approved clinical trial and registry. However, it is a fact and needs to be pointed out, that only one third of our identified IAR (80 of 205) participated in the recommended screening programme. A pilot study on 32 of these IAR using standard questionnaires and interviews (Beck Depression Inventory (BDI) and Brief Symptom Inventory (BSI)) around counselling (days −7, 0, +30) conducted by a psychiatrist revealed, that these IAR were critically biased by cognitive coping strategies (unpublished data). Pancreatic cancer (PC) screening is clearly different from other cancer screening programmes, given the disastrous prognosis of PC, the unknown true penetrance in the different settings of hereditary PC, the lack of a major gene defect, the lack of reliable imaging or biomarkers, the lack of evidence to improve prognosis or to save lives by any screening, and the high risk of morbidity and mortality of potential preventive surgery. Some authors even advocate that at present 'doing nothing' provides the greatest remaining quality of life-adjusted years and the lowest costs.[6]

We fully agree that we need to gain much more knowledge about hereditary PC to draw a definite conclusion about the true value of PC screening in IAR. However, based on our data, we strongly believe, in accordance with the recommendations of the Fourth International Symposium of Inherited Diseases of the Pancreas,[5] that all screening procedures should be performed as part of peer-reviewed protocols combined with a scientific appraisal of the screening methods and human subject protection. At present there is no data, that would justify a general PC screening even of high risk individuals outside of such protocols as suggested by Harinck *et al*. In contrast, it has to be feared that uncritical use and interpretation of screening results obtained with the presently available tools on a healthcare basis may cause unnecessary physical harm and psychological distress. On the other hand over-estimation of the power of our present screening tools may lead to a deceptive, unjustified and potentially dangerous level of safety, if done uncritically and uncontrolled. The message of our paper thus is not 'to do nothing', but to carefully evaluate screening methods for IAR from familial pancreatic cancer (FPC) families in the setting of board approved clinical trials, to continuously improve our knowledge and strategies.

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CORRECTIONS

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