

THE CHANNEL

A COOK NEWS PUBLICATION

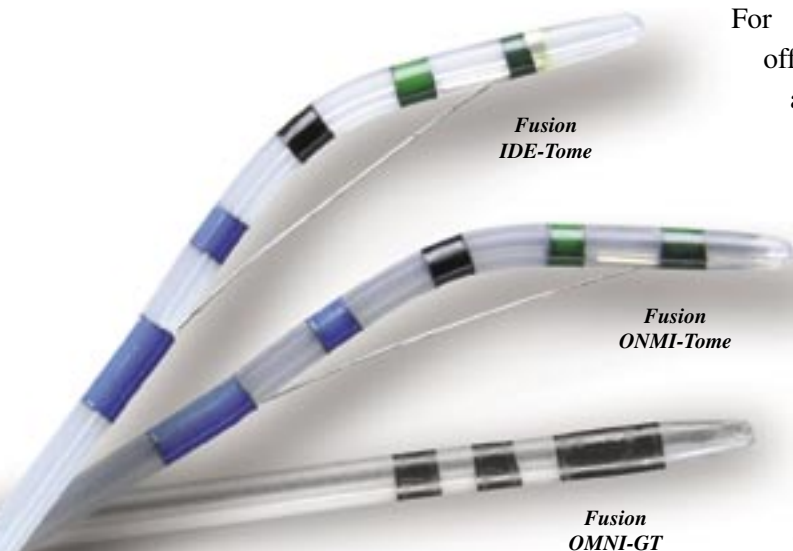
ISSUE 2, 2005



DOMETIP™

The New Shape of Access

Cook is introducing an evolution in tip design for cannulation devices. The new DomeTip feature replaces the traditional flat shelf tip with a smooth rounded dome shape. This new shape potentially allows the tip to glide through, instead of catching on the papilla and the fronds within the duodenal end of the biliary ductal system.



*Fusion
IDE-Tome*

*Fusion
OMNI-Tome*

*Fusion
OMNI-GT*

For endoscopists, DomeTip offers the potential for faster access, less trauma, and procedural efficiency.

This unique patent pending technology truly changes the shape of access in ERCP. The new tip will appear on the Fusion IDE-Tome, Fusion OMNI-Tome, Fusion OMNI ERCP Catheter, and DASH Sphincterotomes.

According to John Curran, Product Manager: "Engineers at Wilson-Cook, long time leaders in tip design, have developed a breakthrough product with the potential to solve a long-standing clinical problem."

For additional information about our DomeTip products, contact your Cook territory manager at 1-800-457-4500 (USA only). Or, visit us at www.wilsoncook.com.

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For more
information on
DomeTip...

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COOK® Wilson-Cook Medical
GI Endoscopy



U know the
problems.



C much
improvement?



Oh wow, how did
they do that!

Introducing Fusion OMNI[™] The new face of channel design

In the evolution of catheter design for cannulation, this is revolutionary!
The patent pending, ultra-short wire Breakthrough Channel[™] design:

- Maintains structural strength for maximum precision
- Accepts a variety of Wilson-Cook wire guides
- Allows flushing the catheter with minimal leakage

To find out how OMNI with Breakthrough Channel design can revolutionize your procedures, contact your Wilson-Cook Sales Representative at 800-457-4500 (US only) or visit www.fusion-cook.com

Pending 510 (k). Not available for sale in the United States.



Initiate wire
guide
separation



Continue
separation of
wire guide



Lock wire
guide

FUSION

FUSION OMNI

A breakthrough to the next generation

The 2004 Intraductal Exchange technology has vaulted to the next generation. Because Wilson-Cook listened to customers, Fusion is even better in 2005.

The new system for Fusion cannulation meets numerous requests from doctors and nurses. For example, instead of 6 cm, with an exit at the IDE port, the new system allows the wire guide to travel all the way to the nurse's hands. In addition, the assistant now has the option of manipulating the ultra short wire guide during the case.

Other enhancements stem from physician input: The sphincterotome is now packaged with a pre-loaded wire guide, eliminating an additional step and valuable preparation time. Fusion OMNI provides the option of starting the case without a wire guide loaded into the device. Finally, the OMNI-Tome can be used in the Ultra Short Wire format with a smaller 3.2 mm channel diagnostic scope.

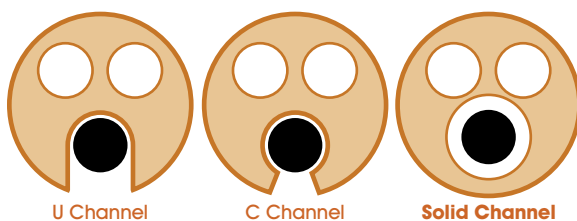
To create the OMNI system, Wilson-Cook engineers had to overcome some of the limitations of the open channel devices on the market. The original, open U channel catheters allowed the wire guide to exit from an opening down the side of the device, a design that comprised its structural integrity. Wilson-Cook's goal was to devise a catheter that would have structural integrity similar to that found in standard triple lumen catheters. Fluid leakage was another issue to be addressed, particularly regarding the continual flushing necessary when using hydrophilic coated wire guides. Wilson-Cook also wanted to give the clinician the option of various wire guide sizes when using OMNI devices. The open U channel design required that the wire guide match the opening so precisely that the clinician was limited to using that size wire guide only.

This U channel was improved somewhat by narrowing the opening of the U. This is referred to as a C channel. The original limitations, while now physically smaller, remained as real and ever present during cases.

Breakthrough Channel™ design: The Solid Channel.

Wilson-Cook challenged its engineers to find an entirely new channel technology and they responded by developing a fully closed channel. Shaped like a solid O, this closed channel design prevents fluids and air from leaking from the open wire guide lumen. The closed system offers more stability and less buckling and kinking. Finally, the Breakthrough Channel maintains the hard won "all wire" status, which was the original concept of the fully compatible Fusion system.

OMNI, Latin for ALL, explains the name of the devices (accepts all wires). What is not explained is the secret of this special channel design. How does it work?



The answer came from Jack Calloway, materials manager, Dave Waller and Dave Hardin, the chief engineers for the project. Working closely with the entire Wilson-Cook engineering group, they broke down the design problem and created a novel and revolutionary idea.

Even though the new technology uses a closed wall design, the wire guide can exit through the wall of the device at the point of exchange. Thanks to the patent pending Breakthrough Channel design, nurses and doctors can free the wire from the closed, solid wire guide channels.

How Wilson-Cook engineers overcame the limitations of open channel design

NEW OMNI DEVICES

OMNI devices with breakthrough wire guide channels are available with the Fusion Ultra Short Wire system. The OMNI devices are:

OMNI-GT

The ultra short wire OMNI ERCP catheter with DomeTip design

OMNI-Tome

The ultra short wire OMNI sphincterotome with DomeTip design

Preloaded OMNI-Tome

The ultra short wire OMNI sphincterotome with DomeTip design packaged with a preloaded 185 cm, .035 Fusion wire guide



*Pending 510(k), not available for sale in USA.

“The ScopeDoc frees your hands, so you can manipulate accessories”

Prof. Guido Costamagna, Università Cattolica del Sacro Cuore, Rome



“Having that extra hand can be very useful”



Prof. Paul Fockens, Head of Endoscopy, Academic Medical Center, Amsterdam, The Netherlands



“This is ‘endoscopy heaven’ ”

Dr. Irving Waxman, University of Chicago



SCOPEDOC • Give yourself a hand!

with the hands-free endoscope docking station

Give yourself a hand! That’s Wilson-Cook Medical’s message to endoscopists everywhere. The reason is: the innovative ScopeDoc, a first-of-its-kind accessory that allows both of the endoscopist’s hands to be free during procedures.

This hands-free, endoscope-docking device, worn around the operator’s waist, secures the scope in a unique holder, essentially freeing the former “scope-holding” hand. “Using the ScopeDoc, in effect, gave me another hand,” says Dr. Willis Parsons, Northwestern University, Chicago.

The ScopeDoc affords unprecedented freedom and control during procedures, as well as reduced physical stress for the operator. “The ScopeDoc frees your hands, so you can manipulate accessories,” says Prof. Guido Costamagna, Università Cattolica del Sacro Cuore, Rome. “Plus, if you don’t have to constantly hold the scope in the left hand, it’s possible to relax your shoulders.”

Prof. Paul Fockens, Head of Endoscopy, Academic Medical Center, Amsterdam, The Netherlands adds, simply, “Having that extra hand can be very useful.”

The next logical step

Since its earliest beginnings in the late nineteenth century, the practice of endoscopy has seen many changes. Some of the first EGDs were performed on sword swallowers. The scope itself has evolved from completely rigid scopes to semi-rigid devices to flexible fiberscopes, and eventually to the flexible video scopes, which has become the standard endoscopic instrument of choice.

But throughout the entire history of endoscopy, one thing never changed: the endoscopist had to hold the scope at all times with at least one hand and often with two. Until now! With its ability to free the

operator’s hands and potentially allow for more complex procedures, the ScopeDoc is the next logical step in the evolution of the practice of endoscopy.

Enhancing patient care

Freeing the “scope hand” can enhance procedural efficiency and that efficiency can translate into enhanced patient care and decreased procedural costs, as well as increased lab turnover.

With ScopeDoc, the endoscopist’s free hand is now available for more tactile device control when



performing such maneuvers as bowing

a sphincterotome, closing and activating a snare, adjusting the traction of a stone extraction basket, or greater FNA precision and control during therapeutic EUS procedures.

Also, ScopeDoc gives the clinician the ability to simultaneously manage two separate devices, through one scope, with greatly enhanced control. And, ScopeDoc can facilitate advanced techniques, such as “mother-daughter” scope procedures, without the need for a second physician.

“This is ‘endoscopy heaven,’” says Dr. Irving Waxman, University of Chicago. “When deploying hemostasis clips, I was able to decrease the amount of misfires and wasted clips.”

SCOPEDOC Continued on page 8

COOK®

Wilson-Cook Medical
GI Endoscopy

**Give
yourself a
hand.**

Introducing ScopeDoc™
The hands-free endoscope docking station

The ergonomically designed ScopeDoc
deserves a big hand - yours.

- Have both hands free to control and coordinate your procedures
- Your assistant is free to be more involved with patient care
- Fatigue is reduced with the built-in lumbar support

To find out how you can experience a new level of freedom and comfort in every endoscopic procedure, contact your Wilson-Cook Sales Representative at 800-457-4500 (US only) or visit www.wilsoncook.com




SCOPEDOC™

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The FUSION System

INTRADUCTAL EXCHANGE (IDE) AND MULTIPLE STENT PLACEMENT

NEW
delta wire[®]
 FULLY HYDROPHILIC COATED WIRE
OFFERS MULTIPLE SIZES AND BENEFITS

Endoscopists performing difficult ERCPs often require a fully-hydrophilic, fully-radiopaque wire guide. The new Wilson-Cook Delta Wire meets these needs, and provides multiple options. It will come in a 260 cm length, .025" and .035" diameters, and with straight and angled tips.

The Delta Wire assists in cannulation of the biliary and pancreatic ducts and helps bridge difficult strictures during ERCP. Placement of the wire allows continual access to the desired duct and facilitates exchange of compatible wire-guided accessories.

Additional benefits

There are other benefits, as well: The Delta Wire works well with the Fusion System because it allows both intraductal exchange and "zip" exchanges. It can be used with long wire cannulation devices to gain access to the duct of choice, and once access is achieved, the Delta Wire can be exchanged with a compatible wire-guide. Finally, endoscopists can manipulate the angled tip Delta Wire to gain access through difficult strictures, and, with a torque device, into various branch ducts.

"Our engineering staff is proud to introduce this fully-hydrophilic wire-guide. In addition, we already are introducing several options for endoscopists," said Steve Mouw, Product Manager. "This represents a clear example of our mission to serve the health care industry with the latest technology."



*Joseph Leung, MD, FRCP, FACP, FACG
 Mr & Mrs CW Law Professor of Medicine,
 University of California, Davis School of Medicine,
 Chief, Section of Gastroenterology,
 VA Northern California Health Care System.*

The Fusion system is a novel way of exchanging accessories and placing multiple stents during ERCP examinations. The unique design of this system facilitates the exchange of accessories without having to remove the guide wire or exchange the initially

placed catheter/sphincterotome over the full length of the guide wire. The main difference between this new system and the conventional design is that a side hole (IDE port) is placed at 6 cm from the tip of the catheter (or any accessories from this line of products except the stent introducer system in which the IDE port is placed at 2.5 cm).

The total length of the guide wire is 185 cm and the length of most of accessories is 200 cm. To provide proper control of these much shorter accessories and guide wire, the system utilizes a special disposable biopsy valve with a locking mechanism (locking device) to anchor the guide wire while performing exchanges. There is a double membrane within this biopsy valve to prevent leakage of air or bile. The locking device is held in place by a clip-on mechanism. For diagnostic cannulation, the guide wire is inserted through the IDE port of the catheter and exits through the tip (i.e. only 6 cm of the guide wire lies within the lumen of the catheter). The rest of the guide wire stays alongside the catheter within the instrument channel of the duodenoscope. To prepare the device the guide wire is initially positioned through the IDE port and advanced up to the tip of the catheter. It is held in place by a nylon "wire stop" inserted through the proximal wire guide port at the handle of the catheter. Friction is created when the wire stop is luer locked in to the handle holding the wire guide in place. Now the catheter and the wire guide can be passed together through the scope.

For wire guide cannulation it is important to "free" the guide wire initially by unlocking the wire stop and pulling it back 1-2 cm. Manipulation of the guide wire is easy when only the distal tip of the catheter protrudes from the instrument channel as the first 6 cm of the guide wire is contained within the catheter and the rest of the wire is within the scope channel. At times it is difficult to manipulate the guide wire if a loop is formed within the duodenum. It is therefore important to stay close to the papilla when manipulating the accessories to avoid looping of the guide wire.

Deep cannulation of the bile duct can be achieved with the catheter and guide wire (as one unit) and is better controlled by the endoscopist. Insertion of the catheter and guide wire into the bile duct is easy if there is no significant distal bile duct obstruction. The shorter accessory in theory allows the endoscopist to perform manipulation and exchange of accessories. However, if the guide wire is used to achieve selective cannulation, an assistant can help with the manipulation of the guide wire. Despite better control by the endoscopist, manipulation of these short accessories may require a two hands approach as there is a potential risk of losing control of the scope position if manipulating is done only by the endoscopist.

Intraductal Exchange (IDE)

Deep cannulation of the bile duct is performed either directly with the catheter or with the help of the guide wire. The tip of the guide wire is freed by unlocking and pulling back the wire stop allowing the endoscopist to manipulate the guide wire. The guide wire is used to



negotiate a stricture or to achieve deep cannulation of the bile duct. The much shorter guide wire allows better torque to be applied with rotation of the tip of the wire for selective cannulation. Once the guide wire is in a good position, the proximal end of the guide wire is locked with the locking device. The catheter is advanced over the guide wire to secure its position within the bile duct and for repositioning of the guide wire if necessary.

Exchange of accessories over the guide wire can be done in two ways. With the proximal end of the guide wire locked with the locking device, the tip of the catheter is advanced up the bile duct. Because the proximal end of the guide wire is locked, the tip of the wire will eventually come out of the IDE port of the catheter and lie free within the bile duct. This is done under fluoroscopic visualization. The catheter can then be removed leaving the guide wire locked in place. Another accessory can then be placed over the proximal end of the guide wire and advanced into the bile duct. The guide wire should be locked in place with the locking device during insertion and removal of the accessory over the wire. The proximal end of the guide wire is only freed to allow removal or a quick exchange of the accessory.

An alternative method of intraductal exchange is to deep cannulate the bile duct with the catheter and guide wire.

THE FUSION SYSTEM *Continued on page 9*



CANADA WELCOMES FUSION

The "Power of Fusion" continues to garner acclaim in the Canadian GI market as news spreads on Wilson-Cook's new line of biliary accessories with Intraductal Exchange (IDE) technology. In response to the increasing demand for information about the exciting new Fusion system, Cook (Canada) Inc. is sponsoring a number of one-day workshops across the country.

In July 2004, St. Michael's Hospital, a centre renowned for its therapeutic endoscopy program, was one of the first sites to host a one-day Fusion workshop. Dr. Paul Kortan and Dr. Gary May welcomed close to 30 GI physicians and nurses from across the Greater Toronto Area (GTA) to their facility. The aim of this in-service was not only to promote product awareness, but to offer hands-on experience with a variety of new Fusion devices. The group was also joined by guest speaker Dr. Stephen Deal (Carolina Medical Centre, Charlotte, North Carolina) who delivered a presentation on the features and benefits of this new technology.

Overall, the feedback received from participants was very positive and the workshop was considered a great success. In fact, a number of centres in the GTA have since adopted the Fusion system and are using it with great success.

These workshops have proved to be instrumental in promoting the effectiveness of this revolutionary new technology. With several more of these training sessions in the works, Cook (Canada) Inc. is looking forward to an exciting future with Fusion!



Wilson-Cook has recently developed a new device for treatment of superficial early cancers in the oesophagus. The device, Duette, was developed in collaboration with **Professor Nib Soehendra** in Hamburg. Professor Soehendra is one of the world's most respected opinion leaders and is an expert in Endoscopic Mucosal Resection (EMR). EMR was originally developed in Japan but is now gaining acceptance worldwide as a means of treating superficial lesions and early cancers in the oesophagus. The incidence of oesophageal cancer is growing and early detection and treatment of the precursor stages are very important in this disease. Endoscopic therapies offer great hope to patients due to the high mortality rate with surgery and it is hoped that Duette will allow more physicians and surgeons to perform EMR and thereby offer more options to their patients.

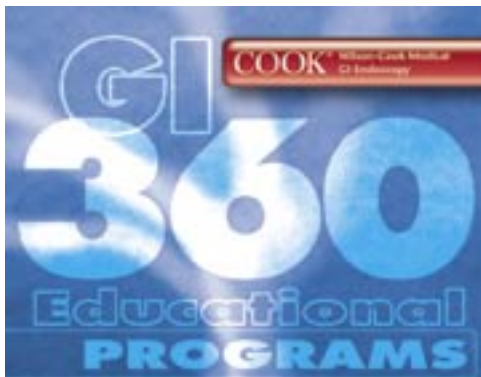
Duette consists of a modified multi-band ligator and a snare which can be passed through the ligator handle. The snare may be retained in place during the procedure without affecting suction. When a target lesion is identified endoscopically it is suctioned into the barrel of the ligator and a rubber band is placed on it creating a pseudopolyp. This pseudopolyp may be immediately resected using the preloaded snare.



Duette offers simplicity and efficiency to the user. The setup is similar to a standard multiple-band ligator device. Up to six

resections per device may be made and the snare has excellent characteristics and shape retention in between resections.

Duette is CE-marked for use in Europe and registration is underway in the United States, Japan and Canada. The device has been successfully used by many of the leading experts in endoscopic mucosal resection in Europe.



Wilson-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 in the first quarter of 2005. Wilson-Cook, in partnership with HealthStream (an accredited provider of continuing nursing education), will offer three new courses: "Endoscopic Polypectomy," "Malignant Biliary Disease," and "Options for Enteral Feeding."

The courses are offered free of charge when presented by your Wilson-Cook 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 in the year including "Endoscopic Ultrasound," "PSC or Primary Sclerosing Cholangitis," "Biliary Stone Management," "Hemostasis," and "Esophageal Cancer."

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

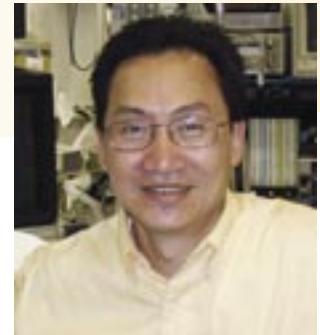
Courses are available worldwide, only CEU will be issued in the US.

TRICLIP

Physician Viewpoint

Endoscopic clipping further contributes to physician treatment capabilities in the control of GI bleeding. It represents an option in a rescue course of action for specific GI bleed presentations. Pre-loading of the clips and disposable devices has combined successfully to contribute to the efficiency of the treatment modality.

Dr. Simon Lo of Cedars-Sinai Medical Center is a TriClip user and shares some of his thoughts with us regarding device performance and feature manifestations. Dr. Lo states "the three-pronged clipping device is beneficial in approaching the targeted site with three prongs rather than two while providing three different pressure points." He views this as an opportunity to maximize the amount of tissue obtained when the clip is released.



*Dr. Simon Lo,
Cedars-Sinai Medical Center*

Endoscopic clipping with the TriClip also offers, according to Dr. Lo "ease of orientation to the site and does not require the ability to rotate creating more efficient deployment."



The three-pronged clip approach is advantageous in that it is not limited to addressing the bleed site perpendicularly.



Another key to endoscopic clipping utilization is the ability for nursing personnel to adapt quickly to the support actions required when clips are utilized in the GI Lab. Dr. Lo comments, "my nursing staff had no problems at all with the clip from the beginning."

Within his clipping experience, Dr. Lo has noted that the TriClip does have challenges when deployment is attempted on a slant. The three prongs can make this a positioning issue which is not easy to resolve. He states "the duodenum and the descending duodenum can be difficult areas for a three-pronged approach."

However, Dr. Lo notes that the maximum grasp capabilities of the three prongs continue to provide "excellent" results in the majority of his clipping situations. He further comments that "clipping used for rescue provides a valuable option."

SCOPEDOC *Continued from page 4*

Enhancing "clinician care"

In addition to the enhanced patient care resulting from diagnostic and therapeutic advantages of having both hands free, the ScopeDoc enhances "clinician care." Lengthy, repeated procedures using traditional one-handed support of the endoscope can cause physical stress and strain at the wrist, elbow, shoulder, neck, and/or back. Some endoscopists even suffer severe carpal tunnel syndrome from the stresses endured during diagnostic and therapeutic endoscopy. The ScopeDoc is designed to reduce these stresses and strains.

The ergonomically contoured lumbar support allows the waist and hips – not the hand, wrist, elbow, or shoulders – to bear the brunt of the endoscope's weight, along with the weight of lead, if performing an ERCP. "The ScopeDoc seems to lessen the weight of the instrument," says Dr. Schumacher, Evangelisches Krankenhaus Düsseldorf.

With its clinical advantages and its potential to alleviate the physical stresses often suffered by endoscopists, the history of endoscopy may one day be viewed in two major eras: "before ScopeDoc" and "after ScopeDoc."

THE FUSION SYSTEM *Continued from page 7*

The catheter should be advanced to a minimum of 10 cm into the duct as indicated by two black bands endoscopically viewed on the catheter. The guide wire is freed by unlocking the wire stop. The guide wire is then pulled back from the tip of the catheter until the wire is seen fluoroscopically separating from the catheter at the IDE port. The guide wire is now free within the bile duct lumen. The wire is then gently advanced up the bile duct to maintain access and locked to the locking device. Now the catheter can be removed while keeping the guide wire in position. Other accessories can then be inserted over the guide wire.

Since the guide wire is locked to the scope during exchanges, scope position should be held steady as dislodgment of the wire can occur if the tip of the scope is displaced thus dragging the wire out of the bile duct. If scope displacement occurs, it is important to unlock and free the end of the guide wire, lower the elevator to avoid gripping the wire before repositioning the scope to minimize the risk of dislodging the wire.

Use of the FUSION system for

Multiple Biliary Stenting

Multiple biliary stent placements for benign bile duct strictures is technically challenging as difficulties may arise from accessing the stricture with repeated cannulation and guide wire placement, and the subsequent exchanges done over a very long guide wire. In the conventional way, repeated bile duct cannulation and exchanges are necessary in order to place multiple stents to attain the maximum lumen diameter for the stricture. Direct cannulation with the stent preloaded on an Oasis system without a prior inserted guide wire can be tricky or difficult.

The major advantage of the Fusion Oasis is in the placement of multiple stents for benign bile duct strictures (or malignant stricture) following balloon dilation. With the Fusion system and intraductal exchange, the guide wire is left within the bile duct across the stricture facilitating deployment of subsequent stents without concerns of accessing or, for the same reason, losing access across the stricture. In addition, because the stent is “caught” between the guide wire entering the IDE port and the pusher, repositioning (especially in pulling back a malpositioned stent) can be performed easily to adjust the stent position before final deployment.

Since the design is different to conventional stenting methods, stent deployment requires disengagement of the guide wire from the IDE port within the bile duct lumen. This is achieved by advancing the inner catheter further above the tip of the stent to free the guide wire. The stent is then deployed by pulling back the inner catheter while holding it in position with the pusher. Alternatively, the proximal end of the guide wire is unlocked from the locking device and pulled back gently to free the distal tip. The free wire is then advanced further back into the bile duct and locked to the locking device before final stent deployment. Once the first stent is deployed the Fusion Oasis may be removed from the scope and loaded with the second stent. Once the stent is loaded on to the Oasis it is placed over the guide wire and the stent deployment procedure is repeated. Although stent deployment requires a systematic approach and could be tedious with locking and unlocking the guide wire, the fact that the guide wire is left above and across the stricture certainly facilitates subsequent multiple stent placements with one Fusion Oasis.

Conclusion

The concept of intraductal exchange revolutionizes wire guided therapeutic ERCP procedures by allowing and maintaining continuous access to the bile duct (or across a stricture) with minimal exchange conducted over a very short guide wire. Finally, in situations where intervention requires use of standard length accessories or when control over the guide wire is difficult, a standard length guide wire can be inserted through the end of the accessory and exchange performed in the usual manner.

ECHOTIP[®]

ULTRA

*By Dr. Salem Omar
Senior Fellow in Endoscopic Ultrasound,
Dept. of Interdisciplinary Endoscopy,
University Hospital Hamburg-Eppendorf,
Hamburg, Germany.*

EchoTip Ultra needles are designed with new features for comfortable aspiration combined with optimal performance to obtain the best cytological specimens.

ECHO-25 is the only 25 gauge needle available in the market. The introduction of this needle into the working channel of a non-therapeutic curvilinear echoendoscope is as effortless as other needles in the EchoTip Ultra range. The sheath comes out easily even though the distal end of the scope has to be torqued maximally or positioned in an odd position for optimal aspiration position.



Dr. Salem Omar

The thin, fine and sharp tip of the needle allows easy, effortless and precise targeted penetration of even the smallest and hardest lesions.

The upward and downward movements of the handle needed for the continuous aspiration of the lesion are smooth without any resistance and need for excessive force and movements of the wrist, thus minimizing the risk of repetitive stress injury to the operator.

The specimens obtained are often adequate for a definitive cytological interpretation despite the small inner luminal diameter and has less artefacts as compared to those obtained with needle of a larger diameter.

I will definitely recommend ECHO-25 needle for small, hard lesions and when adequate specimens are needed for accurate cytological diagnosis.



GREAT IDEA.

Introducing DomeTip™
The new shape of access

Here's an idea so right, everything else just looks flat.
Wilson-Cook's unique, patent pending DomeTip design provides:

Easier access • Potentially less trauma • Ease-of-use that can save time

To see the shape of things to come in therapeutic endoscopy, contact your
Wilson-Cook Sales Representative at 800-457-4500 (US only) or visit www.wilsoncook.com

DOMETIP

How Wilson-Cook *Inspiration* and **COORDINATION** created breakthrough DomeTip technology



Buffed Tip Tapered Tip DomeTip

Jerry Shelton, an engineering technician for Cook, faced a challenge: design more efficient ERCP cannulating device tips. But tips already had neared their limit in size reduction. Catheter designs required anywhere from one to four lumens for cutting, injection, and wire guides insertion. Clearly, breakthrough technology was required.

Like many Cook innovations, Jerry's answer was inspired. The shape, not the size of the catheter, determined the entry effectiveness. The shape Jerry envisioned was a dome.

This dynamic and novel shape perfectly filled a market need to optimize patient care. It was also logical. After all, a dome shape (and not the final French size of a squared-off tip) is the logical shape for access. From the beginning, the Cook DomeTips were designed with two basic goals in mind: 1) to create a shape that would potentially allow fast access, and 2) minimize trauma to the ampulla.



Leonard Erickson

The second challenge for the Cook team was making the dome work with lumens for injection, cutting and wire guides.

Leonard Erickson, the computer aided/designer for Cook, translated Jerry's idea into a real design the company could manufacture. Together, Jerry and Leonard coordinated the design to bring all elements together. It was both an art and a science, because they had to predict material flow patterns with time, heat and tube thickness variables.

Finally, Engineering Technician P.J. Chilton tweaked the process into true production terms and helped train the tipping experts who would be making the actual catheters with the dome shapes.

The DomeTip is a great example of the art of possibility, and the DomeTip project was truly a team effort. Cook salutes this team of creative designers and catheter experts. Their results can be seen in the new dome designs, which continue to demonstrate Cook's commitment to patient care.



Jerry Shelton



P.J. Chilton



THE CHANNEL

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NEW PRODUCTS

Ask your territory
manager for CD's,
Quick Reference Cards
and Clinical Clips
on products of interest.

COOK® Wilson-Cook Medical
GI Endoscopy

UPCOMING 2005 EVENTS

DDW	Chicago, IL	May 15 - 18
SGNA	Minneapolis, MN	May 15 - 17
Advanced Endoscopy Update Dr. Peter Cotton, Medical University of South Carolina	Isle of Palms, SC	May 20 - 22
ICS - European Congress of Endoscopic Ultrasound Scanning	Copenhagen, Denmark	June 2 - 3
23rd European Workshop on Gastroenterology & Endotherapy Professor Jacques Devieré, Brussels Exhibition Centre http://www.live-endoscopy.com/	Brussels Belgium	June 20-22
Diagnostic & Therapeutic Techniques in Endo. GI Nurses	Lake Tahoe, NV	June 23-24
Current Topics in Gastro. & Hepatology	Brewster, MA	July 21-24
Mayo Clinic EUS	Rochester, MN	July 28-30
GO 2005 GI Practice Management	Seattle, WA	Aug. 18-21
WCOG 2005 Palais des congrès http://www.wcog2005.org/	Montréal, Canada	Sept. 10 - 14
APDW 2005 - Asia Pacific Digestive Week 2005	Seoul, Korea	Sept. 25 - 28
UCI - 2nd Annual Symposium on International Endoscopy Dr. Chang	Orange, CA	Sept. 30 - Oct. 2
Digestive Disease Week Japan www.ddw.jp	Kobe, Japan	Oct. 5 - 8
13TH UEGW http://www.webasistent.cz/guarant/uegw2005/Uvod.aspx	Copenhagen	Oct. 15 - 19
ACG	Honolulu, HI	Oct. 28 - Nov. 2

INSIDE Joke

