scores ⩾ 6 in the brief version of the SPIN (Mini-SPIN)[3] were included. All selected individuals were then interviewed with the Portuguese version of the SAD module of the SCID-IV.[4] Diagnosis was confirmed for 237 (10.2%) of the total sample; the average age at SAD onset was 11.4 years (± 0.27) with an average time of disease of 10.2 years (± 0.3). All subjects gave written informed consent after being fully informed of the research procedure, following approval by the local Research Ethics Committee (no. HCRP 11570/2003).

Patients with early- (< 18 years) and late- (⩾ 18 years) SAD onset were compared and contrasted regarding clinical and sociodemographic aspects, and academic performance (evaluated by weighted average grades) - Table 1. There were no statistical differences between groups in respect to symptom severity as assessed by the SPIN[2] scale and its factors scores, academic performance, severity of SAD according to the SCID-IV,[4] and use of general and psychotropic medications. In contrast to the study by Menezes et al.,[1] we have not found differences between groups in respect to the frequency of the generalized subtype of social phobia and economic productivity. In addition, there was no significant correlation between age at onset of SAD and the SPIN scores ($r = -0.08$, $p = 0.21$) and academic performance ($r = 0.01$, $p = 0.75$). All of these results persisted even when we adopted an age cut-off point of 15 years old to define early onset[5] (Table 1).

These different findings may be explained by the fact that in the study by Menezes et al. the sample was composed solely of subjects who sought treatment spontaneously at a specific research center, whereas in our study the SAD population was found in the scope of an epidemiological survey, not consisting of a clinical sample. Moreover, at this point of our study we did not systematically assess psychiatric comorbidity and only a subsample accepted treatment, not allowing for any conclusions regarding the influence of the therapeutic response and the effect of other psychiatric conditions between groups.

Thus, in conclusion, our data are not supportive of differences between early- and late-onset SAD subtypes. Nevertheless, future studies in different settings and SAD populations are clearly needed and opportune.

Acknowledgements
The authors thank Alaor Santos Filho, Maria Cecília Freitas, Stella Mesquita, Moisés Chaves, Marilene Pinho and Carolina Menezes Gaya for helping with data collection. We are also grateful to Kathy Connor and Jonathan Davidson for authorizing the use of the SPIN and for the collaboration with the process of translation of the instrument.

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Financing: Research is supported in part by Fundação de Amaparo à Pesquisa do Estado de São Paulo (FAPESP, 02/13197-2) and Fundação de Apoio ao Ensino, Pesquisa e Assistência, Hospital das Clínicas, Faculdade de Medicina de Ribeirão Preto, Universidade de São Paulo (FAEPA) fellowships. JASC and SRL are recipients of Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq, Brazil) fellowships.
Conflict of interests: None

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Reply to Dr. Crippa's letter "Are there differences between early- and late-onset social anxiety disorder?"

Resposta à carta do Dr. Crippa "Existem diferenças entre transtorno de ansiedade social de início precoce e tardio?"

Dear Editor,

We appreciate the thoughtful letter from Dr. Crippa and colleagues, who raised some interesting issues based on the findings of our article entitled "Early-onset social anxiety disorder in adults: clinical and therapeutic features",[1] which was published in the *Revista Brasileira de Psiquiatria*. In our study, we evaluated the sociodemographic and clinical characteristics of a sample of adult patients diagnosed with social anxiety disorder (SAD). The objective of our analysis was the identification of differences between the subgroups presenting early- and late-onset forms of the disorder. We found that patients from the former group were more frequently economically unproductive, presented a higher frequency of the generalized subtype of SAD, and exhibited greater rates of multiple comorbid psychiatric disorders.

Despite Crippa et al.'s comments, our socioeconomic findings dovetail with the results previously described both in clinical and epidemiological studies of patients with SAD from the developed countries. For example, in an epidemiological study, Wells et al. found that early-onset SAD was associated with lower levels of education and low frequency of marriage.[2] Likewise, in a clinical study, Lecrubier found that patients with early-onset SAD (< 15 years) had lower levels of education than those from the late- onset group.[3] In terms of clinical features, the finding that the generalized subtype of SAD was more common in the early-onset group was also observed in studies of both epidemiological and clinical samples conducted by Wittchen and Manuzza, respectively, in which a significant correlation was found between earlier age at onset and the generalized subtype.[4-5]

We believe that the discrepant findings described by Crippa et al. in their letter might be ascribed to the particular sociodemographic characteristics of their sample, which was composed exclusively by undergraduate subjects. Although we acknowledge that our study has some limitations, including its small sample size and the fact that it has enrolled individuals who sought treatment at a research center, it certainly covers a wider age range than does the study by Crippa et al. This feature may have provided the required heterogeneity to unveil more clear-cut differences between early- and late-onset SAD. Moreover, since we have described our findings using a treatment-seeking sample, our results may be considered as more relevant for the daily clinical practice.

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Financing: None
Conflict of interests: None

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Quem ainda lê a produção científica psiquiátrica brasileira?

Who still read the Brazilian's psychiatric scientific production?

Sr. Editor,

Revisitando periódicos nacionais e revendo a rica produção dos nossos pesquisadores, deparei-me com um volume (suplemento) da Revista Brasileira de Psiquiatria de 2003,[1] dedicado ao transtorno de estresse pós-traumático (TEPT). Fui tomado por uma espécie de surpresa retrospectiva, por não ter encontrado nenhuma alusão aos trabalhos de José Waldo Saraiva da Câmara Filho.

Espantoso que num país onde existe uma produção científica de qualidade, confeccione-se um periódico, sobre um tema cujos autores pioneiros nacionais contemporâneos sejam completamente omitidos, enfim,desconhecidos.

Pasmem, porque tive a curiosidade de observar que nem ao menos nas citações bibliográficas encontrávamos a lembrança ao estudo do hoje Prof. José Waldo Saraiva Câmara Filho, gerado no Programa de Neuropsiquiatria e Ciências do Comportamento da Universidade Federal de Pernambuco e pioneiro no Brasil.[2]

Publicamos mais dois artigos em periódicos de ampla divulgação nacional.[3-4] Pergunto então, quais são as razões para que essas omissões aconteçam?

Será que estaríamos cometendo algum tipo de equívoco nacionalista? O que é isso, uma espécie de condenação?

Considero que essa forma de cegueira é injusta, incompreensível, preconceituosa e nos faz pensar que há algo de "errado" no reino da Dinamarca.

Todavia, o Prof. José Waldo continua estudando TEPT e, futuramente, quem sabe, as suas publicações abram-lhes as portas para o reino dos céus.

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Financiamento: Inexistente
Conflito de interesse: Inexistente

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