implants. A recent publication by Schouten et al\(^3\) reported no procedure-related adverse events and a mean excess weight loss of 19% in the 85% of patients who completed the 3-month trial. There is certainly a learning curve with the introduction of new technologies, and this is no exception. Since the earlier reports in 2009,\(^4\) the safety profile has continued to improve as new iterations of the DJBL have resulted in improved anchor stability and longer-term implantation, now up to 1 year. We continue to remain encouraged by this novel and exciting technology.

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Thoughts on ERCP and fluoroscopy

To the Editor:

I read with interest the editorial by Dr Sun and Dr Faulx\(^1\) entitled “ERCP and fluoroscopy use: is experience the difference?” Having been trained in ERCP and having performed ERCP in practice for 6 years, I find this topic both relevant and important. Although many of the points made in the editorial and in the original article by Jorgensen et al\(^2\) are valid, I think several important factors contributing to fluoroscopy use in ERCP need to be discussed further. One of the biggest contributors to overuse of fluoroscopy during ERCP, as I have discovered from observing mentors and colleagues performing the procedure, relates to a heavy reliance on the use of magnification during examinations. I have seen many experienced endoscopists perform an entire 20- to 30-minute procedure while using magnification. Some have even told me they did not realize that the magnification mode resulted in more radiation output! This greatly contributes to how much fluoroscopy is used during an ERCP. Although it certainly is required at times for seeing small lesions, such as stones or strictures, in general the use of magnification for anything other than brief periods is unnecessary. Two other techniques, including keeping fluoroscopy on only when viewing the image and using a wire-guided cannulation technique rather than an injection-guided technique, can minimize use of fluoroscopy. These methods can be used by physicians of any experience level and, in my opinion, can lead to great reductions in radiation exposure to staff and patients. Future studies focusing on easily correctable technical issues such as these, rather than generalities such as endoscopists’ experience—which are much more difficult to change—can hopefully lead to reductions in radiation exposure and improvements in safety for all physicians using fluoroscopy.

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