Answers to Reviewer 1 :

At first, thanks very much to reviewers' valuable recommendations that let us learn a lot and to improve our manuscript. Here, we answer as follows according to the reviews' suggestions.

Answers to reviewer 1 suggestions:

1. The abbreviation of muscularis propria should be not MM, correctly MP. MM means generally muscularis mucosae.

   Ans: Thanks very much, we've corrected" SMTMM" as" SMTMP" in the text.

2. Introduction (Page4 line8) [2] When EUS reveals a hypoechoic submucosal tumor originating from muscularis propria (SMTMP) in the stomach・・・

   The abbreviation of submucosal tumor originating from muscularis propria should be initially mentioned in Introduction section.

   Ans: Indeed. We should initially make the abbreviation in the introduction session, not in abstract.

3. **Materials and Methods:**

   In this session of EUS modality and examination, EUS interval should be defined in the study. For exam: The decision of the EUS interval ultimately depended on the discretion of the clinician in this study.

   Ans: It is very reasonable to clearly mention the interval of EUS in the Method. Therefore, we added the sentence "The intervals of EUS follow up were not defined, mainly depended upon the clinician's discretion." in line 5 of the paragraph of *EUS modality and examination*

4. **Results:**

   Among another 12 patients in progressive subgroup, we followed up them until 2016. 2 patients eventually underwent surgery and were confirmed GISTs in low malignant potential. Let me mention the reason why these 2 patients underwent surgery (tumor progression/ patient's willing, etc).

Ans: Thanks the reviewer for reminding us. We added the sentence “2 patients eventually underwent surgery due to gradually enlarged tumors and were confirmed GISTs in low malignant potential”. See line 32 of Results section.

5. **Discussion**

(Page10 line8—Page11 line6)

EUS can detect the tumor’s size, border, ・・・・～However, its accuracy is reduced when the tumor is small or difficult to approach.[12]Furthermore, EUS FNA cannot provide adequate information for the evaluation of mitotic count.

These sentences are repeated and duplicative in the session of introduction and discussion.

Thus, the discussion are needed to be summarized shortly and clearly.

Ans: Actually, these sentences are duplicative and we’ve omitted these sentences in Discussion section.

6. References

Ref. no 8 and 14 are same. Thus, please modify Ref no. thorough the whole text.

Ans: Thanks again. We’ve omitted the Ref.14 and revised Ref no in the whole text.

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Answers to reviewer 2 suggestions:

GIST are one of the most common mesenchymal tumors of the GI tract, and size is the most important parameter for making surgical decisions. The general rule is surveillance in less than 3 cm in diameter GIST. There is scarce data on evolution because of the low frequency of these lesions. The authors made a good revision on the EUS images and size in a series of submucosal tumors originating in muscularis propria in the stomach. The malignant potential of GIST (EUS images and histological data) described in the Discussion should be moved to the Methods section since the data have been studied and reported in the Results and Table 2. Figure 2 needs some other additional information to more easily understood why the authors consider 1.4 cm the optimal size predicting potential tumor progression. The Results and Discussion are adequate and conclusions are in accordance with the results and bibliography available. Some spelling errors should be corrected. The paper is interesting and needs only few minor corrections for acceptance to be published.

Ans:

1. Thanks for review's suggestions. Regarding the descriptions of malignant potential of GIST, they should be placed in Method session. After all, the result of Table 2 was based on them. Therefore, we've moved these descriptions to Method section.
2. In order to let readers more clearly understand the Figure 2, we added more descriptions. That is "Regarding initial tumor size, a receiver operating characteristic (ROC) curve analysis determined 1.4cm as the optimal cut-off size for predicting potential tumor progression with a sensitivity of 68.0%, a specificity of 66.7%, and an accuracy of

67.0 %”.