Continuous ambulatory pH−metry with
the Bravo “catheter−free” monitoring sys−
tem (Medtronic, Minneapolis, Minnesota,
USA) is becoming more and more popular
[1 /C1773]. As experience with this technique
has grown, it has become evident that up
to 50% of patients report mild chest pain
[2 /C1774] or even severe chest pain requiring
endoscopic removal of the capsule [3, 5].
We have also had three patients with in−
supportably severe chest pain that oc−
curred 2−3 hours after placement of a
Bravo capsule. Because treatment with
analgesics was ineffective we decided to
remove the first capsule after 2 days. The
pain ceased promptly. On the basis of our
experience with this patient, we removed
the capsules immediately after comple−
tion of 24 hours of recording in the other
two patients.
We tried to remove the
first capsule
(l
“Fig. 1
) by exerting gentle pressure
with the tip of the endoscope [5], grasp−
ing it with a biopsy forceps in an attempt
to push it off the mucosa [3]. However,
the capsule was attached too firmly and
could not be dislodged. We eventually
placed a polypectomy snare around the
capsule (l
“Fig. 2
) and were able to de−
tach it easily from the esophageal wall
with electrocautery. The capsule was re−
covered using the same snare (l
“Fig. 3
),
leaving only a small mucosal defect sim−
ilar to that left after a small mucosectomy
(l
“Fig. 4
). This procedure appears to be
fairly safe because only mucosa and not
the whole esophageal wall can be aspirat−
ed due to the small size of the vacuum
well in the capsule (l
“Fig. 5
). Detaching
the capsule with a polypectomy snare
would therefore be very unlikely to cause
an iatrogenic esophageal perforation. Fur−
thermore, no bleeding will occur due to
the electrocautery.
Endoscopic removal of the capsule with a
polypectomy snare is a reasonable treat−
ment strategy in the event of capsule−in−
duced severe chest pain. This method
seems safe and prevents bleeding from
the mucosa.

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