

MoCA (90%; CI 82%–95%). It is unlikely that the specificity of the SCOPA-COG for the PD-N vs PD-MCI comparison would improve with a larger sample for a screening cutoff because this instrument is sensitive to minor impairments evident in the PD-N group (table 2).¹

Relative to the values given for the whole sample in table 3,¹ no diagnostic performance values worsened and some improved when the MoCA analysis was restricted to those patients with PD-N and patients with PD-MCI who were tested on both the MoCA and the SCOPA-COG. The cutoffs suggested for optimal screen, diagnostics, and maximum accuracy remained the same. However, specificity for the optimal screen cutoff increased from 75% to 86% while PPV increased from 61% to 73%; the PPV for the optimal diagnostic cutoff increased from 79% to 90%; and both specificity (75% to 86%) and PPV (61% to 73%) increased for the maximum accuracy cutoff. The base rates used to estimate PPV

and NPV were population base rates, not sample base rates, which will vary across different criteria especially in PD-MCI.³

This evidence suggests that our original conclusion of the value of MoCA regarding cognitive screening for PD is sound.

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Disclosure: See original article for full disclosure list.

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CORRECTION

Olfactory copy number association with age at onset of Alzheimer disease

In the article “Olfactory copy number association with age at onset of Alzheimer disease” by C.A. Shaw et al. (*Neurology*[®] 2011;76:1302–1309), there is an error in the disclosure. Dr. Doody “... [receives] research support from Medivation Inc. and Sonexa Therapeutics, Inc.” should have read Dr. Doody “... holds stock options in Medivation Inc. and Sonexa Therapeutics, Inc.” The editorial staff regrets the error.

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