

## Peer Review File

Article information: <https://dx.doi.org/10.21037/joma-23-21>

---

### Review Comments

#### Reviewer A

Comment 1: Very interesting. But It adds very little to our knowledge.

Reply 1: Many thanks for your review, I hope that the article provides a more comprehensive look at the aspects surrounding extubation which unfortunately is the subject of relatively little research. I have collated together the available evidence and gone beyond what is currently available to provide the reader with an in depth review.

Comment 2: I suggest to talk about One Lung Ventilation, cuff leak test, etc.

Reply 2: I am unclear as to how one lung ventilation is linked to extubation, does Reviewer A mean with regards to tube exchange as this would not really differ to the AEC / bronchoscope method of tube exchange. I would also highlight that one-lung ventilation is very unlikely to be used in oral or maxillofacial surgery and would therefore disagree that this would add to the article. Cuff leak tests are on the whole of no value in the assessment of suitability for extubation after surgery and are of more (although limited) value in the ICU setting which is beyond the scope of this article.

Comment 3: I suggest to cite more accurately cut offs, dose of drugs used, how to use them (intravenosi vs aerosol with equipment for rotative circuits).

Reply 3: Evidence based doses have been provided for all of the medications outlined in the section titled phamacological attenuation of the physiologic response to extubation and coughing.

Comment 4: Also, I suggest to cite confidence intervals, funnelplots, etc.

Reply 4: Due to relative scarcity of publications with hard cut offs on numbers / clear data there is very little that can be transformed into a funnel plot that would add to the readers understanding of the topic.

Comment 5: All this in order to publish a review based on solid evidence and numbers. It seems like a lesson for students. You need to talk to experienced anesthetists

Reply 5: The topic requested and accepted by JOMA was on the topic of extubation, this is a broad and diverse topic which as previously mentioned remains a relatively neglected area of research with no large RCT evidence base. The Difficult Airway Society acknowledged this in their own guidelines published in 2012 and stated that much of their guidance had to be based on expert opinion and experience rather than hard data. Since 2012 unfortunately not much has changed however there is more experience and evidence on the use of drugs such as Dexmedatomidine, IV lidocaine and methods such as the use of the staged

extubation equipment as so this has been included to make this the most up to date article on the topic. There has been discussion and review by senior airway anaesthetists and they agree that there is little more to add to the topic at this point in time.

#### Reviewer B

Comment 1: 1.The initial usage of an abbreviation should be accompanied by an explanation of what the abbreviation stands for. For example, “NMB”in Line 119, “AEC”in Line 448.

Reply 1: As below.

Changes in text: Abbreviation now included for NMB in line 115. AEC abbreviation included already in paragraph title, repeated in first line of paragraph 432 for clarity.

Comment 2: Could you please rephrase Lines 200-202 and Lines 210-213 for me? I find them challenging to comprehend.

Reply 2: Rephrased for clarity.

Changes in text: Paragraph starting on line 200 replaced with:-

Consensus has not been reached on the optimum inspired oxygen concentration delivered to patients prior

to extubation. This remains a balance between the potential complications of hypoxia should airway

obstruction occur versus the consequences of absorption atelectasis following delivery of high inspired

oxygen concentrations. The DAS guidelines recommend aiming for an end expiratory oxygen concentration

(FEO<sub>2</sub>) of above 0.9 maximising pulmonary oxygen stores, thus providing a safe window of apnoea and

delaying the onset of hypoxia should difficulties be encountered at extubation. However, it has been shown

that alveolar atelectasis may occur after as little as 6 minutes at an inspired oxygen concentration of 100%.

22

Comment 3: Please modify the format of Line 255.

Reply 3: Formatting appears correct on my version

Changes: Rechecked my version, justification appears correct, no changes possible

Comment 4: Please rewrite “O<sub>2</sub>”in Line 460, and “FiO<sub>2</sub>”in Line 543

Reply 4: This have been placed in subscript

Changes: Modified to O<sub>2</sub> and FiO<sub>2</sub>

Comment 5: Please standardize the spacing between paragraphs to ensure consistency.

Reply 5: Standardised to single line spacing between paragraphs and double spacing between headed topics.

Comment 6: Could you enhance clarity by including a diagram to illustrate the appropriate approaches for handling various issues?

Reply 6: This is something I had worked on but I was unsure if it added much value, I have worked on some other formats with more text but felt they became too busy and a repeat of the content of the text. Happy to include the below version as a summary flow diagram?

Changes: Inclusion of below figure.