with lesions detected in the RC. We agree with Rex that the second RC inspection can be done either with scope retroflexion or in forward view, as none appears superior (1); however, we prefer the direct view in the elderly, as we have shown that there is an increased risk for scope retroflexion failure in this patient cohort (3).

**CONFLICT OF INTEREST**
The authors declare no conflict of interest.

**REFERENCES**

**Response to Triantafyllou et al.**

Douglas Rex, MD, MACG

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**To the Editor**: Thanks for submitting your small study on predictors of detecting lesions during right-colon retroflexion after a forward examination. I agree that your study is too small to exclude detection of lesions on the first examination as a predictor of lesions during a second examination. Two much larger observational studies involving 1,000 patients (1) and 1,351 patients (2) both found that identification of lesions on the initial forward exam was the single best predictor of lesion detection during subsequent retroflexion. Further, the largest randomized trial of a second examination of the right colon in forward view vs. retroflexion identified adenomas on the first examination as a predictor of adenomas on the second examination (3).

Similarly, it would be premature to conclude based on your study that anemia (vs other bleeding indications) should be singled out as an indication for a second right-colon examination. Your study had only 60 patients, including only 10 with anemia, and anemia barely reached significance as a predictor of lesions on the second examination. It has long been known that all of the bleeding indications (positive fecal occult blood test, hematochezia, iron-deficiency anemia, and melena with a negative upper endoscopy) have high predictive value for colorectal cancer compared to the indications of screening, polyp surveillance, and other colonic symptoms (e.g., change in bowel habit, abdominal pain) when there is no evidence of bleeding (4). Available data on predictors of interval cancers after colonoscopy are very relevant to the issue of when to perform a second right-colon examination. Both a positive fecal blood test (5) and higher amounts of fecal blood in quantitative fecal immunochemical tests (6) predict interval cancers. This likely reflects the high prevalence of advanced neoplasia including earlier-stage cancers in asymptomatic patients with positive fecal blood tests. Clearly, a positive fecal blood test should be on the list for consideration of two-right-colon examinations.

For now, clinicians could reasonably consider that adenomas or serrated lesions on first examination of the right colon warrant a second examination. Further, any indication or demographic feature that is associated with high prevalence of neoplasia, or that is a predictor of interval cancers, should lead to consideration of a second right-colon examination. This would include all of the bleeding indications and increasing age. It seems reasonable to extend the policy to Lynch Syndrome, where there is a high incidence of proximal cancer where detection of even small lesions is considered valuable (7). Although the article described “how I approach” second-right-colon examinations currently, we could anticipate that some practitioners will reason that the maneuver is potentially beneficial to any patient at risk for colorectal cancer, and will extend the performance of two right-colon examinations to nearly all colonoscopies.

**CONFLICT OF INTEREST**
The author declares no conflict of interest.

**REFERENCES**

**About the Diagnosis and Management of Functional Heartburn: Heartburn and Oesophageal Motility Disorders**

Stefano Scaringi, MD; Francesco Giudici, MD and Paolo Bechi, MD
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