Round 1:

Comments: Thank you for submitting this manuscript. This study included 119860 endoscopic procedures and reported on the impact of a triage tool for risk stratification on sedation reversal events during outpatient endoscopy procedures. 1. Are there any other factors beyond age, BMI, procedure type, indication for sedation reversal, and ASA grade that the authors believe could impact sedation reversal events in this study? 2. How do the authors assess the cost-effectiveness of implementing this triage tool in clinical practice, considering the 26 recorded sedation reversals out of 119860 endoscopic procedures? 3. Over 80% of the current 57 references are over five years old. It is recommended that the authors update the references. If no additional recent studies are available, the author should discuss in the manuscript the reasons for the scarcity of research in this field in the past five years.

1. No major factors that we believe could have impacted outcomes, there may have been some interobserver variability in ASA grading. For example, some patients could have been given higher ASA grading on initial chart review by physicians based on their problem list. This has been mentioned in the limitations of study.

2. While our study was not designed to look at the cost effectiveness of a triage tool, this has been added to limitations of study, we assume that using this triage tool helps us to funnel more patients towards outpatient endoscopy suite while creating space in the busy inpatient endoscopy centers so that only high risk patients get channeled towards the hospital setting. While not significant, anesthesia reversal events were fewer at DHC as compared to APC, this could be attributed to the effectiveness of our sedation tool. Literature does show that sedation reversal does add further cost to the procedure (1). As we confront a growing shortage of anesthesia providers, particularly impacting timely access to surgical procedures like gastrointestinal endoscopies, the necessity for practical triage tools becomes increasingly apparent (2). These tools are vital for stratifying patients based on risk and determining the most suitable setting (inpatient vs ambulatory) and type of sedation (such as moderate conscious sedation, deep sedation with monitored anesthesia care or general endotracheal intubation). This approach should not only address resource utilization but also ensure patient safety and uphold the standards of quality care.

3. We have updated our references with more than 50% of references currently being within the last 10 years, however we would also like to bring to the attention of editors that when we performed a google search using the term
‘triage tool’ ‘endoscopy’, since 2020 no studies have been published on this topic to our knowledge, hence some of our references are old.


Round 2:

Comments: Thank you for submitting the revised manuscript and the Answering Reviewers document. The authors' responses are acceptable. A minor reminder is that the clarity of the image in Figure 1 could be improved.