COOK® MEDICAL

The Channel

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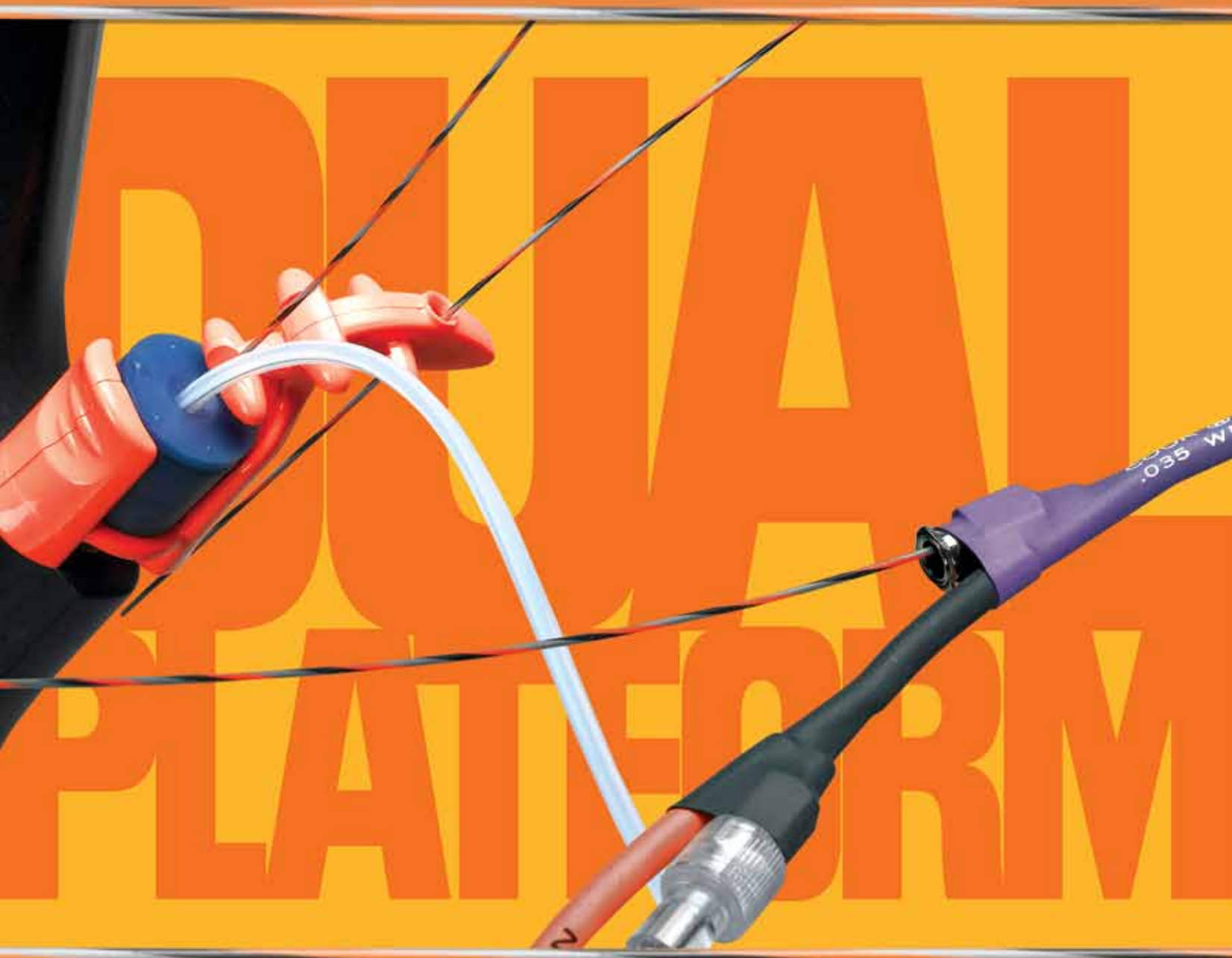
Fusion® Dual Platform ERCP



Solving the Long Wire vs. Short Wire Dilemma

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Short wire? Or long wire? Today's gastroenterologists are confronted everyday with the dilemma of deciding on one type of ERCP device or another. But why should clinicians have to choose between one wire guide technique and the other? That question led engineers at Cook Medical to ask their own questions: Why not both? What if one device gave you the option of two delivery methods?

It was those questions that led to the development of Fusion's Dual Platform, the first and only ERCP product line that gives the clinician the ability to effortlessly shift from a short wire platform to a traditional long wire platform without compromising access. Fusion devices deliver the trusted performance of the over-the-wire, long wire technique while also providing the modern, efficiencies of a monorail, short wire technique. It is one product line that meets both physician preferences and represents a major step in the evolution of how ERCP procedures are performed.

ERCP: the long view

For almost four decades, endoscopic retrograde cholangiopancreatography (ERCP) has been the noninvasive approach of choice for clinicians treating patients with pancreaticobiliary indications, such as choledocholithiasis or malignant stricture management. One of the more advanced procedures in the GI setting, ERCP has transitioned over the years from a diagnostic to a therapeutic procedure.[1]

Early ERCP devices were developed quickly to provide interventional treatment. To maintain ductal access for additional therapy with these devices, physicians and assistants alike had to learn to manage excessively long wire guides, using the over-the-wire, long wire approach. This long wire approach delivered the coaxial force or support that practitioners sometimes needed when working farther away from the papilla and/or dealing with difficult strictures or tortuous anatomy.

In skilled hands, the over-the-wire, long wire technique can be quite efficient. However, there are special considerations and possible pitfalls associated with this technique, including: the need for excellent communication between the physician and assistant; the possibility of wire guide contamination due to the excessive length hitting the floor; and the ability for the assistant to perform multiple tasks, such as advancing or retracting the wire guide, contrast injection, bowing or relaxing the sphincterotome.[2]

Short wire's short history

In the late 1990s, a short wire technique was introduced to the ERCP market that used a 260 cm wire. One of the main benefits of the short wire system was its ability to provide physician wire guide control.[2] This product line predominantly offered a monorail technique, in which the wire guide exits a port at the distal end of the catheter. And, while this product line could be used with a long wire guide, it lacked the ability to provide the coaxial force of an over-the-wire technique because it did not have a traditional long wire lumen.

Shortly thereafter Cook Medical entered the market with Fusion, the first and only product line to offer Dual Platform ERCP. Dual Platform means clinicians experience the proven performance of the over-the-wire, long wire technique and the efficiencies of short wire—in one product line.

The Fusion Difference

***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 needs to recannulate	No	Yes	No
Physician control of wire	Yes	Yes	Yes
Pushability of short-wire devices[1]	††	†††	†††

*Reddy SC, Draganov PV. ERCP Wire Systems: The Long and the Short of it. *World Journal of Gastroenterology.* 2009:15(1):55-60.
[1]Author's own experience.
**Now available in 205 cm length.

One device, two platforms

What makes Fusion a true "dual platform" product line is that it has a fully functional, long wire lumen as well as a port on the distal end of the device to facilitate the monorail/short wire technique. This means that physicians can move easily back and forth between two viable options to complete ERCP procedures from the simple to the complex and never lose access.

A recent article, "ERCP wire systems: The long and the short of it," states that the real advantage of Fusion is the ability to move from the short wire technique where the physician has control of the wire to the long wire technique where there is reliance on an assistant at any point during the procedure.[2] All other product lines on the market will allow for only one technique or the other—but not both. (See table for comparison of three ERCP wire systems.)

A recent randomized, blinded comparative study, evaluating Fusion, showed not only statistical significance, but also clinical significance in procedural outcomes[3]. Procedural efficiency advantages are magnified even during more complex ERCP procedures that require multiple device exchanges or placement of multiple stents[3]. Although statistical significance was not achieved, trends towards shorter procedure, fluoroscopy and cannulation times were noted[3].

Enhancing confidence

Over the years, ERCP product advancements evolved to manage the simplest to the most complex ERCP procedures. Fusion's Dual Platform ERCP product line has taken ERCP to the next level in technology, giving the physician the choice of how to use the device. Fusion provides: physician preference, unified training and the capability of streamlining inventory.

From gaining access to complex stricture management, there is a full range of Fusion devices to meet the clinical challenges of diagnostic and therapeutic ERCP. Perhaps one of the most important features of Fusion devices is the added confidence clinicians experience knowing that they will never have to be concerned about losing access, even as they shift effortlessly between long and short wire guide techniques.

References

[1] Baron T, Kozarek R, et al. Complications of ERCP: prediction, prevention and management. ERCP. Philadelphia, PA: Elsevier Inc; 2008:51-59.

[2] Chandrupatla S, Draganov P. ERCP wire systems: the long and the short of it. World J Gastroenterol. 2009; 15(1):55-60.

[3] Draganov P, Kowalczyk L, et al. Prospective randomized blinded comparison of a short-wire endoscopic retrograde cholangiopancreatography system with traditional long-wire devices. Dig Dis Sci. 2010;55:510-515.

Meeting your clinical needs

New preloaded

COOK MEDICAL Fusion OMNI-Tome SPHINCTEROTOME

Options

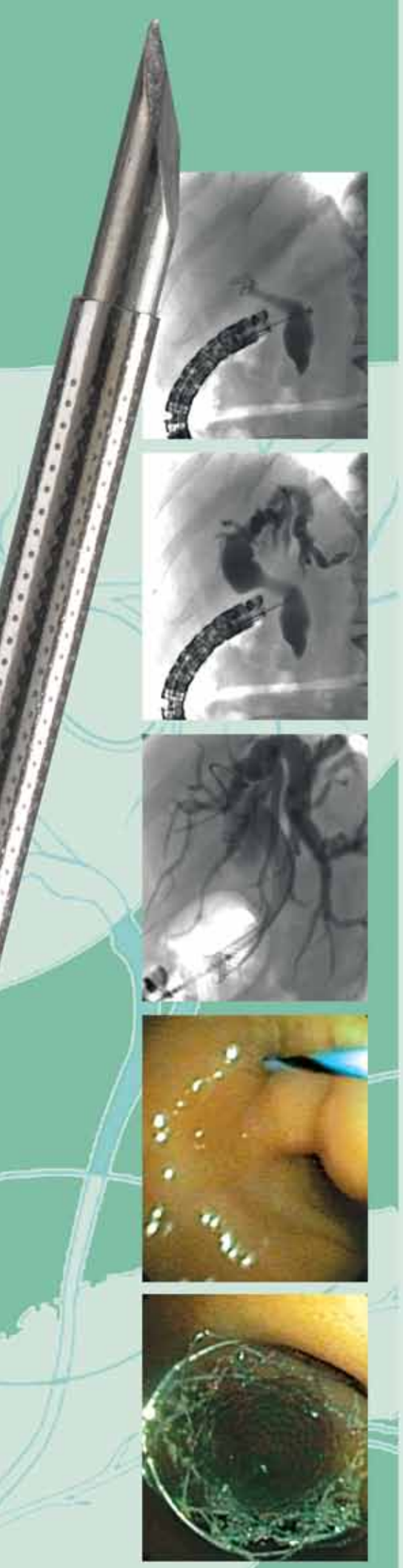
The goal for ERCP is to gain access in order to achieve successful patient outcomes. The Fusion OMNI gives you everything you need for achieving your most difficult task: cannulation. Our exclusive DomeTip shape is designed with anatomy in mind for smooth, ease of access. With Fusion's Dual Platform ERCP capability, you will never have to choose between using the device monorail/short wire or over-the-wire/long wire. You get both preferences in one device.

Now with two additional preloaded options, you have the choice of using any wire guide length that is desired: 205 cm, 260 cm or 480 cm.

FS-OMNI-35
FS-OMNI-35-260*
FS-OMNI-35-480*

Please contact your local representative for additional product information.

***Check for availability**



EUS-guided Choledochoduodenostomy with COOK MEDICAL EchoTip® Ultra

HIGH DEFINITION ULTRASOUND ACCESS NEEDLE

J. Romagnuolo, MD, MSc, FRCPC
Associate Professor of Medicine
Division of Gastroenterology and Hepatology
Medical University of South Carolina
Charleston, South Carolina

The following two cases represent examples of using the Cook Access Needle to rescue failed conventional ampullary access to drain the obstructed biliary tree upstream from a malignant biliary stricture. The Access needle allows the inner stylet to act as the "needle" to get access to a structure. The inner stylet is then withdrawn, leaving the blunt ended, more wire-coating-friendly, metal sheath as the conduit for wire exchange and other therapies.

Case 1

This patient presented with painless jaundice and was found to have a circumferential duodenal tumor involving all of the second part of the duodenum. EUS was consistent with this being a T4 duodenal primary, invading some pancreas. The periampullary duodenum was only accessible with a slim forward-viewer, and the ampulla was lost in the tumor. As such a "rendezvous" was not feasible, and the option of percutaneous transhepatic cholangiography (PTC) and drain versus EUS-guided access was discussed.

A prototype Olympus linear EUS scope (forward-viewing, no elevator) was used to visualize the upstream bile duct through the duodenal bulb, a puncture was made with the Access needle, and then a .035 inch wire was used to gain access to the duct. With the wire in the intrahepatics, a 10 x 60 mm fully covered expandable stent was inserted, after a 7 FR step dilator was passed, and then the stent was inserted and deployed across the duodenal wall, creating a choledochoduodenostomy, all with the EUS scope. The inner catheter had some difficulty coming back through the waist of the stent and was only removable after balloon dilating the waist, after cutting off the introducer's catheter end and exchanging it over the scope. The inpatient stayed one more night in-house, and went home feeling well the next day.

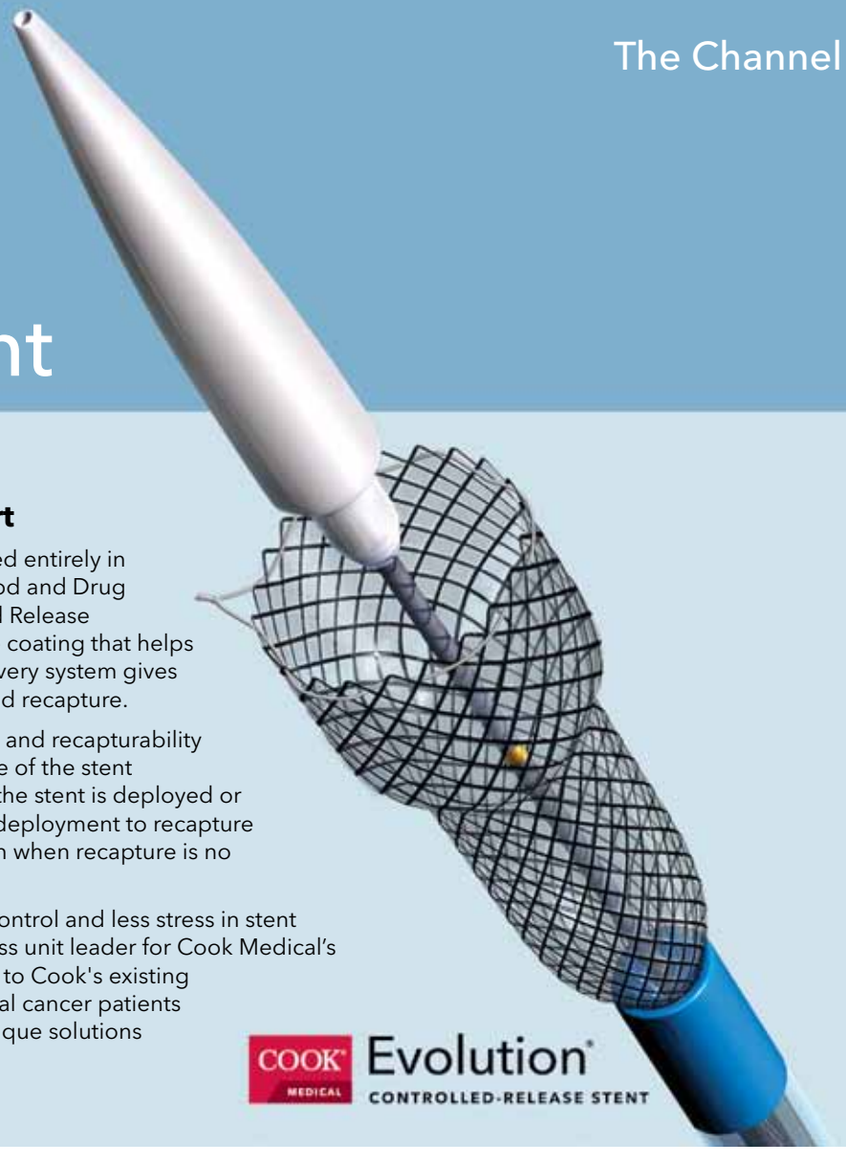
Case 2

This patient developed jaundice several months after undergoing chemoradiotherapy for an inoperable body of pancreas tumor that appeared to progress while on therapy. Two attempts at conventional ampullary access resulted in a cholangiogram but attempts to feed a wire through the ampullary stricture failed both times despite a needle knife precut sphincterotomy at the first ERCP. There were two options here beyond a PTC: EUS-guided rendezvous, accessing the duct above the main CBD stricture, hoping that the ampullary stricture would be traversable from above versus a direct choledochoduodenostomy into the upstream bile duct. The latter was chosen.

The same prototype EUS linear scope was used to access the upstream bile duct through the duodenal bulb, and over a .035 inch wire passed into the intrahepatic ducts, a 7 FR step-dilator was passed, and a covered 10 x 60 mm metal stent was placed draining the common hepatic duct into the duodenal bulb. This inpatient stayed one extra night, and felt well the next morning, and was discharged.

In both cases, the wire passages and exchanges were performed without difficulty, and without trauma or stripping of the wire coating, representing a major improvement over the conventional FNA needle in this regard. Needle puncture of the bile duct with the Access device did not appear any more difficult than with a traditional 19 gauge FNA needle.

First-of-its-Kind Fully Covered Esophageal Stent



Advances Cancer Care and Patient Comfort

The first and only controlled-release esophageal stent coated entirely in silicone recently received 510(k) clearance from the U.S. Food and Drug Administration (FDA). Cook Medical's Evolution® Controlled Release Esophageal Fully Covered Stent is fully covered in a silicone coating that helps prevent tumor ingrowth. In addition, controlled release delivery system gives physicians unparalleled control during stent deployment and recapture.

Evolution's breakthrough design enables controlled release and recapturability featuring a "point-of-no-return" indicator. With each squeeze of the stent system's trigger-based introducer, a proportional length of the stent is deployed or recaptured. The directional button switches smoothly from deployment to recapture mode, and the "point-of-no-return" mark alerts the physician when recapture is no longer available – repositioning, however, is still an option.

"The Evolution Fully Covered Stent offers physicians more control and less stress in stent placement and recapture," said Barry Slowey, global business unit leader for Cook Medical's endoscopy division. "The addition of the fully covered stent to Cook's existing Evolution product line provides more options for esophageal cancer patients and further establishes Cook as an innovator in bringing unique solutions to our patients and the physicians treating them."

ANNOUNCING

COOK MEDICAL **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.

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. Available in the US only.

COOK® MEDICAL

4,6,10 Shooter™

SAEED® MULTI-BAND LIGATOR

Testimonials from Around the World

When the Saeed 4, 6, 10 Shooter Multi-Band Ligator was first released in the mid-1990s, it set the standard for band ligation technology. After leading the market for more than a decade, the Saeed Multi-Band Ligator now features Universal-fit barrels that further streamline procedures and simply inventory.

With bands that demonstrate lower slippage rates when compared to others on the market[1], it can potentially reduce the risk of rebleeding. The 4, 6, 10 Shooter is known for its Opti-Vu® Barrel, which provides a wide, uninterrupted procedural view, and it is available in the widest range of sizes to fit any endoscope.

Those are some of the reasons why the 4, 6, 10 Shooter has become the ligation bander of choice for clinicians everywhere, as evidenced by testimonials from gastroenterologists around the world.

[1] "In-vitro bench studies have shown differences in the resting inner diameters and radial retraction force of bands on different ligation devices. The larger resting inner diameter and a significantly lower retraction force in neoprene bands, compared to rubber bands predisposed these bands to early slippage." J. M. Polski, E. M. Brunt, Z. A. Saeed (2001). Chronology of Histological Changes after Band Ligation of Esophageal Varices in Humans. Endoscopy, 33, 443-447.

Tiing Leong Ang, MD, *Changi General Hospital, Singapore*

"The 4, 6, 10 Shooter from Cook Medical is my multiband ligator of choice for the endoscopic treatment of esophageal varices. It is user friendly and can be easily and quickly loaded up for use. Multiple bands can be securely deployed in rapid succession to achieve endoscopic hemostasis of esophageal variceal bleeding. This is very important when there is active bleeding which may impair the endoscopic view."

Jesus A. Hernandez, MD, *El Paso Gastroenterology Consultants, El Paso, Texas*

"After many years of experience with the 4, 6, 10 Shooter multiband ligation device I continue to use it extensively. The system is reliable and flexible. The string trigger cord allows banding to be performed in a retroflexed position and facilitates banding when the instrument tip is at an angulated position. The fact that the cords are contained within the handle during the banding procedure minimizes the risk of exposure to blood and secretions to the endoscopist and assistants. I also find the visibility to be excellent with the 4, 6, 10 Shooter device."

Jae-Young Jang, MD and Sung-Won Jeong, MD, *Soon Chun Hyang University Hospital, Korea*

"We have experience with several types of multiband ligation devices. However, the 4, 6, 10 Shooter provides better visibility than others. Also it is very convenience to use. We are really satisfied with 4, 6, 10 Shooter. We love it."

Andrew E. Katz, MD, *The Lutheran Medical Group, Fort Wayne, Indiana*

"With the release of the Cook 4, 6, 10 Shooter, EBL became the treatment option of choice for esophageal varices. The device is reliable, well constructed, and fast. It allows treatment of actively bleeding as well as stable non-bleeding varices. The friction fit cap fits the endoscope well, the cap itself is transparent, allowing a better field of view, and the next to last band is white, giving an indication that the load of bands is almost exhausted. Moreover, the system for feeding the control line through the working channel is almost flawless. The deployment wheel fits very well into the biopsy port valve and is very sturdy in that position, without any straps required. The handle itself has a good hand feel and the positive clicks give excellent feedback regarding deployment. I also use the 4, 6, 10 Shooter on an upper endoscope to band internal hemorrhoids. It is easily retroflexed in the rectum and the bands are easily, reliably, and comfortably applied. In short, the Cook 4, 6, 10 Shooter is my band ligation device of choice."

Prof. Giampiero Macarri, *Università Politecnica delle Marche, Ospedale A. Murri, Fermo (Asur Marche, Italy)*

"The 4, 6, 10 Shooter is a multiband ligator with natural rubber bands that allows ligation of multiple varices during a single insertion. It is my favorite device for treating esophageal varices for many different reasons. One of the reasons is that this method allows me to have a good view of the whole procedure. I can also use it in the emergency management of bleeding esophageal varices. In fact, it is very easy to use and is also technically feasible and safe. It is also highly effective in obliterating esophageal varices and allows faster ablation of esophageal varices. Moreover, we have observed very low slippage rates. Even if the bands are made of natural rubber, no allergic reactions have been reported in our series."

Enzo Masci, MD and Benedetto Mangiavillano, MD, *San Paolo University Hospital – University of Milan, Milan, Italy*


"The advent of the 4, 6, 10 Shooter has increased the quality of work, especially during endoscopy performed for urgency. Despite the endoscopic esophageal variceal ligation (EVL) is, up to now, the elective treatment of choice in the prophylaxis of bleeding in patients with esophageal varices, its role in the emergency endoscopy is growing increasingly. We treated many cirrhotic patients during the bleeding of esophageal varices in the ER with the 4, 6, 10 Shooter, obtaining optimal results with the immediate stop of bleeding. Cook 4, 6, 10 Shooters results then as an excellent option in life-threatening bleeding patients, considering also its clear and smooth plastic barrel, providing a best endoscopic view in all direction. I guess that it is of relevant weight to have a safe device during esophageal variceal bleeding in emergency endoscopy."

Prof. Ibrahim Mostafa, MD, *Theodor Bilharz Research Institute, Imbaba Giza , Egypt*

"Egypt has the highest prevalence of liver cirrhosis in the world and hence patients with portal hypertension. Variceal bleeding is the most common cause of upper GI bleeding in Egypt."

"From my own experience, band ligation is extremely useful in the management of first attach variceal bleeding as well as follow up (secondary prophylaxis)."

"There is no contraindication to use band ligation after injection of gastric extension. Our protocol in cases of combined esophageal and gastric varices is to manage gastric extension first, then ligate esophageal varices. But in case of esophageal alone, the answer is to ligate, ligate, ligate."

"Being a fan of the 4, 6, 10 Shooter, I use it in 90 percent of situations in both bleeders as well as follow up. It is optimal in everything: size of the cap and number of bands. Sometimes with acute bleeders with huge varices, we use a 10 Shooter and also during follow up, a 4 Shooter may be used."

"If I were to summarize my 30 years experience in management of varices, it would be: Band ligation is a bloodless, pain free procedure."

D. Nageshwar Reddy, MD, *Asian Institute of Gastroenterology, Hyderabad, India*

"I have been using the 4, 6, 10 Shooter for many years and we never found any unwanted events or outcomes with it. Its reliability and superior band retention has made it the gold standard of band ligation."

"The 4, 6, 10 Shooter remains my preferred endoscopic banding device for various indications, as it is the original and the best one on the market. Significantly superior in terms of fewer complications, quicker eradication of varices and a lower rebleeding rate, when compared to other bands available. Intubation was no more difficult with the endoscope loaded with the 4, 6, 10 Shooter than with the endoscope alone. Band release is always possible in the retroflexed position. I found band retention with the 4, 6, 10 Shooter is more secure when compared to non-latex bands and demonstrate lower slippage rates when compared to other bands."

"The 4, 6, 10 Shooter has enhanced visibility thanks to the Opti-Vu barrels, which maximizes endoscopic view while maintaining suction."

"Endoscopic band ligation is reported to be preferred to endoscopic sclerotherapy as it is easier to perform and has lower complication rerates."

Prof. Alexandr Shertcinger and Svetlana Zhigalova, MD, *Russian Scientific Center of Surgery, Moscow*


"Our department specializes on treatment of patients with portal hypertension. Every year we treat more than 320 patients with portal hypertension and esophageal and gastric varices. We have used endoscopic ligation for esophageal varices since 2001; we performed more than 1200 procedures of ligation. We think that endoscopic ligation is a method of choice to arrest and to prevent hemorrhage from esophageal varices. We prefer the Cook 4, 6, 10 Shooter. The 4, 6, 10 Shooter is very simple to work with. Usually it takes only 3-5 minutes to ligate all varices. The rubber bands remain in place for 5-7 days, resulting in eradication of varices in most cases. We have never observed any complications like allergic reaction to latex, esophageal perforation or stricture after application of elastic bands. We prefer to use kits with 10 bands, because only with them we can eradicate all varices."

Shou Tang, MD, *University of Mississippi Medical Center, Jackson, Mississippi*

"I prefer the Cook 4, 6, 10 Shooter not only because it is the original one on the market but still the best one today. I was trained with the 4, 6, 10 Shooter during GI fellowship and I have tried other banding devices since. The 4, 6, 10 Shooter remains to be my preferred endoscopic banding device for various indications. Compared to neoprene bands, the rubber bands on the 4, 6, 10 Shooter offer much better elasticity and they tend to stay on the banded tissue more securely. Neoprene bands tend to pop off prematurely which mitigates its therapeutic intent and causes bleeding in some cases. For the same reason, rubber bands are preferred in all dedicated hemorrhoidal banding devices. Compared to other banding devices, the clear and smooth plastic 4, 6, 10 Shooter barrel provides the best endoscopic view at all directions. It is easy to load and insert in the GI tract. Overall, I have not had any unwanted events or outcomes with the 4, 6, 10 Shooter."

Sun Ziqin, MD, *General Hospital of the Jinan Military Region, People's Republic of China*

"Over the past 20 years, great progress has been made in the research and development of ligators and application of ligation techniques for esophageal varices. Since we began using esophageal variceal ligation in 1992, we have treated over 3,000 patients with five different models of ligators. Five hundred of these patients were treated with the Cook 4, 6, 10 Shooter using the two-time dense ligation method. In the initial treatment, we ligate each varicose vessel near the upper margin and proceed superiorly until we have ligated all visible varices. In most patients, we initially ligate 12–18 sites. One month after the initial treatment, a second procedure is performed to ligate the remaining varices. Patients who underwent this pair of procedures with the Cook 4, 6, 10 Shooter had complete disappearance of more than 90% of the varices, and the hemostasis rate reached 100%."

"We feel that the 4, 6, 10 Shooter has the following advantages: the rim of the front tip of the barrel is relatively soft, allowing it to be closely apposed to the esophageal mucosa and the varicose vessels while reducing damage to these areas; the force of the ligation band release is gentle and does not cause significant damage to the target veins; upon release of the ligation band, the sensation of a failed ligation is clear, which allows for an accurate assessment of a successful release and prevents overdeployment; the design of color-coded markings and indicator bands makes the structure of the ligator straightforward and practical; the barrel is transparent, allowing for a clear field of view; and the ligator bands are uniform and regular in shape and structure, eliminating the hidden hazards of uneven ligator band thicknesses that can produce uneven stresses and have a tendency to break."

NEW ASSOCIATION OF FRENCH ENDOSCOPISTS

CONVENES IN *Marseille*

Professor Marc Barthet
Department of Gastroenterology and Hepatology
Hôpital Nord, Chemin des Bourrely
Marseille, France

Last spring, a new group called GRAPHE convened in Marseille, bringing together 25 endoscopists from across France. The endoscopists work predominantly in the field of therapeutic endoscopy at university hospital departments of gastroenterology and most are the chiefs of the endoscopy units.

The goal of this new association is to promote scientific works and multicenter studies under the auspices of SFED (Société Française d'Endoscopie Digestive) and to debate the specific problems related to new and/or difficult endoscopic procedures. In addition, the members share and solve issues they experience in Public Hospital.

The day spent in Marseille was dedicated to the conclusion of a randomized multicenter study protocol with the Hercules Balloon Dilator. It was also dedicated to training for ESD and therapeutic ESD in four live pigs.

Cook Medical was the major sponsor of this event, cordially represented by Hervé Audoin and Stéphane Jaillot. Endoscopes and echoendoscopes were provided by Pentax, with Bruno Morel and Jean-Marc François. Hitachi also provided ultrasonograpy equipment. All the GRAPHE group wishes to thank Cook and also Pentax-Hitachi for their contribution in this constructive and interesting day.

Interventional Endosonography
IN CHEST MEDICINE

Making EBUS and EUS more accessible

The 8th annual course on "Interventional Endosonography in Chest Medicine" was held in Leiden University Medical Centre, The Netherlands, on Thursday June 24, 2010. The hosts for this well-attended meeting were Dr. Jouke Annema and Dr. Klaus Rabe of the Centre for Pulmonary Diseases at LUMC.

Cook Medical and Hitachi Medical Systems sponsored the event. This is a popular meeting for those interested in the growing area of bronchial ultrasound. Faculty for the meeting included Dr. Robert Rintoul, Consultant Pulmonologist of Papworth Hospital, Cambridge; and Dr Veseliç, cytopathologist for the LUMC.

The meeting included lectures, live patient demonstrations from the therapy rooms in LUMC and hands-on sessions with Olympus and Pentax equipment and phantom models. Cook Medical EchoTip Ultra Endobronchial Ultrasound (EBUS) needles were used throughout the day.

The theme of this year's course was facing the challenge to implement EBUS and EUS on a large scale to ensure widespread accessibility of these methods for the care of patients with mediastinal diseases. One of the lectures concerned the issues involved in setting up an EBUS service. Of particular interest to the attendees was the use of transesophageal ultrasound to image mediastinal nodes from the esophageal window. The meeting concluded with a quiz on the presentations of the day.

From the Simple to the
30 Years of Pancreaticobiliary

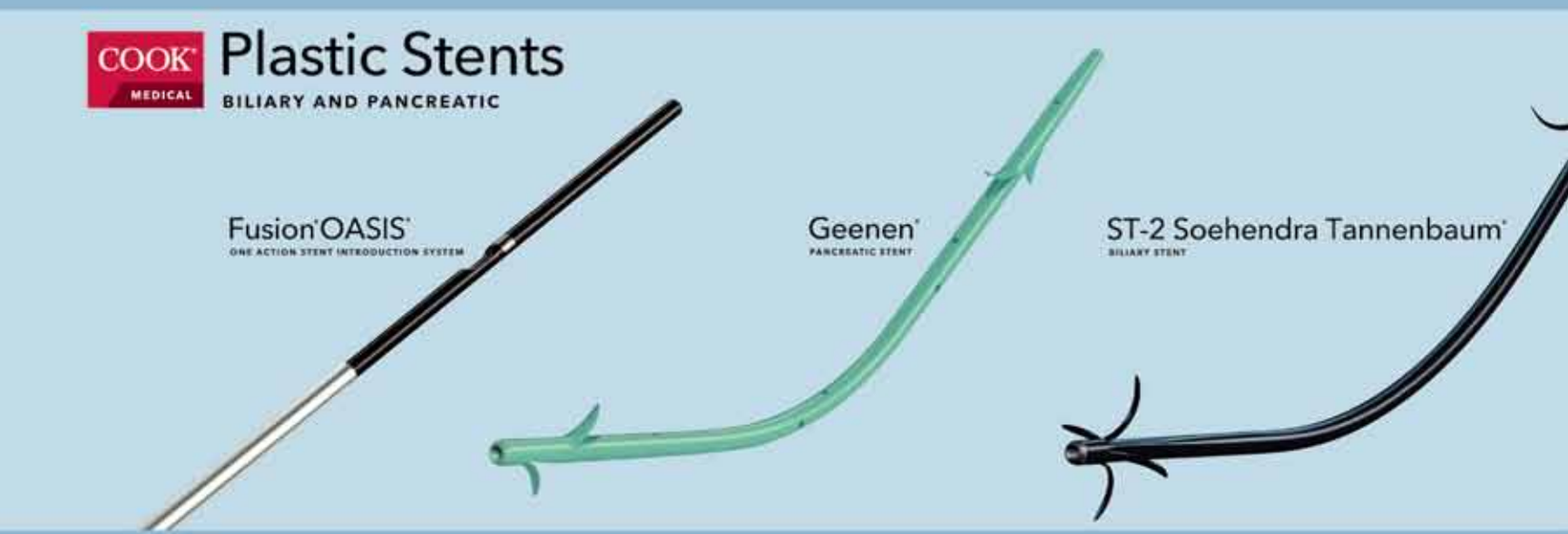
For almost three decades, Cook Medical has provided the broadest range of pancreaticobiliary stents to drain obstructed biliary and pancreatic ducts. The reason Cook offers such a broad range of plastic stents is because every patient is different. Only a comprehensive selection of stents can meet a variety challenging clinical scenarios.

Plastic stents are used to manage bile and pancreatic ductal obstructions and leaks, which result from a variety of conditions.[1] The table lists some of the indications as to why a patient may need to have a plastic biliary or pancreatic stent.

For biliary applications, plastic stents vary from 5–11.5 Fr in diameter and range from 2-18 cm in length. According to the ASGE Technology Status Evaluation Report, biliary stents are chosen based on the largest diameter that accommodates the ductal anatomy.[1] In relation to strictures, the goal is to bridge the entire length, from just above the stricture until the stent is secured transpapillary, keeping the duodenal end free from the opposing wall, which reduces the likelihood of trauma.[1]

BILIARY INDICATIONS	PANCREATIC INDICATIONS
Malignant biliary obstruction	Malignant pancreatic duct obstruction
Benign biliary strictures *Postoperative injuries* *Liver transplantation* *Primary sclerosing cholangitis* *Chronic pancreatitis*	Benign pancreatic diseases *Chronic pancreatitis* *Pancreas divisum* *Pancreatic duct leaks*
Postoperative bile leaks	Prevention of post-ERCP pancreatitis
Retained stones	

For more complicated stricture management, when placing multiple stents is necessary, Cook's Fusion OASIS has the ability to maintain ductal access for express introduction of additional stents. With Fusion's Intraductal Exchange technology, the need for recannulation is eliminated, allowing clinicians to maintain wire guide access. An abstract titled, "Clinical Results of Double Stenting for the Palliation of Lower Biliary Obstruction



Gregory A. Cote, MD, MS
Assistant Professor of Clinical Medicine
Indiana University
Indianapolis, IN

"I use the Fusion Oasis Stent System because of its compatibility with the short wire platform. The guide catheter is well visualized fluoroscopically to help with stent deployment. Similarly, the stents are easily viewed fluoroscopically. The stents offer an excellent balance of flexibility and pushability to help traverse tight strictures. The flanges are easily passed through the working channel of the duodenoscope yet effectively prevent stent migration. Perhaps the greatest advantage of this Cook stent deployment system is the ability to deploy multiple stents across a stricture while keeping your guide wire in place."

Rishi Pawa, MD
Assistant Professor of Medicine
University of Kentucky
Lexington, KY

"This stent is specifically designed for pancreatic applications. It is made of polyethylene and has multiple side holes and four flaps to prevent proximal or distal migration after placement. It ranges from 3 FR to 11.5 FR in diameter."

"I specifically use it to facilitate biliary cannulation in patients with difficult biliary access. It is easy to deploy, straightens the common channel and decreases the likelihood of repeated PD cannulation. In patients with small ampullary orifice, occasionally it can be challenging to place the sphincterotome adjacent to a pigtail pancreatic stent. Since this is a straight stent, it does not get in the way of cannulating the bile duct after PD stenting. As an added benefit, it reduces the risk of post ERCP pancreatitis."

Travis Rutland, MD
Gastroenterologist
Southeast Alabama Medical Center
Dothan, AL

"Choosing the most appropriate stent in a biliary case is often a challenge. Many factors come into play when making this decision, and one of these is stent migration. As of the last year or so, I find myself depending more and more upon the Soehendra Tannenbaum stent system (TTSO)."

"The TTSO offers me the comfort of a stent that will not migrate into the biliary system. Certain cases, where one has a large sphincterotomy or the bile duct is severely dilated, there are frequent concerns that the stent could migrate. We have all spent time 'fishing' migrated stents out of the choledocus, and I have not had this issue with the TTSO stents. I feel that these stents are very reliable and appear to have a decreased migration potential."

Complex
Plastic Stenting Solutions

Associated with Unresectable Pancreatic Cancer," states that "intraductal exchange allows the guide wire to be disengaged from devices within the bile duct and left across the stricture, facilitating deployment of subsequent stents without concern of losing access across the stricture."[2]

There are major risks associated with ERCP; the most critical is the development of pancreatitis. When managing pancreatic stenting indications, a more delicate approach may be needed. Cook offers stents with the traditional polyethylene material as well as a more supple, Sof-Flex® material design that, without comprising performance, allows the stent to conform to the duct rather than the duct conforming to the stent.

One of the more common indications for pancreatic stenting is the prevention of post-ERCP pancreatitis. A recent meta-analysis of five pooled studies with 481 patients concluded that placement of a pancreatic duct stent during ERCP reduces the incidence of post-ERCP pancreatitis by two-thirds in selected high-risk patients.[1] According to Dr. Freeman, careful endoscopic technique and refinements such as wire-guided cannulation go only so far in avoiding pancreatitis and are not alone adequate to prevent this type of complication in high-risk patients.[3] The focus should always be successful patient outcomes and "although it is not necessary or practical to place a pancreatic stent in all ERCPs, one analysis suggested that cost-effectiveness would justify pancreatic stent placement in fully one half of all ERCPs, the proportion of all ERCPS that were estimated to be at high risk for the purposes of the model."[3]

Given the broad range of applications and indications for plastic stenting, it's important to have access to a wide variety of stenting solutions. With over 700 stenting options in three material choices—polyethylene, PTFE and Sof-Flex—Cook offers the broadest range of pancreaticobiliary stents available anywhere. All are designed to help clinicians deal with any stenting situation, from the simple to the complex and all procedures in between.

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Wahid Wassef, MD
Director of Endoscopy
Professor of Clinical Medicine
University of Massachusetts
Memorial Medical Center

"We use the Solus stent almost exclusively at our institution. We find the stent and its system to be very pliable, easy to use, and easy to manipulate. As such, this stent is versatile and has become the workhorse of our department."

"We use the Solus double pigtail stent in situations often reserved for straight stents. In our experience, the pigtail is soft enough to be placed into the intrahepatic ducts, but strong enough to hold the stent in place. By placing the proximal end into the intrahepatic ducts, we have seen less stent migration out of the duct, even with sphincterotomies and single stent placement. Additionally, when the proximal pigtail is fully opened, it gives us additional length, which is helpful for stenting more proximal lesions. With increasing frequency, we have also been using multiple Solus stents placed serially to dilate strictures of all types. The design of the stent and its system makes this easy to accomplish and less likely to migrate out of the bile duct."

Henry Wong, MD, FRCP(C)
Gatroenterology
Surrey Memorial Hospital
Surrey, British Columbia

"A major innovation [in treating biliary disease] was the development of self-expanding metal stents (SEMS), where stent diameter was no longer limited by the caliber of the working channel of the duodenoscope. This allows for metal stents with luminal diameters of 10 mm (30 FR) when deployed and correspondingly longer stent patency durations. As a result, the use of metal stents has increased. However, metal stents have not completely replaced plastic stents for alleviation of malignant biliary obstruction due to several factors. Some of these factors include a substantially higher upfront cost, inability to remove current metal stents, tumor ingrowth/overgrowth, and stent malfunction. This means plastic stents still play a major role in not only malignant but also benign strictures, bile leaks and maintenance of biliary drainage."

"At our center, for more than 15 years when a plastic stent is indicated, I predominantly use Cotton-Huibregtse, Tannenbaum and Zimmon stents by Cook Medical. These stents in conjunction with the OASIS stent insertion kits allows for rapid, easy and straight forward stent placement and replacement. The Fusion OASIS stent insertion kits make this simple process even faster and allows the endoscopist excellent control of biliary guide wire access."

Performing EUS biopsy in a difficult location

John Deutsch, MD
Gastroenterology
SMDC Medical Center
Duluth Clinic
Duluth, MN

Figure 1: CT at the level of the aortic bifurcation showing an enlarged node/ mass.

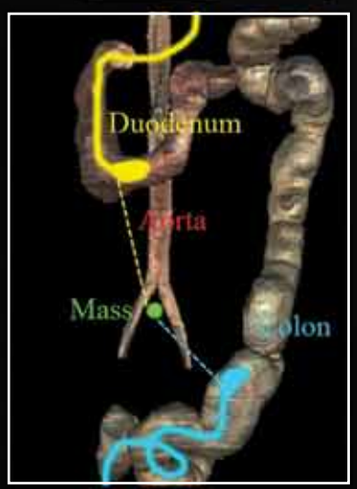


Figure 2: Visible Body models obtained from the TolTec dissector showing potential routes in which a biopsy could be obtained.

Figure 3: Failure to visualize the lesion from the transduodenal approach.

Figure 4: The lesion identified from a transcolonic approach.

Figure 5: Fine needle aspiration of the mass. Bladder cancer was obtained.

A 74-year-old patient was found to have a sarcomatoid bladder cancer eight months prior to presentation. Definitive therapy included a cystoprostatectomy with creation of ileal conduit and bilateral pelvic lymph node dissection. Staging revealed a T1, N0 lesion.

The patient presented with abdominal fullness and a low-grade fever. A subsequent CT scan of his abdomen and pelvis showed the ileal conduit to be twisted upon itself with a high-grade obstruction. He also had a 2.7 cm enlarged node in the area of the aortic bifurcation. Figure 1 shows a CT of the abnormal node.

Metastatic bladder cancer was suspected and the patient was referred for potential EUS.

The anatomic question for endosonographers:

What is the best way to access this lymph node for biopsy?

There appears to be two potential routes, transduodenal and transcolonic and are shown in Figure 2. The transduodenal approach would be more difficult, but this biopsy would seem to be less likely to become infected. The transcolonic route might be impossible if the colon was too tortuous. Therefore, the patient received a full colonic preparation, and an attempt was made to access the node from the transduodenal approach. But, as shown in Figure 3, visualization of the mass could not be accomplished.

The transcolonic approach was therefore performed. Figure 4 shows the mass at the level of the aortic bifurcation, and Figure 5 shows a needle entering the lesion. Cytology revealed atypical cells, consistent with metastatic bladder carcinoma.

The patient tolerated the procedure well without complication.

Conclusion

As EUS becomes more and more commonly utilized, endosonographers are being called upon to attempt biopsies in unusual and difficult to access locations. Anatomic considerations become crucial when these types of biopsies are performed. Digital anatomy resources are particularly useful when planning biopsies, and can provide alternative routes of obtaining tissue when a primary attempt is unsuccessful.

Endoscopy at United Kingdom's Nottingham Digestive Diseases Centre

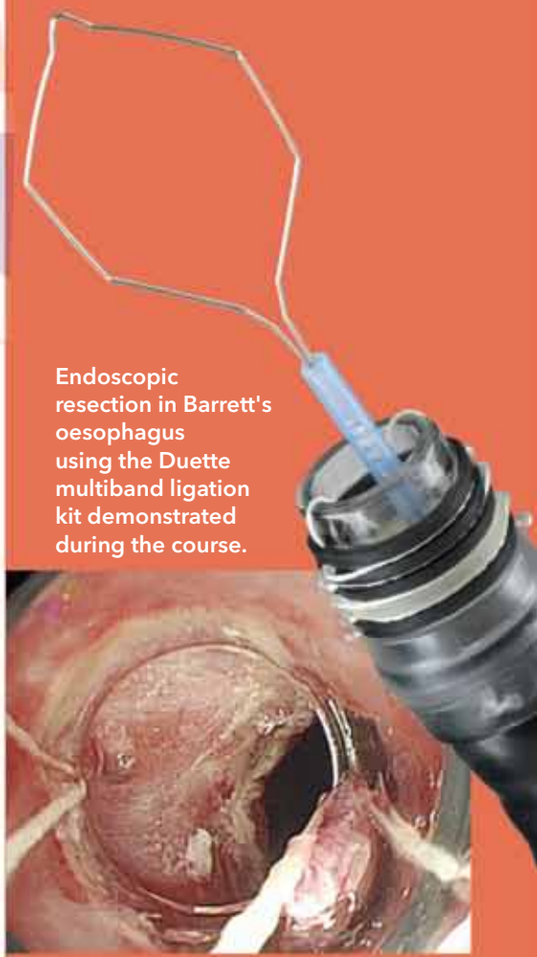
The Nottingham Digestive Diseases Centre (NDDC) is the academic division of Gastroenterology and GI Surgery based at the Queen's Medical Centre campus of the Nottingham University Hospitals (NUH) NHS (National Health Service) Trust. It is one of the largest integrated GI and liver research groupings in the UK. In 2008, the NDDC in partnership with NUH was awarded a Biomedical Research Unit worth £ 7.2 million by the National Institute of Health Research.

NDDC focuses in GI cancer pathogenesis and prevention, particularly colon and upper GI cancers, inflammatory bowel disease, Helicobacter pylori, aspirin/NSAID damage, peptic ulceration, neurogastroenterology and irritable bowel syndrome, GI infections, surgical sepsis and wound infection, pancreatitis, viral hepatitis, and fatty liver. In addition, NDDC has a special interest in endoscopy research with a particular emphasis in advanced endoscopic imaging modalities—including endoscopic ultrasound (EUS), zoom endoscopy, narrow band imaging (NBI), autofluorescence imaging (AFI)—and their application in the diagnosis and treatment of early GI neoplasia.

During the past years NDDC, thanks to the guidance and continuous efforts of Dr. Krish Ragunath (Associate Professor and Reader in GI Endoscopy), has managed to organize a number of highly informative courses focusing on advanced endoscopic imaging and minimally invasive endoscopic management of Barrett's oesophagus and early oesophageal cancer.

In June 2010, Dr. Ragunath successfully organized another state-of-the-art, hands-on course with a faculty panel of national and international experts in the field of Barrett's, which took place at the Postgraduate Medical Education Centre in Queen's Medical Centre. The course included lectures, live and video demonstrations and hands-on training in currently available endoscopic resection techniques and radiofrequency ablation for the treatment of early Barrett's neoplasia. Cook Medical, BARRX Medical Inc. and Olympus-Keymed kindly supported this event, which was attended by physicians from across the UK.

NDDC is dedicated in providing trainees and young GI professionals the means and guidance to carry out innovative research in the field of gastroenterology, hepatology and endoscopy. Many of NDDC trainees have received worldwide recognition of their research work and their contribution in advancing our knowledge of GI diseases. Recently, NDDC research fellow Dr. Jayan Mannath (pictured with ASGE president Dr. Jacques Van Dam) was awarded the ASGE Cook Medical Marsha Dreyer Award for submitting an outstanding scientific abstract by an international trainee at Digestive Disease Week 2010. Dr. Mannath was recognized at the 2010 Crystal Awards ceremony, which took place during DDW in May 2010.



Endoscopic resection in Barrett's oesophagus using the Duette multiband ligation kit demonstrated during the course.

Dr. Ragunath during a live endoscopy demonstration.

Dr. Ragunath teaching in one of the endoscopy courses held in Nottingham.

Selective Cannulation with

COOK® MEDICAL

Fusion® LoopTip™ WIRE GUIDE

for Billroth II Patients

TWO CASE STUDIES

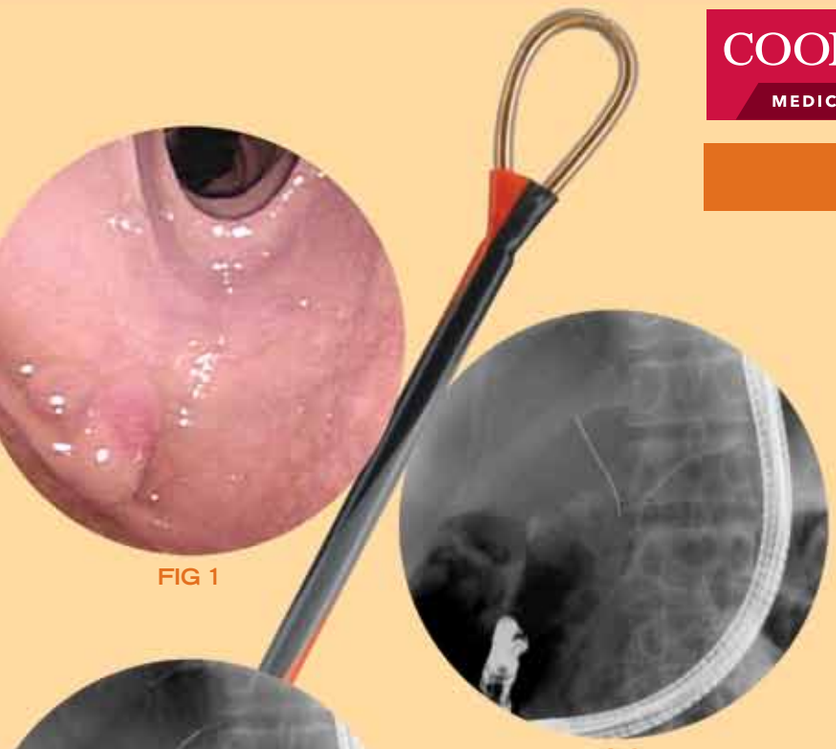


FIG 1

FIG 2

FIG 3

FIG 4

Jeong-Hyeok Kim, MD
Division of Gastroenterology
Hallym University Sacred Heart Hospital

CASE 1

A 72-year-old patient was hospitalized for diagnostic tests when gallbladder masses were found by chance during an abdominal ultrasound scan at the health screening center of our hospital. He had previously undergone a subtotal gastrectomy with a Billroth II procedure in 1990 due to EGC. On the CT image, mild dilatation was observed in the intrahepatic ducts (IHD) and the common bile duct (CBD), and hyperdense stones were observed inside the gallbladder. To find out why there was diffuse dilatation in the IHD and CBD, we performed an ERCP. Consistent with the history of this patient who underwent the Billroth II gastrectomy, we observed that the major papilla was reversed (Fig. 1). We initially attempted cannulation with a traditional standard metal tip catheter, but were only successful in the pancreatic duct.

Since we were not able to cannulate as we intended with other traditional methods, such as using a rotatable sphincterotome and swing-tip catheter, we tried cannulation using the LoopTip Wire Guide. After aligning the wire guide with the axis of the CBD, we were able to cannulate successfully (Fig. 2).

After successful cannulation, we were able to remove the stones using a wire-guided 8-wire Memory basket (Fig. 3 and 4).

Hallym University Medical Center

Hallym University Medical Center (HUMC), one of the largest medical institutions in Korea, consists of five general hospitals and a dental hospital: Hallym University Sacred Heart Hospital; Hangang Sacred Heart Hospital; Kangnam Sacred Heart Hospital, Chuncheon Sacred Heart Hospital; Kangdong Sacred Heart Hospital; and Hallym University Dental Hospital. HUMC operates 3,200 patient beds. Its hospitals have 6,000 employees, including 500 medical professors, who dedicate themselves to enhancing public healthcare and realizing human welfare under the founding principle: "To Become a Cornerstone for Public Health Care, To Practice Medical Services of Love and Equality, and To Pursue the Happiness of All Human Beings."

Since opening its doors in 1999, Hallym University Sacred Heart Hospital (HUSHH) has been offering a full spectrum of primary and specialized medical care. The hospital is known for its excellent medical professionals, quality treatment, the state-of-the-art equipment and many convenient facilities for patients and their family.

With 33 medical departments and about 800 beds, it employs more than 1,500 staff, including 373 full-time physicians and 523 nurses. The hospital also delivers comprehensive care of the highest quality,

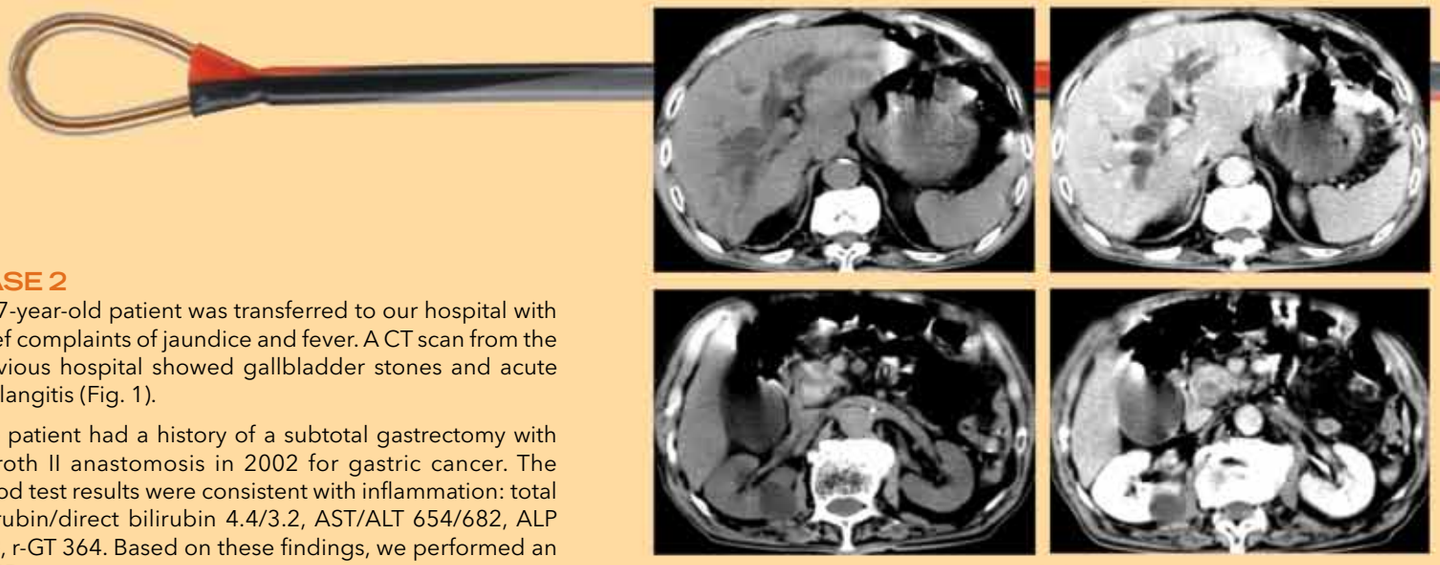


FIG 1

CASE 2

A 77-year-old patient was transferred to our hospital with chief complaints of jaundice and fever. A CT scan from the previous hospital showed gallbladder stones and acute cholangitis (Fig. 1).

The patient had a history of a subtotal gastrectomy with Billroth II anastomosis in 2002 for gastric cancer. The blood test results were consistent with inflammation: total bilirubin/direct bilirubin 4.4/3.2, AST/ALT 654/682, ALP 578, r-GT 364. Based on these findings, we performed an ERCP.

The CT images demonstrated dilatation of the intrahepatic ducts, the gallbladder, and the CBD, as well as CBD stones with high density. As in Case #1, the major papilla was reversed and was exuding whitish pus (Fig. 2).

In this case, we used a LoopTip Wire Guide for our initial attempt at cannulation and were able to succeed without difficulty. This cannulation allowed us to verify the size and quantity of the stones with contrast, using a standard ERCP catheter, and to remove the stones by performing a sphincterotomy and sphincteroplasty (Fig. 3).

FIG 2

FIG 3

CONCLUSION

Traditional wire guides are manufactured with a flexible tip, which can make it difficult to attempt wire-guided cannulation. However, the Fusion LoopTip wire guide has a closed loop, so that it does not damage tissue. In addition, the wire below the loop is sufficiently stiff to support the loop and maintains a straight axis. Therefore, we believe that the Fusion LoopTip wire guide is effective in patients who have previously undergone any operation leading to a reversed major papilla (e.g., Billroth II anastomosis or Roux-en-Y anastomosis), as well as in normal cannulation cases.

operating specialized centers including centers for stroke, cardiology, and breast and endocrine disease. To provide customized medical care, it uses a multidisciplinary approach.

The hospital is equipped with its digitalized systems, such as OCS (Order Communication System), EMR (Electronic Medical Records) and PACS (Picture Archiving and Communication System). Its cutting-edge technologies include CT, MRI, navigator, angiography and PET-CT and cyclotron.

The stroke center is renowned for its outstanding treatment services. In 2009, the hospital was designated as a specialized medical center for severe trauma patients by the Ministry for Health, Welfare and Family Affairs.

The Division of Gastroenterology and Hepatology specializes in the full range of diagnosis and treatment of diseases in the digestive tract and liver, such as functional gastrointestinal disorders, peptic ulcer, pancreatitis, cholelithiasis, hepatitis, gastric cancer, colon cancer, rectal cancer and liver cancer.

The division offers state-of-the-art diagnostic services using upper gastrointestinal endoscopy, colonoscopy, cholangiopancreatography, pathological tests, ultrasonography, CT and MRI.

Highly advanced endoscopic procedures performed in the division include endoscopic hemostasis for bleeding gastroduodenal ulcer and esophageal varix, colon polypectomy, resection for early gastric cancer, removal of pancreatic duct stones, cholelithotomy and pancreatic drainage.

Experienced specialists in gastroenterology and hepatology operate multiple subspecialty clinics for liver, intractable gastroenterology, 24-hour therapeutic endoscopy, digestive motility, constipation, gastrointestinal cancer and gallbladder-pancreas.

Advances in Therapeutic Endoscopy

A Live Endoscopy Course

Abhijit Kulkarni, MD

Gastroenterologists, surgeons, endoscopy RNs and technicians gathered on Friday, November 5, 2010 in the Magovern Conference Center at Allegheny General Hospital (AGH) in Pittsburgh to advance their techniques and knowledge in therapeutic endoscopy.

The conference, "Advances in Therapeutic Endoscopy: A Live Endoscopy Course," explored the most current developments in therapeutic endoscopy with special attention to pancreatic-biliary procedures. Using didactic sessions and live feeds, the latest techniques in gastroenterology procedures were showcased and the audience was allowed to interact with the faculty.

AGH's Division of Gastroenterology sponsored the conference and faculty included AGH staff members, including: course director Abhijit Kulkarni, MD; Katie Farah, MD; Marcia Mitre, MD; Shyam Thakkar, MD; Manish K. Dhawan, MD and Pam Nero, RN.

Conference participants came away from the event having learned how to: utilize endoscopic ultrasound in the diagnosis and treatment of gastroenterology and pancreaticobiliary disease and evaluate the role of exploratory cholangioscopy in the management of pancreaticobiliary disease.

CONVENIENT
COST-EFFECTIVE
OPTION

Colonoscopy AND THREE-QUADRANT Hemorrhoidal Ligation

In 2005, Cook released ShortShot® Hemorrhoidal Multi-band Ligator with TriView® Anoscope as a new and innovative non-surgical treatment for internal hemorrhoids. Since then, the procedure has been increasingly performed at the same setting as colonoscopy, and has evolved into one of the most convenient and cost-effective GI procedures available. The ShortShot/TriView combination also allows all three internal hemorrhoids to be ligated simultaneously, avoiding the need for multiple procedures, which was necessary with conventional single hemorrhoidal ligation.

More than 2 million colonoscopies are performed in the US every year. Most non-screening colonoscopies are performed to identify the source of rectal bleeding, and in 90% of cases, internal hemorrhoids are identified as the source. Prior to the ShortShot with TriView Anoscope, there were few readily available options to treat bleeding internal hemorrhoids at the time of colonoscopies. Sometimes, GI staff would attempt to locate an old, non-disposable McGivney Ligator Kit, but more often than not, it could not be found, or if located, a key component would be missing.

The development of the disposable ShortShot with TriView Anoscope has provided a readily available, convenient and cost-effective option to treat internal hemorrhoids at the same setting as colonoscopy. As testament to the popularity of this new procedure, Dr. David N. Armstrong has performed over 1,000 cases of colonoscopy and three-quadrant hemorrhoidal ligation over the last five years. Of his 1,123 cases, 93% of patients reported complete resolution of their symptoms after the procedure. Seven percent of patients required a second ligation, and three patients required a third ligation. There were no complications in any of the cases he performed, and importantly, there were no instances of post-ligation hemorrhage or sepsis.

A sensible precaution prior to performing the procedure is to instruct patients to avoid aspirin or other anticoagulants for 7-10 days before and after the procedure to eliminate the risk of post-ligation hemorrhage. Additionally, immunosupressed patients are offered other forms of hemorrhoidal treatment to minimize the risk of sepsis.

Patients are quick to recognize the convenience of performing both procedures simultaneously, which minimizes discomfort, time off work and inconvenience. For the physician, the availability of a disposable hemorrhoidal ligator in the GI lab provides a simpler, easier and more effective option for treating internal hemorrhoids in a timely and cost effective manner.

David N. Armstrong, MD, FRCS, FACS, FASCRS
Director Georgia Colon and Rectal Surgical Clinic
Atlanta, GA

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Captura's smooth coated sheath enhances passage through the scope, while the ergonomic, color-coded handle provides ease of use and quick identification of device length. The stainless steel serrated edge cups are fenestrated for tissue acquisition and have exceptional jaw strength – facilitate a viable pathological sample, key to any successful biopsy. This device is disposable eliminating cleaning and reprocessing.

Order Number	GPN	Description	Shaft Length	Scope	Color Code	Qty
DBF-3.3SM-160-S	G54166	Non-spiked with 3.3 mm cup diameter	160 cm	Gastroscope	Green	Multiples of 10
DBF-3.3SM-160-20-S	G56054	Non-spiked with 3.3 mm cup diameter	160 cm	Gastroscope	Green	Multiples of 20
DBF-3.3SM-160SP-S	G54168	Spiked with 3.3 mm cup diameter	160 cm	Gastroscope	Green	Multiples of 10
DBF-3.3SM-160SP-20-S	G56053	Spiked with 3.3 mm cup diameter	160 cm	Gastroscope	Green	Multiples of 20
DBF-3.3SM-230-S	G54167	Non-spiked with 3.3 mm cup diameter	230 cm	Colonoscope	Red	Multiples of 10
DBF-3.3SM-230-20-S	G56058	Non-spiked with 3.3 mm cup diameter	230 cm	Colonoscope	Red	Multiples of 20
DBF-3.3SM-230SP-S	G54170	Spiked with 3.3 mm cup diameter	230 cm	Colonoscope	Red	Multiples of 10
DBF-3.3SM-230SP-20-S	G56055	Spiked with 3.3 mm cup diameter	230 cm	Colonoscope	Red	Multiples of 20
DBF-3.3SM-230SP-40-S	G56060	Spiked with 3.3 mm cup diameter	230 cm	Colonoscope	Red	Multiples of 40

Minimum accessory channel 3.8 mm.

NEWS FROM

SIGNEA
Society of International Gastroenterological Nurses and Endoscopy Associates

SGNA Recognizes Norah Connelly

This past May, SIGNEA attended the SGNA Annual Education Course in Orlando, Florida as we do every May. However, this past meeting had special meaning for SIGNEA. Our Immediate Past President, Norah Connelly, was bestowed with the "Distinguished Service Award". Norah was nominated for this prestigious award by then SGNA President, Terri Vos. The Distinguished Service Award recognizes an individual's contributions and services in the following areas:

Exhibits service and leadership to the society on a national and regional level

Contributes to the growth of the organization

Contributes to education programs and publications of the society

Actively promotes the society and specialty in public service, legislation and community involvement

Supports certification and the specialty of gastroenterology nursing

In Terri's nomination she states "that for over 30 years, Norah Connelly's dedication and endless energy has helped guide the way in advancing our society and its mission. Norah has a familiar and respected presence. Her knowledge and expertise has been invaluable in the supporting the role of nursing and the care of the GI patient. From its earliest age, Norah supported national certification from its early days and the need for professional development. She served from 1994-95 as President of then Certifying Board of Gastroenterology Nurses and Associates. For the past 4 years, Norah has served as President of SIGNEA. She was one of three individual international course directors for the GI Nurse 2009 Education Meeting that was held in conjunction with the World Congresses of Gastroenterology in London this past November. SGNA was well represented and Norah played a notable role in guiding SGNA's entry into the international arena. Norah has now begun a four year Past President's term with SIGNEA. We know Norah will continue to spread the mission of SGNA to our colleagues throughout the world. Through Norah's commitment to SGNA and those we continue to serve, she continues to promote the voice of the GI nurse and associate within the patient care team."

In 1994, SGNA awarded Norah the "Gabrielle Schindler Award for Clinical Excellence". To date, Norah and Doris Barnie are the only two nurses to have been awarded both the "Distinguished Service Award" and the "Gabrielle Schindler Award for Clinical Excellence". We at SIGNEA are extremely proud to be able to call Norah one of our own and look forward to Norah's continued accomplishments. Congratulations Norah!

NEWS FROM
SIGNEA
Society of International Gastroenterological Nurses and Endoscopy Associates

Two cases of FOREIGN BODIES

Is it detecting something new?

Oleg Poniatoff, M.D., Andrey Zaynullin, M.D., Batyr Sahatov, Ph.D., Alexander Muravenko, Ph.D.
GI-Endoscopy department, Niazov Treatment and Consulting Centre, Ashgabat, Turkmenistan

ABSTRACT

Background: We have previously shown that diagnosis and treatment of foreign bodies (FB) is challenging. The "foreign body" syndrome is similar to esophageal dysmotility.

Two persons diagnosed with unusual Barrett's Esophagus (BE), who appeared in GI Endoscopy department mimicking foreign body syndrome. Despite the experience of FB, no study has described the composition of globus sensation (GS), whether esophageal feeling should be considered in the differential diagnosis.

Objective: To describe and quantify the endoscopic findings, to report our experience and outcome in the management of esophageal foreign body (FB) sensation in Turkmen patients.

Design: Observational case series.

Setting: Tertiary-care center.

Patients: One adult and one child diagnosed with foreign body (FB) sensation in the esophagus.

Interventions: All patients underwent endoscopic procedures after admission.

Main Outcome Measurement: Clinical resolution, types of Barrett's esophagus (BE) and associated upper-GI diseases.

Results: Upper endoscopy (UE) was performed successfully in all patients. Rapid improvement in the differential diagnosis of FB sensation in the esophagus.

Limitations: Small sample size, single center experience.

Conclusion: To our knowledge, this is the first report with esophageal pictures and the largest series that studied endoscopic management of globus sensation (GS) in Turkmenistan, Central Asia region. We emphasize that esophageal FB sensation may have been erroneously diagnosed as an esophageal foreign body.

The following two cases report on the pathological diagnosis of gastric polyp with intestinal metaplasia and corresponded well to the characteristic features of atypical manifestation, which interferes with the differential diagnostics of foreign body syndrome.

CASE 1

A 10-year-old patient suffered from FB sensation in the esophagus, intermittent abdominal pain and was admitted to our department. The patient reported an increasing frequency and duration of FB sensation which was independent from food intake or physical exercises. A gastrointestinal barium study was performed and neither abnormal gastric emptying nor intestinal transit was found. Physical examination was unremarkable. An upper endoscopy (UE) was performed for the diagnosis of a foreign body. Topical pharyngeal anesthesia was very well tolerated for the patient. A relevant endoscopic finding was detected. Upon the UE examination, the distal aspect of the esophagus was inflamed, and fiberoptic endoscopy confirmed the presence of an intramural polypoid reaching to the cardia. The rise of the gastric folds indicated the end of the tubular esophagus, and was rigid toward polypoid (Fig. 1). The bland polyp was found just above the squamo-columnar junction in the esophagus by air insufflation. The tumor was completely covered with mucosa. Endoscopic gastric-type mucosa above the level of the rise of the gastric folds is termed "endoscopically visible columnar-lined esophagus" (CLE). Additionally, a small hiatal hernia (HH) was seen.

The patient had a severe atrophic corpus as well as antral gastritis. Helicobacter pylori (HP) titers declined to normal levels.

CASE 2

The second case involved a 36-year-old patient with a medical history significant for foreign body syndrome (FB) was evaluated in the emergency department because of a sudden onset of FB sensation in the esophagus after eating sturgeon. The patient had no history of weight loss, change in bowel habits or excessive alcohol consumption. Clinical examination was unremarkable. Biochemistry revealed high level of cholesterol, total 215 mg/dL (normal, 150-200 mg/dL). The patient underwent an X-ray examination for a suspicion of FB in GI tract. X-ray films of the esophagus and stomach did not show any pathological findings. During an upper endoscopy (UE), a polypoid lesion, which measured 4 mm in dimension, was located 34 cm from the incisor teeth. In this patient, the UE findings corresponded well to the endoscopically characteristics of CLE (endoscopically visible columnar-line esophagus) and polypoid lesion as presented in the previous report. In addition to the above mentioned endoscopic findings, the diagnosis in the previous report was a great help.

Presence of a hiatal hernia and reflux alteration of the esophageal mucosa was observed. Inflammation of esophageal mucosa was assessed according to the Los Angeles Classification. The endoscopic diagnoses were the following: Barrett's esophagus-associated non-erosive gastro-esophageal reflux disease (GERD), esophageal polyp, hiatal hernia and erosive pyloritis. Biopsy specimens were obtained from the endoscopically visible CLE and the polypoid lesion of the esophagus. The pathology results revealed leukoplakia, infiltration of lymphocytes, vascular degeneration of the epithelial cells, and proliferation of glandular cells, but no cell atypism was observed.

H. pylori was assessed by serologic and rapid-helicobacter-urease-test (Hut-Test) evaluation, which confirmed activity of corpus and antral gastritis.

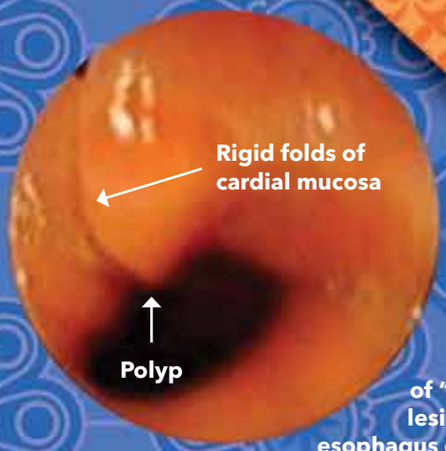

Figure 1

Endocopic view of "bland polypoid lesion" in the distal esophagus of a 10-year-old patient with chronic gastro-esophageal reflux, small hiatal hernia and short-segment Barrett's disease.

Figure 2

Case 1 is located in Turkmenabat.

Case 2 is located in Ashghabat.

DISCUSSION

Gastro-esophageal reflux disease, Helicobacter Pylori and Barrett's esophagus are risk factors for adenocarcenoma, and the incidence is increasing. Esophageal adenocarcenoma (EAC) may develop from Barrett's esophagus, a metaplastic change of the esophageal epithelium from squamous to intestinalized columnar and gastric mucosa, which is associated with chronic reflux. According to Holly and Mellinger, leukoplakia is known to occur in the mucous membranes of the body, including those of the urinary tract, rectum, vagina, uterus, vulva, para-nasal sinuses, gallbladder, esophagus, eardrums and pharynx. Esophageal and oral leukoplakia is not a rare finding in Turkmenistan. Upper endoscopy of the esophageal mucosa frequently shows tiny white patches, termed leukoplakia indicating "white plaque". Multiple theories have been postulated for the cause of leukoplakia. Currently, the clinical term "leukoplakia" is thought to causing squamous metaplasia or small round foci of epithelial hyperplasia. Such damage is visible by endoscopy and if unchecked can in some cases lead to a precancerous condition known as Barrett's esophagus and thence to esophageal cancer. In our experience, the upper endoscopy demonstrated Barrett's esophagus, hiatal hernia and the polypoid lesions. Leukoplakia diagnosis was done by endoscopic biopsy. Endoscopic findings and pathologic report for these cases were compared with the preliminary report of globus sensation.

This manifestation of globus sensation has consistently been observed in patients from various provinces of Turkmenistan (Fig. 2). We could not exclude the possibility that Helicobacter Pylori and GERD by themselves increase the chance for the development of globus sensation. It could be considered that the globus sensation might be an early symptomatic mechanism in the genesis of pre-neoplastic related alteration in the metaplasia-dysplasia-EAC, as many unanswered questions are still remaining regarding an appropriate approach to this diagnosis.

These cases are presented with a particular focus on the problems associated with globus sensation as mimicking a foreign body sensation. We emphasize that esophageal FB sensation may have been erroneously diagnosed as an esophageal foreign body.

Generally it may be assumed that globus sensation is a condition which unites all the above-mentioned disorders. Future studies should determine and examine whether the globus sensation will be an alarm symptom of esophageal cancerogenesis.

DISCLOSURE

The authors have no commercial association that might be a conflict of interest in relation to this article.

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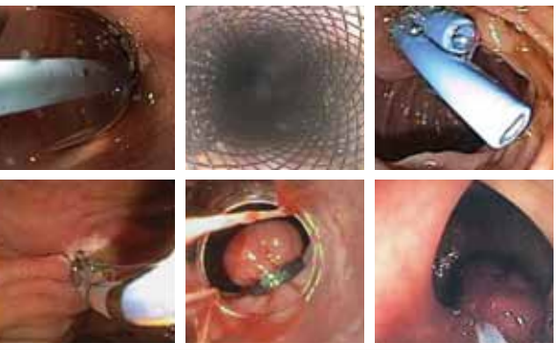
GI 360

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

Updates in Esophageal Cancer with Focus on Diagnosis and Palliation

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.

HealthStream® COOK® MEDICAL

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

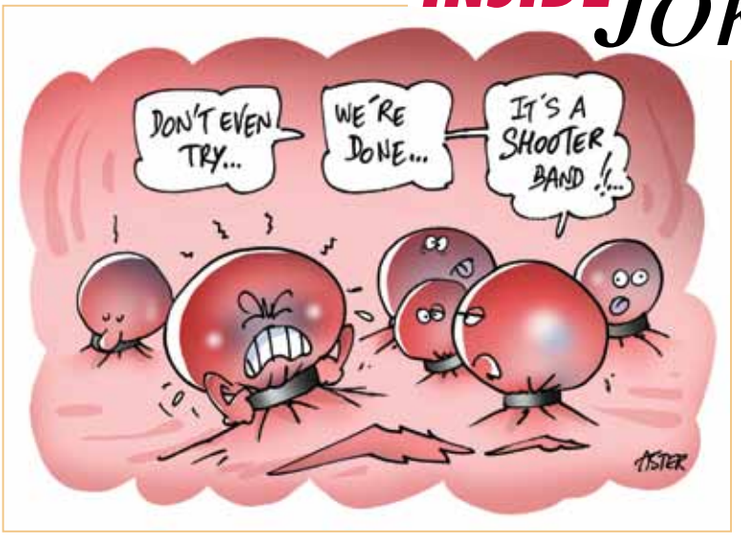
UPCOMING EVENTS

Endoclub Nord	Hamburg, Germany	**Nov. 5-6**
Fellows ERCP Workshop - Northwest Community Hospital	Arlington Heights, IL	**Nov. 5-6**
Wisconsin SGNA	LaCrosse, WI	**Nov. 5-6**
Maine SGNA	Portland, ME	**Nov. 6**
University California Irvine - ERCP Course	Orange, CA	**Nov. 9-10**
30th National Gastroenterology Congress (Concert Hall of Athens)	Athens, Greece	**Nov. 11-14**
North Coast SGNA	Mayfield Heights, OH	**Nov. 13**
University California Irvine - EUS Course	Orange, CA	**Nov. 16-17**
New England SGNA	Burlington, MA	**Nov. 20**
Indiana University ERCP Workshop - Nurses	Indianapolis, IN	**Dec. 2-3**
25th International Workshop on Therapeutic Endoscopy	Hong Kong, China	**Dec. 7-9**
University California Irvine - ERCP Course	Orange, CA	**Dec. 14-15**
New York Society Gastroenterology Endoscopy	New York, NY	**Dec. 15-18**

2011

Pancreatic & Biliary Endoscopy - Simon Lo	Los Angeles, CA	**Jan 28-30**
Rocky Mountain Interventional Endoscopy Course	Denver, CO	**Feb. 16-18**
3rd Annual Interventional Endoscopy Course for GI Nurses & Tech's	Las Vegas, NV	**Feb. 25-27**
Digestive Disease Week	Chicago, IL	**May 8-10**
Society of Gastroenterology Nurses & Associates	Indianapolis, IN	**May 8-10**

INSIDE Joke



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