Response to the editor and reviewers:

We would like to thank the editor and reviewers for the feedback concerning our paper. Our responses to the editor's and reviewers' comments are as follows. We have highlighted the revisions in the manuscript.

Response to the Editor:

Thank you for the opportunity to submit our article to the World Journal of Orthopedics. We revised our manuscript according to your suggestions. Manuscript type, author contributions, data sharing statement and comments were updated and highlighted in the manuscript. An audio core tip was created.

Response to Reviewer 00505427:

Thank you for reviewing and accepting our manuscript.

Response to Reviewer 03069301:

Thank you for reviewing and accepting our manuscript.

Response to Reviewer 00526025:

Thank you very much for reviewing our manuscript in such detail. We tried to implement all of your suggestions for improvement.

I would recommend the authors describe early symptoms and signs of impending airway compromise in more detail after cervical surgery.

We absolutely agree with the reviewer. We described the signs and symptoms of our patients again in the discussion.

It would be much informative if you would describe the methods of airway management, i.e., oro- or nasotracheal intubation, or tracheostomy. If you secured the airway by oro- or naso-tracheal intubation, was it easy or not? Who managed the airways of the patients?

We agree with the reviewer.

Patients were reintubated nasally after topical lidocaine using a flexible fiberoptic bronchoscope to allow for assessment of airway swelling and vocal cord function.

They were easily performed, however, all were done by experienced attending anesthesiologists.

None of the patients required tracheostomy for initial reintubation. The only indication for tracheostomy was failure to wean subsequently.

We have updated the manuscript to reflect this.

Specific comments: As you describe "Introduction" in one paragraph, it is not easy to read through. I would recommend the authors divide "Introduction" into a few paragraphs.

We agree with the reviewer. We have divided the introduction into several paragraphs.

Page 7 You write "Five patients were kept intubated…" Your Table 3 says that the tracheas of four patients were intubated after surgery. Which is correct?

We agree with the reviewer. Table 3 is correct. We have updated the manuscript to reflect this.

I am keen to know your criteria of extubation after emergency airway management of the patients. Did you confirm regression of pharyngeal/laryngeal edema by fiberscopy?

For extubation patients had to meet standard extubation criteria:
- NIF > -30
- TV >6cc/kg ideal body weight
- successful completion of a minimum of 15 minutes spontaneous breathing trial without tiring.
- awake and following commands and a leak of air around the endotracheal tube when the cuff was deflated.

Assessment of pharyngeal edema by fiberoptic bronchoscopy was attempted in some cases, however, with an endotracheal tube in place, the view of the supraglottic area was limited due to residual obstruction by the tube.

Discussion The authors thought that the trachea was compressed by hematoma. Can hematoma compress the rigid trachea? I would recommend the authors read through two papers listed below. 1. Wade JSH: Respiratory obstruction in thyroid surgery. Ann R Coll Surg Engl 1980; 62: 15-24. 2. Wells DG1, Zelcer J, Wells GR, Sherman GP: A theoretical mechanism for massive supraglottic swelling following carotid endarterectomy. Aust N Z J Surg 1988; 58: 979-81.

We agree with the reviewer. As recommended we read through the two very interesting papers. In the first paper by Wade the author explains that the normal trachea cannot easily be obstructed by postoperative hematoma since it is such a firm

structure. In the second paper by Wells et al. the authors explain mechanisms for supraglottic swelling. We have updated the manuscript to reflect this.

Response to Reviewer 01436637:

Thank you for reviewing our manuscript.