

The Syrex[®] Difference

Syrex Prefilled Flush Syringes

Exceeding Your Standards. . .

- Safety
- Patient Care
- Value



Normal saline



10 U/mL heparin



100 U/mL heparin



Sterile field saline flush

Excelsior Medical Product Offering

	Part Number	Units/Box	Units/Case
Syrex Saline Flush Syringes			
2.5mL Saline	100 33 - 1000	100	1000
3mL Saline	100 31 - 1000	100	1000
	100 31 - 240	30	240
5mL Saline	100 51 - 1000	100	1000
	100 51 - 240	30	240
10mL Saline	100 11 - 1200	100	1200
	100 11 - 240	30	240

	Part Number	Units/Box	Units/Case
Syrex Heparin Flush Syringes			
10U/mL Heparin, 5mL	500 51 - 1000	100	1000
	500 51 - 240	30	240
100U/mL Heparin, 5mL	600 51 - 1000	100	1000
	600 51 - 240	30	240

	Part Number	Kits/Box	Kits/Case
SASH Kits			
(2) Saline 5mL in 10mL Syringe	116 51	10	100
(1) 100U/mL Heparin 5mL in 10mL Syringe			

	Part Number	Pouches/Box	Pouches/Case
Sterile Field Flush			
(2) 10mL in 10mL Syringe in a sterile field pouch	100 92	30	240

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The Syrex™ Difference

Clinical Data for Patient Safety

Position Statements

I.V. admixture contamination rates: Traditional practice site versus a class 1000 cleanroom.
Thomas, M, et al. Amer. J Health-System Pharm, Vol 62, Issue 22, 2386-2392.

Using a medium-fill simulation to evaluate the microbial contamination rate for USP medium-risk-level compounding. Trissel, LA, et al. Amer. J Health-System Pharm, Vol 62, Issue 3, 285-288.

Summary of USP <797>, Pharmacopeial Form, Vol. 29 (4) July-Aug, 2003.

“Position statement on using pre-filled 0.9% saline flush syringes.” American Journal of Hospital Pharmacy - Vol. 51, June 15, 1994.

Multi-Dose Vials

“Patient Safety movement calls for reexamination of multi-dose vial use.” ISMP Safety Alert Vol. 5, Issue 12, June 14, 2000.

“Near-fatal pediatric accident should force reassessment of a common cost-cutting measure.” ISMP - August 25, 1999.

“Multi-dose vial linked to nosocomial HCV outbreak.” Hospital Infection Control/May 2000.

“Hepatitis B outbreak related to multiple dose heparin vials should serve as a wake up call.” ISMP Safety Alert - July 17, 1996.

Single Dose Vials

“Awareness growing about IV catheter-associated infections due to inappropriate use of disposables”. ISMP Safety Alert, January 15, 1997.

Bags (500 mL and 1 liter)

“Polymicrobial gram-negative bacteremia associated with saline solution flush used with a needless intravenous system.” Chodoff A, Pettis AM, Schoonmaker D, Sheily, M. AJIC, December 1995, pp. 357 - 363.

Higher contamination rates / mislabeled syringes manually filled by nursing staff

“Are contaminated flush solutions an overlooked source for catheter related sepsis?” Elliott, TS, et al. Journal of Hospital Infection, 2001 Sept; 49(1):81-3

“Neuromuscular blocking agents, proposed labeling and packaging standards for medication error prevention.” Recommendations of the USP Advisory Panel on Medication Errors, USP Quality Review, February 2000, no 72.

“Nosocomial Malaria and Saline Flush.” Jain, Sanjay K, et al., Emerging Infectious Disease, Vol. 11, No.7, July 2005. pp 1097-1099

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