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No potential conflict of interest relevant to this letter was reported.

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THE AUTHORS REPLY: To allow for easier participation across multiple sites, details regarding antimicrobial susceptibility were not recorded, and thus our ability to retrospectively determine the adequacy of empirical therapy is limited. As Marks and Pollara point out, in an attempt to limit inadequate initial therapy, participants in the STOP-IT trial were allowed to use any empirical agent that complied with SIS-IDSA guidelines.¹ However, although the focus on empirical therapy is understandable, it may not be relevant. Bloos et al. found that for patients requiring surgical source control, the only independent risk factor for death at 28 days was a delay in source control of more than 6 hours. Neither the timing of antimicrobial initiation nor the adequacy of empirical treatment was associated with mortality on multivariable analysis.² Our group at the University of Virginia has found similar results.³ Regardless, clinicians outside North America should use local guidelines when considering empirical therapy.

In response to Roger et al.: our study was limited to the duration of antimicrobial therapy after diagnosis and source control. Therefore, not only can our results not be applied to pa-

tients with inadequate source control, but they also should not be used as evidence for or against specific programs to monitor for infections. The STOP-IT trial did not limit the severity of illness required for enrollment. Subsequently, the Acute Physiology and Chronic Health Evaluation II scores in this trial reflect wide variability in the presentation of intraabdominal infections. This inclusion makes our results more generalizable but less applicable to specific cases such as severe infections and fungal infections.

There is a tendency in the discussion of infectious disease to forget, or rather downplay, that an intraabdominal infection is a surgical disease. Source control, through percutaneous or surgical intervention, is the primary treatment for these patients. Antimicrobial therapy plays an important, albeit secondary, role. Our trial highlights this point by showing that, in patients with adequate source control, the duration of antimicrobial therapy can be halved without any clinically significant change in outcomes.

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Since publication of their article, the authors report no further potential conflict of interest.

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Causality and Chance in the Development of Cancer

TO THE EDITOR: Luzzatto and Pandolfi (July 2 issue)¹ highlight the combined role of stem-cell turnover, stochastic mutation, and environmental mutagens in the development of cancer. They note the low prevalence of cancer of the small bowel, despite the size of the organ and rapid epithelial turnover. However, among patients with Crohn's disease, the risk of small-bowel adeno-

carcinoma is 20 to 30 times that among patients without Crohn's disease.² This disparity in rates illustrates the power of the inflammatory microenvironment to manipulate an apparently genetically stable system. Intestinal inflammation provides a proliferative drive, provokes intestinal stem-cell turnover, and may induce progenitor-cell dedifferentiation and intestinal dysbiosis;

iatrogenic radiation (repeated small-bowel imaging) imposes an environmental mutagenic pressure.³

In the past decade, there has been a major change in the management of Crohn's disease through diagnosis by means of magnetic resonance enterography and treatment with powerful anti-tumor necrosis factor agents.^{4,5} Small-bowel cancer in Crohn's disease may thus provide a natural test of the hypothesis of Luzzatto and Pandolfi: improved treatment of inflammation and reduction of mutagenic drivers may result in a reduction in the risk of small-bowel cancer to the level of risk imposed by chance alone.

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No potential conflict of interest relevant to this letter was reported.

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THE AUTHORS REPLY: We could not agree more with East and colleagues. In a previous version of

our article, we wrote: "Inflammatory bowel disease, which increases the rate of cell proliferation, is significantly associated with colon cancer, and it is interesting that with Crohn's disease, cancer becomes much less rare even in the small intestine" (this sentence was eventually left out owing to space constraints). With respect to the association between Crohn's disease and cancer in the small intestine, we had referred to an article by Floch et al.¹ from 1978. The link between the inflammatory process and cell proliferation is complex,² but there is evidence that it may be mediated by the nuclear factor κ B–interleukin-6–STAT3 cascade.^{3,4} It does seem reasonable to expect that new therapies for inflammatory bowel disease will not only relieve patients of most unpleasant symptoms but also reverse their risk of intestinal cancer to that of the general population.

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The Affordable Care Act at 5 Years

TO THE EDITOR: Blumenthal et al. (June 18 issue)¹ claim that three Medicare experiments saved money. In fact, two of the programs, the Medicare Shared Savings Program (MSSP) and the Comprehensive Primary Care Initiative, have raised Medicare spending, and the third, the Pioneer accountable care organization (ACO) program, saved much less money than Blumenthal et al. claimed.

Blumenthal et al. report the reduction in claims payments by the Center for Medicare and

Medicaid Services (CMS) and ignore the costs the programs impose on CMS. These costs consist primarily of "shared savings" payments to ACOs in the MSSP and Pioneer programs and subsidies for "medical home" clinics in the Comprehensive Primary Care Initiative.

For example, Blumenthal et al. claim that the Comprehensive Primary Care Initiative "has reduced monthly Medicare expenditures per beneficiary by \$14." However, the report that Blumen-