

Peer Review File

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Reviewer A

The manuscript submitted by Belitova M et al. is about a case of a 47-year-old female patient with a delayed respiratory distress (26 postoperative days) after thyroidectomy, due to a neck infection secondary to gauze left in peritracheal space during thyroidectomy. Drafting of the manuscript and presentation of figures are correct.

Comment 1: Special concern about the Ethics of the case report must be addressed. The details/copy of the patient written consent should be added for review of editorial office, if manuscript is considered for publication.

Reply 1.1: Ethical approval for our case report was obtained from the Clinical Research Ethics Committee of the University Hospital “Queen Giovanna – ISUL” at the meeting on 31.08.2022 with decision number CREC 2022/166.

Changes in the text: We added these data on Page 4, lines 79, 80, 81, using Track Changes Word (marked with red vertical line).

Reply 1.2: The copy of the patient written informed consent was provided during Submission – files: [GS-22-534-OTHER3-8225.jpg](#) 0.2MB GS consent 1.jpg and [GS-22-534-OTHER4-8078.jpg](#) 0.1MB GS consent 2.jpg

Changes in the text: We have modified the text as advised (See Page 6, line 147, 148).

Comment 2: The role of otorhinolaryngologist cited in the Abstract is not detailed in the body of the manuscript. Was this medical specialist the main surgeon? Authors should give more information.

Reply 2: The main surgeon who performed the thyroidectomy was an endocrine surgeon. His decision – to perform a tracheostomy at the end of thyroidectomy was proved to be correct. Although the most optimal outcomes are achieved when endocrine operations and postoperative follow-up are performed by specialists, due to a relative scarcity of endocrine surgeons in most countries our patient’s general practitioner was in charge for the postoperative follow-up. The patient was referred to consulting otorhinolaryngologist by a general practitioner, because of a new onset of dyspnea, suspicion of tracheostomy tube occlusion or an aggravation in the patient’s long-standing and known COPD by tracheostomy tube in place.

Changes in the text: we have cleared the role of consulting otorhinolaryngologist and modified our text as advised (see Page 5, lines 96, 97, 98; 99, 101, 102, 103, 104 and Page 6 line 153, 155, 156)

Comment 3. Drug trade names should be removed, for example Spiriva®.

Reply 3: The trade name Spiriva® was removed from the text as advised; only the generic name Tiotropium bromide is in the text.

Changes in the text: Please see the Page 5 line 109.

Comment 4. Was an emergent tracheotomy considered for patient ventilation in the ED? What about the role of this procedure in emergent conditions such as in the reported patient? How many attempts of endotracheal intubation must be performed before an emergency tracheotomy is indicated? This information should be addressed in Discussion section.

Reply 4: The airway establishment is of prime importance to survival. The emergent tracheotomy is a potentially life-saving measure in a “can’t intubate, can’t ventilate” situation. Unfortunately, the Emergency Physicians are occasionally confronted with an airway that is extremely difficult or even impossible to obtain by surgical intervention or endotracheal intubation. This was the case with our patient: total physical exhaustion, desaturation, recent thyroidectomy and tracheostomy, RLN paralysis, unknown origin of a cavity filled with a gaseous content seen on neck CT scan (suspicion of abscess, what is the plan of tissues beneath the trachea?) and on video-laryngoscopy – a picture of a glottic closure. To find a surgeon who is willing to perform tracheostomy or even emergent tracheotomy, not to mention finding an anesthesiologist who is willing to perform an endotracheal intubation in such a patient is a difficult task. The operating team was unanimous: firstly it would be better to attempt endotracheal intubation before tracheotomy, because of untoward tracheal transection possibility due to insertion site infection which would lead ultimately to the patient’s death. Moreover, enabling the ventilation and oxygenation by endotracheal intubation in a situation of extreme promptitude, gives time for precision during surgical airway creation.

On the question “How many attempts of endotracheal intubation must be performed before an emergency tracheotomy is indicated?” – we could reply: There is no time for attempts! Because after strong hypnotics and muscle relaxants intubating doses administration and abolishing spontaneous breathing efforts, sustaining the life in face of unsuccessful intubation, to prevent patient’s death, as a cry of desperation would be to perform as quickly as possible some of surgical airway creation procedures, usually those, which the particular surgeon is most familiar with.

Changes in the text: we added comments in Discussion section as advised, See page 7 lines 177, 178, 179, 180, 181 and Page 8 lines 194, 195, 196, 197, 198.

Comment 5. Lung respiratory distress by sepsis was ruled out?

Reply 5: The suspicion of adult respiratory distress syndrome (ARDS) triggered by sepsis in a particular patient was ruled out by a typical clinical presentation: suffocating patient (no breathing sounds on auscultation of the lungs, biphasic stridor, high-pitched sound during every inspiratory and expiratory effort, tripod position, aphonia) and infection purulent sputum, fever, neck inflammation signs. In extreme promptitude we performed Chest X-Ray but because of patient’s agitation and involuntary body movements in attempts to take a breath, the quality is

not satisfactory. We decided to perform a CT scan, which revealed a relatively preserved lung parenchyma, seen on the initial plan of CT scan of the neck (Fig.4). To enable an immobile suffocating patient for a few seconds, we gave i.v. 2mg Morphine.

Changes in the text: We added some data. See Page 2, line 32 (number of Figures is now 4 instead 3) ; Page 6, line 133, 134, 135, 136; and Fig. 4.