

THE CHANNEL >>>

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ISSUE 3, 2005



DOMETIP

A Clinical Perspective

Douglas Howell, M.D - Maine Medical Center

Access in ERCP is defined as achieving deep cannulation of the Ampulla of Vater through the biliary or pancreatic sphincters to begin the sequence of therapeutic intervention. Direct access involves using a single device to achieve immediate deep access without initial preliminary devices or efforts.

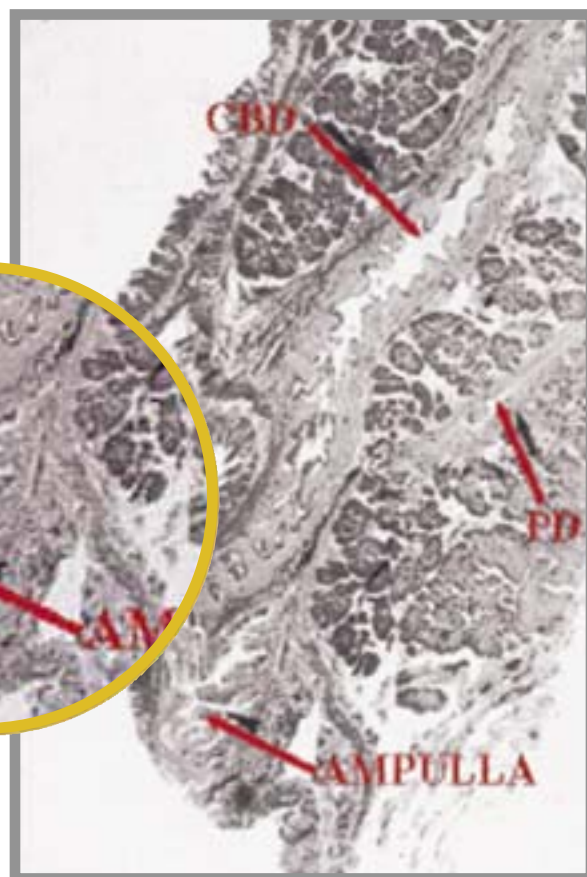
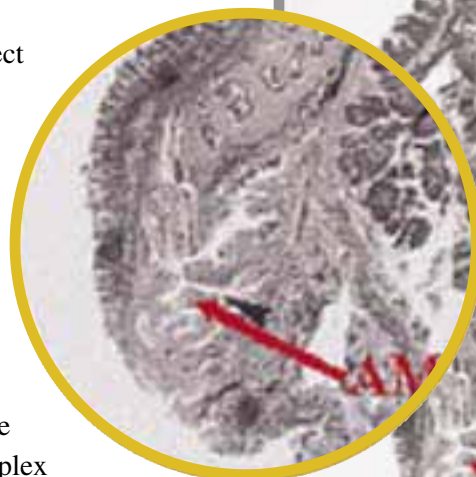
Difficulties facing the endoscopist in achieving direct access include the approach and orientation to the ampulla, alignment of the cannulating device to the sphincter and negotiation of the complex anatomy of the sphincter itself.

A new major innovation, which can be seen on the .025 DASH sphincterotome, is the creation of an ultra-smooth tapered rounded polished clear tip. (above). The new DomeTip addresses a major problem in gaining deep access. The anatomy of the normal sphincter of Oddi includes multiple complex papillary fronds (right). These fronds tend to “catch” any device

DOMETIP Continued on page 9

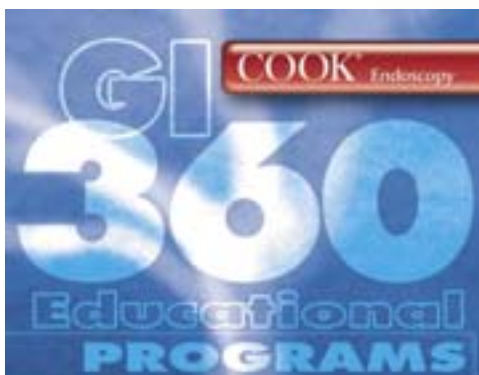
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Cook Endoscopy has long understood that optimal patient care is your focus, and it continues to be our focus as well. That's why for more than twenty years we have assisted healthcare professionals in learning the latest in endoscopic GI technology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

That tradition continues as Cook Endoscopy, in partnership with HealthStream (an accredited provider of continuing nursing education), now offers two new courses: "Endoscopic Polypectomy" and "Options for Enteral Feeding."

The courses are offered free of charge when presented by your Cook Endoscopy Sales Representative, and each course has a value of one contact hour. Please check with your state licensing board or agency regarding specific renewal requirements in the U.S.

Additional courses will be made available later this fall including "Malignant Biliary Disease," "Biliary Stone Management," and "Primary Sclerosing Cholangitis (PSC)."

Please check with your sales representative for course availability and to discuss future presentation opportunities.

A Physician's Viewpoint

Erwin M Santo, M.D.
Director of Endoscopy
Department of Gastroenterology and Liver Diseases
Tel Aviv Sourasky Medical Center



Dr. Erwin M Santo, M.D.

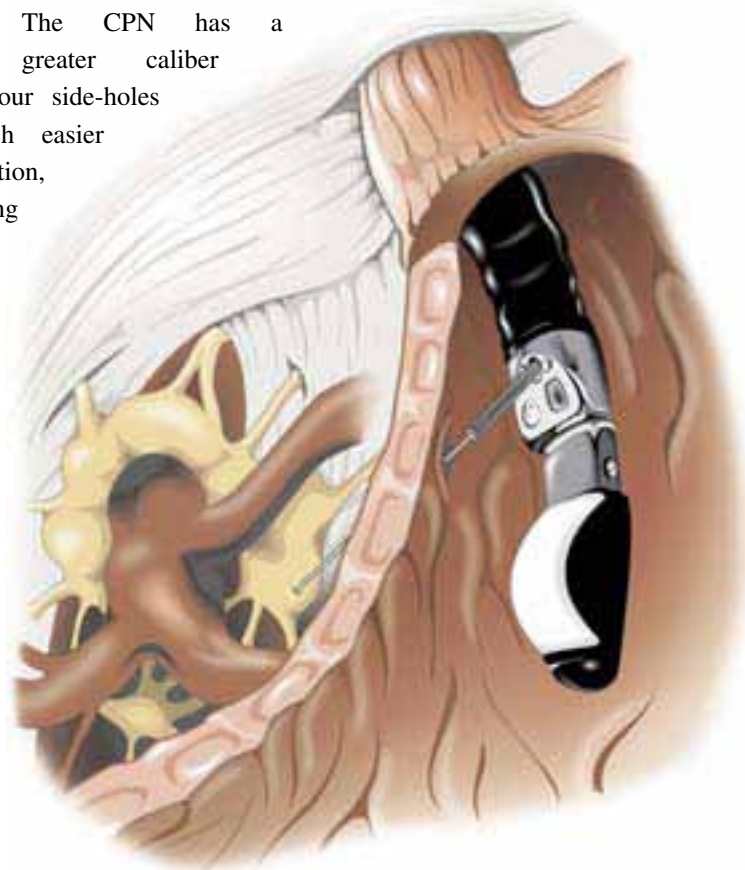
(20G vs. 22G) with four side-holes making injection much easier with better distribution, subsequently shortening procedure time. The tip of the CPN Needle is blunter, lessening the risk of inadvertent vessel puncture without compromising its good echogenic quality.

Using the CPN Needle, Celiac Plexus Neurolysis has become easier, shorter and safer and is better tolerated by patient and staff.

The EUSN-20-CPN will be available in the U.S. this fall.

I have been working with the Cook Celiac Plexus Neurolysis (CPN) Needle in my unit since it became available several years ago. We perform at least two blocks per week. Before the CPN Needle, we used to use Cook's EUSN-1 Needles to perform celiac blocks. During this procedure, we inject 6 cc of Marcaine 0.5% + 20 cc of alcohol 95%. It was very difficult to inject the alcohol in one 20 cc syringe, so we divided the alcohol into smaller doses of 5 cc each. Even in the smaller doses, injection proved quite difficult. With the new CPN, injection is much easier.

The CPN has a greater caliber



**CELIAC
 PLEXUS
 NEUROLYSIS
 (CPN)
 NEEDLE**

Study HIGHLIGHTS

Zilver Performance

Stent occlusion is a major concern when using self-expanding metal stents (SEMS). The degree of stent occlusion reflects the stent's patency rate, as well as the necessity for re-intervention(s). In a recent study, published for Digestive Disease Week 2005, the Zilver Biliary Stent was shown to exhibit longer patency rates and fewer instances of re-intervention when compared with various metal stents.

Comparison Between Endoscopically Placed Self-Expanding Metal Stents for Inoperable Malignant Biliary Obstruction: Single Center Retrospective Review

L. Vesga, K.C. Bagatelos, S. Mein, E. Cruz, J.W. Ostroff

Aim: Endoscopic biliary stenting is an alternative to surgery in patients with obstructive jaundice secondary to inoperable malignancy for palliation of symptoms. However, the duration of stent patency and relief of jaundice among various metal stents are unknown. The aim of our study is to compare outcomes in palliative relief of inoperable malignant biliary obstruction with Zilver stents compared with three different self-expanding metal stents (SEMS): the Wallstent, Spiral Z, and Diamond stents.

Methods: A retrospective review using endoscopic and medical database from October 1997 to November 2004 was done. The primary outcome is stent occlusion measured by the need for re-intervention in <6 months from the index SEMS placement, such as ERCP with balloon sweep, plastic stent or additional SEMS placement. The secondary outcome evaluated was bilirubin level at >60 days post index ERCP with SEMS.

Results: A total of 140 patients with malignant biliary obstruction who underwent endoscopic placement of SEMS were evaluated. Patient characteristics were comparable with regard to age, sex, gender, and indication for stent placement with pancreatic cancer (50%) and cholangiocarcinoma (18.5%) being the most common. A total of 39 patients (28%) required re-intervention, 64% of which required re-intervention within 6 months of index SEMS placement. Overall, fewer re-interventions were required in the Zilver group compared with the Wallstent group, 15% vs. 40% respectively, ($p = 0.0034$), but no difference was seen in Spiral Z ($p = 0.0987$) or Diamond ($p = 1$) stent groups compared with the Zilver stent group. There was no difference between the Zilver groups and the others in regards to re-interventions at <6 months (Wallstent $p = 0.3425$, Spiral Z $p = 1$, Diamond $p = 0.5810$). No difference was seen in total bilirubin levels at 60 days post-SEMS placement amongst the groups (Wallstent $p = 0.6483$, Spiral Z $p = 1$, Diamond $p = 0.1357$). The stent placement and re-interventions were not associated with any procedure related complications although fever was usually associated with stent occlusion.

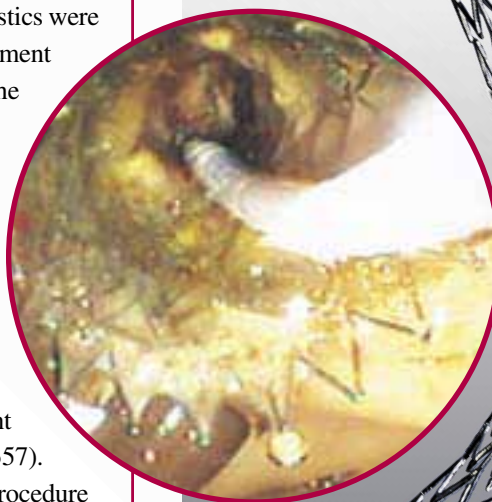
Conclusion: Patients who received Zilver stents had longer patency rates requiring fewer re-interventions overall compared with those receiving Wallstents, but not compared to the other stent groups. There was no difference in re-interventions within a 6 month period amongst stent groups. Mean bilirubin levels were comparable amongst all groups at 60 days post-procedure.

Reprinted from Gastrointestinal Endoscopy, Vol. 61, No. 5, April 2005; L. Vesga, K.C. Bagatelos, S. Mein, E. Cruz, J.W. Ostroff, "Comparison Between Endoscopically Placed Self-Expanding Metal Stents for Inoperable Malignant Biliary Obstruction: Single Center Retrospective Review", page AB221, copyright 2005, with permission from The American Society for Gastrointestinal Endoscopy.



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Recurrent Acute Pancreatitis: A DomeTip Case

*Andrew Holt, MD
The Pancreatic Disease Center
University of Cincinnati Medical Center*

*Andres Gelrud, MD
Co-Director of The Pancreatic Disease Center
University of Cincinnati Medical Center*

A female patient with a history of recurrent acute pancreatitis presented to the University of Cincinnati Pancreatic Disease Center for a second opinion regarding evaluation and treatment of pancreas divisum.

The patient had multiple documented attacks since 2000 with amylase and lipase levels in the thousand range. She underwent a cholecystectomy in December of 2000 without improvement. An ERCP in March of 2001 revealed possible pancreas divisum but multiple attempts to cannulate the minor papilla were unsuccessful. A minor sphincterotomy was then performed with a needle-knife but the endoscopist was unable to obtain deep cannulation via the minor papilla. The patient initially did well with symptom resolution for approximately for one year.

In June 2004, the patient redeveloped attacks of documented pancreatitis. Laboratory values during her last admission were: amylase 324 IU/L (normal 30 – 60 IU/L), lipase 1617 U/L (normal 10 – 100 U/L), AST 16 IU/L, ALT 50 IU/L, alkaline phosphatase 75 IU/L, total bilirubin 0.4 mg/dL, and hemoglobin 12.6 G/dL. The patient continued to have episodes of documented recurrent acute pancreatitis.

The patient was then referred to the University of Cincinnati Pancreatic Disease Center in December of 2004. Another ERCP was attempted in February 2004 to cannulate the minor papilla and investigate for re-stenosis of the minor papilla. Again, the minor papilla was unable to be cannulated.

A second ERCP was attempted a few months later. The major papilla was identified and the pancreatogram revealed a small ventral pancreatic duct. The minor papilla was located using secretin 8 microgram IV in two divided doses of 4 cc / each. Attempt to cannulate the minor papilla was unsuccessful using a tapered tip cannula followed by a DASH-21-480 sphincterotome. However, using a Cook DASH with DomeTip sphincterotome with a .025 wire, the minor papilla was successfully cannulated. The pancreatogram through the minor papilla revealed a mildly dilated dorsal duct proximally. The catheter initially acted as a dilator device and then a minor papilla sphincterotomy was successfully performed. A 3 Fr x 5 cm single flap pancreatic stent was then placed.

One week later, an abdominal X-ray revealed passage of the pancreatic stent.

The patient was seen in the clinic two months after the minor sphincterotomy was performed and continued to be symptom free on a regular diet.





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DOMETIP

Successful Holistic Approach TO

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- Second Annual Symposium on Interventional Endoscopy, September 30 – October 2, 2005. (CME Accredited)
- Intensive, 16-Hour ERCP Course for Nurses and GI Technologists, November 17 – 18, 2005.
- Post Graduate Advanced Training in EUS and GI Oncology, July 1, 2007 – June 30, 2008

For more information:
Grace Chen, (714) 456-3721,
gracec@uci.edu

The CDDC is located at UCI Medical Center, 101 The City Drive South in Orange. For more information or to refer a patient, call toll free 1-888-717-GIMD (4463) or visit www.ucihealth.com/cddc.

In the complex and often fragmented digestive disease field, achieving a holistic approach poses challenges for academic medical centers. Many universities strive to integrate subspecialty patient care, research and education, with mixed success. The Medical Center at the University of California, Irvine, however, provides replicable proof that cohesion is possible and optimal for patients with a wide range of digestive diseases.



The H. H. Chao Comprehensive Digestive Disease Center (CDDC) in Orange, California opened Feb. 1, 2003 at the University of California, Irvine Medical Center, featuring hi-tech diagnostic and treatment services and a team of world-renowned physicians and specialists.

Patients with disorders of the esophagus, stomach, colon, liver and pancreas receive care from an integrated team of CDDC specialists, including internists, gastroenterologists, medical oncologists, laparoscopists, surgeons, psychologists, nurses and social workers.

“We have assembled a team that can diagnose or treat virtually any problem associated with the digestive tract”

– Kenneth Chang, M.D.

“We have assembled a team that can diagnose or treat virtually any problem associated with the digestive tract,” explains Dr. Kenneth Chang, CDDC director. “It is only within a university hospital setting -- like UCI Medical Center -- that you will find a cohesive team of specialists who can handle the very simple and complex cases, from colonoscopies to liver transplants or gastrointestinal surgeries.”

Meeting MULTIPLE OBJECTIVES within one center

Adds John G. Lee, MD: “The center focuses on total care for the patient – medical, surgical oncology, radiology, and ancillary services. We provide a friendly, caring, and convenient environment for the patient.”

A second objective is research, says Dr. Lee. As examples, the center is involved in 16 clinical trials for the pancreas, liver/GIST, colon and rectal, gastric/GE junction and esophagus.

Third, the center meets a critical teaching need by helping community physicians, nurses, patients, and the general public become aware of therapies and new technologies. (For example, The Don Wilson Room, a viewing room to observe procedures, donated by Cook Endoscopy, helps serve educational needs for area physicians.)

The Don Wilson Room, a viewing room to observe procedures, donated by Cook Endoscopy, helps serve educational needs for area physicians.

UCI Medical Center's H. H. Chao Comprehensive Digestive Disease Center

DIGESTIVE DISEASE

Finally, as a cutting-edge facility, the center features the newest therapies for GI disorders. "We adopt international techniques, and our medical staff travels, lectures, and demonstrates procedures world wide – most recently in Mexico, Europe, China, Italy, Vietnam, South America," says Dr. Lee.

SERVICES offered by the center

The Motility Disorders and Gastroesophageal Reflux Disease (GERD) Program offers diagnostic and therapeutic services for patients with disorders of the gastrointestinal tract.

The Pelvic Floor Center specializes in treating female incontinence, using radiofrequency treatments, biofeedback, and rectal endoscopic ultrasound.

UCI's Gastrointestinal Oncology Program is renowned for its research in the development and application of endoscopic ultrasound-guided fine needle aspiration (EUS-FNA) for cancer diagnosis, staging, pain management and therapy. It is also the only facility to offer photodynamic therapy for esophageal and lung cancer.

The Pancreatobiliary Program offers diagnosis and treatment of complex pancreatic and biliary problems, such as recurrent or chronic pancreatitis and pancreatic and bile duct stones.

UCI's Hepatology Program was established in 1980 and is the only dedicated liver program in Orange County. Hepatologists treat patients for hepatitis and nonviral chronic liver disease.

The Colorectal Surgery Program places a strong emphasis on quality of life through the use of minimally invasive surgery and sphincter-saving procedures.

UCI's Bariatric Surgery Program offers minimally invasive surgery for severely obese patients (those who are 100 or more pounds overweight or twice their body weight).

Although other academic medical centers are challenged to integrate a wide range of services such as these for the benefit of patients, it comes naturally to the staff at the UCI CDDC. According to Dr. Lee, the key to working well together is simply "dedication to a common goal. The professionals at the center agree with the philosophy and the vision."



Dr. Phuong Nguyen and Dr. John Lee, M.D.

The key to the center's successful interdisciplinary approach is "dedication to a common goal. The professionals at the center agree with the philosophy and the vision."

- John Lee, M.D.

GI Oncology/ Interventional Endoscopy Services

- Endoscopic ultrasound (EUS) and EUS-guided FNA for diagnosis and staging of esophageal, gastric, pancreatic, mediastinal and rectal lesions
- Endoscopic ultrasound (EUS) and EUS-guided FNA for staging lung cancer
- EUS-guided celiac nerve block for control of cancer pain
- Cholangioscopy and laser ablation therapy for intrabiliary lesions
- High-frequency mini-probes for staging early esophageal and gastric cancer
- Stents for esophageal, duodenal, biliary and colorectal obstructions
- Minimally invasive placement of feeding tubes in the stomach or jejunum
- Laser ablation for esophageal cancer
- Photodynamic therapy (PDT) for esophageal cancer and lung cancer
- Endoscopic mucosal resection (EMR) for diagnosis and complete excision of precancerous lesions and early cancers
- Endoscopic diagnostic and ablative techniques for Barrett's esophagus (including high-grade dysplasia) using EMR, laser and PDT Gastrointestinal Oncology

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SCOPEDOC™

The Ergonomics Of Endoscopy

*Kenneth F. Binmoeller, MD
California Pacific Medical Center,
San Francisco, CA*

Endoscopists are busier than ever, spending most of their time performing procedures. Whether doing back-to-back screening colonoscopies or difficult ERCPs, the physical stresses secondary to repetitive hand, wrist, and shoulder movement are significant. Over time, these stresses add up to overuse injuries that represent a significant threat to the endoscopist's health and career. In an American Society for Gastrointestinal Endoscopy (ASGE) survey of 400 endoscopists, 77% of respondents experienced some type of overuse symptom. The bad news is that overuse injuries will increase as the demand for procedures grows and as practitioners age (the age of the average gastroenterologist increases each year). The good news is that help is on the way. The ScopeDoc is the first device of its kind, designed for "hands-free" operation to reduce stress and fatigue from flexible endoscopy.

Endoscopy has evolved from a purely diagnostic tool to a multifaceted interventional modality. Yet, surprisingly, performing endoscopic procedures is not much different today than half a century ago, except that today's endoscopists handle a much more extensive workload, compounding the occurrence of fatigue and joint stress. That fatigue and stress results from two factors: having to carry

the sheer weight of the endoscope during the entire procedure, and having to steer the endoscope with the hands. A logical way to reduce fatigue and joint stress would be to eliminate endoscope holding, and provide a method to generate navigational movements with the body.

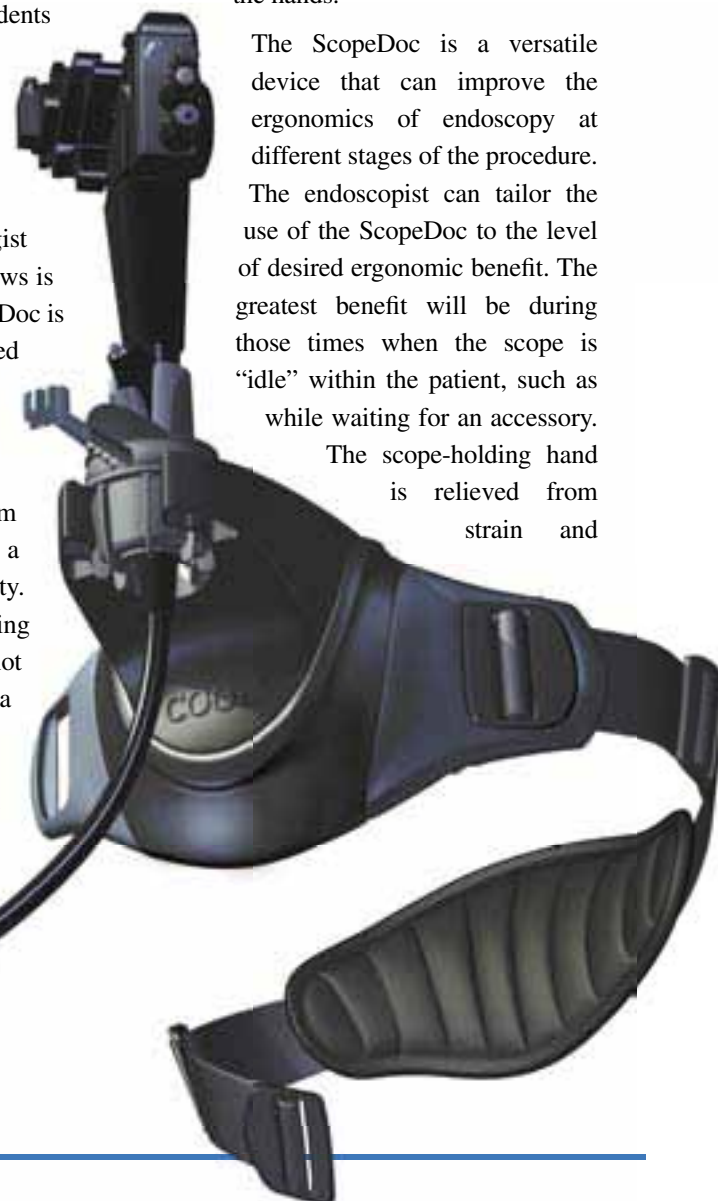
The ScopeDoc accomplishes both. First, the weight of the endoscope is transferred from the hand to the body. Second, with the endoscope cradled to the ScopeDoc, subtle changes in body position are transferred to the endoscope shaft and the endoscope tip. The endoscopist can thereby steer the endoscope with the body rather than the hands.

The ScopeDoc is a versatile device that can improve the ergonomics of endoscopy at different stages of the procedure. The endoscopist can tailor the use of the ScopeDoc to the level of desired ergonomic benefit. The greatest benefit will be during those times when the scope is "idle" within the patient, such as while waiting for an accessory.

The scope-holding hand is relieved from strain and

A logical way to reduce fatigue and joint stress would be to eliminate endoscope holding, and provide a method to generate navigational movements with the body.

The ScopeDoc accomplishes both.



DOMETIP - A CLINICAL PERSPECTIVE *Continued from page 1*



figs. 1 & 2

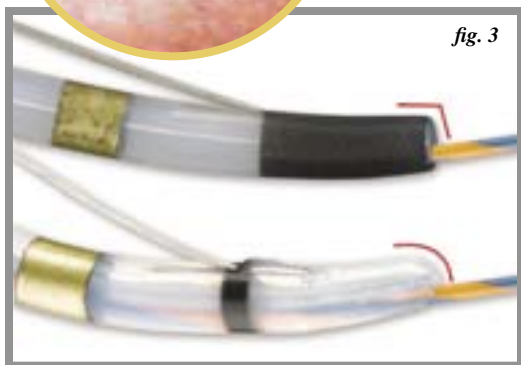


fig. 3

and resist insertion. Forceful efforts often produce injury, edema or hemorrhage, aggravating the problem of gaining entry to the chosen duct. Smaller tapered tips are helpful, but sharp or excessively pointed tips can pierce or tear tissue creating a so-called “false channel.” This traumatic defect results in a path-of-least-resistance, often causing repeated entry with subsequent efforts or with other devices. Finally, inadvertent injection of contrast into a false channel produces a large “bleb” of fluid compressing and obscuring the true channel.

The DomeTip permits smooth, atraumatic, deep access by sliding over this difficult, irregular surface due to its extremely smooth, rounded profile. (figs. 1 & 2) The asymmetry of the design dramatically reduces the contact angle with the tissue, reducing friction and preventing catching, tearing, or false channels. This change can best be described as changing the “angle of insertion” for access (fig. 3).

The new DASH sphincterotome with DomeTip represents a culmination in ERCP access design, producing smooth, safe and successful deep access without requiring additional devices or efforts. Higher risk techniques, such as forceful blind guide wire insertion, pre-cutting, or needle knife unroofing, can then generally be avoided.



Maine Medical Center



SCOPEDOC - THE ERGONOMICS OF ENDOSCOPY

Continued from page 8

fatigue, and freed up to perform other tasks. The endoscopist has the option of keeping the endoscope docked to take greater control of an accessory, greatly facilitating some recent trends in endoscopic instrumentation, such as the use of short-wire ERCP technology. Fine adjustments in the endoscope position can be made with subtle body movements. The ScopeDoc can be helpful while advancing or withdrawing the endoscope, but there is a learning curve to this. Docking and undocking the endoscope is very easy, allowing the endoscopist to seamlessly shift between “manual” and “ScopeDoc” mode.

Although intended as an adjunct for routine endoscopic procedures, the ScopeDoc provides an important platform for future endoscopic interventions. As endoscopic tools become more complex and resemble the instruments used in laparoscopic surgery, bimanual manipulation and instrument stability will gain importance. Hence, the ScopeDoc is not only a long overdue adjunct for daily endoscopy, but an important platform for future technology. We look forward to new horizons of endosurgical intervention that will be facilitated by the ScopeDoc.

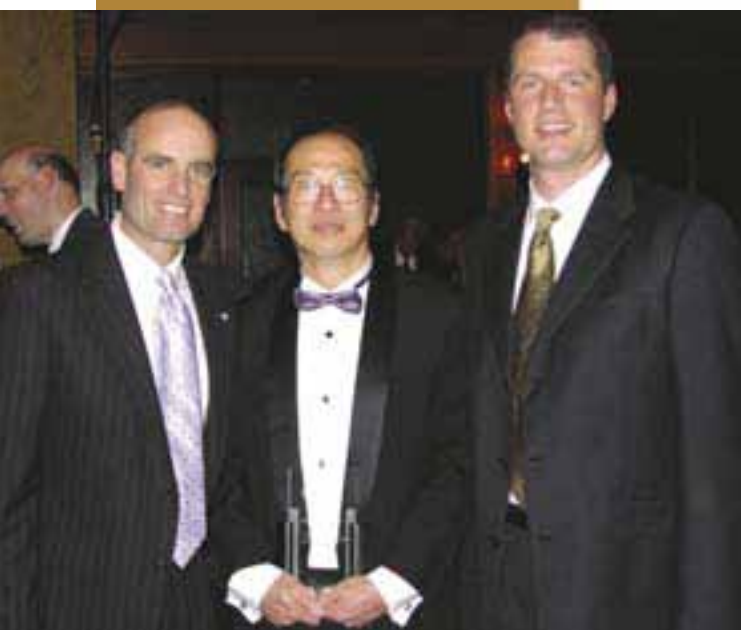
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INAUGURAL

2005 ASGE CRYSTAL AWARDS DINNER



Rudolf V. Schindler Award recipient, Dr. Richard Kozarek.



Master Endoscopist Award recipient, Dr. Joseph Leung, with Cook Endoscopy representatives, Doug McLaren and Matt Henderson.

It's not often that practitioners, researchers and teachers in GI endoscopy are invited to an elaborate gala that celebrates their achievements. That's why the inaugural Crystal Awards Dinner was so special.

"The leadership of the American Society for Gastrointestinal Endoscopy (ASGE) and ASGE Foundation felt it was important to create a forum that appropriately recognizes the honorees for their expertise, their achievements and their dedication to the specialty and the Society," said Dr. Rob Hawes, President of ASGE.

More than 280 people attended the 2005 Crystal Awards Dinner on May 15th at the Art Institute of Chicago. Hosted by the ASGE and ASGE Foundation and held in conjunction with Digestive Disease Week (DDW) 2005, the inaugural dinner raised more than \$100,000, which will directly support GI endoscopic research and public education.

Thirty-five honorees were formally recognized – some for a single, ground-breaking achievement, others for a lifetime of exemplary accomplishment – all for their unique contributions to the Society and the GI endoscopy specialty.

The event featured live music, dinner and presentations to awardees by Dr. David Bjorkman, immediate Past President of ASGE; Dr. Michael Kimmey, immediate Past Chair of the ASGE Foundation; and Dr. David Carr-Locke, ASGE Past President and Foundation Trustee.

"The Crystal Awards honor those who have brought to bear their unique contributions and expertise to the field of GI endoscopy," Dr. Kimmey said. "ASGE is proud to honor them."

The Rudolf V. Schindler Award, ASGE's highest honor, went to Dr. Richard A. Kozarek (Virginia Mason Clinic, Seattle, WA). The Schindler Award is given to an ASGE member whose accomplishments in endoscopic research, teaching and/or service exemplifies the standards and traditions of Dr. Rudolf Schindler, founder of the American Gastroscopic Club, the forerunner of ASGE.

Dr. Kozarek's accomplishments and contributions to clinical gastroenterology and GI endoscopy are considerable. Many of the techniques used in the field today were developed and evaluated by Dr. Kozarek, including pancreatic duct stenting, endoscopic pseudocyst drainage and ESWL of pancreatic stones. In addition to his work in the areas of hepatobiliary and pancreatic disorders, he has also excelled in the areas of inflammatory bowel and esophageal disease. He has produced more than 300 peer-reviewed papers, editorials, chapters and articles. A true mentor, Dr. Kozarek has trained a generation of endoscopists, and served as president of ASGE in 1997-98.

"I am grateful to have been part of the evolutionary process that now allows us to remove bile and pancreatic duct stones and resect benign tumors and superficial

GI cancers,” said Dr. Kozarek. “These advances and the procedures yet to come have as their foremost goal the improvement in the health and well-being of our patients using minimally invasive, endoscopic techniques.”

Dr. Joseph Leung (University of California, Davis, Medical Center, Sacramento, CA) was the night’s only honoree to walk away with two Crystal Awards. He received a Master Endoscopist Award as well as a Research and Outcomes and Effectiveness (ROE) Award.

The Master Endoscopist Award recognizes physicians who spend the majority of their time in patient care and are recognized regionally or nationally for their expertise and contributions to the practice of gastrointestinal endoscopy over an extended period of time.

A talented and accomplished endoscopist who attracts the most difficult ERCP cases from a broad region, Dr. Leung is an educator who has trained scores of fellows in the US and Asia. He is an ERCP expert who performs challenging procedures live during teaching conferences, as well as a widely published author who routinely lectures around the world. Dr. Leung is an innovator who has designed numerous endoscopic accessories and devices, enabling practitioners to more effectively deliver treatment. His exceptional endoscopic skills are combined with a passion for teaching and a relentless desire for evaluation.

“I am deeply honored by this award which recognizes my contribution to GI endoscopy in the United States and in Asia,” said Dr. Leung. “It was my privilege to share this honor with my family, teachers, students and colleagues at this lovely dinner.”

Dr. Leung was also one of ten physicians to receive ROE Awards. These grants are awarded to physicians who received the highest scores from a vigorous peer-review process for their projects in basic and clinical endoscopic technology research and outcomes and effectiveness of endoscopy research. Dr. Leung received the award for a project titled “A Correlative Study of the Bacteriology of Blocked and Unblocked Biliary in Relation to Loss of Damage Function.”

The Don Wilson Award – named for Wilson-Cook Medical Inc. founder Don Wilson, who was a strong advocate and supporter of international education and training in GI endoscopy – provides advanced fellows or junior faculty the opportunity to train outside their home country with a premier GI endoscopist or group to advance their training. The award assists in underwriting travel and living expenses for a period of one to three months. Three awards are available annually: two for ASGE members in North America to travel abroad to an ASGE-member site, and one for an international member to come to a North American ASGE-member site. This year, Don Wilson Awards went to: Dr. Timothy Kinney (University of Chicago, Chicago, Illinois), Dr. Erika Rodriguez Wulff (Hospital Militar Carlos Arvelo, Caracas, Venezuela), and Dr. Federico Rossi (Yale University School of Medicine, New Haven, Connecticut).

“I had a phenomenal experience doing ERCPs in Santiago, Chile, thanks to the generous support of Cook Endoscopy and the ASGE,” said Dr. Kinney. “It was very rewarding, both on a professional and personal level.”

In addition to underwriting the Don Wilson Award, Cook Endoscopy supports the Research and Outcomes and Effectiveness Awards and the Career Development Awards.

“It was an honor to be part of this inaugural Crystal Awards Dinner,” said Bill Gibbons, President, Cook Endoscopy. “It is a wonderful way to connect with friends and colleagues while paying tribute to the many bright and talented individuals whose hard work and dedication to service bring honor and continual advancement to the field of GI endoscopy.”

Cook Endoscopy congratulates all the 2005 Crystal Award winners. For a complete listing of all Crystal Award winners, visit: www.asge.org/nspages/foundation/crystalAwards2005.cfm. The second annual Crystal Awards Dinner is scheduled for May 2006, during DDW in Los Angeles.



Don Wilson Award recipient, Dr. Timothy Kinney, with Bill Gibbons and Minda Wilson of Cook Endoscopy.



Don Wilson Award recipient, Dr. Erika Rodriguez Wulff, with Bill Gibbons and Minda Wilson of Cook Endoscopy.



Don Wilson Award recipient, Dr. Federico Rossi, with Bill Gibbons and Minda Wilson of Cook Endoscopy.

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UPCOMING 2005 EVENTS

WCOG 2005 <i>Palais des congrès, http://www.wcog2005.org/</i>	Montréal, Canada	Sept. 10 - 14
APDW 2005 - Asia Pacific Digestive Week 2005	Seoul, Korea	Sept. 25 - 28
Boston Int. Live Endoscopy	Boston, MA	Sept. 29 - Oct. 2
Endoscopic Ultrasonography	Durham, NC	Sept. 30 - Oct. 1
UCI - 2nd Annual Symposium on International Endoscopy <i>Dr. Chang</i>	Orange, CA	Sept. 30 - Oct. 2
Diagnostic Therapeutic ERCP Geenen	Chicago, IL	Oct. 1 - 2
Digestive Disease Week Japan <i>www.ddw.jp</i>	Kobe, Japan	Oct. 5 - 8
ERCP A-Z Mayo Clinic	Rochester, MN	Oct. 6 - 8
EUS Workshop	Indianapolis, IN	Oct. 13 - 14
13TH UEGW <i>http://www.webasistent.cz/guarant/uegw2005/Uvod.aspx</i>	Copenhagen	Oct. 15 - 19
ACG	Honolulu, HI	Oct. 28 - Nov. 2
ERCP Live - Beth Israel	New York, NY	Nov. 2
AASLD	San Francisco, CA	Nov. 11 - 15
NYSGNA	New York, NY	Dec. 15 - 16
Pancreatic & Biliary Endoscopy <i>Dr. Simon Lo</i>	Los Angeles, CA	Jan. 20 - 22

INSIDE Joke

