ANSWERING REVIEWERS

August 25, 2012

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 10823-review.doc).

Title: Signet-ring cell carcinoma arising from a fundic gland polyp in the stomach

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The manuscript has been revised according to the suggestions of from both:
The format has also been updated and references and typesetting are now correct. Our responses to the reviewers' suggestions are included below.

Reviewer 1 made a helpful comments, we thank this reviewer for their suggestions. We have taken these comments into account as follows:

1) The correct version of Figure 2B is now included.

We thank **Reviewer 2** for the critical comments and helpful suggestions. We have taken all these comments and suggestions into account, and they have improved our manuscript considerably.

1) *Is it true that the diagnosis before polypectomy is FGP? If true, what did you make a diagnosis for the erosive part?*

The first polyp was diagnosed as FGP by endoscopic appearance. When the surface of a FGP is eroded the regenerative appearance can be interpreted as dysplasia. We thought that a true dysplasia or a malignant transformation of sporadic FGPs could exist although it was exceedingly rare, so the polyp was removed by snare polypectomy.

2) *The histological figures you attached have no demonstrated the relationship between erosive part and signet ring cell carcinoma. Please clarify this.*

Histologically, the tumor cells were in the superficial portion of the polyp but the direct relationship between the cancerous focus and the erosive surface was not clear. Little is known about the pathogenesis that may be associated with malignant transformation of FGP. Also risk factors for carcinoma within FGP are not known. Inflammation or molecular alterations related to an erosive surface may be associated with the malignant transformation of FGPs. So, we think that this rare case can emphasize the necessity of a thorough visual inspection of FGPs and the possibility of malignant transformation of sporadic FGPs.

3) *You should show other endoscopic findings, for example, erosive lesions in other parts of stomach, the degree of atrophy, or mucosa with or without infection of H. pylori.*

We have added other endoscopic findings. Please refer to Figure 1. We have revised the information on *H pylori* infection.

4) *In the Discussion part, you should comment that endoscopists should obtain biopsy specimens from*

sporadic FGPs with erosive or irregular surface, even if they are small. However, in this case, relationship between erosive parts in the FGP and carcinoma is unknown. So is biopsy from FGP useful? You should explain about this.

Some reports indicate FGPs should be biopsied or removed if size is larger than 1 cm, if there is ulceration, and if it is an unusual area such as the antrum. However, in this case a signet ring cell carcinoma was found in a FGP that had an erosive surface and a small size(<1cm). So we think that we can comment that endoscopists should obtain biopsy specimens from sporadic FGPs with erosive surface, even if they are small. Although little is known about pathogenesis or risk factors for carcinoma within FGP, some inflammatory reactions or molecular alterations or pathways related with a erosive surface may be associated with malignant transformation of FGP.
We have revised the Discussion to include this information.

3 References and typesetting were corrected

Thank you again for considering our manuscript for publication in the *World Journal of Gastroenterology*.

Sincerely yours,

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