1. What is PowerSpiral Enteroscopy?

1-1 Introduction

- The PowerSpiral Enteroscope is unique in that it incorporates a user-controlled motor.

- The specially designed overtube is mounted on to the enteroscope as an attached segment. It is located behind the bending segment of the enteroscope tip.

- With forward motion, the PowerSpiral segment is rotating clockwise. With backward motion, the PowerSpiral segment is rotating counterclockwise. Rotational movement is activated by the footswitch, for both forward and backward rotation.

- The system’s control unit delivers torque to the spiral segment which is displayed visually for monitoring on a force gauge. This display provides the operator with visual indication of the direction and the force of rotation throughout the examination.

- There are also auditory signals and automatic safety features built into this unit. Furthermore, the force gauge is also displayed as a picture-in-picture on the monitor screen, over the endoscopic image.
1. What is PowerSpiral Enteroscopy?

1-2 Equipment

- PowerSpiral Enteroscope and Single Use PowerSpiral Tube
- Lubricant: Note: ENDOLAN is the only recommended and designated lubricant
- Mouthpiece: Note: Use a dedicated mouthpiece for transoral insertion

Components:
- Monitor
- Force Gauge
- CO₂ Regulation Unit
- Processor
- Control Unit
- ScopeGuide System
- Flushing Pump
- Suction Pump
- Foot Switch

Note: Use a dedicated mouthpiece for transoral insertion.
1. What is PowerSpiral Enteroscopy?

1-3 Product Overview

- Instrument channel is in the 5 o’clock position
- Water Jet
- Instrument Channel
- Ø3.2mm
- Ø18.1mm
- 400mm
- 240mm
- 160mm
2. Basic Information

2-1 Operator Qualifications

PowerSpiral Enteroscopy is a procedure requiring advanced skills. The operator must be credentialed in upper and lower endoscopy and should be specifically trained in this procedure following the Olympus training module for PowerSpiral Enteroscopy.

2-2 Indications

Patients requiring deep enteroscopy including:
- Patients necessitating definitive diagnosis of small intestinal bleeding, polyposis, tumor, or inflammatory bowel diseases
- Patients necessitating close examination and histopathological diagnosis of impaired digestive absorption, protein-losing enteropathy, or malabsorption syndrome
- Patients necessitating endoscopic therapy of small bowel disease including polypectomy, hemostasis, dilatation, or foreign body removal
- Patients necessitating evaluation of other suspected GI abnormalities such as; Crohn's disease, ulcers, celiac disease, malabsorption, polyps, lymphoma, or other invasive diseases

2-3 Contraindications

Patients not suitable for a prolonged endoscopic procedure under general anesthesia or deep sedation, or general endotracheal intubation including:
- Patients with a medical instability preventing anesthesia
- Non-consenting patients, or for patients where there has been a failure to gain consent
- Patients with known perforation
- Patients who have or have had uncontrolled coagulopathy
- Patients who have had a recently placed feeding jejunostomy (e.g. less than two weeks)
- Pediatric patients, especially infants and toddlers
- Patients with a stent or other instruments implanted in the intestinal tract

Antegrade Approach
- Perforated ulcer
- Esophageal or gastric varices
- Foregut stenosis
- Deep mucosal laceration
- Suspected or diagnosed eosinophilic esophagitis
- Unable to accept mouthpiece

Retrograde Approach
- Severe active inflammation of colon
- Anal stenosis
- Colonic stricture

2-4 Precautions

- Known stricturing diseases such as Crohn’s disease or radiation enteritis
- Pregnancy
- Any prior abdominal or pelvic surgery including altered anatomy
- Radiation enteritis
- History of dysphagia or known esophageal swallowing disorders
- Mild to moderate inflammation of colon
2. Basic Information

2-5 Pretreatment

**Antegrade Approach**
Patient should be fasting according to institutional anesthesia policy.

**Retrograde Approach**
The same pretreatment as that used for lower gastrointestinal endoscopy (colonoscopy), including a thorough bowel lavage.

2-6 Anesthesia

Either general anesthesia or deep sedation is recommended in all cases, and general anesthesia in particular for the antegrade approach.

2-7 Patient Position

**Antegrade Approach**
- The patient is positioned in the left lateral decubitus position with gentle neck extension. Other positions may be necessary.
- The position of the patient can be altered during the procedure to facilitate enteroscope passage as needed.

**Retrograde Approach**
- The patient is positioned in the left lateral decubitus or supine position.
- The position of the patient can be altered during the procedure to facilitate enteroscope passage as needed.
3. Assembly Information

3-1 Assembly and Preparation

Assembly and preparation of the PowerSpiral Enteroscope begins with loading of the spiral tube onto the distal enteroscope. The spiral tube has a yellow marking line which must not be visible when securely locked and ready for use.

1. The distal end of the enteroscope is first lubricated, beginning with the rotational segment and continuing to the tip.

2. The lubricated portion of the enteroscope is straightened and the spiral tube is then loaded onto the enteroscope with the connector end towards the upper scope, cephalad.

3. As the spiral tube is advanced over the rotational segment of the enteroscope, the ridges on the rotational segment must be aligned with the grooves of the spiral tube.

4. Continuing to slide the tube will allow the tube to lock into place with a click.

5. The spiral tube has a lock collar which must slide onto the connector and lock into place.

6. When this is done, the yellow mark on the spiral tube disappears under the lock collar as the click is generated.

**Note**

Be sure to avoid handling the lock collar when placing the spiral tube onto the enteroscope. This will prevent premature activation of the lock collar.
3. Assembly Information

3-2 System Function Test

After the spiral tube is loaded onto the enteroscope, a system check is performed to confirm correct loading and function.

**Note**

Every time the control unit is turned on or the enteroscope has been replaced, the inspection mode is turned on. The spiral tube will always rotate counterclockwise first and then rotate clockwise in inspection mode.

1. Turn on the power to the control unit. Depress the backward foot switch pedal all the way.

2. Manually bend the spiral tube into a semi-circle position while maintaining the backward rotation.

3. Watch the force gauge display. The level bar indicator should display changing forces, but not excessive forces.

4. Stop the rotation and lubricate the spiral tube.

5. Gently grasp the midpoint of the spiral tube segment with the left hand, while holding the section proximal to the rotation part with the right hand.

6. Activate backward rotation and gradually increase the squeezing pressure at the mid point of the rotating spiral.
3. Assembly Information

3-2 System Function Test

7 Confirm that this force - shown via the level bar indicator - is changing the reactive force against the right hand, and vice versa.

8 Increase pressure on the spiral segment until the limit function is activated and the rotational movement is automatically halted by the built-in safety function of the system.

9 Repeat these same maneuvers with the forward spiral rotation activated by the foot switch, to complete the inspection mode.

10 The PowerSpiral Enteroscope is now ready.

Note
The limit function is designed to protect the rotation part and not intended to guarantee patient safety.
4. Procedure Information

4-1 General Techniques

- If no further advancement is achieved after employing supplemental maneuvers, it should be interpreted as a warning to assess the patient and scope position.
- In the case of continued rotation without advancement after 5-10 seconds, or with repeated activation of the automatic limit function, the user should try to resolve the issue using loop reduction, manual abdominal compression, decompression, water insufflation or other maneuvers.
- The limit function does not guarantee patient safety during the procedure. The operator must judge if safe insertion can be continued on a case-by-case basis.

What is the limit function?

The limit function stops the rotation of the spiral segment when the resistance to rotation reaches a certain limit. To reset, remove your foot from the pedal on the foot switch. Depressing the pedal again will restart the rotation function.

4-2 Insertion Tips

- Gentle forward pressure is applied to the enteroscope when rotation is started to advance.
- Minimize CO₂ insufflation.
- Irrigation using water jet may help with lumen visualization and lubrication.
- Intermittent manual abdominal compression and release is often helpful to facilitate engagement of the bowel to the spiral segment and facilitate advancement.

4-3 Withdrawal Tips

- Insufflation may be used as needed at this time.
- Slow controlled withdrawal is the key. This is accomplished by backward rotation while maintaining the scope position and keeping the tip in motion.

Note

PowerSpiral Enteroscopy is a fundamentally different technique than balloon-assisted enteroscopy and relies on passive pleating and unpleating of bowel. Forceful advancement or withdrawal should not be used with PowerSpiral Enteroscopy.
4. Procedure Information

4-4 Antegrade Approach

The spiral segment is less flexible than the remaining enteroscope. As a result, per oral antegrade passage of the PowerSpiral Enteroscope requires extra steps for safe and successful intubation of the esophagus.

Insertion through the Pharynx and Esophagus

1. The patient’s neck should be extended to ease passage through the pharynx, upper esophageal sphincter and cervical esophagus.

2. Slow forward rotation is engaged using the foot switch as the upper sphincter is entered.

3. Gentle pressure is used to advance the enteroscope through the esophagus maintaining slow forward rotation of the spiral segment.

4. Once the spiral segment has completely passed through the upper esophageal sphincter, there will be a drop in the resistance and torque. At this point, the patient’s neck may be returned to a neutral position.

Note

Patients with suspected esophageal pathology including strictures, varices or dysphagia should undergo an EGD first. Patency of the esophagus should be proven by gentle passage of a 54-60Fr (18-20mm) dilator and confirmed with EGD. This is important because the tip of the scope where the image is generated is smaller in caliber than the rotary spiral section.
4. Procedure Information

4-4 Antegrade Approach

Insertion through the Stomach and Duodenum

1. Gastric passage begins with aspirating residual contents and collapsing the lumen.

2. Forward pressure is maintained on the enteroscope, with the spiral segment rotating as the pylorus is approached and intubated.

3. Forward pressure during intubation of the pylorus will generate a gastric loop which must be reduced by straightening the enteroscope.

4. Forward motion of the spiral segment is maintained as the straightened enteroscope is advanced.

Note: White arrow indicates the direction of the operator's right hand.

Tips

Straightening by pulling and re-advancement by pushing may need to be repeated until the enteroscope and spiral segment have passed through the pylorus and duodenal bulb and are within the post-bulbar duodenum.
4. Procedure Information

4-4 Antegrade Approach

Insertion through the Small Bowel

1. The first major anatomic location to pass during intubation of the small bowel is the fixed ligament of Treitz.

2. Once this has been accomplished, the PowerSpiral Enteroscope can be more readily advanced.

3. Deep passage into the small bowel is made possible by keeping the lumen decompressed.

4. Passage through the small bowel is accomplished by using forward rotation of the spiral segment and gentle forward pressure on the enteroscope.

Tips

Liberal water irrigation is used in place of CO₂ insufflation to allow visualization of the lumen and also enable forward passage.
4. Procedure Information

4-4 Antegrade Approach

Reaching the Terminal Ileum

The following images will provide indication of reaching the terminal ileum.

- The ileum becomes apparent with less prominent villi and prominent lymphoid follicles.
- The procedure should be terminated if the cecum is encountered.

Fluoroscopic Image

The pleated bowl will form large, hoop-like loops.
4. Procedure Information

4-4 Antegrade Approach

Withdrawal after maximum insertion

**Note**
Maximum insertion will be noticed either by passage through the ileocecal valve or the inability to advance the PowerSpiral Enteroscope any further despite straightening, decompression, and advancement with forward pressure on the enteroscope with active rotation of the spiral segment.

1. At the point of maximum or complete passage, stop rotation as soon as the cecum is seen to prevent the spiral segment from crossing the ileocecal valve.

2. Press the backward foot switch pedal and allow sufficient time for the unpleating of the bowel to start.

3. The enteroscope is allowed to passively withdraw as the pleated bowel releases itself over the enteroscope tip.

4. Controlling the speed of backward spiral rotation will modulate the rate the pleated bowel is released into view for examination.

5. The tip is “wiggled” using the directional controls randomly in all directions to facilitate unraveling of the bowel.

6. Prudent CO₂ insufflation may be used during the withdrawal phase of the examination.
4. Procedure Information

4-4 Antegrade Approach

Withdrawal after maximal insertion

7 As the spiral segment re-engages the pylorus, there may be resistance noted. Once this passes, the spiral segment has re-entered the stomach.

9 The enteroscope is withdrawn through the esophagus with backward rotation of the spiral segment maintained.

8 Once the 80 cm mark on the enteroscope is seen, this indicates the spiral segment will be engaging the lower esophageal sphincter.

10 The patient’s neck is extended once again to ease withdrawal from the cervical esophagus and upper esophageal sphincter.

Note

It is important to be sure that the spiral segment has passed completely out of the duodenum not to engage the esophagus. This is evident by seeing the pylorus from within the antrum. Exiting the duodenum is accomplished by stopping withdrawal of the enteroscope when the 80 cm mark is at the incisors and allowing 10-15 seconds of backward spiral rotation. With the pylorus in view, withdrawal into the esophagus is begun.

Patients with altered GI anatomy

! The safety of this endoscope has not been established in patients with altered GI anatomy. Perform endoscopy and endoscopic treatment in these patients only when its potential benefits are greater than its risks.

Recommendation of PowerSpiral experts:

In the absence of studies confirming the safety of PowerSpiral in patients with altered anatomy, when considering its use, one should consider alternative techniques and conclude that the potential benefit of PowerSpiral outweighs the potential risks. At least 10 cases experiences (per physician) and at least 20 cases experiences (per center) of deep enteroscopy with PowerSpiral is recommended before treating patients with altered GI anatomy.
4. Procedure Information

4-4 Antegrade Approach

Q What maneuvers are needed when resistance is encountered and rotation ceases during intubation?
A First, deflate the endotracheal tube cuff. Then, using backward rotation, withdraw the enteroscope and inspect the mucosa. If there is no injury present, repeat intubation modulating forward rotation and pushing force. Rotation may be used intermittently.

Q How can I keep the lumen decompressed when the lumen may not been seen?
A At times when the lumen may not be visible, the mucosa should still be able to slide by the tip of the enteroscope. An overly inflated lumen will prevent the spiral segment from engaging the small bowel and the necessary pleating of the small bowel behind the spiral segment (cephalad) will not occur.

Q What action is required when resistance is increased?
A Increased resistance is an indicator of remaining pleated bowel on the spiral segment. This requires advancement of the scope holding position and then resuming backward rotation.

Q What action should be taken if a lesion is encountered?
A If a lesion is encountered, rotation of the spiral segment is stopped. Forward pressure on the enteroscope is maintained in order to keep the position of the enteroscope and visualization of the lesion for biopsy or therapy. Both the forward and backward rotation may be used to obtain accurate positioning of the enteroscope tip relative to a lesion.

Q What maneuvers are useful when sharply angled bends are encountered?
A 1. Slowly withdraw the enteroscope -
First, stop the spiral segment along with any forward pressure on the enteroscope. Decompress the bowel. Slowly withdraw the enteroscope, using intermittent rotation as needed, to straighten the involved segments of small bowel on either side of the sharp turn.

2. Use water installation -
Use water installation to open the lumen of the bend.

3. Apply manual abdominal pressure -
Apply manual abdominal pressure with a massage action over the area and restart the spiral segment followed by gentle forward pressure on the enteroscope. This sequence of actions can be repeated if not successful after the first try.
4. Procedure Information

4-5 Retrograde Approach

The PowerSpiral Enteroscope may be used for retrograde examination of the small bowel, which is more complex than the antegrade approach. It requires additional maneuvers, especially during the colonoscopy phase of the procedure, enlisting loop reduction, manual abdominal compression, and passage through the ileocecal valve.

Entering the Colon

1. Forward rotation of the spiral segment is necessary for passage across the anal sphincter.

2. The colonoscopy is performed using standard technique supplemented by forward rotation of the spiral segment within the sigmoid.

3. Loops are reduced by withdrawing the enteroscope while simultaneously maintaining forward rotation of the spiral segment.

4. As the enteroscope enters the descending colon minimal insufflation is continued. Forward push pressure is used with forward rotation of the spiral segment.

Tips

Stalling during sigmoid passage may indicate increased resistance. After a loop reduction effort, resume slow forward motion. Use water irrigation for both lubrication and distention of the lumen.
4. Procedure Information

4-5 Retrograde Approach

Tips

Looping may also occur within the transverse colon. The same technique, withdrawing the enteroscope with forward rotation of the spiral segment, as used in the sigmoid, is also used in this location. The principal is to minimize the amount of scope inserted in the colon thereby preserving as much scope length as possible with which to examine the small bowel.

Passing through the ileocecal valve

1. Once the ileocecal valve is seen, it is approached for intubation with the tip of the enteroscope in the same fashion as during a colonoscopy.

2. Aided by manual abdominal compression as needed, forward rotation is used to allow the spiral segment to be advanced across the valve into the terminal ileum.
4. Procedure Information

4-5 Retrograde Approach

Passing through the Small Bowel

1. After the ileocecal valve and terminal ileum have been completely intubated, the enteroscope is advanced by maintaining forward rotation of the spiral segment with minimal manual movement of the enteroscope.

2. Bowel insufflation is minimized with the use of water irrigation to permit visualization during passage.

Note

When the passage is stalling, there should be attention paid to the force gauge, especially if the limit function is activated and rotation of the spiral segment stops automatically. This indicates significant resistance against the bowel wall and further rotational advancement could lead to an adverse event.

Tips

With rotation of the spiral segment stopped, use water irrigation to lubricate the small bowel.

Manual abdominal compression is then applied and passage with forward rotation of the spiral segment is resumed after first reducing any loops.
4. Procedure Information

4-5 Retrograde Approach

Withdrawal after maximum retrograde insertion

**Note**

Maximum retrograde insertion can be recognized when further advancement stops despite the maneuvers described previously, if a tattoo placed during a prior integrate enteroscopy is seen, or the duodenum is identified.

1. Withdrawal after maximum retrograde insertion is accomplished by using the backward foot switch pedal.

2. The speed of withdrawal can be altered by slowing backward rotation of the spiral segment while continuing to withdraw the enteroscope out of the patient.

3. If a lesion is encountered, the same maneuvers are used as described in the antegrade section.

4. Once the enteroscope has exited the ileocecal valve, it is removed from the colon in a standard fashion with the spiral segment maintained in backward mode, particularly when passing the anal sphincter.
4. Procedure Information

4-6 Treatment

Techniques

1. Snare resection/EMR
2. Hemostasis
3. Dilatation
4. Foreign body removal
5. Tattoo placement
6. Clipping
7. Endoloop placement

Note

- Passage of the spiral segment through a stricture is not advised.
- The spiral segment is not intended to be used for dilatation.
- Use extreme caution when advancing beyond dilation of stricture.

4-7 Reported Adverse Events

Several adverse events have reported as below. (August - December 2019)
In order to improve your routine procedural quality, please carefully see and understand.

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Location</th>
<th>Age, gender, and body measurements</th>
<th>Patient’s condition</th>
<th>Insertion direction</th>
<th>Anesthesia</th>
<th>Experts’ comments</th>
<th>Relevant information link</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Bowel perforation</td>
<td>NA</td>
<td>NA</td>
<td>Crohn’s disease (Diagnosed via exam)</td>
<td>Retrograde</td>
<td>NA</td>
<td>Safety unknown for known strictureting diseases such as Crohn’s disease: Perform exam only when benefits outweigh risks.</td>
<td>Precautions</td>
</tr>
<tr>
<td>2 Esophageal tear</td>
<td>NA</td>
<td>NA</td>
<td>Dysphagia</td>
<td>Antegrade</td>
<td>NA</td>
<td>Safety unknown for history of dysphagia and esophageal stricture: Perform exam only when benefits outweigh risks. All patients with a history of dysphagia should undergo a formal evaluation which includes an EGD before performing PowerSpiral.</td>
<td>Precautions</td>
</tr>
<tr>
<td>3 Ileal perforation</td>
<td>Terminal ileum</td>
<td>81-year-old, Female, 154cm, 59kg, BMI:23.2</td>
<td>Small intestine bleeding Diverticulosis</td>
<td>Retrograde Deep sedation</td>
<td>- Continuous rotation in the same location may result in bowel injury with mucosal disruption, bleeding, and deeper injury with perforation, especially within the terminal ileum. Repositioning the patient and the scope or adding manual abdominal compression if no advancement is achieved. If the rotating power segment is in the same position, this should be a warning to assess continuing efforts or terminating the procedure.</td>
<td>General Techniques Insertion Tips</td>
<td></td>
</tr>
<tr>
<td>4 Superficial esophageal tear Small esophageal perforation</td>
<td>Upper esophagus</td>
<td>50-year-old, Female, 175cm, 51kg, BMI:17.0</td>
<td>Tight upper esophageal sphincter No past medical history of dysphagia</td>
<td>Antegrade GA</td>
<td>Patient’s thin body habitus (BMI 17.0) may be problematic for scope intubation. Confirmation of PowerSpiral insertion accommodation using a bougie (54-60Fr) is highly recommended, especially in early experience (first 10 cases). If passage into the esophagus remains difficult, repositioning of the patient’s position and use of head and neck repositioning by the anesthesiologist or anesthetist may be useful.</td>
<td>Insertion Tips Withdrawal Tips Antegrade Approach Note Emergency Withdrawal</td>
<td></td>
</tr>
<tr>
<td>5 Severe mucosal injury in proximal esophagus</td>
<td>Proximal esophagus</td>
<td>70-year-old, Female, 160cm, 71kg, BMI:27.7</td>
<td>The proximal esophagus may have been less relaxed No past medical history of dysphagia</td>
<td>Antegrade Deep sedation</td>
<td>Pre-intubation bougie dilation useful if there is any resistance to intubation. General anesthesia may provide more complete muscle relaxation Neck positioning is important</td>
<td>Insertion Tips Withdrawal Tips Antegrade Approach Note</td>
<td></td>
</tr>
</tbody>
</table>
5. Troubleshooting

5-1 Emergency Withdrawal

Unexpected clinical events may necessitate prompt extraction of the enteroscope. If the procedure has been performed under monitored anesthesia care, the patient in an unexpected life threatening emergency situation may require endotracheal intubation. In this circumstance, the enteroscope may be left in place until tracheal intubation is accomplished. Withdrawal can then follow. Please note that emergency withdrawal will inherently require extra time to perform if the enteroscope is well advanced into the small bowel and pleated onto the scope. Removal efforts are directed at freeing the pleated bowel. If this is not accomplished, there is risk of intussusception. The first step is to insufflate the lumen with CO₂ and water. The water will provide lubrication. Backward rotation is maintained as the enteroscope is slowly pulled out. Tip deflection in all directions may enable unpleating of the bowel and the withdrawal. The same precautions must be taken when the 80 cm mark is noted at the mouthpiece. Withdrawal must be interrupted at this point. With active backward rotation maintained, the tip of the enteroscope must be seen to first exit the duodenum and pass through the pylorus into the antrum before resuming withdrawal with backward rotation into and through the esophagus. The patient’s neck should be straightened to ease passage through the esophagopharyngeal segment.

5-2 Equipment Failure

Loss of power or other major equipment failure such as a cable break or motor failure will stop the spiral segment from rotating. Similar to emergency withdrawal, removal of the enteroscope will take extra-time to accomplish. It is important to insufflate the bowel in order to release the pleated portions from the scope. This is accomplished by instilling CO₂ or air as well as water for lubrication directly through the scope channel. Tubing may be connected via luer lock to the working channel or syringes may be used. Once insufflation is apparent, the scope is slowly withdrawn. Fluoroscopy may be used to monitor effective insufflation and avoid excessive insufflation. Tip deflection in all directions may facilitate unpleating of the bowel. If there is resistance to withdrawal, pulling should halt followed by a pause, additional insufflation or instillation of water performed, followed by forward pushing 5-10 cm before gentle pulling withdrawal is re-initiated. When the 80 cm mark is noted exiting the mouthpiece, extra effort at tip deflection to release the scope from the duodenum and pylorus is performed before the final pull through the esophagus. Neck straightening is needed to aid esophagopharyngeal passage.

5-3 Detachment with loss of the spiral tube

If the spiral tube becomes released from the scope attachment rotational activity within the lumen will cease. Pull the enteroscope until the spiral tube has completely separated from the scope and obtain an optimum field of view. The pleated bowel must be released by using gas insufflation and water as the scope is withdrawn. If the spiral tube becomes completely separated from the scope and free within the lumen, retrieval efforts are made similar to extraction of a foreign body using forceps or inflated balloon at the distal end of the spiral tube. The enteroscope with captured spiral tube are slowly withdrawn. Failure to retrieve the spiral tube may require surgical removal.

**Note**

Do not, under any circumstances, forcefully withdraw the enteroscope. Instead, allow the pleated bowel to be unraveled off of the spiral segment through backward rotation.
6. Recommended Products

6-1 Recommended Products

Imaging using fluoroscopy or ScopeGuide is available and recommended when the configuration of the enteroscope is uncertain.

CO₂ is the mandatory gas for gas insufflation.

Application of the water jet lubricates the mucosa enhancing pleating of the small bowel onto the enteroscope. Instillation of water is recommended to facilitate visualization as well as navigation around tightly angled turns.
6. Recommended Products

6-2 Compatible Endoscopic Instrumentation

The length of the PowerSpiral Enteroscope from the tip of the biopsy port is 1680 mm. The working channel is 3.2 mm wide. Olympus or non-Olympus manufacturer equipment of sufficient length and diameter should be compatible.
7. Supervisors

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