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7041 Koll Center Parkway, Suite 160, Pleasanton, CA 94566, USA
Telephone: +1-925-399-1568
E-mail: bpgoffice@wjgnet.com
https://www.wjgnet.com

SPECIFIC COMMENTS TO AUTHORS

this is a nice case, but there are multiple comments mentioned below: 1- the title is long and wordy, try to shorten it. 2- it is better to give a brief history about the medical status of the patient i.e is it the first upper gi endoscopy, is there any barrett esophagus... 3- please add pictures for NBI and also for histopathology after laparoscopic resection. 4- did the patient undergo EUS. 5- as regards figures, please add scale bar, annotations, magnifications. 6- can you please add the affliations of the authors. who do the histopathology of the patient. 7- language editing is needed as i think this report is written in a hurry.

1. According to the comments of reviewer 4, it was changed to： ” Esophagogastric junctional 'neuroendocrine tumor' (NET) with adenocarcinoma: A rare case”.
2. Added content: “Previous gastroscopy had shown a 0-IIa-like lesion of the cardia and chronic atrophic gastritis with erosions. Pathological indications: cardia: tubular adenoma with high-grade intraepithelial neoplasia; antrum: mild chronic atrophic gastritis; intestinalization+; HP-.”
3. Image added as requested.
4.No, the patient did not undergo EUS.
5. Annotation has been added.
6.The pathology was carried out by the pathology department of our hospital.
7. We have been language edited by AJE Corporation in the US.

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The authors report a rare case of Esophageal neuroendocrine tumor（E-NET）combined with cardia moderately differentiated adenocarcinoma. Comments are given below. 1. Commonly used terms should be used. Some unclear words are used and need to be explained. (e.g., Duct structure, white attachments, itouter etc) 2. Please specify the meaning of the numbers listed ⑤ or ⑦. 3. Please delete the following text if it is not relevant to the characteristics of the lesion. "Three months after the operation, the patient had a little abdominal pain, throat discomfort, and a large amount of sputum. He was re-admitted to the hospital. After admission, he was given symptomatic treatment, and was discharged after the symptoms improved" 4. There are not enough endoscopic pictures to provide much information. The capturing of photos (vertical) is not good. Please import as prescribed. 5. What is the depth of gastric cancer?

1.Modified as required.

2. Modified as required.

3. Modified as required.

4. Image added as requested.

5. Infiltrated into the mucosal muscle layer (MM).

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SPECIFIC COMMENTS TO AUTHORS

The topic of this manuscript falls within the scope of World Journal of Gastroenterology. The Authors reported a case of esophageal neuroendocrine tumor combined with cardias adenocarcinoma. The patient underwent laparoscopic subtotal gastrectomy with esophagogastric anastomosis. Candias cancer combined with esophageal neuroendocrine tumor is extremely rare. The manuscript is good. Case report is complete. Figures are good. Discussion sound well. Complete the References.

Thank you.

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SPECIFIC COMMENTS TO AUTHORS

Thanks authors for efforts to bring this rare combination of two tumours in a given patient. The article high lights the rarity and appreciate the gross and microphotographs of the ESD specimen. Comments; 1. The title should be better off; Esophago-gastric junctional 'Neuro-endocrine tumour' (NET) with adenocarcinoma; a rare case 2. From the first statement, there are spelling and grammar errors, for eg. endoscopic submucosal dissecfion - should be dissection 3. I would question the validity of adding a few statements that are inexplicable in the last paragrapgh about gastric cancer types etc, that would not connect well to the core of the reported case. 4. Urge authors to add a statement on what radical surgery was undertaken , with final histology report (the same is not clear)

1. Modified as required.
2. Spelling mistakes have been corrected.
3. The authors agree with the expert opinion, which has been deleted.
4. Radical surgical resection.

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SPECIFIC COMMENTS TO AUTHORS

It would have been better if CT Scan report and endoscopic biopsy mentioned before ESD.. I think the incidence of re admission after 3 months was not required for this case report.. Pleased elaborate the procedure that is subtotal gastrectomy and especially margins given in cms..

1. Modified as required. (Previous gastroscopy had shown a 0-IIa-like lesion of the cardia and chronic atrophic gastritis with erosions. Pathological indications: cardia: tubular adenoma with high-grade intraepithelial neoplasia; antrum: mild chronic atrophic gastritis; intestinalization+; HP-. The enhanced Ct scan of the full abdomen was examined after hospitalization (Figure 1): the local gastric wall of the gastric cardia was slightly thickened, no significantly enlarged lymph node shadow was seen around the cardia, and the rest was unchanged)
2. The authors agree with the expert opinion, which has been deleted.
3. Modified as required. (The majority of laparoscopic gastric resections are followed by esophageal-gastric anastomosis. Thickening of the gastroesophageal junction was seen during the operation, and no obvious metastatic nodules were seen in the liver, peritoneum, pelvis, or pancreas. The upper section of the stomach was pulled out of the abdominal cavity from the opening of the upper abdomen, the cutting closure was vertically cut along the small curved side of the antrum to form a His angle of approximately 3 cm, and the gastric body was cut to the distal end at approximately 4 cm of the cardia next to the base of the stomach so that the residual stomach body was a tubular stomach. The width of the gastric cavity was approximately 4 cm, going to approximately 1 cm below the original vertical cutting site, and the specimen was removed)