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Dear editor,

I have revised the paper according to the review report and your comments.

I have written the final diagnosis and follow-up treatment in two parts and confirmed that there are no repeated references. To revise the figures according to your advice, I have deleted the figures,added more pictures and rewritten the legend.

The following is the point to point answer to the three reviewers.

**Reviewer's code:**00505438

Q1.The authors do not tell us what biopsies were attempted at OGD: how many biopsies, were there attempts at ink well biopsies to take deeper tissue.

**Answer**: We took usual biopsy at OGD instead of ink well biopsies and two or three pieces of tissue were taken at a time.

Q2. It is commented that EUS biopsies were not taken. With a lesion in submucosa, this seems a little strange unless EMR was intended regardless of outcome. This should be clarified.

**Answer**: In this case, we unfortunately didn't perform EUS-guided FNA which had been referred in the discussion. EUS-FNA and ESD are two different methods for diagnose. After communicating with the patient, to relieve the economic burden, we performed the ESD directly according to the new consensus guideline. If possible, EUS-FNA should be priority choice before ESD.

Q3. The lesion was seen at CT and EUS as well as OGD. Doesn't this case simply emphasis the importance of regarding EMR/ESD as simply being a large biospy in these types of cases which may be curative but will also give diagnostic certainty with moving onto formal resection should the criteria of T1b, margin involvement, poor differentiation, lymphovascular involvement etc

**Answer:** Firstly, although the lesion was seen at CT and EUS as well as OGD, these methods could not give diagnostic certainty. Secondly, this case is different from

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most carcinomas which usually invade from mucous layer to submucosal layer. Thirdly, this kind of lesion is really easy to be ignored and the mechanism is obscure. Lastly, of course, the methods for diagnostic certainty or therapy are also deserved discussion.

Q4. It would be useful for the authors to briefly also discuss linitis plastica. We are all well aware that there may be minimal mucosal changes in these cases with the vast majority of the tumor being submucosal. Microscopic mucosal involvement may be missed but this may simply be a case of an early linitis plastica being identified.

**Answer**: In the discussion section, we referred as "The mechanism of SMT-like adenocarcinoma is obscure" and at the end of this paragraph, we referred as"There is no conclusion if SMT-like GC is the earlier stage of Bormann type IV GC or of linitis plastica".

**Reviewer's code:**02954782

Q1.Please check Figure 2 image, is it magnifying endoscopy image? Then put the magnification size.

**Answer:** Figure 2 image(now figure 1C) is indeed the magnifying endoscopy image, and we have put the magnification size (40×)

Q2.Please put the postoperative pathology microscopic image and legend.

**Answer:** I am so sorry that this patient's operation was performed at another hospital in another city and he can only offer us the pathological result instead of the pathology microscopic image. Instead of it, we put the ESD pathology image and legend.

Q3. I think the patient laboratory data is important in case reports. Please put some more data of the patient.

**Answer**: We have put more laboratory data of this patient in the Laboratory examinations section including routine blood tests, routine urine tests, routine fecal tests

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and occult blood test, blood biochemistry and some serum tumor markers including Carcinoembryonic Antigen, Carbohydrate antigen 199, Alpha-fetoprotein, serum pro-gastrin-releasing peptide, Neuron Specific Enolase, Squamous Cell Carcinoma Antigen and Carbohydrate antigen 724.

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**Reviewer's code:**00068458

Q1.Did they find any submicosal heterotopic gastric gland or gastritis cystic profunda in this case? It will be interesting for readers to understand the origin of this submucosal gastric cancer.

**Answer:** We didn't find any submicosal heterotopic gastric gland or gastritis cystic profunda in this case.

Q2. The authors need to rewrite the legend of Figure 4 and add H&E image of submucosal gastric cancer.

**Answer:** We have rewritten the legend of Figure 4 and add H&E image of submucosal gastric cancer (Figure2 A-D).