Olympus and a consultant for Medtronic. The other author disclosed no financial relationships relevant to this publication.

Majidah Bukhari, MD, FRCPC
Division of Gastroenterology and Hepatology
Johns Hopkins Medical Institutions
Baltimore, Maryland, USA
Division of Medicine and Gastroenterology and Hepatology
King Faisal Specialist Hospital and Research Center
Jeddah, Saudi Arabia
Mouen A Khashab, MD
Division of Gastroenterology and Hepatology
Johns Hopkins Medical Institutions
Baltimore, Maryland, USA

REFERENCES

1. Yang D, Draganov PV. ERCP in patients with Roux-en-Y gastric bypass: one size does not fit all. Gastrointest Endosc 2019;89:646.
2. Bukhari M, Kowalski T, Nieto J, et al. An international, multicenter, comparative trial of EUS-guided gastrogastrostomy-assisted ERCP versus enteroscopy-assisted ERCP in patients with Roux-en-Y gastric bypass anatomy. Gastrointest Endosc 2018;88:486-94.
3. Abbas AM, Strong AT, Diehl DL, et al. Multicenter evaluation of the clinical utility of laparoscopy-assisted ERCP in patients with Roux-en-Y gastric bypass. Gastrointest Endosc 2018;87:1031-9.
4. Tyberg A, Nieto J, Salgado S, et al. Endoscopic ultrasound (EUS)-directed transgastric endoscopic retrograde cholangiopancreatography or EUS: mid-term analysis of an emerging procedure. Clin Endosc 2017;50:185-90.
5. Schreiner MA, Chang L, Gluck M, et al. Laparoscopy-assisted versus balloon enteroscopy-assisted ERCP in bariatric post-Roux-en-Y gastric bypass patients. Gastrointest Endosc 2012;75:748-56.
6. Frederiksen NA, Tveskov L, Helgstrand F, et al. Treatment of common bile duct stones in gastric bypass patients with laparoscopic transgastric endoscopic retrograde cholangiopancreatography. Obes Surg 2017;27:1409-13.
7. Aiolfi A, Asti E, Rausa E, et al. Trans-gastric ERCP after Roux-en-Y gastric bypass: systematic review and meta-analysis. Obes Surg 2018;28:2836-43.
8. Kedia P, Tarnasky PR, Nieto J, et al. EUS-directed transgastric ERCP (EDGE) versus laparoscopy-assisted ERCP (LA-ERCP) for Roux-en-Y gastric bypass (RYGB) anatomy: a multicenter early comparative experience of clinical outcomes. J Clin Gastroenterol. Epub 2018 Apr 17.
9. Kedia P, Tyberg A, Kumta NA, et al. EUS-directed transgastric ERCP for Roux-en-Y gastric bypass anatomy: a minimally invasive approach. Gastrointest Endosc 2015;82:560-5.
10. Irani S, Yang J, Khashab MA. Mitigating lumen-apposing metal stent dislodgment and allowing safe, single-stage EUS-directed transgastric ERCP. VideoGIE 2018;3:322-4.

https://doi.org/10.1016/j.gie.2018.10.033

Pancreatic stent during biliary cannulation: How can we catch 2 hares?

To the Editor:

Unintentional guidewire insertion to the pancreatic duct commonly occurs during biliary cannulation and provokes post-ERCP pancreatitis (PEP).[1] Several cannulation approaches have been reported in this setting.[2,3] In a recent issue of *Gastrointestinal Endoscopy*, Eminler et al[4] reported that the double-guidewire (DGW) method was superior to wire-guided cannulation after pancreatic stent placement (WGC-PS) in terms of the successful cannulation rate: 90% versus 54%. Notably, they proceeded to precut sphincterotomy over a pancreatic stent after 5 minutes of cannulation attempts.

We recently reported our experience with WGC-PS.[5] WGC-PS was associated with a lower rate of PEP compared with repeated wire-guided cannulation and had comparable final biliary cannulation rates (>95%). When we

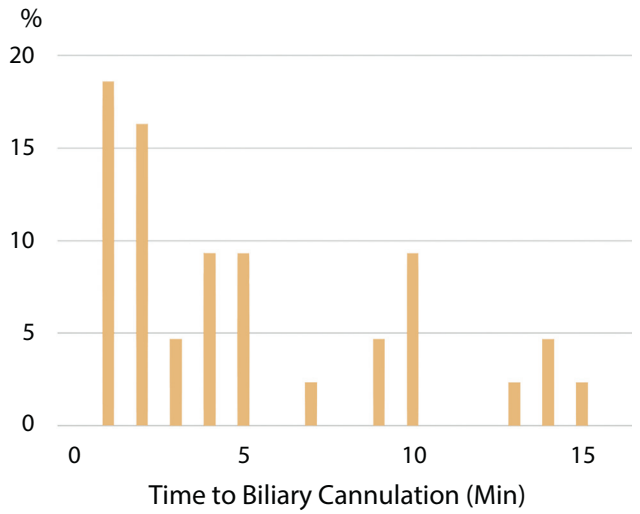

Figure 1. Time to successful biliary cannulation during wire-guided cannulation with an indwelling pancreatic stent.

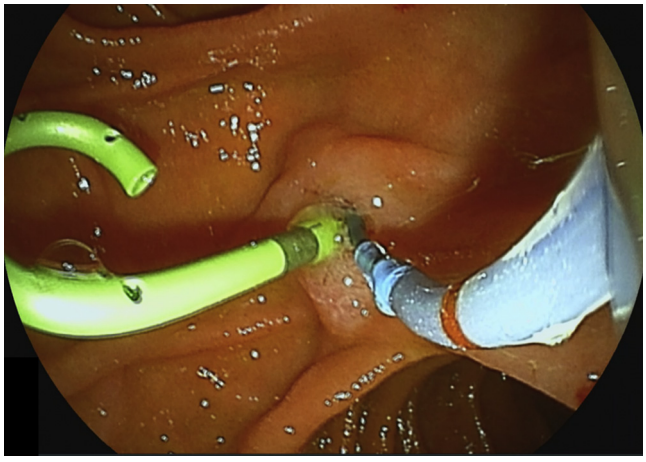

Figure 2. Wire-guided biliary cannulation with an indwelling pancreatic stent. We attempt to cannulate the bile duct keeping a guidewire tip outside a cannula and manipulate the guidewire when the tip is supposed to be in the biliary orifice ("the nontouch technique"). This technique is particularly helpful in patients with a small ampulla where the touch technique is difficult. In patients with an indwelling pancreatic stent, the nontouch technique helps avoid guidewire insertion into the pancreatic duct.

reanalyzed our data using the endpoint of the current study,[4] our successful selective cannulation (<5 minutes) rate was quite similar (56%), but a substantial number of patients underwent successful cannulation thereafter (Fig. 1). Compared with the DGW method with a risk of guidewire-induced pancreatitis,[6,7] WGC-PS may be reasonably performed for longer than 5 minutes without a significant increase in PEP. Prior studies also suggest that an indwelling pancreatic stent may not hamper biliary cannulation,[8,9] and we use the so-called nontouch technique during WGC-PS, especially in patients with a small ampulla (Fig. 2).[10]

The rates of PEP were remarkably low in both groups in the current study, probably because of early placement of a prophylactic pancreatic stent (rather than at the end of the procedure)[2,5] and the expertise of the endoscopists. However, in many academic centers, trainees are involved in most ERCPs, and precut sphincterotomy in 5 minutes is not always possible. Despite the established effectiveness of prophylactic pancreatic stents, stent placement at the end of the procedure may reduce its preventive effects.[5] Further research is warranted to identify the best cannulation strategy after early pancreatic stent placement in different settings.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

Ryunosuke Hakuta, MD
Tsuyoshi Hamada, MD, PhD
Yousuke Nakai, MD, PhD
Department of Gastroenterology
Graduate School of Medicine
The University of Tokyo
Hiroyuki Isayama, MD, PhD
Department of Gastroenterology
Graduate School of Medicine
The University of Tokyo
Department of Gastroenterology
Graduate School of Medicine
Juntendo University
Kazuhiko Koike, MD, PhD
Department of Gastroenterology
Graduate School of Medicine
The University of Tokyo
Tokyo, Japan

REFERENCES

1. Nakai Y, Isayama H, Sasahira N, et al. Risk factors for post-ERCP pancreatitis in wire-guided cannulation for therapeutic biliary ERCP. Gastrointest Endosc 2015;81:119-26.
2. Sasahira N, Kawakami H, Isayama H, et al. Early use of double-guidewire technique to facilitate selective bile duct cannulation: the multicenter randomized controlled EDUCATION trial. Endoscopy 2015;47:421-9.
3. Yasuda I, Isayama H, Bhatia V. Current situation of endoscopic biliary cannulation and salvage techniques for difficult cases: current strategies in Japan. Dig Endosc 2016;28:62-9.
4. Eminler AT, Parlak E, Koksal AS, et al. Wire-guided cannulation over a pancreatic stent method increases the need for needle-knife precutting in patients with difficult biliary cannulation. Gastrointest Endosc 2019;89:301-8.
5. Hakuta R, Hamada T, Nakai Y, et al. Early pancreatic stent placement in wire-guided biliary cannulation: a multicenter retrospective study. J Gastroenterol Hepatol. Epub 2018 Aug 27.
6. Tse F, Yuan Y, Moayyedi P, et al. Double-guidewire technique in difficult biliary cannulation for the prevention of post-ERCP pancreatitis: a systematic review and meta-analysis. Endoscopy 2017;49:15-26.
7. Fukasawa M, Takano S, Enomoto N. Pancreatic guidewire technique increases the risk of post-endoscopic retrograde cholangiopancreatography pancreatitis. Dig Endosc 2016;28:102-3.
8. Yang MJ, Hwang JC, Yoo BM, et al. Wire-guided cannulation over a pancreatic stent versus double guidewire technique in patients with difficult biliary cannulation. BMC Gastroenterol 2015;15:150.
9. Cote GA, Mullady DK, Jonnalagadda SS, et al. Use of a pancreatic duct stent or guidewire facilitates bile duct access with low rates of precut sphincterotomy: a randomized clinical trial. Dig Dis Sci 2012;57:3271-8.
10. Bassi M, Luigiano C, Ghersi S, et al. A multicenter randomized trial comparing the use of touch versus no-touch guidewire technique for deep biliary cannulation: the TNT study. Gastrointest Endosc 2018;87:196-201.

https://doi.org/10.1016/j.gie.2018.09.018

Response:

We thank Hakuta et al[1] for their interest in and comments on our study.[2] We agree that repeated guidewire cannulation of the pancreatic duct may increase the risk of post-ERCP pancreatitis. Although there is some debate on this isssue, we think that successful insertion of a prophylactic pancreatic stent, inadvertent cannulation of the side branches of the pancreatic duct, and injection of contrast material are among the determining factors. Additionally, there is some controversy about the timing of pancreatic stent insertion, which usually depends on the preference of the endoscopists. We prefer to insert a pancreatic stent immediately after biliary sphincterotomy, not at the end of the procedure.

Finally, the authors emphasized the usefulness of a nontouch technique during wire-guided cannulation over a pancreatic stent, especially in a patient with a small ampulla. The success of this technique depends on the patient's anatomy, the position of the duodenoscope, and other factors such as a papilla with a small orifice. We also prefer this technique in some cases; however, only 1 randomized trial has compared the touch and nontouch techniques with naïve papillae, and it revealed a significantly higher primary cannulation rate in favor of the touch technique, with similar adverse event rates.[3]