Supplementary

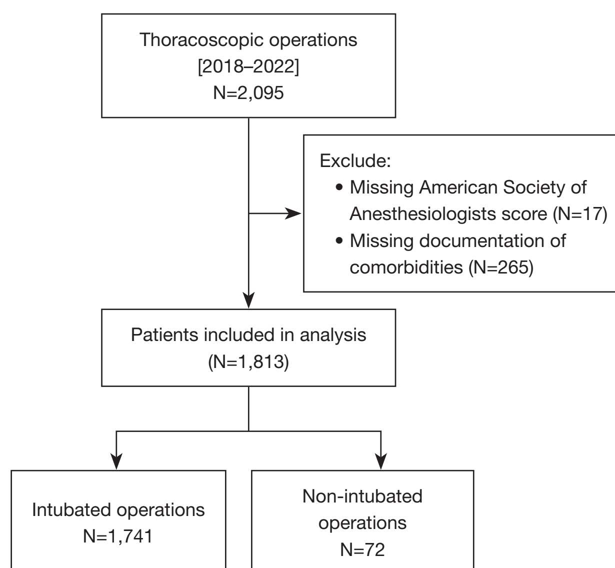

Figure S1 Inclusion and exclusion criteria.

Table S1 Surgical procedures in 19 non-intubated patients who did not undergo a pulmonary resection

Surgical procedures	N (%)
Resection/biopsy of mediastinal nodule	7 (36.8)
Decortication for empyema	5 (26.3)
Pleurodesis	3 (15.8)
Pleural biopsy	2 (10.5)
Pericardial window	2 (10.5)

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Appendix 1 Institutional rules for thoracic operations without endotracheal intubation

(I) These rules apply to any operation involving the opening of one or both pleural spaces or any operation conducted with open pneumothorax, in the absence of endotracheal intubation.

(II) The decision to operate without endotracheal intubation requires explicit joint agreement after direct communication between the attending anesthesiologist and thoracic surgeon before the operation. The conversion of a thoracic operation to endotracheal intubation requires the decision of only one attending, anesthesiologist or surgeon. Once the decision to intubate is made, the operation is interrupted (elective intubation) or intubation is facilitated as circumstances permit (urgent or emergent intubation).

(III) The available methods for analgesia, sedation and regional anesthesia are selected in communication between anesthesiologist and surgeon to enable adequate locoregional infiltration of local anesthetic agents by both anesthesiologist and surgeon.

(IV) A BMI of 25 kg/m2 or less is strongly advised for all candidates selected for an operation without intubation. Patients with BMI exceeding 25 kg/m2 require individual consideration before operation. Any patient comorbidity raising concern about airway management are discussed to the satisfaction of both anesthesiologist and surgeon before institution of anesthesia.

(V) When during operation a conversion to endotracheal intubation is required, both attending anesthesiologist and surgeon must be present in the operating room. During elective conversion, the surgeon interrupts the operation and facilitates the anesthesiologic procedure by optimizing patient position and assisting the anesthesiologist. While urgent or emergent conversion may not permit such assistance, close communication about airway priorities is expected between anesthesiologist and surgeon.

(VI) Changes in airway management during an operation without endotracheal intubation, for example insertion of a LMA or institution of positive pressure ventilation, are communicated to the surgeon.

(VII) Changes in the planned extent of operation, for example the resection of more than one lobe, the presence of vascular injury or the opening of a large airway, are communicated to the anesthesiologist, if possible, prior to these events.

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