Nevertheless, the psychiatrist did trigger a mental healthcare consultation in 9.7% of notifications. This raises the question of whether these patients would have been correctly treated otherwise, as patients who are referred for psychiatric consultation by the healthcare team are often not those who truly need psychiatric care, while those in need are not always referred.[4] These results suggest that case discussion with a specialist can help identify which patients can be managed by the healthcare team and which actually need specialist care.

Interestingly, the psychiatrist was able, through case discussions, to question the accuracy of previously established psychiatric diagnoses or suggest a second hypothesis that could be addressed by the healthcare team. Notably, the most prevalent presumed diagnostic hypothesis represents a major issue of concern in general hospitals: organic disorders, which, left undiagnosed, can lead to death; depression, which affects disease prognosis; and personality disorders, which may cause adverse events.[5] Further studies should address the consistency of the hypothesis achieved through risk discussion, thereby clarifying its contribution to quality of care.

In conclusion, the PRE-CL can be an important tool to address mental health situations in general hospitals.

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New-onset psychiatric symptoms following intracranial meningioma in a patient with schizophrenia: a case study

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Intracranial tumors affect the central nervous system (CNS) by different mechanisms, including pressure and edema.[1] Despite adaptive mechanisms, when this compensatory system is exhausted, CNS deterioration can occur rapidly with a host of manifestations, including neuropsychiatric symptoms.[2] These may include new-onset psychiatric symptoms and treatment resistance.[1] Herein, we describe the case of a patient diagnosed with schizophrenia who developed reactivation of psychiatric symptoms secondary to a meningioma.

A 52-year-old woman with a 20-year history of schizophrenia, with 15 years' remission of positive symptoms under adequate pharmacotherapy (olanzapine 20 mg daily), presented with new onset of persecutory delusions, anhedonia, disorganized speech, decreased appetite, and suicidal ideation over a 2-week period. Clozapine 50 mg/day was initiated; however, within 5 days of this medication change, the patient experienced dizziness and a convulsive episode, followed by expressive aphasia. Computed tomography (CT) of the head showed a 7-cm tumor in the left frontoparietal transition (Figure 1). The patient underwent neurosurgery for tumor removal and recovered uneventfully, with no neurological deficit and progressive amelioration of psychiatric symptoms. Histopathological examination was consistent with a meningothelial meningioma. Throughout a 3-year follow-up period, the patient remained stable with a new medication regimen: sertraline 150 mg/day, valproate 1,000 mg/day, lithium carbonate 300 mg/day, and aripiprazole 60 mg/day.

Meningiomas may present initially with psychiatric symptoms. In a study conducted by Gupta and Kumar, 21% of meningioma cases presented with psychiatric symptoms in the absence of neurological manifestations. Affective disorders were the most common presentation, and no correlation between brain laterality and psychiatric comorbidity was reported.[3] In another study, psychiatric disorders were diagnosed in 44% of convexity meningiomas, with a significant correlation between edema volume and the presence of coexisting psychiatric disorders, but not between tumor mass volume and psychiatric symptoms.[4] It has also been reported that meningiomas compressing the frontal lobes may cause progressive behavioral and intellectual changes with no other symptoms or signs until the mass effect becomes too great.

A recent meta-analysis of published cases reports that the associations between brain tumor location and specific psychiatric symptoms are not precise, except for anorexia

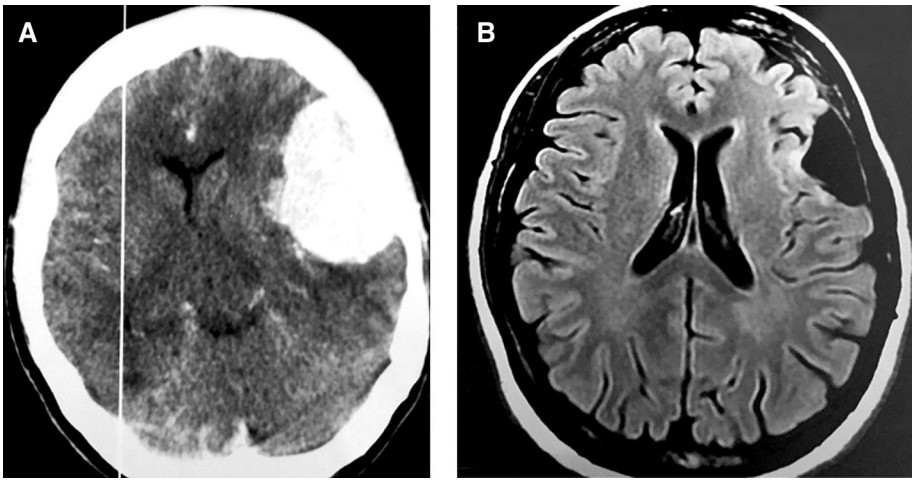


Figure 1 A) Preoperative computed tomography (CT) scan showing a tumor over the left frontotemporal convexity with mass effect; B) follow-up magnetic resonance imaging (MRI) scan showing surgical removal of brain meningioma.

symptoms without body dysmorphic symptoms and hypothalamic tumor.[5] Hence, the correct diagnosis is often delayed, since health professionals usually refer patients with these conditions first to a psychiatrist, with no suspicion of malignant etiology.

Although brain tumors usually present clinical manifestations with neurological localizing signs, psychiatric symptoms may be the only clue, and, as noted above, these symptoms usually offer no localizing value.[1] Therefore, the present case study highlights the importance of performing a thorough medical workup, with a detailed physical and psychiatric examination, to exclude organic and toxic causes of psychosis in patients with new-onset psychotic symptoms (or new-onset treatment resistance in those with a psychiatric history).

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The Clinician-Administered PTSD Scale (CAPS-5): adaptation to Brazilian Portuguese

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Establishing the diagnosis of posttraumatic stress disorder (PTSD) has always been a challenge in clinical practice, as well as in academic research. Since this diagnosis was first published in DSM-III,[1] several of its criteria have been modified and updated, reflecting current understanding of the disorder.

PTSD is currently considered a debilitating condition that develops from exposure to traumatic events such as actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence. One can develop PTSD symptoms by direct exposure (e.g., witnessing a traumatic event; learning that a relative or close friend was exposed to trauma) or by indirect exposure to aversive details of the event, usually in the course of professional duties. The DSM-5 lists 20 diagnostic criteria[2] divided into four symptom clusters: re-experience of the traumatic event; avoidance; persistent negative thoughts or feelings; and trauma-related arousal and reactivity.

The Clinician-Administered PTSD Scale (CAPS) is the non-self-administered scale most widely used for PTSD