



Current Concepts In the Management Of the Difficult Airway

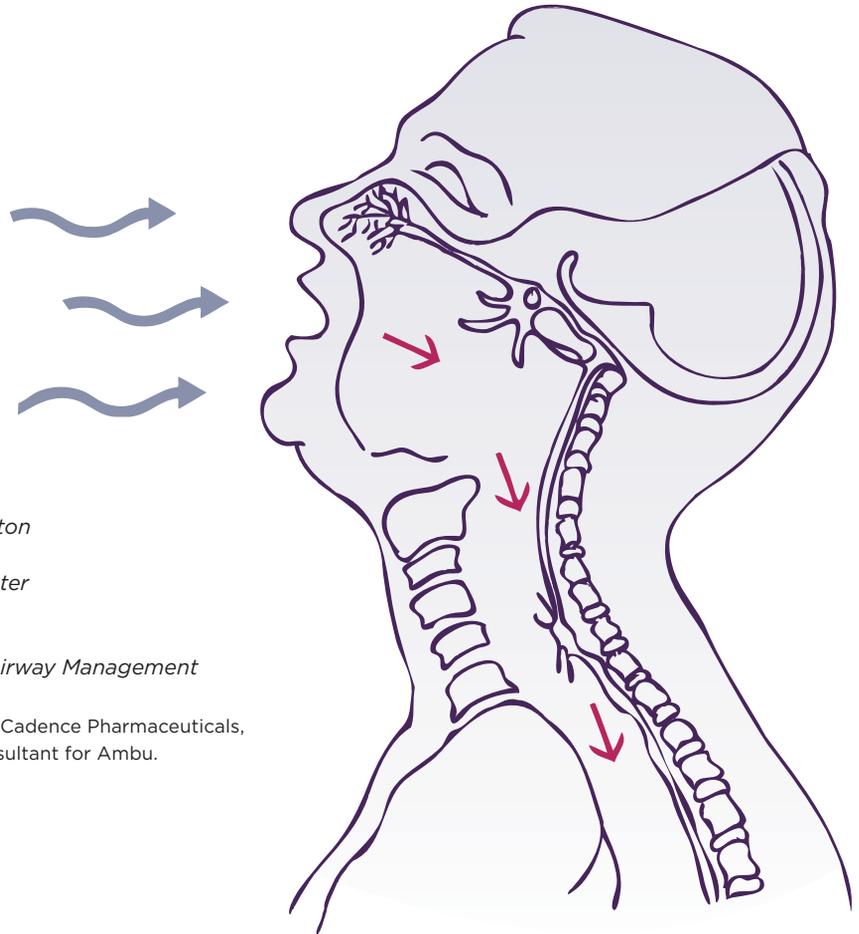
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Management of the difficult airway remains one of the most relevant and challenging tasks for anesthesia care providers. This review focuses on several of the alternative airway management devices/techniques and their clinical applications, with particular emphasis on the difficult or failed airway. It includes descriptions of many new airway devices, several of which have been included in the American Society of Anesthesiologists (ASA) Difficult Airway Algorithm (Figure).

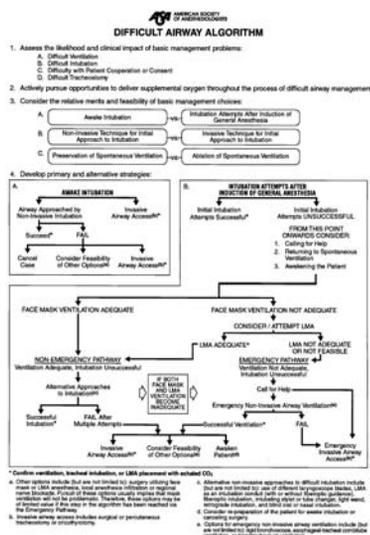


Figure. The ASA Difficult Airway Algorithm.

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The algorithm can be viewed at: www.asahq.org/publicationsAndServices/practiceparam.htm

Alternative Airway Devices

A common factor preventing successful tracheal intubation is the inability to visualize the vocal cords during the performance of direct laryngoscopy. Many devices and techniques are now available to circumvent the problems typically encountered with a difficult airway using conventional direct laryngoscopy.

ENDOTRACHEAL TUBE GUIDES

Several endotracheal tube (ET) guides have been used to aid in intubation or extubation, including both reusable/disposable and solid/hollow introducers, stylets, and tube exchangers (Table 1).

LIGHTED STYLETS

In the past decade, many lighted stylets have been developed, including light wands, which rely on transillumination of the tissues of the anterior neck to demonstrate the location of the tip of the ET—a blind technique, unless combined with direct laryngoscopy, and visual scopes, which use fiber-optic imagery and allow indirect visualization of the airway. They also can be used alone or in conjunction with direct laryngoscopy (Table 2).

VIEWING STYLETS

Viewing stylets provide a view from the tip of the endotracheal tube. Whereas the view from a video laryngoscope is at the end of the laryngoscope, viewing stylets provide a view from the tip of the ET for steering the ET through the cords. The stylet size for this device allows it to be placed within an ET as an independent instrument, or as an adjunct to video or direct laryngoscopy. In addition, some can be used to

place an ET through intubating supraglottic ventilatory devices for visualization of ET placement through the SGA (Table 2A).

RIGID/VIDEO LARYNGOSCOPES

Video-assisted techniques have become pervasive in various surgical disciplines, as well as in anesthesiology. As more video laryngoscopes are introduced into clinical practice, and as airway managers become more skillful with the technique of video-assisted laryngoscopy, it could well become standard procedure for patients with known or suspected difficult airways. It also may become the standard for routine intubations as the equipment and users' skills improve and the cost of the devices decreases, with the potential for important savings in time and decreased morbidity in patients. It is beyond the scope of this review to discuss all of the laryngoscopes that have been manufactured; thus, only some of the most recently developed blades will be described (Table 3).

INDIRECT RIGID FIBER-OPTIC LARYNGOSCOPES

These laryngoscopes were designed to facilitate tracheal intubation in the same population that would be considered for flexible fiber-optic bronchoscopy, such as patients with limited mouth opening or neck movement. Relative to the flexible fiber-optic bronchoscopes (FOBs), they are more rugged in design, control soft tissue better, allow for better management of secretions, are more portable (with the exception of the new portable FOBs), and are not as costly. Intubation can be performed via the nasal or oral route and can be accomplished in awake or anesthetized patients (Table 4).

SUPRAGLOTTIC VENTILATORY DEVICES

The Laryngeal Mask Airway (LMA, LMA North America, a Teleflex Company) is the single most important development in airway devices in the past 25 years. Since its introduction into clinical practice, it has been used in more than 200 million patients worldwide with no reported deaths. Other supraglottic ventilatory devices are available for routine or rescue situations. The most recently developed supraglottic ventilatory devices have a gastric channel or are intended to be used as a conduit for fiber-optic guided intubation (Table 5).

Special Airway Techniques

AWAKE INTUBATION

For managing patients in whom a difficult airway is suspected or anticipated, securing the airway before induction of general anesthesia adds to the safety of anesthesia and helps minimize the possibility of major complications, including hypoxic brain damage and death. To perform awake intubation, the patient must be adequately prepared for the procedure. Good topical anesthesia is essential to obtund airway reflexes and can be provided by various topical agents and administrative devices (Table 6). Other relatively new devices

can be used to best position patients and maintain an open airway during awake intubation (Table 7).

Atomizing devices currently available for delivering topical anesthesia to nasal, oral, pharyngeal, laryngeal, and tracheal tissues include the DeVilbiss Model 15 Medical Atomizer (DeVilbiss Healthcare), the Enk Fiber-optic Atomizer Set (Cook Medical), and the LMA MADgic Laryngo-Tracheal Atomizer (LMA North America, a Teleflex Company). Although any technique of tracheal intubation can be performed under topical anesthesia, flexible fiber-optic intubation is most commonly used.

FLEXIBLE FIBER-OPTIC INTUBATION

Flexible fiber-optic intubation is a very reliable approach to difficult airway management and assessment. It has a more universal application than any other technique. It can be used orally or nasally for both upper and lower airway problems and when access to the airway is limited, as well as in patients of any age and in any position. Technological advances—including improved optics, battery-powered light sources, better aspiration capabilities, increased angulation capabilities, and improved reprocessing procedures have been developed. The Airway Mobilescope (MAF; Olympus) is a portable, flexible endoscope with expanded viewing and recording capability, incorporating a monitor, LED light source, battery and recording device in a single unit. A completely disposable system, the aScope (Ambu) also is available. Rescue techniques, such as direct laryngoscopy and placing a retrograde guidewire through the suction channel, may be used if the glottic opening cannot be located with the scope, or if blood or secretions are present. Insufflation of oxygen or jet ventilation through the suction channel may provide oxygen throughout the procedure, and allow additional time when difficulty arises in passing the ET into the trachea.

RETROGRADE INTUBATION

Retrograde intubation (Table 6) is an excellent technique for securing a difficult airway either alone or in conjunction with other airway techniques. Every anesthesia care provider should be skilled in employing this simple, straightforward technique. It is especially useful in patients with limited neck mobility (that is associated with cervical spine pathology, or in those who have suffered airway trauma). Cook Medical has 2 retrograde intubation sets: a 6.0 Fr for placing tubes of 2.5 mm or greater ID, and a 14.0 Fr for placing tubes of 5.0 mm or greater ID.

TRANSTRACHEAL JET VENTILATION

Transtacheal jet ventilation (TTJV) is a well-accepted method for securing ventilation in rigid and interventional bronchoscopy, and there are several commercial manual jet ventilation devices available (Table 6). The Enk Oxygen Flow Modulator (Cook Medical) is a device recommended for use when jet ventilation is appropriate but a jet ventilator is not available. A MRI

Conditional 3.0 Tesla manual jet ventilator (Anesthesia Associates, Inc., AincA) is also now available to enable TTJV in the MRI suite for both planned and emergency procedures (Table 6).

CRICOTHYROTOMY

Cricothyrotomy (Table 8), a lifesaving procedure, is the final option for “cannot-intubate, cannot-ventilate” patients according to all airway algorithms, whether they concern prehospital, emergency department, intensive care unit, or operating room patients.

In adults, needle cricothyrotomy should be performed with catheters at least 4 cm and up to 14 cm in length. A 6 Fr reinforced fluorinated ethylene propylene Emergency Transtracheal Airway Catheter (Cook Medical) has been designed as a kink-resistant catheter for this purpose.

Percutaneous cricothyrotomy involves using the Seldinger technique to gain access to the cricothyroid membrane. Subsequent dilation of the tract permits passage of the emergency airway catheter. Surgical cricothyrotomy is performed by making incisions through the cricothyroid membrane using a scalpel, followed by the insertion of an ET. This is the most rapid technique and should be used when equipment for the less invasive techniques is unavailable and speed is particularly important.

TRACHEOSTOMY

Tracheostomy (Table 9) establishes transcutaneous access to the trachea below the level of the cricoid cartilage. Emergency tracheostomy may be necessary when acute airway loss occurs in children under 10 years of age or children whose cricothyroid space is considered too small for cannulation, as well as in individuals whose laryngeal anatomy has been distorted by the presence of pathologic lesions or infection.

Percutaneous dilatational tracheostomy is the most commonly performed tracheostomy technique, yet it is still considered invasive and can cause trauma to the tracheal wall. Translaryngeal tracheostomy, a newer tracheostomy technique, is considered to be safe and cost-effective, and it can be performed at the bedside. It may be beneficial in patients who are coagulopathic. Surgical tracheostomy is more invasive, and should be performed on an elective basis and in a sterile environment.

Conclusion

Most airway problems can be solved with relatively simple devices and techniques, but clinical judgment born of experience is crucial to their application. As with any intubation technique, practice and routine use will improve performance and may reduce the likelihood of complications. Each airway device has unique properties that may be advantageous in certain situations, yet limiting in others. Specific airway management techniques are greatly influenced by individual disease and anatomy, and successful management may require combinations of devices and techniques.

Table 1. Endotracheal Tube Guides

Name (Manufacturer)	Description	Length, cm	
Aintree Intubation Catheter (Cook Medical)	Polyethylene 19 Fr AEC allows passage of an FOB through its lumen. Has 2 distal side holes and is packaged with Rapi-Fit adapters. Color: light blue.	56	
Arndt Airway Exchange Catheter Set (Cook Medical)	Polyethylene 8 and 14 Fr AEC with a tapered end, multiple side ports, packaged with a stiff wire guide, bronchoscope port, and Rapi-Fit adapters. Color: yellow.	50, 65, 78	
Cook Airway Exchange Catheters (Cook Medical)	8, 11, 14, and 19 F Polyethylene designs facilitate exchange of SLT or DLT of ≥ 4.0 mm ID. The DLT versions are extra firm with soft-tips. Colors: Yellow, green; soft-tip is purple.	43, 83, 100	
Cook Staged Extubation Set (Cook Medical) (Available outside of USA only)	Soft-tipped marked extubation wire to maintain continuous airway access, wire holder and Tegaderm for securement, soft-tipped Reintubation Catheter, Rapi-Fit adapters to assist in oxygen delivery, if necessary.	This set can facilitate reintroduction of ETs with ID >5 mm.	
CoPilot VL Single-Use Bougie (Magaw Medical)	14 Fr polyethylene single-use ET introducer with coudé tip.	60 cm length. For use with ETs ≥ 6.0 mm ID.	
CoPilot VL Rigid Stylet (Magaw Medical)	Reusable CoPilot VL intubation stylet.	For use with ET ≥ 6.0 mm ID.	
Frova Intubating Introducer (Cook Medical)	Polyethylene 8 and 14 Fr AEC with angled distal tip with 2 side ports. Has hollow lumen and is packaged with a stiffening cannula and removable Rapi-Fit adapters. 14 Fr also packaged in box of 10. Colors: 8 Fr, yellow; 14 Fr, blue.	35, 65	
GlideRite Rigid Stylet (Verathon)	Reusable, sterilizable, semirigid stylet that conforms to GlideScope unique blade angulation; provides improved maneuverability in ET placement.	Stylet rod length is 26.6 cm. Accommodates ETs ≥ 6.0 mm ID.	
Introes Pocket Bougie (BOMImed)	Single-use 14 Fr (4.7 mm) malleable ET introducer made from special blend of Teflon. Packaged in box of 10.	60 accommodates ETs ≥ 5.0 mm ID.	
Muallem ET Tube Stylet (VBM Medizintechnik GmbH)	Single-use 8, 12, 14 Fr stylet; malleable, but with soft and atraumatic coudé tip. Color: green.	40, 65	
OptiShape Stylet (Truphatek International Ltd)	Reusable, sterilizable, semirigid stylet with optimal shape memory for indirect intubation procedures.	4 sizes. Accommodates ETs 2.5-3.5, 4.0-5.5, 5.0-6.5, and 7.0-9.0 mm ID.	
Pocket Introducer (VBM Medizintechnik GmbH)	Single-use 15 Fr Introducer with coudé tip. Color: blue.	65	
Portex Venn Tracheal Tube Introducer (Smiths Medical)	15 Fr ET introducer made from a woven polyester base, with a coudé tip (angled 35 degrees at its distal end). Also known as the gum elastic bougie. Color: golden brown.	60	
Single-Use Bougie (Smiths Medical)	15 Fr, PVC ET introducer with coudé tip. Has a hollow lumen that discourages reuse and is provided sterile. Color: ivory.	70	
Truflex Flexible Stylet (Truphatek International Ltd)	Reusable, stainless steel stylet. Has flexible tip with upward lift action of 30-60 degrees, depending on size of ET.	Suitable for use with ETs 6.5-8.5 mm ID.	

Abbreviation key for all tables is on page 28.

Clinical Applications	Special Features
Exchange of SGAs for ETs ≥ 7.0 mm using an FOB. Its hollow lumen allows insertion of an FOB directly through the catheter so that the airway can be indirectly visualized.	Large lumen (4.7 mm) allows passage of FOB. Rapi-Fit adapters allow both jet ventilation and ventilation with 15-mm adapter (anesthesia circuit or Ambu bag). Single use.
Exchange of LMAs and ETs using an FOB.	Tapered end and multiple side ports. Rapi-Fit adapters allow both jet ventilation and ventilation with 15-mm adapter (anesthesia circuit or Ambu bag). Single use.
The Cook airway exchange catheter is intended for uncomplicated, atraumatic, ET exchange for both single- and double-lumen tubes.	EF with 2 distal side holes. The soft-tip version offers a more flexible tip to help minimize tracheal trauma. Rapi-Fit adapters as above, but should be used primarily for jet ventilation because of length. Single use.
Provides a tool for a more complete extubation strategy, which should be in place for every patient.	Utilizes an atraumatic wire to maintain continuous airway access and a soft-tipped reintubation catheter to facilitate a successful reintubation if required and delivery of oxygen when desired.
Facilitate endotracheal intubation.	
Designed to shape the ET and facilitate intubation with VL.	
Facilitates endotracheal intubation and allows simple ET exchange. Can also be used by placing it first in the ET, with its tip protruding, or placing it directly into the glottis and then placing the ET over it.	Can be used in pediatric population for ETs as small as 3.0 mm. Hollow lumen allows oxygenation/ventilation in all sizes. Single use.
Designed to work with GlideScope AVL, GVL, Cobalt, and Ranger video laryngoscopes to facilitate intubations in OR, ED, and emergency settings.	Reusable, durable stainless steel; easy to clean and sterilize in an autoclave.
Designed to facilitate endotracheal Intubation for both direct and video laryngoscopy. Unique curvature designed to follow natural path of the airway. Flexibility allows for manipulation of distal tip for anterior airways. Customizable coude tip angles.	Self-lubricated bougie, Tactiglide technology for tactile sensation, optimal curve with shape memory, balanced rigidity with soft tissue protection, non-removable depth markings, packaged sterile.
Difficult intubation.	Malleable stylet with soft coude tip and graduation marks for insertion depth.
Facilitates smooth passage of ET in both routine and difficult intubations. Especially useful in combination with the variety of video laryngoscopes that employ >42 -degree angles. Designed with the ideal curve to closely follow the blade shape and ensure successful passage of ET through vocal cords.	Easily adjustable to a variety of ET sizes. Suitable for use in combination with a variety of video laryngoscopes that employ >42 -degree angle of vision.
Facilitates endotracheal intubation.	Folded to only 20 cm, unfolds to 65 cm within seconds, ideal space solution for emergency bags.
Proven useful in patients with an anterior larynx (grades 2b, 3, and 4) and those with limited mouth opening. Can be used by slightly protruding through the ET, or placing it directly into the glottis and then placing an ET over it.	Non-disposable and reusable. Size 5 Fr is single use. Has memory properties. Coude tip effectively detects "tracheal clicks" to confirm correct placement. Part of a range of introducers, stylets, and guides for adults and pediatrics. Can be reused after cold-water disinfection.
Single-use product reduces the risk for cross-contamination. Otherwise, same as Portex Venn Tracheal Tube Introducer.	Similar to Portex Venn Tracheal Tube Introducer, but hollow lumen allows oxygenation/ventilation. Single use.
Eases clinical coordination difficulties associated with use of video laryngoscopes by providing greater control of ET tip direction.	Adjustable stopper allows use with e-tubes of differing lengths.

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Table 1. Endotracheal Tube Guides (continued)

Name (Manufacturer)	Description	Length, cm
VBM Introducer (VBM Medizintechnik GmbH)	Single-use 15 Fr introducer with coude tip and hollow for oxygenation. Color: orange.	65
VBM Tube Exchanger (VBM Medizintechnik GmbH)	Single-use 11, 14, and 19 Fr tube exchanger that is hollow to allow oxygenation. Color: blue.	80

Table 2. Lighted Stylets

Name (Manufacturer)	Description	Size
Aaron Surch-Lite (Bovie Medical Industries, Inc.)	10-in sterile, single-use, flexible stylet.	Adult.
AincA Lighted Stylet (Anesthesia Associates, Inc.)	Easily malleable, lighted stylet with adjustable ET holder. Shapes and guides ET while forwardly illuminating the passage. Completely reusable device consisting of removable handle with xenon bulb.	Adult and children (ETs ≥ 5 mm). Infant (ETs ≥ 3 mm).
Rüsch Trachlight Stylet & Tracheal Light Wand (Teleflex Medical)	Consists of 3 parts: a reusable handle, a flexible wand, and a stiff retractable stylet.	Available in 3 sizes: adult, child, and infant. Accommodates ETs 3.0-10.0 mm ID.
Tube-Stat Lighted Intubation Stylet (Medtronic)	Similar to AincA lighted stylet.	Nasotracheal: 33 cm shaft. Orotacheal: 25 cm shaft.
Vital Signs Light Wand Illuminating Stylet (GE Healthcare)	Similar to AincA lighted stylet.	Adult.

Table 2A. Viewing Stylets

Name (Manufacturer)	Description	Size
AincA VideoStylet (Anesthesia Associates, Inc.)	Easily malleable, video imaging stylet with built-in ET holder. Shapes and guides ET while forwardly illuminating the passage and providing color image. Completely reusable device consisting of removable VideoStylet and attached rechargeable LCD monitor.	Adult and children (ETs ≥ 6 mm).
air-Vu Plus Fiber-optic Stylet (Cookgas LLC; distributed by Mercury Medical)	High-resolution, stainless steel, rigid stylet. Incorporates an adjustable tube stop and optional oxygen port for oxygen insufflation.	Adult (ETs ≥ 5.5 mm).
Bonfils Retromolar Intubation Endoscope (KARL STORZ Endoscopy)	High-resolution rigid fiber-optic stylet with a fixed 40-degree curved shape at the distal end. Available with a standard eyepiece or with a DCI to endoscopic camera system. Can be used within the C-MAC system while using the portable monitor of the C-MAC VL with C-CAM camera head.	3.5 and 5.0 mm OD. ET must be ≥ 0.5 mm larger to fit.

Clinical Applications	Special Features
Difficult intubation with oxygenation possibility.	Supplied with unique removable connector to allow oxygenation with 15-mm connector or jet. Graduation marks for insertion depth.
Exchange of tracheal tubes.	Similar to Muallem ET Tube Introducer.

Clinical Applications	Special Features
Although usable for routine blind intubations or additional illumination during laryngoscopy, it is especially useful when the FOB is unavailable (eg, outside locations or ambulances), or when bronchoscopy is difficult to perform (eg, obscured airway or limited head motion allowed).	Can be used alone or with other techniques. System is completely disposable. Intended for single use. Individually packaged in boxes of 3.
Same as Aaron Surch-Lite.	Can be used alone or with other techniques. Handle-mounted xenon light source is always on and keeps stylet tip cold. Uses 2 AA batteries. System is completely reusable and sterilizable.
Although it can be used for routine intubations, it is especially useful in situations in which the FOB is unavailable (eg, in ambulances or outside locations), or in which bronchoscopy is difficult to perform (eg, when an airway is obscured by blood or secretions or when a patient's head cannot be flexed or extended).	Blind technique that can be used alone or with other techniques.
Ideal for difficult intubations, teaching.	Minimizes neck flexion and head hyperextension in trauma cases.

Clinical Applications	Special Features
Although usable for routine intubations or video imaging during laryngoscopy, it is especially useful when the FOB is unavailable (eg, outside locations or ambulances), or when bronchoscopy is difficult to perform (eg, obscured airway or limited head motion allowed). Low price allows for multiple units in all critical locations and reusable nature ensures economy of use.	Provides rapid learning curve due to similarity to standard ET advancement techniques, but with the added benefit of an attached, clear video image of all landmarks forward of the ET tip. Allows for one-handed use with imaging or used in conjunction with a laryngoscope, as desired for physical alignment.
Allows for visualization during intubation through an air-Q laryngeal mask.	A portable, durable rigid stylet that allows for a fiber-optic view during intubation through the air-Q. Light source options include GreenLine laryngoscope handle or fiber-optic light source (4 AA batteries).
Able to elevate a large, floppy epiglottis and navigate through the oropharynx of patients with excessive pharyngeal soft tissue, midline obstruction, limited mouth opening, or fragile veneers on incisors.	Fixed-shape shaft with an adjustable eyepiece that allows ergonomic movement during intubation, in addition to an adapter for fixation of ETs and oxygen insufflation. Portable, rugged, and better maneuverability than the flexible FOB. Used with a battery-powered or portable light source.

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Table 2A. Viewing Stylets (continued)

Name (Manufacturer)	Description	Size	
Brambrink Intubation Endoscope (KARL STORZ Endoscopy)	High-resolution semi-rigid fiber-optic stylet with a 40-degree curved shape at the distal end, 40× magnification, a fixed eyepiece, a movable ET holder, and an insufflation port.	2.0 mm OD. ET must be ≥0.5 mm larger to fit.	
Clarus Video System 30000V (Clarus Medical)	Malleable (shapeable) rigid stylet scope with attached LCD screen and adjustable curve shape provides view from end of stylet; USB for recharging lithium ion battery and option to connect to notebook or monitor; red LED for transillumination. Assist with DL/VL or used as independent device. Also malleable to be used through intubating supraglottic ventilatory devices.	5 mm OD. ETs ≥5.5 mm.	
Levitan GLS (Clarus Medical)	Portable high-resolution optics from end of stylet, malleable (shapeable) rigid stainless steel stylet that protects the illumination optic fibers. Comes in a preformed hockey-stick shape that can be changed, if necessary. Built-in tube stop to hold ET in place with integral oxygen port for oxygen insufflation during intubation. Assist with DL/VL like regular stylet or used as independent device. Also malleable to be used through intubating supraglottic ventilatory devices. Optional adapter uses smartphones to transform optics to video.	Adult (ETs ≥5.5 mm ID).	
PocketScope (Clarus Medical)	Conveniently sized, easy to clean, and cost-effective (reusable) flexible stylet that has a patented, deflected, non-directable tip. Optional adapter uses smartphones to transform optics to video. Often used to confirm placement and patency of airways.	Adult (ETs ≥4.0 mm ID).	
SensaScope (Acutronic Medical Systems AG)	Hybrid S-shaped, semi-rigid fiber-optic intubation video stylet. Has a 3 cm steerable tip with video chip that can be flexed in sagittal plane 75 degrees in both directions with lever at proximal end of device. Has no working channel.	6.0 mm OD. ET must be >0.5 mm larger to fit.	
Shikani Optical Stylet (SOS; Clarus Medical)	Viewing stylet: High-resolution, stainless steel, malleable (shapeable) fiber-optic stylet that comes in a preformed hockey-stick shape. Has an adjustable tube stop and integral oxygen port for oxygen insufflation. Use to assist with DL/VL like regular stylet or used as independent device. Also malleable to be used through intubating supraglottic ventilatory devices. Optional adapter uses smartphones to transform optics to video.	Adult (ETs ≥5.5 mm ID). Pediatric (ETs 2.5-5.0 mm ID).	

Table 3. Rigid/Video Laryngoscopes

Name (Manufacturer)	Description	Size	
Airtraq Avant (Prodol Meditec SA; distributed by Airtraq LLC)	Disposable video laryngoscope that provides a magnified angular view of the glottis without alignment of oral, pharyngeal, and tracheal axes. Includes a guiding channel to both hold and direct ET toward the vocal cords. Reusable optic piece (up to 50 intubations) and anti-fog heater resists lens clouding. Disposable blade and eyecup.	Regular adult for ET 7.0-8.5 mm ID. Small adult for ET 6.0-7.5 mm ID.	
Airtraq SP (Prodol Meditec SA; distributed by Airtraq LLC)	The SP model is single-use with all the features of the Avant but fully disposable. Both Airtraq models have an optional snap-on camera, with integrated 2.8" Touch Screen that flips and rotates on 2 axes and can be attached to all Airtraq models. It records and can Wi-Fi connect to iPad/iPhone/PC.	6 color-coded sizes available: regular adult for ET 7.0-8.5 mm ID; small adult for ET 6.0-7.5 mm ID; pediatric for ET 4.0-5.5 mm ID; infant for ET 2.5-3.5 mm ID; non-channeled blade; and double-lumen endobronchial tubes.	

Clinical Applications	Special Features
Similar to Bonfils Retromolar Intubation Fiberscope.	Available for DCI video cameras.
ET intubation, confirmation, extubation (with video); LMA placement, positioning, and intubation with certain LMAs. Provides access with limited mouth opening; malleable stylet provides shaping to reduce cervical movement.	Red LED provides better illumination than the white LED, and better transillumination when used like a light wand in cases when use of the scope is contraindicated because of blood or vomit.
Originally designed as an adjunct to direct laryngoscopy. Many use it as a stand-alone device similar to the Shikani for intubation, cric/trach tubes, LMAs, and intubation through LMAs or just positioning or checking placement of the same.	GreenLine laryngoscope handle or a Turbo LED can be used for light sources. Very similar to the SOS, but requires the user to cut the ET because it does not have a movable tube stop.
Allows for visualization during intubation through ILMA or quick confirmation of SGA, DLTs, or ET placement/positioning patency. May also be used for extubation.	This device has been modified with a patented deflected tip that allows it to be used for viewing while performing nasal intubation.
Similar to Brambrink Intubation Endoscope.	Offers an improved view of glottis, simultaneous direct and endoscopic views, full visual control over passage of ET, and confirmation of final position. No need for extreme head extension or forced traction of laryngoscope. Can be rapidly assembled for immediate use.
Similar to flexible FOB. Can be used alone or as an adjunct to laryngoscopy and is especially useful for those unable to maintain skills with a bronchoscope.	Has the simple form of a standard stylet, plus the advantage of a fiber-optic view and maneuverability of its tip. Portable, rugged, and able to lift tissue. Light source options are light cable, Turbo LED or GreenLine laryngoscope handle with adapter.

Clinical Applications	Special Features
Intended to facilitate intubation in both routine and difficult airway situations. Useful in all cases where ET intubation is desired. Also appropriate for emergency settings, cervical spine immobilization, fiberscope guidance, tube exchange, and foreign body removal.	Optics fully isolated from patient, preventing cross-contamination. Advanced airway device with built-in anti-fog system, and low-temperature light source. Can be used with standard ETs. Integral tracking channel allows ET to be directed without a stylet or bougie. May be used in MRI suite as MRI-compatible.
Same as Airtraq Avant.	Same as Airtraq Avant but totally disposable and self-contained. 3-year shelf-life.

table continues on next page

Table 3. Rigid/Video Laryngoscopes (continued)

Name (Manufacturer)	Description	Size
Berci-Kaplan DCI Video Laryngoscope System (KARL STORZ Endoscopy)	Video laryngoscope system with interchangeable laryngoscope blades. Platform system enables a DCI camera head to snap onto any standard eyepiece fiberscopes (flexible or semi-rigid). Required components include a camera control unit, xenon light source, and monitor. Telepack portable combination video/light source/monitor unit is also available for use with this system.	MAC 2-4, Miller 0, 1, 4, Dörge universal blade and D-Blade for difficult very anterior airways.
C-MAC Video Laryngoscope (KARL STORZ Endoscopy)	Instant on, battery-powered video laryngoscope with standard shaped interchangeable Macintosh and Miller blades for obese adults through neonates as well as a difficult airway blade (D-Blade) for very anterior airways. Blades house high-resolution CMOS distal chip and LED technology. Real-time viewing on 7-inch LCD monitor. Dörge D-Blade has angle of view that is approximately 80 degrees acute curvature design.	MAC 2-4, Miller 0 and 1, MAC 3 and 4 with channel for suction, D-Blade, and S-Blade (single-use).
C-MAC Pocket Monitor (KARL STORZ Endoscopy)	Highly portable rescue device, 2.4-in monitor fits directly on all C-MAC blades. LCD 4.3 ratio high-resolution screen works in direct sunlight; rechargeable battery lasts one hour; ergonomic screen can be moved in several directions and folded away for transportation; fully immersible.	Same as C-MAC.
CoPilot VL (Magaw Medical)	Next-generation portable VL with an acutely angled blade and C-shaped channel for a bougie. Rechargeable lithium polymer internal battery provides over 2 hours of continuous use. Built-in anti-fog mechanism.	Adult sizes 3 and 4.
GlideScope Titanium Video Laryngoscope (Verathon)	GlideScope Titanium systems are available in reusable or single-use options and feature streamlined, low-profile blade designs and durable, lightweight titanium construction. Built-in anti-fog mechanism.	4 blade designs available in reusable or disposable format: LoPro 3 & 4 angled blades, and Mac-style 3 & 4 blades. Compatible with full line of GlideScope AVL pediatric blades.
GlideScope AVL (Advanced Video Laryngoscope; Verathon)	Portable advanced VL features a digital color monitor and digital camera for DVD clarity. Also includes integrated real-time recording and onboard video tutorial. Anti-fog feature to resist lens fogging. Reusable and single-use options available.	6 disposable blades, sizes 0-4. Reusable blades in 4 sizes: GVL 2-5.
GlideScope Ranger and Ranger Single Use Video Laryngoscopes (Verathon)	Portable video laryngoscope designed for EMS and military paramedics. Compact and rugged. Operational in seconds.	Reusable Ranger offers 2 blade sizes, 3 and 4. Ranger Single Use is offered with 6 disposable Stats sizes 0-4.
King Vision Video Laryngoscope (Ambu Inc.)	Durable, fully portable digital video laryngoscope with a high-quality reusable display and disposable blades. Display aligned with blade, ergonomic handle integrated into blade, the disposable blades incorporate the camera and light source, anti-fog coating on distal lens. Channel is soft, allowing for easy ET detachment.	One size, 2 versions, correlating to size 3 laryngoscope. Channeled blade allows use of 6.0 to 8.0 mm ET and minimum mouth opening of 18 mm. Standard blade requires minimum mouth opening of 13 mm.
McGrath MAC (Aircraft Medical Ltd; distributed by Covidien)	Portable VL designed for everyday use in the OR, ICU, and ED. Uses disposable Macintosh shaped blades as well as acutely curved X3 Blade. Durable (drop tested up to 2 m). Screen displays minute-by-minute battery life countdown.	Blade sizes 2, 3, and 4 and X3.

Clinical Applications	Special Features
Useful for anterior airways, obese patients, and patients with limited mouth opening or neck extension. Variety of blade sizes and designs accommodates patients ranging from morbidly obese to neonate (500 g). Additionally useful for teaching purposes, verification of ET position, aiding application of external laryngeal manipulation, or passage of an intubating introducer. May also be used for nasal intubation and ET exchange.	The wide-angle camera allows improved visualization and video documentation of laryngoscopy and intubation. Extreme positioning of the head is unnecessary. Blades provide 80-degree field of view.
Same as DCI. Highly portable system for use in all hospital settings.	Unique platform design is compatible with multiple intubation devices, including video laryngoscopes, the F.I.V.E. distal chip flexible video scopes, and standard eyepiece scopes (fiber-optic and semi-rigid) via C-CAM camera head. Built-in still and video image capture on memory card, with real-time playback on monitor. Angled distal lens provides 80-degree field of view. Inherent anti-fog design. Unit can be pole-mounted or inserted into waterproof field bag. No special ETs or stylets needed. Can be used while battery is charging.
Ideal for ICU, crash carts, ED and all prehospital environments including EMS, ambulatory services, air transport, and military. Has familiar blade design and 80-degree field of view.	Lightweight, handheld, and battery-operated device well suited for areas outside the OR. Waterproof.
Same as DCI.	Patent-pending Bougie Port is designed to enhance glottic entry. A 14 Fr suction catheter, FOB, reusable rigid stylets, or regular malleable stylets may also be used via this port. A built-in heating mechanism helps prevent fogging.
More VL options for routine and difficult airways—including new Mac-style blades—provide clinicians with a choice of airway tools for a wide range of patients, clinical settings, and teaching purposes.	Reusable blades and video cable, as well as the single-use Smart Cable, can be completely immersed in the recommended cleaning solution (IPX8 compliant). Includes anti-fog capability, plus real-time recording, display, and playback features on 6.4-in digital, color GlideScope Video Monitor.
DVD-quality airway view enables intubation in a wide range of adult and pediatric patients, including preterm/small child and morbidly obese, bloody or anterior airways, and patients with limited neck mobility. Optimized for demanding applications in the OR, ED, ICU, and NICU. Can be used for teaching.	Real-time recording, onboard video tutorial, anti-fog feature to resist lens fogging, advanced resolution output to an external monitor, intuitive user controls and status icons, lightweight and easily transportable, impact-resistant, durable polycarbonate-coated video screen. Disposable blades allow quick turnaround and help limit the possibility of cross-contamination.
Ideal for EMS (ground and air), military, ED, ICU, and crash cart settings. Offers same benefits as AVL, GVL.	Ranger models are compact, rugged, portable, and built to military and EMS specifications. Powered by rechargeable lithium polymer battery; 1.5 lb. Awarded US Army Airworthiness and US Air Force Safe-to-Fly certifications. Reusable and disposable.
Facilitates both routine and difficult intubations.	Can be used alone or with other techniques. Powered by 3 AAA batteries. OLED screen allows wide-angle viewing in various lighting conditions. Video out available for connection to external display or video capture device.
Its dual capability combines the benefits of a video-supported anterior view as well as a direct visualization to support a wide range of airways from routine to more extreme cases.	Does not require additional training. Supports direct and indirect visualization due to video support. Blade is very slimline for improved agility. Blade shape requires less tube curvature than other video laryngoscopes for easier insertion and a stylet is not always required. Highly portable and lightweight. Does not require an electrical outlet and thus is ideal for settings outside the OR. Uses disposable blades for quick turnaround between uses and for limiting cross-contamination. The monitor is located on the handle to remain in a more natural line. Waterproof.

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Table 3. Rigid/Video Laryngoscopes (continued)

Name (Manufacturer)	Description	Size
McGrath Series 5 Video Laryngoscope (Aircraft Medical Ltd; distributed by LMA North America, a Teleflex Company)	Portable VL with adjustable-length single-use disposable blade that can be disarticulated from the handle to further assist with difficult airways. The flat screen monitor is located on the handle to remain in a more natural line of sight with the patient. The McGrath Series 5 HLDi is the new “High Level Disinfection Immersible” system that is entirely waterproof.	Adjusts to fit many adult and pediatric sizes.
Truview PCD-R Optical Laryngoscope blades with recording capabilities (Truphatek International Ltd)	Fully portable, lightweight and compact system with interchangeable, low-profile, stainless steel 47-degree angled narrow tip laryngoscope blades with built-in oxygen delivery system. Can be used independently or magnetically linked to the camera and 5-in LCD color monitor with picture and video recording capabilities.	Blade sizes 0, 1, 2, 3, and 4.
Venner AP Advance Video Laryngoscope (Venner Capital S.A.)	Fully portable VL with 3.5-in monitor that attaches to a reusable handle. Self-contained LED light source. Built-in anti-fogging mechanism.	MAC 3 and 4, and Difficult Airway Blade.
VividTrac (Mercury Medical/ FujiFilm/SonoSite)	Video intubation device that works on many computer systems equipped with USB II port as a standard USB camera, using available video camera applications on Windows, Mac, and Linux systems. Alternatively, automated video display software (VividVision) can be downloaded.	ET 6.0-8.5 mm.

Table 4. Indirect Rigid Fiber-Optic Laryngoscopes

Name (Manufacturer)	Description	Size
Dörge Emergency Laryngoscope Blade (KARL STORZ Endoscopy)	Developed in Europe as a universal blade that combines features of both the MAC and Miller laryngoscope blades.	One size only for patients >10 kg to adult.
Modified MAC Blades		
AincA Flex-Tip Fiber-Optic Laryngoscope Blade (Anesthesia Associates, Inc.)	Flexible tip or levering fiber-optic MAC laryngoscope blades are designed with a hinged tip controlled by a lever at the proximal end. Designed to fit standard handles.	Adult sizes 3 and 4. Pediatric size 2.
Flipper (Teleflex Medical)		Adult sizes only.
Heine Flex Tip Fiber-Optic Laryngoscope Blade (Heine USA, Ltd.)		
AincA Macintosh Viewing Prisms (Anesthesia Associates, Inc.)	An optically polished viewing prism for attachment to most Macintosh laryngoscope blades (conventional OR fiber-optic). Effectively repositions the practitioner’s viewpoint to the forward portion of the MAC curve via a 30-degree refraction without inverting the image. Clips to the vertical flange of the MAC to “look around the curve of the blade.”	Sizes 2, 3, and 4 for use on Macintosh laryngoscope blades of sizes 2, 3, and 4.
Rüsch Truview EVO (Truphatek International Ltd; distributed by Teleflex Medical)	Indirect rigid laryngoscope with specially designed 42-degree blade curvature; fits onto all standard endoscopic camera heads. Provides clear, unmagnified view of the glottis. Oxygen channel for demisting, clearing secretions, and insufflation.	Adult, small adult, and infant sizes.

Clinical Applications	Special Features
Useful in patients with limited mouth opening or head and neck movement, anterior airways; obese patients; patients in whom an increased hemodynamic response is a concern; and for teaching.	Highly portable and lightweight. Uses disposable blades for quick turnaround between uses and for limiting cross-contamination. An adjustable blade allows use of different blade lengths on the spot. Low-profile blade and disarticulating handle can accommodate patients with very limited mouth opening and severely limited movement of the head and neck. The monitor is located on the handle to remain in a more natural line of sight with the patient.
Difficult intubation cases where mouth opening and neck extension are limited and stable oxygen saturation levels are critical.	Blades can be linked to STORZ HD or other endoscopic systems.
Similar to C-MAC VL.	Can be used as traditional laryngoscope and converted to video laryngoscope by attachment of monitor.
Intended to facilitate intubation in both routine and difficult airway situations.	VividTrac is inserted more like an oral airway device (or LMA) than a laryngoscope blade. The ET can be preloaded or inserted once visualization is achieved in the VividTrac tube channel.

Clinical Applications	Special Features
Blade is inserted into the oropharynx to the appropriate depth, which correlates with the patient's size.	Has 10-kg and 20-kg markings on the blade.
Controlled manipulation of large or floppy epiglottis. Also useful in patients with a recessed mandible and decreased mouth opening.	A lever controls the tip angle through 70 degrees during intubation to lift the epiglottis, if necessary, to improve laryngeal visualization.
Useful in patients with a recessed mandible and decreased mouth opening.	
Allows viewing of the vocal cords even in a patient with an anterior airway position. Also useful during nasal intubation (with impaired view) and for postoperative examination of the larynx.	A built-in clip on each prism allows attachment to any Macintosh-type laryngoscope blade that has a standard thickness vertical flange. Usable on both conventional and fiber-optic type MAC blades. Reusable and sterilizable.
Useful for difficult adult and infant airways, including patients with an anterior airway and limited neck extension.	Rugged, portable, easy to maintain. Depth lines on the blade to guide insertion. Can be used with all fiber-optic laryngoscope handles. Designed to provide indirect laryngoscopy with continuous oxygen insufflation. Infant size features an LED light and rechargeable battery.

Table 5. Selected Supraglottic Ventilatory Devices

Name (Manufacturer)	Description	Size
AES The Guardian CPV (AES, Inc.)	All-silicone laryngeal mask with a vented gastric tube and CPV that constantly monitors cuff pressure.	Adult sizes 3, 4, 5.
AES Ultra (AES, Inc.)	All-silicone laryngeal mask with standard cuff valve.	Adult sizes 3, 4, 5, 6.
AES Ultra Clear (AES, Inc.)	Silicone cuff and PVC tube, laryngeal mask with standard cuff valve.	Adult sizes 3, 4, 5, 6.
AES Ultra Clear CPV (AES, Inc.)	Silicone cuff and PVC tube, laryngeal mask with cuff pilot valve (CPV) that constantly monitors cuff pressures.	Pediatric to adult sizes 1, 1½, 2, 2½, 3, 4, 5, 6.
AES Ultra CPV (AES, Inc.)	All-silicone laryngeal mask with CPV that constantly monitors cuff pressures.	Pediatric to adult sizes 1, 1½, 2, 2½, 3, 4, 5, 6.
AES Ultra EX (AES, Inc.; distributed by Anesthesia Associates, Inc.)	All-silicone, multiple-use laryngeal mask (40 uses).	Pediatric to adult sizes 1, 1½, 2, 2½, 3, 4, 5, 6.
AES Ultra Flex CPV (AES, Inc.)	Wire-reinforced, silicone cuff and tube with CPV that constantly monitors pressure changes in the cuff.	Pediatric to adult sizes 1, 1½, 2, 2½, 3, 4, 5, 6.
AES Ultra Flex EX (AES, Inc.; distributed by Anesthesia Associates, Inc.)	All-silicone, wire-reinforced, multiple-use laryngeal mask (40 uses).	Pediatric to adult sizes 1, 1½, 2, 2½, 3, 4, 5, 6.
air-Q Blocker Disposable Laryngeal Mask (Cookgas LLC; distributed by Mercury Medical)	Combines the features of air-Q Disposable Laryngeal Mask, with an additional soft flexible guide tube located to the right of the breathing tube. This channel provides access to the esophagus with a nasogastric tube or Blocker tube that allows clinicians to vent, suction and further block the esophagus.	Sizes (2.5, 3.5, and 4.5) that can accommodate standard ETs up to 8.5 mm. Also available in kits with syringe and lubricant packet.
air-Q Disposable Laryngeal Mask (Cookgas LLC; distributed by Mercury Medical)	Same features as air-Q Reusable Laryngeal Mask, except disposable.	Sizes (1.0, 1.5, 2.0, 2.5, 3.5, and 4.5) that can accommodate standard ETs up to 8.5 mm.
air-Q Reusable Laryngeal Mask (Cookgas LLC; distributed by Mercury Medical)	Hypercurved intubating laryngeal airway that resists kinking, and removable airway connector. Anterior portion of mask is recessed; a larger mask cavity allows intubation using standard ETs. Air-Q removal after intubation is accomplished by using air-Q reusable removal stylet.	Sizes (2.0, 2.5, 3.5, and 4.5) that can accommodate standard ETs 5.5-8.5 mm.
air-Q SP (Cookgas LLC; distributed by Mercury Medical)	Combines the features of the air-Q disposable and reusable laryngeal masks with the added advantage of a self-pressurizing mask. No inflation line or pilot balloon is needed.	Sizes (1.0, 1.5, 2.0, 2.5, 3.5, 4.5) that can accommodate standard ET tubes up to 8.5 mm.
Ambu AuraFlex (Ambu Inc.)	Disposable wire-reinforced flexible LMA.	Adult and pediatric sizes 2-6.

Clinical Applications	Special Features
Similar to LMA Supreme, but with built-in CPV to minimize postoperative sore throat. Color indicator bands provide instant feedback regarding pressure changes.	The CPV detects changes caused by temperature, nitrous oxide levels, and movement within the airway, enabling clinician to maintain a recommended cuff pressure of 60 cm H ₂ O. Single use.
Standard all-silicone SGA.	All silicone. Single use.
Combines all-silicone cuff with PVC tube for cost savings.	All-silicone cuff with PVC tube. Single use.
Similar to AES Ultra CPV.	Similar to AES Ultra CPV.
Similar to LMA Classic, but with built-in CPV to minimize postoperative sore throat. Color indicator bands provide instant feedback regarding pressure changes.	The CPV detects changes caused by temperature, nitrous oxide levels, and movement within the airway, enabling clinician to maintain a recommended cuff pressure of 60 cm H ₂ O. Single use.
Reusable, standard SGA.	40 uses.
Wire-reinforced SGA that accommodates repositioning of the head and neck. Color indicator bands provide instant feedback regarding pressure changes.	Single use. The cuff pressure indicator detects changes caused by temperature, nitrous oxide levels, and movement within the airway. The CPV enables the clinician to maintain a recommended cuff pressure of 60 cm H ₂ O.
Reusable, wire-reinforced SGA, designed to accommodate repositioning of the head and neck during surgery.	40 uses.
Enhanced version of the standard air-Q. It is indicated as a primary airway device when an oral endotracheal tube is not necessary or as an aid to intubation in difficult situations.	The soft guide tube allows access to the posterior pharynx and esophagus by supporting and directing medical instruments beneath the air-Q mask and into the pharynx and esophagus. Medical instruments especially suited are suction catheters, nasogastric tubes up to size 18.0 Fr, and the newly designed air-Q Blocker tubes. The Blocker tubes are designed to suction the pharynx, or suction, vent and block the upper esophagus during use of the air-Q Blocker airway. Removable color-coded connector allows intubation with standard ETs up to 8.5 mm.
Same as air-Q Reusable Laryngeal Mask.	Removable color-coded connector allows intubation with standard ETs up to 8.5 mm.
Similar to both LMA Classic and LMA Fastrach. Allows easy access for flexible fiber-optic devices. Use as routine masked laryngeal airway. Removable connector allows intubation with standard ETs up to 8.5 mm.	Designed to minimize folding of the cuff tip on insertion. Same use and benefits as LMA Classic and LMA Fastrach. Integrated bite block reinforces the tube while diminishing the need for a separate bite block. Color-coded removable connectors are tethered to the airway tube, avoiding episodes of misplaced connectors.
Same as regular air-Q but eliminates the need for mask inflation.	PPV self-pressurizes the mask cuff. On exhalation, mask cuff decompresses to the level of PEEP. Removable connector allows intubation with standard ETs.
Designed for use in ENT, ophthalmic, dental, and torso surgeries.	Integrated pilot tube, and high flexibility enables positioning away from the surgical field, without a loss of seal. Single use. EasyGlide texture and extra-soft cuff ease insertion and removal. Convenient depth marks for monitoring correct position of the mask.

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Table 5. Selected Supraglottic Ventilatory Devices (continued)

Name (Manufacturer)	Description	Size
Ambu Aura-i (Ambu Inc.)	Laryngeal mask with built-in curve and bite blocker designed as a conduit for optical endotracheal intubation.	Adult and pediatric sizes 1-6.
Ambu AuraOnce (Ambu Inc.)	A laryngeal mask with a special built-in curve that replicates natural human anatomy. It is molded in 1 piece with an integrated inflation line and no epiglottic bars on the anterior surface of the cuff.	Adult and pediatric sizes 1-6.
Ambu AuraStraight (Ambu Inc.)	Similar to the LMA Unique but without epiglottic bars on the anterior surface of the cuff.	Adult and pediatric sizes 1-6.
Ambu Aura40 (Ambu Inc.)	Same design as the Ambu AuraOnce, but reusable.	Adult and pediatric sizes 1-6.
Ambu Aura40 Straight (Ambu Inc.)	Similar to the LMA Classic. No epiglottic bars on the anterior surface of the cuff.	Adult and pediatric sizes 1-6.
CobraPLA (Pulmonary)	Large ID laryngeal tube, which is soft and flexible with a tapered, striated tip. Now has an improved distal curve, softer tube, and softer head. It has a high-volume, low-pressure oropharyngeal cuff.	Adult and pediatric sizes ½-6.
CobraPLUS (Pulmonary)	Similar to the CobraPLA. Includes temperature monitor and distal gas sampling in all sizes.	Adult and pediatric sizes ½-6.
Esophageal Tracheal Combitube (Covidien)	A disposable DLT that combines the features of a conventional ET with those of an esophageal obturator airway. Has a large proximal latex oropharyngeal balloon and a distal esophageal low-pressure cuff with 8 ventilatory holes in between.	Two adult sizes. 41 Fr: height >5 ft. 37 Fr: height 4-6 ft.
i-gel (Intersurgical Inc.)	SGA with a noninflating cuff, designed to mirror the anatomy over the laryngeal inlet, with an integral bite block, buccal cavity stabilizer and a gastric channel. It also incorporates a wide-bore airway channel that can be used as a conduit for intubation with fiber-optic guidance (sizes 3, 4, and 5).	Adult sizes 3-5 and pediatric sizes 1-2.5. Adult sizes accommodate ET sizes 6.0-8.0 mm.
i-gel O ₂ Resus Pack (Intersurgical Inc.)	SGA with a supplementary oxygen port, an integral color-coded hook ring for securing of the airway support strap and identification of size and is designed to facilitate ventilation. It also includes a non-inflating cuff to mirror the anatomy, with an integral bite block, buccal cavity stabilizer and a gastric channel. The pack contains an i-gel O ₂ second-generation SGA, a sachet of lubricant and an airway support strap.	Adult sizes 3-5. Adult sizes accommodate ET sizes 6.0-8.0 mm.
KING LT (Ambu Inc.)	Multiuse, latex-free, single-lumen silicone tube with oropharyngeal and esophageal low-pressure cuffs, 2 ventilation outlets, insertion marks, and a blind distal tip (almost like a single-lumen, shortened Combitube). Color-coded connectors for each size.	Sizes 0-5.

Clinical Applications	Special Features
Combines everyday routine use of SGA with direct intubation capability in case of difficult airway situations.	Anatomically correct curve designed as Ambu AuraOnce and Ambu Aura40 but specially designed as a conduit for intubation. Compatible with standard ETs.
Allows easy access for flexible fiber-optic devices. For use in both anesthesia and emergency medicine.	Anatomically correct curve facilitates placement. One-piece mold. EasyGlide texture for ease of insertion. Convenient depth marks for monitoring correct position of the mask. MRI safe. Extra-soft cuff. If intubation becomes necessary or desired, recommend intubation over Aintree AEC. -Single use.
For use in both anesthesia and emergency medicine.	Single-use, one-piece mold. EasyGlide texture for ease of insertion. Convenient depth marks for monitoring correct position of the mask. MRI safe. Extra-soft cuff.
Same as LMA Classic.	Same as LMA Classic, but reusable.
Same as LMA Classic.	Reusable. Available only in the United States.
Same as LMA Classic.	Disposable. If intubation becomes necessary or desired, will accommodate ET up to 8.0 mm. Single use.
Same as LMA Classic. An added benefit is the ability to measure core temperature. In addition, distal CO ₂ can be monitored in pediatric patients.	Similar to CobraPLA, but CobraPLUS allows monitoring of the patient's core temperature. In neonatal and infant patients, CobraPLUS has the ability to increase the accuracy of end-tidal CO ₂ and volatile gas analysis. If intubation becomes necessary or desired, will accommodate ET up to 8.0 mm. Single use.
Same as LMA Classic but not contraindicated in non-fasting patients. Appropriate for prehospital, intraoperative, and emergency use. Especially useful for patients in whom direct visualization of the vocal cords is not possible, patients with massive airway bleeding or regurgitation, limited access to the airway, and patients in whom neck movement is contraindicated.	Ventilation is possible with either tracheal or esophageal intubation. Distal cuff seals off the esophagus to prevent aspiration of gastric contents. Allows passage of an orogastric tube when placed in the esophagus. Single use.
Indicated for use in routine and emergency anesthesia and resuscitation in adult patients. i-gel is not indicated for use in resuscitation in children. Can be used as a conduit for intubation with fiber-optic guidance (sizes 3, 4, and 5). Gastric channel provides an early warning of regurgitation, allows for the passing of a nasogastric tube to empty the stomach contents and can facilitate venting of gas from the stomach (except size 1).	The non-inflating cuff allows easy and rapid insertion, provides high seal pressures and minimizes the risk for tissue compression. Gastric channel provides an early warning of regurgitation. Buccal cavity stabilizer reduces the risk for rotation or displacement and the integral bite block prevents occlusion of the airway channel. The wide-bore airway channel also allows for use as a conduit for intubation with fiber-optic guidance (sizes 3, 4, and 5).
Indicated for use in routine and emergency anesthesia and resuscitation in adult patients. Can be used as a conduit for intubation with fiber-optic guidance. i-gel O ₂ can also be used for providing supplementary oxygen during postoperative care or patient transfer. Gastric channel provides an early warning of regurgitation, allows for the passing of a nasogastric tube to empty the stomach contents and can facilitate venting of gas from the stomach.	The non-inflating cuff allows easy and rapid insertion, provides high seal pressure and minimizes the risk for tissue compression. The supplementary oxygen port allows for the administration of passive oxygenation as a component of cardio-cerebral resuscitation. Gastric channel provides an early warning of regurgitation. Buccal cavity stabilizer reduces the risk for rotation or displacement and the integral bite block prevents occlusion of the airway channel. The wide-bore airway channel also allows for use as a conduit for intubation with fiber-optic guidance.
Same as LMA Classic, but with ventilatory seal characteristics like those of LMA ProSeal.	Easily inserted, possible aspiration protection, and allows both PPV and spontaneous breathing. Reusable (up to 50 times).

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Table 5. Selected Supraglottic Ventilatory Devices *(continued)*

Name (Manufacturer)	Description	Size
KING LT-D (Ambu Inc.)	Same design as the KING LT, except disposable.	Adult sizes 3-5 and pediatric sizes 2, 2.5.
KING LTS (Ambu Inc.)	Double-lumen laryngeal tube that incorporates a second (esophageal) lumen posterior to the ventilation lumen.	Adult sizes 3-5 and pediatric sizes 0, 1, 2, 2.5.
KING LTS-D (Ambu Inc.)	Same as KING LTS, except disposable.	Adult sizes 3-5.
LMA Classic (LMA North America, a Teleflex Company)	Supraglottic ventilatory device that consists of an oval inflatable silicone cuff in continuity with a wide-bore tube that can be connected to an Ambu bag or anesthesia circuit. Designed to fit the pharynx of patients of various weights.	Adult and pediatric sizes 1-6, accommodating ET 3.5-7.0 mm.
LMA Classic Excel (LMA North America, a Teleflex Company)	The Classic Excel has the benefits of LMA Classic and an improved design to facilitate intubation.	Adult and pediatric sizes 3-5.
LMA Fastrach (LMA North America, a Teleflex Company)	Consists of a mask attached to a rigid stainless steel tube curved to align the barrel aperture to the glottic vestibule. The set includes an LMA with a stainless steel shaft covered with silicone (reusable version) and a single movable epiglottic elevating bar, ET stabilizer, and silicone wire-reinforced ET. The single-use Fastrach is made of PVC and includes a disposable wire-reinforced ET.	Adult sizes 3-5 that can accommodate special ETs 6.0-8.0 mm.
LMA Flexible (LMA North America, a Teleflex Company)	Original LMA cuff design attached to smaller diameter, flexible armored tube that allows repositioning of the tube without cuff displacement. New single-use version is easier to insert.	Adult and pediatric sizes 2-6.
LMA ProSeal (LMA North America, a Teleflex Company)	Designed with a modified cuff and dual tubes to separate the respiratory and alimentary tracts. Has a built-in bite block.	Adult and pediatric sizes 1-5.
LMA Supreme (LMA North America, a Teleflex Company)	Has a gastric drain tube designed to suction the stomach, channel gases and fluids away from the airway, and confirm placement of the tip of mask at upper esophageal sphincter. The airway tube has a gentle curve and oblong shape to allow easier insertion and more stable placement.	Adult and pediatric sizes 1-5.
LMA Unique (LMA North America, a Teleflex Company)	Original, disposable LMA design. Sterile, latex-free, available with or without syringe and lubricant. Soft cuff and airway tube allow for conformity to patients' natural anatomy.	Adult and pediatric sizes 1-5.
Rüsch Easy Tube (Teleflex Medical)	Disposable LT that combines the features of a conventional ET with those of an esophageal obturator airway similar in design to the Combitube.	Small 28 Fr; large 41 Fr.
Soft-Seal Laryngeal Mask (Smiths Medical)	Similar in shape to the LMA Unique, but differs in its 1-piece design, in which the cuff is softer and there is no "step" between the tube and the cuff, an integrated inflation line, no epiglottic bars on the anterior surface of the cuff, and a wider ventilation orifice.	Adult and pediatric sizes 1-5.

Clinical Applications	Special Features
Same as KING LT.	Also available in a kit. Single use.
Same as KING LT, except that it has a second lumen for gastric access, similar to LMA ProSeal.	Allows easy passage of a gastric tube to evacuate stomach contents. Distal tip reduced in size to facilitate insertion. Reusable.
Same as KING LTS.	Allows passage of 18 Fr gastric tube. Also available in a kit.
Although originally developed for airway management of routine cases with spontaneous ventilation, it is now listed in the ASA Difficult Airway Algorithm as an airway ventilatory device or a conduit for endotracheal intubation. Can be used in both pediatric and adult patients in whom ventilation with a face mask or intubation is difficult or impossible. Can also be used as a bridge to extubation and with pressure support or PPV.	Reusable.
Same as LMA Classic.	Removable connector and epiglottic elevating bar to facilitate intubation. Works with ET up to 7.5 mm. Reusable up to 60 times.
Useful for ventilation and intubation. Designed for blind orotracheal intubation but can be used with lighted stylets, FOB, or Flexible Airway Scope Tool. FOB recommended when using PVC ET.	Both reusable and disposable versions now available. Can be utilized as a blind or visually guided technique. Benefits include ability to intubate with larger ET and remove the device easily over the ET.
Particularly useful in ENT/head and neck procedures.	Both reusable and disposable versions now available. Airway tube resists kinking and cuff dislodgment, and thus may be positioned away from the surgical field without loss of seal.
Same as LMA Classic except drain tube also allows for evacuation of stomach contents.	Second cuff allows tighter seal for PPV. Reusable.
Same as LMA ProSeal.	A single-use LMA with a redesigned mask that achieves a 50% higher seal pressure than the Classic or Unique. Similar to all LMAs, the Supreme is designed to protect the airway from epiglottic obstruction—in this model with molded fins in the bowl of the mask.
Same as LMA Classic. Included in AHA 2000 Guidelines for CPR and Emergency Medicine Cardiovascular Care.	Single use.
Same as Esophageal Tracheal Combitube.	Similar to Combitube with following differences: single lumen at distal tip, soft latex-free cuff, open proximal second lumen allows use of fiber-optic device or passage of a suction catheter or tube exchanger. Single use.
Same as LMA Classic. Allows easy access for flexible fiber-optic devices.	If intubation becomes necessary or desired, will accommodate ET up to 7.5 mm. Single use.

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Table 5. Selected Supraglottic Ventilatory Devices *(continued)*

Name (Manufacturer)	Description	Size
Solus Satin Laryngeal Mask Airway (Intersurgical Inc.)	A range of single-use, latex-free laryngeal mask airways with a softer airway tube to provide more flexibility.	Adult sizes 3-5.
Solus Standard Laryngeal Mask Airway (Intersurgical Inc.)	A range of single-use, latex-free laryngeal mask airways.	Adult sizes 3-5 and pediatric sizes 1-2.5.

Table 6. Devices for Special Airway Techniques

Name (Manufacturer)	Description	Size
Awake Intubation		
DeVilbiss Model 15 Medical Atomizer (DeVilbiss Healthcare)	Metal atomizer; includes glass receptacle (for liquid), pair of metal outlet tubes extending from metal atomizing nozzle, and adjustable tip for directing spray to inaccessible areas of the throat. Can be used with or without RhinoGuard tip cover.	Length: 10.5 in.
Enk Fiberoptic Atomizer Set (Cook Medical)	Device for atomizing small doses of local anesthetics. Atomizer set consists of a pressure-resistant oxygen tube and a connecting tube attached by a 3-way side-arm fitting with a small flow control opening. The set also contains an introducer catheter and 2 syringes (1-mL).	
EZ-Spray (Alcove Medical)	Disposable atomizer device which comprises a plastic receptacle, atomizer nozzle, and gas inlet tube. Tubing is connected from an air or oxygen flowmeter nipple to the gas inlet tube on the device.	
LMA MADdy Pediatric Mucosal Atomization Device (LMA North America, a Teleflex Company)	Pediatric Mucosal Atomization Device delivers intranasal/intraoral medications in a fine mist that enhances absorption and improves bioavailability for fast and effective drug delivery.	Typical particle size: 30 microns. System dead space: 0.12 mL (with syringe), 0.07 mL (device only). Tip diameter: 0.19 in (4.8 mm). Applicator length: 4.5 in (11.4 cm).
LMA MADgicWand Mucosal Atomization Device (LMA North America, a Teleflex Company)	Combines atomized topical anesthesia and oxygen delivery in a fiber-optic oral airway. Packaged in a box of 20.	Typical particle size: 30-100 microns. System dead space: 0.25 mL.

Clinical Applications	Special Features
Indicated for use in anesthesia and emergency medicine. Single-use laryngeal mask airway, provided sterile and ready for use.	Classic cuff shape for optimum anatomic conformance with a firm, smooth-surfaced back plate to aid ease of insertion. The Satin Solus has a softer airway tube to provide more flexibility. Clear, pliable airway tube allows for early detection of rising fluids. Cuff size indicators are accurately aligned and prominently displayed at top of tube and on pilot balloon. Essential user information on exposed section of airway tube for quick visual reference.
Indicated for use in anesthesia and emergency medicine. Single-use laryngeal mask airway, provided sterile and ready for use.	Classic cuff shape for optimum anatomic conformance with a firm, smooth-surfaced back plate to aid ease of insertion. Clear, pliable airway tube allows for early detection of rising fluids. Cuff size indicators are accurately aligned and prominently displayed at top of tube and on pilot balloon. Essential user information on exposed section of airway tube for quick visual reference.

Clinical Applications	Special Features
Intended for the application of topical anesthetics to the nose, oropharynx, and upper airway of patients, at the direction/discretion of a clinician.	Includes glass receptacle for dispensing the liquid; adjustable swivel top and vented nasal guard attached to a hand bulb. Can be used with all types of oil or water solutions that are compatible with rhodium metal plating. The all-metal top can be autoclaved. Reusable.
To apply topical anesthetics to laryngotracheal area through the working channel of a bronchoscope using oxygen flow. Designed and intended to be used by those trained and experienced in techniques of flexible fiber-optic intubation.	Device is an accessory to a bronchoscope. Delivery form is a fine spray mist using oxygen flow through the working channel bronchoscope. Sterile. Single use.
Application of topical anesthetic to the nose, oropharynx, and upper airway of patients, at the direction/discretion of a clinician.	Trigger-valve system provides controlled release of compressed gas to an atomizing nozzle, creating a liquid spray. Gas flow is adjusted to the desired setting. Use with either oil- or water-based solutions. Nonsterile. Single use.
Application of topical anesthetics to oropharynx and upper airway region. Fits through vocal cords, down LMA, or into nasal cavity.	Child-friendly and no sharps (bright colors in a toy-like presentation make the procedure less scary for young patients). Flexible (internal stylet provides support, malleability and memory). Disposable (single patient use, eliminates risk for cross-contamination). Practitioner-controlled (patient needs targeted specially by medication, concentration, position, and location).
Allows retraction of soft tissue while applying topical anesthesia in a fine, gentle mist. Used to apply topical anesthetic to the airway before awake intubation.	Device blade positioned along floor of the mouth can be directed immediately in front of laryngeal inlet to generate a fine mist by a piston syringe. Nonsterile. Single use.

table continues on next page

Table 6. Devices for Special Airway Techniques (continued)

Name (Manufacturer)	Description	Size	
LMA MADgic Laryngo-Tracheal Atomizer (LMA North America, a Teleflex Company)	Mucosal atomization device that incorporates a small flexible, malleable tube with an internal stiffening stylet that connects to a 3-mL syringe.	Typical particle size: 30-100 microns. System dead space: 0.25 and 0.13 mL. Tip diameter: 0.18 in (4.6 mm). Applicator length: 8.5 in (21.6 cm) and 4.5 in (11.4 cm).	
LMA MAD Nasal-Intranasal Mucosal Atomization Device (LMA North America, a Teleflex Company)	Disposable, compact atomizer for delivery of medications to the nose and throat in a fine, gentle mist.	Typical particle size: 30-100 microns. System dead space: 0.13 and 0.07 mL. Tip diameter: 0.17 in (4.3 mm). Applicator length: 1.65 in (4.2 cm).	
Retrograde			
Cook Retrograde Intubation Set (Cook Medical)	Available as a complete set in 6.0, 11.0, or 14.0 F. 14 F version includes Airway Exchange Catheter with Rapi-Fit adapters to allow for delivery of oxygen.	6.0 F=50 cm; 14.0 F=60 cm, extra stiff floppy tipped guide wire = 110 cm.	
Face Mask Ventilation			
Boussignac CPAP System (LMA North America, a Teleflex Company)	Open CPAP with an integral pressure-relief system. The CPAP device has 2 ports: a green one with integral oxygen connecting tube, and a colorless port for controlling pressure, monitoring CO ₂ , and adding oxygen.	Small, small adult, medium adult, and large adult.	
Endoscopy Mask (VBM Medizintechnik GmbH)	Face mask with diaphragm to allow simultaneous ventilation and endoscopy.	Newborn, infant, child, and adult.	
Transtracheal Jet Ventilation			
AincA Manual Jet Ventilator (Anesthesia Associates, Inc.)	Portable jet ventilation device with thumb depression mechanism that initiates a controlled burst of oxygen flow. Customizable assembly includes DISS inlet connection, 5 ft of inlet tubing, flow control knob, on/off thumb control, internal filter, back pressure gauge, and 2 ft of outlet hose ending in a Luer-Lok male fitting. Connects to any tool or port that has a Luer-Lok female connection (ie, malleable stylets, various adapters, etc).	Jet ventilation catheters of malleable copper with Luer fittings accommodate adults, children, and infants. Adapters allow direct connection to bronchoscope or ET.	
AincA MRI Conditional 3.0 Tesla Manual Jet Ventilator (Anesthesia Associates, Inc.)	Similar to AincA Manual Jet Ventilator but certified MRI Conditional-compatible for use in units up to 3.0 Tesla strength.	Jet ventilation catheters of malleable copper with Luer fittings accommodate adults, children, and infants. MRI Conditional 3.0 Tesla.	
Enk Oxygen Flow Modulator Set (Cook Medical)	Complete set including 15-gauge needle with reinforced fluorinated ethylene propylene catheter, syringe (5 cc), connecting tubing, and Enk oxygen flow modulator with tracheal catheter connector.	7.5 cm (2.0 mm ID).	
Manual Jet Ventilator (Instrumentation Industries)	Complete set includes an on/off valve, 6 ft of high-pressure tubing, and 4 ft of small-bore tubing.	Jet ventilation catheter size 13G can accommodate adults, and 14G children.	
Manujet III (VBM Medizintechnik GmbH)	Complete set including 13 ft high-pressure hose assembly with oxygen DISS fittings, 40-degree small bore tube assembly (with luer lock fitting) and 3 jet ventilation catheters (13G, 14G, and 16G).	Jet ventilation catheters can accommodate adults, children, and infants.	

Clinical Applications	Special Features
Application of topical anesthetics to oropharynx and upper airway region. Fits through vocal cords, down LMA, or into nasal cavity.	Malleable applicator retains memory to adapt to individual patient's anatomy. Delivery of a fine spray mist is generated by a piston syringe. Luer connection adapts to any luer lock syringe. Nonsterile. Single use.
Intranasal medication delivery offers a rapidly effective method to deliver selected medications to a patient without the need for a painful shot and without the delays in onset seen with oral medications.	Rapidly effective (atomized nasal medications absorb directly into blood stream, avoiding first-pass metabolism; atomized nasal medications absorb directly into the brain and cerebrospinal fluid via olfactory mucosa to nose-brain pathway, achieves medication levels comparable to injections). Controlled administration (exact dosing, exact volume, titratable to effect [repeat if needed], atomizes in any position, atomized particles are optimal size for deposition across broad area of mucosa).
Technique used for securing a difficult airway, either alone or with other alternative airway techniques. Especially useful in patients with limited neck mobility or patients who have suffered airway trauma. 6.0 Fr places tubes ≥ 2.5 mm ID; 14.0 Fr places tubes ≥ 5.0 mm ID.	Packaged as a complete kit with everything needed to perform a retrograde intubation. The recently added Arndt Airway Exchange Catheter allows for patient oxygenation and facilitates placement of an ET. Disposable.
Provides respiratory assistance to patients breathing spontaneously. Effective postoperatively in obese patients with sleep apnea.	Compatible with all face masks, ETs, and tracheostomy tubes. Mask head harness is designed for patient comfort.
<ul style="list-style-type: none"> • Fiber-optic intubation • Airway endoscopy • Gastroenterology • Transesophageal echocardiography 	Available in different sizes and with different sizes of diaphragms for a perfect seal during endoscopy. Special Bronchoscope Airway available to protect equipment and aid endoscopy.
Manual Jet Ventilation for oxygen saturation maintenance and usable for emergency direct TTJV and for laser throat surgery (elimination of plastic ET in laser path).	Easy factory customization available for hose lengths and oxygen source connection type (DISS vs various quick-disconnect types) as well as optional pressure regulator (with gauge) and standard or custom regulator-to-source connection hoses. Adapters, fittings, and connectors available. Completely reusable and sterilizable.
Similar to the AincA Manual Jet Ventilator, but fully certified for use in MRI suites with coil strength to 3.0 Tesla. Allows emergency oxygen saturation maintenance while determining how to solve airway issues.	Easy factory customization available for hose lengths and oxygen source connection type (DISS vs various quick-disconnect types). Adapters, fittings, and connectors available. Completely reusable and sterilizable.
Similar to the AincA Manual Jet Ventilator. Recommended for use when jet ventilation is appropriate but a jet ventilator is unavailable.	Packaged as a complete set with everything needed to perform TTJV. Disposable.
Same as Manujet III. Can also be used in unobstructed difficult airway management.	Offered with and without an adjustable pressure regulator. Partially reusable outlet tube is disposable. NOTE: Outlet tube is single-use.
Well-accepted method for securing ventilation in rigid and interventional bronchoscopy. Because airflow is generally unidirectional, it is important that air has a route to escape (unobstructed airway).	Packaged as a complete kit with jet ventilation catheters to perform TTJV. Includes gauge and regulator.

Table 7. Positioning Devices

Name (Manufacturer)	Description
Chin-UP (Dupaco Inc.; distributed by Mercury Medical)	Hands-free airway support device used to lift up the patient's chin and hold it in position to keep the airway open.
Face-Cradle (Mercury Medical)	Fully adjustable cushion set accommodates most adult head sizes.
JED Jaw Elevation Device (Hypnoz Therapeutic Devices; distributed by LMA North America, Inc., a Teleflex Company)	Hands-free, noninvasive device that helps clinicians maintain an open airway during any procedure in which a patient is sedated and the airway may be compromised.
RAMP Rapid Airway Management Positioner (Airpal Patient Transfer Systems, Inc.)	Air-assisted medical device that can be inflated to transfer and position patients for various procedures.
Troop Elevation Pillow (Mercury Medical)	Foam positioning device that quickly achieves the head-elevated laryngoscopy position (HELP). Includes many accessories (head cradle, arm board pads, additional pillow).

Table 8. Cricothyrotomy Devices

Name (Manufacturer)	Description	Size
Needle Cricothyrotomy		
Emergency Transtracheal Airway Catheter (Cook Medical)	6 Fr reinforced fluorinated ethylene propylene catheter.	5.0 and 7.5 cm.
Percutaneous Cricothyrotomy		
Melker Emergency Cricothyrotomy Catheter Set (Cook Medical)	Complete set including syringe (10 cc), 2- to 18-gauge introducer needles with TFE catheter (short and long), 0.038-in diameter Amplatz extra-stiff guidewire with flexible tip, scalpel, curved dilator with radiopaque stripe, and PVC airway catheter. Also available in a Special Operations kit, which includes all of the above in a slip peel-pouch and 2 airway catheters.	Standard kit: 3.8 cm (3.5 mm ID), 4.2 cm (4.0 mm ID), and 7.5 cm (6.0 mm ID). Special kit: 4.2 and 7.5 cm.
Pertrach Emergency Cricothyrotomy Kit (Pulmodyne)	Contents include 2 splitting needles, cuffed or uncuffed Trach tube, dilator with flexible leader, twill tape, syringe, extension tube, and scalpel (optional).	Adult: 6.8 cm (5.6 mm ID). Child: 3.9 cm (3.0 mm ID), 4.0 cm (3.5 mm ID), 4.1 cm (4.0 mm ID), and 4.4 cm (5.0 mm ID).
Quicktrach Emergency Cricothyrotomy Device (VBM Medizintechnik GmbH)	Complete kit includes airway catheter, stopper, needle, and syringes that come preassembled.	Adult (4.0 mm ID) and child (2.0 mm ID).

Clinical Applications	Special Features
Aids during monitored anesthesia care and total intravenous anesthesia sedation procedures.	Disposable polyurethane foam cushions.
For use in prone-position surgeries.	
OR procedures, MRI, recovery, FOB intubation, and interventional radiology, oral surgery, and endoscopy procedures.	Assists provider in maintaining an open airway in sedated or anesthetized patients without the need for additional instrumentation. Frees medical personnel from the need to hold the jaw manually in sedated patients. When left in place after a procedure, reduces postoperative airway complications. Noninvasive and easy to use. Reusable device with disposable pads.
Allows for the positioning of a patient for direct laryngoscopy, extubation, and central venous access. Enhances the safe apnea period, bag valve mask ventilation, and chest wall excursion.	Base of the RAMP is integrated with an Airpal platform (air-assisted lateral patient transfer and positioning device). Inflates and deflates, thus can remain in place during surgery and reinflate for extubation. Reusable.
Aids airway management for obese patients by aligning upper airway axes, and facilitating mask ventilation, laryngoscopy, direct laryngoscopy, and central venous access. Allows patients to breathe more comfortably during preoxygenation and regional anesthesia.	Available in disposable and reusable formats. Troop Elevation Pillow may be added for super morbidly obese patients.

Clinical Applications	Special Features
A lifesaving procedure that is the final option for “cannot-ventilate, cannot-intubate” patients in all airway algorithms.	Designed to be kink-resistant specifically for the purpose of needle cricothyrotomy.
Same as Emergency Transtracheal Airway Catheter. Intended to be used with the Seldinger technique via the cricothyroid membrane; however, it has the capability to be used as a surgical cricothyrotomy.	Packaged as a complete kit with everything needed to perform a percutaneous cricothyrotomy. The Special Operations kit comes in a slip peel-pouch for easy transport to offsite locations. Also can be used in the OR. It comes with 2 differently sized airway catheters to reduce the number of kits needed in the field. Disposable.
Use in failed orotracheal or nasotracheal intubation and/or fiber-optic bronchoscopy. Immediate airway control in patients with maxillofacial, cervical spine, head, neck, and multiple trauma. Also used when endotracheal intubation is impossible and/or contraindicated. Immediate relief of upper airway block.	Serves as an emergency cricothyrotomy or tracheostomy device that uses a patented splitting needle and dilator to perform a rapid and simple procedure.
Same as Melker Emergency Cricothyrotomy Catheter Set.	Packaged as a complete kit with everything needed to perform a percutaneous cricothyrotomy—even the neck tape and connecting tube. The removable stopper is used to prevent a “too-deep” insertion and avoid the possibility of perforating the rear tracheal wall. The conical needle tip allows for the smallest necessary stoma and reduces the risk for bleeding. Easily transported to offsite locations. Disposable.

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Table 8. Cricothyrotomy Devices (continued)

Name (Manufacturer)	Description	Size
Surgical Cricothyrotomy		
Melker Surgical Cricothyrotomy Set (Cook Medical)	Cuffed cricothyrotomy tube, scalpel, tracheal hook Trousseau dilator, and blunt curved dilator in compact package for convenient storage.	9.0 cm (5 mm ID).
Melker Universal Emergency Cricothyrotomy Catheter Set (Cook Medical)	Same as Melker Cuffed Emergency Cricothyrotomy Catheter Set for percutaneous technique. Also includes for surgical technique: tracheal hook, safety scalpel, Trousseau dilator, and blunt curved dilator.	9.0 cm (5.0 mm ID).
Surgicric 1 (VBM Medizintechnik GmbH)	Surgical cricothyrotomy.	7.0 mm ID.

Table 9. Tracheostomy Devices

Name (Manufacturer)	Description	Size
Percutaneous Dilatational Tracheostomy		
Ciaglia Blue Dolphin Balloon Percutaneous Tracheostomy Introducer (Cook Medical)	Complete kit with size-specific Blue Dolphin balloon dilator. Available with or without Shiley 6 or 8 PERC tracheostomy tubes. A tray version is available that includes lidocaine/epinephrine, 15-mm swivel connector, chlorhexidine skin prep, drape, and suture.	21, 24, 26, 27, 28, 30 Fr introducers.
Ciaglia Blue Rhino Percutaneous Introducer Set (Cook Medical)	Complete kit includes 24.0, 26.0, and 28.0 Fr loading dilators and Shiley 6 or 8 PERC disposable dual-cannula tracheostomy tube. A tray version is available that includes lidocaine/epinephrine, connector, chlorhexidine skin prep, drape, needle driver, and suture.	74 mm (6.4 mm ID); 79 mm (7.6 mm ID).
Portex Ultraperc Percutaneous Dilatational Tracheostomy Kit (Smiths Medical)	Complete set with or without a tracheostomy tube.	70.0 mm (7.0 mm ID); 5.5 mm (8.0 mm ID); 81.0 mm (9.0 mm ID).
Weinmann Tracheostomy Exchange Set (Cook Medical)	Includes Cook Airway Exchange Catheter, Tracheostomy loading dilators, and a Blue Rhino dilator for re-dilation if necessary.	For use with tracheostomy tubes as follows: 74 mm (6.4 mm ID); 79 mm (7.6 mm ID).
Shiley TracheoSoft XLT Extended-Length Tracheostomy Tubes (Covidien)	Available in 4 ISO sizes (5.0, 6.0, 7.0, and 8.0 mm ID). Each size offers the choice of cuffed or uncuffed stylets, and proximal or distal extensions. Disposable inner cannula; replacements sold in packages of 10.	90 mm (5.0 mm ID); 95 mm (6.0 mm ID); 100 mm (7.0 mm ID); 105 mm (8.0 mm ID).

Surgical Tracheostomy

Surgical tracheostomies are performed by making a curvilinear skin incision along relaxed skin tension lines between sternal notch and cricoid cartilage. A midline vertical incision is then made dividing strap muscles, and division of thyroid isthmus between ligatures is performed. Next, a cricoid hook is used to elevate the cricoid. An inferior-based flap or Bjork flap (through second and third tracheal rings) is commonly used. The flap is then sutured to the inferior skin margin. Alternatives include a vertical tracheal incision (pediatric) or excision of an ellipse of anterior tracheal wall. Finally, the tracheostomy tube is inserted, the cuff is inflated, and it is secured with tape around the neck or stay sutures.

Clinical Applications	Special Features
This set provides the tools that clinicians can use if they prefer a surgical approach to performing emergency cricothyrotomy.	Complete and convenient packaging.
Same as Melker Emergency Cricothyrotomy Catheter Set.	One-half of the tray is the same as Melker Cuffed Emergency Cricothyrotomy Catheter Set for the percutaneous technique. The other half of the tray includes all items needed to perform a surgical emergency cricothyrotomy.
Surgical cricothyrotomy according to the Rapid Four-Step Technique. A lifesaving procedure that is the final option for “cannot-ventilate, cannot-intubate” situations.	Complete kit including scalpel, tracheal hook, dilator, cuffed tracheal tube, fixation and extension tubing.

Clinical Applications	Special Features
One-step dilation and tracheal tube insertion. Establishes transcutaneous access to the trachea below the level of the cricoid cartilage by Seldinger technique.	Unique balloon-tipped design dilatation and tracheal tube insertion in one step. Packaged as a complete kit with everything needed to perform a percutaneous dilatational tracheostomy.
Same as Portex Ultraperc Percutaneous Dilatational Tracheostomy Kit.	Packaged as a complete kit with everything needed to perform a percutaneous dilatational tracheostomy. The single dilator with a hydrophilic coating and flexible tip results in a simpler, less traumatic insertion. The wire guide has a Safe-T-J tip to reduce trauma. Disposable.
Establishes transcutaneous access to the trachea below the level of cricoid cartilage. Allows for smooth insertion of the tracheostomy tube over a Seldinger wire.	Packaged as a complete kit with everything needed to perform a percutaneous dilatational tracheostomy. The dilator is single-staged and prelubricated with an ergonomic handle to facilitate insertion. Disposable.
This set is used to facilitate exchange of adult tracheostomy tubes allowing for stomal redilation if required.	This is the only device available that provides an airway exchange catheter to maintain stomal access and that also allows redilation of stoma if resistance is met.
Flexible dual cannula tube for patients with unusual anatomy. Proximal length extension for thick necks; distal length extension for long necks, tracheal stenosis, or malacia.	The only fixed-flange extended-length tube with disposable inner cannula. Flexible inner cannula conforms to the shape of the outer cannula. Sixteen configurations to fit a wide variety of patients. Disposable.

Recommended Reading

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Abbreviation Key

AEC	airway exchange catheter	ISO	International Organization for Standardization
AHA	American Heart Association	LCD	liquid crystal display
ASA	American Society of Anesthesiologists	LED	light-emitting diode
CCD	charge-coupled device	LMA	laryngeal mask airway
CMOS	complementary metal oxide semiconductor	LT	laryngeal tube
CPAP	continuous positive airway pressure	LTA	laryngeal tracheal anesthesia
CPR	cardiopulmonary resuscitation	MAC	Macintosh
DCI	direct coupled interface	NICU	neonatal intensive care unit
DISS	diameter index safety system	NTSC	National Television System Committee
DL	direct laryngoscopy	OD	outer diameter
DLT	double-lumen tube	OR	operating room
ED	emergency department	PEEP	positive end-expiratory pressure
EF	extra firm	PPV	positive pressure ventilation
EMS	emergency medical services	PVC	polyvinyl chloride
ENT	ear nose and throat	PVP	polyvinylpyrrolidone
ET	endotracheal tube	SGA	supraglottic airway
FOB	fiber-optic bronchoscope	Stat	sterile single-use blade
Fr	French	TFE	tetrafluoroethylene
ICU	intensive care unit	TTJV	transtracheal jet ventilation
ID	internal diameter	USB	universal serial bus
ILMA	intubating laryngeal mask airway	VL	video laryngoscopy