



AN INTERVIEW WITH *David Carr-Locke, MD, Beth Israel Medical Center, New York, New York, on cannulation techniques during endoscopic retrograde cholangiopancreatography (ERCP) and the importance of sphincterotomes to these procedures.*

Q **How do you deal with some of the procedural challenges often associated with anatomy during ERCP?**

An essential element of cannulation is the need to lift the papilla that one sees endoscopically to overlap the access to the bile duct. That important lifting or shortening of the intramural segment of the bile duct is the key to successful cannulation. Catheters, guidewires, sphincterotomes and other devices that have been produced for cannulation are designed to overcome that part of the bile duct in normal anatomy. When there are anatomical challenges caused by surgical alteration, we often use an end-viewing endoscope. Therefore, normal accessories do not work very well so you may want those accessories to do different things like rotate or work upside down.

Q **When do you use sphincterotomes in your practice and how often do you use them?**

The place of sphincterotomes in ERCP has changed considerably over the last 20 years; initially they were used purely for sphincterotomy. Today, they have become essential tools for cannulation as well as sphincterotomy. We also occasionally use the deflection capabilities of a sphincterotome within the bile duct to direct guidewires.

Q **What is important to you in a sphincterotome? Why is sphincterotome performance important in your procedure?**

A sphincterotome has to orientate correctly; it has to be strong enough in the axial direction so that it has adequate pushability; it has to be atraumatic at the tip; and it has to bow reliably for sphincterotomy. When a sphincterotome orientates correctly, it facilitates an efficient procedure and makes the procedure much more likely to be successful. This will benefit the patient.

Q **Would a sphincterotome that rotated be a benefit? How could rotation make a procedure more efficient or successful?**

In the past sphincterotomes were static, they could not be rotated unless we made them rotate ourselves. But for a sphincterotome to have good one-to-one rotation ability may be an advantage in certain situations, for biliary cannulation, sphincterotomy, and for selective intrahepatic duct access. The ability to rotate a device is an advantage. Having a reliable sphincterotome is critical to a successful procedure and that helps patient care by reducing the risk of complications.

Q **When a company is investing in both improving their legacy or core devices as well as developing new devices, what does this mean to you and is it something that matters to you?**

The interaction between clinicians and industry is essential for the development of new devices and also the improvement of existing devices. The Ultratome™ XL Sphincterotome is a good example of that. Over a period of time many of us have contributed ideas and have tested new versions of the sphincterotome for cannulation and for sphincterotomy to help improve its ability to do all of the things that we want it to do. This sort of interaction that takes place between the engineers on the industry side and us as clinicians, the end user, helps to make that happen. If that interaction did not occur, either certain devices would never get developed or it would take a lot longer. It is a partnership that allows optimal products to be developed that meet clinicians' needs.

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