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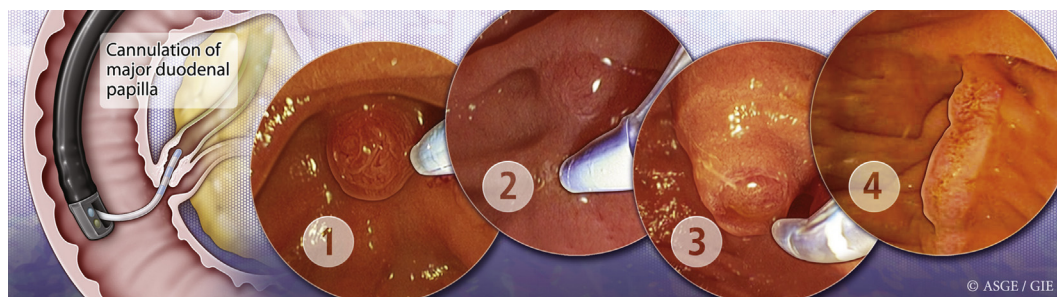


Macroscopic appearance of the major duodenal papilla influences bile duct cannulation: a prospective multicenter study by the Scandinavian Association for Digestive Endoscopy Study Group for ERCP (CME)

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GRAPHICAL ABSTRACT



Background and Aims: Certain appearances of the major duodenal papilla have been claimed to make cannulation more difficult during ERCP. This study uses a validated classification of the endoscopic appearance of the major duodenal papilla to determine if certain types of papilla predispose to difficult cannulation.

Methods: Patients with a naïve papilla scheduled for ERCP were included. The papilla was classified into 1 of 4 papilla types before cannulation started. Time to successful bile duct cannulation, attempts, and number of pancreatic duct passages were recorded. Difficult cannulation was defined as after 5 minutes, 5 attempts, or 2 pancreatic guidewire passages.

Results: A total of 1401 patients were included from 9 different centers in the Nordic countries. The overall frequency of difficult cannulation was 42% (95% confidence interval [CI], 39%-44%). Type 2 small papilla (52%; 95% CI, 45%-59%) and type 3 protruding or pendulous papilla (48%; 95% CI, 42%-53%) were more frequently difficult to cannulate compared with type 1 regular papilla (36%; 95% CI, 33%-40%; both $P < .001$). If an inexperienced endoscopist started cannulation, the frequency of failed cannulation increased from 1.9% to 6.3% ($P < .0001$), even though they were replaced by a senior endoscopist after 5 minutes.

Conclusions: The endoscopic appearance of the major duodenal papilla influences bile duct cannulation. Small type 2 and protruding or pendulous type 3 papillae are more frequently difficult to cannulate. In addition, cannulation might even fail more frequently if a beginner starts cannulation. These findings should be taken into consideration when performing studies regarding bile duct cannulation and in training future generations of endoscopists. (Gastrointest Endosc 2019;90:957-63.)

(footnotes appear on last page of article)

How to best achieve a safe and effective bile duct cannulation during ERCP has always been, and still is, a much-debated issue.¹⁻³ Both technical- and patient-related aspects of cannulation and cannulation difficulties have previously been investigated⁴⁻⁶; however, if and in what way the endoscopic appearance of the major duodenal papilla may influence cannulation has not been investigated.

All endoscopists who perform ERCP recognize the obvious differences in the macroscopic appearance of the major duodenal papilla.⁷ This has led to a widespread conception among endoscopists that certain specified appearances of the papilla are more difficult to cannulate and therefore more prone to adverse events.⁸⁻¹² However, until now there has not been a structured investigation of what kind of influence the macroscopic appearance of the major duodenal papilla has on difficulties during bile duct cannulation.

Before determining the association between the macroscopic appearance of the major duodenal papilla and cannulation difficulties, some prerequisites have to be met. First, there has to be a clear definition of what is to be considered a difficult bile duct cannulation to make any evaluation of cannulation difficulties relevant and reproducible. Several different definitions have been used to investigate this matter.¹³ However, since 2016 the European Society for Gastrointestinal Endoscopy (ESGE)¹⁴ recommends the use of the definition presented in the Scandinavian Association of Digestive Endoscopy group study¹⁵ when investigating issues regarding difficult bile duct cannulation. This definition shows a clear increase in adverse events when any of the criteria of more than 5 minutes, 5 attempts, or 2 pancreatic guidewire passages were met.

Second, to make certain that different endoscopists are in agreement on the endoscopic appearance of the papilla, an interobserver-validated endoscopic classification has to be established. In our previously published article, the first interobserver- and intraobserver-validated classification of the endoscopic appearance was presented¹⁶ (Fig. 1). With a validated classification and an accepted definition of difficult cannulation in place, we aim to determine the possible influence the endoscopic appearance of the major duodenal papilla has on the ability to perform bile duct cannulation during ERCP.

METHODS

Patients from 9 different centers in the Nordic countries who, on clinical grounds, were scheduled for ERCP were prospectively included into the study. To be included, patients had to be over 18 years old; have an intact, naïve, major duodenal papilla; and the desired duct to cannulate had to be the common bile duct. Exclusion criteria were a papilla hidden inside a large diverticulum or bulky tumors of the papilla that made classification impossible, and also patients with surgically altered anatomy.

The primary outcome measure was differences in the frequency of difficult cannulation distributed between the different papilla types. Difficult bile duct cannulation was defined using the 5-5-2 criterion, that is, after 5 minutes, 5 attempts, or 2 pancreatic guidewire passages and when any of those limits are reached.¹⁵ The endoscopic appearance of the major duodenal papilla was classified into 1 of 4 distinctive papilla types: regular (type 1), small (type 2), protruding or pendulous (type 3), and creased or ridged (type 4) of our previously published classification¹⁶ (Fig. 1). When, during the ERCP, the duodenoscope reached the papillary region in the duodenum, the endoscopist classified the endoscopic appearance of the papilla into 1 of 4 predefined papilla types. Two photographs of the papilla were captured with and without a cannulation catheter or sphincterotome alongside it for size reference. Thereafter, bile duct cannulation was initiated. Time was recorded from the first intentional touch of the papilla. The number of intentional contacts with the papilla, attempts, were recorded as well as all guidewire passages into the main pancreatic duct. When a guidewire or catheter was securely placed inside the common bile duct, determined by fluoroscopy, the stopwatch was terminated. The number of cannulation attempts and pancreatic guidewire passages was summarized. Data regarding the indication for the ERCP, patient demographics, methods used for cannulation, measures taken to avoid post-ERCP pancreatitis (PEP; nonsteroidal anti-inflammatory drugs and/or protective pancreatic endoprosthesis insertion), and post-ERCP adverse events occurring during the first 24 hours or before discharge were recorded. Adverse events were defined according to consensus criteria.¹⁷ No further follow-up of the severity of the adverse events was made.

To determine the influence of endoscopists' experience on difficulties during bile duct cannulation of the different papilla types, endoscopists of different levels of experience were allowed to start cannulation attempts. When an inexperienced endoscopist (ie, a "fellow") attempted bile duct cannulation and could not achieve deep bile duct cannulation within 5 minutes, a more senior colleague replaced the fellow and continued cannulation efforts. A fellow was defined as an endoscopist who had performed fewer than 200 career-long ERCPs.¹⁸ Expert endoscopists were defined as having performed over 1000 ERCPs, and intermediate endoscopists were those who had performed 200 to 1000 ERCPs during their career. Power calculations were not possible because the distribution of the different papilla types was previously unknown, as was the overall frequency of difficult cannulation using the ESGE-approved definition. The 5-5-2 (more than 5 minutes, more than 5 attempts, 2 or more wire passages or contrast injections into the pancreatic duct) definition is based primarily on the work by the Scandinavian Association of Digestive Endoscopy study group of ERCP,¹⁵ consisting of expert endoscopists. However, the ESGE

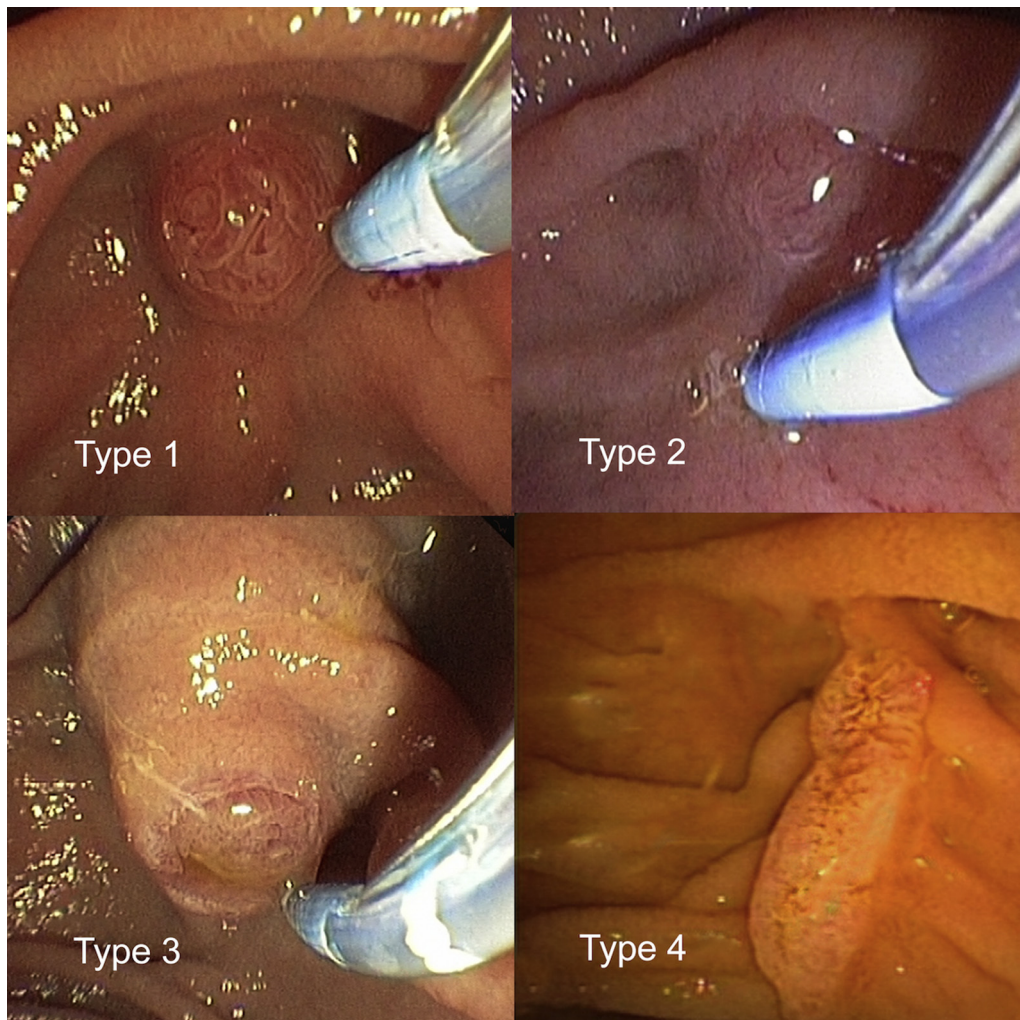


Figure 1. Classification of the endoscopic appearance of the papilla of Vater. Type 1 “regular papilla,” most common type with no distinctive features, “classic appearance.” Type 2 “small papilla,” small, often flat with a diameter not bigger than 3 mm (~ 2 sphincterotome diameter). Type 3 “protruding or pendulous papilla,” papilla that is protruding or bulging into the duodenal lumen, sometimes hanging down, pendulous with the orifice oriented caudally. Type 4 “creased or ridged papilla,” the ductal mucosa seems to extend distally out of the orifice either on a ridge or in a crease.

has recommended that this definition should be used in future studies investigating difficult cannulation.

All statistical calculations were made with SPSS version 25 (IBM, Armonk, NY). The χ^2 test or Fisher exact test were used for categorical data as appropriate, as well as odds ratio (OR) calculation. The Mann-Whitney U test was used for non-normally distributed continuous data. The study was approved by the ethical review board at the Karolinska Institutet, Stockholm (Dnr 2013/908-31/2).

RESULTS

In total, 1401 patients were included in the study. Classification of the papilla into the predefined types was possible in 98% of the cases. In 2% of the cases ($n = 24$), the endoscopist was unable to select an appropriate papilla type, and these 24 cases were excluded from further analyses. The endoscopist was asked to state a

reason for inability to classify the papilla. In most cases ($n = 13$) a swollen papilla caused by inflammation, impacted stones, or an unexpected finding of a tumor (exclusion criteria) was indicated as the causative factor. In 5 case reports, no explanation for the inability to perform classification was given. It was in violation with the study protocol to classify the papillae in retrospect using the photos taken during the ERCP. In only 1 case did the endoscopist have problems in choosing between the defined papilla types. In the remaining 5 cases, classification was impossible because of the inability to find the papilla because of extensive mucosal folds, large diverticulum (exclusion criteria), or narrow duodenal lumen hindering movement of the duodenoscope. The distribution of the different papilla types is shown in Figure 2, with regular papilla type 1 being the most frequent (56%) followed by type 3 protruding or pendulous papilla occurring in 23%.

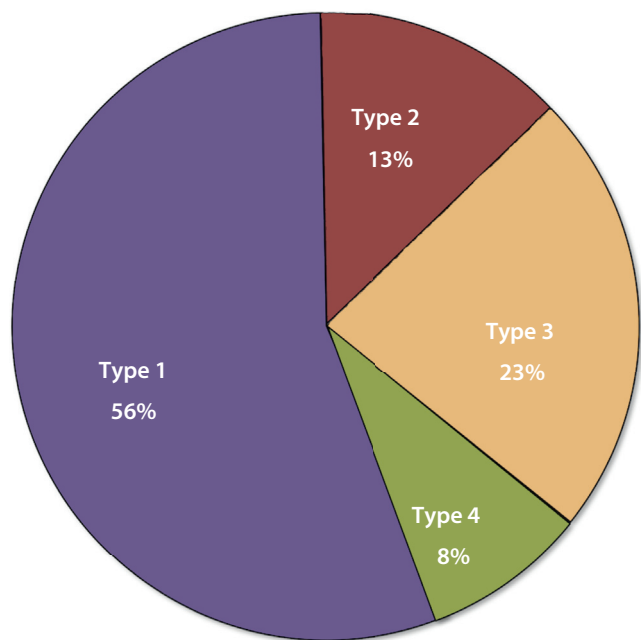


Figure 2. Distribution of the different papilla types.

The mean age of the patients was 66 years (range, 18-101), and 52% were women. The most common indications for ERCP were common bile duct stones (44%), followed by periampullary tumor¹⁹ (excluding tumors invading the papilla itself) and jaundice (Table 1). No significant differences were seen between the different papilla types regarding age, sex, previous cholecystectomy rate, nonsteroidal anti-inflammatory drug use, protective pancreatic stent, or indications for ERCP, except for patients with creased or ridged papilla, type 4. Compared with type 1 papilla, patients with type 4 papilla were, on average, younger (mean, 59 years vs 66 years; $P < .0001$) and more frequently had primary sclerosing cholangitis as an indication for ERCP (18.7% vs 5.7%, $P < .0001$). In patients with type 3 papilla, periampullary diverticulum was not as frequent as in type 1 papilla (6% vs 13%, $P = .001$).

In most instances cannulation attempts were started by an expert endoscopist ($n = 870$, 62%) and to a lesser extent by an endoscopist in the intermediate category ($n = 240$, 17%). In 291 cases (21%), a fellow started the cannulation attempts. The level of endoscopist experience was evenly distributed among the different papilla types, with only minor, nonsignificant differences.

The overall frequency of difficult cannulation regardless of papilla type was 42% (95% CI, 39%-44%). Among the different papilla types, difficult cannulation varied, as shown in Figure 3. Small papilla type 2 (52%; 95% CI, 45%-59%) and protruding or pendulous papilla type 3 (48%; 95% CI, 42%-53%) were significantly more often difficult to cannulate compared with regular type 1 papilla (36%; 95% CI, 33%-40%). There was, accordingly, an increased OR for difficult cannulation for both small

TABLE 1. Patient characteristics (n = 1401)

Characteristic	Value
Female, %	52
Mean age, y (standard deviation)	66 (16)
Indication for ERCP, %	
Common bile duct stones	44
Periampullary tumor	15
Jaundice	13
Stricture	9
Primary sclerosing cholangitis	7
Bile leak	4
Other	8

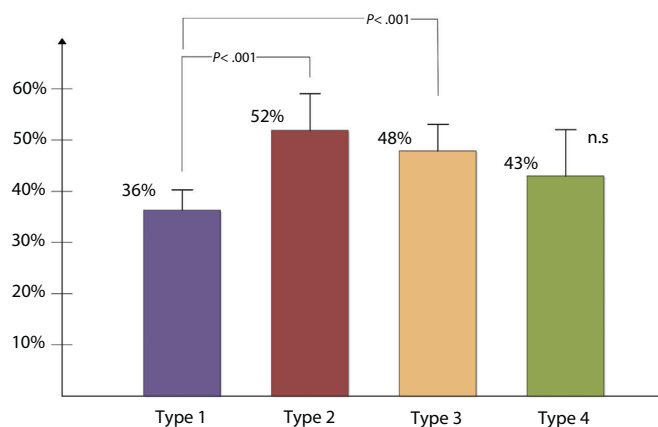


Figure 3. Frequency of difficult cannulation distributed among the different papilla types (95% confidence intervals).

papilla (OR, 1.89; 95% CI, 1.37-2.62) and protruding or pendulous type 3 papilla (OR, 1.61; 95% CI, 1.24-2.10) compared with regular type 1 papilla. Creased or ridged type 4 papilla (43%; 95% CI, 34%-52%) did not show any significant difference from regular type 1 papilla in the frequency of difficult cannulation.

Cannulation difficulties were even more evident when endoscopists with different levels of experience attempted bile duct cannulation. Regardless of papilla type, bile duct cannulation was more often difficult when a fellow started (69%; 95% CI, 64%-74%) as well as when an endoscopist from the intermediate category started (49%; 95% CI, 42%-55%) compared with when an expert started (30%; 95% CI, 27%-34%; both $P < .0001$). The frequency of difficult cannulation for endoscopists with varying degrees of experience is shown in Table 2

If analyzing only expert endoscopists performing cannulation on their own, the result was comparable to the result from the entire study population: a significantly higher frequency of difficult cannulation when cannulating small papilla type 2 (43%; 95% CI, 34%-53%; $P = .0002$) or protruding or pendulous papilla type 3 (36%; 95% CI, 29%-

TABLE 2. Frequency of difficult cannulation, depending on experience and papilla type

Papilla type	Experience		
	Expert (percent)	Intermediate (percent)	Fellow (percent)
Type 1, regular papilla	25	45*	66*
Type 2, small papilla	43	49†	83*
Type 3, protruding or pendulous papilla	36	63*	69*
Type 4, creased or ridged papilla	32	44†	73*
Overall	30	49*	69*

*Significant difference ($P < .05$) compared with expert.

†Nonsignificant compared with expert.

43%; $P = .0075$) was seen, compared with regular papilla type 1 (25%; 95% CI, 21%-29%). No difference was found when comparing creased or ridged papilla type 4 (32%; 95% CI, 21%-45%; $P = .22$) with type 1.

The median time to successful bile duct cannulation was significantly longer for both type 2 papilla (median time, 269 seconds; interquartile range, 622) and type 3 papilla (median time, 245 seconds; interquartile range, 794; both $P < .05$) compared with type 1 papilla (median time, 139 seconds; interquartile range, 455). Cannulation time for creased or ridged papilla type 4 (median, 210 seconds; interquartile range, 515) was not significantly different from type 1.

In 99% of the ERCPs the endoscopists used guidewire-assisted cannulation. If cannulation became difficult, 50% of the endoscopists continued with guidewire cannulation until cannulation succeeded or failed. In the remaining patients, different auxiliary cannulation techniques were used. The standard precut technique as the only auxiliary method was used in 9%, pancreatic sphincterotomy in 15%, double-wire technique in 15%, and combination of several techniques in 10%. No significant differences between the papilla types regarding choice of auxiliary technique was found.

The overall PEP frequency regardless of papilla type was 6.7% (95% CI, 5.5%-8.2%). When there was difficult cannulation, the frequency of PEP increased to 8.9% compared with 5.1% ($P = .006$) when cannulation was not difficult. There was also a variation in the frequency of PEP between the different papilla types, but none of the differences was statistically significant. Regular type 1 papilla had a PEP frequency of 6.1% (95% CI, 4.6%-8.0%), whereas small type 2 papilla had 9.4% (95% CI, 5.9%-14.6%), protruding or pendulous type 3 papilla 6.4% (95% CI, 4.1%-9.7%), and creased or ridged-type 4 had 7.5% (95% CI, 3.6%-14.3%). There was overall a low frequency of other adverse events such as postinterventional bleeding (.2%) and cholangitis (.6%), and there were no significant differences between the papilla types.

The overall frequency of failed cannulation was low (2.8%; 95% CI, 2.1%-3.9%), with only nonsignificant differences between the different papilla types. However, the

frequency of failed cannulation regardless of papilla type increased from 1.9% to 6.3% ($P < .0001$) if a fellow started cannulation attempts compared with an expert, even though they had to turn the endoscope over to a more senior colleague after 5 minutes. This was especially pronounced for small type 2 papilla with an overall 14% failed cannulation frequency when a fellow started compared with 2.7% ($P = .018$) when an expert performed the cannulation single-handedly. The OR, regardless of papilla type, for failed cannulation when a fellow started to cannulate compared with when an expert endoscopist started was 4.0 (95% CI, 2.0-8.2; $P = .0001$). When a fellow started, the OR for failed cannulation on a small papilla was 6.1 (95% CI, 1.4-27; $P = .017$) and on a protruding or pendulous papilla 5.2 (95% CI, 1.3-21; $P = .022$) compared with when an expert started.

DISCUSSION

Although many endoscopists assume the appearance of the major duodenal papilla has implications on bile duct cannulation, no prospective investigation of this matter has previously been performed. By using our classification of the endoscopic appearance of the major duodenal papilla combined with the ESGE-approved definition of difficult cannulation, we have determined that small type 2 papillae and protruding or pendulous type 3 papillae are more frequently difficult to cannulate. Accordingly, they also have a higher OR for difficult cannulation compared with regular type 1 papillae. These findings have previously only been assumed, based on expert opinion, and not on a validated classification of different papilla types and a prospective data collection.^{4,11,12} With these results in mind, further research regarding cannulation difficulties should take these aspects into consideration.

In addition, this study demonstrates clear differences regarding frequency of difficult cannulation between a fellow starting cannulation of a certain type of papilla compared with when an expert is starting. This finding is, of course, obvious but has previously not been quantified using the present definition for difficult cannulation

or in regard to differences in endoscopic appearance of the papilla types. The differences in frequency of difficult cannulation might also be of use when evaluating competence among different endoscopists and during ERCP training. With beginners having a high ratio of difficult cannulation and experts a significantly lower ratio and because difficult cannulation is a considerably more frequent phenomenon than failed cannulation and affects every endoscopist to a varying degree, it can be used as an intraprocedural quality measure along with failed cannulation frequency.^{20,21} Further studies regarding this might determine a benchmark for what frequency of difficult cannulation one should accomplish and maintain to be considered a qualified ERCP endoscopist.

A more unexpected but intriguing and important finding is that when a fellow starts cannulation, the odds for failed cannulation increase significantly even as a more senior endoscopist continues cannulation attempts after 5 minutes. These findings also have implications on how education and training in ERCP and bile duct cannulation is conducted. For example, it may be suggested that when a fellow is confronted with a certain papilla type (ie, small type 2 or protruding or pendulous type 3 papilla), they probably should abstain from any cannulation attempt and hand the endoscope over to a more experienced endoscopist from the very start so as not to jeopardize further cannulation success. Perhaps during initial ERCP training focus should be shifted from bile duct cannulation attempts by the trainee, leaving that to the trainer, and instead focusing on other technical skills to complete a successful ERCP, not putting the patient at increased risk for failed cannulation. Simulator training, training on models, or only starting procedures on patients who have previously been sphincterotomized is a safer path in the early phase of ERCP learning.²²

In previous studies it was found that the factor "trainee participation" might have a slight negative influence on bile duct cannulation.^{23,24} No definitive explanation for this finding was shown, but trauma to the papilla was discussed as a possible explanation. In contrast, other studies have not been able to identify this problem when evaluating trainees learning ERCP.^{25,26} Frost et al²⁷ made a structured effort to answer this question. However, in contrast to the present study they could not find any negative impact of letting a trainee start cannulation. None of these studies²⁵⁻²⁷ has, on the other hand, considered the impact of the endoscopic appearance of the papilla on cannulation difficulties. The present study was not designed to investigate this unexpected finding, and consequently it needs to be evaluated in a more dedicated study to make any definitive statements regarding this finding.

The same holds true for the PEP frequencies for the different papilla types. No significant differences between the papilla types regarding PEP frequency was seen in the present study, although there is a tendency that small papillae have a frequency of PEP in parallel with the

increased frequency of difficult cannulation. In the present study, as well as in previous studies, there is a higher frequency of PEP if cannulation is difficult.^{28,29} The definition for difficult cannulation used is constructed with the risk of PEP as a decisive factor.¹⁵

When a new classification is made to be used in a clinical setting, one has to make some kind of compromise between usefulness and precision. Previously, there have been suggestions for a classification of the endoscopic appearance of the papilla, but it has not undergone any interobserver validation and only been applied in studies concerning precut cannulation technique,^{9,30} not regarding difficult cannulation per se. In the present study, we aimed at implementing a more universal, easy-to-use classification in an everyday clinical setting to make the results more generalizable. As in all studies where different observers are called on to make a judgement and determine what they believe is the correct classification, there will always be an uncertainty as to whether the "correct" decision is made. In contrast, one could ask oneself how useful, in the clinical situation, is a classification if only dedicated experts can determine the "correct" answer? In the present and our previous study, we have tried to balance these opposing aspects to make a classification that is easy to use and understand but still interobserver-validated to a substantial degree to both experts and beginners, making it relevant in everyday clinical practice.

To summarize and conclude, the present study has shown that the endoscopic appearance of the major duodenal papilla affects bile duct cannulation. Small type 2 and protruding or pendulous type 3 papillae are often more difficult to cannulate, especially for inexperienced endoscopists. Furthermore, the finding that when a fellow endoscopist attempts bile duct cannulation the frequency of failed cannulation rises, even when a more experienced endoscopist continues cannulation, raises some concerns regarding endoscopy training. These findings should be taken into consideration when performing studies regarding bile duct cannulation and in the training of future generations of endoscopists.

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Abbreviations: CI, confidence interval; ESGE, European Society of Gastrointestinal Endoscopy; OR, odds ratio; PEP, post-ERCP pancreatitis.

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See CME section; p. 971.

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