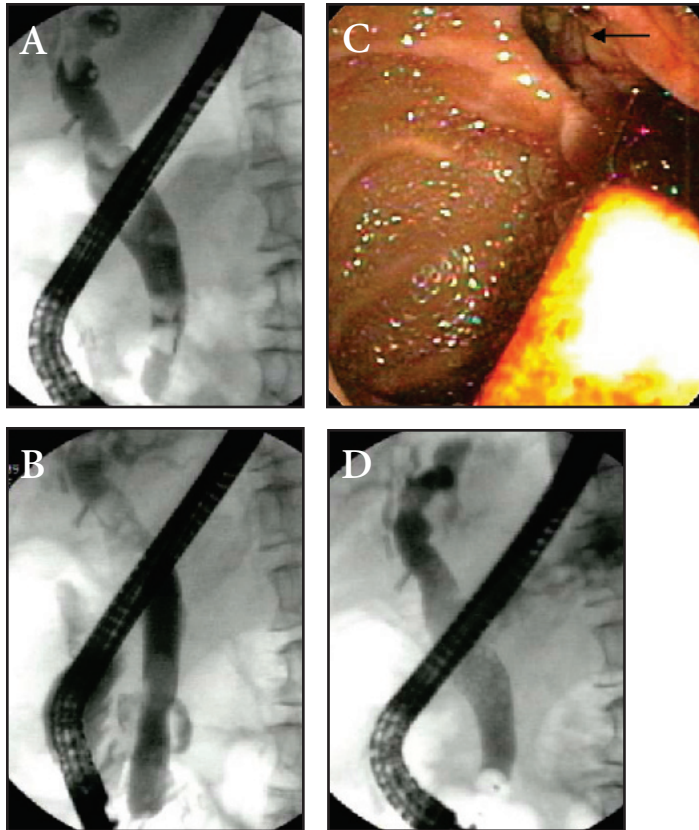


Figure 29-1. (A) Postoperative ERCP shows multiple large stones. (B) Sphincterotomy and balloon dilation using a 14-mm balloon was done. (C) All the stones were removed intact without lithotripsy. Note the 14-mm biliary orifice (arrow). (D) Final cholangiogram shows stone clearance and air in the biliary tree.



referral centers and should be at least in the high 80% in nonreferral centers (Figure 29-1). The success rate of ERCP is not entirely dependent on the ability of the endoscopist. For example, urgent ERCP may not be possible or very difficult in some hospitals, or some smaller hospitals may not even have emergency ERCP coverage. Again, I think the demand to perform routine preoperative ERCP will be relatively uncommon in centers with readily available good ERCP capabilities because most surgeons already recognize it. If you feel the surgeon is misinformed or falsely pessimistic, then you could try to educate him or her about your skills, training, experience, and outcome of ERCP. Round-the-clock availability of a tertiary care center with a proven track record for performing successful ERCP in a timely, customer service-oriented manner should also help allay the surgeon's concern about having to perform second surgery after failed ERCP and reduce the request for routine preoperative ERCP.

Preoperative ERCP should be only considered in patients with cholangitis, jaundice, elevated liver tests, imaging showing bile duct stones, or worsening gallstone pancreatitis.^{1,2} Preoperative ERCP should also be done as dictated by the surgical plan, for example in patients with anticipated anatomical problems such as prior biliary tract surgery (Figure 29-2). Preoperative ERCP is not indicated in patients with suspected but unconfirmed common duct stone or resolving jaundice because magnetic resonance cholangiopancreatography (MRCP), or better yet, endoscopic ultrasound (EUS) can be as accurate and significantly less risky compared to ERCP.