

THE INTERVIEW TO DOCTORS BY ABIS

Special version

WALK ON

東京医科大学 消化器内科

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MTW Endoskopie Manufaktur
ERCP-Catheter, filiform



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This year marks the 20th anniversary of the launch of the MTW catheter. How has endoscopic treatment changed during this time?

Even today, 20 years later, the MTW catheter is undoubtedly a standard product and an excellent catheter. The reasons for its long-standing use are obvious: the concept was well thought out. Twenty years ago, the prevailing mood in Japan was to introduce wire-guided cannulation (WGC), which was common in Europe and America. Currently, however, catheter insertion is still the common method in about 70 to 80% of cases. I believe this reflects the fact that there was no reason to look for changes.

What was your first impression of the MTW catheter when it came on the market?

At that time, the mandrin had to be removed from the common types of catheters, which caused numerous inconveniences, such as the inability to insert a guide wire during angiography. When I tried the MTW catheter, which was still relatively unknown at the time, I was impressed by its high level of sophistication. It was a groundbreaking device that enabled angiography with a guide wire in place. It was just the right amount of flexible, fit comfortably in the hand, and made catheter manipulation exceptionally easy. It is probably the only catheter that allows for a “pause” during catheter manipulation.

When I actually visited MTW, I was deeply impressed by the sight of the craftsmen making each catheter by hand. I was particularly impressed by how they carefully ground the tip, a process that takes a lot of time. Seeing the craftsmen making basket catheters and loops by hand also filled me with admiration for their quality and passion and gave me a feeling of security. The newly introduced Ultra Taper catheter was designed specifically for 0.025-inch guidewires to minimize the gap between the guidewire and the catheter.

Can you share your impressions of using this model?

Compared to the current product, it is slimmer, and I have no doubt that it will prove invaluable in difficult cases. Although angiography with the guidewire takes a little longer than with previous catheters, the overwhelming advantage is that there is almost no gap at the tip. Several products with similar concepts have now come onto the market.

What position do you think the MTW catheter currently occupies for you?

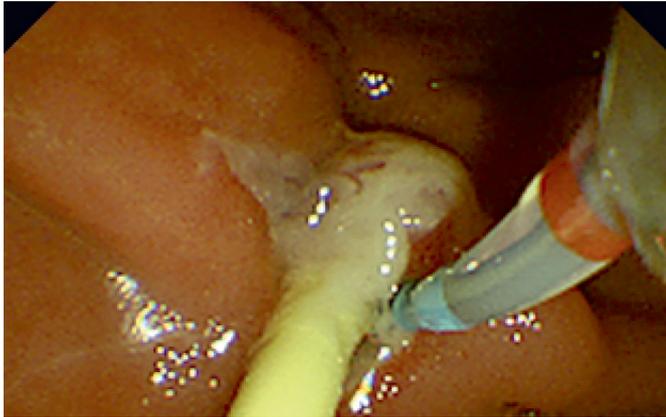
Although various companies have launched comparable catheters, the MTW catheter has a unique “reserve” that makes it arguably the only catheter that truly responds to the creativity of the user. In terms of its “flexibility,” I firmly believe that there is a difference that cannot be expressed in mere numbers. Furthermore, while disposable products are necessary in certain cases, reusability is also widespread given current costs and other factors. I believe that not all scenarios require disposable solutions.



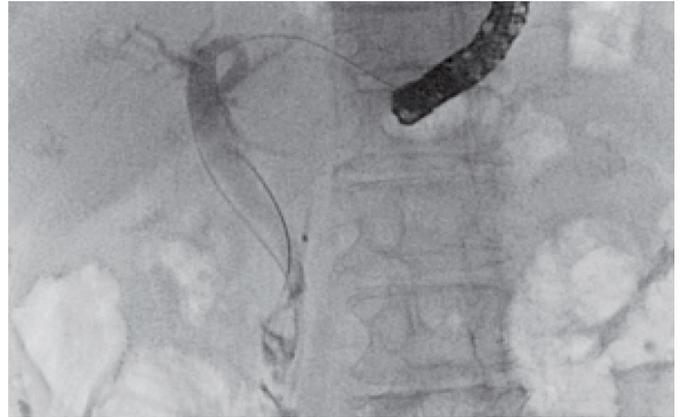
Michael Kettler from MTW Endoskopie Manufaktur at Tokyo Medical University with Professor Takao Itoi

Case 1:

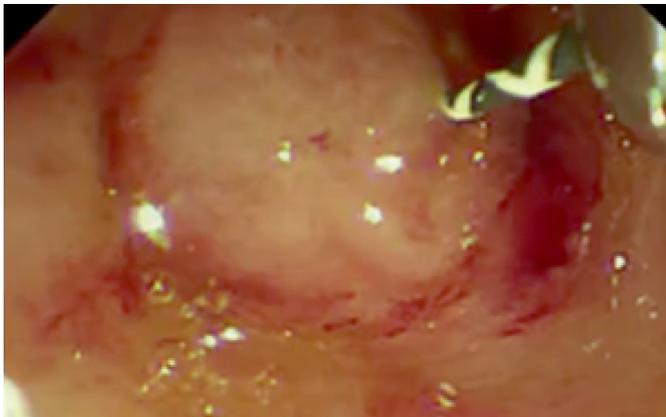
A case of bile duct stones following total gastrectomy with Roux-en-Y reconstruction for gastric cancer. Previous attempts at transpapillary stone removal using small bowel balloon endoscopy proved difficult. To enable antegrade stone removal, endoscopic ultrasound-guided hepaticojejunostomy (EUS-HJS) was performed one month earlier. Since a fistula had also formed this time, antegrade stone removal was performed via the HJS route.



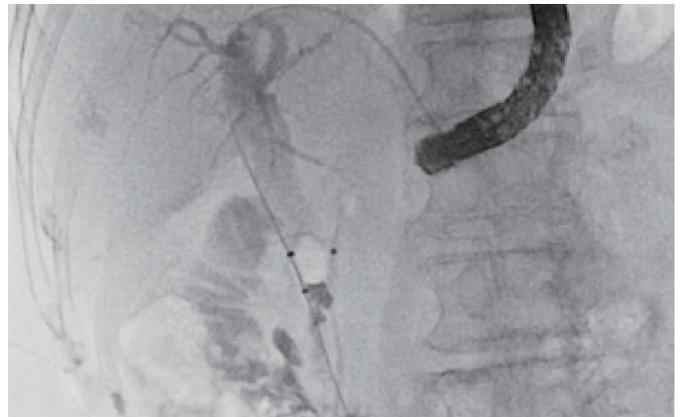
1 a



1 b



1 c



1 d

1 a: A 7-Fr plastic stent is inserted into the fistula tract; an ultra-conical catheter is inserted next to the stent. Its small diameter allowed for relatively smooth insertion.

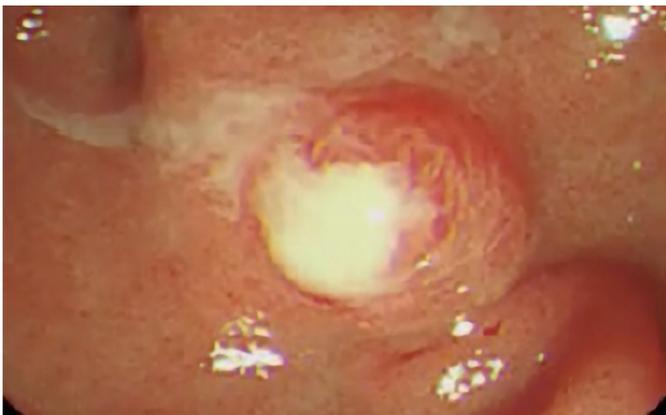
1 b: The stone was confirmed by contrast imaging.

1 c: A 0.025-inch guidewire (GW) was used, which could be maneuvered smoothly.

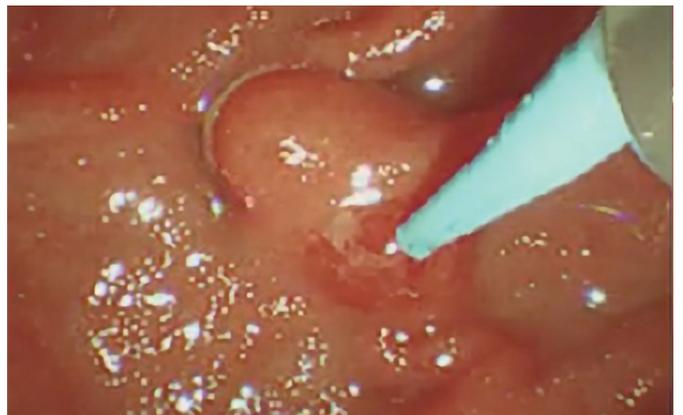
1 d: The stone was pushed into the intestine using a stone removal balloon.

Case 2:

Emergency ERCP for acute cholangitis due to bile duct stones. The papilla was a primary papilla without prior endoscopic papillotomy (EST) and had adherent purulent bile. Emergency drainage was performed using an ultra-conical catheter and a 0.025-inch guidewire.



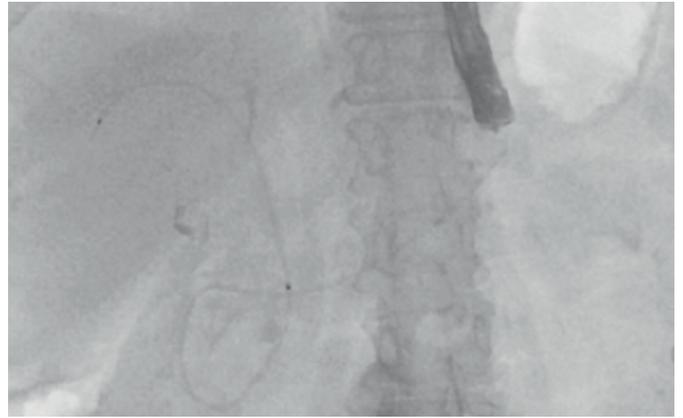
2 a



2 b



2 c



2 d

- 2 a: Purulent bile adhering to the papilla.
- 2 b: Attempt to insert a bile duct catheter using an ultra-conical catheter.
- 2 c: Successful insertion of a bile duct catheter using an ultra-conical catheter and a 0.025-inch guidewire.
- 2 d: Infected bile is suctioned out. Due to severe inflammation, an endoscopic transnasal bile duct drainage tube was placed.

Case 3:

A case of distal bile duct stricture and duodenal stenosis due to pancreatic head cancer. Due to duodenal stenosis, it was not possible to advance the duodenoscope, which made transpapillary stent placement at the bile duct stricture difficult. Therefore, endoscopic ultrasound-guided hepatogastrostomy (EUS-HGS) was performed about a month earlier. This time, a metal stent was placed antegrade via the HGS route in front of the stricture.



3 a



3 b

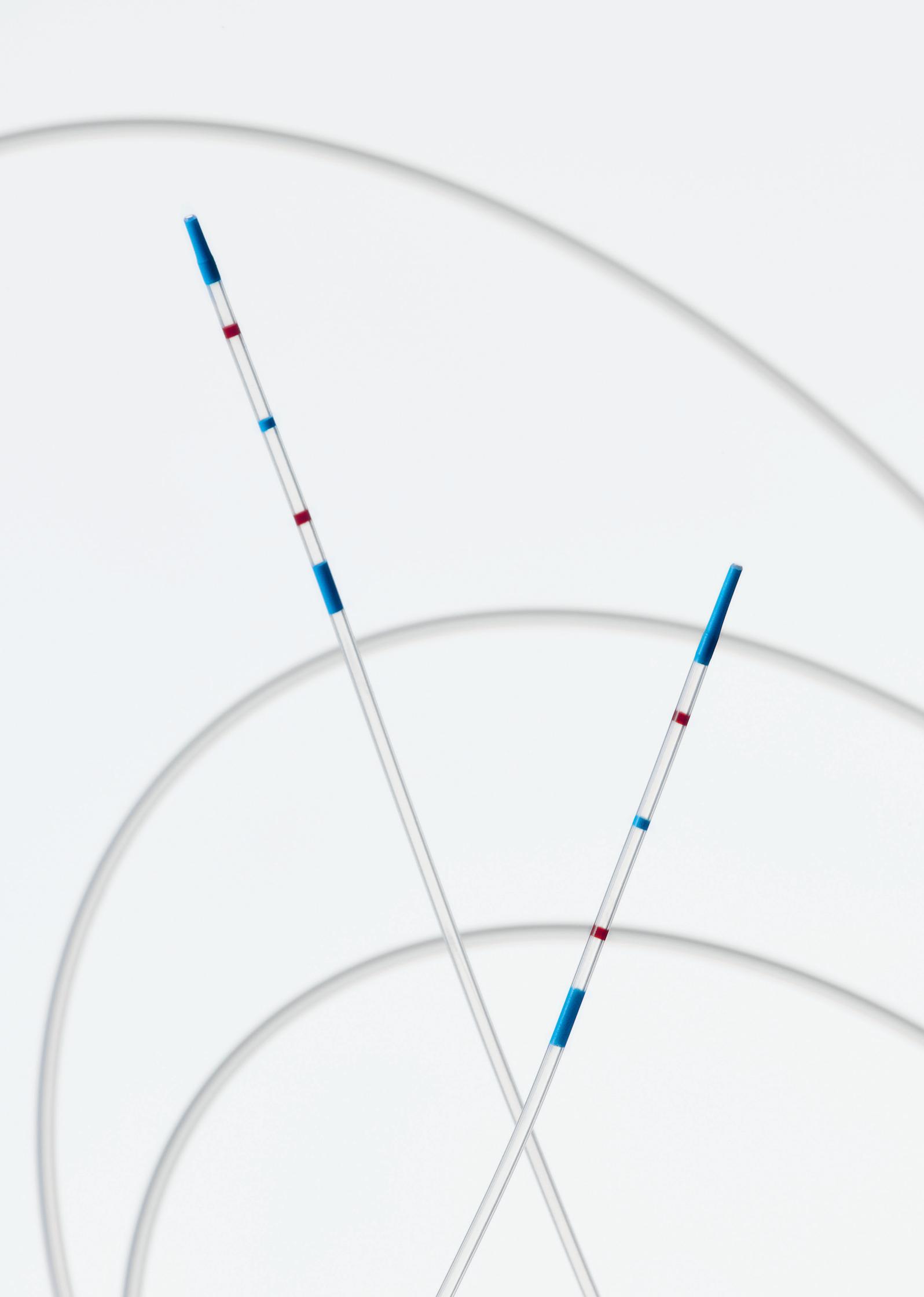


3 c



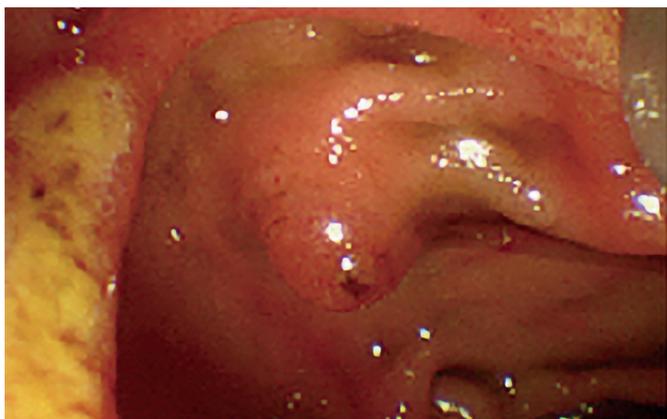
3 d

- 3 a: A 7-Fr plastic stent is located in the fistula tract; an ultra-conical catheter is inserted next to the stent.
- 3 b: Due to its small diameter, insertion was relatively smooth.
- 3 c: Contrast imaging confirmed the tumor-related narrowing. Despite the severe stenosis, the catheter could be inserted without any problems.
- 3 d: A metal stent was placed antegrade within the narrowed segment.



Case 4:

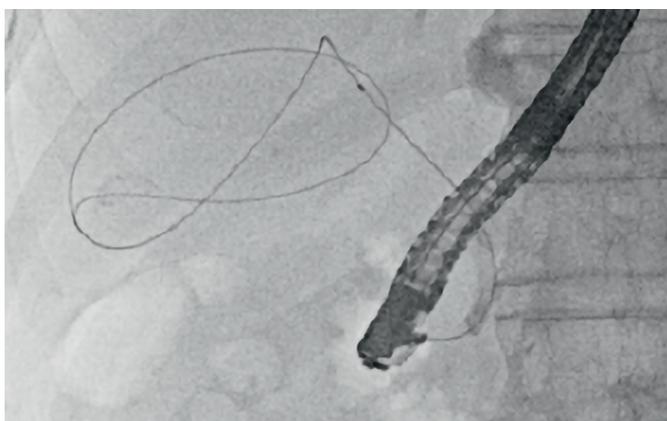
In a case of acute cholecystitis due to gallstones, emergency endoscopic drainage was performed using an ultra-conical catheter and a hydrophilic 0.025-inch guidewire.



4 a



4 b



4 c



4 d

- 4 a: A 7-Fr plastic stent is located in the fistula tract; an ultra-conical catheter is inserted next to the stent.
- 4 b: Due to its small diameter, insertion was relatively smooth.
- 4 c: Contrast imaging confirms the tumor-related stenotic segment. Despite the severe narrowing, catheter guidance was smooth.
- 4 d: A metal stent was placed antegrade within the stenotic segment.

Advantages:

It has sufficient stiffness and a cleanly tapered tip, making it ideal for passage through stenotic areas. The offset between the tip and the 0.025-inch guidewire during passage was virtually imperceptible. In addition, passage through the bile duct during gallbladder drainage was relatively uncomplicated. It allows for more precise puncture and cannulation at the initial papilla.

Disadvantages:

Handling with the 0.025-inch guidewire feels slightly stiffer compared to a standard catheter (MTW: tapered type). Aspiration of bile with the guidewire in place takes time, and contrast injection with the guidewire in place also takes slightly longer. In addition, the Ultra Taper catheter was developed for the Japanese market and thoroughly optimized for compatibility with 0.025-inch guidewires, so it cannot be used with 0.035-inch guidewires. Caution should be exercised in cases where a switch to a 0.035-inch guidewire is necessary.

Order no.	Article no.	Catheter tip	Diameter mm	Length cm	For guide wire inch	PU
990120111 x5	990120111	filiform / with inside metal ring	2,3 > 1,5	215	0.025	5