

## Response to letter to the editor – “Training in ERCP: a multifaceted enterprise now more than ever”



We are pleased that our study looking at whether trainee presence impairs biliary cannulation success rate has generated some interest and would be happy to answer the questions asked by Drs. Tabibian and Leung to the best of our ability.

1. Were the groups balanced (e.g. with regard to patient age, gender, and location and appearance of the papilla)?

Unfortunately, the study proforma was not designed to capture specific details on age, gender or ampullary morphology and location. Therefore, we cannot provide evidence at this stage to state that factors such as those were balanced between the two groups. We feel it is unlikely, however, that age and gender would have any impact specifically on the ability to cannulate the common bile duct.

2. Could “pragmatic” determination of trainee participation have led to triaging of complex or challenging cases to consultant only?

Trainees were allocated to regular lists but attendance was inconsistent due to on-call general medicine commitments, mandatory regional training days and annual leave. Trainers were not always aware of trainee absences beforehand and there was no intentional pre-selection of “challenging cases” to consultant-only lists. On reviewing the “cotton grades” of difficulty across the two groups, we can say that there was no statistically significant difference with *P* values of 0.4, 0.3, and 1.0 for cotton grades 1, 2, and 3, respectively, although we recognize that is not the only measure of “difficulty” when performing endoscopic retrograde cholangiopancreatography (ERCP).

3. Is the 6-minute rule used in the training protocol irrespective of number

of “touches” or patient-level (e.g. anatomical)?

During the study, trainees were allowed 6 minutes to cannulate the ampulla irrespective of the number of touches or any difficult patient-level factors. That was under direct supervision from the trainer, who would often suggest a “wire-led” cannulation technique if superficial papillary cannulation with the sphincterotome was proving difficult (as a means to minimize any trauma to the ampulla).

4. At what number of ERCPS did the trainees in the investigators’ training protocol achieve competency?

Gastroenterology and endoscopy training in the UK is done on a rotational basis with specialist registrars moving between trusts within a region on a regular basis (normally every 12 months with occasional exceptions). All trainees had performed fewer than 50 procedures when they began their placement within the trust and none of the trainees were competent for independent practice at the end of their rotations.

5. There were no cases of “complicated pancreatitis” out of the 219 ERCPS included in the study. Did any patients require hospitalization or additional investigations for pancreatitis (but no “further intervention”)?

The main focus of our study was to determine whether presence of a trainee on a routine ERCP list impaired successful biliary cannulation and our study proforma was designed to specifically address that as opposed to other “trainee-related” outcome measures. Although that allowed us to capture any local and immediate complications during the procedure, we were not able to monitor for delayed presentations with post-pro-

cedural pain or pancreatitis and therefore, we cannot comment at this stage any further as to whether any patients were hospitalized with that. We do know, however, that none of the patients in our cohort required admission to the intensive care unit and that no further radiological or endoscopic intervention was required.

We hope this answers some of the questions posed and would be happy to respond to any further queries if required.

### Competing interests

None

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### Bibliography

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