

níveis acima do normal em ambos os sexos e a redução dos níveis de estrogênio e testosterona, aumentando o risco para osteoporose.<sup>2,5-6</sup>

A osteoporose é esperada em pacientes mulheres que desenvolveram amenorréia como resultado da hiperprolactinemia secundária aos antipsicóticos, mas não há mecanismos plausíveis nos homens.<sup>5</sup> Sugere-se que, em homens, a hiperprolactinemia resulte hipogonadismo e perda óssea.<sup>2</sup>

A prevalência de osteoporose, bem como do aumento da prolactina induzida pelos antipsicóticos, ainda não está determinada adequadamente.<sup>2,4,6</sup> Apesar da diminuição da densidade mineral óssea já ter sido reconhecida há algum tempo, somente recentemente tem sido investigada e o que existe é um reduzido número de estudos clínicos de prevalência, marcados pelo pequeno tamanho de amostra.

De qualquer forma, as pesquisas sobre o uso prolongado de neurolépticos alertam para a necessidade de uma maior atenção aos efeitos adversos dos mesmos, especialmente com respeito à hiperprolactinemia, uma vez que esta aumenta o potencial para desenvolvimento de osteoporose.<sup>2,4</sup> Paralelamente, outros estudos sugerem que neurolépticos atípicos podem ser mais seguros do que os típicos em termos de redução da DMO<sup>3</sup> e demonstram menor efeito sobre a prolactina, como clozapina, ziprazidona e olanzapina.<sup>6</sup> Apesar destas evidências acumuladas, os antipsicóticos ainda não são reconhecidos pela *World Health Organization* (WHO) ou pelo *Royal College of Psychiatrists* como fatores de risco para osteoporose e ainda não existem estudos epidemiológicos adequados para verificar o tamanho do efeito dos neurolépticos sobre a diminuição da DMO em esquizofrênicos. Considerando esta situação e o potencial impacto negativo sobre a vida dos pacientes usuários crônicos de neurolépticos, os autores recomendam urgentemente a execução de estudos de seguimento com tamanho amostral, determinação sistemática de DMO e tempo de acompanhamento adequados.<sup>4</sup>

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## Good news for Brazilian eating disorders researchers

### Boas novas para os pesquisadores de transtornos alimentares no Brasil

Dear Editor,

We would like to congratulate the Revista Brasileira de Psiquiatria for the publication of the paper *The Eating Disorders Section of the Development and Well Being Assessment (DAWBA): development and validation*, by Dr. Tatiana Moya et al from PROTAD, USP, Brazil.

The paper describes a well-controlled study of the validation and test-retest reliability of the Portuguese version of the Eating Disorders (ED) section of the DAWBA.<sup>1</sup> The DAWBA is an assessment package designed for the psychiatric evaluation of children and adolescents.

Results from Dr. Moya's study demonstrate that DAWBA eating disorders diagnoses have high levels of agreement with expert clinical assessment and yield high sensitivity, specificity, positive and negative predictive values for the discrimination between ED diagnoses (irrespective of type) and its absence, when compared to independent clinical interview. Test-retest reliability of the DAWBA final ED diagnoses is also very good. One important advantage of the DAWBA system is that it can also generate preliminary computer diagnoses. The computer program can be used when experts are not available or when financial resources are scarce.

This publication represents a major advance for eating disorders researchers in Brazil, where there is a lack of well-validated, easily-administered and cost-effective diagnostic instruments suitable for the use with younger populations. The DAWBA has good psychometric properties and also combines the advantages of respondent-based (structured) interviews with clinician-based (semi-structured) interviews and, therefore, can be adapted to different settings and needs.

Eating disorders are known to have a peak age of incidence during adolescence and specialized ED centers have witnessed, in the last five years, an increase in the number of patients below 18 years of age seeking help for eating problems. In our ED program (PROATA), at UNIFESP, referrals of children and adolescents have not been uncommon, with patients as young as 12 years old being treated by our team.<sup>2</sup>

Mean age of Dr. Moya's sample was 16 years. It would be interesting to know the minimum age of her subjects and to verify the psychometric performance of DAWBA's ED section with prepubertal patients. It is somewhat surprising that the assessment of children with less than 11 years of age is restricted to the parent-interview, which is how the DAWBA as a whole was originally designed. Even though the inclusion of a parent interview has major advantages because of the tendency of ED patients to deny their symptoms,<sup>3</sup> restricting the assessment to parents excludes the possibility of detecting secretive behaviors, particularly purging behaviors and eating in secret. To help clarifying this issue, studies could be accomplished comparing parent and child interviews of subjects in the lower age range covered by the instrument.

Finally, we would like to recommend a visit to the fascinating and user-friendly site of the DAWBA ([www.dawba.com](http://www.dawba.com)). The ED section has already been incorporated to online and text Portuguese versions of the

DAWBA, which were validated by Fletlich-Bilyk and Goodman, both available at no cost.<sup>4</sup>

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**Interviewing younger children has costs as well as benefits**

**Entrevistar crianças mais jovens tem custos assim como benefícios**

Dear Editor,

We would like to thank Morgan and Claudino for their complimentary review of *The Eating Disorders Section of the Development and Well Being Assessment (DAWBA)* and for raising the important question as to why children under the age of 11 are not interviewed directly as part of the DAWBA assessment (though their parents are). They are obviously right that children under the age of 11 can develop eating disorders, though this is rare. In our sample of 58 children and adolescents with eating disorders (10 assessed as part of the pilot study<sup>1</sup> and 48 as part of the main study)<sup>2</sup> only one was under the age of 11. Morgan and Claudino are also right that parents are sometimes unaware of all their children's symptoms, though it is also worth remembering that children who have hidden their symptoms from their family may not choose to reveal them even to the most skilled and sympathetic of interviewers. The extra benefits, therefore, of administering eating disorders interviews to young children may be small – and it would take a multi-centre study many years to accumulate the relevant evidence.

As against the possible benefits, there are two important disadvantages in interviewing younger children. Firstly, previous studies have shown poor test-retest reliability for psychiatric interviews administered to children under the

ages of 11 or 12,<sup>3</sup> and this was also our experience during the pre-piloting of the DAWBA with 8-10-year-olds.<sup>4</sup> To some extent, limitations in children's understanding and reliability can be overcome by using lengthy semi-structured interviews administered by highly trained interviewers. However, this expensive solution leads us to the second disadvantage. We have estimated that there are between six and eight million children and adolescents with psychiatric disorders in Brazil,<sup>5</sup> and there are not enough resources currently – in terms of money or professional time – to provide adequate assessment and treatment for them all. The DAWBA was designed to make high-quality assessments cheaper and more widely available, but this has involved some compromises. In the long term, Morgan and Claudino's counsel of perfection must be right – every Brazilian child deserves the very best assessment money can buy. In the short term, however, it may be necessary to get the best value out of very limited resources by using less-than-perfect assessments that are substantially quicker and cheaper to administer.

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