Response to reviewers:

1. I appreciate the rationale provided for a brief test that is relatively independent of education and/or literacy in light of literacy rates provided in the discussion section. I think this would be a helpful point to make in the intro as well.

The following had been added in the intro part:

“In this study, a brief test named Memory and Executive Screening was developed in which the instruction and content were acceptable for illiterate and low-educated people. In addition, this test didn’t require the participants to write. Therefore, we can expect that this is a test relatively independent of education.”

2. In the 3rd paragraph of the intro section the point is made that “…simple scoring and administration methods without the necessity for training make them of low sensitivity and specificity in detecting MCI.” This seems like a bold statement based on one cited study.

The Ref 17 is a review of many research articles which compared many screening tests. They found that although some other non-comprehensive tests, e.g., the Clock drawing test and MIS, take a short time to administer, the simple scoring and administration methods without the necessity for training, their sensitivity and specificity in detecting MCI were relatively low.

3. Also in the 3rd paragraph, the point is made the memory and executive functions may be more important than attention, visuospatial skills, and language for detecting MCI. However, at the end of this paragraph you say that, “Because MCI is a syndrome with different subtypes, a better test should be not only suitable for identifying MCI or AD, but also facilitate differentiating the subtypes of MCI.” This seems contradictory.

Thank you for pointing out the contradictory statement. “Because MCI is a syndrome with different subtypes, a better test should be not only suitable for
identifying MCI or AD, but also facilitate differentiating the subtypes of MCI.” This is the requirement for the whole neuropsychological assessment battery, not for screening test like MES. We had deleted this sentence in the revised manuscript.

4. In the methods section it would be helpful to clarify who is classifying patients as normal, MCI, or AD—was it a neurologist, neuropsychologist, consensus?

Thank you for the kind suggestion. In this study, neurologists were in charge of the classification of patients as normal, MCI and AD, considering the medical history, neuropsychological assessment and neuroimaging results.

5. In the discussion section, you state that, “the score range for memory and executive function was large enough to identify MCI and it’s subtypes.” As you do not measure all major domains of cognition, this instrument can’t identify all subtypes.

Thank you for the kind comments. MES can’t distinguish subtypes of MCI. We deleted “and it’s subtypes” in the revised manuscript.

6. The second sentence in the 2nd discussion section paragraph is unclear.

The sentence had been revised into “With regard to the memory materials in the neuropsychological tests, the sentence, rather than word list, is more suitable for the illiterate and low-educated people.”

7. The verbal fluency process is unclear.

Thank you for the comments. In our opinion, the category verbal fluency reflects memory while the FAS reflect more executive function. However, we could not find Chinese test that is equivalent to FAS under Chinese cultural background. FAS requires participants to shift frequently from many sub-categories to generate more words. Therefore, FAS relies more on executive function. Of course, this opinion needs more study and discussion.

Since this part of discussion is not very clear and not closely related to our manuscript, we deleted this paragraph in the revised manuscript.