diseases, including sudden death.[3] Therefore, it is interesting to review some findings[3] that explain an increase in cardiac events to cold temperatures: there is 53% more cases of acute myocardial infarction reported during the winter compared with the summer. During the winter, increases in hemoconcentration (erythrocyte count, plasma cholesterol and plasma fibrinogen levels) have been reported, which could contribute to arterial thrombosis. Cold weather can induce a higher systemic vascular resistance with an increase in the blood pressure (thus increasing oxygen demand). Winter temperatures may be associated with flu season and an increase in upper respiratory tract infections could place stress on the heart. According to these lines of evidence, we believe that cold weather could also be considered a new potential risk factor of sudden cardiac death in patients with schizophrenia.

At the moment, there is no information in the literature that describes the relationship between winter temperatures and SUDS. In accordance with this reasoning, we are totally in agreement with Davidson's perspectives:[4] "Because the modifiable risk factors for coronary atherosclerosis and sudden death are so prevalent within the schizophrenic population, it is important for clinicians treating patients with schizophrenia to know what these risks are and understand how they can contribute to increased mortality in these patients".

In the mean time, some actions (medical or non-medical therapies) may help to prevent SUDS. For that, Kloner[5] has described some very interesting commonsense and prudent tactics that the physician should consider during the winter time (called "Merry Christmas Coronary" and "Happy New Year Heart Attack"), especially for patients with established cardiac disease or for those with known risk factors for cardiac disease: 1) Instruct patients to avoid delay in seeking medical attention, should cardiac symptoms occur; 2) Instruct patients to avoid the known triggers for acute myocardial infarction, as excess physical exertion (especially shoveling snow), overeating, lack of sleep, emotional stress, illegal drugs, and anger. Avoid excess salt and alcohol intake. (Alcohol can also precipitate arrhythmias such as atrial fibrillation – the "holiday heart syndrome" and can depress cardiac contractility; 3) Modify and treat known cardiovascular risk factors (e.g., hypertension, smoking, diabetes, dyslipidemia); 4) Consider aspirin or δ-blockers, or both, if appropriate; 5) Instruct patients to avoid exposure to severely cold temperatures; 6) Consider flu shots where appropriate.

Finally, the next logical steps to us, neuroscientists, are to understand and associate the mechanisms by which cold weather could influence the cardiovascular system of patients with schizophrenia. These mechanisms are likely to be important for developing new strategies in the prevention of SUDS.

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Com menos hospitais psiquiátricos, morrem mais portadores de transtornos mentais no Brasil?

Are more persons with mental disorders dying due to fewer mental hospitals in Brazil?

Sr. Editor,

Na edição de 9 de dezembro de 2007, o jornal O Globo publicou a reportagem "Sem hospícios, morrem mais doentes mentais", que apresentou a informação de que o "número de mortes de doentes mentais e comportamentais" aumentara 41% entre 2001 e 2006 (respectivamente, 6.655 e 9.398 mortes) no Brasil, mencionando que "[n]o mesmo período, um quarto dos leitos psiquiátricos do país foi fechado, sem que fossem criados serviços substitutos suficientes".[1] Será que a ilação proposta pela matéria é cientificamente consistente? Proponho aqui analisarmos brevemente se os dados apresentados podem sustentar que o fechamento substancial de leitos psiquiátricos no país estaria associado a um acréscimo nas mortes de portadores de transtornos mentais (TM).

Já de início se percebe um erro grave na interpretação dos dados, que não dizem respeito à mortalidade geral de portadores de TM, mas sim à mortalidade específica por TM – comparável a se confundir a morte de anêmicos com a morte por anemia. Verificando na Tabela 1 os registros de mortalidade específica do Sistema de Informações sobre Mortalidade (SIM), disponíveis

Tabela 1 - Causas primárias de morte registradas em declaração de óbito segundo o ano, e variação absoluta e percentual entre os anos 2001 e 2005. Brasil, 2001-2005

Causas primárias de morte	2001	2002	2003	2004	2005	Variação 2001/2005	
						absoluta	percentual
Transtornos mentais e comportamentais	6.655	7.011	7.356	8.158	8.931	2.276	+ 34,2%
Uso de álcool	5.044	5.096	5.213	5.762	6.351	1.307	+ 25,9%
Uso de outras substâncias psicoativas	324	321	366	451	538	214	+ 66,0%
Outros transtornos mentais e comportamentais	1.287	1.594	1.777	1.945	2.042	755	+ 58,7%
Outras causas							
Doenças do sistema nervoso	12.296	12.857	13.750	15.156	16.384	4.088	+ 33,2%
Doenças do aparelho geniturinário	14.350	15.167	15.858	17.094	18.365	4.015	+ 28,0%
Doenças osteomusculares e reumáticas	2.606	2.885	3.001	3.002	3.084	478	+ 18,3%
Neoplasias	125.348	129.923	134.691	140.801	147.418	22.070	+ 17,6%
Doenças endócrinas, nutricionais e metabólicas	47.800	49.222	51.190	53.134	53.983	6.183	+ 12,9%
Doenças do aparelho digestivo	44.393	45.797	46.894	48.661	50.097	5.704	+ 12,8%
Doenças da pele e tecido subcutâneo	1.825	1.932	1.977	1.886	2.014	189	+ 10,4%
Doenças do aparelho respiratório	90.288	94.754	97.656	102.168	97.397	7.109	+ 7,9%
Doenças do aparelho circulatório	263.417	267.496	274.068	285.543	283.927	20.510	+ 7,8%
Causas externas (acidentes, violência, suicídio)	120.954	126.550	126.657	127.470	127.633	6.679	+ 5,5%
Gravidez, parto e puerpério	1.587	1.650	1.597	1.672	1.661	74	+ 4,7%
Malformações congênitas e genéticas	9.520	9.733	10.143	10.210	9.927	407	+ 4,3%
Doenças infecciosas e parasitárias	45.032	45.175	46.533	46.067	46.628	1.596	+ 3,5%
Doenças hematológicas e imunitárias	5.240	5.217	5.354	4.978	4.999	- 241	- 4,6%
Doenças do olho e do ouvido	141	126	141	140	125	- 16	- 11,3%
Afecções originadas no período perinatal	34.274	33.136	32.040	31.011	29.799	- 4.475	- 13,1%
Causas mal-definidas	135.766	134.176	133.434	126.922	104.455	- 31.311	- 23,1%
Percentual de causas mal-definidas	14,1%	13,7%	13,3%	12,4%	10,4%		
Total	961.492	982.807	1.002.340	1.024.073	1.006.827	45.335	+ 4,7%

Fonte: (2)

– infelizmente, só até o ano de 2005 – no portal do Datasus,[2] podemos constatar que 2001 apresentou as 6.655 mortes citadas pela reportagem.

Ainda assim, teria a diminuição de leitos causado um aumento na mortandade por TM? Aqui, embora de maneira mais sutil, também há dificuldades na sustentabilidade da suposição. A confiabilidade dos dados de mortalidade é particularmente escorregadia em países em desenvolvimento e a sua comparação em períodos distintos deve ser feita de maneira cautelosa, devido a possíveis alterações na captação das informações.[3] Examinando novamente a Tabela 1, observa-se que houve uma sistemática queda nos registros de causas mal-definidas, de 14,1%, em 2001, para 10,4%, em 2005, ou mais de 31 mil declarações de óbito que deixaram de ser obscuras no período. Neste contexto, dois estudos nacionais, realizados entre 1999 e 2000, que aplicaram métodos de correção de causas mal-definidas, apresentaram incrementos na mortalidade por TM de 112%[3] e 68%.[4] Além disso, como mostra a Tabela 1, entre 2001 e 2005 houve também aumentos substanciais nos registros de mortalidade por doenças neurológicas e geniturinárias, sem qualquer queixa de redução no número de leitos para estas afecções.

Diante dos dados expostos, é lícito concluir que não há como sustentar, com as evidências disponíveis na reportagem, a conclusão de que a redução do número de leitos psiquiátricos levou ao aumento da mortalidade por TM, muito menos nas mortes de portadores de TM.

Isso, no entanto, não reduz a importância do estudo científico das perguntas lançadas sobre este tema. Portadores de TM têm maior mortalidade do que a população sã, mas a associação entre redução nos leitos psiquiátricos e mortalidade é mais elusiva: embora haja algumas evidências neste sentido, elas não são uníssonas na literatura.[5] A chave para sua compreensão pode estar no escrutínio de uma quantificação usada na reportagem de forma falsamente certa, mas que ainda é um mistério a ser respondido na pesquisa avaliativa em saúde mental: "serviços substitutivos suficientes".

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Selective mutism and the anxiety spectrum – a long-term case report

Mutismo seletivo e o espectro da ansiedade – relato de um caso de longa evolução

Dear Editor,

Selective mutism (SM) is a disorder characterized by inability to talk in specific situations, despite of being able to talk in familiar places. With a prevalence of 0.3%-1% in school-age children,[1,2] most cases (79%) start at preschool age and have transitory course.[3,4] Psychotherapeutic interventions and selective serotonin reuptake inhibitors are considered first and second line treatments, respectively.[1,5]

We report a case of SM in a 17-year-old girl whose symptoms started when she was 4 years old and have persisted during adolescence. She stopped talking to everyone after a haircut. She panicked every time her mother went out or when she was left at school. She didn't talk for 45 days, and then progressively recovered, talking first to her sisters, then to other relatives.

One year later, she stopped talking again after her bike had been stolen. Three months later, she started to chat with relatives and two close friends. She hasn't talked to anyone else since then. Despite this fact, she regularly goes to school and has friends of her age, with whom she communicates through e-mails and mimics. Neither academic nor cognitive impairment have been detected along all school years. She likes to dance and to play handball. When she needs something that requires talking, her mother does it on her behalf, which prevents her from being exposed and increases avoidance of anxiety situations.

According to DSM-IV criteria, a diagnosis of SM was made. Assessed through a semi-structured interview (Schedule for affective disorders and schizophrenia for school-age children, K-SADS), she met diagnostic criteria for Separation Anxiety Disorder (in the past), current diagnosis of Specific Phobia. She didn't have any other anxious (including social anxiety), affective or psychotic symptoms.

Before her referral, she was treated with psychodynamic therapy and took paroxetine (20 mg/daily) for 12 months without improvement. At our service, she was treated with cognitive-behavioral therapy (CBT) for 10 months with poor outcome. Then, CBT was associated with sertraline (150 mg/daily). After 3 months, the level of anxiety on CBT exposures lowered. She started to shout when playing handball, she talks louder to her mother in public places, and talks to friends through lips movements. Though she isn't talking to many people yet, she is clearly less anxious.

There is some controversy whether SM is an anxiety disorder (AD) or an independent diagnosis. Previously, SM was considered an oppositional behavior, a psychotic symptom or a dissociative disorder. In DSM-IV, SM is classified under Other Disorders of Childhood. SM has many aspects in common with AD: pre-morbid temperament (shyness, behavioral inhibition), parent-child overdependence, overlapping diagnoses with other AD (social phobia, separation anxiety), and high prevalence of parents with AD.[5] Some authors propose that SM is an extreme manifestation of social phobia.[2] Our patient denied having social anxiety in situations that don't involve talking, but other anxiety symptoms were observed, such as early manifestation of separation anxiety, supporting the hypothesis that SM should be considered an anxiety spectrum disorder.

Although genetic, behavioral, psychodynamic and family factors must be considered, the etiology of SM remains unknown.[1] The available options for clinical treatment are based on open-label studies, case reports and clinical experience.[3,5] This case has shown a better outcome when biological and psychotherapy interventions were associated, which may indicate a field for future researches. Having SM as a subcategory of AD may benefit its comprehension, not only as a symptom, but as a unique disorder with its own characteristics.

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