Peer Review File

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**Reviewer Comments**

**Comment 1:** *INTRO: Many complications are actually avoidable, not unavoidable.*

**Reply 1:** Thank the reviewer for the careful modification of my article. We have corrected it.

**Changes in the text:** “Some complications may occur during the induction of anesthesia.” (see Page 3, line13-14)

**Comment 2:** *Preoxygenation: PEEP can increase apnoea time. Please read recent editorial by Lam & Irwin concerning HFNO and it's limitations https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15473. I think you HFNO is not as useful as you suggest.*

**Reply 2:** Thanks for the advisement, we have carefully read the editorial suggested by the reviewer and discussed the shortcomings of HFNO in the article.

**Changes in the text:** Although the use of HFNO in preoxygenation and during apnea is theoretically more advantageous than using a face mask alone, current studies remain inconclusive and then we cite recent researcher as examples. (see Page 7, line12-Page 9, line3)

**Comment 3:** *SGA: "an integrated bite block to reduce the risk of aspiration" bite block doesn't affect the risk of aspiration.*

**Reply 3:** Thanks for the reminding and based on another reviewer's comments that second generation supraglottic airways are already very well published and do not require a review, we have deleted the specific description of SGA.

**Comment 4:** *You should include a brief discussion of the role of dexmedetomidine in facilitating airway management such as awake FOI. More useful than remimidazolam.*

**Reply 4:** Thanks for the advisement and we have included a brief discussion about the dexmedetomidine in the induction of anesthesia especially in awake FOI.

**Changes in the text:** The recently released ‘Guidelines for Awake Tracheal Intubation (ATI) in Adults’ by Difficult Airway Society has pointed out that

remifentanil and dexmedetomidine are ideal drugs with high levels of patient satisfaction and low risk of over−sedation and airway obstruction. And the specific narration (see Page 16, line16-Page 17, line3)

**Comment 5:** *Several of the subtopics you have written are no longer novel and have been around for a long time. E.g. Supraglottic airway, video laryngoscopes, bougie and stylets.*

**Reply 5:** Thanks for you reminding and we have deleted some parts of Supraglottic airway, video laryngoscopes, bougie and stylets. We have focused on the latest equipments and techniques, including video supraglottic airway, awake intubation with videolaryngoscopes, and the new flexible bougie based on the reviewers' suggestions afterwards. The details will be marked in the following text.

**Comment 6:** *The paragraph on oxycodone also seems out of place. It should be compared to remifentanil instead. Remifentanil in airway management is also well published and in Difficult Airway Society guidelines for extubation.*

**Reply 6:** Thanks for the suggestion and we have deleted the part of the oxycodone and given a brief discussion about remifentanil.

**Changes in the text:** Remifentanil is a potent short-acting synthetic opioid with fast onset and rapid metabolism. It can provide profound analgesia, suppress airway reflexes and show a minimal effect on cognitive function, so that it can be an attractive sedative drug for awake fibreoptic intubation. Moreover, remifentanil has been recommend for managing ‘at-risk’ extubation to attenuate some undesirable responses such as coughing, agitation and haemodynamic disturbances. (see Page 16, line10-line15)

**Comment 7:** *Preoxygenation also is a very well known concept and may not require much discussion. More importantly, the mechanism of apneic oxygenation may be more informative to the reader for advances in airway management. Apneic oxygenation using the NODESAT method described by Dr Levithan is also not mentioned.*

**Reply 7:** Thanks for the reminding. We have deleted some parts of the preoxygenation and added the discussion about the mechanism of apneic oxygenation. Moreover, we have cited the NODESAT method and give a profile.

**Changes in the text:** the mechanism of apneic oxygenation (see Page 6, line6-line12); the NODESAT method (see Page 6, line13-line17)

**Comment 8**: *I would encourage the authors to consider reconfiguring the manuscript to only mention key highlights which are novel from the last decade, vis-a-vis video supraglottic airway devices (no mention in your manuscript), artificial intelligence, remimazolam, flexible tip bougie, awake intubation with videolaryngoscopes (no mention in your manuscript), sugammadex (especially for reversal of dense or profound block) and apneic oxygenation.*

**Reply 8:** Thanks for reviewer's advertisement, We have reconfigured the manuscript according to the suggestions. We have added the discussion about the video supraglottic airway devices, awake intubation with videolaryngoscopes and apneic oxygenation which were not mentioned before. Meanwhile, we have deleted some widely known details about supraglottic airway devices and videolaryngoscopes. We reserve the part of artificial intelligence. In the part of bougie, we have deleted parts of introduction and highlighted the flexible tip bougie. In the end, we have discussed more about sugammadex.

**Changes in the text:** apneic oxygenation (see Page 6, line5-17); video supraglottic airway devices (see Page 9, line12-Page 11, line 9); awake intubation with videolaryngoscopes (see Page 12, line3-Page 13, line 3); flexible tip bougie (see Page 13, line5-20); sugammadex (see Page 18, line9-14); artificial intelligence (see Page 18, line19-Page 20, line7)

**Comment 9**: *Topics like video laryngoscopes and second generation supraglottic airways are already very well published and does not require a review. In fact, by shortening these topics to a couple of paragraphs, the nuances of these important topics are not appreciated fully.*

**Reply 9:** Thanks for the reminding. We have deleted some parts about video laryngoscopes and second generation supraglottic airways, and highlighted the latest progress such as video supraglottic airway devices, awake intubation with videolaryngoscopes mentioned before.

**Changes in the text:** video supraglottic airway devices (see Page 9, line12-Page 11, line 9); awake intubation with videolaryngoscopes (see Page 12, line3-Page 13, line 3).