

**Peer Review File****Article Information:** <http://dx.doi.org/10.21037/ajo-20-81>**Reviewer A:**

Laryngeal webs and laryngeal webs can present management challenges. Children with 22q11.2DS have an added level of complexity due to their comorbidities. This paper explores the authors experience over a 10 year period in this patient cohort and is one of the largest series in the literature. It describes the viability of repair at around 1 year of age either without tracheostomy or a limited requirement for covering tracheostomy.

Dysphagia is recognised as a common presentation in this patient group and this was also identified in this paper. Dysphagia is very important to manage pre surgery to ensure aspiration doesn't result in pulmonary complications that would complicate surgery, thus would be useful to know how authors managed this. Further data on the pre and post surgery swallow assessment would be interesting.

**In this retrospective series pre-op VFSS or FEES was not uniformly performed. However, this analysis would suggest that in addition to clinical assessment it may be useful for objective evaluation of swallow prior to surgical intervention (especially if open surgery is contemplated)**

Worth noting that none of these children had life threatening stenosis (grade 4). They were able to be grown on average to 1 year of life before the surgery was required. Thus this algorithm may not be appropriate in the neonate with acute airway distress. → See 266

Can the authors comment on what they feel is the ideal age/weight etc to progress to reconstruction if there is no acute airway distress. Is this influenced by cardiac and immunological status?

**There is no lower limit for endoscopic airway surgery. The age and weight prior to open surgery is determined by the co-morbidity usually. Even though not reported in this series a patient with high grade stenosis (Cohen grade IV) and severe co-morbidity may require a tracheostomy prior to reconstruction. Laryngotracheal reconstruction in children under 5kg should be undertaken by experienced units only. See 221, 240**

Where patients supported respiratory wise in the lead up to surgery eg low flow O<sub>2</sub> or CPAP? **None of these patients were high flow or CPAP before airway procedure. With an exception of patient 4 – who underwent surgery on 10<sup>th</sup> of life and was in neonatal unit on nasal high flow until surgical intervention.**

Did they have sleep studies or over measures of obstruction measured as part of work up? **Sleep study was not a routine part of the work up for kids with laryngeal atresia in this series. It is not our policy to perform sleep studies in patients with glottic and subglottic stenosis to assess the severity of stenosis.**

Can the authors comment on how many had required cardiac surgery prior to their airway surgery and how many were requiring immunoglobulin therapy and whether this influenced decision making. **See 115,117 and 241**

The authors method for inserting keels might be useful for the readers. As would a clinical photo. The technique used is well described in this recent article Ref: **Surgical Management of Anterior Glottic Webs see 205**

*I-ChunKuo and MichaelRutter*

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As mitomycin C is often discussed in this setting a comment on keel vs mitomycin C in this patient group → **see 225**

Line 16 - can pulmonary aspiration be a key point when not mentioned in the abstract? **See line 293**

Line 23 - grammatical error - being partial laryngeal atresia (PLA) one of the most common - **Corrected**

Line 32- the 2 who didn't undergo surgery - observed. Method was only to include those who had surgery. Perhaps better for method to be to include all patients with 22q11DS with PLA. → **corrected in the main text.**

Line 40 - is it a common finding in 22q? 10/64 16% → **We believe that considering the frequency rate in the normal population 1:50.000 births, 16% is probably common?**

Line 82 - how where the patients identified? Coding, departmental database? **See line 83**

Line 96 - speech therapy for? Swallow assessment? **See line 99**

Line 97-98 - this isn't really method, the method is to collect data on diet modification → **edited on main text.**

Line 107 - using this database isn't mentioned in the methods → **see line 85**

Line 108 - 71% should be written as the raw number as well ?10 → **see line 112**

Line 109 - age 4days to 17 months - can the author make this clear this is age of diagnosis not age of surgery → **see line 113.**

Line 121 - endoscopic treatment - the age of these cases may be worth including ie at what age is the author comfortable inserting a silastic skill without a tracheotomy. **See line 205.**

Line 134- - which is it 2 or 6 weeks – **2 weeks (corrected)**

Line 149 - it would be useful to know what dietary modifications were implemented prior to surgery for those with dysphagia – **see line 166.**

**Reviewer B:**

Can the authors comment on whether the comorbidities in the patients played a role in affecting the treatment of the patients with partial laryngeal atresia. For example the timing of the ENT airway surgery and discussion. → **Please see lines 240.**

The paper describing the case series contributes to the literature on this rare condition.