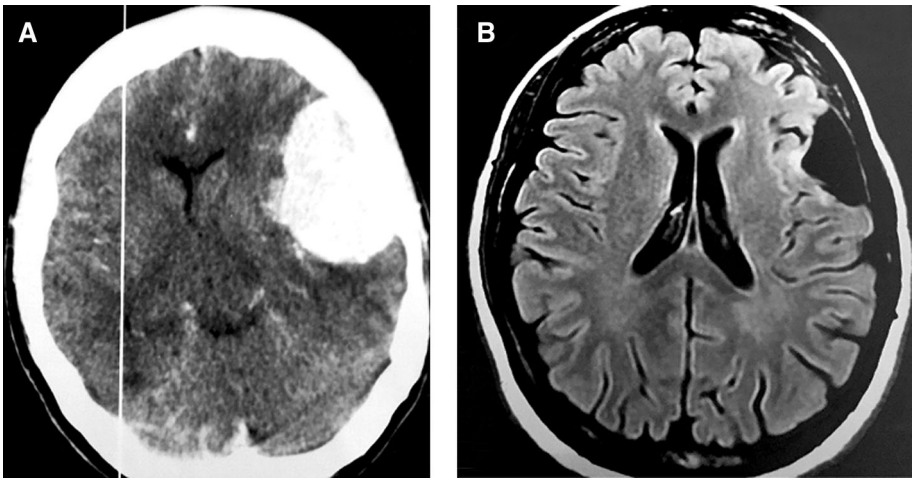


Figure 1 A) Preoperative computed tomography (CT) scan showing a tumor over the left frontotemporal convexity with mass effect; B) follow-up magnetic resonance imaging (MRI) scan showing surgical removal of brain meningioma.

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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Disclosure

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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

assessment in clinical and research scenarios. It assesses diagnostic status and symptom severity, and was developed in 1989 at the U.S. Department of Veterans Affairs National Center for PTSD.[3] To reflect recent changes in the definition and diagnostic criteria of PTSD, the CAPS has been adapted to the DSM-5 criteria,[4] and has demonstrated good psychometric properties when compared to its previous version. Even though the CAPS-5 is available in English, there is still no DSM-5-based, clinician-administered structured interview in the Brazilian Portuguese language to measure presence and severity of PTSD symptoms. In this letter, we describe the process of cross-cultural adaptation of the CAPS-5 for use in Brazil.

For the cross-cultural adaptation process, we used a formal, structured methodology to ensure conceptual, semantic, and operational equivalence.[5] The original scale was translated into Brazilian Portuguese by two native Brazilian translators, experts in English, and both first versions merged by one of the authors of this study (RCS, bilingual and qualified in use of the previous version). Back-translation was performed by a native English speaker who is fluent in Portuguese and has extensive experience with psychological instruments. Then, an expert team evaluated the equivalence of the instrument to review cultural differences. A pilot study of this version of the instrument was conducted with five individuals who sought treatment at PROVE, a specialized outpatient PTSD clinic of the Universidade Federal de São Paulo (UNIFESP) Department of Psychiatry. The operational equivalence process was conducted by the expert team to analyze some discrepancies found when the target population completed the instrument, and a final version was proposed.

It is our opinion that incorporation of the CAPS-5 as a diagnostic instrument in the context of Brazilian violence is critical. A reliability study to assess the internal consistency of the final version of this instrument, after the cross-cultural adaptation process, is already ongoing. An important step to follow is validation of the translated version, which will allow it to be widely used in Brazil.

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Mosaic 15q duplication syndrome (tetrasomy 15q11.1-q13.2) in a child with behavior disorders: case report

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Chromosome 15q duplication syndrome, also known as isodicentric chromosome 15, idic(15), or invdup(15) syndrome, is a rare chromosomal disorder characterized by distinctive features such as autism spectrum, epilepsy, and developmental delay.[1] According to the literature, the 15q11.2-q13.1 segment is the most common region of the large idic(15) syndrome that is duplicated.[2,3] We report a new case of mosaic isodicentric chromosome 15 with 15q11.1-q13.2 tetrasomy (duplication of the 15q11.1-q13.2 region) in a 4-year-old female referred for medical evaluation due to autistic behavior, anxiety, facial dysmorphism, and developmental delay. Physical examination revealed large, low-set ears, a broad forehead, and malformed pinnae. She also suffered from reflux. The patient exhibited several signs of autistic behavior, including repeated and stereotyped movements (such as rotating objects) and echolalia (repetitive speech patterns). The parents described their daughter as a cheerful and loving child with good eye-to-eye contact. According to medical records, an echocardiogram showed a ventricular septal defect with no significant hemodynamic changes. An organic acids test and electroencephalogram were normal.

Array comparative genomic hybridization (array CGH) analysis of genomic DNA samples (blood) was performed