To the Editor—I read with interest the paper "Validation of the abbreviated mental test (Hong Kong version) in the elderly medical patient" by Chu et al published in the Hong Kong Medical Journal (HKMJ;1995;1:207-11).

I cannot agree more with the authors' suggestion that the AMT be routinely used as a screening test for cognitive impairment in all elderly patients as such impairment is prevalent in this age group. One minor comment on the study, is that psychiatrists should have been involved in excluding cases of depression as this is also common in the elderly and may greatly affect the AMT score.

Studies so far carried out in Hong Kong share the common finding that the Chinese elderly population has a relatively lower cut-off point for standardised screening instruments for cognitive deficit.[1-3] I agree with the authors' hypothesis that a lower educational standard may be the underlying factor. Moreover, different settings, target populations and screening purposes probably result in different optimal cut-off points and should be determined specifically for each study.

In my pilot study on MMSE, I established concurrent validity with another 10-item test (the Mental Status Questionnaire) [MSQ] that is the widely used in the United States and many other countries.[2] As I have mentioned in an article promoting the use of the short portable MSQ, another brief cognitive screening test for primary care physicians, there are quite a number of brief tests which are virtually equivalent in their validity, sensitivity, and specificity. All can serve well in detecting possible cognitive impairment in the elderly worthy of further examination.[4] The AMT (Hong Kong version) certainly has also been proven to be valid and can be one choice.

One of the many purposes of these standardised screening tests is to provide a common language for different professionals when screening and assessing the cognitive functions of the elderly. Hence, it is desirable that all health care professionals involved in caring for the aged including psychogeriatricians, psychiatrists, geriatricians, primary care physicians, medical social workers, nurses, and old age home staff be using the same screening instruments.

One of the brief screening tests (e.g. AMT, MSQ, SPMSQ) can be administered by non-medical personnel or a primary care physician, as little training is required. For geriatricians and psychiatrists, the standard screening test should be the locally-validated MMSE, which can reveal by the score not only the probability of cognitive deficit but also the pattern of cognitive deficit.[2,3] The other alternative is to perform an MMSE if the AMT/MSQ is below the cut-off point. Preferably, another locally-validated screening instrument for depression in the elderly (e.g. Geriatric Depression Scale) should also be included.

With the emphasis on early detection and management of cognitive impairment and depression in the elderly, I believe it is the right time to propose that all health care workers for the aged sit together in a conference or task force to unify the use of standardised screening tests. If we can agree on the use of the MMSE and one of the short screening tests, then some more collaborative researches could be carried out on larger samples in various settings, thus yielding a more reliable and useful cut-off point. A conversion table for the MSQ/AMT with MMSE would further enhance the usefulness of these screening tests.

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In reply—We thank Dr TW Fan for his interest in our paper. On the whole, we share with him the same understanding and feeling about the routine use of cognitive screening tests. For depression, we knew that it might result in pseudodementia syndrome. We did endeavour to exclude depression in our study. Probably due to sampling variation, we did not encounter any depression in the study period (five months). We also involved our psychogeriatrician in the study. However, the practical difficulty of doing this (i.e. time constraint) was the main obstacle. We do look forward to future collaborative service/research between the geriatrician and the psychiatrist.

In our daily geriatric practice, a two-level cognitive assessment approach is used. The AMT is part of our multi-dimensional geriatric assessment; it serves as a screening test. Patients with low scores are further evaluated by the MMSE and are given a global clinical assessment. Psychogeriatric consultations are included when indicated.[2,3]

For the Geriatric Depression Scale, we have routinely been using the GDS (short-form) in certain patient groups (e.g. geriatric nutrition clinic).[4] We will evaluate the usefulness of the GDS as a routine test in our geriatric inpatient and other outpatient settings later.

Finally, we welcome Dr Fan's suggestion of future collaborative research in the early detection and management of cognitive impairment and depression in the elderly population. We believe a two-level assessment strategy would be a cost-effective approach for both the clinic/hospital and population settings.

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