Ultraslim endoscope-assisted therapeutic ERCP for inaccessible papilla by a double-balloon enteroscope in patients with Roux-en-Y anastomosis

Roux-en-Y anastomosis has been thought to preclude endoscopic access for endoscopic retrograde cholangiopancreatography (ERCP) [1]. The balloon enteroscopy can be useful for performing ERCP in patients with Roux-en-Y anastomosis [2–5]. However, even if the enteroscope reaches a terminal portion of the afferent limb, the major papilla cannot always be detected. Here, we describe a case of successful ERCP using an ultraslim endoscope for inaccessible papillae by double-balloon enteroscopy (DBE) in a patient with Roux-en-Y anastomosis.

An 82-year-old man who had undergone total gastrectomy with Roux-en-Y anastomosis for gastric cancer, was admitted for obstructive jaundice due to a pancreatic abscess (**Fig. 1**). We performed DBE-assisted ERCP (EN-450T5, Fujinon Co., Ltd., Saitama, Japan). Although DBE could reach the major papilla, ERCP failed because the location of the papilla made selective cannulation difficult. We therefore tried ultraslim endoscope-assisted ERCP. First, the enteroscope was replaced with an ultraslim endoscope (FF-470N5, Fujinon). The shorter working length of the ultraslim endoscope necessitated modification of the overtube by creating an aperture 100 cm from its tip, on the side opposite to the pressure line to enable the balloon to remain inflated (**Fig. 2**) [5]. Finally, we performed, simultaneously, placement of a 5-Fr biliary stent and transpapillary nasocystic catheter for the drainage of the pancreatic abscess without any complications (**Fig. 3 a–d**).

To our knowledge, this is the first report on an ultraslim endoscope-assisted therapeutic ERCP. One of the most important issues regarding the use of an ultraslim endoscope is that there are few dedicated accessories for ultraslim endoscopes. Nonetheless, when we encounter a papilla in a difficult location, the ultraslim endoscope can be useful for access to the major papilla due to its flexibility.

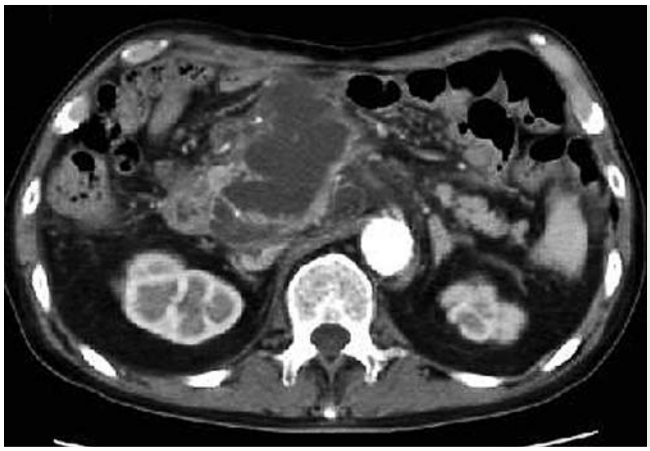

Fig. 1 Computed tomography showed pancreatic abscess.

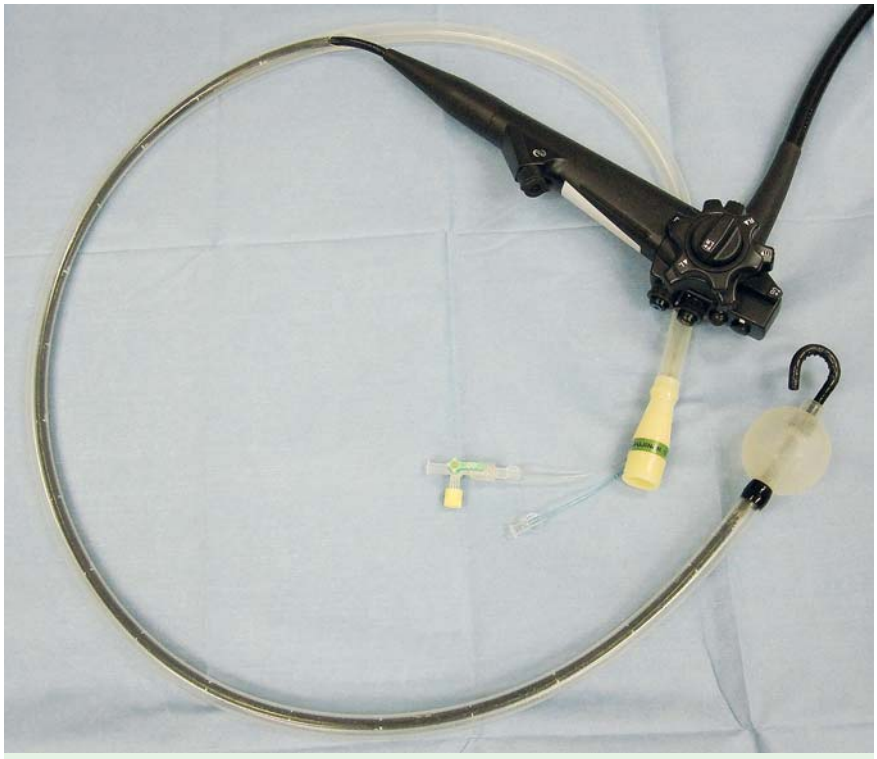

Fig. 2 Modification of the overtube for an ultraslim endoscope. An aperture was made in the overtube at a point 100 cm from its tip on the side opposite to the pressure line, to enable the balloon to remain inflated, for possible insertion of an ultraslim endoscope.

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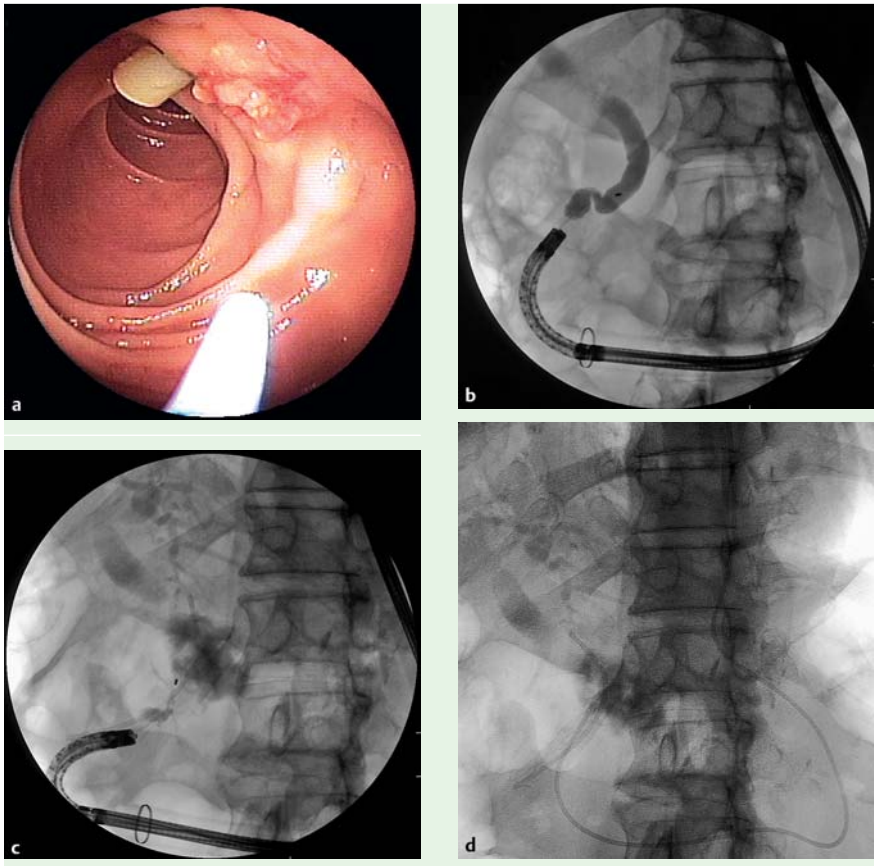

Fig. 3 Ultraslim endoscopy-assisted endoscopic retrograde cholangiopancreatography. **a** Ultraslim endoscopy could detect the major papilla. **b** Successful bile duct cannulation was achieved. **c** Radiograph shows biliary stenting and pancreatic abscess. **d** Finally, we performed placement of a biliary stent and nasopancreatic cyst catheter.

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