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Combining cytology and histology to create the ultimate EUS needle

In recent studies, Kenneth Chang, MD, Executive Director, H. H. Chao Comprehensive Digestive Disease Center (University of California-Irvine), found that a new 25 gage biopsy needle developed by Cook Medical combined the attributes of both FNA and FNB, and delivered a single-pass diagnosis of 88% in suspected tumors of the pancreas when pathologists examined both the histological and cytological yield obtained.¹

"We haven't done a head-to-head comparison yet," says Dr. Chang, "but I think we'd be able to say that this 25 gage needle is as good if not better than the standard 25 when comparing cytology yields. In addition, without sacrificing cytology, you're obtaining histological samples. And overall–on a single-pass or a limited-pass basis–I predict this is going to be the 'go-to' needle for tissue acquisition."

Bigger not always better

Over his 24-year career, Dr. Chang has studied and pioneered novel uses of endoscopic ultrasound. "In the FNA world, going back 15-20 years, we went through a paradigm shift," he says. "We initially thought bigger was

INSIDE THIS ISSUE

| COMBINING CYTOLOGY AND HISTOLOGY TO CREATE THE ULTIMATE EUS NEEDLE | 1 |
|---|----|
| CASE PRESENTATION: COMBINING HISTOLOGY AND CYTOLOGY INFLUENCES PATIENT TREATMENT | 3 |
| ASGE CRYSTAL AWARDS | 4 |
| CLINICAL NUTRITION WEEK 2012 | 6 |
| NATIONAL COLORECTAL CANCER AWARENESS: TWO GASTROENTEROLOGISTS ON THE FRONTLINE | 7 |
| ILLINOIS GI PRACTICE GIVES BACK TO THE COMMUNITY | 7 |
| DR. MUSKA ANSWERS: WHAT MAKES A PATIENT HIGH RISK FOR COLON CANCER? | 7 |
| ALEXIAN BROTHERS HEALTH SYSTEM | 8 |
| CHECKING IN ON KENTUCKY'S COLON CANCER PREVENTION PROJECT | 9 |
| COLON CANCER STATISTICS IN KENTUCKY AND THE USA | 9 |
| KENTUCKY'S COLON CANCER PREVENTION PROJECT CONTACT INFORMATION | 10 |
| TREATING GASTRODUODENAL OUTLET OBSTRUCTION | 11 |
| RELIEVING HIGH-GRADE PARTIAL BOWEL OBSTRUCTION | 12 |
| EVOLUTION FAMILY OF INNOVATIVE STENTS EXPAND COLONIC STENT | 13 |
| NEWS FROM SIGNEA - MY HONG KONG JOURNEY AS A GI NURSE | 14 |
| PETER COTTON'S "ENDOSCOPIC JOURNEY" RAISES FUNDS FOR ADVANCED TRAINING | 15 |
| G1360 | 16 |

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THE QUEST FOR THE BEST EUS NEEDLE

Continued from page 1

better. So we started with 22 gage, then went to 19 gage needles. We found out in those early days that bigger was not necessarily better, but actually worse. And then we discovered that if we went in the other direction–smaller–that smaller is actually better. And now the market is reflecting that. Now we're seeing a dramatic shift to smaller needles, such as the 25 gage EchoTip ProCore.

"I was already familiar with the 19 and 22 gage ProCore needles," Dr. Chang continues. "But eventually we asked a simple question: 'What would happen if you made a 25 gage EUS needle in the same configuration?' The initial thought was, of course, you're going to have a worse yield. Because you're looking at a core needle that is smaller; therefore, the yield should decrease. But, pushing that assumption aside, we knew that if we didn't try we would never know for sure. So, based on initial discussions, Cook Medical decided to manufacture a limited number of 25 gage needles. And, so far, we feel that it outperforms the 19 gage and the 22 gage for tissue acquisition. So now, in our treatment center, the 25 gage is our favorite needle for FNA."

Modifying the technique

In his clinical studies, Dr. Chang initially used the traditional technique for tissue acquisition: high suction and three to-and-fro motions of the needle. "We did that in 20 consecutive patients and we were very disappointed in the results," he recalls. "We weren't getting a high histology yield, we weren't getting a high cytology yield." Dr. Chang was close to discontinuing the trial since the results with the 25 gage needle were looking no better than the 19 gage.

"But before totally abandoning the study," says Dr. Chang, "I decided to try one more strategy: To change the needle technique to what we were using with the standard 25 gage needle, which is: low suction–or essentially no suction. We just used the amount of suction generated when pulling the stylet back ('capillary action'), along with ten-to-twenty rapid to-and-fro motions, using a fanning technique, similar to standard FNA, basically. We referred to this as the 'modified technique' in comparison to the standard technique using high suction. It was a slow-pull stylet, combined with rapid/multiple to-and-fro needle technique. We just call it 'slow pull' for short."

The results of the study led Dr. Chang to conclude that the new 25 gage biopsy needle delivered a histologic yield of 90% and an overall diagnostic yield of 95%, and that the needle and technique appeared to be optimum for EUS tissue acquisition.

What it may mean to the future of EUS practices

Dr. Chang feels that with his recent findings and with future research, EUS procedures may become more streamlined. "The thing about this which is attractive is that if we can increase that single-pass yield of 88% to, say, into the 90s, then it would make a lot of sense in a busy practice to just do two passes. The single pass would get you 88-92%; and a reassurance pass may hopefully get you above 95% and then end the case. Then you would have both cytology and histology that you can send to the pathologist and then they can take their time reading at their desk. Maybe one in every 20 patients might have to be called back, which is not too different from our current practice now even with pathologists at the bedside."

There's more research to do, but Dr. Chang is optimistic about the results thus far. "It's hard to make definitive statements until further studies are done, but it's possible that the ProCore 25 may the ultimate tissue acquisition needle."

¹ Data on file at Cook Medical

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Figure 1



Figure 2



Figure 3











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Case presentation:

Combining histology

patient treatment

and cytology influences

Kenneth Chang, MD Executive Director H. H. Chao Comprehensive Digestive Disease Center University of California-Irvine

A 48-year-old patient with a pancreatic mass on CT presented for further evaluation with endoscopic ultrasound (EUS). EUS revealed an iso-echoic solid tumor, measuring 23 x 14 mm, in the body of the pancreas. Subsequent EUS-guided fine needle aspiration biopsy was performed with a new 25 gage biopsy needle (Cook Medical 25 gage EchoTip ProCore) (Figure 1).

Macrosopic evaluation of specimen showed whitish core tissue (Figure 2). The core specimen was transferred into a formalin bottle for histological processing. The remainder of the non-core specimen was smeared and submitted for cytology. On-site cytological analysis showed adequate specimen on Diff-Quik™ stain (Figure 3). Histological analysis of the core specimen showed pancreatic neuroendocrine tumor on H.E. stain (Figure 4). Immunohistochemical staining with Chromogranin A and Synaptophysin (Figure 5) confirmed the diagnosis.

Based on this precise tissue diagnosis, the patient underwent surgery with successful resection of the tumor.



ASGE Crystal Awards Celebrating Leadership, Research and Scientific Pursuit in Endoscopy

The American Society for Gastrointestinal Endoscopy (ASGE) recently honored important contributions to the field of endoscopy during the eighth annual ASGE Crystal Awards in San Diego, California during Digestive Disease Week (DDW^{*}). Hosted by ASGE and the ASGE Foundation, this year's event was held against the backdrop of San Diego Bay and the city skyline at PETCO Park, home of the San Diego Padres.

The ASGE Crystal Awards symbolize the finest in leadership, research and scientific pursuit. This year's event featured dinner and presentations to honorees by 2011-2012 ASGE President Gregory G. Ginsberg, MD, FASGE; ASGE Foundation Chair, Robert A. Ganz, MD, FASGE; ASGE leaders; and Master of Ceremonies and ASGE Past President David L. Carr-Locke, MD, FASGE.

Dennis M. Jensen, MD, West Los Angeles VA Healthcare Center, Los Angeles, California, received the prestigious Rudolf V. Schindler Award. Other award recipients included: Distinguished Service Award winner Glenn D. Littenberg, MD, Gastroenterology Associates, Pasadena, California; Distinguished Educator Award winner Douglas A. Howell, MD, FASGE, Portland Gastroenterology Center, Portland, Maine; Distinguished Endoscopic Research Mentoring Award winner Michael B. Wallace, MD, MPH, FASGE, Mayo Clinic, Jacksonville, Florida; and Master Endoscopist Award winner Martin L. Freeman, MD, FASGE, University of Minnesota, Division of Gastroenterology, Minneapolis, Minnesota.

We would also like to congratulate the winners of Crystal Awards that are underwritten by Cook Medical, including the Don Wilson Awards, which provide advanced fellows or junior faculty with the opportunity to train outside of their home country with a premier GI endoscopist or group to advance their training. The award was named to honor Dr. Don Wilson, co-founder and former president of Wilson-Cook Medical (now Cook Medical Endoscopy division), who was a strong advocate and supporter of international education and training in GI endoscopy. The Don Wilson Awards went to: Rees Cameron, MD, Wellington Hospital, Wellington, New Zealand; Muhammad Dawwas, MD, The Freeman Hospital, Newcastle upon Tyne, United Kingdom; and Hyoung-Chul Oh, MD, PhD, Chung-Ang University Health Care System, Seoul, South Korea.

The Cook Medical Marsha Dreyer Awards honor Marsha, who was passionately committed to the support of continuing education opportunities for GI professionals around the globe. The awards, which provide scholarships for international physicians to attend DDW annually, went to: Sergio Coda, MD, Imperial College, London, United Kingdom; Meike MC Hirdes, MD, University Medical Center Utrecht, Utrecht, The Netherlands; Bronte A. Holt, MBBS, Westmead Hospital, Sydney, Australia; Payal Saxena, MBBS, FRACP, Westmead Hospital, Sydney, Australia; and Nicholas J. Tutticci, MBBS, The Prince Charles Hospital, Brisbane, Australia.



Don Wilson



Marsha Dreyer



Sergio Coda, MD



Payal Saxena, MBBS, FRACP



Dr. Peter Siersema accepted the award on behalf of Meike MC Hirdes, MD



Muhammad Dawwas, MD



Nicholas J. Tutticci, MBBS



Bronte A. Holt, MBBS

ASGE President Gregory G. Ginsberg, MD, FASGE (left in all above photos), presents the Don Wilson and Marsha Dreyer Awards. Not pictured: Rees Cameron, MD and Hyoung-Chul-Oh, MD, PhD.



Rick Davis accepts the Lyn Howard Advocacy Award from A.S.P.E.N. President Jay Mirtallo, MS, RPh, BCNSP, FASHP.

Clinical Nutrition Week 2012 An enchanted setting for vital information

The American Society of Parental and Enteral Nutrition (A.S.P.E.N.) held its annual Clinical Nutrition Week conference at the magical Walt Disney World Swan and Dolphin Resorts in Orlando, Florida, in January 2012. More than 2,000 physicians, dietitians, pharmacists, nurses, educators and researchers from the U.S., Europe, Mexico, South America, Asia and Canada gathered to exchange information on clinical nutrition and metabolic research.

In the U.S. alone, more than 340,000 people of all ages are receiving enteral nutrition and, as Dr. Mark DeLegge puts it, "Enteral access is the foundation of enteral feeding." Dr. DeLegge was honored at the conference as past president of A.S.P.E.N.

Believing that patients are an integral part of the enteral feeding industry, A.S.P.E.N. leaders presented the Lyn Howard Advocacy Award to Rick Davis, a patient who lost the ability to swallow after a stroke. Davis is president of the Oley Foundation, an organization providing information and support to patients and their families. Oley's Executive Director, Joan Bishop explains, "tube feeding allows the patients to resume their life to the fullest within the extent that their disease state allows." Dr. DeLegge adds: "Enteral tubes are long-term implants and the patient's inputs need to be considered."

Enteral feeding devices are extremely vital, patient-driven products and represent Cook's core mission: To provide clinical professionals, and ultimately the patient, with quality medical devices.

Three divisions of Cook (Endoscopy, Critical Care and Interventional Radiology) were represented at the conference by Ryan Fitzpatrick, Brion O'Toole, Michael Maryan, Walter Mitchell and Bruno Gagnon.

ADDITIONAL SIZES AVAILABLE COOK[®] Triton[™] BALLOON REPLACEMENT GASTROSTOMY TUBE

New Triton Balloon Replacement Tube helps deliver patient care with added efficiency.

Cook Medical recently introduced the new Triton Balloon Replacement Tube. With separate lumens for inflation, feeding and delivering medications, the Triton adds convenience and efficiency to enteral feeding procedures. The dedicated medication tube accepts smaller syringes and the clear feeding tube, made of flexible, high-grade silicone, allows caregivers to easily visualize nutrient flow. The external bolster has been newly designed for patient comfort. For more information on the Triton BRT, contact your Cook representative.

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| G56112 | PEG-16-BRT-TRI | 16 | 10 |
| G56113 | PEG-18-BRT-TRI | 18 | 15 |
| G53883 | PEG-20-BRT-TRI | 20 | 20 |
| G56114 | PEG-22-BRT-TRI | 22 | 20 |
| G53885 | PEG-24-BRT-TRI | 24 | 20 |

Components include: 1 bolster and 1 water soluble lubricant pack.

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National Colorectal Cancer Awareness Two gastroenterologists on the frontlines



Among cancers that affect both men and women, colorectal cancer is the second leading cause of cancer-related deaths in the United States and is one of the most commonly diagnosed cancers. Many of these deaths occur needlessly, as they could be prevented if more people received colorectal cancer screening. It is estimated that as many as 60% of colorectal cancer deaths could be prevented if all men and women aged 50 years or older were screened routinely.

In acknowledgement of National Colorectal Cancer Awareness, this issue of The Channel explores the selfless work of two gastroenterologists whose dedication to raising awareness and providing colorectal cancer screenings is exemplary.

Illinois GI practice gives back to the community

Editor's Notes: During 2011, physicians with Advanced Gastroenterology Associates in Elk Grove, Illinois, performed 26 free colonoscopies during two Saturday sessions. The procedures took place at hospitals affiliated with the Alexian Brothers Health System, a diversified Catholic healthcare organization headquartered in Arlington Heights, Illinois. Brian Muska, MD, who initiated the screenings, explains how he became involved, and offers advice to other medical professionals considering similar programs.



Brian Muska, MD Advanced Gastroenterology Associates Alexian Brothers Medical Center St. Alexius Medical Center Hoffman Estates and Elk Grove Village, IL

In September 2010, we met with a local public health nurse, who asked us to participate in a program to increase awareness of the need for colon cancer screenings. As a colon cancer survivor, the nurse is very dedicated to this cause.

During some brainstorming, she wished there was a way to help those who couldn't afford a colonoscopy. I, too, had always wanted a way to help out those people; it was a way to give back to the community, especially with the problems in the Illinois economy.

After a while, we jointly reached the conclusion that we should plan a Saturday of free screens for identified, high-risk patients.

Continued on page 8

Dr. Muska answers: What makes a patient high risk for colon cancer?

- I have found the leading risk in the family history. A first-degree relative (father, mother, etc.), who experienced colon cancer under the age of 60 is a clear warning sign.
- Also at high risk are persons related to two previous generations with colon cancer.
- There is some evidence that the African-American population is at higher risk.



Alexian Brothers Health System Pulling together to serve those in need

The Alexian Brothers Health System has a long-standing reputation for providing free or discounted services to Chicago area residents. That's why Dr. Muska and his team approached Alexian Brothers for assistance with the free-colonoscopy program. "When our health care leadership learned of the need for these life-saving procedures," says Matthew Wakely, Vice President of Communications for the Health System, "we pulled together as a health care system and everyone up and down the line agreed to waive their fees. We felt deeply that this is what we should be doing. It exemplifies the Alexian Brothers' mission and values of serving the poor, the disenfranchised and those in need."

ILLINOIS GI PRACTICE GIVES BACK TO THE COMMUNITY Continued from page 7

Finding high-risk, uninsured patients

The public health nurse held health fairs and distributed pamphlets, questionnaires and Hemoccult test kits to patients at risk for colon cancer. She identified more than a dozen candidates for free colonoscopies, and we began working with the Alexian Brothers Health System on the next step.

The Alexian Brothers system has an established tradition of providing free or discounted care to people in the Chicago area. Administration requires a W-2 form to determine who is eligible for free care. The system then uses a sliding scale based on demographics.

On a Saturday in March 2011, my practice partner, Richard Song, MD, and I participated in the first set of 13 screenings at the St. Alexius Medical Center in Hoffman Estates, Illinois. We did one after another all day.

Anesthesiologists volunteered their time and the Center provided their staff, the procedure rooms and all products needed. In November 2011, Peter Rantis, MD, a surgeon in the Alexian Brothers system, joined us to perform the second set of free screenings, at the Alexian Brothers Medical Center in Elk Grove, Illinois.

Immediate results: Colon cancer cases identified

To date we have screened 26 high-risk patients–13 on each Saturday. We found early-stage colon cancer in the very first patient we screened! That experience honestly choked me up a bit–it was almost like it was meant to be. In November we found another cancer. The Alexian Brothers Health System provided surgery services for these two persons.

We've received several moving letters from families, including two who had loved ones with colon cancer. It makes it all worthwhile, and makes me want to continue doing this.

We plan to do a third set of free screenings in March 2012 in conjunction with National Colon Cancer Awareness Month. Our hope for the future is to involve several other hospitals in our area.

Advice to other medical professionals

If your practice is considering offering free colonoscopies to those in need, I recommend coordinating your program with your local public health professionals. They are closest to the community and can identify those who are most at risk. Further, public health professionals can help smooth the process. I predict you will also find that other medical professionals are very willing to help.

Checking in on Kentucky's Colon Cancer Prevention Project



Whitney Jones, MD, Clinical Professor of Medicine at the University of Louisville, was preparing to testify before a Kentucky General Assembly Committee in Frankfort in January 2012. As founder of the Colon Cancer Prevention Project, he was vitally interested in pending legislation.

His testimony was a follow-up to a November 2011 meeting. At that time, his team promoted a proposal to direct \$8 million in state funds to a colon cancer screening project over the next two years.

"Each year, more people in Kentucky die from colon cancer than breast cancer, cervical cancer HIV/AIDS and tuberculosis combined," explains Dr. Jones. "By supporting this program, we can make education, prevention and early detection of colon cancer a funded priority."

Awards and information from national conferences

The year 2011 was a busy and rewarding one for Dr. Jones and Andrea Uhde Shepherd, Executive Director of the Project. "Last March, we attended the National Colon Cancer meeting, and our entire team was honored to receive the Laurel Award for advocacy," recalls Dr. Jones.

In November 2011, Dr. Jones attended a Bethesda, Maryland, national conference. "It was an impressive gathering of cutting-edge colon cancer prevention specialists," says Dr. Jones. "The objective was collaboration, freely sharing ideas, across state boundaries. A key message was the need to increase awareness among all socio-economic aspects, with emphasis on the underserved. We also recognized that the African-American rural population is not being screened for colon cancer," he says.

"Several states, including New York, Delaware and Maryland are promoting screens, and colon cancer in these states is being dramatically reduced. This is a major public health issue," continues Dr. Jones. *Continued on page 10*

Colon cancer statistics in Kentucky and the USA

- Colon cancer is the leading cancer killer in Kentucky and the U.S. among non-smokers.
- Colon cancer kills more people each year than breast cancer and HIV/ AIDS combined.
- Kentucky currently ranks among the worst states in the country in colon cancer deaths due to low screening rates.
- An increase in Kentucky colon cancer screenings led to a 16 percent decrease in both incidence and mortality rates in Kentucky.
- Ninety percent of colon cancer deaths can be prevented with timely, appropriate screening.
- The average cost of colon cancer if treated at a late stage is more than \$120,000 a case.
- Screening is cost-effective. Research shows that screening has a cost effectiveness ratio of \$10,000 to \$25,000 per life-year saved.

Statistics from the Colon Cancer Prevention Project.



Mary Doroshenk; Dr. Whitney Jones, Prevent Cancer Foundation President and Founder; Carolyn "Bo" Aldigé and Dr. Sanja Percac-Lima.



Kentucky's Colon Cancer Prevention Project Contact information

Colon Cancer Prevention Project PO Box 4039 Louisville, KY 40204

Physical address 2117 Payne Street, Suite 306 Louisville, KY 40206

Phone

Local: (502) 290-0288 Toll Free: (800) 841-6399 Fax: (502) 721-0400

E-mail for Executive Director Andrea Uhde Shepherd ashepherd@c2p2ky.org

Facebook www.facebook.com/ coloncancerprevention **CHECKING IN ON KENTUCKY'S COLON CANCER PREVENTION PROJECT** Continued from page 9

"We really gleaned the importance of setting up screening programs. Federally qualified health centers with Medicaid insurance must now apply known and effective colon cancer screens to entire populations. Physicians can help with expertise in screenings. It is a wonderful opportunity to reach into community health organizations and develop more preventive care options.

"However, President Obama's Affordable Care Act will not solve all the problems," Dr. Jones says. "For example, 20 percent of Kentuckians are uninsured. Under the Act, that number is expected to drop to seven percent, but even that still leaves hundreds of thousands of people uninsured."

Screening urged for people patients beginning at age 40

"We want to change the communication strategy of screening to begin the dialogue with and include those down to age 40," says Dr. Jones. "We want everyone to: one, recognize symptoms earlier; two, place appropriate focus on their family history to encourage more compliance with current screening guidelines; and three, increase the likelihood that they get screening at age 50 (if completely at normal risk) rather than later in their 50s as is the current status quo. Currently, the average age of first-time colonoscopy recipients is approximately 56 years old, which is not a good communication-strategy outcome. We hope that this new communication strategy will change that."

The project is also seeking \$250,000 for a publicity program to increase awareness for all Kentucky citizens. "We need education to raise the Medicare screening rates. South Carolina, Colorado, Texas and Delaware are all active in this," Jones says.

To date 26 states have received Center for Disease Control money for colon cancer screening programs focused on the uninsured. Kentucky will be the first to develop its own funding line for this program.

Dramatic improvements

"We have been working with the Kentucky General Assembly in 2008, 2010 and now in 2012. We have made dramatic improvements, but more access is needed for the uninsured," says Dr. Jones.

"As physicians, we need to be community leaders, and there is a great opportunity for GIs to take leadership roles," Dr. Jones concludes. "We have been able to prove skeptics wrong. Public health programs can save more lives than private medical practices can do alone. This is not theoretical; we have down-to-earth results."

Treating Gastroduodenal Outlet Obstruction with Evolution Controlled-Release Duodenal Stent



Francesco Di Matteo, MD Gastroenterologist GI Endoscopy Unit University Campus Bio-Medico Rome, Italy

A 73-year-old patient was referred to us with a "painless" obstructive jaundice and pruritus secondary to a solid lesion of the pancreas. The patient was admitted to our unit with MRI and CT-scan imaging of solid lesion of the head of the pancreas with signs of vascular involvement of mesenteric vessels and bile duct obstruction and no certain metastasis. Underlying diseases: diabetes and hypertension. Blood test showed: AST 168 U/L; ALT 79 U/L; γ -GT 1066 U/L; ALP 650 U/L; total Bilirubin 21.52 mg/dL; dir. Bil. 14.54 mg/dL.

Under deep sedation with Propofol, the patient underwent ERCP that failed for a tight stricture of the second part of duodenum (Figures 1-A, 1-B). During the procedure we decided to place a duodenal 6 cm Evolution stent (Cook Medical EVO-22-27-6-D) after a measurement of the length of stenosis with the guide catheter (Cook Medical SIS-10). The deployment of the Evolution stent under fluoroscopy was comfortable as usual (Figures 2-A, 2-B).

After two days an ERCP was technically unsuccessful as the papilla was inaccessible despite probing within the duodenal stent. Thus, EUS-guided puncture was performed transgastrically into left intrahepatic ducts. A linear array echoendoscope was placed near the gastric lesser curve allowing visualization of a dilated left hepatic duct (Figures 3-A, 3-B).

Upon confirming a tight stricture of the distal part of the common bile duct, a guide wire, under fluoroscopy, was passed into the biliary tree and towards the stricture till the third part of duodenum. Fistula creation was necessary to allow the insertion of a SEMS. We placed an anterograde biliary stent (Cook ZILBS-635-10-6) across the stricture trans-papillary (Figures 4-A, 4-B).

An immediate good bile and contrast efflux was seen. The patient continues to show no signs or symptoms of gastric outlet obstruction or stent dysfunction. He is currently free of pruritus and undergoing palliative care.



Relieving high-grade partial bowel obstruction with Evolution Controlled-Release Colonic Stent

Figure 1





Dr. Julio Faria Assistant Professor of Surgery McGill University Jewish General Hospital Montreal, Quebec, Canada

Background: Up to 30% of patients with colon cancer present for the first time with symptoms of large bowel obstruction. At least half of these cases are palliative at the time of diagnosis. The following case illustrates placement of the new Evolution Controlled-Release Colonic Stent to relieve high-grade partial bowel obstruction and permit restoration of oral intake without surgical intervention in the setting of metastatic colon cancer.

Case Information: A 61-year-old patient presented to our emergency department with a 1 month history of lower back pain and one episode bright red rectal bleeding. Additional symptoms included epigastric and left sided abdominal pain, worsening constipation, loss of appetite and a 40 lb weight loss over several months. On examination the patient appeared cachectic, his liver was enlarged and tender, and an irregular mass was palpable in the epigastrium. Laboratory testing showed elevated total bilirubin 18 umol/L, Alk Phos 488 U/L, GGT 527 U/L, LDH 237 U/L, CEA 1149 ug/L and Ca 19-9 >10000 kU/L. CT imaging revealed a large mass (7.9 x 7.6 cm) in the distal transverse colon, multiple liver lesions involving all segments, enlarged retroperitoneal lymph nodes and bilateral lung metastases. (Figure 1) Colonoscopy was normal up to the distal transverse colon at which point a circumferential narrowing was encountered. (Figure 2) The colonoscope could not be advanced through this area and biopsies were taken of the stricture. The patient had tolerated the polyethylene glycol preparation. He was discharged home and given outpatient follow up with the medical oncologist.

Several days after discharge from hospital, the patient returned to the emergency department complaining of inability to eat because of increasing abdominal pain aggravated by oral intake. He reported the presence of flatus but not bowel movements. Physical examination was unchanged. Repeat CT imaging was the same and without clear-cut large bowel obstruction. Nonetheless, the patient was referred for colonic stenting.

The procedure was performed in the operating room under conscious sedation and without bowel prep. The distal colon contained minimal stool and the colonoscope was advanced to the distal transverse colon where there was colonic narrowing and edematous mucosa. Using a catheter, a 450 cm guidewire was advanced through the obstructed area with great difficulty. There appeared to be two strictures, one on either end with a dilated segment in between. Despite various maneuvers, the guidewire had a tendency to coil within the central segment. Upon advancing the tip of the cannula over the guidewire into the central segment, the colonoscope was able to traverse the first inflammatory stricture. With the tip of the colonoscope now within a segment of circumferential necrotic tumor, the proximal stricture was directly visualized and the guidewire easily passed into the proximal colon. Cysto-Conray II contrast was injected proximally through the cannula confirming a tight stricture at this level with a typical apple-core appearance. (Figure 3) The cannula was removed leaving the guidewire in place and a through-the-scope Evolution (25 x 100 mm) colonic stent was deployed using both endoscopic and fluoroscopic visualization. The tip of the stent was opened in the colon proximal to the obstruction. (Figure 4) The remaining portion of the stent was opened, reaching and overlapping the second stricture as well. (Figure 5) The colonoscope was now advanced into the stent and the tumor biopsied under direct vision through one of the stent interstices. (Figure 6)



Post Procedure/Follow up: Post stenting, the patient reported less abdominal pain, tolerated regular diet and had a normal bowel movement. He was discharged home 1.5 days after the procedure. Biopsy results showed intestinal type adenocarcinoma and the patient was started on palliative chemotherapy one week post discharge.

Evolution family of innovative stents expand



Cook Medical's family of Evolution controlledrelease stents is expanding once again. The Evolution Controlled-Release Colonic Stent system, which has been available outside the US, is now available to US endoscopists.

The Evolution Colonic stent is the latest example of Cook's commitment to develop solutions that can positively impact the care that physicians deliver to their patients. With its excellent control and maneuverability, Evolution allows clinicians to precisely deliver a stent for the palliative care for patients unsuitable for curative resection and relieve large bowel obstruction prior to colectomy in patients with malignancy.

This new stent is designed with 20 crowns for enhanced, evenly distributed radial force and better wall apposition–potentially reducing post-placement risks. Dual flanges potentially reduce the risk of migration and four radiopaque markers promote accurate placement.

And, like all Evolution devices, the Colonic stent features the market's only delivery system with controlled release and recapturability for unprecedented precision while Flexor® Kink-Resistant Technology delivers excellent pushability for difficult anatomical challenges.



My Hong Kong Journey as a GI Nurse...



Above: International Workshop on Therapeutic Endoscopy was celebrating its 25th anniversary, 1985-2010. 55 nurses attended the Pre-Congress Nurse Program.

Center: Hong Kong nurses holding postcards from their American colleagues.

Right: Group photo of the GI nurse attendants at the Pre-Congress Nurse program.





Phyllis Malpas, MA, RN, CGRN Nurse Manager, Endoscopy Medical University of South Carolina Digestive Disease Center Charleston, SC

It began one day in August, 2010. I came home and was reviewing e-mail, when much to my surprise there was a message from Hong Kong! As I tentatively looked into it I realized that is was from Dr. James Lau, Prince of Wales Hospital at the Chinese University of Hong Kong. This was an invitation to be a guest international lecturer at the Pre-Congress Nursing Workshop held just prior to the International Workshop on Therapeutic Endoscopy, which was celebrating its 25th anniversary, 1985 – 2010. The opportunity to visit Hong Kong and its people remains a treasured and unforgettable journey.

Dr. Lau and the GI Nurses in Hong Kong requested I speak about "My Journey as a GI Nurse." This topic, perhaps like a shallow pond on the surface, afforded me the opportunity to think more deeply, identifying more clearly first, what sets GI Nursing, and in my case, Endoscopy nursing apart from other nursing specialties, secondly what is necessary to develop a robust practice in GI nursing and third, what is needed to secure a bright future. This shallow pond turned into a broad and deep river of experiences gained through diverse education and



years of varied practice, from procedures to management, which I was able to share with this engaged group!

The lecture was presented to 55 nurses from Hong Kong and Singapore. During the nursing workshop, we enjoyed some didactic lectures, followed by a hands-on education program with excellent physician and nursing instruction. The Chinese University of Hong Kong is sponsoring a program to train nurses as endoscopists for the future. The first nurse trained, Alman, had performed approximately 200 colonoscopies, which were all completed. She was able to complete 187 on her own and 13 were assisted by Dr. Lau. The training program is to be continued into the future.

Additionally, there was great camaraderie among the group as new friends met from across the globe, including post cards shared with the course attendees from the Endoscopy nurses in Charleston, South Carolina! All the nurses, faculty and the outstanding staff from the Chinese University thoroughly enjoyed the program. The following day, the group joined in the entire Advanced Therapeutic Endoscopy program, observing didactic lectures, as well as actual procedural cases. The physician faculty is outstanding and included GI greats such as Dr. Nib Soehendra, Dr. N. Reddy, Dr. Peter Cotton and Dr. Joseph Leung.

Bringing the entire program together for me was an afternoon spent in the Endoscopy Unit at Prince of Wales Hospital, observing procedures, talking with staff, offering patients a greeting from across the world and even lending a helping hand with the daily work of the unit. We shared the lunch room, shared photos, and shared our continued passion for Gastroenterology nursing wherever it is practiced!



Peter Cotton's "endoscopic journey"raises funds for advanced training

Renowned endoscopist Peter Cotton, founder and initial director of the Digestive Disease Center, Medical University of South Carolina in Charleston, recently retired from clinical work. He was one of the pioneers of digestive endoscopy and has written an amusing book about his experiences, called The Tunnel at the End of the Light: My Endoscopic Journey in Six Decades.

The book covers a wide spectrum of Cotton's work, life and play. It includes descriptions of the beginnings of flexible endoscopy and ERCP, the challenges of lecturing and demonstrating procedures in over 50 countries, especially in the early days. It also contains chapters on the importance of golf, the confusions of cricket, relationships with industry, some endoscopic poems and unusual entertainment.

All proceeds from the book benefit the new "Peter Cotton Endoscopy Training Fund" to support those wishing to gain more experience in advanced endoscopic procedures. Book sales have raised over \$30,000 to date, with bulk orders from India and Australia. The book is being translated into Chinese. More excerpts are posted, and signed copies can be obtained, from www.peterbcotton.com.

<http://www.peterbcotton.com>

GI 360 EDUCATIONAL PROGRAMS



Cook Medical has long understood that optimal patient care is your focus, and it continues to be our focus as well. That's why for more than twenty years we have assisted healthcare professionals in learning the latest in endoscopic GI technology and related disease information.

That tradition continues as Cook Medical, in partnership with HealthStream (an accredited provider of continuing nursing education), offers five new educational activities:

> Business Management of the Endoscopy Unit

Malignant Biliary Disease Management

Updates in Colorectal Cancer

Barrett's Esophagus

These activities are presented without charge by your Cook Medical district manager. Educational activity descriptions, objectives and the related accreditation information can be found at http://www. cookmedical.com/esc/educationResource. do?id=Educational_Activity.

Contact your Cook representative for more information or to arrange a presentation opportunity.



A continuing nursing education activity sponsored by HealthStream. Grant funds provided by Cook Medical.

UPCOMING EVENTS

| XX International Course in Advance Therapeutic Endoscopy | Sao Paulo, Brazil | Jul 3-5 |
|---|--------------------------|--------------|
| International Course of Gastroenterology & Endoscopy | Chiclayo, Peru | Jul 7-9 |
| AP-EUS | Shenyang, China | Jul 8-10 |
| X Congreso Nacional de Gastroenterologia | Antigua, Guatemala | Jul 19-21 |
| XXX III Congreso Nacional de Gastroenterologia | Valencia, Venezuela | Jul 19-23 |
| X Paraguay National Congress in Gastroenterology & Endoscopy | Asuncion, Paraguay | Jul 21-23 |
| Cook R&D Collaboration Meeting | Como, Italy | Jul 27-28 |
| 50th SAGES /SASES Congress | Durban, South Africa | Aug 9-11 |
| Swedisch Surgical Week | Linkoping | Aug 20-24 |
| IV Curso Internacional ENDOSUR | Santiago, Chile | Aug 20-22 |
| II Curso Internacional ENEO | Rio de Janeiro, Brazil | Aug 31-Sep 1 |
| LUKS Workshop | Koln, Germany | Sep 8 |
| Congreso Nacional de Endoscopia Gastrointestinal | Merida, Mexico | Sep 12-16 |
| ESGE Live | Budapest, Hungary | Sep 14 |
| London Live Endoscopy | London, UK | Sep 20-21 |
| SGG Congress | Interlaken, Switzerland | Sep 20-21 |
| DGVS | Hamburg, Germany | Sep 20-21 |
| Boston International Live Endoscopy Course | NAM/Boston | Oct 3-5 |
| Toronto Live | Toronto, Canada | Oct 3-5 |
| XVII Congreso Nacional de Gastorenterologia y Endoscopia | Cuenca, Ecuador | Oct 3-6 |
| Japanese Digestive Disease Week (JDDW) | Kobe, Japan | 0ct 10-13 |
| Australia Gastro Week | Adelaide, Australia | Oct 16-19 |
| UEGW | Stockholm, Sweden | Oct 20-24 |
| Nottingham Meeting | Nottingham, UK | Oct 25-26 |
| 18. Endoclub Nord Hamburg | Hamburg, Germany | Nov 2-3 |
| Video Digest | Paris, France | Nov 2-3 |
| XXX III Panamerican Congress in Gastroenterology and Endoscopy | Ciudad de Panama, Panama | Nov 7-10 |
| Spanish Endoscopy Society | Madrid, Spain | Nov 9-10 |
| UK EUS Users Group | Glasgow, UK | Nov 14-16 |
| EUS/ERCP Course | Locklomond, UK | Nov 16-17 |
| Congreso Nacional de Gastroenterologia | Merida, Mexico | Nov 17-21 |
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