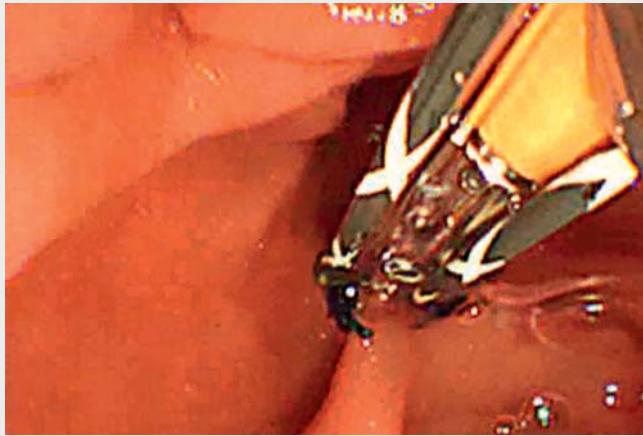


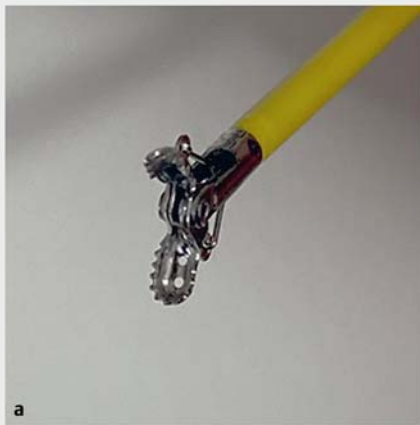
The “funitel” technique for endoscopic target biopsy at a biliary bifurcation



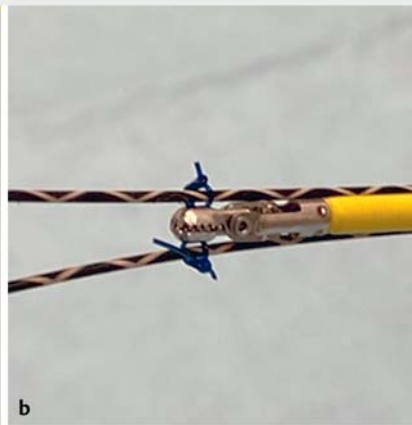
▶ **Video 1** The “funitel” technique for target biopsy at a biliary bifurcation during endoscopic retrograde cholangiopancreatography.



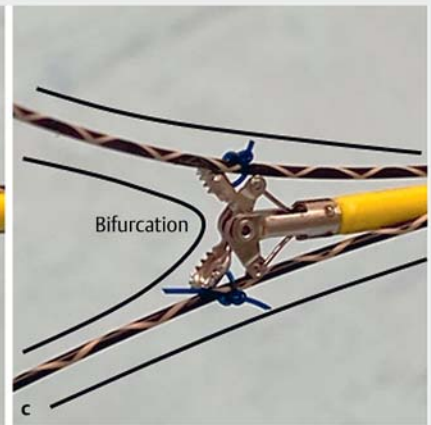
▶ **Fig. 1** Cholangiogram delineating a stricture between the right hepatic duct and hilar bile duct with irregularity of the distal bile duct.



a



b



c

▶ **Fig. 2** The “funitel” technique for targeted biopsy of biliary epithelium at the bifurcation of B2 and B3 during endoscopic retrograde cholangiopancreatography. **a** Photograph of biopsy forceps (Radial Jaw 4 pediatric; Boston Scientific, Marlborough, Massachusetts, USA) with two holes at each cup, which are designed to facilitate tissue acquisition. **b** A looped nylon thread passed through the holes of each cup of the forceps, which allows the forceps to be advanced over prepositioned guidewires. **c** Schema of the two guidewires and positioning of the biopsy forceps at the bifurcation.

Endoscopic retrograde cholangiopancreatography (ERCP) with biopsy is a gold-standard procedure for pathological assessment of spreading of cholangiocarcinoma [1, 2]. Tumor existence at landmark biliary bifurcations should be assessed to consider the indication and extent of surgical resection. However, technical

difficulties in pushing biopsy forceps against a biliary bifurcation may inhibit precise target biopsy. Here, we present a simple modification of widely used biopsy forceps for highly selective biopsy at the bifurcation of bile ducts at segments II and III (B2 and B3) (▶ **Video 1**).

An 80-year-old woman with suspected hilar cholangiocarcinoma was referred to our centre for hepatopancreatoduodenectomy (▶ **Fig. 1**). We conducted ERCP and obtained tissue specimens from hilar and distal bile ducts, all of which revealed adenocarcinoma. Tumor absence at the bifurcation of B2 and B3 was a prerequi-



► **Fig. 3** Biopsy forceps grasping biliary epithelium at the bifurcation of B2 and B3.

site for curative resection. During the following session, no obvious cancerous epithelium at the bifurcation could be visualized using digital cholangioscopy (SpyGlass DS; Boston Scientific, Marlborough, Massachusetts, USA), although the visualization was not good. Cholangioscopy-guided biopsy for pathological confirmation acquired only a small amount of tissue. Therefore, we added a looped nylon thread to each cup of the standard biopsy forceps (Radial Jaw 4 pediatric; Boston Scientific) and inserted the forceps with loops over 0.025-inch guidewires (VisiGlide 2; Olympus, Tokyo, Japan) positioned in B2 and B3 (► **Fig. 2**). The forceps were successfully pushed against the bifurcation, and enough tissue was obtained (► **Fig. 3**). Based on positive pathological findings, the disease was considered unresectable, and chemotherapy was administered. High costs and the limited amount of tissue obtained via mini biopsy forceps have been drawbacks of peroral cholangioscopy with biliary biopsy [3–5]. The “funitel” technique presented here would help to target lesions at biliary bifurcations at minimal additional cost. Biopsy forceps with holes in the cups and smooth guidewires may facilitate this technique.

Endoscopy_UCTN_Code_TTT_1AR_2AD

Competing interests

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