An in vitro comparison of tracheostomy tube cuffs

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Introduction: The Shiley™ Flexible adult tracheostomy tube with TaperGuard™ cuff has been designed through its geometry, materials, diameter, and wall thickness to minimize micro-aspiration of fluids past the cuff and to provide an effective air seal in the trachea while also minimizing the risk of excessive contact pressure on the tracheal mucosa. The cuff also has a deflated profile that may allow for easier insertion through the stoma site. This unique design is known as the TaperGuard™ cuff. The purpose of the observational, in vitro study reported here was to compare the TaperGuard™ taper-shaped cuff to a conventional high-volume low-pressure cylindrical-shaped cuff (Shiley™ Disposable Inner Cannula Tracheostomy Tube [DCT]) with respect to applied tracheal wall pressure, air and fluid sealing efficacy, and insertion force.

Methods: Three sizes of tracheostomy tubes with the two cuff types were placed in appropriately sized tracheal models and lateral wall pressure was measured via pressure-sensing elements on the inner surface. Fluid sealing performance was assessed by inflating the cuffs within the tracheal models (25 cmH2O), instilling water above the cuff, and measuring fluid leakage past the cuff. To measure air leak, tubes were attached to a test lung and ventilator, and leak was calculated by subtracting the average exhaled tidal volume from the average delivered tidal volume. A tensile test machine was used to measure insertion force for each tube with the cuff deflated to simulate clinical insertion through a stoma site.

Results: The average pressure exerted on the lateral wall of the model trachea was lower for the taper-shaped cuff than for the cylindrical cuff under all test conditions (P<0.05). The taper-shaped cuff also demonstrated a more even, lower pressure distribution along the lateral wall of the model trachea. The average air and fluid seal performance with the taper-shaped cuff was significantly improved, when compared to the cylindrical-shaped cuff, for each tube size tested (P<0.05). The insertion force for the taper-shaped cuff was ~40% less than that for the cylindrical-shaped cuff.

Conclusion: In a model trachea, the Shiley™ Flexible Adult tracheostomy tube with TaperGuard™ cuff, when compared to the Shiley™ Disposable Inner Cannula Tracheostomy Tube with cylindrical cuff, exerted a lower average lateral wall pressure and a more evenly distributed pressure. In addition, it provided more effective fluid and air seals and required less force to insert.

Keywords: airway device, air seal, fluid seal, taper-shaped cuff, intra-cuff pressure, cuff pressure

Introduction

High-volume low-pressure (HVLP) cuffs, on both endotracheal and tracheostomy tubes, have been the predominant cuff type used to create a seal between the tube shaft and the tracheal wall of patients for many years. The primary feature of a HVLP cuff is a
large diameter and a large residual volume such that the cuff
resting diameter is larger than the patient’s tracheal diameter.
The intra-cuff pressure of an un-stretched HVLP cuff cor-
relates closely with the tracheal wall pressure, which is not
the case for low-volume cuffs.\(^1\) In order to ensure that the
wall of the cuff is not stretched during use, the cuff resting
diameter must be greater than the tracheal diameter. Another
important characteristic of HVLP cuffs is the thin compliant
wall material that, when inflated, adapts and conforms easily
to the topography of the trachea wall. This cuff technology
was developed several decades ago and in vivo experiments
as well as clinical studies have demonstrated the effectiveness
of HVLP cuffs at creating low-pressure seals in the trachea.\(^3\)
Research has also demonstrated that, when inflated, HVLP
cuffs, which are traditionally cylindrical shaped, form lon-
gitudinal folds with micro-channels that allow for the direct
passage of air and fluid past the cuff.\(^4,6\)

While the intra-cuff pressure of un-stretched HVLP cuffs
correlates closely with the pressure applied to the tracheal
wall, patient complications can still occur when excessive
pressure is exerted on the tracheal wall that may damage the
tracheal mucosa. These complications can be attributed to over
inflation of the cuff or, as demonstrated in this study, to poor
cuff design and the use of excessively rigid cuff materials. In
theory, a HVLP cuff constructed of an infinitely flexible mate-
rial will conform perfectly to the wall of the trachea, creating
pressure on the tracheal wall that equals the intra-cuff pressure.
In practice, however, cuff material is not infinitely flexible and,
therefore, there will be areas of contact and noncontact between
the wall of the trachea and the cuff because the intra-cuff
pressure is not sufficient to overcome the rigidity of the cuff.
This intermittent contact will create areas of higher and lower
contact pressure.\(^7\) Traditional tracheostomy tubes, including the
Shiley\(^\text{TM}\) Disposable Inner Cannula tracheostomy (DCT) tube,
have a cylindrical-shaped HVLP cuff (Figure 1A and B).

Significant advancements have been made in cuff design
to overcome deficiencies in the performance of traditional
HVLP cuffs. The Shiley\(^\text{TM}\) Flexible Adult tracheostomy tube
has a taper-shaped TaperGuard\(^\text{TM}\) cuff which is constructed
from a thinner, more compliant, and lower friction material
than that used for the predecessor Shiley\(^\text{TM}\) tracheostomy
tube line, with a geometry designed to seal more effectively.
A lower friction surface may also promote a more effective
seal because friction between the cuff and tracheal wall might
lead to the formation of folds in the cuff.\(^7\)

Studies of the TaperGuard\(^\text{TM}\) cuff in endotracheal tubes
have demonstrated that the smaller-volume TaperGuard\(^\text{TM}\)
cuff, with its reduced tracheal contract area, can effectively
seal the trachea.\(^8,9\) However, assessment of the pressures at
which this effective seal is achieved in tracheostomy tubes
has not been undertaken. In addition, comparison between
tracheostomy tubes having the DCT tube cylindrical-shaped
and TaperGuard\(^\text{TM}\) taper-shaped cuffs has not been made.
Therefore, bench tests were performed to compare the new
Shiley\(^\text{TM}\) Flexible Adult tracheostomy tube with the Taper-
Guard\(^\text{TM}\) cuff to the Shiley\(^\text{TM}\) DCT tube with cylindrical cuff
with respect to lateral wall pressure, air seal performance,
fluid seal performance, and insertion force.

**Methods**

**Lateral wall assessment**

The lateral wall pressure test was performed to compare the
average pressure exerted by each cuff type at its point of
contact with the lateral wall of a model trachea. In addition,
the pressure profile exerted by each cuff type against the
tracheal model wall was also examined.

The smallest (6.5 mm), midrange (7.5 mm), and largest
(10.0 mm) internal-diameter (ID) models of the adult tra-
cheostomy tubes were tested to ensure that the extreme, as
well as the most commonly used, sizes were included. The
Shiley\(^\text{TM}\) DCT tubes, which use the Jackson sizing system,
were matched to the Shiley\(^\text{TM}\) Flexible tubes which use the
International Organization for Standardization sizing system.
Table 1 lists the dimensions of the tubes and the sizes of the
model tracheas in which they were tested.

Polycarbonate model tracheas with pressure sensors mounted
on the inner surface were used. Three model tracheas were
constructed for use with each tube size having internal diameters
of 18.0 mm, 20.5 mm, and 22.5 mm. The pressure-sensing strips
mounted on the model tracheas contained multiple individual
elements that generated an electrical response in proportion to
the pressure applied to that element. This pressure-mapping
system contained the electronic hardware necessary to amplify
the signal from the array which was then transmitted to a com-
puter for further processing and analysis by Chameleon TVR\(^\text{TM}\)
software version 1.6.2.0 (Pressure Profile Systems, Los Angeles,
CA, USA). Each tube was inserted into the corresponding model trachea and the average pressure was measured at contact points between the cuff and model trachea along the cuff profile. The tracheal wall pressure was measured for each size tracheostomy tube as cuff inflation was increased in a stepwise fashion from 0 to 10, 20, and 30 cm H\textsubscript{2}O pressure. Each test was performed on ten samples of each product type. The test method used a rigid model trachea which did not expand, allowing the pressure applied by the cuff to be captured without variability in the rate and degree to which a flexible model may respond to the force applied, thus adding noise into the measurement system. In addition, current “state of the art” low-pressure sensors do not expand, therefore, it was not practical to perform this test using a soft, flexible model trachea.

The average pressure exerted by each cuff type was quantified and the pressure distribution was qualitatively assessed and graphically represented using a high-resolution pressure-sensing array. This assessment was performed on the 7.5 mm Shiley™ Flexible tracheostomy tube, with the TaperGuard™ cuff and a size 6 Shiley™ DCT tube with cylindrical cuff. This design enabled the examination of the smaller contact band of the taper-shaped cuff compared to the larger contact area of the HVLP cuff. All experiments were conducted according to an internally created cuff-pressure-mapping protocol.

### Air seal assessment
The purpose of this test was to determine the efficacy of the tracheostomy tube cuffs at creating a seal with the trachea to prevent air leakage past the cuff to the atmosphere. Tracheostomy tubes were connected to a ventilator via a breathing circuit to simulate the cyclic air flow applied to the cuff during routine use. Tracheostomy tubes of each size were placed into a rigid acrylic tracheal model attached to a Dual Adult Test Lung test lung (Michigan Instruments, Grand Rapids, MI, USA). The tracheostomy tube cuff was inflated and the tube connected to a Puritan Bennett 760 ventilator (Covidien, Carlsbad, CA, USA) via a breathing circuit. Ventilator settings were as follows: pressure control, inspiratory pressure 15 cm H\textsubscript{2}O; respiratory rate, 20 breaths per minute; inspiratory to expiratory time ratio, 1:2; rise time, 70 ms; positive end-expiratory pressure, 5 cm H\textsubscript{2}O; sensitivity, 15.2 L/min; and oxygen, 21%. The cuff was inflated to 25 cm H\textsubscript{2}O via a cuff inflation system attached to a digital pressure manometer which allowed for continuous cuff pressure monitoring and adjustment. The compliance of the test lung was adjusted to obtain an exhaled tidal volume of 330–338 mL for 6.5 mm tubes and 495–505 mL for other tube sizes. Tidal volume ranges were based on the average predicted body weight of the patients in which tubes are used. It is recommended that adult females and males should receive, at least initially, tracheostomy tubes with outer diameters of 10 mm and 11 mm, respectively. Therefore, a 55 kg female would receive a 6.5 mm tube and, when ventilated at 6–8 mL/kg, have an expected tidal volume of ∼330 mL (eg, a 75 kg male ventilated at 6–8 mL/kg would have a tidal volume of ∼500 mL). Thirty samples of each tube type were tested. The system was stabilized for 60 seconds, after which time five breaths were recorded. The average exhaled volume was subtracted from the average delivered volume as measured by the ventilator. The delta volume of delivered volume minus exhaled volume is the loss in air past the cuff.

### Fluid seal assessment
The purpose of this test was to determine the efficacy of the tracheostomy tube cuffs to create a seal with the trachea to prevent the passage of fluid past the cuff. A tracheostomy tube was inserted into an acrylic trachea and the cuff inflated to 25 cm H\textsubscript{2}O while the tracheal model was maintained in a 37°C–39°C water bath for 15–30 minutes. A distilled water reservoir at 37°C–39°C was maintained 2.0–2.4 cm above the proximal cuff via a siphon tube for 10 minutes. Any water able to leak past the cuff was collected in a beaker under the model trachea. The weight of the water was used to calculate the leak.
Ease of insertion assessment
The insertion-force bench test assessed the maximum force required to insert a deflated cuffed tracheostomy tube through an artificial stoma opening. The artificial stoma consisted of a synthetic latex sheet 0.49 mm thick with an incision 30 mm long. The sheet was held taut within a support fixture. An Instron® Tensile Test Machine (Instron®, Norwood, MA, USA) was used to measure and record the insertion force.

Statistical analysis
Two-sample t-tests were performed to detect differences between cuff types in terms of lateral wall pressure, fluid and air leak, and mean insertion force for each tube size. Data are summarized as mean and standard deviation.

Results
Lateral wall pressure
The relationship between the intra-cuff pressure and the pressure applied by the cuff to the model trachea wall is shown for each tracheostomy tube size in Figure 2A–C.

For each tube size, the average pressure exerted on the lateral wall of the model trachea was lower for the Shiley™ Flexible tube with TaperGuard™ cuff than for the Shiley™ DCT tube with the cylindrical-shaped cuff. As tube size increased, so did the difference between the cuff types in terms of pressure applied to the tracheal wall, with applied pressure differences reaching ∼10 cmH₂O at each intra-cuff pressure for the largest tracheostomy tube sizes (Figure 2C).

Graphical representations of the pressure array exerted by the 7.5 mm Shiley™ Flexible tracheostomy tube with the TaperGuard™ cuff and a size 6 Shiley™ DCT with cylindrical cuff on the lateral wall of the model trachea are shown in Figure 3, with the cuffs inflated to increasing intra-cuff pressures from 0 to 30 cmH₂O. As stated earlier, it is widely accepted that, for un-stretched HVLP cuffs, the intra-cuff pressure will correlate closely with tracheal wall pressure. This was found to be true when the quantitative analysis was performed, as shown in Figure 2. However, deviations from the expected 1:1 relationship between the intra-cuff pressure and the pressure applied to the tracheal wall are also apparent. The graphical representation in Figure 3 demonstrates that, given that materials are not infinitely flexible, there will be points of contact and noncontact between the cuff and the model trachea.

![Figure 2](image-url)

Figure 2 Mean pressure exerted on tracheal wall plotted against intra-cuff pressure. (A) Small tube size, (B) midrange tube size, (C) large tube size.

Note: *Significance at the P<0.05 level.

Abbreviations: DCT, Disposable Cannula tracheostomy; TG, TaperGuard™.
Air seal
The average volume of air leak past the two cuff types is listed in Table 2. Results demonstrated that the air leak was significantly lower for the Shiley™ Flexible tracheostomy tube with TaperGuard™ cuff than for the Shiley™ DCT tube with cylindrical cuff when both cuffs were inflated to an intra-cuff pressure of 25 cmH₂O.

Fluid seal
The average volume of water leak past each cuff type is shown in Table 2. Results demonstrate that the Shiley™ Flexible tube with TaperGuard™ cuff had significantly less fluid leakage past the cuff than the Shiley™ DCT tube with cylindrical cuff for all tube sizes tested.

Insertion force
The average insertion force for each tube type is listed in Table 2. The force required to insert the Shiley™ Flexible tracheostomy tube with TaperGuard™ cuff was 40% less than that needed to insert the Shiley™ DCT tube with cylindrical cuff. Insertion force was significantly lower with the TaperGuard™ cuff for each tube size tested.

Discussion
The cuff on a tracheostomy tube seals the tracheal lumen, permits the maintenance of airway pressure and tidal volume during mechanical ventilation, and guards against aspiration. A known hazard of the inflated cuff is tracheal damage caused by pressure transmitted to the tracheal wall that exceeds mucosal perfusion pressure. Current standard practice includes the maintenance of intra-cuff pressure between 20 and 30 cmH₂O, which will seal the airway to prevent aspiration while minimizing damage to the trachea. The intra-cuff pressure range used in the study was 0 to 30 cmH₂O, which is considered clinically relevant.
The pressure distribution of the cuff on the lateral tracheal wall was not uniform or homogeneous for either cuff type, as depicted by the intermittent appearance of red- and green-tipped spikes that indicate higher pressure points (Figure 3). The TaperGuard™ cuff has a more homogeneous and lower pressure distribution than the DCT cuff.

As in this study, Li Bassi et al also observed points at which the pressure exerted on the lateral tracheal wall was higher than the intra-cuff pressure and suggested that this may be due to the formation of folds pressing on the trachea. They proposed that the portion of the tracheal wall that abuts the cuff fold may be exposed to higher transmitted pressure due to tangential force exerted on a smaller contact area. This is common to all HVLP cuffs and is the result of the device design such that the cuff inflated to atmospheric pressure has a larger diameter than the internal tracheal diameter.

The TaperGuard™ cuff provides a more effective seal of the trachea with a smaller tracheal contact area. The TaperGuard™ cuff forms a small band where the inflated cuff has a diameter equal to the trachea at a point between the oversized proximal and undersized distal portions of the cuff. This band of contact reduces the number of micro-channels and the associated passage of air and fluid leaking past the cuff. The leakage of secretions or gastric contents through these channels and into the lungs increases the risk for complications including ventilator-associated pneumonia. An incomplete seal resulting in gas leakage can result in a failure to maintain positive end-expiratory pressure and hypoventilation.

In a bench study using a model of the trachea, Madjdpour et al demonstrated that an endotracheal tube with a taper-shaped cuff made from polyvinyl chloride (PVC) significantly improved air sealing compared to standard cylindrical-shaped cuffs. The cylindrical-shaped PVC cuff did not effectively seal the trachea, even at the high end of clinically accepted intra-cuff pressure (ie, 30 cmH₂O), when measured by both sevoflurane concentration passing around the cuff and the ratio of expired tidal volume to inspired tidal volume. In a clinical study, when the two cuff types were compared during short-term use on surgical patients, the taper-shaped cuff demonstrated better protection against aspiration.

Changing the patient’s cuffed tracheostomy tube may cause irritation to the stoma due to the bulk of the deflated cuff material. The Shiley™ Flexible tracheostomy tube with its taper-shaped cuff, made from thinner material and having a smaller volume than the Shiley™ DCT tube cuff,

### Table 2 Cuff performance data

| Size (mm) | Mean air leak (mL) | Mean fluid leak (mL/h) | Mean insertion force (kgf) |
|-----------|-------------------|------------------------|---------------------------|
|           | DCT | TG  | DCT | TG  | DCT | TG  |
| 6.0       | 120.3 (58.2)     | 9.1 (7.5)*             | 828.9 (964.7)             | 4.4 (15.5)*            | 0.250 (0.06) | 0.119 (0.06)* |
| 7.5       | 119.4 (89.7)     | 11.3 (10.5)*           | 928.9 (651.9)             | 2.8 (5.3)*             | 0.683 (0.19) | 0.370 (0.13)* |
| 10.0      | 163.8 (89.9)     | 16.2 (16.6)*           | 1070.9 (618.4)            | 2.1 (8.6)*             | 0.496 (0.11) | 0.374 (0.27)* |
| Average   | 134.5 (82.4)     | 12.2 (12.4)*           | 943.0 (759.1)             | 3.1 (10.6)*            | 0.476 (0.22) | 0.298 (0.21)* |

**Notes:** Data are presented as mean (standard deviation). *Significance at the P<0.05 level.

**Abbreviations:** DCT, Disposable Cannula tracheostomy; kgf, kilogram force; TG, TaperGuard™.
requires less force when inserted into the simulated patient’s stoma (Table 2) and, therefore, may cause less trauma to the patient.

Another enhancement to the Shiley™ Flexible tracheostomy tube is a transparent, soft PVC flange designed to conform to the patient’s clavicle. The central portion of the flange has symmetrical windows and is offset to help reduce contact with the patient’s skin. These changes in flange characteristics may improve the comfort of patients with tracheostomy tubes, many of whom have these devices in place for extended periods of time. The flange of the Shiley™ Flexible tracheostomy tube is constructed from a new non-di-(2-ethylhexyl)-phthalate (DEHP) PVC formulation. PVC is softened through the use of plasticizers of which DEHP is the most commonly used in tracheostomy tubes and many other medical devices. Health concerns related to the release of DEHP into biological fluids and tissues have been raised by the US Food and Drug Administration; the Ministry of Health, Labor and Welfare, Health, Canada; and the European Commission. As a precaution, DEHP has been removed from the Shiley™ Flexible tracheostomy tube and replaced with a citrate and dioctyl terephthalate-based plasticizer. Citric acid, a metabolite of plants and animals, and dioctyl terephthalate are widely used in food packaging, medical products, soft toys for children, and cosmetics and are not known to have any ill-effects on human health.

Study limitations
The trachea model used in the bench testing was a rigid circular tube, while an actual trachea is non-circular and somewhat distensible. Therefore, the study conditions do not necessarily reflect what might happen in a clinical situation. In addition, the products were tested at approximately room temperature, while, when in clinical use, tracheostomy tubes are used at body temperature, which could impact device performance.

Conclusion
The Shiley™ Flexible tracheostomy tube with TaperGuard™ cuff offers several improvements compared to the Shiley™ DCT tube with a cylindrical-shaped cuff, including a tapered shape and thinner cuff. The results of this study demonstrate that, in a model trachea, the Shiley™ Flexible tracheostomy tube with TaperGuard™ cuff, when compared to the Shiley™ DCT tube with cylindrical cuff, exerted a lower average lateral wall pressure and a more evenly distributed pressure. In addition, it provided more effective fluid and air seals and required less force to insert.

Disclosure
Frances Haury, Seamus Maguire, and Korinne Jew all work for Covidien, the manufacturer of the Shiley™ tracheostomy tubes tested and discussed in this paper. The authors report no other conflicts of interest in this work.

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