gutflix
GI learning, personalised

Summary

Panel discussion: Are you stuck in the biliary cannulation nightmare: Wake up, here comes the sun

Postgraduate Teaching Programme Barcelona 2026 | Presentation

Hepatobiliary | Endoscopy

October 17, 2026

This panel discussion addressed technical strategies for managing difficult biliary cannulation and stone extraction in ERCP, emphasizing adaptive approaches, balloon dilation sizing, and pancreatic protection techniques.

KEY POINTS

- The speaker uses 10mm balloon dilation without sphincterotomy in patients at high bleeding risk (cirrhotic patients, those on clopidogrel or DOAC, or during laparoscopic-assisted ERCP) to reduce bleeding complications.
- With native papilla, balloon size should not exceed 10mm; for larger stones requiring sphincterotomy and large balloon dilation, perform a limited sphincterotomy first because dilating to 12-15mm after complete sphincterotomy risks perforation.
- In malignancy cases where the guidewire enters the pancreatic duct, the speaker places a pancreatic stent for fast cannulation, posterior wall protection during duplication, and to lower pancreatitis risk.
- Advanced cannulation techniques (double guidewire, transpancreatic sphincterotomy, needle knife pre-cut) can be merged or switched sequentially based on dynamic conditions rather than following a rigid protocol.
- For bariatric surgery patients with malignant jaundice, the speaker suggests EUS-guided biliary drainage provides re-treatment options compared to percutaneous transhepatic cholangiography, which requires repeat liver puncture.

VIEW THIS CONTENT ON GUTFLIX

https://gutflix.eu/search/d/d050fb6a-d14f-11f1-8429-daaa6dbee0a2

AI-generated summary

This summary was generated by an AI large language model based on the content transcript. It is for informational purposes only and should not be considered a substitute for clinical judgment. Always rely on your professional expertise and the full clinical context when making clinical decisions.