the second and third parts of the duodenum only. Thus, the 10-cm proximal duodenal segment explored by the authors, while probably including the periampullary area, did not examine and may not have been representative of those more distal areas predominantly involved by adenomas in FAP, a limitation not discussed by the authors.

Second, in their endoscopic assessment of duodenal neoplasia burden, the authors did not state whether they also detected flat adenomas within the study segments in their patients. Besides polypoid neoplasias, flat adenomas can be found in the duodenum of approximately 30% of patients with FAP, and careful follow-up of these patients has been recommended. It would be of interest to know more about these lesions in their study.

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In Reply To clarify Dr Matuchansky’s first point, the 10-cm section examined began just distal to the duodenal bulb and always included the duodenal papilla and a distance past that area. This is the area of the duodenum commonly examined as part of upper endoscopy, very representative of polyp formation in FAP, and the major area of duodenal adenocarcinoma formation. Although areas more distal, including the jejunal itself, are interesting, cancer in those areas is much less common. The study was not meant to be a comprehensive assessment of the distal duodenum and small bowel.

The purpose instead was to demonstrate the proof of principle that the drug combination could regress polyps in the duodenum, especially in areas around the duodenal papilla, that are seen on typical endoscopy. Future studies may well want to examine the small bowel more extensively.

We agree that most duodenal polyps are flat and plaque-like. Thus, the assessment in the study included size and number of flat polyps.

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