Extraglottic Tube with ventilation- and endoscopy lumen for control of Airway patency during gastrointestinal endoscopic procedures.

- autoclavable up to 134°C
- Material: Silicone, latex-free

**VBM Gastro-Laryngeal Tube G-LT**

- Distal Cuff
  - blocks esophageal inlet
  - reduces possibility of gastric ventilation

- Proximal Cuff
  - stabilizes the tube and blocks oro- and nasopharynx
  - high volume, adjusts to the anatomical situation

- Ventilation Holes
  - lie in front of the larynx

- Inflation Line
  - for inflation and deflation of both cuffs

- Ventilation Lumen
  - with 15 mm ISO Connector

- Endoscopy Lumen
  - fits duodenoscopes with max. 13.8 mm O.D.
  - coated, to avoid friction

- Bite block
  - avoids occlusion and protects the endoscope

- Valve Opener

**Gastro-Laryngeal Tube G-LT**
for adults ≥ 155 cm
REF 32-90-004 Box 1
Gastro-Laryngeal Tube G-LT

The G-LT is designed for obtaining and maintaining control of airway patency during medium to long-term complex gastrointestinal endoscopic procedures performed on adults under deep sedation or general anaesthesia while maintaining spontaneous or assisted ventilation.

• Diagnostic ERC (Endoscopic Retrograde Cholangiography)
• Diagnostic and therapeutic ERCP (Endoscopic Retrograde Cholangiopancreatography) for pancreatic and biliary disease:
  - Brush cytology and biopsy
  - Endosonografic gastrointestinal diagnosis
  - Removal of bile and pancreatic duct stones
  - Papillotomy or duodenal ampulla dilation
  - Treatment of biliary strictures (endoprosthesis, stent placement)
  - Palliation of malignancy: obstructive jaundice (drainage decompression)
• Enteroscopy
• Percutaneous Endoscopic Gastrostomy (PEG), particularly in neurologic patients.

The G-LT can also be used for performing short term or minor duodenal and oesophageal gastric endoscopies whenever the patient has particular high risk factors or refuses conscious sedation/anxiolysis and asks for deep sedation or anaesthesia, or whenever there are specific indications.

Advantages

• Prevention and control of hypoventilation and desaturation (supraglottic obstruction caused by the duodenoscope, gastro duodenal gaseous distention, respiratory depression due to over-sedation, etc.)
• Greater stability of the sedation or anaesthesia plan and a reduction in cardio circulatory instability
• Faster endoscopic procedures and fewer interruptions due to intolerance or agitation (under-sedation)
• Facilitates the oesophageal insertion of the duodenoscopes, especially when the manoeuvre is repeated, without impeding mobility and handling
• Its positioning does not require direct laryngoscopy or muscle relaxation
• Substitutes endotracheal intubation, preventing associated anaesthesiological problems and difficulties arising in the execution of the endoscopic procedure
• Enables clinical checks and instrumental monitoring (capnometry and capnography) of the sufficiency and adequacy of lung ventilation
• Enables oxygen supply and ventilatory support of spontaneous respiration with manual or instrumental techniques without interrupting and interfering with the endoscopic procedure
• Less use of anaesthetic drugs
• Protects the airways from gastro-oesophageal reflux and inhalation of gastric content
• Enables suction of secretions in the upper airways using a small size catheter (max. CH10) inserted in the ventilation tube (consider lubrication)