

Nasal/Gastrostomy Tubes *(continued on next page)*

Mark IV Nasal Tube

The triple-lumen Moss™ Nasal Tube provides 12 to 14 times more effective decompression while simultaneously feeding enterally. The suction channel supplements the inefficient aspiration within the distal esophagus and proximal duodenum. Patented "Suction Buster"™ holes prevent mucosal occlusion. The second bore delivers an elemental diet three inches farther downstream into the distal duodenum. Refluxing excess is automatically and safely removed while still within the proximal duodenum. The third lumen inflates a gastric retention balloon.

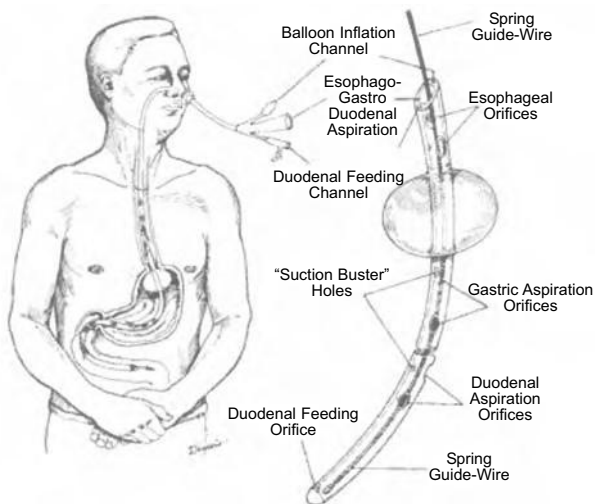


Mark IV Nasal (SIL) Tube

Stock Number #AF-6-87168
Size/Length #18 FR/44"

Individually packaged, sterile (ETO). Sold separately. Minimum order quantity 2, or 10/box.

Mark IV Nasal Tube Details



The Moss Nasal Tube is an occlusion resistant nasogastric tube indicated for decompression and simultaneous enteral feeding. Features patented "Suction-Buster" orifices to permit uninterrupted function over the entire suction range. Multiple aspiration sites ensure highly efficient removal of air and liquids. Distal esophagus orifice aids in removal of swallowed air and permits "sham" drinking. Stomach orifice (permits immediate feeding and) helps prevent gastric distention. Proximal duodenum orifice allows tube self-cleansing by digestive juices and helps prevent gastric reflux. The nutrient delivery site at the distal duodenum helps to provide ease of positioning, earliest propulsion and maximum absorption. The balloon site at the esophagus junction helps position and secure the device without tension.

Suggested Directions for Use

1. Balloon and inflation valve of each tube should be tested by inflation prior to use. Using a luer tip syringe, test inflate balloon with air, then evacuate balloon completely.
2. Lubricate with a water soluble lubricant
3. If during insertion an obstruction is encountered, do not force the tube
4. The surgeon should guide the tube through the pylorus, palpating the balloon to determine correct placement in the stomach.
5. Inflate the balloon with 30cc water and position without tension at the cardia.

6. Adjust barrier until it almost contacts the patient's nose.
7. Withdraw and discard the spring obturator.
8. Apply continuous suction (40-100 mm Hg). **Note:** The lower levels of suction are adequate if the trap bottle is below level of the patient.
9. Irrigate aspiration channel with 60 ml bolus of warm water or saline every two hours and as required, keeping the patient's head elevated to reduce the chances of aspiration.
10. The patient should sip clear, preferable warm liquids (e.g., tea) to serve as an additional irrigant and to monitor tube function. Swallowed bolus should return promptly.
11. Phlegm should be expectorated, not swallowed. Tissues and a waste container must be made available to the patient.
12. Feed full strength elemental diet at 75-150 ml/hour via the feeding channel.
13. Deflate balloon and withdraw tube following currently accepted medical techniques.
14. Discard soiled tube.

Moss Tubes™ are unique among gastrointestinal decompression/feeding devices because they are designed to aspirate within the close confines of the distal esophagus and/or proximal duodenum. This results in efficiency improvements of 12x to 14x over conventional devices which rely exclusively on gastric suction.

Moss tubes were first introduced at the 1963 Clinical Congress of the American College of Surgeons. The initial generation of prototype devices has been followed by four successive generations of improved products which were more "user friendly," more efficient and less traumatic to patients. These products have been manufactured exclusively by Moss Tubes, Inc., West Sand Lake, NY, since 1986.

To provide maximum absorption and safety, Moss tubes are designed for simultaneous feeding into the distal duodenum, rather than the stomach. The highest and earliest rates of nutrient absorption are achieved with this regimen.

With Moss tubes, decompression is so much more effective that GI function is maintained and can be exploited immediately after surgery. Extensive case histories demonstrate that within the first 24 hours after surgery, patients are able to absorb 300 kcal to 5000 kcal of an elemental diet, able to consume a general diet and may be discharged safely at this time. These studies also demonstrate increased rates of wound healing and resistance to sepsis. Substantial hospital and post-hospital cost savings are reported.

G-Tube PEG Kit

The Moss™ Percutaneous Endoscopic Gastrostomy (PEG) regimen minimizes patient trauma and maximizes physician efficiency. The kit was specifically developed to deliver the patented Moss "Suction Buster"™ G-Tube, which provides the most efficient gastro-duodenal decompression for safest enteral feeding. Exclusive features include a rigid steel "Break-Away"™ introducer and a T-Anchor Introducer Gun™.



Tray Components

Moss Gastrostomy Tube, #18 Fr.
Needle, Seldinger, 18 Ga. x 3-1/2"
Field Drape
Surgical Gloves
Gauze Sponges, 3" x 3"
Syringe, 3 ml
Lubricating Jelly
Moss Anchor Gun

2 Double-Ended T-Anchors
Steel "Break-Away" Introducer & Dilator, 7mm
Guide Wire, .038" x 125 cm
Fenestrated Drape
Syringe, 10 ml, Prefilled w/ Water
Needle, 23 Ga. x 2-1/2"
Scalpel Handle w/ Attached #11 Blade

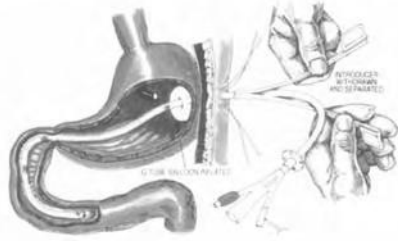
PEG Kit

Stock Number #AF-PEG-18

Individually packaged, sterile (ETO). Sold separately. 10/box.

Nasal/Gastrostomy Tubes (continued from previous page)

G-Tube PEG Kit Details Percutaneous Endoscopic Gastrostomy Techniques...Step by Step



Anchors and Introducer



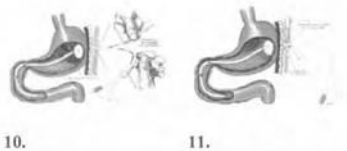
Direct Guide Wire Placement



Direct G-Tube Placement



Completing Procedure



Duodenal Suction & Safe Feeding



Gastrostomy Tube

The triple-lumen Moss™ G-Tube provides 12 to 14 times more effective decompression while simultaneously feeding enterally. The suction channel supplements the inefficient gastric site with more efficient aspiration within the proximal duodenum. Patented "Suction Buster"™ holes prevent mucosal occlusion. The second bore delivers an elemental diet three inches farther downstream into the distal duodenum. Refluxing excess is automatically and safely removed while still within the proximal duodenum. The third lumen inflates a gastric retention balloon.



Gastrostomy (SIL) Tube

Stock Number	Size/Length	Qty.
#AF-5-17719	#18 FR/18"	10/Box
#AF-5-17719P		2/Box

Individually packaged, sterile (ETO). Sold separately.

Moss™ advanced technology permits early enteral feeding for quicker patient recovery

Patented Moss Gastrostomy Tubes ensure maximum nutritional absorption. Within the first 24 hours after surgery, patients fed with Moss Tubes can absorb 3,000 to 5,000 kcal of an elemental diet.

Moss Tubes aspirate within the confines of the distal esophagus and/or proximal duodenum, providing 12x to 14x more effective decompression than conventional gastric suction devices.

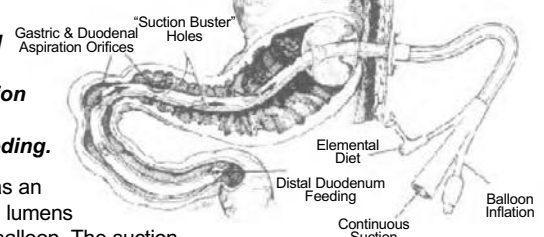
Improving on "peel-away" plastic introducers that often lack sufficient rigidity, Moss developed a unique steel "break-away"™ introducer, making tube placement easier.



Administration of enteral feeding immediately after surgery has been proven to speed patient recovery and shorten hospital stays. The original and still the leading technology for early post-operative feeding is the Moss Gastrostomy Tube. Updating of the basic patent-protected design has made the tube more "user friendly" while increasing efficiency and patient comfort. Feeding with Moss Tubes can begin in the recovery room, quickly providing the nutrition needed to enhance sepsis resistance and accelerate wound healing. In addition, by delivering nourishment directly to the distal duodenum and not the stomach, the risk and discomfort of distention is avoided.

Gastrostomy Tube Details Moss™ Gastrostomy Tube Moss Suction Buster™

For gastric and proximal duodenal decompression plus distal duodenal feeding.



This device has an x-ray tip, three lumens and a gastric balloon. The suction channel has multiple openings in both the stomach and proximal duodenum for efficient removal of swallowed air and liquid. The feeding channel opens at the distal tip to deliver enteral nutrition. The tube is induced surgically through the abdominal and gastric walls within a serosa lined tunnel (Stamm or Witzel technique). The tip is manipulated through the pylorus and into the distal duodenum. The gastric balloon is inflated with 20 ml of sterile water and secured in position by a retainer gently resting against the skin. The patient is kept N.P.O.

1. Pull the tube through the abdominal wall by its leading tip, then excise the solid traction tip.
2. Introduce the tube through a gastric puncture and deliver into the distal duodenum. Remove the obturator.
3. Use Stamm or Witzel technique to produce a serosa lined tunnel. Secure the stomach to the abdominal wall.
4. Inflate the balloon with 20 ml of sterile water.
5. Slide retainer gently against abdominal wall and secure with monofilament skin suture. Loosen after 24 hours PRN.
6. Apply continuous H₂O suction at 35-70 mm Hg (50-100 cm).
7. Irrigate suction channel with 60 ml warm saline Q2H and PRN.
8. Return filtered aspirate via feeding channel or provide comparable volumes of appropriate IV replacement.
9. Feed full strength Vivonex® T.E.N. @ 100-500 ml/hour via the feeding channel.
10. Monitor blood/urine glucose to guide insulin therapy.