Inodaya Hospitals

GASTRO DEPT MANUAL

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CONTROL OF THE MANUAL

The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable manner.

The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

Radiology Department is responsible for issuing the amended copies to the copyholders and the copyholder should acknowledge the same and he /she should return the obsolete copies.

The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment or assessment audits by NABH.

The procedure manual with original signatures of the above on the title page is considered as 'Master Copy', and the photocopies of the master copy for the distribution are considered as 'Controlled Copy'.

Distribution List of the Manual:

- ENDOCSOPY DEPARTMENT

COLONOSCOPY

Colonoscopy may be done for a variety of reasons. Most often it is done to investigate the cause of blood in the stool, abdominal pain, diarrhea, a change in bowel habit, or an abnormality found on Colonic X-rays. Individuals with a previous history of polyps or Colon Cancer and certain individuals with a family history of some types of non-Colonic Cancers or Colonic problems that may be associated with Colon Cancer (such as ulcerative colitis and Colonic polyps) may be advised to have periodic Colonoscopies because their risks are greater for polyps or Colon Cancer.

Colonoscopy frequency depends on the degree of the risk and the abnormalities found at previous Colonoscopies. Recommendation: Even healthy people at normal risk for Colon Cancer should undergo Colonoscopy at age 50 and every 10 years thereafter, for the purpose of removing Colonic polyps before they become cancerous.

REQUIREMENTS:

1. The Colon must be completely cleaned.

2. Patients are given detailed instructions about the cleansing preparation. (Colonoscopic Preprartion Protocol)

3. Consultant will prescribe the type of Solution or Medicines to be taken for preparation.

PROCEDURE:

1. Prior to Colonoscopy, intravenous fluids are started, and the patient is placed on a monitor for continuous monitoring of heart rhythm and blood pressure as well as oxygen in the blood.

2. Medications (sedatives) usually are given through an intravenous line so the patient becomes sleepy and relaxed, and to reduce pain.

3. If needed, the patient may receive additional doses of medication during the procedure.

4. Colonoscopy often produces a feeling of pressure, cramping, and bloating in the abdomen; however, with the aid of medications, it is generally well-tolerated and infrequently causes severe pain.

5. Patients will lie on their left side or back as the Colonoscope is slowly advanced.

6. Once the tip of the Colon (cecum) or the last portion of the small intestine (terminal ileum) is reached, the Colonoscope is slowly withdrawn, and the lining of the Colon is carefully examined.

7. Colonoscopy usually takes 15 to 60 minutes. If the entire Colon, for some reason, cannot be visualized, the physician may decide to try Colonoscopy again at a later date with or without a different bowel preparation or may decide to order an X-ray.

8. If an abnormal area needs to be better evaluated, a biopsy forceps can be passed through a channel in the Colonoscope and a biopsy (a sample of the tissue) can be obtained.

9. The biopsy is submitted to the Laboratory to be sent to Outsourced Pathology for examination.

10. If infection is suspected, a biopsy may be obtained for culturing of bacteria (and occasionally viruses or fungus) or examination under the microscope for parasites.

11. If Colonoscopy is performed because of bleeding, the site of bleeding can be identified, samples of tissue obtained (if necessary), and the bleeding controlled by several means.

12. Polyps, (benign growths that can become cancerous) they can be removed through the Colonoscope. Removal of these polyps is an important method of preventing colorectal cancer, although the great majority of polyps are benign and do not become cancerous.

13. Patients will be kept in an observation area (Casulaty) for an hour or two post-Colonoscopy until the effects of medications that have been given adequately wear off.

14. If patients have been given sedatives before or during Colonoscopy, they should be supported by their attendants. Patient should be adviced for food intake.

15. Prior to the patient's departure from the Coloscopic unit, the findings can be discussed with the patient.

COMPLICATIONS:

1. Complications of Colonoscopy are rare.

2. Bleeding may occur at the site of biopsy or removal of polyps, but the bleeding usually is minor and self-limited or can be controlled through the Colonoscope. It is quite unusual to require transfusions or surgery for post-Colonoscopic bleeding.

3. perforation or a tear through the Colonic wall, but even perforations usually do not require surgery.

4. Reactions to the Sedatives used, localized irritation to the vein where medications were injected (leaving a tender lump lasting a day or two), or complications from existing heart or lung disease.

5. The Colonoscopist who performed the Colonoscopy should be contacted if a patient notices severe abdominal pain, rectal bleeding of more than half a cup, or fever and chills.

Colonoscopy is the method available to detect, diagnose, and treat abnormalities within the Colon. The alternatives to Colonoscopy are quite limited. Barium enema is a less accurate test performed with X-rays. It misses abnormalities more often than Colonoscopy, and, if an abnormality is found, a Colonoscopy still may be required to biopsy or remove the abnormality. At times, an abnormality or lesion detected with a barium enema is actually stool or residual food in a poorly cleansed Colon. Colonoscopy may then be necessary to clarify the nature of the lesion. Flexible sigmoidoscopy is a limited examination that uses a shorter Colonoscope and examines only the last one-third of the Colon

COLONOSCOPY PRE PROCEDURE/PREPARATION

PREPARATION: THE DAY BEFORE THE TEST

1. Take light meals before 8 pm.
2. Take two tablets of Dulcolax (sodium Pico sulfate) after the dinner.
3. If you are a diabetic patient, consult your doctor about skipping or reducing the dose of your drug or insulin dosage.
4. In case of any query please contact your Consultant.

DAY OF COLONOSCOPIC PROCEDURE:

1. Mix the Peglec powder or any other preparation of your choice as per the instructions given in the insert & take it slowly over 2 hours from 6 am- 8 AM. If you feel nauseated while taking the liquid slow down the intake of the preparation.
2. Avoid any liquid or solid diet after completing the colonoscopy preparation.

3. If the test is to be done under Anesthesia, it is mandatory to be nil by mouth for at least 3 hours after completing the preparation part.
4. If you are hypertensive, you should take your Anti hypertensive's before starting the preparation.

COMPLETION OF THE PREPARATION:

Preparation is considered adequate, if you are passing liquid & watery stools with little or no solid content in it.

CLEANING & DISINFECTION PROCESS FOR SCOPES

STAGES:

1. PRE CLEANING
2. STERILIZATION
3. HIGH LEVEL DISINFECTION

1. PRE CLEANING

STAFF SHOULD WEAR PERSONAL PROTECTIVE EQUIPMENT (PPE), SUCH AS GOOGLES, MASK, GLOVES, APRON ETC

↓

SOILED EQUIPMENTS SHOULD BE COLLECTED CAREFULLY

↓

DILUTION TO BE DONE FOR ENZYMATIC PRE CLEANER (SANIENZYME) IN WARM WATER

MODERATE SOILED ITEMS: TO PREPARE 1 LITRE OF SOLUTION: 5 ML OF SANIENZYME SHOULD BE DILUTED IN 995 ML OF WARM WATER

HEAVY SOILED ITEMS: TO PREPARE 1 LITRE OF SOLUTION: 8 ML OF SANIENZYME SHOULD BE DILUTED IN 992 ML OF WARM WATER

↓

INSTRUMENTS SHOULD BE SOAKED IN TO THE SOLUTION FOR 10 MINS & THEN IT SHOULD BE CLEANED WITH BRUSH

INSTRUMENTS SHOULD BE RINSED WITH STERILE WATER 3 TIMES & SHOULD BE DRIED, AFTER WHICH IT CAB BE USED

1. HIGH LEVEL DISINFECTION

SCOPES USED FOR HIV, HBSAG, & HCV POSITIVE PATIENTS REQUIRES HIGH LEVEL DISINFECTION

5 LITRES OF ORTHOPHATHALDEHYDE SHOUD BE POURED IN TO TUB

↓

INSTRUMENTS SHOULD BE IMMERSED INTO THE SOLUTION FOR 12 MINS AT 21^{o}C & COVERING LID TO BE PLACED ON THE TUB

↓

INSTRUMENTS SHOULD BE RINSED WITH STERILE WATER 3 TIMES & SHOULD BE DRIED, AFTER WHICH IT CAB BE USED

UGI ENDOSCOPY

Upper Gastrointestinal Endoscopy is a procedure that enables the examiner to examine theEsophagus (swallowing tube), stomach, and duodenum (first portion of small bowel) using a thin, flexible tube called the Upper Endoscope through which the lining of the Esophagus, Stomach, and Duodenum can be viewed using a monitor.

REQUIREMENT:

1. To accomplish a safe and complete examination, the stomach should be empty. The patient should be Nil by Mouth for six hours or more prior to the procedure.

2. Consultant should consider Allergic & Health Problems of the patient in order to prescribe medication if required for the procedure. (Eg, Antibiotics requiremnt)

3. Patient has to share health problems to his Consultant, so that the Medical Team will have Knowledge whether the patient has any major health problems, such as heart or lung diseases, which will alert the Doctor of possible need for special attention during the procedure.

ADVANTAGES OF UGI ENDOSCOPY

1. Upper endoscopy usually is performed to evaluate possible problems with the esophagus, stomach or duodenum, and evaluate symptoms such as upper abdominal pain, nausea or vomiting, difficulty in swallowing, or intestinal bleeding anemia.

2. Upper endoscopy is more accurate than X-ray for detecting inflammation or smaller abnormalities such as ulcers or tumors within the reach of the instrument.

3. Its other major advantage over X-ray is the ability to perform biopsies (obtain small pieces of tissue) or cytology (obtain some cells with a fine brush) for microscopic examination to determine the nature of the abnormality and whether any abnormality is benign or malignant (cancerous).

4. Biopsies are taken for many reasons and may not mean that cancer is suspected.

5. The endoscope's channels permit passage of accessory instruments enabling the examiner to treat many of the conditions such as stretching areas of narrowing (strictures, Schatzki ring),removal of benign growths such as polyps, retrieving accidentally swallowed objects, or treating upper gastrointestinal bleeding, as seen in ulcers tears of the lining.

6. These capabilities have markedly reduced the need for transfusions or surgery.

RE-PROCESSING OF ENDOSCOPES :

USE OF SEDATIVES:

1. The patient may have the throat sprayed with a numbing solution (LOX Spray: 10% Lidocaine)& tip of the scope will be applied with Lox Jelly (2%) and will probably be given a Sedating and pain alleviating medication through a vein.

2. Medication (usually Midazolam for sedation and fentanyl for pain relief) and patient may even go to sleep. This form of sedation is called conscious sedation and is usually administered by a Nurse who monitors you during the entire procedure.

3. Patient may also be sedated using propofol, called "deep sedation," usually administered by Anesthesiologist who monitors vitals during the procedure.

4. After Sedation, patient will be lied down on the procedure table, &on left side the flexible video endoscope, is passed through the mouth into the Esophagus, Stomach, and Duodenum.

5. Most patients experience only minimal discomfort during the test and many sleep throughout the entire procedure using conscious sedation. Deep sedation ensures that you feel no discomfort during the entire procedure.

6. After the test the patient will be observed and monitored by a qualified individual in the recovery area until a significant portion of the medication has worn off.

7. Patient is left with a mild sore throat, which promptly responds to saline gargles, or a feeling of distention from the air that was used during the procedure.

8. When fully recovered, the patient will be instructed when to resume their usual diet (probably within a few hours).

9. The examining physician will inform the patient of the test results or the probable findings prior to discharge from the recovery area.

10. The results of biopsies or cytology usually take 72-96 hours and the doctor may only give the patient a presumptive diagnosis pending the definitive one, after the microscopic examination.

ENDOSCOPY DISINFECTION OR STERILIZATION:

The liquid chemical sterility involves five steps after leak testing.

1. **Clean** : Mechanically clean internal and external surfaces, include brushing internal channels and flushing each internal channel with water and a detergent or enzymatic cleaner (leak testing is recommended for endoscopes before immersion.

2. **Disinfect**: immerse endoscopy in high-level disinfectant (or chemical sterilant) and perfuse (eliminates air pockets and ensures contact of the germicide with the internal channels) disinfectant into all accessible channels, such as the suction/ Biopsychannel and air water channel and expose for a time recommended for specific products

3. **Rinse:** rinse the endoscopy and all channels with sterile water, filterd water (commonly used with AER's) or tap water (i.e) high-quality potable water that meets federal clean with water stands at the point of use.

4. **Dry:** rinse the insertion tube and other inner changes with alcohol and dry with foced air after disinfection and before storage.

COMPLICATIONS:

1. Localized irritation of the vein where the medication was administered, reaction to the medication or sedatives used, complications from pre-existing heart, lung, or liver disease, bleeding may occur at the site of a biopsy or removal of a polyp (which if it occurs is almost always minor and rarely requires transfusions or surgery).

2. Major complications such as perforation (punching a hole through the Esophagus, Stomach, or Duodenum) are rare but usually require Surgical repair.

ENDOWASH DATA SHEET

S.NO.	DATE	NAME OF THE DISINFECTANT	NO. OF CYCLES	COLOR OF INDICATOR STRIP	DISINFECTANT CHANGING DATE
1					
2					
3					

4					
5					
6					
7					
8					
9					
10					

FACTS OF ERCP

- ERCP is performed under intravenous Sedation, usually without general Anesthesia.
- ERCP is an uncomfortable but not painful procedure. There is a low incidence of complications.
- ERCP can provide important information that cannot be obtained by other diagnostic examinations, for example, abdominal Ultrasound, CT Scan, or MRI.
- Frequently, therapeutic measures can be performed at the time of ERCP to remove stones in the bile ducts or to relieve obstruction of the bile ducts.
- Endoscopic retrograde cholangio-pancreatography (ERCP) is a diagnostic test to examine:

o The duodenum (the first portion of the small intestine),

o The papilla of Vater (a small nipple-like structure with openings leading to the bile ducts and the pancreatic duct),

o The bile ducts, and

o The gallbladder and the pancreatic duct.

REQUIREMENTS:

1. The stomach must be empty. The patient should not eat anything after midnight on the evening preceding the exam.

2. In case the procedure is performed early in the morning, no liquids should be taken. In case the examination is performed at noon time, a cup of tea, juice, milk, or coffee can be taken four hours earlier.

3. Heart and blood pressure medications should always be taken with a small amount of water in the early morning.

PROCEDURE:

1. While the patient is lying on the left side on the X-ray table, the Intravenous medication is given, and then the instrument is inserted gently through the mouth into the duodenum.

2. The instrument advances through the food pipe and not the air pipe. It does not interfere with the breathing and gagging is usually prevented or decreased by the medication.

changing the body position on the X-ray table.

3. The procedure can last anywhere from fifteen minutes to one hour.

4. The procedure is performed by using a long, flexible, viewing instrument (a duodenoscope) about the diameter of a pen.

5. The duodenoscope can be directed and moved around the many bends of the stomach and duodenum. The modern duodenoscope uses a thin fiber-optic bundle to transmit light to the tip of the endoscope, and a thin wire with a chip also at the tip of the endoscope to transmit digital video images to a TV screen.

6. The duodenoscope is inserted through the mouth, through the back of the throat, down the food pipe (Esophagus), through the stomach and into the Duodenum.

7. Once the papilla of Vater is identified, a small plastic catheter (cannula) is passed through an open channel of the Endoscope into the opening of the papilla, and into the bile ducts and/or the pancreatic duct.

8. Contrast material (dye) is then injected and X-rays are taken of the Bile Ducts and the Pancreatic Duct. Another open channel in the Endoscope also allows other instruments to be passed through it in order to perform biopsies, to insert plastic or metal stents or tubing to relieve obstruction of the bile ducts or pancreatic duct caused by Cancer or scarring, and to perform incisions by using electrocautery (electric heat).

9. An important procedure related to ERCP is Endoscopic Ultrasonography which uses a similar Endoscope that, in addition to the camera, has an Ultrasound probe on its tip to examine the Bile Ducts, Gallbladder, Pancreatic Duct, and Pancreas Ultrasonographically. Ultrasonographically-directed needle biopsies of the Pancreas can be taken through a channel in the Endoscope.

10. A second, newer procedure related to ERCP is the use of miniature endoscopes that are passed through the operating channel of a duodenoscope and can be inserted directly into the bile and pancreatic ducts. The inside of the ducts can be visualized, and directed biopsies can be taken. Other therapeutic interventions also are possible.

POST PROCEDURE:

1. After the procedure, patients should be observed in the recovery area until most of the effects from the medications have worn off. This usually takes one to two hours.

2. The patient may feel bloated or slightly nauseated from the medications or the procedure.

3. Very rarely a patient experiences vomiting, and may belch or pass some gas through the rectum.

The liver, bile ducts, gallbladder, pancreas and the papilla of Vater can be involved in numerous diseases, causing myriad of symptoms. ERCP is used in diagnosing and treating the following conditions:

- Blockage of the bile duct by gallstones, cancer, strictures (scarring) or compression from adjacent organs or tumors.
- Jaundice (yellow coloring of the skin) due to obstruction of the bile duct, also causing darkening of the urine and light colored stool.
- Persistent or recurrent upper abdominal pain which cannot be diagnosed by other tests.
- Unexplained loss of appetite and weight.
- Confirming the diagnosis of cancer of the pancreas or the bile duct, so that surgery or other treatment can be tailored to the disease.

- When there is suspicion that the Sphincter of Oddi within the Papilla of Vater, that controls the flow of bile and pancreatic juice, is not working normally (Sphincter of Oddi dysfunction).

- The most common complication is Pancreatitis which is due to irritation of the Pancreas from the dye used to take pictures and can occur even with very experienced Physicians. This "injection" pancreatitis usually is treated in the hospital for one to two days.

- Another possible complication is infection. Other serious risks including perforation of the intestine, drug reactions, bleeding, depressed breathing. Irregular heart beat or heart attack are extremely rare and is mainly due to the sedation. In case of complications, patients usually need to be hospitalized, but surgery rarely is required.

- The procedure provides important information upon which specific treatment can be tailored. In certain cases, therapy can be performed at the same time through the duodenoscope, so that traditional open surgery can be avoided. ERCP, combined with endoscopic ultrasonography, is currently the diagnostic and therapeutic procedure of choice in most patients for identifying and removing gallstones in the bile ducts

ERCP BILIARY STENTS

DOUBLE PIGTAIL

1. 7Fr-10Cm - 5
2. 7Fr-12Cm - 5
3. 8Fr-8Cm - 3
4. 8Fr-10Cm - 3
5. 8.5Fr-10Cm - 3
6. 8.5Fr-12Cm - 3
7. 10Fr-7Fr - 3
8. 10Fr-10Cm - 4

STANDARD

1. 8.5Fr-10Cm -4
2. 8.5Fr-12Cm -4
3. 10Fr-10Cm - 9
4. 10Fr-12Cm - 3

COTTON-LEUNG BILIARY STENT

1.

7Fr -5Cm (2.8mm) -3

2. 7Fr – 7Cm(2.8mm) -3

3. 7Fr – 10Cm(2.8mm) – 2

4. 8.5Fr -5Cm(3.2mm) – 8

5. 10Fr-4Cm (3.7mm) -1

6. 10Fr-5cm(3.7mm) - 5

7. 10Fr -7Cm(3.7mm) -2

8. 10Fr-10Cm(3.7mm) -1

GEENEN PANCREATIC STENT

1. 7FR-3CM-1

2. 7FR-5CM-1

3. 7FR-6CM-1

4. 7FR-7CM-1

LEAK TESTING FOR SCOPES

Flexible EndoScopes are subject to severe damage from fluid invasion. Pressure testing or Leak Testing can allow a user to find potential Leaks prior to immersing the Scope in fluid. When performed effectively and at the correct point in each reprocessing cycle, Leak Testing can eliminate all but the most extreme circumstances for fluid invasion. Through Leak Testing, problem areas are located before they cause Scope damage or cross-contamination of patients.

A Leak Test may be performed manually (using a hand-held bulb and gauge) or mechanically (using an automated pressure delivery system) and with or without fluid immersion. Regardless of the method chosen, the general process is the same.

The Leak Test should be performed after every procedure prior to immersing the EndoScope in fluid. A Leak may occur at almost any point in the daily life cycle of the Scope, and this proactive approach to Leak Testing can help prevent expensive fluid invasion repairs. More importantly, it ensures the integrity of the Scope, thereby eliminating potential adverse patient outcomes such as cross-contamination of chemicals or proteinaceous materials from antecedent procedures.

The Steps for Leak Testing a Scope are:

1. Visually inspect the Scope for tears, holes, and joints that may leak. Pay close attention to the seams and body joints. If any tears or holes are found, the Scope cannot be submerged.

2. Remove all valves and attachments from the EndoScope.

3. Attach the Leak Tester to the ETO venting connector of the fiberoptic Scope of to the Leak Tester connector of the water-resistant cap on video EndoScopes and pressurize the Scope before placing the Scope in water. Never place the Scope under water before pressurizing; water can invade the interior of the Scope in just a few seconds. When the interior of the Scope is pressurized with are, you will be able to see or feel the bending rubber expand. A continuous steam of bubbles coming from the interior of the Scope will indicate a Leak.

4. Check the bending rubber at the distal tip of the insertion tube. The most common area for Leaks is the bending rubber, always check this area first. With only the distal end of the insertion tube submerged in water, angulate the distal tip in all directions to make sure you "open" any small holes that may be sealed by the bending rubber. The control knobs must be out of the water when angulating the distal tip because the rubber o-rings between the control knobs are not designed to operate under water with excessive pressure. When manipulated to the maximum position, these o-rings may Leak and allow fluid past them and into the Scope's interior. Next, completely submerge the Scope under water.

5. Observe the control knobs. Bubbles will appear if one of the o-rings is damaged.

6. Observe for holes in the Scope's internal channels. If this happens, you will see air bubble coming out of a channel opening at the valve ports, the air and water inlets, the suction port of the light guide connector, the biopsy port, of the channel opening(s) at the distal tip of the insertion tube. Air trapped in the channels may take a few minutes to clear and may falsely appear to be a Leak. You can clear this air by flushing the channels with water. However, a continuous stream of bubbles indicates a Leak.

7. Observe the insertion tube and light guide tube. Examine the entire length of both tubes for bubbles when Leak Testing. If either tube is buckled anywhere the chance of holes forming is increased.

8. Remove the Scope from the water and drain.

9. Release pressure by:

- Video Scope – by taking off water-resistance cap.
- Leak Tester – Leak Tester still hooked to Scope, but disconnect from light source or pump.
- Hand tester – turn air release knob to allow pressure to release. Verify deflation of the Scope by observing the bending rubber or the air release sound.

10. Disconnect the Leak Tester from the Scope. Never disconnect the Leak Tester under water; water could enter the Leak Tester connector and invade the Scope's interior.

PATIENT TRANSPORTATION IN ENDOSCOPY UNIT

CATEGORY OF PATIENTS

1. **OUTPATIENT**
2. **INPATIENT**

OUTPATIENT:

S.NO.	ACTIVITIES	RESPONSIBILITIES
1	In case of Outpatients, Patients after consultation gets billed for the procedure as per the requirement.	Consultant, DMO & Front Office Staff
2	Patient file will be prepared & sent to Endoscopy Unit for Serialwise Intake of the Patients.	Front Office & Endoscopy Department
3	Patient will be called for Process. (PrePreparation would be done, if required)	Endoscopy Staff
4	Procedure will be done & Reporting to be done for the same, if possible. (Incase of Biopsies & Cultures the reporting may get delay)	Endoscopy Staff & Lab Department
5	Patient will be sent home.	Hospital Staff

INPATIENT:

S.NO.	ACTIVITIES	RESPONSIBILITIES
1	In case of Inpatients, Patients will be advised by the Consultant/DMO for the procedure.	Consultant, DMO & Nursing Staff
2	Nursing Staff will coordinate with Endoscopy Unit in order to send Patients & will send the requisition.	Nursing staff & Endoscopy Staff
3	Patient will be shifted on wheelchair/stretcher according to the requirement by HK Staff under the supervision of Nursing staff, after getting Confirmation from	Nursing Staff

	Endoscopy Staff.	
4	Procedure will be done. Patient will be shifted back to the ward.	Endoscopy Staff & Nursing Staff
5	Reporting will be done & copy will be sent to Nursing staff of the respective ward.	Endoscopy Staff

S.No	NAMES	LOT NO. & EXPIRY DATE	STATUS	FREQUENCY
1	Top Spinal Needle -18G		SINGLE USAGE- REUSED	**5**
2	Teurmo Guide Wire -150cm		SINGLE USAGE- REUSED	**5**
3	Teurmo Guide Wire -180cm(Running)		SINGLE USAGE- REUSED	**5**
4	Amptlaz Ultra Stiff Guide Wire -150cm(Running)		SINGLE USAGE- REUSED	**5**
5	Amptlaz Ultra Stiff Guide Wire -180cm		SINGLE USAGE- REUSED	**5**
6	Amptlaz Ultra Stiff Guide Wire -260cm(Running)		SINGLE USAGE- REUSED	**5**
7	Billroth ll Sphincterotome		SINGLE USAGE- REUSED	**5**
8	Needle Knifes		SINGLE USAGE- REUSED	**5**
9	Jag wire (0.025x260cm)		SINGLE USAGE- REUSED	**5**
10	Guide wire visiglide (0.025inch 2700mm)		SINGLE USAGE- REUSED	**5**
11	Glide wire [0.025”(0.64mm)450cm]		SINGLE USAGE- REUSED	**5**
12	Stiff shaft straight 0.035		SINGLE USAGE- REUSED	**5**
13	Stiff shaft straight 0.020		SINGLE USAGE- REUSED	**5**
14	ERCP Cannula		SINGLE USAGE- REUSED	**5**

15	Stent insertion Kit		SINGLE USAGE- REUSED	**5**