A 68-year-old man was admitted to our hospital with right upper quadrant pain and jaundice. Laboratory studies revealed leukocytosis, elevated liver enzymes, and hyperbilirubinemia. Magnetic resonance cholangiopancreatography examination revealed distal bile duct stenosis. On duodenoscopy, the papilla was hidden within a diverticulum. We tried using two devices simultaneously to perform endoclips-assisted biliary cannulation but without success (Fig. 1a). Thus, the duodenoscope was withdrawn and a gastroscope (GIF Q260; Olympus, Tokyo, Japan) was inserted. Cannulation of the pancreatic duct was achieved but deep access of the common bile duct remained impossible (Fig. 1b). A pancreatic duct plastic stent was then inserted to facilitate biliary cannulation. Endoscopic retrograde cholangiopancreatography confirmed the distal biliary stricture (white arrow), which was caused by the duodenal diverticulum. The patient was treated with balloon dilation (black arrow), and the pancreatic stent was clearly visible (red arrow).

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Fig. 1 Biliary cannulation in a patient with periampullary diverticula. a View of the intradiverticular papilla (black arrow), with biopsy forceps. b The guidewire was inserted into the pancreatic duct. c A pancreatic duct stent (red arrow) was used to facilitate biliary cannulation. Endoscopic retrograde cholangiopancreatography confirmed the distal biliary stricture (white arrow), which was caused by the duodenal diverticulum. d The patient was treated with balloon dilation (black arrow), and the pancreatic stent was clearly visible (red arrow).