COMENTARIOS AL EDITOR

Dear Dr. Mario Rey Tovar:

I hope your doing well, Dr. Rey. Dr. Emura ask me to send you agreement of his letter to editor. Because I can not read Spanish, Dr. Emura showed me below comment.

Comment:

Indication for endoscopic resection in gastric lesions are strict y and well defined (1,2), and different to those used in this study. Low grade displasia in the stomach is not considered an indication for endoscopic resection since it is accepted that carries a low malignant potential and in addition, many regress or do not progress.

Reader should make reference to (3,4,5,6,7). Endoscopic follow up is the choice. On the other hand, the method of treatment of carcinoid tumors, GIST and adenocarcinomas depends among others on the size of the lesion, the endoscopic estimation of depth, the presence of ulcer and ultrasound features (if apply). Curability depends on the depth of invasion, differentiation, ulcer finding and lymphovascular involvement. (there are not data of these important features in the article)

Comment

Figure 2 presents inappropriately high grade displasia and carcinoma in two different groups. Based on the agreement between Japanese and western pathologist s (Vienna Classification), high grade displasia and carcinoma in situ are considered the same lesion (8), are included in one group (group IV) and suggest a similar method of treatment (9).

I agree with his opinion as the generalities. In Japan, we usually follow patients with low grade dysplasia. If a lesion show over 4.2 of Vienna classification, it can be applied for endoscopic treatment, I think.

Best regard,

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