

Dear Editor:

Thank you very much for your attention and the referee's comments on our manuscript entitled "Successful treatment of an enormous rectal mucosa-associated lymphoid tissue lymphoma by endoscopic full-thickness resection: A case report and literature review" (ID: 69137). We have revised the manuscript according to your kind advice and referee's detailed suggestions (using red color text), and sincerely hope this manuscript will meet the requirement of *World Journal of Gastroenterology*. In addition, we list our responses to the comments in this document as request. For easier-to-distinguish, the comments or questions are shown in black font and the responses in blue font.

Sincerely,

Xiao-Long Zhang

Responds to the reviewer's comments:

Reviewer #1:

Scientific Quality: Grade B (Very good)

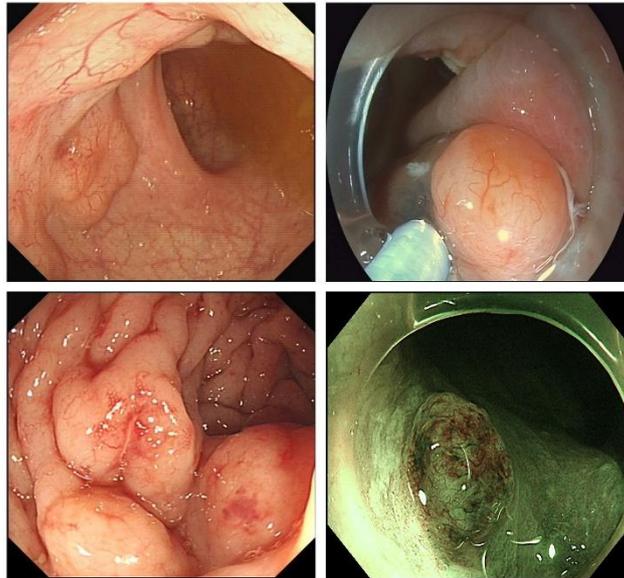
Language Quality: Grade A (Priority publishing)

Conclusion: Major revision

Specific Comments to Authors: This case report has two important topics. First one is endoscopic feature (tree-like appearance, TLA) and Second is endoscopic full-thickness resection as a treatment option for rectal Maltoma. 1. TLA The authors suggested that 'the TLA sign may also be a specific feature of colorectal Maltoma'. However, the evidence is insufficient. Authors' reference was just a case report of gastric Maltoma. Because TLA was the most important endoscopic feature on this article, more solid references or detailed description may be required. Although 'Core Tip' said TLA sign, there is no comment on TLA sign in Abstract and no word of 'TLA' in 'Important diagnostic work-up' section. 2. endoscopic full-thickness resection (EFTR) Please comment whether antibiotics were used or not. Important and difficult step of EFTR is endoscopic suture of wall defect. Authors' suture method was the purse suture consisting of SureClips and endoloop. I also frequently use endoscopic suture consisting of Olympus hemoclips and endoloop in clinical situations and I watched the movie of this article. However, it's hard to understand how the purse suture procedure works. More detailed explanation and photos about the purse suture are needed.

Response: Thank you for pointing out our problems. Actually, many previous case reports and series have described the endoscopic signatures of colorectal MALToma lesions. However, due to different descriptive habits of different endoscopists, many statements on the MALToma lesion were termed as *branch-like capillary pattern*^[1,2], *vascular ectasia*^[3,4] etc. We carefully reviewed the lesion pictures in most of these papers and we surprisingly recognized that all these statements were indicating the

same endoscopic characteristics. On the other hand, we also retrospectively analyzed colorectal MALToma in our center, as is shown below, the TLA sign was observed in almost all these lesions. Accordingly, we inferred that TLA may be a specific feature of colorectal MALToma. We have added some adequate explanations in relevant sections for better understanding. Meanwhile, we attached two relevant references in the revised manuscript to support our view.



Next, we have added the statement in the new manuscript. "The preventive antibiotic was prescribed for 3 days after the operation." Besides, we have attached a video showing the whole procedures of purse suture with more details (supplementary material). Given the diameter of endoloop, the purse suture can't close the whole EFTR wound in such a big size. Take the local depth of the lesion into consideration, we fixed the deep area of the wound which was close to the serosal layer by purse suture. This management could not only promote wound healing, but also help to reduce the local tension and decrease the risk of hemorrhage and perforation. We have added some explanation in the revised manuscript.

Reviewer #2:

Scientific Quality: Grade B (Very good)

Language Quality: Grade A (Priority publishing)

Conclusion: Accept (General priority)

Specific Comments to Authors: As the authors mention, the key message of this article is that "TLA sign tends to be a specific feature of colorectal MALToma and EFTR seems to be a feasible and economical choice for the treatment of enormous colorectal MALToma." Congratulations on this interesting paper, with a relevant take home message.

Response: We are really appreciative for your kind comment. Actually, this report still has defects to some extent, we will try to summary more MALToma cases in the next stage, which would provide more comprehensive understanding for readers worldwide. We really look forward to publish our report soon and thank you again

with best wishes!

Authors must revise the manuscript according to the Editorial Office's comments and suggestions, which are listed below:

(1) Science editor:

1. Because TLA was the most important endoscopic feature on this article, more solid references or detailed description may be required. Although 'Core Tip' said TLA sign, there is no comment on TLA sign in Abstract and no word of 'TLA' in 'Important diagnostic work-up' section. 2. More detailed explanation and photos about the purse suture are needed.

Language Quality: Grade A (Priority publishing)

Scientific Quality: Grade B (Very good)

Response: Thank you for your kind advises. As is responded above, we have added adequate explanations and two relevant references in relevant sections of the revised manuscript. A video has also been attached to show the procedure of purse suture with more details.

(2) Company editor-in-chief:

I have reviewed the Peer-Review Report, full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Gastroenterology, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors.

Response: We are really thankful for your affirmation of our job. We really look forward to publish our report soon. Thank you again!

References:

[1]Seo S W, Lee S H, Lee D J, Kim K M, Kang J K, Kim D W, Lee J H. Colonic mucosa-associated lymphoid tissue lymphoma identified by chromoendoscopy [J]. World J Gastroenterol, 2014, 20(48): 18487-18494.

[2]Hasegawa D, Yoshida N, Ishii M, Takamasu M, Kishimoto M, Yagi N, Naitou Y, Yanagisawa A. [A case of colonic mucosa-associated lymphoid tissue lymphoma observed under endoscopy with narrow-band imaging] [J]. Nihon Shokakibyō Gakkai Zasshi, 2013, 110(12): 2100-2106.

[3]Akasaka R, Chiba T, Dutta A K, Toya Y, Mizutani T, Shozushima T, Abe K, Kamei M, Kasugai S, Shibata S, Abiko Y, Yokoyama N, Oana S, Hirota S, Endo M, Uesugi N, Sugai T, 等 Suzuki K. Colonic mucosa-associated lymphoid tissue lymphoma [J]. Case Rep Gastroenterol, 2012, 6(2): 569-575.

[4]Saito T, Toyoda H, Yamaguchi M, Nakamura T, Nakamura S, Mukai K, Fuke H, Wakita Y, Iwata M, Adachi Y, Shiku H. Ileocolonic lymphomas: a series of 16 cases [J]. Endoscopy, 2005, 37(5): 466-469.