ERCP is the standard procedure for endoscopic biliary therapy. The endoscopic approach to the ampulla followed by selective deep biliary cannulation is the first step before further therapy. Difficult biliary access can occur during endoscope intubation or when attempting selective biliary cannulation in normal or surgically altered anatomy. Difficult cannulation increases the risk of post-ERCP adverse events, particularly post-ERCP pancreatitis (PEP) and perforation. In normal anatomy, about 11% of therapeutic ERCPs may be considered difficult biliary cannulation.1 Biliary access in patients with surgically altered anatomy, such as Billroth II or Roux-en-Y anastomosis, is considered difficult because special instruments and maneuvers are often needed.

Various methods are used to overcome difficult biliary access, including advanced ERCP-based techniques using precut papillotomy or double guidewires (DGWs), specialized instruments like echoendoscopes or device-assisted enteroscopy, or percutaneous approach. These techniques and procedures are more complex and carry significant risks, requiring specific training. This consensus aims to develop an evidence-based framework for biliary endoscopists to tackle difficult biliary access.

**METHODS**

Based on literature search through MEDLINE, Cochrane Library, and Embase, a planning panel (W.C.L., P.A., H.I., R.R., H.P.W.) drafted statements on 3 areas: difficult biliary access in normal anatomy, difficult biliary access in surgically altered anatomy, and EUS- or percutaneous-guided biliary access. The first draft was distributed electronically to the panel members who evaluated each statement (Table 1). A face-to-face meeting was conducted in July 2015 in Taipei, Taiwan, to review and discuss the evidence and revise the statements. The members then independently voted on each statement via an electronic system. Consensus was considered to be achieved when 80% or more of voting members indicated “accept completely” or “accept with some reservation.” A statement was rejected when 80% or more of voting members “reject completely” or “reject with some reservation.” Finally, 13 statements achieved consensus. The level of evidence and grade of recommendation were rated with the evidence leveling system2 (Table 1).

**CONSENSUS STATEMENTS**

1. Difficult biliary access is defined as the inability to achieve selective biliary cannulation by standard ERCP techniques within 10 minutes or up to 5 cannulation attempts or failure of access to the major papilla.

Evidence level: II-A
Recommendation grade: B
Voting on recommendation: A, 56%; B, 44%; C, 0%; D, 0%; E, 0%

Guidewire-assisted cannulation is considered the standard technique for biliary access.3,4 Increased cannulation time, number of cannulation attempts, and number of pancreatic duct injections/cannulations have been associated with increased risk of PEP.5 Therefore, an upper limit of cannulation time and number of attempts should be set...