

Dear Editors,

We would like to thank you and your reviewers for your time and suggestions to make the manuscript more useful for the readers

**Title: Endoscopic Full Thickness Resection for Gastric tumors originating from muscularis propria**

Author: Deepanshu Jain, MD; Ejaz Mahmood, MD; Aakash Desai, MBBS; Shashideep Singhal, MD

**We have made the following changes as per the reviewer comments.**

Reviewer: 1

Comments to the Author

It is not always possible to reach a definitive histopathological diagnosis in cases of subepithelial gastric tumors. In the present report, the patients did not undergo preoperatively diagnostic endoscopic biopsies. Even if EUS-FNA is not always accurate I think, to achieve a definitive histopathological diagnosis, and thus make a better endoscopic and/or surgical plan, an endoscopic ultrasonography (EUS)-assisted deep biopsy should be carried out because gastric cancer may resemble infiltrating subepithelial tumor. As known, the standard surgical treatment for cT1cN+ and the potentially curable cT2-cT4 gastric cancer is a gastrectomy plus a D2 lymphadenectomy. Preoperatively; what is the criteria for rule out of gastric carcinoma in presented study especially for large tumors (as 5 cm)? . In my opinion; only evidence of EUS is insufficient and EUS-FNA should be tried more than one. Otherwise, may be move away from principles of oncological surgery. Authors should emphasize this point

**Author response-** we have added the following to the manuscript.

*Small size gastric tumors arising from MP can be either benign or malignant. EUS does not allow definite discrimination of benign from malignant lesions. <sup>[20, 21]</sup> Even tissue sampling by EUS guided fine needle aspiration, trucut biopsy or other biopsy techniques fails to reliably differentiate between benign and malignant lesions. <sup>[22-29]</sup> Hence, the only accurate way is complete resection of the target lesion. Nonetheless, authors from each study have used any potential sign of malignancy like large regional lymph nodes, metastatic disease on CT scan, large tumor size, high risk features on EUS (irregular border, cystic spaces, ulceration, echogenic foci or heterogeneity) as an exclusion criteria.*

Reviewer: 2

Comment to the author

The manuscript presents the endoscopic full thickness resection for gastric tumors originating from muscularis propria. Most of tumors were gastrointestinal tumors(GISTs) and leiomyomas. GISTs have a malignant potential. The main objectives of surgical treatment of GIST are to acquire negative margins and to resect the tumor without causing tumor rupture. Endoscopic dissection should follow the principles of oncologic surgery. Although endoscopic resection was a feasible surgical approach if tumor is small and favorable located. An endoscopic shell-out procedure or enucleation should be avoided if GIST is suspected. Tumor rupture is an independent prognostic factor in operable GIST. If the shell of tumor is broken during procedure, we may lose the opportunity to cure GIST. There are several weak points in the manuscript. Two journals were not suitable for including criteria. The longer period is required to evaluate the metastasis or recurrence. Accordingly, I do not think the manuscript is suitable for publishing in WJG.

**Author response-** Diagnosis of malignant GIST or gastric cancer among small gastric lesions originating from muscularis propria cannot be confirmed with EUS, biopsy or imaging. Thus the only way of confirming the benign or malignant nature of these lesions is to resect them and examine the whole specimen histologically. EFTR allows complete resection of these deep located lesions (origin in MP) and thus decreasing the chances of tumor rupture in case it turns out to be malignant GIST. Our modification to

the manuscript is as followed (same as the response to reviewer 1)-

*Small size gastric tumors arising from MP can be either benign or malignant. EUS does not allow definite discrimination of benign from malignant lesions. <sup>[20, 21]</sup> Even tissue sampling by EUS guided fine needle aspiration, trucut biopsy or other biopsy techniques fails to reliably differentiate between benign and malignant lesions. <sup>[22-29]</sup> Hence, the only accurate way is complete resection of the target lesion. Nonetheless, authors from each study have used any potential sign of malignancy like large regional lymph nodes, metastatic disease on CT scan, large tumor size, high risk features on EUS (irregular border, cystic spaces, ulceration, echogenic foci or heterogeneity) as an exclusion criteria.*

In addition we have modified table 1 to more accurately describe the inclusion and exclusion criteria and have added a column for the surveillance method used by different authors across each study.

Reviewer: 3

Comment to the author

This is a good summarization of classification and option of therapeutic method of SMTs. The necessity of EFTR for SMTs is convincing and the outcome of EFTR is satisfactory and promising. Hope the paper will be published sooner. A little suggestion: maybe the “Figure 1 to 4 illustrates EFTR of gastric lesion originating from muscularis propria with assistance of OTSC” is not necessary in this paper.

**Author response-** We have deleted the figure 1- 4.

Thank you again for considering our manuscript for publication in WJGE.

Sincerely,

Deepanshu Jain