ENDO 2020: HONORARY LECTURERS APPOINTED BY THE MEMBER SOCIETIES OF THE ASIA-PACIFIC, EUROPE/MEDITERRANEAN, AND THE AMERICAS REGIONS

ENDO 2020, the 2nd World Congress of GI Endoscopy, has the privilege of hosting Honorary Lectures delivered by distinguished endoscopists. These lectures cover topics that affect the everyday practice of endoscopy and introduce new areas of research.

We are pleased to announce that Honorary Lecturers have been appointed by the following member societies: the Asia-Pacific Society of Digestive Endoscopy (A-PSDE), the European Society of Gastrointestinal Endoscopy (ESGE), and the Inter-American Society of Digestive Endoscopy (SIED).

The Honorary Lectures, delivered as they are by luminaries in the field of GI endoscopy and gastroenterology will be a highlight of ENDO 2020.

Join us in welcoming ENDO 2020’s Honorary speakers:

**Professor Hisao Tajiri (Japan),** President of the Japan Gastroenterological Endoscopy Society (JGES), will present the Asia-Pacific Society of Digestive Endoscopy (A-PSDE) Sadataka Tasaka Honorary Lecture on March 8, 2020 at ENDO 2020. Professor Tajiri’s topic will be “Digestive endoscopy – lighting the pathway to the future.”

**Professor Mário Dinis-Ribeiro (Portugal),** President of the European Society of Gastrointestinal Endoscopy (ESGE), will present the European Society of Gastrointestinal Endoscopy (ESGE) Francois Moutier Honorary Lecture on March 9, 2020 at ENDO 2020, on the subject of “Endoscopic diagnosis of superficial carcinoma and preneoplastic lesions of the stomach.”

**Dr Roque Saenz Fuenzalida (Chile),** former President of the Chilean Society of Gastroenterology (SCHGE) will present the Inter-American Society of Digestive Endoscopy (SIED) Rudolph Schindler Honorary Lecture on March 7, 2020 at ENDO 2020, on the subject of “Endoscopy. Just Quality?”

ABSTRACT SUBMISSION FOR ENDO 2020: WHAT YOU NEED TO KNOW

Abstract and video submission for ENDO 2020 is well underway. This is where you have the opportunity to present your latest research findings to the international endoscopy community.

BITESIZE FACTS:

- Authors are invited to submit their abstracts in English.
- All accepted abstracts will be published in the *Digestive Endoscopy* (DEN) ENDO 2020 abstract Supplement.
- ENDO 2020, the 2nd World Congress of GI Endoscopy, together with the 24th Pan American Congress of GI Endoscopy, will be one of the most important congresses for endoscopy worldwide.
- For successful submission of your findings, go to abstracts, check the guidelines, and submit your abstract.
The WEO Program for Endoscopic Teachers (PET) seeks to improve training by addressing the particular challenges involved in teaching how to perform safe, high quality endoscopy.

Who should teach endoscopy and what makes a good teacher? Who should be trained, by what methods, and to what level? How are simulators used most effectively? The one-and-half day PET course (June 7–8, 2019, Columbia University College of Physicians and Surgeons, New York, USA), organized in partnership with the New York Society of Gastrointestinal Endoscopy (NYSGE), helps answer these questions, in an intensive and varied program that includes hands-on and video-based sessions.

The aim is to help endoscopy trainers with the skills needed to teach endoscopy, and to provide a forum where they may interact, exchange ideas and thoughts and develop new teaching approaches. The Program will include discussion of training methods, how to assess competency, and the best use of models in endoscopy training.

2019 marks the sixth year of this program and WEO is proud of the four formats for PET courses that have been developed over time: PET Classic, Mini PET, Micro PET and PET 2.0.

Should you wish to host, sponsor or teach a PET course, please refer to the WEO secretariat (secretariat@worldendo.org).

TIPS AND TRICKS FOR DEVICE-ASSISTED ENDOscopic RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)

By Dr Simon Lo, Cedars-Sinai Medical Center, Los Angeles, California, USA

The scope

Device-assisted ERCP procedures are frequently carried out in patients whose biliary orifices are far away from the stomach. This may include those who have undergone bariatric Roux-en-Y gastric bypass (RYGB), biliary diversion surgeries, or a variety of gastrojejunostomies including Whipple surgery. While pediatric or adult colonoscopes may fit into this general category, we typically refer here to single-balloon, double-balloon and spiral overtube enteroscopes as the assisting devices. Most of today’s enteroscopes are 200 cm long and have a 2.8 mm-internal diameter instrument channel. A newer version of the double-balloon enteroscope has a 3.2 mm
channel capable of inserting an 8.5-French stent. There is a shorter 152-cm double-balloon enteroscope that may be used to perform pancreaticobiliary procedures. Finally, a through-the-scope balloon may be used to assist enteral advancement of a colonoscope. Of course, this balloon has to be removed from the instrument channel before any pancreaticobiliary interventions are embarked upon.

**Scope advancement technique**

Single-balloon enteroscopy is probably the simplest to perform. It has a limited range of traveling distance, but that may be sufficient for most purposes except for patients with long-limb RYGB surgery or significant intra-abdominal adhesions. There is no modification of the common technique for passage of double-balloon enteroscopes. It is a tedious procedure, but the reward is a near certainty that it is long enough to reach the biliary orifice. Spiral enteroscopy is rarely practiced these days. Any endoscope supported by the spiral overtube can be used to perform ERCP similarly to the standard single- or double-balloon enteroscope. As opposed to the back-and-forth, pulling and pushing motions used in balloon enteroscopes, spiral enteroscopy relies on a clockwise rotation to drive the scope forward. Getting around the duodenojejunal junction can be quite challenging, but the reward is a stable positioning that is essential for a successful ERCP procedure.

**Anatomical landmarks**

Each surgically altered anatomy has its unique construction and findings that help guide scope passage. Entering the wrong intestinal limb invariably leads to frustration and sometimes physical exhaustion. We often ask ourselves whether it is time to withdraw the scope and explore the other lumen when the major papilla or hepaticojejunostomy is not readily visualized. Is it wise to look for another intestinal lumen without wasting more time, or is it better to be patient and try to go further down the limb? There are some general rules of thumb that may guide us down the right path (see Table 1).

**Cannulation of the intact papilla in surgically altered anatomy**

Despite the challenges of passing an enteroscope and finding the pancreaticobiliary orifices, the real difficulty of

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Traveling wisely up the afferent limb</th>
<th>How to find the biliary orifice</th>
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<tbody>
<tr>
<td>Billroth II gastrectomy</td>
<td>Afferent limb is frequently the acute lumen and it crosses the spine (midline) very quickly</td>
<td>The minor papilla is often easier to visualize. If it is rotated to the 4-o’clock position, the major papilla should be seen at the 6–7-o’clock position by scope withdrawal of roughly 2 cm</td>
</tr>
<tr>
<td>RYGB</td>
<td>The Roux limb opens as the right lumen of the gastrojejunostomy. The afferent jejunoojejunostomy is the forward-facing lumen immediately across the anastomosis</td>
<td>The minor papilla is often easier to visualize. If it is rotated to the 4-o’clock position, the major papilla should be seen at the 6–7-o’clock position by scope withdrawal of roughly 2 cm</td>
</tr>
<tr>
<td>Whipple</td>
<td>The afferent limb is most often found at the 10–12-o’clock position. Same relationship is seen whether it is a conventional or pylorus-preserving Whipple</td>
<td>The biliary orifice is often located at the 8–10-o’clock position and it corresponds with the top point of the afferent loop on fluoroscopy. The pancreatic orifice is likely found at the 4–6-o’clock position, within a 1–2-cm flat patch of jejunal mucosa. It is almost always several cm further upstream from the biliary orifice</td>
</tr>
<tr>
<td>Roux-en Y hepaticojejunostomy</td>
<td>The jejunoojejunostomy opens at a few cm distal to the ligament of Treitz. The afferent limb is recognized as the forward-facing lumen immediately across the anastomosis</td>
<td>Expect to see one to three orifices, depending how high the surgical cut is made in the proximal bile duct. It is almost always located on the left side of the jejunum, but the actual position is quite variable</td>
</tr>
<tr>
<td>Loop gastrojejunostomy</td>
<td>No distinctive feature related to the afferent limb. It is a random selection of one of the two gastrojejunostomy orifices</td>
<td>The major papilla should be readily reached with an enteroscope. The distance from the gastrojejunostomy is typically short to modest in length</td>
</tr>
<tr>
<td>Duodenal switch</td>
<td>This is a rather laborious procedure. An alternative method should be used to study the pancreaticobiliary structure</td>
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© 2019 Japan Gastroenterological Endoscopy Society
Device-assisted ERCP actually begins with bile duct cannulation. Discussion of pancreatic ductal manipulations and treatment is beyond the scope of this article and will not be covered here. The native papilla is best approached with a cap fitted at the tip of the endoscope. It serves to stabilize and even “capture” the papilla for steady probing. Gentle suctioning through the cap may expose the papillary orifice for easier intubation. The papilla should be placed at the 6–8 o’clock position, if possible. Even though it may seem easier sometimes to visualize the papilla at the 12-o’clock position, approaching it from the 5–7 o’clock position where the instrument exits the scope makes it difficult to advance the instrument into the bile duct. Once the bile duct is accessed, the priority is to perform a brief study and, if appropriate, to perform a sphincterotomy. It is rather difficult to get back into the bile duct if the instrument has fallen out of it without a wide-open sphincter. Sphincterotomy should be done with a guidewire in place. Ideally the cutting wire should be perpendicular to the hood of the papilla. Unfortunately the cutting wire in the only commercially available wire-guided sphincterotome does not align well for effective cutting. Therefore, it is best to perform the cutting by modifying the bow-string sphincterotome into a needle knife. With a guidewire maintaining ductal access, the over-the-wire needle knife can be used to cut down towards the guidewire or cut outward (inside-out method) by first extending the needle alongside the guidewire inside the common channel. We prefer to cut downward to avoid the tendency to pull the guidewire out of the bile duct during inside-out cutting.

Approaching a biliary-enteric anastomosis

Hepaticojejunostomy is much easier to cannulate than the intact papilla in an altered anatomy, as the orifice is often seen in straight views. However, the right hepatic duct is typically more difficult to approach because the afferent limb commonly comes up to anastomose with the bile duct from the right side of the patient, thus favoring instrumentation of the left ductal system. Fluoroscopy may help to direct the tip of the endoscope to engage the right system that is otherwise very hard to approach.

Biliary stenting

Placement of plastic stents is often a tedious process through these skinny long scopes. Even for 7-French stents, a stent constrainer (or positioning sleeve) must be used to prevent the stent’s flap(s) from jamming up the small enteroscope channel. Since a single stent of that caliber is typically inadequate for maintaining ductal patency for longer than a month, we often insert 2 to 4 stents in parallel. This requires successive insertions that take a long time to perform. To overcome this issue, we frequently load up 3 or 4 stents, back-to-back, over a guidewire. After a successful placement, we would reinsert the guidewire into the duct for the second stent and repeat the same process for the third stent. Metal stents can be placed through these scopes as well. In this situation, the single- or double-balloon overtube should be advanced as close to the biliary orifice as possible. Through the scope, a long guidewire (600 cm in length) is inserted into the bile duct. The scope is then removed while the guidewire and overtube are carefully kept in place. A biliary metal stenting device can then be advanced over the guidewire into the bile duct, where the stent is released under fluoroscopic guidance. We have even placed side-by-side metal stents successfully in this manner. Since it is often a struggle to pass a scope through a surgically altered upper GI tract, it is best to minimize the need to repeat an ERCP as much as possible. One way to do so is to make use of a nasobiliary (NB) drain. While the commercially available NB drain sets may be too short to allow a standard exchange, it is quite easy to do so by using a long ERCP catheter to push the NB drain beyond the tip of the enteroscope when it is outside of the patient.

THE DOS AND DON’TS WHEN PERFORMING DEVICE-ASSISTED ERCP:

∗ Do pay attention to bile fluid in the intestinal lumen. The first sight of bile is often within 10–30 cm proximal to the jejunojejunostomy anastomosis. Slow down and look for the anastomosis when you see bilious fluid so that you can take time to correctly select the afferent jejunal orifice to enter. It can be a frustrating experience if you unknowingly zoom past the anastomosis and end up spending the next 30 minutes in the efferent limb.

∗ Do bring the overtube as close to the biliary opening as possible. The tip of the scope needs to be stabilized by the overtube balloon to help with cannulation and further manipulations.

∗ Do place tattoo marks to help identify the afferent lumen in future procedures, even if you don’t think that a repeat study is needed at the time. It is particularly important to mark the anastomosis and its afferent limb entrance.

∗ Do use fluoroscopy to help find the biliary orifice, especially when there is no endoscopic clue within the intestinal lumen. Bile duct air is the best guide. But when it is not seen, look for the most cephalad intestinal air and direct the scope to that location to search for the orifice.

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Do use fluoroscopy to confirm the location of the endoscope in the afferent limb of a Billroth II anatomy. It should show a straight scope that crosses the spine within only a few centimeters beyond the stomach.

Do insert a long guidewire into the presumed “wrong” lumen of a Roux-Y construction during withdrawal towards the jejunonjejunostomy anastomosis. It is often difficult to be certain when the scope is coming out of one of the several lumens until it is too late. Having the wire in the lumen allows us to be more confident when searching for the alternative anastomotic opening without going back into the same limb over and over again.

Do apply 0.5 ml of vegetable oil into an enteroscope channel before insertion of most ERCP accessories. The importance of lubricating the scope lumen cannot be overstated. Don’t use an excessive amount of oil, as spilled oil may muddy up the viewing lens of the endoscope.

Don’t use luminal bile to determine whether the scope is within the afferent limb. This is the biggest misconception of most endoscopists. Collections of bile fluid may just as easily be found in the afferent as the efferent limb.

Don’t assume the acute lumen at a jejunonjejunostomy anastomosis is the entrance to the afferent limb. In fact, it is almost always the opposite.

Don’t sweep the bile duct by forceful pulling of the stone balloon or withdrawal of the enteroscope. There is the risk of the scope or balloon falling back by a substantial distance and not getting back to the original position. It is better to pull the balloon down to the distal duct and hold it in place, while rotating or torquing the scope to the side. This will allow controlled balloon sweeps without losing bile duct access or the scope’s falling out of position.

AUTHOR

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WEO EVENTS CALENDAR

WEO upcoming events
- Colorectal Cancer Screening Committee meeting 2019 – Americas
  May 17, 2019 – San Diego, CA, USA
- Program for Endoscopic Teachers (PET) New York
  June 7–8, 2019 – New York City, USA
- Colorectal Cancer Screening Committee meeting 2019 – Europe
  October 18, 2019 – Barcelona, Spain

WEO-endorsed events
- EUS Live in Amsterdam
  June 6–7, 2019 – Amsterdam, The Netherlands
- 9th Nottingham Barrett’s Endotherapy Course
  June 13–14, 2019 – Nottingham, UK
- IMAGE 2019 – 10th International Live Endoscopy Course – a endo global event
  June 13–15, 2019 – Milan, Italy
- International Digestive Endoscopy Network 2019 (IDEN 2019)
  June 13–16, 2019 – Seoul, Korea
- 37th Gastroenterology and Endotherapy European Workshop (GEEW)
  June 17–18, 2019 – Brussels, Belgium
- 13th Byblos International Digestive Workshop (B.I.D.W.)
  June 21–22, 2019 – Jbeil, Lebanon
- EndoSwiss 2019 – Live
  June 21–22, 2019 – Zurich, Switzerland
- GIHep Singapore 2019
  July 11–14, 2019 - Singapore
- 5th Singapore International Advance Therapeutic Endoscopy Course (SIATEC)
  August 22–24, 2019 – Singapore
- 6th International Symposium on Complications in GI Endoscopy
  October 31, 2019 – Hamburg, Germany
- International Educational Endoscopy video Forum (IEEF2019) November 7–9, 2019 – Moscow, Russia

For more information, please visit www.worldendo.org/events.