A TEXAS Roundup of Loop Tip Cases



Cook Medical developed the physician-designed Fusion® LoopTip™ wire guide to facilitate successful cannulation through the irregular surfaces of the pancreatic and biliary ductal systems. The first-of-its-kind in the industry, Fusion LoopTip allows gastroenterologists to cannulate the ductal system with potentially less trauma due to its unique closed distal loop.

Several clinicians in Texas recently shared some of their clinical case experiences with the Fusion LoopTip wire guide, including Dr. Jay N. Yepuri, MD, MS, Digestive Health Associates of Texas, PA, who reported: "The LoopTip offered the right combination of torque and resistance to stay in the main pancreatic duct. Needless to say, I was impressed."

Drs. Sandeep Patel and S. Bennett Hooks, wrote: "Pancreatic endotherapy continues to evolve and is challenging in part because of the anatomical variances that are often encountered. Complications have arisen from wire guide perforations through the main duct or side branches. Our two case studies [below] illustrate how the LoopTip wire guide can safely facilitate navigation through complex ductal variants and strictures in the pancreas. We believe the LoopTip wire guide should be considered a part of your armamentarium while performing pancreatic endotherapy."

Dr. Harish Gagneja, MD, AGAF, impressed with the elegantly simple design of the LoopTip, said: "Wow! Why didn't I think of this? The LoopTip is my favorite wire from now on!"

# **LoopTip Case Studies**



Jay N. Yepuri, MD, MS Digestive Health Associates of Texas, PA Bedford, Texas

## Case 1

A 76-year-old patient presented with metastatic colorectal cancer causing extrinsic compression of the common hepatic duct. A conventional wire could not traverse the tight stricture in this region. The Fusion LoopTip wire guide allowed us to traverse the stricture, perform serial dilation, and then place one stent for palliative decompression.

## Case 2

A 78-year-old patient presented with malignant biliary obstruction secondary to adenocarcinoma of the pancreatic head. The resultant malignant stricture of the distal common bile duct could not be traversed with a conventional wire. Using the Fusion LoopTip wire guide, the common bile duct was successfully cannulated and a Zilver<sup>®</sup> Biliary Self-Expanding Metal Stent was successfully deployed across the stricture.



S. Bennett Hooks, MD The University of Texas Health Science Center at San Antonio

## Case 3

A 54-year-old patient with symptomatic chronic pancreatitis presented to our institution for endotherapy after an ERCP at an outside hospital had failed to access the pancreatic duct beyond a stricture at the level of the genu. ERCP was performed and initial injection of the pancreatic duct revealed anatomy consistent with incomplete divisum. A sigmoid turn in the head of pancreas along with a stricture at the junction of the ventral and dorsal duct was seen. Deep wire cannulation was attempted resulting in selective passage of the wire into the dorsal duct and not across the stricture. Multiple attempts with Boston Scientific's .025 inch Jagwire®, Cook's .021 inch Tracer Metro<sup>®</sup> wire guide and .018 inch Roadrunner<sup>®</sup> wire guide all failed deep wire cannulation. Finally a Cook Fusion LoopTip® wire guide was passed and with gentle pressure it moved through the sigmoid loop in the head, across the stricture, and deep into the tail of the pancreas without seeking the dorsal duct (Figure 1). The use of the Fusion LoopTip wire guide allowed for placement of pancreatic stent across the stricture and at a 4-week follow up visit the patient had continued clinical improvement of symptoms.

# COOK MEDICAL The Channel



Sandeep Patel, MD Assistant professor of medicine The University of Texas Health Science Center at San Antonio



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### Case 4

A 76-year-old patient presented for evaluation of a markedly dilated pancreatic duct on CT scan. At ERCP initial injection revealed a corkscrew turn of the pancreatic duct in the genu and a markedly dilated duct of approximately 1.5 cm in the body of the pancreas with filling defects and dilated side branches. Multiple attempts at wire cannulation for pancreatoscopy with Boston Scientific's .035 inch Jagwire, .025 inch Jagwire, and Cook's .021 inch Tracer Metro wire guide were performed, but were unable to manipulate around the corkscrew turn. The wires would continually migrate into a side branch duct instead of navigating the turn. The Fusion LoopTip wire guide was then used and was able to traverse the corkscrew turn without side branch migration (Figure 1). Pancreatoscopy revealed classic fish egg appearing mucosal changes in the mid body of the pancreas (Figure 2).



**Harish Gagneja, MD** Austin Gastroenterology Austin, Texas

## Case 5

A 72-year-old patient presented with obstructive jaundice in May 2008. The patient had dilated intrahepatic ducts, bilirubin of 5.4 and a mass in the right lobe of the liver. The patient underwent an ERCP, which revealed a very tight 1.5 cm mid-CBD stricture. Brushings were obtained and a 10 FR plastic stent was placed. Brushings were negative for a malignancy; biopsy of liver mass did reveal moderately differentiated adenocarcinoma. The CA 19-9 was 71582 U/mL. The patient was deemed unresectable and an un-covered self-expandable metal stent (SEMS) was placed in June 2008. The patient was seen by an oncologist and was started on systemic chemotherapy with Gemzar and CPT-11. The patient tolerated the chemotherapy well over the next several months and the CA 19-9 levels declined to 4799 U/mL. In July 2009, the patient presented with ascending cholangitis and underwent a repeat ERCP. A cholangiogram revealed almost complete obstruction of a previously placed SEMS secondary to tumor in-growth (Figure 1). Several tries to achieve deep cannulation proximal to the SEMS with a straight wire failed because the wire repeatedly bent inside the crevices of tumor in-growth. Finally, we were able to achieve deep cannulation with the help of the Fusion LoopTip wire guide without much difficulty (Figure 2). A plastic stent was placed co-axially inside the SEMS utilizing Cook's OASIS® (One Action Stent Introduction System) (Figure 3) and successful drainage was established.

Figure 3

Case 4 Figure 1

Case 5

Figure 2