**Reviewer’s report**

**Title:** Evaluation of scoring systems without endoscopic findings for predicting outcomes in patients with upper gastrointestinal bleeding

**Version:** 0  **Date:** 27 Aug 2017

**Reviewer:** Wei-Lun Chang

**Reviewer’s report:**

This retrospective study compared the applicability of Glasgow-Blatchford score (GBS), modified GBS (mGBS), and pre-endoscopy Rockall score (Pre-E RS) in predicting the need for endoscopic intervention and 30-day mortality. The results are quite similar to previous studies showing that GBS is better at deciding endoscopic intervention. And RS is better for predicting 30-day mortality.

**Abstract**

1. "Based on AUC analyses of sensitivities and specificities, the optimal cutoff mGBS and GBS for the need for interventions was (70.71 % sensitivity, 89.35% specificity) and 9 (73.57 % sensitivity, 82.90% specificity) respectively, and optimal cutoff Pre-E RS for 30-day mortality was 4 (88.0 % sensitivity, 97.52% specificity)." There seemed to be a word missing in this sentence. What is the optimal cutoff for mGBS?

**Method**

1. In page 7 line 3: Octreotide and glypressin are two different drugs, please correct.

**Result**

1. Table 3 is suggested to include information of hemostatic intervention, so that the paragraph of "Endoscopic findings" can be shortened.

2. A table or figure showing the patient numbers in each score and the patient numbers that need intervention of the 3 scoring systems will help readers understand the disease severity and the ratio of intervention in each score.

3. Besides the above scoring system, "AIMS65" had been shown to be superior in predicting 30-day mortality and rebleeding (Gastrointest Endosc 2016;83:1151-60; J Dig Dis 2016;17:820-828). How about AIM65 in predicting 30-day mortality compare to pre-RS or full RS in their study population?

4. Previous study showed these scoring system were less accurate in predicting outcome of patients with variceal bleeding (J Gastroenterol Hepatol 2016;31:761-7). However,
the author included patients with variceal bleeding. Will the result be different if the analyses were stratified by non-variceal vs. variceal bleeding?

5. The selection of optimal cut-off is usually based on youden index, did the author select their optimal value based on it?

Discussion

1. The statement "However, RS is not suitable for an early decision on need of urgent interventions or predicting 30-day mortality in the management of patients with UGIB, since it requires endoscopic finding" is not true since their data showed Pre-E RS is good at predicting 30-day mortality. Moreover, they do not show the data of RS to predict 30-day mortality. The statement should be modified.

2. The author stated "Our results suggest that patients with GBS > 9 or mGBS > 9 need hemostatic interventions and have to undergo early gastroscopy". The author should provide data to show that in patients with GBS or mGBS > 9, a shorter presentation-to-endoscopy time is related to a lower mortality.

Reference:


Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes

Are the conclusions drawn adequately supported by the data shown?
If not, please explain in your comments to the authors.

Yes

Are you able to assess any statistics in the manuscript or would you recommend an additional statistical review?
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