Point by point response.

Reviewer #1:

1-Outcome of variceal bleeding has a specific timeframe from index bleed: 5-day for treatment failure, 42 days for early rebleeding/bleeding related death. Apparently, authors described the series only for the first time point and not the second. I suggest completing the analysis, if possible, by considering also the outcome at 42 days from index bleed.

Reply: Thank you for your comment. According to the last British guidelines (Tripathi D, et al. Gut 2015;64:1680–1704. doi:10.1136/gutjnl-2015-309262). Rebleeding was defined as the occurrence of a single episode of clinically significant rebleeding from portal hypertensive sources from day 5. Clinically significant rebleeding is defined as recurrent melaena or hematemesis in any of the following settings:
1. hospital admission;
2. blood transfusion;
3. 30 g/L drop in hemoglobin;
4. death within 6 weeks.
We followed the patients for 2 weeks which fits the definition for rebleeding and this was the longest time interval possible for us.

2-Table 1 dscribes general characteristics of patients. I recommend including other important features related with the staging system of cirrhosis such as proportion of patients with previous decomepnsation and kind of decomepènsation, pateints under non selective beta-blockers +/- endoscopic band ligation as primary or secondary prophylaxius before the bleeding episode, pateints who needed to be managed in intensive care unit, the distribution of liver etiology, at least alcoholic (with active or previous alcoholism) vs non-alcoholic, Child-Pugh class distribution. Possibly some of these variables should be used as adjusting factor for the final analysis in order to seek out the independent prognostic role of the score.

Reply: Thank you for your important notice. However, this is retrospective study and such data were not available at time of data retrieval. Also, in table 3, we discussed the patients distribution according to different scores.

3-Authors should add the comparison of the PALBI score with the modified MELD score also (Reverter et al Gastroenterology 2014)

Reply: Thank you for the significant advice. The comment taken up and we added the score to the analysis. The AUROC is a little bit less than in PALBI but barely significant (P=0.043).

4-The comparison of the AUROCs should be performed by using a statistical test (e.g. Hanley-Mc Neil or others)

Reply: Actually before we performed Delong test. However it was only stated at the end of the results and not stated in the statistical analysis. Now, we added a table to show the AUROCs with the *p* values and stated in the statistical analysis.

5-Some typos or little grammar mistakes can be detected (e.g. “odd’s” instead of odds, “data was” instead or data were etc.)

Reply: Comment taken up and we performed language polishing.

Reviewer #2:

To the best of my knowledge, this is the first study to evaluate the performance of the PALBI score in predicting in-hospital mortality after variceal bleeding. Despite the retrospective single-center design, it is performed at a good methodological level in the large number of patients. Indeed, the PALBI score may be a good option for predicting in-hospital rebleeding and mortality in patients acute variceal bleeding. I have a few questions. It is well known that as well as severe liver failure important predictors of adverse outcome are the values of the hepatic venous pressure gradient (HVPG), measured within 24 hours after stabilization of hemodynamics, exceeding 20 mm Hg. How was portal pressure evaluated? If HVPG was not measured, were alternative methods used?

Reply: Thank you for the kind words and comment. Unfortunately, portal pressure were not assessed in our retrospective cohort. However, this is important point to highlight in a future prospective study.

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