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LETTER TO THE EDITOR

Reply to Letter to the Editor

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WE read with interest the commentary by Vahid Damanpak Moghadam and colleagues. As a matter of fact, Coronavirus Disease 2019 (COVID-19) has been pandemic globally in a very fast speed and raised great concern all over the world. To provide guidance for anesthesiologists and critical care physicians on performance of endotracheal intubation for COVID-19 patients, we developed and released the 1st edition of *Expert Recommendations for Tracheal Intubation in Critically ill Patients with Novel Coronavirus Disease 2019*. [1] The expert panel highly recommends enhanced droplet/airborne PPE, fast and good airway assessment, sufficient muscle relaxant and using video laryngoscope with disposable blade. For patients with normal airway, awake intubation should be avoided, and modified rapid sequence induction is strongly recommended. For patients with difficult airway, good preparation of airway devices and detailed intubation plans should be made.

Among the recommendations, lidocaine was mentioned twice, in the airway device choosing session and in the difficult airway management session. We fully agree with Dr. Moghadam and colleagues regarding the importance of cough preventing strategy during endotracheal intubation for COVID-19 patients. Prophylactic intravenous lidocaine showed beneficial impact on cough incidence reportedly,[2] which we would consider to add to the future editions of expert recommendations. However, it seems not a commonly accepted idea that dexmedetomidine be used for cough preventing during endotracheal intubation on critical COVID-19 patients because of its slow onset of effect [3] and significant hemodynamic variance, such as transient hypertension, bradycardia, and hypotension resulted from the drug's peripheral vasoconstrictive and sympatholytic properties.[4] Nevertheless, dexmedetomidine can significantly decrease the occurrence of delirium among old patients in the intensive care unit,[5] which may benefit critical COVID-19 patients.

We noticed that Dr. Moghadam and colleagues gave several other valuable suggestions based on their experience in the letter. Indeed, pulse oximeter probe should not be applied on cold limbs which may compromise the blood supply and impact monitoring results. However, COVID-19 patients are often in fever. Pulse oximeter probe and any other monitoring probes should be placed as far away from the airway as possible to protect medical staff from unnecessary close contact. We generally intubate after intravenous induction, so patients are supposed to lose their consciousness. What's more, tracheal intubation may help ventilate the patients sufficiently which may alleviate the elevated PCO_2.

The clinical practices are subject to change in dif-

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ferent places. We would like to extend our gratitude to Dr. Moghadam and colleagues for their attention. Medical staff should keep open-minded developing useful and effective measures to take good care of COVID-19 patients. On fighting COVID-19, we are together, and we will be stronger.

Conflicts of interests

None.

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