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Comment on "Comparison of the Accuracy of Short Cognitive Screens Among Adults With Cognitive Complaints in Turkey"

To the Editor:

We read with interest the article of Varan et al titled "Comparison of the Accuracy of Short Cognitive Screens Among Adults with Cognitive Complaints in Turkey." In this article, the accuracies of 3 short cognitive screening instruments in detecting mild amnestic-type cognitive impairment (MCI) and Alzheimer disease (AD) in the elderly with low literacy were compared and the cut-off levels valid for Turkish society were obtained.[1] A scale developed elsewhere in the world, especially cognitive screening tests and mood scales, is also validated for each community due to intercommunal education and socio-cultural differences. Thus, whether the scale is valid for that society and appropriate cut-off values are determined. For example, according to the study results of Varan et al,[1] the most appropriate Qmci cut-off value in the Turkish population was found to be ≤54 with 74.29% sensitivity and 77.78% specificity. However, Qmci's recommended cut-off for Irish society is <62 (sensitivity of 90% and specificity of 87%).[2] Therefore, it is very valuable to determine the values specific to the population for screening tests that help establish the diagnosis of the disease.

However, Varan and colleagues evaluated their depressive symptoms with GDS-15 to exclude patients with depression in their study and used ≥7 cut-off value for the diagnosis of depression.[3] At this point, a methodological error was made. First, in the study by Matias et al,[3] which the authors refer to for this cut-off, ≥6 cut-off was used for GDS, not ≥7 (sensitivity of 80% and specificity of 44%, delimiting the area under the ROC curve of 0.70). Second, the validation of GDS-15 for the elderly Turkish population was already done by our group in 2018 and the analysis performed considering DSM-5 criteria revealed that the sensitivity, and specificity of GDS-15 in determining depression were 92%, and 91%, respectively, when the cut-off value was taken as ≥5.[4] Moreover, given the fact that the questions 2, 9, 10, 11, and 13 of GDS-15 are related to cognitive and motivational abilities,[4,5] in order to exclude patients with depression, it is absolutely necessary to take the GDS cut-off as ≥5 and reanalyze for the accuracy of the results.

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The authors declare no conflicts of interest.

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Response to "Comment on Comparison of the Accuracy of Short Cognitive Screens Among Adults With Cognitive Complaints in Turkey"

In Reply:

We thank Işık and colleagues for their response and feedback on our article. Isık and colleagues refer to our use of the GDS-15 to identify patients with depression and our application of a cut-off score of ≥7 for the diagnosis of depression. We appreciate the authors concerns and would like to take this opportunity to clarify. Use of short screening instruments for depression to identify those meriting more detailed assessment is common in clinical trials of cognitive impairment. In our study, as with others, the GDS-15 was performed only for screening and not for the diagnosis of depression.[1] After screening with the GDS-15, a comprehensive geriatric assessment was conducted. Patients diagnosed with depression were only

The authors declare no conflicts of interest.

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