

Clarifying Baseline Cognitive Eligibility and Cross-Scale Follow-Up in a Randomized Trial of Remimazolam Tosylate for Laparoscopic Surgery [Response To Letter]

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Dear editor

We thank Dr. Zeng et al for their interest in our published work. Below are our responses to the two issues.

Response to Issue I: Consistency Between the MoCA Exclusion Criterion and the Baseline Data

The correspondent points out that the preoperative MoCA scores reported in Table 1 (median [IQR]: 25–26 in Group R, 24–27 in Group P) include values below the exclusion threshold of 26, and questions whether this contradicts the criterion of excluding patients with preoperative MoCA < 26.

We wish to clarify that the MoCA values presented in Table 1 are the raw (unadjusted) scores. During patient screening, we applied educational adjustment to the raw MoCA scores to ensure that all enrolled patients had corrected scores ≥ 26 . A review of the literature indicated that the simple adjustment of “add 1 point for ≤ 12 years of education” is insufficient to fully eliminate the educational bias on MoCA performance.^{1–3} Therefore, we adopted a stratified adjustment scheme based on previous studies, as follows:

- Years of education < 4 years: add 3 points
- Years of education 4–9 years: add 2 points
- Years of education 10–12 years: add 1 point
- Years of education > 12 years: no addition

After applying the above adjustment, all enrolled patients had MoCA scores ≥ 26 , and the adjusted baseline cognitive status was comparable between the two groups. The original text lacked sufficient clarity, which may have led readers to mistakenly believe that the scores in Table 1 were the adjusted ones. We apologize for this ambiguity. However, it should be clarified that this reflects an incomplete connection between the table presentation and the textual description, rather than a deviation from the protocol.



Response to Issue 2: Consistency of TICS-m Cutoff Definitions and the Lack of Preoperative TICS-m Baseline

Regarding the Alleged Inconsistency in Cutoff Definitions

The correspondent suggests that the manuscript provides two different interpretation rules for TICS-m. In fact, the descriptions in the manuscript are consistent, and the classification is as follows:

- TICS-m > 31: normal cognitive function
- TICS-m ≤ 31: cognitive impairment (this is the optimal cutoff for distinguishing impairment from normal)
- TICS-m < 28: within the impaired range, this indicates severe cognitive impairment

Thus, scores between 28 and 31 represent mild-to-moderate cognitive impairment, not severe. There is no contradiction in the text.

Regarding the Lack of a Preoperative TICS-m Baseline

The correspondent notes that without a preoperative TICS-m measurement, the term “postoperative cognitive decline” at 1 month cannot be strictly defined as a decline from baseline. We agree with this point. However, the primary objective of the 1-month follow-up in our study was not to measure individual changes from baseline, but to compare the cognitive status between the two groups at 1 month postoperatively. Because the trial used rigorous randomization, the two groups were comparable in terms of preoperative cognitive level and other confounding factors. Therefore, a preoperative TICS-m baseline is not required for valid between-group comparison at 1 month. The term “postoperative cognitive decline” was used as a general description of postoperative cognitive status, not as a strict individual pre-to-post comparison.

Disclosure

The authors declare that no conflicts of interest in this communication.

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