

Response to Reviewer's Comments

Reviewer #1:

Scientific Quality: Grade D (Fair)

Language Quality: Grade C (A great deal of language polishing)

Conclusion: Major revision

Specific Comments to Authors: Dear author, This is a definite difficult airway before you preanesthesia visit and assessment. However, you selected a wrong way of securing the patent airway (a rapid sequence induction), and at the same CICO occurred, consequently increased the severity of trauma and damage (emergent tracheostomy), why not you use FOB or retrograde guided intubation. Be remember, a wrong way for putting the patient in life threatening situation is definitely not premitted. So I decided to reject the manuscript.

1. However, you selected a wrong way of securing the patent airway (a rapid sequence induction), and at the same CICO occurred, consequently increased the severity of trauma and damage (emergent tracheostomy)

Reply:

I thank the reviewer for the comments. The surgical plan was to remove the parotid tumor under general anesthesia with ventilation from tracheostomy for better surgical view. Although an awake tracheostomy was introduced to the patient initially, out of fear, he asked for tracheostomy under general anesthesia. There was no sign of respiratory distress at the time, and his previous oral fiberoptic examination demonstrated that oral intubation was possible. Thus, our medical team and the patient came to an agreement that we try awake intubation first if he can cooperate well, and we will anesthetized him after securing definite airway and then perform tracheostomy. If there are signs of dyspnea occurred during intubation, we will shift to awake tracheostomy immediately. The reason why we chose awake intubation will be explained in the revised manuscript.

We did not adopt rapid sequence induction in this case. Propofol was given just because we thought our intubation was successful via EtCO₂ monitoring and watching the tube passed through the vocal cord. However, the tube turned out to be dislodged or kinking later on. We have no intention to put our patient's life in danger but to seek every possibility to manage the CICO

crisis in such unanticipated event.

2. why not you use FOB or retrograde guided intubation.

Reply:

I thank the reviewer for the comments. Retrograde guided intubation was not adopted because we fear that the guidewire may penetrate the tumor and cause tumor bleeding.

FOB guided intubation was indeed considered that time. But we chose to use trachway because the previous oral fiberoptic exam showed that the view of laryngeal inlet was clear after bypassing the tumor. We believed that trachway intubation with the retromolar technique can be done as well.

Reviewer #2:

Scientific Quality: Grade C (Good)

Language Quality: Grade C (A great deal of language polishing)

Conclusion: Minor revision

Specific Comments to Authors: The authors have described a case of parotid swelling that was planned for surgery. The intubation was difficult to begin with (authors have themselves written that tracheostomy was planned but they had decided to intubate. This is something which is beyond comprehension. Why an awake tracheostomy was not considered only instead of having multiple failures before doing a tracheostomy. The images clearly show a reduced oropharyngeal space due to compression by the parotid mass The tube in pharynx technique is nothing new as pharyngeal insufflation of oxygen is a well accepted technique for para oxygenation. What strategies were adopted by the author for preoxygenation and para-oxygenation considering it was an anticipate difficult airway? How was airway prepared for awake intubation? Was any sedation given to ensure the ETT is tolerated by the patient it is also surprising that "Throughout the course, the SpO₂ remained 100%, no tumor bleeding nor gastric distention had been noticed" considering multiple attempt to intubation were taken

1. The authors have described a case of parotid swelling that was planned for surgery. The intubation was difficult to begin with (authors have themselves written that tracheostomy was planned but they had decided to intubate. This is something which is beyond comprehension. Why an awake tracheostomy was not considered only instead of having multiple failures before doing a tracheostomy.

Reply:

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tracheostomy. If there are signs of dyspnea occurred during intubation, we will shift to awake tracheostomy immediately.

2:What strategies were adopted by the author for preoxygenation and paraoxygenation considering it was an anticipate difficult airway?

Reply:

I thank the reviewer for the comments. 6 L/min pure oxygen mask was given for preoxygenation for 5 min and paraoxygenation during intubation. As his nasopharynx is nearly complete obstructed, high flow nasal cannula was not used for paraoxygenation.

3:How was airway prepared for awake intubation?

Reply:

I thank the reviewer for the comments. 10% lidocaine 2ml was sprayed to his tongue base as topical anesthesia for awake intubation. Neither translaryngeal block or superior laryngeal block was performed due to patient refusal, out of fear. The patient tolerated the procedure well since intubating with trachway via the retromolar approach did not generate severe discomfort.

4.Was any sedation given to ensure the ETT is tolerated by the patient

Reply:

I thank the reviewer for the comments. Fentanyl 50 µg was administered. No additional sedative drug was given for fear that his muscle tone and patency of upper airway will be affected.

Reviewer #3:

Scientific Quality: Grade B (Very good)

Language Quality: Grade A (Priority publishing)

Conclusion: Accept (General priority)

Specific Comments to Authors: The revised manuscript answer the question which I cared about.

Reply:

Thanks for your reply.