we have had to very often send it back to the company for repair. Therefore, overture-assisted direct peroral cholangioscopy using an ultra-slim gastroscope was the preferred intervention in this patient. Before the procedure, we made a hole at 70 cm from the distal end of the overtube of a single-balloon enteroscope (ST-SB1, Olympus, Tokyo, Japan) [1, 2] (Fig. 2). Then, an ultra-slim gastroscope (GIF-N260; Olympus, Tokyo, Japan) with a 2-mm working channel and 5.9-mm outer diameter was inserted through the hole. In the next step, first the CBD was cannulated with a duodenoscope using a sphincterotome and 0.035-inch jag wire, and then the duodenoscope was replaced with the ultra-slim gastroscope with the overtube over the wire. The overtube was advanced over the scope into the antrum. The overtube was useful for keeping the endoscope straight when inserted in the stomach as it prevented loop formation during advancement of the scope at a more accessible angle to the papilla. Then, without balloon inflation, the gastroscope was supported by the overtube and advanced over the wire into the bile duct (Fig. 3). The CBD stone was visualized (Fig. 4) and EHL was carried out to break the stone into several pieces. The stone fragments were removed using a
Dormia basket and balloon retrieval catheter (Fig. 5). Finally, an occluded cholangiogram showed no residual CBD stones after the procedure.

In our opinion, overtube-assisted direct peroral cholangioscopy, which can be carried out by a single endoscopist, provides superior endoscopic images and a larger working channel than the mother-baby endoscopy. This method also improved the success rate, even though we do not use balloon inflation as other endoscopists [3, 4].

**Competing interests:** None

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**References**


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