The right line. **Every time.**

Achieve the ideal surgical sleeve anatomy[1] every time with the new **STANDARD CLAMP**™.

Standard Bariatrics is committed to creating superior bariatric surgery outcomes. We are leading the charge to harmonize the laparoscopic sleeve gastrectomy with the **STANDARD CLAMP**,™ an anatomy-based approach to sleeve gastrectomy. This combination of repeatable technique and a purpose-built, disposable device empowers surgeons to plan, visualize, hold and create consistent sleeve anatomy every time.

The STANDARD CLAMP™ is enabling surgeons to plan and deliver consistent sleeve anatomy[1] every time. Learn how today at StandardBariatrics.com or call 513-620-7751.

STANDARD BARIATRICS™

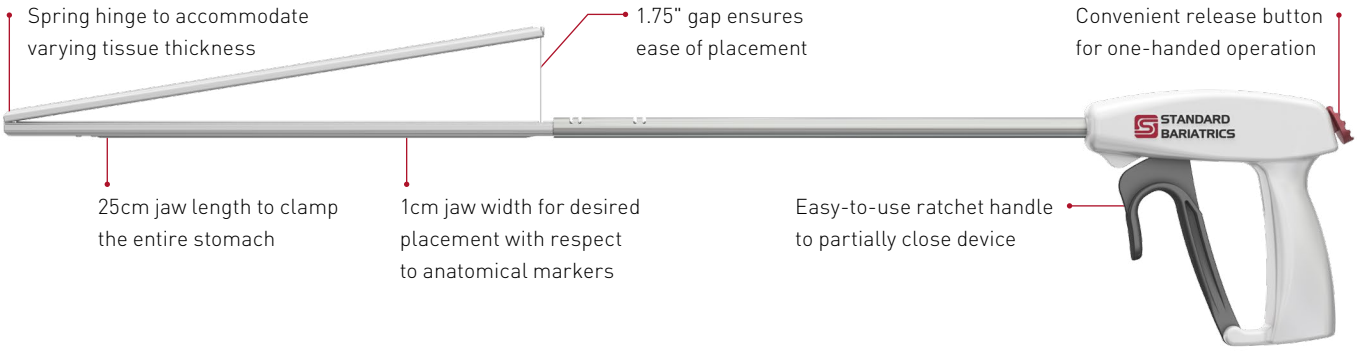
A procedure-specific design: **The STANDARD CLAMP™**

The jaw of the STANDARD CLAMP™ is 25cm in length, allowing fixation of the full cut line across the entire stomach. This results in **clear visualization** and surgical anatomy that is smooth, with no zig-zags in the staple line.

Because the cut is straight, the approach with the STANDARD CLAMP™ requires **fewer staple firings**—4.3 on average,* compared to an expected 5–7 with other freehand sleeve techniques.

The STANDARD CLAMP™ is **atraumatic**, with springs at either end to limit compression force. The distal hinge allows for early sequential clamping from the fundus to the antrum.

* Data on file



An inconsistent approach yields uncertain outcomes

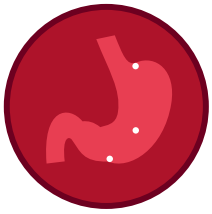
Freehand sleeve gastrectomy techniques can yield inconsistent pouch anatomy. Current techniques and device usage for laparoscopic sleeve gastrectomy are highly variable. Visualization is difficult, tissue management is a challenge, and the devices employed are not purpose-built for this procedure.

Because of these challenges, **bariatric surgeons have been able to achieve the ideal tubular surgical sleeve anatomy less than 40% of the time**, resulting in inconsistent outcomes for the patient, including reduced weight loss efficiency and GERD.[1]

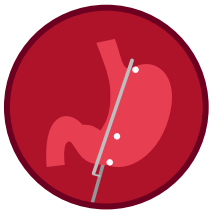
[1] Toro, JP, et al. (2014). Association of radiographic morphology with early gastroesophageal reflux disease and satiety control after sleeve gastrectomy. *Journal of American College of Surgeons*. Sep; 219(3):430-8.

Product code: SCD25-4

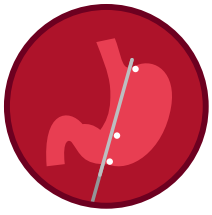
A sleeve gastrectomy with the STANDARD CLAMP™



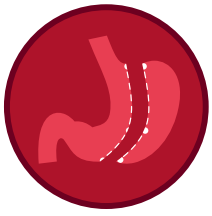
Ink the intended cut line at the three anatomical landmarks to map out the ideal output 1cm from the GE junction, 3cm from the incisura angularis and 6cm from the pylorus.



Manipulate the gastric tissue into the STANDARD CLAMP™ to align the three landmark points. Plan from top to bottom.



Visualize the full cut line in a single plane. After clamp is positioned, staple along the entire length of the intended cut line.



The **ideal tubular surgical sleeve anatomy** is a consistent shape that is free of kinks, twists or spirals.