In Reply We agree with Dr Chen and colleagues that patients with TBI, obesity, and dementia have high prevalence of depressive symptoms and support inclusion of these 3 medical conditions in the Box of medical illnesses with high prevalence of depressive symptoms in our article.†

Regarding the various symptom rating scales listed in the publication (PHQ-2, PHQ-9, BDI-II, HADS, and SCID), we agree with Dr Hahn that the SCID requires a greater degree of training and time for assessment than the other rating scales listed above; use of the SCID has demonstrated superior reliability and validity in both categorical and severity assessment of psychopathology.‡ Additionally, we concur that the PHQ-2 and PHQ-9 are more broadly utilized in many medical settings, including nonbehavioral health settings,§ than other scales discussed above. We also acknowledge that the etiology of many depressive symptoms may be difficult to assess in medically ill patients and support the use of the PHQ-2 or HADS to provide greater diagnostic clarity for these patients.

We also concur with Hahn that bipolar disorder is widely underrecognized in patients presenting with depressive symptoms alone.†,‡ Therefore, careful screening for a history of manic symptoms in all patients with depression is essential to ensure appropriate selection of psychotropic medication. Consideration of bipolar disorder was discussed within the text of our article† and in the algorithm outlined in the article Supplement; however, treatment recommendations were not included. For bipolar disorder, the medical literature supports use of a mood stabilizer (eg, lithium, valproic acid) or a second-generation neuroleptic (eg, olanzapine, quetiapine, aripiprazole, lurasidone) with the possible addition of an antidepressant, instead of use of an antidepressant alone.§

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Conflict of Interest Disclosures: None reported.


CORRECTION

Error in Discussion: The JAMA Diagnostic Test Interpretation article titled “Interpreting SARS-CoV-2 Test Results,” published online on September 17, 2021, included an error in the Discussion that presented an incorrect positive predictive value for a SARS-CoV-2 test. The Discussion has been corrected and indicates that the positive predictive value of the test for the patient was 6.5%. (All other information in the Discussion was correct and is unchanged.)

1. Coffey KC, Diekema DJ, Morgan DJ. Interpreting SARS-CoV-2 test results. JAMA. Published online September 17, 2021. doi:10.1001/jama.202136146

Author Surname Correction: In the Letter to the Editor titled “Therapeutic Drug Monitoring vs Standard Therapy During Infliximab Induction in Patients With Chronic Immune-Mediated Inflammatory Diseases,” published in the September 21, 2021, issue of JAMA,“the first author’s surname should have been listed as “Papamichael.” This article was corrected online.