

Peer Review File

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Reviewer A

I have several minor comments on your manuscript.

- Do you work with a protocol: tamponnade is admission, detamponnade after how many days/hours. would be good to see the rebleeding rate in the first month. It seems that the rate of patients during their hospitalisation going to surgery is rather low.

- Reply: We do not have a formal regarding management of epistaxis at this stage. Many patients will have the pack removed after 24 hours to 48 hours.

If the patients had a presentation to a medical service within the 30 days prior to their admission, it has been counted. However, our study did not examine in detail which service the patient received and the management they received – eg with GP presentation or ED presentation. In the implementation of the risk stratification this data would be prospectively recorded.

- I don't see a referral to an Ethical committee approval
 - Reply: I have reinserted the ethics exemption statement in the methods. This study was approved as a Quality Improvement Project by Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC).
- In the introduction there is in my opinion too much focus on RapidRhino. This is a brand. I would be less specific and use unilateral packing with a balloon tamponnade. A second question the rapid rhino packing you use, is this a pack with or without balloon, this is not clear from the manuscript.
 - Reply: I have altered the introduction to minimise the use of the brand name RapidRhino and have advised that balloon packing is used.
- It would be interesting to check whether the algorithm works and do a second observational study with a follow up of the patients which are packed and not admitted.
- Radiological management I would use the term interventional radiology/embolisation
 - Reply: I have changed to the term interventional radiology/embolisation.
- In the bilateral packed group what was the rate of unplanned medical review, was this different compared to unilateral tamponnade, same for the rate of surgical/interventional radiology.
 - Reply: N= 21 of patients having bilateral rapid rhinos inserted, of these n=7 (33.3%) required medical review and n=1 (4.8%) required surgery and embolisation respectively.

N=3 patients had a posterior pack inserted, n=1 had a review (33.3%) and 0 went on to have surgery or embolisation.

- Range for admission goes from 0-6 days: how do you explain the 0 which means patient was not admitted.

- Reply: A number of patients were admitted for <0.5 days (ie admitted in the morning and discharged in the evening) hence length of stay was rounded down to 0. I have changed this to be expressed in hours for accuracy.
- In the text line 162 and 163 is written that age is predictive for a procedure in theatre, how in table 3 the p value is not significant.
 - Reply: This is a mistake, I have corrected it.

Good luck with the revision!

Reviewer B

Epistaxis is an ENT emergency, resulting in significant emergency department presentations. Traditionally patients requiring packing have been admitted and packs left in-situ for 48hours. This paper explores which patients are likely to require inpatient management, with an attempt to define a subgroup who are safe to be managed in an ambulatory setting.

Abstract:

Keywords - not all mesh terms - <https://meshb.nlm.nih.gov/MeSHonDemand>. Authors may want to look at alternative keywords.

- Reply: I have split the keywords into MeSH headings and keywords to make it clearer.

Introduction:

Method:

Results:

Reminder that tables and figures should not be included within the manuscript but included at the end.

- Reply: The format is altered.

Appendices were not included in available material for review.

- Reply: The remaining statistical tables are included at the end of the document.

Line 151 -SBP - should not be abbreviated first time used.

- Reply: I have first abbreviated systolic blood pressure in line 118.

Paragraph 150 and 160 - are very similar, can these be combined in some way - seem to repeat the same information.

- Reply: I have combined these two paragraphs thereby shortening it.

Risk stratification tool - could the cohort within this study be applied to this tool and the results of this analyses. This is touched upon within the discussion but this analysis would provide some validity to the proposed tool.

- Reply: I have moved this into the results section.

Discussion:

Given the trend towards dissolvable packing options as the first line, the authors may want to define when rapid rhino use is required.

- Reply: I have added info to explain it is the routine management in our health service.

The ENT UK guidelines developed as a consequence of COVID are no longer available on the ENT UK website ie reference 17 but referenced in many of the papers published over this period including this one which discusses the use of dissolvable packing.

Devabalan Y, Cereceda-Monteoliva N, Lorenz H, Magill JC, Unadkat S, Ferguson M, Rennie C. Coronavirus disease 2019: changing the future of emergency epistaxis management. *J Laryngol Otol.* 2021 Aug;135(8):675-679. doi: 10.1017/S0022215121001456. Epub 2021 May 18. PMID: 34002682; PMCID: PMC8245333

Packing is often uncomfortable, could the authors comment on whether this would be a factor for patients managed with packs at home and what the appropriate management at home might look like?

- **Reply: We agree that pain is likely to be a factor for at home management. We have added to the discussion around analgesia.**

Paragraph 225 - 51.3% of those anti-coagulated had their anticoagulation ceased while an inpatient. Would this have an impact on bleeding and how would this be managed in the outpatient setting. What was the protocol for the decision to withhold anticoagulation in this cohort?

- **Reply: It was a retrospective study hence the data was recorded as to whether or not it was withheld. Currently at our health service there is no protocol for whether or not anticoagulation should be withheld, it is usually a risk vs benefit discussion with the patient, particularly in patients who are thought to have ongoing bleeding, and with the cardiology or haematology team.**

Line 251 - using the risk stratification tool can the authors then comment on the 31 that would have been eligible for home management and which of these required medical or surgical management, This information could then be compared to the results of the UK studies. It may be useful to compare the authors proposed stratification tool for home management to those discussed in the UK studies. Similarities and differences.

This preprint available online may offer a useful reference to discuss outcomes using an outpatient model for epistaxis.

- **Reply: Thank you for this suggestion and something we can look at in a prospective study to compare with other studies.**

Kaso Ari, Rachael Collins. Outpatient management of epistaxis during COVID-19 to reduce inpatient stay: a quality improvement project. *Authorea.* September 23, 2022.

DOI: [10.22541/au.166391643.31994105/v1](https://doi.org/10.22541/au.166391643.31994105/v1)

Reference 17 no longer available online - authors may want to amend or include an alternative.

- **Reply: I have included alternate references for this UK epistaxis guideline.**

Editorial Comments

Major comments

1. Figure 1 shows the number of admissions as 206, but it is described as 204 in the manuscript. In addition, according to the inclusion and exclusion procedures in Figure 1, 36 of the 206 people were excluded,

leaving 170 people. Please present the number of patients in each box in Figure 1.

- Reply: This has been updated so the number of admissions in total is 207, with 36 excluded leaving 171.

2. Please kindly revise the form of the P-value in the report according to our latest criteria below (note: Revisions are needed for full text):

If $P < 0.001$, please report “ $P < 0.001$ ”;

If $0.001 \leq P < 0.01$, please report the specific P-value to 3 decimal places, e.g., “ $P = 0.001$ ”, “ $P = 0.009$ ”;

If $P \geq 0.01$, please report the specific P-value to 2 decimal places, e.g., “ $P = 0.01$ ”, “ $P = 0.06$ ”, “ $P = 0.10$ ”, “ $P = 0.90$ ”;

If $P > 0.99$, report “ $P > 0.99$ ”.

Do not round P-values, do not report 'not significant' simply because the data is greater than an arbitrary value, and do not report only vague bounds such as $P < 0.05$.

- The decimal points have been updated.

Regarding the STROBE checklist

3. Item 2

Please cite published articles or data to illustrate the importance of accurate assessments of which patient groups may be suitable for outpatient management. What gaps in current knowledge are addressed by the study?

- Reply: While this topic has been quite extensively studied in the UK, to the authors this is the first Australian study reviewing this topic. A small but significant group of patients with epistaxis are comorbid and would not do well with outpatient management, would likely represent with ongoing bleeding and/or requiring surgical management or radiological embolisation.

4. Item 5

Please provide the time when the data collection.

- Reply: this has been updated.

Minor comments

5. Some points lack evidentiary support. The corresponding references should be cited. For example,

Lines 72-74 “The difficulty arises in predicting those patients requiring non-dissolving packing who will require active inpatient management and therefore would not be suitable for outpatient management.”

Lines 246-249 “Some literature indicates that”

When there is ‘some literature’ or ‘several studies’, multiple references need to be cited accordingly. Please recheck the full text to ensure all the statement is evidence-based (not just the above).

6. Line “84 January 2019 - December 2020”, please give the exact year, month, and day of the start and end times.

- Reply: This has been addressed.