Peer Review File

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Reviewer A

1. **Do the authors have more systemic hemodynamic measures e.g. cardiac output, SVR or splanchnic vascular resistance?**
   Reply: Thanks for the comments. Unfortunately, we did not perform echocardiography or Swan-Ganz catheter for the patients. Thus, the data regarding cardiac output, SVR or splanchnic vascular resistance was not available.

2. **It would be important to compare the delta of the HVPG decrease.**
   Reply: We calculated ΔHVPG as advised, which was defined as the difference between the HVPG before and after drug administration. We added some data(see page 6, line165-168, and table 1). ΔHVPG10min, ΔHVPG20min, and ΔHVPG30min were not significantly different between the two groups.

Reviewer B

1. **All of your patients had a history of variceal bleeding in the past. However in the section of "methods" you mention that patients taking b blockers had been excluded. Taking on account that b blockers remain an important part of the treatment of patients with variceal bleeding (in combination with banding ligation), how do you explain that your patients had not been taking this kind of treatment?**
   Reply: Thanks for the comments. We excluded the patients taking β-blockers because we were concerned that the pharmacodynamic effect of β-blockers would influence the HVPG. Many patients were admitted or referred to our hospitals after the initial bleeding episode. In our clinical practice, β-blockers would be prescribed to the patients appropriately after a full examination and evaluation (including HVPG measurement).

2. **It is very important to investigate the differences on HVPG before and after the administrative treatment (terlipressin or octreotide) regarding the degree of patients' liver failure (child-pugh score and MELD score) as stage of liver disease plays an important role on the response to treatment. Unfortunately the vast majority of your patients had a child-pugh score A and only a small number of patients had C-P score C. For that reason it could be interesting to compare at least patients with C-P A versus a group including both C-P B and C patients**
   Reply: $\chi 2$ test was performed to investigate the differences on HVPG before and

after the administrative treatment (terlipressin or octreotide). Child-pugh grouping(Child A vs. Child B/C) was used as a stratified factor.

There was no significant difference in the response rate between the two groups at 10 min, 20min, and 30min when taking Child-pugh grouping into account. There was tendency of higher response rate in the terlipressin group compared to the high-dose octreotide group among the patients with Child B/C(46.3% vs. 39.1%, P=0.127) at 30 minutes after drug administration. However, the difference was not statistically significant. We have modified our text as advised (see Page 7, line 201-206).

Responders/study population at the time point		Terlipressin group	High-dose octreotide group	P value
10 min	Child A	8/17(32.0%)	12/22(35.3%)	0.751
	Child B/C	17/27(38.6%)	14/20(41.2%)	0.758
20 min	Child A	13/18(41.9%)	16/22(42.1%)	1.000
	Child B/C	16/27(37.2%)	12/20(37.5%)	1.000
30 min	Child A	10/14(41.7%)	8/15(34.8%)	0.268
	Child B/C	19/22(46.3%)	9/14(39.1%)	0.127

3. **The response to treatment depends also on the HVPG levels at the beginning. It would be worthy to classify your patients regarding their HVPG before the initiation of treatment. Not the mean value of HVPG as you did (per example to categorize them to those with HVPG < 10mmHg, 10-12 mmHg, > 12 mmHg)**
Reply: The HVPG before drug administration(baseline HVPG) was used as a stratified factor. There were only 22 patients with HVPG≤12mmHg. Therefore, we divided the patients into HVPG ≤ 12mmHg and HVPG > 12mmHg.

Among the patients with HVPG>12mmHg, the terlipressin group tended to have higher response rate at 30 minutes after drug administration compared to the high-dose octreotide group(85.2% vs. 62.5%), but the difference did not reach statistical significance(P=0.064). No significant difference in response rates was found between the two groups at 10 or 20 minutes after drug administration taking baseline HVPG grouping into account. We have modified our text as advised (see Page 7, line 201-206).

Responders/study population at the time point		Terlipressin group	High-dose octreotide group	P value
10 min	HVPG≤12mmHg	6/12(50.0%)	4/10(40.0%)	0.691
	HVPG>12mmHg	19/32(59.4%)	22/32(40.7%)	0.434
20 min	HVPG≤12mmHg	7/12(58.3%)	5/10(50.0%)	1.000
	HVPG>12mmHg	22/33(66.7%)	23/32(71.9%)	0.649
30 min	HVPG≤12mmHg	6/9(66.7%)	2/5(40.0%)	0.580

	HVPG>12mmHg	23/27(85.2%)	15/24(62.5%)	0.064

4. **It is also important to investigate if the etiology of liver disease is a factor that influences the response to treatment**

Reply: The etiology of liver disease was used as a stratified factor. The patients were divided into HBV, alcoholic, and other causes. Among the patients with alcoholic liver cirrhosis who completed the HVPG measurement at 30 minutes, the response rate was significantly higher in the terlipressin group than the high-dose octreotide group(100% vs. 0%, P=0.005). These data might be interpreted with caution since the sample size was relatively small. Thus, future work with larger sample size is required to verify the conclusion. There was no significant difference in response rates between the two groups at 10 or 20 minutes after drug administration when taking etiology grouping into account. We have modified our text as advised (see Page 7, line 201-209; Page 10, line 282-286).

Responders/study population at the time point		Terlipressin group	High-dose octreotide group	P value
10 min	HBV	11/23	15/23	0.234
	Alcoholic	6/8	2/4	0.547
	Others	8/13	9/15	0.934
20 min	HBV	12/24	14/23	0.454
	Alcoholic	8/8	2/4	0.670
	Others	9/13	12/15	0.091
30 min	HBV	14/18	10/15	0.697
	Alcoholic	6/6	0/4	0.005
	Others	9/12	7/10	1.000