



Editorial

Evolving Excellence in ERCP Quality—Key Updates and Clinical Implementation



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Endoscopic retrograde cholangiopancreatography (ERCP) remains a cornerstone of therapeutic intervention for biliary and pancreatic disorders. In 2026, the American Society for Gastrointestinal Endoscopy (ASGE) and the American College of Gastroenterology (ACG) released the updated ERCP quality indicators,¹ consolidating 15 metrics from the 2015 version into 13 streamlined,² priority-focused core measures. This update represents a paradigm shift from structural metrics toward high-value process and outcome indicators, with stronger evidence alignment, greater emphasis on post-procedural safety, and improved real-world applicability. This editorial summarizes the major revisions across pre-, intra-, and post-procedural domains, highlights clinically actionable implications for daily practice, and critically addresses implementation challenges. We further provide concrete guidance for endoscopists and clinical programs to adopt these indicators in a stepwise manner, especially for community and low-volume centers. The 2026 framework sets a new global standard for safer, more effective, and more standardized ERCP care.

A defining shift in the 2026 guidelines is the reinforcement of precision in appropriate ERCP indications. With the widespread use of noninvasive, safe, and diagnostically equivalent modalities such as magnetic resonance cholangiopancreatography (MRCP) and endoscopic ultrasound (EUS), ERCP has evolved from a combined diagnostic and therapeutic tool to an almost exclusively therapeutic procedure.^{3,4} Accordingly, the performance target for appropriately indicated and documented ERCPs has been raised from >90% (2015) to >98% (2026).

Controversial or low-value indications, such as type III sphincter of Oddi dysfunction without objective biliary obstruction, have been explicitly excluded. For primary sclerosing cholangitis, MRCP is now endorsed as the first-line diagnostic modality, with ERCP reserved for therapeutic purposes only. For resectable malignant biliary obstruction, routine preoperative biliary drainage is no longer recommended except for patients undergoing neoadjuvant therapy. These changes directly reduce unnecessary ERCPs

and their associated risks.

Intra-procedural revisions center on preventing post-ERCP pancreatitis (PEP) and improving therapeutic success. Two landmark changes address PEP prophylaxis based on strong evidence^{5–7}

1. Routine use of rectal indomethacin or diclofenac in all patients with an intact papilla (evidence grade 1A, target >90%).
2. Mandatory documentation and tracking of prophylactic pancreatic stent placement in high-risk cases (evidence grade 1A, target >98%).

Notably, the 2026 indicators expand the successful stone extraction indicator from stones <1 cm to all extrahepatic bile duct stones in patients with normal anatomy (evidence grade 1B, target >90%), reflecting the maturation of advanced techniques including transpapillary large-balloon dilation and laser lithotripsy.⁸ While advanced lithotripsy is mentioned, the current framework does not specify a separate successful clearance rate target for difficult or large stones, representing an area for future clarification.

The most transformative change involves post-procedural monitoring, which shifts from isolated complication tracking to holistic outcome evaluation. Two new priority indicators were introduced: 30-day unplanned hospital visit rate (target <15%) and 30-day unplanned biliary intervention rate (target <15%). These metrics capture the full spectrum of procedure-related morbidity, including pain, suboptimal drainage, and technical failure, which traditional complication metrics often miss. Meanwhile, monitoring of PEP, hemorrhage, and cholangitis now emphasizes documentation and tracking rates (>95%) rather than fixed incidence targets, acknowledging the strong influence of case mix on complication rates.

The elimination of annual endoscopist procedural volume—a structural metric retained in 2015—has sparked debate in the GI community. Multiple studies confirm that higher volume correlates with lower complication rates.⁹ However, the task force prioritized process metrics (e.g., cannulation rate, stone extraction rate, PEP prophylaxis adherence) as more direct and reliable indicators of technical competence than raw procedure numbers. Process measures reflect quality of care rather than quantity, reducing incentives for volume-driven practice. Nonetheless, for low-volume and community centers, volume remains a practical consideration for maintaining proficiency, highlighting a tension between guideline ideals and real-world safety.

The introduction of 30-day unplanned hospital visits represents a major advance in outcome measurement but imposes a mean-

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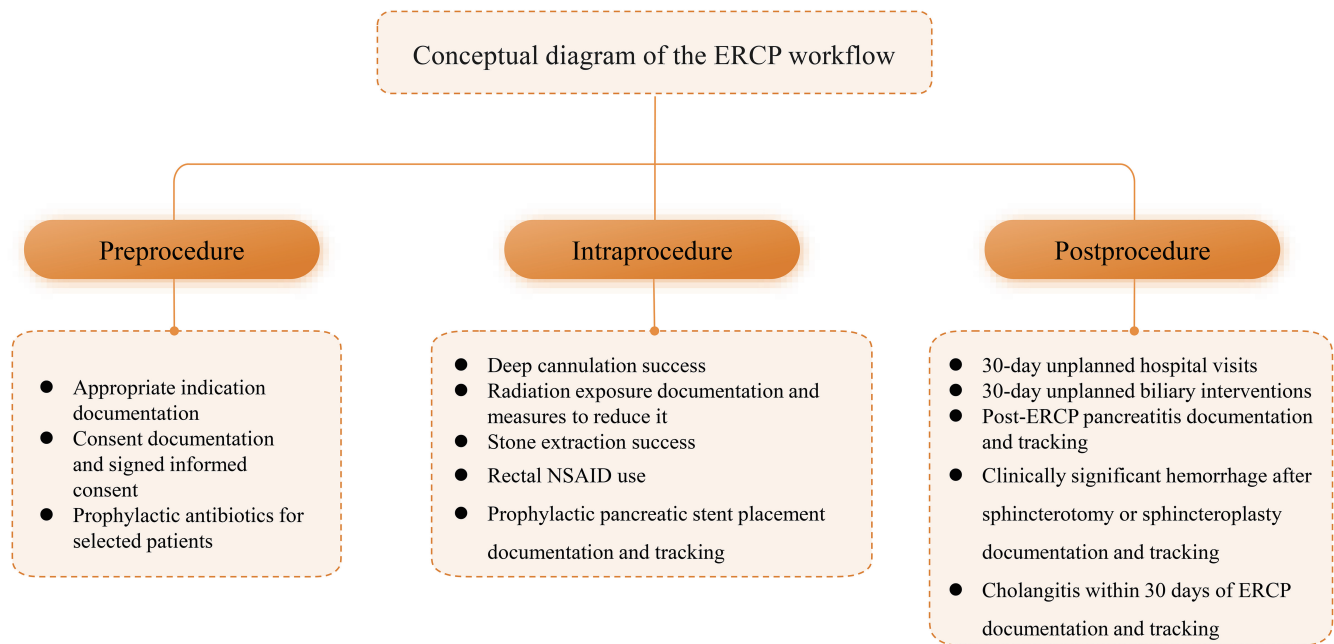


Fig. 1. Conceptual diagram of the ERCP workflow showing the 2026 ASGE/ACG quality indicators across pre-, intra-, and post-procedural domains. ACG, American College of Gastroenterology; ASGE, American Society for Gastrointestinal Endoscopy; ERCP, endoscopic retrograde cholangiopancreatography; NSAID, nonsteroidal anti-inflammatory drug.

ingful administrative burden. For community hospitals, long-term follow-up is often hampered by difficulty contacting patients, fragmented healthcare systems, and limited personnel. Accurate tracking requires care coordination across emergency departments, outpatient clinics, and external facilities, which is often unavailable in resource-limited settings. These real-world challenges must be recognized during guideline implementation.

Although laser lithotripsy and advanced techniques are acknowledged, the 2026 indicators do not define a separate successful clearance rate target for large, impacted, or multiple bile duct stones. Given the technical difficulty of these cases, a unified target of >90% may not accurately reflect performance or support targeted quality improvement. Future iterations should consider risk-stratified stone clearance targets.

To facilitate translation into practice, we emphasize the following recommendations:

1. Prioritize the six core priority indicators: appropriate indication documentation, deep cannulation success, stone extraction success, rectal nonsteroidal anti-inflammatory drug use, 30-day unplanned hospital visits, and 30-day unplanned biliary interventions.
2. Implement a tiered adoption strategy for low-volume and community centers.
3. Establish standardized follow-up systems to improve 30-day outcome tracking.
4. Use EUS before diagnostic ERCP for suspected choledocholithiasis when available.
5. Develop internal benchmarks that account for case complexity and anatomical variations.

The 2026 indicators are rigorous and pragmatic but have important limitations. Some metrics require specialized infrastructure (e.g., radiation exposure monitoring). Universal numerical targets for PEP are not provided because of case-mix variation. Furthermore, the 30-day unplanned visit and intervention indicators are

difficult to track accurately in community settings, as noted above. These limitations do not diminish the value of the framework but call for thoughtful, context-appropriate implementation.

The 2026 ASGE/ACG ERCP quality indicators represent a landmark advancement in endoscopic quality assurance. By streamlining metrics, strengthening evidence-based targets, expanding post-procedural outcome monitoring, and resolving longstanding clinical controversies, this framework supports safer, more cost-effective, and more homogeneous ERCP care worldwide. Successful implementation will reduce practice variability, narrow the quality gap between centers, and improve patient outcomes (as illustrated in the conceptual diagram of the ERCP workflow shown in Fig. 1). As ERCP continues to evolve, these indicators will remain essential for aligning technical innovation with consistent, high-quality clinical practice.

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Conflict of interest

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Author contributions

Study concept and design (YT), drafting of the manuscript (HL),

critical revision of the manuscript (YT), and supervision (YT). Both authors have approved the final version and publication of the manuscript.

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