

Dear Editor,

Thank you for considering the manuscript entitled “An Overlooked Risk for Needle Tract Seeding Following Endoscopic Ultrasound (EUS)-Guided Minimally Invasive Tissue Acquisition” (57361). We really appreciate all the valuable comments and constructive suggestions from reviewers. We have revised the manuscript and a point-by-point response was enclosed. We would like to re-submit the revised manuscript to the World Journal of Gastroenterology, and hope it is acceptable for publication in the journal. Please do not hesitate to contact us for any question or concern.

We look forward to your final decision.

Sincerely yours

Jun Yao

Responses to reviewer:

1. In general, this is a good review and analysis of a little considered problem in diagnostic tissue acquisition for cancer patients - "needle seeding" of tumor cells resulting in tumor growth spread. Two minor revisions are suggested. First, the authors write: "However, what is

puzzling is that three patients (11.5%) have tested positive for post EUS-FNA luminal fluid cytology within 26 patients with pancreatic cancer. " Can the authors expand here about what exactly is puzzling - for the reader who doesn't necessarily have the surgical or gastroenterological medical expertise of the authors. Is this related to the head vs. body/tail distinctions of the pancreas mentioned later? Just add a little bit more clarification for the reader. Second, the authors use the phrase "Someone has suggested..." Should not use "Someone" - be more specific. Who suggested it?

Response: Thank you. We have supplemented the points and revised the phrase mentioned by the reviewer.

2. Dear Authors, thanks for your efforts in summarizing available evidence in this field. Among the rare complications of EUS-TA, seeding is reported but its actual impact although probably low, remains unclear. In the past previous papers had addressed the topic for FNA, but the recent introduction of FNB requires some revisions. I suggest acceptance of your paper after minor revisions: first, in introduction you describe FNB needles as "...reverse bevel technology needles"). Actually FNB needles are characterized by microcore acquisition technology which is consistent with side bevel for the Procore needle by Cook but you must

include also other type of needles (i.d. Acquire by Bosto Scientific, Shark needle by Medtronitc etc...). So I would suggest to change your definition with "micro-core acquisition technology". Second, EUS-FNB has greatly improved the diagnostic efficacy of EUS guided TA (most of your referenced papers confirm these data both in prospective and retrospective studies) with fewer passes and limited ocmplications. This is brobably a change which will impact also the already low rate of seeding. Finally, what matters the most to me, is that EUS-TA is still the best option we have to obtain tissue samples in the setting of GI wall or pancreatic lesions. Percutaneous US or TC guided approaches are far less efficient with higher risk of seeding, as repoerted in literature. I would suggest to address this topic in discussion. Best regards

Response: Thank you. We have changed the definition of FNB needles and added relevant points in the discussion section.