

From Revolution to Evolution

Perhaps the greatest "power of Fusion" is its staying power

Even though Fusion™ – the revolutionary integrated ERCP system – was ahead of its time, almost from its inception the focus shifted from revolution to evolution. Being ahead of the times is one thing, staying ahead is quite another.

But that is Cook Medical's mission. Now, three years after the initial launch, a "third" generation of Fusion devices has been created to meet the needs of practitioners and researchers alike.

In the beginning

The first intraductal exchange (IDE) was performed on an anatomical model in Cook's laboratory in 2003 – the "power of Fusion" was born. It was a revolutionary moment, bringing new options to procedure rooms everywhere.

The key to the Fusion system is its capability to quickly gain and securely maintain wire guide access. This exceptional wire guide security created new opportunities for procedural success for everything from sphincterotomies and extractions to dilations and cytological sampling.

But perhaps nowhere was this capability more groundbreaking than in plastic stenting procedures. With Fusion, plastic stents could be accurately repositioned or removed while maintaining ductal access with a secure wire guide. And for the first time – with IDE – clinicians could place multiple stents with one cannulation.

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FROM REVOLUTION TO EVOLUTION

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A Big Addition to a Growing Product Line

In our continuing effort to help you achieve exceptional ductal access, we created the Fusion™ OMNI-TOME 21, Cook Endoscopy's first triple-lumen sphincterotome on a .021" wire guide platform. The fully functional wire guide lumen, completely independent from the contrast lumen, facilitates the use of smaller standard or completely hydrophilic wire guides when needed.

This new sphincterotome features a 5.5 FR catheter design with a smaller, more flexible DomeTip™. The slimmer catheter paired with the smooth, potentially less-traumatic DomeTip shape makes the OMNI-TOME 21 an ideal choice for your most difficult cannulations.

Orientation is also an important factor in gaining access during sphincterotomy. That's why every OMNI-TOME 21 comes with our patented 3-D forming wire. The unique forming wire preserves optimal tip shape during shipping and storage, assuring excellent orientation during the procedure.

Another hallmark of Fusion devices is control, and the OMNI-TOME 21 is no exception. It features the revolutionary breakthrough channel that allows the wire guide to be controlled by either the physician or assistant. The assistant will appreciate the superb handle memory when multi-tasking between contrast injection and wire guide management. Also, when transitioning to your next device of choice, because of the smaller platform and wire guide, the ZIP exchange is even easier to perform.

The Fusion OMNI-TOME 21 will be offered preloaded or non-preloaded, giving you options to best meet your patient's clinical needs.

FROM REVOLUTION TO EVOLUTION

Continued from page 1

Responding to feedback

Once Fusion was in the hands of more and more practicing thought leaders and researchers around the world, Cook actively solicited their feedback, identifying new opportunities and new ways to continually advance the Fusion line. As data came in, engineers responded by making Fusion the ERCP system that fulfills the needs of clinicians and patients.

For instance, within the first year of launch, the pushing catheter of the Fusion OASIS® was reinforced to add greater stability and control. The new OASIS inspires increased confidence not only during routine procedures but also during more complex multiple stenting.

When clinicians told Cook they wanted Fusion devices with complete wire guide compatibility, the company answered with OMNI™. OMNI's unique Breakthrough Channel™ allows a wire guide (of any length or diameter) and catheter to separate, and the wire can then be manipulated by either the assistant or the physician.

Since physicians want safer and more efficient ductal access, Cook soon fitted all Fusion OMNI devices with the contoured DomeTip. By replacing the "flat" distal tip of conventional cannulating devices with a smooth, rounded surface, the DomeTip navigates more smoothly through the papilla and fronds and opens up the potential for faster and less traumatic access during cannulation.

The evolution continues

Applying what was learned from earlier Fusion generations, the company incorporated their own research and the feedback from Fusion users everywhere. This latest generation of Fusion devices is aimed at those doing advanced interventional ERCP.

One prevalent issue Cook identified was the importance of gaining access during difficult cannulations. In seeking a viable solution, engineers worked with slimmer catheter designs and developed the Fusion OMNI-TOME 21, the company's first triple-lumen sphincterotome on a .021" wire guide platform. At the distal end of the device, a smaller, more flexible DomeTip assists clinicians in accessing challenging anatomical configurations that larger devices cannot navigate effectively.

In the quest for a high-performance extraction balloon, the objective was to build a multi-staging device with increased stability and responsiveness during multiple balloon sweeps. The result is the Fusion Quattro, which inflates to four distinct diameters and has a new, stiffer catheter for better pushability.

Another challenging project is the Fusion Lithotripsy Compatible Extraction Basket. Now, when routine extractions become more difficult lithotripsy cases, clinicians can convert quickly to mechanical lithotripsy mode and not lose endoscopic visualization.

Future generations

Evolution requires a commitment to continuous improvement, responding to new opportunities, discovering new ways of thinking. As the field of interventional endoscopy evolves, Fusion will continue to evolve with it. Whatever the future holds, Cook is making sure that the Fusion will be a part of it.

The Endoscopic Management of

Barrett's Dysplasia

A Master Class on Resection & Ablation

By Martine Kinsman

The Cook UK team held their first master class on Barrett's Dysplasia at Gloucestershire Royal Hospital on June 5, 2007. The day was hosted by Professor Hugh Barr, Consultant General and Upper GI Surgeon, in Redwood House, the hospital's medical centre.

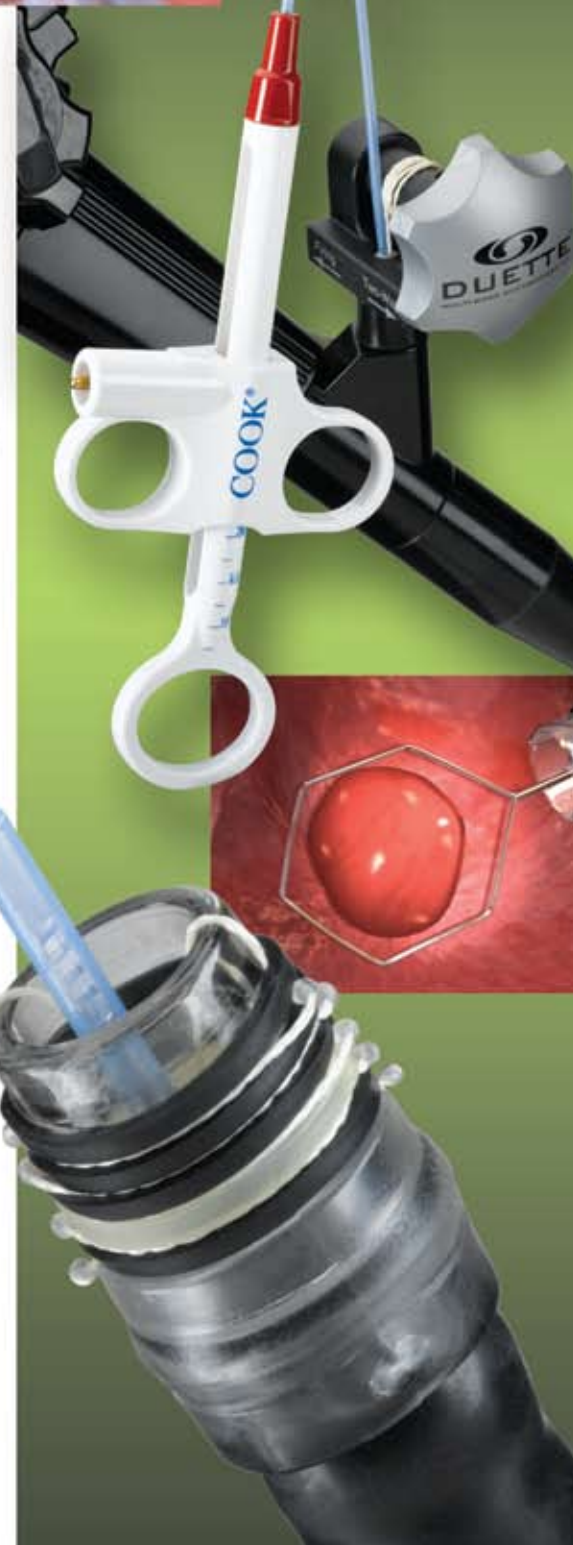
Professor Barr has published over 100 papers in peer-reviewed journals and 22 book chapters. His major interest is in the early optical detection and early treatment of disease, in particular related to Barrett's Oesophagus.

The aim of the day was to raise awareness of resection techniques in the upper gastrointestinal tract and to raise the profile of the Duette®, Cook's Multi-Band Mucosectomy device. The event was very well attended by doctors, specialist nurses and surgeons – all with an interest in Barrett's Oesophagus.

The morning consisted of lectures from eminent physicians and surgeons, covering Mucosal Ablation and EMR for Barrett's, Practical Techniques of EMR, and the Use of Capsule EMR, Histopathology of EMR and Quality Control and Minimally Invasive Oesophagectomy. The afternoon provided an opportunity to observe live cases and to have hands-on time with the Duette and Argon Beam Therapy. The day was rounded off with a question and answer session, where all delegates were issued an evaluation form.

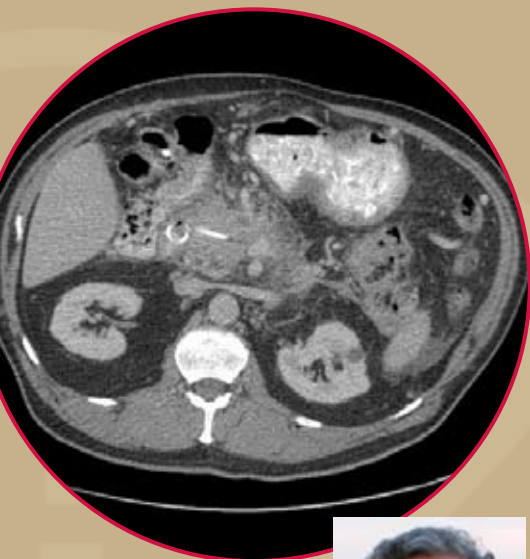
The organizers were very pleased with the feedback provided by the delegates, which was positive and constructive. The majority of comments received suggested that a greater opportunity to observe live cases would be useful with the opportunity to question the experts. It was also suggested to take this course further and develop it into an EMR training day for doctors to learn resection techniques and practice on pig models.

Due to the phenomenal response to this course, the UK team hopes to make this an annual event and will act on the feedback received to make the next one even more successful.



What's Up DOC?

Welcome to a new section in The Channel where we present a clinical image and ask you to participate.



Dr John Baillie

The figure above is an abdominal CT scan performed in a patient who recently underwent ERCP with endoscopic ampullectomy (removal of an adenoma of the duodenal papilla). A technique was employed to reduce risk of post-ERCP pancreatitis? What was this technique?

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 to expand this column 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

Celebrating Clinical

What might the "Wizard of Menlo Park," James Bond's "Q," and Cook have in common? Aspects of their respectively unique contributions and expertise regarding "inventorship" and its culture came together for an interesting evening at the International Spy Museum in Washington, DC during Digestive Disease Week. This special forum celebrated some of the most distinguished and innovative device inventions and expert clinical relationships in the 25 year history of Cook Endoscopy.

Thomas Edison, the "Wizard of Menlo Park" and one of the world's most renowned inventors, would have undoubtedly appreciated the dedication and commitment of the clinical device innovators honored during the evening for their abilities to accurately define a patient problem and to create the appropriate solution. Edison, famous as the inventor of the electric light, successfully identified the involved challenge when he realized that the major dilemma he faced was how to efficiently deliver electricity as a commodity in a usable medium for average consumer use.¹

Physicians face similar creative challenges in that they must suggest the device solution that addresses the right problem for a majority of patients while working safely, effectively, and efficiently in the hands of the interventionalist. Guests of the International Spy Museum event learned more about such clinical ingenuity in a video documentary in which many expert endoscopists and pioneers of the subspecialty described how they defined a clinical challenge and worked with Cook Endoscopy to resolve it.

Now what about the "Q" connection? Where would "Bond, James Bond" be without "Q"? The character's name is shortened from "Quartermaster" which was taken from the real title of the supplier of British Secret Intelligence.² The fictional Mr. Bond and his Q-supplied gadgetry have a presence in the International Spy Museum

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Ingenuity

alongside the “real” spies of history, many of whom changed the world as we know it, with their risk-taking spirit and daring commitment to pursue their exploits and further a cause or to aid others.

Such risk-taking commitment empowers the spirit of clinical ingenuity as well and works for the advancement of the technologies and devices needed to resolve the industry’s continuing challenges. The evening’s panel discussion, moderated by Dr. Baron and featuring Drs. Sherman and Haber and Professors Cotton and



Fockens, focused on some of the current clinical needs facing endoscopists, the changing business environment created by quality outcomes monitoring and pay-for-performance, as well as how endoscopic ultrasound and ERCP technologies are interacting to enhance the care delivery options and interventional capabilities of the endoscopist.

In wrapping up the evening, Kem Hawkins, Cook Incorporated President and CEO, provided the event attendees with news

CELEBRATING CLINICAL INGENUITY

Continued on page 13



Photographs courtesy of the International Spy Museum

Suction ^{vs} Forcep

band ligation for hemorrhoid treatment a prospective, randomized study



Objective: This is a prospective, randomized clinical trial to compare the efficacy and safety of hemorrhoid band ligation with either the suction elastic band ligator or the forcep ligator.

Methods: Forty consecutive patients with second- and third-degree hemorrhoids presenting between October 2005 and May 2006 were randomized to receive either suction (group A) or forcep (group B) rubber band ligation. Eradication after one or more ligation sessions, discomfort and pain, work-days lost, and rate of complications were assessed at 15 days and at 6 months of follow up. The pain occurrence within 24 hours after the procedure was assessed using a verbal numeric scale. The amount of analgesics consumed was also noted.

Results: Hemorrhoids were eradicated after only one session in 14 (70%) patients of Group A and in 6 (30%) of Group B ($p < 0.001$). In the remaining patients, further sessions were required. Overall, the mean number of sessions for group A was 1.15 ± 0.4 and 2 ± 1 for group B ($p < 0.005$). Median pain perception at 24 h tended to be worse in group B than in group A (2.5 vs 1 ; $p = 0.5$). The amount of analgesics consumed after banding tended to be lower in group A than in groups B (0.4 tablets vs 1.05 tablets; $p = 0.25$). There was no bleeding during the two procedures. There were no severe complications such as perianal sepsis, urinary retention, sphincter dysfunction or bleeding at 6 month follow up.

Conclusions: Suction band ligation appeared to be superior to forcep ligation for the treatment of second- and third-degree hemorrhoids, being able to eradicate them in most of the patients in only one session. This appears clinically relevant, taking also into consideration that the suction ligation technique may be performed by a single operator.



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Table 1. Demographic and clinical variables for suction ligator (Group A) and forcep ligator (Group B) treatments

	Group A (20 patients)	Group B (20 patients)
Mean age	47.4 \pm 12	51.5 \pm 10
Sex (M/F)	10/10	10/10
Hemorrhoids degree (median, range)	3 (2-3)	2 (2-3)**
Work-days lost	1.75 \pm 0.95	5.3 \pm 3.8*
Post-procedure bleeding	1	0

* $p = 0.06$, ** $p = 0.01$

Large Common Bile Duct Stones

Requiring Mechanical Lithotripsy

A CASE STUDY

COOK
MEDICAL**Fusion™**

LITHOTRIPSY COMPATIBLE EXTRACTION BASKET

A previously healthy 83-year-old male with a history of hypertension, colon polyps and polycythemia vera, presented with symptoms of right upper quadrant (RUQ) pain, fatigue, nausea and vomiting and elevated liver enzymes. Physical examination revealed stable vitals and mild epigastric tenderness. His transaminases showed AST of 375, ALT of 170, Total bilirubin of 4.7 and Alkaline phosphatase of 192. An abdominal CT scan revealed a calcified gallstone in the gallbladder, dilated common bile duct (CBD) and pancreatic ducts.

*Ephraim E. Nsien, MD*

Initially, the patient underwent an endoscopic retrograde cholangiopancreatography (ERCP) under conscious sedation. Upon inspection of the ampullary orifice, there were two large duodenal diverticuli involving the second portion of the duodenum with total obliteration of the ampullary anatomy. Given the altered anatomy, the procedure was unsuccessful and the patient was referred for a percutaneous transhepatic cholangiogram (PTC). Once percutaneous access was achieved, the cholangiogram revealed a markedly dilated CBD to 3 cm, and two calculi measuring 3 cm x 3 cm and 2.4 cm x 1.7 cm. Therefore, the interventional radiologist placed an internal-external stent to aid biliary drainage.

At the second ERCP, a rendezvous procedure with the aid of a previously placed internal stent was used to gain access to the CBD. The previously placed internal-external stent was removed. Cannulation of the CBD was achieved with the Fusion™ OMNI-TOME and a partial sphincterotomy was performed followed by sphincteroplasty with a 10 mm Fusion Biliary Dilation Balloon. The cholangiogram showed the two stones previously mentioned. A Fusion Lithotripsy Basket (3 cm x 6 cm) was used to capture the calculus and with the easy transition to mechanical lithotripsy, successful stone fragmentation was accomplished for both stones. The Fusion Lithotripsy Basket was used multiple times, retaining its shape to effectively complete lithotripsy. Next, the Fusion Quattro™ XL Extraction Balloon

LARGE COMMON BILE DUCT STONES*Continued on page 14*

In Memory of

Marsha Dreyer

November 1, 1936 - September 4, 2007

COOK
MEDICAL

GI SERVICES AT AURORA ST. LUKE'S



More than a quarter century ago, while attending a GI course in Toronto, Joseph E. Geenen, MD, met Don Wilson, an enthusiastic developer of innovative endoscopic equipment. "Don carried the equipment around in the back of his car!" chuckles Dr. Geenen. "He asked if I would help introduce his equipment in the United States. We quickly became friends and collaborated on several pieces of equipment." Endoscopy and technology continued to develop during the late 1980s and 1990s. Geenen continued, "Don Wilson (co-founder of Wilson-Cook, now Cook Medical) was a significant figure in the field of endoscopy and is responsible for the creation of many of the accessories we still use today at Aurora St. Luke's Medical Center, Wisconsin's largest not-for-profit integrated healthcare system."

The St. Luke's GI team, consisting of physicians, nurses, associates, and other health care members, serve a patient population extending from local, national, and international areas and is a worldwide leader in GI endoscopy. This highly skilled endoscopy team collaborates with two large physician groups, GI Associates and Milwaukee Digestive Disease Consultants, as well as other independent physicians. Their goal is to provide evidence-based, quality care for patients with GI disorders.



World-Class Care and GI Education

Dr. Michael Schmalz, Chairman of the Section of Gastroenterology, St. Luke's Medical Center, outlined some of the qualities that make St. Luke's Gastroenterology Department world class:

"Physicians refer difficult cases for gastroenterology to our GI specialists because our physician members are well-published (188 abstracts since 1995), and are thought of as leaders in areas such as pancreatic and biliary disease, manometry, and ultrasound. We have trained more than 70 associates in endoscopic ultrasound and ERCP. These associates have migrated to academic medical centers both national and worldwide, including Australia, Ireland, and France. The result: improved GI care throughout the United States and the world."

Schmalz continues, "Here at St. Luke's, we were the first Wisconsin center to do both Halo ablation procedures on patients diagnosed with Barrett's Esophagus and double-balloon enteroscopy for the treatment of patients with small-bowel disorders. We are also participating in groundbreaking work centering on the diagnosis of cystic neoplasms of the pancreas, using an interdisciplinary approach. In addition, we have a strong affiliation with the University of Wisconsin Medical School. Many of our physicians are on their clinical faculty."

ST. LUKE'S MEDICAL CENTER

Experts in GI Practices Worldwide



Some of the staff of GI Services at ASLMC.

Sue Arndt, RN with patient.

International Conference on EUS

Marc F. Catalano, MD, of GI Associates, has a special interest to create a consensus-based endoscopic ultrasound criteria for diagnosing chronic pancreatitis. "Evaluation is often subjective and controversial despite the often published criteria which may vary symbolically from center to center," he explains. "Further, there is a discrepancy in the number of features of chronic pancreatitis that are necessary to establish the diagnosis. That is why I became involved in organizing a two-day symposium that was held in Chicago in the spring of 2007. At the meeting several European, Japanese, and U.S. experts in endoscopic ultrasound gathered to discuss the controversies centering on the criteria used for the diagnosis of chronic pancreatitis. Our objective was to come to a consensus, focusing on the specifics of such a diagnosis when using endoscopic ultrasound."

Outstanding Patient Care

Patient care remains the top priority in GI Services. Jerome Hanson, MD, of Milwaukee Digestive Disease Consultants, explains the role of the GI physicians in his group: "We are primarily interested in direct, consultative patient care. Some of our specialties include work with a double-balloon enteroscope, ERCP, and small-bowel capsule endoscopy. We have a board certified hepatologist with a special interest in hepatitis C. We also assist in pharmacological research in inflammatory bowel disease and gastroesophageal reflux disease."

"The nurses, associates, and all members of the health care team at St. Luke's are top notch," says Dr. Hanson. "They have the most training and experience of any GI department I've ever worked with. The ongoing training and the experienced and specialized nurses and technical staff make the support staff excellent."

Nursing Programs Define Quality and Competency

Theresa Vos, MS, RN, CGRN, Aurora Metro GI Regional Director, elaborates. "A competent and well-educated team is the center of our program. The staff is dedicated to providing quality patient care based on an understanding of the disease and the treatment options available. They are amazing!" Vos continues, "We are very proud of the many accomplishments of our team. We have held yearly symposiums here at St. Luke's centering on GI-related topics. Our staff members partner with the gastroenterologists to provide a quality educational program for physicians, nurses, and associates. They are very committed to sharing what they know, and patients benefit from their shared knowledge and expertise."

Adds Regional GI Clinical Nurse Specialist Sue Nuccio, APRN, BC, CGRN: "Excellence in nursing care and a shared-governance environment were two key factors in St. Luke's earning the classification of a Magnet Designated Hospital by the American Nurses Credentialing Center. This places us in an elite status among hospitals across the country. The mission of our hospital is to find a better way and that mission is very much alive in our department."

Lead Nurse, Kathy Leistico, RN, BSN, notes that "the physicians collaborate with nurses and associates to monitor current practices and the need to benchmark techniques against national standards. The staff is dedicated to meeting national patient safety goals. This has produced key quality initiatives involving the importance of patient comfort, pain management, infection control, and safety."

"A component of Aurora Health Care's long-term strategy is to employ best practices consistently throughout Aurora. Therefore, education of staff is a priority and supported by leadership," adds Laura Schaefer, MS, RN, CGRN, Supervisor of GI Services at St. Luke's. "I'm proud to say that twelve of our nurses have sought and attained the Certification for Gastroenterology Nurses (CGRN)."

Exporting Excellence

St. Luke's GI Services strives to be a state-of-the-art institution and is dedicated to the continued advancement of technology. One of the more recent lab updates includes the purchase of advanced digital video equipment. Physicians and staff can now videotape endoscopic ultrasound, ERCP, and any other procedures, and instantly edit the procedure adding voiceover commentary if needed.

"With our patients' permission and their privacy assured, we use these videos as teaching aids and send them to conferences and learning centers nationwide. Several have been forwarded to the American Society of Gastroenterologists Learning Center and have been used at educational symposiums for physicians, nurses and associates," notes Dr. Geenen.

What else is on the horizon for St. Luke's? The major focus centers on an interdisciplinary approach to GI care. Research-based care that is supported by quality initiatives, centering on advanced biliary and pancreatic endoscopy, pancreatic cancer, new diagnostic and therapeutic options for small-bowel disease and Barrett's Esophagus, are just a few of the services being developed and offered at Aurora St. Luke's Medical Center in Milwaukee, Wisconsin.

Top Ten Scores

Cynthia Cooperrider, DIPL, RN, CGRN

Alice Gibbs, RN, CGRN

Mary Elizabeth Greenleaf, BSN, RN, CGRN

Kathleen Holt, DIPL, RN, CGRN

Linda K. Holthaus, ADN, RN, CGRN

Mary C. Kilmartin, RN, CGRN

Lory D. Kleinsmith, ADN, RN, CGRN

Linda A. Lawrence, BSN, RN, CGRN

Kathleen Nault, BSN, RN, CGRN

Carol Perrone, MSN, CGRN

Top CGN Score

Vicki Hoebing, LPN, CGN



ABCGN Board of Directors

Front: Suzanne Buchanan, Jenny Parkhurst, Dianna Burns, Nancy Megow, Nancy Eisemon, Rosiland McKeon, Kathryn Miller, Barbara Schwant, Ann Hayes. Back: Sandra Thomas, Gail Steele, Cathy Bolton, Georgette Knoebel, Jeannie Ebbert.

A *New* Name and Look

By Allison Cline and Barb Schwant



The Certifying Board of Gastroenterology Nurses and Associates, Inc. (CBGNA) is now the American Board of Certification for Gastroenterology Nurses (ABCGN). This past year not only produced an external change with a new name and look for ABCGN, but the organization has also transformed through the creation of "membership" for all certificants and the first open elections for the board of directors.

However, the most important task before ABCGN is to offer a valid exam through test question development and exam administration as well as recertification standards. It is only through the maintenance of high standards that ABCGN is able to maintain our own accreditation as well as valuable credentials our certificants hold.

Thank you to all the gastroenterology nurses who have made the commitment to their profession, their patients, and to certification!

A Gala To Remember

ABCGN would like to thank Cook Medical for their continued support of our organization and the ABCGN Annual Gala and Awards Banquet. This year was a wonderful evening, starting off with the Awards Banquet and recognizing the top ten scorers, and top CGN score, for the 2006 exam. Next, Florida's First Coast received the "Outstanding Certified Region Award." This award recognizes the SGNA Regional Society having the highest percentage of members pass the certification exam in 2006. Last, but not least, Laura Strohmeier, RN, CGRN was honored with the GI Professional of the Year Award for her continued commitment to certification and educating the general public.

At this year's Gala, ABCGN also recognized two board members whose terms were ending. Cathy Bolton, RN, CGRN, ABCGN Immediate Past President left the board after serving ABCGN for seven years as did Nancy Megow, RN, CGRN who served as a Director for ABCGN for the past three years. Their dedication, time, and commitment was invaluable to the organization, and we cannot thank them enough for all their efforts throughout their time with the organization.

ABCGN also welcomed their newest board members, Suzanne Buchanan, BSN, RN, CGRN, and Jeannie Ebbert, RN, CGRN. Thank you to all who attended the ABCGN Annual Gala and Awards Banquet, and thanks again to Cook Medical for their continued support of ABCGN and gastroenterology nursing certification.

The Value of Certification

Certification was developed to serve a professional community as a means of self-regulation. Unlike licensure, which sets a minimum requirement for knowledge level and skill sets, certification acknowledges achievement beyond this base

for CBGNA

level of knowledge and ensures continued learning and growth through recertification requirements.

Over the years, certification has moved from an 'internal' professional achievement to a recognized tangible identification of competency. Regulatory agencies such as JCAHO, NAHQ and ANCC are encouraging certification through their standards. Employers are also encouraging certification through increased salary and certification and continuing education reimbursement.

In 2005, ABCGN participated in a research survey, entitled "Value of Certification Survey", through the ABNS (American Board of Nursing Specialties). There were twenty nursing organizations that participated in the survey with a total sample size of approximately 95,000 (including certified nurses, non-certified nurses and nurse managers).

Here are some highlights of the results from ABCGN respondents:

When participants were asked if they agreed/disagreed with the following statements there was an extremely high response of "Strongly Agree" and "Agree" to the following:

99% Certification enhances feelings of personal accomplishment

98% Certification validates specialized knowledge

98% Certification provides personal satisfaction

97% Certification provides a professional challenge

97% Certification indicates professional growth

96% Certification enhances professional credibility

95% Certification provides evidence of professional commitment

92% Certification indicates attainment of practice standards

Overall, the study found high levels of agreement among certified nurses, non-certified nurses and nurse managers that certification is greatly valued. The full results of the survey and in-depth analysis will be published in the GNJ (Gastroenterology Nursing Journal) later this year.

ABCGN 2007-2008 Board of Directors

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Barbara Schwant, BSN, RN, CGRN

Dianna Burns, BS, RN, CGRN

Georgette Knoebel, BSN, RN, CGRN

Jenny Parkhurst, RN, CGRN

Gail Steele, LPN, CGN



President Roz McKeon with
Gala entertainer "Mark"

Scott Sewell,
Vice President,
New Business
Development,
Cook Medical



Excellence in Professionalism Award
Winners (Facilities with 50% of greater
certified nursing staff)



Dr. Whitney Jones
presented
"Colon Cancer
Prevention
Project" at
the ABCGN
Annual Gala

Exploring

NEW FRONTIERS

in Pancreatic Cancer Intervention and Treatment



John G. Lee, MD, Director of Pancreaticobiliary Services, H.H. Chao Comprehensive Digestive Disease Center at the University of California Irvine Medical Center presents "Frontiers in Interventional Endoscopy of Pancreatic Cancer" during SGNA's 34th Annual Course held this year in Baltimore, Maryland. In this continuing education opportunity sponsored by HealthStream with grant funds provided by Cook Endoscopy, Dr. Lee provided the latest information on the incidence, diagnostic methods, and interventional technologies in the management of pancreatic cancer. More than 100 attendees learned more about the benefits of achieving accurate tissue diagnosis, the value of EUS FNA, pain management via celiac plexus block, preoperative stenting and the role of ERCP, as well as chemotherapy and surgical resection options.



Gala Raises for Colon Cancer Screening

Dr. Whitney Jones, a gastroenterologist practicing in Louisville, KY and founder of the Colon Cancer Prevention Project, spoke at the ABCGN Annual Gala and Awards Banquet on May 19th in Baltimore, MD. His goal was to raise awareness of the importance of prevention through colonoscopy screenings and educational outreach.



Colon Cancer
Prevention Project

800-841-6399
502-290-0288

www.coloncancerpreventionproject.org

CONGRATULATIONS!!

You have just completed your colon cancer screening, the #1 solution to the #2 cancer killer in the U.S. By continuing with your screenings and follow-up program, you are virtually eliminating your risk of dying from this **preventable** killer.

BE A BUDDY!

Now that you have completed your own colon cancer evaluation, spread the word! Make an effort to tell at least 5 friends or family members who are at risk but who have not been screened.

Ask them to get tested and get ahead of colon cancer. You can be a hero in the lives of those who matter most to you.

KNOW THE FACTS

- All persons over the age of 50 are at risk and should be screened (African Americans over the age of 45).
- There is a greater chance of developing colon cancer if someone in your family has had colon cancer or polyps. Your physician may want to test you earlier and more often than other people.
- Colon cancer affects all races and both sexes.
- Colon cancer is 90% treatable when detected early.
- It takes 5-15 years for polyps to develop into cancer. Screening tests are designed to detect polyps early and prevent unnecessary pain and death.
- Colon cancer kills more people annually than HIV/AIDS and breast cancer combined!

Congratulations on completing your colon cancer screening!

What if a colon polyp was found?

- If your doctor found and removed colon polyps during your exam, you have likely prevented colon cancer from developing.
- Only certain types of polyps called **adenomas** turn into colon cancer. By removing these polyps, your doctor has stopped their ability to grow into cancer.
- It is important to remember that once you have had adenomas, your risk for developing further polyps is increased.

What about follow up?

- If you are at normal risk and no polyps were found, then you **will not** need another screening for 10 years.
- Even if no polyps were found, some people need more frequent colon check-ups. If you have a **personal history** of ulcerative colitis, Crohn's disease, colon polyps, colon cancer, ovarian or endometrial cancer, your colon check-ups will be more frequent as your doctor advises. Your doctor may advise testing every 1-5 years.
- If you have a **family history** (parent, sibling or child) of colon cancer, colon polyps, family cancer syndromes, ovarian or endometrial cancer, you will need to be followed at closer intervals than those at normal risk.

When do I call the doctor?

- Since no test is perfect, even colon polyps can be missed. If you develop digestive problems such as bleeding, abdominal pain, changes in your bowel habits, or weight loss, call your physician.



A Partner in Colon Cancer Prevention

Do the Test, Find the Polyp,
Skip the Cancer!

Awareness



The main goal of the project is to encourage all healthcare professionals to actively inform all patients and family members of the potential life-saving benefits of seeking appropriate colon cancer screening. The Gala participants were introduced to the Colon Cancer Prevention Project "buddy pamphlet" pictured left. This patient-directed communication tool provides the latest colon cancer facts, what to do if a colon polyp is identified, and general guidelines for appropriate follow-up. Cook is proud to partner in this initiative, and a supply of the "buddy pamphlets" for distribution in your GI unit is available by contacting your Cook Endoscopy territory manager.

For more information, please contact Angela Champion at 502-290-0288 or achampion@c2p2ky.org. You may also visit the website at www.coloncancerpreventionproject.org to learn more and to acquire educational materials.

CELEBRATING CLINICAL INGENUITY

Continued from page 5

of important technological developments especially in the areas of soft tissue repair and cellular and genetic therapies. Innovative treatment modalities such as these have potential for breakthrough therapeutic solutions for the future.

Collaborative relationships, creative problem solving, and a constant eye to the future are all hallmarks of the Edison genius, the "Q" gadgetry mystique that empowers Bond, and the history and commitment represented by Cook's contributions to the medical device world. This memorable evening at the International Spy Museum celebrated this spirit of clinical and inventor ingenuity and much more. Cook salutes all inventors and valued clinical partners who, over the years, have worked tirelessly to bring innovative devices to gastroenterologists and clinicians past and present.

¹ Axelrod, A. (2006) Profiles in Audacity. (pp. 87-91) New York: Sterling Publishing Co., Inc.

² Cork, J. & Scivally, B. (2002) James Bond: The Legacy (pg. 64) New York: HNA Books.



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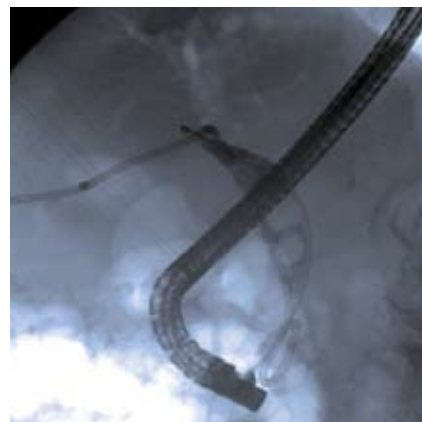
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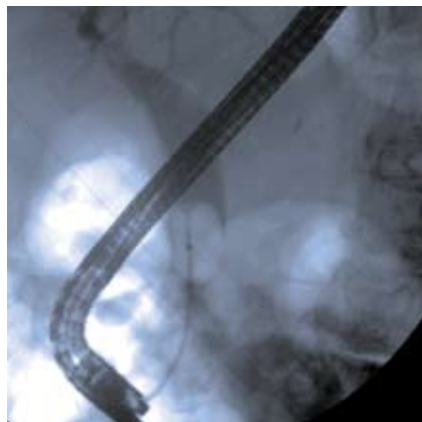
LARGE COMMON BILE DUCT STONES

Continued from page 7

was used to sweep the CBD. The balloon was inflated to the maximum diameter of 20 mm and multiple balloon sweeps performed to assist in the removal of the stone fragments. At the conclusion of the procedure, there were several stone fragments remaining within the dilated CBD. To allow for proper biliary drainage, two Cotton-Leung® Biliary Stents (10 FR x 10 cm and 10 FR x 7 cm) were successfully placed using the Fusion OASIS. After a few days, the patient's bilirubin levels and transaminases levels improved following the biliary clearance and he was subsequently discharged home.

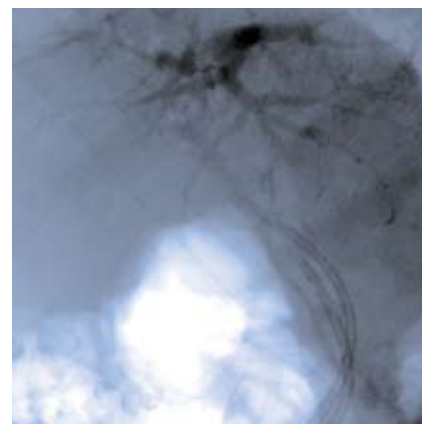


Two large common bile duct stones.



Fusion Quattro XL Extraction Balloon being used to remove stone fragments after lithotripsy with the Fusion Lithotripsy Basket.

the stones. Over the years, nonsurgical techniques such as mechanical lithotripsy, biliary endoprosthesis, chemical dissolution, extracorporeal shockwave lithotripsy and laser stone fragmentation have been developed to enhance bile duct clearance. As a final point, the use of the Fusion Lithotripsy Basket allows ease of converting to mechanical lithotripsy when needed for successful stone fragmentation and ductal clearance while ensuring optimal patient outcomes.



Two stents placed - Cotton Leung 10 FR x 10 cm and 10 FR x 7 cm.

SIGNEA

Society of International Gastroenterological Nurses and Endoscopy Associates



Randomized Clinical Trial

Comparing Sodium Picosulfate With Mannitol In The Preparation For Colonoscopy In Hospitalized Patients

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ABSTRACT

Introduction: The cleansing of the colon for a colonoscopy exam must be complete so as to allow the visualization and inspection of the intestinal lumen. The ideal cleansing agent should be easily administered, have a low cost, and minimum collateral effects. Sodium picosulfate together with the magnesium citrate is a cathartic stimulant and mannitol is an osmotic laxative, both usually used for this purpose.

Objectives: Compare the use of mannitol and sodium picosulfate by assessing colon cleanliness in hospitalized patients undergoing colonoscopy. Evaluate the level of patient satisfaction and the presence of foam, pain, and abdominal distension.

The hypothesis tested was that the tolerability would be greater and the patient more satisfied with sodium picosulfate in comparison with mannitol.

Method: A prospective, randomized, single-blind study with 80 patients that compared two groups: 20% mannitol solution (40) and sodium picosulfate solution (40). Both groups received the same dietary orientation. The patients that were prepared with mannitol, eight hours before the exam were given 750ml of 20% mannitol with 250ml of orange-flavoured juice to be consumed within one hour. The patients that were prepared with sodium picosulfate received an envelope diluted in one cup of water at eight hour intervals before the exam, a total of three doses. In both cases the patients could drink liquid ad libitum up to three hours before the exam.

The study was approved by the hospital's research ethics and research committee. The endoscopist was blind to the type of preparation. The cleanliness of the colon was recorded by the endoscopist based on Chilton's scale. He also recorded the presence of foam and exam duration. On the day of the exam, the patient answered a structured questionnaire about the difficulties presented during the preparation. The self-assessment questionnaire was given and the researcher simply provided it and oriented the patient.

Outcomes Evaluated: Level of the colon's cleanliness, patient's satisfaction, the presence of foam, abdominal pain and distension, and the duration of the exam.

Statistical Analysis: The sample was calculated with alpha 5% and beta 20%, with a difference in groups A and B from 20 to 25%. The data was analyzed by means of the Chi-Squared Test for proportions and Mann-Whitney for independent samples.

Results: There were no statistically significant differences between the groups in relation to the level of the colon's cleanliness, patient's satisfaction, the presence of foam, abdominal pain, and the duration of the exam.

Fifteen percent of the exams of the mannitol group were interrupted while from the sodium picosulfate group it was 5%. The presence of foam was similar for both groups (2 p= 0.829). The average duration for carrying out the exam was 28.44 minutes for the mannitol group and 35.59 minutes for the sodium picosulfate group. Abdominal distension was more frequent in the mannitol group (P = 0.003). If patients were asked if they would be asked to have the same exam again, the answer was yes in 80% of the mannitol group and 92.5% of the sodium picosulfate group (Test 2 p=0.105).

Conclusions: The quality of the colon preparation, foam formation, exam duration, and the collateral effects (nausea, vomiting, and abdominal pain) were similar in both kinds of preparations. Abdominal distension was greater in the mannitol group. Although distension was a statistically significant finding in the mannitol group, it did not have a significant clinical impact in our patients. Since both groups prefer they would repeat the same kind of preparation for cleansing their bowels.



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us carry out this study

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ACG (American College of Gastroenterology)	Philadelphia, PA	Oct. 14-17
Asian Pacific Digestive Week	Kobe, Japan	Oct. 15-18
Japanese DDW	Kobe, Japan	Oct. 18-21
Australian Gastroenterology Week	Perth, Australia	Oct. 24-27
UEGW (United European Gastroenterology Week)	Paris, France	Oct. 27-31
EUS Live	Boston, MA	Nov. 9-11
Endoscopy Workshop (National Congress)	Chile	Nov. 27-30
22nd International Workshop On Therapeutic Endoscopy	Hong Kong	Dec. 11-13
NYSGE	New York, NY	Dec. 13-15
AMC Endoscopy Winter Course	Netherlands	Dec. 17-18
Pancreatic & Biliary Endoscopy - Simon Lo	Los Angeles, CA	Jan. 18-20
Canadian DDW	Quebec Canada	Feb. 3 - March 29
Rocky Mountain Interventional Endoscopy	Denver, CO	Feb. 14-16
XIV FIMAD	Rimini, Italy	March 8-12
Euro EUS 2008	Milano, Italy	April 17-19

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If you would like to submit material for The Channel, please email us at thechannel@wilsoncook.com. We welcome your comments and suggestions.

INSIDE Joke

