A 47-year-old severely ill Caucasian man presented with cholestasis (bilirubin 17.8 mg/dL) due to primary sclerosing cholangitis. Endoscopic retrograde cholangiography (ERC) showed high grade strictures of the common bile duct (CBD), dilation of the common hepatic duct (CHD), and left hilar obstruction. Attempts to maneuver 5–7-Fr bougies across the distal CBD stenosis were not successful.

Via left-sided percutaneous transhepatic cholangio drainage (PTCD), retrograde access to the CBD was not possible even after simultaneous transpapillary wire guidance. Therefore, a 1.2-mm biopsy forceps (SpyBite; Boston Scientific, Ratingen, Germany) was introduced percutaneously through an 8-Fr bougie into the dilated CHD to grab the transpapillary 0.025-inch wire. The wire was carefully exteriorized in a reverse rendezvous maneuver. Given the lack of bougienage options, a 5.2-Fr angiography catheter (Super Torque Plus; Cordis, Baar, Switzerland) was inserted as a temporary spacer across the papilla under duodenoscopic view. Upon PTCD exchange, spurting bleeding from the access site was stopped by upgrade to an 8.5-Fr Yamakawa drain (Peter Pflugbeil GmbH, Zorneding, Germany). Parenchymal damage from initial wire manipulation was suspected, so the percutaneous tract was subsequently closed.

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**Video 1** Reverse rendezvous with endoscopic retrograde cholangiography and percutaneous transhepatic biliary drainage.
occluded with hemostyptic gelatine (Gelita; B. Braun, Melsungen, Germany), and a transpapillary 8.5-Fr pigtail stent was inserted.

The patient gained 10 kg in weight and the bilirubin level persistently dropped to 0.8 mg/dL. After repeated stent upgrades and dilations (▶ Fig. 1 e), dysplasia was ruled out by cholangioscopic biopsies. After 20 months, the patient was well and continued to have regular follow-up with no evidence of recurrence of cholestasis.

To our knowledge, reverse rendezvous, with percutaneous uptake of a transpapillary wire, has not been reported previously. The “lucky punch” of being able to grab the transpapillary wire with a port-guided forceps can be facilitated by C-arm rotation. Unsheathed transparenchymal wire extraction is not recommended as the wire may cut the liver parenchyma, necessitating hemostyptic occlusion of the percutaneous tract, as in our patient. Reverse ERC-PTCD rendezvous is a nonstandard rescue maneuver that can offer significant benefit in technically demanding situations.

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Competing interests

Martin Goetz is in the advisory board for Boston Scientific.

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