## Qeios

### Peer Review

# Review of: "Pathways of Elderly People Aged 75 and Over Hospitalized in the Geriatric Department of the University Hospital of Bordeaux"

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This timely study examines the outcomes of Unscheduled Direct Admission (UDA) versus Emergency Department Admission (EDA) in elderly patients, a question with growing relevance amid widespread ED crowding and aging populations. The work is methodologically sound, drawing on a large cohort with appropriate use of multiple imputation, competing risk models for mortality, and multinomial logistic regression for discharge disposition. Subgroup analyses by disease category further enhance the clinical relevance of the findings.

The main conclusion—that UDA is associated with similar adjusted mortality and discharge outcomes, but shorter hospital stays—is clearly presented and significant.

Several phrases could be more concise and accessible. For example:

Abstract:

"The UDA patients who were discharged alive more often returned home (83% vs 75% for EDA)"  $\rightarrow$ 

Consider: "Among survivors, UDA patients were more often discharged home (83% vs 75%)."

"The UDA should be the admission pathway..."  $\rightarrow$ 

Consider softening to: "UDA may represent a suitable alternative..."

Main Text:

"arousing increasing interest from the public authorities"  $\rightarrow$  Consider: "gaining interest from policymakers"

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"logically had a longer hospital stay"  $\rightarrow$ 

Consider: "had a longer hospital stay, as expected"

Consider highlighting adjusted results more clearly in the Results and Discussion:

While bivariate differences are informative, the adjusted models are more meaningful for causal inference and policy application. Specifically:

Emphasize the adjusted hazard ratio for mortality (HR = 1.00 [0.54–1.85]) as the key finding, rather than the shared 10% mortality.

In discussing discharge disposition, highlight the adjusted odds ratios (e.g., OR = 0.91 [0.52–1.61] for transfer to rehab) rather than just percentages.

In subgroup findings (e.g., hematologic disease), clarify when results remain significant after adjustment (e.g., Table A3, OR = 0.10 [0.01–0.88] for rehab transfer among UDA patients).

#### Improve figure/table clarity:

Table 1 contains a lot of information; consider noting that it shows unadjusted comparisons. To improve usability, state explicitly in the title or footnote that comparisons are unadjusted descriptive statistics. Consider using subheadings (e.g., "Sociodemographics," "Clinical Characteristics," "Outcomes") to help readers scan the table more easily. Use consistent formatting for percentages: currently, some are n (%), others only %. Clarify the denominator when needed. Consider dropping redundant or low-value rows (e.g., home in CUB1) or moving them to a supplemental table to streamline focus.

Figure legends should be expanded slightly so that plots are interpretable without referring back to the text.

The limitations section is generally appropriate. A brief acknowledgment of residual confounding especially due to the lack of clinical severity markers (e.g., functional status, vitals)—would enhance transparency.

#### Declarations

Potential competing interests: No potential competing interests to declare.