

Thanks for the reviewers' comments, which we found very helpful and revised the manuscript.

Point-to-point response to reviewers' comments:

Answering Reviewer #1:

1. Most of the sentences in the introduction are unreferenced. Please add the correct references to justify what was described in the text.

Response: I have added the correct references in the introduction.

2. The multidisciplinary section with the name of the expert is not appropriate. Please remove it.

Response: The multidisciplinary section with the name of the expert was removed.

3. The abbreviation of gastric glomus tumor should be reported the first time the authors consider the topic (before discussion).

Response: The question of the abbreviation of gastric glomus tumor has been modified.

4. Several definitions are repeated in the discussion (that the authors have already reported).

Response: We have revised it in the manuscript.

5. How long is the follow-up?

Response: The follow-up question was revised on page 8, line 19 of the manuscript "The patient was able to get out of bed 1 day after the surgery, and he recovered and was discharged from the hospital 1 week after the surgery. One month after the operation, the patient did not feel any uncomfortable, and after two years of follow-up, the patient was no any recurrence or discomfort."

6. Many surgeons would still have performed a biopsy of the lesion and a possible resection. The choice of the authors was identified right, but I believe that the clinical practice management it is very difficult to make it.

Response: We answered this question on page 7, line 32 and page 8, line 7. "It is difficult to accurately determine the location of the region growing into the cavity and surgery is traumatic and invasive for treatment and may cause some corresponding complications." "First, there would be more bleeding during the operation. Second, if part of it grows in an extracavity manner, it will inevitably perforate and will be difficult to close under endoscopy due to the large perforation area. Third, if the cutting edge of the tumor is positive, additional surgery will be required. The traditional surgery is relatively risky and traumatic. After consultation with surgery and pathology departments, gastroscopy combined with laparoscopy was used to remove the tumors in this case."

7. The title must be changed to: "combined laparoscopic-endoscopic approach for gastric glomus tumor:"

Response: The title of the manuscript was revised as Combined Laparoscopic-Endoscopic Approach for Gastric Glomus Tumor: A Case Report and Review of The Literature.

Answering Reviewer #2:

1. The case is well reported, I would call attention in the text to the estimated percentage of malignancy of Gastric Glomus.

Response: Malignant gastric glomus tumor is very rare and it is rarely reported in the

literature, so it is difficult to estimate its percentage. We have corrected the question on page 7, line 2 “GGT is usually a benign tumor and rarely undergoes malignant transformation.”

2.A controversy point is not performing biopsy in the preoperative period, even though the patient had made a choice for surgical resection (as informed by the authors), since the suspicion of malignancy could lead to the need for change the approach. I would reinforce the discussion of this argument.

Response: Since the suspicion of malignancy could lead to the need for change the approach, in line 25 of page 31“Laparoscopic resection can be used in the treatment of gastric hemangioma (Figure 8). However, it is difficult to accurately determine the location of the region growing into the cavity. Since surgery is traumatic and invasive for treatment and may cause some corresponding complications and is usually used for the treatment of malignant GGT”, we answered the question of surgical methods for malignant gastric glomus tumor. Meanwhile, Fig. 8 is attached to explain the surgical methods for malignant gastric glomus tumor.

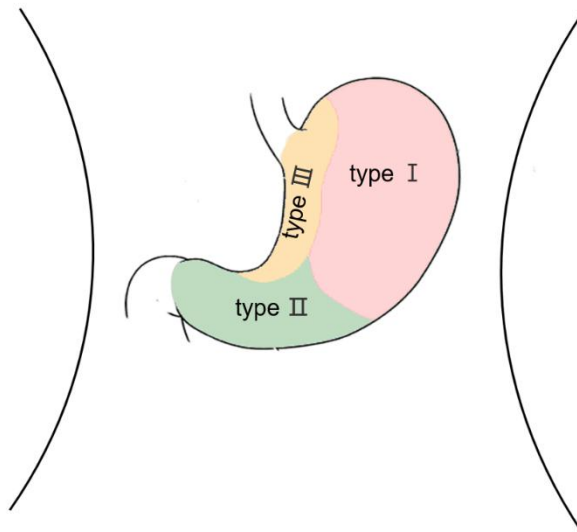


Figure 8

Figure 8: Tumor location and corresponding traditional surgical technique: type I (laparoscopic partial gastrectomy), type II (laparoscopic distal gastrectomy), and type III (laparoscopic transgastric resection).

Answering Reviewer #3:

Thanks for your comment.