AirLife™

AIR-Q®sP3G
SUPRAGLOTTIC AIRWAY

AIR-Q®sP3G
INTUBATING LARYNGEAL AIRWAYS (ILA)

AirLife™

The advanced, all-silicone Air-Q®sp3G helps deliver safety and confidence in airway management, no matter what airway challenges you face. The unique ET tube ramp and epiglottis elevator aid in fast, easy and safe intubations.

SPECIFICALLY DESIGNED FOR EMS IN MIND

Air-Q®sp3G - Features

- Uses positive pressure ventilation to self-pressurize the cuff
- Pressures cycle between peak airway pressure and PEEP levels
- Has an extra wide gastric inlet access and two gastric channels that accommodate NG tubes up to 18 Fr

Colour coded connector for easy size identification. Removable tethered connector enables insertion of FT tube through the airway tube

Anatomically curved, medical grade silicone airway tube with integrated bite block

Soft medical grade silicone cuff

Self pressurizing cuff inflation is controlled by inspiratory/ expiratory pressure.
No manual inflation needed.

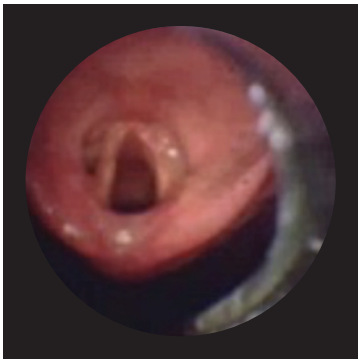
AIR-Q®sP3G
PERFECT PLACEMENT MADE EASY

AirLife™

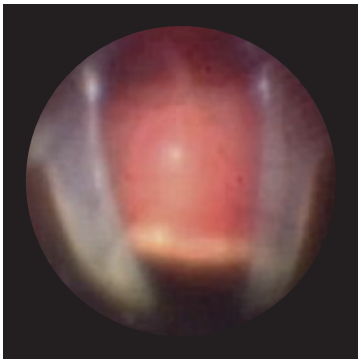
Air-Q®sp3G SUPRAGLOTTIC AIRWAY PROVIDES

- Anatomically correct placement of the masked airway
- Lifting of the epiglottis to maximize access
- Guide ramp to assist with ETT insertion and placement

Air-Q®sp3G PROVIDES BETTER VISUAL CLARITY



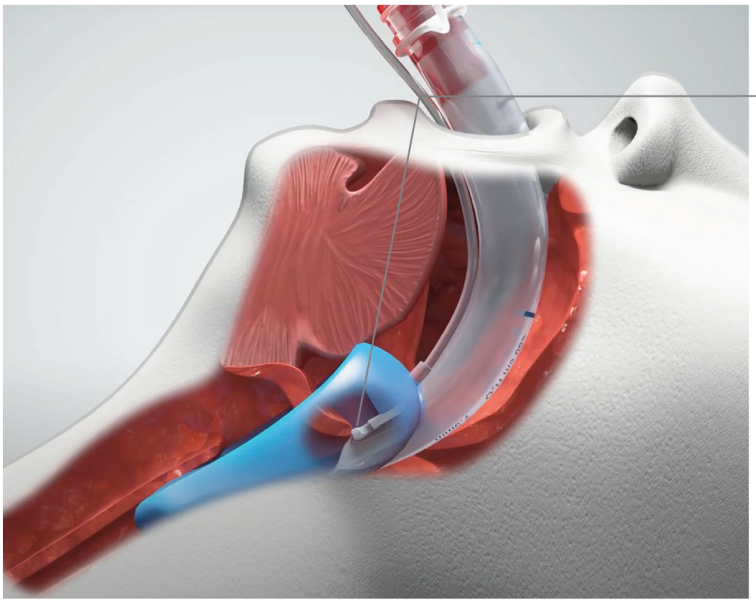
Air-Q®sp3G Series with Epiglottis Elevator

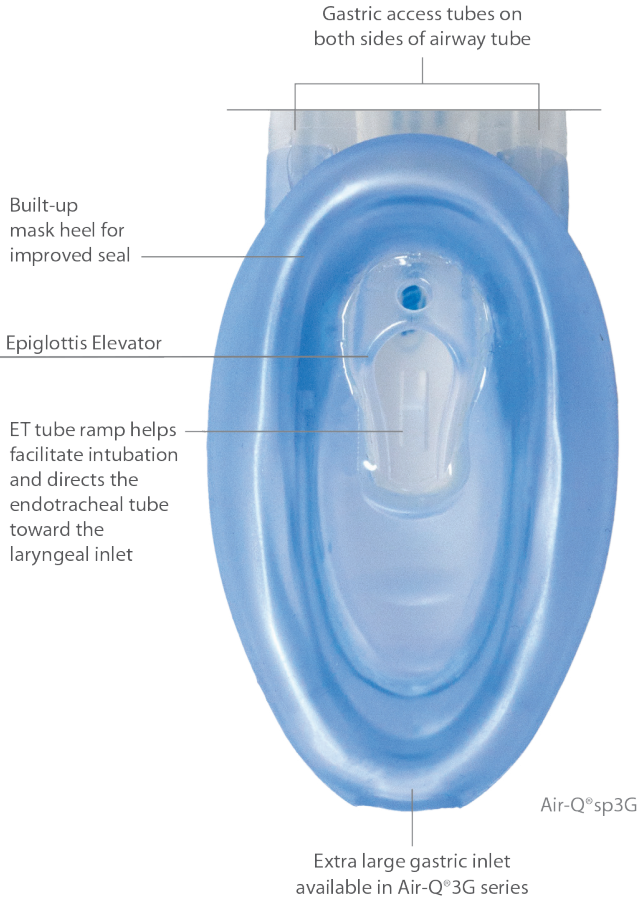


Competitive ILA

EPIGLOTTIS ELEVATOR

Our unique supraglottic airway includes an epiglottis elevator and raised heel to optimize airway placement and seal.





AIR-Q®sP3G
PERFECT PLACEMENT MADE EASY

AirLife™

AIR-Q®sP3G INTUBATING LARYNGEAL AIRWAY WITH 15MM CONNECTOR

ITEM	DESCRIPTION	SIZE	ADAPTER COLOR	IDEAL BODY WEIGHT	MAXIMUM OEETT	MOUTH OPENING	LENGTH OF TUBE	MAXIMUM OG TUBE	ET TUBE CONNECTOR
2114-60005	Air-Q®sp3Q	0	Light Purple	<2.0kb	3.0 mm	5 mm	6.0 cm	5 Fr	15 mm
2114-60055	Air-Q®sp3Q	0.5	Pink	2 – 4 kg	4.0 mm	8 mm	7.0 cm	6 Fr	15 mm
2114-60105	Air-Q®sp3Q	1.0	Blue	4 – 7 kg	4.5 mm	11 mm	9.0 cm	8 Fr	15 mm
2114-60155	Air-Q®sp3Q	1.5	Green	7 – 17 kg	5.0 mm	14 mm	11.0 cm	8 Fr	15 mm
2114-60205	Air-Q®sp3Q	2	Orange	17 – 30 kg	5.5 mm	17 mm	14.0 cm	10 Fr	15 mm
2114-60305	Air-Q®sp3Q	3	Yellow	30 – 60 kg	7.0 mm	20 mm	16.0 cm	14 Fr	15 mm
2114-60405	Air-Q®sp3Q	4	Red	60 – 80 kg	8.0 mm	23 mm	18.0 cm	16 Fr	15 mm
2114-60505	Air-Q®sp3Q	5	Purple	> 80 kg	9.0 mm	25 mm	20.0 cm	18 Fr	15 mm

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air-Q SP® 3/3G
INTUBATING LARYNGEAL AIRWAY
Instructions for Use

The air-Q SP 3/3G (Self-Pressurizing) Airway is an enhanced version of the standard air-Q masked laryngeal airway. As such, it is indicated as a primary airway device when an oral endotracheal tube (OETT) is not necessary or as an aid to intubation in difficult airway situations.

The air-Q SP 3/3G represents a revolution in airway device design. It functions similarly to the original air-Q in that it retains the soft perimeter mask cuff. This gives the mask the ability to change its size and shape depending on each patient's pharyngeal anatomy, improving fit. Like the original, it can also be used as a conduit for intubation in difficult airway situations. It differs in that it does not contain an inflation valve and so does not inflate normally. Instead, the air-Q SP 3/3G incorporates a large aperture between the internal volumes of the breathing tube and the peripheral cuff. This aperture allows fluid communication between the tube and cuff to "self-pressurize", causing inflation of the cuff during positive pressure ventilation.

This product is to be used by trained personnel only.

Available in Single Use Only

Recommendations:

Size	IBW	Max. OETT	Mouth Opening1	<- -> 2	Max OG Tube3
5	>80 kg	9.0 mm	25 mm	20 cm	18
4	60-80 kg	8.0 mm	23 mm	18 cm	16
3	30-60 kg	7.0 mm	20 mm	16 cm	14
2	17-30 kg	5.5 mm	17 mm	14 cm	10
1.5	7-17 kg	5.0 mm	14 mm	11 cm	8
1.0	4-7 kg	4.5 mm	11 mm	9 cm	8
0.5	2-4 kg	4.0 mm	8 mm	7 cm	6
0	< 2 kg	3.0 mm	5 cm	6 cm	5

1. **Minimum mouth opening for insertion.**
2. **Distance from the external edge of the airway tube to the internal ventilatory opening.**
3. **Maximum OG size (airQ SP 3G only).**

air-Q SP 3/3G Placement Procedure

The procedure below is intended as a guide. Many techniques can be successfully used to properly place the air-Q SP 3/3G into the pharynx.

1. Lubricate the external surface including the mask cavity ridges.
2. Open the patient's mouth and elevate the tongue. Elevating the tongue lifts the epiglottis off the posterior pharyngeal wall and allows the air-Q SP 3/3G easy passage into the pharynx. A mandibular lift is especially recommended. A tongue blade placed at the base of the tongue also works well for this purpose.
3. Place the front portion of the air-Q SP 3/3G mask between the base of the tongue and the soft palate at a slight forward angle, if possible.
4. Pass the air-Q SP 3/3G into position within the pharynx by gently applying inward and downward pressure, using the curvature of the air-Q SP 3/3G mask and airway tube as a guide. Simply rotate the air-Q SP 3/3G forward and inward. Minimal manipulation may be necessary to turn the corner into the upper pharynx. Continue to advance until fixed resistance to forward movement is felt. Correct placement is determined by this resistance to further advancement. Some users place the back of the left index finger behind the mask, flexing the finger forward to help guide the mask around the corner into the pharynx. Once the mask has negotiated the turn, the left hand is then used to do a mandibular lift while exerting downward and inward pressure on the air-Q SP 3/3G with the right hand during final advancement into the pharynx. This technique seems to be easy to learn and is particularly successful.
5. Tape the air-Q SP 3/3G in place.
6. Check the air-Q SP 3/3G connector to ensure it is fully engaged within the airway tube, and attach the connector to the appropriate breathing device. Check for adequate ventilation.
7. Place a bite block between the patient's teeth. Keep the bite block in place until the air-Q SP 3/3G is removed.

air-Q SP 3/3G Intubation Procedure

The air-Q SP 3/3G by Cookgas® LLC is intended not only to be an outstanding airway for general use, but also to be a simple and reliable tool for intubation of the trachea with OETTs. Due to its patented design, standard OETTs (sizes 9.0 mm - 3.0 mm) can be easily passed through the air-Q SP 3/3G and into the trachea. Further, the air-Q SP 3/3G can be easily removed following intubation with the aid of the patented air-Q Removal Stylet, also by Cookgas® LLC. The following procedure for intubation is only intended as a guide. Many techniques can be successfully used for tracheal intubation using the air-Q SP 3/3G.

1. Prior to intubation, the laryngeal musculature and vocal cords must be relaxed, either by an aerosolized local anesthetic or with the aid of a muscle relaxant.
2. Pre-oxygenate.
3. Prepare the appropriately-sized OETT by completely deflating the OETT cuff and lubricate well. It is important to deflate the OETT cuff completely to allow the OETT to slide easily within the air-Q SP 3/3G.

4. Disconnect the air-Q SP 3/3G from the ventilation device and remove the air-Q SP 3/3G connector. This can be easily done by squeezing the air-Q SP 3/3G tube between the index finger and thumb just distal to the connector with one hand, then rocking the air-Q SP 3/3G connector back and forth while pulling the connector outward away from the airway tube with the other.
5. Insert the previously deflated and lubricated OETT through the air-Q SP 3/3G to a depth of approximately 6 - 20 cm, depending on the air-Q SP 3/3G size. This will place the distal tip of the OETT at or just proximal to the opening of the air-Q SP 3/3G airway tube within the mask cavity. It is very important to lubricate the OETT and the air-Q SP 3/3G airway tube completely to ensure easy passage of the OETT through the air-Q SP 3/3G.
6. The following suggestions for advancement of the OETT are intended as a guide. Many techniques can be successfully used to further advance the OETT into the trachea.

CAUTION: Always check for adequate ventilation and oxygenation following placement of the OETT.

a. *Fiber Optic Technique*: Using a Fiber Optic Endoscope, pass the scope through the OETT and into the trachea under direct visualization. Stabilize the Fiber Optic Endoscope and pass the OETT through the laryngeal inlet and into the proximal trachea, using the scope as a guide. Check the position of the OETT with direct visualization of the tracheal carina. Remove the Fiber Optic Endoscope. Add a small amount of air to the OETT cuff, then replace the OETT connector if necessary. Check for adequate ventilation. (If epiglottic intrusion or down-folding is seen during visualization, the air-Q SP 3/3G usually need not be completely removed.) Perform an external mandibular lift to elevate the epiglottis and pass the endoscope beneath the epiglottis and into the trachea followed by the OETT.

b. *Stylet Technique*: Using an appropriate coude-tipped intubating stylet or a lighted stylet, pass the intubation stylet through the OETT within the air-Q SP 3/3G, through the laryngeal inlet and into the trachea. Pass coude-tipped stylets with tip pointing upward (anterior). By gently placing the fingers of the left hand over the cricoid area of the patient's throat, the stylet can usually be felt as a scraping or rubbing sensation as it passes through the cricoid ring. If properly positioned, the lighted stylet will also produce a bright yellow/red illumination over the cricoid area. Once the stylet passes into the trachea, simply advance the OETT over the stylet, through the laryngeal inlet and into the trachea, using the intubation stylet as a guide. Add a small amount of air to the OETT cuff, replace the OETT connector and check for adequate ventilation.

NOTE: If the OETT fails to advance over the stylet into the trachea, it is usually helpful to rotate the OETT counterclockwise while passing the OETT. If this fails, try again with a smaller size OETT.

air-Q SP 3/3G Removal Procedure

Removing the air-Q SP 3/3G following OETT intubation is easily accomplished with the aid of the air-Q Removal Stylet by Cookgas® LLC. The air-Q Removal Stylet consists of an adapter connected to a rod. The adapter is tapered from bottom to top, and has horizontal ridges and vertical grooves. The taper allows the stylet to accommodate multiple OETT sizes. The ridges engage the OETT in a firm, secure grip, giving the user control of the OETT during the air-Q SP 3/3G removal process. The grooves allow spontaneously breathing patients unimpeded air passage within the OETT during removal of the air-Q SP 3/3G. By immobilizing and exerting an inward stabilizing force on the OETT, the air-Q SP 3/3G Removal Stylet allows for the swift removal of the air-Q SP 3/3G without dislodging the previously-placed OETT from the patient.

1. Remove the OETT connector from the OETT.
2. Squeeze the proximal portion of the OETT between the index finger and the thumb, leaving enough room for the adapter portion of the stylet to enter the proximal opening of the OETT. Alternatively, squeeze the proximal end of the air-Q SP 3/3G airway tube, trapping the OETT inside.
3. Insert the tapered end of the air-Q Removal Stylet into the proximal OETT (the long axis should be in the 12 o'clock - 6 o'clock position) until the adapter fits snugly within the OETT.
4. For larger sizes, (2.0 - 4.5), with firm inward pressure, rotate the stylet adapter in a clockwise direction (into the 3 o'clock - 9 o'clock position) until the adapter firmly engages the OETT. For smaller sizes (0 - 1.5) simply push the stylet firmly into the OETT**.** Please practice this a few times prior to attempting on a patient.
5. Deflate and lubricate the pilot balloon on the OETT prior to withdrawing the air-Q SP 3/3G. Reinflate the OETT following air-Q SP 3/3G removal.
6. While exerting an inward stabilizing force on the stylet, slowly withdraw the air-Q SP 3/3G outward over the stylet rod.
7. For larger sizes (2.0 - 4.5) pass the stylet through and through. For smaller sizes (0 - 1.5) remove the stylet from the proximal end of the air-Q SP 3/3G while stabilizing the OETT at the mouth. Discard single-use air-Q SP 3/3Gs following use.
8. Reposition the OETT to the proper depth within the patient, if needed, and then tape into place.
9. Replace the OETT connector within the OETT. Inflate the OETT, if needed, and attach to an appropriate breathing device. Check for adequate ventilation.

⚠ Cautions/Warnings

1. Inspect all air-Q SP 3/3G devices prior to use. Discard defective devices.
2. Do not use sharp instruments on or near the air-Q SP 3/3G.
3. Confirm that the air-Q SP 3/3G size matches the connector size prior to use.
4. The air-Q SP 3/3G connector is removable and airway disconnect is possible. Take standard precautions to minimize the chance of disconnect.

5. Confirm complete connector engagement within the airway tube prior to use.
6. The air-Q SP 3/3G connector is removable and airway disconnect is possible. Take standard precautions to minimize the chance of disconnect.
7. Do not use excessive force during air-Q SP 3/3G placement or removal.
8. Immediately check for adequate ventilation following placement.
9. If airway problems occur and persist, remove the air-Q SP 3/3G and establish an effective airway by another method. Back-up means for ventilation should be readily available.
10. air-Q SP 3/3G connectors may dislodge during use following lubrication. Clean the breathing tube and connector thoroughly with alcohol prior to re-use.
11. Supralaryngeal Airways, including the air-Q SP 3/3G, do not fully protect the patient from aspiration.
12. Recheck airway position and patency following all changes in the patient's head or neck position.
13. Supralaryngeal Airways are potentially flammable in the presence of lasers and electrical cautery.
14. Placement and maintenance of a bite block is recommended during air-Q SP 3/3G use.
15. Re-use of single-use devices may lead to mechanical malfunction and potential microbiological contamination. **Discard all single-use air-Q SP 3/3G's following use. DO NOT REUSE.**
16. The single-use air-Q SP 3/3G has been sterilized utilizing Ethylene Oxide, a known carcinogen.

Contraindications

The air-Q SP 3/3G is contraindicated in patients at high risk for regurgitation and/or aspiration. This includes, but is not limited to, patients undergoing major thoracic or abdominal surgery, patients who are non-fasted, morbidly obese, pregnant > 14 weeks, or suffer from delayed gastric emptying or esophageal reflux. Users must weigh the benefits of emergency airway needs with the potential risk of aspiration in these patients. air-Q SP 3/3Gs should be used in unconscious or topically anesthetized patients only.

Adverse Effects

Previously reported adverse events with masked laryngeal airways include: sore throat, aspiration, regurgitation, vomiting, bronchospasm, gagging, hiccup, coughing, transient glottic closure, airway obstruction, laryngeal spasm, retching, breath holding, arytenoid dislocation, trauma and/or abrasion to the epiglottis, larynx, pharynx, uvula, hyoid and tonsils, tongue cyanosis, lingual nerve, vocal cord and hypoglossal nerve paralysis, tongue macroglossia, parotid gland swelling, dry mouth, dysphagia, feeling of fullness, mouth ulcer, dysarthria, dysphonia, hoarseness, stridor, pharyngeal ulcer, pulmonary edema, laryngeal hematoma, head and neck edema, myocardial ischemia and dysrhythmia.

Warranties

Cookgas® LLC agrees to warrant the disposable air-Q SP 3/3G for a period of 30 days following the invoice date. Warranty covers materials and manufacturing defects provided that the airway is used according to the procedures outlined in the Instructions For Use (IFU) manual. Warranty is valid only following purchase from authorized distributors.

Cookgas® LLC disclaims all other warranties whether expressed or implied.

Patents U.S
5,937,860
US 6,422,239 B1
US 6,892,731 B2
US 7,331,347 B2
US 7,900,632 B2
US 9,320,864 B2
US 6,705,321 B2
US 7,357,845 B2
US 7,780,900 B2
US 7,784,464 B2
US 7,934,502 B2
US 8,622,060 B2
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2,410,043
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5296058
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GB2357437B
Other USA & Foreign Patents Pending

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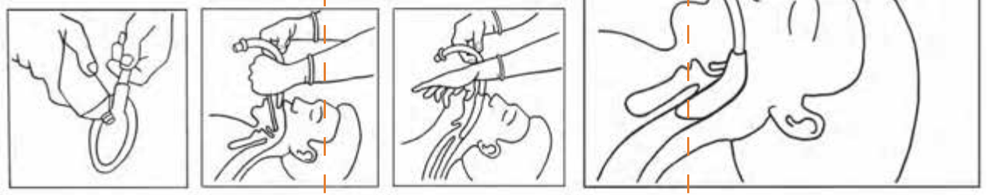
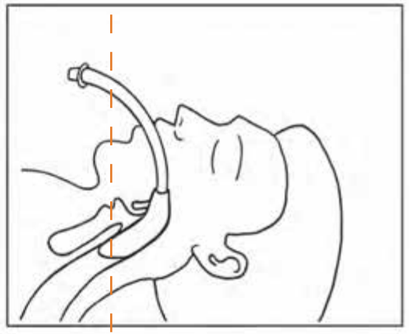
Recommended insertion Technique

Anbefalet indføringsteknik
Aanbevolen inbrengtechniek
Technique d'insertion recommandée
Empfohlenes Einführungsverfahren
Συνιστώμενη τεχνική εισαγωγής
Tecnica di inserimento consigliata
Anbefalt innføringsteknikk
Zalecana technika wsuwania
Técnica de Inserção Recomendada
Рекомендованная техника введения
Técnica de inserción recomendada
Rekommenderad införselteknik
Önerilen Sokma Tekniği
推荐插入方法



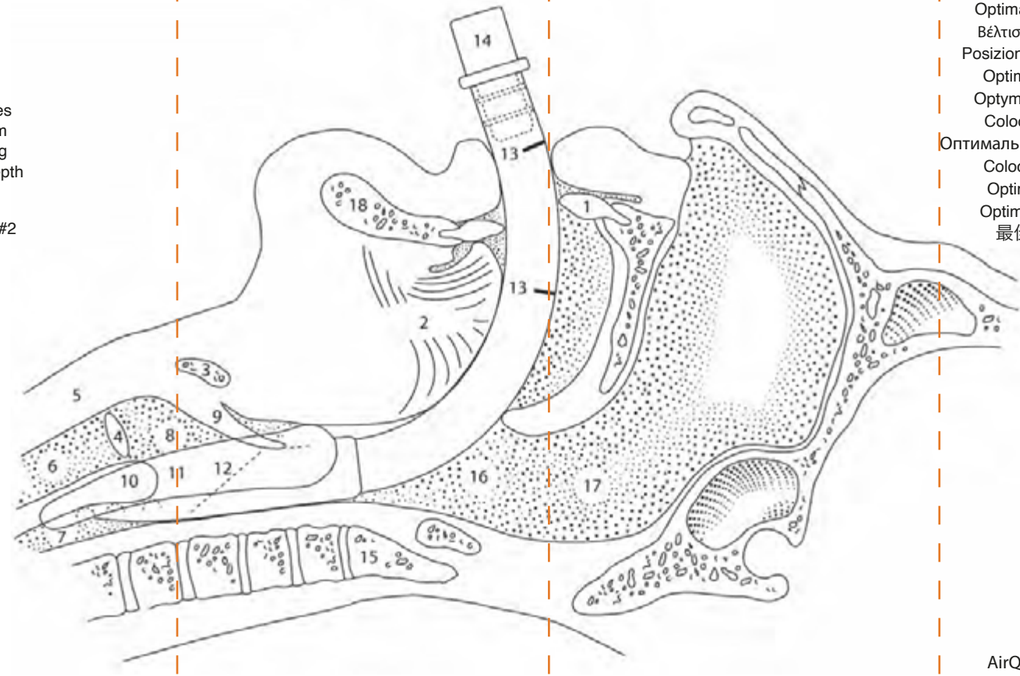


Recommended Depth of Insertion Range

Anbefalet område for indføringsdybde
Aanbevolen inbrengdieptebereik
Profondeur recommandée de la portée d'insertion
Empfohlener Einführtiefenbereich
Συνιστώμενο βάθος εύρους εισαγωγής
Gamma di profondità di inserimento raccomandata
Anbefalt område for innføringsdybde
Zalecany zakres głębokość wsuwania
Intervalo de Profundidade de Inserção Recomendada
Рекомендованный диапазон глубины введения
Profundidad recomendada del rango de inserción
Rekommenderat djup för införselspann
Önerilen Sokma Aralığı Derinliği
推荐插入深度的范围

LENGEND

1. Incisors
2. Tongue
3. Hyoid Bone
4. Vocal Cords/folds
5. Thyroid Cartilage
6. Trachea
7. Esophagus
8. Laryngeal Inlet
9. Epiglottis
10. Arytenoid Cartilages
11. Sealing Mechanism
12. Ventilatory Opening
13. Recommended Depth of Insertion Marks
14. Connector
15. Cervical Vertibrae #2
16. Oral Pharynx
17. Nasal Pharynx
18. Mandible



Optimal Placement

Optimal placering
Optimale plaatsing
Mise en place optimale
Optimale Platzierung
Βέλτιστη τοποθέτηση
Posizionamento ottimale
Optimal plassering
Optymalne położenie
Colocação correta
Оптимальное расположение
Colocación óptima
Optimal placering
Optimal Yerleştirme
最佳放置方案

AirQ 3/3G 10905, Rev. 1 2023/07