Professor Andrzej S Tarnawski, DSc, MD, PhD,

Editors-in-Chief

World journal of Gastroenterology,

Dear Dr. Tarnawski:

We very much appreciate the comments of the reviewers and would like to respectfully respond to the comments as noted below.

Reviewer Comments:

The authors researched the effectiveness of NCI CRC risk prediction tool. The result showed some clinical value. However, due to retrospective single center study and the limitation, some questions need to be asked.

Firstly, what is the relationship between colonoscopy and CRC prediction tool? If the tool predicts a low risk of CRC, does the patient still need to take colonoscopy for the future?

Thank you very much for the comments. There is a close relationship between the NCI CRC risk prediction tool and colonoscopy. This tool predicts the CRC risk based on number of variables and gives 5-year, 10-year or life time risks. Our study has revealed its additional significance of categorizing patients as high risks and row risk for CRC. It is necessary for the high-risk group to undergo colonoscopy for assessment of CRC as it can detect the cancer at earlier stage.

The low risk group even though has lower risk as compared to high risk group but still can't avoid colonoscopy due to the mortality and morbidity with this preventable cancer. According to NCI CRC risk prediction tool, the chances of having AP and subsequent CRC are low for these low risk patients but still not nil and hence they should continue to have screening colonoscopy as recommended by GI society guidelines.

S**econdly, why did the authors choose adenomatous polyps (AP) but no other kind of polyps for the research?**

We choose adenomatous polyps (AP) over other kind of polyps in our study because these are more commonly associated with colorectal cancer. Also, identifying and removing the AP will subsequently result in lesser chances of CRC. In addition, we did not have other polyps like serrated polyps reported in our study group and hence were not reported in the study. This is mentioned in the Patient selection section/subheading of the material and methods and highlighted in the manuscript.

Thirdly, what should the patients do if CRC prediction tool give a high-risk result of the patient?

NIH CRC risk assessment tool scoring does predict who has less or more chance of CRC as seen in the tables in the manuscript. High risk group should be aggressively dealt. For example, for this high-risk group if they decline colonoscopy then more time should be spent explaining them the risk with their refusal and helping them make an informed decision. As for the providers a longer withdrawal time and closer surveillance intervals should be chosen for this high-risk group.

Please let us know if there are other questions or concerns. Thank you in advance for consideration of our paper.

Sincerely,

Muhammad Umar Kamal, MD

BronxCare Health System

1650 Selwyn Ave, Suite #10C

Bronx, New York 10457

Phone : 718-960-1234

Fax: 718-960-2055

Email: muhammadumarkamal@gmail.com