

adenomas. We agree that based on 13 lesions that were detected in our study population no general recommendation can be made. Nevertheless, we want to emphasise that most radiologists will find it difficult to not report a finding that can be clearly identified.

When looking at our data more carefully, one has to note that in only two patients (0.6%) was the largest lesion <6 mm and showed advanced histology, and in three patients (1.0%) whose largest lesion was <10 mm this polyp was an advanced adenoma. These data are similar to those reported by Lieberman *et al.*,³ where advanced histology was found in 1.7% of patients whose largest lesion was <6 mm, and in 6.6% of patients with <10 mm polyps only. In this study, the authors concluded that patients with lesions <10 mm should be offered colonoscopy. Similarly, Butterly and colleagues⁴ reported that out of 1933 small (5–10 mm) and diminutive (≤ 4 mm) polyps found in 1235 asymptomatic patients, 10.1% and 1.7% of lesions, respectively, were advanced adenomas. These figures again agree well with our findings.

As long as CTC is not integrated into colorectal cancer screening programmes, it will not be used on sufficient numbers of screening participants to clarify finally whether or not the referral of patients with small lesions will be cost-effective or beneficial for the individual patient. In our study population the fact that more advanced adenomas (AAs) were detected in lesions <6 mm than in 6–9 mm polyps can be attributed to sample size bias. Generally, we agree that more AAs should be found in larger lesions.

Regarding size measurements of polyps, we feel that our classification of lesions was

probably more accurate than what Hassan and colleagues suggest. Most researchers agree that CTC is more exact in determining polyp sizes than colonoscopy (OC), and that comparison of a lesion with a biopsy forceps is not an accurate way of determining its true dimensions. Accordingly, we used CTC size measurements to classify polyps, and OC was used for comparison only; if a lesion was significantly smaller or larger on OC than on CTC, CTC measurements were used as the gold standard.

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Authors' response to Hassan *et al*

Regarding the letter to the editor by Hassan *et al* (in the January issue of *Gut*),¹ we agree that not all patients in whom diminutive polyps are identified should be referred to colonoscopy for resection of these lesions. However, we noted in our trial² that high resolution CT colonography (CTC) allows for reliable identification of lesions that are <10 mm; even polyps that are <6 mm in size will be detected at a sensitivity of 72% if they are adenomas, and 59% if they are non-



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