

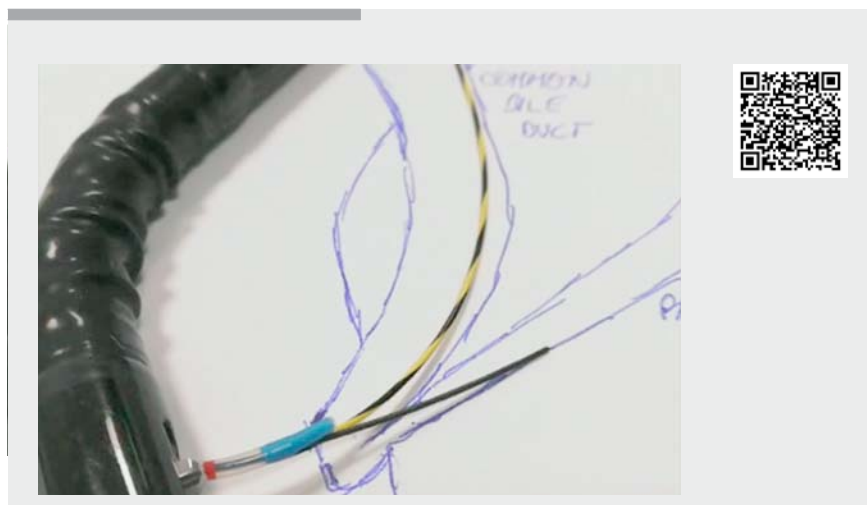
Biliary hitch and ride technique for blind pancreatic duct cannulation

Endoscopic pancreatic therapy is indicated in several pancreatic disorders [1, 2]. Selective pancreatic cannulation can be challenging when pancreatic inflammatory changes are extended to the duodenal wall, as the papilla might be very difficult to identify with the duodenoscope. We have developed a variation of the “hitch and ride” technique [3], providing blind access to the pancreatic duct in patients with edematous duodenal folds. In this situation, if biliary cannulation is achieved, a guidewire is left in the common bile duct, as described in the double-wire technique [4]. A slitted cannula, as described in the “hitch and ride” technique [3], is used with a second preloaded guidewire. The cannula is hitched on to the biliary guidewire, which can be done in the segment of the guidewire immediately exiting the duodenoscope channel. The cannula is advanced over the guidewire to the location of the ampulla, which is anticipated by the fluoroscopic image, as the edematous folds preclude direct visualization. Once the tip of the cannula is considered by the fluoroscopic image to be slightly enter-

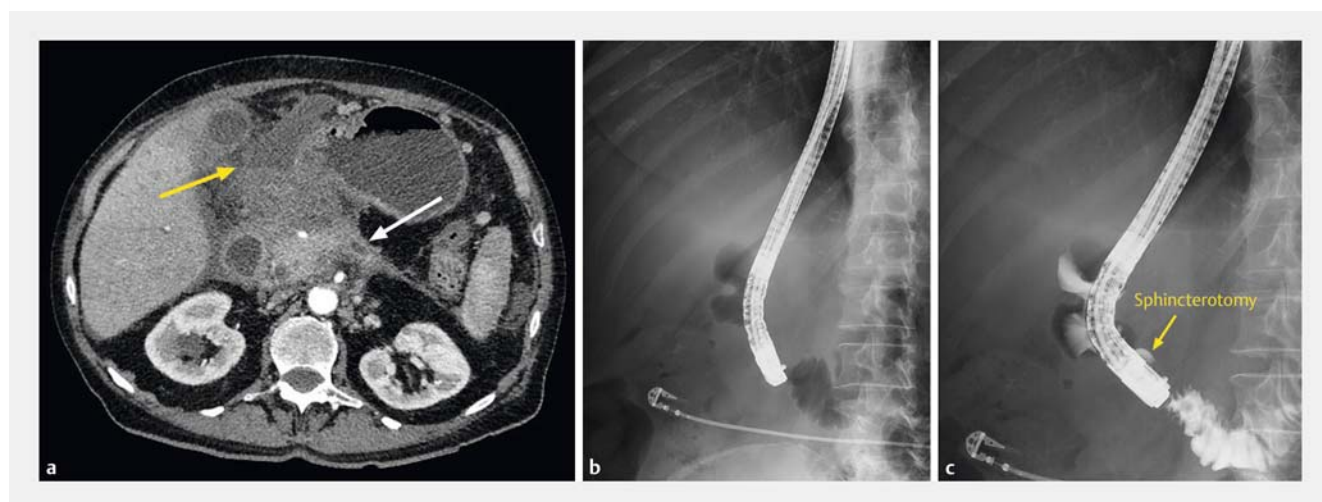
ing the papillary orifice, the preloaded guidewire is advanced. If the tip of the cannula is not deeply advanced into the common bile duct, the preloaded guidewire exits the cannula with a perpendicular orientation into the pancreatic duct. If the preloaded guidewire enters the biliary duct, cannulation might be too

deep and the cannula must be withdrawn slightly. Several attempts may be needed to achieve pancreatic duct cannulation with the preloaded guidewire.

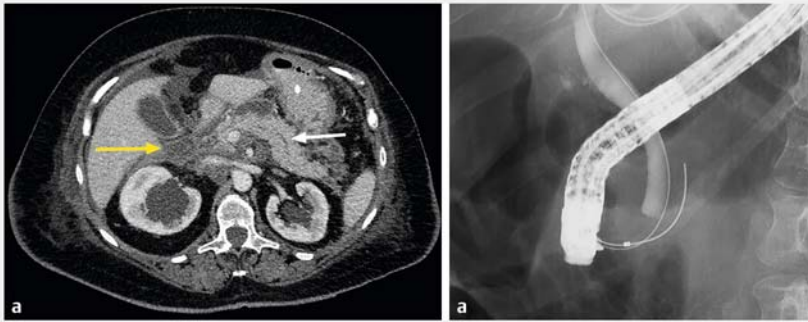
We present our experiences in two patients (▶ **Video 1**), both 72-year-old women. The first patient had symptomatic pancreatic duct disruption (▶ **Fig. 1**).



▶ **Video 1** The “hitch and ride” technique for blind pancreatic cannulation.



▶ **Fig. 1** Patient 1. **a** This patient experienced recurrent bouts of epigastric pain after a biliary pancreatitis episode. Computed tomography showed new peripancreatic collections (yellow arrow) with mild dilation of the pancreatic duct (white arrow), and therefore pancreatic disruption was suspected. **b** Partial stenoses of the second duodenal portion caused by edematous duodenal folds could be seen on fluoroscopy. **c** Biliary cannulation could be blindly achieved by directing the cannula toward a luminal depression caused by previous biliary sphincterotomy.



► **Fig. 2** Patient 2. **a** This patient complained of persistent abdominal pain with increased periduodenal inflammatory parameters (yellow arrow), worsening of pancreatic collections, and dilation of the pancreatic duct (white arrow) 4 weeks after an acute pancreatitis episode, consistent with a diagnosis of smoldering pancreatitis. **b** After biliary cannulation was achieved, the cannula had to be slightly withdrawn and the tip of the scope gently angulated to find the correct alignment with the pancreatic duct.

The second patient had smoldering pancreatitis (► **Fig. 2**). In both patients, endoscopic retrograde cholangiopancreatography could be completed with clinical success.

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Competing interests

Juan J. Vila is consultant for Boston Scientific.

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Bibliography

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