

Peer Review File

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Reviewer: A

Comment 1: Figure 3 A is not mentioned in the text.

Reply 1: We appreciate your suggestion. We added the following sentence in “Case presentation” section ‘On POD 5, subglottic stenosis progressed further (Fig.3A)’ (see Page 6, line 17-18).

Comment 2: The type of the cannula should be described.

Reply 2: We appreciate your suggestion. We added the following sentence in “Case presentation” section ‘The tracheotomy tube was used Mera Sofit D-7CFS (Senko Medical Instrument Mfg. Co., Ltd, Tokyo, Japan)’ (see Page 6, line 15-16).

Comment 3: The level of the stenosis should be specify (distance from vocal cord).

Reply 3: Thank you for your comments. We have not measured the distance from vocal cord to the stenosis. As you pointed out, we modified ‘Laryngoscopy showed submucosal hemorrhage around the vocal cords and mild subglottic stenosis’ to ‘Laryngoscopy showed submucosal hemorrhage around the vocal cords and mild subglottic stenosis just below the glottis’ in the section “Case presentation”. (see Page 6, line 10-11)

Comment 4: Adverse effects of both endotracheal intubation and tracheotomy are common. It is estimated that about 2-3% of patients who undergo intubations and/or tracheotomy will develop tracheal stenosis.

In this case, was the patient extubated after the end of surgical procedure? (this should be specify). It seems so, consequently the intubation time was short (about 1h and 28 minutes). As suggested by the authors, the stenosis could be related to the trauma after a complicated intubation. In addition, the authors described a narrow glottis, without any symptoms (hoarseness..). However we know that symptoms may occur when tracheal lumen is less than 25%. So, could a glottic stenosis be unacknowledged? Were there any underlying unrecognized systemic disease such as vasculitis (for example Granulomatosis with polyangiitis) that may promote an inflammatory reaction after a tracheal trauma?

Reply 4: Thank you for your comments. The patient extubated after the end of surgical procedure. We added the following sentence in “Case presentation” section ‘The patient was extubated in the operating room after the end of surgical procedure’ (see Page 6, line 6-7).

The degree of narrow glottis was only 35-Fr left-sided DLT difficult to pass, and we presumed that it was not enough to cause symptoms. It was possible that the symptoms have not appeared because of mild narrow glottis.

We added the following sentence in “Discussion” section ‘There were no systemic diseases that promote an inflammatory response, and the anesthesia time was not particularly long, lasting less than 3 hours. The instantaneous and powerful damage to the tracheal mucosa by the DLT rather than the intubation time may be the cause of sever subglottic stenosis’ (see Page 8, line 4-6).

Reviewer: B

Comment 1: Please note which lung was deflated for this procedure.

Reply 1: We appreciate your suggestion. We added the following sentence in “Case presentation” section ‘(deflated right lung)’ (see Page 6, line 4).

Comment 2: Was there any surgical impact on the recurrent laryngeal nerve?

Reply 2: Thank you for your comments. There was no surgical impact on the recurrent laryngeal nerve.

Comment 3: What is new or different about this case as compared to other publications related to subglottic stenosis developing?

Reply 3: Thank you for your comments. Compared to other publications, we report more details of subglottic stenosis, including endoscopic images, from the immediate onset of the disease to the recovery process.

Comment 4: Why do you think this happened with only 2 plus hours of intubation? Traumatic intubation? Was there a tracheal tear in the mucosal that could have caused the subglottic problem?

Reply 4: Thank you for your comments. Since the anesthesia time was not particularly long, we believed that the instantaneous and powerful damage to the tracheal mucosa by the DLT, rather than the intubation time, may be the cause of the severe subglottic stenosis. Although we could not confirm whether there was a tear in the tracheal mucosa, it was possible that a tear in the tracheal mucosa could have caused subglottic stenosis.

Comment 5: Did this lady have any allergies or any autoimmune process that could have hasten this problem?

Reply 5: Thank you for your comments. The patient had no allergies and systemic diseases that promote an inflammatory response. We added the following sentence in “Discussion” section ‘There were no systemic diseases that promote an inflammatory response, and the anesthesia time was not particularly long, lasting less than 3 hours. The instantaneous and powerful damage to the tracheal mucosa by the DLT rather than the intubation time may be the cause of sever subglottic stenosis’ (see Page 8, line 4-6).

Comment 6: What was the inflammatory nodule in the lingual? That was in the left lung that you were ventilating. Was it removed or biopsied?

Reply 6: Thank you for your comments. We have not performed biopsy for the nodule in the lingual. We suspected nontuberculous mycobacteriosis by CT imaging findings. We continue to follow up on the image.

Comment 7: On laryngoscopy the vocal cords moved normally?

Reply 7: Thank you for your comments. Vocal cord moved normally and no paralysis was observed.

Comment 8: When was the fistula diagnosed? How? Under what type of procedure was this accomplished? What type of anesthesia was used?

Reply 8: Thank you for your comments. Trachea-cutaneous fistula is synonymous with a tracheostomy orifice. Tracheostomy closure was performed under local anesthesia with simple suture closure.