

Jin-Lei Wang, Ph.D.

Editor-in-Chief

World Journal of Clinical Cases

Dear Dr. Wang,

Thank you very much for the comments from the reviewers, and the chance to revise and resubmit our manuscript entitled, “ Gastric schwannoma misdiagnosed as gastrointestinal stromal tumor by ultrasonography before surgery: A case report and review of literature ” for possible publication in World Journal of Clinical Cases . We have revised our manuscript based on the reviewers’ suggestions, and tracked changes in the text for the reviewers’ convenience. The comments are addressed below in a point-by-point manner. We hope the changes are satisfactory, and that you will now find the manuscript acceptable for publication.

Mainly because of the language barrier and many clinical work, we spent a lot of time revising the manuscript. Now this manuscript hasn't been edited. We have already sent it to Filipodia, to ensure the use of grammatically correct and idiomatic English. And we'll send you a polished manuscript as soon as possible.

## **EDITORIAL OFFICE’S COMMENTS**

(1) Science editor:

In this article, the authors described Gastric Schwannoma misdiagnosed as a gastrointestinal stromal tumor by ultrasonography before surgery. It is fit for World Journal of Clinical Cases. However, there are several concerns, as reviewers mentioned. The authors should describe the detail of diagnostic procedures such as the order of Endoscopy and CT. The authors should add

arrows in the Figure to clarify the involved layers. In addition, the authors should describe the details of the procedure of surgery and why they chose the procedure.

Language Quality: Grade B (Minor language polishing)

Scientific Quality: Grade C (Good)

**Response:** 1. In the manuscript, we listed CT, endoscopy and endoscopic FNA in order of examination date. 2. We have added surgical details to the "treatment". 3. In this case, there were enlarged lymph nodes around the lesion. Considering that a few malignant cases of GS were reported, intraoperative freezing was performed, and lymph node dissection was performed at the same time to meet the surgical criteria of R0D2. (R0 : no microscopic residue after resection. D2 : the lymph nodes at the second station are completely cleared)

(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 Clinical Cases, 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. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor.

**Response:** We read the editor's comments and found it very sensible. We have prepared figures and tables as required. There are 6 figures and 1 table in our manuscript.

Reviewer #1:

**Scientific Quality:** Grade B (Very good)

**Language Quality:** Grade A (Priority publishing)

**Conclusion:** Accept (General priority)

**Specific Comments to Authors:** I have read this review article focus on Gastric schwannoma misdiagnosed as gastrointestinal stromal tumor by ultrasonography before surgery: A case report and literature review sent to be publish in on World Journal of Clinical Cases. As endoscopist no new data has been provided or no algorithm/table illustrates the manuscript. A table/figure summarizing the article would be good

**Response:** We thank the reviewers for the constructive comments and suggestions. We have listed a table and a figure as required, named as: "Table 1" and "Figure 6". In this table, endoscopic ultrasonography mainly observed that the mass was heterogeneous and hypoechoic, with clear boundaries and calcification foci, originating from mucous muscle layer. In the process table(Figure 6), we emphasized that we should pay attention to the role of transabdominal ultrasound and endoscopic ultrasound in our future work, summarize the characteristics of GIST and GS stromal tumor, and improve the ultrasound accuracy of preoperative diagnosis.

Reviewer #2:

**Scientific Quality:** Grade C (Good)

**Language Quality:** Grade B (Minor language polishing)

**Conclusion:** Major revision

**Specific Comments to Authors:** 1. What about the baseline bloods? 2. To clarify the BP (noted as 190/100 mmHg, 130/75 mm Hg). Was the BP controlled / what antihypertensive was used? 3. Was Endoscopy done before CT? 4. Dimensions of the lesion on sonography not mentioned 5. Was FNAC done in the repeat / II sitting of Endoscopic US? What is the extent of involvement (layers involved) on Endoscopic US? 6. After a final diagnosis of

Schwannoma, why was proximal subtotal gastrectomy + radical abdominal lymph node dissection + esophagogastric end-to-end anastomosis undertaken? 7. What about the surgical details (open / minimal access / ports/ incision)? 8. In retrospect, would a frozen section have helped / made a change in the management? 9. What about staging of the tumor? 10. Relevant CT image can be also included 11. The surgical planning recommendation for a gastric schwannoma to be indicated in the conclusion.

**Response:** We appreciate the comment and suggestion.

1. We went back to the patient records, her routine blood tests, routine fecal tests , occult blood test, and blood biochemistry were all within normal limits. Tumor marker tests did not reveal any obvious abnormalities.
2. The patient had a history of hypertension for 20 years,She was admitted to the clinic because of a sudden rise in blood pressure, dizziness and discomfort. So 190/100 mmHg was her blood pressure at the clinic. She took oral nifedipine controlled release tablet 60 mg daily, bisoprolol fumarate tablet 10 mg daily, and indapamide tablet 1.25 mg daily. After blood pressure was stabilized, she was admitted to the general surgery department for gastric tumor.Her blood pressure was 130/75 mmHg at this time.
3. The date of CT was 2015-2-5, and the date of Endoscopy was 2015-2-10.
- 4.Transabdominal ultrasound showed a mass size of 4.7×4.4 cm.
- 5.Endoscopic ultrasonography showed that the mass originated from the mucosal muscularis. We made FNA twice, on 2015-2-10 and 2015-3-4 respectively.
- 6..In this case, there were enlarged lymph nodes around the lesion. Considering that a few malignant cases of GS were reported, intraoperative freezing was performed, and lymph node dissection was performed at the same time to meet the surgical criteria of R0D2.(R0 : no microscopic residue after resection.D2 : the lymph nodes at the second station are completely

cleared).

7. It was an open procedure. An upper abdominal midline incision was made with a length of about 20cm.

8. We did do a frozen section, but it was to ensure a complete removal of the mass, so it seemed at the time that even with the a frozen section, the surgery would still be done.

9. According to postoperative pathology and the 2010 WHO Clinicopathological Classification Guidelines for gastric neoplasms, the clinicopathological stage was T<sub>0</sub>N<sub>0</sub>M<sub>0</sub>.

10. We provided CT images in the manuscript as requested. That's a good suggestion.

11. After the diagnosis of GS before surgery is confirmed, the treatment is as follows :A. Complete surgical resection is recommended, which can be performed under endoscopy, endoscopy or laparotomy according to the tumor size, location and relationship with surrounding organs. B. Simultaneous resection is recommended for patients with locally enlarged lymph nodes.

Best regards,

Sincerely, Qing-Qing Li.