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Summary

Video case: Failed ERCP in a Billroth II patient with altered anatomy: What to do now?

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Postgraduate Teaching Programme Barcelona 2026 | Presentation

Hepatobiliary | Endoscopy

October 17, 2026

The speaker presented technical approaches to ERCP in Billroth II anatomy, demonstrating two cases where initial attempts failed and discussing US biliary drainage as a rescue option when conventional ERCP is unsuccessful or too demanding.

KEY POINTS

- The speaker reported overall clinical success of roughly 75% for ERCP in Billroth II anatomy, with intubation failure occurring in roughly 10% of cases, limited mainly by device maneuverability and difficulty identifying landmarks with reversed papilla orientation.
- In the first case, the speaker switched from a frontal view scope (which failed after guidewire entered only pancreatic side branches) to a duodenoscope, then performed pre-cut sphincterotomy and placed both pancreatic and biliary stents.
- In the second case involving malignant gastroenteral obstruction, the speaker placed two enteral stents before attempting ERCP, describing the procedure as very difficult, time-consuming, and carrying high X-ray burden.
- The speaker stated that US biliary drainage is extremely successful technically and clinically compared to single-balloon-assisted ERCP and has fewer adverse events than percutaneous drainage when ERCP fails or is too demanding.
- The speaker recommended recognizing and accepting procedure failure early, changing strategy quickly (scope, position, or approach), and thinking of rescue options such as enteroscopy-assisted ERCP, US biliary drainage, or percutaneous transhepatic biliary drainage depending on center experience.
- The speaker personally prefers US biliary drainage over percutaneous drainage and emphasized that in emergency situations the patient's safety is paramount, recommending pragmatic choice of any available drainage method or surgery if needed.

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