

The Ambu® Aura-i™ is compatible with the Ambu® aScope™ and standard ET tubes.

Ambu® Aura-i™

Sophisticated Simplicity



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The obvious choice for everyday use

Easy and correct placement the first time

The Ambu® Aura-i™ laryngeal mask is so easy to place that it doesn't take much to learn. The airway tube of the Ambu® Aura-i™ is preformed to follow the anatomy of the human airway.

Enhanced patient safety

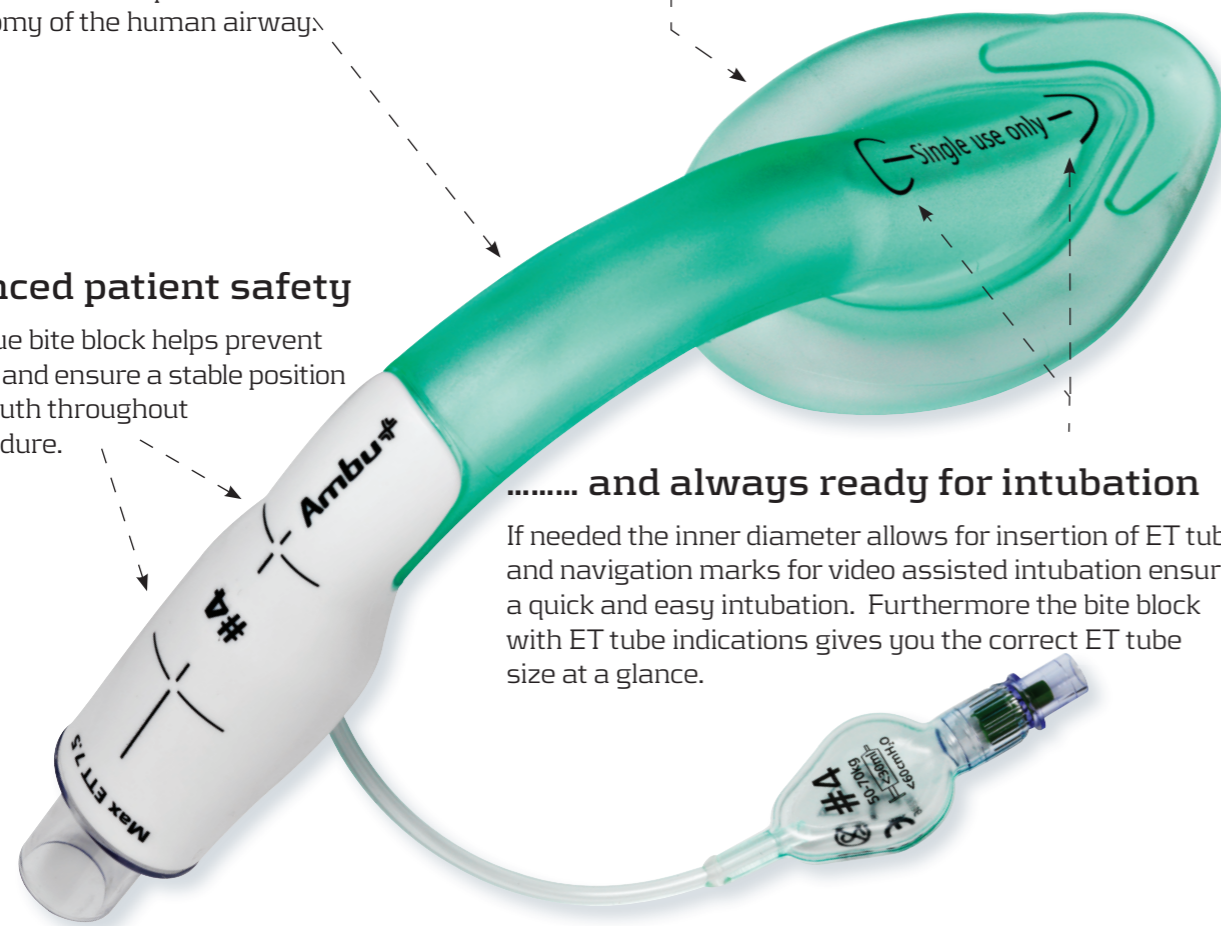
The unique bite block helps prevent occlusion and ensure a stable position in the mouth throughout the procedure.

High seal pressure

The Ambu® Aura-i™ has the same soft and anatomically shaped cuff with proven high seal pressure as the Ambu® AuraOnce™.¹

..... and always ready for intubation

If needed the inner diameter allows for insertion of ET tube and navigation marks for video assisted intubation ensure a quick and easy intubation. Furthermore the bite block with ET tube indications gives you the correct ET tube size at a glance.



With the Ambu® Aura-i™ only one mask is needed making it the obvious choice for an everyday mask.

When patient safety is a must

Difficult direct laryngoscopy occurs in 1.5 - 8.5% of general anaesthesia and difficult intubation occurs with a similar incidence.² Failed intubation occurs in 0.13-0.30% of all general anaesthesia² - far more often than e.g. aspiration and regurgitation.^{3,4,5,6} Yet focus is often here.

Acting as a conduit for endotracheal intubation the Ambu® Aura-i™ fits perfectly into the difficult airway algorithm in case of a Cannot Intubate - Cannot mask Ventilate (CI-CV) situation.

With the Ambu® Aura-i™ in place the patient is always ready to be intubated and a critical situation may be avoided.

Case story

A male patient with a difficult airway was, due to his anatomy, scheduled for an awake fiberoptic intubation.

The anesthesiologist in charge initiated the case with a low dose of anesthesia and analgesia including a good local anesthesia. Hereafter intubation was initiated under fiberoptic guidance but in neither the first nor the second attempt was it possible to identify trachea or any other landmarks in the larynx. With decreasing oxygenation it was decided to insert an Ambu® Aura-i™.

Once the Ambu® Aura-i™ was inserted a flexible optical scope was railroaded via the airway tube of Ambu® Aura-i™. All anatomical landmarks became visual and as soon as the epiglottis, vocal cords and trachea were identified the patient was successfully intubated.



References

1. D. Cattano, MD, PhD, C.A. Hagberg, MD, A Comparison Of Two Laryngeal Masks As A Conduit For Fiberoptic Tube Exchange, Anaesthesia Product News, January/February 2009
2. Crosby ET et al. The unanticipated difficult airway with recommendations for management. Can J Anaesth 1998 Aug;45(8):757-76
3. Burkle CM et al. Airway management after failure to intubate by direct laryngoscopy: outcomes in a large teaching hospital. Can J Anaesth. 2005 Jun-Jul;52(6):634-40.
4. C. Verghese et al. Prospective survey of the use of the laryngeal mask airway in 2359 patients. Anaesthesia 1993;48:58-60
5. C. Verghese, J.R. Brimacombe. Survey of Laryngeal Mask Airway in 11910 Patients: Safety and Efficacy for Conventional and Nonconventional Usage. Anesth Analg 1996;82:129-33.
6. Bernardini A. et al. Risk of pulmonary aspiration with laryngeal mask airway and tracheal tube: analysis on 65712 procedures with positive pressure ventilation. Anaesthesia 2010;64(12):1289-129