnosis. Severe diseases may be overlooked if this recommendation is disregarded.[5]

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Sexual abuse and suicide attempt in bipolar type I patients

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Bipolar disorder (BD) is the psychiatric diagnosis that carries the highest risk for suicide behavior. Many different factors are associated with suicide behavior in BD, such as genetics,[1] first-episode bipolarity,[2] and early life adversities (ELA).[3] However, specifically concerning