A 68-year-old woman was referred to our hospital because of obstructive jaundice. The patient had itching, but no abdominal pain, fever, or weight loss. Laboratory tests showed elevated levels of alkaline phosphatase (2035 U/L; normal 35–104 U/L), γ-glutamyltransferase (497 U/L; normal <39 U/L), and bilirubin (16.8 mg/dL; normal <1.2 mg/dL). C-reactive protein (1.35 mg/L; normal <0.5 mg/L) and tumor antigen CA 19-9 (960.8 U/L; normal <37 U/L) levels were slightly raised. Abdominal computed tomography (CT) revealed enhanced wall thickening of the intrahepatic duct (IHD), the confluent portion, and the common hepatic duct (CHD), which was compatible with Klatskin’s tumor, bismuth type IIIa. CT also revealed massive tumor invasion of the right hepatic artery (Fig. 1). We performed emergency endoscopic retrograde cholangiopancreatography (ERCP) and a plastic biliary stent (8.5 Fr, 10 cm) was inserted into the right hepatic bile duct. Cytological examination of the bile revealed a class V adenocarcinoma. After 20 days, the patient again had fever, jaundice, and tarry stool. We carried out a repeat emergency ERCP and endoscopic nasobiliary drainage (ENBD). The patient was diagnosed as having hemobilia, since the ERCP showed blood oozing from the papilla of Vater. Enhanced CT revealed a class V adenocarcinoma. After 20 days, the patient again had fever, jaundice, and tarry stool. We carried out a repeat emergency ERCP and endoscopic nasobiliary drainage (ENBD). The patient was diagnosed as having hemobilia, since the ERCP showed blood oozing from the papilla of Vater. Enhanced CT revealed a class V adenocarcinoma. After 20 days, the patient again had fever, jaundice, and tarry stool. We carried out a repeat emergency ERCP and endoscopic nasobiliary drainage (ENBD). The patient was diagnosed as having hemobilia, since the ERCP showed blood oozing from the papilla of Vater. 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