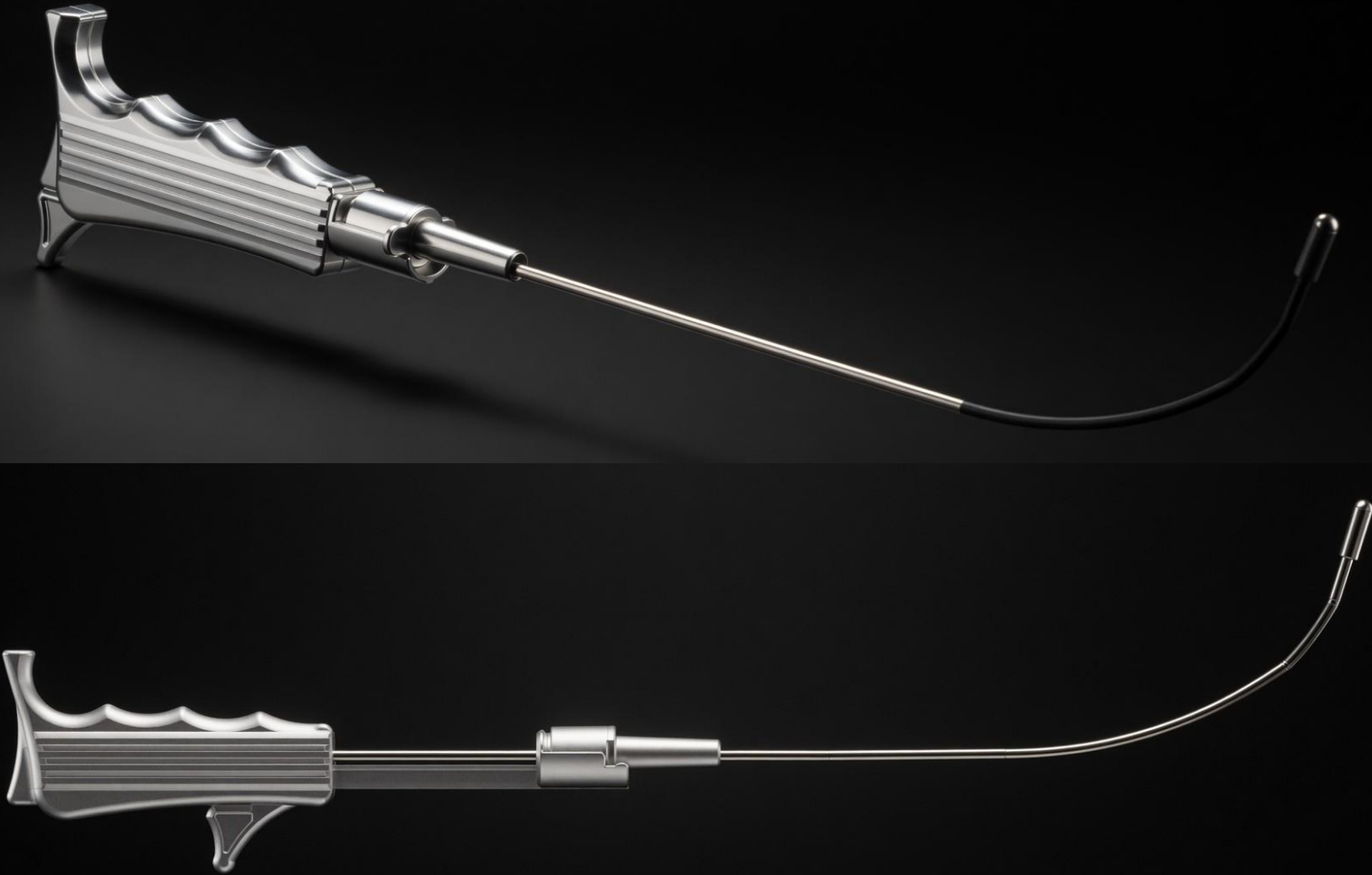


SUREGLIDE

TUBE ADVANCING STYLET

Engineered for controlled tube advancement during intubation with a video laryngoscope



Clinical Advantages:



Controlled Advancement

Posterior tube advancement eliminates anterior wall hang-up.



Reduced Tracheal Damage

Eliminates the need for metal to go past the vocal cords.



Enhanced Procedural Control

Ergonomic single-operator control enables precision tube delivery and handling stability.



TABLE OF CONTENTS

I. Introduction	
Product Information	2
II. Clinical Impact	
Endotracheal Tube Intubation Overview.....	3
Biomechanical Comparison.....	6
Sureglide – How It Works.....	7
II. Value Proposition.....	8
III. Intended Use.....	9

THE SUREGLIDE ADVANCING STYLET

SureGlide Advancing Stylet rethinks endotracheal intubation by addressing the frequently underappreciated second curvature of the airway, helping clinicians fully leverage the advantages of video laryngoscopy.

The device's ergonomic grip and rigid stylet configuration provide improved tube control during glottic targeting, while the thumb-actuated advancement system facilitates controlled tracheal delivery along the native airway trajectory.

Designed to support procedural consistency, stability, and single-operator airway securement.

Product Name	Description	Quantity	Price
Sureglide Advancing Stylet	Endotracheal intubation stylet with user activated 2.5" tube advancement, inverted load capable, ergonomic handle, single use, sterile, latex free, fits size 7.0 - 8.0 tubes	10/Box 50/Case	\$29.00ea



ANAMED, INC. | INNOVATORS OF AIRWAY MANAGEMENT

The Evolution of Endotracheal Intubation

The Final Step in Modern Video Laryngoscopy

Traditional direct laryngoscopy relied primarily on line-of-sight alignment to achieve endotracheal tube placement. While video laryngoscopy dramatically improved visualization, it also introduced new challenges in advancing the tube into the trachea.

Studies have shown that 50% of failed first-pass video laryngoscopy attempts occur despite an adequate view of the vocal cords, often due to difficulty directing the tube through the airway and into the trachea.

Much of this challenge arises because conventional airway tools were designed to reach the cords, but not necessarily to navigate the distal serpentine curvature of the airway during advancement. As a result, clinicians may achieve excellent visualization while still encountering resistance, anterior deflection, or repeated repositioning during tube delivery.

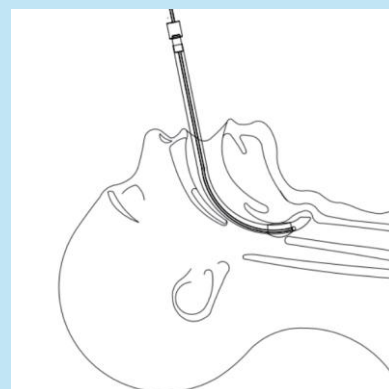
The Sureglide was engineered to bridge the remaining gap, mechanically perfecting tube delivery - unlocking the full potential of the video laryngoscope.

THE VIEW

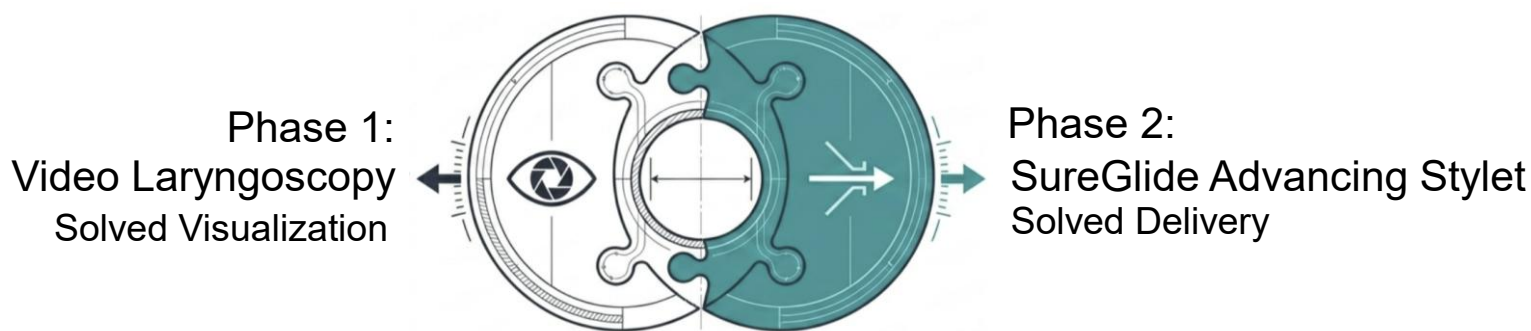


Perfect visualization achieved.

CURRENT REALITY



The endotracheal tube still hangs up, impacts the anterior tracheal wall, and resists smooth advancement



Difficult Airway Characteristics Associated with First-Attempt Failure at Intubation Using Video Laryngoscopy in the Intensive Care Unit (2016) PubMed: 27983871

Evaluation of six video laryngoscopes in 720 patients with a simulated difficult airway: a multicentre randomized controlled trial – British Journal of Anesthesia (2016)



Endotracheal Tube Intubation – The Most Critical Routine Procedure in Medicine

Successful intubation on the first attempt is crucial to minimize the risk of complications such as hypoxia (low oxygen levels), aspiration, and cardiac arrest, which often occur with repeated attempts. After just one minute without ventilation, patients will become hypoxic and brain cells will begin to die, by minute 2.5 - extensive neuron damage, by minute 3 - irreversible brain damage. By minute five – Death.

25,000 Americans die every year from failed intubation

- 4,000,000 Intubations occur annually in United States Emergency Departments and ICUs
- The Emergency Department was shown to experience a 23.2% failure rate of intubation attempts
- The ICU was shown to experience a 18.3% failure rate of first pass intubation attempts
- Every year, these failed attempts lead to 4,000 Cardiac arrests, 16,000 Aspiration events, 300,000 major hypoxemia patient injuries and 700,000 cases of hypotension - costing billions between 6,000 hospitals.

Endotracheal Tube Cuff Pressures in the Operating Room of a Pediatric Hospital: A Quality Improvement Initiative : Kelly M Moon ^{*,†,☒}, Sherry Donaworth ^{*}, Molly S Hagele [†], Stephani S Kim [†], Brittany L Willer ^{†,‡}, Joseph D Tobias ^{†,‡}

Video Laryngoscopy Is Associated With First-Pass Success in Emergency Department Intubations for Trauma Patients: A

Propensity Score Matched Analysis of the National Emergency Airway Registry : Stacy A. Trent MD, MPH ^{a b}

, Amy H. Kaji MD, PhD ^{c d}, Jestin N. Carlson MD ^e,

Taylor McCormick MD ^{a b}

, Jason S. Haukoos MD, MSc ^{a b f}, Calvin A. Brown III MD ^{g h},

National Emergency Airway Registry Investigators

Difficult Airway Characteristics Associated with First-Attempt Failure at Intubation Using Video Laryngoscopy in the Intensive

Care Unit : Raj Joshi ^{1,2}, Cameron D. Hypes ^{1,2}, Jeremy Greenberg ^{1,2}, Linda Snyder ¹, Josh Malo ¹, John W. Bloom ^{1,3},

Harsharon Chopra ³, John C. Sakles ², and ORCID IconJarrod M. Mosier ^{1,2}



ANAMED, INC.

SUREGLIDE

Designed to reliably achieve an inverted endotracheal tube load. As the tube advances, it naturally curves downward, perfectly matching the second downward half of the airway's S-shaped pathway. SureGlide guides the tube posteriorly along the airway's natural secondary curve with a simple thumb-controlled advancement.

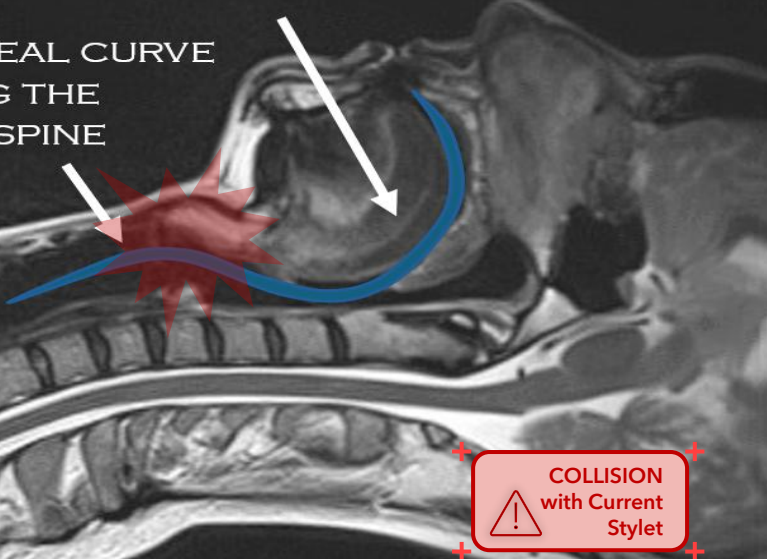
Current Standard Rigid Stylet

As the stylet is retracted through either a second provider or using a technically demanding maneuver, the distal tip of the tube often turns anteriorly. This can cause the tube tip to impinge on the laryngeal structures, particularly the laryngeal notch, preventing smooth advancement into the trachea.



TWO CURVES OF THE AIRWAY

1. THE CURVE AROUND THE TONGUE
2. THE TRACHEAL CURVE FOLLOWING THE THORACIC SPINE



COLLISION
with Current
Stylet

Biomechanical Control Comparison

Biomechanical Vector	Traditional (Rigid) Stylet	SUREGLIDE
Loading Orientation	 Conventional J-Curve Loading	 Inverted Precision Load
Advancement Mechanism	 Stylet Pulled Backward out of Stationary Tube	 Tube Pushed Forward off Stationary Stylet
Tip Trajectory	 Upward / Anterior Deflection Bias 	 Controlled Downward Tracheal Alignment 
Transition Stability	 Low (Reduced Stability During Withdraw Phase)	 High (Secured 2.5 Inches in Trachea Before Withdraw)
Device Control	 Minimal Control via Small T-Grip	 Full Procedural Control with Ergonomic Pistol Grip

Key Takeaway: Sureglide maintains controlled tube delivery throughout alignment advancement and transition.

Clinical Implication:

Controlled trajectory and stabilized transition mechanics may improve procedural consistency during airway advancement



ANAMED, INC.

SUREGLIDE – HOW IT WORKS

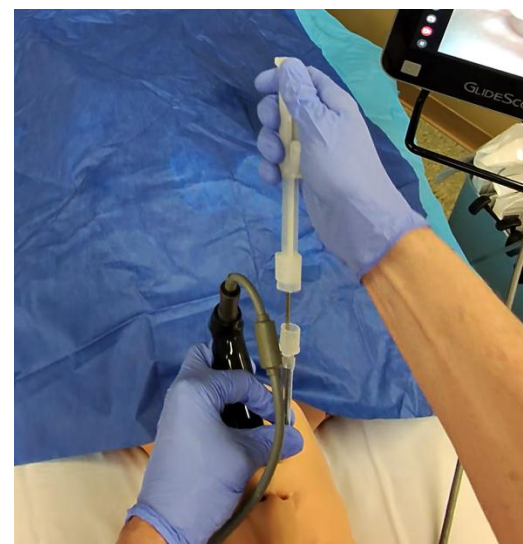
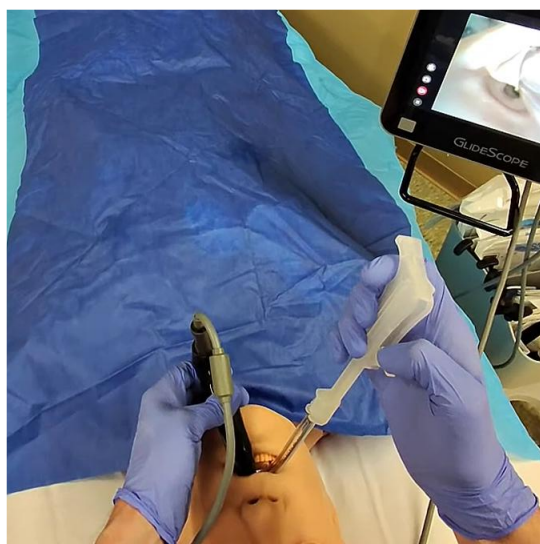
Step 1: Using a firm grip, load the endotracheal tube onto the Sureglide in an inverted (180° rotation from standard), advancing it over the distal tip until it seats on the white connector. Confirm correct orientation by ensuring the endotracheal tube's Murphy's eye is facing left

Step 2: Using a video laryngoscope with the left hand and the SureGlide held and controlled by the right around its pistol grip, obtain a clear view of the vocal cords and introduce the loaded Sureglide device through the mouth, advancing along the video laryngoscope blade and to the vocal cords until the endotracheal tube tip is aligned at the vocal cords.

Step 3: With the Sureglide device stabilized in the right hand, press the thumb actuator on the back of the pistol grip to advance the tube into the trachea (up to 2.5 inches).

Step 4: Using the thumb and index finger stabilize the tube with the left hand to hold the endotracheal tube in place, remove the SureGlide from the patient by simultaneously moving it forward, down and out.

Step 5: Remove the video laryngoscope from the patient. The endotracheal tube cuff is then inflated and connected to a breathing circuit. End-tidal CO₂ and a stethoscope should be used to confirm proper endotracheal tube placement.



SureGlide is engineered to provide controlled single-operator delivery of an endotracheal tube during video laryngoscopic intubation. Its rigid stylet architecture and ergonomic control platform allow clinicians to maintain continuous procedural control from glottic targeting through tracheal advancement.

By aligning tube delivery with the native serpentine anatomy of the airway, SureGlide is designed to reduce advancement resistance and improve delivery consistency during video laryngoscopy-assisted intubation. A single provider having full control of the intubation combined with serpentine tube advancement results in a safer, more efficient, risk reduced, and less expensive intubation.

Maintaining primary operator control throughout the intubation process may help reduce procedural variability associated with multi-operator tube manipulation and coordination.

The device's serpentine advancement pathway is engineered to follow the secondary curvature of the airway, addressing the tube advancement and tracheal access challenges commonly encountered with video laryngoscopy.

Existing Options for Difficult Airways

Rigid Stylet

- Standard requires two operators
- Increased risk as 2nd operator is often the most inexperienced person in the room
- No depth control
- **Does not deliver tube with the second curve of the airway** – often resulting in physicians twisting the tube (in a corkscrew fashion) to obtain proper depth – damaging the vocal cords trachea.
- **Many physicians force the metal of the stylet through the cords to achieve tracheal access (leaving this to be known as the tracheal perforator)**

Fiber Optic Bronchoscope

- \$300-\$400 Per Use
- Not immediately available in the OR
- Five minutes to retrieve (Hospitals spend roughly \$50 per minute in an operating OR)
- Requires two operators
- Significant training required
- Requires costly sterilization after use

Cricothyrotomy

- Extremely Invasive
- Used because intubation attempts failed and time is running short
- Additional cost and care required after cutting the neck
- Increased patient recovery time
- Significant risk
- \$200 per single use Cric Kit

SUREGLIDE

- Easy to use
- Non-invasive
- Requires only one operator
- Solves the issue of operator's inability to deliver tube
- If you see the vocal cords, you can intubate
- Solves the tube delivery difficulties video laryngoscopes create
- Solves depth issues of Bougies
- Prevents damage to the vocal cords and trachea
- Utilizes existing endotracheal tube inventory
- Carried on the GlideScope cart for easy access
- Provides depth control
- Single use
- Supplied sterile in peel open packaging
- Manages risk, the most experienced person in the room now has total control
- The most efficient per result method of intubation on market
- Aim and deliver

\$29 Per use.



ANAMED, INC.



SUREGLIDE ADVANCING STYLET – INTENDED USE

CAUTION: U.S. Federal Law restricts this device to sale by or on the order of a physician (or properly licensed practitioner).

INTENDED USE

The Sureglide Advancing Stylet is intended to facilitate endotracheal intubation with a video laryngoscope.

DEVICE DESCRIPTION

The Sureglide Advancing Stylet is a tracheal tube delivery stylet capable of advancing the endotracheal tube along the tracheal serpentine to facilitate endotracheal tube placement during tracheal intubation. The device has a rigid stainless steel stylet, with a rounded tip, that is secured by a housing in the shape of an ergonomic grip, which houses a slide that articulates to facilitate the advancement of an endotracheal tube into the trachea under visualization with a video laryngoscope. Intended for one-time use. The devices are supplied sterilized by Gamma Radiation (R) in peel-open packages.

The single size Sureglide Advancing Stylet is available to facilitate single lumen endotracheal tube placement in adults. The single size Sureglide should be used only with endotracheal tube sizes 7.0mm – 8.0mm ID on patients >16yrs of age.

CONTRAINDICATIONS

- Entrance to the trachea cannot be visualized when performing laryngoscopy, i.e., Grade III or Grade IV Cormack & Lehane laryngoscopy classification.
- Inability to place a laryngoscope into patient's airway
- Patients with abnormal tracheal anatomy
- Patients with existing or potential tracheal trauma.

WARNINGS

- CAUTION: U.S. Federal Law restricts this device to sale by or on the order of a physician (or properly licensed practitioner).
- The Sureglide Advancing Stylet is only intended to be used with the inverted load of the endotracheal tube.
- Only use the provided Sureglide tube connector that comes pre-attached to the Sureglide Advancing Stylet.
- Remove any non-Sureglide tube connectors from an endotracheal tube before use.
- Do not use the Sureglide Advancing Stylet with Flex-Tip® endotracheal tubes.
- For best results, use the Sureglide Advancing Stylet only with video laryngoscopes.
- The Sureglide Advancing Stylet is supplied sterile for single use only. It should be discarded after use and must not be re-used. Reuse may cause cross infection and reduce product reliability and functionality.
- Store devices in an environment that avoids direct sunlight and extreme temperatures.
- Excessive force must be avoided at all times.
- Care must be taken not to provoke injury to the epiglottis, glottis, or trachea.
- Possible allergic reactions should be considered.
- Lubricate the stainless steel stylet surface and endotracheal tube prior to loading.

PRECAUTIONS

- The product is intended for use by clinicians trained and experienced in airway management.
- If intubation cannot be completed, the endotracheal tube and the Sureglide Advancing Stylet should be removed.

INSTRUCTIONS FOR USE

1. Confirm the Sureglide Advancing Stylet package is unopened and undamaged. Note: Do not use product if there is doubt as to whether the product is sterile. Upon removal from the package, inspect the product to ensure no damage has occurred.
2. Remove tube connector included with the endotracheal tube.
3. Using a firm grip holding the endotracheal tube in a position rotated 180 degrees longitudinally from its natural position so that its curvature is opposite that of the stylet, slide the endotracheal tube over the distal tip of the Sureglide until the inside wall of the

proximal end of the tube is secured over the white tube connector, which is supplied pre-attached to the Sureglide Advancing Stylet, with moderate force to secure the tube on the connector. Note: This may be referred to as the “inverted load” of an endotracheal tube.

4. Confirm the slide of the Sureglide Advancing Stylet is in contracted position. Adjust if necessary.
5. Confirm the endotracheal tube is properly loaded in the inverted fashion. By holding the Sureglide Advancing Stylet with the right hand on the pistol grip, the Inverted load of the endotracheal tube is validated by the Murphy’s eye of the endotracheal tube at the distal tip of the tube facing left. *If not, the tube may be adjusted by rotating longitudinally along the stylet on the white tube connector.
6. Advance the video laryngoscope into the patient's mouth and position it for a view of the vocal cords.
7. Using the right hand to hold and control the Sureglide Advancing Stylet with inverted loaded tube, insert the distal tip of the stylet and tube into the patient's mouth following the video laryngoscope blade and then through the vocal cords until the proximal end of the endotracheal tube cuff is in line with the vocal cords.
8. Using the right thumb, press the button on the back of the Sureglide to advance the endotracheal tube into the desired position in the trachea. Note: the maximum amount of tube advancement the device is capable of is 2.5”. Note: If significant resistance is encountered, do not force the tube to advance further. Do not use any more than half the strength that one thumb can provide.
9. Using the thumb and index finger of the left to hold the endotracheal the tube in place, remove the Sureglide Advancing Stylet from the endotracheal tube and patient by rotating it forward.
10. Remove the video laryngoscope from the patient.
11. Confirm the tube connector is secured in the endotracheal tube.
12. Confirm the endotracheal intubation with end tidal CO₂.