



Features:

- Endoluminal preservation – EndoRotor enables resection of scarred lesions without removing muscle, maintaining lumen patency
- Non-thermal mechanical resection of persistent adenoma
- Used clinically to facilitate EMR lateral margins and tissue bridges
- Potential to replace multiple instruments and eliminate instrument exchange time



EndoRotor close up with console

Now you can determine your resection limits – instead of your instruments imposing their limitations on you. The EndoRotor[®] allows you to simultaneously dissect, resect and collect tissue. This 3-in-1 endoscopic interventional tool provides features that complement today's GI toolkit.

FAQ's

How does the EndoRotor help me?

What are the advantages over how I perform resection today?

The incidence of incomplete resection during EMR is well documented throughout clinical literature. Because of combined suction and rotation, the instrument allows the user to remove residual tissue without the need to lift, including post-EMR scarred lesions and lateral margins in primary resections. The EndoRotor is a versatile tool that is not limited by tissue morphology.

What about pathological specimens?

The EndoRotor is cleared for use by a trained gastroenterologist to resect and remove residual tissue, not intended for biopsy, of the gastrointestinal (GI) system including post-endoscopic mucosal resection (EMR) tissue persistence with a scarred base and residual tissue from the peripheral margins following EMR.

Procedures completed by physicians globally routinely involve specimens evaluated by pathologists without challenge.

What about margins?

In a recent series (Emmanuel et al.) following wide-field EMR, physicians used magnification chromoendoscopy to confirm negative margins. Using the EndoRotor to resect the margins, pathology revealed a 13% residual tissue in the margins and base previously shown as negative by magnification chromoendoscopy. There were no recurrences at follow up.¹

What about perforation or bleeding?

The EndoRotor has been in use globally since 2016. Prophylactic epinephrine helps to mitigate bleeding risk. Perforation risk is within the standards of reported literature.

¹Emmanuel A, et al. The incidence of microscopic residual lesion left after apparent complete wide-field EMR of large colorectal superficial neoplastic lesions: evidence for the pathophysiological mechanism of recurrence. Digestive Disease Week Poster No 1087, 2018.

Figure 1 – 3 Images courtesy of: Dr. M Sachdev, Therapeutic Endoscopy, Phoenix, AZ

Colon:

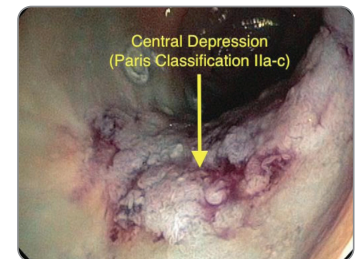


Figure 1 – Day 0 Before 5cm x 6cm Adenoma with scarred base and following incomplete EMR.

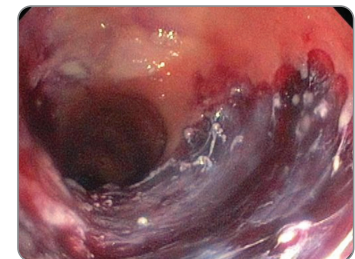


Figure 2 – Day 0 After The EndoRotor was used to resect disease down to the muscle to ensure complete removal.

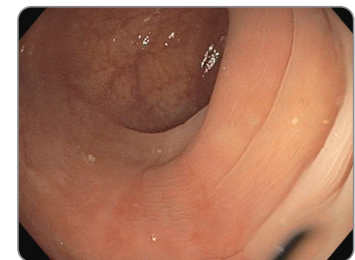


Figure 3 – Day 75 After 6 month surveillance: well-healed mucosa throughout the resection area without recurrence.



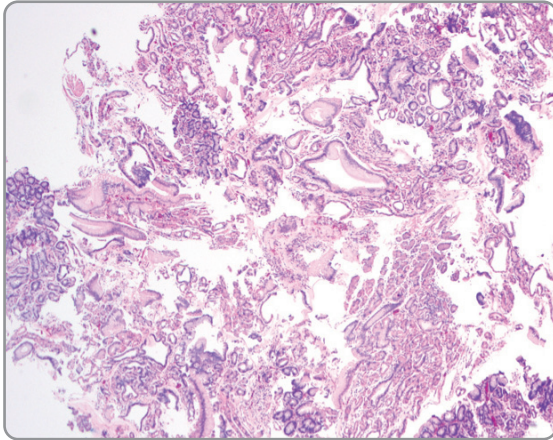
EndoRotor Head Closeup

Customer Service

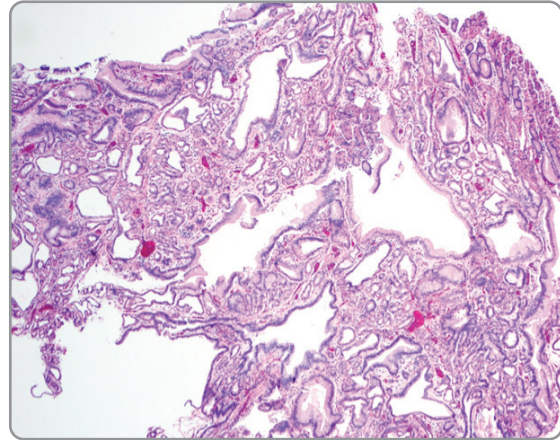
+1 800.461.4289

info@interscopemed.com

www.interscopemed.com

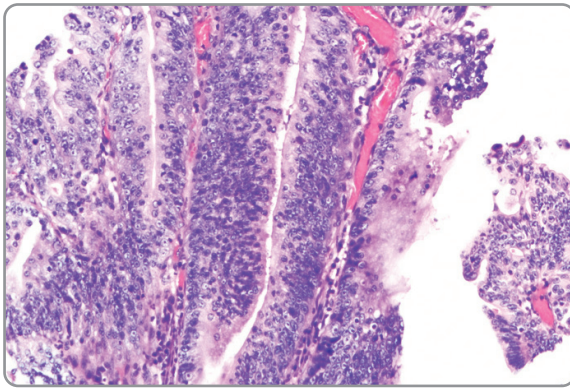


EndoRotor

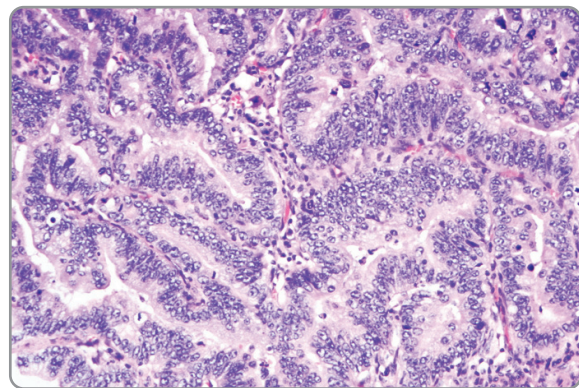


Standard biopsy

Figures 4 & 5 – Morphological findings and quality in EndoRotor-obtained fundic gland polyp (left) is comparable to standard biopsy (right).



EndoRotor



Standard biopsy

Figures 6 & 7 – Morphological findings in EndoRotor-obtained fundic gland giant polyp with high-grade dysplasia (left) shows the characteristics and nuclear features (nuclear stratification, round nuclei, prominent nucleoli) needed for diagnosis and is comparable to standard biopsy forceps (right).

Hear what Gastroenterologists have to say

“The EndoRotor is an exciting and safe invention that would be easier for flat polyp removal when piecemeal removal is necessary. Studies have shown it to be useful for clean up after piecemeal polypectomy.”

– Norio Fukami, MD
 Advanced Endoscopy Fellowship Director, Mayo Clinic

“EndoRotor is a great adjunct in the treatment of residual/recurrent tissue at prior polypectomy sites that can be difficult to remove with standard techniques. We have had great success with use of this device in this setting. I am even more excited about EndoRotor's use in removing necrotic tissue from pancreatitis related walled-off necrosis collections. Necrosectomy with conventional devices generally takes several discrete endoscopy sessions to complete. I have done several of these procedures using the EndoRotor device and been able to remove all debris in just one session, thereby saving the patient from multiple repeat procedures. I am excited to see future data on EndoRotor's usage in this patient population.”

– Rebecca Burbridge, MD
 Division of Gastroenterology, Director of Advanced Endoscopy,
 Duke University Medical Center, Durham, North Carolina

“EndoRotor is an exciting new addition to our armamentarium in the management of difficult to remove lesions. This includes partially, resected polyps, and lesions in challenging locations, e.g., lesions in the appendiceal orifice, in the diverticula, and in some parts of duodenum. It is also useful in the management of refractory Barrett's esophagus. In addition, we are seeing the EndoRotor as a significant advancement in endoscopic management of walled-off pancreatic necrosis.”

– Kamran Ayub, MD
 Interventional and Therapeutic Endoscopy, New Lenox, Illinois

“The EndoRotor provides a unique platform to remove unwanted tissues from the foregut, midgut and hindgut by essentially debriding premalignant, non-lifting lesions that have invaded as deep as the sub-mucosa, while capturing fragmented tissues. The process is safe, efficient and without a steep learning curve, offering an alternative to other methods such as endoscopic submucosal dissection.”

– Stuart Amateu, MD
 Interventional and Therapeutic Endoscopy,
 Associate Professor University of Minnesota