Hemorrhage as a complication of ERCP may occur during or up to 10 days after the procedure. It is most often seen in the setting of a sphincterotomy, and it takes place in 1.3% of the time. Bleeding is rarely fatal, but the incidence rate is 0.05%. There are patient factors, procedure techniques and choice of instruments that may predispose to bleeding. Systematic reports on the management of ERCP hemorrhage are lacking. Almost always, the problem is witnessed or confirmed at endoscopy; therefore, it would make sense that an endoscopically delivered therapy is attempted during that moment. Virtually all tools and techniques used for treatment of a bleeding peptic ulcer may be applied, and they are frequently used in combination. However, some methods are uniquely suited for ERCP hemorrhage such as balloon tamponade and biliary stenting. While highly effective, placement of clipping devices is technically challenging, especially if the duodenal lumen is obscured by large blood clots. Inadvertent injury of the pancreatic sphincter is of particular concern and every hemostasis intervention must be carried out with that in mind. Bleeding that takes place in a strategically located peri-ampullary diverticulum, concomitant perforation, surgically-altered anatomy or in a patient with bleeding tendency must be approached with great caution. In the rare events of uncontrollable bleeding, early utilization of angiographic coil embolization or surgery will likely bring about effective hemostasis.