

## Letter to the Editor: Useful Tricks in ERCP Technique

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**Abstract:** A team approach is mandatory to carry out a successful ERCP, the endoscopist understanding the complications of such complex procedure has a bag of solutions in difficult situations should coordinate and control the team; at least two nurses are needed to assist, a radiologist and a practitioner anthropologist, all should understand such innovative ERCP skills would help through the overall ERCP success, here we will present to useful tricks should be very helpful in both diagnostic and therapeutic ERCP.; Alenezi (*Kuwait*) and Durazo (*USA*) techniques. Nevertheless, ERCP innovation of skills lead to easy success with fewer complications.

**Keywords:** Alenezi, Durazo, ERCP, tricks.

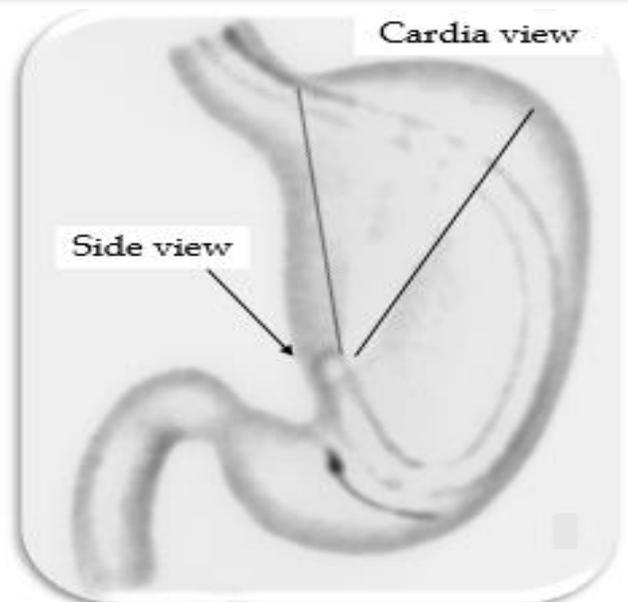
**Abbreviations;** ERCP; Endoscopic Retrograde Cholangiopancreatography, LT; Liver transplantation.

### Discussion

Endoscopic Retrograde Cholangiopancreatography (ERCP) is a radiologic image of the hepatobiliary tree and the pancreatic duct can discover lesions and treat adequately such causes of obstruction. Over last 2 decades, ERCP has almost totally replaced surgical treatment of bile duct stones. In addition, a variety of congenital, benign and malignant conditions, however the technique itself is complex, required much training and innovative skills would decrease time factor and treat without complications. However, there are many tricks in ERCP maneuver will make the technique easier, more applicable, performed in a timeless and avoid complications.

One of the most important tricks we learned that not to make J-shaped stomach, the endoscope tip will fail to negotiate the pylorus and easy slipped into retroflexion position, hence further advancement of the endoscope will result in retrograde intubation of the cardia, the stomach will increase in size and the endoscope shaft required for facing papilla will be longer, make the procedure difficult with suspected complications, the problem solved by many techniques.

One of easy tricks is Alenezi technique by Prof. Saleh Alenezi, Kuwait (figure 2), in such a trick endoscopist may reach duodenum in seconds, make the technique easy and simple, depends on approach making the stomach as small in size as possible for endoscope advancement, Alenezi technique shafting the endoscope from greater to lesser curvature in one trick, moving the endoscope from left to right while slight downward of the big wheel during the procedure (figure 2).



**Figure (1) J-shaped stomach with retroflexion when advancing the Endoscope**

ERCP has evolved also into primarily therapeutic procedure. The main worldwide indication is an obstructive pathology of biliary system or pancreatic duct, sometimes-major papilla itself. Biliary stricture post liver transplant especially living donor operations is common complications may reach up to 20% indicated for ERCP therapy. According to Prof. Francisco Antonio Durazo; (USA) recommendation, the implementation of maximal stenting depended on the length of time since Liver transplantation (LT) and the dose of

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steroids: if the patient had undergone LT within the past 3 months or was taking more than 5 mg of prednisone per day, dilation was performed with a 10-Fr biliary dilator (Soehendra dilator; Cook Endoscopy, Winston-Salem, North Carolina, USA), and a 10-Fr stent was placed for 12 weeks.

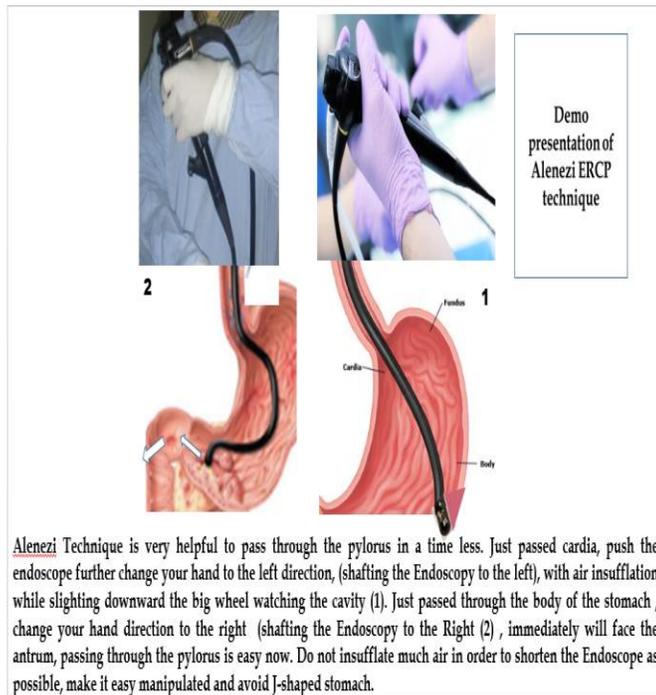


Figure (2)



Figure (3): Durazo technique with maximal stenting of nine (9) stents post LT biliary stricture.

During a subsequent ERCP, the stent was removed, and balloon dilation was performed (balloon dilator; Cook Endoscopy) with a balloon 6–10 mm in diameter, according

to the size of the donor's and recipient's ducts (the duct with the smaller diameter, donor's or recipient's, determined the diameter of the balloon), for 1 min. When balloon dilation was completed, a sphincterotomy was performed following the standard technique (Ultratome; Boston Scientific, Natick, Massachusetts, USA), and a maximal number up to 10 stents of 8.5–11.5 Fr (Cotton-Leung; Cook Endoscopy) were placed across the anastomosis (Figure 3). The maximal stenting technique of Prof. Durazo for post-transplant biliary stricture would be highly beneficial in countries where only living donor operations are performed because of a higher incidence of biliary complications [1-15].

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