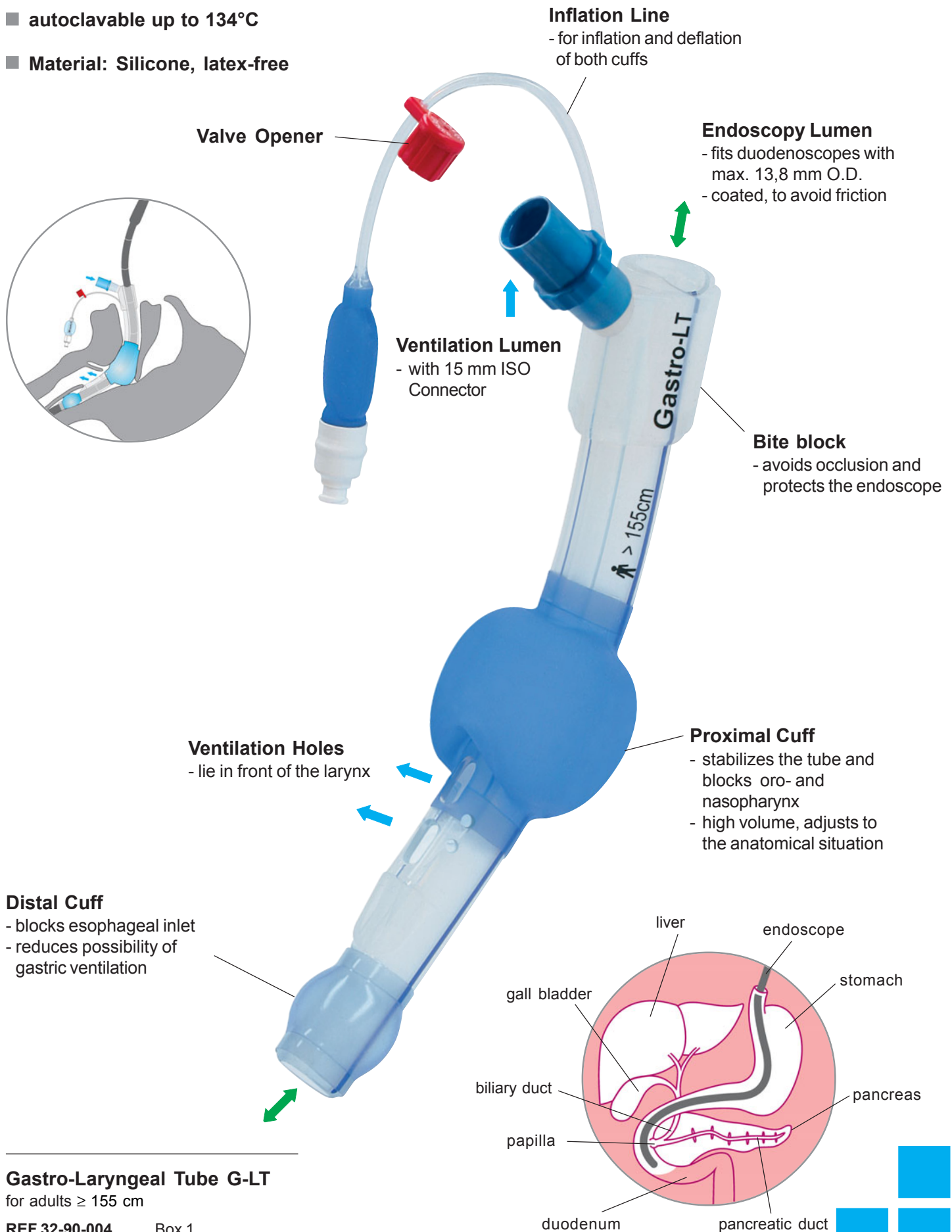


VBM Gastro-Laryngeal Tube G-LT

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



Gastro-Laryngeal Tube G-LT
for adults ≥ 155 cm

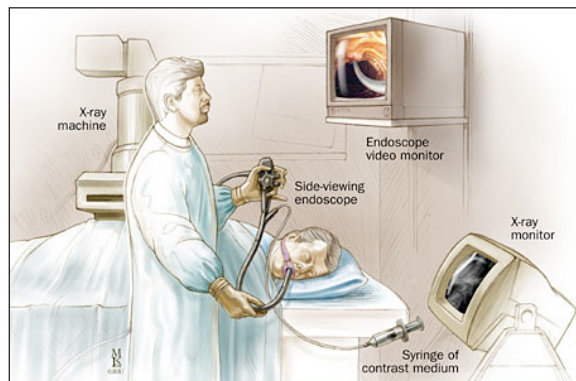
REF 32-90-004 Box 1



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
 - Endosonographic 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/anoxiolysis 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)