TODD BARON: So we've gone to using the cold AXIOS for all fluid collection drainages and all necrosis cases. And I think where it's made the biggest difference is that you have one device, one stent deployment. It's very reliable. Rather than have to put in a guidewire, put in a stent, try to re-access and put in another stent, you can do everything with one device.

If you can not only just improve the overall outcome of the patient, reduce hospital days, you're going to have a savings there. But also, in terms of procedural time, as people get better and better in using this, that counts for a lot, as well, as more rapid procedural time, higher success rate, technically, which reduces cost of care.

The technology is exciting, not for what we can do with it now-- it is very exciting in that regard-- but what we can do with it in the future and what it's going to lead to allow us to do. I think we're just seeing the very beginning with what we have now.

I would recommend that, if there's no resistance on the guidewire, they should just continue to push the wire. It's nice when you can see it looping, but if it's pushing without resistance, put a fair amount of wire in, so you know you're at least looping quite a bit. And that gives you a buffer during exchange, that you're not going to lose wire. Because you might lose a little bit on your exchange, but if you have plenty inside the cavity, I think that gives you a good buffer.

What I recommend is that you actually start the dilation farther into the cavity than you think, and do your first dilation, even if it's entirely dilating in the cavity in free space, and then, pulling the balloon back until you get resistance. Because one mistake that can be made is that you push in and you're actually between the cavity and the collection, and you haven't actually dilated the wall. So you're dilating the gastric or duodenal wall and the space between the gastric or duodenal wall and the cavity and not actually dilating the cavity, itself.

Keeping the echo view is really crucial because, if you rely too much on the endoscopic view, the angles and things can change. I also think getting the good dilation is very key.

One can go freehand, so to speak, without a guidewire. I think that is a very appropriate way to go when it's a very large target and the endoscopist is very comfortable that they're going to absolutely hit the target that they're aiming for. If there's any bit of being less comfortable with doing that, then I think going with the puncture and a guidewire is a good alternative. And then, track the hot AXIOS over the guidewire.

If you've cauterized, and you're not exactly sure before deployment where everything is, I recommend removing as much air as possible, getting close again to the cyst wall or whatever cavity that you're draining, and then try to rotate the endoscope until you find the introducer system inside the cavity.

Again, rotation, I think, is very important. People tend to freeze sometimes. And it's good to just keep maneuvering the endoscope and rotating, so that you can find your way inside-- the echo inside the cavity.

It's important to keep the echo view as you're passing instruments or accessories, because that angle that you had on puncture is the best angle for trajectory of everything. And when you, then, rely and step back and do endoscopy, it might look good endoscopically, but it doesn't mean that it-- inside, what's happening is in the proper alignment.

I think that when you do the echo deployment predominantly, or almost exclusively, again, what's nice is you can see the entire stent as it deploys on the end inside the cavity well under echo. And you can watch it as you pull it up to where it's in the configuration of the football shape.

At that point, even if you stay with your echo view, you're not actually seeing the proximal end. You're still seeing the end that's inside the cavity. As long as you have that view, that means you're very, very close to the cavity wall. And if you deploy the second part, it also means that you're deployed inside the endoscope, but outside the cavity.

I relied less so now on endoscopy, although it can be done endoscopically and, I would say, even less so on fluoroscopy. Where I think fluoroscopy is helpful is when you first put the delivery system inside the cavity. So I think people might find comfort that it's tracking the guidewire in the proper orientation.

If they've put contrast into the cavity during their initial puncture, if they went with the needle and then injected contrast, they'll be able to see the delivery system track nicely inside the cavity. But that last step of deployment, I don't think it's as helpful as they might think.

I think the new physician to AXIOS might be comfortable or feel more comfortable if they have fluoroscopy during their initial deployments before they get completely comfortable with the device, with endoscopy, and echo deployment. So I don't think it's a bad idea to have it. And the physician will probably find, over time, that they're going to use it less and less.