

Video Transcript Interscope – Endorotor-System (English Translation)

Endoskopie Live 2017, Berlin, April 2017

Speaker	Start	End	Text
Female Introductory Moderator	00:00	00:24	Our next patient presented for a control endoscopy after the resection of an adenoma in the descending colon. A recurrent adenoma was identified in the area of the resection scar without a positive lifting-sign. Professor Hollerbach will demonstrate for us in this case the endoscopic resection with the EndoRotor System.
Off-camera Moderator, Professor Hagenmüller	00:26	00:27	Professor Hollerbach, we're ready.
Professor Hollerbach	00:25	03:58	<p>Yes, hello Professor Hagenmüller, our intention today is to conduct a small world premier - in all modesty, it is the first-ever Live Show I believe, in which this instrument has been featured; but I think, with Nurse Claudia's assistance and her fine team here at Lichtenberg, and Dennis D'Oria from Interscope here on my right side, we're ready to give it a go.</p> <p>One sees here at center screen the suspicious object of our attention, namely this recurrent lesion..., we have injected a little with adrenalin and the usual, and one sees, it is a real challenge, as is only appropriate for a world premier, because the thing is perched on a kind of fold, intermittently irrigation comes shooting down from above, with a little debris mixed in, but we will, as just said, go ahead and begin here.</p> <p>So, to the right on the screen with the black line pointing upward, that is our EndoRotor Catheter, which we now have already moved into position. When one sees the black line, that means that the opening containing the tiny rotating blade is directly under us, that is to say, on the opposite side. One therefore has no direct visualization of that side. I will now start the cutter motor and you see that it immediately responds with rotation, yes the tip begins to slightly oscillate back and forth, so then I know, now it's cutting, and then I place the EndoRotor on this area, and carefully, because we have a recurrent lesion, now lift the tip, and proceed in that manner to resect small pieces...the histology (specimens) will be continuously collected, we don't need to be concerned about losing the tissue, and you see, we are „nibbling,“ like with a miniature vacuum cleaner, the tissue away. Because one does not have perfect visualization (of the target tissue), one should repeatedly</p>

			<p>lift the tip and inspect, then reposition the tip and then again lift and inspect. Don't pull on the catheter, that is not at all recommended, rather I move the endoscope over the mucosa like with a vacuum cleaner, back and forth and harvest my small fragments, and then always look underneath to inspect and ensure that I'm only resecting sub-mucosa. You see that the polyp slowly disappears and one sees nicely the scar tissue bed, here the white scar tissue; ...like with a vacuum cleaner, just with not too much force, very superficially, I remove, piece-by-piece (the tissue). In between we pause briefly, because, particularly with recurrent disease, it is extremely important, not to resect too deeply, and we need to see what's going on behind the fold.</p> <p>So that is all going very well here...despite my pulse being at 180 (bpm), I think we have already resected a large area. I will now switch off the EndoRotor, we will remove the catheter and irrigate the entire area with water. But I think one can see that 98.5% of the polyp is already gone, one sees as well the fibrosis, and we will next turn our attention to the resection of that...sort of, remaining polyp remnant up there; that will however go fast, and then, above all, we will..., the right margin there, where there is a lot of movement, there is of course a small remnant..., we could remove that now conventionally using a small snare, if one is concerned about safety..., but I think you now have an impression.</p> <p>What you hear is not my hairdryer, but rather the irrigator..., but here one sees nicely that we are down to the fibrotic scar tissue in the sub-mucosa. Here...still some small polyp remnants on the left side and we will turn our attention to these too as we proceed..., and I am quite confident that we will remove it all.</p> <p>We will now insert the EndoRotor again, like this; I can also now briefly demonstrate the EndoRotor, if we still have 30 seconds of time.</p>
Professor Hagenmüller	03:59	04:06	Of course..., naturally we are interested in seeing how the device works, and we would also like – can we see the tissue that you have collected?
Professor Hollerbach	04:06	04:25	Yes, we can. Mr. D'Oria has already prepared everything, the filter system, although not the actual one containing tissue, but rather a mock-up, a "Fake" with "Fake News Material", because otherwise one needs to disassemble the setup. But we can also do that at the conclusion. We could cut away and return..., it will take a couple of minutes...
Professor Hagenmüller	04:26	04:27	That means, tissue is aspirated and trapped by the filter...
Professor Hollerbach	04:28	06:52	Right, right, like on a Melitta coffee filter paper, it is

			<p>entrapped. So now, Professor Hagenmüller, here is the EndoRotor's cutter opening. I have intentionally had it rotated upward and you see the small cutting blade. I will now turn it on and, now, observe what happens. The device needs some irrigation; that is, a little irrigation is simultaneously delivered. There, I stopped it again and now you see the tiny rotating blade. OK, there are also a few air bubbles in the way, but one sees it quite well.</p> <p>So now I turn it off again, that is all done using the footswitch, and that is done „blind“. That actually takes some getting used to, it's not witchcraft of course, but also not entirely simple at first. Now rotate it in the other direction, please. Can you just rotate... just flip it upside down; perfect, perfect, thank you, Dennis.</p> <p>OK, there we go, there we go. Excellent, excellent.</p> <p>This is the shooting position as I would call it, because we are now also cutting along the edge and can remove this small remnant here in the front. Here, at this point we need to work very carefully, because now we are in the sub-mucosa, and we naturally don't want to make a hole at the finale of our efforts. All right, there we go.</p> <p>And, we will very carefully also still work on this small remnant here, like that, and the device suctions that up a little here, therefore one should not remain too long at that area. I am now a little tangential, but that is not so bad. We see here again, the mucosa is being dissected away from the fibrosis and because it's naturally of greatest interest, we will try to show the histology of the actual collected material. Now, I just (inadvertantly) pulled on the catheter. Too much force..., but I think we have it. Yes. That's it: what we have achieved with the EndoRotor..., I'll irrigate it off, again. Careful, don't be startled; it's the hairdryer again.</p> <p>OK, I think one sees very well, that most of it has been removed, down to the sub-mucosa and also over and beyond this horrid edge. We'll inspect it all again in detail, but, Professor Hagenmüller, do we still have a moment..., so that we can disassemble the filter?</p> <p>Dennis could you take off the filter, just to remove everything and make sure the audience can take a look at the specimen? That would be great.</p>
Professor Hagenmüller	06:53	06:55	We can also cut back to you once you have removed the filter.
Professor Hollerbach	06:56	07:06	I think that would be better; we will still work a bit more on the margins, and also take a couple of biopsies, to ensure the margins are clear, but I believe this has turned out quite well.
Professor	07:07	07:12	Thank you for this impressive demonstration of a new

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Hagenmüller			concept; we can most certainly discuss this much more tomorrow.
Professor Hollerbach	07:13	07:24	You're most welcome. Thank you, as well. — CUT AWAY — — CUT BACK — OK, Professor Hagenmüller, here is the filter trap and specimen..., is that well visible?
Professor Hagenmüller	07:25	07:28	Yes..., what about if you just lay it down carefully, no fidgeting; that way the camera man can have at it.
Professor Hollerbach	07:29	07:33	Perfect, Professor Hagenmüller.
Professor Hagenmüller	07:32	07:35	Lay it gently down somewhere, then the cameraman can frame it in the screen.
Professor Hollerbach	07:36	08:40	...Here we go, ok. Now it should be in focus. You see, these are really quite small pieces. But these are fully evaluable concerning histology, and our pathologist, Professor Wellmann, who has also had a lot of opportunity during the animal experiments to look at resulting specimens, is enthusiastic because they received intact mucosa and sub-mucosa architecture. In other words, even if these look very small and unspectacular, the pathologist gets a very good histology where the sub-mucosal components are not destroyed, and he also sees, ...if cells migrate into the sub-mucosa he is also able to recognize that. But also, this was of course a recurrence. The fragments are usually larger: if I have naïve polyps, those resected fragments are significantly larger. Now we have placed the micron filter disc in formalin; this is what the filter trap looks like, this is where the fragments are aspirated in. Of course, with a naïve polyp one has much larger pieces, but these are as a rule sufficient for the pathologist, even if the fragments are small.
Professor Hagenmüller	08:41	08:53	We will have the results demonstrated to us tomorrow; thank you again. We have seen a lot of new things in this session, and, didactically-speaking, excellent in my opinion.

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Translator Note:

Pronunciation tip – “Hagenmüller“, pronounce “Hagen moo ler“