

Difficult Airway Management Simulator

— Training Model —

The Difficult Airway management (D.A.M.) Simulator offers not only excellent reality in airway management training but also varying degrees of challenge to trainees through a combination of controllable degree of mouth opening, changeable limit of neck flexibility, and inflatable tongue. It provides wide variations of training experiences in difficult airway management including use of diverse types of devices. Its portable design and durable structure allow training in emergency, pre-hospital, and clinical settings. This innovative simulator facilitates acquiring basic skills, improving the skills to advanced level and attaining ability to respond real-life situations.

Features

- 24 variations (includes 1 normal case) of settings by combinations of:
2 steps of neck flexibility, 3 steps of mouth opening, 2 sizes of tongues and 2 positions of vocal codes

Airway Opening Techniques (Head-Tilt/Chin-Lift, Jaw Thrust)

The neck's flexibility can be changed in two steps. The degree of the mouth opening can be set in three steps.



Normal



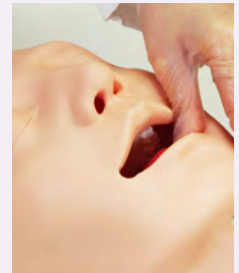
Rigid



Normal (easy)



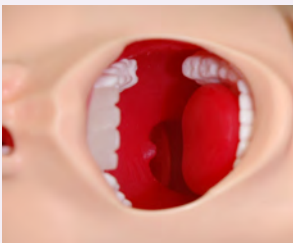
Intermediate



Difficult

Tongue Edema

The tongue can be inflated to represent the swollen tongue.



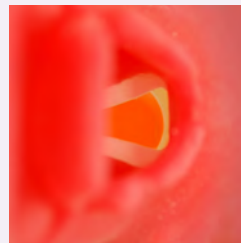
Normal



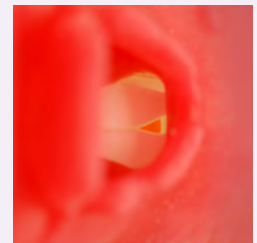
Swollen

Laryngospasm

Realistic laryngospasm



Normal



Laryngospasm

- Robust structure and the stable base for training in various settings including those for pre-hospital scenario
- Anatomically correct airway structure and realistic laryngeal view
- The upper teeth are removable with excess force
- A variety of possible airway skills that include: intubation with a laryngoscope, BVM ventilation, nasal intubation, Laryngeal mask ventilation, and use of a video laryngoscope
- The optional bronchus model that allows for bronchofiberscopy training

Training Skills

- Airway opening techniques (head tilt, jaw thrust)
- Bag-Valve-Mask ventilation
- Pre intubation airway assessment
- "Sniffing position"
- Pressurization of external larynx to improve the laryngeal view
- Intraoral/Intranasal Intubation
- Use of oropharyngeal airway (OPA)
- Use of nasopharyngeal airway (NPA)
- Use of laryngeal mask airway
- Use of video laryngeal scope
- Use of tracheal intubation fiber scope
- Confirmation of successful ventilation by:
 - observation of thoracic and abdominal movement (lung expansion, stomach inflation) or
 - auscultation on the chest
- Feedbacks on incorrect procedures including esophagus intubation and unilateral intubation
- Securing the tube in place with tapes or Thomas™ endotracheal tube holder

Airway Opening Techniques



True-to-life articulation allows for head-tilt/chin-lift and jaw-thrust techniques.

Bag-Valve-Mask Ventilation



Successful ventilation can be confirmed by the movement of the chest.

Intraoral Intubation with Laryngoscope



Setting the head at "sniffing position", intubation with laryngoscope can be performed.

Confirmation of the Placement of Tracheal Tube



The placement of the tube can be confirmed by auscultation or movement of thoracoabdominal area.

Use of Video Laryngoscopes



Use of Laryngeal Mask



Set Includes

- 1 torso manikin
- 3 upper incisors
- 1 lubricant
- 1 syringe (50ml)

Size

manikin size:
approx. 28x15x10 (in)

Consumables and Replacement Parts

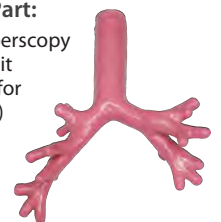
- 11392-020 face mask
- 11392-040 chest cover
- 11392-030 replacement tongue
- 11392-010 upper incisors
- 11392-050 lung(right and left)
- 11392-060 stomach

Recommended Sizes of Devices

- Macintosh laryngoscope: blade size 3, 4
- Tracheal tube: internal diameter 7.0mm, 7.5mm
- Laryngeal mask
 - Air-Q: size 3.5
 - LMA Supreme: size4
 - I-gel : size 4

Optional Part:

- Bronchofiberscopy training unit (available for purchase)



Specifications are subject to change.