Question 1: Have you performed a low US-endoscopy for the precision of the depth of the invasion (despite the small size of the lesion) before to opted of a salvage endoscopic resection?
Answer: Because the size of the tumor was very small and the endoscopic presentation was similar to that of a polyp, the patient underwent direct endoscopic biopsy by forceps removal, and the pathological examination of the specimen after forceps removal revealed positive horizontal margins and negative vertical margins of the tumor, so ultrasonic endoscopy was not performed.

Question 2: What was the decision of the oncologic team of your multidisciplinary consultation meeting in oncology of an eventual systemic treatment in fact of this lympho-vascular invasion?
Answer: After the pathological examination of the biopsy clamped specimen suggested neuroendocrine tumor, the patient underwent multidisciplinary consultation with oncology, surgery and nuclear medicine, and finally decided to complete 68Ga-SSA-PET/CT, and no distant metastasis was found. Therefore, we decided to perform ESD after consulting the patient's consent and followed up regularly after the operation.

Question 3: In lines 108 and 109. How to distinguish between lymphatic and vascular invasion in HIC? Because I studied the question in breast cancer for example, it is impossible to distinguish between the two situations. Thant the scientific community decided to gather them to the same entity.
Answer: When immunohistochemical staining of pathological tissues is performed, positive CD31 and CD34 are often used as markers of vascular infiltration, but these two can also mark small portions of lymphovascular infiltration, so they are usually combined with D2-40 for a comprehensive determination.

Question 4: please precise the rhythm of your follow up in the next 10 years. By what tools only screening evaluation? Do will use the blood test of chromogranine A?
Answer: We first performed a follow-up visit in the 6th month after surgery using endoscopy and CT-enhanced scans of the whole abdomen (including the pelvis), and thereafter, these follow-up visits will be performed annually, with an additional 68Ga-SSA-PET/CT if abnormalities are detected during the follow-up. in addition, plasma CgA was not used for follow-up because of its low positivity rate.