

## Format for ANSWERING REVIEWERS

August 25, 2014



Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 12809-review.doc).

**Title: Gastric foregut cystic developmental malformation**

**Running title: Case series and literature review**

**Author: Yan-Hua Geng, Chang-Xing Wang, Jiang-Tao Li, Qing-Yu Chen, Xiu-Zhen Li, Hao Pan**

**Name of Journal:** *World Journal of Gastroenterology*

**ESPS Manuscript NO:** 12809

The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewer

(1) It is surprising that all 37 cases manifest in adults. Is the delayed onset a consequence of cyst growth?

Answer: Yes, the 37 cases were all adults on digestive tract, but not all at stomach, locations were listed in Table 2. As statistics go, those with an older age and a longer clinical history of symptoms tend to present with a larger mass and are more likely to have an epigastric pain and discomfort caused by mass compression, gastric ulcer and gastroesophageal reflux etc, which suggest that the delayed onset might be a consequence of cyst slow growth.

(2) 1. In Clinical Features section, it is better to report only the numbers of male and female patients, rather than "...with perhaps a slight predominance of women (14 females to 11 males)." 2.

Insert scale bars in fig. 3b, 4, and 5. Please also identify the important structures/tissues in each photomicrograph.

1. In Clinical Features section, reported only the numbers of male and female patients “(14 females to 11 males)”, “with perhaps a slight predominance of women” has been deleted

2. “H&E staining, light microscopy, original magnification  $\times 200$ ” have been inserted in fig. 3A, 3B, 4, and 5.

3. The important structures/tissues in each photomicrograph are also identified in figure comments at the bottom of main document as below:

“**Figure 1** (A) Transversal abdominal contrast-enhanced CT; (B) Coronal abdominal CT. They all demonstrated a homogeneous, low-density and well-circumscribed, subserosal cystic mass on the lesser curvature of the gastric cardia.

**Figure 2** Gross appearance of the resected specimen of proximal gastrectomy: cyst measured  $6.5 \times 5$  cm, was embedded in the gastric muscular layer, and did not communicate with the gastric lumen.

**Figure 3** (A) Submucosal cystic lesion; the cyst wall was lined by PCCE; (B) Submucosal cystic wall with irregular longitudinal muscle bundles (H&E staining, light microscopy, original magnification  $200\times$ ).

**Figure 4** Regular, double-stratified, circular and longitudinal smooth muscles of the cyst and well-developed muscle layers continuous with gastric smooth muscle bundles, cartilaginous tissue, seromucous gland, or gastric epithelium were not identified (H&E staining, light microscopy, original magnification  $200\times$ ).

**Figure 5** Squamous metaplasia tendency of the PCCE (H&E staining, light microscopy, original magnification  $200\times$ ).”

(3) It would be better to discuss the similarities and differences between the cases in greater detail.

The similarities and differences between the cases in greater details have already added in discussion as follows

“As a result of the cyst location within the gastric muscular layer and a lack of communication with the gastric lumen, many such lesions are preoperatively misdiagnosed as intramural GIST and leiomyoma, which present with different imaging

findings, although they probably share similar clinical representation. “

“Patients with an older age or with a longer clinical history of symptoms tend to present with a larger mass and are more likely to have epigastric discomfort, gastric ulcer, gastroesophageal reflux, or occasionally canceration<sup>[5]</sup>. Some of these signs and symptoms are presumably related to the effect of the mass on adjacent structures<sup>[19]</sup>. Morphologically, the lined epithelium with focal squamous metaplasia were sporadically reported also<sup>[21,24]</sup>.”

“In the imaging study, cystic changes in GIST tend to be a focal with irregular internal surfaces rather than smooth as in congenital cysts, and usually do not involve the whole tumor. Moreover, the proteinaceous cyst fluid<sup>[9]</sup> of G-FCDM is very helpful in identifying the necrosis of GIST. G-FCDM can alter their shape with changing posture while they are large enough and with low tension, but GIST can't. Leiomyoma is similar.”

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,

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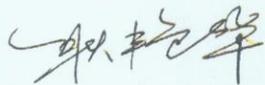
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