



New EUS Histology Needle Has Potential to Advance Diagnoses

An endosonographer and pathologist share their EchoTip ProCore experiences

Traditionally, histological samples have been acquired by relatively invasive modalities to diagnose malignant and benign lesions of the GI tract. But now, with the new Cook Medical EchoTip ProCore HD Ultrasound Biopsy Needle, histological tissue samples can be obtained using the less-invasive EUS procedure. The ProCore allows the targeting of small lesions with increased sampling yields and potentially fewer needle passes compared to what was previously available*.

"Our primary end goals in developing the EchoTip ProCore were to increase tissue yield while decreasing the number of needle passes needed to reach a diagnosis," says Kevin Chmura, Cook Senior Product Manager for the EUS product line. "As a result of these outcomes our hope is that this will subsequently lead to shortened procedure times, which is a benefit from both a clinical and economic viewpoint."

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NEW EUS HISTOLOGY NEEDLE HAS POTENTIAL TO ADVANCE DIAGNOSES

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Dr. Brenda Hoffman, Professor of Medicine, Division of Gastroenterology and Hepatology, Digestive Diseases Center, Medical University of South Carolina, Charleston, SC



Ritu Nayar, MD, Professor of Cytopathology, Northwestern University Feinberg School of Medicine
Director of Cytopathology, Northwestern Memorial Hospital, Chicago, IL

The use and functionality of the ProCore are almost identical to other needles in the EchoTip Ultra family, so physicians familiar those devices do not need to learn a whole new technique. And, also like the EchoTip Ultra devices, the needle surface is dimpled with a high-definition pattern, promoting ultrasound visibility that helps the physicians obtain high-value core samples. "I've used the ProCore in approximately 40 cases and we've had no complications with this needle," says to early ProCore-adopter Dr. Brenda Hoffman, Professor of Medicine, Division of Gastroenterology and Hepatology, Digestive Diseases Center, Medical University of South Carolina, Charleston, SC.

"This needle can actually obtain larger tissue samples and it has the capability of being deployed in the duodenum, which are two big advantages over some of the other 19 gage needles that we've had in the past," says Dr. Hoffman. "When we're doing directed drug therapy, we need larger samples, for molecular analysis, such as those the ProCore provides."

Ritu Nayar, MD, Director of Cytopathology, Northwestern Memorial Hospital, Chicago, IL, adds, "I think the ability to go through the duodenum will allow more difficult pancreatic lesions, not amenable to FNA, to be sampled. Right now we don't really have a good mechanism for obtaining core biopsy samples for lesions in the head of the pancreas."

Dr. Nayar, who is also a Professor of Pathology at the Northwestern University Feinberg School of Medicine, says that if FNA is non-diagnostic, a core sample may be successful in providing an adequate sample for diagnosis. "FNA is basically a vacuum procedure which 'sucks' out the cells. So, for example, if you have a patient with a history of long-standing inflammation of the pancreas or chronic pancreatitis, such episodes could cause scarring or fibrosis. In cases like that, the cells may be 'trapped' in the fibrosis, so a FNA may not be able to easily retrieve them. With a core biopsy," continues Dr. Nayar, "the pathologist or cytotechnologist on site can 'touch' the sample on a slide and stain it to check adequacy, and do any triage—cultures, flow cytometry, etc.—that is necessary before the procedure is terminated. Core biopsy tissue, similar to FNA cell block material, can be used to do immunohistochemical stains and/or molecular studies that can allow more specific tumor diagnosis and/or assist in prognostication or therapeutic decision making."

In the future, it's possible that larger histologic samples may solve the problem of institutions that do not consistently have cytopathology resources on-site. "I think one of the strong points of this needle, if we can prove it," says Dr. Hoffman, "is that we may be able to, with a small number of samples, get that accuracy up to what we'd have if we had a pathologist in the room. What we're trying to do is try to determine how many samples you'd have to have to feel confident that ultimately the pathology will reveal a possible abnormality. With ProCore needle, what we hope we prove is that when we take biopsies and if we visibly see tissue present, then we have a very high accuracy for defining that pathology. That would be a big step."

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If you would like to submit material
for The Channel, please email us at
thechannel@cookmedical.com.

We welcome your comments
and suggestions.

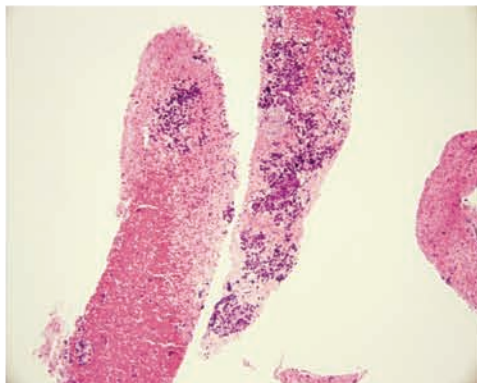
An abstract was presented at DDW by one of Dr. Hoffman's colleagues, Dr. Eddie Irions, about the preliminary data on obtaining core samples, entitled: "Initial experience with the EchoTip ProCore needle for endoscopic ultrasound (EUS) guided-diagnosis of mass lesions."

"If we can achieve the things that we're talking about here," concludes Dr. Hoffman, "that will be a big step forward. It could be a groundbreaker for EUS."

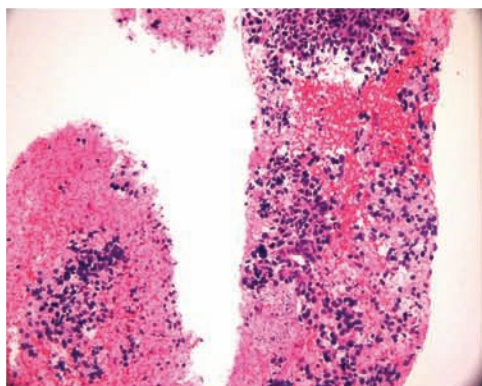
*Data on file at Cook Medical.



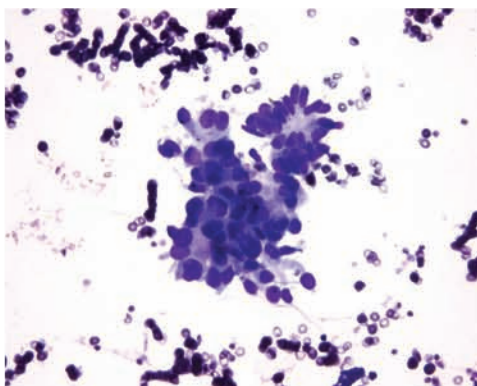
H&E, Pancreas, Core biopsy: Cellular Fragments - 4x



H&E, Pancreas, Core Biopsy: Malignant cells arranged in glandular architecture -10x



H&E, Pancreas, Core biopsy: Clusters of malignant cells consistent with adenocarcinoma - 40x



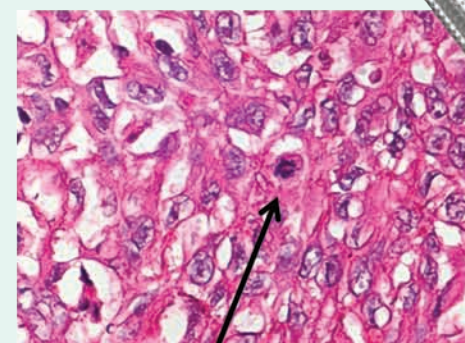
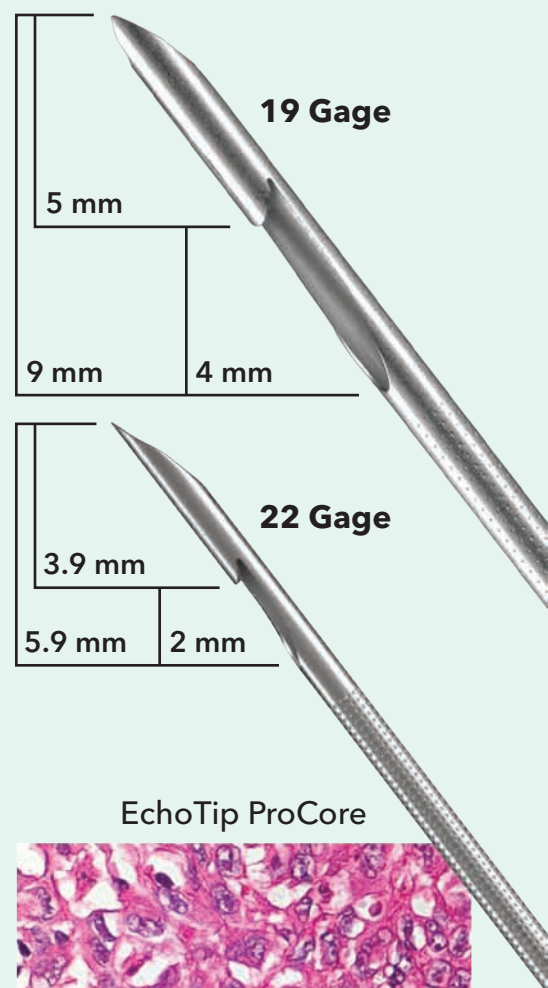
Diff Quik stain: Pancreas, Touch Preparation: Malignant cells arranged in glandular architecture - 40x

Four images above courtesy of Aparna Mahajan, MD, Cytopathology Fellow, Northwestern Memorial Hospital, Feinberg School of Medicine

Image (right) courtesy of Prof. Marco J. Bruno, MD, PhD, Erasmus Medical Centre, University Medical Center Rotterdam

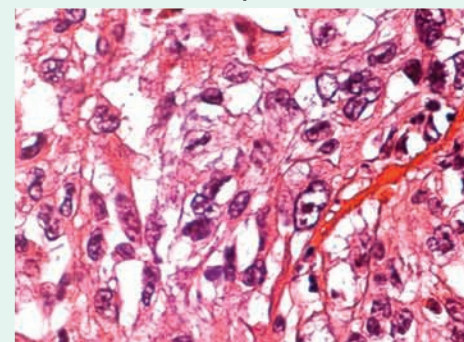


COOK MEDICAL EchoTip® ProCore™ HD ULTRASOUND BIOPSY NEEDLE



Final diagnosis is metastatic sarcomatoid carcinoma of the lung.

EchoTip Ultra



Images courtesy of Ms. Monique Fabre and Doctor Pascal Burtin, I.G.R (Institut Gustave Roussy) Cedex France



Guido Costamagna (Rome) and Richard Kozarek (Seattle) performing ERCP assisted by Annette Büchel (Düsseldorf)



Tsuneo Oyama, Akihisa Tomori (Nagano) and Jerome Way (New York) performing ESD



Richard Kozarek (Seattle) and Nageshwar Reddy (Hyderabad) performing ERCP assisted by Ute Pfeifer (Düsseldorf)



Conference hall, more than 1,600 participants watching ERCP transmitted in high definition



Nageshwar Reddy (Hyderabad) and Takao Itoi (Tokyo)



Haruhiro Inoue (Yokohama) and Horst Neuhaus (Düsseldorf) with the patient who underwent POEM



Richard Kozarek (Seattle), Gregory Ginsberg (Philadelphia) and Jerome Way (New York)

The 13th Düsseldorf International Endoscopy Symposium

The 13th Düsseldorf International Endoscopy Symposium, which took place February 4-5 at the Maritim Hotel Düsseldorf, attracted 1,600 participants. While the audience has traditionally been comprised of predominantly German attendees, this year's symposium continued the trend of attracting physicians from all parts of Europe and beyond. A diversity of disciplines, also, was represented: attendees ranged from gastroenterologists, oncologists, and internists to surgeons, interventional radiologists, nurses, trainees, students and industry.

The course was a creative and effective mixture of live cases transmitted in high definition from the Evangelisches Krankenhaus Düsseldorf, presentations and demonstrations by world-renowned thought leaders and experts, as well as several mini-symposia, state-of-the art lectures and interactive discussions.

Course founders and directors Prof. Horst Neuhaus and Dr. Brigitte Schumacher of the Evangelisches Krankenhaus, created a fascinating schedule that focused on evaluating recent advances in endoscopy while assessing their clinical utility and level of evidence. Attendees learned how to apply new endoscopic techniques, instruments and accessories, and compared them with traditional methods and devices.

Live cases were transmitted in high definition by a superb professional audiovisual team from the Evangelisches Krankenhaus. Procedures were simultaneously performed in five different theaters so that the moderators of the live sessions could switch from one room to another, depending on participants' preference. The spectrum ranged from easy to complex cases, including advanced imaging technologies and therapeutic interventions in the biliopancreatic system and the upper, middle and lower GI tract.

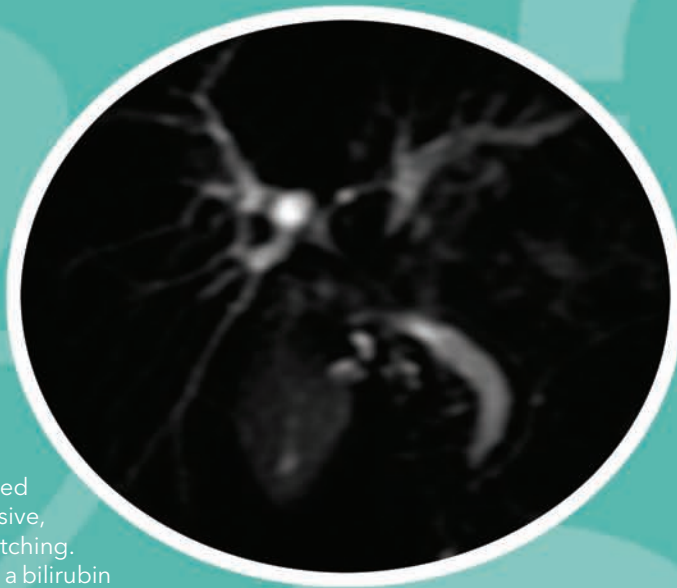
A special highlight was the first peroral endoscopic myotomy (POEM) for achalasia performed in a European conference, demonstrated by Dr. Haruhiro Inoue, Digestive Disease Center, Showa University Northern Yokohama Hospital, Yokohama, Japan. Another highlight was Dr. Marc Giovannini's live demonstration using Cook's new EchoTip ProCore EUS Needle in which he successfully obtained core histology samples.

More than 50 biomedical companies presented their products in a large exhibition area, which participants visited for further information. Attendees were very satisfied with the scientific content and the organization of the symposium according to a detailed evaluation, and 97% plan to attend the next course on February 3-4, 2012. The symposium website (www.endo-duesseldorf.com) provides further information, as well as access to a selection of lectures and live cases.

What's Up Doc?



*John Baillie , MB, ChB
Professor,
Gastroenterology
Wake Forest
University Baptist
Medical Center,
Winston-Salem, NC*



A 22-year-old presented with a week of progressive, painless jaundice and itching. Her liver panel showed a bilirubin of 10.2 mg/dl, AST 22 iu/l, ALT, 108 iu/l and alkaline phosphatase 458 iu/l. A hepatitis panel drawn in the ED was negative for hepatitis A, B and C infection. She was taking no medications that might cause liver upset. She had no known comorbidities. Her magnetic resonance cholangiopancreatography (MRCP) study is shown above.

Describe the appearances.

What would be the most likely explanation of these appearances in an 80-year-old patient?

What is the most likely explanation in a previously healthy 22-year-old female?

How would you treat this patient's jaundice?

Acknowledgement: My thanks to Dr. Sean Lynch, MD, of the Section on Gastroenterology of Wake Forest University Baptist Medical Center, Winston-Salem, NC, for his assistance in investigating and managing this very unusual case.

To confirm your diagnosis, click on newsletter button on endoscopy homepage of www.cookmedical.com <<http://www.cookmedical.com>>

We are looking for more submissions and welcome your participation. If you want to submit an image with a written case history and clinical explanation, please contact Kevin Chmura at kevin.chmura@cookmedical.com.

Evolution Duodenal Stent System

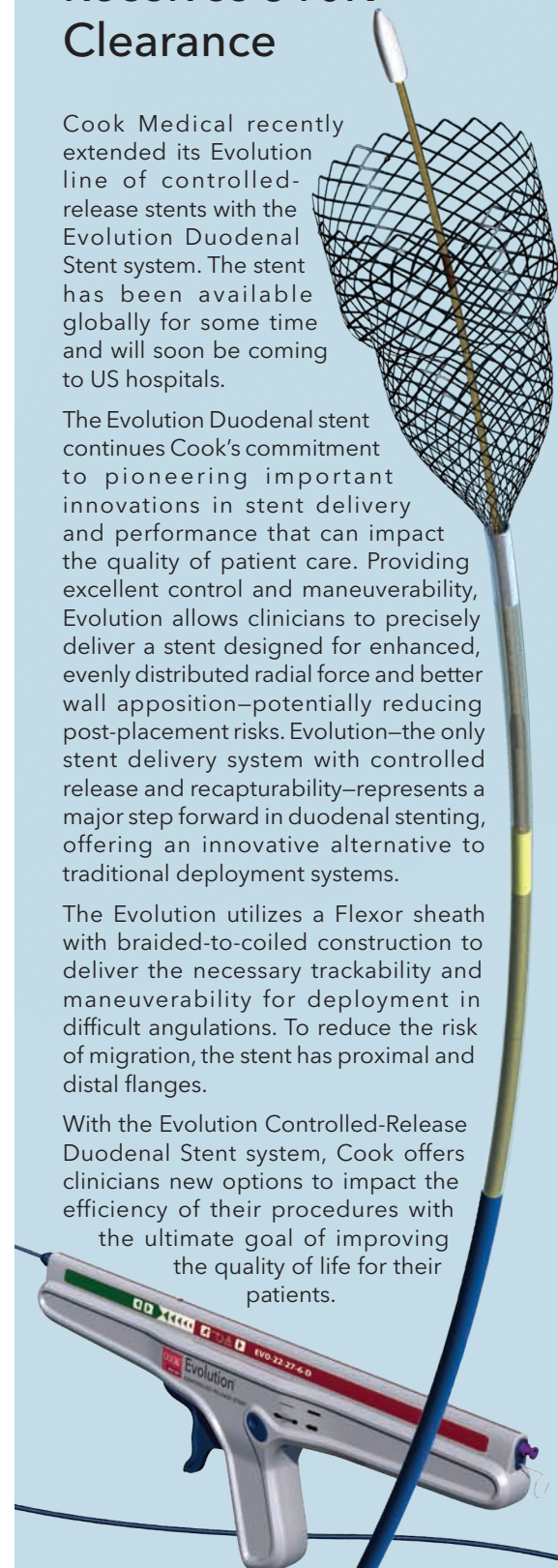
Receives 510K Clearance


Cook Medical recently extended its Evolution line of controlled-release stents with the Evolution Duodenal Stent system. The stent has been available globally for some time and will soon be coming to US hospitals.

The Evolution Duodenal stent continues Cook's commitment to pioneering important innovations in stent delivery and performance that can impact the quality of patient care. Providing excellent control and maneuverability, Evolution allows clinicians to precisely deliver a stent designed for enhanced, evenly distributed radial force and better wall apposition—potentially reducing post-placement risks. Evolution—the only stent delivery system with controlled release and recapturability—represents a major step forward in duodenal stenting, offering an innovative alternative to traditional deployment systems.

The Evolution utilizes a Flexor sheath with braided-to-coiled construction to deliver the necessary trackability and maneuverability for deployment in difficult angulations. To reduce the risk of migration, the stent has proximal and distal flanges.

With the Evolution Controlled-Release Duodenal Stent system, Cook offers clinicians new options to impact the efficiency of their procedures with the ultimate goal of improving the quality of life for their patients.





Performance
of long wire,
efficiency of
short wire.

COOK[®] **Fusion[®]**
MEDICAL DUAL PLATFORM ERCP

"The ability to move from the short wire system where the physician has control of the wire to the long wire system where there is reliance on an assistant at any point during the procedure is a real advantage of the Fusion system."^{*}

Dr. Peter Draganov,
University of Florida

The Fusion Difference

The most technically challenging procedure in GI

Many clinicians would agree that endoscopic retrograde cholangiopancreatography (ERCP) is one of the most technically challenging procedures performed in the GI setting. It takes a tremendous amount of skill on the part of the physician and the assistant to ensure the successful outcomes that are key to outstanding patient care. One such challenge is gaining access to the duct of choice and securely maintaining that access, while optimizing efficiencies to help reduce the likelihood of unwanted procedural complications.

In today's clinical settings, there are two main wire guide techniques for ERCP: the over-the-wire/long wire technique and the monorail/short wire technique. Physician preference predominantly determines which wire guide technique is utilized. In recent years, the monorail technique has been gaining in popularity because it gives the physician control of wire guide. Many physicians prefer this option because of the tactile sensation during cannulation and it precludes the need for extensive communication between the physician and an assistant.

Having a choice should not cause a dilemma

Until now, when gastroenterologists have faced the dilemma of choosing a particular ERCP system, they've had to do so without the benefit of objective comparative data, shown below. Moving from the over-the-wire/long wire technique to monorail/short wire technique or vice versa, can induce anxiety and uncertainty. And there are additional external pressures that come from the current, overall economic climate. All this can leave clinicians thinking they must make an "either/or" situation. They may think it's advantageous to stock one type of system or the other in an effort to help reduce inventory costs.

Actually, you don't have to choose

With Fusion's Dual Platform ERCP product line, clinicians don't have to choose whether to exclusively use an over-the-wire/long wire technique or a monorail/short wire technique. That's because Fusion is the only product line on the market that gives gastroenterologists the performance of long wire and efficiency of short wire—all in one product line. Since both techniques are available to the clinician, there is no need to feel anxious about losing any of the clinical benefits to which they've are accustomed.

*Results from a comparative peer reviewed article.

Characteristics	Competitor A	Fusion System	Competitor B
Type of Endoscope	Standard	Standard	V-scope
Type of Lock	External at biopsy port	External at biopsy port	Internal lock design
Type of Device	Open channel tear-away	Close channel breakthrough	Close lumen device
Short track technology	Yes	Yes	No
Wire length	260 cm	185 cm**	270 cm
Can be used with standard guidewires	Yes	Yes	Yes
Can be used with .025" or .018" or angled wires	No	Yes	Yes
Can be used with hydrophilic glidewire	No	Yes	Yes
Ability to flush wire channel	No	Yes	Yes
Intraductal exchange ability	No	Yes	No
Insertion of multiple stents without the need to recannulate	No	Yes	No
Physician control of wire	Yes	Yes	Yes
Pushability of short-wire devices [†]	††	†††	†††

*Reddy SC, Draganov PV. ERCP Wire Systems: The Long and the Short of it. *World Journal of Gastroenterology*. 2009;15(1):55-60.

[†]Author's own experience.

**Now available in 205 cm length.

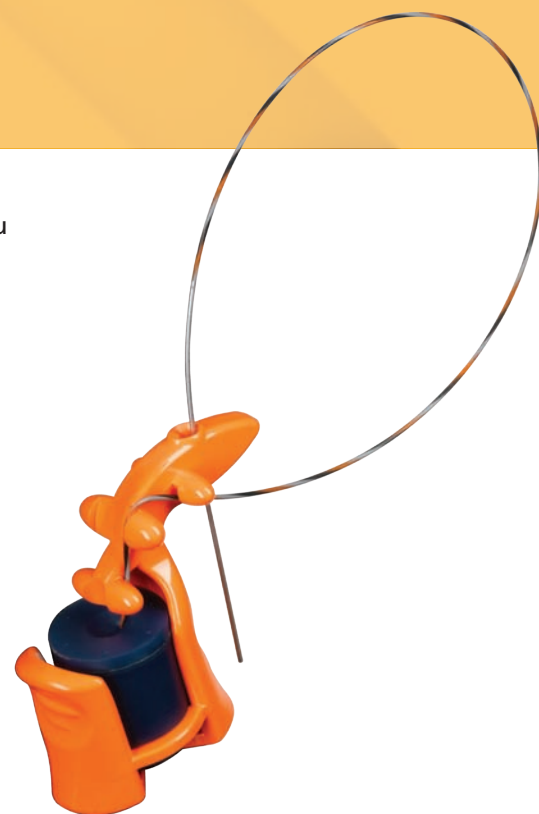
Physician preference, unified training and streamlined inventory.

The long wire vs. short wire debate ends here.

Now there's Fusion Dual Platform, the only ERCP product line that gives you the performance of long wire and the efficiencies of short wire. That means if pushability is needed for difficult strictures or tortuous anatomy, you can simply move from a short wire to a traditional long wire—without ever compromising access.

Cook Medical—Advancing ERCP.

www.cookmedical.com



Fusion[®]
DUAL PLATFORM ERCP

AORTIC
INTERVENTION

CRITICAL
CARE

ENDOSCOPY

INTERVENTIONAL
RADIOLOGY

LEAD
MANAGEMENT

PERIPHERAL
INTERVENTION

SURGERY

UROLOGY

WOMEN'S
HEALTH



(L to R)
Anand Sahai, MD and
Sarto Paquin, MD

(L to R)
First Row: Ruth Castro, nurse;
Manon Godin, orderly;
Louise Turcotte, nurse
Second Row: Pierre Aubry, nurse;
Denyse Fournier, head nurse;
Brigitte Girard, scheduler;
Anand Sahai, MD
Third Row: Annick Lapointe, nurse;
Sarto Paquin, MD;
Ahmed El Wassief, EUS fellow;
Antonio Gimines, EUS fellow

25,000 EUS Cases and Going Strong: University of Montreal Hospital Centre

From the University of Montreal's health care network, a leading endoscopist is developing an endoscopic ultrasound specialty with a worldwide reach. The program completed its 25,000th procedure last year. However, the program began amid serious doubts about the future of EUS—first in the mind of Dr. Anand Sahai, and later in the opinions of administrators at Centre Hospitalier de l'Université de Montreal, known familiarly to residents of the province of Quebec as CHUM.

Dr. Sahai shares his remarkable saga of EUS progress in Montreal: "Overall, the University of Montreal Hospital Centre encompasses three separate hospitals: St. Luc's, Notre Dame and Hotel Dieu. The three hospitals perform about 25,000 GI procedures per year. All three hospitals are located in the Montreal area and in the province of Quebec, which has about eight million inhabitants, sixty percent of which live within 50 miles of the university hospitals."

St. Luc's Hospital has the busiest endoscopic practice in the entire province and is a pancreatic and biliary disease specialist hub. "In fact," he says, "in regards to EUS procedures, about 85 percent of our cases are pancreatic/biliary, ten percent are non-GI and five percent are esophageal. About 50 percent of EUS procedures—about 1,000-1,200 per year—involve biopsies. We perform about 2,000 ERCP procedures per year, with 1,500 of those at St. Luc's."

Dr. Sahai and his EUS partner, Dr. Sarto Paquin, perform approximately 3,000 EUS procedures per year. "Ninety percent of those are at St. Luc's," says Dr. Sahai. "The remainder are performed at Notre Dame. The CHUM hospitals also account for another 22,000 regular endoscopy procedures."

Initial skepticism about a fledgling modality

As a GI fellow in 1992, Dr. Sahai wasn't sure EUS was going anywhere, but he saw the potential. He remembers: "After deciding to give EUS a try, I searched for a nice city in Europe to obtain advanced EUS training, and that appeared to be Bologna in Italy, under the direction of Prof. Giancarlo Caletti. So I began taking lessons in Italian to prepare for the move."

"Meanwhile, my chief here in Quebec was a friend of Dr. Ian Taylor at the Medical University of South Carolina (MUSC). Dr. Taylor offered me the opportunity to come to MUSC to work with Dr. Robert Hawes, a pioneer in the field. I was able to obtain an ASGE-Olympus Advanced Endoscopy Training Scholarship, and planned to spend two years at MUSC—spending one year doing EUS and one year doing ERCP."

In the end, Dr. Sahai spent three years at MUSC, concentrating on EUS only. "I am thankful I did," he says. "All of us at MUSC saw the potential of EUS and EUS research progressed rapidly. In addition, compared with ERCP, I found EUS to be safer and less stressful."

From zero cases to almost 2,000

When Dr. Sahai returned to Montreal in 1999, he had a new challenge: convince a skeptical hospital administration to dedicate a room and a full-time nurse to EUS. Any doubts vanished within 14 months, when the number of cases jumped from zero to more than 1,800 per year.



Building a Worldwide EUS Reputation

"I gave a lot of EUS talks at medical forums to GI and non-GI professionals," recalls Dr. Sahai. "Over time, we built a referral base and reached a volume of approximately 3,000 procedures a year. In 2004, Dr. Paquin, then a GI fellow, joined us and we divided the EUS load between us. Today, we average 12-14 cases a day, using an auxiliary nurse and support from GI fellows."

Procedural simplifications and innovations

"Our goal is to make EUS accessible to as many clinicians—and their patients—as possible," Dr. Sahai continues. "That's why we are training a large number of fellows and working to try and simplify EUS training and procedures. For example, we perform FNA (fine needle aspiration) without a stylet. As a result, the nurse doesn't have to re-insert the stylet after each pass. Further, we are focusing on performing only linear EUS to make EUS a 'one-scope' procedure."

"We also believe that we are one of the few hospitals in North America performing EUS-guided cystogastrostomy without fluoroscopy," he says. "We have seen over 300 proven cases of pancreatic cancers per year over the last ten years. We have performed over 800 celiac plexus block or neurolysis procedures. We recently completed a randomized sham controlled trial of early celiac plexus neurolysis for inoperable pancreatic cancer, and we have started a placebo-controlled trial of celiac block for benign, chronic pancreatitis."

Impacting international GI practice with training, research and published articles

Perhaps the most profound influence of Dr. Sahai's work comes from preparing future endoscopists to perform EUS procedures. "We provide a tutorial program for physicians to train. It lasts from one week to three months," he says. "About 95 percent of participants come from the US. They receive a solid grounding, often participating in 250 EUS cases in a month. Word-of-mouth has expanded our EUS teaching fellowship to an international status with a two-year waiting list. It currently includes specialists from Egypt, the Canary Islands, Singapore, Australia and Belgium. In addition, the St. Luc's staff conducts several conferences a year, ranging from local to national to international. I am pleased to be on the faculty for the Cook Euro EUS program. This year we will participate in a conference in Marseilles."

Reflecting on the future

"Our ultimate goal here in Montreal," Dr. Sahai says, "is for EUS to become part of general GI training. In our opinion, fellowship training should allot the same amount of time to diagnostic EUS as it does to EGD and colonoscopy. We believe that this could enable all GI professionals to become proficient in basic, diagnostic EUS by the end of their regular GI training. An EUS procedure should not be a major production. When one becomes proficient in diagnostic EUS, it does not take much more time than a diagnostic EGD and this could greatly reduce the overall cost per procedure."

Centre Hospitalier de l'Université de Montréal and its Research Center

Located in the heart of Montreal, CHUM provides general, specialized and ultra-specialized medical care to patients in the immediate Montreal area and from other regions of Quebec. The Center's three hospitals—St. Luc's, Notre Dame and Hotel Dieu—perform about 25,000 GI procedures per year.

The Center's mission encompasses teaching; research; assessment of technologies and intervention methods in health; and health promotion.

CHUM facts:

- 10,000+ employees working in 35 medical disciplines
- 1,000 physicians
- 500,000 patients/year
- 300+ interns and students

Research areas include:

- Hepatogastroenterology
- Circulatory and respiratory health
- Oncology
- Hormonal signaling and metabolism
- Population health
- Neurological sciences



Asian Pacific Society Training Center for Digestive Endoscopy Advancing Endoscopic Care in China

An Overview of Specialty Areas

The Asian Pacific Society Training Center for Digestive Endoscopy covers 2,600 square meters and is outfitted with state-of-art equipment:

EUS and Enteroscopy

Five rooms for endoscopic examination, equipped with a mechanical radial ultrasonic gastrovideoscope and an ultrasonographic endoscope.

Gastrosocopy and Capsule Endoscopy

One room furnished with a capsule endoscopy system; five rooms for endoscopic examination equipped with a confocal laser tomography endomicroscope.

Colonoscopy

Five endoscopy examination rooms equipped with the most advanced colonoscopes.

ERCP

Three x-ray control rooms for ERCP procedures; one room equipped for extracorporeal shock wave lithotripsy.

VIP Clinic and Endoscopy Training Center

A separate, comfortable area and well-equipped clinics.



The Asian Pacific Society Training Center for Digestive Endoscopy of Changhai Hospital, the Second Military Medical University, began as a single endoscopy room in the gastroenterology department. Under the leadership of two renowned endoscopists—Prof. Zhou Daiyun and Prof. Xu Guoming—the Chinese Training Center for Digestive Endoscopy was established in 1991. In 1999, the center evolved into the Shanghai Endoscopy Quality Control Center and then, in 2003, became the Chinese Medical Association Training Center for Digestive Endoscopy. Today it is known as the Asian Pacific Society Training Center for Digestive Endoscopy and specializes in more than 30 new technologies and methods in digestive endoscopy.



Professor Zhao Shen Li, MD, Director of Gastroenterology Department and the Pancreatic Disease Center, leads the center. He is also president of the Chinese Society of Digestive Endoscopy and vice president of the Shanghai Chinese Society of Gastroenterology.

Specialties at the center include: EUS-guided radioactive seed implantation in treating advanced pancreatic cancer, celiac plexus brachytherapy, particles stent in treating malignant obstruction of pancreatic and biliary duct, ESD for gastrointestinal early stage tumor, single-balloon enteroscopic therapy and NOTES.

Asian Pacific Society Training Center for Digestive Endoscopy physicians have published nearly 300 papers in the field of digestive endoscopy and have trained more than 500 medical personnel, many of whom became leaders in the field.

Internationally renowned experts and scholars in digestive disease and endoscopy have spent time at the center as visiting professors and emeritus professors, including Prof. William Chao, president designate of World Digestive Endoscopy, president of the Asian Pacific Digestive Endoscopy Association and chairman of the Chinese Medical Association of Hong Kong; Prof. Joseph Sung, headmaster of the Chinese University of Hong Kong; and Prof. Sydney Chung, president of Prince of Wales Hospital at the Chinese University of Hong Kong.

In 2005 and 2009, the center hosted sessions of the influential Global Chinese Academic Conference in Digestive Endoscopy.

The Asian Pacific Society Training Center for Digestive Endoscopy takes pride in serving a huge population with first-class skills and facilities and by building a humanistic atmosphere. The center's continuing goal is to train top specialized personnel, develop excellent creative technology and conduct cutting-edge scientific research with the help of experts from all over the world to advance digestive endoscopy in China.

From cytology to histology: Increase your predictive values.

With EchoTip ProCore, you can obtain histological yields while decreasing your needle passes.* That means you can more efficiently obtain core biopsies that can lead to confidence in diagnosis. Advanced technology for enhanced patient care.

Cook Medical—Leading the way in EUS.

www.cookmedical.com



EchoTip® ProCore™
HD ULTRASOUND BIOPSY NEEDLE

AORTIC
INTERVENTION

CRITICAL
CARE

ENDOSCOPY

INTERVENTIONAL
RADIOLOGY

LEAD
MANAGEMENT

PERIPHERAL
INTERVENTION

SURGERY

UROLOGY

WOMEN'S
HEALTH

Images courtesy of Prof. Marco J. Bruno, MD, PhD,
Erasmus Medical Centre, University Medical Center Rotterdam
*Data on file at Cook Medical.

Video celebrates GI nursing excellence

During this year's ABCGN Certification Dinner at SGNA Indianapolis, attendees were treated to the premiere of a special video production. "ABCGN Focus on Excellence" celebrates the Jersey Shore University Medical Center's Endoscopy Nursing staff for their best practice approach to patient care support and education.

ABCGN selected the Jersey Shore team after reviewing descriptions of innovative nursing practice efforts submitted by facilities already recognized for prior achievements in professional excellence and with a staff majority demonstrating GI certification.

Last summer, members of Cook Medical's marketing department went on location to interview and film the JSUMC Endoscopy team. The video portrays the important difference these dedicated GI professionals make in the lives of their patients.



Promoting Certification and Research

*Christina Barrett, RN, BSN, CGRN,
Clinical Research Scholar
Jersey Shore University Medical Center
Endoscopy Unit*

Meridian Health has a long-standing reputation for encouraging ongoing learning, education, mentorship and professional growth for their nurses. Meridian and Jersey Shore University Medical Center (JSUMC) are proud to be recognized as an ANCC designated Magnet Hospital.

Eighty percent of our nurses in Endoscopy are nationally certified in their specialty. Participation in national organizations such as the Society for Gastroenterology Nurses & Associates (SGNA) is encouraged as a forum for nurses to seek new and innovative approaches to evidenced-based care.

Meridian also provides a CARE Clinical Ladder to encourage nurses to become active participants in evidence-based patient care. CARE stands for "Clinical Advancement and Recognition of Excellence."

As part of my CARE Clinical Ladder at JSUMC, I applied to become a Clinical Research Scholar. In my position in the Endoscopy Unit at JSUMC, I had implemented a PDCA ("Plan, Do, Check, Act") performance-improvement initiative. We had revised our outpatient pre-call instructions to our patients to provide more information and education. Our goal was to increase patient education and thereby increase patient satisfaction with outpatient procedures. When the Clinical Research Scholar opportunity came along, I chose to take my research a step further.

Endoscopic procedures can be anxiety-provoking experiences for all patients. Pre-education before arriving at the hospital helps patients to feel prepared and gives them an opportunity to ask questions. Additionally, proper preparation for a procedure reduces the risk that a procedure will be cancelled if the patient did not understand the pre-operative instructions.

The purpose of this study is to determine if pre-procedure patient education via telephone by an RN, which is accompanied by written instruction prior to arrival to the hospital, will reduce pre-procedure anxiety and improve patient satisfaction post-procedure.

After conducting a literature review on this topic, I found that few studies have demonstrated the relationship between receiving preparatory information, anxiety level and patient satisfaction with services provided. This study aims to improve patient satisfaction and reduce anxiety with endoscopic procedures through verbal and written education material and opportunity.

I have learned a great deal about the challenge and the importance of doing nursing research since I have become a Clinical Research Scholar. I must give credit to my fabulous mentors: the Nursing Research Scientists at Meridian Health. Through their knowledge, expertise and guidance, they have helped me to make this research study happen.

The nurses at Meridian Health are proud to work in a culture that recognizes the value of nursing research and encourages education, mentorship and professional growth to provide the best possible outcomes for our patients.



Top Photo: Robyn McNamara, RN, CGRN and Eric Rosenstock, MD, Director of Gastroenterology.

Middle Photo: Christina Barrett, BSN, RN, CGRN; Peggy DeAngelo, RN, CGRN and Ryan Fields, MD, Anesthesia.

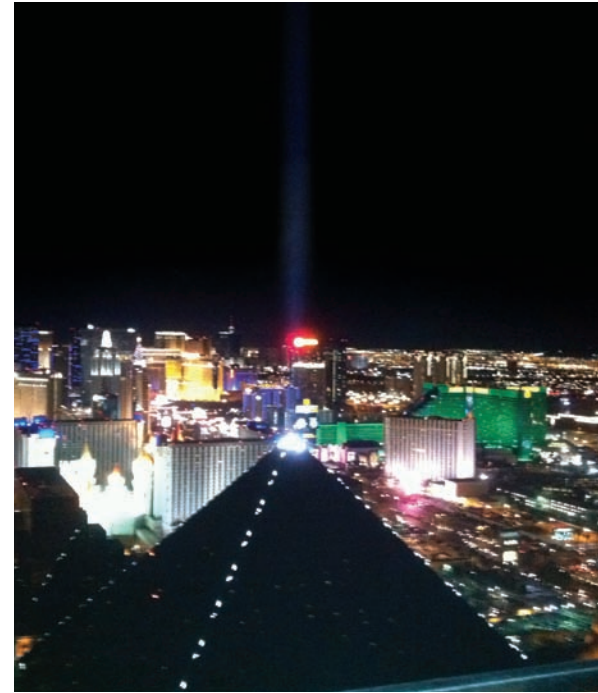
Bottom Photo: Endoscopy Nursing Team - Pamela Holmgren, LPN, CGN; Christina Barrett, RN, BSN, CGRN; Leslie Stewart, BA, RN, CGRN; Peggy DeAngelo, RN, CGRN; Janice Irvine, RN, BSN, CGRN; Ernestine Dickerson, RN, CGRN and Marianne Paolise, Secretary.

The 3rd Annual Interventional Endoscopy Course Draws 170 GI Nurses and Technicians

The 3rd Annual Interventional Endoscopy Course for GI Nurses and Technicians, held February 25-27 at the fabulous Caesars Palace Hotel in Las Vegas, attracted 170 nurses and technicians from 25 states. The attendees learned about the latest advances in the fields of ERCP, EUS, the Business of Running a GI Lab, Surgical Intervention for Pancreatic Diseases, Hands-On Education and even participated in a Managing Stress through Exercise session.

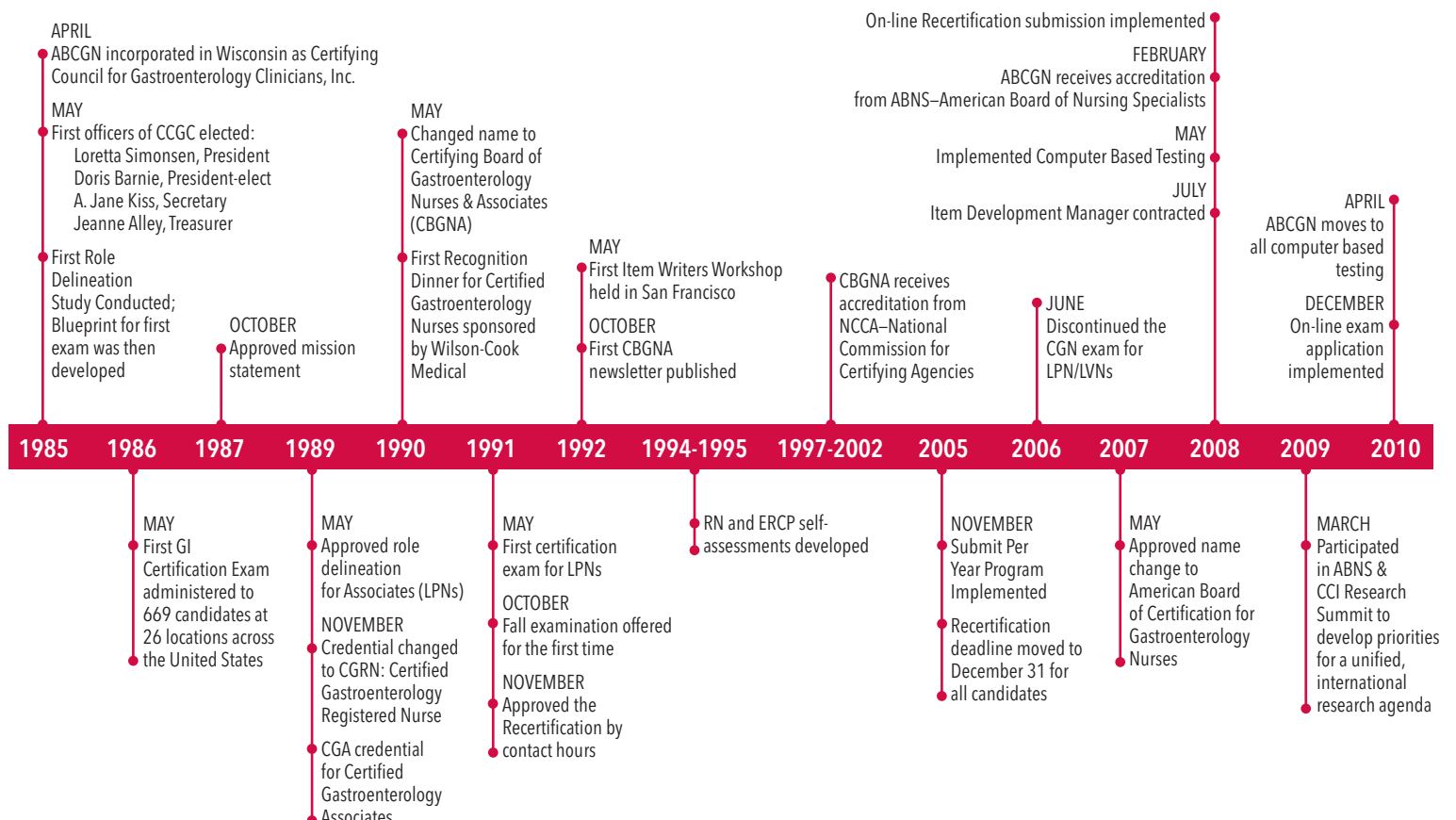
The response to the course was outstanding. The course directors included William Parsons, MD, and Medical Director of the Gastroenterology Center at Northwest Community Hospital outside Chicago and Kathy Lamont, RN, Director of GI Services at Northwest Community Hospital. Featured faculty included Rameez Alasadi, MD, Malcolm Bilimoria, MD, Brian Cadre, MD, and Terri Vos, RN.

The course directors and faculty are excited about future meetings and plan to expand the participation and topics and continually grow the event into one of the premier nurse and technician educational conferences in the world. For information on next year's meeting, contact your Cook representative.



ABCGN Celebrates 25th Anniversary

Cook Medical would like to congratulate the American Board of Certification for Gastroenterology Nurses for their 25 years of dedicated service to GI professionals and to the entire GI field. We should all be grateful to ABCGN for recognizing the need to standardize our specialty area through certification. Remember to express your appreciation to the countless volunteers and others who have served and continue to serve on the ABCGN Board of Directors and its committees.





ASPEN Clinical Nutrition Week 2011 Goes International



Gary Kunz and Sue Graham

Earlier this year, the annual ASPEN (American Society of Parenteral and Enteral Nutrition) Clinical Nutrition Week 2011 was held for the first time outside of the US. The setting for the meeting was beautiful Vancouver, British Columbia, Canada, where more than 1,700 physicians, dietitians, nurses, pharmacists, educators and researchers from throughout the world gathered in this high-energy learning environment. In 48 sessions and workshops, almost 200 globally recognized faculty provided participants with all the latest knowledge available on clinical nutrition.

Among topics explored at the meeting were: "Healing the Wound: Inside and Out," "GI Dysfunction in Critical Care," "Global Perspectives on Complimentary Alternative Medicine (CAM) or Complimentary Integrative Medicine" and "Enteral and Parenteral Lipids: What Does the Future Hold?" During the event, ASPEN awarded continuing education credits to physicians, nurses, pharmacists and dietitians who attended certified sessions.

Three divisions of Cook Medical—Critical Care, Interventional Radiology and Endoscopy—were among the 50 exhibitors showcasing the newest clinical nutrition products and services, with a major focus on pediatrics and nutrition support. All Clinical Nutrition Week 2011 participants enjoyed three outstanding days of learning and networking.

Clarification: In Issue 4, 2010 of The Channel, in the article, "From the Simple to the Complex: 30 Years of Pancreaticobiliary Plastic Stenting Solutions," Dr. Rishi Pawa's title was incorrectly identified as Associate Professor of Medicine, University of Kentucky, Lexington, KY. He is actually Assistant Professor of Medicine at that institution. We regret the error and any inconvenience it may have caused.

ANNOUNCING



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.

*Available in
the US only.*

Order Number	GPN	Description
PEG-20-BRT-TRI	G53883	20 Fr balloon replacement gastrostomy tube with 20 cc balloon capacity
PEG-24-BRT-TRI	G53885	24 Fr balloon replacement gastrostomy tube with 20 cc balloon capacity

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

NEWS FROM

SIGNEA

Society of International Gastroenterological Nurses and Endoscopy Associates



What Do We Know About Wilson's Disease?

Debbie den Boer BSN, RN, CGRN

Wilson's disease is a genetic disorder that prevents the body from getting rid of extra copper. It is named after Dr. Samuel Wilson who first described the disorder in 1912.

It is a rare autosomal-recessive disorder where copper builds up in the liver, brain, eyes and other organs. A small amount of copper obtained from food is needed for the human body to stay healthy, but too much copper is toxic. Although the accumulation of copper begins at birth, symptoms of the disorder appear later in life, between the ages of 6 and 40. Too much copper in the liver cells (the hepatocytes) is harmful and leads to liver damage. Damage to brain tissue mainly occurs in an area called the lenticular nucleus. Hence, Wilson's disease is also called Hepatolenticular Degeneration. If left untreated, the damage becomes severe and eventually fatal.

People who get Wilson's disease inherit two abnormal copies of the ATP7B gene, one from each parent. Symptoms usually present before the age of 15 in about 50% of cases. Wilson's disease carriers, who have only one copy of the abnormal gene, do not have symptoms. The disease affects men and women equally.

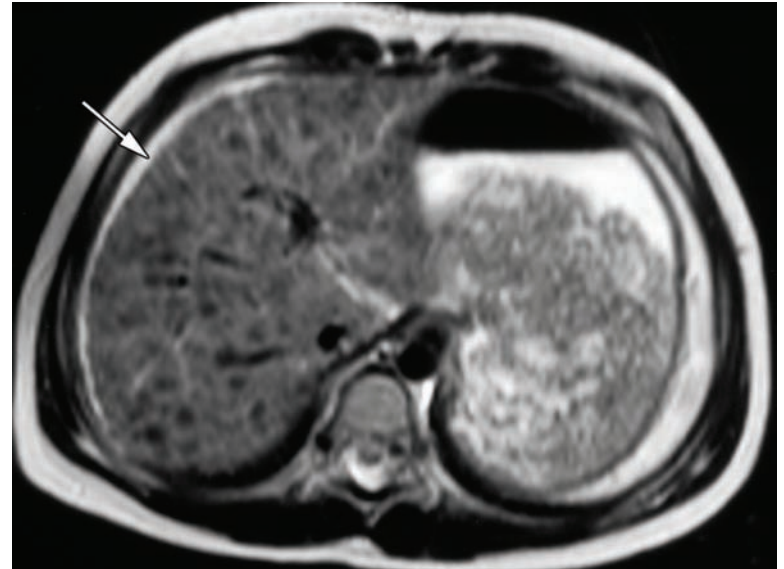
Causes

Wilson's disease is caused by a buildup of copper in the body and is not released by the liver at a normal rate. The liver serves as a filter, but due to a mutation of the ATP7B gene, a particular gene on chromosome 13, the copper is not filtered out and the copper storage capacity of the liver is exceeded. Copper is then released into the bloodstream and travels to other organs—including the brain, kidneys and eyes.

What symptoms of Wilson's disease can we detect in the GI lab?

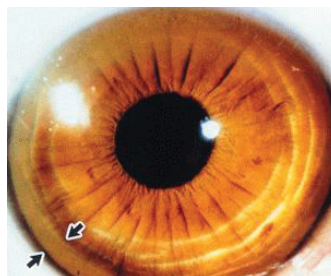
First of all, signs and symptoms of chronic liver disease are swelling of the liver or spleen, jaundice, fluid buildup in the legs or abdomen, a tendency to bruise easily and fatigue.

This image shows Wilson's disease with chronic active hepatitis.



Secondly, neurologic symptoms are problems with speech or swallowing or physical coordination, tremors or uncontrolled movements, muscle stiffness, behavioral changes, clumsiness, depression, difficulty speaking or swallowing or walking, drooling, easy bruising, involuntary shaking, joint pain, loss of appetite, nausea and skin rash.

Other signs and symptoms are a brown ring around the edge of the iris and in the rim of the cornea, called Kayser-Fleischer ring; anemia; low platelet or white blood cell count; slower blood clotting, measured by a blood test; high levels of amino acids, protein, uric acid, and carbohydrates in urine; and premature osteoporosis and arthritis.



Diagnosis

Laboratory tests

- Blood: lower than normal level of copper in the blood; lower level of the protein ceruloplasmin that carries copper in the bloodstream
- Genetic testing
- Urine: 24-hour urine collection will show increased copper in the urine in most patients who display symptoms
- Liver Biopsy: retaining too much copper

Physical Exam

- Visible signs
- Kayser-Fleischer rings in the eyes
- Signs of neurologic damage

Screening for Wilson's disease

- Anyone with unexplained liver disease or neurologic symptoms with evidence of liver disease
- People with a family history of Wilson's disease, especially those with an affected sibling or parent.

Treatment

- Early treatment can reduce or even prevent illness
- Initial therapy includes the removal of excess copper
- Reduction of dietary copper intake
- Avoid shellfish or liver, as these foods may contain high levels of copper. Other foods high in copper are mushrooms, nuts, and chocolate
- Check drinking water for copper content
- No multivitamins that contain copper
- Treatment of any liver or central nervous system damage
- Medications: d-penicillamine (Cuprimine) and trientine hydrochloride (Syprine)
- Zinc in combination with d-penicillamine or trientine hydrochloride. Zinc is safe to use at full dosage during pregnancy.

Wilson's disease requires lifelong treatment to reduce and control the amount of copper in the body.

Maintenance therapy typically includes taking zinc and low doses of either d-penicillamine or trientine hydrochloride.

Prognosis

If treatment is begun in the early stages of the disease, it usually is successful with normal life expectancy and quality of life.

Without treatment, Wilson's disease is usually fatal, usually before the age of 40.

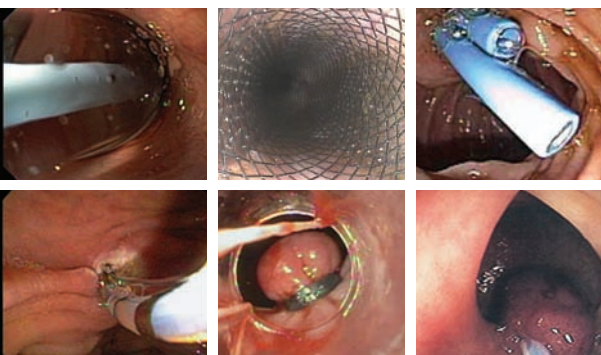
References

National Institute of Diabetes and Digestive and Kidney Diseases

SGNA Gastroenterology Nursing Core Curriculum

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 three new educational activities:

**Business Management
of the Endoscopy Unit**

**Malignant Biliary
Disease Management**

Updates in Colorectal Cancer

Updates in Enteral Feeding

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

UCI Hands-On EUS for GI Nurses & Techs	Orange, CA	June 7-8
EUS Live	Amsterdam	June 9-10
ERCP & Adv. Endoscopy Workshop GI Nurses & Techs (Northwest Community Hospital)	Arlington Heights, IL	June 10
Spanish Digestive Diseases Week	Sevilla	June 11-14
International Digestive Disease Forum	Hong Kong, China	June 11-12
UCI Hands-On ERCP for GI Nurses & Techs	Orange, CA	June 14-15
IU ERCP Workshop for Nurses	Indianapolis, IN	June 15-16
IX International Workshop in Digestive Endoscopy	Bello Horizonte, Brazil	June 16-18
GEEW	Brussels	June 20-22
Gastro Symposium for Nurses, Adv. RN's & Physicians Assist (Johns Hopkins)	Las Vegas, NV	June 24-25
XX International Course in Advance Therapeutic Endoscopy	Sao Paulo, Brazil	July 3-5
AP-EUS	Shenyang, China	July 8-10
UCI Hands-On ERCP for GI Nurses & Techs	Orange, CA	July 12-13
Mayo Clinic EUS Course & Pancreatology	Rochester, MN	July 20-23
X Paraguay National Congress in Gastroenterology & Endoscopy	Asuncion, Paraguay	July 21-23
IU ERCP Workshop for Nurses	Indianapolis, IN	Aug. 4-5
UCI Hands-On ERCP for GI Nurses & Techs	Orange, CA	Aug. 9-10
International Course in Endoscopy Clinica Las Condes	Santiago, Chile	Aug. 17-19
ERCP & Adv. Endoscopy Workshop GI Nurses & Techs (Northwest Community Hospital)	Arlington Heights, IL	Aug. 26
National Gastroenterology Week AMEG	Veracruz, Mexico	Aug. 31-Sept. 4
UCI Hands-On ERCP for GI Nurses & Techs	Orange, CA	Sept. 13-14
Florida Gastro Society/Florida SGNA	Lake Buena Vista, FL	Sept. 16-18
UCI Hands-On EUS for GI Nurses & Techs	Orange, CA	Sept. 20-21
IU ERCP/EUS Workshop for Physicians	Indianapolis, IN	Sept. 22-23
CSGNA (Canadian Society of Gastroenterology Nurses Associates)	Ottawa, ON	Sept. 29-Oct. 1
APDW (Asia Pacific Digestive Week)	Singapore	Oct. 1-4
24th Interantional Therapeutic Endoscopy Live	Toronto, ON	Oct. 11-15
GI Forum	Vancouver, BC	Oct. 13-14
UCI Hands-On ERCP for GI Nurses & Techs	Orange, CA	Oct. 18-19
Japanese Digestive Disease Week (JDDW)	Fukuoka, Japan	Oct. 20-23
UEGW (United European Gastroenterology Week)	Stockholm	Oct. 23-26
American College of Gastroenterology	Washington D.C.	Oct. 30-Nov. 1