

emergency tracheostomy to secure the airway.² Jagtap et al³ gained access to the airway via retrograde intubation for abdominal hysterectomy in a 16-year-old female. Failure to secure the airway due to subglottic stenosis lead to abandoning of surgical procedure in another patient.⁴ A check laryngoscopy under inhalational anesthetic with spontaneous breathing can help document the degree of airway abnormality and need for intubation. A pediatric fiberoptic might not be available in all centers and requires more expertise than use of a video laryngoscope. Furthermore, video laryngoscope provides a wider field of vision assisting in further airway management.⁵ Check laryngoscopy helped us decide on the use of supraglottic airway device and avoid tracheal intubation. The use of multimodal analgesia decreased need for opioids and their unwanted side effects. The use of sophisticated piston anesthesia ventilators has made it possible to effectively ventilate these babies obviating use of muscle relaxants.

We would like to highlight that a check laryngoscopy and airway assessment after induction allowed the safe use of a supraglottic airway device without need for tracheal intubation in this patient with Fraser syndrome. This technique of doing check laryngoscopy following anesthetic induction may also be used in other pediatric patients with suspected difficult airway to decide on airway management options. However, meticulous preoperative assessment, planning, and all difficult airway equipment necessary to secure a pediatric airway should be kept ready in case the need arises.

CONFLICT OF INTEREST

The authors have no conflict of interest.

FUNDING INFORMATION

The study was funded by departmental resources.

ETHICAL APPROVAL

The authors confirm that explicit written consent to publish has been received from parents for reporting this case. No part of image/text enclosed discloses information that could identify the subject.

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DOI: 10.1111/pan.13794

Association between children's emotional/behavioral problems before adenotonsillectomy and postoperative pain scores at home: Answer to a comment

We thank the authors for appreciating the methodological strengths of our study which shows that after adenotonsillectomy, preoperative internalizing problems in children and parental need for information were independently associated with children's increased pain at home. The authors underline the clinical necessity to establish specific therapeutic strategies to reduce children's postoperative pain.

Since we also acknowledge the importance of a more individualized holistic approach, we recommend preoperative psychological screening specifically on children's preexisting internalizing problems, aiming to prevent postoperative pain, sleep problems, and psychosocial problems

in children. For this aim, as a starting point, the short version of the Child Behavior Checklist (ie, the ASEBA Brief Problem Monitoring)¹ could be used which has well-defined cut-off values to screen on psychological vulnerability in children. Through early detection, the healthcare staff are able to attune therapeutic strategies to the individual child and parents. This should ideally lead to the prioritization of behavioral preparation programs.^{2,3} We recommend to use a multi-informant approach in a structural screening, including both self-reports, attuned to (young) children, as well as father's and mother's reports. In clinical practice, screening can be implemented by using privacy secured online tools

to be completed preoperatively at home, or by having a screening tool completed in the hospital waiting room on a PC or tablet.



Considering that more anxious parents had a higher information need, and that parents with a higher information need, reported more postoperative pain for their children, we recommend to provide parents with specific information regarding children's pain management at home. We also found that parental adherence to prescribed pain medication was low. Therefore, parental knowledge gaps and misconceptions regarding pain medication at home (including cultural aspects, parental socio-economic status) should be screened for to identify parents in need for more support (also at home).

Online tools providing such specific information and psychoeducation regarding coping with children's postoperative pain and psychological problems could be implemented. To prepare both children and parents for surgery, preparation tools such as Virtual Reality Exposure Tools,^{4,5} a psychoeducational app, or Skype sessions with the medical staff could reduce anxiety and postoperative pain, enhance coping mechanisms and self-efficacy of the child and parent.

In conclusion, we admit that the holistic approach remains a challenging and even complicated domain. Although there is actually already a lot of knowledge available to identify specific vulnerable children and parents, it is still too fragmentary and its clinical implementation is often limited. To this end, a lot more attention should be given in research to develop specific practical and user-friendly tools that prove useful in a clinical context.

CONFLICT OF INTEREST

No conflicts of interest declared.

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DOI: 10.1111/pan.13795

Comment on: Rehearsing for a rare event: One small step in the right direction

Sir—Dr Howe uses the story of Neil Armstrong's landing on the moon, depicted in the movie "First Man," as an analogy for how we should prepare and train for rare events in anesthesia, and in particular for the Can't Intubate, Can't Oxygenate (CICO) emergency in children.¹ He describes how difficult airways in children are most often predicted and that the emphasis of our pediatric airway management training would be best focussed on common problems,

rather than preparing for the extremely rare CICO event. He further points out that Emergency front of neck access (eFONA) in children is difficult, and is associated with high morbidity and a poor success rate.¹

The APRICOT study has shown that most airway morbidity in children is functional in nature, and is therefore reversible with deepening of anesthesia and muscle paralysis.² Furthermore,