

with APS and have even been found in 27% of patients with APS.⁵ SREAT may occur in the absence of thyroid function abnormalities; MRI can be normal or reveal the presence of diffuse white matter changes, atrophy, or ischemic lesions.

Similar to APS, SREAT is responsive to steroid therapy.⁴ Although this condition is rare and its clinical manifestations are nonspecific, it should be included in the differential diagnosis of neuropsychiatric disorders in elderly patients, especially in association with APS.

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Reply from the Authors: We thank Smida-Rynkowska et al. for their comments and agree that SREAT should be considered as a differential diagnosis of neuropsychiatric disorders. This diagnosis was included in our patient but antithyroid antibodies were negative in serum and in CSL.

Furthermore, our patient had a history of venous thrombosis, which is not usually associated with isolated SREAT. Thyroiditis encephalopathy is known

to have good response to steroids, but this is very unusual in neuropsychiatric symptoms related to a primary APS.

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Disclosure: The author reports no disclosures.

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CORRECTION

Calibrated finger rub auditory screening test (CALFRAS^T)

In the article “Calibrated finger rub auditory screening test (CALFRAS^T)” by D. Torres-Russotto et al. (*Neurology*[®] 2009;72:1595–1600), there were two errors. In table 2, the total true positive (TP) for CALFRAS^T-Strong70 was 92 and not 90. The correct number was printed in the Results section. In the Methods section, the correct CALFRAS^T measured intensity at 70 cm was a mean of 30 dB, not 31 dB. The authors regret the errors.

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