

The reply according to Reviewer #1 #2 and Editorial Office's comments is as follows:

1. the Institutional Review Board's official approval and the Conflict-of-interest statement have been uploaded.
2. The limitations have been added in the discussion section of the manuscript, such as the technique used, intraoperative surgical dexterity, etc.
3. Ninety-four patients were divided into 2 groups as elaborated in the Materials and methods section of the manuscript.
4. The distribution of patient sex and age is shown in Table 1
5. Histogram of tumor size has been increased
6. Restrictions on tumor location were added to the draft
7. The manuscript has been professionally corrected according to Editorial Office's comments

All operations were performed by the same endoscopist with the same equipment, which excluded the influence of operation differences among different operators on the operation. Before the procedure, computed tomography (CT) scans and EUS were performed in all patients to determine the tumor size, the layer of origin, echotexture, and the characteristics of neighboring blood vessels. In this study, most cases (n = 73) were diagnosed as GIST. Resection is advised for GISTs larger than 2 cm. For SMTs less than 2 cm in diameter with clinically malignant features during endoscopy, the guidelines suggest detailed examination with EUS, contrast - enhanced CT,

and/or EUS - guided fine - needle aspiration. When there are no clinically malignant features, SMTs less than 2 cm can be followed up with periodic endoscopy or EUS. However, even if the tumor sizes are under 2 cm, more than 5% of tumors have an intermediate risk of malignancy. Besides pathological examination after complete resection, there is no direct way to differentiate between benign and malignant tumors. Moreover, with the rapid progress of endoscopic techniques and endoscopists gaining more experience, studies have shown that endoscopic operations, like endoscopic submucosal dissection (ESD) and endoscopic full - thickness resection (EFR), are highly effective and safe for treating these small lesions. Although traditionally removal of these small tumors isn't recommended, physicians often face anxious patients who prefer to have the tumors removed. Additionally, during follow - up in our center, it was found that some GISTs grew too quickly, missing the opportunity for endoscopic treatment, and the patients had to undergo surgical resection. An alternative could be surgical resection. Although laparoscopic wedge resection of gastric submucosal tumors has the advantage of being minimally invasive, endoscopic full - thickness resection (EFTR) is also minimally invasive and preserves organ function without postoperative peritoneal adhesions. Furthermore, for lesions in the submucosal gastric wall, it's often hard to accurately determine their location using laparoscopy, making resection difficult. Laparoscopy is more beneficial for lesions that obviously protrude into the gastric cavity. However, for lesions at complex and hard - to - access locations. And a histogram of tumor size has been added to the manuscript.