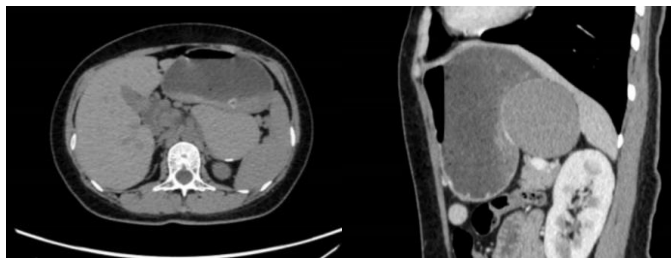**1. Were tumor markers measured preoperatively? If so, please provide the details.**

By reviewing the previous cases, we found that only 4 patients had elevated tumor marker levels before surgery, and these patients' levels returned to normal after surgery. These findings suggest that gastrobronchogenic cysts are somewhat correlated with tumor marker levels, but large amounts of data are still lacking to support this view. We preliminarily considered that this gastric mass was a cyst based on the findings on enhanced CT and EUS before surgery and ruled out the possibility of gastric malignancy. Moreover, considering the patient's individual and family factors, we concluded that determining the tumor marker levels was not necessary.

2. If there are noncontrast CT images available, please add them. Additionally, cross-sectional images that show the relationship between the lesion and the diaphragm were obtained.

3. Was fine-needle aspiration (FNA) performed during EUS? If so, a more accurate preoperative diagnosis might be possible.

Before surgery, an EUS examination was performed to determine which layer of the gastric wall the cyst had originated from. However, because the cyst wall was evaluated by CT, because there was calcification on the cyst wall, and because the contents of the cyst were mainly composed of liquid components according to density, there was concern that FNA may cause rupture of the cyst before surgery and increase the risk of infection. Second, we suspected that the patient's chest tightness was caused by compression of the diaphragm muscle by the large cyst. To eliminate the patient's symptoms and because the patient strongly desired surgery, after consultation and discussion with many experts, we decided to prudently remove the cyst and obtain a complete pathological specimen so that a safe postoperative examination could be performed to obtain the most accurate diagnosis. Based on these two points, we did not use preoperative FNA.

4. The final diagnosis should be described after the treatment.

Thank you very much for the reviewer's opinion. I have included the final diagnosis in the text after the treatment section in the manuscript and described the final diagnosis in more detail. In future writing, I will always keep in mind this valuable advice from reviewers.

5. If there are surgical photos illustrating the continuity between the stomach and the lesion, please present them. Furthermore, if corresponding CT images are available, this approach would be even better.

In view of the large size of the cyst, conventional laparoscopic surgery is more difficult than open

surgery, possibly because the cyst could not be fully removed. Also, there is a risk of postoperative recurrence, and the risk of intraoperative cyst rupture is greater. Thus, we chose a safer and more effective open surgery. Therefore, intraoperatively, there was no communication between the stomach and the lesion that was recorded.

6. Could the authors discuss what diseases were considered as preoperative diagnoses? Please refer to Table 1 for further discussion of this point.

Through our systematic review of existing cases, we conclude that GIST is the most common preoperative diagnosis of gastrobronchogenic cysts. The two conditions are difficult to distinguish by imaging, and an accurate preoperative diagnosis can be obtained via EUS-FNA before surgery. However, there are risks such as infection and bleeding. During the operation, masses can be distinguished by observing their nature. GISTs are brittle and prone to bleeding, while gastrobronchogenic cysts are composed mainly of cystic components[1]. Second, due to the rarity of bronchogenic cysts, clinicians lack understanding of this disease, which is also one of the reasons for the failure to obtain an accurate preoperative diagnosis of this disease.

1.   Xiao J, Zhang R, Chen W, Wu B: **Ectopic bronchogenic cyst of the gastric cardia considered to be a gastrointestinal stromal tumor before surgery: a case report.** *BMC Surg* 2020, **20:**42.