Introducing...

The **air-Q** Blocker
Masked Laryngeal Airway

A new design incorporating a soft, flexible guide tube allowing access to the posterior pharynx and upper esophagus.

The Everyday Disposable
"Rescue" Airway
designed to facilitate intubation...
and manage the upper esophagus.
To all Mercury Medical® Distributor Sales & Customer Service Representatives

Over ten years ago, Daniel J. Cook, M.D., researched, developed and patented the air-Q Masked Laryngeal Airway that has gained worldwide acceptance. We are now pleased to introduce a new design incorporating the best product features of the air-Q with additional features built into in the new air-Q Blocker!

Mercury Medical is pleased to announce the latest addition of its family of airway management products.

The manufacturers listed in this document are the holders of their respective names and/or trademarks and are not to be taken as an endorsement or affiliation with Mercury Medical.®
The Disposable \textit{air-Q\textsuperscript{*}} Blocker airway

and

Optional Blocker Tube

From the initial response of clinical evaluations, we anticipate wide customer acceptance of this innovative airway management device, especially in the emergency markets. The combination of a unique device design, along with superior features over competitive devices, has already received customer acceptance for quality and reliability. Mercury is now ready to offer this innovative product to you and your customers.

Mercury Medical is the exclusive U.S. and International Master Distributor for this unique product.

- Please read and understand all of the important product information included in this new product launch package.

- General Product Overview.

- Market Overview. Target Markets include Pre-Hospital EMS Agencies, Hospital Emergency, Anesthesia, Respiratory Departments and Surgi-Centers.

- Key Decision Makers . . . Emergency Medical Directors, EMS Educators, Paramedics, Anesthesiologists, Anesthesia Technicians, RT Directors, Surgi-Center Nurse Managers and Nurse Anesthetists.

- Sales Objectives & Strategies.

- Sample Sales Presentation.

- Comprehensive “Features and Benefits” Section.

- Frequently Asked Questions & Answers.

- Sales Tips for Overcoming Objections.

- Pricing Strategies.

- Ad/Promo/Convention Schedule
Masked Laryngeal Airways:

What they are and why the new Blocker Airway is an important addition to the masked laryngeal product offering.

Supraglottic Mask Airways such as the LMA have been in the U.S. market since the early 1990’s. They are used as an alternative to the combination of face masks and other airway devices. These airways are inserted into the pharynx and create a low pressure seal around the laryngeal inlet in the pharynx. All alternative airways share the same basic principle - a tube delivers oxygen and/or gas without penetrating the vocal cords (glottis) - hence the generic name of supraglottic airways. These airways generally have one or two cuffs that inflate in the lower pharynx to create a seal enabling oxygen (gas) delivery. These devices are alternatives to ET tubes that penetrate the glottis and to mask ventilation.

Supraglottic Airways provide an effective method of forming an airway during anesthesia in patients. These airways are more secure than a face mask while less invasive than intubation with an ET tube. They are used when tracheal intubation is not necessary or during an unexpected difficult airway situation. Patients requiring controlled or assisted-ventilation receive fresh gas through the airway connector.

In general, masked laryngeal airways such as air-Q® and LMA have been used in the acute care markets. The popularity of these devices stem from their ease-of-use, their role in the difficult airway and the advantages they offer over the face mask and more invasive tracheal intubation.

General Advantages of Supraglottic airways over tracheal intubation with an ET tube are:

- Clinicians find they are quicker and easier to insert.
- Less resistance to breathing.
- Less incidence of sore throat.
- Smaller hemodynamic and respiratory response to insertion, maintenance and removal.
  This allows use of lighter levels of anesthetic agents than what might otherwise be necessary.
- Lower drug costs.
- Less trauma to the vocal tract than an ET tube
- May be used in delivery of anesthesia, resuscitation, intensive care and management of the difficult airway.
Disadvantages of existing Supraglottic Airways over tracheal intubation with an ET tube are:

- Ventilation pressure greater than 20cm H₂O may cause gas leaks around the seal.
- Greater incidence of gastric insufflation.
- Less secure airway.
- Greater incidence of post-operative dysphagia.
- Increased risk of aspiration.

**Tube Cuff Devices in Pre-Hospital Market:**

While masked laryngeal airways are standard hospital equipment, this is not the case in the pre-hospital market. Intubation remains the most common method of maintaining a patient airway, this skill requires frequent practice to keep EMS providers competent and comfortable with performing it. Pre-hospital intubation success rates are shockingly low. Due to these facts, alternative rescue airways such as King Laryngeal tube/cuff devices are becoming increasingly popular in the pre-hospital market. The ease of the tube cuff device placement, for establishing an airway for positive pressure ventilation, have become a standard of care.

**Disposable Laryngeal Mask Airway - Market Size Overview:**

Use of Supraglottic Airway devices grew rapidly in the acute care market as clinicians learn and understand their advantages as an alternative to tracheal tube intubations. Overall, the US hospital disposable laryngeal mask/tube cuff device market share is quite large with 4-million in unit sales and $46-million in disposable revenue annually.
Supraglottic Airway Devices . . . Masked Laryngeal vs Tube/Cuff devices:

While the hospital market is extremely large, sales over the last several years are flat. Seeing this, LMA launched their new LMA Supreme several years ago. This premium-priced device featured an added gastric channel designed to manage the esophagus.

Knowing that the EMS market must deal with patients who, unlike the fasted hospital patient, may have just eaten, LMA designed their “Supreme” device for use in pre-hospital and difficult airways in acute care. It features a drain tube at the tip of the mask that enters the esophagus. This is intended to assist clinicians in managing gastric fluids should they occur during ventilation. In 2010, LMA “Supreme” captured 17% of the hospital market with $8-million in US hospital sales revenue. We are just beginning to see “Supreme” device evaluations in the EMS market.
King LTS-D tubes are tube/cuff devices: These airways generally have two cuffs that inflate in the lower pharynx to create a seal enabling oxygen (gas) delivery. They are preferred by EMS for their ease-of-placement and claim to manage the esophagus with an integrated drain tube. The tube/cuff devices such as the King LTS-D are prominent in the pre-hospital field. While EMS data is difficult to obtain, King’s disposable tube devices total $558,000 in US Hospital sales or 10.5% market share in disposable alternative airway revenue.

The following table represents IMS hospital disposable Supraglottic airway annual sales data.

<table>
<thead>
<tr>
<th>Region</th>
<th>Annual Disposable Sales $ as of September 2010</th>
<th>Units as of September 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$46,360,451</td>
<td>3,965,839</td>
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</table>

Overall sales revenue was down 1.16% while disposable unit sales were down 2% over the prior year. This included all masked and tube/cuff devices.

**Major Opportunity EMS Market for Masked Laryngeal Growth:**

The hospital market, while large, has not seen growth in disposable airways for the last few years. *The biggest opportunity for growth is in the EMS market!* As an added opportunity . . . the leading EMS airway device, King LT-D & LTS-D cuff/tubes experienced 3 FDA recalls since January, 2011. At a recent EMS national meeting, a leading EMS educator lectured on the advantages of air-Q®. These EMS provider leaders are actively looking to replace their King tubes with another device. It is the right time to take air-Q and the new air-Q Blocker into all of your EMS contacts to assist them with the clinical solution to their current airway dilemma.
Advantages of Mercury’s air-Q® Blocker “Rescue” Airway . . .

Dr. Daniel J. Cook spent the last 4 years developing an improved Supraglottic airway that assists clinicians in managing patients system-wide . . . from the pre-hospital to the hospital setting. He patented this new airway called the air-Q Blocker. Dr. Cook’s 3 major design objectives are simple and unlike any existing Supraglottic airway products including LMA’s Supreme. The new air-Q Blocker is the first airway designed for system-wide use:

air-Q Blocker Design Objectives:

♦ The disposable air-Q Blocker should be used routinely as a classic passive airway. The air-Q Blocker is user-friendly, placement in patients is easy and air movement is outstanding. With seal pressures consistently at or above 20 cm, it is ideal as a pre-hospital rescue airway.

♦ It has the added “benefit” of allowing for intubation using standard ET tubes: In addition to delivering oxygen and/or gas to the patient, the patented Intubating Laryngeal Airway allows clinicians to intubate through it using a standard oral endotracheal tube (OETT sizes 5.0 – 8.5). It allows for air-Q Blocker removal after intubation; The user can easily remove the air-Q Blocker without dislodging the ET tube with the air-Q Removal Stylet.

♦ It includes the new, built-in, soft guide channel that accepts regular Nasal Gastric (NG) tubes to suction or optional Blocker Tubes for accessing the posterior pharynx and managing the esophagus. When using the Blocker Tube through the Blocker channel, clinicians can suction the pharynx or suction, vent and block the upper esophagus.
Introducing...

The air-Q Blocker

A new design incorporating a soft, flexible guide tube allowing access to the posterior pharynx and upper esophagus.

- Use as a primary airway device when an oral endotracheal tube is not necessary.
- As an aid to intubation in difficult airway situations.
- Well suited when a bite block and/or access to posterior pharynx and upper esophagus is desired.

The Everyday Disposable "Rescue" Airway designed to facilitate intubation... and manage the upper esophagus.

Mercury Medical®
11333 - 49th Street North
Clearwater, Florida 33762-4037
www.mercurymed.com
Directions for Use

The air-Q Blocker Masked Laryngeal 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 alternative to an OETT. It is especially suited for applications when a bite block is necessary or access to the posterior pharynx and upper esophagus is desired.

Thank you for purchasing the air-Q Blocker Masked Laryngeal Airway by Cookgas. Due to its patented design, the air-Q Blocker is user-friendly. Placement is easy, air movement is outstanding, and intubation using standard oral endotracheal tubes (OETT), sizes 8.5mm and 7.5mm is straightforward and reliable. The air-Q Blocker remains following intubation is quickly accomplished using the patented air-Q Removal Valve, also by Cookgas, LLC.

Welcome to the Next Generation of Airway Management: Say Goodbye to the Difficult Airway, and Hello to the air-Q.

The Only Airway You’ll Want, The Only One You’ll Need!

This product is to be used by trained personnel only.

Available in Single Use

<table>
<thead>
<tr>
<th>Size</th>
<th>4.5</th>
<th>3.5</th>
<th>3.0</th>
<th>2.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>70-100 kg</td>
<td>8.5mm</td>
<td>7.5mm</td>
<td>6.5mm</td>
<td>5.5mm</td>
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<tr>
<td>55-75 kg</td>
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<td>40-55 kg</td>
<td>6.5mm</td>
<td>5.5mm</td>
<td>4.5mm</td>
<td>3.5mm</td>
</tr>
</tbody>
</table>

- Minimum mouth opening for insertion.
- Distance from the external edge of the airway tube to the internal ventral opening.
- Internal volume from the external edge of the connector to the internal ventral opening.
- Recommended inflow volume following insertion with inflation valve open to air.

Distributed exclusively by: Mercury Medical®

For Ordering Information, Contact:
11300 – 49th Street North
Clearwater, Florida 33762-4807 USA
Telephone: 800-237-6418 • Fax: 800-990-6375
www.mercurymed.com

Manufactured by Cookgas, LLC in Malaysia

CE 0482

LC 1080 - Rev/A2 4/1/11
air-Q® BLOCKER TUBE

INDICATIONS

The air-Q® Blocker Tube is indicated as an endotracheal blocker, ventilation device to be used in conjunction with supraglottic airways, preferably with the air-Q® Blocker Airway when blocking, ventilation, and suctioning the upper airway is desired.

Thank you for purchasing the air-Q® Blocker Tube by Cookgasp® LLC. Due to its unique combination of features, the air-Q® Blocker Tube is an outstanding addition to airway management. The air-Q® Blocker Tube is designed to efficiently and safely block vent, and secure the upper esophagus during use in combination with supraglottic airways. It is especially useful in conjunction with the air-Q® modified laryngeal mask airway containing the guide tube feature, a unique design by Cookgasp® LLC.

Welcome to the Next Generation of Airway Management. Say Goodbye to the Difficult Airway, and hello to the air-Q® Blocker Tube.

The Only Airway You’ll Want, The Only One You’ll Need!

This product is to be used by trained personnel only.

Instructions for Use:

<table>
<thead>
<tr>
<th>Size</th>
<th>IBW</th>
<th>Inflation Volume</th>
<th>Inflation Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5</td>
<td>70-100 kg</td>
<td>5-10 ml</td>
<td>500 cm H2O</td>
</tr>
<tr>
<td>3.5</td>
<td>50-70 kg</td>
<td>5-10 ml</td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>30-50 kg</td>
<td>5-10 ml</td>
<td></td>
</tr>
</tbody>
</table>

air-Q® Blocker Tube Placement Procedure

The procedure below is intended as a guide. Many techniques can be successfully used to place the air-Q® Blocker Tube into the proper position within the upper airway:

1. Completely deflate the air-Q® Blocker Tube balloon.
2. Generously lubricate the blocker balloon area.
3. Pass the air-Q® Blocker Tube into the guide tube located on the airway device using a twisting motion to first introduce the blocker tube into the guide tube feature.
4. Slide the air-Q® Blocker Tube up and down while twisting to spread the lubricant within the guide tube until the blocker tube is loose enough.
5. Pass the air-Q® Blocker Tube forward until the blocker stops contacting the upper edge of the guide tube.
6. Inflate the blocker balloon using the recommended chart as a guide.
7. Check proper esophageal placement by gently pulling back on the blocker tube. The air-Q® Blocker Tube should encounter resistance to further advancement within 1/2-1 inch as it becomes obstructed by the distal tip of the airway device, preventing further withdrawal. This confirms proper placement of the blocker tube just distal to the tip of the airway device and within the upper esophagus.
8. If the distance of withdrawal is significantly greater than 1/2 to 1 inch, this suggests that the blocker balloon fails to pass beyond the tip of the airway device. This obstruction occurs when the blocker balloon engages the distal end of the guide tube. In this case, simply deflate the blocker balloon, re-enter the air-Q® Blocker Tube, and re-check for proper depth according to Steps 4-7 above.
9. Once the proper placement of the blocker balloon (beyond the distal tip of the airway device and into the upper esophagus) is confirmed, advance the blocker tube until the blocker stops engaging firmly within the upper guide tube. This is accomplished by pulling the guide tube to the airway device for the duration of the use.

air-Q® Blocker Tube Removal

1. Completely deflate the blocker balloon.
2. Withdraw the blocker tube until it exits the guide tube.
3. Alternatively, connect the section tip of the blocker tube to a suction device, include the suction tubing's vent of the suction line, and use the blocker tube as a suction catheter for suctioning the pharynx during withdrawal of the blocker tube.
4. Discard used blocker tubes.
Cautions/Warnings

1. Discard all air-Q® Blocker Tubes with damaged packaging.
2. Inspect all devices prior to use. Discard all damaged devices.
3. Do not use sharp instruments or cut the air-Q® Blocker Tube.
4. Confirm that the air-Q® Blocker Tube matches the correct size of the aneurysm device.
5. Do not use an aneurysm device on the air-Q® Blocker Tube prior to insertion.
6. Always check for proper placement of catheter prior to insertion.
7. If perforation is seen within the aneurysm tube during use, it is highly recommended to maintain away from the lesion. For more information, refer to the aneurysm device.
8. Single patient use only. Discard following use. The use of Single Use Device may lower the likelihood of cross-contamination.
9. A minimum recommended occlusion balloon pressure is 20 mm Hg. Balloon volume increase may change with the use of different sizes or different patient. DO NOT OVERINFLATE.
10. The air-Q® Blocker Tube does not protect the patient from aspiration.
11. The air-Q® Blocker Tube is potentially flammable in the presence of oxygen and electrical spark. Exercise caution.

Contraindications

The air-Q® Blocker Tube is contraindicated in patients with known oropharyngeal pathology, including but not limited to oropharyngeal ulcers, lacerations, and fistulae.

Adverse Effects

Possible adverse effects include but are not limited to oropharyngeal emphysema, emphysema bleeding, mucosal tears, or perforations, and partial or complete occlusion of the lumen distal to the occlusion.

Warranty

Coolguard LLC warrants the air-Q® Blocker Tube for a period of 90 days following the invoice date. Warranty covers materials and manufacturing defects provided the air-Q® Blocker Tube is used according to the instructions and is not used for purposes other than those intended. Warranty is void only following purchase from an authorized distributor.

The original packaging label must accompany the detector for Q® Blocker Tube device for valid warranty insurance.

Coolguard LLC disclaims all other warranties, express or implied.
Optimal Placement

1. Generator
2. Switchgear
3. Transformers
4. Main Distribution Board
5. Emergency Generator
6. Switchgear
7. Transformer
8. Generator
9. Control Panel
10. Auxiliary Transformer
11. Switchgear
12. Emergency Generator
13. Switchgear
14. Control Panel
15. Generator
16. Switchgear
17. Transformer
18. Switchgear
19. Generator
20. Switchgear
21. Emergency Generator
22. Switchgear
23. Transformer
24. Switchgear
25. Control Panel
3 Sizes Available

♦ **3 air-Q® Blocker single-patient-use available in sizes (2.5, 3.5, 4.5).** Can be used for most adults and adolescent patients. They are available in ½ sizes since these fit a broader range of patients.

♦ **The superior design allows for proper positioning. Once positioned, the air-Q Blocker maintains proper position throughout each procedure.**

Unique recessed front balloon and flattened overall balloon cuff facilitates a smooth insertion and proper placement. The cuff of the heel is built up to provide a better seal offering consistent ventilation pressures of 20 cm without leaking. Placement within the pharynx preserves the normal alignment of the pharyngeal airway passage and the laryngeal inlet. The air-Q Blocker fits snugly in place making it difficult to twist out of alignment. Clinicians can easily achieve proper alignment between the air-Q Blocker, the pharyngeal airway passage and the laryngeal inlet. Proper alignment is vital to oral-tracheal intubation through the air-Q Blocker.

♦ **air-Q Blocker Design directs OETT’s toward laryngeal inlet.** As in the regular air-Q, the air-Q Blocker keyhole-shaped airway outlet and elevation ramp directs OETT’s midline and upward toward the laryngeal inlet. This also creates ample space for other medical instruments used for intubation.

♦ **Ridges and Blocker Channel provide access to posterior pharynx and upper esophagus for reduced potential for aspiration.** Once the balloon is inflated, the ridges are moved against the posterior larynx improving the mask seal. This helps to isolate the esophagus reducing the potential for aspiration. If needed, the Blocker channel provides esophageal access behind the mask. Clinicians can lubricate their NG tubes and place them into the esophagus through the guide channel to suction.

♦ **Optional Blocker Tubes** are designed to insert through the guide channel, (lubricated first), to suction the pharynx or suction, vent, and block the upper esophagus.
Design reduces potential for airway obstruction by the epiglottis. The auxiliary airway holes help to prevent the suction effects of drawing the epiglottis inside the airway tube and obstructing the airway. In the event of partial airway obstruction by the epiglottis, the auxiliary airway holes improve airway flow. Extension of the airway tube into the mask cavity together with the beveled tube outlet gently elevates the epiglottis up allowing direct access to the laryngeal inlet.

Built-in Bite Block improves ease-of-placement and lessens incidence of airway tube kinking. The hyper-curved airway tube better approximates the shape of the oral-pharyngeal passage. This eliminates the need to “over bend” the airway tube decreasing the incidence of the airway tube kinking during use.

Ridges improve seal. The ridges below the airway connection of the airway tube improve the tube seal. They also allow for easy removal of the connector during intubation through the device.

The Oval-Shaped Airway tube creates a larger internal volume. This accommodates large ET tubes during oral-tracheal intubation through the air-Q Blocker. The oval shape minimizes the air-Q Blocker from twisting in the mouth during use.

Sterile Single-Patient-Use Device eliminates unnecessary costs in time and cleaning. Disposable design also helps to eliminate cross-contamination.

Latex-Free Material. Disposable Device is manufactured with Latex-Free PVC. All optional accessories are 100% Latex-Free.

Mercury Medical® is the leading manufacturer of Airway Management devices. By introducing air-Q Blocker, we extend this product line by offering a superior Supraglottic airway ideal for pre-hospital and hospital use in acute care and pre-hospital markets we already address. These wedge products also serve to increase market awareness for increased sales of compatible Mercury Medical® products such as the Flow-Safe™, Neo-Tee®, StatCO2® family, CPR, Flex-Link™ and EZflow®/EZflow® MAX, etc.

This new single-patient-use product addresses the new and growing EMS market opportunities presented by the King competitive product recalls. Air-Q Blocker is ideal for EMS with all of the distinct “rescue” airway requirements and advantages for intubation and managing the esophagus. Hospitals and EMS agencies are already purchasing an increasing number of alternative airways.

Now Mercury provides the ideal solution in one air-Q® Blocker airway that allows:

- Rescue ventilation
- Rescue intubation
- Rescue suctioning and venting of the esophagus.
MARKETING & SALES OBJECTIVES . . .

○ Key Markets/Contacts:

- Target and contact key EMS agencies and hospitals in all territories currently using King LTS-D Tubes, LMA Supreme or other competitive airways. Contact all hospital departments that provide emergency, respiratory, anesthesia and patient transport services.

- Key Departments include Emergency Rooms, Respiratory, Anesthesia, OR and Surgi-Centers. The primary call points are with the Anesthesiologist, Anesthesia Technician, ER Director, RT Director, Nurse Anesthetist and Purchasing Director as primary decision makers.

○ Advertising General Plan:

- We will help you to gain market share by creating vast market awareness through planned Advertising and Promotions for the Disposable air-Q® Blocker availability. Marketing has set the foundation by bringing Dr. Cook to major EMS meetings and introducing him to key EMS Directors and EMS journal publishers. We filmed him at the recent EMS Today Show and will present the video via a JEMS.com link. We plan to have this available on YouTube shortly. Full page ads will launch in JEMS & EMS World emergency trade journals that reach over 40,000 EMS Clinicians monthly along with Anesthesiology News starting in June 2011.

- Ads and direct mail campaigns are tied to EMS, Anesthesia and RT conventions we attend.

- Direct mail with sample offers to EMS Educators, Medical Directors and EMS Clinicians in conjunction with advertising in trade journals are planned that carry the ad themes.

- All leads will be available through the CRM system for Mercury’s direct territories. Marketing will provide distributor leads to appropriate lead territory contacts.

○ Maintain Pricing Strategy:

- The air-Q® Blocker offers distinct advantages over LMA Supreme, King airways and competitive clones. We are providing competitive pricing for these premium value-added products.

○ Forecasting New Business:

- All distributors and direct representatives will report all new business to their Regional Manager for Marketing to ensure sufficient inventory levels. This information is critical as we introduce this product! Please obtain all relevant competitive information such as pricing, catalogs, sales sheets or product samples and forward this information to your Regional Manager who, in turn, will forward to the Marketing Department.

○ Clinical Support Studies:

- Pending air-Q® Blocker Abstract
Tips & Techniques

A. Selecting the Proper Size and Pre-Insertion suggestions:

1. Sizing the air-Q® Blocker correctly is very important. Ask the clinician what size LMA or King Laryngeal Tube device they would use on the patient and select the appropriate size air-Q Blocker according to cross-referenced sizes. (Typically, LMA Supreme size 2.5 cross-references to air-Q size 2.5, LMA 3.0 to air-Q Blocker 3.5, and LMA 4 & 5 to air-Q Blocker 4.5).

2. Look at the patient’s Ideal Body Weight, IBW, not the patient’s actual weight. IBW is what the recommended weight range air-Q Blocker refers to, not actual weight. If, for instance, a 5’2”, 250 lb. woman would have an IBW of approximately 50 - 60 kg, not 120 kg, it would be more appropriately sized at 3.5.

3. Visualize the patient, especially the facial structures and laryngeal area. Small structures should guide you to smaller air-Q Blocker sizes, etc.

B. Insertion of the air-Q Blocker is typically easy, but there are certain things that will help to maximize success:

1. Elevating the tongue is very important. Make sure the clinicians know to do this. If they force the air-Q Blocker in, the epiglottis may down-fold or become lodged into the keyhole opening. The patient will still be able to breathe without difficulty, but intubation is more difficult.

   Jaw Lift is the best way to do this and is very easy to do. Performing a jaw lift also makes sliding the air-Q Blocker into the pharynx much easier as well. Doing a jaw lift during insertion is important with all Supraglottic airways, not just the air-Q Blocker. Many clinicians do this routinely, but there are some who do not.

2. Prior to insertion, lubricate both the front and back of the air-Q Blocker. Be sure to lubricate the ridges within the mask cavity also. If the patient’s mouth is dry, which it frequently is, the air-Q Blocker ridges can get hung up on the back of the tongue during placement. Proper lubrication only takes a few seconds.

3. When using the Blocker tube or NG tube through the guide channel, make certain that you lubricate the top of the guide channel and the Blocker tube or NG tube thoroughly.

4. Place the air-Q Blocker with the red tab on the pilot balloon in place. Once placed, remove the red tab and inflate with 2 - 5 cc of air or just until you get a nice, firm bounce on the pilot balloon. Keeping the red tab in place during insertion keeps the valve open allowing the mask to adjust easily and conform to the pharyngeal space.
Tips & Techniques

C. Minimizing Leaks:

- If the clinician hyper-extends the head during placement, put the head in the neutral position after placement. This is better for the patient overall and helps minimize leaks.

- With the air-Q® Blocker inflated, pull the air-Q Blocker back 1/4 - 1/2 inch. This can help to correctly place it.

- Again, it is important to use a jaw lift during insertion. If not done during the original insertion, ask the clinician to remove air from the mask, back the air-Q Blocker out about 3 - 4”, then re-insert using a jaw lift.

- Try a different size of air-Q Blocker. If you use a 3.5, and the patient looks a little big, go up to a size 4.5. If you use a 4.5, and the patient looks a little small, go down to a 3.5.

D. Intubation Tips:

1. Prior to intubation, lubricate the OETT generously and lubricate the inner portion of the air-Q Blocker airway tube by sliding the OETT up and down within the air-Q Blocker airway tube several times. If it is still a little sticky, then remove the OETT and place a little more lubricant near the end of the OETT and replace the OETT into the air-Q Blocker airway tube. This will really lubricate the tube well which is the secret to easy passage within the air-Q Blocker. Again, all this just takes a few moments, but is very important. If the tubes are not lubricated well, the clinician will find it harder to tell when he/she enters the trachea or hits an obstruction.

2. Difficult Visualization: If the clinician using Fiber Optics does not immediately see the opening to the trachea and the cords, the epiglottis is most likely down-folded (partially shut) or sitting within the air-Q Blocker’s keyhole opening into the mask. This usually happens when a jaw lift has not been done during insertion. The epiglottis can then get caught by the keyhole tunnel structure and this will either partially close the epiglottis, which obstructs the view entirely, or entrap the epiglottis within the keyhole opening leading to a partially obstructed view. Alternatively, a bi-manual external jaw lift will usually expose the glottis for visualization.

   This can usually be alleviated by performing the “Klein Maneuver.” Deflate the air-Q Blocker, and pull the air-Q Blocker back about 2 - 3 inches. Next, reinsert the air-Q Blocker using a lower jaw lift. This will generally lift the epiglottis up and into proper position. This is demonstrated nicely in the Air-Q Video on CD and on the Mercury Medical and Cookgas websites.
3. Bougie Insertion Tips:

a. Lubricate the bougie, the air-Q Blocker and the ET tube. It is important to lubricate the bougie so it slides easier, giving the clinician better tactile feedback while passing the bougie.

b. Prior to bougie insertion, first place the ET tube through the air-Q Blocker airway tube approximately 12 - 15 cm, but not completely into the patient. This is called pre-loading the ET tube. The ET tube is much smaller than the air-Q Blocker airway tube and will help to keep the bougie centered and help to guide it toward the glottic opening. If the clinician passes the bougie alone through the air-Q Blocker before the ET tube is inserted, it is much more likely that the bougie will spin off center during placement. The air-Q Blocker airway tube is much larger than the ET tube and also is oval-shaped, giving the bougie much more room to move off center.

c. Next, insert the bougie through the ET tube with the tip pointing anterior, and gently pass the bougie forward feeling for obstruction to further passage. Do Not Force the bougie. If it goes into the trachea, it will go quite easily. If it does not, it is probably off to one side or the other, or hitting the epiglottis as described above. (Remember this is very delicate tissue!) Feel over the cricoid area of the neck during passage, a nurse or medic can do this for you. A scraping sensation will usually be felt as the bougie passes over the cricoid ring. It takes a little practice to get the feel of this.

d. Once the bougie passes into the trachea, advance the ET tube into the trachea using the bougie as a guide. Note: Sometimes the bougie, or any type of stylet for that matter, can be properly placed within the trachea, but the clinician is unable to pass the ET tube. In this case, the ET tube is probably hanging up on the lower aspect of the inlet. If this happens it usually helps to deflate the air-Q Blocker cuff and apply cricoid pressure while passing the ET tube. Also turning the ET tube ¼ turn to the left (counterclockwise) will help by placing the bevel of the ET tube facing down. If this does not help, try a smaller ET tube. This obstruction to passing the ET tube is not a specific problem to the air-Q Blocker; this happens occasionally with all stylet intubations and intubation devices.

e. If the bougie does not go into the trachea easily, it usually misses to one side or the other. It usually misses to the right. Pull the bougie back a few centimeters, twist the bougie slightly to the left if you believe it missed to the right, and try to pass again. With a little practice, the clinician can usually “walk” the bougie slowly over to the midline and into the trachea. This does take some practice. Remember, the bougie will advance quite easily when you enter the trachea, DO NOT FORCE the bougie. Hint: A helper feeling over the cricoid area of the neck can often feel the bougie if it misses to one side or the other. Remember if the epiglottis is causing an obstruction, this can lead to unsuccessful attempts with the bougie as well.
Frequently Asked Questions and Answers

What size ET tubes will the AIR-Q BLOCKER take? (Normally recommend ½ size lower than the maximum.)

- The 2.5 air-Q Blocker will accept up to a size 6.5 ET tube.
- The 3.5 air-Q Blocker will accept up to a size 7.5 ET tube.
- The 4.5 air-Q Blocker will accept up to a size 8.5 ET tube.

How much volume should inflate the cuff?

2-5 cc’s of air. You want a nice firm bounce in the pilot balloon.

What is the extra hole above the airway inlet for?

The auxiliary hole acts like a hole in the bottom of a straw to prevent the epiglottis from getting suctioned into the keyhole-shaped airway inlet. This hole also acts as an auxiliary breathing pathway similar to the Murphy’s Eye of an endotracheal tube.

Is the air-Q Blocker CE marked? Yes.

Can we intubate blindly through the air-Q Blocker?

Blind intubation success rate in 65 - 70% on the first attempt. We recommend you use a gum elastic bougie to assist in proper ET tube placement.

How do I select the correct size of air-Q Blocker airway?

Maximum use of the air-Q Blocker airway can be dependent upon appropriate size selection. Clinical judgment based on multiple variables, including patient anatomy and physiology as well as weight, should be taken into consideration when selecting an air-Q Blocker.

It is important to understand that if the maximum inflation volume of air is necessary to create a seal, the use of a larger size mask should be considered. A mask that is too small and over-inflated may result in a non-optimal fit.

Start by choosing the largest size you think will fit and inflate with the smallest volume required to obtain an adequate seal. A general rule of thumb is that the larger the mask size, the lower the intracuff pressure needed to obtain an adequate seal.
Should I insert an NG Tube or the Blocker Tube through the guide channel every time I use the air-Q® Blocker? If I insert a tube, can I leave it in place for the duration of the procedure?

The Blocker Channel has been designed primarily for access to the posterior pharynx and upper esophagus when needed. The guide channel allows passage of an NG or Blocker Tube and is an additional advantage. Depending upon a number of factors use of an NG Tube or Blocker Tube is a clinical decision. It may be left open to the atmosphere.

I feel resistance when trying to pass the NG Tube . . . What Should I Do?

Never use force when passing the NG or the Blocker Tube. If you feel resistance, check for adequate lubrication and try inserting again.
**DISPOSABLE air-Q® Blocker COMPETITIVE CROSS REFERENCE CHART**  
Major air-Q Blocker Competitors in Premium Disposable Airways

<table>
<thead>
<tr>
<th>Airway Type and Clinical Application</th>
<th>Air-Q BLOCKER</th>
<th>LMA Supreme</th>
<th>King LTS-D Tube/Cuff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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. It is especially suited for applications when a bite block and/or access to the posterior pharynx or upper esophagus is desired. Addition of the soft flexible guide tube allows NG tube or Blocker tube access to posterior pharynx and upper esophagus. Optional Blocker tubes are designed to suction the pharynx or suction, vent and block the upper esophagus.</td>
<td>Masked Laryngeal Airway. Use as an LMA Classic/Unique with integrated drain tube designed to channel fluid and gas away from the airway.</td>
<td>Tube/Cuff device consists of a double lumen tube with separate pathways for ventilation and access to the stomach. It provides a patent airway for patient ventilation and ability to pass a gastric tube through a second channel of the airway into the esophagus.</td>
</tr>
<tr>
<td>FDA Recalls</td>
<td>No</td>
<td>No</td>
<td>Yes – 3 since January 2011</td>
</tr>
<tr>
<td>Ability to Intubate</td>
<td>Yes using standard ET Tubes up to 8.5</td>
<td>Recommends clinicians use the Fastrach</td>
<td>No</td>
</tr>
<tr>
<td>Able to remove Masked Airway after Intubation</td>
<td>Yes-with removal stylet</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Sizes</td>
<td>2.5, 3.5, 4.5 air-Q Blocker and 2.5, 3.5, 4.5 air-Q Blocker Kits (w/double swivel elbow/syringe and lube pack)</td>
<td>Sizes 1-5 LMA Supreme and Sizes 3, 4, 5 LMA Supreme Kits (w/syringe and lube pack)</td>
<td>Sizes 3, 4, 5</td>
</tr>
<tr>
<td>Maximum Gastric Tube through Channel</td>
<td>18 Fr</td>
<td>14 Fr</td>
<td>18 Fr</td>
</tr>
<tr>
<td>Maximum ET Tube</td>
<td>Up to 8.5</td>
<td>While they recommend the Fastrach for intubating they state a size 6 ET tube is the maximum size for Supreme</td>
<td>N/A - Must remove device to intubate.</td>
</tr>
<tr>
<td>Packaging</td>
<td>10/box</td>
<td>10/box</td>
<td>10/box</td>
</tr>
<tr>
<td>Average U.S.Hospital Sell Price/each</td>
<td>$25.00</td>
<td>$ 22.32</td>
<td>$38.87</td>
</tr>
</tbody>
</table>
**air-Q Blocker™**

...The everyday airway designed to facilitate intubation.

3 sizes available

Creating the color standard for masked laryngeal airways

<table>
<thead>
<tr>
<th>Item #</th>
<th>Size</th>
<th>Description</th>
<th>Quantity</th>
<th>Weight</th>
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<tbody>
<tr>
<td>#10-9025</td>
<td>2.5</td>
<td>air-Q Blocker Disposable Airway only, yellow connector</td>
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<td>50 - 60 kgs</td>
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<td>#10-9035</td>
<td>3.5</td>
<td>air-Q Blocker Disposable Airway only, red connector</td>
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<td>50 - 70 kgs</td>
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<tr>
<td>#10-9045</td>
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<td>air-Q Blocker Disposable Airway only, purple connector</td>
<td>10/Box</td>
<td>70 - 100 kgs</td>
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<td>#10-9026</td>
<td>2.5</td>
<td>air-Q Blocker Disposable Airway kit w/lubricant &amp; 10 cc syringe</td>
<td>10/Box</td>
<td>30 - 50 kgs</td>
</tr>
<tr>
<td>#10-9036</td>
<td>3.5</td>
<td>air-Q Blocker Disposable Airway kit w/lubricant &amp; 10 cc syringe</td>
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<td>50 - 70 kgs</td>
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<tr>
<td>#10-9046</td>
<td>4.5</td>
<td>air-Q Blocker Disposable Airway kit w/lubricant &amp; 10 cc syringe</td>
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<td>70 - 100 kgs</td>
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<tr>
<td>#10-9027</td>
<td></td>
<td>air-Q Blocker Tube for airway size 2.5</td>
<td>10/Box</td>
<td></td>
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<tr>
<td>#10-9037</td>
<td></td>
<td>air-Q Blocker Tube for airway size 3.5</td>
<td>10/Box</td>
<td></td>
</tr>
<tr>
<td>#10-9047</td>
<td></td>
<td>air-Q Blocker Tube for airway size 4.5</td>
<td>10/Box</td>
<td></td>
</tr>
<tr>
<td>#10-1005</td>
<td></td>
<td>Disposable Removal Stylet for 2.5 airway</td>
<td>10/Box</td>
<td></td>
</tr>
<tr>
<td>#10-1004</td>
<td></td>
<td>Disposable Removal Stylet for 3.5 &amp; 4.5 airway</td>
<td>10/Box</td>
<td></td>
</tr>
</tbody>
</table>

Distributed by: Mercury Medical

Registered trademark, air-Q®, property of Cookpro, LLC

Other patents pending.
Air-Q® Blocker
Intubating Laryngeal Airway

with

Optional Blocker Tube

Pricing Strategy:

Begin your pricing negotiations well above your cost . . .

Mercury is providing a high quality product superior to what is currently available, the air-Q Blocker with added-value that the competition currently cannot provide.

Superior Features . . .

Concentrate on the superior “design features” allowing for easier insertion, better placement, reduced incidence of epiglottis obstruction, ability to perform oral endotracheal tube intubation, etc.

Discuss all pricing with your Regional Manager . . .

If you have a difficult or competitive situation, we will assist you in providing the special pricing you require to “close the deal” and obtain new business.

Bundle Products . . .

Mercury has many products that meet the needs of your target departments including a full line of laryngoscope blades and handles, manometers, face masks, hyperinflation bags, StatCO₂® end tidal CO₂ detectors, the Flex-Link™ and the PowerMate®/IsoMate® power outlets.
The predominant EMS airway of choice has evolved into the disposable King LTS-D tube/cuff device. Due to the recent series of FDA recalls (3 since January, 2011), now is the opportune time to meet with your EMS contacts to introduce the new air-Q Blocker and demonstrate all of the advantages.

Sales Rep Question: What alternative airway are you currently using?

Most will reply they are using the King tube/cuff devices.

Sales Rep Response: Yes, most EMS agencies are using the tube/cuff devices since they are very good rescue airways, easy to insert and ventilate.

Question: Have you had any product or supply concerns since the recent series of King tube/cuff device FDA recalls?

Question: Would you be interested in a new device that is easy-to-place, provides good ventilation, allows the option to intubate and suction, vent and block the esophagus - It is like having 2 devices (tube/cuff device and masked laryngeal device) in one.

Problems can occur, once the patient reaches the emergency room they usually remove that device and use another airway or possibly intubate. These procedures could compromise the airway.

Take out an air-Q, air-Q Blocker, ET Tube, Removal Stylet and Blocker Tube, (samples for demo).

“If you are looking for an alternative airway to your current device, we represent the latest innovation for Emergency Airway Management in the new EMS “rescue” airway called, the air-Q Blocker. It is the first airway device designed by a clinician for system-wide use - from pre-hospital through acute care to control and manage the patient airway.

First, the original air-Q and air-Q Blocker airways were created by an anesthesiologist who, for the last 15 years of his career has designed and developed airway devices. The air-Q Blocker is a primary rescue airway that can also facilitate intubation “without removing the mask” in difficult airway situations. The primary difference between this and the regular air-Q device is the integrated soft, flexible guide tube that is especially suited for access to the posterior pharynx or upper esophagus.

From what we are hearing from clinicians across the country, the air-Q Blocker’s unique design overcomes several problems that clinicians face when using other “rescue” airway devices.

Like the regular air-Q, the air-Q Blocker has a built-in bite block that aids in preventing broken teeth while keeping the patient from occluding the airway tube.
It is also easy to place. The air-Q® Blocker is designed with a more rigid, recessed front tip designed to prevent it from folding “backwards.” (Demo by putting the air-Q Blocker directly down onto your hand showing how it bends forward, not backward.) With a little lubrication on the internal ridges and dorsal side of the cuff, the air-Q Blocker easily rounds the oropharyngeal curve to seat in the esophageal inlet. The large bowl of the mask conforms to the soft tissue and traps the laryngeal inlet inside the bowl while the keyhole-shaped tube inlet lifts the epiglottis.

Maintaining the tube opening aligned with the laryngeal inlet maximizes the air-Q as a conduit for breathing and for intubation.

Just like the regular air-Q, the air-Q Blocker facilitates intubation. You can remove the color-coded connecter and pass any standard ET tube up to size 8.5. The air-Q Blocker comes in 3 sizes - 2.5, 3.5, and 4.5. In general, the 2.5 is for pediatrics, the 3.5 for small adults or generally females, and the 4.5 for large adults or generally males.

As a rule of thumb, whatever size Blocker that you are using - just add 4 to the air-Q Blocker size, and that is the largest size “standard” ET tube that will fit (for instance, add 4 to the size 3.5 and you see that the 7.5 ET tube is the largest ET tube recommended for the size 3.5 air-Q Blocker). This information is readily available on the Blocker airway tube.

The new air-Q Blocker eliminates the need for auxiliary costly intubating devices like the (disposable Fastrach), that are very costly (typically around $90.00).

Take a look at this video . . . (view the air-Q Blocker video on your laptop). As you can see . . . a clinician is able to utilize a standard ET tube.

1. Remember to remove the connector.

2. Lubricate the mask portion, including inside ridges, along with the ET tube.

3. Insert the ET tube through the oval-shaped airway tube.

Now, when inserting the ET tube, we recommend visualization with a Fiber Optic Scope or with a gum elastic bougie when placing it blind - particularly until comfortable with the air-Q Blocker.

**Exit Strategy:**

Another special “feature” of this device is that once the ET tube is placed, you can remove the air-Q Blocker with our removal stylet. It is specifically designed with ridges and is “vented.” A spontaneously breathing patient can still breathe when the stylet is attached to the ET tube. (Demonstrate air-Q Blocker removal with the stylet and make certain the stylet is snuggly attached to the ET tube). **Important** for field clinicians - instead of removing the air-Q Blocker, many clinicians simply leave the ET tube in place – inflating the cuff of the ET tube while deflating the cuff of the air-Q Blocker. Once the patient arrives at the emergency room, clinicians can make the decision to leave both in place or remove the Blocker from the patient with the removal stylet.
Guide Tube:

The addition of the guide tube on the Blocker airway allows clinicians access to the posterior pharynx and upper esophagus with either a Nasal Gastric (NG) tube or the new Blocker tube.

Just lubricate the tube and the top of the guide tube prior to placement through the guide tube. The tube will run behind the mask and into the esophagus.

The Blocker tube is basically a suction catheter with a balloon and a multi-orifice tip. Lubricate the blocker tube and pass it into the guide tube. Once in the esophagus, inflate the cuff. Now you have the esophagus blocked and you have a vent distal to the blocker cuff.

With the air-Q Blocker and Blocker tube you now have a “rescue” airway combination of a laryngeal mask and laryngeal tube all in one device. You have a new “rescue” airway in the air-Q Blocker® that allows you to ventilate, intubate, block the esophagus, suction and vent the esophagus and remove the mask when intubated all in one device. It is the first “rescue” airway for EMS that makes the transition from the field to the hospital.

We would like to get the new air-Q Blocker to you for trial. How do we go about getting samples in for evaluation?