Peer Review File

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Reviewer A

Comment 1: It highlights the importance of shared information between blood centers and transfusion services. Consider including the reference by Berry, et al PMID 30230552.
Reply 1: Yes, in this case as with others, transferring care can often lead to lost or delayed information and patient histories that can affect care.
Changes in Text: We have added a reference to Berry et al in the discussion, specifically regarding anti-D detection in pregnant patients and the effect that a lack of history can have on patient care.

Comment 2: Consider modifying the title to ensure that it is clear that this is primarily a case report (per CARE guidelines).
Reply 2: We agree that “brief report” is ambiguous and does not clearly emphasize that this is a case report.
Changes in Text: We have changed “brief report” to “case report”.

Comment 3: Throughout the text, consider using more formal language to refer to your institution, instead of "our" or "here".
Reply 3: We agree this language does make the case presentation less formal.
Changes in Text: We have adjusted the case presentation to not include the words “our” or “here”.

Comment 4: Page 2, line 30, consider changing to "occasionally"
Reply 4: Using “occasionally” expresses that incorrect conclusions are made, even if only rarely, as opposed to saying “potentially”.
Changes in Text: We have reworded the sentence and changed “potentially” to “occasionally”.

Comment 5: For the cases where the anti-D was identified, what platform/manufacturers were used at the hospitals?
Reply 5: We agree that adding this information would be useful to the readers.
Changes in Text: We have added the platform/manufacturer of the antibody screening method used at the hospitals.

Comment 6: What method/platform/manufacturer for antibody detection were used at the Blood Center?
Reply 6: We agree that adding this information would be useful to the readers.
Changes in Text: We have added the platform/manufacturer of the antibody screening method used at the Blood Center.

Comment 7: Page 4, line 72, was the further testing due to the anti-D? Was there concern for DHTR?

Reply 7: The repeat type and screen was performed when the patient was readmitted to our facility in order to address the patient's anemia. Due to the negative DAT, we felt the concern for DHTR to be low.
Changes in Text: We have added that the negative DAT indicated a low likelihood of DHTR and is better explained by the passive transfusion of anti-D from a previous blood unit.

Comment 8: Page 5, consider giving further explanation for why blood center factors into donor alloimmunization status.
Reply 8: This is an interesting finding, included in the REDS-III study by Karafin et al., however we feel it may be best not to include that in our manuscript. It may only add confusion or distraction and is slightly out of scope.
Changes in Text: We have removed this statement from the manuscript.

Comment 9: Page 6, line 115, consider using "are" instead of "is".
Reply 9: Thank you for the correction.
Changes in Text: We have changed "is" to "are".

Comment 10: References: Confirm the appropriate citation for #4 and #11 (CFR).
Reply 10: I believe these can be directly referenced in the text.
Changes in Text: We have included the CFR# in parentheses and removed them from the references. The remaining citations have been reordered.

Reviewer B
Comment 1: Line 20, 21: "In those cases where 21 ABO and Rh are known (through duplicate testing)" / Please, explain what "ABO" and "Rh" refers to (system, antigens...)
Reply 1: Good point, we meant to antigens.
Changes in Text: We added "antigens" after ABO and Rh.

Comment 2: Line 23 "RBC" / Please, describe what "RBC" refer to.
Reply 2: Yes, we have written out in the abstract but forgot to explain the first abbreviation in the text.
Changes in Text: We have added "red blood cell (RBC)" to the text.

Comment 3: Line 24 "AABB" /Please, describe what "AABB" refer to.
Reply 3: We think it is best to keep AABB first, as this is the actual name of the organization, and explain its revised meaning in parentheses.
Changes in Text: We gave explanation to what AABB in parentheses.

Comment 4: Line 32 No reference /The paragraph is lacking reference.
Reply 4: We agree that the paragraph needs adjusted and added reference.
Changes in Text: We have restructured the paragraph and added reference to the CARE guidelines.

Comment 5: Line 48 “At the time of receipt of the unit, the unusual label was noticed, and the outside blood [..]” /Please, explain the reason it was unusual or change the writing for a more adequate expression.
Reply 5: As stated earlier in the text, it is common for donated blood units to be quarantined however seldomly they are sent for use. So, from the perspective of blood bank personnel it may be unusual to see ‘anti-D’ on the label. However, rather than explaining that in the text, it seems best just to remove “unusual” as it can be confusing.
Changes in Text: We removed the word “unusual”.

Comment 6: Line 61 “the implicated unit was one of a double RBC collection (via apheresis)” /It is the first time it is said the unit was originated from apheresis. If it refers to the same blood unit the patient received, please, clarify earlier in the text (Around lines 43-44)
Reply 6: Yes, in real time it was not known these units were a double-unit collected via apheresis. It was determined after the second patient had received her unit. However, to make it more clear we agree that it can be added at the time we are discussing the reception of the units.
Changes in Text: We moved that sentence to the suggested area and adjusted paragraph of the second recipient.

Comment 7: Line 62 "The second recipient was a 56-year-old female" / Did the second recipient receive the same blood batch as the patient previously described?
Reply 7: Yes that is correct. We think that the adjustments made (in comment 6) will also provide clarification to this.
Changes in Text: After “The second recipient” we added “of the other implicated unit from the same donor” to provide clarification.

Comment 8: Line 74 “but DAT was negative” /Please, describe what “DAT” refer to. Lines 133-135 With the lack of a national surveillance system, good interpersonal and institutional communication is vital to guarantee safe blood component therapy and avoid delays in testing and transfusion therapy. / The conclusion lacks the description on the importance of this study for the field of hemotherapy and its contribution.
Reply 8:
Changes in Text: We have added “direct antiglobulin test” prior to DAT.