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Resident in Gastroenterology

RECORD	Full training record · 12 Mar 2024 – 15 Jul 2026
PROCEDURES	342 in total: 222 recorded case by case, 120 reported from before this record
ASSESSED AGAINST	The ESGE curriculum for ERCP training (2021). No society has endorsed this document.
PREPARED FOR	Evidence for moving to independent mentored practice. Section 7, page 9, is the supervisor's form.
HOW TO READ	Every figure comes from cases entered on the endoscopist's own device. Nothing missing is filled in by assumption.

AT A GLANCE

Cannulation of a native papilla, the trainee's own 87 of 113	77.0%	≥80% [†]
Stone clearance, stones under 10 mm 42 of 53	79.2%	≥85% [†]
Stenting below the hilum, stricture or stones 41 of 49	83.7%	≥90% [†]
Post-ERCP pancreatitis 7 of 185	3.8%	≤10%
Procedures · 222 recorded, 120 reported before	342	
Cannulation rate, last 50 cases · 38 of 50	76.0%	≥80% [†]
Performed independently, the latest quarter with at least 20 recorded levels (Q1 26) · 13 of 25	52%	
Adverse events · 17 in 211 procedures · 2 severe, 2 not yet graded		

[†] The interval crosses the published figure, so this record cannot show which side of it the rate lies on.

CONTENTS

1	Procedure volume against the curriculum's figure	2
2	Competence measures	3
3	Cannulation over time	4
4	Supervision trajectory	5
5	Case-mix exposure	7
6	Safety record	8
7	Supervisor sign-off	9
8	Methods and sources	11

SECTION 1

Procedure volume against the curriculum’s figure

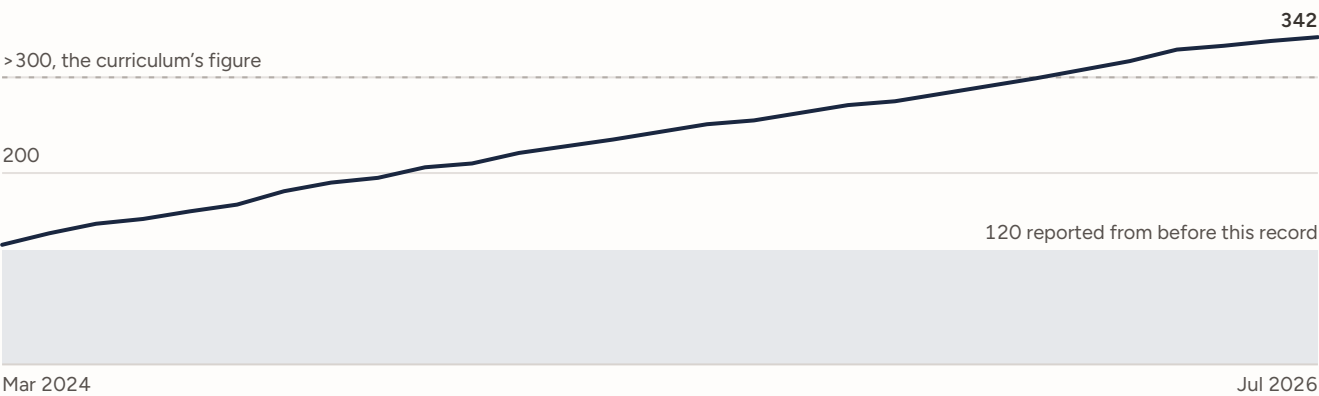
The curriculum states that “most trainees are likely to need to have performed > 300 ERCPs to be in a position to demonstrate competency.”

Recorded case by case in this record	222
Reported from before this record ^a	120
Lifetime volume	342
The curriculum’s figure	> 300

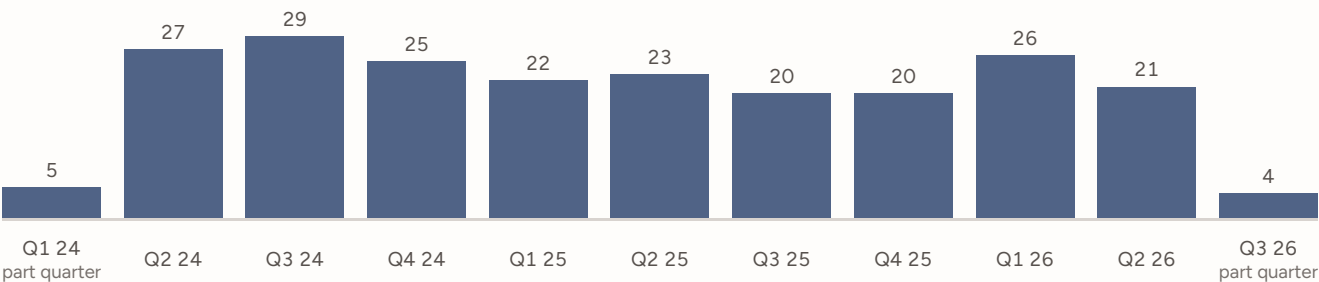
The curriculum calls a count alone “an inexact means to demonstrate competence.”

a Prior volume is a single self-reported figure with no case-level detail. It is shown separately and enters no rate in this document.

LIFETIME VOLUME, FROM THE REPORTED FIGURE ONWARDS



CASES PER QUARTER



SECTION 2

Competence measures

These are the curriculum’s measures for a trainee moving to independent mentored practice, each against the figure the curriculum sets. A case the trainer completed after taking over counts as unsuccessful for the trainee.

MEASURE	CASES	RATE	95% INTERVAL	FIGURE
Cannulation, the trainee’s own (native papilla, normal anatomy) Procedure-level rate, whoever completed the case: 92.2%, 107 of 116 (85.9 – 95.9) Trainer support: 30 independent, 24 minimal, 33 significant, 17 taken over, 3 not graded for support and left out of this rate.	87 of 113	77.0%	68.4 – 83.8 [†]	≥80%
Stone clearance (stones under 10 mm after successful selective cannulation) Procedure-level rate, whoever completed the case: 83.3%, 55 of 66, over the 66 cases anyone cannulated (72.6 – 90.4) Trainer support: 20 independent, 9 minimal, 13 significant, 3 taken over, 1 not graded for support and left out of this rate.	42 of 53	79.2%	66.5 – 88.0 [†]	≥85%
Stenting below the hilum (a stricture or retained stones, after successful selective cannulation) Procedure-level rate, whoever completed the case: 85.7%, 48 of 56, over the 56 cases anyone cannulated (74.3 – 92.6) Trainer support: 17 independent, 11 minimal, 13 significant, 2 taken over, 1 not graded for support and left out of this rate.	41 of 49	83.7%	71.0 – 91.5 [†]	≥90%
Post-ERCP pancreatitis (native anatomy, outcome reviewed)	7 of 185	3.8%	1.8 – 7.6	≤10%

[†] The interval crosses the published figure, so this record cannot show which side of it the rate lies on.

- CANNULATION

The curriculum notes that even competent trainees have cases the trainer must take over, so a trainee’s own rate will not reach that of an equally competent independent endoscopist.
- PANCREATITIS

The pancreatitis figure is Recommendation 22’s, for an endoscopist working independently.

CANNULATION BY COMPLEXITY GRADE (ASGE 2011) · THE TRAINEE’S OWN RATE

The 113 cases in the cannulation measure, by grade. Each grade is counted on its own. No grade carries a published figure of its own.

COMPLEXITY GRADE	CASES	RATE	95% INTERVAL
Grade 1	23 of 38	60.5%	44.7 – 74.4
Grade 2	45 of 51	88.2%	76.6 – 94.5
Grade 3	15 of 20	75.0%	53.1 – 88.8
Grade 4	1 of 1		
Ungraded	3		

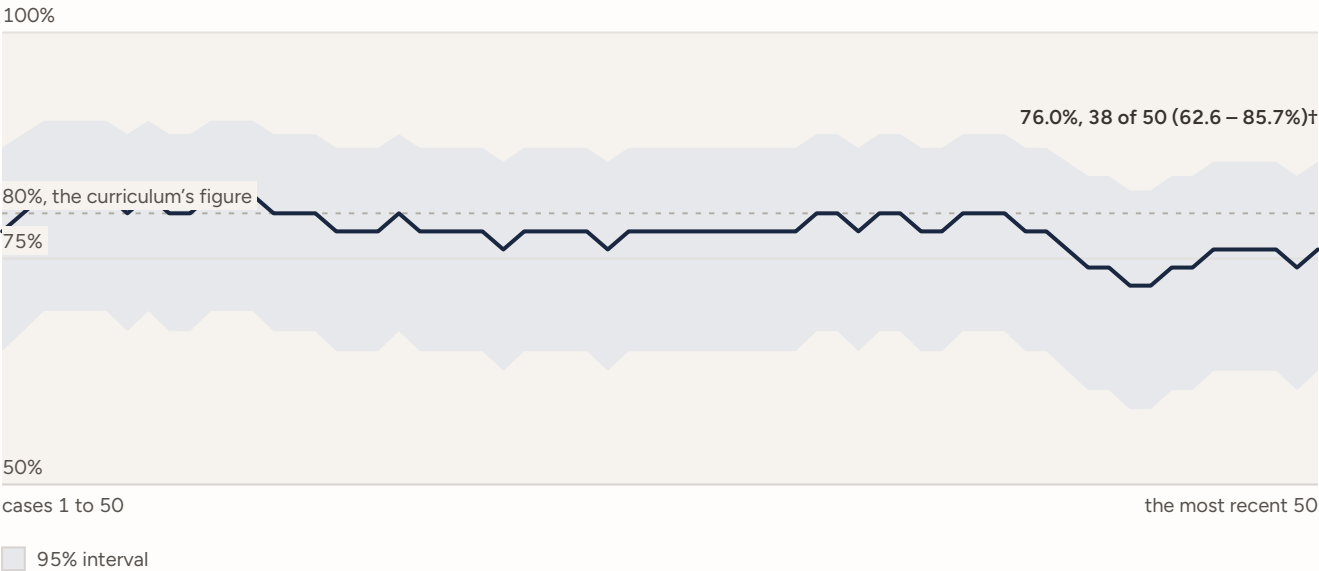
THE CURRICULUM’S TWO STAGES

Basic ERCP, grades 1 and 2	68 of 89	76.4%	66.6 – 84.0
Advanced ERCP, grades 3 and 4	16 of 21	76.2%	54.9 – 89.4

SECTION 3

Cannulation over time

CANNULATION RATE, LAST 50 CASES

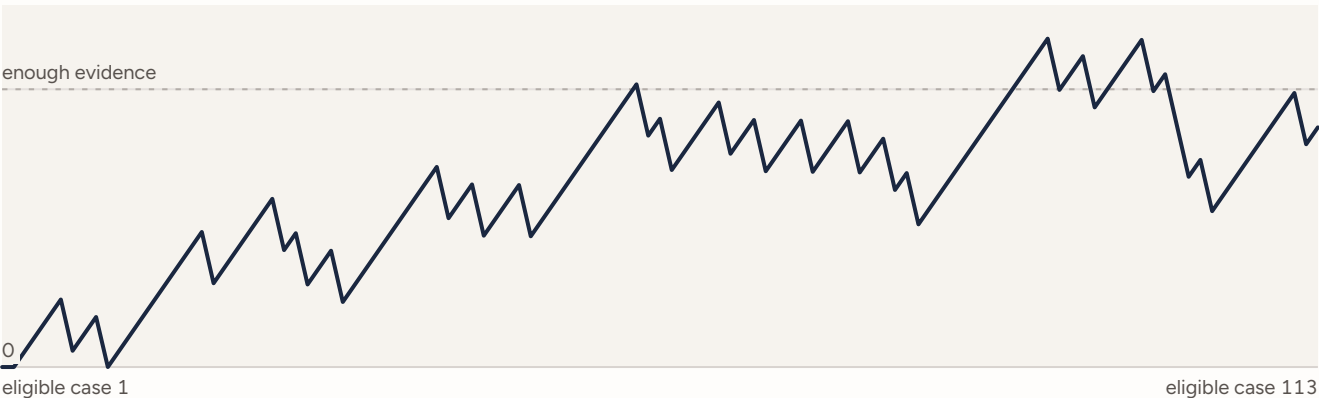


† The interval crosses the published figure, so this record cannot show which side of it the rate lies on.

EVIDENCE THAT THE TRAINEE CANNULATES AT 80%, THE CURRICULUM'S FIGURE

Enough evidence since eligible case 55, May 2025.

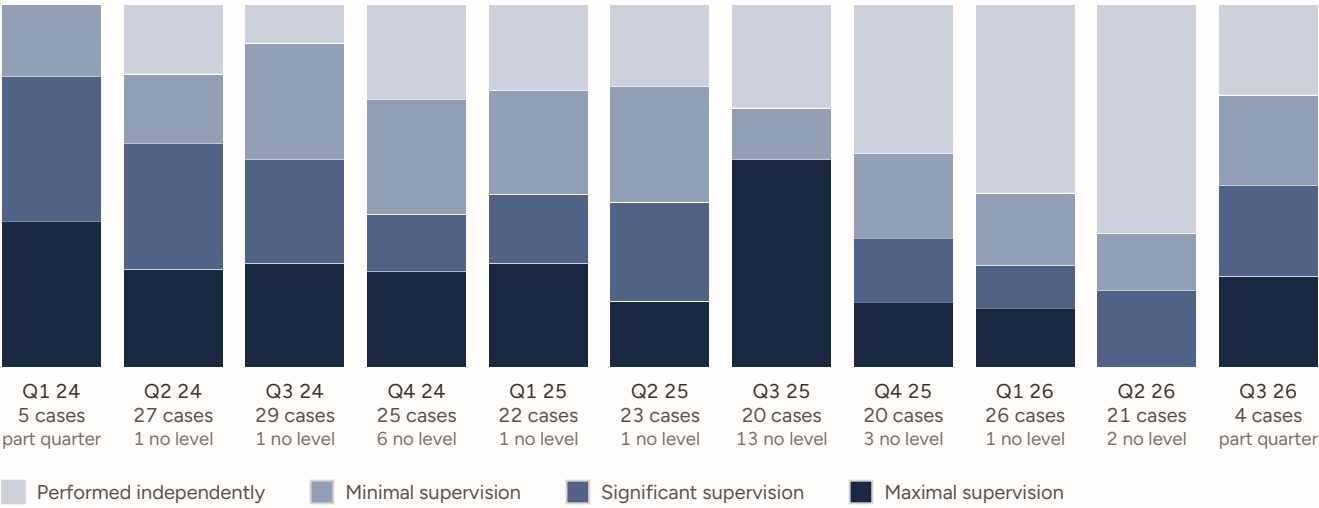
Each cannulation the trainee completed without takeover moves the curve up; every other case on it moves the curve down.



SECTION 4

Supervision trajectory

SHARE OF CASES WITH A RECORDED LEVEL, PER SUPERVISION LEVEL, BY QUARTER

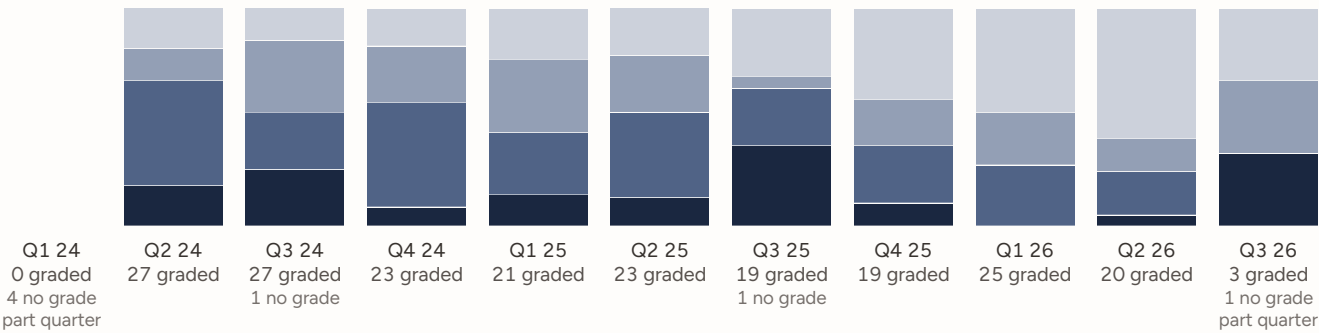


TRAINER SUPPORT PER MEASURED ASPECT, BY QUARTER

The form’s four levels, read per aspect over the cases that asked for the grade: every attempt, whether or not the attempt succeeded. The app grades these three of the form’s items and no other. On an aspect the top level is a takeover, so the key names it Taken over.

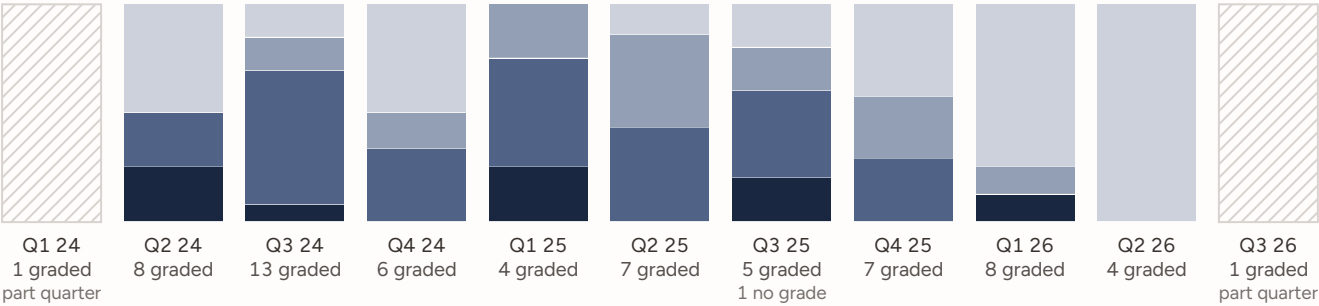


CANNULATION

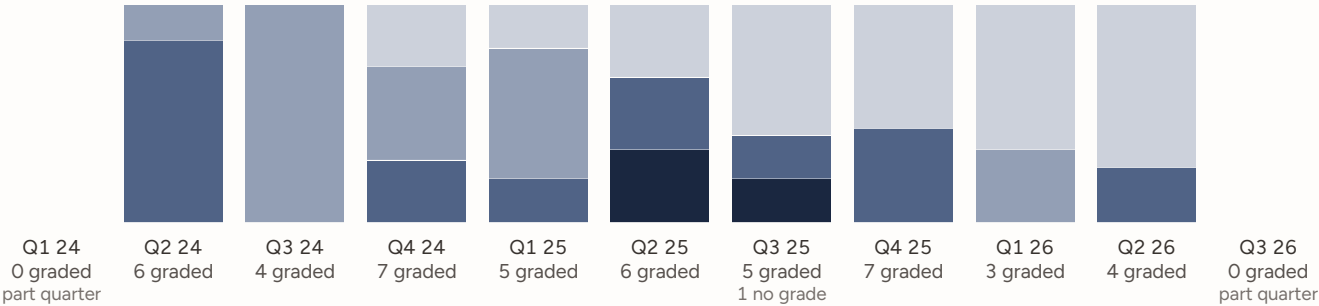


SECTION 4, CONTINUED

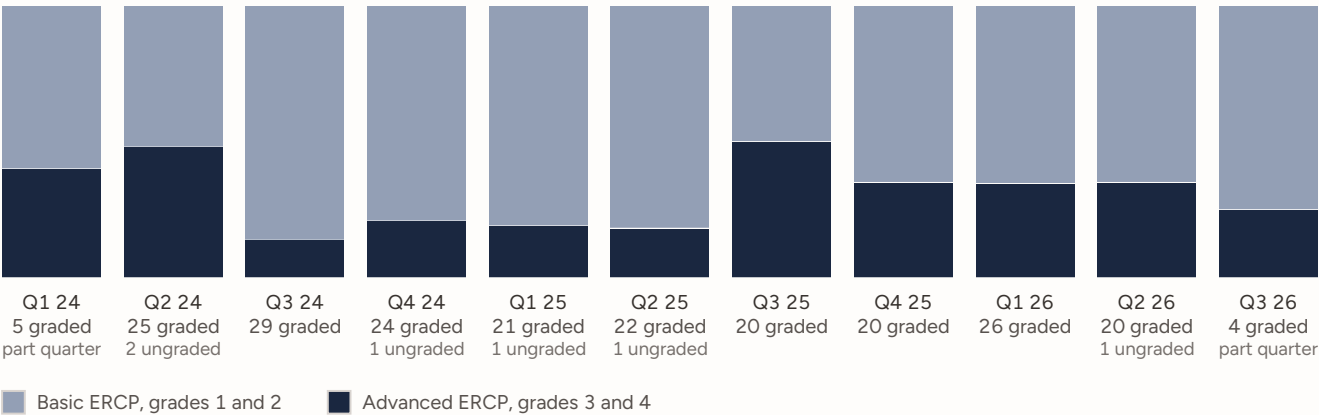
STONE CLEARANCE



STENTING BELOW THE HILUM



SHARE OF BASIC AND ADVANCED ERCP, OF GRADED CASES, BY QUARTER



SECTION 5

Case-mix exposure

The 222 recorded cases, by indication, difficulty and treatment.

INDICATION

Biliary stones and infection, 94		42.3%
Malignant or indeterminate obstruction, 50		22.5%
Access and procedural, 33		14.9%
Benign stricture and bile leak, 27		12.2%
Pancreatic, 9		4.1%
Ampullary, 9		4.1%

222 recorded cases, none without an indication

PROCEDURAL DIFFICULTY, ASGE COMPLEXITY GRADE

Grade 1, 58		26.1%
Grade 2, 93		41.9%
Grade 3, 42		18.9%
Grade 4, 23		10.4%
Not graded, 6		2.7%

THE CURRICULUM’S TWO STAGES

Basic ERCP, grades 1 and 2, 151		68.0%
Advanced ERCP, grades 3 and 4, 65		29.3%

THERAPEUTIC EXPOSURE, PROCEDURES INCLUDING EACH MECHANISM

Mechanical lithotripsy		4
Electrohydraulic lithotripsy		2

of the 222 recorded cases

No recorded case names any of the other 15 mechanisms.

CURRICULUM EXPOSURE

Native-papilla cannulation	116
Stone clearance, stones under 10 mm	66
Stenting below the hilum	56

The three rows overlap.

SECTION 6

Safety record

Adverse events across the recorded cases.

222 cases recorded; 220 reached endoscopy; 211 of those have a reviewed outcome; of those, 185 with native anatomy are eligible for the pancreatitis rate.

EVENT	CASES	RATE	95% INTERVAL
Post-ERCP pancreatitis	7 of 185 eligible cases	3.8%	1.8 – 7.6
9 events recorded, 7 in the 185 eligible cases. Revised Atlanta classification (2012): 5 mild · 2 moderately severe · 1 severe · 1 not yet graded			
Bleeding	3 of 211 reviewed procedures	1.4%	0.5 – 4.1
2010 ASGE lexicon: 1 mild · 1 moderate · 1 not yet graded			
Perforation	2 of 211 reviewed procedures	0.9%	0.3 – 3.4
Stapfer type: 1 of type II, peri-Vaterian injury · 1 of type III, distal bile duct injury 2010 ASGE lexicon: 1 mild · 1 severe			
Cholangitis	3 of 211 reviewed procedures	1.4%	0.5 – 4.1
Tokyo Guidelines 2018: 2 Grade I · 1 Grade II			

STILL OPEN

Outcome not yet reviewed	9 of 220 reaching endoscopy
Recorded, severity not yet graded	2 of 17 recorded events

9 cases have no recorded outcome review and are held out of every rate here.

SECTION 7

Supervisor sign-off

A supervisor checks a sample of this record at the device and signs on the next page.

THE CHECK

- 1 Choose at least five cases. Pick them yourself, or let the app draw a random sample.
- 2 Each case is opened in full on the device.
- 3 Check each against the unit’s documentation: report, imaging, discharge record.
- 4 Then pick two or more cases from the unit’s own procedure list and check they appear in the record.

WHAT THE CHECK FOUND

Case references, the unit’s procedure numbers

from the record

from the unit’s list

Any case that did not match:

FORMATIVE ASSESSMENTS

Number of formative assessments (DOPS or TEESAT) in the period supervised

The curriculum asks that formal assessment tools be used regularly and sets no number; it reports UK practice as about one formative DOPS per 10 ERCPs.

SECTION 7, CONTINUED

THE DECLARATION

Entries can be corrected or removed after the case; this document carries no history of changes. The 120 procedures reported from before this record are not part of this check.

111 of 222 cases entered on the day of the procedure, 104 within a week, 7 later.

I checked of 222 recorded cases against the unit's documentation.

☐ They matched

☐ One or more did not match; noted on the first sheet

☐ For the period I supervised, the recorded supervision levels are consistent with my experience of this trainee's practice.

Cases

☐ chosen by the supervisor

☐ drawn at random at the device

Date of the check

THE SUPERVISOR'S RECOMMENDATION

☐ Ready to continue to independent mentored practice

☐ Not yet

What should change, and notes for the trainee

SIGNATURES

Training supervisor

Name

Position

Institution

Professional registration number

Supervised from

Supervised to

Date

Signature

Trainee

I confirm that the cases in this record are mine and that I entered every ERCP I performed between 12 Mar 2024 and 15 Jul 2026.

Name

Date

Signature

Methods and sources

DATA	Every figure is computed from the endoscopist's own entries. Nothing is imported and nothing is estimated. The record is held only on that device.	
WHAT EACH RATE COUNTS		
MEASURE	COUNTED OVER	THE FIGURE'S SOURCE
Cannulation, the trainee's own	Cases with normal anatomy and a papilla recorded as intact and native, in which biliary cannulation was attempted	The curriculum
Stone clearance	Stones under 10 mm, after a successful selective cannulation	The curriculum
Stenting below the hilum	A stricture or retained stones, after a successful selective cannulation	The curriculum
Post-ERCP pancreatitis	Cases that reached endoscopy, without post-surgical altered anatomy, and whose outcome has been reviewed	The curriculum
Bleeding, perforation, cholangitis	Cases that reached endoscopy and whose outcome has been reviewed	None published
	The three cannulation and therapy figures are the curriculum's for a trainee at this stage. The curriculum sets no pancreatitis figure for a trainee; the $\leq 10\%$ printed is its figure for an endoscopist working independently. Counting a case the trainer took over as unsuccessful is the curriculum's own treatment for cannulation. For the two therapy measures it is this document's convention. The procedure-level rate beside each personal rate counts the case as it turned out. For the two therapy measures it runs over a different set of cases: whose cannulation succeeded decides which are eligible. A success whose own aspect is not graded for support is left out of the trainee's rate. A graded success stays in, a taken-over aspect included, and a takeover counts against, as it does on the curve. A left-out case could have gone either way; the count is printed so the reader can see how much is unknown.	
INTERVAL	Every rate set against a figure, and every rate in the grade table, is events divided by eligible cases, with a 95% confidence interval (Wilson); shares of the record carry none. † marks a row whose interval includes its figure.	
FLOOR	A rate prints from 20 eligible cases; below that the counts print and the rate columns stay empty. Charts by period use the finest calendar unit, from month to year, that draws at least four periods and at most twelve and in which a typical period holds 20 or more cases; where no unit holds 20, the coarsest of those is drawn.	
CONVENTIONS	Each of the following is how this document applies its sources. Spot-check. The form asks for at least 5 cases, and two or more from the unit's list. Rolling sample. The last 50 eligible cases. 50 cases is the trainee sample the JAG certification pathway uses; the curriculum sets no period of its own.	

SECTION 8, CONTINUED

Attainment curve. The figure tested is the curriculum's for this stage, and at this stage it is this document's own position. One-sided, held at zero, with no reset. Cannulation only: the therapy measures rarely hold enough cases in a training record for the curve to conclude.

Complexity grades. Basic and advanced ERCP follow the curriculum's two stages, grades 1 and 2 and grades 3 and 4; section 2 also shows each grade alone.

ATTAINMENT CURVE

The curve is a running score of the trainee's cannulations, a learning-curve cumulative sum (LC-CUSUM). Each cannulation completed without takeover adds 0.13 to the score; each other case on it takes 0.41 off, about what three successes add. The line sits at 2.20: seventeen takeover-free successes from zero with no miss between them. A score at the line means the cases behind it are nine times more likely at a rate of 80% than at 70%; the spacing and the line are Wani 2016's, and a long record crosses by chance more readily than a short one. It reached the line, and a line once crossed stays crossed. The score has since fallen back to 1.90: a run of misses after the crossing moves the score, not the crossing. Wani 2016 tested five advanced endoscopy trainees against 90%; none crossed for native-papilla cannulation during the study.

ADVERSE EVENTS

Post-ERCP pancreatitis is new or worsened abdominal pain with amylase or lipase more than three times the normal value at more than 24 hours after the procedure, requiring admission or a longer stay than planned. Bleeding is hematemesis or melena, or a hemoglobin drop of more than 2 g/dL. Perforation is gas or luminal contents outside the gastrointestinal tract on imaging. Cholangitis is a new temperature above 38 °C for more than 24 hours with cholestasis.

An event counts here only where it is attributable to the procedure and occurs within 14 days of it. Events that neither interfered with the planned procedure nor changed the patient's care are not counted.

The curriculum writes $\leq 10\%$; the 2018 performance measures write $< 10\%$. This document prints the curriculum's form.

THE RECORD

The figures in this dossier are computed over the whole recorded training record, 12 Mar 2024 to 15 Jul 2026 (222 cases). Section 7 is how the record is checked; the page it is signed on says what can change after entry.

Supervision levels, support grades and adverse events are all recorded by the trainee, and none is countersigned case by case.

The curriculum names logbooks as an important source of evidence for a trainee's key performance measures, and asks that the assessment process include an independent review to determine that the procedure numbers and performance measures it sets out have been attained. The curriculum publishes no list of exposure domains; the three named in section 5 are this document's reading of its Recommendation 21.

The curriculum's two stages, basic and advanced ERCP, are defined by Schutz level (1 and 2; 3 and 4). This record grades ASGE 2011, and this document reads grades 1 and 2 as basic and grades 3 and 4 as advanced.

Every figure and eligibility rule here that comes from a source paper is quoted verbatim from it. The rules applied are those in force on the date and time in the footer.

SECTION 8, CONTINUED

WHAT THE RECORD DOES NOT HOLD

MISSING	CASES	EFFECT
Outcome never reviewed	7	removes the case from every rate
Recorded event not yet graded	2	counted in its rate, absent from the severity split
Rectal NSAID never recorded	23	no measure here reads it

This counts fields missing inside recorded cases. It cannot count cases that were never recorded.

FORMATIVE ASSESSMENTS

The app records no formative assessment; the sign-off form carries one line for the supervisor to fill in.

THE SOURCES

The curriculum states that it is not a guideline but a proposal for training in ERCP and EUS. The performance measures state that they are not guidelines but guidance on how quality can be monitored, carrying no legal implications. This document treats both as what they say they are. The curriculum's performance measures indicate competence; they do not certify it, and the competence named is basic ERCP rather than ERCP at large.

THE VERSION

The app that made this document is version 0.2.0. Its measures were computed under these rules: cannulation ESGE2018.cannulation.v5; stone clearance ESGE2018.stone-extraction-small.v4; stenting below the hilum ESGE2018.subhilar-stent.v7; post-ERCP pancreatitis ESGE2018.post-ercp-pancreatitis.v1. Two documents of one record naming different versions were computed under different rules.

SOURCES

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Cotton PB, Eisen G, Romagnuolo J, et al. Grading the complexity of endoscopic procedures: results of an ASGE working party. *Gastrointest Endosc* 2011;73:868-874. PMID 21377673.

Domagk D, Oppong KW, Aabakken L, Czako L, Gyökeres T, Manes G, Meier P, Poley JW, Ponchon T, Tringali A, Bellisario C, Minozzi S, Senore C, Bennett C, Bretthauer M, Dinis-Ribeiro M, Hassan C, Kaminski MF, Rees CJ, Spada C, Valori R, Bisschops R, Rutter MD. Performance measures for ERCP and endoscopic ultrasound: a European Society of Gastrointestinal Endoscopy (ESGE) Quality Improvement Initiative. *Endoscopy* 2018;50:1116-1127. DOI 10.1055/a-0749-8767.

Dumonceau JM, Kapral C, Aabakken L, et al. ERCP-related adverse events: European Society of Gastrointestinal Endoscopy (ESGE) Guideline. *Endoscopy* 2020;52:127-149. PMID 31863440.

SECTION 8, CONTINUED

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Joint Advisory Group on GI Endoscopy (JAG). Formative DOPS: endoscopic retrograde cholangiopancreatography (ERCP). Royal College of Physicians, London; (c) 2016, all rights reserved; date of last review 17 January 2024. Published under the JAG download-centre folder "DOPS forms (international and reference use only)".

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Kiriyama S, Kozaka K, Takada T, et al. Tokyo Guidelines 2018: diagnostic criteria and severity grading of acute cholangitis (with videos). *J Hepatobiliary Pancreat Sci* 2018;25:17-30. PMID 29032610.

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Wani S, Hall M, Wang AY, et al. Variation in learning curves and competence for ERCP among advanced endoscopy trainees by using cumulative sum analysis. *Gastrointest Endosc* 2016;83:711-719. DOI 10.1016/j.gie.2015.10.022.

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