Magill Medical

SafeLM® Video Laryngeal Mask System

The First and Only Video Laryngeal Mask with an Adjustable Camera

New Era of Airway Management

SafeLM® Creates the New Era of Airway Management

Studies published in the *British Journal of Anaesthesia* show that malposition occurs in 50-80% blind laryngeal mask (supraglottic airway, SGA) placements! [1] Video laryngeal mask is regarded as the next generation SGA and the future of airway management. [2]

With continuous real-time visualization of airway and high sealing pressure up to 40 cmH_2O, SafeLM® can be used for most surgeries and reduce unnecessary intubation which will prolong operation time, cause extra drug costs and postoperative complications. The new era of airway management is coming! From Basic SGA indications to Advanced SGA indications, SafeLM® is the best and only solution.

SafeLM® Advanced SGA Indications

1. Laparoscopic surgery and robotic surgery
2. Tubeless thoracic surgery
3. Procedure >2 hours or unpredictable surgery duration, such as orthopedic surgery
4. Lateral, Trendelenburg or prone position surgery
5. Overweight patients
6. Video-guided intubation for difficult airways
7. Difficult extubation, such as eye surgery and neurosurgery
8. Bronchoscopy including interventional bronchoscopy
9. Patients requiring hemodynamic stablity, such as ASA 3/4, elderly, or with heart disease
10. Emergency airway management

Contact:
Email:

Magill Medical Technology www.magill med.com

1. A. A. J. Van Zundert et al, Malpositioning of supraglottic airway devices: preventive and corrective strategies British Journal of Anesthesia 116 (5): 579–82 (2016)
2. A. A. J. Van Zundert et al, The case for a 3rd generation supraglottic airway device facilitating direct vision placement . Journal of Clinical Monitoring and Computing (2021) 35:217–224

SafeLM® Improves Hospital Efficiency and Reduces Total Costs

1. Improved Operating Room Efficiency

Operating room time may be reduced by approximately **20 minutes** per case with SGA, improving operating room efficiency and increasing the average daily number of surgery cases, saving approximately **$900-$1,200** per case in operating room costs.

2. Faster Recovery and Shorter Hospital Stay (ERAS)

SGA may accelerate postoperative recovery (ERAS), shorten hospital stay by approximately 3 days, and save approximately **$2,000–$5,000** per day in hospitalization costs.

3. Reduce Muscle Relaxants and Antagonists Usage and Save Drug Costs

SGA may reduce the usage of muscle relaxants and Antagonists (Sugammadex etc.), avoids side effects related to these drugs and reduce drug costs by **$40-$300,** depending on the manufacturer.

SafeLM® Improves Safety and Contributes to ERAS

Surgery/Patient Type	Current Device	SafeLM® Clinical Benefits VS Current Device
Laparoscopic/Robotic surgery	• Endotracheal Tube (ETT)	- Quicker emergence and improved OR efficiency - Reduce postoperative complications and faster recovery (ERAS)
Orthopedic surgery	• ETT > 2 hours • Blind SGA < 2 hours	- Provide Plan B for unpredictable duration surgeries - Avoid the use of muscle relaxants and antagonists (e.g., Sugammadex)
Bronchoscopy	• Blind SGA	- Avoid air leakage and aspiration risk by SGA malposition or shift
Pediatric surgery	• ETT > 2 hours • Blind SGA < 2 hours	- Avoid air leaking and aspiration risk by SGA malposition or shift - Reduce airway trauma and postoperative complications associated with intubation - Avoid the use of muscle relaxants and antagonists (e.g., Sugammadex)
Thoracic surgery	• Double lumen tube • Blocker	- Reduce postoperative complications and faster recovery (ERAS) - Reduce device costs (double lumen tube, blocker, etc.)
Eye Surgery and Neurosurgery	• ETT	- Reduce severe coughing and intracranial pressure elevation
Overweight Patient	• ETT	- Avoid the use of muscle relaxants and antagonists (e.g., Sugammadex) - Reduce postoperative complications and recover quicker (ERAS)
ASA 3/4, elderly or cardiac patients	• ETT > 2 hours • Blind SGA < 2 hours	- Improve hemodynamic stability during intubation, operation and extubation - Reduce postoperative complications and recover quicker (ERAS)

References

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2. Nathaniel W, Michelle S K, Alan L B, Monika M, Lee P S: The use of laryngeal mask airway for tonsillectomy and adenoidectomy. Int J Pediatr Otorhinolaryngol 2021, 144(0).
3. Madni T, Imran J, Clark A, Cunningham H, Taveras L, Arnoldo B, Phelan H, Wolf S: Prospective Evaluation of Operating Room Inefficiency. Journal of burn care & research : official publication of the American Burn Association 2018, 39(6):977-981.
4. Childers C, Maggard-Gibbons M: Understanding Costs of Care in the Operating Room. JAMA surgery 2018, 153(4):e176233.
5. Marrone S: Perioperative accountable care teams: Improving surgical team efficiency and work satisfaction through interprofessional collaboration. Journal of perioperative practice 2018, 28(9):223-230.
6. Jarineshin H, Kashani S, Vatankhah M, Abdulahzade Baghaee A, Sattari S, Fekrat F: Better Hemodynamic Profile of Laryngeal Mask Airway Insertion Compared to Laryngoscopy and Tracheal Intubation. Iranian Red Crescent medical journal 2015, 17(8):e28615.
7. Jia Y, Zhang Y, Wang Z, Pan W, Fu H, Du W: Influence of endotracheal tube and laryngeal mask airway for general anesthesia on perioperative adverse events in patients undergoing laparoscopic hysterectomy: A propensity score-matched analysis. Journal of research in medical sciences : the official journal of Isfahan University of Medical Science1s 2023, 28:88.
8. Huang J, Huang W, Zhang J, Tan Z, Wang D: Application of laryngeal mask airway anesthesia with preserved spontaneous breathing in children undergoing video-assisted thoracic surgery. Frontiers in pediatrics 2023, 11:933158.