#1. Reviewed by 02991201

It is a very good case report, with many images that allow an easy reading of the manuscript. It is well written, and the explanation and conclusion is clear.

→ Thank you for your review.

#2. *Reviewed by 01799429*

This was a well-written case report of IFP in the stomach, however, this case was unusual as IFP. IFP is usually semi-pedunculated shape and size is smaller than this case. The authors should discuss about this point, including the review of literature.

→ In the original manuscript we did not adequately discuss the shape and size of usual IFP. To address the reviewer's comment, we have added the review of literature at this point.

: The size of gastric IFP is range from 1.2-6.5cm and mean diameter about 2cm. However, maximum diameter is up to 11cm and unexpected growth of IFP has been reported [1, 3, 4, 7]. The size of our case is measuring 4.5 x 4 x 3 cm on histopathology and 7cm in length on CT that is slightly larger than usual case. The morphology features of gastric IFPs are commonly pedunculated, semi-pedunculated or sessile with covered normal mucosa. It can appear intramural mass with smooth, well-defined margins forming obtuse angles with the surrounding bowel wall [1, 6, 9]. The latter is consistent with our case.

#3. Reviewed by 00004485

1. See minor grammar suggestions.

→ Thank you for your kindness and we revised the grammar suggestions.

2. This is a reasonable case report with excellent imaging; however, this patient could have undergone a core biopsy of the stomach using EUS. Please comment on this and whether a preoperative diagnosis of IFP would have changed the need for

antrectomy.

→ We agree with the reviewer. To address reviewer's comment, we have enhanced the paragraph by adding a few sentences to clarify why our patient had antrectomy with gastroduodenostomy.

: The patient had undergone an additional core biopsy of the submucosal lesion using EUS. However, fibrosis of submucosal lesion was extremely severe so failed biopsy using EUS. As a result, we could not preoperative diagnosis of IFP. Also, the slight large size, non-pedunculated, intramural mass with fibrosis made it difficult for endoscopic resection.

: Previous study, Advanced gastric cancer(AGC) showed delayed enhancement on CT (after 180s for the start of infusion of contrast material) without regard to Borrmann's type. Correlation of the histopathologic findings with radiologic enhancement pattern, signet ring cell type showed good and delayed enhancement but mucinous type was poorly enhanced due to high mucin content [13]. Another previous study, when gastric wall thickening in AGC on CT, high-degree contrast enhancement was more usual in signet ring cell carcinoma(SRC) than that with non-signet ring cell carcinoma(NSRC). When histopathological findings are considered, malignant cells and immature fibrosis are causes of enhancement in SRC [14]. Since in our case, the lesion had marked wall thickening with delayed enhancement, malignant tumor could not be ruled out, particularly signet ring cell carcinoma. The operation was performed because the cancer was not excluded in the radiological findings.

3. Please elaborate on the etiology of IFPs. Motility disorder? Response to luminal toxins/antigens?

→ In the original manuscript we did not adequately discuss the etiology of IFP. To address the reviewer's comment, some sentences were added as suggested.

: Although the exact etiology remains unknown, there are many postulate supposed to be related to IFPs including inflammation, trauma, previous surgery, infection or allergy. Some authors suggest that the IFP could be a result of

inflammatory response of submucosa due to the localized damage to mucosa. Furthermore, inflammatory reactive process can be stimulated by bacterial, chemical, metabolic factors. Lately, several study have postulated that Helicobacter pylori infection is related with IFPs [1,3,7,9].

4. Likewise, comment on the cause of symptoms in these patients. The latter question refers to the need for antrectomy had a diagnosis been made pre-operatively.

→ To address reviewer's comment, some sentences were added as suggested.

: Our patient had history of dyspepsia, epigastric pain and mild anemia and these may be related to superficial ulcer of mucosa underlying intramural mass located in gastric antrum. Symptoms were too mild for antrectomy, but the operation was performed because the cancer was not excluded in the radiological findings and difficult for endoscopic resection.

#4. Reviewed by 03547837

In this case report, the authors describe the imaging findings of an inflammatory fibroid polyp (IFP) with massive fibrosis in the stomach. The authors' state that no previous report has described about the CT findings of a gastric IFP showing delayed enhancement and they report the dynamic enhanced CT imaging findings of a case of gastric IFP with massive fibrosis. My biggest concern about this case report is that the authors are not adding anything new in the already known literature about this entity. The authors' state that low attenuated area in IFP is pathologically correlated with edematous and myxoid changes. On similar note, I would think it is logical that delayed enhancement of thickened submucosal layer is due to fibrosis and hyalinized stroma.

→ To address reviewer's comment, we have enhanced the paragraph by adding and revising a few sentences to why our case different from previous study.

: Several studies about gastric IFPs have reported its computed tomography(CT) findings and included only enhancement images of the single portal phase [3-8]. However, to the best of our knowledge, no previous report has been described

about the CT findings of a gastric IFP showing delayed phase enhancement.

In fact, some papers have talked about evolutionary stages of IFP with more frequent "younger lesion" as well as the less common "older/senescent" lesions which show collagenization/hyalinization. Some minor concerns: 1. The histopathologic examination write-up is incomplete. The authors do not mention about the onion-skinning of lesional spindle cells around the blood vessels. Usually, the more fibrotic or hyalinized (presumably older) IFP have low eosinophil count. The authors may want to comment upon this finding.

→ In the original manuscript we did not adequately discuss the histopathologic findings including evolution of IFP. To address the reviewer's comment, we have added the review of literature at this point.

: The evolution of IFP is divided into four stages based on size and histology. First, nodular stage shows diameter range from 0.2-0.5cm and major component is immature fibroblasts. Second, fibrovascular stage is most common, shows diameter range from 0.7-3.4cm. This stage describes the characteristic onion-skin appearance of mature fibroblasts surrounding blood vessels or irregular, coarse arrangement. These typical findings are more frequently seen at younger stage and seen only peripheral areas of the senescent stage or even in mucosal layer in cases without superficial ulcer. Other components of second stage include eosinophil infiltration and numerous inflammatory cells. When the size of IFP became larger, the histopathological components become changes. Third, organized stage is sclerotic or edematous type and range from 2.5-12.0cm. Major components of sclerotic stage are thick collagen bundle and prominent hyalinization. Edematous stage shows vascular proliferation, edema due to intracellular fluid. Although classic histopathologic findings of perivascular onion skinning and prominent eosinophils infiltration are well known, but IFPs evolve, they may manifest short fascicular growth pattern, a sparse eosinophils and remarkable hyalinization. Interestingly, as the size of the IFPs increased to find mixed histopathologic features more commonly, suggesting change of the original histologic characteristics [11,12]. Our case showed fibroblastic cells with

well-vascularized fibrotic stroma and infiltrate of chronic inflammatory cells, including many eosinophils. This may be explained by mixed histologic pattern of fibrovascular and organized stages. Also superficial ulcer in mucosal layer, which may be contributed to the absence of characteristic onion-skin appearance of spindle cells around the blood vessels.

2. The authors say that the signet ring cell carcinoma was in the clinical differential and hence the patient underwent a surgery. They may want to discuss the possible differences in radiologic imaging between these 2 entities.

→ We agree with the reviewer. Some sentences were added as suggested.

: Previous study, Signet ring cell type showed good and delayed enhancement but mucinous type was poorly enhanced due to high mucin content [13]. Another previous study, when gastric wall thickening in AGC on CT, high-degree contrast enhancement was more usual in signet ring cell carcinoma(SRC) than that with non-signet ring cell carcinoma(NSRC). When histopathological findings are considered, malignant cells and immature fibrosis are causes of enhancement in SRC [14]. Since in our case, the lesion had marked wall thickening with delayed enhancement, malignant tumor could not be ruled out, particularly signet ring cell carcinoma. The operation was performed because the cancer was not excluded in the radiological findings. However, several CT features such as a preserved mucosal layer and lesions without perigastric fat infiltration or lymphadenopathy help the diagnosis IFP rather than malignant tumor.