Current status of ERCP

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Personal potential conflicts

• Consultant to Olympus America
• Royalties from Cook Medical
• Board member
  – Apollo Endosurgery
  – SE Healthcare Quality Consulting
Towards better quality ERCP

- Understanding complexity
- Refining indications (research)
- Protecting patients
- Maximizing and measuring expertise
- Teamwork

Complexity, or “degree of difficulty”

Any ERCP can turn out to be “difficult”
But, some are predictably so, such as
- Big stones
- Hilar strictures
- Surgical biliary diversions

New ASGE complexity classification

Use for

• Structuring stages of training
• Credentialing, revalidation
• Personal assessment and growth
• Benchmarking


Basic ERCP level 1 and 2

• Deep cannulation of duct of interest, sampling
• Biliary stent removal/exchange
• Biliary stone extraction <10mm
• Treat biliary leaks
• Treat extrahepatic benign, malignant strictures
• Place prophylactic pancreatic stents
Advanced ERCP level 3

• Biliary stone extraction >10 mm
• Minor papilla cannulation and therapy
• Remove internally migrated biliary stents
• Intraductal imaging, biopsy, FNA
• Manage acute or recurrent pancreatitis
• Treat pancreatic strictures
• Remove pancreatic stones mobile and <5mm
• Treat biliary strictures, hilar and above
• Manage suspected SOD (+- manometry)

Tertiary ERCP level 4

• Remove internal migrated pancreatic stents
• Intraductal guided therapy (PDT, EHL)
• Pancreatic stones impacted and/or >5mm
• Intrahepatic stones
• Pseudo cyst drainage, necrosectomy
• Ampullectomy
• Whipple, Roux-en-Y, Bariatric surgery
Up one level (to max 4) for

- Out of normal working hours
- Aged < 3 years
- Failed procedure elsewhere

Changing indications

Many things can be done at ERCP
What should be done is evolving
- Advanced imaging (CT, MRCP, EUS)
- Surgery less invasive and safer
- Better evidence through research
Questionable indications

- Gall stone pancreatitis
- Chronic pancreatitis
- Pre-op biliary stenting
- Sphincter of Oddi dysfunction
  - Pain syndromes
  - Recurrent acute pancreatitis
- Pancreas divisum
- Hilar tumors

From my medico-legal experience

- DO NOT DO ERCP (let alone sphincterotomy) for patients with “pain only” ± minimal labs
- Pancreatitis rate may be as high as 40%
- You will be sued, and you will lose

MRCP and EUS are excellent and safe tools
What should be done depends also on who is doing it

Competence = independent practice

How skilled are your graduates?

Would you let him work on your mother

(mother-in-law)?
Would YOU submit to ERCP by an “80%” doctor?

How would you know?

DATA


Report cards and Benchmarking

• Endoscopists should collect their data using standard quality metrics, and be able to see how they compare with peers
• ERCP quality network (GIQUIC)
• Getter easier with report-writers
ERCP Quality Network

Mean biliary cannulation rates by endoscopist

Practice volume is important

- **Individuals**
  - < 50/yr: higher complications & less success
  - < 100/yr: lower cannulation rate
  - < 100/yr: cannulation rate 92% (vs 98%)
  - < 1 sphincterotomy/wk: higher complications

- **Center volumes**
  - Low-volume centers: higher LOS and failures
  - < 200/yr: higher complications

Annual volumes

British Society of Gastroenterology proposed

- Individuals >75/year
- Centers >200/year

In USA

- 40% of ERCPists do <50/year
- Half of hospitals do <50/year

What is a reasonable number?


The problem of ERCP call

Practices should collaborate
Certification of ERCPists?

- Cars, trucks, trains, planes
- Endoscopes?

Protecting patients

- Solid communications and consent process
  - Benefits, risks, limitations and alternatives
- Managing co-morbidities and meds
- Reducing the risk of pancreatitis
  - Non-steroidals
  - Pancreatic stents?
- Reducing the risk of infection
  - Antibiotics for predicted undrainable systems
  - Scope reprocessing
- Comfort issues
  - CO2 insufflation
  - Sedation/anesthesia
Controversial technical issues

- Guide wire or contrast cannulation
- Difficult biliary access
  - Double wiring, temporary stent
  - Precutting
  - EUS guided alternative access routes
  - ERCP after gastric and biliary bypass

- Balloon dilation without sphincterotomy for small stones
- Direct cholangioscopy (value and safety)
- Pseudo cyst debridement
- Hilar tumors (type and number of stents)
- Metal stents for benign conditions
Quality ERCP depends on

• Expert **clinical** care and communications
• Well trained and experienced ERCPists
  – Optimal indications and techniques
  – Accountable for results
• More focused research
• TEAMWORK

More ramblings

[www.peterbcotton.com](http://www.peterbcotton.com)

First and last ERCPs on youtube