Clinical Handbook of Cardiac Electrophysiology

Benedict M. Glover
Pedro Brugada
Editors

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BMG: Pro auxilio sempiterno eorum, toti familiae meae, maxime, uxori, Nualae et filiae, Luciae et filio, Hugo, maximas gratias ago. Cum amore, Benedictus

Foreword

Clinical Handbook of Cardiac Electrophysiology, written and edited by Benedict M. Glover and Pedro Brugada, is a unique book. As the authors acknowledge in the preface, many excellent textbooks have been published on this topic. However, Glover and Brugada make the point that few provide a practical synopsis to bridge the chasm separating basic physiology, anatomy, and pharmacology from its practical application. That is the admirable goal of this book: to serve as the conduit between the basic scientist and beginner, for cardiology fellows, residents, and support personnel. The first three chapters lay a foundation for the rest of the book, including cardiac anatomy and basic electrophysiology (Chap. 1); the electrophysiology study, maneuvers, and ablation (Chap. 2); and electroanatomic mapping (Chap. 3). This book then embarks on a journey discussing the major cardiac arrhythmias including AV nodal reentrant tachycardia (Chap. 4), accessory pathway conduction (Chap. 5), atrial tachycardia (Chap. 6), atrial flutter (Chap. 7), atrial fibrillation (Chap. 8), ventricular tachycardia (Chap. 9), and antiarrhythmic drugs (Chap. 10).

I found this book to be authoritative and to the point with its main strength being the presentation at a level easily comprehended by the early learner. The many figures are very well done in that regard, very helpful and easily comprehended. This book will serve as an excellent stepping-stone for those who wish to delve further into electrophysiology mysteries, or as a final resting place for those contents with a basic understanding. Either way, *Clinical Handbook of Cardiac Electrophysiology* is an important contribution for learners.

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Preface

Cardiac arrhythmia management has evolved as one of the most rapidly expanding fields within medicine. The development of catheter ablation has transformed the treatment of many arrhythmias, providing highly effective treatment options for the majority of tachyarrhythmias. There is also considerable research and development of more effective antiarrhythmic and anticoagulant drugs. Despite these huge technical advances, it is important to understand the basic principles of arrhythmia mechanisms in order to help make a diagnosis and chose an effective treatment strategy.

Although there are many excellent and detailed reference texts in this field, there are few handbooks which provide a practical overview bridging the gap between basic physiology, anatomy, pharmacology and interventional catheter ablations with precise details which should help in the intricate management of the patient.

This book covers all the important aspects of cardiac electrophysiology, presented in an easy-to-use format. For each arrhythmia, the aetiology, classification, clinical presentation, mechanism, electrophysiology set up (including precise set up and ablation parameters) and trouble-shooting are presented and demonstrated using illustrations, fluoroscopy images, ECGs and endocavity electrograms.

The overall aim of this book is to provide a logical and practical approach to cardiac arrhythmia management. We hope that this provides a useful resource and, importantly, helps to promote this wonderful sub-specialty.

This book is aimed at cardiac electrophysiologists, fellows, cardiologists, physicians, family practitioners, cardiology trainees, students, allied professionals and nurses. Given its succinct summary of electrophysiology, this should be available as a reference guide in the electrophysiology laboratory. We hope that this reaches a truly international audience and provides an important guide for those studying for heart rhythm exams.

Kingston, ON, Canada — Benedict M. Glover
Brussels, Belgium — Pedro Brugada

Contents

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Chapter 1
Cardiac Anatomy and Electrophysiology

Benedict M. Glover, Orla Buckley, Siew Yen Ho, Damian Sanchez-Quintana, and Pedro Brugada

Abstract Cardiac electrophysiology has rapidly moved from the mapping and ablation of accessory atrioventricular connections and ectopic foci to more extensive mapping and substrate modification. Training in cardiac electrophysiology requires a detailed knowledge of the anatomy and physiology of the heart. In order to understand the basis of cardiac electrophysiology it is important to discuss the different phases of the cardiac action potential, variability in morphology and duration throughout the heart and the most important ion channels and electrolyte shifts responsible for depolarization and repolarization of the cardiac cells. Electrophysiology continues to rely heavily on an understanding of these basic principles as well as the relevant anatomy of all cardiac chambers and surrounding structures. It is therefore fundamental to have a thorough understanding of cardiac anatomy as visualized on fluoroscopy, echocardiography, CT, MRI and 3 dimensional cardiac mapping systems.

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The Cardiac Action Potential

Spontaneous depolarization of cells within the sinus node (SN) results in propagation of excitation throughout adjacent cells within the right atrium (RA) and left atrium (LA). The electrical impulse spreads through the atrioventricular (AV) junction into the His bundle, through the Purkinje network and then into the ventricular muscle where activation occurs from the septum spreading through the endocardium, mid-myocardium and finally the epicardium.

Each cardiac cell undergoes a process of depolarization and repolarization, which is recorded across the cell membrane as an action potential and occurs as a result of the relative concentration of ions (predominantly potassium, sodium and calcium) and electrostatic forces across the membrane. As shown in Fig. 1.1 this is composed of 5 components in atrial and ventricular myocytes and 3 components in the SN and AV node. The QTc on the surface ECG is an approximation of the mean duration of the ventricular action potential.

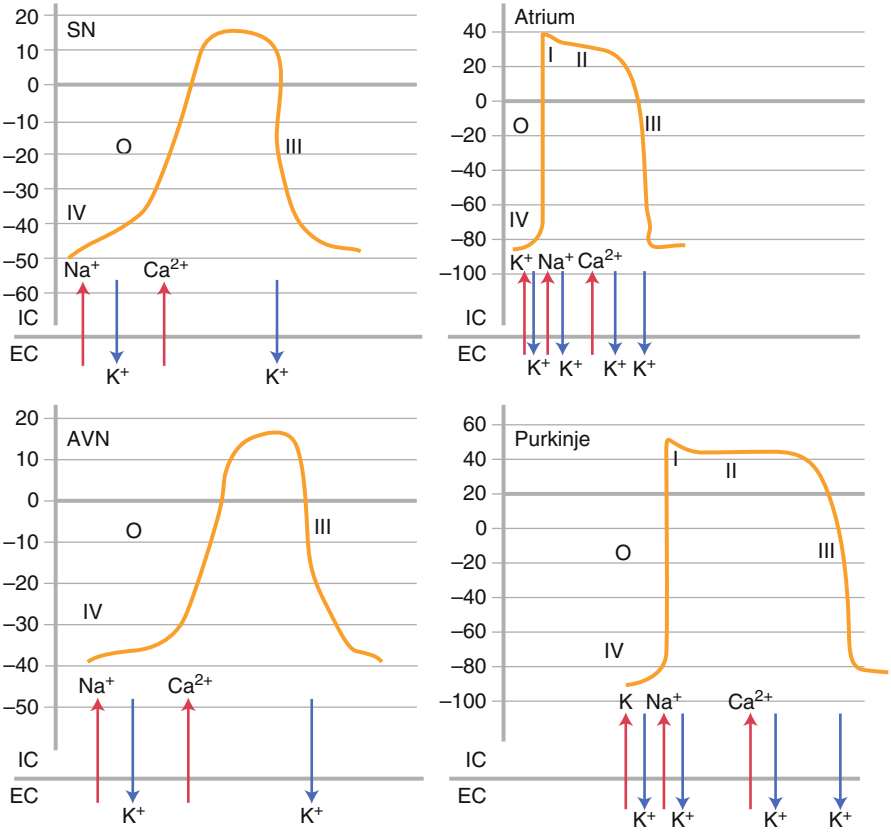


Fig. 1.1 Cardiac action potentials recorded from the SN (*top left*), atrium (*top right*), AV node (AVN) (*bottom left*) and Purkinje network (*bottom right*) and the predominant ionic currents responsible for theses changes in membrane potential (*IC* intracellular, *EC* extracellular, Na^+ sodium, Ca^{2+} calcium, K^+ potassium)

Phase IV is known as the **resting membrane potential**. This is recorded as −80 to −95 mV in atrial, Purkinje and ventricular cells. It is slightly less negative in the atrium than the ventricle. In the SN it is −50 to −60 mV and the AV node −60 to −70 mV. In both the SN and AV nodes there is a slow spontaneous diastolic depolarization which merges with Phase 0 resulting in spontaneous automaticity while Phase IV in other cells is generally more flat.

This is followed by **Phase 0** where the membrane potential becomes positive and is therefore known as **rapid depolarization**.

Phase I, **rapid repolarization** occurs in the atrium and ventricle but not in the SN and AV node. It is much more prominent in the Purkinje and epicardial cells.

Phase II is the **plateau phase** where the action potential becomes relatively flat and does not occur in the SN or AV node. It is followed by **Phase III**, which is known as **rapid repolarization** resulting in restoration of the membrane potential to the resting phase.

Phase IV (Resting Phase)

In the atrium and the ventricle this occurs largely as a result of the balance of potassium (K^+) across the cell membrane and is relatively flat with only a very slight slope.

K^+ is found in much higher concentrations in the intracellular space compared with the extracellular space. As a result of this there is an outward motion of K^+ leaving predominantly negative anions inside the cells at baseline.

This is counteracted during the resting phase by the inward rectifying current, (IK1). In general rectifier currents allow current to pass in a preferential direction. In the case of IK1 the transmembrane channel responsible allows the inward movement of K^+ at more negative potentials than the reversal outward K+ potential with less current movement at more positive membrane potentials [1]. This results in a very slight upward curve as the cell becomes less negative.

The resting phases in the SN and AV node are different from those recorded in the atrium and ventricle. As well as being less negative there is a continual slow spontaneous diastolic depolarization. This occurs as a result of the funny current (If) which plays the predominant role in this phase as opposed to the Ik1 current. This current is activated at voltages in the diastolic range resulting in a slow and steady inward Na^+ current (INa) which would normally occur in the depolarization phase in atrial and ventricular cells. There is also a slow outward movement of K^+ with the overall combined effect of a less negative cell membrane potential.

Phase 0 (Depolarization)

In the atrium and ventricle as a result of electrical stimulation from adjacent myocytes, a rapid inward sodium current (INa^+) results in the abrupt initial upstroke in the action potential known as Phase 0.

There are principally two Na^+ gates responsible for depolarization called the **activation** and **deactivation gates**. At the start of depolarization the activation gates are closed while the deactivation gates are open. As the action potential becomes less negative the activation gates tend to open rapidly allowing the inward movement of Na^+ while the deactivation gates tend to close slowly. This continues beyond zero voltage at which point the rate of Na^+ entry into the cell slows. As the deactivation gates close the fast Na^+ channels become inactive. These remain closed until Phase III of the action potential.

Depolarization in the SN and AV node does not occur as a result of INa^+ but rather as a result of calcium entry through the L-type calcium channels (ICaL) and T-type calcium channels (ICaT).

Phase I (Early Repolarization)

As the vast majority of the inward current deactivates, a rapid transient outward potassium current (Ito) results in early rapid repolarization. Phase I is much more prominent in Purkinje fibers and in epicardial myocytes and does not occur in the SN or the AV node.

Phase II (Plateau Phase)

The plateau phase occurs in the atrium and ventricles as a result of an inward movement of calcium ions (ICaL) combined with an outward movement of potassium (IKs, IKr and IKUr). As the voltage becomes less negative during depolarization the ICaL and ICaT channels become active.

ICaL channels are the predominant type found in cardiac myocytes and are activated when the voltage reaches −30 mV. ICaT channels which are less common in cardiac myocytes are activated at more negative voltages.

Overall ICaL activation begins in late depolarization. Ca^{2+} crosses from outside the cell where the concentration is higher relative to the inside.

K^+ shift is also partially responsible for the plateau phase. The balance of K^+ across the cell membrane is similar to that during the resting phase but the voltage is positive rather than negative which results in an outward movement of K^+ from the cell. The overall balance between the inward movement of calcium and the outward movement of K^+ results in the plateau phase. The transient outward current (Ito) is expressed in the atrium more than the ventricle. As a result of this there is a greater outward movement of K^+ versus the inward movement of calcium resulting in a shorter plateau phase.

Phase II does not occur in the SN or the AV node.

Phase III (Repolarization)

As the outward movement of K^+ exceeds the inward movement of Ca^{2+} the voltage becomes more negative resulting in repolarization. Although the delayed rectifier currents Ikr and Iks are activated during depolarization their action tends to be delayed and gradually increases during the plateau phase. Next to Ito the inwardly rectified K^+ current (Ik1) is also responsible for repolarization although this is more active as the voltage across the cell membrane becomes less negative and is responsible for the small bump seen in the action potential during repolarization.

All these K^+ currents are responsible for restoration of the K^+ balance. The Na^+ which entered the cell during depolarization is removed by the Na^+/K^+ ATPase enzyme while calcium which entered the cell during the plateau phase is removed by the Na^+/Ca^{2+} exchanger.

Repolarization in the SN occurs as a result of the rapid outward movement of K^+ as well as inactivation of the inward Ca^{2+} current making the cell more negative.

Refractoriness

Refractoriness describes the period after phase 0 of the cardiac action potential during which a stimulus does not result in a new depolarization.

There are three different types of refractory periods (RP): relative, absolute and effective.

The **relative RP** is the longest coupling interval resulting in local capture therefore marking the end of refractoriness.

The **absolute RP** is the longest coupling interval which does not result in local capture. The absolute and relative RP's are depicted in Fig. 1.2.

The **effective RP** is the longest coupling interval delivered which fails to propagate through the distal tissue.

In the clinical electrophysiology laboratory the RP is calculated by performing an **extrastimulus test**. In order to perform this the threshold for stimulation is measured in diastole by pacing at a fixed rate and decreasing the intensity of the pacing stimulus until capture fails.

Following a drive of eight beats at a fixed rate (to establish a steady state) a single extrastimulus is introduced at twice the diastolic threshold at shorter intervals until capture no longer occurs. This can be seen in Fig. 1.3 where pacing from the high RA is performed at a cycle length of 600 msec for 8 beats (drivetrain) in order to achieve a steady state followed by a decremental extrastimulus. In this example the first beat on the left is the final beat of the drive train. The extrastimulus occurs at a cycle length of 280 msec and captures the atria but fails to conduct over the AV node. This is considered to be the AV node ERP.

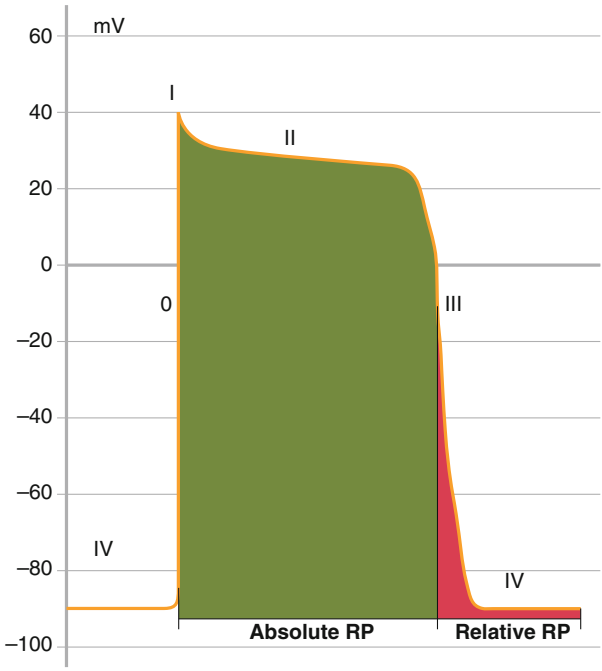


Fig. 1.2 Diagram showing the absolute RP and relative RP during the cardiac action potential. The absolute RP occurs from phase 0 until the transmembrane potential reaches -60 mV during phase III. During this time a stimulus will not result in depolarization. The relative refractory period follows this in which a high voltage stimulus may result in further depolarization

Arrhythmia Mechanisms

Arrhythmias may be classified as either **macro re-entry** or **focal**. Focal arrhythmias may be caused by **micro re-entry**, **enhanced automaticity**, **or triggered activity**.

Re-entry

A very common mechanism of clinical cardiac arrhythmia is re-entry. During re-entry a wave of excitation moves around a circuit which is determined anatomically, functionally or a combination of the two. A macro re-entry circuit which makes understanding of re-entry easy is the circuit during circus movement tachycardia in patients with the Wolf-Parkinson-White (WPW) syndrome (Fig. 1.4).

For re-entry to occur the following conditions have to be fulfilled:

1. There must be two or more pathways for conduction (for example the AV node and accessory pathway in WPW)
2. Unidirectional block in one pathway
3. Alternative conduction over the other pathway with sufficient delay as to retrogradely invade the formerly blocked pathway.

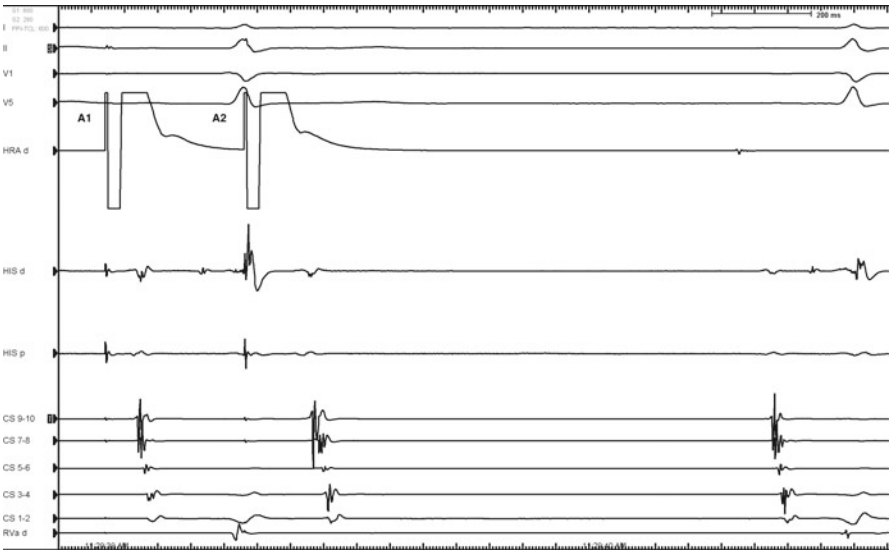


Fig. 1.3 Example of extrastimuli testing by pacing from the high RA (HRA d). The first paced beat on the *left of the image* is the final beat of the drive train where pacing is performed at 600 msec (*A1*). This beat conducts through the His to the ventricle via the AVN. This is followed by an extrastimuli which is performed at a progressively shorter cycle length. In this example this occurs at 280 msec (*A2*). Capture is seen on the high RA (HRA d) and the coronary sinus (*CS*) with lack of conduction through the AV node. This is considered to represent the AV node refractory period. (CS 9–10 is positioned in the proximal CS while CS 1–2 is in the distal CS, His d is positioned along the distal His, His p along the proximal His and RV a d is positioned in the RV apex)

For a re-entry circuit to sustain, the length of the circuit must be greater than or equal to the product of the conduction velocity and the refractory period termed the wavelength of the circuit. The pathways involved in these circuits must therefore have different conduction properties and refractoriness. A slow conduction pathway ensures that the wave of depolarization does not reach tissue which is refractory and thus terminate the arrhythmia.

Another requirement is the existence of a region of conduction block. This may be either anatomical or functional. Anatomical block may be structural such the tissue which exists between the slow and fast pathways in AV nodal re-entry tachycardia (AVNRT) or scar tissue in ischemic VT or functional such as occurs in typical atrial flutter. Functional block occurs as wavelets collide with each other and thus prevents the leading edge of the circuit stimulating refractory tissue resulting in termination of the arrhythmia. Most re-entry circuits involve a combination of structural and functional regions of block. A diagrammatic representation of a re-entry circuit is shown in Fig. 1.5.

The **wavelength of the circuit** is a product of the conduction velocity and the refractory period.

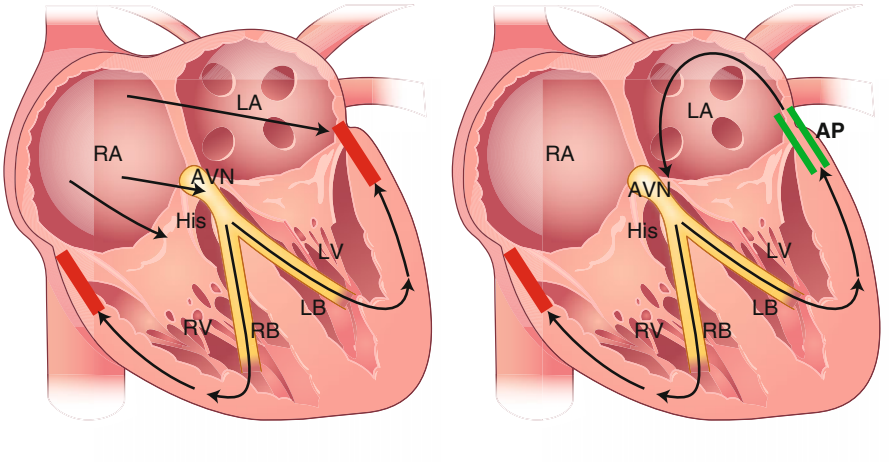


Fig. 1.4 Diagram showing the initiation of circus movement tachycardia (CMT) in a patient with WPW. In the *left image* conduction occurs antegradely through the AV node and is blocked retrogradely as there is no accessory pathway present. In the *right image* a re-entry tachycardia is demonstrated utilizing the AV node as the antegrade limb and the AP as the retrograde limb. *Arrows* indicate the predominant direction of conduction. The *red lines* indicate blocked conduction which prevents a re-entry circuit while the green lines indicate retrograde conduction over an accessory pathway. A denotes atrium, AVN is the AV node, V is ventricle and AP is the accessory pathway

Automaticity

Automaticity results from spontaneous depolarization during phase IV of the AP. Although this is a feature of automatic cells such as the SN, AV node, His bundle and Purkinje cells, if it occurs in other cells then it is considered to be abnormal (ectopic focus).

Spontaneous depolarization does not normally occur in atrial and ventricular myocytes but may occur as a result of various physiological or pathological changes which on a cellular level may result in a reduction in the expression or function of the IK1 channel [2].

Latent automatic cells are normally suppressed by SN activity and only become functional if the sinus rate becomes slower than the rate of spontaneous discharge of these cells. Some regions of increased automaticity are protected from SN discharge and therefore discharge independently of this. These cells which demonstrate evidence of entrance block with exit conduction are called **parasystolic foci** and tend to result in ectopic beats with intervals which are multiples of each other [2]. Incomplete entrance block may also occur resulting in entrainment of the focus at a defined rate resulting in ectopic beats with a fixed coupling interval.

One of the typical features of increased automaticity is the ability to overdrive pace at a rate faster than the tachycardia cycle length. This occurs as a result of an

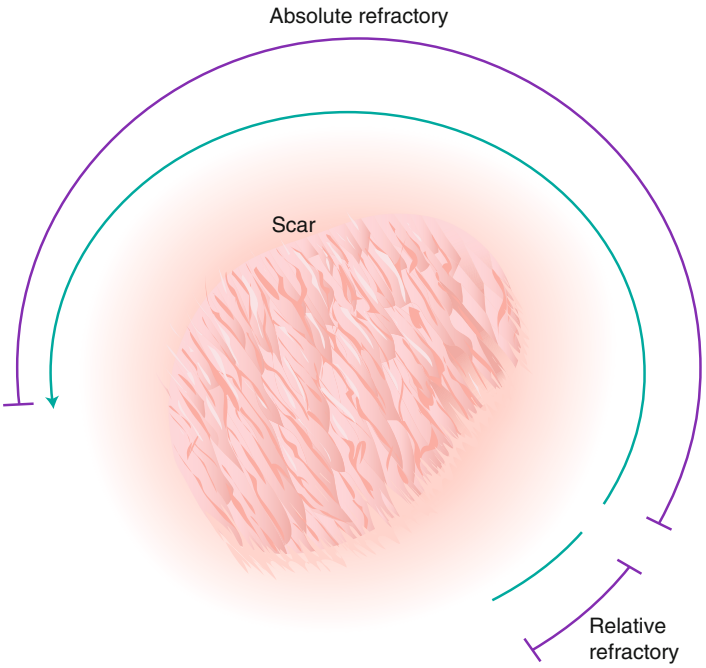


Fig. 1.5 Diagrammatic representation of a re-entry circuit circulating around a conduction barrier in this case scar. The region of tissue where the wavefront is propagating corresponds with tissue during the absolute RP. The tail of the wavefront corresponds with tissue during the relative RP

increase in the activity of the Na^+/K^+ ATPase pump resulting in the generation of a hyperpolarizing current which inhibits phase IV of the action potential [3].

Afterdepolarizations and Triggered Activity

Afterdepolarizations are defined as depolarizations which occur after Phase 0 of the cardiac action potential and may result in a spontaneous action potential known as a triggered response. These are divided into early afterdepolarization (EAD) or delayed afterdepolarization (DAD). These are depicted in Fig. 1.6.

EAD occurs during phase II and phase III while DAD occur after the cardiac action potential is complete. EADs tend to occur when there is an increase in the inward movement of positive ions during the plateau phase of the action potential.

DAD occur as a result of an increase in the inward movement of calcium. This can occur in the setting of digoxin toxicity or in conditions such as catecholamine induced polymorphic ventricular tachycardia (CPVT).

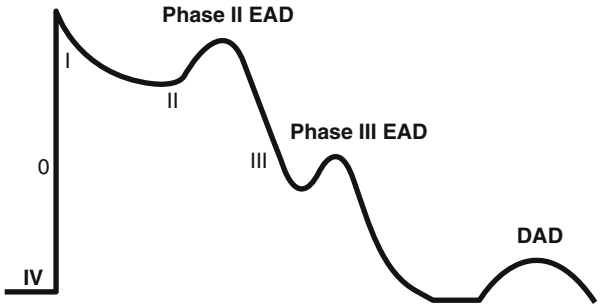


Fig. 1.6 Diagrammatic representation of phase II and phase III early atrial depolarizations (*EADs*) and delayed atrial depolarizations (*DADs*) at the end of the cardiac AP

Anatomy of the Cardiac Chambers

The cardiac chambers may be visualized prior to a complex ablation using computed tomography (CT) or magnetic resonance imaging (MRI) or during the procedure using fluoroscopy, echocardiography and electroanatomic mapping (EAM). The majority of procedures rely on a certain amount of fluoroscopic imaging and often our anatomical understanding is based on the locations of the catheters in various views. The most common views in the electrophysiology laboratory are the right anterior oblique (RAO), left anterior oblique (LAO), posterior – anterior (PA) and left lateral (LL). These views are shown in Fig. 1.7.

The RAO projection helps to demonstrate the postero-anterior (PA) location of a catheter within the cardiac chambers and shows the AV groove more clearly than the PA view. In this view the spine is on the left. Moving the catheter to the right results in a more anterior orientation while moving to the left is more posterior. The left cardiac border is formed by the RV outflow tract (RVOT) superiorly with the RV superior wall inferior to this and the LV apex at the apex. More steep RAO images result in a greater proportion of the RV being visualized with less LV present. The inferior wall of the RV forms the base of the image while the right cardiac border is formed by the posterior wall of the RA and posterior wall of the LA. The AV annular fat strip is best seen in the RAO projection. This 1 cm thick white line is formed as a result of the overlap of the ring of fat in the right anterior, septal and left posterior annulus and either marks the course of, or is slightly ventricular to the coronary sinus (CS). Any catheter posterior to the fat strip is in the atrium and anterior to this is in the ventricle.

In the LAO view the AV rings are viewed parallel to the image. The left cardiac border is formed by the LA superiorly and the lateral wall of the LV inferiorly. Steeper LAO views image more LA and less LV. The right cardiac border is formed by the right atrial appendage superiorly and the RV free wall inferiorly. In this view the spine is on the right side of the image. In the LAO projection anterior is to the left and posterior to the right.

In the PA view the left cardiac border is formed superiorly by the tip of the left atrial appendage (LAA) and the anterior wall of the left ventricle (LV) more inferiorly and the LV apex at the apex. The right heart border is formed by the superior

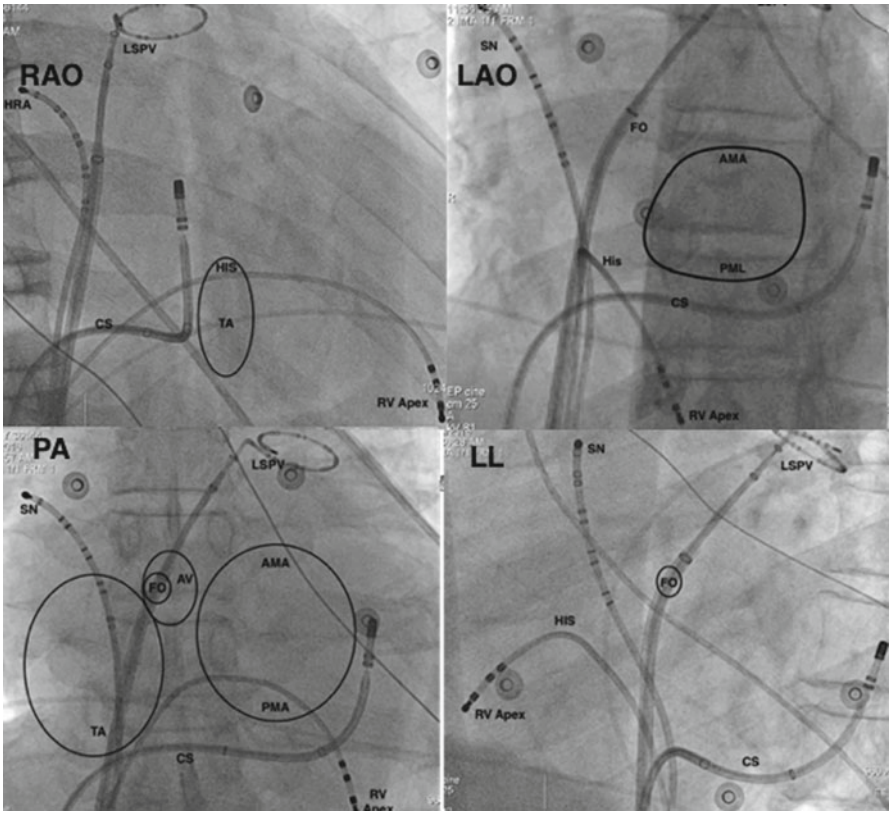


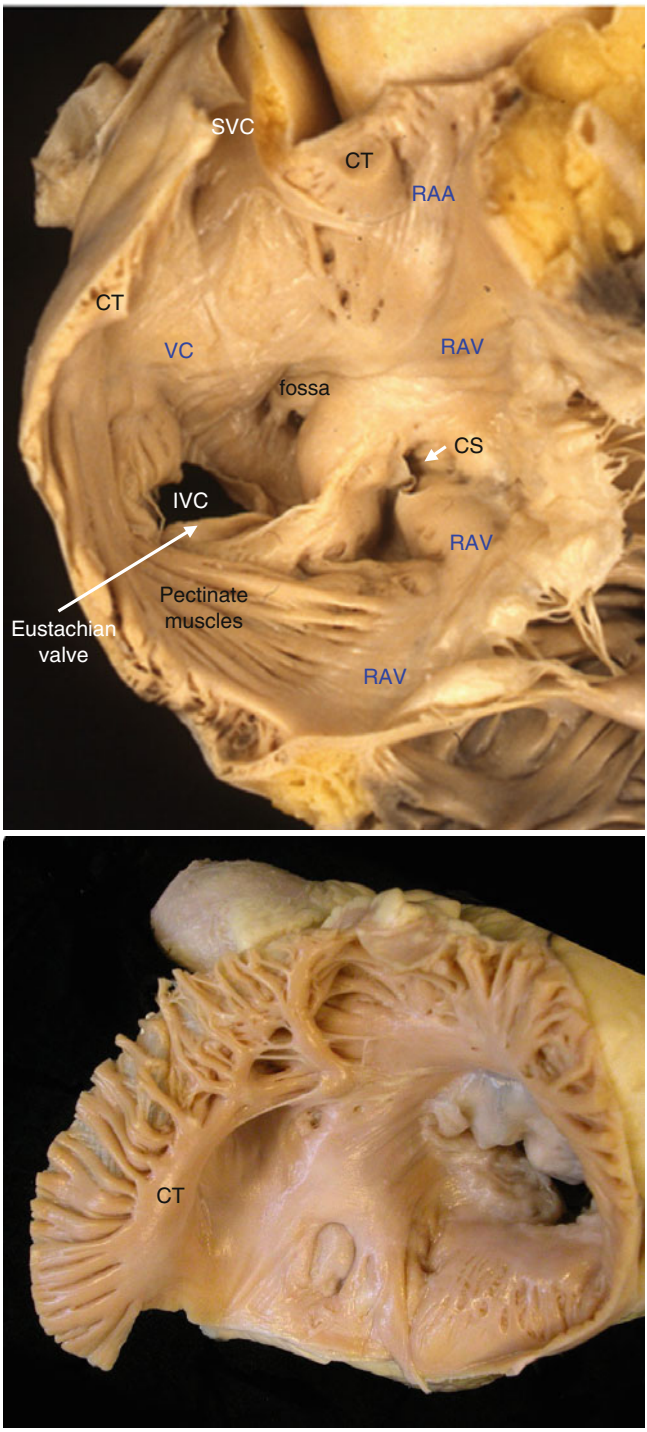
Fig. 1.7 The main fluoroscopic views used in the electrophysiology laboratory. All images have a catheter positioned in the coronary sinus (*CS*), RV apex, high right atrium (*HRA*) close to the sinus node (*SN*) and a catheter positioned across the fossa ovalis (*FO*) into the left superior pulmonary vein (*LSPV*). The location of the His is superimposed on the image. The tricuspid annulus (*TA*), mitral annulus (*MA*, anterior mitral annulus (*AMA*) and posterior mitral annulus (*PMA*)) and aortic valve (*AV*) are superimposed on the four views. The *top left view* shows the RAO projection, *top right* shows an LAO projection, *bottom left* a PA view and the *bottom right* shows a *left lateral view*

vena cava (SVC) to right atrial (RA) junction superiorly and the lateral wall of the RA inferior to this. The base is comprised of the inferolateral wall of the RV.

The LL view is very helpful in determining the anterior – posterior location of the catheter. This is useful for trans-septal access as well as for epicardial access in VT ablation.

The RA

The RA lies anterior, inferior and rightward from the LA and is composed of the venous component, appendage and vestibule. The anatomy of the RA is shown in Fig. 1.8.


SVC
CT
RAA
CT
VC
RAV
fossa
CS
IVC
RAV
Pectinate muscles
Eustachian valve
RAV
CT

The superior and inferior vena cava drain systemic blood into the smooth-walled posterior venous component of the RA. Coronary blood flows through the CS into the RA through the CS os which is located between the inferior vena cava (IVC) and the tricuspid annulus (TA). The CS os is to a variable degree covered by the Thebesian valve which is a thin crescent shaped structure attached at the posterior and inferior boundary of the coronary sinus os. The degree of coverage varies but may practically occlude the CS os in up to 25 % of individuals [4].

The RA appendage is a triangular broad based structure composed of pectinate muscles originating from the **crista terminalis** and is generally where atrial pacemaker leads are positioned for stability. The crista terminalis is one of the most common regions responsible for focal atrial tachycardia's as well as acting as a functional electrical barrier essential for typical atrial flutter. It separates the pectinated appendage from the venous component (or intercaval area) of the atrial body. The latter is posterior whereas the vestibule which surrounds the atrial outlet leading to the tricuspid valve is anterior.

The SN

The SN is a collection of nodal cells within a tough matrix of connective tissue lying just below the epicardium and separated from the endocardium by a layer of atrial myocardium. It is located at the junction between the superior vena cava and the RA, at the antero-lateral quadrant marked by the crista terminalis (CT) (Fig. 1.8) and statistically measures 10–20 mm in length, 3 mm in width and 1 mm in depth but there is an enormous anatomical variation between individuals [5]. Cells in the SN tend to be much smaller than those in the RA measuring approximately 5–10 μm. Typical nodal cells known as P cells are located in the centre of the SN and are generally poorly organized myofilaments. There are fibroblasts and collagen fibers interspersed throughout the SN. There is a gradual transition between the SN and the RA with a disparity in conduction velocity between the cells thus preventing SN depolarization as a result of atrial depolarization [6].

Spontaneous phase IV diastolic depolarization starts at −65 mV until the activation threshold is reached at −40 mV resulting in rapid depolarization. The action potential of the SN differs from that of a Purkinje myocyte with a more gradual upslope and the absence of a plateau phase. Diastolic depolorization occurs as a

Fig. 1.8 Anatomy of the RA (*top image*) and the crista terminalis (*bottom*). The RA is antero-inferior to the LA and is composed of the venous component (*VC*), RA appendage (*RAA*) and RA vestibule (*RAV*). The superior (*SVC*) and inferior vena cava (*IVC*) are seen connected posteriorly into the RAV. The RA appendage is an anterior structure composed of pectinate muscles originating from the crista terminalis (*CT*). The coronary sinus (*CS*) is inferior and posterior. Superior and slightly posterior on the interatrial septum is the fossa ovalis. In the image below the crista terminalis is seen with pectinate muscles radiating out

result of activation of the If current. This operates in a voltage range more negative than normally occurs in the central pacemaker cells (less than −45 mV). It therefore has maximum activity during hyperpolarization and progressively increases opposing repolarization and then initiating diastolic depolarization [7].

The rate of diastolic depolarization in the SN is affected by both sympathetic adrenergic and parasympathetic muscarinic stimulation. This is predominantly affected by the If channel.

Sympathetic adrenergic stimulation results in an increase in the gradient and duration of diastolic depolarization with minimal effects on the overall action potential duration [8]. This occurs as a result of a shift in the activation curve to more positive voltages without a change in the conductance of the If channel as a result of an increase in intracellular cAMP [9].

The reverse occurs with parasympathetic muscarinic stimulation [10]. Slow inward Ca^{2+} channels are involved in the later phase of diastolic depolarization [8] as well as the upslope in the action potential. The transient T type Ca^{2+} channel is activated at more negative voltages and therefore opens first followed by the long lasting L component which opens during the upslope of the action potential [8].

The delayed rectifier Ik channel is the predominant potassium channel in the SN and contributes to repolarization allowing the following depolarization to be initiated.

Respiratory sinus arrhythmia occurs as a result of a reduction in the PP interval with inspiration and a prolongation of the PP interval with expiration. The maximum difference between the longest PP and shortest PP interval should be less than 160 ms. This phenomenon reduces with age.

Ventriculophasic sinus arrhythmia is seen in association with third degree AV block in which the PP interval surrounding a QRS complex is shorter than the PP interval not surrounding a QRS complex.

SN dysfunction encompasses sinus bradycardia, sinus pause, sinoatrial exit block, chronotropic incompetence and inappropriate sinus tachycardia.

Sinus bradycardia is a relatively common finding and in the absence of symptoms is generally of no clinical significance. A sinus pause is defined as the absence of a P wave for greater than or equal to 2 s (although generally not considered clinically significant unless greater than or equal to 3 s while awake or 5 s while asleep). If the duration of the sinus pause is a multiple of the PP interval, then sinoatrial node exit block should be considered. **Chronotropic incompetence** is defined as failure to achieve 70–80 % of maximal predicted heart rate (maximal predicted heart rate = 220-age) during peak exercise.

Inappropriate sinus tachycardia is a persistent elevation in heart rate greater than 100 bpm at rest with no obvious precipitating cause. There is an exaggerated increase in sinus rate with minimal activity and a reduction or normalization of sinus rate during sleep. The p wave morphology and axis are unchanged.

It is important to rule out all potential causes as well as other arrhythmias such as right atrial tachycardia close to the SN or SN re-entry tachycardia. Inappropriate sinus tachycardia is most likely multifactorial with a change in the overall autonomic supply to the SN which may include a reduction in the sensitivity to

anticholinergic effects or an increased sensitivity to adrenergic activity [11]. Pharmacological options for inappropriate sinus tachycardia include beta adrenergic blockers, nondihydropyridine calcium channel blockers and the selective If channel inhibitor ivabradine. Given the selective nature of ivabradine this has been shown to have a useful role in patients with symptomatic inappropriate sinus tachycardia unresponsive to beta adrenergic blockers and calcium channel blockers [12]. Further data is awaited whether this may be considered as first line treatment in this condition.

Catheter ablation for SN modification is an alternative strategy in select cases of inappropriate sinus tachycardia. The SN is often difficult to modify from the RA endocardium as there are multiple connections with sites of early activation between the SN and the RA. Additionally the bulk of the SN is subepicardial, has a significant amount of connective tissue, is often covered by thick muscle of the CT and there is a significant cooling effect from the SN artery. The usual area to target is the superomedial aspect of the CT targeting areas of local activation 15–60 msec ahead of the surface p wave looking for a reduction in the sinus rate to less than 90 bpm and a 20–25 % reduction in the maximum sinus rate with isoprenaline [13]. Although acute results are good long term maintenance is less successful [14]. High output pacing should be performed at sites being considered for ablation to avoid phrenic nerve injury. The need for a permanent pacemaker is unusual but a potential complication of this procedure.

Crista Terminalis (CT)

As shown in Fig. 1.8 this is a C-shaped structure which begins septally at the superior aspect becoming more anterior as it traverses the connection with the SVC and then moves posterior and inferior along the lateral wall of the RA towards the junction with the IVC [15]. The pectinate muscles which form the right atrial appendage span out from the CT. Approximately two thirds of focal atrial arrhythmias occur along this structure [16].

RA Conduction

Following discharge from the SN, conduction occurs through the RA using the muscular architecture of the atrial wall that comprises muscle bundles with well aligned working myocytes that preferentially carry the sinus impulse [17]. The notion of three specific internodal tracts is controversial because histologically specialized tissue tracts akin to the insulated ventricular conduction bundles have never been demonstrated anatomically.

Bachmann's bundle, which is also known as the anterior bundle is responsible for right to left atrial conduction. It is not a discrete bundle nor is it insulated with a

fibrous sheath. Instead, it is a muscle bundle with well aligned myocytes, superficially located across the anterior interatrial groove. Its rightward extension reaches superiorly to the area of the sinus node and inferiorly toward the right atial vestibule. Usually it is the most prominent interatrial bundle [18].

Cavotricuspid Isthmus (CTI)

This is the region of slow conduction in typical atrial flutter bounded anteriorly by the septal component of the TA and posteriorly by the Eustachian valve (EV) and the IVC (Fig. 1.9). Conduction in this region is slow due to the criss-cross arrangement of the myocytes and distal ramifications of the crista terminalis relative to the better aligned and circumferential arrangement of myocytes in the vestibule leading to the tricuspid valve (TV) [19].

In an LAO projection the ablation catheter is generally positioned in the mid isthmus in the 6 o'clock position. In the RAO position the catheter is moved from the right to the left keeping the catheter inferiorly. The EV separates the vestibular

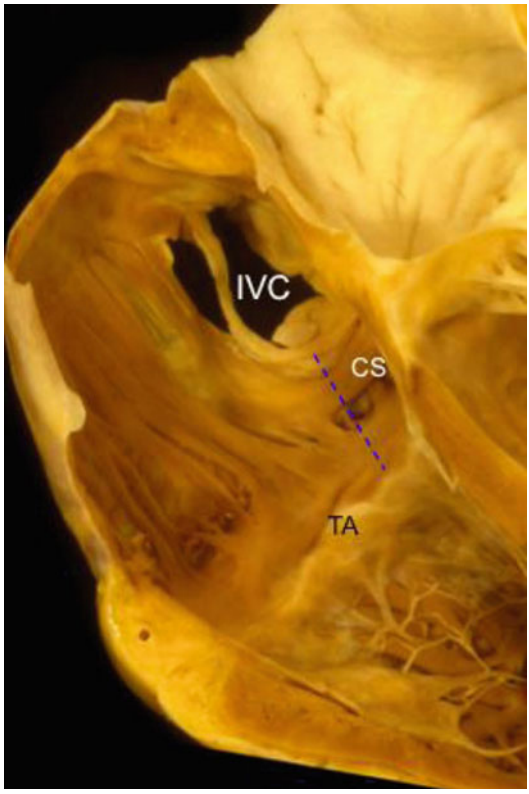


Fig. 1.9 Anatomy of the cavo-tricuspid isthmus (*CTI*). The CTI runs between the tricuspid annulus (*TA*) and the inferior vena cava (*IVC*). The dotted line shows a septal approach close to the coronary sinus (*CS*) which may be used as a line for catheter ablation in order to transect the isthmus

inferior RA from the inferior vena cava (IVC). The Eustachian ridge is an elevated region of tissue between the fossa ovalis and the coronary sinus in continuation with the insertion point of the EV. The Tendon of Todaro (TT) runs in this rim towards the AV node [18].

LA

The LA is posterior, superior and to the left of the RA. The tip of the left atrial appendage (LAA) contributes to the left side of the cardiac silhouette in a PA image. The LA is a smoother structure with the muscular appendage confined to a small tube-like structure arising from the superior and left side of the chamber. As shown in Fig. 1.10 the four pulmonary veins (PV's) drain into the posterior quadrants of the smooth-walled area, which is actually the most posterior region of the heart.

The left sided pulmonary veins are best seen in the LAO projection and are posterior to the left atrial appendage. The right pulmonary veins are best visualized in an RAO projection. The right superior pulmonary vein is posterior to the junction between the right atrium and superior vena cava.

The LA myocardial fibers extend over variable distances into the pulmonary veins. These connections are generally the targets for pulmonary vein isolation.

The LA wall is generally a thin structure and therefore care must be taken when manipulating catheters in this region. The lateral wall is approximately 3.9 ± 0.7 mm in thickness, the posterior wall 4.1 ± 0.7 mm, anterior wall 3.3 ± 1.2 mm and the roof 4.5 ± 0.6 mm when measured on cadaver heart specimens [19].

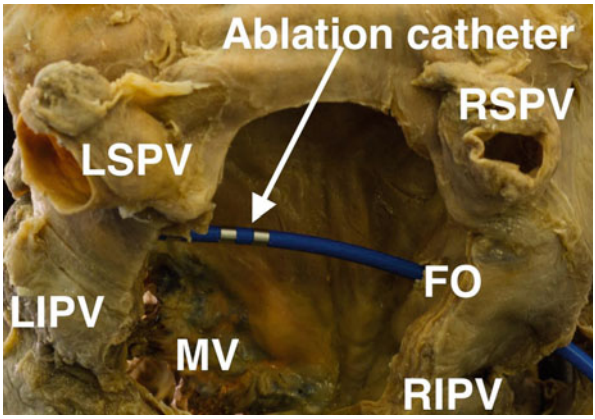


Fig. 1.10 Anatomy of the LA. This is seen from a posterior view. An ablation catheter is positioned via the intra-atrial septum at the location of the fossa ovalis. The left superior pulmonary vein (*LSPV*), left inferior pulmonary vein (*LIPV*), right superior pulmonary vein (*RSPV*) and right inferior pulmonary vein (*RIPV*) are seen as posterior structures in the left atrium. The mitral annulus (*MA*) is seen inferior to the LIPV

The LA is anterior to the esophagus. This is of real importance in terms of posterior wall ablation. The esophagus has a variable course in relation to the LA. There is also a variability in the thickness of the fibrofatty tissue between the LA and the esophagus. In clinical practice this generally results in the application of lower power (25–30 W) and shorter duration lesion in the posterior left atrial wall in order to attempt to minimize the possibility of esophageal injury.

Anterior to the LA is the ascending aorta which is an important consideration when performing trans septal access.

Atrio-Ventricular (AV) Junction

The compact AV node is the atrial component of the specialized AV junctional area and is located between the coronary sinus os and the septal leaflet of the tricuspid valve. It therefore lies inside the **triangle of Koch**.

It measures approximately 5 mm in length and is histologically quite complex. It is not insulated by connective tissue and therefore may potentially be damaged by RF application. The inferior extensions of the compact AV node also run within the triangle of Koch with the rightward extension (fast pathway) parallel to the tricuspid valve and the leftward extension (slow pathway) towards the coronary sinus. These extensions pass either side of the AV nodal artery and also are not protected structures. The histological appearances of these extensions are the same as the compact AV node and are involved in the AVNRT circuit [20]. The boundaries of the triangle of Koch are shown superimposed on an anatomic specimen in Fig. 1.11.

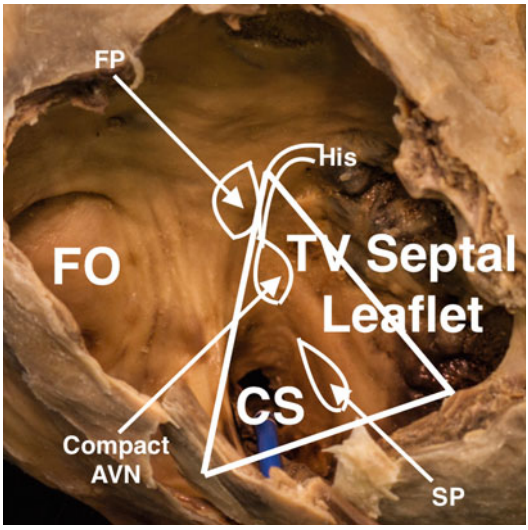


Fig. 1.11 Boundaries of the triangle of Koch superimposed on an anatomic specimen. This is formed by the coronary sinus (*CS*), septal leaflet of the tricuspid valve (*TV*) inferiorly and the tendon of Todaro anterosuperiorly. A catheter is positioned via the inferior vena cava (*IVC*) into the coronary sinus (*CS*). Also shown is the fossa ovalis, approximate location of the slow pathway (*SP*), compact AV node, fast pathway (*FP*) and His

His Bundle

The His bundle is a continuation of the compact AV node and with similar specialized cells although these are more parallel aligned [21]. It is better insulated than the AV node and therefore is not as easily damaged with RF, although this is still possible. The proximal bundle runs from the distal AV node into the fibrous tissue of the central body where it is termed the penetrating portion. Following this it emerges on the ventricular side of the fibrous body, sandwiched between the membranous septum and the muscular ventricular septum, Taking an initial course usually to the left side of the septum, it then bifurcates into the right bundle (RB) and left bundle (LB) branches, still insulated by fibrous tissue sheaths. The RB tends to have a more anterior origin in the membranous septum.

The CS

The CS is a tubular shaped structure which runs from either the Valve of Vieussens or in its absence the entrance of the vein/ligament of Marshall to the CS os where it enters the RA. It is approximately 7 cm in length [22] and 6–16 mm in diameter [23].

As shown in Fig. 1.12 the CS receives blood from the great cardiac vein that channels blood from its tributaries, the anterior interventricular vein, the middle cardiac vein, the left obtuse marginal vein, the right coronary vein and atrial veins of which the most well known is the vein of Marshall. The coronary sinus is generally surrounded by myocardial musculature which extends from the right and left atrial walls [24]. This musculature may extend for a further 2–11 mm along the great cardiac vein [25]. Distal to this the venous wall is not surrounded by musculature and therefore perforation through instrumentation is more likely.

The Valve of Vieussens rarely causes a significant obstruction to the advancement of a catheter but rather the acute bend in the vein beyond this or an advancement into a side branch are more common causes of cannulation problems. It is therefore better to slowly withdraw and rotate the catheter rather than to try to advance further.

The anterior interventricular vein courses from close to the LV apex and then continues into the great cardiac vein that into the left AV groove under the left atrial appendage [26]. Distally the great cardiac vein receives left atrial veins including the Vein of Marshall and more proximally ventricular veins from the anterior RV and LV and the interventricular septum.

The middle cardiac vein joins the CS close to the os. Occasionally it may also enter the RA directly. This vein runs along the diaphragmatic surface between the LV and RV with a close proximity to the right coronary artery and in particular the branch to the AV node. It may be used to map accessory pathways in the pyramidal space.

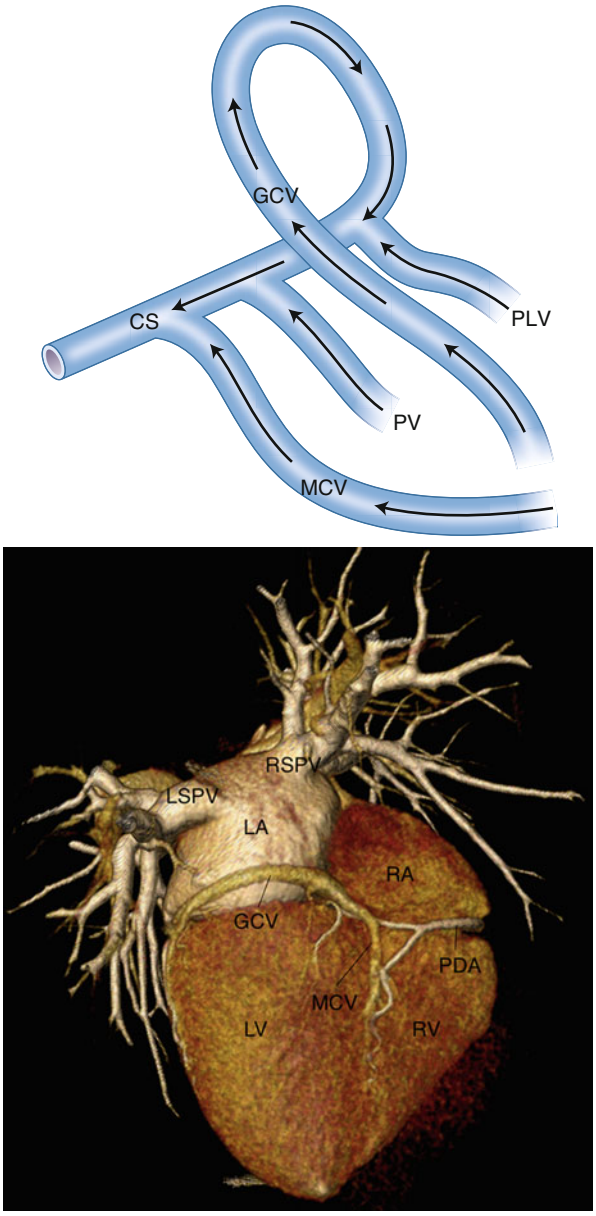


Fig. 1.12 The coronary sinus and its branches. The top image is a diagrammatic representation of the coronary sinus (*CS*) and its main tributaries the great cardiac vein (*GCV*), middle cardiac vein (*MCV*) as well as posterior veins (*PV*) and posterolateral veins (*PLV*) seen in an LAO view. In the image below this the CT shows the coronary sinus running along the inferior left atrium (*LA*) as the great cardiac vein (*GCV*). The middle cardiac vein (*MCV*) runs between the left ventricle (*LV*) and the right ventricle (RV). The posterior descending artery (*PDA*) is seen running between the right atrium (*RA*) and the right ventricle (*RV*). Also seen in this image is the left superior pulmonary vein (*LSPV*) and the rightsuperior pulmonary vein (*RSPV*)

LV Conduction System

The atrioventricular conduction bundle emerges from the central fibrous body to pass below the right and non-coronary cusps and continue into the branching atrioventricular bundle that gives origin to the RB and LB branches. The LB branch courses along the LV septal surface and divides into three fascicles (Fig. 1.13). The **anterior fascicle** which is **superior** runs towards the base of the anterosuperior papillary muscle, the **posterior fascicle** which is **inferior** runs towards the posteroinferior papillary muscle and in 60 % of cases a central or **septal fascicle** which runs to the mid septum. In the remaining 40 % of cases this area is supplied by the anterosuperior and posteroinferior fascicles.

Given that there are often more than two fascicles the term hemiblock is generally not accurate and fascicular block seems more appropriate.

Anterior fascicular block is more common than posterior fascicular block and results in a leftward QRS axis deviation poor R wave progression in V1–V3, with a negative QRS in II, III and aVF and positive QRS in lead I. There is also a tall R wave in aVL and aVR. The QRS is not broad.

Posterior fascicular block is less common due to the short and wide nature of this fascicle. The ECG features are a QRS axis greater than 100° with an rS morphology in leads I and aVL; and a qR pattern in leads II, III, and aVF. The QRS is not broad. Diagrammatic representation of both anterior and posterior fascicular bock are shown in Fig. 1.14.

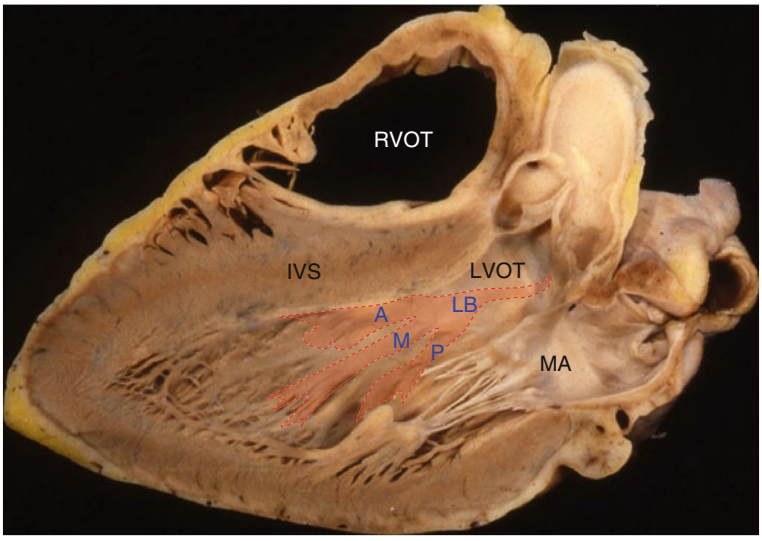


Fig. 1.13 Anatomy of the LV showing the walls of the chamber, interventricular septum (*IVS*), mitral annulus (*MA*) and left ventricular outflow tract (*LVOT*). Superimposed on this image are the approximate locations of the left bundle (*LB*), anterior fascicle (*AF*), posterior fascicle (*PF*) as well as the Purkinje system

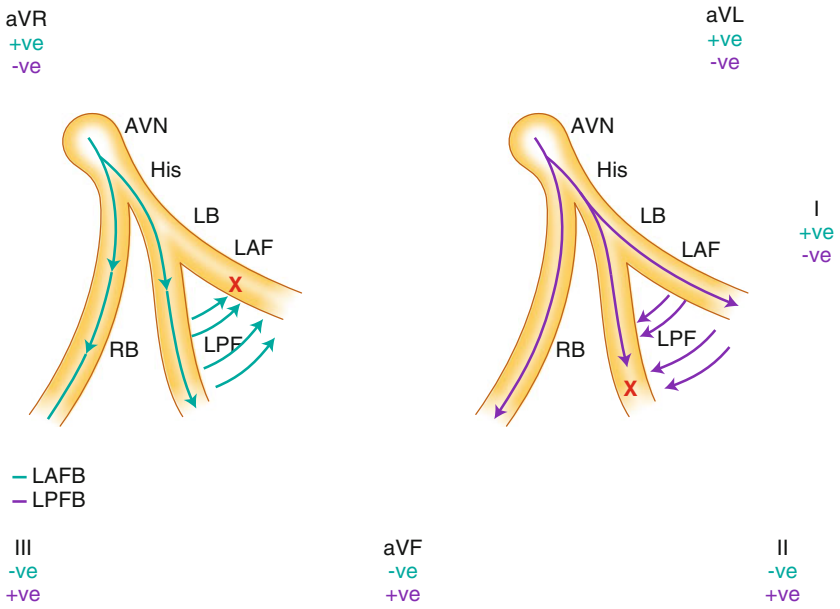


Fig. 1.14 Diagrammatic representation of left anterior fascicular block (*LAFB*) on the *left image* with activation in orange and left posterior fascicular block (*LPFB*) on the *right* with activation in *red* and the effects on the ECG limb leads

Septal fascicular block is the least clinically described of all the fascicular blocks. This may be due to the multiple ventricular connections of this fascicle making complete block of this fascicle less likely [27]. There is a variability in the ECG appearances. In general the changes noted are Q waves in V1 and V2 as a result of anteriorly directly right ventricular depolarization [28].

This may also cause a qrS in V1 and V2. There is also loss of q waves in leads V5, V6 and I due to loss or reversal of left to right ventricular septal activation. The QRS is not significantly broad because activation of the left ventricular free wall and apex occurs via the anterosuperior and posteroinferior fascicles.

Complete bundle branch block occurs as a result of either partial or complete structural or functional block in one of the two bundle branches resulting in a widening of the QRS greater than 120 ms as well as a change in morphology, which generally reflects conduction down the contralateral bundle with secondary repolarisation.

In **left bundle branch block** (**LBBB**) the initial activation is rightward and anterior resulting in small q waves in I, avL, and V6 with an rS in V2. Following this depolarisation spreads from the apex to the base and to the RV free wall and apex. During this process, septal activation is the pre- dominant force and therefore the vector is anterior and to the left, resulting in a wide slurred QRS in I, aVL and V6 (Fig. 1.15). Depolarization then occurs in a leftward and posterior direction through the LV. Finally, the anterior wall of the LV is depolarized.

RV Conduction System

The RV is anterior to the LV as shown in Fig. 1.16. The RB branch is an insulated bundle of specialized myocytes that runs as a direct continuation of the atrioventricular conduction bundle distal to origin of the left bundle branch. It penetrates the

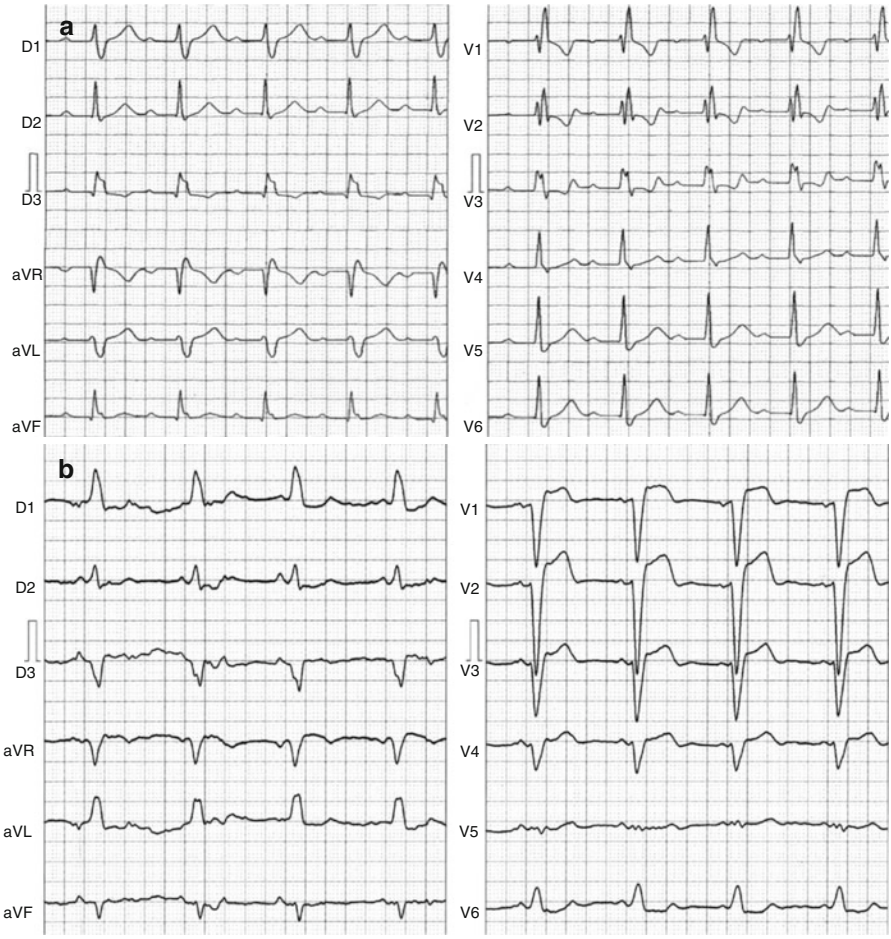


Fig. 1.15 12 lead ECG's showing RBBB (**a**), LBBB (**b**), Left Anterior Fascicular Block (**c**) and Left Posterior Fascicular Block (**d**). The ECG in panel **a** shows RBBB with first degree AV block (PR Interval 280 ms). The QRS duration is 120 ms with an rsR pattern in leads V1 and V2. (**b**) This ECG shows a LBBB with a QRS duration of 165 ms. An rS is seen in leads V1 and V2 and a dominant R wave in leads I, aVL and V6. (**c**) This ECG shows a left anterior fasicular block. The QRS duration is within normal range with a leftward axis. There is poor R wave progression V1–V3. The QRS is negative in leads II, III and aVF and positive in lead I. There is also a tall R wave in lead aVL. (**d**) This shows left posterior fasicular block. The QRS axis is in a rightward direction. There is an rS in lead aVL. There is a small q wave in lead III and a dominant R in leads II, III and aVF with the R wave being greater in amplitude in lead III than lead II

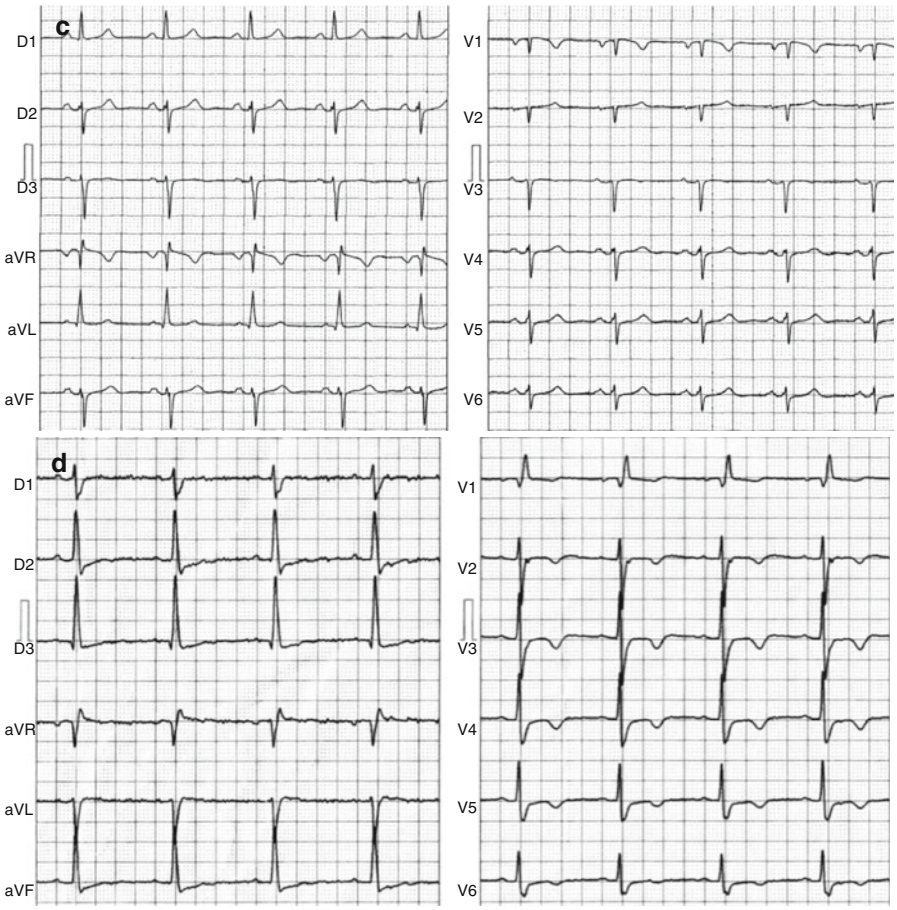


Fig. 1.15 (continued)

musculature of the ventricular septum toward the midseptum where it becomes subendocardial running along the posterior margin of the septal band. Continuing toward the apex, it divides into several branches one of which courses through the moderator band to the base of the anterior papillary muscle, and then the right ventricular free wall. It gives off septal branches which activate the septum almost immediately after left ventricular activation. Septal activation is generally complete within 35 ms and terminates in Purkinje fibres at the apex.

Right bundle branch block (**RBBB**) is more common than LBBB and as shown in Fig. 1.15 the initial septal activation is followed by depolarization of the left ventricle, resulting in R waves in I, aVL and V6. Following this, right ventricular free wall and septal depolarization results in S waves in these leads. Overall, the QRS is ≥120 ms in adults with an rsr, rsR, or rSR in leads V1 or V2. The R or r deflection is usually wider than the initial R wave. ST segment deviation is generally discordant to the QRS vector.

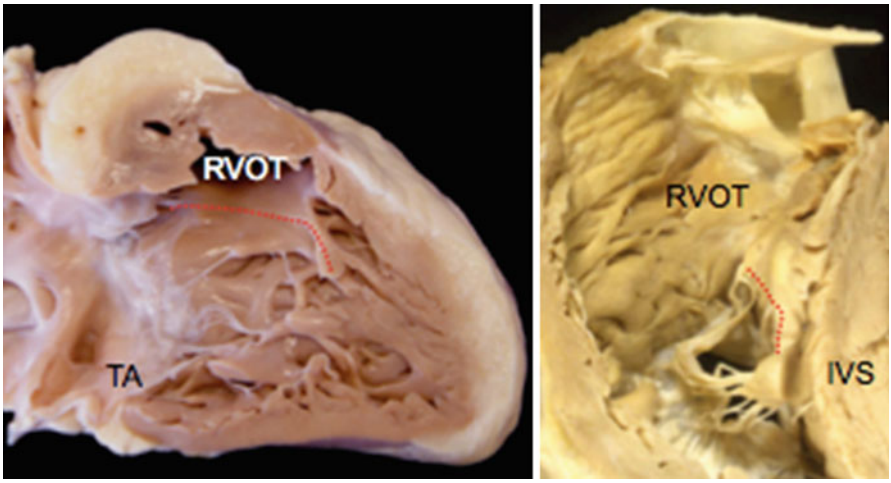


Fig. 1.16 Anatomical image of the Right Ventricle in Right Anterior Oblique (RAO seen on the *left*) and Left Anterior Oblique (LAO seen on the *right*) showing the walls of the chamber, interventricular septum (*IVS*), Tricuspid annulus (*TA*) right ventricular outflow tract (*RVOT*)

Aberrant Ventricular Conduction

This occurs when a supraventricular beat conducts rapidly to the His Purkinje system while one of the bundle branches is refractory and then depolarizes the other bundle branch, resulting in a wide QRS complex.

There are four types of aberrancy:

1. **Phase III dependent** (**Ashman Phenomenon**)
   This occurs when a short RR interval follows a longer RR interval. The longer RR interval results in a prolonged action potential in the His and bundle branches. The right bundle usually has a longer action potential duration than the left bundle and therefore the following beat with the shorter RR interval is blocked in the right bundle, which is still refractory and conducts down the left bundle with a RBBB morphology (Fig. 1.17). This may be seen in AF, where there is a variable cycle length and may be misinterpreted as a PVC.
2. **Acceleration dependent**
   This occurs with very slight acceleration of the heart rate (less than 5 ms) at a critical cycle length which is often within normal heart rate ranges. This tends to occur more commonly in the left bundle resulting in a LBBB morphology (Fig. 1.18). Of note as the rate increases further, the aberrancy often resolves as the action potential duration of the bundles reduces more than that of the AV node. Additionally the action potential duration of the bundle branches often reduces in a time dependent manner known as restitution.
3. **Deceleration dependent**
   This occurs following a long pause during which a premature atrial beat conducts to the ventricle with a resultant bundle branch block pattern (Fig. 1.19). This

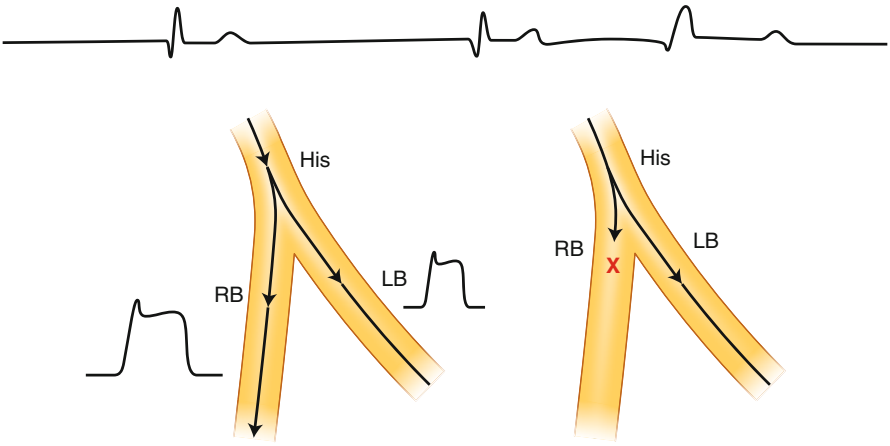


Fig. 1.17 Diagrammatic representation of Phase III dependent aberrant conduction. During AF the longer RR interval on the left results in a prolongation of the action potential in the Right Bundle (*RB*) and to a lesser extent the Left Bundle (*LB*). An early activation occurs during phase III of the action potential in the RB resulting in conduction down the LB with a RBBB morphology

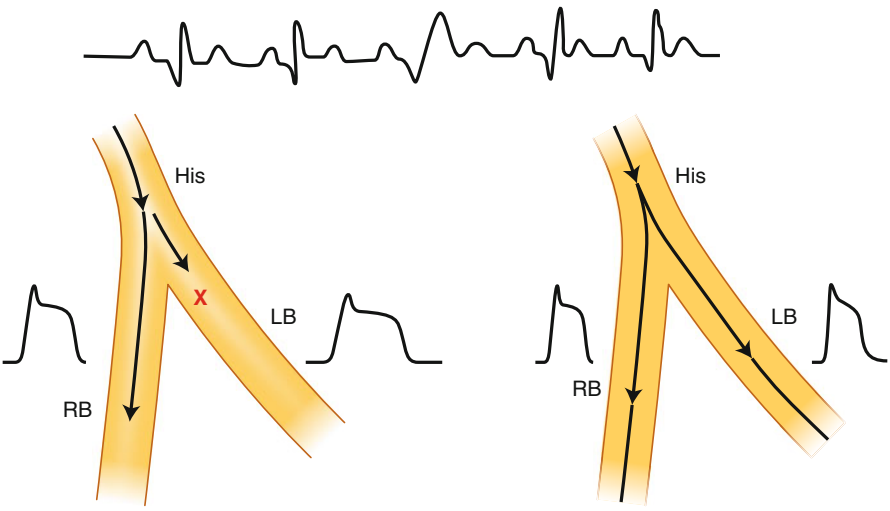


Fig. 1.18 A very slight acceleration in the RR interval results in antegrade block in the left bundle (*LB*). An increase in the rate after this results in a narrowing of the action potential duration with normalization of the surface QRS

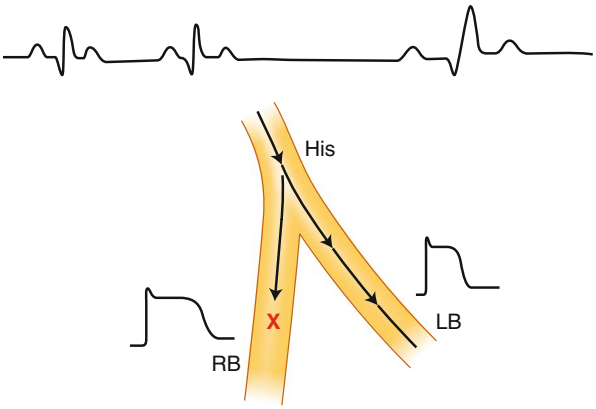


Fig. 1.19 A slow rate with a long pause results in prolongation of the action potential duration in both the right bundle (*RB*) and left bundle. A premature atrial complex (*PAC*) conducts through the His and conducts along the LB with block in the RB

occurs as a result of slow phase IV depolarization of the bundle branches resulting in refractoriness of one of the bundles as the atrial beat results in depolarization. This can be either a RBBB or LBBB pattern,

An example of deceleration dependent right bundle aberrancy is shown in Fig. 1.20. The His catheter is positioned so that the proximal electrogram is recording a His deflection and the distal recording is recording a right bundle potential.. The first beat shows a His potential on the proximal electrogram and a right bundle potential on the distal electrogram followed by ventricular activation. Following this a PAC is introduced by pacing the high RA (arrow). The following beat shows a His potential on the proximal electrogram with no right bundle potential on the distal electrogram and a characteristic RBBB pattern on the surface ECG.

4. **Concealed retrograde conduction**
   This occurs when retrograde conduction in one of the bundle branches from a PVC results in refractoriness for the next antegrade beat. As the bundle recovers the next beat which conducts down the contralateral bundle conducts retrogradely up the bundle again (Fig. 1.21). This continues until a different PVC alters the activation retrograde activation of the bundle. This is a relatively common cause of aberrancy during SVT.

ECG Signal Acquisition

The ECG is used to record the alterations in electrical potentials during the cardiac action potential. Any number of leads can be recorded in order to electrically visualize the heart from different angles.

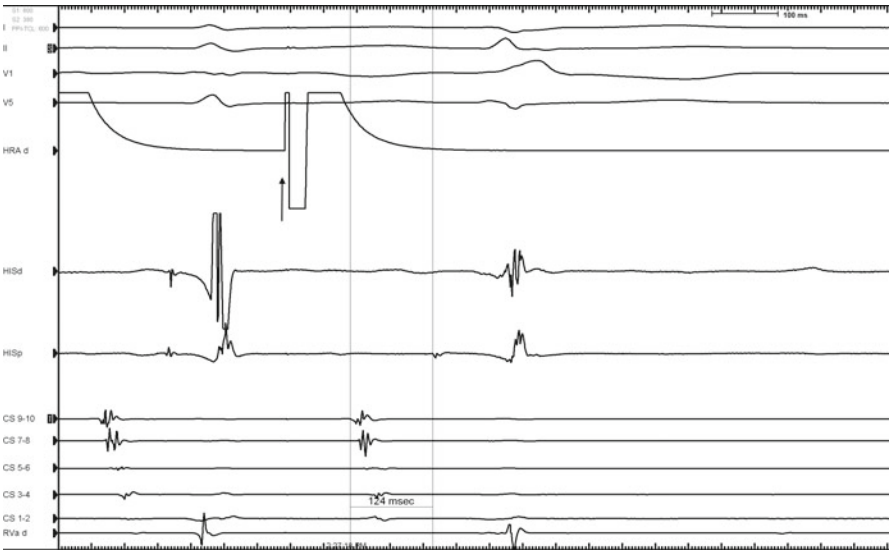


Fig. 1.20 Electrograms showing right bundle abberancy from a PAC (from HRA pacing labeled with an *arrow*). The HIS d is positioned along the proximal right bundle while the HIS p is positioned along the His. The PAC conducts along the His but does not conduct down the right bundle (no RB potential on HIS d on the second beat) with a RBBB morphology QRS. (CS 9–10 is positioned in the proximal CS with CS 1–2 in the distal CS. RV a is positioned in the RV apex)

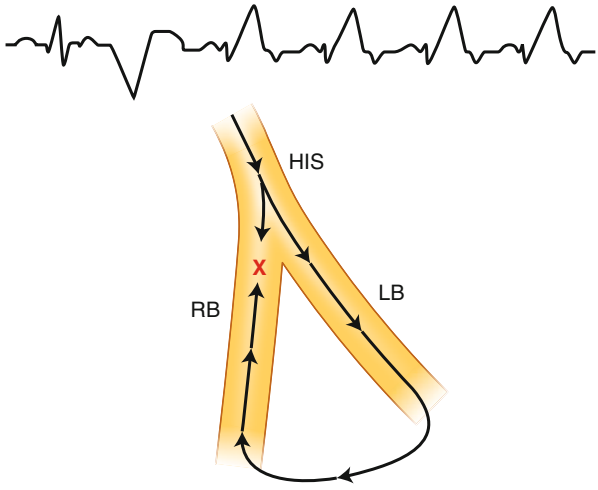


Fig. 1.21 Following the first sinus beat a PVC conducts retrogradely up the right bundle (RB) resulting in antegrade block in the RB with conduction down the left bundle (LB) (from third beat onwards). These beats then conduct retrogradely up the RB which is no longer refractory

The standard 12 lead ECG is composed of six unipolar precordial leads positioned as follows across the anterior chest wall:

V1 4th Intercostal Space Right Parasternal
V2 4th Intercostal Space Left Parasternal

V3 Midway between V2 and V4
V4 5thIntercostal Space Mid Clavicular Line
V5 5th Intercostal Space Anterior Axillary Line
V6 5th Intercostal Space Mid axillary line

The locations of these leads relative to the cardiac chambers can be seen on Fig. 1.22.

Each lead records electrical activation between the precordial electrode and **Wilsons Central Terminal** (WCT). This is a theoretical point close to zero potential created from the electrodes between the right arm, left arm and left leg (Fig. 1.23). These vectors create three bipolar leads I (right arm to left arm), II (right arm to left leg) and III (left arm to left leg) through three large resistors. The electrical activation between these three leads therefore cancels out to come close to a zero potential (WCT). The remaining three leads aVR, aVL and aVF are augmented unipolar leads created from the limb electrodes and referenced to **Goldberger's Central Terminal** (GCT) rather than WCT. GCT is created from two of the three

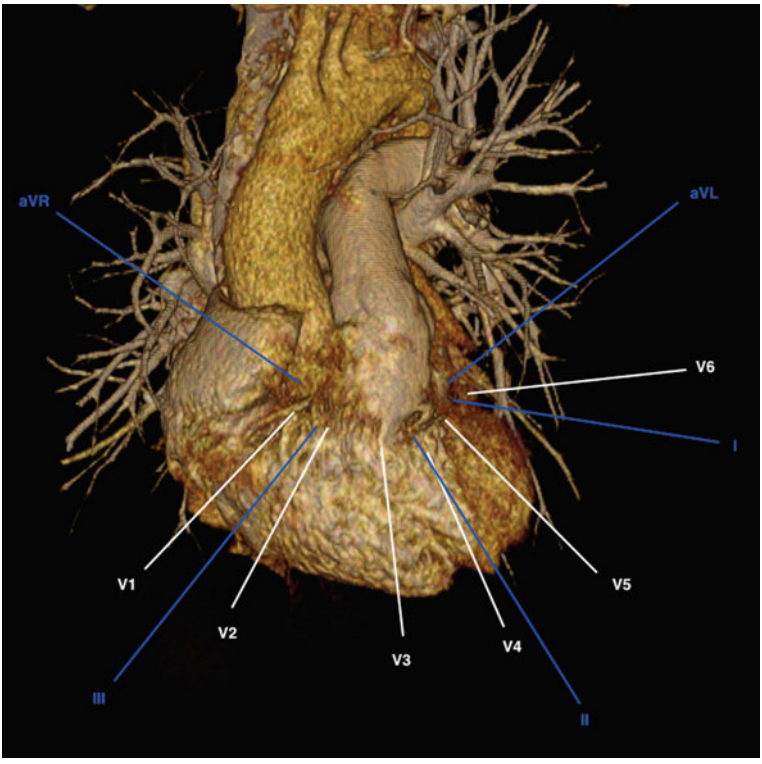


Fig. 1.22 CT Image of the Thorax showing the positions of the surface ECG leads relative to the cardiac chambers. The precordial leads V1–V6 are seen as well as the augmented leads aVR, aVL, II, III and aVF

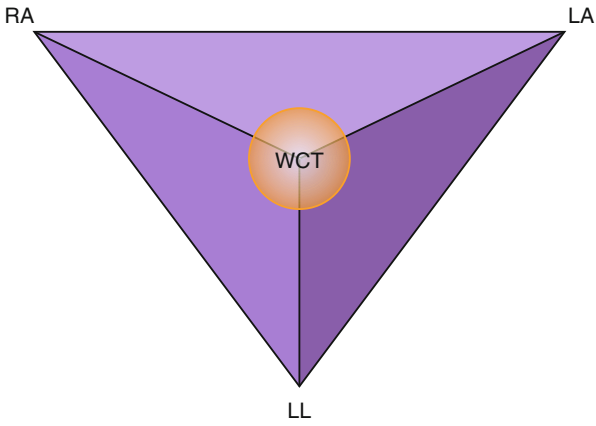


Fig. 1.23 Diagrammatic Representation of an ECG Vector created from the ECG leads from the Right Arm (*RA*), Left Arm (*LA*), Left Leg (*LL*) and Wilsons Central Terminal (*WCT*)

limb leads. When aVR is being recorded the GCT is composed of left arm and left leg, for aVL this is formed by right arm and left leg and for aVF is the right arm and left arm.

The right leg lead is used to introduce a current to the patient in order to maintain a voltage equivalent to that of the amplifier. This feeds back an inverse of potential low frequency interference and which increases if this lead is disconnected.

The QRS axis refers to the mean direction of ventricular activation in the frontal plane. In order to calculate the QRS axis the first step is to identify a limb lead where the QRS complex is isoelectric. In theory, the overall direction of electrical activation should be perpendicular to this. As there are two potential perpendicular directions, the leads either side of the isoelectric lead need to be examined and the axis is in the direction of the more positive lead. For example, if the QRS complex is isoelectric in lead I and positive in lead II, the QRS frontal axis is +90. In general principles the QRS axis shifts for several reasons. If there is chamber hypertrophy the QRS axis will shift in the direction of the hypertrophied ventricle as there is a greater component of electrical activation in that direction. In bundle branch block, activation moves from the opposite side to the side with the bundle branch block and therefore the axis will be in the same direction. In cases of myocardial infarction, the axis tends to move in the opposite direction away from the infarcted tissue.

Autonomic Innervation of the Heart

There is a continual balance between the two main components of the autonomic nervous system; the **sympathetic** (**adrenergic**) and **parasympathetic** (**vagal**) **innervation**.

The sympathetic efferent neurons innervate the SN as well as the atria, AV node and ventricles acting principally on the beta-adrenoceptors. Increased sympathetic

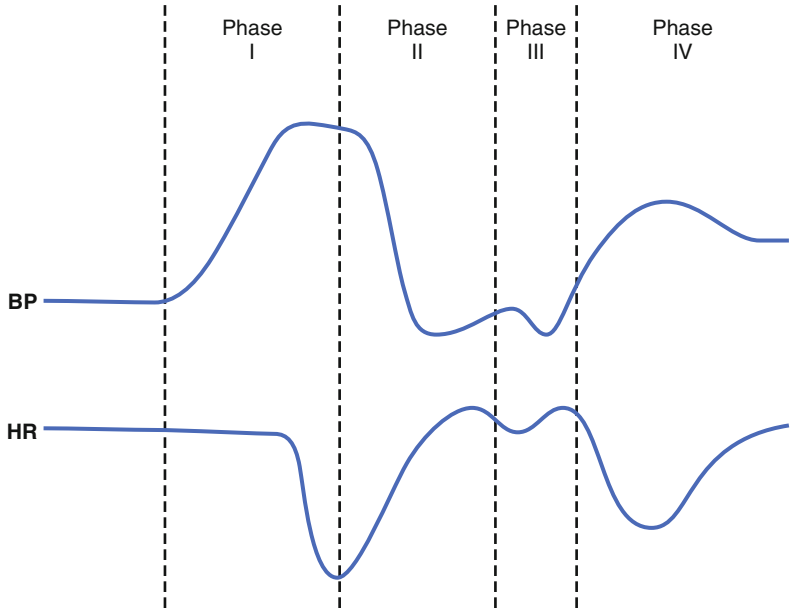


Fig. 1.24 Phases of the valsalva maneuver. The initial rise in intrathoracic pressure results in a elevation in blood pressure (*Phase I*) with a stable and then compensatory drop in heart rate. As well as an elevation in aortic pressure there is a reduction in preload which results in a drop in blood pressure with a rise in heart rate (*Phase II*). As the actual maneuver ends pressure on the aorta is reduced and the blood pressure transiently decreases with a resulting increase in the heart rate (*Phase III*). As the cardiac output increases to normal the blood pressure then increases with a compensatory drop in heart rate (*Phase IV*)

activity results in positive inotropy, positive chronotropy and an increased conduction velocity.

The parasympathetic (vagus) nervous system synapses with ganglia acting on muscarinic receptors in the heart. In general the right vagus innervates the SA node while the left vagus innervates the AV node. The vagus nerve innervates the atria to a lesser extent. There is minimal innervation of the ventricles. Increased vagal stimulation results in negative chronotopy and reduced conduction velocity. Given the lack of vagal innervation in the ventricles there is minimal inotropy.

There are several methods of assessing autonomic activity of the heart including the **valsalva maneuver** and the **tilt table test**.

The valsalva maneuver is performed by exhaling with a closed glottis for a period of 10 s therefore increasing intrathoracic pressure. There are four phases as depicted in Fig. 1.24.

Phase I: Transient increase in blood pressure with no change in heart rate as a result of compression of the ventricles and aorta.

Phase II: A significant reduction or plateau in blood pressure as a result of compression of the intrathoracic vena cava reducing venous return. As a result of this

there is a baroreflex mediated increase in heart rate via the sympathetic nervous system.

Phase III: As the maneuver has now stopped the intrathoracic pressure returns to normal reversing phase I and resulting in a reduction in left ventricular output and an increase in right ventricular output as a result of an increase in venous return.

Phase IV: As the venous return increases further there is an increase in the cardiac output and blood pressure. This results in stimulation of baroreflex which increases parasympathetic activity resulting in a reduction in heart rate.

A tilt table test may be useful in patients with a history of pre-syncope, syncope or postural symptoms such as palpitations when structural heart disease has been excluded. During this test the patient is attached to a specialized table and positioned at a 60–70 degree angle. The ECG and non-invasive blood pressure are continually monitored. Although some laboratories do not gain an intravenous (IV) due to the potential effects on vagal tone, it is reasonable to insert an IV for the administration of pharmacological agents and wait for 15 min prior to commencing the test.

The patient is monitored in the supine position for five minutes and then placed in an upright position at a 60–70 degree angle. The heart rate and blood pressure are monitored and recorded every five minutes for 45 min. If there is an acute drop in blood pressure or loss of consciousness, the table is returned to the supine position. Some centers administer 300–400 microgrammes of sublingual nitrate within the last five minutes of the study while others repeat a negative tilt table test with the administration of isoprenolol at a rate of 1–3 microgrammes per minute in order to increase the heart rate by 25 % above the baseline. It is not uncommon to get a slight drop in blood pressure with isoprenolol and therefore this test is generally only considered positive if syncope occurs. Carotid sinus massage can often be performed either in the supine or erect position, the latter having a slightly higher yield.

Carotid sinus hypersensitivity is defined as a ventricular pause greater than or equal to three seconds with or without a drop in systolic blood pressure by $\geq$50 mmHg. If there is associated syncope then this is defined as carotid sinus syndrome. Carotid sinus hypersensitivity is more common in the elderly and in males, and is extremely uncommon in individuals under the age of 40 years. Carotid sinus massage should not be performed in patients with a prior transient ischemic attack or stroke within the prior three months, or in patients with a carotid artery bruit unless significant carotid artery disease has been excluded on carotid dopplers. Both nitrates and isoprenolol increase the sensitivity but reduce the specificity of the tilt table test.

If syncope occurs in association with bradycardia or reflex hypotension the diagnosis is **neurocardiogenic syncope**. If the major precipitant is bradycardia this is **cardio-inhibitory**, and if the major precipitant is hypotension it is **vasodepressor**.

Postural Orthostatic Tachycardia syndrome (**POTS**) is defined as an increase of heart rate of greater than or equal to 30 bpm or a rate of greater than or equal to 120 bpm within the first 10 min of moving from a supine to erect position with

associated symptoms [29]. Other potential causes such as medications or prolonged bed rest which may alter vascular tone should be excluded prior to making this diagnosis.

POTS can be divided into either partial dysautonomic or hyperadrenergic types.

In **partial dysautonomic POTS** the increase in heart rate is partially due to increased blood pooling in the lower limbs as a result of an alteration in the control of vascular tone.

In **hyperadrenergic POTS** there is often an associated increase in blood pressure associated with the increase in heart rate.

The tilt table results depend on the age of the patient, with younger patients more likely to have cardioinhibitory neuro- cardiogenic syncope, and older patients more likely to have vasodepressor neurocardiogenic syncope.

Important Points to Remember

1. The cardiac action potential is composed of 4 phases.

   Phase IV (resting membrane potential) occurs with a membrane potential of −80 to −95 mV in atrial, purkinje and ventricular cells, −50 to −60 mV in the SN and −60 to −70 mV in the AV node. In both the SN and AV nodes there is a slow spontaneous diastolic depolarization which merges with Phase 0 resulting in spontaneous automaticity while Phase IV in other cells is generally more flat.

   Phase 0 (rapid depolarization) occurs when the membrane potential becomes positive.

   Phase I (rapid repolarization) occurs in the atrium and ventricle but not in the SN and AV node. It is much more prominent in the purkinje and epicardial cells.

   Phase II (plateau phase) occurs when the action potential becomes relatively flat and does not occur in the SN or AV node.

   Phase III (rapid repolarization) occurs when there is restoration of the membrane potential to the resting phase.

2. Refractoriness describes the period during which a stimulus does not result in a new depolarization after phase 0 of the cardiac action potential. There are three different types of refractory periods (RP): relative, absolute and effective.

   The relative RP is the longest coupling interval resulting in local capture therefore marking the end of refractoriness.

   The absolute RP is the longest coupling interval which does not result in local capture.

   The effective RP is the longest coupling interval delivered which fails to propagate through the distal tissue.

3. Re-Entry occurs when a wave of excitation moves around a circuit which is determined anatomically, functionally or a combination of the two. For re-entry to occur the following conditions have to be fulfilled:

   There must be two or more pathways for conduction
   Unidirectional block in one pathway
   Alternative conduction over the other pathway with sufficient delay as to retrogradely invade the formerly blocked pathway

4. Automaticity results from spontaneous depolarization during phase IV of the action potential.
5. Afterdepolarizations are defined as depolarizations which occur after Phase 0 of the cardiac action potential and may result in a spontaneous action potential known as a triggered response. These are divided into early afterdepolarization (EAD) or delayed afterdepolarization (DAD).

   EAD occurs during phase II and phase III while DAD occur after the cardiac action potential is complete. EADs tend to occur when there is an increase in the inward movement of positive ions during the plateau phase of the action potential.

   DADs occur as a result of an increase in the inward movement of calcium. This can occur in the setting of digoxin toxicity or in conditions such as catecholamine induced polymorphic ventricular tachycardia (CPVT).
6. The RAO projection helps to demonstrate the postero-anterior (PA) location of a catheter within the cardiac chambers and shows the AV groove more clearly than the PA view. In this view the spine is on the left.
7. In the LAO view the AV rings are viewed parallel to the image. The left cardiac border is formed by the LA superiorly and the lateral wall of the LV inferiorly.
8. Following discharge from the SN conduction occurs through the RA predominantly utilizing aligned myocytes. Conduction occurs preferentially from the RA to the LA using the Bachmann's bundle.
9. AV conduction occurs through the AV junctional region, the atrial component of which is termed the AV node. This is located between the coronary sinus os and the septal leaflet of the tricuspid valve.
10. The His bundle is a continuation of the compact AV node. Although it has similar cellular components it is better insulated than the AV node and therefore is not as easily damaged with RF. The proximal bundle runs from the distal AV node to the fibrous tissue of the central body where it is termed the penetrating portion. Following this it bifurcates into the right bundle (RB) and left bundle (LB) branches at the level of the septal TV leaflet. The RB tends to have a more anterior origin than the LB.
11. The LB branch originates below the right and non-coronary cusps and then courses along the LV septal surface. It divides into two or three

fascicles. The anterior fascicle which is superior runs towards the base of the anterosuperior papillary muscle, the posterior fascicle which is inferior runs towards the posteroinferior papillary muscle and in 60% of cases a central or septal fascicle which runs to the mid septum. In the remaining 40% of cases this area is supplied by the anterosuperior and posteroinferior fascicles.

12. In LBBB the initial activation is rightward and anterior resulting in small q waves in I, avL, and V6 with an rS in V2. Following this depolarisation spreads from the apex to the base and to the RV free wall and apex. During this process, septal activation is the pre- dominant force and therefore the vector is anterior and to the left, resulting in a wide slurred QRS in I, aVL and V6. Depolarization then occurs in a leftward and posterior direction through the LV. Finally, the anterior wall of the LV is depolarized.
13. Anterior fascicular block results in a leftward QRS axis deviation poor R wave progression in V1-V3, with a negative QRS in II, III and aVF, positive in lead I. There is also a tall R wave in aVL and aVR. The QRS is not broad.
14. Posterior fascicular block results in a QRS axis greater than 100° with an rS morphology in leads I and aVL; and a qR pattern in leads II, III, and aVF. The QRS is not broad.
15. Septal fascicular block has a variable ECG appearances. In general the changes noted are Q waves in V1 and V2 as a result of anteriorly directly right ventricular depolarization. This may also cause a qrS in V1 and V2. There is also loss of q waves in leads V5, V6 and I due to loss or reversal of left to right ventricular septal activation. The QRS is not significantly broad because activation of the left ventricular free wall and apex occurs via the anterosuperior and posteroinferior fascicles.
16. The RB branch is an insulated bundle of fibers as a direct continuation of the penetrating atrioventricular bundle. It runs along the RV septum to the apex where it becomes subendocardial in the mid septum running along the posterior margin of the septal band, courses through the moderator band to the base of the anterior papillary muscle, and then the right ventricular free wall. It gives off septal branches which activate the septum almost immediately after left ventricular activation. Septal activation is generally complete within 35 ms and terminates in Purkinje fibres at the apex.
17. In RBBB the initial septal activation is followed by depolarization of the left ventricle, resulting in R waves in I, aVL and V6. Following this, right ventricular free wall and septal depolarization results in S waves in these leads. Overall, the QRS is ≥120 ms in adults with an rsr, rsR, or rSR in leads V1 or V2. The R or r deflection is usually wider than the initial R wave. ST segment deviation is generally discordant to the QRS vector.

18. Phase III dependent aberrancy also known as Ashman Phenomenon occurs when a short RR interval follows a longer RR interval. The longer RR interval results in a prolonged AP in the His and bundle branches. The right bundle has a longer AP duration than the left bundle and therefore the following beat with the shorter RR interval is blocked in the right bundle which is still refractory and conducts down the left bundle with a RBBB morphology.
19. Acceleration dependent aberrancy occurs with very slight acceleration of the heart rate (less than 5 ms) at a critical cycle length which is often within normal heart rate ranges. This tends to occur more commonly in the left bundle resulting in LBBB.
20. Deceleration dependent aberrancy occurs following a long pause during which a premature atrial beat conducts to the ventricle with a resultant bundle branch block.
21. Aberrancy due to concealed retrograde conduction occurs when retrograde conduction in one of the bundle branches from a PVC results in refractoriness for the next antegrade beat. As the bundle recovers the next beat which conducts down the contralateral bundle conducts retrogradely up the bundle again.

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Chapter 2
Cardiac Electrophysiology Study, Diagnostic Maneuvers and Ablation

Benedict M. Glover, Orla Buckley, Siew Yen Ho, Damian Sanchez-Quintana, and Pedro Brugada

Abstract The overall aim of an invasive electrophysiological (EP) evaluation is to accurately diagnose the mechanism and substrate responsible for a documented or suspected arrhythmia to treat the patient's symptoms or improve his/her prognosis. Significant developments in the understanding of arrhythmias as well as technological advances have allowed electrophysiology studies to be considered as a diagnostic first line option. This chapter discusses the fundamental principles of invasive electrophysiology and provides an essential guide in terms of establishing the correct diagnosis and ablation strategy.

Indications for an EP Study and Ablation

The overall decision on whether to perform an EP study and ablation depends on the balance between the potential benefits, alternative treatment options, risks as well as the individual patient preference. In general for symptomatic supraventricular

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arrhythmias an EP study and ablation should be considered early as the success rates are high and the results of pharmacological treatment are often suboptimal. The decision for the invasive management of AF and VT is often more complex and requires very careful examination of the patients symptoms and potential complications which must be balanced against alternative treatment options. As techniques and technology improve for more complex ablations the threshold for an invasive strategy is already clearly changing.

Supraventricular Arrhythmias (SVT)

Ablation can be considered as first line therapy for the treatment of symptomatic SVT due to AV nodal re-entry tachycardia (AVNRT), atrioventricular re-entry tachycardia (AVRT) or atrial tachycardia (AT) (Class I Indication, Level of Evidence B) [1]. Although it is ideal to have inducible tachycardia at the start of the EP study this is not critical and it is entirely reasonable to perform an ablation if either dual AV nodal anatomy or accessory pathway conduction is present in the setting of electrocardiographic evidence of an SVT.

The issue of ablation in the setting of asymptomatic ventricular pre-excitation is somewhat more complex. Ablation is indicated in patients with high-risk occupations such as pilots, scuba divers and school bus drivers [1]. Inducibility of AVRT in the absence of symptoms may be considered as an indication for ablation although this is not a clear cut decision and may also depend on patient and physician preference as well as the conduction properties of the pathway. Accessory pathways that can lead to rapid ventricular rates during atrial fibrillation should be ablated.

Atrial pacing may be used to calculate the antegrade refractory period of the AP with a measurement greater than 250 ms being considered lower risk. The **Shortest Pre-Excited R-R Interval** (**SPERRI**) may be a more useful measurement with an RR interval greater than 250 ms probably being associated with a lower risk. These measurements may help to guide the decision regarding ablation of an AP.

Typical Atrial Flutter

Typical atrial flutter involving the cavo-tricuspid isthmus (CTI) can be successfully ablated in the majority of cases. An ablation may be considered after a single episode of typical atrial flutter (Class IIa Indication; Level of Evidence B) or following a recurrent episode (Class I Indication; Level of Evidence B) [1]. Ablation can also be considered for atypical atrial flutter (Class IIa Indication; Level of Evidence B) although the overall success may not be as high as for typical atrial flutter [1] (Fig. 2.1).

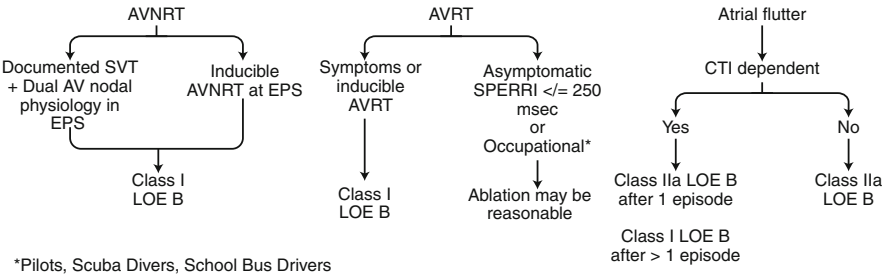


Fig. 2.1 Decision tree for ablation for AV Nodal Re-entry Tachycardia (*AVNRT*), AV Re-entry Tachycardia (*AVRT*) and Atrial Flutter regarding consideration for Catheter Ablation. *SPERRI* shortest pre-excited R-R interval)

Atrial Fibrillation (AF)

In order to consider a catheter ablation for a patient with AF the patient must have symptoms attributed to the arrhythmia. This is extremely important as symptoms may be non-specific and therefore it is often useful to consider an electrical cardioversion and reassess after sinus rhythm has been established. Additionally all patients who are being considered for a catheter ablation must be able to tolerate anticoagulation therapy at least during and after their ablation [2]. There is insufficient data to support routine withdrawal of oral anticoagulation following an AF ablation even if it appears successful and the longer term decision regarding oral anticoagulation should be based on the CHADS2VASC score [2]. This is because patients may continue to have asymptomatic episodes of AF which continue to pose a thrombo-embolic risk.

For patients with symptomatic paroxysmal AF catheter ablation can be considered if at least one Class I/III anti-arrhythmic drug has been tried and is ineffective or poorly tolerated. (Class I Indication, Level of Evidence A) [2]. Catheter ablation may also be considered prior to commencing a Class I/III antiarrhythmic drug in some patients with symptomatic paroxysmal AF. (Class IIa Indication, Level of Evidence B) [2].

Catheter ablation may also be considered in patients with symptomatic persistent AF not controlled effectively with at least one Class I/III antiarrhythmic drug. (Class IIa Indication, Level of Evidence A)

The recommendations and evidence for performing catheter ablation for symptomatic persistent AF prior to commencement of a Class I/III antiarrhythmic drug are not as strong. (Class IIb Indication, Level of Evidence C) [2]. Catheter ablation can also be considered for the management of longstanding persistent symptomatic AF (Class IIb Indication, Level of Evidence B) although the overall success for such a procedure may not be high. If available in the center, a hybrid ablation with thoracoscopic approach and closure of the left atrial appendage offers a better future in these patients [3] (Fig. 2.2).

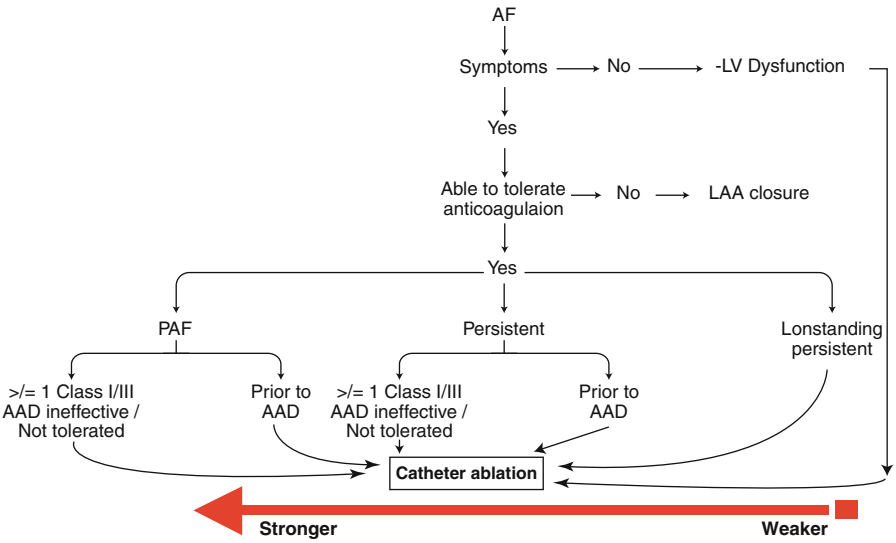


Fig. 2.2 Decision tree for consideration for catheter ablation for atrial fibrillation. *AAD* anti-arrhythmic drug therapy

Ventricular Arrhythmias

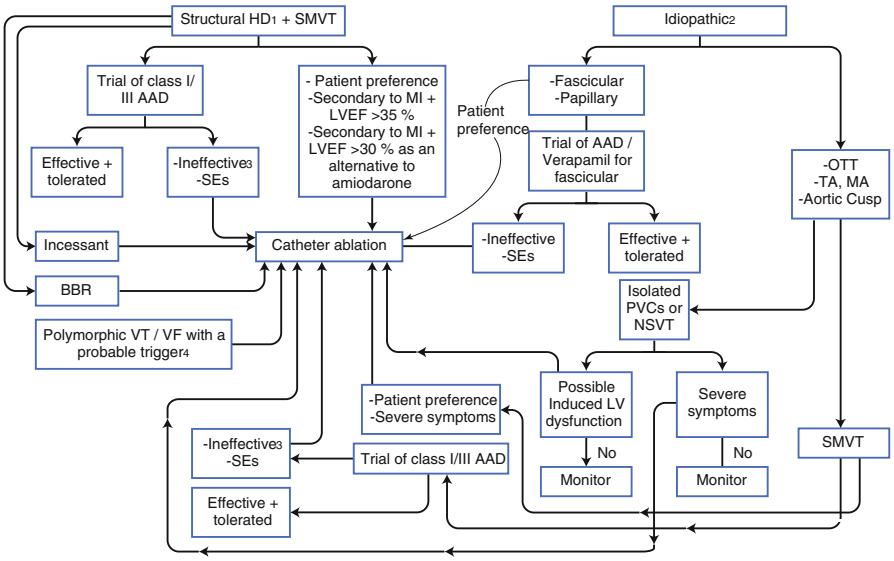
Catheter ablation is recommended for patients with sustained monomorphic VT including VT terminated by an ICD where anti arrhythmic drug therapy is either ineffective or not tolerated as well as the control of incessant VT [4].

It may also be considered when anti-arrhythmic drug therapy has not failed and in particular may be a suitable alternative to amiodarone therapy. Catheter ablation is also recommended for bundle branch re-entry VT and interfascicular VT and for patients with frequent PVC's or non sustained VT resulting in left ventricular dysfunction. It is not recommended for the treatment of asymptomatic PVC's or non-sustained VT not resulting in left ventricular dysfunction (Fig. 2.3).

EP Study and Ablation: Patient Preparation

The most useful test for any patient prior to an EP Study is an ECG or rhythm strip of the arrhythmia as this may guide the entire approach, chamber of access and threshold for potential ablation.

A baseline ECG should be performed as well as electrolytes and urea, full blood count and an international normalized ratio for patients taking warfarin [5].



1 Previous Myocardial Infarction; Dilated cardiomyopathy; ARVC; Congenital Heart Disease

2 Outflow Tract Tachycardia; Annular Tachycardia, Aortic Cusp Tachycardia; Fascicular VT; Papillary Muscle VT

3 ≥ 1 episode of MSVT despite the use of ≥ 1 antiarrhythmic drug

4 For either structural or idiopathic VT

Fig. 2.3 Decision tree for the ablation of ventricular arrhythmias. *HD* heart disease, *SMVT* sustained monomorphic VT, *SE* side effects, *BBR* bundle branch re-entry, *OTT* outflow tract tachycardia, *TA* tricuspid annulus, *MA* mitral annulus

Additionally a pregnancy test in any female of childbearing age should be checked within the 2 weeks prior to the procedure [5].

For potentially high risk procedures a group and crossmatch should be considered.

In general for most diagnostic studies anti-arrhythmic drugs should be stopped for at least 5 half lives. This is not required in patients undergoing catheter ablation unless an EP study or rotor mapping is also being performed.

EP Study and Ablation: Potential Risks

The risks associated with EP studies and ablation vary greatly depending on the procedure being performed. General complications include groin hematoma, vascular injury and pericardial effusion. More specific complications may occur in AF and VT ablations. In general many of these risks can be significantly minimized if care is taken and appropriate action taken. These risks, as well as preventative measures are summarized on Table 2.1.

Table 2.1 Reported incidence, features, prevention and management of potential complications associated with EP procedures

Complication	Features	Prevention and management	Reported incidence (%)	
Groin hematoma Pseudoaneurym AV Fistula	Swelling Tenderness Bruit	Careful palpation of femoral artery Medial approach to the vein Careful post procedure groin management	SVT	0.3 [6] – 0.4 [7]
			AF	1.8 – 2.7 [8]
			VTs	2.0 – 3.6 [9]
			VTsn	0.7 – 0.8 [10]
AV Block	PR prolongation Loss of AV conduction	Map His prior to ablation If close to compact AV node consider lower energy RF or cryoablation Monitor for Accelerated Junctional rhythm, loss of VA conduction, prolongation of AH or PR interval	SVT	0 [7] – 1 [11]
			AF	0.1 [8] – 0.2 [12]
			VTs	0 [6] – 1.6 [13]
			VTsn	0 [6] –0.4 [10]
Coronary Artery Injury	ST elevation Chest pain	Careful use of RF in certain locations of the coronary sinus, LVOT, epicardium. Do not deliver RF if closer than 5 mm	SVT	0 [7] – 0.1 [14]
			AF	0 [7] –0.1 [15]
			VTs	0.6 (epi) [16]
			VTsn	<0.1 [17]
Pericardial Effusion	Hypotension Tachycardia Change in left heart border motion in LAO view Accumulation of pericardial effusion on ICE/TEE	Caution when manipulating catheter, sheaths and wires Cautious use of RF in certain areas considered higher risk such as RVOT, RV apex, RV free wall, LAA, LA roof and LA posterior wall Monitor closely during trans–septal access	SVT	0.4 [18] – 1.0 [7]
			AF	1.8 [7] – 2.5 [8]
			VTs	1.4 [7] – 2.7 [19]
			VTsn	1.3 [20] – 1.7 [7]
Thrombo-embolism	TIA/stroke Systemic embolism	Maintain ACT greater than 350 s for left sided ablations Use of heparinized saline through sheaths on left side Careful use of equipment to ensure no air embolism	SVT	0 [7] – 0.2 [11]
			AF	0.3 [7]–1.0 [5]
			VTs	0.8 [7]–2.7 [18]
			VTsn	0.8 [7]
Phrenic Nerve Injury	Loss of movement of hemidiaphragm, post procedure dyspnea, pleural effusion, consolidation on CXR	Monitor movement of hemidiaphragm Pacing from ablation catheter to monitor for phrenic nerve capture	SVT	<0.1
			AF	0.2 [9]
			VTs	<0.1
			VTsn	<0.1

VTs VT ablation in the setting of structural heart disease; *VTns* VT ablation in structurally normal ventricle; *Epi* Epicardial

Collateral Damage During Ablation

Pericardial Effusion

Pericardial effusion may occur as a direct result of catheter, sheath or wire manipulation as well as during or after trans-septal access or as a direct result of catheter ablation. It is therefore important to be gentle with all of the equipment being used. Some regions within the heart are particularly thin and extra caution should be taken. As demonstrated in Fig. 2.4 these regions include the RV apex, RV free wall, RVOT, LAA, LA posterior wall and LA roof. A pop and/or sudden rise in impedance during ablation may be associated with perforation. The incidence of perforation resulting in either a pericardial effusion or tamponade is 1.3 % for all EP procedures [7]. For SVT ablations this is 0.2 %, 1.8 % for patients undergoing catheter ablation for AF, 1.7 % for VT in a structurally normal heart (predominantly outflow tract tachycardia) and 1.4 % in patients with structural heart disease undergoing VT ablation [7].

Although the pericardial space may accommodate up to 500 cc of fluid accumulated over a long period of time decompensation may occur with 50–100 cc when

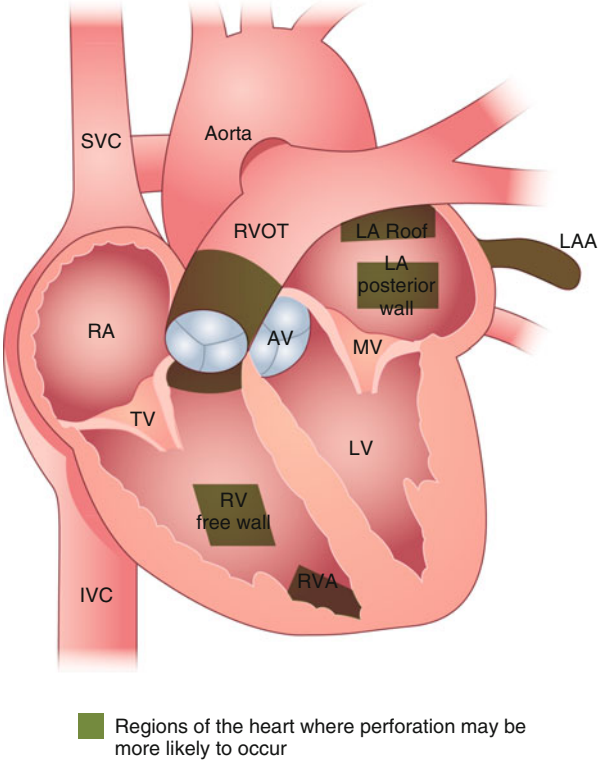


Fig. 2.4 Diagrammatic representation of regions of the heart which are at an increased risk of perforation during instrumentation with catheters and wires; *SVC* superior vena cava, *IVC* inferior vena cava, *RA* right atrium, *TV* tricuspid valve, *RV* right ventricle, *RVOT* right ventricular outflow tract, *LA* left atrium, *LV* left ventricle, *LAA* left atrial appendage

fluid accumulation occurs quickly. This tends to be most evident around chambers with the lowest pressures first; the RA followed by the RV, LA and finally the LV. Accumulation may also be localized and therefore may occur on the left side prior to the right side.

The accumulation of a significant pericardial effusion may be associated with an increase in heart rate with or preceding a drop in blood pressure. It must also be noted, however, that an increase in sympathetic drive may initially result in an increase in the blood pressure. Pericardial stretch may occasionally result in an increase in parasympathetic tone with a transient bradycardia and hypotension. A drop in blood pressure is a relatively late sign of acute pericardial effusion and it is therefore important to monitor for earlier signs.

A reduction in the left lateral wall excursion in the LAO fluoroscopic view has been shown to be associated with pericardial effusion [21]. This occurs as the pericardium is relatively fixed to the spine and the sternum and therefore fluid in the pericardial space is more likely to accumulate posterolaterally followed by anterolaterally. The accumulation of pericardial fluid during ablation can easily be observed using Intracardiac Echo (ICE) or Trans-esophageal echo (TEE). The accumulation of a small pericardial effusion detected on ICE during an AF ablation may indicate an increase in the risk of a late post procedure pericardial effusion while no evidence of effusion on ICE indicates a very low post procedural risk.

All EP laboratories should have equipment for emergency pericardiocentesis including rapid access to echocardiography. In order to keep this as simple as possible the needle used to access the femoral vein and a 0.35 wire can be kept on the table for rapid access. After confirmation that the wire is within the pericardial space by pushing it as far as possible and ensuring that it is not within one or more cardiac chambers a short sheath and a pigtail catheter can be used to rapidly drain the effusion.

Phrenic Nerve Injury

The right phrenic nerve runs alongside the SVC and passes laterally along the RA running anteriorly to the right pulmonary veins passing more closely to the superior than the inferior right pulmonary vein (Fig. 2.5). The left phrenic nerve runs over the fibrous pericardium with a variable course over the LA and LV and terminates in the left hemidiaphragm. The incidence of phrenic nerve palsy following an AF ablation is approximately 0.2% [8] and more commonly affects the right than the left side. This generally occurs with isolation of the right superior pulmonary vein or the superior vena cava. Left phrenic nerve palsy is less common but may occur in left atrial appendage ablation. The incidence of phrenic nerve palsy is much higher with cryoablation and has been reported to occur in approximately 6% of cases although it is usually transient [22].

Various techniques may be used to help map the location of the phrenic nerve before or during catheter ablation. Pacing at high output may be performed in order to assess for phrenic nerve capture. This should be discussed with the anesthesiologist

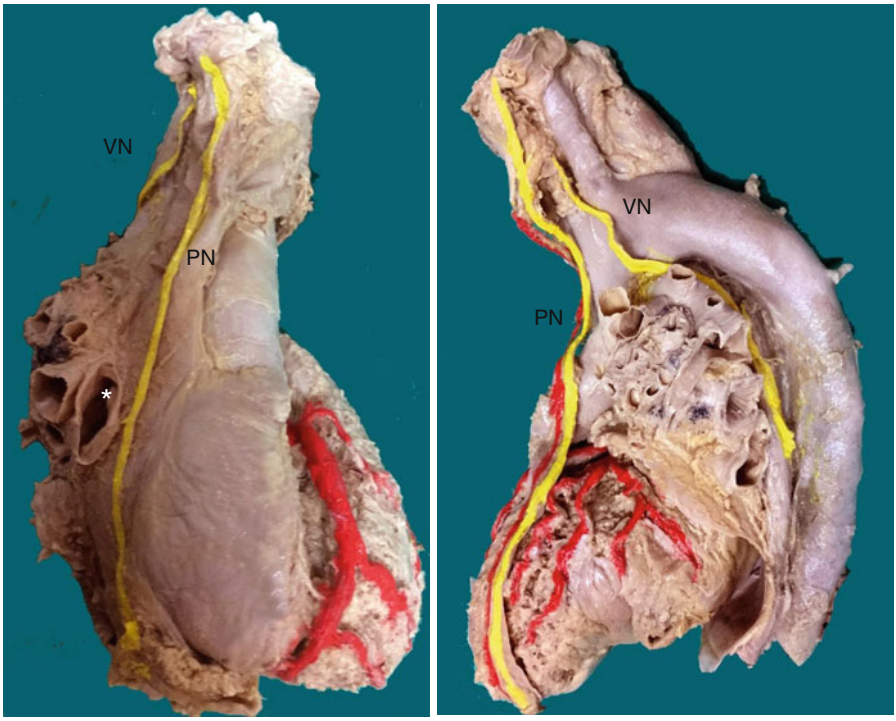


Fig. 2.5 Anatomical images showing the course of the right phrenic nerve (PN) on the *left image* and the left phrenic nerve (PN) on the *right image*. The right lareral view on the *left* shows the close relationship of the right PN to the right inferior pulmonary vein (*). The vagus nerve is also seen in both images

prior to performing this maneuver as muscle relaxants are often administered which will inhibit the effects of pacing on the phrenic nerve. Additionally the diaphragm can be monitored using fluoroscopy during ablation in the absence of nerve paralytic agents. More novel techniques such as recording electromyograms from the diaphragm have been described in which either a catheter is positioned in the hepatic vein or modified surface electrodes are positioned over the diaphragm with pacing performed from either subclavian vein.

Phrenic nerve palsy is generally noted on CXR as an elevated hemidiaphragm and may be associated with dyspnea, a cough or hiccups. The majority of phrenic nerve palsy recovery within 9 months.

Esophageal Injury

As shown on the CT scan in Fig. 2.6 the esophagus is immediately posterior to the LA separated by a thin layer of fibrous pericardium and a layer of fibrofatty tissue containing esophageal arteries as well as the vagus plexus. The distance between the

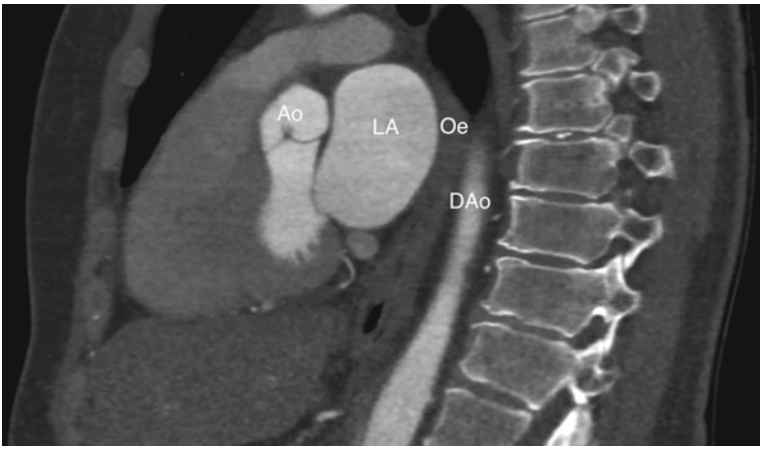


Fig. 2.6 CT showing proximity of esophagus to the posterior wall of the left atrium. In this lateral image the ascending aorta (*Ao*) is anterior to the left atrium (*LA*). The oesophagus (*Oe*) is posterior to the left atrial wall. Also seen in this image is the descending aorta (*DAo*)

posterior wall of the LA and the anterior portion of the esophagus is variable but may be as little as 5 mm [23]. The location of the esophagus may run either central to the posterior wall of the left atrium, towards the left pulmonary veins or towards the right pulmonary veins as is generally closer at the atrial pulmonary vein junction and in more inferior locations. Although the esophagus can be clearly visualized on a pre-ablation CT scan the esophagus is a mobile structure and therefore the location may change during the procedure.

Esophageal injury occurs predominantly as a result of direct thermal injury from catheter ablation along the posterior wall of the LA. Other contributing factors may include damage to the arterial flow to the esophagus as well as to the vagus nerve and plexus. This may result in mucosal erythema, esophagitis or atrioesophageal fistula. Discrete mucosal changes have been noted to be present in approximately half of all patients who undergo catheter ablation for AF with almost one fifth developing esophageal ulceration [24].

The incidence of fistula formation between the left atrium and the esophagus as a result of catheter ablation for AF ranges from 0.03 [25] to 0.2 % [26].

Symptoms relating to atrio-esophageal fistula may occur from 3 days to 6 weeks post ablation and are often non specific. The most common is a pyrexia followed by neurological symptoms relating to thrombo-embolism. Other symptoms include chest pain and dysphagia. The white cell count is generally elevated. Management depends on acute recognition of the condition followed by surgical repair.

Although the esophagus can be visualized pre-procedure this is generally unreliable due to intra-procedural movement. The esophagus can be visualized during ablation using fluoroscopy with a marker such as a naso-gastric tube, a temperature probe or barium paste. This requires fluoroscopy being performed during ablation

along the posterior wall of the left atrium and although it marks the lumen of the esophagus it does not provide an accurate distance from the ablation catheter to the most anterior aspect of the esophagus.

Esophageal temperature monitoring is performed by some operators using a temperature probe. Evidence for the efficacy in preventing esophageal injury is limited and conflicting and overall there is no general consensus as to whether luminal esophageal temperature is a good predictor of mucosal injury.

It is generally considered reasonable to limit maximum power to 25–30 W and to spend no longer than 30 s on one region when ablating along the posterior wall of the left atrium. It is also common to prescrive proton pump inhibitors post ablation in order to reduce the effects of acid reflux on the esophagus.

Coronary Artery Injury

This may occur if ablation is performed in close proximity to a coronary artery such as the aortic cusps. Other regions where ablation may be in close proximity to a coronary artery or one of its branches include the coronary sinus (as shown in Fig. 2.7), great cardiac vein, CTI, mitral annulus, base of the LAA or in the epicardium.

Endocardial ablation of accessory pathways along the mitral and tricuspid annulus carries a low risk of coronary artery stenosis. The risk is increased when ablation is performed in the proximal CS which may be the optimal location for posteroseptal AP's as well as occasionally the slow pathway and focal atrial tachycardia's. The posterolateral branch of the RCA or the circumflex coronary artery often run closely to this location and this may be a closer to the anterior and inferior walls of the

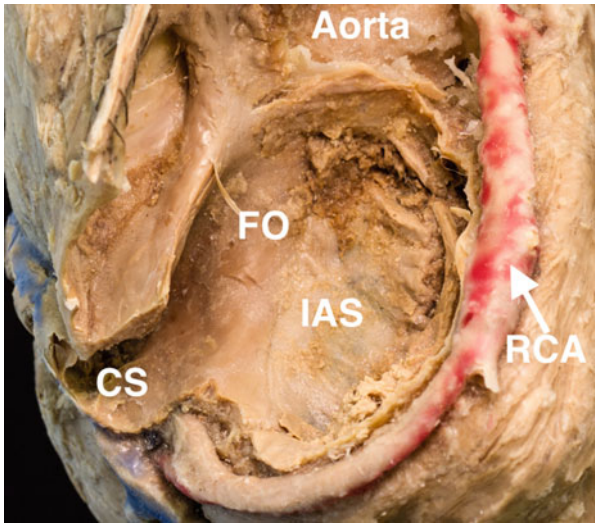


Fig. 2.7 Anatomical images showing proximity of the right coronary artery (*RCA*) to the coronary sinus (*CS*). The RCA originates in the right coronary cusp of the aortic root and courses along the right atrioventricular grove anteriorly and inferiorly where it eventually courses towards the proximal coronary sinus (*CS*). In this region there is close proximity to the CS. Also shown in this image is the right ventricular outflow tract (*RVOT*) and the fossa ovalis (*FO*)

CS. If ablation is being performed in this location a coronary angiogram should be considered and a minimum distance of 5 mm should be maintained between the site of ablation and the coronary artery.

Ablation in the distal cardiac vein for PVC's along the epicardial annulus may also result in coronary artery damage and similar precautions have to be taken in terms of distance.

Epicardial ablation is now increasingly performed particularly for non-ischemic VT and to a lesser degree ischemic VT. Coronary CT or angiography should be performed in these cases prior to ablation.

Important Note on Ionizing Radiation

Ionizing radiation may result in molecular injury to the DNA. In the EP laboratory this is measured in Grays (Gy) or Sieverts (Sv). One gray is defined as the absorption of 1 J of ionizing radiation by 1 Kg of matter. The equivalent dose Sievert is the absorbed dose in Gy multiplied by the radiation weighting factor which varies according to the source of radiation and is 1 for X-rays. This can be further modified in order to calculate the effective dose when the radiation is predominantly exposed to certain regions of the body. It is important to achieve as low as reasonably achievable (ALARA) radiation doses. This can be achieved by reducing the frame rate to as low as possible, minimizing the duration of time performing fluoroscopy and not taking cine images. The development of 3 D mapping systems has had a significant impact on reducing the need for fluoroscopy particularly in complex ablations.

Administration of Sedation and Anesthesia

The requirements for sedation and anesthesia vary according to the precise procedure being performed. For EP studies minimal doses of sedation are given for anxiolytic effects as larger doses may reduce the inducibility of the arrhythmia particularly in adrenaline sensitive focal atrial tachycardia and outflow tract tachycardia. Moderate doses of sedation are often required for ablation and in particular for performing anatomical lesions such as a cavotricuspid isthmus ablation. Ablation for AF and complex VT may be performed with moderate to deep sedation or general anesthesia. There are several potential advantages to the use of general anesthesia in such procedures such as minimizing patient discomfort and movement thus facilitating 3D mapping as well as allowing the use of TEE visualization. Care must be taken in order to minimize the doses of paralytic agents when assessing for phrenic nerve capture.

Benzodiazepines and opioids are used in the EP laboratory for their anxiolytic and partial amnesic effects. If these agents are used it is ideal to administer low

doses before the procedure is performed in order to assess the effect on the individual patient. All patients undergoing any procedure involving the administration of intravenous sedation should have a history and rapid airway assessment prior to starting the procedure. Ideally there should be involvement of an anesthesiologist. It is also advisable to have an individual whose sole purpose is to monitor the patient's respiratory rate, oxygen saturations as well as heart rate and blood pressure throughout the procedure. All patients should be closely monitored post procedure until their vital parameters have returned to normal limits.

The most common benzodiazepines used in the EP laboratory are midazolam and diazepam. Although either of these agents can be used midazolam tends to have a shorter duration of action particularly in the elderly or in those with reduced cardiac output, respiratory depression, hepatic and renal impairment.

Midazolam can be administered at a dose of 0.03–0.07 mg/kg over 2 min for most adults adult with additional doses given after 3 min, if required, at 25 % of the initial dose. Generally no more than 10 mg is needed for the entire procedure.

Midazolam tends to have less effect on suppression of induction of supraventricular tachycardia compared to diazepam. Routine administration of the benzodiazepine antagonist flumazenil should not be performed and this should be reserved only for cases of significant over sedation. A dose of 0.2 mg over 15 s with another dose of 0.2 mg after 45 s and then every 1 min up to a maximum dose of 1 mg should be used. The patient should be monitored closely for 2 h in order to ensure that there are no further sedative effects as the drug effects wear off.

Fentanyl is a useful opioid which can be administered at the start of the case at a dose of 0.5 microgrammes/kg if used with a benzodiazepine or 2 microgrammes/kg if used alone. The effects can be re-assessed after 15 min and a further 25 % of the initial dose administered if required. The overall duration of action is approximately 30–60 min. If used in conjunction with a benzodiazepine fentanyl may result in respiratory depression and therefore monitoring is required. The effects of fentanyl can be partially reversed by naloxone at a dose of 0.1–0.2 mg over 2 min.

Propofol is frequently used in the EP laboratory. The individual responsibility for this depends on the country where the procedure is performed. Propofol is generally administered at a dose of 0.5 mg/kg over a period of 3–5 min. Further doses may be administered in 5 mg boluses if required. It has no significant electrophysiological effects on arrhythmia induction.

Very occasionally propofol infusion syndrome may occur particularly at higher doses and for longer periods of time. This may occur as a result of mitochondrial respiratory chain inhibition or impaired fatty acid metabolism and results in acute refractory bradycardia leading to asystole with either metabolic acidosis, rhabdomyolysis, hyperlipidaemia, and or fatty liver. Coved type ST elevtaion with RBBB occurs in the precordial leads. The only effective treatment for this condition is haemodialysis or haemoperfusion with cardiorespiratory support.

Peri-procedural Anticoagulation

For the majority of right sided ablations anticoagulation is not required although some operators choose to give low dose heparin in order to try to lower the potential risk of deep venous thrombosis and pulmonary embolism. For left sided ablations intravenous heparin is administered aiming for an Activated Clotting Time (ACT) of greater than 350 s. In patients who are already taking oral anticoagulation the decision to continue, discontinue or bridge with heparin depends on the risks of thrombo-embolism compared to the risk of bleeding.

Patients undergoing ablation for AF are at an increased risk of thrombo-embolism due to a combination of pre-existing factors involved in Virchow's triad as well as potential for embolic formation during ablation in the left atrium and possible reversion from AF to normal sinus rhythm. The need for pre-procedural anticoagulation depends on the patients CHADS2VASC score. If this is 0 then anticoagulation is generally not required pre-ablation however in all other cases therapeutic anticoagulation is recommended for a minimum period of 4 weeks [2] (Table 2.2).

Even in patients considered to have a low baseline CHADS2VASC score there is an increased risk of thrombo-embolism post ablation. This occurs as a result of endothelial injury as well as potential mechanical dysfunction of the left atrium post ablation. As shown in Fig. 2.8 manipulation of ablation and mapping catheters and guidewires results in endothelial injury and activation of factor XII which results in intrinsic pathway activation and tissue factor which activates the extrinsic pathway. It is therefore necessary to administer heparin for left sided ablations aiming for an activated clotting time (ACT) of 350 s [2] even in patients who are receiving warfarin. In patients who are allergic to heparin bivalirudin may be considered.

It is recommended that oral anticoagulation is continued for at least 8 weeks post ablation in these patients and long-term in patients with a higher risk of thromboembolism [2].

The choice of whether to continue with oral anticoagulation compared with heparin bridging is largely dependent on individual operator and center experience. Continuation of warfarin during catheter ablation for AF is likely superior to bridging with heparin with reported lower rates of thrombo-embolism, pericardial effusion and major bleeding [27]. Although there is limited data regarding the use of uninterrupted direct oral anticoagulants in AF catheter ablation given the shorter half life of the direct oral anticoagulants minimal interruption can be performed pre-ablation and appears to be effective particularly if a pre-procedure

Table 2.2 Pharmacological properties of Warfarin and direct oral anticoagulants

Drug	Mechanism of action	Time to peak (h)	T1/2 (h)	Renal excretion (%)
Warfarin	Vitamin K antagonist	96–120	40	0
Dabigatran	DTI	1–2	12–17	80
Rivoroxaban	Xa inhibitor	2–3	7–11	33
Apixaban	Xa inhibitor	1–2	12	25

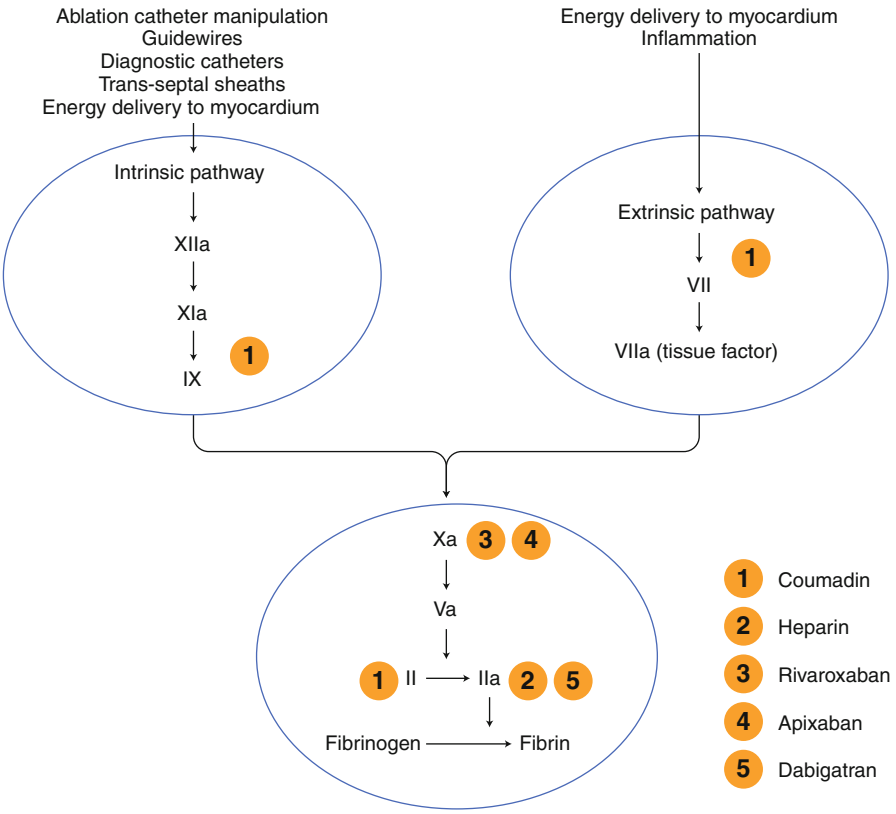


Fig. 2.8 Effect of catheter ablation, sheath and wire manipulation on the coagulation cascade and pharmacological intervention

transesophageal echocardiogram (TEE) is performed. In general provided the patient has normal renal function the last dose of oral anticoagulant can be administered 24 h pre ablation with the first dose post procedure administered 4 h after sheath removal.

EP Laboratory Set-Up

The EP lab is composed of an EP recording system, a stimulator, a RF generator with the potential for irrigation and an electroanatomic mapping (EAM) system as well as a cryoablation system and the cables and interfaces which connect these systems. Additional to this is resuscitation (at least one defibrillator with rapid access to a second and ventilation equipment) and fluoroscopic equipment for image acquisition (Fig. 2.9).

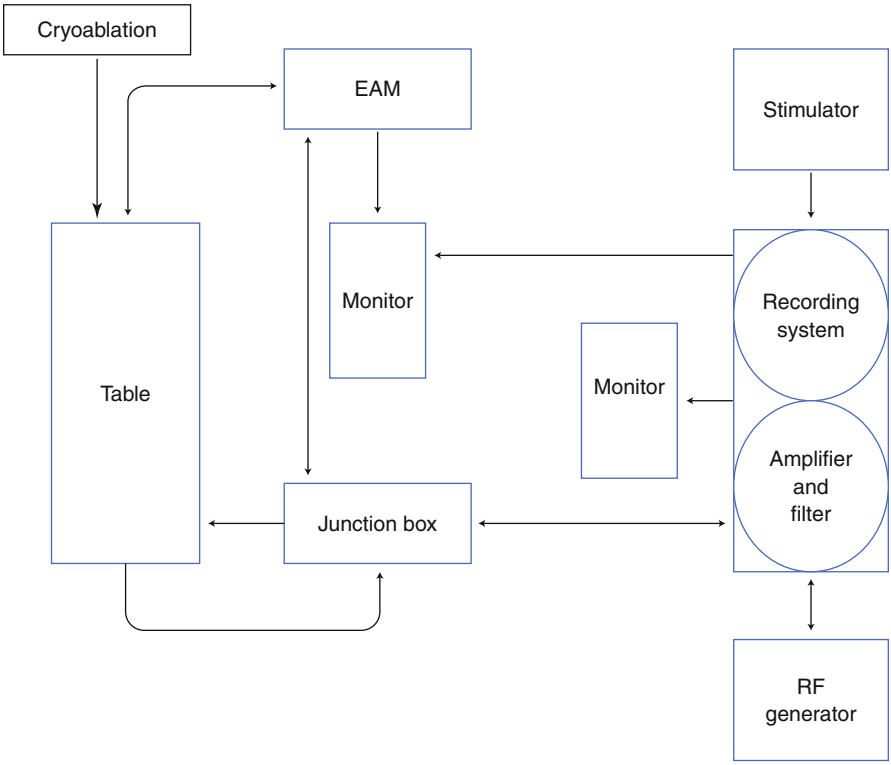


Fig. 2.9 Diagrammatic representation of a typical setup for an EP laboratory. *EAM* electroanatomic mapping system

How Electrograms Are Derived: Amplification and Filtering

Electrograms recorded in the heart are generally less than 5 mV in amplitude and often as small as 0.01 mV in scarred tissue. In order to display these signals they must be amplified and filtered. Signals may be amplified up to 10,000 times prior to being filtered.

The amplified signal then passes through a **high pass filter**. This allows higher frequency signals to pass through while removing signals below a designated frequency. On the **surface ECG** this is set very low at **0.05 Hz** therefore allowing a larger range of low frequencies to pass through. For **bipolar intracardiac signals** this is set higher at **30 Hz** which therefore filters out a larger range of low frequencies that may occur as a result of catheter movement, electrical farfield or respiratory variability.

For **unipolar intracardiac signals** where the morphology of the signal is more relevant the setting is similar to the surface ECG at **0.05 Hz** or else switched off.

This signal then passes through an isolation amplifier which isolates the current from the patient and is subsequently transmitted through a **low pass filter**. This

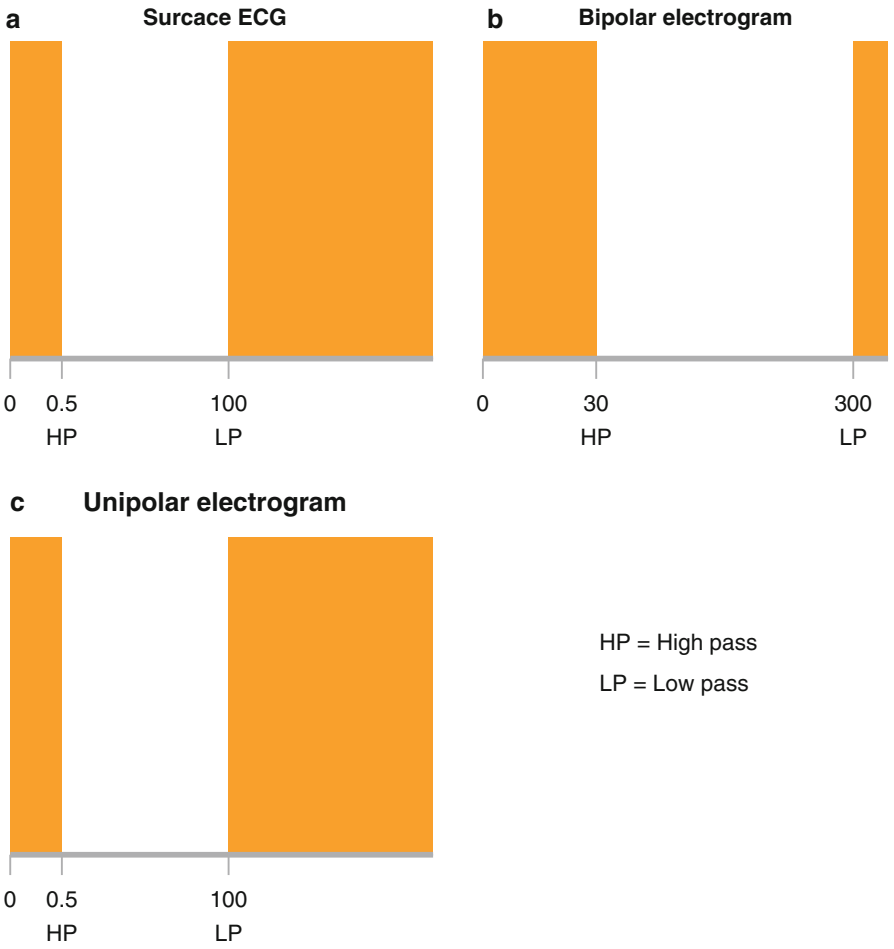


Fig. 2.10 High Pass (*HP*) and Low Pass (*LP*) settings for the surface ECG (**a**), Bipolar intracardiac electrograms (**b**) and Unipolar intracardiac electrograms (**c**)

allows lower frequency signals to be transmitted while filtering out higher frequencies. This is generally set at **300 Hz for bipolar intracardiac electrograms and filtered and unfiltered unipolar electrograms and 100 Hz for surface ECG signals** (Fig. 2.10).

Additionally most EP systems have a **notch filter**, which removes signals at a specific frequency range generally in the range of electrical frequency. This is often set at **50 Hz in Europe and 60 Hz in North America** and is designed to reject interference outside of the range around this. This also has several potential disadvantages including a reduction in the amplitude of certain electrograms such as pulmonary vein potentials as well as the potential to add interference.

Electroanatomic mapping systems have their own high pass and low pass filters programmed and can also be adjusted and are generally set with the range of

30–500 Hz for intracardiac electrograms. For unipolar electrograms the low pass is either minimized or switched off in order to reduce artifact on the signal. If the standard settings are kept on for unipolar signals often an artefactual R wave may appear on the signal.

Despite filtering of signals the best policy is to minimize noise in the first place. This can be due to direct electrical interference from other devices in the lab, leakage current from other devices as well as electrical cables which may be closely coupled with cables transmitting electrograms. It is therefore important when designing the EP laboratory in the first place that electrical cables are not positioned beside cables used for transmitted electrocardiograms. **Leakage current** is the total current from patient connections through the patient to earth and is required to be less than **10 μA** [28]. This cumulative current also may result in considerable electrical interference which must be filtered.

Noise which occurs specifically during ablation may often be due to the fact that the pacing function is enabled at the distal electrode at the same time as the ablation function. This is the result of a slight difference in the current between the distal and proximal poles which exists even when pacing is not being performed.

Other potential causes include problems with the ablation catheter or cable, issues with the grounding pad and inadequate gel on the back patch.

Electrogram Signals: Unipolar and Bipolar

Electrogram signals occur as a result of voltage gradients which occur between myocytes at different phases of the cardiac AP. **Unipolar electrograms** are amplified signals which are recorded between the distal pole of the catheter (+) and Wilsons Central Terminal (−) and are in essence bipolar signals between two regions spaced far apart. This therefore records both near and farfield, the latter of which may distort the local signal.

Bipolar signals are amplified signals recorded from two closely spaced unipoles. In general the distal pole is negative while the proximal pole is positive. Bipolar recordings are affected by the direction of the wave front with respect to the electrode orientation, electrode spacing and configuration and are generally considered more useful in clinical practice.

Both types of signal can be used in cardiac mapping for example in exit site and accessory pathway localization where a deep Q wave with no R wave may indicate proximity to the activation site in unipolar electrograms [29]. This is not perfect for localization of the focus. As shown in Fig. 2.11 during a PVC originating from the LV inferior wall there is a deep Q wave with no R wave in the ABL WCT electrogram. Despite this the electrogram is not significantly earlier than the surface QRS. Although this was the earliest unipolar and bipolar electrogram on the endocardium this focus was found to be located on the epicardial surface.

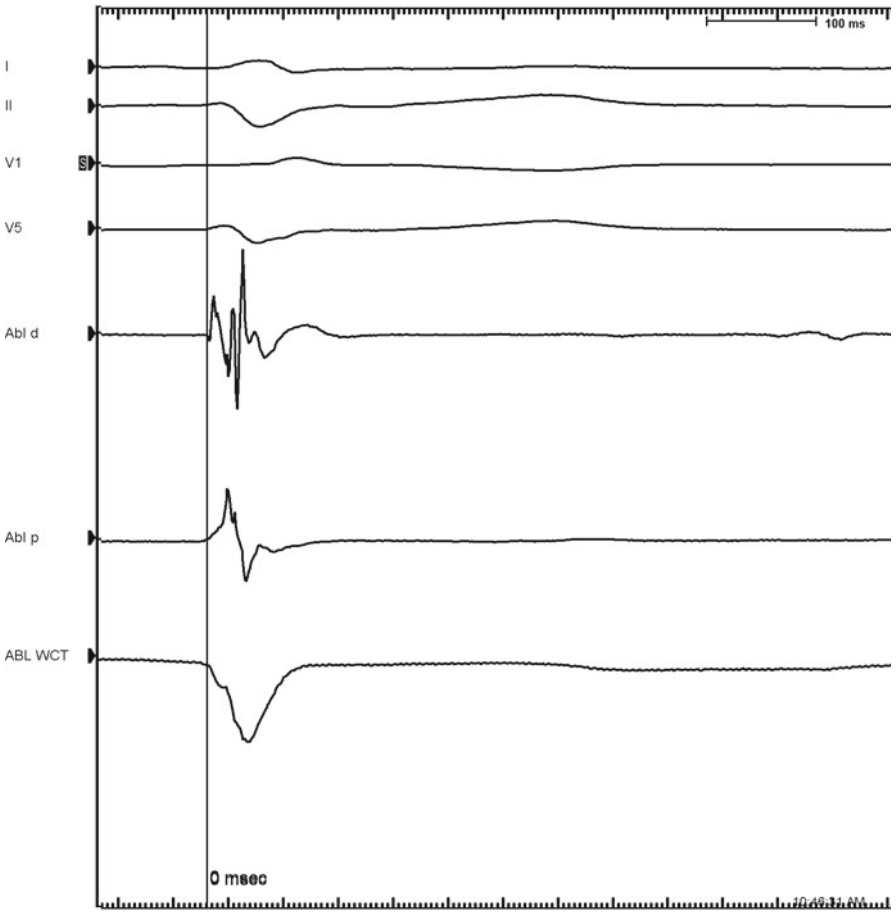


Fig. 2.11 A PVC originating from the inferior LV wall. The bipolar and unipolar electrograms are on time with the onset of the surface QRS. The unipolar electrogram has no R wave and a deep Q wave. Although this indicated activating moving away from the catheter the fact that the signal is not early indicated that this was not the focal site of the PVC. This was mapped to the epicardial surface of the inferior wall of the LV where the local signal was 20 ms ahead. (Abl d is recorded as a bipolar electrogram recorded from the distal electrode on the ablation catheter, Abl p is the bipolar electrogram recorded from the proximal electrode on the ablation catheter, ABL WCT is the unipolar electrogram recorded from the distal electrode on the ablation catheter to Wilson's Central Terminal)

RF Generation and Ablation

Radiofrequency (RF) energy is the most commonly used energy source using for creating an ablation lesion. The generator produces a continuous sinusoidal waveform at a frequency between **500** and **1000 KHz** which is then delivered between

the catheter tip and a patch electrode placed on the skin. As a result of the difference in the surface area between the tip of the ablation catheter and the dispersive electrode pad the maximum zone of resistive heating, which is directly related to current density is generally within 2 mm of the catheter tip. The majority of this is lost in the blood flow as blood has a lower resistance than myocardium.

The rest of the lesion, which is in fact the majority, is formed by conductive heat. This diminishes as a function of $1/r^4$ where r is the distance from the point of maximum resistive heating. The size of the lesion increases as the temperature increases. In general an irreversible lesion occurs at or above 50 °C. If the temperature at the electrode-tissue interface rises to greater than 100 °C the tissue immediately adjacent to the electrode forms a coagulum and a steam pop is heard.

The actual impedance during RF ablation is dependent on the tissue in contact with the catheter, the temperature, body characteristics, catheter properties, cables and reference patch. During the delivery of RF in order to create a lesion there is generally a reduction in the impedance of greater than 10 Ω. A sudden rise in the impedance as shown in Fig. 2.12 is often associated with a steam stop and potential perforation.

A thermocouple incorporated into the tip of the ablation catheter measures the temperature. In temperature guided ablation the temperature of the ablation electrode is set at the start of the ablation and automatically adjusts power output to

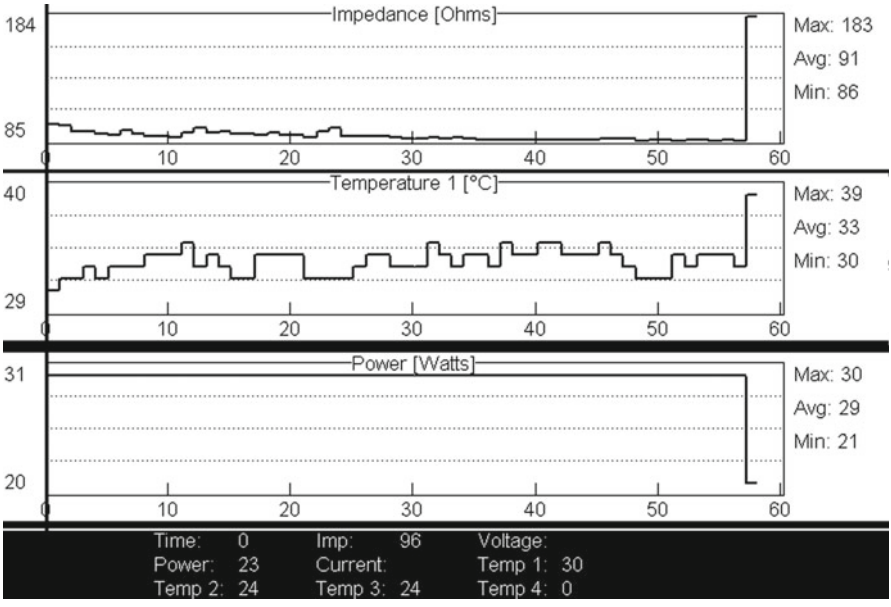


Fig. 2.12 RF ablation in the left atrium using a 4 mm irrigated catheter. There is a sudden rise in impedance and temperature at the interface between the catheter and the endocardium. This results in a steam pop

achieve a targeted electrode temperature of between **55** and **70 °C**. Ablation can also be set at a power limit so that RF is delivered until a certain power is achieved.

Lesion sizes are usually 5 mm in diameter but can be increased by the use of a larger diameter ablation catheter or with the addition of irrigation, which flushes the tip of the catheter.

Cryoablation

Cryoablation has been used in the ablation of slow and accessory pathways anatomically close to the compact AV node as well as in pulmonary vein isolation (PVI). There are several potential benefits in the use of this modality. Following the application of cryoablation there is an initial degree of reversibility in lesion formation, particularly between −10 and −25 C. This confers the potential advantage in the case of ablation of a nodal or accessory pathway that is close to the compact AV node where the risk of AV block is considered to be significant. Permanent tissue damage occurs at temperatures less than −50 C.

During the application of cryoablation the catheter tends to remain stuck to the tissue which results in increased catheter stability.

The concept relies on localised hypothermia at the catheter endocardial surface. There are three biophysical phases to this process.

1. Freezing – thawing phase
   This occurs acutely during delivery of cryoablation. During the first few minutes this may be reversible. Microscopic extracellular ice formation occurs as the temperature drops below −15 °C. Intracellular ice formation then occurs as the temperature drops to less than −40 °C. As a result of this there is an increase in ion concentrations in the extracellular space which becomes hypertonic resulting in a shift of fluid from the intracellular space to the extracellular space. This results in a reduction in intracellular pH causing mitochondrial damage. There is progressive microcirculatory vasoconstriction resulting in further localised damage to the local tissue. Following the completion of localised freezing passive rewarming occurs knowing as thawing. This results in fusion of the ice crystals with further cellular damage as well as resulting in microvascular occlusion as a result of platelet aggregation and microthrombi formation.
2. Hemorrhagic – inflammatory phase
   As thawing continues the changes in the microvasculature result in regional hyperemia and tissue edema with microscopic hemorrhagic changes and inflammation. This tends to occur within 48 h of the thawing process and may continue for up to 1 week.
3. Replacement – fibrosis phase
   Replacement fibrosis and apoptosis of cells near the periphery of the lesion occurs within the first week and up to 3 months after the delivery of the lesion. Neovascularisation and collagen remodelling occurs until finally a fibrotic scar forms.

Ablation Catheters

Ablation catheters in their simplest form delivery energy to the myocardium while providing feedback in terms of tissue temperature and impedance. They vary in the size of the tip electrode as well as ability to delivery irrigation. Some catheters also provide feedback in terms of contact force data. The majority of available catheters tend to have a platinum tip. Other materials such as gold have also been studied and also appear to be efficacious.

Ablation Catheter Size

Larger electrode sizes have a larger percentage of surface area exposed to blood rather than endocardium. As shown in Fig. 2.13 as a result of the cooling effect of the blood flow a smaller lesion is delivered using similar power with a larger diameter catheter [30]. A higher power is therefore required in order to achieve the target temperature which results in a larger lesion. Smaller electrodes have a better electrogram resolution.

Larger tip catheters have been shown to be more effective with a reduced number of RF applications and reduced fluoroscopy time in atrial flutter ablation [31].

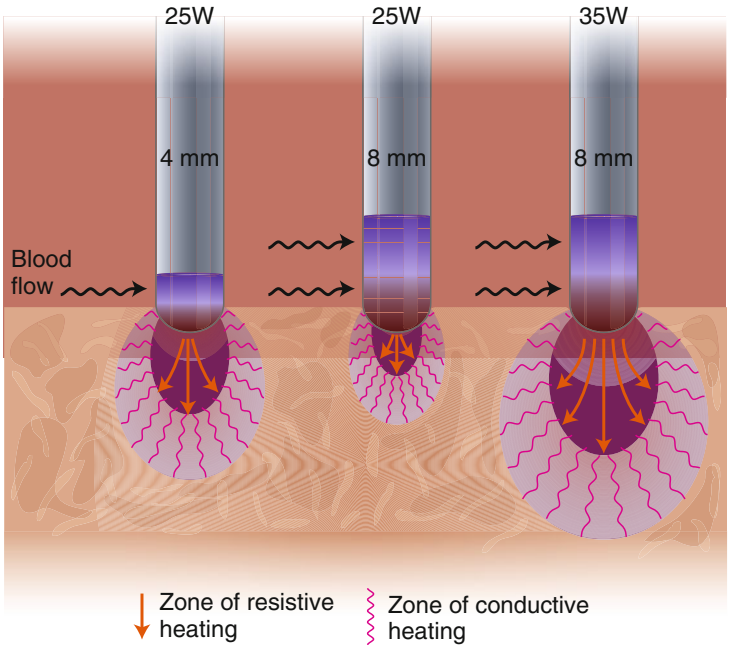


Fig. 2.13 Effect of ablation catheter tip size on the ablation lesion consisting of the zone of resistive heating and the zone of conductive heating. A higher power is required for a lesion to be created by a larger tip electrode due to an increase in loss of energy through an increase in flow across the larger surface area of the catheter

There is a better electrogram resolution with smaller tip catheters and overall smaller tip irrigated catheters have been shown to be very effective in atrial flutter ablation. The temperature measured at the tip of the catheter is not a good estimate of the tissue temperature.

Irrigation

In open loop irrigation saline is flushed through the ablation catheter resulting in cooling of the catheter tip with lowering of the catheter tip temperature resulting in the ability to create deeper lesions, with less focal hot spots and a reduced risk of thrombus formation. As shown in Fig. 2.14 a larger lesion is created over a shorter time period using a catheter with irrigation when compared with no irrigation. Using the same power and electrode size a catheter with irrigation tends to result in a larger lesion (Fig. 2.15). Temperature feedback is not reliable and therefore ablation is limited by power.

Although lesion sizes are larger using irrigation they tend to grow beyond 60 s and therefore a longer application should be considered.

The rate of irrigation should be altered according to the power delivered.

The general recommendations are **2 ml/min during mapping**, **17 ml/min during ablation at a power of less than 30 W** and **30 ml/min at a power of greater than or equal to 30 W**.

Contact Force Catheters

The contact force and orientation between the catheter tip and the endocardial surface provides valuable information regarding whether delivery of RF energy is having a significant impact on the tissue rather than the blood pool. It has been shown

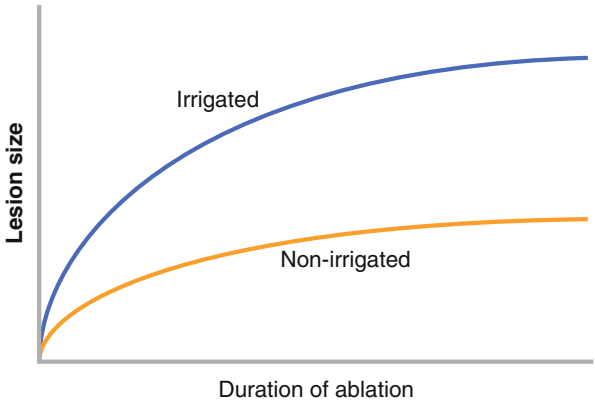


Fig. 2.14 Diagrammatic representation of lesion size developed over time for irrigated and non-irrigated ablation showing a larger lesion created over a shorter time for an irrigated catheter when compared with a non irrigated catheter

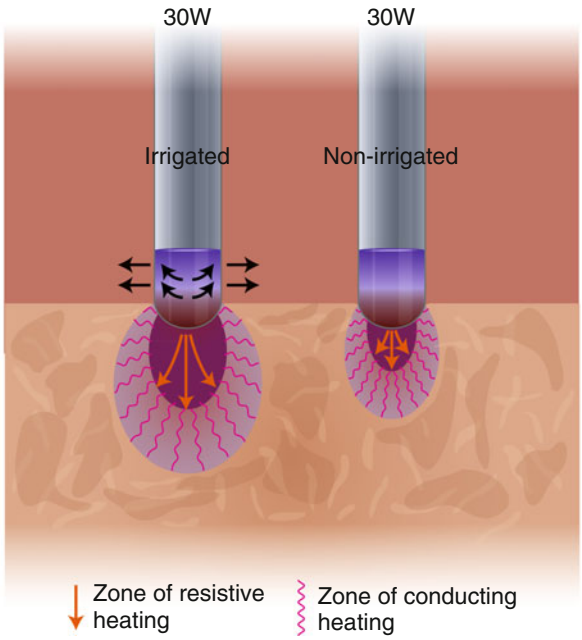


Fig. 2.15 Representation of the effects of irrigation on lesion size using a catheter with the same electrode size and at the same power

that poor tissue contact results in a higher recurrence of AF in patients who underwent a PVI [32, 33]. Excessive contact force may result in perforation. There are two commercially available contact force catheters which employ different technologies.

The SmartTouch catheter (© Biosense Webster, Inc) is shown in Fig. 2.15. This is an irrigated 7.5 Fr catheter with an 3.5 mm electrode in which a magnetic transmitter connected to the main body of the catheter with a spring. This is able to transmit data regarding directionality of the electrode tip relative to the shaft of the catheter to the processing unit. In order to measure the force applied there are an additional 3 sensors within the shaft. Although this records a minimum change of 1 g every 50 ms the mean force is displayed every 1 s [34].

Minimum contact force, duration of force as well as catheter stability, power, impedance and temperature changes can all be programmed on in order to set a minimum criteria for display of a lesion using Visitag software on Carto 3. Given the sensitivity of the electrode tip an introducing tool should be used when advancing the catheter through a sheath. A zero baseline reference should also be obtained after the catheter has been in the blood pool for a minimum of 15 min while the catheter is not in contact with any cardiac structure (Fig. 2.16).

The Tacticath catheter (St. Jude Medical, Cardiology Division, Inc., Plymouth, Minnesota) is an irrigated unidirectional 7 Fr catheter with a 3.5 mm tip electrode with a triaxial fibreoptic sensor shown in Fig. 2.17. Contact force is measured

Fig. 2.16 Image showing the distal component of the SmartTouch Catheter (© Biosense Webster, Inc)

every 100 ms and continually displayed. The force time interval (FTI) can also be displayed and may help to guide ablation. Using the Tacticath a contact force greater than 20 g appears to result in durable pulmonary vein isolation while a contact force less than 10 g tended to be associated with recurrences [32]. A target of 20 g with a minimum greater than 10 g and a minimum force time index greater than 400 g appears to result in a higher likelihood of transmural lesions in the left atrium [33].

Vascular Access

Electrophysiology catheters are positioned in the heart by gaining access via the central veins; generally the femoral veins for most catheters and occasionally the internal jugular or subclavian veins for coronary sinus catheter placement.

Femoral Cannulation

Femoral vein access is the most commonly used for most EP procedures. The femoral artery is palpated and cannulation is performed medial to the femoral artery while maintaining a position inferior to the inguinal ligament. Superior to the

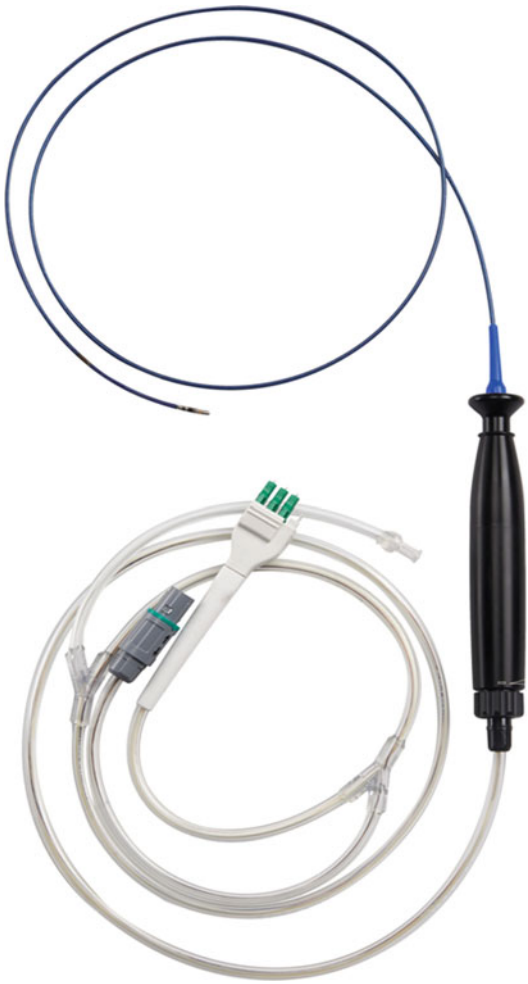


Fig. 2.17 Image showing the TactiCath Catheter and Connector (St. Jude Medical, Cardiology Division, Inc., Plymouth, Minnesota)

inguinal ligament may result in a difficultly with compression and potential bleeding into the retroperitoneal space. In generally up to three standard EP catheters can be positioned into a femoral vein provided separate cannulations are performed although this depends on the overall size of the patient. If there is any concerns regarding the potential for vein occlusion then the left femoral vein can also be cannulated.

The femoral artery may be used to access the left ventricle and in particular LVOT focal tachycardias. It may also be used for LV VT's and left sided accessory pathway ablations. It is important to maximize the distance between the femoral venous and arterial access points in order to minimize the risk of arteriovenous fistula. The relationship of the right femoral vein to the femoral artery is shown on the anatomical images in Fig. 2.18.

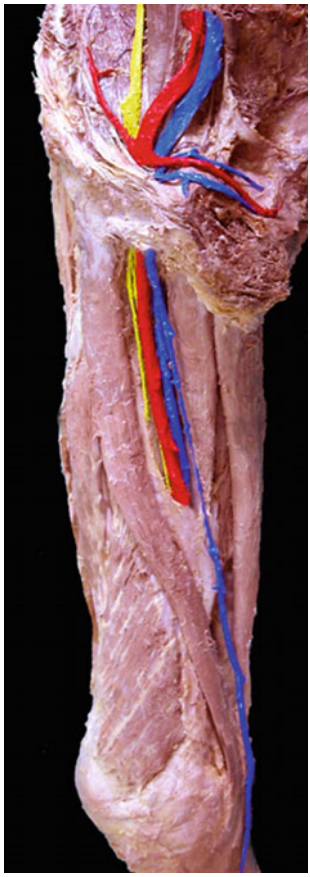


Fig. 2.18 Anatomical images showing the relationship of the femoral vein (*blue*), the femoral artery (*red*) and the femoral nerve (*yellow*)

Subclavian/Axillary Vein

The axillary vein combines with the cephalic vein to become the subclavian vein as it passes superficial to and medial to the anterior portion of the first rib. The course of the left axillary and subclavian vein are shown on the CT scan in Fig. 2.19. Following infiltration with local anesthesia the needle is directed towards and very slightly deep to the junction of the medial one third of the clavicle with the remainder of the clavicle. This should be superficial to the first rib. If fluoroscopy is used this can be achieved. If venous flow is not obtained a slightly deeper approach can be made. Provided the needle does not pass medial to the first rib or deep to the first rib via the second intercostal space then a pneumothorax should not occur. Alternatively a venogram can be performed. The advantage of subclavian access over internal jugular is that the vein does not appear to collapse and remains patent due to soft tissue attachments with the costoclavicular ligament and the clavicular periostium. The Trendelenberg position is therefore not required to

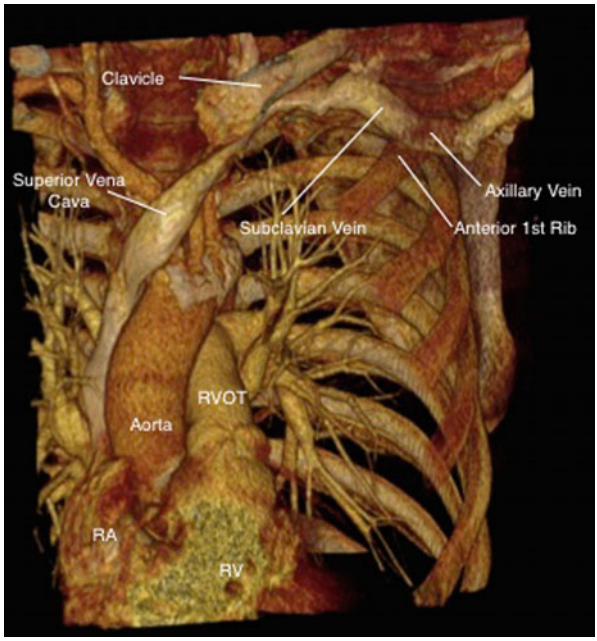


Fig. 2.19 Anatomic course of the left axillary and subclavian vein on a CT scan. The axillary vein runs anterior to the first rib towards the clavicle. Medial to this it becomes the subclavian vein which joins the superior vena cava. Also seen in this image is the ascending aorta. the right ventricular outflow tract (*RVOT*), the right atrium (*RA*) and the right ventricle (*RV*)

increase vein patency although it may reduce the incidence of air embolism. At the subclavian axillary junction the subclavian artery is significantly posterior and slightly superior to the vein. These two structures are separated by the anterior scalene muscle which is 1–1.5 cm thick and reduces the risk of accidental arterial puncture. This muscle is not present laterally however and the risk of arterial puncture increases in more lateral positions. More medial to the juncture of the subclavian and axillary juncture the apical pleura of the lung is posterior to the vein. It is therefore important to keep the needle as horizontal as possible with only slight increases in depth if a more medial approach is being made. More inferior locations are also more likely to puncture the pleura and lung due to the conical shape of the chest.

Internal Jugular Vein

Cannulation of the internal jugular vein may occasionally facilitate positioning of the coronary sinus catheter. Infiltration of local anaesthesia following by Seldinger cannulation should be performed at the apex of the triangle of Sedillot. This triangle is formed medially by the sternal head of the sternocleidomastoid, laterally by the clavicular head of the sternocleidomastoid and inferiorly by the medial one third of the clavicle. Transient flexion of the neck should help to accentuate these landmarks in most patients if they are not clear. If the patient is under general anesthesia

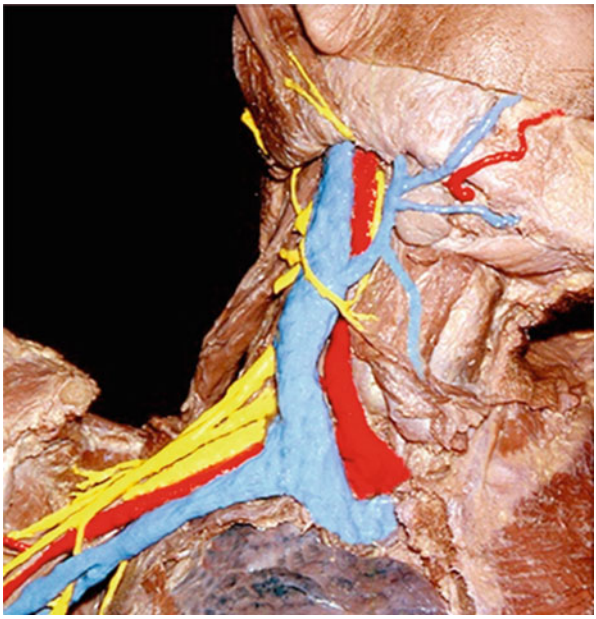


Fig. 2.20 Anatomical image showing the relationship of the right internal jugular vein (*blue*) which lateral to the right common carotid artery (*red*). The right internal jugular passes anterior to the right subclavian artery and joins the right subclavian vein where the two become in innominate vein. The right brachial plexus is shown in *yellow*

palpation of the trachea can be performed while palpating laterally over the sternal head of the sternocleidomastoid into the recess of the triangle. The carotid pulse can also be palpated prior to but not at the same time as cannulation as this often compresses the internal jugular vein. The carotid artery runs medial and posterior to the internal jugular although on occasions may only be posterior. Excessive contralateral rotation of the head beyond a 45 degree angle pushes the carotid artery more lateral and posterior to the internal jugular vein.

The internal jugular vein generally lies 1–2 cm deep in the skin at the apex of the triangle. The needle should be advanced at a 45 degree angle. Advancing the needle greater than 2 cm increases the risk of a pneumothorax. The use of an ultrasound may be helpful to differentiate between vein and artery. The artery is in general more medial, deeper, non compressible and has a visible pulsation. The anatomy of the right internal jugular vein is shown on Fig. 2.20.

Electrophysiology Catheters and Positioning

Electrophysiology catheters are generally made of platinum coated electrodes with polyurethane coated shafts. They are categorized according to the diameter of the shaft, the number of poles used to record and pace through, the spacing between electrodes and the ability to deflect. Ablation catheters are also categorized according to the curve, length of the tip of the catheter, ability for irrigation and ability to measure contact force.

The external diameter of an EP catheter in measured in **French** (**Fr**) where **1 Fr is 1/3 mm**. Therefore to convert the French size to mm it is simply divided by 3. The majority of diagnostic EP catheters are either 5 Fr or 6 Fr. The number of poles recording and pacing can range from 2 up to 20. Commonly quadripolar catheters are positioned in the right atrium, His bundle and right ventricle while a decapolar is positioned in the coronary sinus. A duodecapolar catheter may be used to map right atrial activation during a cavotricuspid isthmus ablation although this is generally not required.

Catheters that are deflectable are easier to position.

The high right atrium (RA) catheter in an EP study is generally positioned in the high posterolateral wall at the junction of the RA with the superior vena cava close to the sinus node. The catheter can also be positioned in the RA appendage. A non deflectable quadripolar catheter is sufficient for this. This can generally be positioned in either the RAO or LAO views.

The RV catheter is generally best placed along the base or septum. It may be positioned close to the His and used to record the His and ventricular signals. This position is achieved in the RAO or LAO projection while withdrawing the catheter from the RV with a clockwise rotation towards the septum.

The coronary sinus catheter is initially positioned in the RA and advanced with a clockwise rotation towards the more posterior CS Os in the LAO projection. Alternatively it can be positioned in the RV and withdrawn with clockwise rotation in the same view. The general locations of EP catheters are shown in Fig. 2.21.

Baseline Measurements

Sinus Node Recovery Time (SNRT)

SNRT is measured using the principle of overdrive suppression in which pacing is performed close to the sinus node at a rate faster than the sinus rate and the time taken from the last paced beat to the first intrinsic sinus beat is measured. This is performed at a cycle length of 600/500/400/300/200 ms for a period of 30 s during each drive train. As shown in Fig. 2.22 the interval from the last paced beat to the first intrinsic beat is then measured. This is longer than the baseline sinus rate and generally takes 5 to 6 beats to return to normal after this maneuver is performed. A prolonged sinus node recovery time **greater than 1500 ms** is abnormal. This may not always occur at faster cycle lengths as entry block may intermittently occur in the perinodal cells and therefore not every beat may depolarize the sinus node. The SNRT is also dependent on the baseline sinus cycle length and is longer for longer baseline cycle lengths and shorter for shorter cycle lengths. In order to correct for this the corrected SNRT can be calculated as:

$$\text{cSNRT} = \text{SNRT} - \text{BCL}$$

A cSNRT of 525 ms or more is considered abnormal.

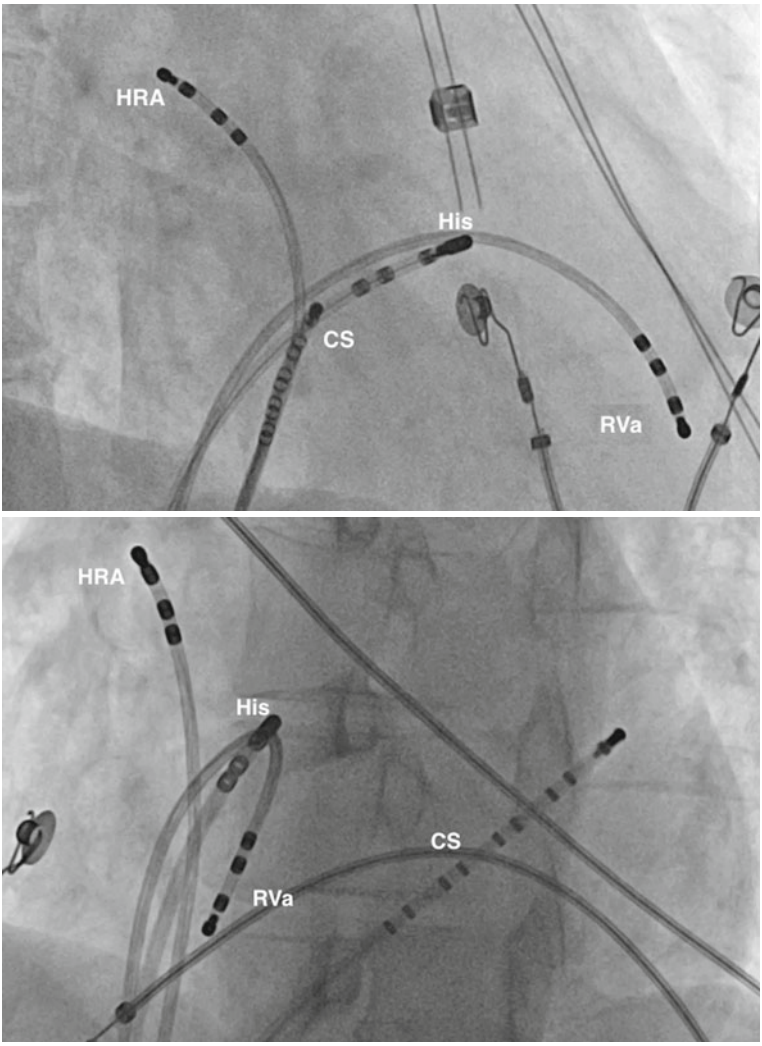


Fig. 2.21 Fluoroscopic image in RAO 30 (*top*) and LAO 30 (*bottom*) showing the locations of EP catheters in the high right atrium (*HRA*), coronary sinus (*CS*), His and right ventricle apex (*RVa*)

Sinoatrial Conduction Time (SACT)

This is the conduction time from the SN to the RA tissue. This is measured by positioning a catheter close to the sinus node and pacing at a rate slightly faster than the baseline cycle length for a single beat only in order to avoid overdrive suppression. As shown in Fig. 2.23 the interval from the last paced beat to the next intrinsic sinus beat is measured and is known as the return cycle length. If the basic cycle length is subtracted from the return cycle the remaining interval is equivalent to the time

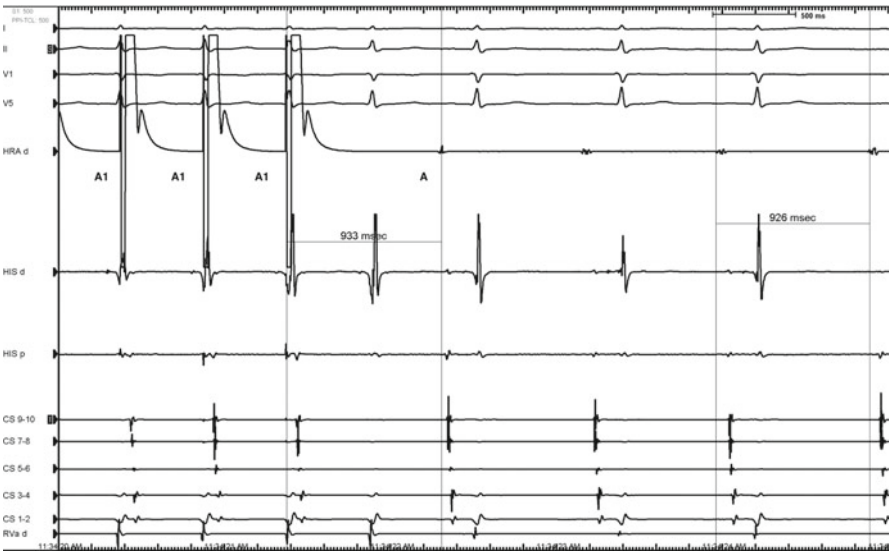


Fig. 2.22 Showing calculation of the sinus node recovery Time (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex) *A1* = paced atrial complexes. *A* = spontaneous sinus beat post pacing

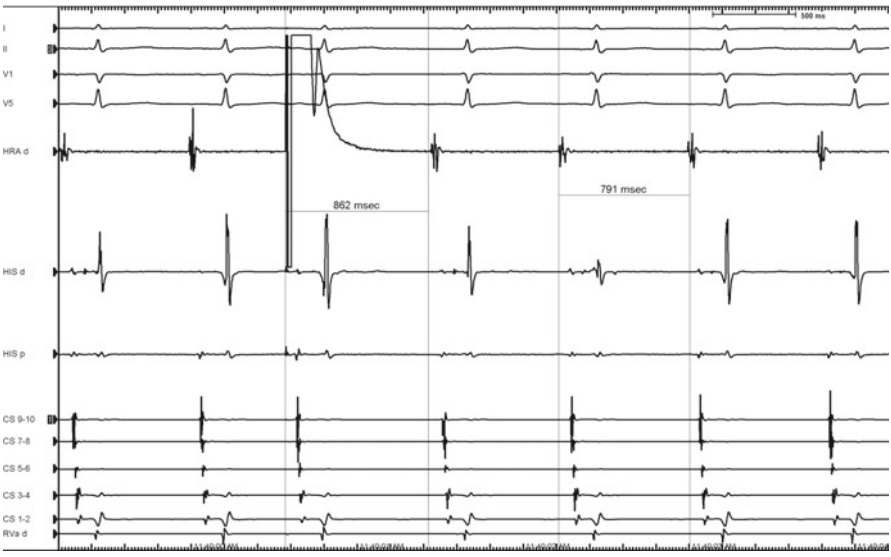


Fig. 2.23 Calculation of sino atrial conduction time (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

taken to conduct into and out of the sinus node. This is therefore divided by two in order to calculate the SACT. **A normal SACT** is considered to be to be **50–125 ms**.

AV Conduction Times (AH and HV Intervals)

The **AH interval** is recorded from the onset of the local atrial electrogram recorded in the His catheter to the onset of the His signal and is considered to represent conduction through the AV node (Fig. 2.24). The normal range is **50–120 ms**. A prolonged AH interval may occur as a result of intrinsic AV nodal dysfunction, as a result of increased vagal tone or a result of antiarrhythmic drugs. A short AH interval can occur spontaneously or under the effect of sympathetic stimulation.

The **HV interval** is measured from the onset of the local His signal to the earliest ventricular signal on the surface ECG (Fig. 2.24). This generally reflects the

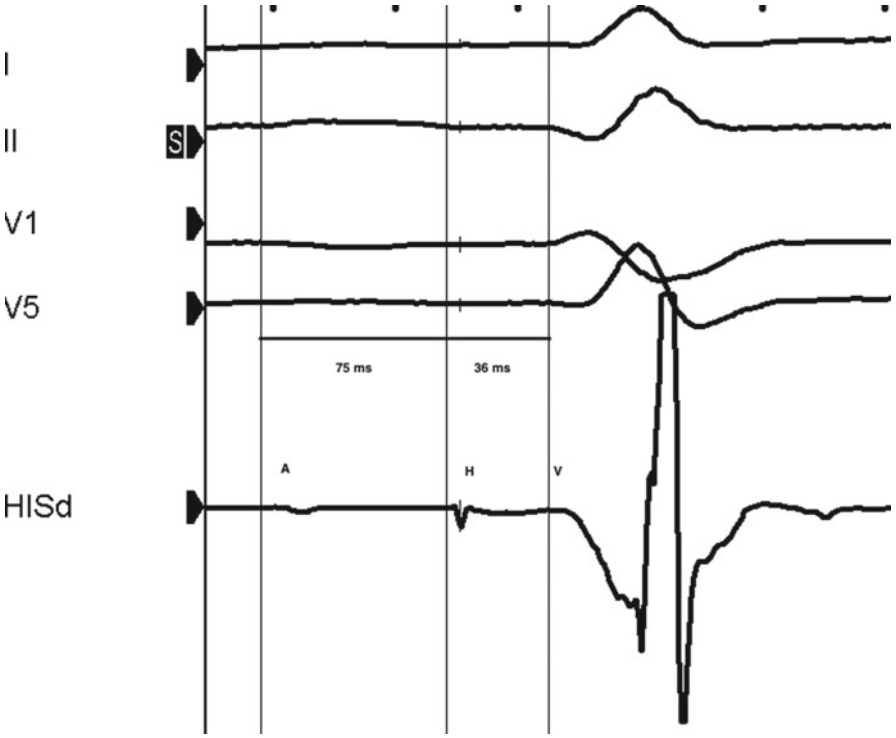


Fig. 2.24 Calculation of the AH interval (75 ms) from the onset of the atrial electrogram on the His recording to the start of the His electrogram and the HV Interval (36 ms) measured from the onset of the His signal to the onset of the ventricular activation on the surface ECG (HIS d is positioned in the distal His)

conduction time through the proximal His, bundle branches and the Purkinje system. The normal range is considered to be between **30** and **55 ms**. Intrinsic His dysfunction or antiarrhythmic drugs may prolong the HV interval. A short HV interval may be seen with accessory pathway conduction which may even be negative. In the presence of accessory pathway conduction the HV does not reflect His-Purkinje conduction but is the result of accessory pathway conduction the true HV interval.

Care must be taken not to confuse the right bundle electrogram as the His electrogram as this may artificially lead to what may seem like a short HV interval.

Refractory Periods (AERP, AVNERP, VERP, VANERP)

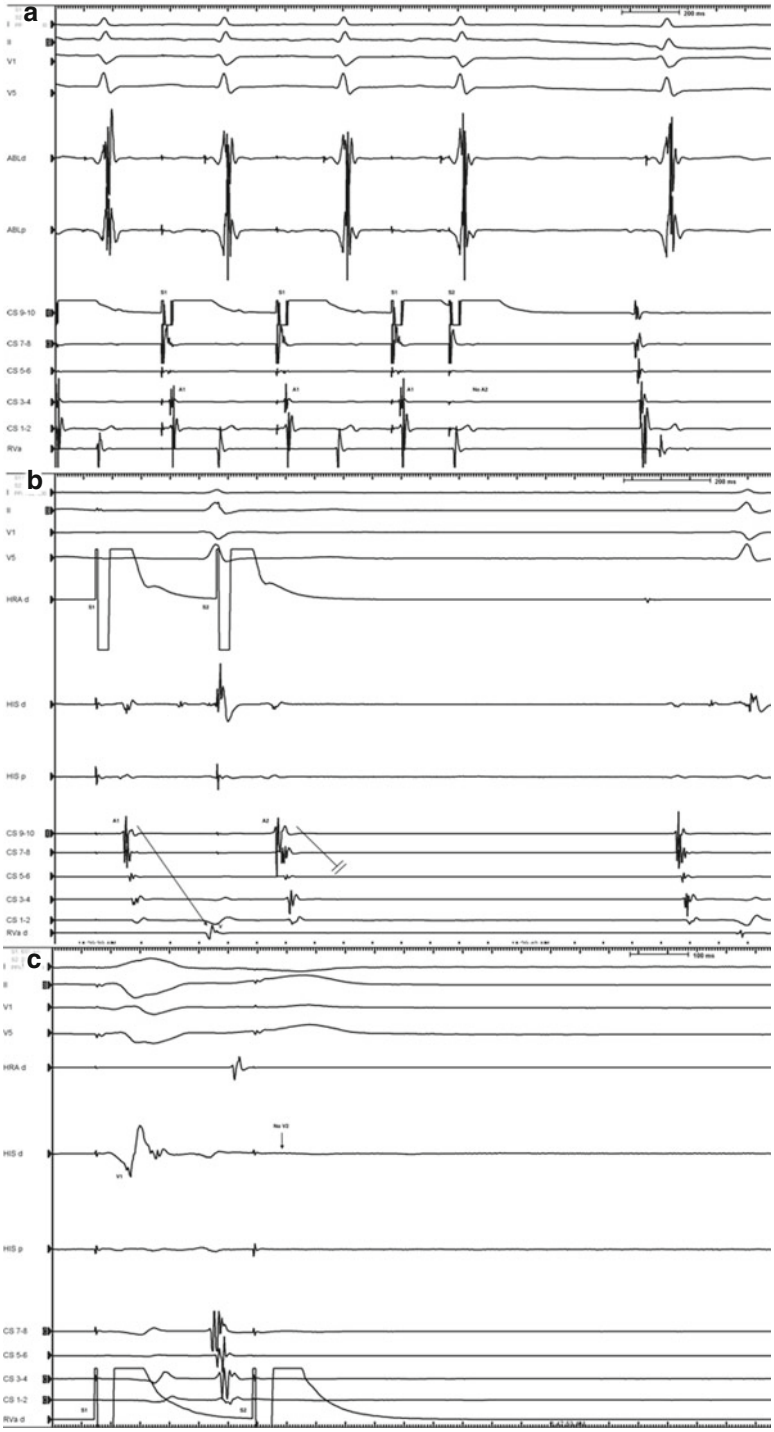
During an EP study the **effective refractory period** (**ERP**) is recorded. This is the longest coupling interval in which the stimulus **fails** to stimulate the myocardium at twice the diastolic threshold.

As shown in Fig. 2.25 to calculate the ERP a drive train of eight beats followed by a progressively shorter extrastimulus is performed. The **normal atrial ERP is 170–300 ms while the ventricular ERP is 170–290 ms** [35]. In order to evaluate the AVNERP the atrium is paced in the same way as when calculating the AERP. During decremental atrial extrastimuli the AH interval gradually prolongs while the HV interval remains the same. The **normal AVNERP is 230–425 ms** [35].

AV Wenckebach Point

As shown in Fig. 2.26 decremental atrial pacing can be performed at progressively shorter cycle lengths until AV block occurs. The AV Wenckeback point is defined as the **longest cycle length which results in AV block**. This provides some data on the functional conduction through the AV node.

Fig. 2.25 Calculation of the atrial RP (**a**), AV node RP (**b**), and ventricular ERP (**c**). In each case a drive train is performed at a cycle length of 600 ms for 8 beats in order to achieve a steady state. This is followed by a progressively shorter extrastimulus until capture fails to occur. In the case of the atrium and ventricle this is seen as lack of local capture. In the case of the AV node local capture of either the atrium or ventricle occurs with failure of the impulse to propagate through the AV node either antegradely (AV Node ERP) or retrogradely (VA ERP). (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)


a
I
II
V1
V5
ABLd
ABLp
CS 9-10
CS 7-8
CS 5-6
CS 3-4
CS 1-2
RVa
S1
S2
A1
A2
No A2
200 ms
b
I
II
V1
V5
HRA d
HIS d
HIS p
CS 9-10
CS 7-8
CS 5-6
CS 3-4
CS 1-2
RVa d
200 ms
c
I
II
V1
V5
HRA d
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CS 3-4
CS 1-2
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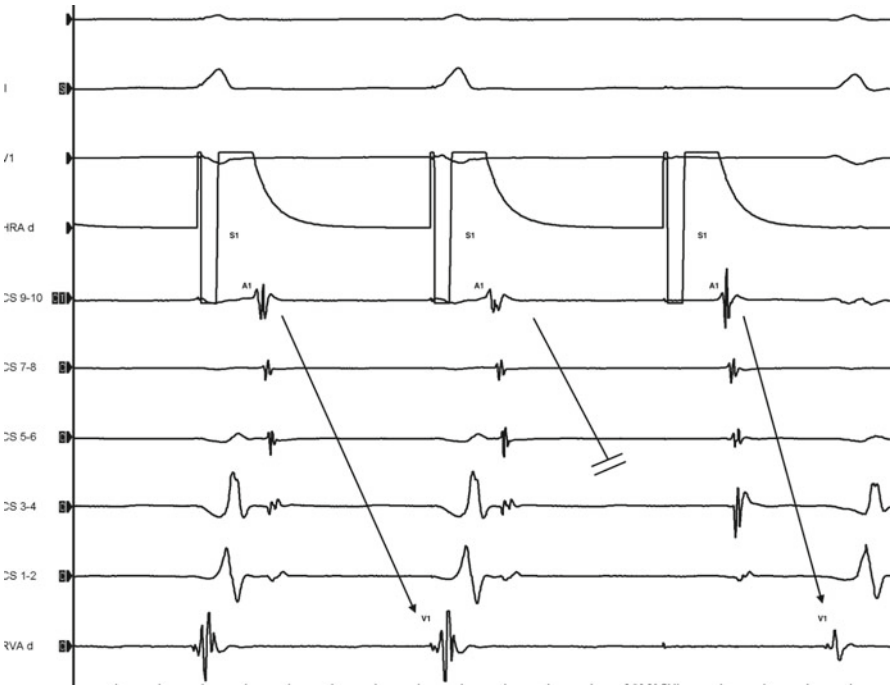

Fig. 2.26 Calculation of AV Wenckeback Point during decremental atrial pacing. (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

Basic EP Study

There is a considerable variability in the number of catheters and positioning of these. In most diagnostic EP studies a quadripolar catheter is positioned in the HRA as well as the RV septum and a decapolar catheter is positioned in the coronary sinus. The RV quadripolar catheter can sometimes be used to record the AH and HV intervals.

Pacing is performed from the RV septal catheter at a constant rate faster than the sinus rate. This is to look for the presence of VA conduction, and if present the atrial activation sequence. As shown in Fig. 2.27 decremental VA conduction is initially anterior and septal. This generally indicates VA nodal conduction. This is not always the case and it is important not to miss an anteroseptal accessory pathway with decremental retrograde conduction. On the converse lack of decrement does not always exclude VA conduction as rapid ventricular pacing from the RV may result in infrahisian block.

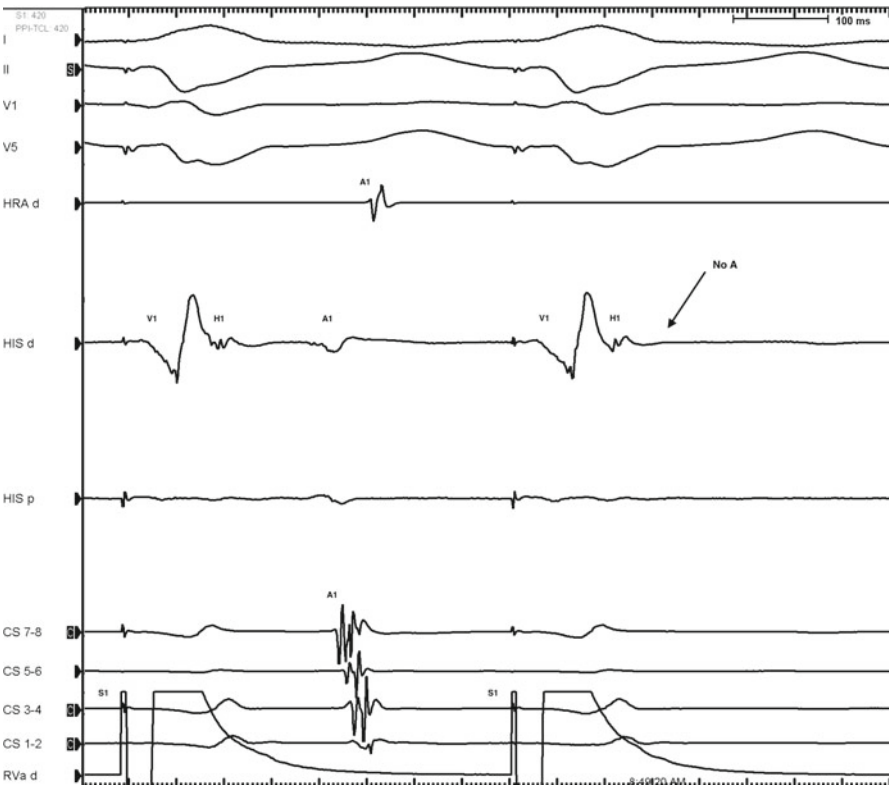

Fig. 2.27 Decremental ventricular pacing (*S1*) from the RV apex (*RVAd*). The first paced beat on the left propagates from the RV apex retrogradely up the right bundle and activates the His. A small His deflection (*H1*) is seen after the ventricular activation (*V1*) on the distal his (*HIS d*) channel. Following this there is atrial activation (*A1*) recorded on the HIS d channel followed shortly thereafter by the proximal his recording (*HIS p*). Atrial activation (*A1*) then occurs from the proximal CS (in this case CS 7–8) and spreads distally. The high RA (*HRAd*) is activated (*A1*) after the proximal CS. This activation is concentric with the His first followed by proximal to distal CS activation and then the HRAd last). In the following beat there is no conduction from the RV activation followed by His activation and no atrial activation

As shown in Fig. 2.28 pacing from the RV does not always result in VA conduction. Although this may infer that AVRT is not possible it is generally better to repeat pacing during infusion of isoprenaline where VA conduction may become evident.

A **ventricular extrastimulus test** is performed by pacing at a contant cycle length and adding in an extrastimulus at a progressively shorter cycle length. This pacing mode is used to calculate the VERP and the retrograde conduction properties.

Pacing from the HRA is performed in order to calculate sinus node function. Atrial extrastimulus testing is then performed looking at the AERP and AVNERP as well as the antegrade conduction properties.

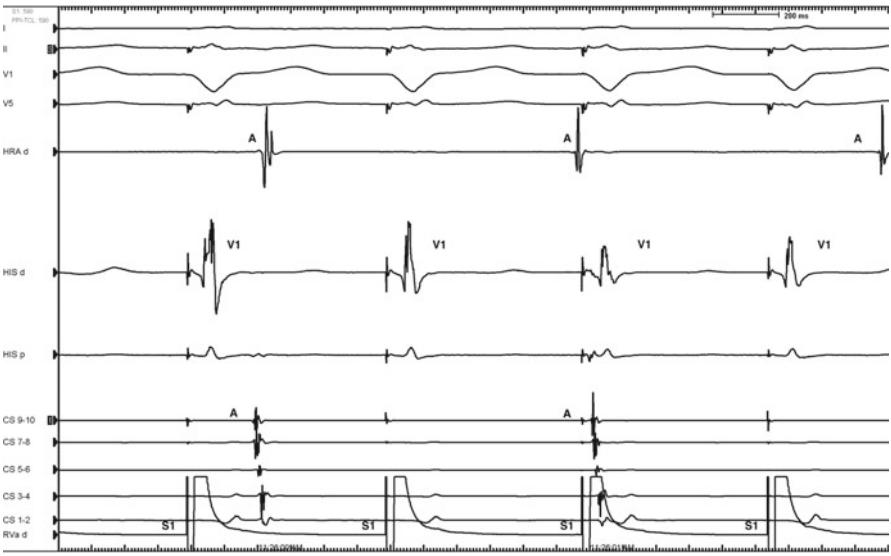

Fig. 2.28 Pacing from the RV (S1) does not penetrate the His and there is no evidence of VA Conduction. (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

An example of an AH jump caused by dual AV nodal pathways is shown in Fig. 2.29. In panel A conduction occurs antegradely over the fast pathway. In panel B a sudden reduction in the atrial extrastimulus by 20 ms results in an increase in the AH interval by more than 50 ms. Antegrade conduction has suddenly shifted from the fast to a slow pathway.

The AV nodal conduction curve in dual AV nodal physiology is shown in Fig. 2.30. A1A2 refers to the interval from the last paced beat of the drive train to the onset of the atrial extrastimulus. A2H2 refers to the interval from the extratimulus (A2) to the his activation A2H2. As the atrial extrastimulus becomes earlier the interval to the His prolongs until there is a sudden increase from 300 to 350 ms which is most likely indicative of a change in antegrade activation from the fast pathway to the slow pathway.

An example of a AH jump and echo beat are shown in Fig. 2.31. In this example there is a jump as antegrade conduction occurs along the slow pathway with ventricular activation and retrograde activation up the fast pathway.

Decremental atrial pacing is used to calculate the AV Wenckebach Point.

Further decremental atrial and sometimes ventricular pacing may be used to initiate tachycardia. If this is ineffective the addition of one or more atrial extrastimuli and the use of incremental doses of atropine or isoprenaline may be required.

In Fig. 2.32 an atrial extrastimulus results in an AH jump in which conduction occurs antegradely along the slow pathway followed by tachycardia in which retrograde conduction occurs along the fast pathway resulted in a short VA interval. This is most likely in keeping with a typical AVNRT

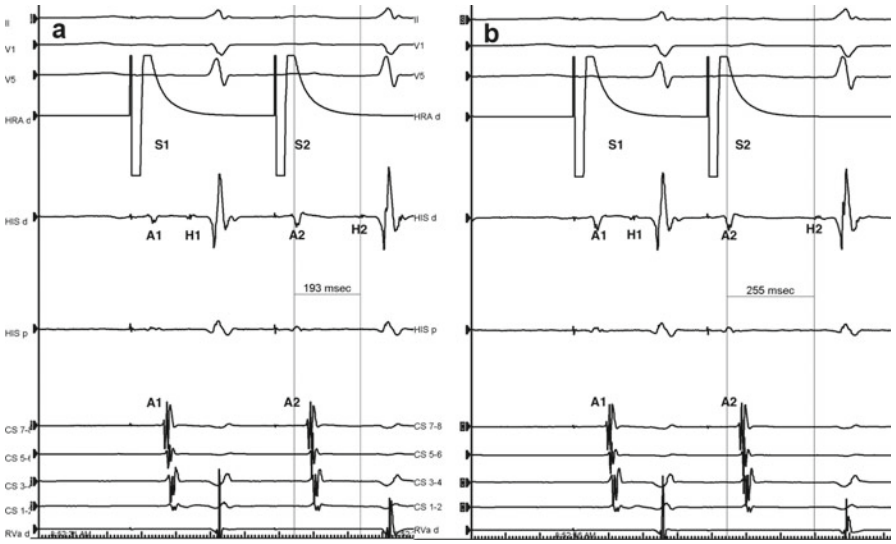

Fig. 2.29 Panel **a**: Atrial extrastimulus testing showing conduction antegradely over the fast pathway. Panel **b**: Antegrade conduction over the slow pathway. Continuous pacing is performed at a cycle length of 600 ms (*S1*). Following this an extrastimulus (*S2*) is given after 400 ms on panel **a** with conduction over the fast pathway. In panel **b** the S2 is shortened to 380 ms. The fast pathway is refractory and conduction shifts to the slow pathway. This is evidenced by a sudden prolongation in the AH interval by more than 50 ms. (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

VT Stimulation Protocol

The general principle of a VT EP study is to assess the potential future risk of VT in a susceptible patient by performing a basic drive train followed by the introduction of extrastimuli at shorter cycle lengths. In general this should be performed at the RV apex and the RV outflow tract with a single quadripolar catheter and another catheter in the right atrial appendage. A basic drive train (S1) of eight beats is introduced at a cycle length of 600 ms followed by an extrastimulus (S2) which is reduced in 10 ms intervals until the ventricular myocardium is refractory. Following this, S2 pacing rate is brought to 20 ms greater than refractoriness and an S3 introduced in the same manner. S3 is then set 20 ms higher than refractoriness and S1 is reduced to 400 ms and the same protocol repeated. If VT is not induced then S1 is brought back to 600 ms and S2 and S3 set at 20 ms above refractoriness and then an S4 is introduced in a similar manner to that describes above.

Following this, S1 is reduced to 400 ms. If no VT is induced then the protocol can be reintroduced with an isoprotenolol infusion. Induction of a monomorphic VT using this protocol is considered a significant finding and if possible this can be compared with the clinical VT. An example of a VT stimulation using a drive train at a cycle length of 400 ms with 3 extrastimuli is shown in Fig. 2.33.

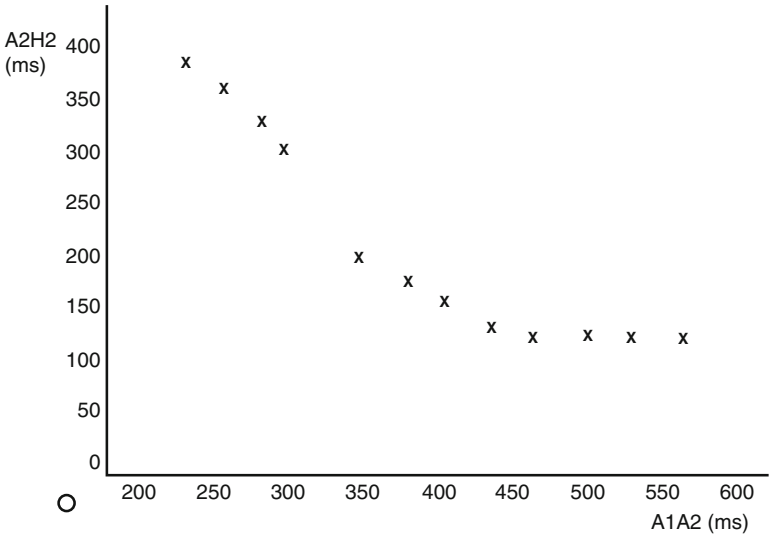

Fig. 2.30 Pacing is performed with a drive train (*A1*) followed by a gradually decmrental atrial extrastmulus (*A2*). As this interval shortens the interval from the atrial extrastimulus (*A2*) to the His (*H2*) prolongs. There is then a sudden increase in this interval by 50 ms which is generally suggestive of antegrade conduction shifting from the fast pathway to the slow pathway

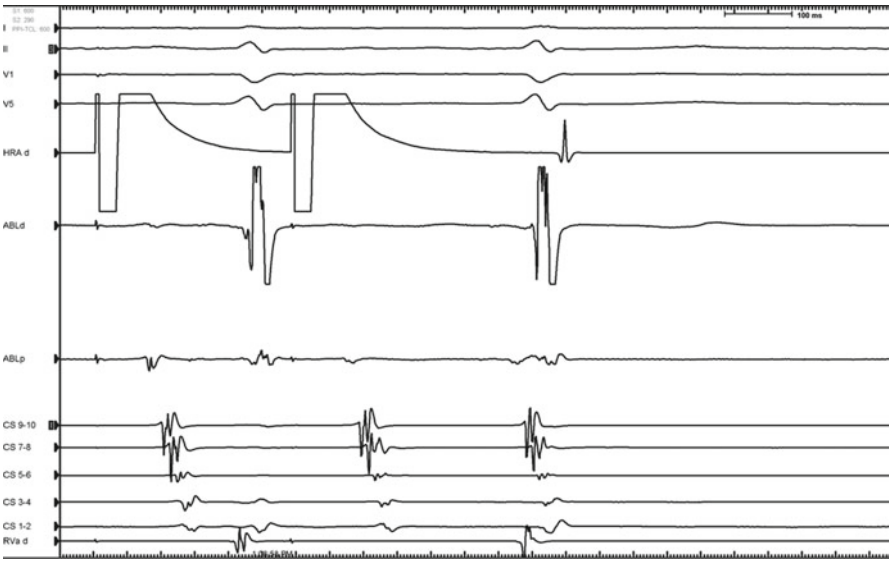

Fig. 2.31 Antegrade conduction occurs along the slow pathway with ventricular activation and retrograde activation up the fast pathway. This is an example of an atrial echo beat

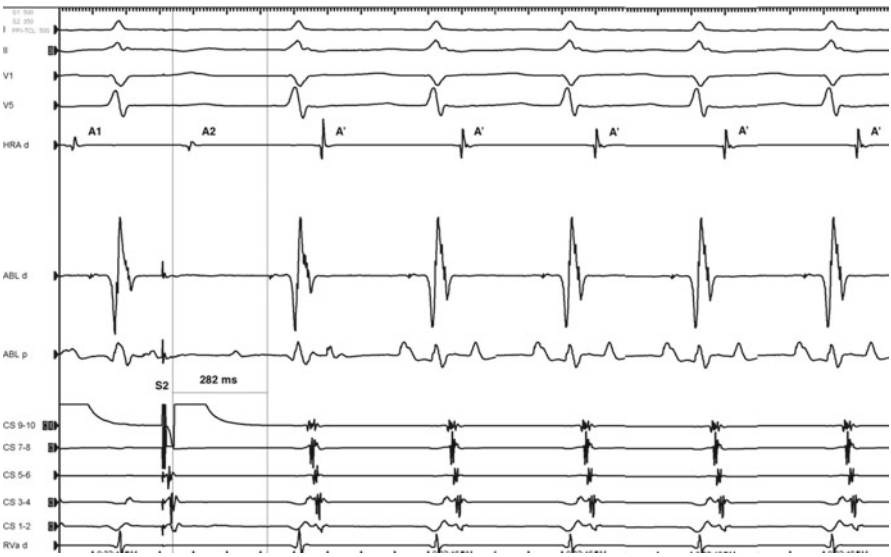

Fig. 2.32 Induction of typical AVNRT. Following a drive train at 500 ms (not shown) an extrastimulus is given after 350 ms from the proximal CS (*S2*). This results in an AH interval of 282 ms (200 ms on prior S2 indicating an AH jump of 82 ms). This is indicative of antegrade conduction shifting from the fast to the slow pathway followed by tachycardia. The ablation distal (*ABL d*) is positioned in the location of the His. Activation is earliest in the proximal CS with a short VA interval. Overall the inititiation and activation sequence is suggestive of a typical AVNRT. (HRA d is positioned in the high right atrium, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

Initiation of polymorphic VT or VF may be non-specific, although this depends on the clinical context. Torsades de pointes in the setting of long QT syndrome is not inducible by ventricular pacing. On the contrary, a polymorphic VT in Brugada syndrome is highly significant.

VT induced during the study can often be terminated by pacing at a rate 20 ms faster than the VT. If this is unsuccessful or the patient is hemodynamically unstable, a DC cardioversion should be performed.

SVT Diagnostic Maneuvers

Although specific maneuvers will be discussed in each chapter this section provides an overview on this topic. Although the diagnosis can frequently be made during basic pacing occasionally it may be difficult to differentiate between AVNRT, AVRT in particular utilizing paraseptal AP's and atrial tachycardia's. In order to help, certain baseline observations can be made which may help followed by pacing maneuvers. In cases where tachycardia cannot be easily initiated parahisian pacing can be

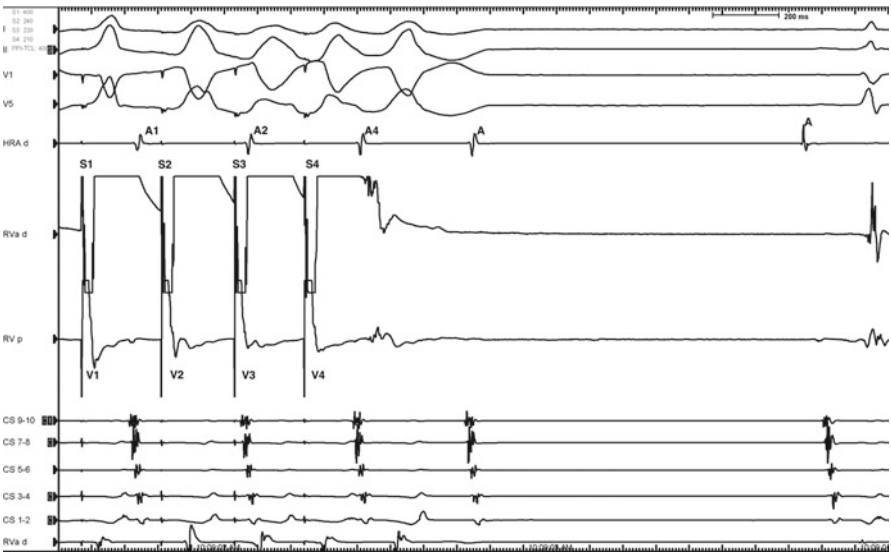

Fig. 2.33 VT stimulation protocol in which a drive train is performed at 400 ms with an S2 of 240, S3 220 and an S4 of 210 from the RV apex. Ventricular activation (*V*) and atrial activation (*A*) can be seen corresponding to each extrastimulus. (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

performed. In those cases where tachycardia can be initiated entrainment, His synchronous PVC's and overdrive pacing can be performed. The choice of maneuver is therefore dependent on the individual case.

Baseline Observations

During baseline testing the presence of dual AV nodal physiology, the onset and termination of tachycardia, presence and effect of tachycardia variability, VA relationship and atrial activation sequence and effect of bundle branch block can all be used to establish the diagnosis.

The presence of functional dual AV nodal physiology may increase the suspicion of AVNRT. This can be demonstrated as an **AH jump** of greater than or equal to **50 ms** in the case of a typical AVNRT or a HA jump of greater than or equal to 50 ms in the case of an atypical AVNRT. The presence of dual AV nodal physiology is reasonably predictive that the mechanism of the tachycardia is AVNRT in a patient with a prior documented SVT and no evident of AP conduction.

Initiation and Termination

Both AVNRT and AVRT can be initiated by a PAC. In the case of a typical AVNRT there is a sudden prolongation of the duration between the PAC and the initial QRS complex as antegrade conduction occurs down the slow pathway (AH jump) (Fig. 2.34).

In orthodromic AVRT the time from the PAC to the initial QRS is shorter as antegrade conduction occurs along the fast pathway. As seen in Fig. 2.35 pacing is performed at a drive train (S1) of 400 ms with an extrastimulus (S2) at 280 ms. This atrial beat conducts antegradely along the fast pathway which shows decrement but no jump. Conduction then occurs retrogradely with a VA interval of 94 ms. This could be in keeping with a paraseptal AP, atypical AVNRT or less likely an AT. In this case the diagnosis was a posteroseptal AP.

Atrial tachycardias tend to warm up and cool down with a gradual shortening of the tachycardia cycle length at the onset. The initial P wave in an atrial tachycardia has a different morphology in general to the preceding sinus beats although occasionally this may be subtle if the focus is close to the sinus node.

PVC's rarely initiate an AVNRT as the His is generally refractory during the timing of retrograde activation. On the other hand PVC's can commonly initiate an AVRT (Fig. 2.36).

Termination of tachycardia with AV block occurring either spontaneously, following a vagal maneuver or following the administration of IV adenosine occurs in arrhythmias in which the AV node plays a vital role in the circuit i.e., AVNRT and AVRT and does not occur in atrial tachycardia. AT's generally but not exclusively terminate with a ventricular complex (Fig. 2.37).

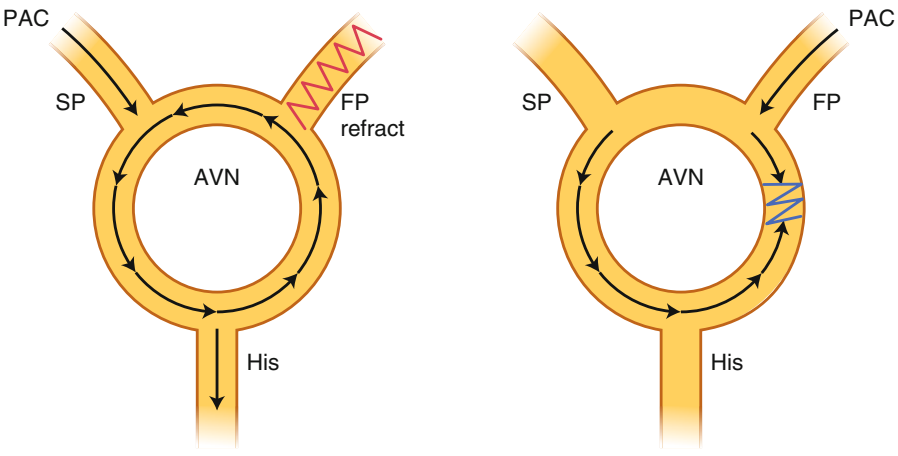

Fig. 2.34 Initiation of a Typical (Slow Fast) AVNRT with a PAC (1) and termination with another PAC (2)

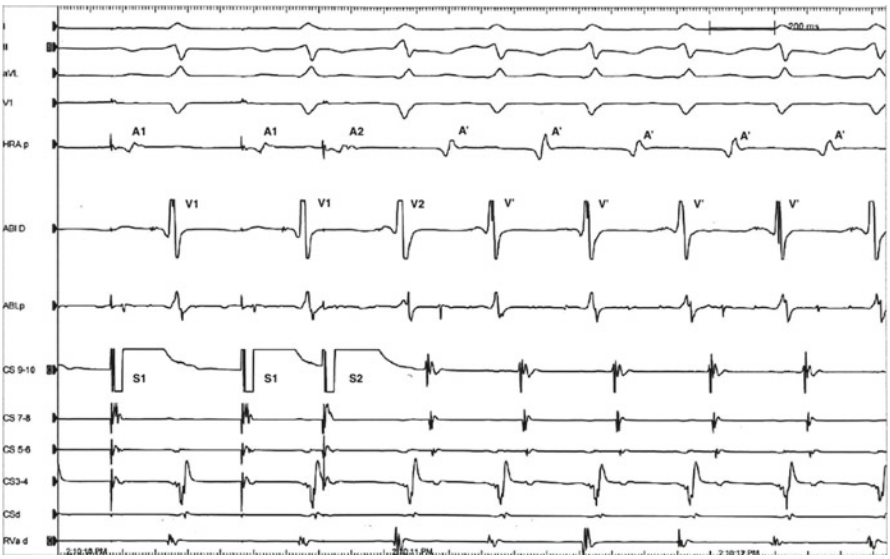

Fig. 2.35 Initiation of an ORT utilizing a retrograde posteroseptal AP. Following a drive train at 400 ms (*S1*) an atrial extrastimulus is given after 280 ms (*S2*). This conducts antegradely over the fast pathway and retrogradely over the AP with a VA interval of 94 ms. The corresponding atrial (*A*) and ventricular (*V*) activations are shown. (HRA p is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS d is in the distal CS and RVa d is located in the RV apex)

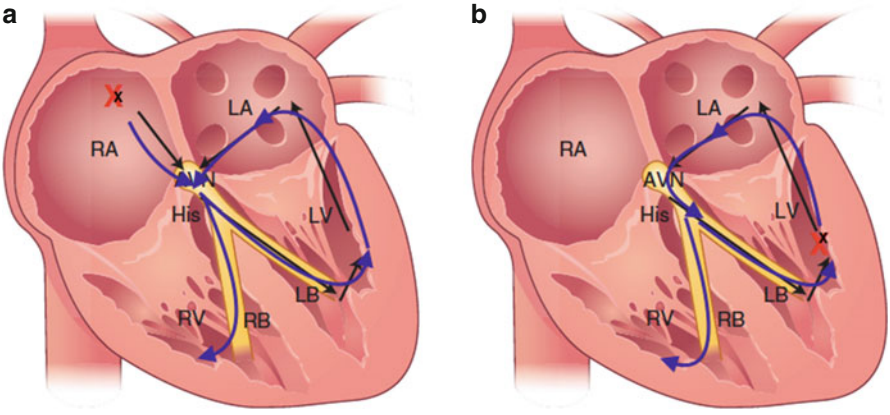

Fig. 2.36 Initiation of AV Re-entry Tachycardia with either a Premature Atrial Complex (PAC) (**a**) or Premature Ventricular Complex (PVC) (**b**)

The continuation of tachycardia despite the presence of AV block however only rules out the possibility of AVRT, but AVNRT and AT may continue to occur in the presence of AV block.

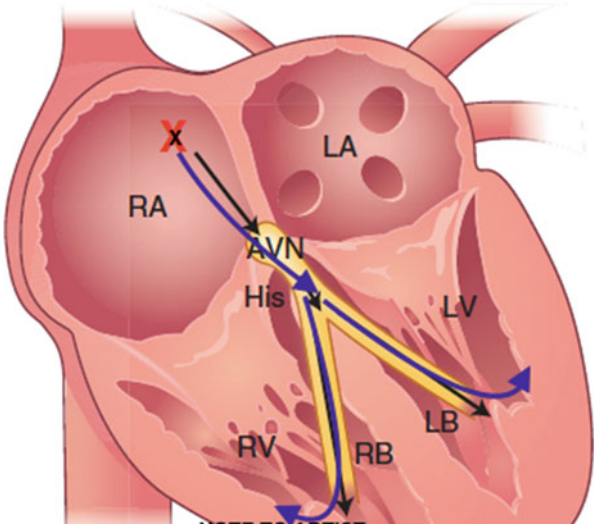

Fig. 2.37 Initiation and termination of Atrial Tachycardia with a long RP Interval

All SVT's can be terminated by varying degrees with either atrial or ventricular premature complexes. In the case of AVNRT the number of atrial beats required depends on the location of the circuit. Generally at least 2 premature ventricular complexes are required to terminate AVNRT. For AVRT termination may occur with either premature atrial complexes or ventricular premature complexes. The number of beats required depends on the distance from the circuit as well as the rate of the tachycardia. In atrial tachycardia the mechanism of the arrhythmia determines the ability for premature atrial complexes to terminate the tachycardia. In general at least 3 PVC's are required for termination of an AT.

VA Relationship and Atrial Activation

The P wave should always be identified in SVT in order to help ascertain the diagnosis. The VA interval corresponds with the RP interval in the surface ECG and is useful in helping to discriminate between various SVT mechanisms. If the septal VA interval is less than 70 ms, this is highly predictive for a typical AVNRT. The VA time is generally longer than 70 ms in cases of orthodromic AVRT, atrial tachycardia and atypical AVNRT. Coumel's tachycardia also known as permanent junctional reciprocating tachycardia (PJRT) results in a long VA time with negative P waves in leads II, III and aVF during tachycardia. This is caused by an orthodromic reciprocating tachycardia using the Av node as the antegrade limb and a slowly conducting accessory pathway as the retrograde limb. The accessory pathway is generally a right sided posteroseptal pathway with an atrial insertion point close to the coronary sinus.

It is useful to compare the P wave morphology during tachycardia with sinus rhythm. This is particular helpful in helping to localize the focus of an atrial tachycardia with narrower P waves more indicative of septal origins.

The atrial activation sequence is very useful in discriminating between the potential causes of SVT. However, central atrial activation may occur with any SVT while eccentric activation more commonly but not exclusively occurs with AVRT or an atrial tachycardia. Eccentric activation may also be seen with AVNRT depending on the atrial insertion point of the retrograde slow pathway. For this reason pacing maneuvers are required to help further differentiation.

Effect of Bundle Branch Block

If the tachycardia cycle length (TCL) prolongs with induction of BBB then this implies that the arrhythmia is AVRT with a VA connection on the same side as the BBB. This principle is known as **Coumel's sign** and is represented on Fig. 2.38 and on the electrogram in Fig. 2.39. As BBB does not affect the AV nodal common pathway this does not affect AVNRT. It also has no effect on AT. Due to the rapid ventricular conduction ventricular aberration is relatively common in the setting of SVT. Bundle branch block on the contralateral bundle has no impact on tachycardia cycle length.

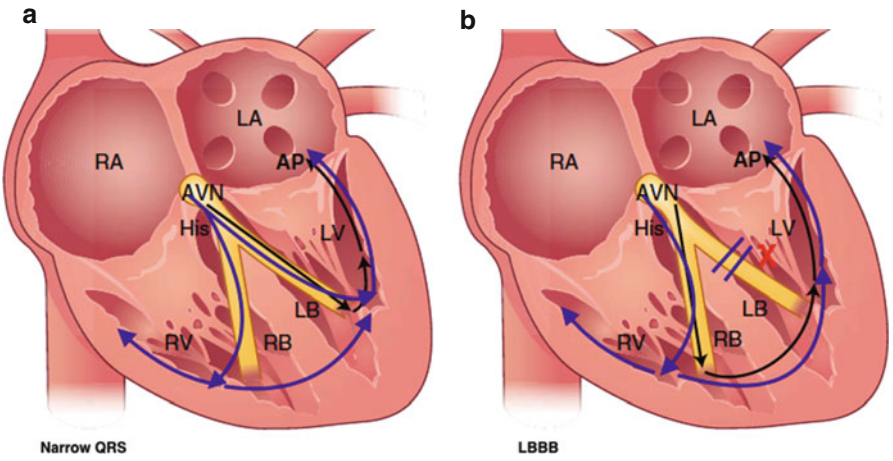

Fig. 2.38 Schematic demonstrating the effect of bundle branch block on the same side as a retrograde accessory pathway. In both images a orthodromic reciprocating tachycardia (ORT) using the AV node as the antegrade pathway is seen. Conduction then occurs through the His and bundle branches. The accessory pathway is located in the left lateral position. In image (**a**) conduction occurs through both the right and the left bundle. Given that this is a left lateral accessory pathway activation along the left bundle will activate the accessory pathway rapidly. In image (**b**) a LBBB occurs thus delaying activation which occurs through the right bundle and then across the interventricular septum. This results in an increase in the VA interval and prolongation of the tachycardia cycle length (TCL)

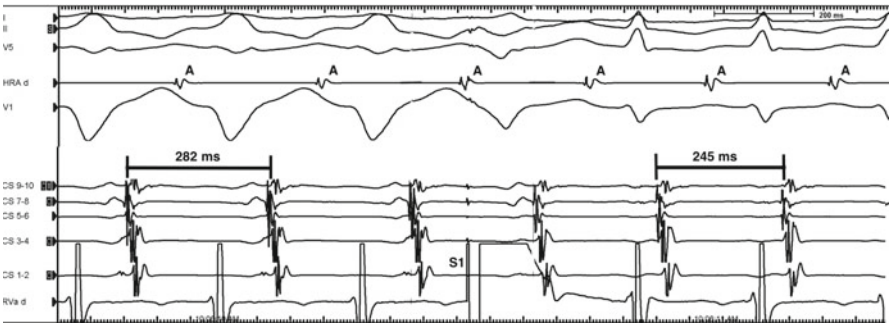

Fig. 2.39 Electrogram showing the effect of bundle branch block on the tachycardia cycle length in a orthodromic reciprocating tachycardia using a left sided accessory pathway as the retrograde limb. On the left of the electrogram the patient is in tachycardia with a wide complex left bundle pattern and a tachycardia cycle length of 282 ms. The atrial activation sequence is earliest in CS 7/8 which is located in the mid coronary sinus and indicates left sided activation. The introduction of a PVC during His refractroriness retrogradely penetrates the left bundle and retrogradely activates the accessory pathway with shortening of the tachycardia cycle length. Following resolution of the left bundle branch block the QRS is narrow and the tachycardia cycle length is shorter. This is indicative of a left sided AP playing a fundamental role in the tachycardia. This electrogram not only demonstrates the effect of a bundle branch block on the tachycardia cycle length but also the effect of a His refractory PVC advancing the next atrial activation. (HRA d is positioned in the high right atrium, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

RV Entrainment

Entrainment is the continual resetting of a re-entry tachycardia by pacing at a site close to or within the circuit at a cycle length slightly shorter that the tachycardia cycle length. The pacing stimulus travels both orthodromically in the same direction as the preceding tachycardia beat and antidromically resulting in a fused beat which is morphologically different to the tachycardia and the paced beats. This continues for all beats during entrainment apart from the final entrained beat where there is no collision of an antidromic beat with the orthodromic waveform.

As the RV apex is closer to the ventricular insertion point of an accessory pathway and further from the AV node entrainment from the RV apex will result in a shorter post pacing interval (PPI) minus tachycardia cycle length for AVRT versus AVNRT. This concept is demonstrated in Fig. 2.40.

This pacing is performed at the RV apex cycle length 20–30 ms shorter than the TCL. This is then examined in order to ensure that capture during pacing has occurred.

If this is confirmed then the PPI – TCL is measured, and the post pacing activation sequence is examined.

As shown in Fig. 2.41 in patients with **AVNRT** (**typical or atypical**) **the PPI – TCL is generally greater than 115 ms** [36]. Figure 2.39 demonstrates a short PPI-TCL of less than 115 ms which is indicative of AVRT.

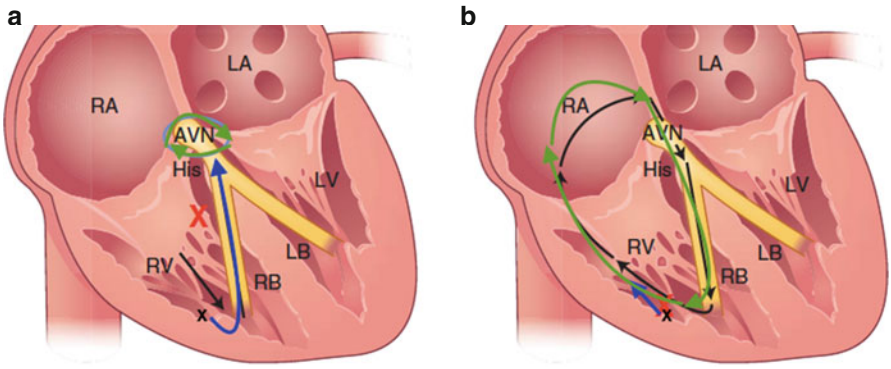

Fig. 2.40 Diagrammatic representation of entrainment from the RV apex. (**a**) On the *left image* the AVNRT circuit is located in the slow and fast pathways in the AV node and pacing from the RV apex is anatomically and electrically distant from the critical circuit resulting in a long PPI – TCL. (**b**) In the image on the *right* the ORT is utilizing the ventricle as part of the circuit and therefore pacing in the RV apex results in a PPI – TCL of less than 115 ms

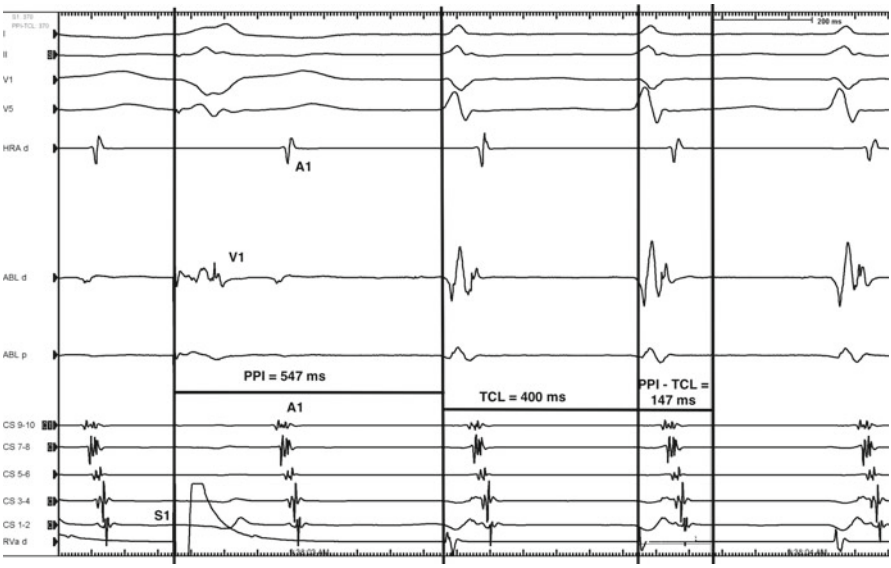

Fig. 2.41 Right ventricular entrainment during SVT. The tachycardia cycle length (*TCL*) of the tachycardia is 400 ms. Pacing is performed at a cycle length of 370 ms from the RV apex. Following confirmation of entrainment (not shown on this tracing) the post pacing interval (*PPI*) is calculated as 547 ms. The post pacing interval (PPI) minus the tachycardia cycle length (*TCL*) is 147 ms which is more indicative of an AVNRT (A refers to atrial activation while *V* is ventricular activation and S is stimulus. The ablation catheter (*ABL d*) is positioned close to the His, HRA d is positioned in the high right atrium, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

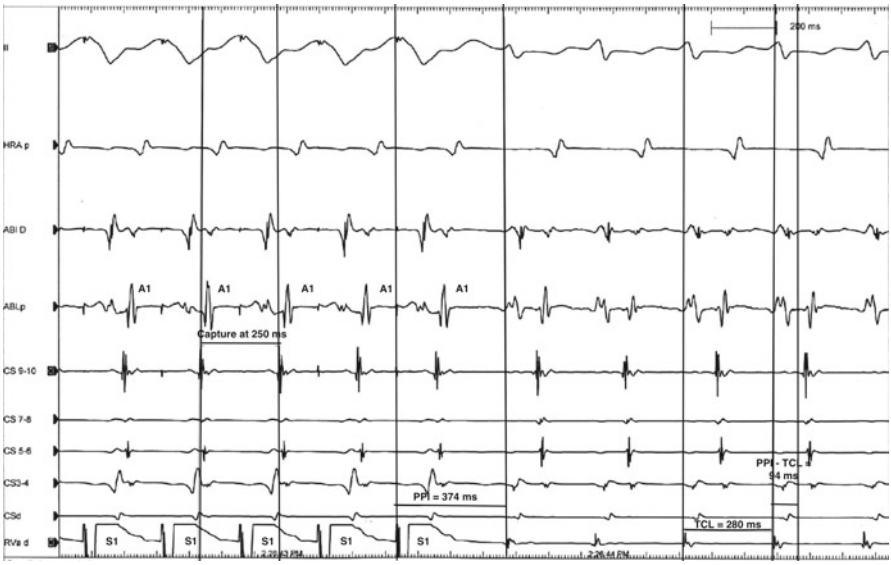

Fig. 2.42 RV entrainment during SVT. The tachycardia cycle length (*TCL*) is 280 ms. Pacing is performed at the RV apex at 250 ms with confirmation of atrial capture at that rate. The PPI – TCL is 94 ms which is suggestive of an ORT. The atrial activation sequence is suggestive of a left sided paraseptal pathway with the earliest retrograde atrial activation at CS 7/8. (The ablation catheter is positioned on the His, HRA d is positioned in the high right atrium, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

It should be noted that rapid ventricular pacing may result in AH prolongation which could artificially prolong the PPI. Therefore this should be corrected by subtracting the baseline AH interval from the PPI. The corrected PPI-TCL should be less than 110 ms for AVRT and greater than 110 ms for an AVNRT.

Examination of the post pacing activation sequence is also important. If the final entrained ventricular beat is followed by an atrial and then ventricular beat this is more likely to be due to an underlying AVNRT or AVRT. If the post pacing sequence is AAV then this is more likely to represent an underlying atrial tachycardia.

An alternative maneuver is to pace from the RV apex and compare the PPI-TCL with pacing from the RV base. A difference of greater than 30 ms between these two locations is suggestive of an AVNRT. This implies that there is a longer PPI-TCL moving further from the septum [37]. A difference less than 30 ms is more indicative of an AP (Fig. 2.42).

PVC During Tachycardia

This is performed in order to differentiate an SVT in which the critical component of the circuit is not dependent on the His such as an AVNRT versus a mechanism which is dependent on the His such as an ORT.

In order to perform this maneuver a PVC is delivered from the RV base earlier and earlier during tachycardia until the His is refractory. The subsequent atrial activation sequence and timing is then compared with that during the tachycardia. If it has no impact on the VA timing then there either is no accessory pathway or it was not penetrated by the PVC. This may occur if the accessory pathway is anatomically distant from the site of pacing such as a left lateral accessory pathway or if it has decremental retrograde conduction properties in which the activation is blocked.

If the next atrial activation is advanced then this implies the presence of an accessory pathway which conducts retrogradely. This does not mean that the accessory pathway is part of the tachycardia circuit. If the atrial activation sequence for this beat is different to that during tachycardia then this is a bystander. If the atrial activation sequence is then the following AH, AA and AV intervals have to be examined in order to assess if the tachycardia has been reset. If the subsequent AH, AA and AV intervals are increased then this implies that the PVC has reset the tachycardia and therefore that the accessory pathway is part of the circuit.

If a PVC delivered during His refractoriness post excites the next atrial activation or terminates the tachycardia then the accessory pathway is part of the circuit. The concept of delivering a PVC during tachycardia is demonstrated in Fig. 2.43.

Para-Hisian Pacing

This can be performed if the tachycardia cannot be induced and is used to differentiate retrograde conduction over the fast or slow pathway in the AV node from that over an accessory pathway. Although it is most commonly used for differentiating septal accessory pathway's from AVNRT it may also be used for left lateral (posterior) and right lateral (anterior) accessory pathway's.

There are two ways to perform this maneuver. The first is to position the mapping catheter towards the RV outflow tract slightly superior to the His recording and pace at 5 mA and 2 ms pulse duration [38]. The catheter is then slowly withdrawn with slight clockwise rotation along the RV anteroseptum until a His signal is recorded on the distal electrodes. The signal is then monitored for evidence of His capture and loss of capture with variability in respiration. With both capture of the His and the local anteroseptum the QRS is less broad than with loss of His capture.

Another method is to position the catheter along the RV basal anteroseptum so that a His signal is recorded on the distal electrodes and pacing is performed during normal sinus rhythm at a high output starting at 10 mA with a pulse width of 2 ms and reducing the output. At high pacing output there is capture of both the His and the local ventricle. As the output is lowered there is loss of His capture with widening of the QRS complex indicating activation of ventricular myocardium further away from the pacing site at the RV basal anteroseptum.

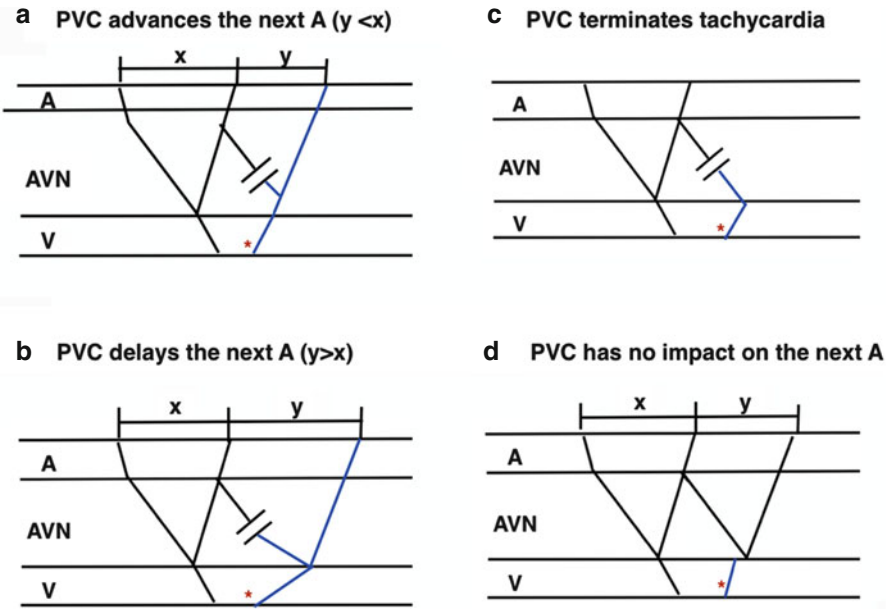

Fig. 2.43 Diagrammatic representation showing the effect of a PVC delivered during His refractoriness during tachycardia. The PVC (*) is delivered in the RV base. In (**a**) the PVC advances the next atrial activation. This indicates the presence of an accessory pathway however does not prove that this is a critical part of the circuit. In image (**b**) the PVC delays the next atrial signal. This indicates the presence of an accessory pathway which is a critical part of the circuit. In image (**c**) the PVC terminates the tachycardia. This also indicates the presence of an accessory pathway which is a critical component of the tachycardia circuit. In image (**d**) the PVC has no effect on the next atrial signal. This may indicate the absence of an accessory pathway. However an accessory pathway may be present but may be anatomically distant from the site of the PVC or may be a decremental pathway which is refractory to the PVC

The following measurements are then compared between a single beat with His and local ventricular capture compared with a single beat with loss of direct His capture:

Stimulus: Atrial Interval (SA)

His: Atrial Interval (HA)

Atrial Activation Sequence (AAS)

The basic principle relies on the anatomic fact that the His is subendocardial and encapsulated in annular tissue meaning that direct capture can only occur when a catheter is positioned along the RV anteroseptum at high pacing outputs. Lowering

the output therefore results in local ventricular capture which activates the RV apex with retrograde conduction up the right bundle to the His resulting in a significant delay to His activation. Although any pacing catheter can be used to perform this maneuver the use of a deflectable catheter with 1 mm spaced electrodes allows easier visualization of the His signal by reducing the width of the recorded local ventricular signal. This principle is demonstrated in Fig. 2.44.

The usual responses to this are shown in Table 2.3. In VA conduction using only the AV node loss of direct His capture results in a prolongation of stimulation to

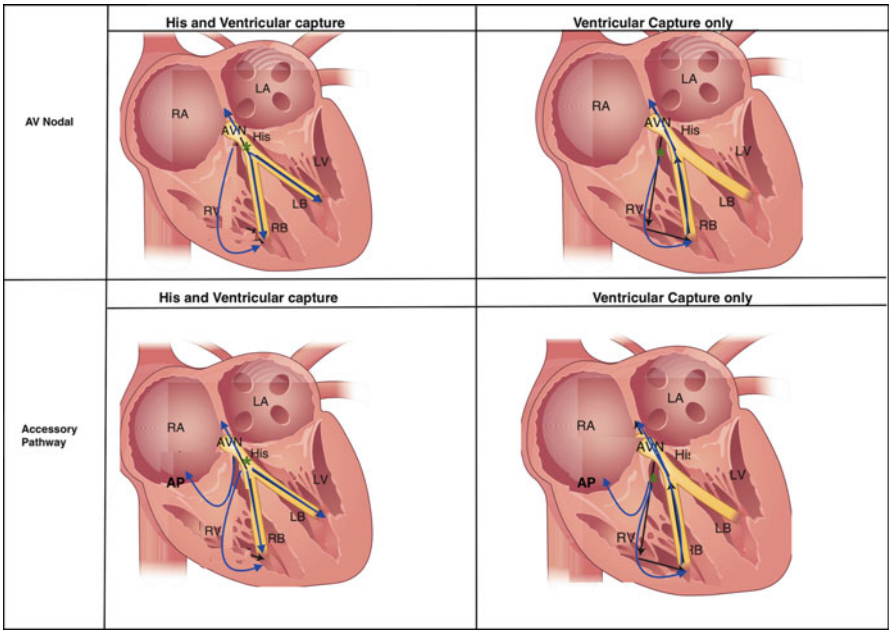

Fig. 2.44 Diagrammatic representation of Parahisian Pacing. In the *top left image* there is capture of both the His and the Ventricle resulting in a relatively short VA time and stimulation to RV apical time. In the *top right* image ventricular capture only conducts via the distal bundle branches via the His and to the atrium resulting in a prolonged VA time. This is indicative of AV nodal conduction. In the bottom left image conduction through the His and ventricle results in the most rapid conduction through an accessory pathway (AP). Conduction through the ventricle only (*bottom left*) results in a similar short VA conduction time through the AP

Table 2.3 Responses to ParaHisian pacing in AV nodal and AP conduction

VA conduction	SA	HA	AAS
AVN	Prolongs	Generally no change but may shorten with dual AVN physiology	Generally no change but may change with dual AVN physiology depending on the atrial insertion point of the slow pathway
AP conduction only	Unchanged or shorter	Shorter	May or may not change

atrial activation interval. In general there is no change in the HA interval although this may shorten in cases of dual AV nodal physiology. This is shown on the electrogram in Fig. 2.45 in which the His and ventricle and the His are both captured at a higher pacing output resulting in a stimulus to atrial interval of 76 ms. When the pacing output is reduced there is only ventricular capture with a prolongation of the stimulus to atrial activation of 136 ms. There is no change in the AAS. This is suggestive of AV nodal conduction only. Generally in AV nodal conduction the atrial activation sequence is generally unchanged, however in certain cases it may change. The slow pathway may have a left atrial insertion point, the CS to atrial connections could be distal or there may be functional block along the Eustachian ridge resulting in activation in the left atrium preceding septal and right atrial activation. Therefore the retrograde AAS is not sufficient to rule out AV nodal conduction only.

In VA conduction using an accessory pathway loss of direct His capture does not prolong the stimulation to atrial activation as the accessory pathway conduction is not dependent on conduction through the His. The HA interval often shortens. The AAS may or may not change depending on the atrial insertion point of the AP and occurs as a result of fusion of retrograde VA nodal and AP conduction.

This maneuver cannot be performed in patients with retrogradely conducting fasciculoventricular accessory pathways as direct His capture will occur at the site

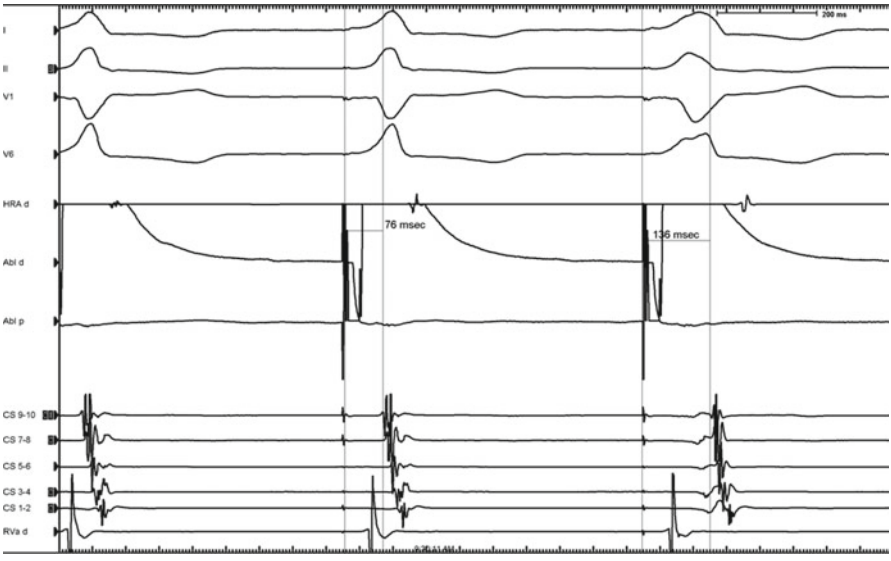

Fig. 2.45 Parahisian pacing in a patient with AV nodal conduction only. Pacing is performed from the ablation catheter which is positioned on the His. The narrower beat indicates capture of both the ventricle and the His with a stimulus to atrial time of 76 ms. When the pacing output is reduced there is only ventricular pacing with loss of His capture. The stimulus to atrial time is longer at 136 ms. This is indicative of AV nodal conduction. (HRA d is positioned in the high right atrium, HIS d in the distal His, HIS p at the proximal component of the His, CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS and RVa d is located in the RV apex)

of the accessory pathway insertion point during both high and low output pacing with no widening of the QRS at lower pacing output. In the reverse situation proximal RBBB may mean that direct pacing of the His via the proximal right bundle is not possible resulting in a wide QRS at high and low pacing output.

High output pacing may result in capture of other closely related structures resulting in an incorrect interpretation. Direct atrial capture at high output may reveal an apparent short stimulus to atrial activation time. High output pacing may also result in capture of the left bundle branch which may result in shortening of VA conduction for left sided pathways with an apparent increase in VA conduction time as the pacing output is reduced.

Transseptal Access

Transseptal access is used in order to gain access to the left atrium and left ventricle for AP mapping and ablation, left sided AT's, AF ablation, VT ablation and left atrial appendage occlusion. This procedure is performed using a combination of fluoroscopic images, pressure monitoring, contrast and often with the assistance of echocardiographic information.

Equipment

Trans-septal Needles

A number of transseptal needles are available for use which vary both in length and angulation. The most commonly used is the Brockenbrough (BRK) which is an 18 Guage needle with an arrow at the proximal end which indicates the direction of the tip of the needle. The BRK needle has a shaft to needle tip angle of 19° while the BRK 1 needle shown in Fig. 2.46 has a shaft to needle tip angle of 55°.

Additionally BRK needles vary in length. For the majority of standard non deflectable sheaths the needle is 71 cm while for a long deflectable sheath this is 98 cm.

The NRG RF transseptal needle shown in Fig. 2.47 (Baylis Medical, Montreal, Canada) is a 21 Guage device which allows delivery of RF at the tip of the needle. This comes in similar lengths to the BRK needle with similar curve option. This needle is useful for aneurysmal septums and has been shown to have a lower incidence of sheering from the inside of a transseptal sheath [39]. The needle is positioned against the fossa ovalis and RF is applied to the tip at 10 W for 2 s. On TEE and ICE entry into the left atrium is seen as bubbles in this chamber.

Fig. 2.46 Showing the main types of BRK Transseptal Needles (St Jude Medical, St Paul, MN, USA). The image on the top shows the 71 cm BRK needle at the top with a shaft to tip angle of 19°, below this is the 71 cm BRK1 needle which has a shaft to tip angle of 55°. Below this is the 56sm BRK needle. On the *bottom right image* the tips of the three needles are shown in closer detail. The image on the *bottom left* shows the *pointer arrow* which in general should be directed at 4–5 o'clock

Fig. 2.47 Showing the Baylis NRG ® Needle (Baylis, Montreal, Canada)

Transseptal Sheaths

There are various sheaths available for trans-septal access. These are either fixed or deflectable. The Swartz Left (SL) range of sheaths (St Jude Medical, St Paul, MN, USA Medical) is most commonly used. These sheaths were principally designed to deflect towards the mitral annulus for accessory pathway mapping and ablation. All of these sheaths have a primary curve of 50° with a secondary curve of 0° in the SLO, 45° in the SL1, 90° in the SL2 and 135° in the SL3. The SL4 has a 35° primary curve and has an angulation of 180°. Other non-deflectable transseptal sheaths include the Channel FX (Boston Scientific Way Marlborough, MA, USA) and the Convoy Advanced (Boston Scientific Way Marlborough, MA, USA).

Several deflectable sheaths also exist. The Agilis sheath (St Jude Medical, St Paul, MN, USA Medical, St Paul, MN, USA) is 91 cm long and requires the 98 cm transeptal needle. This sheath is available in medium and long reach options. Other deflectable sheaths include the Channel steerable (Boston Scientific Way Marlborough, MA, USA), the Direx (Boston Scientific Way Marlborough, MA, USA) and the Mobicath (© Biosense Webster, Inc).

Guidewires

These are generally 0.032 in. in diameter with a J shaped distal end of approximately 3 mm in length at the tip. These wires are placed into the superior vena cava and are used to advance the sheath and dilator over. They may also be advanced through the sheath and dilator into the left superior pulmonary vein in order to confirm position and allow dilatation of the transseptal access point while minimizing the potential risk of the dilator advancing through the lateral left atrial wall. If unsure whether the transseptal needle is in the left atrium an angioplasty wire can also be advanced through the needle prior to advancement of the sheath and dilator.

Fluoroscopic Approach

In order to help with fluoroscopic access a catheter can be positioned in the coronary sinus and the His. The His catheter is at the same level but anterior to the fossa ovalis. The electrode recording the proximal His acts as a surrogate for the aortic root. The coronary sinus catheter shows the direction in which the transseptal needle should pass in an LAO projection. This is parallel and inferior to the direction of the transseptal needle. The distal end of the coronary sinus also marks the lateral wall of the left atrium. The relevant anatomy is demonstrated on the CT in Fig. 2.48.

Fig. 2.48 Relevant anatomy in a trans septal approach. In the top image the fossa ovalis (*FO*) is posterior to the aorta (*Ao*). Also seen in this image is the right atrial appendage (RAA) anteriorly, the coronary sinus (*CS*) posteriorly and the left atrium (*LA*). The mid image shows a trans-septal sheath engaging the fossa ovalis (*FO*) posterior to the aorta). The image at the bottom is a CT showing the right atrium (*RA*) and left atrium (*LA*). The fossa ovalis (*arrow*) is posterior to the ascending aorta (*AAo*). Also seen in this image is the right superior pulmonary vein (*RSPV*), right inferior pulmonary vein (*RIPV*), left superior pulmonary vein (*LSPV*), left inferior pulmonary vein (LIPV), left atrial appendage (*LAA*) as well as the right ventricle (*RV*), left ventricle (*LV* and descending aorta (*DAo*)

Although various fluorosocopic views may be used the most useful are the LAO 30, RAO 30 and the left lateral. The sheath and dilator are flushed with heparinized saline in order to eliminate all air. The trans-setpal needle is flushed and in the case of a BRK the stylet is placed back inside the needle and locked in

place. The needle can be placed inside the sheath and dilator in order to ensure that these are compatible in terms of length. The needle is then removed and the sheath and dilator are introduced over a 0.032 J shaped wire into the superior vena cava. The wire is then removed and the dilator is aspirated and flushed with heparinized saline. The transseptal needle is then introduced into the dilator and sheath with the tip of the needle kept inside the dilator. In the case of a BRK needle it is important that the stylet is kept inside the needle while introducing this into the dilator in order to prevent sheering of plastic from the dilator. This is not required for the NRG RF which has a less sharp tip. Once the needle is close to and still inside the dilator tip the stylet is removed and the needle is aspirated and flushed with heparinized saline. This can then be connected to a three way tap and connected to pressure monitoring and contrast if required. Systemic heparin is then administered to the patient prior to transseptal access being achieved.

The sheath with dilator and needle are positioned between 4 and 6 o clock and withdrawn from the superior vena into the right atrium using an LAO 30 projection. As the apparatus is withdrawn along the superior vena cava the sheath and

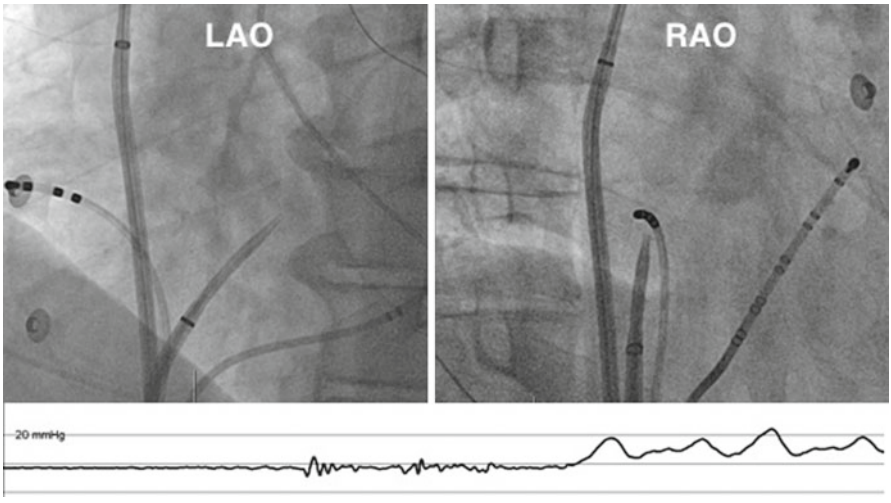

Fig. 2.49 Fluoroscopic guidance of trans-septal access in the *LAO* view (*top left*) and *RAO* view (*top right*). In the LAO projection the tip of the dilator should be superior to and parallel to the coronary sinus which demonstrates the AV groove parallel and posterior to the mitral annulus. The proximal poles of the quadripolar catheter are positioned along the His which acts as an approximate marker of the aortic root. In the RAO image on the *top right* the needle and sheath is clearly posterior to the His catheter. The pressure tracing on the bottom is recorded through the trans septal needle and shows a damped pressure tracing as it is against the septum followed by a left atrial pressure as access is achieved

dilator jumps to the left as it deflects from the descending aorta into the right atrium, Further withdrawal results in a second jump as the apparatus engages the fossa ovalis. In the LAO projection the tip of the dilator should be superior to and parallel to the coronary sinus which demonstrates the AV groove parallel and posterior to the mitral annulus, thus helping to demonstrate the widest portion of the LA. The relevant anatomy for trans septal access is shown in Fig. 2.49. In the RAO projection the anterior and posterior projections can be checked relative to the His catheter. This can also be demonstrated in the left lateral position with the His catheter pointing anterior and the CS posterior. The needle is pointed at 1 o'clock in this view for engagement of the fossa ovalis. The proximal His recording identifies the central fibrous body at the most inferior aspect of the noncoronary aortic cusp. Prior to transseptal access a bolus of heparin should be administered.

The apparatus is then withdrawn very slightly and then advanced with the needle outside of the sheath and dilator with pressure measured from the tip of the needle. There is usually a jump as the needle crosses the septum. Confirmation should be performed by checking the pressure and injecting contrast. As soon as this is confirmed, the dilator and sheath can be advanced over the needle, and the needle and dilator removed so that a long J wire can be gently advanced into the left superior pulmonary vein. Care must be taken at all times to ensure that the sheath and dilator are not advanced too far resulting in a perforation, or that the wire is not advanced into the left atrial appendage. For the second transseptal sheath, some operators withdraw the sheath and leave the J wire in place and then advance the ablation catheter through the puncture site, while others perform a second transseptal puncture using the same puncture.

Echocardiographic Visualization

Although fluoroscopic guidance is fundamental in achieving transseptal access variations in anatomy may result in difficulties crossing the foramen ovale. These include an aneurysmal atrial septum defined as a deviation during the cardiorespiratory cycle of at least 10 mm, prior cardiac surgery, congenital heart disease, dilated atria, multiple prior trans-septal procedures and a dilated aortic root. The interatrial septum cannot be reliably differentiated from the aortic root on trans thoracic echocardiogram and therefore either ICE or TEE can be used. The advantage of both of these imaging modalities is that the fossa can be directly visualized. The disadvantage of ICE is that it often required additional vascular access and is generally quite expensive. TEE is extremely useful but requires the patient to be under general anesthesia and has the potential for esophageal injury. Tenting of the fossa ovalis can be seen on TEE in Fig. 2.50.

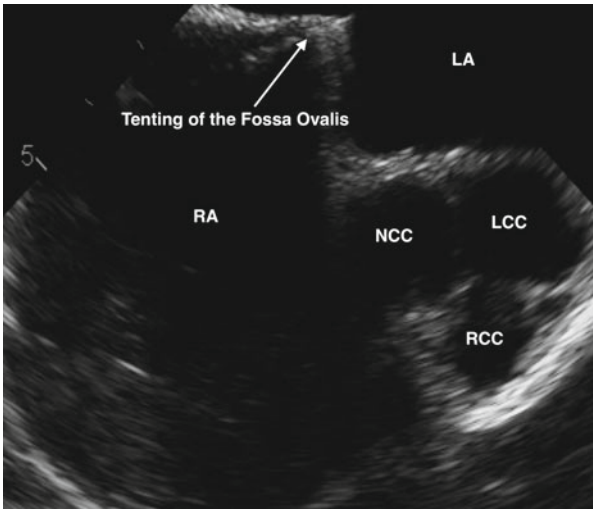

Fig. 2.50 Transesophageal imaging showing tenting of the Fossa Ovalis during trans-septal access. The right atrium (*RA*) and left atrium (*LA*) are seen as well as the non coronary cusp (*NCC*), left coronary cusp (*LCC*) and right coronary cusp (*RCC*) of the aortic valve

Important Points

1. Unipolar electrograms are amplified signals recorded between the distal pole of the catheter (+) and Wilsons Central Terminal (−).
2. Bipolar signals are amplified signals recorded from two closely spaced unipoles. In general the distal pole is negative while the proximal pole is positive.
3. All signals are amplified and filtered. The amplified signal first passes through a high pass filter which allows higher frequency signals to pass through while removing signals below a designated frequency. This then passes through an isolation amplifier which isolates the current from the patient and is subsequently transmitted through a low pass filter. This allows lower frequency signals to be transmitted while filtering out higher frequencies.
4. SNRT is measured using the principle of overdrive suppression in which pacing is performed close to the sinus node at a rate faster than the sinus rate and the time taken from the last paced beat to the first intrinsic sinus beat is measured. A sinus node recovery time, taken as the longest interval after pacing at any cycle length is generally considered abnormal if longer than 1500 ms.
5. SACT is the conduction time from the SN to the RA tissue. A normal SACT is considered to be to be 50–125 ms.

6. The AH interval is measured from the onset of the local atrial electrogram recorded in the His catheter to the onset of the His signal and represents conduction through the AV node. The normal range is anywhere from 50 to 120 ms. A prolonged AH interval may occur as a result of intrinsic AV nodal dysfunction or a result of antiarrhythmic drugs. A short AH interval generally occurs in the presence of catecholamines.
7. The HV interval is measured from the onset of the local His signal to the local ventricular signal on the His catheter (Fig. 2.24). This generally reflects the conduction time through the proximal His, bundle branches and the Purkinje system. The normal range is considered to be between 30 and 55 ms. Intrinsic His dysfunction or antiarrhythmic drugs may prolong the HV interval. A short HV interval may be seen with accessory pathway conduction which may even be negative. Care must be taken not to confuse the right bundle electrogram as the His electrogram may artificially lead to what may seem like a short HV interval.
8. The effective refractory period (ERP) is the longest coupling interval in which the stimulus fails to stimulate the myocardium at twice the diastolic threshold.
9. The AV Wenckebach point is defined as the longest cycle length which results in 2:1 AV block.
10. If the tachycardia cycle length prolongs with induction of BBB then this implies that the arrhythmia is AVRT with a VA connection on the same side as the BBB known as Coumel's sign.
11. Entrainment is the continual resetting of a re-entry tachycardia by pacing at a site close to or within the circuit at a cycle length slightly shorter that the tachycardia cycle length. During an SVT entrainment from the RV results in a shorter PPI-TCL for AVRT versus AVNRT.
12. If a PVC delivered at the same time as the antegrade His signal results in an advancement of the next atrial activation with no change in the AAS this implies the presence of an accessory pathway which participates in the circuit. A change in the AAS implies that the accessory pathway is not participating in the tachycardia. If a His refractory PVC does not affect the following atrial beat then there is either no AP or the PVC has not conducted retrogradely up the AP. This may occur if the AP has decremental retrograde conduction or is anatomically far from the location of delivery of the PVC.
13. If a tachycardia cannot be easily induced parahisian pacing may be helpful to study retrograde conduction properties. In the presence of VA conduction using only the AV node loss of direct His capture results in a prolongation of stimulus to atrial activation interval. In general there is no change in the HA interval although this may shorten in cases of dual AV nodal physiology. In VA conduction using an AP loss of direct His capture does not prolong the stimulation to atrial activation as the AP conduction is not dependent on conduction through the His. The HA interval often

shortens. The AAS may or may not change depending on the atrial insertion point of the AP and occurs as a result of fusion of retrograde VA nodal and AP conduction.

14. Trans septal access may be obtained using a fluoroscopic approach or with the addition of echocardiographic guidance. In the fluoroscopic image the coronary sinus catheter shows the direction in which the transseptal needle should pass in an LAO projection. This is parallel and inferior to the direction of the transseptal needle. The distal end of the coronary sinus also marks the lateral wall of the left atrium.

This can also be demonstrated in the left lateral position with the His catheter pointing anterior and the CS posterior. As shown in Fig. 2.49 pointing the needle at 1 o'clock is reasonable in this view for engagement of the fossa ovalis. The proximal His recording identifies the central fibrous body at the most inferior aspect of the noncoronary aortic cusp.

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Chapter 3
Electroanatomic Mapping

Benedict M. Glover and Pedro Brugada

Abstract Electroanatomic mapping (EAM) involves the rapid acquisition of multiple electrical and anatomical points in order to create a 3 dimensional map encompassing this data. These systems use **magnetic**, **impedance or a combination** of the two for the non-fluoroscopic location of the catheters. Data can be displayed on a recreated anatomic structure. This data includes activation times, voltage recordings and entrainment mapping. One of the original mapping systems the Localisa (© Medtronic plc 2015) has been replaced by three systems which are used most commonly in clinical practice which include CARTO (© Biosense Webster, Inc), NavX (St Jude Medical, St Paul, MN, USA) and Rhythmia (Boston Scientific Way Marlborough, MA, USA). Despite advances in the automation of these systems it is important to examine electrogram quality and annotation otherwise the map may not make any sense.

General Principles of EAM Mapping

Although the current mapping systems differ in the specific technology employed for catheter localization and electrogram acquisition and processing there are several important general principles for all aspects of mapping systems. It is important that useful data are processed. In the electrophysiology laboratory the most common mapping includes activation (isochronal), voltage (isopotential) and entrainment mapping. If respiratory gating is used all points in all systems are generally recorded during the same phase of respiration which is generally end expiration.

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Reference Point

A stable reference point is required for activation mapping so that all points can be measured relative to the same electrogram. An ideal reference electrogram should be stable with an obvious positive or negative peak for measurement. The trigger is then set on either the most positive or negative change in voltage over time (dV/dT). In the ventricle a surface QRS can be used for this or the electrogram from the RV apical catheter. In the atrium the surface P wave is not satisfactory and therefore the coronary sinus catheter is generally used given its relative stability. It is important that this is positioned in a stable position with a clear atrial signal.

Window of Interest

It is important to ensure that every point taken for an arrhythmia is related to the same beat. For a **focal arrhythmia** such as PVC's, focal VT and many AT's the window of interest is set relative to the onset of the P wave or QRS. **The earliest component may be set at 80 ms ahead of the surface signal and 30 ms after the offset**.

For a **re-entry tachycardia** such as atrial flutter (both typical cavotricuspid isthmus dependent and atypical), some atrial tachycardia's and scar related VT the window of interest is chosen as **90 % of the tachycardia cycle length** (TCL) to allow for a degree of cycle length variability. The earliest component in the window is half of the value prior to the onset of the P wave or QRS and the latest component is half of the value after the onset of the P wave or QRS. The early and late signals in this method are arbitrary and only used to have an understanding of the mechanism and anatomical regions involved in the circuit. The best location for ablation may therefore not be the earliest recording on this map but a critical isthmus within it.

In order to perform an activation map which helps to locate the isthmus in an atrial re-entry circuit a slightly different technique is used while setting the window of interest. The **earliest component** of the window is set for **mid diastole of the beat of interest and the late component of the window is set for mid diastole for the following beat**. [1] This means that the region where early meets late is the **mid-diastolic region**.

The P wave duration is measured from the surface ECG at 100 mm/s with or without the administration of intravenous adenosine. The early component of the window is calculated by subtracting the P wave duration from the tachycardia cycle length and dividing by two. As the window is being set from the reference signal the distance from the reference to the onset of the P wave is subtracted if the reference occurs before the p wave or added if its occurs after the P wave. This should correspond with mid-diastole. In order to calculate the late component to the window the duration of the early window is subtracted from the tachycardia cycle length and multiplied by 90 % (Fig. 3.1).

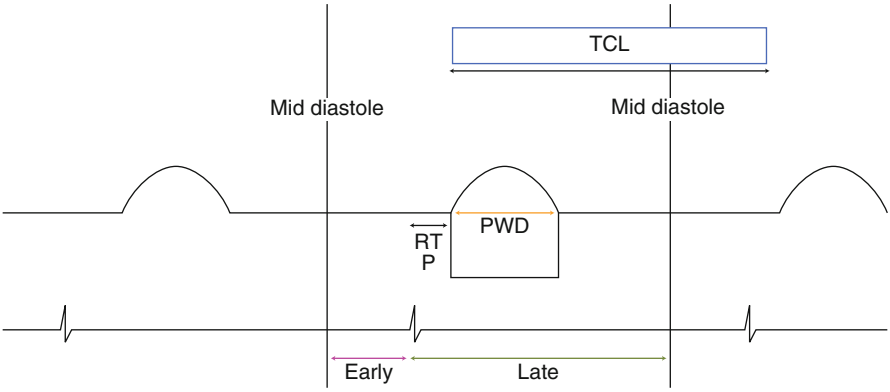

Fig. 3.1 Calculation of window of interest in a re-entry tachycardia. *TCL* tachycardia cycle length, *PWD* P wave duration, *RTP* reference to onset of P wave

Activation Mapping (Isochronal)

One of the many advantages of electroanatomic mapping is the ability to acquire multiple electrogram signals during a tachycardia and color code these so that an activation map can be acquired. Following selection of an appropriate reference signal and window of interest points are acquired and selected relative to the reference signal. Electrograms can be individually viewed and a marker is used to designate the onset of the signal which can then be moved if required. These signals are then color coded so that early is designated as red followed by yellow, green blue, and purple which indicates later activation. In focal arrhythmias regions which are coded red tend to be reasonable areas to explore and consider ablation particularly for the very earliest signal with a QS and no R wave on the unipolar electrogram. In unipolar electrograms the distal pole of the catheter (anode) is connected to a remote electrode known as the indifferent electrode (cathode). Depolarization towards the distal electrode results in a positive deflection while depolarization away from the electrode results in a negative deflection. A QR therefore implies that the wave of depolarization is moving away from the electrode. In cases of poor electrode contact a slurred S wave may also be present which implies that better catheter manipulation is required.

In macro re-entry circuits the earliest site as designated by red is not generally targeted with ablation. Rather the activation sequence should be examined in order to understand the basis of the arrhythmia and further mapping with the catheter should be performed in order to help localize the critical isthmus with mid diastolic signals. As shown in the activation map in Fig. 3.2 a re-entry circuit is seen rotating around a right atrial lateral wall atriotomy scar. Ablation (light and dark red dots) is performed along the lateral wall from the superior vena cava to the inferior vena cava after pacing for phrenic nerve stimulation is performed and marked as a white line. This resulted in termination of the tachycardia.

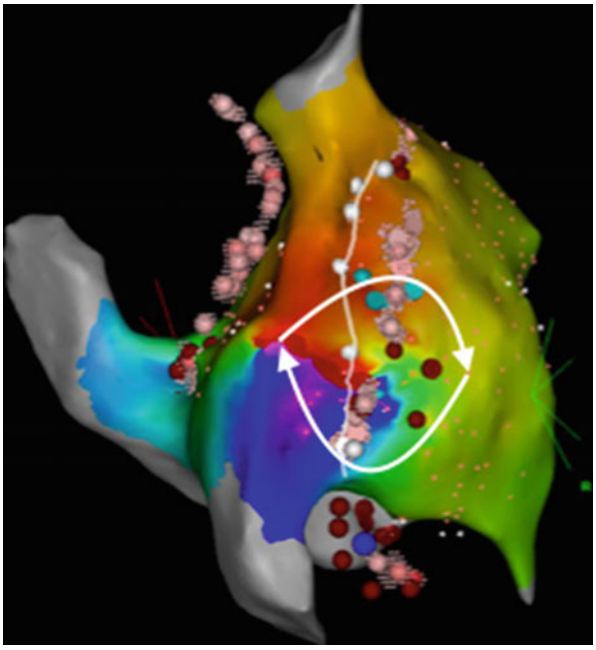

Fig. 3.2 Activation map showing a macro re-entry circuit around an atriotomy scar in a patient who previously underwent mitral valve surgery. The earliest activation is seen as *red* followed by *yellow*, *green*, *blue* and then *purple*. The *white arrow* shows the overall direction of conduction. Prior to ablation high output pacing was performed and the approximate location of the right phrenic nerve was mapped out (shown as a *white line*). Ablation was performed (*light and dark red dots*) from the superior vena cava to the inferior vena cava with termination of the tachycardia. The *light blue* dots indicate fractionated potentials. Also seen on the *left side of the image* in the background is an ablation line along the left interatrial septum which resulted in termination of a second tachycardia and at the inferior aspect of the image a cavotricuspid ablation line which terminated a third tachycardia

Prior to delivery of ablation in this region entrainment can be performed to ensure that the location is within the circuit. If the tachycardia terminates pace mapping may be performed and compared with the clinical arrhythmia. In order to perform pace mapping the minimum output is used from the distal electrodes of the ablation catheter and the paced beats are compared with the clinical arrhythmia. It is possible to have multiple different pace maps by pacing from the same site as the same isthmus may have multiple exit sites. In VT a long stimulation to onset of QRS with an excellent pace map generally indicates close proximity to the isthmus which then conducts to the exit site. Data acquired from an activation map can be used to create a propagation map. This demonstrates a wavefront of activation color coded red with a background blue image. This demonstrates conduction velocity and the overall direction of depolarization for both focal and re-entry circuits.

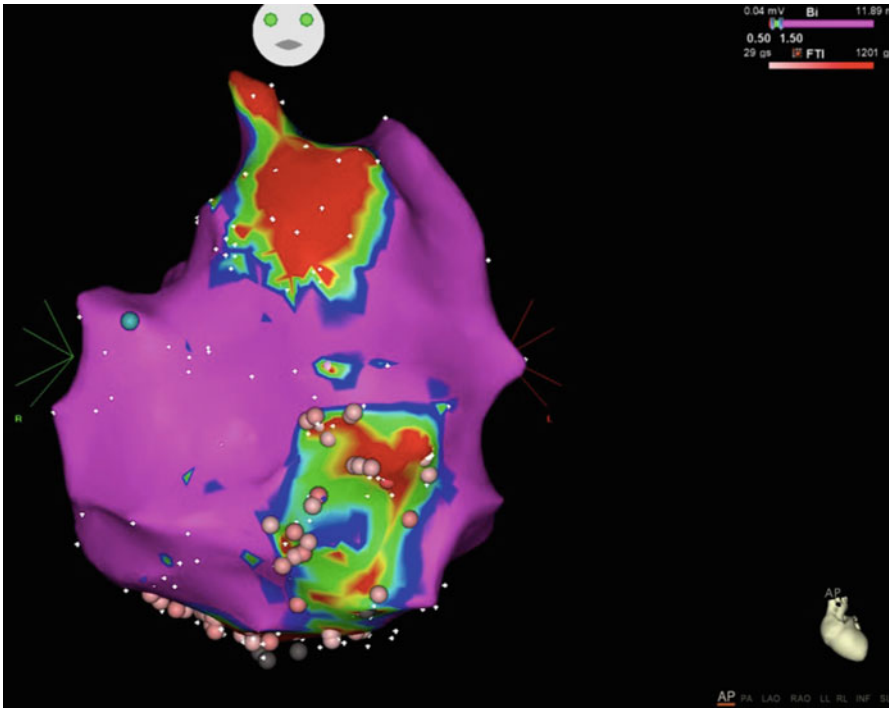

Fig. 3.3 Voltage map of the right ventricle in a patient with a history of tetralogy of fallot. Two regions of dense scar are seen, one in the anterosuperior tricuspid annulus and the other in the anteroapical region. Both of these are surrounded by heterogenous tissue. The inducible VT was found to circulate around the anteroapical scar which terminated with ablation

Voltage Map (Isopotential)

Is used to map local potentials during either sinus rhythm, tachycardia or pacing. The concept is that low amplitude endocardial signals are more indicative of regions of scar while higher amplitudes imply relatively healthy myocytes. As well as the amplitude of the signal the degree of fractionation and duration of the signal are very important as this may imply regions of slow conduction, which are often targeted for ablation.

The amplitude of each signal can be color calibrated so that red implies scar with orange, yellow, green, blue and purple indicating progressively higher amplitudes.

In the right ventricle normal bipolar electrograms have an amplitude of 3.7 ± 1.7 mV and in the left ventricle 4.8 ± 3.1 mV with **1.5 mV or less defined as scar and 0.5 mV or less dense scar**. [2] An example of a voltage map in a patient with tetralogy of Fallot is shown in Fig. 3.3.

In the left atrium normal bipolar amplitudes are considered to be greater than 0.5 mV [3] although in patients with AF this cutoff may be 0.45 mV. [4]

A **late potential** is defined as an isolated potential occurring greater than 10 ms after the end of the surface QRS complex while a **mid diastolic potential** is defined as a high frequency localized potential occurring between two QRS complexes with an isoelectric line either side. **Fractionated potentials** are defined as low amplitude signals with multiple sharp deflections with an overall duration greater than or equal to 70 ms. **Complex fractionated atrial electrograms** (**CFAE's**) are defined as low amplitude fractionated atrial electrograms with a cycle length of less than 120 ms.

Entrainment Mapping

Entrainment mapping can be performed by pacing from the ablation catheter in various locations where the tachycardia circuit location is suspected. By overdrive pacing at a cycle length shorter than the tachycardia cycle length the tachycardia is continuously reset without terminating to the same cycle length with manifest and concealed entrainment. In general the pacing cycle length is 20–30 msec shorter than the tachycardia cycle length although in certain circumstances such as an orthodromic reciprocating tachycardia a rate just slightly less than the tachycardia cycle length is chosen from the RV apex as faster rates may penetrate the AV node and result in termination of the tachycardia.

A short PPI – TCL generally indicated closer proximity to the circuit. This difference can then entered onto the mapping system as a color coded time where red is less than 30 msec followed by yellow, green, blue and finally purple where the difference is greater than 100 msec. This is an effective strategy to help map out the regions of the chamber involved in the re-entry circuit. It does not provide data on where exactly to ablate and this decision must be made based on the location of the isthmus or by joining various anatomic structures. In a diseased atrium where multiple ablations have been performed it may be difficult to capture all areas as well as the potential to terminate the arrhythmia as well as initiation of a different tachycardia.

Specific Mapping Systems

CARTO Mapping System (© Biosense Webster, Inc)

This system uses a combination of magnetic and impedance based technology for catheter localization and data acquisition. A locator pad composed of three coils is positioned under the table and emits very low intensity magnetic fields between 5×10^{-6} to 10^{-5} T. As demonstrated in Fig. 3.4 each coil emits a slightly different field strength which is then detected by a sensor in the proximal tip of the ablation catheter. The relative magnetic field from each coil is then fed back to the system with a three dimensional location in the x,y and z axis and catheter orientation in three

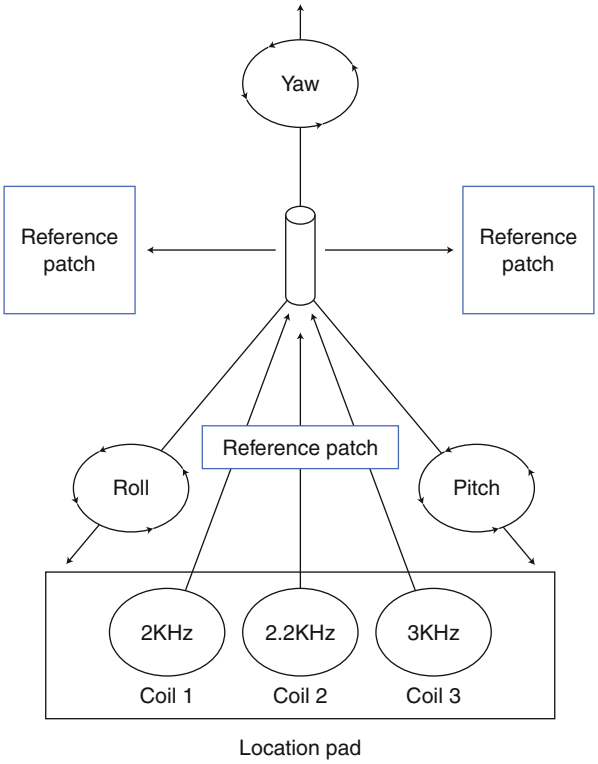

Fig. 3.4 Concept of Electroanatomic mapping using the CARTO system (© Biosense Webster, Inc)

planes termed roll, pitch and yaw. The ablation and diagnostic catheters also emit a low level current which is detected by six reference patches. Although the locations of diagnostic catheters can be visualized the electrogram's can unfortunately only be seen in specific catheters designed by the company such as the Lasso, the Pentarray and the Decanav.

The Lasso is a 10 or 20 pole circular deflectable catheter (Fig. 3.5) which is predominantly used for left atrial mapping and in particular pulmonary vein isolation. The circular component is flexible with a 4.5 Fr diameter and a shaft which fits through an 8 Fr sheath.

The Pentarray catheter consists of 20 electrodes on 5 arms (Fig. 3.6). Each arm is soft with a 3 Fr diameter and a shaft, which can be positioned through a 7 Fr sheath and comes in different curves. Each individual electrode is 1 mm in length with varying electrode spacing; either 4 mm spacing or 2-6-2 mm spacing.

The Decanav catheter is a 10 pole catheter in which each electrode is 2 mm in length and with electrode spacing of 2-8-2 mm (Fig. 3.7). This allows the rapid acquisition of multiple points during mapping and can be useful for both atrial tachycardia and ventricular tachycardia including outflow tract tachycardia. Like

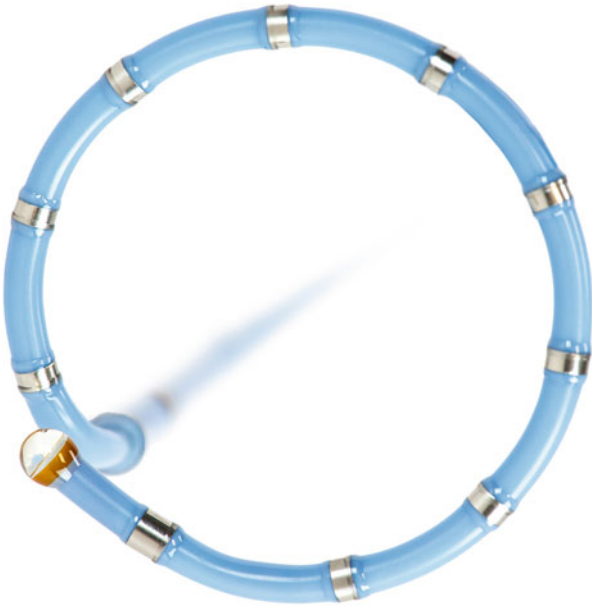

Fig. 3.5 Showing bipolar electrodes on the circular Lasso Catheter with 10 poles on the catheter (© Biosense Webster, Inc)

Fig. 3.6 Image of the Pentarray Mapping Catheter (© Biosense Webster, Inc) showing 20 electrodes on 5 arms with variable spacing

the Pentarray it can be advanced through a 7 Fr sheath and is available in both a D and an F curve.

The location patches also transmit low level current to each other, which helps to record chest impedance allowing for respiratory gating. This is calibrated at the start

of the procedure so that points are taken during end expiration and is particularly useful for accurate fast anatomic mapping. In order to gate the circular mapping catheter should be in contact with the wall of the left atrium. This can easily be achieved by positioning the catheter along the mitral annulus or in one of the pulmonary veins. A threshold for respiratory gating can be set with lower values resulting in more accurate but slightly slower data acquisition.

Merging the Baseline CT/MRI onto the Anatomic Map

Often baseline imaging is useful in order to assess pulmonary vein anatomy and assess for aberrant pulmonary veins. The baseline CT or MRI of the left atrium can also be superimposed on the left atrial shell obtained during fast anatomic mapping in order to create a merge. In order to perform this the baseline CT has to be imported onto the mapping system. This is then segmented so that the chamber of interest is enhanced. Following creation of the map the CT or MRI can be integrated by using a combination of both landmark and surface registration. As shown in Fig. 3.8 select points are chosen on the map and the same points on the CT which are used during the merge process. Inaccuracies may exist between the CT and the map due to changes in time with alterations in either the rhythm or hydration affecting the LA geometry.

Fig. 3.7 Image showing the distal end of the Decanav Mapping Catheter (© Biosense Webster, Inc)

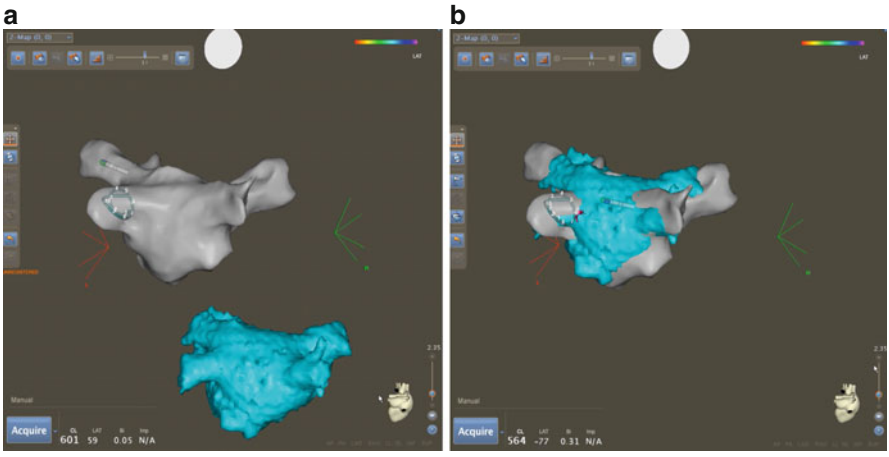

Fig. 3.8 Fast Anatomic Map created using the Lasso Catheter with a CT LA in the *top image*. Landmarks are selected on both the map and the CT and the images are merged as shown in the *bottom image*. (© Biosense Webster, Inc)

Additional Features of Carto

This system has several software features which may be considered to be clinically useful.

Visitag (© Biosense Webster, Inc) uses automation in order to create 4 mm^2 points on the map which fulfill specific pre-programmed parameters. These parameters consist of the minimum time at a particular point, the maximum range of movement of the catheter tip, the minimum force applied as well as the percentage time that the force was obtained for. Impedance and temperature changes can also be tracked. Additionally a grid feature marks 2 mm^2 points along the entire ablation lesion.

Paso (© Biosense Webster, Inc) software has been introduced into the Carto 3 platform in order to help to perform accurate pace mapping. This provides a numerical value for each lead and provides an overall assessment of the accuracy between the clinical arrhythmia and the paced beat. Although the overall efficacy has yet to be studied it appears to have a useful clinical role in particular for focal PVC's as shown in Fig. 3.9 and VT.

CartoUnivu (© Biosense Webster, Inc) allows real time catheter movement to be tracked on a pre-recorded cine angiogram. This is particularly useful for AF ablations where a 3 dimensional rotational angiogram of the left atrium is performed at the start of the procedure following the administration of intravenous adenosine or with rapid ventricular pacing. This image can then be integrated onto the map and viewed in any angle. Coronary angiograms can also be integrated for epicardial ablation as well as LVOT ablations. This may have an overall effect in lowering the total radiation exposure for the entire case, however, data proving this statement are still missing.

Ensite Velocity System (St Jude Medical, Minnesota 55442, USA)

This system emits a 8.136 kHz current between three pairs of surface electrodes in three different planes; cranial to caudal, right to left and posterior to anterior. This is detected by the ablation and diagnostic catheters which use the current degradation to estimate the location of the catheters in the x, y and z axis and allows the processing of up to 128 electrodes on up to four catheters. Impedance variability can lead to an inaccuracy in localising the catheter location and an intracardiac reference is therefore preferred as opposed to the external reference in CARTO. This may be partially compensated for by using field scaling which uses the inter-electrode spacing to attempt to compensate for inconsistencies in the map. Respiratory motion is also compensated for by recording variations in transthoracic impedance during respiration. One of the major advantges of Ensite over CARTO is the ability to acquire data from any catheter rather than a catheter designated by the system. Another attractive feature is the ability of the system to review data while still acquiring further data. An example of a velocity map using the Tacticath is shown on Fig. 3.10.

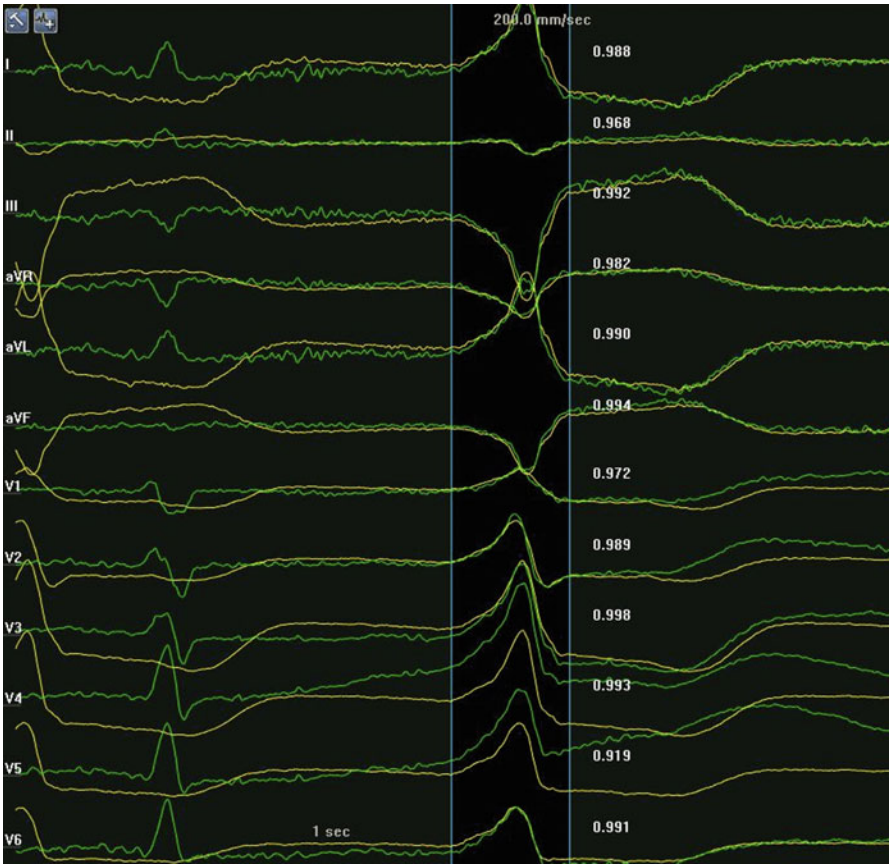

Fig. 3.9 Paso Software (© Biosense Webster, Inc) Used to compare a paced ventricular beat (*yellow*) with intrinsic ectopic beat (*green*) in the anterior mitral valve annulus

A further incorporation called **Mediguide** (**St Jude Medical**, **Minnesota 55442**, **USA**) now allows visualisation of catheters on a fluoroscopic image acquired at the start of the procedure. This employs a electromagnetic field with a sensor in the catheter and a reference sensor on the patients chest allowing imaging of catheter positions on a pre-acquired cine loop. The electromagnetic transmitter unit is installed in the fluoroscopy detector.

Rhythmia Mapping System (Rhythmia Mapping, Rhythmia Medical, Boston Scientific Inc., Marlborough, MA, USA)

This system uses a combination of magnetic and impedance degradation in order to localize catheters. A magnetic sensor in the tip of the Orion mapping catheter is the predominant guide to location with impedance used for additional clarification of

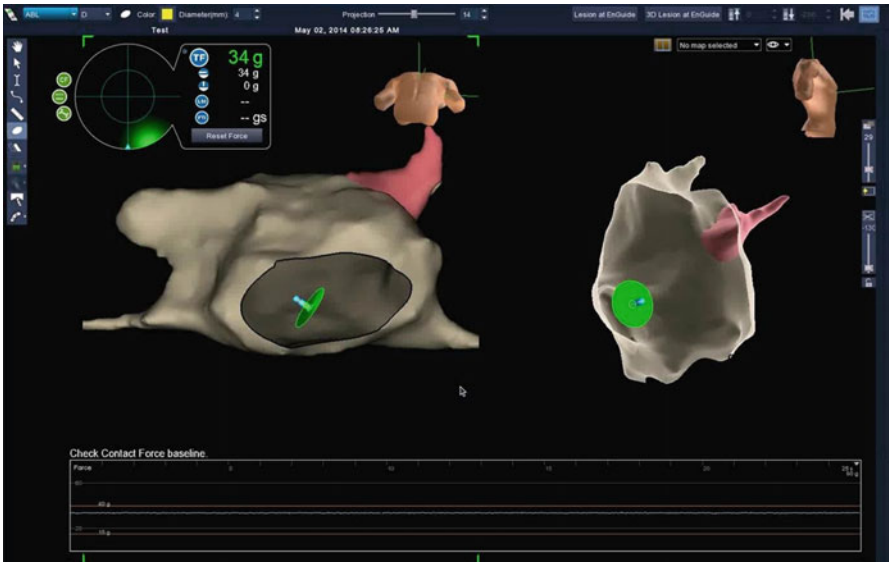

Fig. 3.10 Velocity Mapping system ((St Jude Medical, Minnesota 55442, USA) with Tacticath contact force catheter showing the left atrium from the mitral annulus on the left and right lateral image showing the left superior and left inferior pulomnary veins posteriorly (*left of the image*) and the left atrial appendage anteriorly (*right of the image*)

Fig. 3.11 Orion Mapping Catheter (Rhythmia Mapping, Rhythmia Medical, Boston Scientific Inc., Marlborough, MA, USA) fully deployed (*left*), intermediate deployment (*middle*) and minimally deployed (*right*)

location on each of the electrodes. As any diagnostic or ablation catheter can be used catheter localization for all other catheters is based on impedance. The Orion catheter requires irrigation at a rate of 1 ml/min.

One of the major advantages to this system appears to be the ability to rapidly acquire a high spatial resolution map using the Orion mapping catheter. This is a 64 electrode small basket catheter mounted on 8 splines in which each electrode is separated by 2 mm. Signals as small as 0.01 mV can be collected. The catheter is deflectable and can be advanced through an 8.5 Fr sheath. As shown in Fig. 3.11 mapping can be performed with the catheter either fully closed (3 mm diameter), fully opened (22 mm diameter) or any range between these two extremes. Anatomic data is only acquired if the electrode is deemed to be within 2 mm of the

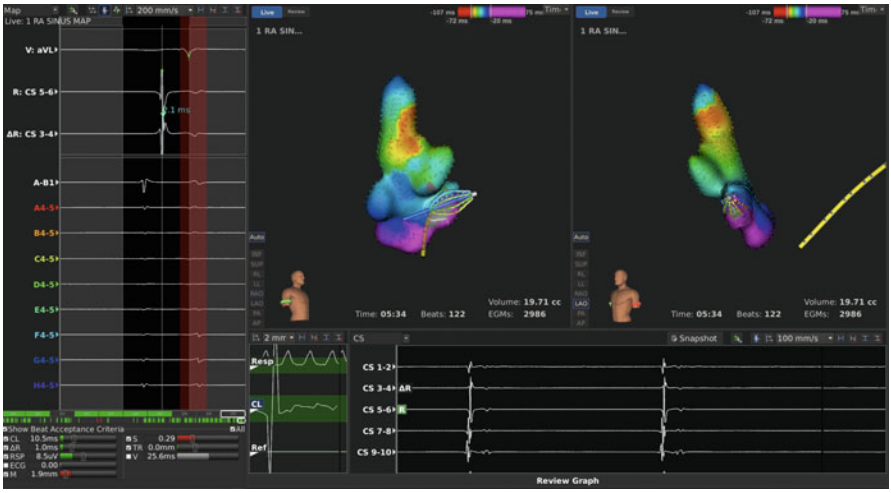

Fig. 3.12 Rhythmia (Rhythmia Mapping, Rhythmia Medical, Boston Scientific Inc., Marlborough, MA, USA) screen setup. A surface lead is chosen on the *top left image*. Below this is the CS which is used as a reference electrode. As well as using the electrode timing a change in activation is also recorded in order to minimize the chance of a change in the activation sequence. Both the RAO image on the *left* and LAO in the *right* show the RA during normal sinus rhythm

endocardial surface. Each electrode has a surface area of 0.4 mm^2 with an inter-electrode separation of 2.5 mm. This catheter is irrigated and it is recommended that heparin is administered for all procedures where this catheter is used with an ACT of 300 s.

The setup of Rhythmia is shown in Fig. 3.12. The surface ECG is seen on the top left with reference signals from the CS below this and a combination of electrograms from the Orion catheter below this. Each electrode is code by letter and number. An RAO image of the RA and LAO of the RA are shown during normal sinus rhythm.

Given that multiple signals are acquired simultaneously this system must have the ability to rapidly self annotate signals and in particular activation times. This is achieved by recording the maximum deflection on the bipolar signal or the most negative dV/dT on the unipolar electrogram. There is continuous and automatic electrogram acquisition based on beat acceptance criteria.

In order to set up the system at the start of the case the chamber of interest and type of map is programmed as well as the rhythm (sinus, paced, tachycardia) and the reference. Although the mechanism of the arrhythmia should be programmed at the start i.e. either focal or re-entry this can be changed during or after completion of the map. The system makes recommendations based on analysis of the last 10 s of the intracardiac signals and calculates the tachycardia cycle length and therefore calculates the mapping window as well as suggesting the reference electrograms. An example of mapping across a previous CTI ablation by pacing from the proximal CS during sinus rhythm is seen in Fig. 3.13.

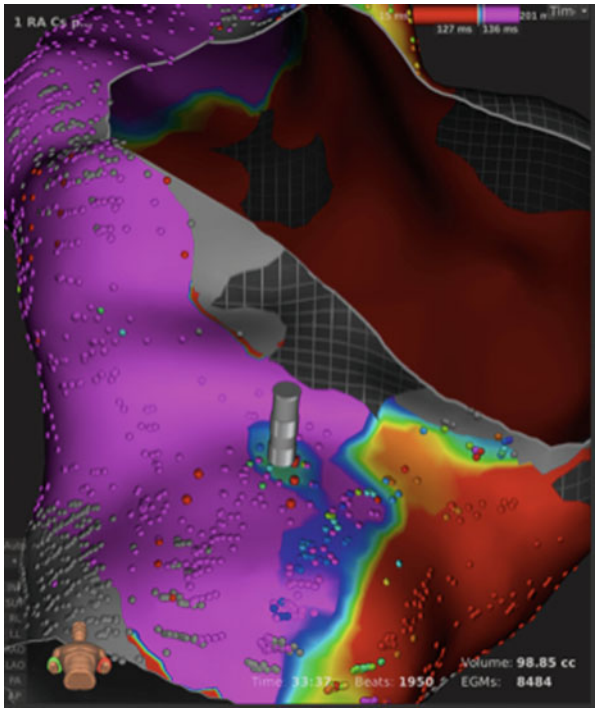

Fig. 3.13 Activation mapping using Rhythmia (Rhythmia Mapping, Rhythmia Medical, Boston Scientific Inc., Marlborough, MA, USA) with pacing from the proximal coronary sinus and mapping the right atrium in a patient with a recurrence of atrial flutter following a previous CTI ablation. The image is taken from an inferior angle with the tricuspid annulus at the *top of the image* and the inferior vena cava at the *bottom*. Although conventional pacing maneouvres suggested clockwise block there is a region of slow conduction in the mid CTI which required further ablation

Important Points

1. A stable reference point is required for activation mapping so that all points can be measured relative to the same electrogram. An ideal reference electrogram should be stable with an obvious positive or negative peak for measurement. The trigger is then set off either the most positive or negative change in voltage over time (dV/dT).
2. The window of interest is set according to whether the arrhythmia mechanism is focal or re-entry. For a focal tachycardia the earliest component may be set at 80 msec ahead of the surface signal and 30 msec after the offset. For a re-entry tachycardia the window of interest is chosen as 90 % of the tachycardia cycle length to allow for a degree of cycle length variability.
3. In activation mapping electrical signals are color coded according to how early or late they are in the window of interest. The earliest is coded as red followed by yellow, green blue, and purple which indicates later activation. In focal arrhythmias early signals are generally targeted. In re-entry ablation is often performed where early meets late.
4. In voltage mapping bipolar signals of 1.5 mV or less defined as scar and 0.5 mV or less dense scar in the ventricle.
5. CFAE's are defined as low amplitude fractionated atrial electrograms with a cycle length of less than 120 msec.

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Chapter 4
AV Nodal Re-entry Tachycardia (AVNRT)

Benedict M. Glover and Pedro Brugada

Abstract AVNRT is the most common paroxysmal supraventricular tachycardia seen in adults. It occurs as a result of dual AV nodal physiology in which an ectopic beat from the atrium or the ventricle conducts along either a slowly conducting or fast pathway and retrogradely along the other pathway which is no longer refractory. In the case of a typical AVNRT this occurs antegradely along the slow pathway and retrogradely along the fast pathway resulting in a short RP tachycardia. In an atypical AVNRT conduction occurs antegradely along the fast pathway and retrogradely along the slow pathway resulting a long RP tachycardia. It is important to carefully map during tachycardia and perform the relevant maneuvers in order to help establish the diagnosis. AVNRT is treatable with catheter ablation and this is highly successful with a low recurrence rate.

Introduction

AVNRT is the most common paroxysmal supraventricular arrhythmia in adults, accounting for approximately 60 % of all SVTs [1]. It generally presents at an age less than 40 years (median age 28 years) and is more common in females than males [2–4]. Presentation tends to occur with intermittent palpitations of acute onset and termination with vagal maneuvers and a normal baseline ECG. During tachycardia the RP interval for typical AVNRT is short and atrial activation is often in or at the terminal end of the QRS complex. The P wave is generally negative and narrow indicating an inferior to super activation from the retrograde fast pathway location.

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Anatomy

The relevant anatomy for AVNRT is contained within the triangle of Koch, bounded anteriorly by the septal leaflet of the tricuspid valve, posteriorly by the tendon of Todaro and inferiorly by the superior aspect of the coronary sinus os [5]. The compact AV node is located at the base of the inter atrial septum. Surrounding the compact AV node there is a zone of transitional cells which connect the compact node to the atrial myocytes. This transitional zone is composed of cells which share similar feature to both nodal and atrial myocytes [6]. There are three atrial extensions from the compact AV node to the atria as well as a single common pathway which connects to the ventricular aspect. The ventricle is not part of the circuit involved in AVNRT and helps to distinguish this from AVRT. AVNRT can therefore continue in the presence of AV block.

The superior extension equates to the fast pathway and is located in the anterior portion of the triangle of Koch, the rightward inferior extension which is located anteriorly to the coronary sinus and is often termed the slow pathway and the leftward inferior extension which is directed towards the mitral annulus (Fig. 4.1).

Mechanism

Mechanistically AVNRT involves at least two connections between the atria and the ventricles, often referred to as dual AV nodal conduction. These pathways are classified according to the speed of velocity through the tissue. The **slow pathway** has slower conduction velocity but a shorter refractory period and is located posteriorly along the tricuspid annulus, closer to the coronary sinus os. The **fast pathway** has a faster conduction velocity and is formed by transitional cells crossing the tendon of Todaro superiorly. It has a longer refractory period.

Classification

Slow/Fast AVNRT (Typical AVNRT)

This occurs when a premature atrial complex (PAC) travels antegradely down the slow pathway (right inferior extension) between the CS os and the tricuspid annulus followed by retrograde conduction along the fast pathway. Less commonly in approximately 5 % of cases antegrade conduction may occur along an anatomically different slow/intermediate pathway (left inferior extension). These are generally associated with an AH interval greater than 200 ms. As shown in Fig. 4.2 there is generally a short septal VA interval. The HA interval should be less than 90 ms i.e., AH > HA.

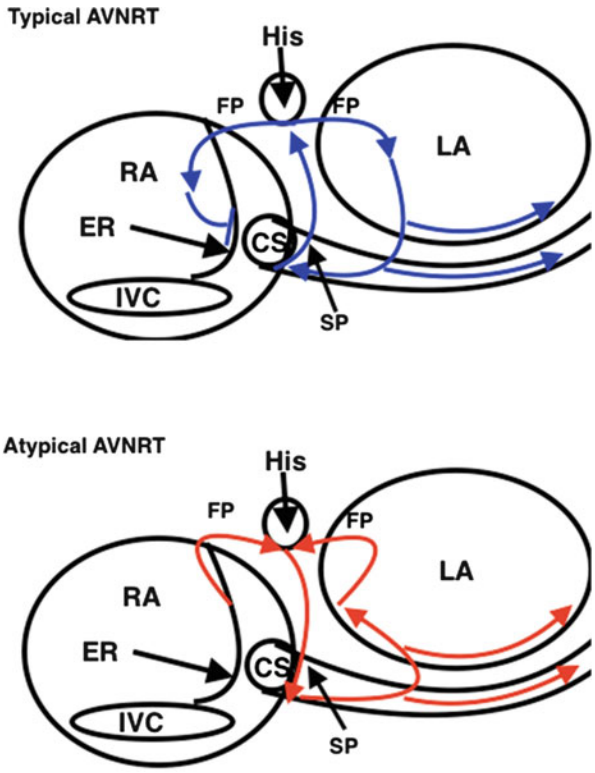

Fig. 4.1 Schematic of the AVNRT circuit in an LAO view showing a typical slow/fast AVNRT utilizing an antegrade slow pathway (*SP*) and retrograde fast pathway (*FP*) (*top image*) and in the *bottom image* an atypical fast/slow AVNRT utilizing the fast pathway antegradely and the slow pathway retrogradely

The earliest atrial activation occurs along the superior septum posterior to the Tendon of Todaro which helps to differentiate this from a Slow/Slow AVNRT. Activation on the left side of the septum continues laterally and inferiorly activating the coronary sinus. Activation on the right side of the septum is blocked by the Eustachian ridge and conducts towards the slow pathway with propagation of the circuit.

Fast/Slow AVNRT (Atypical AVNRT)

As demonstrated in Fig. 4.3 antegrade conduction occurs down the fast pathway and retrograde conduction occurs up the right inferior extension (slow pathway) with earliest atrial activation at the inferior septum. Occasionally retrograde conduction occurs up the left inferior extension (leftward slow pathway). The AH

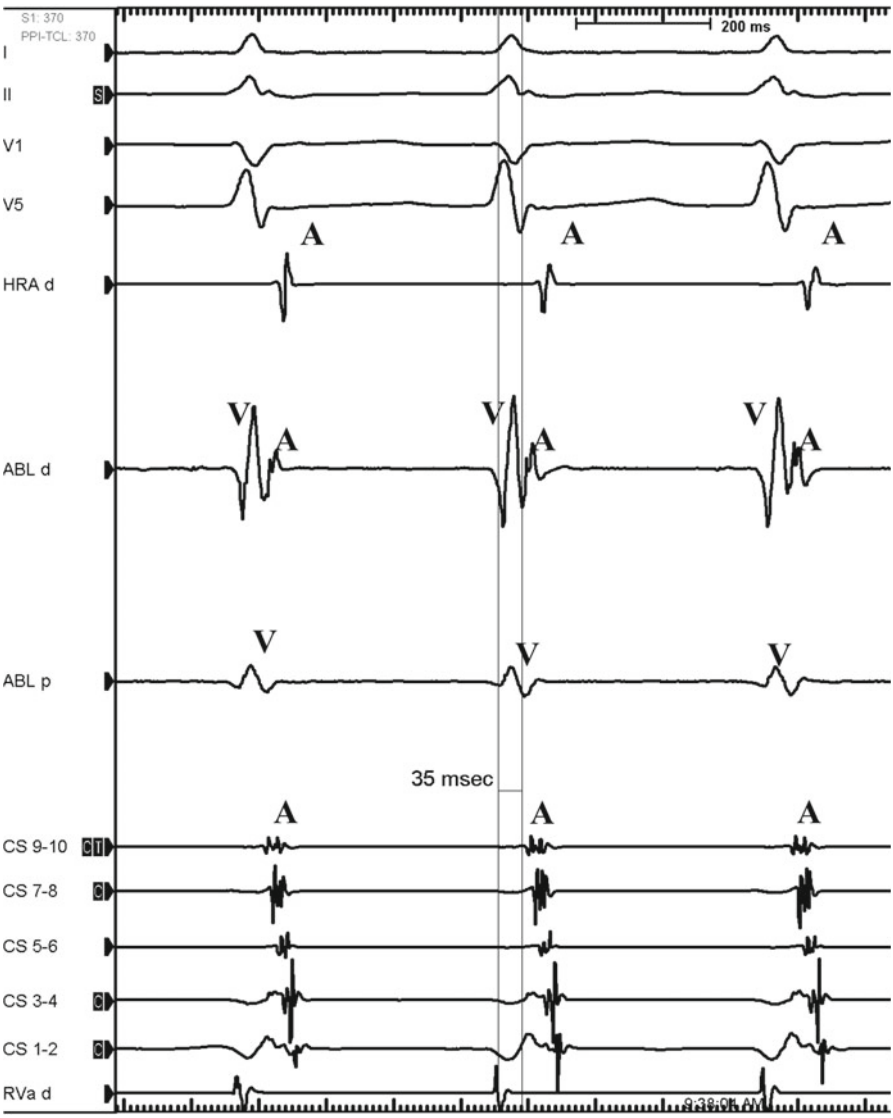

Fig. 4.2 Typical AVNRT. Earliest atrial activation is in the proximal coronary sinus with a short septal VA interval of 35 ms. This could also be a septal AP or an AT and further maneuvers are required to diagnose this. (HRA d is positioned in the high right atrium, Ablation catheter is positioned on the His, CS 9 10 are positioned in the proximal CS with CS 1 2 in the distal CS and RVA d are positioned in the RV apex)

interval is shorter than the HA interval. As the RP interval is long it is straightforward to identify the P wave which is negative in II, III, aVF and V 6 and positive in V1. This should be differentiated from an AT from close to the CS Os or a septal AP.

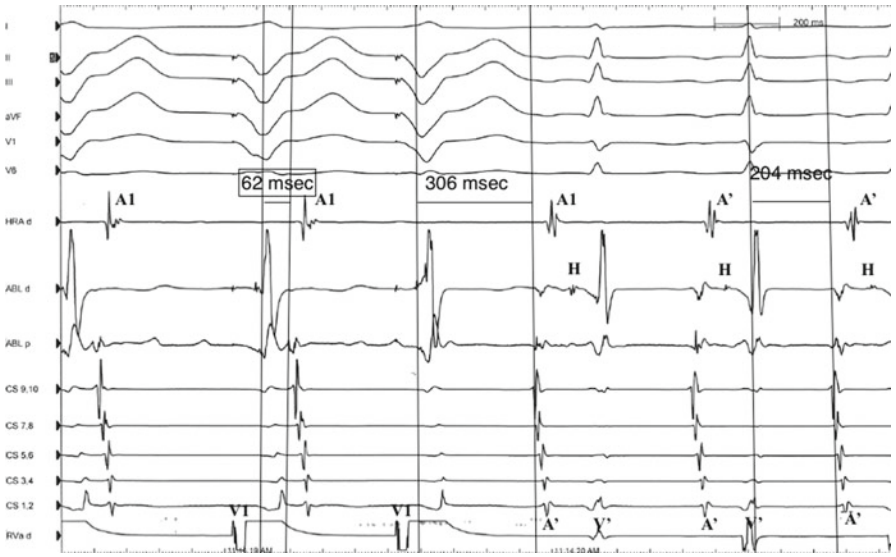

Fig. 4.3 Initiation of an atypical AVNRT. Decremental pacing from the RV apex results in retrograde conduction along the fast pathway for the first two beats as evidenced by the earliest activation recorded in the His with a septal VA interval of 62 ms. The third beat results in a prolonged VA interval of 306 ms with the earliest atrial activation in the proximal coronary sinus in keeping with a retrograde jump from the fast to the slow pathway. This subsequently conducts antegradely along the fast pathway and back up the slow pathway with a long RP tachycardia. (HRA d is positioned in the high right atrium, ablation catheter is positioned on the His, CS 9 10 is in the proximal CS with CS 1 2 in the distal CS, RVa d is in the RV apex)

Slow/Slow AVNRT

In general in Slow/Slow AVNRT conduction occurs antegradely down the rightward inferior extension and retrogradely up the leftward inferior extension. The earliest retrograde atrial activation is therefore often the roof of the coronary sinus although it may also be between the coronary sinus and the tricuspid annulus if retrograde conduction occurs along the rightward inferior extension. There are often multiple AH jump's reflecting multiple slow pathways. The AH interval is generally greater than 200 ms and is longer than the HA interval.

Electrophysiological Evaluation

Baseline Data

The ECG generally shows a QRS duration less than 120 ms with a short RP interval in the case of a typical AVNRT and a long RP interval in the case of an atypical AVNRT. If aberrancy is present then this more frequently is a RBBB morphology.

A p wave superimposed closely on the QRS is generally suggestive of a typical AVNRT. A negative p wave with a long RP interval in the precordial and inferior leads is more suggestive of an atypical Slow/Slow AVNRT. If the RP interval is longer than the PR interval this is more suggestive of a Fast/Slow AVNRT. RR alternans may occur in AVNRT due to a potential figure of eight type circuit involving the right and left inferior extensions along with the fast pathway.

Risks of EP Study and Ablation

As for all SVT studies the risks of an EP study and ablation include groin haematoma, vascular injury, cardiac tamponade, thrombo-embolism and AV block. The risk of AV block is generally considered to be the most significant complication and has an incidence of less than 0.5 %. AV block is more common if the distance between the slow pathway and fast pathway is less, if a more superior approach is required for successful ablation, if more ablation lesions are required and in patients with retrograde block in association with a junctional rhythm. It is therefore important to monitor these signs during application of RF and stop if necessary. It is generally good practice if the risk of AV block is considered high to stop and discuss further with the patient.

The acute success of a slow pathway ablation is approximately 97 % with a recurrence rate of 0.7–5.2 %.

Procedure

The diagnostic EP evaluation is generally performed with minimal sedation in order to maintain normal physiological parameters of the pathways involved and therefore maximize the chance of arrhythmia induction. Mapping catheters are positioned in the right ventricle, His, coronary sinus and high right atrium. Decremental pacing is first performed from the RV in order to assess retrograde conduction, the atrial activation sequence, and to search for evidence of dual VA nodal conduction. Following this, decremental atrial pacing is performed in order to search for the presence of dual or multiple AV nodal pathways and to try to induce AV nodal re-entry tachycardia. It is extremely uncommon for a ventricular paced beat to initiate AVNRT as the bundle of His is generally refractory to retrograde conduction. This is in contrast with accessory AV pathways, where induction of the re-entry arrhythmia by ventricular pacing is common.

Dual AV nodal physiology is demonstrated by the presence of an AH or HA jump, the presence of an atrial or ventricular echo beat or the induction of AV nodal re-entry tachycardia. An **AH jump** is defined as an increase in the AH interval of **greater than or equal to 50 ms at the moment when the coupling of the atrial extrastimuli is reduced by 10 ms during decremental atrial pacing or**

during single premature stimuli testing [7, 8]. This jump is the result of a change in antegrade conduction from the fast pathway to the slow AV nodal pathway. During ventricular pacing a HA jump of greater than or equal to 50 ms generally represents a retrograde switch from the fast to the slow pathway. Although this may suggest the possibility of AV nodal re-entry tachycardia this finding is common in the general population as the majority of people have superior and inferior atrial extensions into the compact AV node. The administration of intravenous sedation may depress fast pathway conduction thus increasing the incidence of a jump to the slow pathway. Conversely, in some patients with dual AV nodal physiology an AH jump may not be seen particularly if the conduction properties are similar between the two pathways such as an antegrade intermediately conducting left inferior extension pathway [9]. Additionally, the administration of isoproterenol may increase fast pathway conduction which may mask the appearance of an AH jump.

If tachycardia cannot be induced with multiple atrial extrastimuli or decremental atrial pacing then isoprenaline should be administered at a dose of 1–4 microgrammes/min. Isoprenaline should be stopped prior to ablation because it causes hypercontractility of the heart leading to catheter instability.

Differentiation Between AVNRT and AVRT

The fact that the AVRT circuit involves the ventricle as a component can be used to differentiate these arrhythmias from AVNRT in terms of basic observations as well as the maneuvers, that may be performed for the differential diagnosis.

The VA conduction time is generally less than 50 ms in Slow/Fast AVNRT and occasionally Slow/Slow AVNRT and greater than 50 ms in AVRT.

The delivery of ventricular extrastimuli in order to assess the effect on atrial activation is the most straightforward method to help differentiate between the two arrhytnmias. A pacing catheter is positioned in the RV corresponding closely with the location of the earliest atrial activation. If the earliest atrial activation is the inferior aspect of the triangle of Koch the optimal position for introducing ventricular extrastimuli is the inferobasal RV. If the earliest atrial activation is the superior septum close to the apex of the triangle of Koch then this is better positioned close to the His. These positions help to ensure that ventricular activation occurs first with subsequent retrograde His activation via the apex of the RV making much easier to interpret the individual signals.

In order to perform this maneuver a ventricular extrastimulus is delivered 50 ms after the onset of the His electrogram during tachycardia and advanced in 10 ms decrements. Any advance in atrial activation with no advance in the His electrogram implies the presence of an accessory pathway. If the atrial activation sequence of the advanced beat is identical to the tachycardia sequence and the next His electrogram is delayed then this proves that the accessory pathway is part of the arrhythmia mechanism.

As previously described, RV entrainment, delivery of a His synchronous PVC and parahisian pacing should also be performed.

Differentiation of AVNRT from Atrial Tachycardia

In general a typical AVNRT can be distinguished from a septal atrial tachycardia by the short duration of the RP interval. It may be more difficult to distinguish an atypical AVNRT as the RP interval is generally longer and entrainment from the RV apex may be more useful.

As shown in Fig. 4.4 following entrainment of the tachycardia from the RV apex the following sequence is an A followed by V. In the case of an atrial tachycardia this is generally seen as an A-A-V [10]. A pseudo A-A-V response may occur in the setting of a prolonged HV interval where the ventricular electrogram is artificially delayed. If the tachycardia is terminated during ventricular pacing and if the ventricular beat resulting in termination did not conduct to the atrium then atrial tachycardia can be excluded as the critical circuit is outside of both atria.

Several other useful techniques may also be used. If tachycardia can be induced then the AH interval can be recorded during tachycardia and compared with the AH interval during pacing from the high right atrium at the same cycle length. In cases

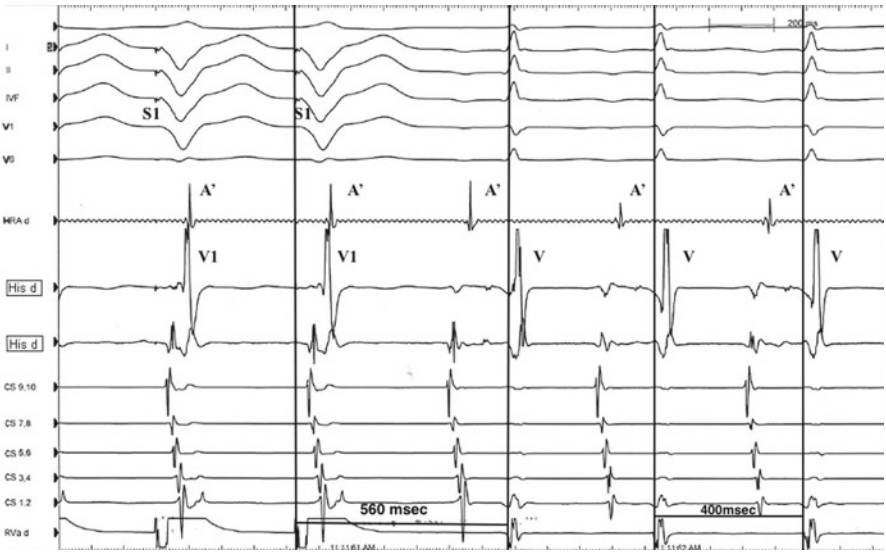

Fig. 4.4 A-V Response to Right Ventricular Entrainment during tachycardia. The tachycardia cycle length (TCL is 400 ms pacing is performed from the RV apex at 370 ms The PPI-TCL is 160 ms which is more suggestive of an AVNRT

of atypical AVNRT the AH interval during atrial pacing is longer by more than 40 ms compared to tachycardia [11].

In cases of either atrial tachycardia or AVRT with a slowly conducting retrograde pathway there is very minimal different in the AH during high right atrial pacing compared with tachycardia.

Additionally pacing from the high right atrium at different rates during tachycardia can be performed and the VA interval recorded. If the VA interval at different rates is unchanged then atrial tachycardia can be excluded.

If ventricular extrastimuli advance the retrograde His without affecting the atrial activation then atrial tachycardia is the most likely diagnosis.

Ablation Techniques

Following confirmation of the diagnosis a 4 mm non-irrigated ablation catheter is positioned in the right ventricle and withdrawn with flexion on the catheter in order to maintain a posterior septal position to the level of the coronary sinus. This is demonstrated on the fluoroscopic images on Fig. 4.5 which shows the ablation catheter position in an RAO and LAO view.

Mapping is then performed between the coronary sinus os and the tricuspid annulus. An A:V ratio of 1:2 to 1:10 should be recorded in which the atrial signal is approximately 20 ms later than the A on the His. As shown in Fig. 4.6 a small discrete slow pathway potential may be recorded in the ablation catheter. If this is seen the latest and highest frequency slow pathway potential should be targeted. Often a degree of clockwise rotation is required while trying not to fall into the coronary sinus. This is required to counteract the counterclockwise force of the Eustachian ridge which tends to rotate the catheter away from the septum during systole.

RF is generally started at 30 W with a maximum temperature set at 55–60 C. This can be increased to 40 W and occasionally 50 W is required.

Junctional beats during ablation are generally considered a indicator of slow pathway modification. These are seen in Fig. 4.7. These beats are likely due to conduction of current injury from the slow pathway to the AV junctional area enhancing diastolic depolarization of the cells in this region [12, 13]. Other potential explanations for junctional beats include an increase in AV junctional automaticity as a result of post ganglionic noradrenaline release exceeding the increase in vagal tone associated with RF application in this region therefore increasing the rate of diastolic depolarization [14] as well as a possible heat sensitive region close to the AV node which may lead to increased junctional activation [15].

Accelerated junctional beats occurring at a cycle length of less than 350 ms or with transient VA are an indicator of potential AV block [16]. It is also useful to monitor the AH interval during ablation. Ablation should stop in the event of any prolongation of the AH interval or if there is a sudden increase or reduction in impedance.

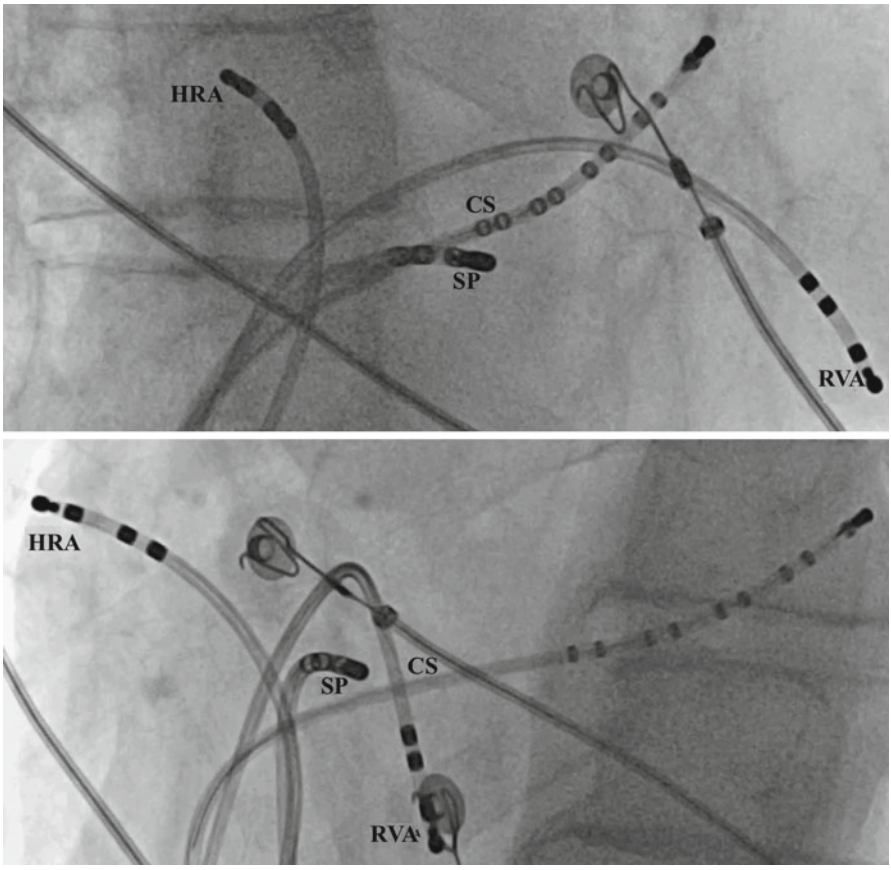

Fig. 4.5 Fluoroscopic location of ablation catheter when mapping the slow pathway. The ablation catheter is recording a A:V ratio with a small slow pathway potential. The *top image* is an RAO view and on the *bottom image* is an LAO view. In both views the ablation catheter is seen anterior to the coronary sinus os. Also seen in the image is a quadripolar catheter in the high RA, RV apex and a decapolar catheter in the coronary sinus

If there are no junctional beats during ablation alternative sites should be chosen. This generally involves a more superior position although this increases the risk of AV block and caution above the level of the roof of the coronary sinus should be taken.

Other potential locations for the slow pathway are the leftward inferior extension which can often be successfully ablated in the proximal coronary sinus.

If AVNRT develops ablation should stop due to catheter instability as well as a difficulty in establishing early signs of AV block.

AV block may be due to ablation injury of the compact AV node or may reflect underlying poor fast pathway conduction. AV block occurring at a more inferior position, including within the coronary sinus os may occur due to a posterior fast pathway variant or as a result of the effects of ablation on the AV nodal artery.

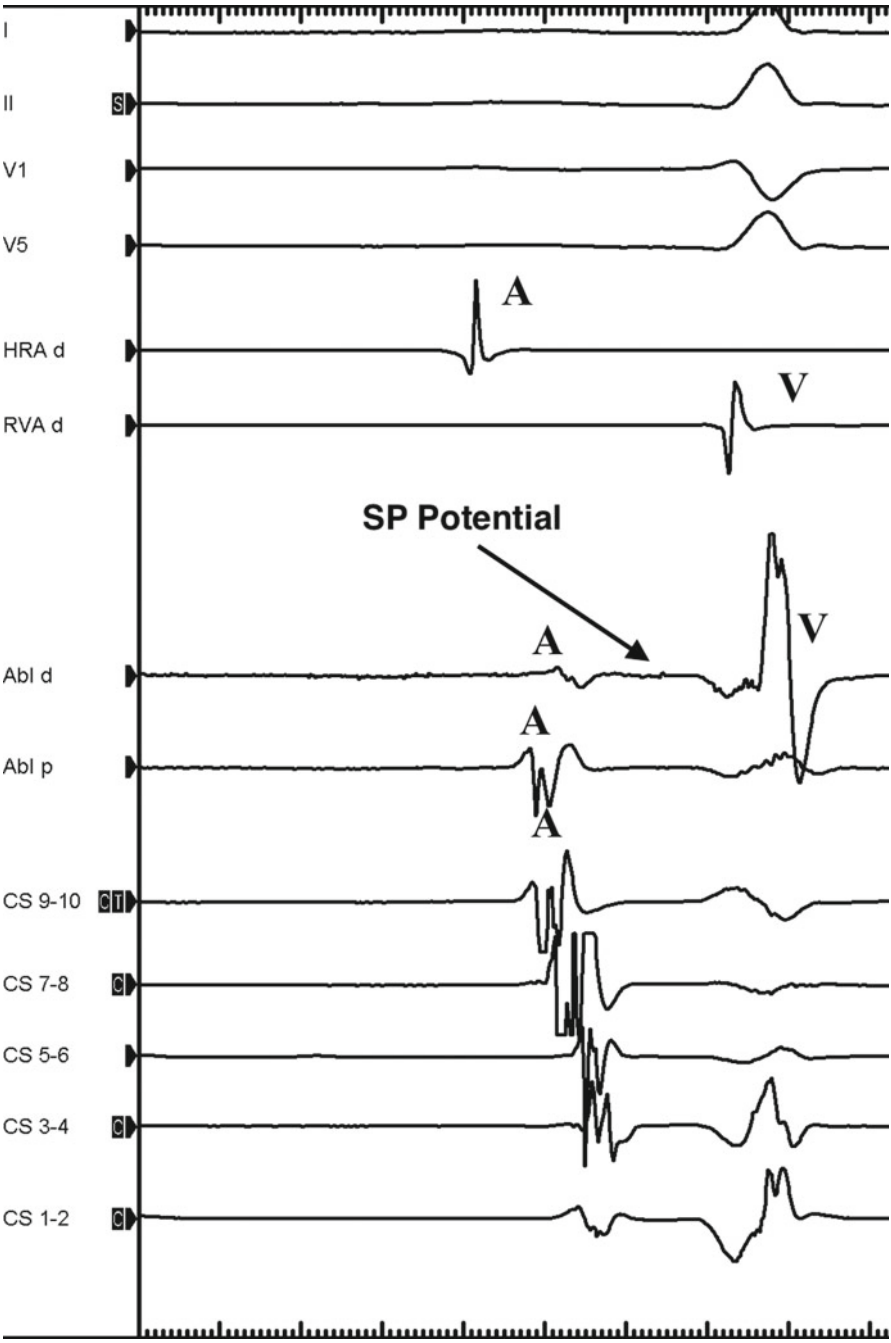

Fig. 4.6 Mapping of the slow pathway. The ablation catheter is positioned anterior to the coronary sinus with an A:V ratio of 1:6. On the first beat there is a small discrete potential recorded on the distal ablation catheter where is in keeping with a slow pathway potential. Ablation at this location was successful in slow pathway modification with no further inducible AVNRT

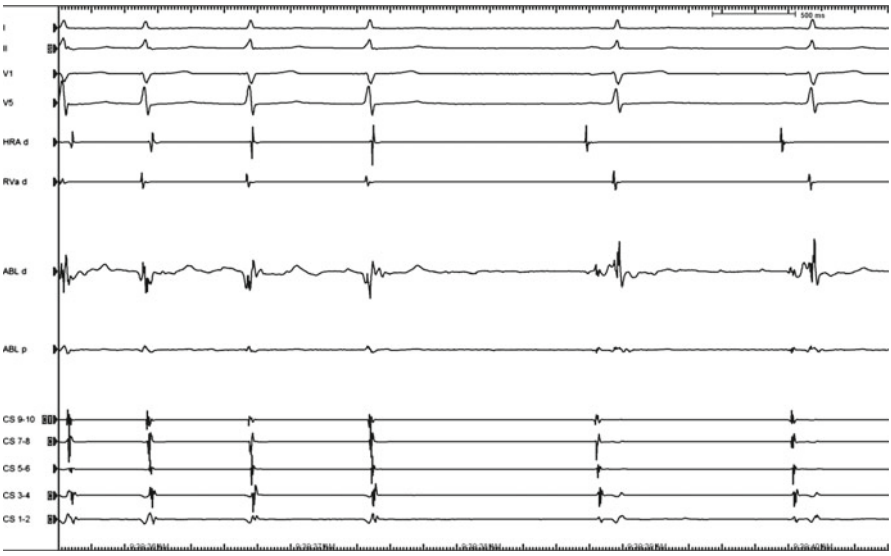

Fig. 4.7 Junctional beats seen during RF ablation at the site of a slow pathway ablation. Following the first 4 beats of junctional rhythm normal sinus rhythm resumes with 1:1 AV conduction. This is generally considered a sign of a good ablation. (HRA d is positioned at the high right atrium, RVa d is positioned at the RV apex, CS 9 10 is positioned at the proximal CS while CS 1 2 is positioned at the distal CS)

Ablation Endpoints

Following application of RF with good target temperatures and junctional beats a repeat EP study should be performed to try to re-induce the tachycardia using the same protocol as pre-ablation. If tachycardia cannot be re-induced this is a good endpoint. The presence of an AH jump or an atrial echo beat can still be considered reasonable as these may often be due to other slow pathways which may be clinically not significant such as a left inferior extension.

Isoprenaline should always be administered at the end of the procedure even if it was not required for induction of the tachycardia at baseline.

Trouble Shooting the Difficult Cases

The main anatomical difficulties which may arise are often related to a large coronary sinus os, difficult to reach slow pathways, close proximity between the slow and fast pathways and variability in the location of the slow pathway.

In general a slight clockwise rotation is required when applying ablation to the slow pathway. In cases where the CS os is large it can be difficult to maintain a

stable position and often a balanced clockwise with counterclockwise rotation is required. In extreme cases a long sheath may be helpful in order to maintain catheter stability.

Occasionally ablation at the conventional slow pathway location results in junctional beats but with still further inducible AVNRT. In these cases a more superior approach is required. This most likely targets the junction of the right and left inferior extensions rather than just the right inferior extension. If a higher position is unsuccessful the roof of the proximal coronary sinus (1–3 cm from the coronary sinus os) may result in a successful ablation.

In some very rare cases the slow pathway has a left sided insertion point and therefore cannot be successfully ablated from any sites on the right side of the interatrial septum. In these cases either transseptal or trans aortic access if required with mapping of the earliest atrial activation during AVNRT along the mitral annulus. This may range from septal to inferolateral mitral annulus.

Important Points

1. The triangle of Koch is bounded anteriorly by the septal leaflet of the tricuspid valve, posteriorly by the tendon of Todaro and inferiorly by the superior aspect of the coronary sinus os.
2. The fast pathway is located in the anterior portion of the triangle of Koch. The slow pathway is generally located anteriorly to the CS although may have a variable course including within the CS.
3. An AH jump is defined as an increase in the AH interval of greater than or equal to 50 ms in association with a reduction in an atrial extrastimuli of 10 ms during decremental atrial pacing.
4. Discontinuous AV conduction curves are not present in all patients with proven AVNRT
5. The presence of two or more AV nodal pathway may be present in patients without AVNRT
6. In Slow/Fast AVNRT (Typical AVNRT) a PAC travels antegradely along the SP with retrograde activation along the FP. This generally results in a short VA tachycardia with the earliest atrial activation along the superior septum posterior to the Tendon of Todaro
7. In Fast/Slow AVNRT (Atypical AVNRT) antegrade conduction occurs down the FP and retrograde conduction occurs up the SP with a long VA time during tachycardia.
8. In Slow/Slow AVNRT antegrade conduction occurs antegradely down the rightward inferior extension and retrogradely up the leftward inferior extension with a long VA time and the earliest activation often anterior to the CS.
9. SP ablation is generally performed using a 4 mm non-irrigated ablation catheter is positioned between the CS os and the tricuspid annulus with

an A:V ratio of 1:2 to 1:10 and ideally a SP potential. RF is generally started at 30 W with a maximum temperature set at 60 C. This can be increased to 40 W and occasionally 50 W is required.

10. Junctional beats during ablation are most likely due to conduction of current injury from the SP to the AV junctional area enhancing diastolic depolarization of the cells in this region and are generally considered a indicator of SP modification.
11. Accelerated Junctional beats occurring at a cycle length of less than 350 msec or with transient VA are an indicator of potential AV block.
12. The most useful endpoint following SP ablation is lack of inducibility of the tachycardia. The presence of an AH jump or an atrial echo beat can still be considered reasonable as these may often be due to other slow pathways which may be clinically not significant such as a left inferior extension.

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Chapter 5
Accessory Pathway (AP) Conduction

Benedict M. Glover and Pedro Brugada

Abstract Ventricular pre-excitation occurs as a result of an extranodal accessory pathway connecting the atrium with the ventricle along the AV groove. Although the baseline ECG may be normal, the common features seen are a short PR interval during normal sinus rhythm, slurring of the initial portion of the QRS complex resulting in a delta wave, a QRS duration greater than 120 ms in adults, and secondary ST and T wave changes, all of which result from a combination of eccentric accessory pathway and midline AV nodal conduction. Ventricular pre-excitation in association with a history of palpitations is named the Wolff–Parkinson–White (WPW) syndrome.

Anatomy

Accessory pathways are muscle fibers which connect the atrium to the ventricle through the fibrofatty and fibrous parietal AV junctional regions. They are generally up to 3 mm in diameter and up to 1 cm in length [1].

They are generally not found in the aortomitral continuity due to the distance between the atrial and ventricular tissues in this region [2]. It has been shown that the majority of accessory pathway's contain ventricular myocytes which function in a similar fashion [3].

Thin extensions of atrial myocardium overlie thicker ventricular myocardium at the right anterior, mid, and posterior septum. The left anterior and left mid septal regions tend to have fibrotic tissue and therefore it is unusual to find AP's in this location.

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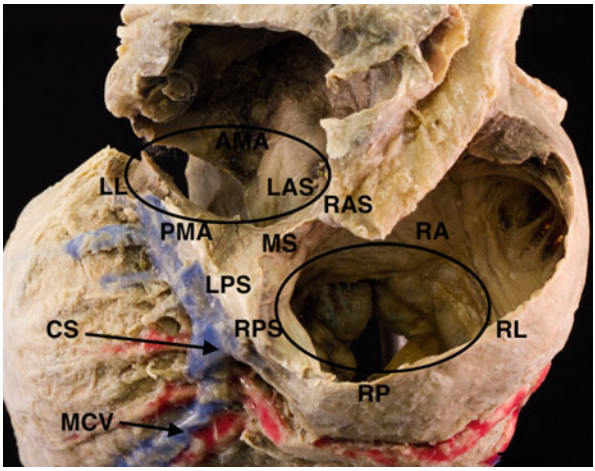

Fig. 5.1 Anatomical specimen with the posterior wall of the right atrium and left atrium removed. *On the left side* AP's may be located in the left lateral (*LL*), anterior mitral annulus (*AMA*), posterior mitral annulus (*PMA*) as well as left anteroseptal (*LAS*) and left posteroseptal (*LPS*). *On the right side* accessory pathways may occur in the right anterior (*RA*), right lateral (*RL*), right posterior (*RP*), right anteroseptal (*RAS*) and right poseroseptal (*RPS*). Mid septal (*MS*) pathways are generally located on the right side but may also be left. Also shown on the image are the coronary sinus (*CS*) and the middle cardiac vein (*MCV*)

The majority of accessory pathways are located within the endocardial atrioventricular fat pad close to the atrioventricular junctions. The anatomy of the tricuspid and the mitral annuli is shown in Fig. 5.1 with the superimposed traditional locations of AP's.

The traditional description of accessory pathway locations has been dependent on a combination of anterior to posterior and left to right in which the coronary sinus is the most posterior landmark and the aortic valve the most anterior. In the LAO view posterior is therefore seen as being at the most inferior location along both the mitral and tricuspid annulus while anterior is located at the most superior aspect. In this view septal is in the centre of the image with lateral being located at the periphery. In reality what is described as anterior is actually superior. As the left atrium is actually posterior to the right atrium what is described as right lateral should in fact be described as right anterior while left lateral is in fact left posterior. This is shown in Fig. 5.2.

Less common accessory pathway locations are shown in Fig. 5.3.

Mechanisms

During normal sinus rhythm, conduction may occur antegradely down the AP as well as through the AV node, resulting in **manifest pre-excitation** on the ECG. Occasionally, this may not be evident as the time taken for conduction through

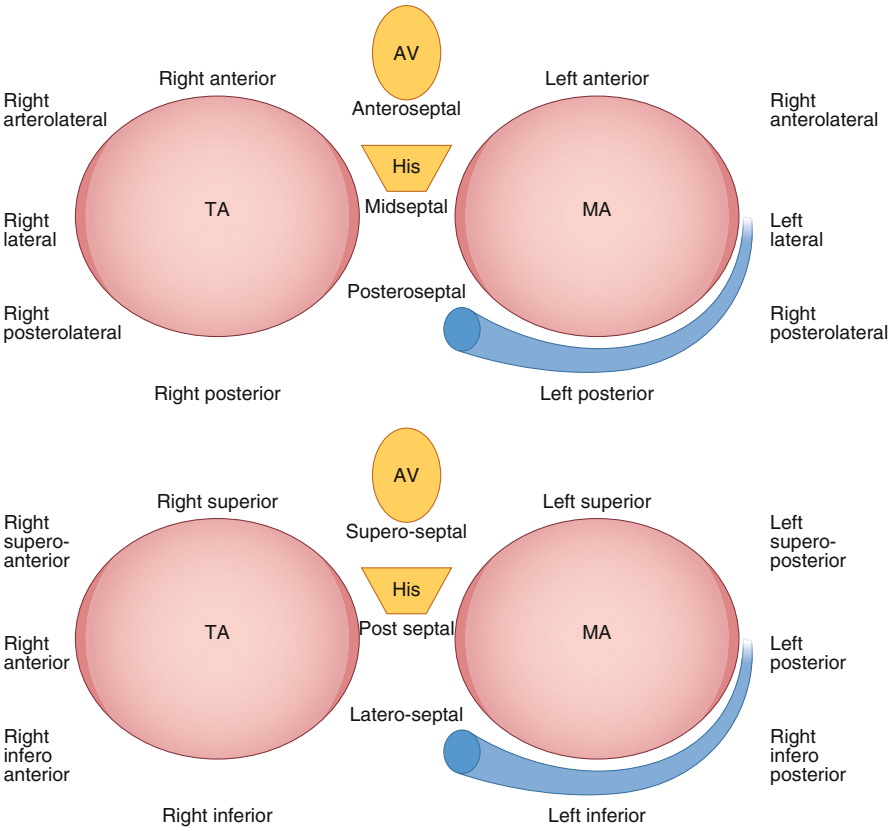

Fig. 5.2 Schematic in LAO view showing Attitudinally Correct (*top*) and historic (*bottom*) locations of Accessory Pathways along the Tricuspid and Mitral Annulus (*TA* tricuspid annulus, *MA* mitral annulus, *AV* atrioventricular)

the accessory pathway is so long that the ventricle has depolarized through the AV node such as in a slowly conducting left lateral accessory pathway. This is called **latent pre-excitation** as the 12-lead ECG during normal sinus rhythm may appear normal. If the AP conducts retrogradely during normal sinus rhythm the ECG will also appear normal and this is called **concealed pre-excitation**. Generally concealed accessory pathways are not capable of conducting AF with pre-excitation. The majority of accessory pathways have antegrade and retrograde properties. Diagrammatic representation of the predominant direction of conduction of accessory pathways is shown in Fig. 5.4.

Orthodromic AVRT occurs when the antegrade accessory pathway is refractory and conduction occurs antegradely through the AV node activating the His and ventricle and retrogradely along the accessory pathway if it is no longer refractory. This is shown in Fig. 5.5. The VA time required for this to occur is generally greater

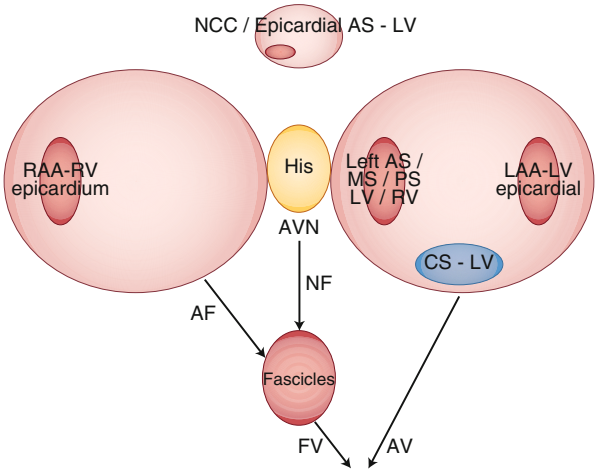

Fig. 5.3 Unusual locations of accessory pathway connections including right atrial appendage (*RAA*) to right ventricular (*RV*) epicardium, the non coronary cusp (*NCC*)/epicardial anteroseptal to left ventricle (*LV*), left sided anteroseptal, midseptal and posteroseptal to left ventricle or right ventricle, left atrial appendage (*LAA*) to left ventricular (*LV*) epicardium, coronary sinus (*CS*) to left ventricle (*LV*) as well as atriofascicular (*AF*), nodofascicular (*NF*), atrioventricular (*AV*) and fasciculoventricular (*FV*) pathways

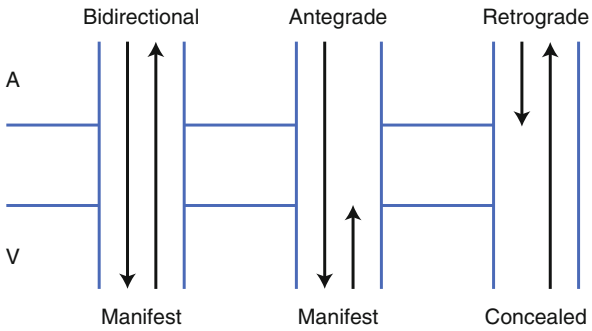

Fig. 5.4 Direction of conduction in accessory pathways. Bidirectional (antegrade and retrograde) resulting in manifest pre-excitation, antegrade only resulting in manifest pre-excitation and retrograde only resulting in concealed conduction

than 70 ms. Despite slight changes in antegrade conduction via the AV node the VA time which represents the time taken to conduction along the accessory pathway is generally stable and does not change.

In antidromic AVRT conduction occurs antegradely via the accessory pathway as the AV node is refractory. This is generally associated with a pre-excitated QRS as conduction is only via the accessory pathway. Ventricular conduction and retrograde His conduction may conduct via the AV node provided it is no longer refractory. HA times are generally greater than 70 ms as conduction is via the VA node. This is more commonly seen in left lateral accessory pathway's as the longer conduction is required to allow the AV node to recover.

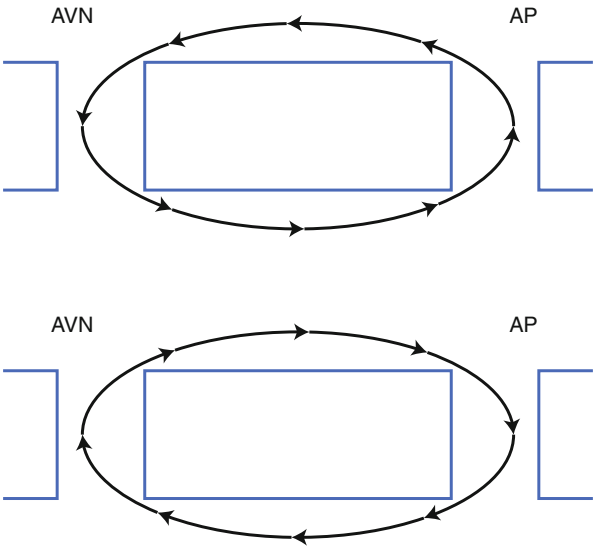

Fig. 5.5 Mode of conduction of circuit in AVRT. Orthodromic reciprocating tachycardia (*Top image*) in which antegrade conduction occurs through the AV node and retrograde through the accessory pathway and Antidromic Reciprocating Tachycardia (*Bottom image*) in which antegrade conduction occurs down the accessory pathway and retrograde through the AV node

Classification

Accessory pathway's are classified according to their anatomical location, direction of conduction, conduction properties and mechanism of action during tachycardia.

Anatomically these are divided into septal (paraseptal) which include posteroseptal, midseptal and anteroseptal, left lateral (left posterior), left posterolateral (left infero-posterior), left posterior (left inferior), left anterolateral (left superoposterior) and left anterior (left superior). The equivalent locations are also possible on the right side using similar nomenclature. Additionally some accessory pathways may be directly connected into the specialized conduction system such as atriofascicular, atrioventricular, nodoventricular and fasciculoventricular pathways. Accessory pathway's may also be located in unusual anatomical locations involving epicardial connections between the coronary sinus and the left ventricle, the non-coronary cusp of the aortic valve to the left ventricle, the right atrial appendage to right ventricle or left atrial appendage to left ventricle.

Accessory pathways can also be described according to the direction of conduction. While most accessory pathway's may conduct in both directions concealed retrograde accessory pathways are more common in the left lateral position. Almost all accessory pathways exhibit rapid and non-decremental conduction but a few paraseptal pathways may have slow decremental conduction somewhat like the AV node.

Finally accessory pathways may be described according to the direction of conduction during tachycardia with orthodromic AVRT much more common than antidromic AVRT.

Electrophysiological Evaluation

Baseline ECG

The location of the accessory pathway can be estimated from the ECG based on the polarity of the delta wave. This is measured 20 ms from the onset from the delta wave. Additionally an exercise stress test and Holter may be used for non invasive monitoring. The presence of intermittent pre-excitation on an ECG or Holter during sinus rhythm suggests that rapid antegrade conduction of atrial fibrillation through the AP is less likely to occur. The shortest pre-excited R-R interval (SPERRI) may be measured on an ECG or Holter although it is more commonly assessed during invasive EP measurements. A measurement less than 220 ms or 220–250 ms may be associated with a higher risk of rapid antegrade conduction during AF and ventricular fibrillation. Abrupt loss of preexcitation on an exercise stress test indicates preferential AV node conduction rather than antegade AP conduction with increasing sympathetic stimulation.

Algorithms

Localization of the accessory pathway on the 12 lead ECG is useful in order to help plan the EP study and ablation. Several algorithms have been developed to help predict the location of the accessory pathway based on the 12 lead ECG during normal sinus rhythm. These generally use the axis of the delta wave, the R wave transition and the QRS morphology which is dependent on the ventricular insertion point of the accessory pathway and the degree of fusion of accessory pathway conduction with AV node conduction. Given the variability in anatomy, as well as differences in underlying ECG patterns, the possibility of more than one accessory pathway and variability in the conduction properties of the AV node as well as the accessory pathway itself no algorithm is 100 % accurate. An example of a useful and practical algorithm for accessory pathway localization is shown in Fig. 5.6.

The polarity of the delta wave is measure 20 ms after the initial onset and is described as either positive, negative or isoelectric.

In general a negative or isoelectric delta wave in certain ECG leads implies that the ventricular activation is originating from that location.

A negative or isoelectric delta wave in leads I, aVL and V6 implies a left lateral accessory pathway or less commonly an anteroseptal accessory pathway. In order to differentiate between these, the QRS morphology should be examined. An atypical

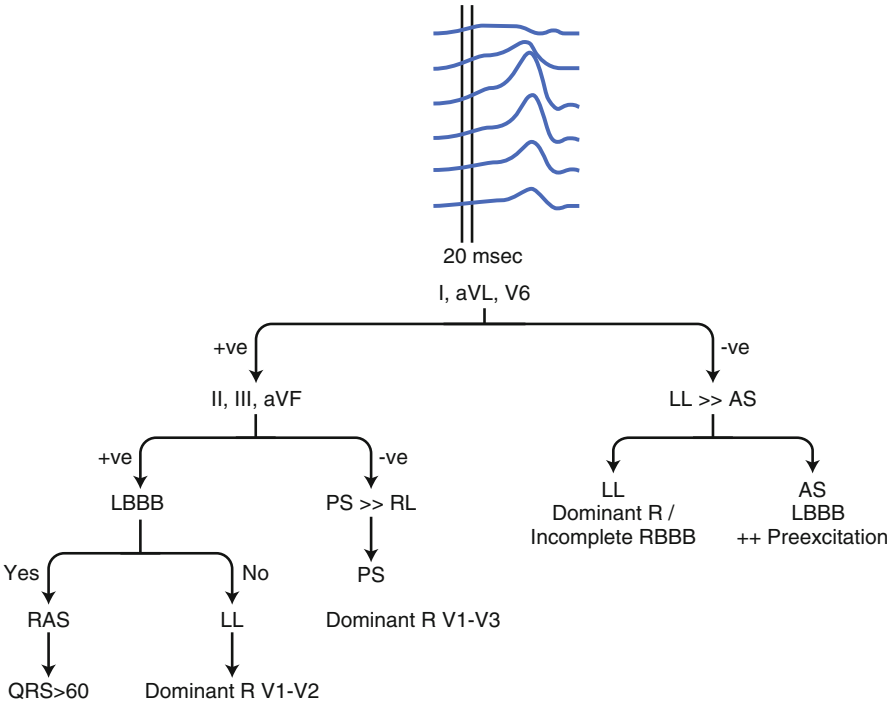

Fig. 5.6 Algorithm to estimate the location of an accessory pathway from the delta wave polarity. The first stage relies on interpretation of the delta wave in leads I, aVL and V6. If this is negative then the accessory pathway is located either in the left lateral (*LL*) location of less likely in an anteroseptal (*AS*) location. A left lateral location is more likely to have either a dominant R wave in V1 or V2 or an incomplete RBBB. An anteroseptal accessory pathway is more likely to have a LBBB pattern and more prominent pre-excitation when compared with a left lateral accessory pathway. If the delta wave is positive in leads I, aVL and V6 then the inferior leads II, III and aVF should be examined. A negative delta wave in these leads indicates either a posteroseptal (*PS*) or right lateral (*RL*) location. A posteroseptal location is more likely than a right lateral and tends to have a dominant R wave in V1–V3. If the delta wave is positive in the inferior leads then the ECG is analyzed for a LBBB pattern. The absence of a LBBB is likely to represent a left lateral location in which there is a dominant R wave in V1–V2. If there is a LBBB this is likely a right anteroseptal (*RAS*) location in which the QRS axis tends to be greater than 60°

LBBB and the presence of more manifest pre-excitation generally points towards a right anteroseptal accessory pathway. The presence of an incomplete RBBB or a dominant R wave in V1 generally points towards a left lateral accessory pathway. More posterior locations tend to have a negative or isoelectric delta wave in the inferior leads as these are more inferior locations while more anterior locations will have a positive delta wave in the inferior leads as these locations are more superior.

If the delta wave is positive in the lateral leads then the inferior leads should be examined. If the delta wave in the inferior leads is negative or isoelectric in the presence of a positive delta wave in the lateral leads then the accessory pathway is most

likely posteroseptal or less commonly right lateral. In order to differentiate a posteroseptal accessory pathway from a right lateral there is more of a tendency for a dominant R wave in V1–V3 in posteroseptal accessory pathway's.

If the delta wave is positive in the lateral leads and positive in the inferior leads then the ECG should be examined for the presence of a LBBB. If there is a LBBB with a QRS axis greater than 60° then the accessory pathway is likely to be located in the right anteroseptal position [4]. The absence of a LBBB with a dominant R wave in V1 or V2 implies that this is likely a left lateral accessory pathway.

ECG Features of Posterospetal Accessory Pathway's

As shown in Fig. 5.7 the delta wave in posteroseptal accessory pathway's is generally negative in III, with a smaller R than S wave in lead II and an R:S ratio in V2 greater than 1. Not all posteroseptal pathways follow this exact pattern.

The majority of posteroseptal accessory pathway's have negative P waves in the inferior leads during tachycardia.

The majority of posteroseptal pathways can be ablated from the right side. It is important to try to differentiate right sided and left sided posteroseptal accessory pathway's. Although this is difficult to conclude from an ECG it has been suggested that a negative delta wave in V1 may favor a right sided AP while a positive delta wave in V1 maybe more suggestive of a left sided AP [5]. An R wave greater than S wave in V1 is suggestive of a left sided accessory pathway as is a narrower QRS in V1. A positive delta wave in II with a negative delta wave in III is also more suggestive of a right sided posteroseptal accessory pathway.

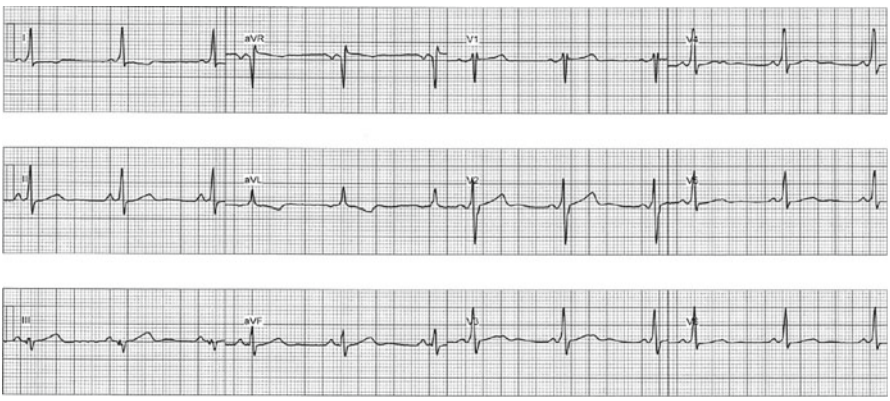

Fig. 5.7 ECG of posteroseptal accessory pathway. There is a negative delta wave in lead III. Although the positive delta in V1 is suggestive of a left sided location the fact that the R wave in V1 is less than the S wave and the positive delta wave in lead II with a negative delta in lead III are more suggestive of a right sided posteroseptal pathway

Coronary Sinus Accessory Pathways

Some posteroseptal accessory pathways are within the coronary sinus. These accessory pathways tend to utilize electrical connections between the ventricle and the coronary sinus and the coronary sinus and the atria. Although the majority of accessory pathways involving coronary sinus connections do not occur in the presence of a coronary sinus diverticulum it is worth checking for this anomaly (Fig. 5.8). These diverticula contain fibres which connect to the coronary sinus myocardial coat and the ventricle. The coronary sinus myocardial coat is generally connected to both atria unless previously disconnected by ablation. There are certain ECG features which may help suggest that a CS connection is involved. The most reliable of them is the presence of a negative delta wave in lead II. As shown in Fig. 5.7 this is not, however, always present. Other features include a steep positive delta wave in lead aVR as well as a deep S wave in V6.

ECG Features of Anteroseptal Accessory Pathway's

Given that anteroseptal accessory pathway's connect from the RA to the RV paraseptal region the delta waves are positive in the inferior leads II, III and aVF as well as the lateral leads I, aVL and V3–V6. An example of an ECG in a patient with an anteroseptal accessory pathway is shown in Fig. 5.9.

ECG Features of Mid-Septal Accessory Pathway's

There is a greater degree of variability in the ECG patterns of mid-septal accessory pathway's reflecting the variability in the atrial and ventricular insertion points and course within this region. In general there are positive delta waves in lead II as well as in the lateral leads with an earlier praecordial transition from V2–V6. Unlike anteroseptal accessory pathways the delta wave is negative in lead III.

ECG Features of Left Lateral Accessory Pathway's

The most important ECG feature of a left lateral accessory pathway is a negative delta wave in leads I, aVL and V6. Additionally, the delta wave in V1 is positive with an R wave greater than S wave in V1. Figure 5.10 shows an example of a left anterolateral accessory pathway. More posterior left lateral accessory pathways are negative in the inferior leads. Anterior accessory pathways are positive in the inferior leads. A negative P wave in lead I during tachycardia is a feature of an ORT involving a left lateral accessory pathway. The first beat shows pre-excitation with a positive delta and R wave in V1 and a positive delta wave in lead II. With the application of RF the next beat shows loss of pre-excitation.

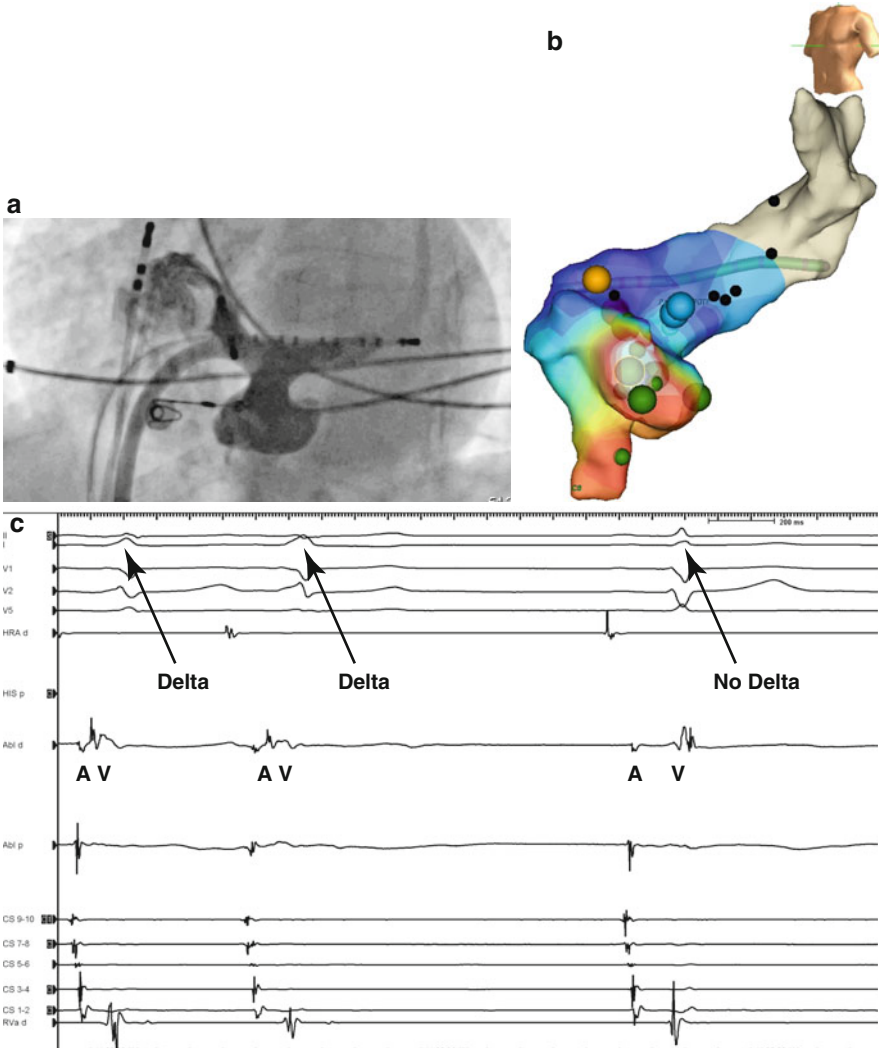

Fig. 5.8 Pre-excitation involving an accessory pathway located on the epicardial surface of a CS diverticulum. Panel **a** shows a venogram of the diverticulum in a PA view which is also shown in the electroanatomic map (Panel **b**). The ECG (Panel **c**) shows clear pre-excitation with a positive delta wave in lead II followed by a slight negative deflection. There is loss of pre-excitation during the third beat with an increase in the AV interval

ECG Features of Right Freewall Accessory Pathways

It can be difficult to differentiate right free wall accessory pathway's from other accessory pathway's. This is because a positive delta wave in V1 may also occur in left lateral accessory pathway's. In order to differentiate these the R wave in V1 should be less than the S wave with a late precordial transition. The delta wave is also positive in the lateral leads I and aVL. The presence of a positive p wave in lead I

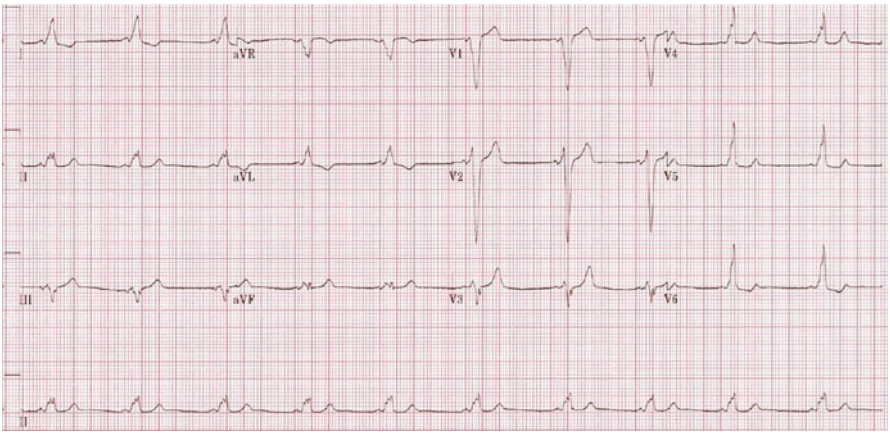

Fig. 5.9 ECG of anteroseptal accessory pathway. There is a LBBB type pattern. The delta wave is positive in lead I and the lateral precordial leads as well as leads II and aVF

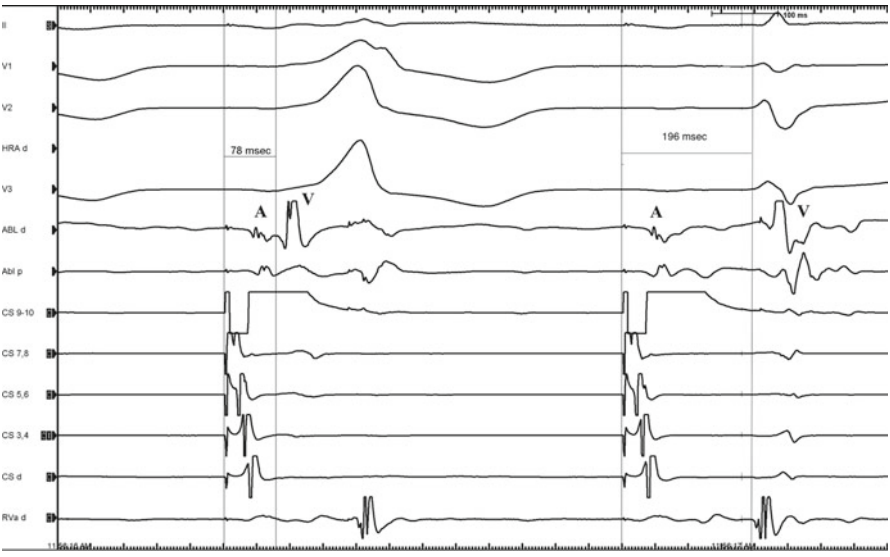

Fig. 5.10 ECG and intracardiac electrograms of ablation being performed for a left anterolateral accessory pathway. The first beat is pre-excited with a positive delta and R wave in lead V1 and a positive delta wave in lead II. Coronary sinus activation is from proximal to distal as a result of atrial pacing with ventricular activation earliest in the distal coronary sinus. There is a short AV interval at the site of the ablation catheter The second beat shows loss of pre-excitation with RF ablation. The surface ECG normalizes with AV prolongation and although the atrial activation in the CS is the same the ventricular activation is proximal to distal implying activation through the AV node. The atrial stimulation to surface QRS is measured and is prolonged from the pre-excited beat at 78–196 ms during normal AV conduction. (CS 9–10 is positioned in the proximal CS while CS 1 2 is located in the distal CS, RVa d is located in the RV apex)

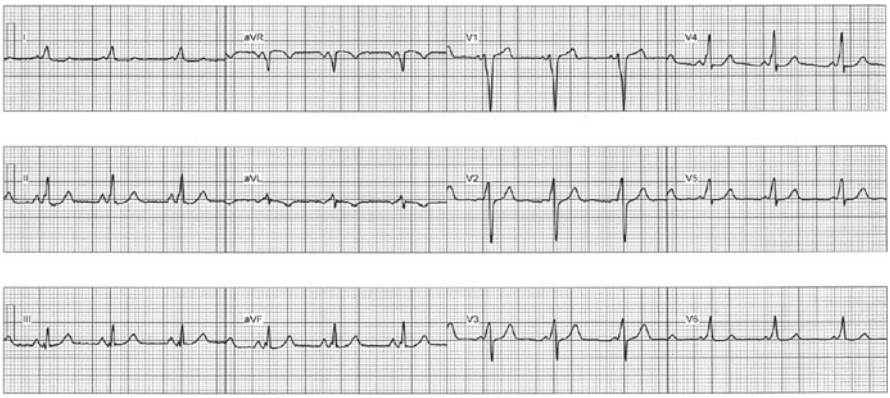

Fig. 5.11 ECG of right lateral accessory pathway. There is a large S wave in lead V1 with a small R wave. Precordial transition occurs in lead V3. There is a positive delta wave in leads I, aVL and the lateral precordial leads

during tachycardiais suggestive of a right freewall accessory pathway. An example of pre-excitation in a patient with a right freewall accessory pathway is seen in Fig. 5.11.

Risks of EP Study and Ablation

The most common complication is that of groin haematoma and vascular injury in approximately 1.4 % [6], particularly if a transaortic retrograde approach is used. The overall risk of thrombo-embolism is 0.6–0.8 % [7], which is generally not of any clinical significance on the right side but on the left side could result in a cardio-embolic stroke or TIA.

The risk of AV block is highest for septal pathways and virtually zero for left lateral accessory pathway's (provided that AV nodal conduction is intact at baseline).

Ablation, particularly if performed within the coronary sinus may result in coronary stenosis or spasm. The incidence of coronary artery injury is 0.06–0.1 % in adults. This generally occurs acutely or shortly after an ablation. Delayed coronary injury as a result of intimal hyperplasia which may increase the risk of coronary thrombosis may present weeks later.

The overall success rate for ablation is approximately 85–95 % and is highest for a left lateral AP and lowest for a posteroseptal accessory pathway.

Diagnostic EP Study

A quadripolar catheter is positioned in the RV septum, a quadripolar in the HRA and a decapolar catheter in the coronary sinus. The RV quadripolar or ablation catheter can be positioned along the His in order to measure the AH and HV intervals. In

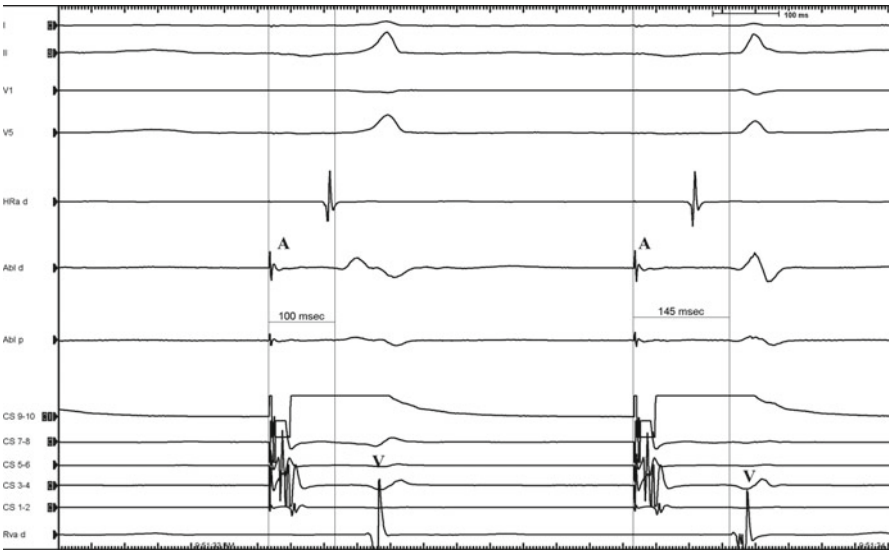

Fig. 5.12 Effective refractory period of the accessory pathway. Decremental pacing from the proximal coronary sinus shows that the first beat is pre-excited with an AV interval of 100 ms. The following beat shows a normal QRS complex with a longer AV interval of 145. At this point antegrade conduction is through the AV node and the accessory pathway is refractory at a cycle length of 480 ms

cases of manifest pre-excitation baseline measurements show a **HV interval that is less than 35 ms** which may even be negative. In order to calculate the accessory pathway ERP an atrial extrastimulus is performed. As the S2 is reduced the AH interval prolongs however the HV interval shortens so that the AV interval is unchanged provided that there is still antegrade accessory pathway conduction. The **antegrade accessory pathway ERP** is defined as the maximum atrial cycle length which results in lack of conduction along the accessory with conduction only along the AVN. This is seen as loss of pre-excitation with normalization of the AH and HV intervals. Figure 5.12 demonstrates loss of pre-excitation with decremental pacing and prolongation of the AV interval as antegrade conduction moves from a combination of AV node and accessory pathway to AV node only. If AV conduction is lost with no normalization of the QRS then the AVN RP is less than or equal to the AP ERP.

Atrial pacing should be performed from both the catheter in the right atrial appendage and the distal coronary sinus as pre-excitation may be more prominent depending on the direction of antegrade atrial pacing. Additionally, there will be a change in the morphology of the QRS or direction of ventricular activation if more than one accessory pathway is present.

Ventricular pacing will reveal the predominant activation sequence of retrograde conduction and may help to localize the accessory pathway as well as calculate the retrograde accessory pathway ERP.

Following this, attempts are made in order to induce AVRT. During decremental atrial pacing antegrade block of the accessory pathway may occur with conduction

antegradely through the AV node. This then activates the ventricle and may conduct retrogradely up the accessory pathway if it is no longer refractory. This may conduct further antegradely through the AV node if it is no longer refractory resulting in an orthrodromic AVRT. Less commonly, with atrial pacing the AV node is refractory and conduction occurs antegradely down the accessory pathway with conduction retrogradely through the AV node resulting in an antidromic AVRT.

Differentiation Between AVNRT and AT

Parahisian pacing may be performed during normal sinus rhythm in order to differentiate between VA nodal conduction and retrograde accessory pathway conduction. Decremental ventricular pacing during sinus rhythm may be useful in order to assess for decrement versus non decremental conduction but is not foolproof as some accessory pathway's have decremental retrograde conduction and also the accessory pathways may not be involved in the tachycardia mechanism. If a tachycardia can be induced a His refractory PVC may be introduced in order to assess if this has any effect on the atrial activation. A His refractory PVC which advances or delays the next atrial depolarization without changing the activation sequence is indicative of an AVRT. Also a His refractory PVC which terminates the tachycardia is indicative of an AVRT. If the PVC advances the next atrial depolarization only by advancing the local His i.e., the His is no longer refractory by an amount slightly greater than the degree of His advancement, then the most likely mechanism is an AVNRT. As shown in Fig. 5.13 in the case of a posteroseptal accessory pathway RV entrainment can be performed during tachycardia with a V-A-V response and a PPI-TCL less than 115 ms.

Mapping the Accessory Pathway

If an accessory pathway is perpendicular to the AV groove then mapping can be performed by localizing the earliest atrial signal during ventricular pacing or mapping the earliest ventricular signal during sinus rhythm or during atrial pacing.

When mapping along the annulus an atrial and ventricular signal are evident. When the catheter is positioned at the location of the accessory pathway then the atrial and the ventricular signals are close together and often merged.

The shortest AV or VA is not always the perfect location for ablation particularly given that a significant percentage of accessory pathway's are oblique and therefore an ideal electrogram also has an accessory pathway potential. This should be recorded between these signals prior to ablation being performed. If this signal disappears with loss of pre-excitation then it is likely an accessory pathway potential.

In order to check whether the potential is an accessory pathway potential ventricular and atrial extrastimuli can be delivered. During mapping of an accessory pathway

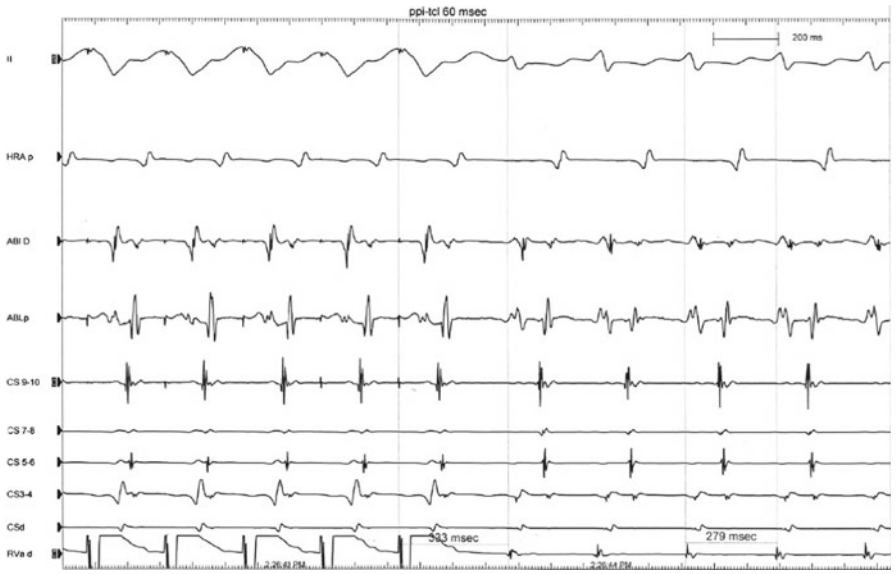

Fig. 5.13 Atrial activation is earliest on the proximal coronary sinus followed by the distal ablation (positioned on the His). The tachycardia cycle length is 279 ms Entrainment is performed from the RV apex at 250 ms The post pacing interval is 323 ms The PPI – TCl is therefore 44 ms which is indicative of an AVRT rather than an AVNRT (HRA p is positioned in the high right atrium, the ablation catheter is positioned in the location of the His, CS 9 10 is located at the proximal CS while CS 1 2 is located in the distal CS and RVa d is located in the RV apex)

during antegrade conduction a late ventricular extrastimuli will advance the ventricular electrogram with no effect on the accessory pathway potential. An early ventricular extrastimuli will advance the accessory pathway potential with no effect on the local atrial electrogram. For mapping of the accessory pathway with retrograde conduction a late atrial extrastimuli will advance the atrial electrogram with no effect on the accessory pathway potential while an early atrial extrastimuli will advance the accessory pathway potential with no effect on the atrial electrogram.

An accessory pathway potential may be mapped in 89 % of all cases provided appropriate pacing maneouvres are performed in order to separate out the signals [8]. In order to separate out the local atrial and ventricular signals and expose the accessory pathway potential pacing can be performed from two different locations in either the atrium of the ventricle. A difference in the local AV interval of greater than or equal to 15 ms without moving the mapping catheter when pacing from two different sites implies an oblique accessory pathway. In order to perform this from the atrium pacing can be performed from the right atrial appendage and the distal coronary sinus. The locations of pacing from the ventricular aspect depends on the location of the accessory pathway.

For left lateral, anterolateral, posteroseptal and RV free wall accessory pathway's a counterclockwise activation is achieved from pacing from the inferobasal RV while in anteroseptal and right anterior septal accessory pathway's counterclockwise activation is achieved by pacing from the parahisian location.

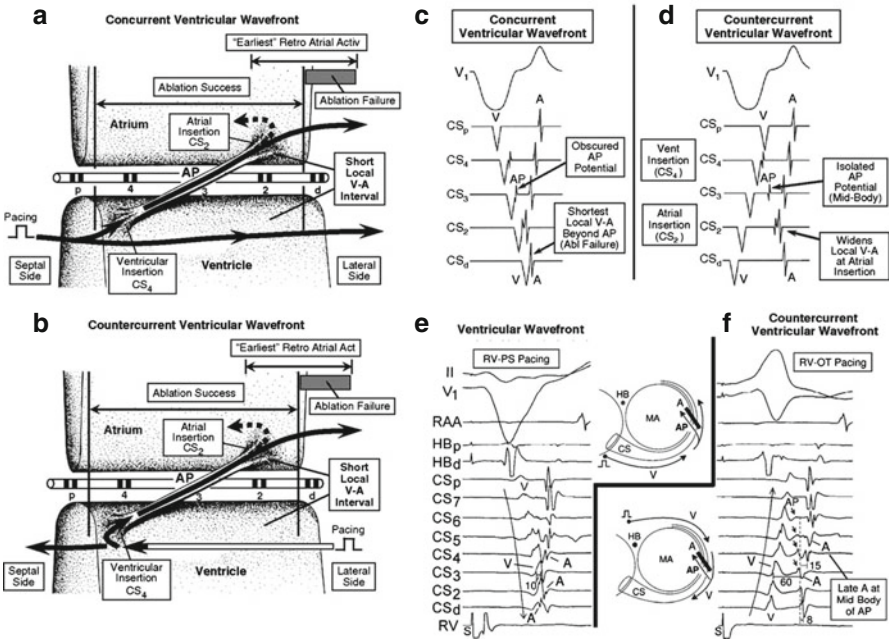

Fig. 5.14 Effects of the oblique course in a left free-wall accessory pathway on the timing of ventricular (*V*), atrial (*A*), and accessory pathway potentials by reversing the direction of the ventricular wave front. (**a**–**d**) Schematic representations. (**e**, **f**) Recordings from a patient with a left lateral accessory pathway. Reversing the ventricular wave front from the concurrent direction (**e**; posteroseptal basal RV pacing [RV-PS]) to the counter current direction (**f**; distal RV outflow tract pacing [RV-OT]) increased the local VA interval at the site in the coronary sinus of earliest atrial activation (electrogram CS3) from 10 to 60 ms and exposed the accessory pathway potential. The ventricular insertion (*left*) was located 15 mm septal to the atrial insertion (*right*). RAA indicates right atrial appendage (**c**–**f**) (Reproduced with permission from Nakagawa and Jackman [9], Wolters Kluwer Health, Inc)

As shown in Fig. 5.14 pacing from lateral to medial in a concurrent direction to the direction of the accessory pathway prolongs the local VA time and therefore exposes the accessory pathway potential. Targeting this region where a potential can be recorded results in a successful ablation of the accessory pathway.

Clockwise activation for left lateral and anterolateral accessory pathway's is achieved by pacing from the RVOT, for posteroseptal accessory pathway's clockwise activation is achieved by pacing from a lateral coronary vein with ventricular capture. For right free wall accessory pathway's clockwise activation is achieved by pacing from the base of the RV septum while for anteroseptal and right anterior septal accessory pathway's clockwise activation is achieved by pacing from the basal anterolateral RV free wall. The optimal ablation location is around the middle of this oblique pathway. In order to separate these potentials pacing can be performed in the opposite direction to course of the accessory pathway [9].

Occasionally mapping has to be performed during tachycardia. This is frequently the case during mapping of an ORT with unreliable VA conduction during RV

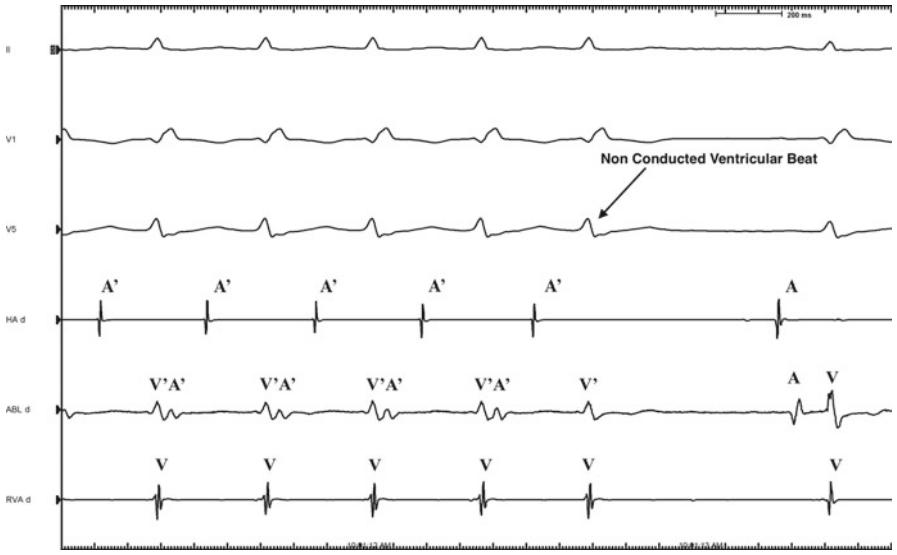

Fig. 5.15 Ablation during orthodromic reciprocating tachycardia in a concealed retrograde left lateral accessory pathway. Mapping is performed during tachycardia looking for the shortest VA interval. Ablation results in block with a non conducted ventricular beat. Thereafter there is sinus rhythm with a normal AV interval is observed. (HRA d is positioned in the high right atrium, ABL d is positioned along the left lateral accessory pathway location and RVa d is located in the RV apex)

pacing. As shown in Fig. 5.15 ablation can be performed during tachycardia looking for the shortest VA interval. If ablation is performed during tachycardia the catheter often falls off the annulus on termination of tachycardia. In order to maintain catheter stability on termination of tachycardia either ventricular pacing can be performed at a faster rate to avoid an abrupt change in the rate and loss of catheter position or further ablation can be performed in the anatomic region during sinus rhythm.

Accessory pathway potentials may be recorded on a unipolar or bipolar electrogram. Both of these can be recorded at the same time but the sharp unipolar signal is more accurate as it reflects the distal pole of the ablation catheter where RF is delivered.

Ablation of Accessory Pathway's

Posteroseptal Accessory Pathway's

These are located between the inferior wall of the right atrium and the superoposterior aspect of the left ventricle [10]. The left border of this region is the left posterior paraseptal region, the right border the right posterior paraseptal region and the anterior and superior border the midseptum.

Local electrograms in this region tend to show a small atrial signal with a large ventricular signal. This occurs as the thin atrial myocardium in this region overlies the thicker ventricular myocardium.

An accessory pathway in this region is posterior to the coronary sinus os and may be either on the tricuspid annular or mitral annular side of the septum. Pacing from the RV catheter and mapping the earliest atrial signal is often unreliable in posteroseptal accessory pathway's. Near simultaneous atrial and ventricular activation in this region results in an AV interval which appears ideal but is not. The optimal approach is targeting of an accessory pathway potential.

As shown in Fig. 5.16 mapping is first performed on the right side of the septum posterior to the coronary sinus and only moved to the left if the accessory pathway cannot be mapped or successfully ablated. Pacing the atrium from either side of the atrial insertion point while mapping for an accessory pathway potential is generally the most accurate method of mapping. Ablation can be performed with 30 W with a target temperature of 60 °C and the power can be titrated up if necessary for a minimum period of 60 s. In general, ablation should be performed during atrial or ventricular pacing during sinus rhythm rather than during AVRT as following cessation of the AVRT the catheter tip can move as sinus rhythm is restored. The patient can be monitored for a period of 30 min with atrial and ventricular pacing to ensure that accessory pathway conduction has not recovered.

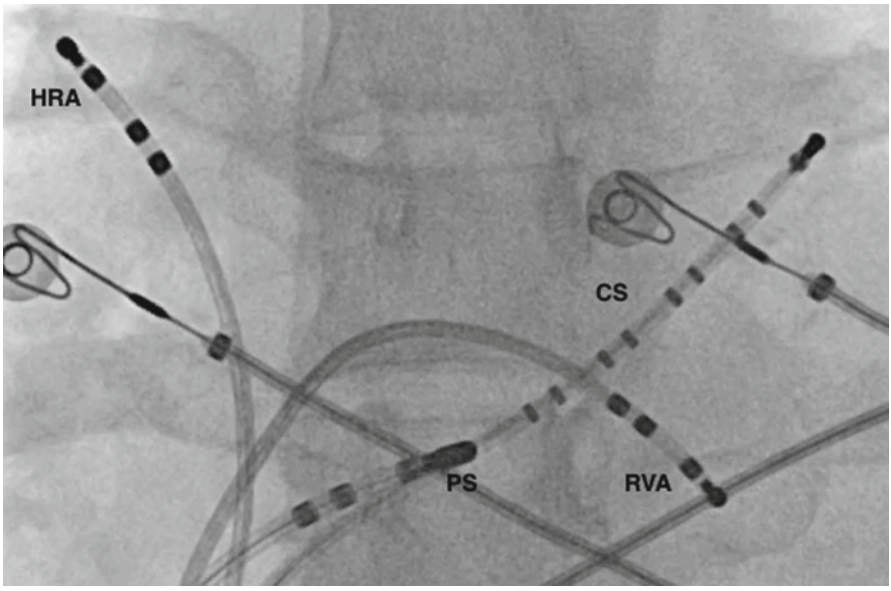

Fig. 5.16 LAO view of a successful site for a right sided posteroseptal accessory pathway. The ablation catheter is posterior to the coronary sinus catheter. A catheter is also positioned in the HRA and the RV Apex

Posteroseptal Accessory Pathway: Difficult Case

Occasionally posterospetal accessory pathways may be subepicardial and involve myocardial connections between the coronary sinus os or within the middle cardiac vein and the epicardium of the left ventricle. In these cases endocardial mapping does not reveal any sites of early activation and the mapping catheter should be advanced into the coronary sinus looking for early ventricular activation during atrial pacing as well as an accessory pathway potential. It is useful to perform a coronary sinus venogram in order to assess for diverticula where accessory pathways may be located. A coronary angiogram should also be performed and ablation should not be attempted if the coronary artery is within 5 mm of the site of ablation. If ablation has to be performed within the coronary sinus at a lower power to 10 W up to a maximum of 25 W irrigated and ablation should be stopped immediately in the event of a rise in the impedance.

Anteroseptal Accessory Pathway

These accessory pathway's are located anteriorly along the central fibrous body close to the His bundle. They are manifest in 80 % of cases in concealed in 20 % and are less common than posteroseptal accessory pathway's.

The difficulty with anteroseptal accessory pathway's is the ability to map them separately from AV nodal conduction and the proximity to the AV node with the potential risk of AV block. The actual His bundle is relatively well insulated and therefore ablation close to the His is generally not high risk. The actual risk is essentially related to potential damage to the compact AV node.

Ablation of an anterospetal accessory pathway can be performed by positioning the ablation catheter in the RV and then curved back on the tricuspid annulus looking for an accessory pathway potential. There is often a small His potential in this region. Mapping can be performed looking for the earliest ventricular signal during sinus rhythm or atrial pacing. The ventricular electrogram should precede the surface delta wave by up to 40 ms.

Midseptal Accessory Pathway

Midseptal Accessory pathway's occur between the His and the CS close to the compact node and therefore carry the highest risk of AV block. In order to minimize this risk the ablation catheter should be positioned with a more dominant ventricular signal. If ablation is unsuccessful despite good contact and a stable position the left side may be mapped.

Mahaim Accessory Pathways

Atriofascicular accessory pathways are the most common of these and account for approximately 80 %. Uncommonly nodofascicular and nodoventricular connections may occur. Fasciuloventricular connections do not seem to present a true clinical issue. Mahaim accessory pathways tend to connect from the lateral tricuspid annulus to or close to the right bundle close to the apex of the right ventricle.

ECG Features

Given that the ventricular insertion point is so close to the right bundle the baseline ECG generally has minimal or no pre-excitation. The degree of pre-excitation increases as the distal insertion point is further from the conduction system. Subtle ECG findings may include a lack of Q waves in the lateral leads V5 and V6. Sometimes a LBBB is present with a normal PR interval. Latent pre-excitation may be seen in Mahaim accessory pathways. Examples of the baseline ECG and the ECG with atrial pacing for atriofascicular and atrioventricular accessory pathways are shown in Fig. 5.17.

EP Study and Mapping of Mahaim

As pre-excitation is often minimal at baseline pacing from the right atrium tends to result in a greater degree of pre-excitation and generally the development of LBBB. Decremental pacing from close to the atrial insertion point tends to result in increasing LBBB as conduction occurs antegradely along the accessory pathway and retrogradely up the right bundle. There is an increase in the AH interval reflecting the decremental conduction and a shortening of the HV interval. If tachycardia is induced the morphology is a LBBB with a superior directed axis.

As these accessory pathways only conduct antegradely the tachycardia is always an antidromic AVRT. The activation sequence is therefore through the pathway into the fascicle followed by retrograde conduction up the right bundle and His followed by the AV node. This activation sequence is useful in order to establish the diagnosis. If an atrial extrastimulus is introduced along the lateral tricuspid annulus whenever the atrial septum is refractory and the extrastimulus advances the tachycardia then there is likely to be a atriofascicular accessory pathway. In order to prove that this accessory pathway participates in the tachycardia a late atrial extrastimulus can be delivered from close to the atrial insertion point of the accessory pathway. If this is advances the ventricular activation and in particular does not advance the His signal during tachycardia then this accessory pathway is participating in the circuit.

Mapping of an atriofascicular accessory pathway may be difficult. Although the right atrium can be paced and the ventricular insertion point can be mapped this does not always prove successful and may cause injury to the right bundle branch with an incessant tachycardia with a longer cycle length conducting retrogradely up the left bundle.

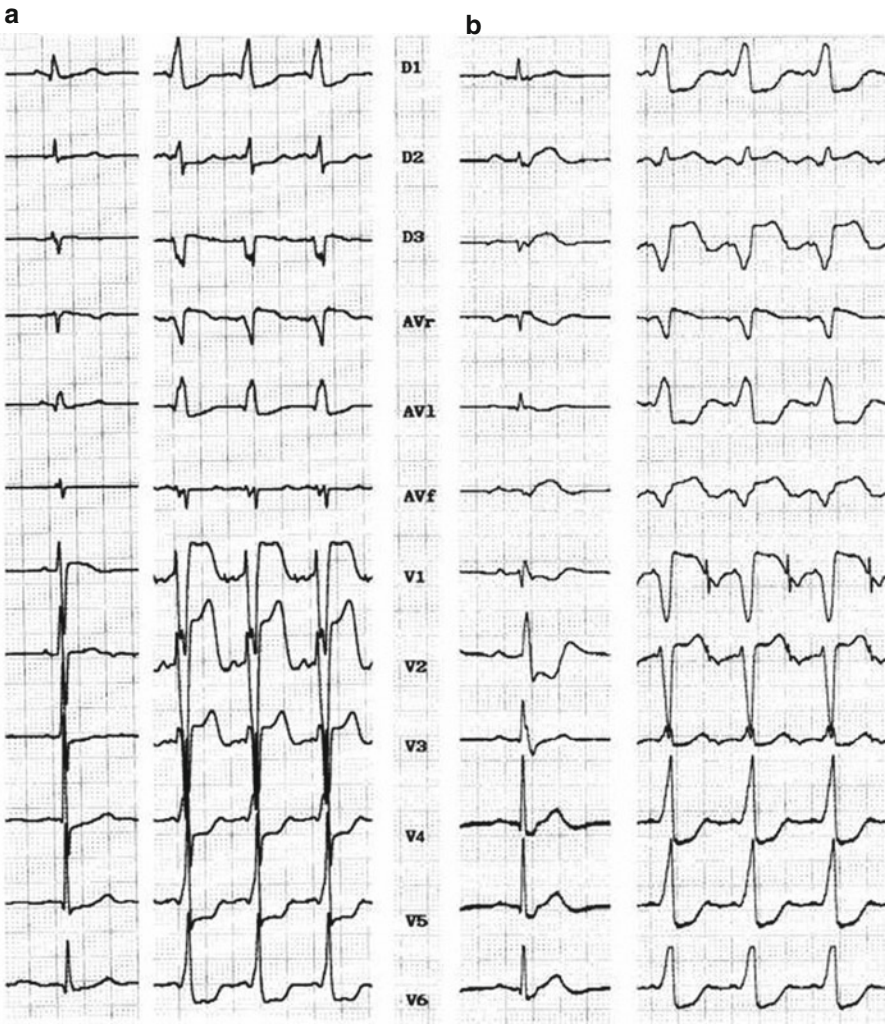

Fig. 5.17 ECG at baseline and with atrial pacing at a faster rate for an atriofascicular pathway in (**a**) and an atrioventricular pathways in (**b**). For an atriofascicular accessory pathway there is minimal preexcitation with a PR interval of 120 ms A LBBB develops with atrial pacing at a faster rate. For an atrioventricular pathway the baseline PR interval is normal with a RBBB. With atrial pacing at a faster rate there is manifest pre-excitation with a LBBB (Courtesy of Sternick [13])

Additionally, given that these pathways do not conduct retrogradely mapping the earliest atrial activation during ventricular activation cannot be performed. The most ideal method is therefore to use a 20 pole catheter along the tricuspid annulus in order to map for a Mahaim potential which is recorded along the length of the accessory pathway.

A Mahaim potential is seen as a sharp deflection between the A and the V which are both widely separated due to the distance between the atrial and ventricular

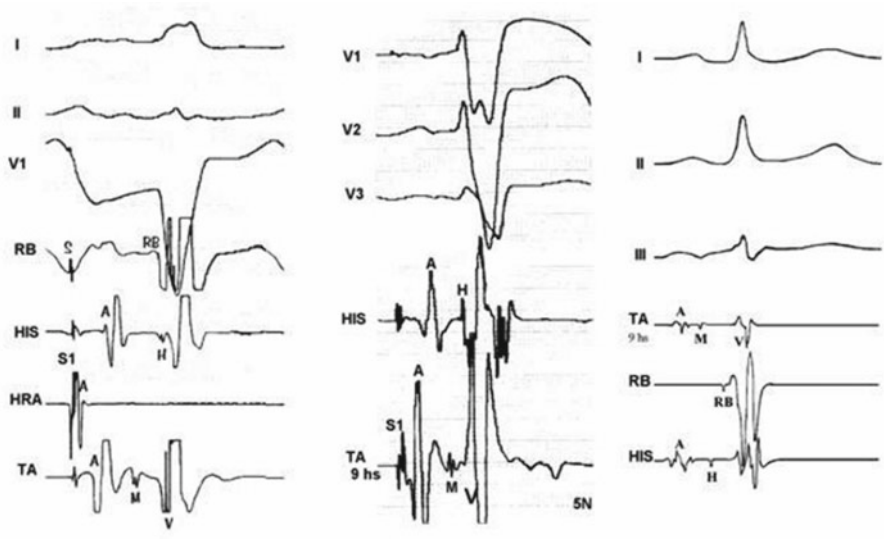

Fig. 5.18 Mahaim (*M*) potentials from left to right: first two cases with His-like potentials and the third with narrow and low amplitude potential. Ablation was successful in each of those sites (*TA* tricuspid annulus electrograms) (Courtesy of Sternick [13])

insertion points. Examples of these are shown in Fig. 5.18. The interval between this potential and the ventricular potential is constant with decremental atrial pacing. Care must be taken when positioning this catheter that the accessory pathway is not bumped and therefore cannot be mapped.

If the Mahaim potential does disappear while bumped with the ablation catheter this is a reasonable location to apply RF. During ablation there is often a slow accelerated rhythm for several seconds known as Mahaim automaticity [11]. This is generally considered a good sign during the application of RF.

Often a sheath is helpful in order to maintain catheter stability along the tricuspid annulus. During ablation transient Mahaim junctional acceleration may occur as shown in Fig. 5.19 which is similar in morphology to the tachycardia. Although a multipolar catheter can be positioned along the tricuspid annulus in order to map the Mahaim potential occasionally electranatomic mapping may also be helpful.

Left Lateral Accessory Pathway

These are the most common accessory pathways with the highest success rate for ablation of 95 % [12]. They may have either minimal pre-excitation given the distance of the ventricular insertion point from the AV nodal conduction. They also have the highest rate of concealed retrograde conduction of all accessory pathway's.

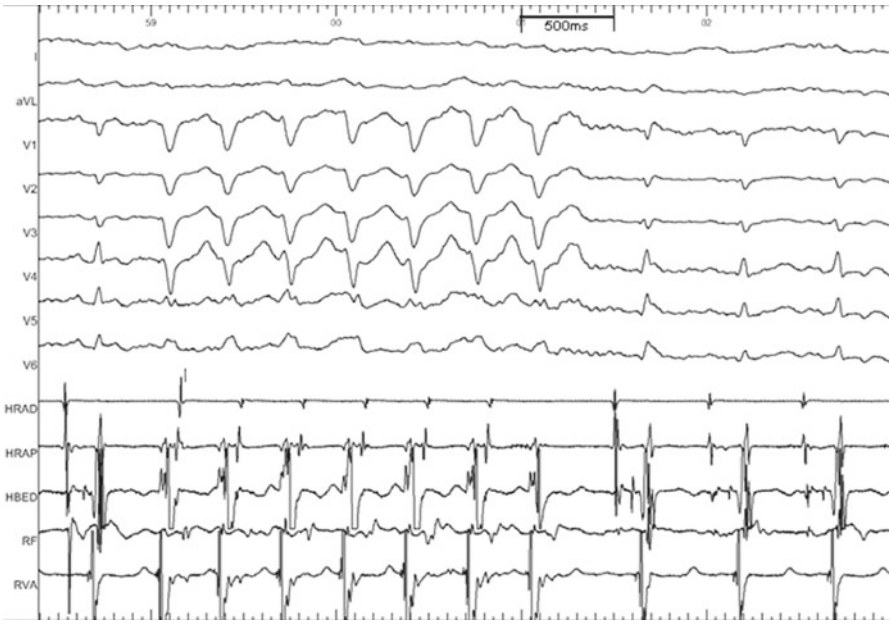

Fig. 5.19 Radiofrequency ablation at the site of Mahaim fibre location resulting transient Mahaim junctional acceleration. The QRS morphology is similar to Mahaim tachycardia. HRAP, high right atrium proximal (Courtesy of Bohora et al. [14]. Oxford Press)

Mapping of the accessory pathway is guided by the coronary sinus catheter which is slightly superior to the mitral annulus but runs along in the same direction as the annulus and therefore gives an approximate idea of where the accessory pathway may be located. Following confirmation of the accessory pathway further mapping can be performed with an ablation catheter either via a transseptal or retrograde approach. The electrodes are parallel to the CS electrodes and the catheter is moved along the catheter with ventricular pacing on order to assess the earliest atrial signal and an A:V ratio of 1:1.

Transseptal access is generally relatively straightforward through the fossa ovalis as the atrial anatomy is normal and can be achieved with a Brockenborough needle and a long non deflectable sheath. For a retrograde approach femoral arterial access is gained and the ablation catheter is prolapsed across the aortic valve in an RAO view with the curve pointing in an anterior direction to the right of the image. After crossing the aortic valve the catheter is then rotated counterclockwise with the curve maintained bringing it in a posterior alignment toward the coronary sinus in the plane of the posterior mitral annulus. The curvature is then slowly released in order to move along the annulus. In order to achieve a greater atrial signal the catheter is withdrawn slightly with an A:V ratio of approximately 1:10 and an atrial electrogram amplitude of 0.4–1.0 mV. Although a retrograde approach may be associated with greater catheter stability it is generally more straightforward to maneuver the catheter via the transseptal access.

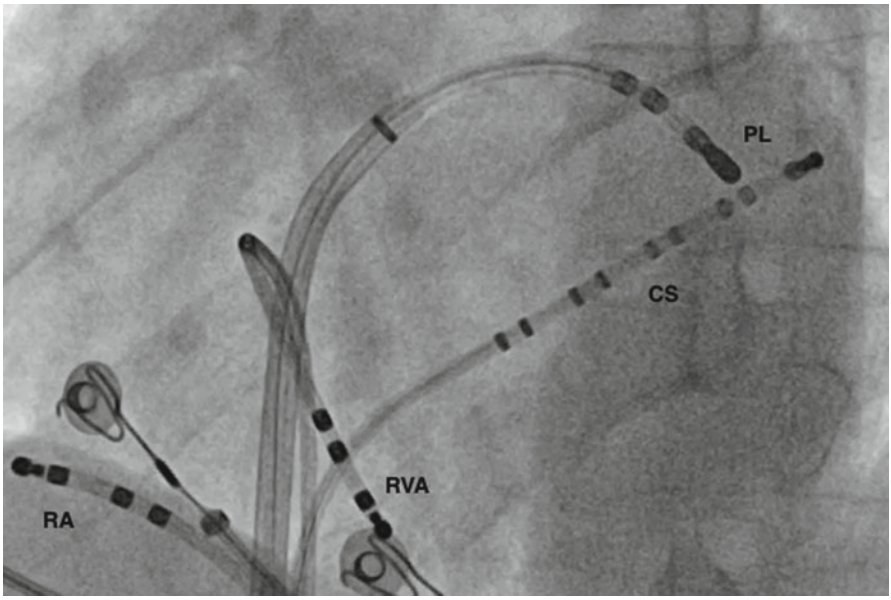

Fig. 5.20 Ablation catheter position on the posterolateral concealed retrograde accessory pathway

As soon as either transseptal access has been obtained or the aortic valve has been crossed heparin should be administered at an initial dose of 100 units/kg aiming for an ACT greater than 300 s. A continual infusion of heparinized saline should be infused through the side arm of the long sheath. Provided there is retrograde conduction along the accessory pathway the most straightforward method of mapping is to pace the ventricle and map for the earliest atrial activation. Pacing from different locations can be used in order to separate out the A and the V so as to record an accessory pathway potential. The ablation catheter can be moved along the mitral annulus. An example of the optimal position for an ablation catheter in a concealed retrograde posterolateral accessory pathway is shown in Fig. 5.20.

Mapping for the earliest ventricular electrogram can also be performed during atrial pacing. For a left lateral accessory pathway the local ventricular electrogram should preceded the surface delta by up to 10 ms. A negative QS in a unipolar electrogram is also a sign of a good position.

It is not ideal to ablate during tachycardia as the catheter can move considerably following termination of the tachycardia although it some cases of incessant tachycardia there is no other option.

Catheter stability may not be as good as a retrograde approach but this method is associated with a lower incidence of vascular complications. Additionally the transseptal approach is better for accessing extreme lateral and anterolateral accessory pathway's.

For a retrograde approach femoral arterial access is achieved with a 7Fr sheath. The ablation catheter is directed up the descending aorta and a curve placed in the catheter as it is advanced around the aortic arch.

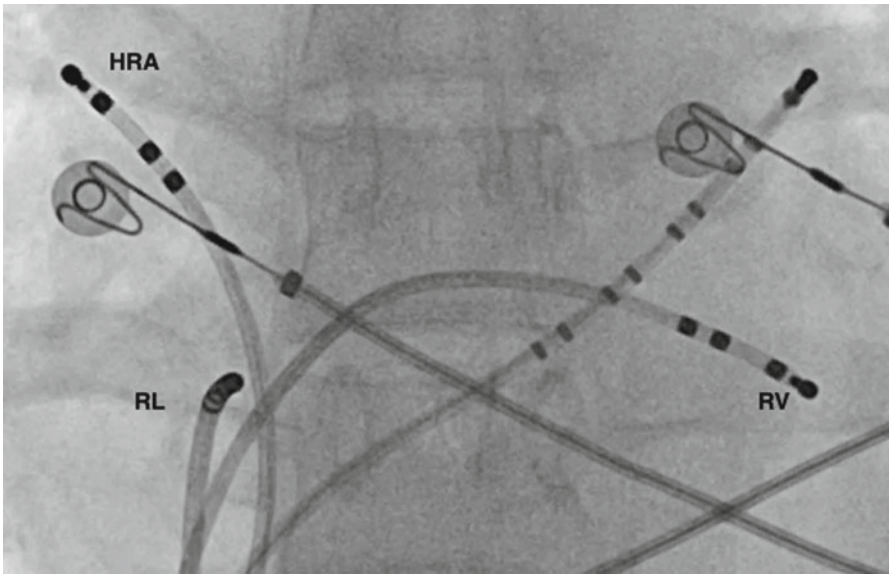

Fig. 5.21 Mapping of an accessory pathway along the tricuspid annulus. The ablation catheter is positioned in the right posterolateral annulus where ablation was successful. Also shown in this image is a catheter in the HRA, RV and CS

Right Free Wall Accessory Pathway

These are considered to be the most difficult accessory pathways to map and successfully ablate. This is due to a combination of catheter instability, the presence of other structural abnormalities such as Ebstein's and the lack of a structure which may assist mapping of the annulus. A 20 pole catheter is often positioned in the RA in order to help map the tricuspid annulus. A deflectable sheath may be helpful for catheter stability and the catheter is moved looking for an early atrial or ventricular signal with an A:V ratio of 1:1 as well as an accessory pathway potential. The local ventricular signal should be compared with the surface delta wave and should be earlier by up to 20 ms [5]. An example of mapping of the tricuspid annulus using an ablation catheter in a right sided accessory pathway is shown in Fig. 5.21.

Accessory Pathway General: Difficult Case

The most common cause for failure to successfully ablate an accessory pathway is the inability to manipulate the ablation catheter to the atrial or ventricular insertion point. For left lateral accessory pathways this may be overcome by switching from retrograde to a transseptal access or vice versa. Changing the curve on the ablation catheter and occasionally the use of a long sheath may also help to maneuver the catheter and provide stability.

The inability to deliver a successful lesion limited by power or temperature may be overcome by repositioning the catheter or changing the angulation of the catheter. If this does not work then switching to an irrigated catheter may help.

If an accessory pathway potential cannot be mapped or is small then the coronary sinus should be mapped. If this is the case then ablation can be performed at lower power from within the coronary sinus.

If the patient is in incessant AVRT ablation can be performed during tachycardia. It is important that ablation is continued after termination of the tachycardia as often the catheter moves during reversion to sinus rhythm.

Important Points

1. Accessory pathway's are muscle fibers which connect the atrium to the ventricle through the fibrofatty and fibrous parietal AV junctional regions. The majority are located within the epicardial atrioventricular fat pad close to the atrioventricular junctions,
2. Anatomically these are divided into septal (paraseptal) which include posteroseptal, midseptal and anteroseptal, left lateral (left posterior), left posterolateral (left infero-posterior), left posterior (left inferior), left anterolateral (left superoposterior) and left anterior (left superior). The equivalent locations are also possible on the right side using similar nomenclature. Additionally some accessory pathways may be directly connected into the specialized conduction system such as atriofascicular, atrioventricular, nodoventricular and fasciculoventricular pathways. Accessory pathway's may also be located in unusual anatomical locations involving epicardial connections between the coronary sinus and the left ventricle, the non-coronary cusp of the aortic valve to the left ventricle, the right atrial appendage to right ventricle or left atrial appendage to left ventricle.
3. Orthodromic AVRT occurs when the antegrade accessory pathway is refractory and conduction occurs antegradely through the AV node activating the His and ventricle and retrogradely along the accessory pathway if it is no longer refractory. The VA time required for this to occur is generally greater than 70 ms.
4. Antidromic AVRT conduction occurs antegradely via the accessory pathway as the AV node is refractory. This is generally associated with a pre-excitated QRS as conduction is only via the AP. VA times are generally greater than 70 ms as conduction is via the VA node.
5. The Shortest Pre-Excited R-R Interval (SPERRI) less than 220 ms or 220–250 ms may be associated with a higher risk of antegrade conduction during AF and may be an indication for catheter ablation.
6. In order to help maximize pre-excitation during an EP study pacing may be performed from different locations on different catheters. This may also help to reveal an accessory pathway potential which should be targeted for ablation.

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Chapter 6
Atrial Tachycardias

Benedict M. Glover and Pedro Brugada

Abstract Atrial tachycardia is a **focal or macro re-entry supraventricular arrhythmia which does not directly involve the AV node**. Overall it accounts for approximately 7 % of all SVT's [1].

Focal atrial tachycardia occurs as a result of either micro re-entry, increased automaticity or triggered activity while macro re-entry occurs over a region of tissue surrounding a region of conduction block. Focal atrial tachycardia due to increased automaticity can usually be initiated with isoprenaline while decremental atrial pacing tends to initiate and terminate micro and macro re-entry.

Although atrial tachycardia's may occur anywhere within the right atrium or left atrium there are more common locations and in particular where anisotropic conduction occurs in which there is rapid linear conduction and slowed transverse conduction. The most common locations are the **crista terminalis**, **coronary sinus os**, **the pulmonary veins and antral regions**, **the tricuspid and mitral annuli**, **the right and left atrial appendages and the interatrial septum**. The location is to an extent dependent on the patient's age, history of structural heart disease, prior ablations or surgery and the presence of other arrhythmias.

Focal Versus Macro Re-entry

It is useful to establish if an atrial tachycardia is either focal or re-entry prior to mapping as this dictates the parameters that are set for mapping as well as interpretation of the mechanism. As shown in Fig. 6.1 a focal atrial tachycardia tends to have a

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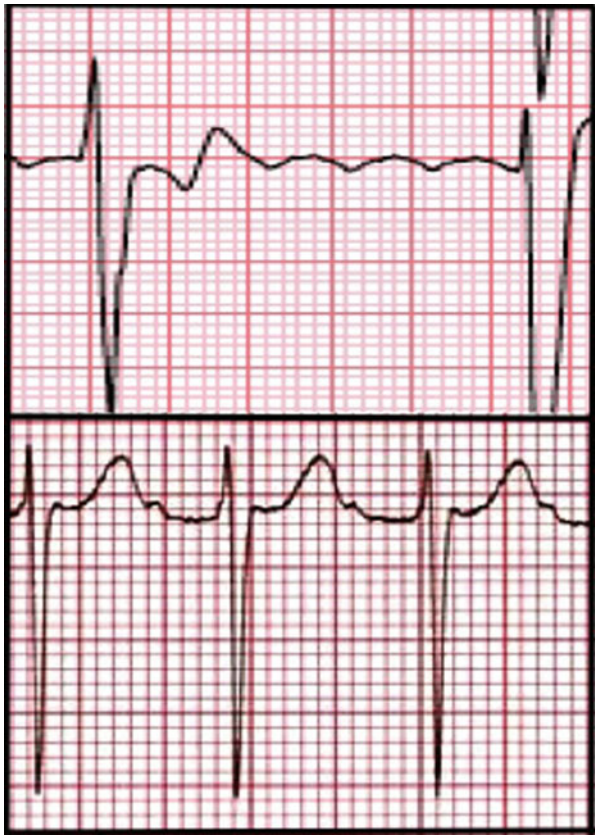


Fig. 6.1 ECG showing macro re-entry tachycardia (*top*) where there is almost continual atrial activation and focal AT (*bottom*) with a clear isoelectric line between atrial activity

very distinct P followed by an isoelectric AV interval while a macro re-entry mechanism tends to have continual atrial electrical activity which may be superimposed on the QRS complex.

If this is unclear vagal maneuvers can be performed or adenosine administered in order to decipher atrial activity more clearly. Of note adenosine may occasionally terminate atrial tachycardia by activation of adenosine sensitive potassium channels [2].

In the electrophysiology laboratory activation mapping can be performed and will easily show whether the entire tachycardia cycle length occupies a region rather than a single focus. Entrainment can also be performed in two anatomically distinct regions to assess if the circuit is macro re-entry, for example the septal and lateral mitral isthmus in mitral annular flutter or anterior and posterior to the roof line in left atrial roof dependent flutter.

For focal atrial tachycardia an early, possibly fractionated signal is often seen as a good target. Fractionation occurs as a result of slow conduction from a region of increased automaticity or micro re-entry connecting into normal atrial tissue [3]. Unipolar electrograms also have a QS pattern [4]. The local signal should be at least 40 ms ahead of the earliest P wave. If the RA is mapped and the earliest signal is no

more than 20 ms ahead of the earliest P wave with septal activation earliest then the left atrium should be mapped because the arrhythmia may originate in the right sided pulmonary veins.

In macro re-entry the critical isthmus is targeted as an area of early meets late during activation mapping. This can easily mapped by performing entrainment in locations likely to contain the isthmus looking for a closely matching PPI-TCL.

Locations of Atrial Tachycardias

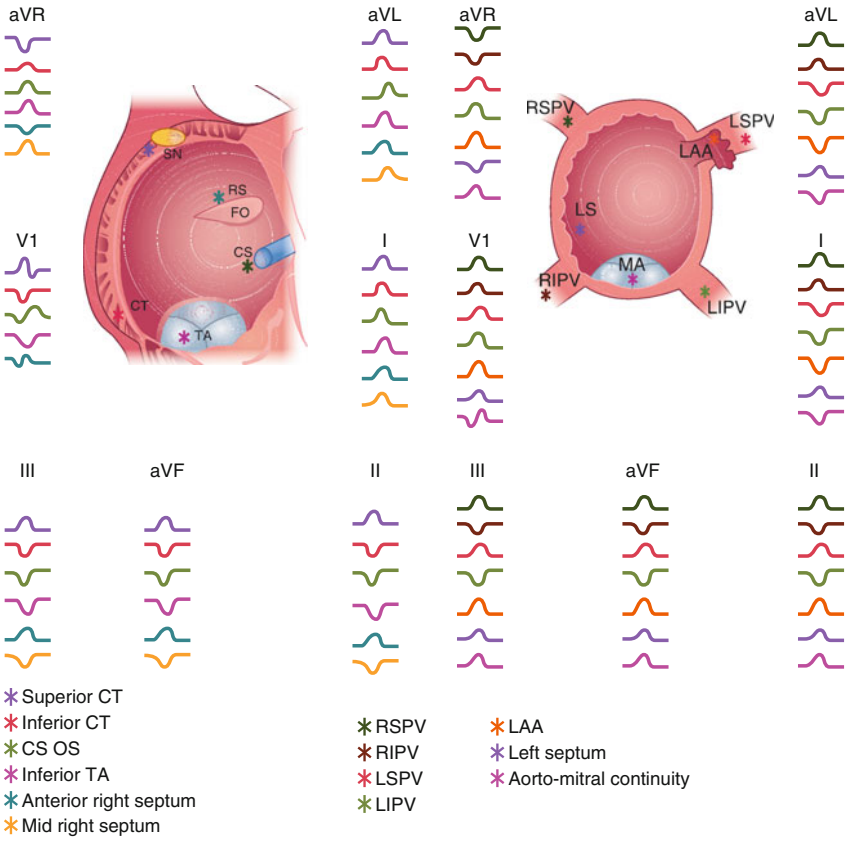
It is useful to use the ECG to predict whether the atrial tachycardia is left or right sided prior to performing an ablation. The most useful leads to examine are V1 and aVL. As the left atrium is more posterior than the right atrium **left sided atrial tachycardia's tend to have a positive P wave in V1. A negative P wave is seen more commonly in V1 in right sided atrial tachycardias. A positive P wave in aVL generally indicates a right sided atrial tachycardia while a negative P wave in aVL generally indicates a left sided atrial tachycardia**. These are general observations and variations exist with anatomy, underlying pathology and previous ablations [5, 6]. The ECG features of atrial tachycardias in the most common anatomic locations are shown in Fig. 6.2.

Crista Terminalis

The crista terminalis runs from the anteromedial high right atrium inferiorly along the lateral RA wall where it ends at the posteroinferior right atrium at the eustachian valve. The majority of right sided atrial tacycardias occur in the region of the crista terminalis. At the superior aspect this may be due to an increase in automaticity as a result of the close proximity of the sinus node. Throughout the structure micro re-entry may occur as a result of anisotropic conduction [7].

Atrial tacycardias originating from this region often have a similar P wave morphology to sinus rhythm and can be confused with sinus tachycardia. Sinus node re-entry tachycardia can also occur at the junction of the sinus node and the crista terminalis. As this is a micro re-entry tachycardia it can be initiated with atrial pacing [8]. As shown in Fig. 6.2 the P wave morphology in atrial tacycardias originating from the crista terminalis depends on the location. Atrial tachycardias from the superior crista terminalis have a similar P wave morphology to sinus rhythm in V1 which is positive and then negative with an inferior directed P wave axis. Atrial tachycardias located in the lower crista terminalis frequently have a negative P wave in V1 with a superior directed P wave axis.

In order to distinguish between atrial tachycardia from the crista terminalis versus sinus tachycardia an abrupt rather than gradual onset and termination with warm up and cool down over several beats favors atrial tachycardia.



Location		V1	II, III, aVF	aVL
CT		Negative if lower down Positive if closer to sinus node	Positive	Positive
Septum	Right	Isoelectric	Positive	Positive
	Left	Negative / Positive	Low amplitude positive	Negative
CS		Negative / Positive or Isoelectric / Positive	Negative	Positive
Annulus	TA	Negative	Negative for Inferoanterior Positive or biphasic for Superior	Positive or isoelectric
	MA	Negative / Positive	Positive	Negative or isoelectric
LSPV	LSPV	Positive	Positive	Negative
	LIPV	Positive	Negative	Negative
	RSPV	Positive	Positive	Positive
	RIPV	Positive	Negative	Positive
LAA		Positive	Positive	Negative

Given the focal nature of these tachycardias activation mapping can be performed looking for a discrete region of early activation. Prior to ablation pacing at high output should be performed in order to ensure that there is no right phrenic nerve capture.

Coronary Sinus os

Atrial tachycardias in this region tend to originate from the superior and posterior regions of the coronary sinus os [9]. The most likely explanation for this is due to anisotropic conduction where coronary sinus fibers connect into the right atrium [10]. This result in either micro re-entry, triggered activity or less commonly increased automaticity [11].

Atrial tachycardias which are located at the os of the coronary sinus have a negative followed by a positive deflection in V1 [9]. The p wave in aVL is positive with a superiorly directed p wave axis.

Given the central activation it is important to distinguish these from atypical AVNRT or AVRT using a septal accessory pathway. Activation mapping should be performed looking for the earliest region of activation. As shown in Fig. 6.2 this is where ablation should be delivered (Fig. 6.3).

Septal Atrial Tachycardias

It is often difficult to ascertain from the ECG as to whether a septal atrial tachycardia is right sided or left sided. Left sided septal atrial tachycardias generally have a positive p wave in V1 while an isoelectric p wave in V1 is more indicative of a right sided focus.

Low septal parahisian atrial tachycardiss are unusual but are associated with a significant risk of AV block. In general the right side is mapped first and if required the left side. Of note the non coronary cusp of the aorta should also be mapped as ablation from this region may reveal an earlier region of activation with a very low risk of AV block.

Fig. 6.2 Common locations of atrial tachycardias along with P wave morphology and ECG features (summarized on table below). In general left sided foci tend to be positive in V1 given the fact that the LA is posterior to the RA. Right sided foci tend to be positive in aVL. Atrial tachycardias originating from closer to the septum tend to be narrower. Superior locations such as the superior CT, anterior septum and superior PV's tend to be positive in the inferior leads while inferior locations such as the CS, inferior TA, inferior MA and inferior pulmonary veins tend to be negative in the inferior leads

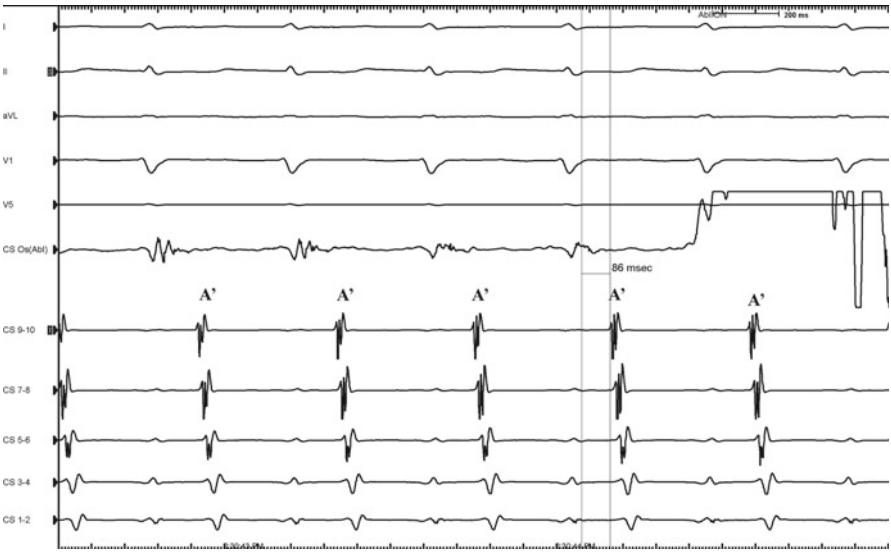


Fig. 6.3 ECG of atrial tachycardia originating from the coronary sinus os. At the *top of the image* the surface ECG leads I, II, aVL, V1 and V5 are shown. The activation sequence of the tachycardia shows the earliest coronary sinus activation recorded on the proximal CS (CS 9–10). The ablation catheter is used to map and shows a local atrial electrogram with is 86 ms ahead of the proximal CS. This is recorded at the junction of the CS os with the low right atrium posterior to the CS. Ablation was performed in this region with termination of the tachycardia and no further inducible tachycardia

Tricupid and Mitral Isthmus Atrial Tachycardia

These are not common and on an ECG may mimic typical atrial flutter or mitral isthmus dependent atrial flutter. The majority of atrial tachycardias originating from the tricuspid annulus tend to be inferior and anterior.

The majority of atrial tachycardias from this region tend be caused by micro re-entry around the annulus. Less commonly as a result of increased automaticity which may occur as a result of AV nodal type tissue in this region [11].

In tricuspid annular atrial tachycardias the P wave is generally negative in V1 as the annulus is anterior with activation in a more posterior direction [12, 13].

Atrial tachycradias from the superior tricuspid annulus tend to have an inferiorly directed axis while those in the inferior annulus tend to have a superiorly directed axis. As shown in Fig. 6.4 a long sheath is often useful for catheter stability in the ablation of annular atrial tachycardias. In this case the addition of a long sheath helps to maintain stability for the ablation of a focal atrial tachycardia along the lateral tricuspid annulus.

Atrial tachycardias in the aorta mitral continuity are uncommon. As this is at the superior aspect of the mitral annulus atrial tachycardias originating from this region have an inferior directed axis and a biphasic P wave in V1 [14].

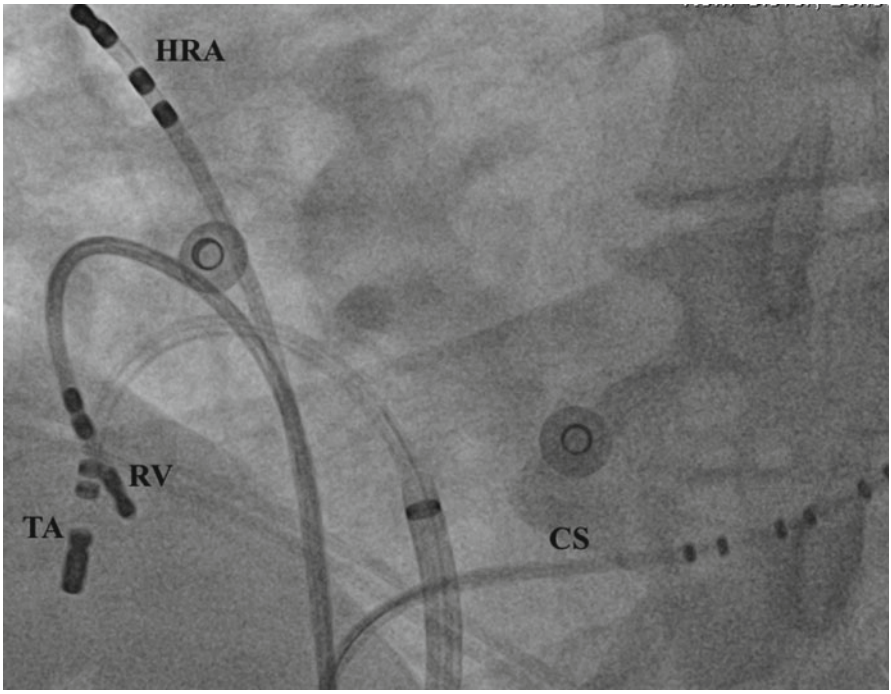


Fig. 6.4 Ablation of a focal atrial tachycardia along the lateral tricuspid annulus using a long sheath in order to maintain catheter stability. This image is taken in an LAO projection with the ablation catheter along the lateral aspect of the tricuspid annulus. Also shown in this image is a catheter in the high right atrium on the *top left of the image*, a catheter in the RV apex shown in the *bottom left of the image* and a catheter in the coronary sinus on the *right of the image*

Pulmonary Vein Atrial Tachycardia

It is generally accepted that ectopic foci from the pulmonary veins may act as initiators for AF in a significant percentage of patients. Atrial tachycardias originating from a single pulmonary vein are relatively common. This tends to occur as a result of increased automaticity but may also result from micro re-entry at the antral areas around the veins. The foci which result in atrial tachycardias tend to be more ostial than those which result in AF [15].

Atrial tachycardias originating from the pulmonary veins are positive in V1 and tend to remain positive across all precordial leads due to the posterior location [15]. Lead I is useful to help differentiate between atrial tachycardias from the right and the left pulmonary veins. The p wave is generally positive in right sided pulmonary veins and negative in left sided pulmonary veins. Atrial tachycardias originating from the left pulmonary veins tend to be broader as septal activation is more delayed when compared with right sided pulmonary veins [16].

It is often difficult to differentiate right superior pulmonary vein from the superior vena cava as the p wave is similar in V1, lead I and both have a similar axis. The p waves in the inferior leads tend to be more positive in atrial tachycardias originating from the superior vena cava.

In order to help differentiate between superior and inferior pulmonary veins the P wave axis should be examined. Atrial tachycardias originating from the superior pulmonary veins have an inferiorly directed P wave axis and those from the inferior pulmonary veins have a superiorly directed P wave axis

Left Atrial Appendage Atrial Tachycardia

Atrial tachycardias originating from the left atrial appendage have a similar morphology in V1 and lead I to those which originate from the left sided pulmonary veins. Given the more anterior position of the left atrial appendage the p waves transition becomes isoelectric in V2 [17].

Clinically atrial tachycardias originating from the LAA tend to be more incessant while those originating from the left superior pulmonary vein may be associated with paroxysmal AF [17]. These may originate from the proximal or distal left atrial appendage. If ablation is performed in the distal left atrial appendage power is usually set at 20–30 W with a target temperature of 45° [18]. This is kept low due to low flow in this region. Prior to ablation high output pacing should be performed in order to ensure that there is no capture of the left phrenic nerve. Access of the distal left atrial appendage may be difficult an a circular catheter may be required in conjunction with the ablation catheter in order to expose the region. Care must be taken to avoid catheter entrapment or perforation of the thin walled appendage.

Important Points

1. Focal atrial tachycardia occurs as a result of either micro re-entry, increased automaticity or triggered activity while macro re-entry occurs over a region of tissue surrounding a region of conduction block.
2. The most common locations are the crista terminalis, coronary sinus os, the pulmonary veins's and antral regions, the tricuspid and mitral annuli, the right and left atrial appendages and the interatrial septum.
3. For focal atrial tachycardia an early, possibly fractionated signal is often seen as a good target.
4. In macro re-entry the critical isthmus is targeted as an area of early meets late during activation mapping. This can easily mapped by performing entrainment in locations likely to contain the isthmus looking for a closely matching PPI-TCL.

5. In order to help decide whether an atrial tachycardia is right sided or left sided the most useful leads to examine are V1 and aVL. As the left atrium is more posterior than the right atrium left sided atrial tachycardias tend to have a positive P wave in V1. A negative P wave is seen more commonly in V1 in right sided atrial tachycardias. A positive P wave in aVL generally indicates a right sided atrial tachycardia while a negative P wave in aVL generally indicated a left sided atrial tachycardia.
6. The majority of right sided atrial tachycardias occur in region of the crista terminalis as a result of anisotropic conduction or changes in automaticity.
7. CS atrial tachycardias tend to originate from the superior and posterior regions of the CS os [9]. The most likely explanation for this is due to anisotropic conduction where CS fibers connect into the right atrial.
8. Tricupid and mitral isthmus atrial tachycardias are relatively uncommon and on an ECG may mimic typical atrial flutter or mitral isthmus dependent atrial flutter. The majority of atrial tachycardias originating from the tricuspid annulus tend to be inferior and anterior.

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Chapter 7
Atrial Flutter

Benedict M. Glover and Pedro Brugada

Abstract Atrial flutter is caused by either macro or micro re-entry circuits within either the right atrium or left atrium. It is broadly divided into either typical or atypical forms. Typical atrial flutter involves the cavotricuspid isthmus as part of the circuit with either a counter-clockwise or clockwise activation. The cavotricuspid isthmus extends from the tricuspid valve to the inferior vena cava, which supports slow conduction.

Atypical atrial flutter involves non-cavotricuspid isthmus dependent circuits in the right atrium, septum or left atrium. Right atrial flutters which are not dependent on the cavotricuspid isthmus include upper loop re-entry, lower loop re-entry, right lateral wall incisional type atrial flutter and circuits around the fossa ovalis. Upper loop re-entry tends to occur around the superior vena cava with slow conduction through the upper component of the crista terminalis. Lower loop re-entry occurs around the inferior vena cava with slow conduction through the lower portion of the crista terminalis.

Left atrial flutters tend to occur around the mitral valve annulus, the ostia of the pulmonary veins or the fossa ovalis on the left side. Mitral annular flutter may propagate either in a clockwise or counterclockwise direction.

ECG analysis of the flutter wave is important in order to help localize the circuit and plan an appropriate ablation strategy for the patient as well as helping to predict the potential success of the procedure.

ECG interpretation does have its own limitations particularly in patients who have undergone prior atrial ablations or in patients with structural heart disease. The most important differentiation is between cavotricuspid isthmus dependent flutter and atypical atrial flutter as well as predict whether the circuit is in the right or left atrium.

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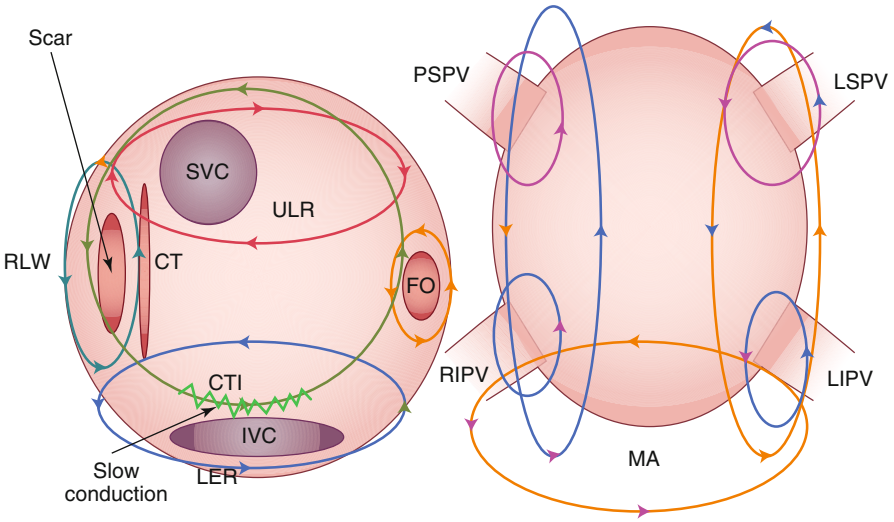

Fig. 7.1 Location of Atrial Flutters in the Right and Left Atrium. Cavotricuspid Isthmus (*CTI*) dependent circulates around the right atrium commonly with counterclockwise propagation (*green arrows*). Upper loop re-entry (*ULR*) rotates around the superior vena cava (*SVC*) with slow conduction through the crista terminalis (*CT*). Lower loop re-entry rotates around the inferior vena cava (*IVC*) also involving the crista terminalis (*CT*). Re-entry may also occur around the right lateral wall (*RLW*) often in post surgical cases where this is related to an incision as well as around the fossa ovalis (*FO*). In the left atrium atrial flutter may occur around the mitral annulus (*MA*) in either a clockwise or counterclockwise direction as well as around the pulmonary veins (*LSPV* left superior pulmonary vein, *LIPV* left inferior pulmonary vein, *RSPV* right superior pulmonary vein, *RIPV* right inferior pulmonary vein)

Cavotricuspid Isthmus Dependent Atrial Flutter

Overall this is the most common flutter circuit and should always be suspected even in cases of congenital heart disease and post atrial fibrillation ablation, even if the ECG does not look typical (Fig. 7.1).

Anatomy

The cavotricuspid isthmus is an important anatomical structure which acts as an area of slow conduction. As seen in the anatomic image in Fig. 7.2 it is located posteriorly to the tricuspid annulus and anteriorly to the Eustachian valve at the junction of the right atrium and the inferior vena cava. The coronary sinus is superior and medial to the cavotricuspid isthmus. During mapping and ablation of the cavotricuspid isthmus the catheter is generally positioned at 6 o'clock in an LAO projection (Fig. 7.3) which is the mid segment and is considered the thinnest portion where ablation can generally be performed. Moving towards the septum this region is shorter in distance but

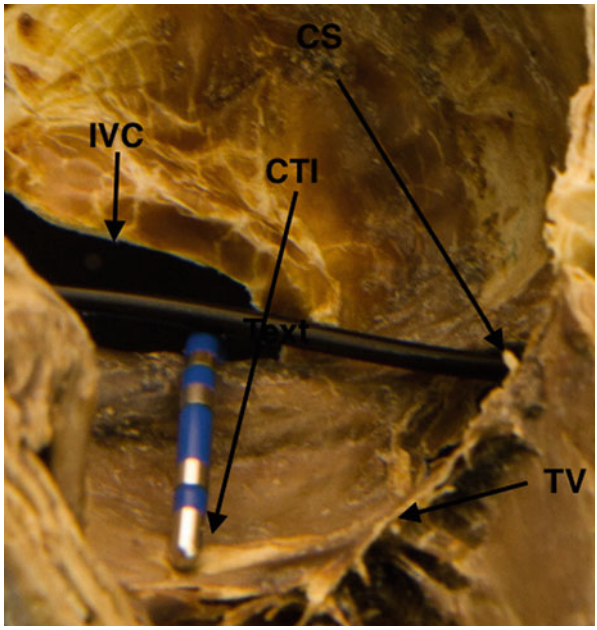

Fig. 7.2 Anatomical image showing the CTI, tricuspid valve (*TV*), inferior vena cava (*IVC*) and coronary sinus (*CS*). Also shown in this image are an ablation catheter in the location of the CTI and a catheter in the coronary sinus

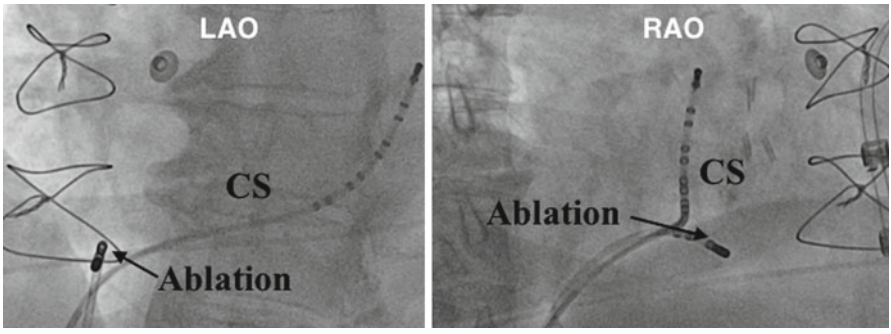

Fig. 7.3 Fluoroscopic image of the catheter location in the mid CTI in an LAO (*left*) and RAO (*right*) projection. The ablation catheter is positioned along the mid CTI. There is a 10 pole catheter positioned in the coronary sinus (CS)

thicker where the fibers merge with the coronary sinus. Inferolaterally it is broader and thicker. The anterior aspect at the tricuspid annulus is muscular while the posterior component at the junction with the inferior vena cava has minimal muscle and is generally fibro-fatty tissue. The cavotricuspid isthmus elevates into the eustachian ridge and this divides it into two components: the sub-eustachian isthmus (between the eustachian ridge and the tricuspid valve) and the crest of the eustachian ridge to the inferior vena cava, separated from the compact AV node by the coronary sinus.

Although the mid cavotricuspid isthmus is the thinnest component and therefore the best target for ablation the anatomy is variable: muscular fibers in this region

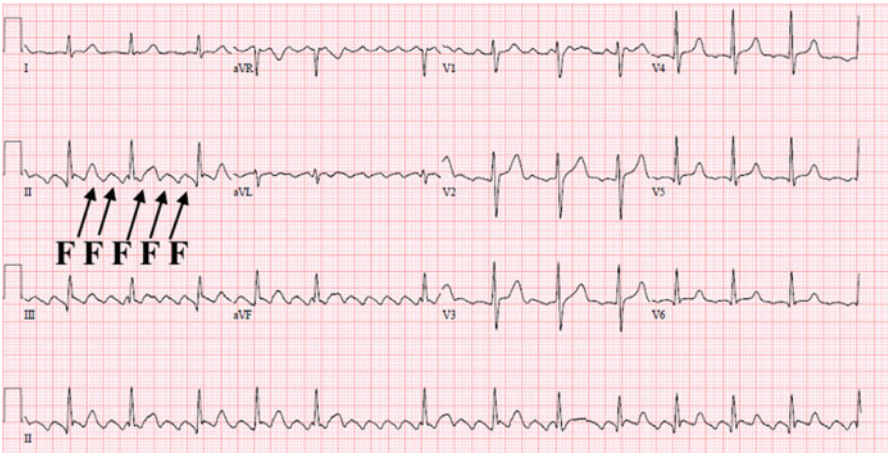

Fig. 7.4 ECG of counterclockwise cavotricuspid isthmus dependent atrial flutter. The flutter waves are negative in the inferior leads II. III and aVF implying activation from inferior to superior in the right atrium

result in irregularities which extend inferiorly and laterally from the coronary sinus wall or medially and superiorly from the crista terminalis. Between the muscular structures are thin membranes. Often these muscular fibres overlap at their superomedial and inferolateral origins and therefore in theory the most parallel segment is the medial cavotricuspid isthmus. The muscular fibers which pass through the cavotricuspid isthmus are of different sizes and therefore have different conduction properties. Narrower fibers in the mid isthmus tend to conduct more slowly than broader fibers in the septal and lateral positions.

ECG Features

Cavotricuspid isthmus dependent atrial flutter tends to have a saw tooth type appearance observed in the inferior leads and V1. The most common direction of conduction is counterclockwise which accounts for approximately 90 % of cases. As shown in Fig. 7.4 this result's in negative flutter waves in the inferior leads with an initial gradual and then steep downslope followed by a steep upslope and then a gradual downslope to baseline. The flutter wave is positive in V1 in counterclockwise activation with a gradual transition from V1 to V6 from positive to isoelectric to negative.

Clockwise (reversed) cavotricuspid isthmus dependent atrial flutter accounts for approximately 10 % of cases of typical atrial flutter. The activation sequence is the reverse of typical counterclockwise atrial flutter. The inferior leads therefore demonstrate a broad positive with a negative flutter wave in V1. There is a transition from V1 to V6 from negative to isoelectric to positive.

Ablation of the CTI for Typical Atrial Flutter

In general this can be performed with two catheters. A quadripolar or decapolar catheter is positioned in the coronary sinus while an ablation catheter can be used for ablation and mapping. Some operators use a multipolar catheter in the right atrium in order to help assess the activation sequence during the atrial flutter as well as to assess for isthmus block at the end of the procedure. This catheter may be positioned in order to map the septum with the proximal electrodes and the lateral wall of the right atrium with the distal electrodes and the mid electrodes spanning across the right atrial roof. The distal electrodes can also be positioned in the proximal coronary sinus with the mid poles spanning the cavotricuspid isthmus and the proximal poles spanning from the high to low right atrium along the crista terminalis in order to assess for bidirectional block at the end of the ablation. This is generally not required and can often lead to diagnostic errors if the catheter is not positioned exactly as described above.

A range of ablation catheters may be considered for ablation of the cavotricuspid isthmus ranging in size from 4 mm to 10 mm as well as the possibility of irrigation versus non-irrigation of the tip. The choice is operator dependent and generally a large curve is used in order to ensure adequate reach of the ventricular side of the isthmus.

It is our practice to use a decapolar catheter in the coronary sinus and a 4 mm irrigated catheter for ablation. A quadripolar catheter may be considered for back up right ventricular pacing in certain cases where the patient is in atrial flutter and there is a suspicion that the patient may develop bradycardia following termination of the arrhythmia.

The ablation catheter is normally positioned at the tricuspid annulus so that the atrial and ventricular electrograms are of equal amplitude. In the LAO projection the ablation catheter is at the 6 o' clock position where the cavotricuspid isthmus is at its narrowest. A more medial position increases the risk of AV block and potential ablation within the middle cardiac vein. A more lateral position generally requires a longer ablation line.

If the patient is in atrial flutter entrainment should be performed from this location at a rate 20 ms faster than the tachycardia cycle length looking for a PPI – TCL of less than 30 ms. An example of this is shown in Fig. 7.5. This patient presented with an atrial flutter following a prior PVI for AF. The tachycardia cycle length was 348 ms. Pacing from the ablation catheter which was positioned along the cavotricuspid isthmus was performed at 320 ms. The PPI was 348 ms which was exactly the same as the tachycardia cycle length indicating that the cavotricuspid isthmus was a part of the circuit.

While pacing from the cavotricuspid isthmus the stimulation to onset of atrial activation is generally quite long due to the slow conduction in the isthmus. This is obviously much shorter on the septal side of the isthmus.

Power settings for a 4 mm irrigated catheter are usually 30–40 W. The temperature limit is generally set at 60 ° C for non-irrigated catheters. Larger 8-mm

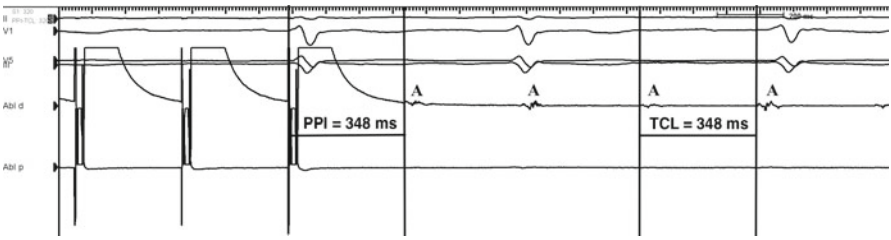

Fig. 7.5 PPI – TCL in Atrial Flutter during and after entrainment from the CTI. This patient presented with atrial flutter following a prior ablation for atrial fibrillation. The tachycardia cycle length was 348 ms. Pacing was performed from the ablation catheter which was positioned along the CTI at 320 ms. The post pacing interval was 348 ms. This was exactly the same as the tachycardia cycle length implying that the CTI was a critical component to the circuit

tip catheters require a higher power often up to 70 W with a maximum temperature of 60 ° C. Following a period of 60–90 s and with significant diminution of the local signal the catheter is moved to a more proximal location. Ablation can be performed either as a point by point technique or a continuous dragging technique from the tricuspid annulus to the junction with the inferior vena cava spending 60–90 s at each position looking for a reduction in local electrogram voltage. Some operators use lack of unipolar pacing to assess whether a lesion has been created prior to moving onto a more proximal location where capture occurs and further ablation is performed in this location. Often atrial flutter terminates prior to the development of bidirectional block across the CTI. If bidirectional block does not occur the same line can be repeated on a more medial or lateral position.

If the patient is in sinus rhythm at the start of the procedure ablation can be performed during proximal coronary sinus pacing assessing for double potentials along the ablation line [1, 2]. The proximal coronary sinus is generally paced at a cycle length of 600 ms and the ablation catheter is moved along the ablation line from the ventricular aspect to the junction with the inferior vena cava. The first potential is recorded from the medial aspect of the line while the second component is lateral to the line. As shown in Fig. 7.6 an interval of greater than 110 ms with minimal variability is generally associated with conduction block across the ablation line [3]. As shown in Fig. 7.7 this can be reversed so that pacing is performed lateral to the ablation line and the interval between this and the proximal coronary sinus can be measured. This is recorded and the ablation catheter is moved further away from the cavotricuspid ablation line and pacing performed. If moving further from the ablation line results in a shorter stimulation to proximal coronary sinus activation then this likely represents counterclockwise block.

When pacing from the proximal CS an interval of less than 90 ms indicates intact conduction across the line.

As shown in Fig. 7.8 the delay from the onset of the first to the second potential is 40 msec. The line between the two potentials is also not isoelectric. This represents intact conduction across the CTI.

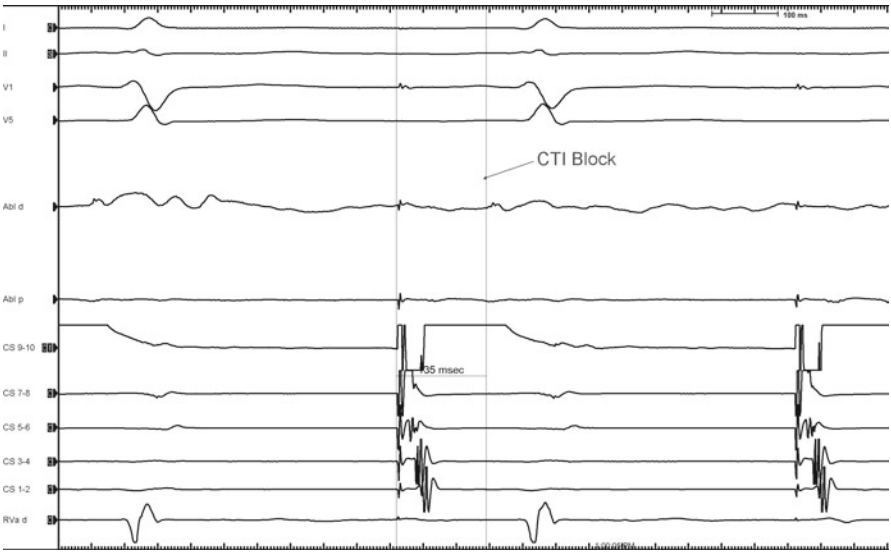

Fig. 7.6 Pacing is performed from the proximal CS (CS 9 10) at a rate of 600 msec. The ablation catheter is positioned along the CTI so that it is recording activation medial to the CTI line seen as the first deflection followed by an isoelectric line and then another atrial activation lateral to the CTI 135 msec later. This represents clockwise block across the CTI. CS 1 2 is located in the distal coronary sinus, RVa d is located in the RV apex

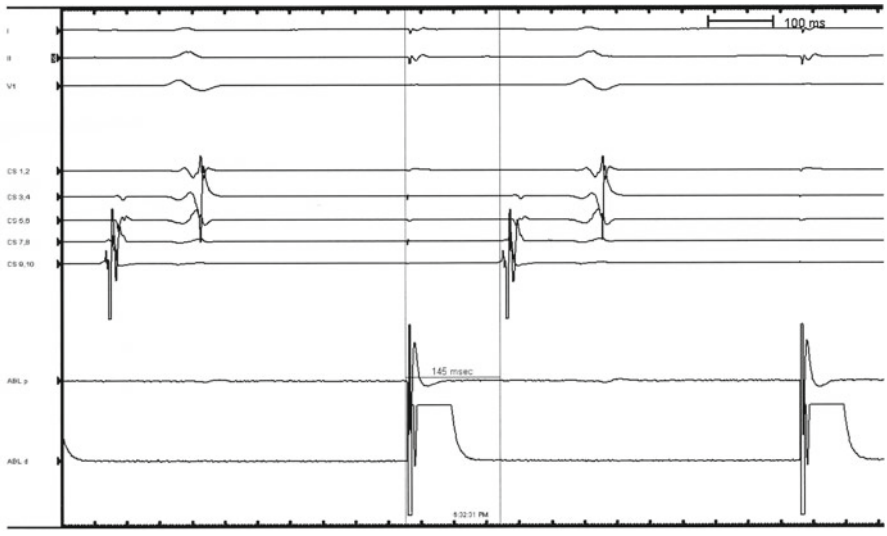

Fig. 7.7 Pacing is performed lateral to the ablation line and the stimulation to proximal CS (CS 9 10) is recorded as 145 msec representing a significant delay. The ablation catheter is moved more superior and lateral to this point and pacing is performed with a delay from stimulation to proximal CS activation of 128 msec (not shown in this image). This is suggestive of counterclockwise block across the CTI. CS 1 2 is positioned in the distal coronary sinus

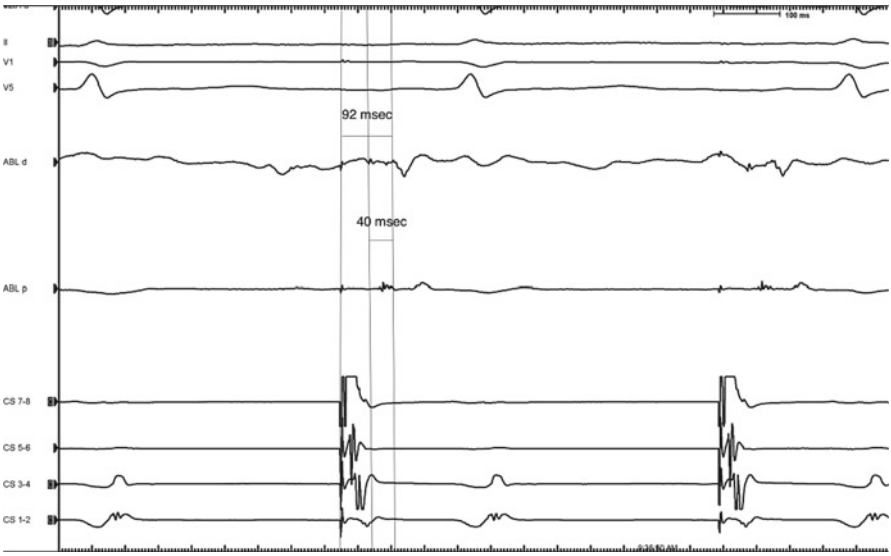

Fig. 7.8 Pacing is performed from the proximal CS (CS 7 8) with the ablation catheter positioned on the CTI. Double potentials are recorded on the ablation catheter. The first potential represents atrial activation medial to the CTI ablation line. The second component represents activation lateral to the CTI ablation line. The time from the proximal CS stimulation to the lateral atrial activation is recorded as 92 msec. The delay from the onset of the first potential to the onset of the second potential is 40 msec. The interval between the two potentials is not isoelectric. This represents intact conduction across the ablation line. CS 1 2 is positioned in the distal coronary sinus

If the interval between the two potentials is between 90 and 110 ms then the electrograms should be examined further. Features indicative of block include an isoelectric line between the first and the second component of the double potential with a negative second potential. The interval between the first and second components of the potentials is generally isoelectric in the presence of block. If this has a fractionated aspect or low amplitude signals there is generally slow conduction across the line.

In the presence of block the second component of the double potential is negative as a result of a change in the polarity of the activation wavefront. The change from positive to negative should be noted on completion of the gap.

The closer to a gap the shorter the distance between the two components. Wider splitting of the double potentials implies a distance further from the gap.

As shown in Fig. 7.9 where the ablation catheter is positioned on the cavotricuspid isthmus while pacing from the proximal CS. The duration from the pacing spike on the proximal CS to the onset of the second potential is 182 ms. The delay from the onset of the first potential to the onset of the second potential is 94 msec. There is a clear isoelectric line between the potentials and the second component is negative. This represents clockwise block across the CTI.

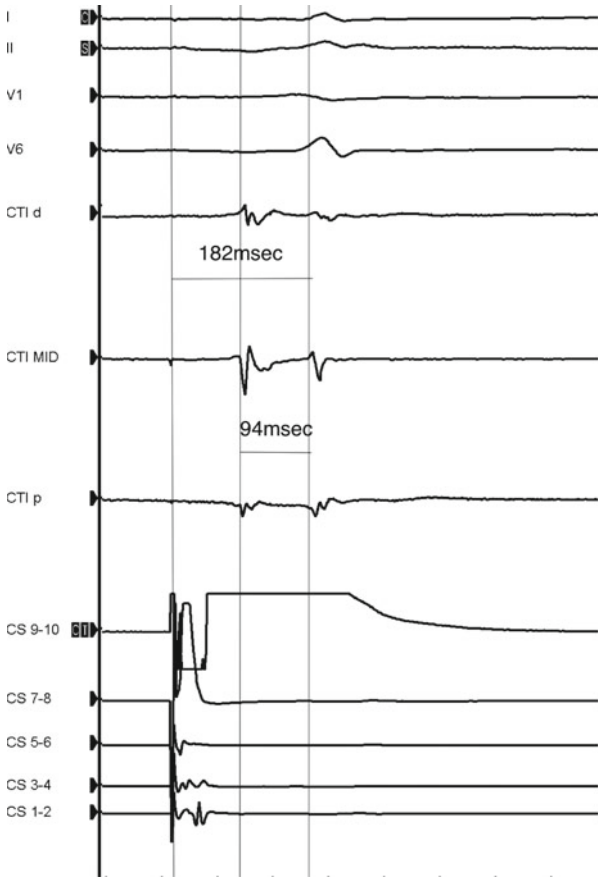

Fig. 7.9 Clockwise block across the CTI. Pacing is performed from the proximal CS (CS 9 10) while the ablation catheter is positioned along the CTI. The duration from the pacing spike to the onset of the second potential is 182 ms. The time from the onset of the first to the onset of the second potential is 94 ms. The line between both potentials recorded on ablation distal (CTId), middle (CTImid) and proximal (CTIp) is isoelectric. The second component of the double potential is negative on the ablation catheter. These features are suggestive of clockwise block across the CTI. CS 1 2 is positioned in the distal coronary sinus

Decremental Pacing

This technique is useful in cases where it is difficult to make a conclusion based on intermediate double potentials [4]. Ablation is performed along the cavotricuspid isthmus until double potentials are noted. Pacing is then performed from the proximal coronary sinus at 600 down to 250 ms while the ablation catheter is used to record double potentials along the ablation line. If the second component of the double potential does not increase by more than 20 ms with decremental pacing then this demonstrates clockwise block. This is then repeated from the lateral right atrial wall in order to prove counterclockwise block. A change in the second component by more than 20 ms with incremental pacing implies conduction through the CTI. A diagrammatic representation of this is shown in Fig. 7.10.

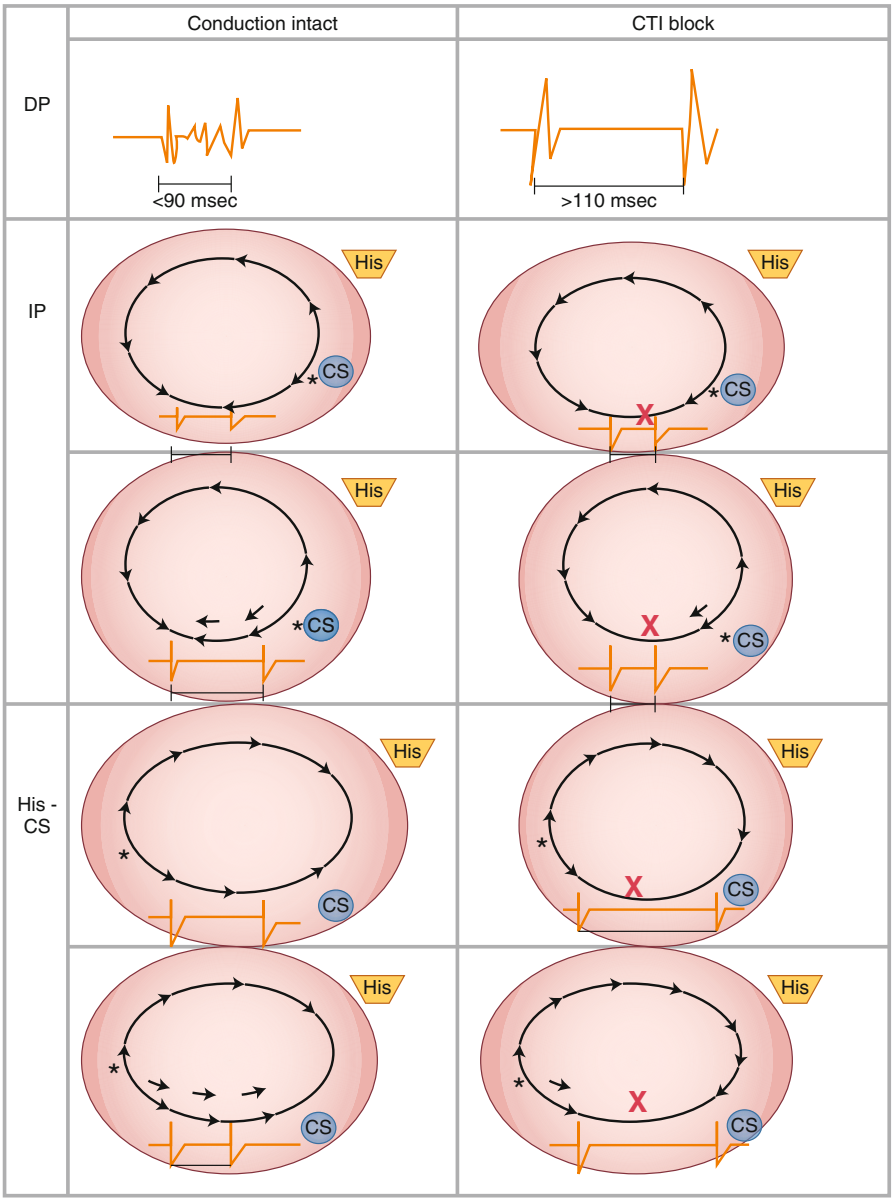

Fig. 7.10 Maneuvers used to prove CTI block. The presence of double potentials with an isoelectric line between potentials of greater than 110 ms is indicative of block across the CTI. Incremental pacing from the CS results in an increase in the separation of the double potentials by greater then 20 msec if CTI conduction is intact. If the CTI line is blocked then there is no significant change with incremental pacing from the CS (*middle images*). Alternatively the atrial signal can be recorded on the His and CS with pacing from the low lateral right atrial wall. If CTI conduction is intact the double potentials narrow with incremental pacing while if the CTI is blocked the potentials separate further but do not decrement with incremental pacing

Decremental His to Coronary Sinus Pacing

This is a modification of differential pacing in which pacing is performed from lateral to the CTI ablation line and activation of the atrial electrogram in the His region is compared with activation of the atrial electrogram in the proximal coronary sinus electrogram [5].

When pacing from the lateral lower right atrium when conduction across the CTI is intact activation occurs in a counterclockwise fashion across the isthmus, via the posteroseptal region followed by activation of the coronary sinus. Activation anterior to the tricuspid annulus results in atrial activation of the His region. Following CTI ablation anterior activation still occurs and the His is still activated which then spreads to coronary sinus which results in an increase in the His – CS timing of >40 ms from baseline. In the presence of CTI block the His to CS timing does not change significantly as activation occurs on the same rather than two pathways.

The advantage of this is that it does not rely on the accurate identification of double potentials which may be difficult to identify. This appears to be an effective strategy in helping to prove block across the CTI

An Alternative Ablation Technique: Maximum Voltage Guided Ablation

Given that different fibers of muscular have different orientations, dimensions and conduction properties there may be discrete regions with high voltage electrograms which can be selectively targeted for ablation [6].

As shown in Fig. 7.11 pacing is performed at 600 ms from the proximal coronary sinus while the ablation catheter is moved from the ventricular of the CTI to the inferior vena cava. The region of highest bipolar voltage is noted and RF delivered in this region for 60 s or shorter if the local potential reduces by more than 50% from baseline [7].

Following this the CTI is remapped looking for the maximum signal and ablated in a similar fashion. This is repeated until bidirectional block is obtained.

This technique appears to be as successful as a conventional line with reduced procedural and fluoroscopy time [8].

Potential Complications of Cavotricuspid Isthmus Ablation

There is a risk of AV block if the ablation performed is septal. This is close to zero if a lateral line is performed. Although the risk of thromboembolism is very low, the patient should be anticoagulated if they are in atrial flutter at the start of the procedure, either with heparin or with continuation of full anticoagulation. Like all catheter ablations there is always a risk of groin hematoma and cardiac perforation.

The risk of coronary artery damage, and in particular the PDA, is very unlikely.

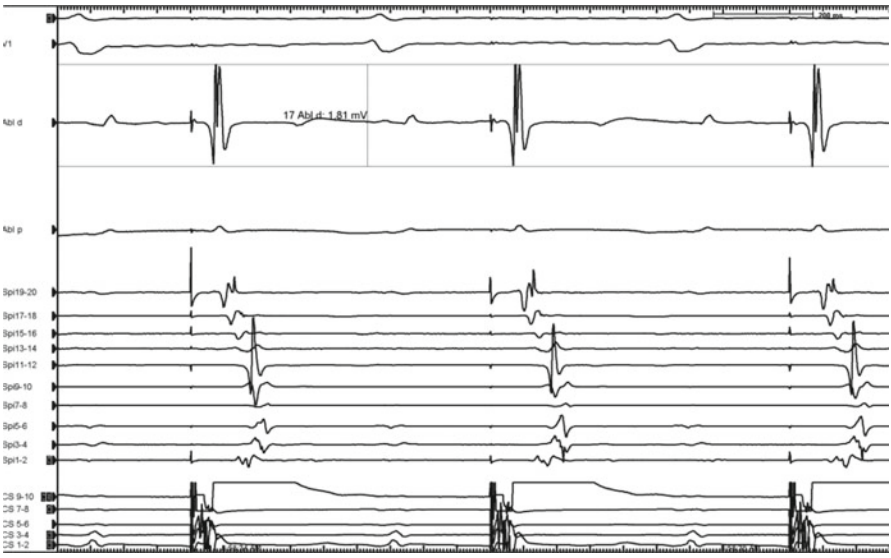

Fig. 7.11 Maximum voltage guided ablation of the CTI. Pacing is performed at 600 msec from proximal CS. A 20 pole catheter (labeled Spi) is positioned in the RA showing earliest activation in the proximal and distal poles and subsequent activation across the RA with no evidence of block across the CTI. The ablation catheter is positioned along the CTI and is recording the region of maximum voltage which in this cases is recorded as 1.81 mV. CS 9 10 is positioned in the proximal coronary sinus with CS 1 2 in the distal CS

Difficult CTI Ablation

Although the majority of cavotricuspid isthmus ablations are relatively straightforward variability in anatomy may result in technical difficulties. The most common of these are difficulty in reaching the ventricular end of the isthmus which is overcome with a long sheath or persistent conduction at the junction between the right atrium and the inferior vena cava which generally requires catheter manipulation.

Additional issues which may not be obvious include prominent pectinate muscles, a prominent Pouch of Keith or prominent Eustachian ridge.

Prominent pectinate muscles in the region of the isthmus may impair the ability to create a line of block. It may be seen on the ablation catheter as large amplitude electrograms. In order to deal with this issue, either a more medial line of ablation can be performed or an irrigated catheter can be considered in order to achieve a deeper lesion.

The Pouch of Keith is located along the isthmus and lateral to the Thebesian valve at the CS orifice. Although this is generally a slight ridge in most patients, occasionally it may be a deep out pouching with poor blood flow, meaning that either the

catheter does not make sufficient contact or, if it does, power delivery is not sufficient to result in a satisfactory ablation line. A prominent Thebesian valve may be a clue to the Pouch of Keith. In order to deal with this problem the isthmus line can be made more laterally.

The Eustachian ridge is a fibrous structure which generally has no impact in an isthmus ablation but if very prominent may actually affect the rotation of the ablation catheter. This means that if the catheter is rotated in a clockwise manner towards the septum, the Eustachian ridge may cause a counter-clockwise rotation away from the septum. In order to counteract this issue a long sheath can be used.

Success of Cavotricuspid Isthmus Ablation

The overall success for an isthmus dependent atrial flutter is approximately 90%, provided bidirectional block has been demonstrated at the end of the ablation. The bigger issue is the occurrence of atrial fibrillation where the reported rate is as high as 82% after 39 months in patients with isolated atrial flutter and no other arrhythmias [9].

Upper and Lower Loop Re-entry

Upper loop re-entry occurs around the superior vena cava with a breakthrough in a gap in the crista terminalis. It often has a similar ECG appearance to clockwise cavotricuspid isthmus dependent flutter with positive flutter waves in the inferior leads. In order to help distinguish upper loop re-entry from clockwise cavotricuspid isthmus dependent flutter lead I can be examined. If the flutter wave in lead I is negative or isoelectric then it is more likely to be upper loop re-entry. If the flutter wave in lead I is positive it may be either. If the flutter wave is less than or equal to 0.07 mV in amplitude then it is more likely to be a result of upper loop re-entry [10]. As the circuit is shorter the tachycardia cycle length is often shorter than typical atrial flutter. It may occur as a result of typical atrial flutter or atrial fibrillation. If entrainment in this region is suggestive for an upper loop re-entry then ablation can be performed at the upper gap along the superior crista terminalis as this may be the narrowest part of the circuit.

Lower loop re-entry uses the cavotricuspid isthmus as part of its circuit but breaks through a gap in the lower portion of the crista terminalis. It is generally counterclockwise and therefore could be confused with typical counterclockwise atrial flutter. As it breaks through at a lower level along the lateral right atrial wall the flutter waves in the inferior leads tend to be less positive and the tachycardia cycle length in general is shorter. Ablation along the cavotricuspid isthmus should result in termination of this tachycardia.

Right Atrial Lateral and Postero-Lateral Wall Flutter

This may occur around areas of scar or low voltage areas such as in patients who have had prior cardiac surgery. It has a variable appearance on ECG depending on the conduction properties in this region, the direction of the circuit and subsequent

activation of the right atrium. Right atrial flutter originating from the lateral wall may often resemble cavotricuspid isthmus dependent flutter. The flutter wave is generally negative in V1. Right atrial flutter involving the septum tends to have an isoelectric or biphasic flutter wave in V1. In general these flutters require detailed mapping looking for regions of scar as well as the activation sequence. Entrainment should help to determine whether the region being mapped is part of the circuit although it may often be difficult to capture due to the presence of scar and low amplitude signals. Certain ablation lines can be performed. For lateral circuits on the lateral wall a line can be made from the region of scar to either the superior or inferior vena cava. If this is performed mapping of the right phrenic nerve should be performed prior to delivery of ablation energy.

Left Atrial Flutter

In order to differentiate a right from a left sided atrial flutter on ECG the most useful lead to examine is V1. If the **initial segment of the flutter wave is negative or isoelectric followed by a positive deflection or the entire flutter wave is negative it is more likely to be right sided while a positive flutter wave is more likely to be left sided**. If the entire flutter wave in V1 is isoelectric it is difficult to localize the flutter to either right or left sided. In left sided atrial flutters as well as these changes noted in V1 the flutter waves in the inferior leads tend to be positive but of low amplitude, generally a reflection of the underlying substrate.

The most simplistic way to distinguish left atrial flutter from atrial tachycardia is to assess the onset and termination of the tachycardia. Re-entry atrial flutter tends to be of acute onset and termination while focal atrial tachycardia tends to accelerate at the onset of the tachycardia and decelerate at the termination of the tachycardia.

Most left atrial flutter circuits either revolve around the mitral annulus in either a clockwise or counterclockwise direction or around the pulmonary veins.

Mitral Isthmus Dependent Atrial Flutter

This circulates around the mitral annulus in either a clockwise or counterclockwise direction and traverses the mitral isthmus. The relevant anatomy is demonstrated in Fig. 7.12. The mitral isthmus is posterior to the mitral annulus and anterior to the left atrial posterior wall. Mitral isthmus dependent flutter may occur following pulmonary vein isolation and in particular as a result of ablation lesions inferior and slightly anterior to the left inferior pulmonary vein.

In order to perform a mitral isthmus line a catheter is positioned in the coronary sinus so that the distal electrodes are slightly posterior to the line. An ablation

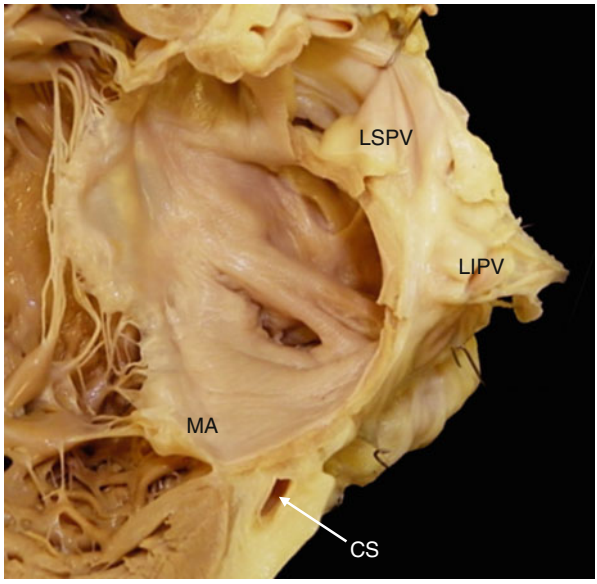

Fig. 7.12 Anatomical image showing the location of the mitral isthmus between the mitral annulus (*MA*) and the left inferior pulmonary vein (*LIPV*). The coronary sinus (*CS*) is also shown in close proximity to the MA

catheter is then positioned along the lateral mitral annulus with an A:V ratio of 1:2 at 4 o'clock in the LAO 30 view. In general a 4 mm irrigated catheter may be used with a power setting of 40 W at the annulus which can then be reduced to 30 W at the inferior pulmonary vein side. In order to move the catheter from the annulus which is anterior to the left inferior pulmonary vein which is posterior, clockwise rotation is applied to the ablation catheter. Following completion of the line pacing can be performed from either the distal coronary sinus or the left atrial appendage to confirm conduction.

If conduction persists then further mapping can be performed looking for early atrial signals during pacing from the left atrial appendage. If conduction persists despite this then ablation can be performed in the coronary sinus in the same location as the endocardial lesions with flexion towards the endocardial mitral isthmus lesions at 25 W. In order to prove block across the mitral isthmus line pacing can be performed from the left atrial appendage which is anterior to the line and the activation sequence examined in the coronary sinus catheter. Clockwise block is demonstrated by an activation from the proximal to the distal coronary sinus indicating counterclockwise activation around the mitral annulus. It is possible to electrically isolate the coronary sinus with resultant proximal to distal activation which may mimic isthmus block. Counterclockwise block is demonstrated by pacing from the distal coronary sinus which is posterior to the mitral isthmus line. Activation therefore occurs from the distal coronary sinus electrodes to proximal prior to activation of the left atrial appendage.

Additionally the ablation catheter can be moved along the mitral line during pacing from either the left atrial appendage or the distal coronary sinus looking for the presence of double potentials.

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Chapter 8
Atrial Fibrillation

Benedict M. Glover and Pedro Brugada

Abstract AF is the most common sustained arrhythmia seen in clinical practice with an overall prevalence of 700–750 per 100,000 of the population in North America (Chugh et al. Circulation 129:837–47, 2014). As well as resulting in considerable adverse sequelae and an increase in hospitalizations there is a 5 fold increase in the risk of stroke associated with non-valvular AF (Wolf et al. Stroke 22:983–8, 1991) and by a factor of 17 in the presence of significant valvular heart disease (Fuster et al. Circulation 123:e269–367, 2011). The risk of AF increases markedly with older age affecting approximately 5 % of people over 65 years and 10 % of people age over 80 years (Miyasaka et al. Circulation 114:119–25, 2006).

Classification of AF

AF is classified as paroxysmal, persistent, longstanding persistent or permanent. **Paroxysmal AF is defined as two or more episodes of AF each of which terminate within seven days and commonly within 24 h. Persistent AF is sustained generally for greater than seven days** (or less if a cardioversion was performed in this time) and requires chemical or electrical cardioversion for termination of the arrhythmia. **Longstanding persistent refers to cases in which AF has been present for more than 1 year and previously may have been designated as being permanent**; **however**, **an electrical cardioversion or ablation strategy is being**

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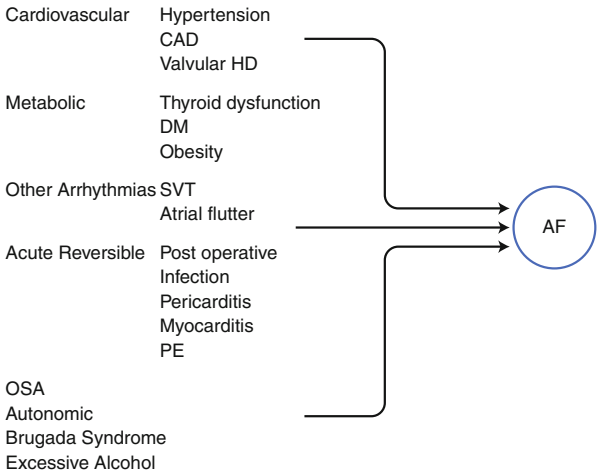

Fig. 8.1 Causes of Atrial Fibrillation. These can be divided into cardiovascular such as hypertension, coronary artery disease (*CAD*) and valvular heart disease (*HD*), metabolic, such as thyroid dysfunction, diabetes mellitus (*DM*) and obesity other arrhythmias such as SVT and atrial flutter and acute reversible causes such as post operative, infections, pericarditis, myocarditis and pulmonary embolism (*PE*). Other causes include OSA, autonomic, Brugada and excess alcohol

pursued and therefore sinus rhythm may be achieved. Permanent AF also continues for more than seven days and cannot be terminated anymore thus a rhythm control strategy has been unsuccessful or not appropriate.

Etiology

The incidence of AF is increased by other cardiovascular and metabolic conditions as well as several lifestyle factors. It may also be secondary to either acute reversible insults or to other arrhythmias.

The main cardiovascular causes of AF are shown on Fig. 8.1 and include hypertension, coronary artery disease and valvular heart disease. Metabolic causes of AF include thyroid dysfunction and diabetes mellitus while lifestyle risk factors include obesity, excessive alcohol and obstructive sleep apnea. AF is frequently seen in the acute setting in post-operative patients as well as those who have infection, or in association with pulmonary embolism, pericarditis and myocarditis. AF may also occur in association with other supraventricular arrhythmias, such as AV nodal re-entry tachycardia, AV re-entry tachycardia and atrial flutter. It is important to perform an EP study in patients who are being considered for an AF ablation and in particular young patients to ensure that there is not an underlying SVT. In patients who have undergone a successful ablation for typical atrial flutter the incidence of AF with 2.5 years post ablation is 50 % [1]. There has been some recent evidence to suggest that triggers from the pulmonary veins may also play a role in the initiation of typical atrial flutter [2]. Other less common causes of AF include autonomic, familial forms (particularly Brugada syndrome) and inflammatory.

Hypertension

The odds ratio for developing AF in association with hypertension is 1.5 for men and 1.4 for women [3]. Although this is not the highest risk for AF in an individual it is the most common cause of AF due to the high incidence of hypertension. Hypertension is often accompanied by left atrial remodeling due to pressure and volume overload as a result of a degree of left ventricular diastolic dysfunction. These changes may result in changes in the electrical properties of the myocytes in the pulmonary veins increasing the potential for them to act as triggers.

Effective treatment of hypertension in patients with AF has been shown to reduce all cause mortality (7.8 %), cardiovascular mortality (4.3 %), nonfatal myocardial infarction (5.3 %) and stroke (2.2 %), independent of blood pressure lowering effects [4]. Additionally effective treatment of hypertension has been shown to reduce the overall risk of developing AF by 28 % [5]. Data supporting this has been inconsistent however which may be a reflection of an the difficulty in optimal blood pressure control.

Coronary Artery Disease

AF is relatively common following an acute myocardial infarction (MI) occurring in approximately 15 % of patients. Early reperfusion as well as the use of beta blockers appears to have had an impact on lowering the incidence of AF post MI. AF may result from occlusion to or proximal to the sinus node artery as well as the hemodynamic changes associated with left ventricular dysfunction. It may also occur as a result of changes in autonomic tone, in particular an increase in adrenergic stimulation or as a result of pericarditis.

Of additional note some patients with AF present with chest pain, an elevated cardiac troponin and no evidence of significant obstructive coronary artery disease. It has been suggested that this may be a result of AT1 receptor mediated oxidative stress accompanied by a reduction in microvascular blood flow [6].

Valvular Heart Disease

The incidence of AF in patients with significant valvular heart disease is approximately 30 % and in patients with mitral stenosis is approximately 50 %. AF tends to be an early manifestation of mitral valve disease and tends to present later in aortic valve disease. Patients with significant mitral and aortic valve disease tend to have elevated left atrial pressure with left atrial dilatation and left atrial fibrosis which increases the possibility of re-entry circuits. The overall reduction in the incidence of rheumatic heart disease in the Western World has lead to a significant reduction in this as an overall contributor to AF.

Diabetes Mellitus

Diabetes mellitus (DM) has been shown to be associated with an increased incidence of AF and this risk increases with diabetes duration and poor glycemic control [7, 8]. DM may result in a disturbance of cardiac autonomic function, in particular an increase in sympathetic tone, which may result in the initiation of AF [9]. The cardiac autonomic dysfunction in patients with DM may also result in coronary microvascular dysfunction and diastolic dysfunction in diabetic subjects [10–12] which may increase the potential for AF. There may also be inflammatory changes responsible for both conditions. CRP and interleukin 6 have been shown to be elevated in atrial biopsies in patients with lone AF which may also be elevated in DM [13, 14].

Obesity and Obstructive Sleep Apnea (OSA)

Obesity is a significant public health concern with increasing prevalence. There is a 2.4 fold increased risk of AF in obese individuals versus those with a normal body mass index (BMI) [15]. Furthermore this risk appears to increase with increasing BMI with a 1.2 fold increase in those with a BMI of 25–30 kg/m^2 and a 2.3 fold increase in those with a BMI greater than 40 kg/m^2 [16].

There are several potential explanations for the increased risk of AF in patients who are overweight or obese. AF may occur as a direct result of obesity or in association with other risk factors, which are more commonly associated with an elevated BMI.

There is a direct association between left atrial dilatation and obesity with a 2.4 fold 10-year risk of left atrial enlargement on echocardiogram [17].

Left atrial pressure may also increase as a result of left ventricular hypertrophy and diastolic dysfunction which may occur in obesity and in particular in association with hypertension. It has also been shown that obese patients have slower left atrial conduction times and shorter effective refractory periods in the left atrium and pulmonary veins even when adjusting for confounding variables including hypertension, DM and OSA [18]. Overall these changes may result in atrial remodeling and atrial arrhythmias.

Atrial remodeling may be summarized as a heterogeneous process characterized by disruption of atrial electrical integrity. Delayed interatrial conduction reflected as a broad and biphasic P wave in the inferior leads has been shown to increase with BMI and waist circumference [19].

Increased pericardial fat occurs frequently with obesity, which may lead to a disturbance in atrial conduction. Variable expression of this adipose tissue may result in heterogeneity of atrial conduction. This has been shown to result in an increased risk of developing AF [20].

OSA may be found in up to 90 % of individuals with obesity [21]. If untreated, this is characterized by significant negative drops in intrathoracic pressure, intermittent hypercapnic hypoxia, and transient repeated wakening at the end of each episode.

These drops in intrathoracic pressure may result in alterations of the left atrial chamber dimensions which may in itself increase the risk of developing AF. Additionally, both hypercapnic hypoxia and frequent changes in sleep patterns may result in an increase in sympathetic tone. Overall these changes may result in an increase in the left atrial volume [22]. Effective treatment with CPAP in patients with OSA and no history of AF has been shown to reduce right and left atrial dimensions [23]. OSA has been shown to be independently associated with failure of catheter ablation for AF [24]. Ablation success rates are higher in patients with OSA who are treated with CPAP versus those not treated [24, 25].

Obesity and its associated conditions are potentially modifiable risk factors for AF. In general, it is currently recommended that individuals with a BMI greater than 25 with 1 associated comorbidity (diabetes, prediabetes, hypertension, dyslipidemia, elevated waist circumference) should be offered advice on dietary and lifestyle modification [25].

Aggressive risk factor modification in patients with a BMI greater than 27 and at least one other risk factor (hypertension, DM, OSA, smoking and excessive alcohol consumption) in patients awaiting catheter ablation has been shown to result in an improvement in patient's symptoms, with 30 % of patients avoiding the need for ablation [26]. In patients undergoing catheter ablation for symptomatic AF there was a significant improvement in symptoms post ablation as measured by the AF severity score [27]. AF-free survival after a single ablation procedure was 62 % for patients with risk-factor-modification and only 26 % for the control arm. After multiple ablations, AF-free survival increased to 87 % in the risk-factor-modification group versus 48 % in the control arm. Structural changes of the heart were also significantly better with left atrial volume and LV diastolic volume reduction.

Autonomic AF

An alteration in sympathetic activity may result in an increase in the potential for the initiation or maintenance of AF. This can occur either by direct effects on the action potential duration and refractory period of the cells in the pulmonary veins or left atrium or by structural changes.

An increase in adrenergic stimulation may result in an enhancement of focal automaticity which may act as a potential trigger for AF. Increased parasympathetic activation increases the action potential duration. However its contribution to AF may result from its ability to shorten the atrial effective refractory period by varying degrees throughout the left atrium, which may contribute to a heterogeneity of conduction properties [28].

Both vagally induced and adrenergic AF tend to occur in younger patients with no other obvious risk factors. Vagally-induced AF is much more common than adrenergic AF and tends to occur after a preceding sinus pause or sinus bradycardia. Vagally induced AF may be partially responsive to flecainide and disopyramide and frequently worsens with beta blockers. Adrenergic AF is often provoked by exercise

or increased emotional stress, and tends to be preceded by an increase in sinus rate. This type of AF responds well to beta-adrenoceptor blockade.

There is a suggestion that ganglionic plexi denervation may have a role in the treatment of AF. Indeed left atrial ablation may have some impact by its effects on the autonomic innervation of the heart. One of the main restrictions in ganglionic plexus denervation using an ablation catheter is the difficulty in optimal access to the nerves which are not easily ablated from the endocardium.

Familial AF

Approximately 5 % of cases of AF may have a genetic component [29]. This may be even higher in patients who develop AF at a younger age and those with no other obvious risk factors for AF. The risk of developing AF in an individual who has a parent with a history of AF is increased by a factor of 1.85 times that of the population [30]. Additionally an increased incidence of AF has been noted in long QT4, short QT and Brugada syndrome.

Several genetic mutations have been implicated in AF. A missense mutation in the KCNQ1 gene has been shown to result in an alteration of the activity of the voltage gated delayed potassium current (IKS) [31]. As well as several other mutations in the KCNQ1 gene upregulation mutations have been detected in the SHOX2, TBX3 and PITX2 genes.

Mutations have also been detected in the KCNN3 gene, which encodes calcium activated potassium channels that predominante in the atria [32].

Oral Anticoagulation

The issue of oral anticoagulation is one of the more complex issues in clinical cardiology. Most risk stratifying scores have been designed to be simple and easy to remember. Currently the most widely used risk scoring system is the CHA2DS2VASc, which is shown in Fig. 8.2. This was based on the CHADS2 score with a greater emphasis on age as well as the addition of vascular disease (prior MI or peripheral vascular disease), female gender and diabetes mellitus. It is generally recommended that oral anticoagulation should be considered in patients with a CHA2DS2VASc of greater than or equal to 2 (Class I Indication, Level of Evidence B) with either Coumadin or a direct oral anticoagulant. In patients with a CHA2DS2VASc score of greater than or equal to 1 oral anticoagulation, aspirin or no antithrombotic therapy can be considered (Class IIb Indication, Level of Evidence C). For patients with a CHA2DS2VASc of 0 no antithrombotic therapy is generally recommended. In general female gender in a patient with no other risk factor for stroke would not result in the institution of oral anticoagulation although this clearly has to be reviewed with increasing age. It should also be

Risk factor	Score	Recommendations
CCF1	1	
Hypertension2	1	0 No OAC
Age 75 years or more	2	
DM3	1	1 Consider OAC / Aspirin / nothing
Ischemic stroke / TIA / TE4	2	
Vascular disease 5	1	2 or greater OAC
Age 65-74 years	1	
Sex6	1	

1 Signs/symptoms of LV/RV/Biventricular dysfunction confirmed with objective testing
2 Resting SBP > 140 mmHg and/or DBP > 90 mmHg on 2 or more measurements or patients receiving antihypertensive medication
3 Fasting plasma glucose greater than or equal to 7.0mmol/L /126 mg/dL or treatment with oral hypoglycemic agent or insulin
4 Ischemic stroke is defined as a sudden focal neurological deficit diagnosed by a neurologist and found to be due to an ischemic orgin lasting greater than 24 hours
TIA is a sudden focal neurological deficit diagnosed by a neurologist and lasting less than 24 hours
5 Vascular disease is considered a prior MI/PVD/aortic plaque
6 Female gender with no other risk factors is not considered sufficient for commencing OAC

Fig. 8.2 Summarizing the CHA2DS2VASc Scoring system for Non-Valvular AF. *SBP* systolic blood pressure, *DBP* diastolic blood pressure, *TIA* transient ischemic attack, *TE* thromboembolism, *MI* myocardial infarction, *PVD* peripheral vascular disease

remembered that each individual risk factor does not confer an equal percentage risk for stroke.

Although CHA2DS2VASc is more sensitive for predicting low event rates in low risks patients it is only modestly effective in terms of its positive predictive value with an area under the receiver-operating characteristic curve of approximately 0.6 [33].

Additional factors which have been examined in order to help calculate the risk of stroke include the use of biomarkers as well as LAA morphology. Biomarkers such as NT-pro-BNP, von Willebrand levels, d-dimers and troponin have been studied. Although they appear to have some merit they have yet to be incorporated into the guidelines. LAA morphology appears to correlate to an extent with the risk of thrombo-embolism with a suggestion that an increase in trabeculations, number of bends and narrowness of the LAA orifice may also increase the risk of thrombus formation. Although this can be documented on TEE or CT widespread use is still not recommended for decision making regarding oral anticoagulation.

Vitamin K Antagonist

Warfarin acts by inhibiting the cyclic interconversion of vitamin K and vitamin K epoxide, thereby reducing the vitamin K-dependent clotting factors II, VII, IX and X. When compared with placebo adjusted dose warfarin maintaining an INR or 2.0–2.9 results in an absolute reduction in ischemic and hemorrhagic strokes of 2.7 % per year [34]. Warfarin has also been shown to be superior to aspirin in patients considered to be at an increased risk of stroke.

Several major limitations concerning warfarin exist. The time within the therapeutic range is often less than 75 % exposing patients to the risk of thrombo-embolism for significant periods of time. There are many interactions with other pharmacological agents as well as food and dose adjustments are frequently required. Despite this there is still a role for warfarin in clinical practice particularly in patients with valvular heart disease and AF. The non-vitamin K antagonist agents are contraindicated in the presence of valvular AF and also need to be used with extreme caution in the setting of renal impairment. There is also more clinical experience using warfarin combined with antiplatelet agents and there is also the ability to monitor the effect of the drug which may provide a reasonable indication of patient compliance. Warfarin is also relatively easily, albeit slowly, reversed with vitamin K.

Non-vitamin K Antagonist Oral Anticoagulation Therapy (OAC's)

These agents act by either directly suppressing thrombin or the conversion of prothrombin to thrombin by blocking the activated Xa factor. They have several theoretical advantages over warfarin such as a rapid onset and offset of action, reasonably predictable pharmacokinetics that do not require ongoing monitoring of anticoagulant and fewer interactions. It is important to monitor renal function particularly in patients where the baseline eGFR is below normal limits.

Direct Thrombin Inhibitors

Direct thrombin inhibitors bind to both soluble and fibrin-bound thrombin. The most commonly used in this group is the pro-drug dabigatran etexilate which was compared with warfarin in the RELY study. This prospective, randomized trial compared either 150 mg or 110 mg twice daily with warfarin (INR 2.0–3.0) for the prevention of stroke and systemic embolism in patients with non-valvular AF [35].

Dabigatran at a dose of 150 mg has been shown to be superior to warfarin with no significant difference in the primary safety endpoint of major bleeding. At a dose of 110 mg dabigatran was non-inferior to warfarin, with fewer major bleeds. The

incidence of intracranial haemorrhage and haemorrhagic stroke were lower with both doses of dabigatran.

Based on these results dabigatran etexilate has been approved by the Food and Drug Administration (FDA) at 150 mg twice daily with 75 mg twice daily in renal impairment. The European Medicines Association (EMA) has approved both the 110 mg twice daily and 150 mg twice daily in patients with non-valvular AF.

Factor Xa Inhibitors

The two major clinically available factor Xa inhibitors are rivaroxaban and apixiban.

Rivaroxaban has a plasma half life of 7–11 h with a flat dose response resulting in a once daily administration. Rivaroxaban was compared with warfarin for the prevention of stroke or systemic embolism among patients with nonvalvular AF who were at moderate-to-high risk for stroke in the Rocket AF Trial [36]. This double blind trial compared rivaroxaban 20 mg once daily (15 mg daily for those with an estimated creatinine clearance of 30–49 mL/min) with warfarin in 14,264 patients. Rivaroxaban was found to be non-inferior compared with warfarin for the primary endpoint of stroke and systemic embolism with a significant reduction in haemorrhagic stroke and intracranial haemorrhage. Rivaroxaban has a distinct advantage in being a once daily preparation. Additionally the ROCKET AF study enrolled older patients (mean age 73 years), with at least two risk factors (congestive heart failure, hypertension, stroke or TIA), higher mean values of CHADS2 score (3.5) and lower median values for therapeutic INR's compared to other trials which is more compatible with real life conditions.

Approximately one-third of active rivaroxaban is renally excreted and a dose reduction from 20 mg once daily to 15 mg once daily is recommended for patients with moderate to severe renal impairment with period monitoring of renal function. A sub-study of the ROCKET AF study showed this lower dose was safe and effective in patients with a creatinine clearance between 30 and 49 mL min^{-1}. Rivaroxaban has been approved by both the FDA and the EMA for stroke prevention in nonvalvular AF.

Apixaban has been shown to reduce the risk of stroke (predominantly through its effects on a reduction in hemorrhagic stroke) or systemic embolism, major bleeding and mortality in comparison with warfarin [37]. Additionally in patients for whom vitamin K antagonist therapy was considered unsuitable, apixaban compared with aspirin, reduced the risk of stroke or systemic embolism without a significant increase in the risk of major bleeding [38]. Apixaban has gained clinical approval with the FDA and EMA in patients with nonvalvular AF. Although the usual dose is 5 mg BiD this should be reduced to 2.5 mg BiD if 2 out of the following 3 criteria; age greater than or equal to 80 years, weight less than or equal to 60 kg or a serum creatinine greater than or equal to 133 mmol/L. The details associated with the major trials in the NOACs are summarized on Table 8.1.

Table 8.1 Showing a summary of randomized clinical trial data supporting NOAC's

Parameter	Rely	Rocket-AF	Averroes
Drug dose	Dabigatran etexilate 150 mg BID or 110 mg BID versus warfarin (INR 2.0–3.0)	Rivaroxaban 20 mg QD (15 mg QD in patients with creatinine clearance 30–49 ml/min) versus warfarin (INR 2.0–3.0)	Apixaban 5 mg BID versus Aspirin 81–315 mg OD
Study design	Randomized, open label	Randomized double-blind, double Dummy	Randomized, double-blind
Inclusion criteria	AF within 6 mths + 1 risk factor	AF within 6 mths +2 risk factors	AF within 6 mths + 1 risk factor
Number of patients	18,113	14,000	5,600
Mean age	71.5 years	73 years	70 years
Prior stroke/TIA	20 %	55 %	13.5 %
Mean CHADS2 score	2.1	3.5	2.1
Stroke and systemic embolism (percent/year)	1.71 % warfarin 1.54 % dabigatran 110 mg (p = 0.34) 1.11 % dabigatran 150 mg (p < 0.001)	2.42 % warfarin 2.12 % rivaroxaban (p = 0.117)	3.9 % aspirin 1.7 % apixaban (p < 0.001)
Major bleeding	3.57 % warfarin 2.87 % dabigatran 110 mg (p = 0.003) 3.32 % dabigatran 150 mg (p = 0.31)	3.45 % warfarin 3.6 % rivaroxaban (p = 0.576)	1.2 % aspirin 1.4 % apixaban (p = 0.33)
Intracranial haemorrhage rate (percent/year)	0.74 % warfarin 0.23 % dabigatran 110 mg (p < 0.001) 0.3 % dabigatran 150 mg (p < 0.001)	0.74 % warfarin 0.49 % rivaroxaban (p = 0.019)	0.3 % aspirin 0.4 % apixaban (p = 0.83)

HAS-BLED Score

This is a scoring system used to predict the 1 year risk of major bleeding defined as intracranial bleeding, hospitalization, blood transfusion or a drop in hemoglobin of greater than 2 g/L. The components of this scoring system are:

Hypertension: uncontrolled systolic blood pressure >160 mmHg

Abnormal renal or liver function: a serum creatinine greater than 200 mmol/L, need for long term dialysis or history of a renal transplant. Abnormal liver function is defined as an elevation of transaminases greater than 3 times the upper limit of normal or a history of chronic liver disease

Stroke

Bleeding

Labile INR: in the therapeutic range less than 60 % of the time
Elderly
Drugs or alcohol: the use of non-steroidal anti-inflammatory or antiplatelet agents

The maximum score is 9 with a score of greater than or equal to 3 indicative of a high bleeding risk where increased caution and regular review should be performed. It should not be used solely to exclude using oral anticoagulation but should be used to highlight patients at a higher risk of bleeding and should also be used to modify any controllable risk factor.

Catheter Ablation for AF

The concept of catheter ablation for the treatment of AF gained significant momentum when it was discovered that ectopic foci, which originate from sleeves of myocardium extending into the pulmonary veins may initiate AF [39]. This resulted in the concept that isolation of these foci by performing catheter ablation may reduce the likelihood of developing AF. Although the foci themselves were initially targeted this resulted in a high incidence of pulmonary vein stenosis and this has now be largely replaced with wide antral circumferential ablation (WACA). This technique has been shown to be associated with a lower incidence of recurrence of arrhythmias compared with segmental antral ablation [40]. This may be due to isolation of regions of the left atrial PV junction where micro re-entry may occur. Additionally WACA may have a greater effect on elimination of other non PV triggers in the posterior LA wall, debulk the left atrium and have a greater effect on autonomic denervation.

Pulmonary vein isolation (PVI) is currently considered the mainstream catheter approach for paroxysmal AF. It also is a very reasonable approach for the management of persistent AF with additional options to be considered. Some centers perform PVI in all patients with a history of persistent AF followed by an electrical cardioversion for the first ablation procedure. If the patient presents with further AF then either linear lesions, CFAE ablation or rotor ablation can be considered at that stage. Other centers perform more ablation for the first procedure although this may increase the potential for developing AT.

Risks of Catheter Ablation of AF

The risk of a significant complication associated with an AF ablation is approximately 2.9 % [41]. The most common complication is vascular (approximately 1 %) which is largely related to groin hematoma and occasionally femoral pseudoaneurysm formation. The risk of stroke and TIA is 0.6 %, cardiac tamponade (1 %) and clinically evident PV stenosis 0.5 %. The incidence of phrenic nerve palsy is approximately 0.4 % and although esophageal injury is common, atrio-oesophageal fistula is unusual occurring in 0.1 % of cases. The overall mortality is 0.06 %.

How to Perform a PVI

Patient Preparation

A PVI can be performed either with the patient under general anesthesia or with intravenous sedation and analgesia. There are several advantages to either strategy. General anesthesia often results in a quicker procedure with less patient discomfort and less patient movement. It may not always be available and some operators prefer sedation as there is more patient feedback during the procedure.

A TEE is performed in order to rule out a LAA thrombus particularly in patients who are in AF and have not been anticoagulated prior to the procedure. In most cases where the patient is receiving warfarin this can be continued throughout the procedure with an upper INR cut off of 3.5 above which the risk of bleeding is increased by a factor of 6 [42].

If the patient is receiving a non vitamin K antagonists OAC a decision must be made whether to stop the agent or not.

Some data suggests that uninterrupted dabigatran compared with uninterrupted warfarin is associated with an increased rick of bleeding and thrombo-embolic complications [43]. Dabigatran increases the effects of heparin often doubling the effects, an effect not seen to the same degree with rivaroxaban and apixaban [44]. It is therefore current practice to interrupt dabigatran prior to performing an AF ablation. The decision on when to hold dabigatran is dependent on the patient's renal function. In patients with normal renal function the drug may be held either the morning of the procedure or the evening prior but not for more than 24 h pre-procedure [45]. Dabigatran should be stopped earlier if renal function is reduced.

In patients with normal renal clearance, the best option may be drug suspension on the morning of the procedure, or the night before, but always <24 h before the procedure. A target ACT of greater than 350 s should be achieved during the procedure. Dabigatran can then be recommenced 3–4 h following removal of the sheaths [45]. The dosage of dabigatran following this should be based on renal function and the potentially risk of bleeding.

Recent data has shown that uninterrupted rivaroxaban therapy appears to be as efficacious as uninterrupted warfarin in preventing thrombo-embolic and bleeding complications in patients undergoing AF ablation [46]. If the decision if made to hold rivoroxaban for an AF ablation the dose on the morning of the procedure may be held. There is currently limited data regarding the use of apixaban in patients undergoing an AF ablation although it may seem reasonable to hold a dose the morning of or the evening before the procedure.

It is our practice to administer the final dose of the OAC 24 h prior to the ablation and perform a pre-procedure TEE. Heparin is then administered throughout the procedure and the OAC is recommenced 3 h following removal of the venous sheaths which are removed at the end of the case with no reversal of heparin.

If the patient is receiving a general anesthetic the TEE probe can be left in position in order to help facilitate the transseptal access and monitor for pericardial effusion.

Venous access is generally achieved via the femoral vein with two 8Fr sheaths and a 6Fr sheath. A decapolar is positioned in the coronary sinus to help with the transseptal puncture and may also be useful for mapping and pacing particularly if an AT develops during the procedure.

Two transseptal sheaths are then positioned over 0.032 wires into the superior vena cava and flushed with heparinized saline. Heparin is then administered at a dose of 100 iu/kg in order to achieve an ACT of greater than 300 s in patients who are either not on warfarin or have an INR less than 2.0 [47]. For patients who are receiving warfarin and have a therapeutic INR 75 iu/kg of heparin should be administered in order to achieve an ACT of greater than 300 s. ACT should be checked every 20 min and either further boluses or an infusion can be administered.

Transseptal Access

A posterior location in the fossa ovalis is chosen in order to facilitate access to all regions around the pulmonary veins. Although his can be performed under fluoroscopic guidance the addition of echocardiographic data is sometimes helpful particularly if the fossa is difficult to cross or is aneurysmal.

A range of sheaths and transseptal needles are available. A BRK1 needle often results in a good location and is useful in patients who have enlarged atria. If this is tenting the fossa without crossing then the flexion can be slightly reduced or a BRK or a Baylis needle can be considered. Transseptal access can generally be achieved using a combination of a PA, left lateral, RAO and LAO views. In general for PVI standard sheaths are sufficient although deflectable sheaths may help with contact and occasionally with access to superior to the right superior pulmonary vein. Deflectable sheaths may be useful for a linear lesion joining the mitral isthmus to the left inferior pulmonary vein. If a non standard sheath is to be switched to a deflectable sheath a 0.032 wire can be extended out to the left superior pulmonary vein for an over the wire switch.

Whatever choice of sheath it is very important that the side arms are flushed with heparinized saline in a closed circuit and that no air bubbles enter the system.

Anatomic Reconstruction of the Left Atrium

The anatomy of the LA is generally constructed using a multipolar circular catheter. This may merged with a pre-procedure CT. A CT may be helpful in determining the presence of aberrant pulmonary veins as well as the presence of variants such as common ostia. MRI of the LA can also be performed but is more time consuming. Either of these modalities can be merged with the electroanatomic image. CartoMerge (Biosense Webster) uses fiducial points taken from selected anatomical structures such as the pulmonary vein ostia. The image is then rotated in order to

compare the anatomic shells of both structures for comparison. If there is a difference between the two images further points can be taken on the electro anatomic map.

NavX Fusion (St Jude Medical) can also be used to integrate the electroanatomic map onto a baseline CT scan. Following acquisition of the anatomic shell this system utilizes a field scaling algorithm which adjusts for the non-linearity of the geometry taking into account the measured inter-electrode spacing for all the locations within the geometry. Four fiducial points are then taken on the CT and the electroanatomic map and secondary fusion is used to reduce mismatch between the two images [48].

Although these systems may be helpful the LA dimensions vary with rhythm status and are also dependent on the intravascular volume. There is overall no convincing data to suggest that image integration increases success or reduces complications but may reduce fluoroscopy times.

Ablation Technique

Following anatomic reconstruction of the LA a circular mapping catheter is positioned within the ostia in one of the pulmonary veins where is should record nearfield pulmonary vein potentials and farfield left atrial potentials. If a contact force catheter is being used for ablation then this is positioned in the middle of the left atrium where there is no contact and a zero is set on the catheter.

The catheter should then be positioned so that it is on the atrial side of the pulmonary vein ostia. The ostia can be difficult to precisely locate on fluoroscopy or even on an electroanatomic map and there is an overlap between left atrial myocytes extending into the pulmonary veins and venous tissue extending into the left atrium. If the demarcation is unclear the ablation catheter can be placed on the venous side of the ostia while pacing and capturing the pulmonary veins. The point at which pulmonary vein capture no longer occurs is a reasonable estimate of the ostia.

Point by point ablation is generally performed using a 3.5–4.0 mm irrigated catheter. Power is delivered at 30–35 W anterior to the pulmonary veins and 25–30 W along the posterior wall in order to limit delivery of energy to the esophagus and branches of the vagus nerve. A target temperature of less than 40 °C and irrigation at 17 ml/min are set. If contact force is used then a minimum of 10 g of force should be aimed for. The catheter is generally moved every 30–60 s.

Certain regions around the pulmonary veins may be technically more challenging than others and require different catheter manipulations. The Coumadin ridge between the left pulmonary veins and the left atrial appendage is an infolding of the lateral atrial wall is shown in Fig. 8.3. It is at its narrowest at the border of the left superior pulmonary vein measuring 2.2–6.3 mm to its broadest aspect at the boundary of the left inferior pulmonary vein measuring 6.2–12.3 mm [49]. It is at its thickest at the anterosuperior region.

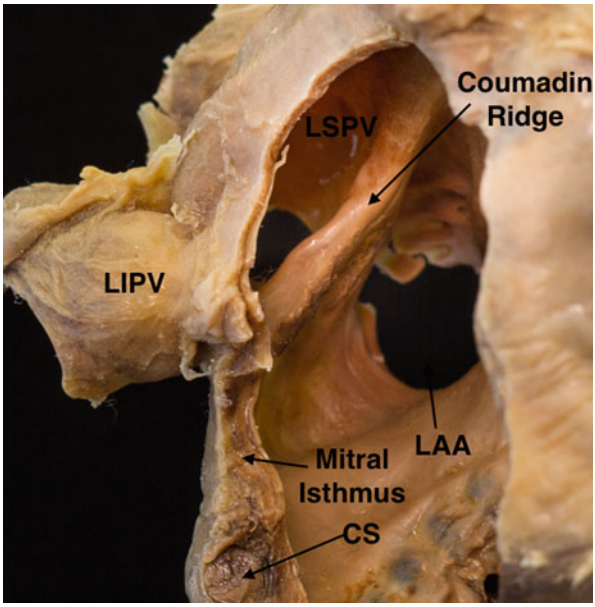

Fig. 8.3 The Coumadin ridge is seen between the left superior pulmonary vein (*LSPV*), the left inferior pulmonary vein (*LIPV*) and the left atrial appendage (*LAA*). Between the LIPV and the mitral annulus (*MA*) is the mitral. Also seen in this image is the coronary sinus (*CS*)

In order to ablate along the Coumadin ridge the ablation catheter can be withdrawn from the left superior pulmonary vein with counterclockwise rotation so that the catheter is moving anterior in the direction of the LAA. This should maximize contact with this region. Excess counterclockwise torque results in the catheter moving into the LAA and this often needs to be counteracted with clockwise rotation. Given the significant autonomic innervation of the Coumadin ridge ablation in this region commonly results in a slowing of the sinus rate.

Flexion and extension of the ablation catheter is required for ablation inferior and superior to the left sided PV's. Ablation starting on the roof superior to the left superior pulmonary vein often results in separation of local pulmonary vein signals and LAA farfield signals.

Ablation superior and inferior to the right sided PV's can be performed often with a combination of rotation with flexion and extension of the catheter. Occasionally a deflectable sheath may be useful in these regions although a bidirectional catheter used through a standard sheath is in general suitable to reach all regions. When ablation is performed inferior to the right inferior pulmonary vein in a small left atrium it is important to flex with an acute angle in order to minimize the risk of losing transseptal access.

Ablation may be required in the carina between the pulmonary veins despite WACA being performed. This may be explained by endocardial to epicardial connections in this region which may result in continued conduction. Additionally con-

nections exist between ipsilateral PV's resulting in several isthmus which may be an important consideration when performing PVI and may in part explain why segmental ablation was previously shown to have limited efficacy [50].

Pulmonary Vein Potentials and Farfield Signals

Electrograms recorded from the ostia of the pulmonary veins show an initial non circumferential lower amplitude atrial signal followed by an isoelectric period followed by sharp pulmonary vein potentials [51]. Depending on the overlap between the left atrium and the surrounding structures as well as the orientation of the mapping catheter there is a variable delay between the farfield electrogram and the pulmonary vein potentials. An example of this is shown in Fig. 8.4 in which the first component is farfield left atrial followed by an isoelectric line followed by a PVP which is a sharp high frequency signal.

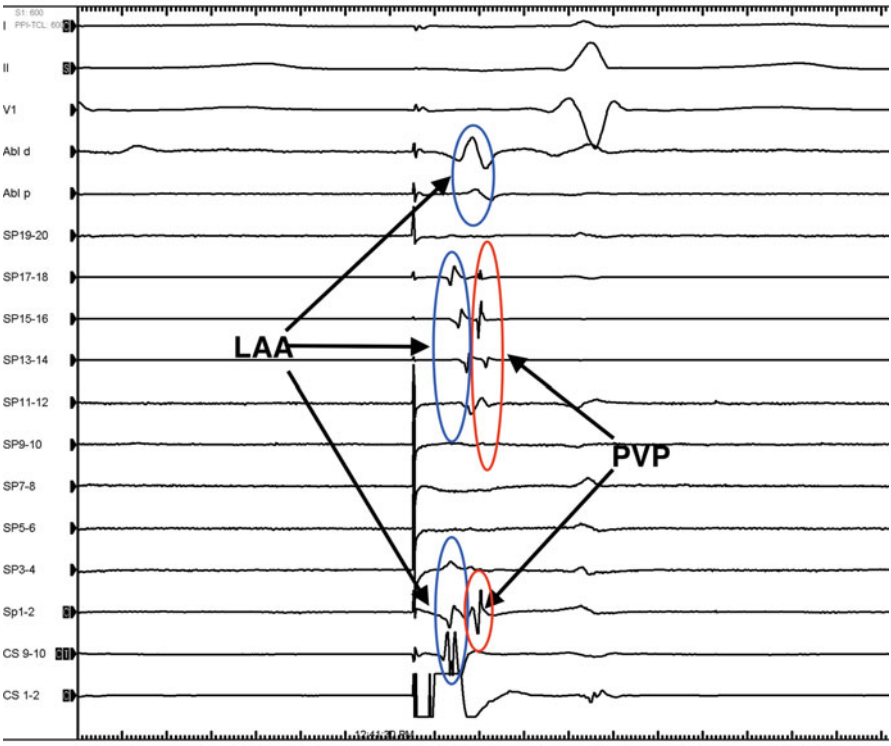

Fig. 8.4 The circular catheter (SP 1–20) is in the left superior pulmonary vein. Pacing is performed from the distal coronary sinus (CS 1–2). The first deflection is farfield from the left atrial appendage (*circled in blue*) followed by an isoelectric line followed by a sharp pulmonary vein potential (*circles in red*)

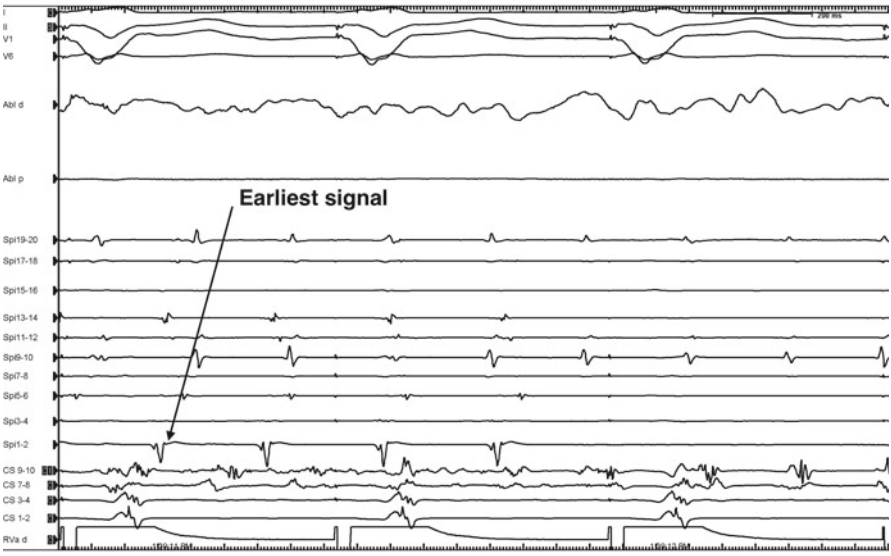

Fig. 8.5 Isolation of the LSPV. The circular catheter is positioned in the LSPV. The earliest nearfield activation is recorded on Spi poles 1–2 followed by 13–14. These poles are almost overlapping and are located along the lower junction between the LSPV and the LAA along the ridge (near to where the ablation catheter is positioned). Ablation in this region results in isolation of the vein with only LAA farfield recorded on the circular catheter. (CS 9 10 is in the proximal coronary sinus and CS 1 2 is in the distal CS). Ventricular pacing from the RV apex is performed as the patient became bradycardic during RF ablation

The LAA is anterior to the left superior pulmonary vein. As a result sharp pulmonary vein potentials can often be merged within LAA signals. In order to help differentiate CS pacing can be used to separate LAA signals from PV potentials as shown in Fig. 8.4. Additionally direct pacing may be performed from the LAA. For the left superior and inferior pulmonary veins pacing from the distal coronary sinus or left atrial appendage can be performed in order to increase the isoelectric line between the farfield and nearfield signals. Although pacing from the distal coronary sinus is reasonably simple it is somewhat dependent on the variable connections between the coronary sinus and the left atrium. Left ventricular farfield may also be recorded in the left inferior pulmonary vein.

This cannot be performed if the patient is in AF and differentiation of farfield LAA signals from local PV potentials can be somewhat more complex. An example of isolation of the LSPV during AF is shown in Fig. 8.5. In this example the circular catheter is positioned in the LSPV during ablation along the ridge between the LAA and the vein. The earliest activation is recorded on poles 13–14 where ablation is performed. This results in isolation of the vein with farfield LAA potentials being recorded on poles 9–10, 11–12 and 19–20 which are all in anterior locations. Another example of isolation of the RSPV is shown in Fig. 8.6. As ablation is performed local PVP's in the vein slow considerably and then disappear with only farfield atrial activation recorded.

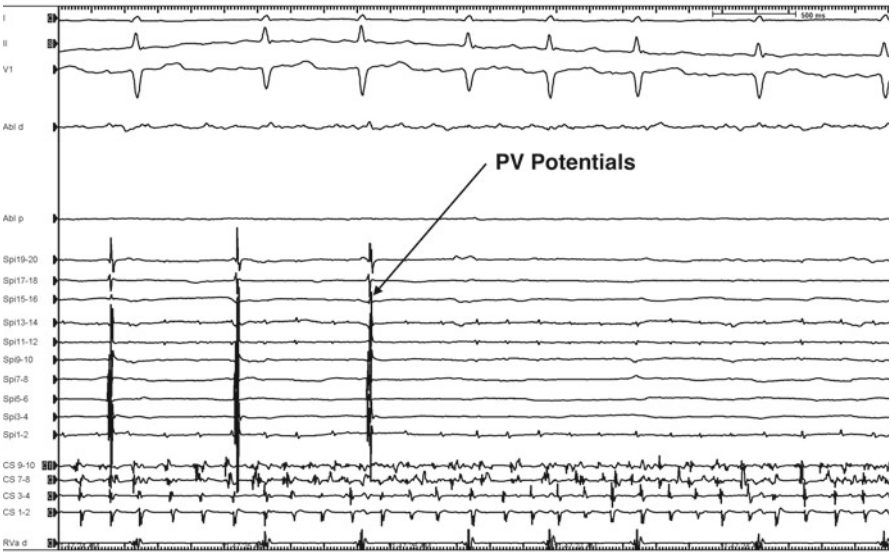

Fig. 8.6 Loss of local PV potentials during isolation of the RSPV. These signals are slowed considerably during ablation and following further ablation only farfield atrial signals are detected. The spiral (Spi) catheter is located in the RSPV (CS 9 10 is positioned in the proximal coronary sinus and CS 1 2 is located in the distal CS)

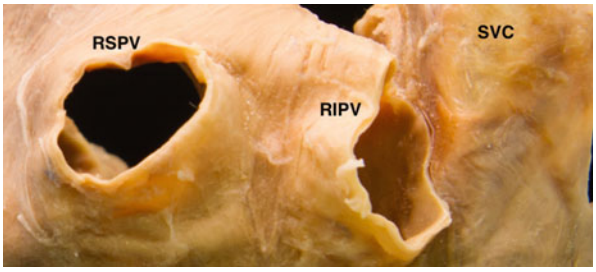

Fig. 8.7 Anatomic specimen showing a posterior view of the right superior pulmonary vein (*RSPV*) and right inferior pulmonary vein (*RIPV*). The superior vena cava (*SVC*) is anterior and close to both of these structures and farfield electrical activity from the SVC may be detected when mapping these veins

As shown in the anatomic image in Fig. 8.7 the superior vena cava is anterior to the right superior pulmonary vein. In order to differentiate superior vena cava potentials from pulmonary vein potentials the signal can be measured relative to the surface p wave. As the superior vena cava is so close to the sinus node signals will be very early if originating from the superior vena cava. If this is within 30 ms of the onset of the p wave it is likely to reflect superior vena cava activity. There is generally no significant farfield recorded in the right inferior PV. The PV potentials recorded on the circular catheter have slowed considerably during ablation. Further ablation results in loss of PV potentials with only farfield atrial signals.

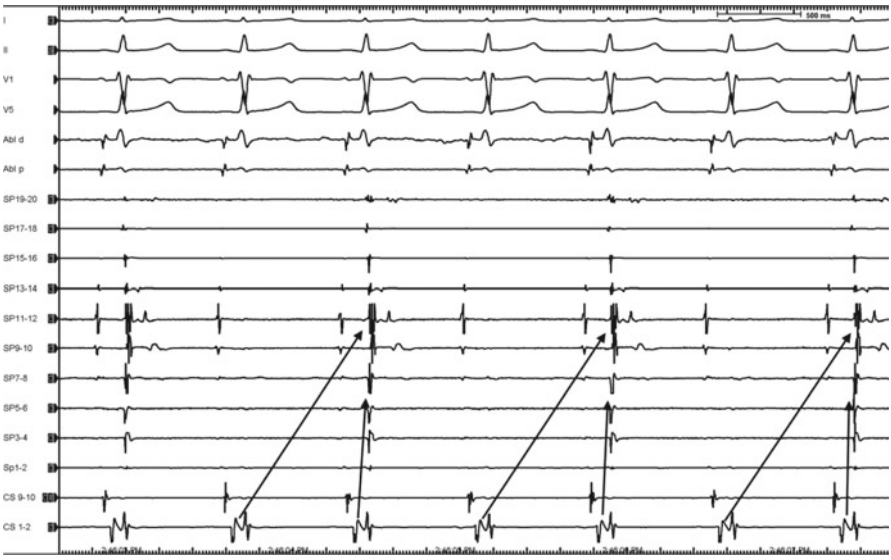

Fig. 8.8 2:1 conduction from the left atrium to the left superior pulmonary vein. A potential is recorded in the vein after every second atrial electrogram. This signified continued conduction in the posterior region of the LSPV (SP 3–4) which required further ablation for isolation of the vein

Confirming Pulmonary Vein Isolation

PVI may be confirmed by proving bidirectional block with or without the administration of intravenous adenosine as well as pacing along the ablation line around the pulmonary veins. Of note, **entrance block without exit block may occur in up to 40 % of the patients** [52].

Entrance block may be observed either during normal sinus rhythm or with atrial pacing during sinus rhythm. The circular catheter is positioned in the PV antra just distal to the line of ablation. The most important principle is to distinguish between PV potentials and LA or RA signals detected as farfield on the circular catheter. Although PV potentials are sharp and of a much higher frequency than farfield atrial potentials they may be superimposed. Pacing the structure or close to the structure where the atrial signals are originating from should result in these signals becoming earlier if they are originating from that structure. For potentials coming from the LAA either the LAA can be paced directly or the distal CS if the catheter is positioned appropriately. An example of 2:1 conduction from the left atrium to the LSPV seen in Fig. 8.8 in which a potential with the vein is recorded after every second atrial electrogram. This represents slow conduction with conduction through SP 3–4 which was positioned posterior to the LSPV. Ablation in this region resulted in isolation of the vein.

In order to prove exit block the ablation catheter can be positioned in the same pulmonary vein as the circular mapping catheter. Although pacing can be performed from either the ablation catheter alone or the circular catheter alone it is often easier

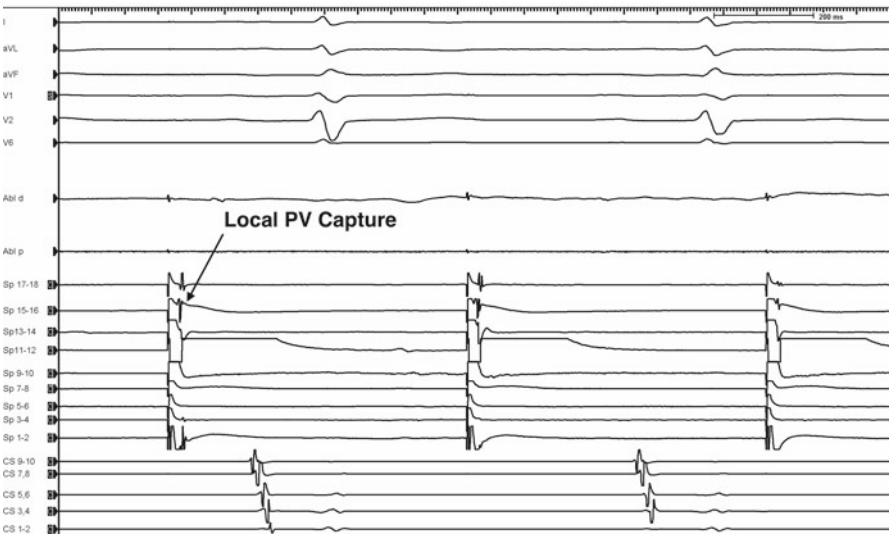

Fig. 8.9 Circular catheter (SP 1–18) in the right superior pulmonary vein with pacing from poles 15–16 showing local capture with sharp local PV potentials which do not capture the left atrium (CS 9 10 is located in the proximal coronary sinus while CS 1 2 is located in the distal coronary sinus)

to discern pulmonary vein potentials from a separate catheter which has closely spaced poles without superimposed pacing arterfact. Pacing can be performed using a decremental output until there is only pulmonary vein capture. This avoids capture of adjacent structures which may mimic intact conduction. Lack of conduction from the pulmonary veins to the left atrium proves that the ablation line is resulting in conduction block. An example of this is shown in Fig. 8.9.

Although the presence of dissociated PV potentials is a useful indicator of exit block conduction may still be present in 10 % of patients who display these [53]. An example of dissociated potentials from the RIPV is shown in Fig. 8.10. Pacing is performed from the high right atrium (HRA). Farfield atrial potentials are seen on the circular catheter with intermittent PV potentials which are not conducted to the atrium.

An additional useful technique to help prove an intact line around the pulmonary veins is to assess for unexcitability to pacing. Following ablation the catheter is positioned along the line during sinus rhythm at an output of 10 mA and a pulse width of 2 ms [54]. If lack of local capture occurs the catheter is moved a further 5 mm along the line and pacing repeated. If local capture occurred then further ablation was performed in this region and pacing performed at the same output.

The administration of intravenous adenosine appears to be of some use in assessing for dormant conduction following isolation of the PV's due to hyperpolarization of myocytes which have been acutely ablated. This can be administered after a period of monitoring post ablation and further ablation performed if there is any evidence of dormant conduction. An example of this is shown in Fig. 8.11.

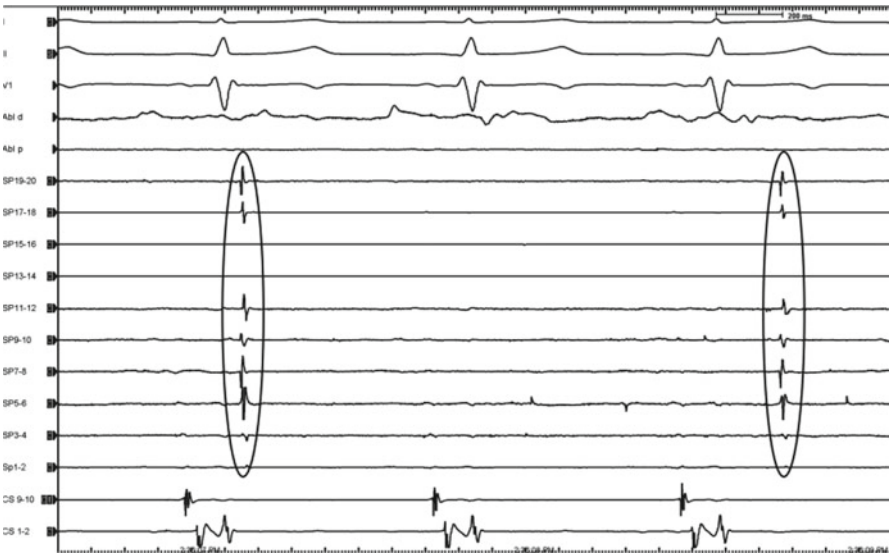

Fig. 8.10 Dissociated PV potentials (*circled*) recorded on a circular catheter (Sp 1–20) positioned in the right superior pulmonary vein (RSPV). Pulmonary vein potentials are seen which do not conduct into the left atrium. The ablation catheter is positioned in the RSPV. CS 9–10 is in the proximal CS while CS 1–2 is in the distal CS

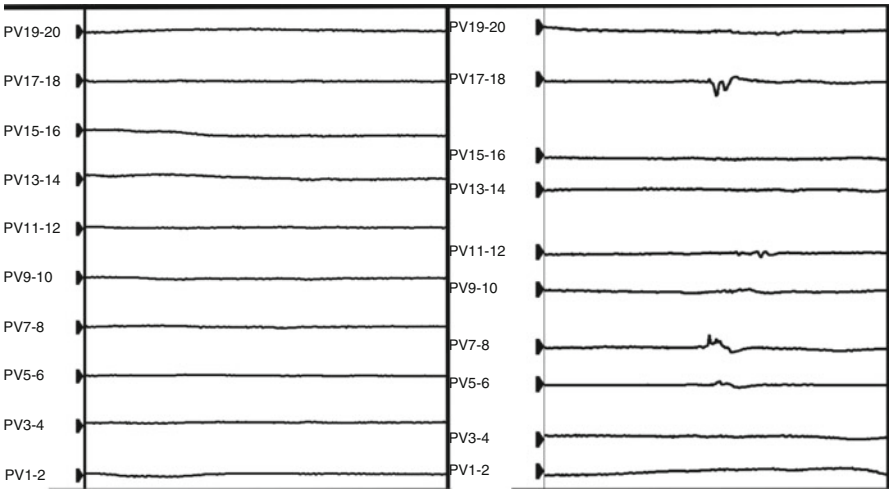

Fig. 8.11 The circular catheter (PV 1–20) is in the right superior pulmonary vein. The image on the right shows the potentials recorded following ablation and before the administration of adenosine. The pulmonary vein appears to be isolated. The image on the right is recorded following the administration of adenosine. This shows early activation in PV 7–8 followed by 5–6, 17–18, 9–10 and 11–12. This region was anterior to the right superior pulmonary vein at the level of the carina. Further ablation was delivered here and the vein was retested with adenosine and found to be isolated

Assessing for Non PV Triggers

Non pulmonary vein triggers may contribute to AF in some cases and are worth looking for particularly in redo ablations where the pulmonary veins have remained isolated. As shown in Fig. 8.12 potential locations include the superior vena cava, coronary sinus, crista terminalis, fossa ovalis, ligament of Marshall and left atrial appendage.

In order to map for non pulmonary vein triggers a multipolar catheter is positioned in the coronary sinus and another along the posterolareral right atrium extending into the superior vena cava. Intravenous isoprenaline is administered in incremental doses from 3 to 20 microgrammes per minute. If AF is not inducible decremental atrial pacing can be performed. Using the earliest sites of activation focal ablation can be performed and further triggers can then be mapped. It may be that given the increasing width of WACA that many triggers may be incorporated into the original lesions.

Cryoablation

Cryoablation utilizes a system (Arctic Front Cardiac CryoAblation, Medtronic, Inc) which pumps the refrigerant N20 into an inflatable balloon as shown in Fig. 8.13. This is positioned at the PV orifice. Contrast is injected into the PV in order to

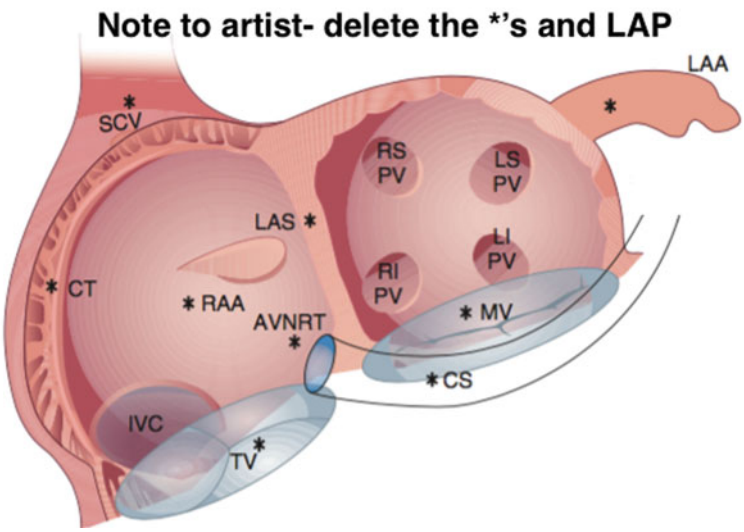

Fig. 8.12 Potential locations of non-pulmonary venous triggers (*RSPV* right superior pulmonary vein, *RIPV* right inferior pulmonary vein, *LSPV* left superior pulmonary vein, *LIPV* left inferior pulmonary vein, *MV* mitral valve, *CS* coronary sinus, *LAA* left atrial appendage, *LAS* left anterior septum, *RAA* right atrial appendage, *AVNRT* AV nodal re-entry tachycardia, *TV* tricuspid valve, *SVC* superior vena cava, *IVC* inferior vena cava)

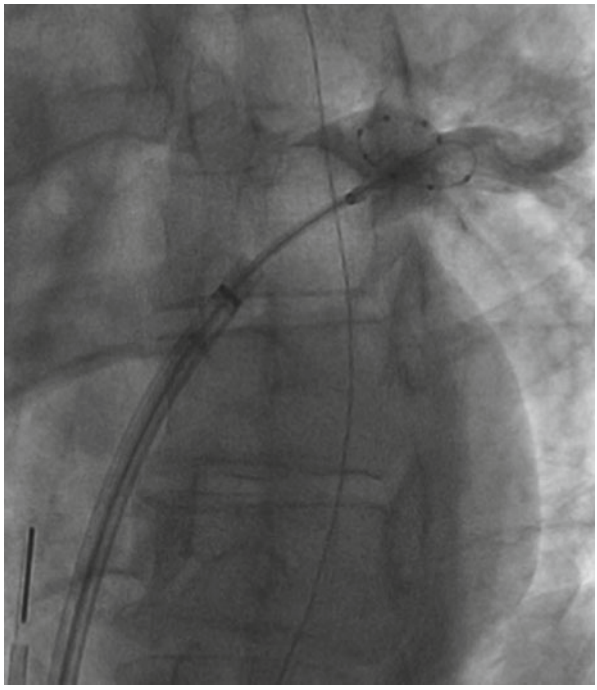

Fig. 8.13 Showing the new generation Cryoballoon used for antral pulmonary vein isolation. On this fluoroscopic image the cryoballoon is positioned in the left superior pulmonary vein (© Medtronic plc 2015)

assess for good contact and applications are generally performed over a period of 4 min. A circular catheter assesses for electrical isolation of the PV's and further applications are performed if required. This procedure generally requires a single trans septal access with a 15 Fr sheath. The balloon is advanced over a guidewire and positioned at the PV ostia. The balloon diameter is available in either 23 or 28 mm. The size can be determined on CT or ICE. Cryoablation has been shown to be non-inferior to point by point RF ablation in terms of freedom from AF and an absence of persistent complications [55]. The second generation cryoballoon has an inner mapping guidewire and an increased number of emission ports.

Hybrid Ablation of AF

Surgical ablation for AF has evolved from the Cox Maze procedure to a minimally invasive epicardial approach. These can be used to deliver RF around the PV antra as well as create a roof and floor line resulting in a posterior box lesion. Although this may be moderately effective in cases of paroxysmal AF freedom from AF for cases of persistent AF is relatively low. As a result of this a hybrid approach has been developed combining endocardial and epicardial ablation. Regions which cannot be easily reached from the epicardial approach can be ablated endocardially such as the CTI and mitral isthmus. Transmural lesions can be created and lines of

block can be assessed and any gaps completed. Although this can be performed at the same time it is often considered reasonable to delay endocardial ablation for several months in order to assess conduction block after a period of time. This may be a useful option in patients with persistent AF and dilated atria.

Ablation of Persistent AF

Ablation strategies in persistent AF are imperfect. Several techniques have been developed for ablation for persistent AF. Linear lesions may be performed until sinus rhythm is restored or until an electrical cardioversion is performed and the lines checked for conduction block. CFAE ablation may be performed in the left and right atria and rotors may be mapped either invasively or non-invasively and selectively targeted.

Linear Lesions

Following isolation of the pulmonary veins linear lesions can be performed. The most common of these involve a linear lesion along the left atrial roof joining the right superior pulmonary vein to the left superior pulmonary vein. A mitral isthmus line may also be performed although it may be difficult to achieve successful and permanent block as the wall may be relatively thick and may require epicardial ablation via the coronary sinus (at a lower power). Rather than performing linear lesions in all cases of AF, these are often performed in cases where the patient develops an atrial flutter either during the ablation or has a documented history of an atrial flutter which is then induced. In such cases the CTI is often mapped first followed by the pulmonary veins. If these are silent then entrainment in certain anatomic locations can then be performed as well as mapping of local signals. The most common locations to map are the mitral annulus and the LA roof as the majority of macro re-entry atrial flutters involve these regions. If there is a significant variability in the tachycardia cycle length (greater than 15 %) then the mechanism is more likely to represent a focal AT. In our experience both a focal AT and a macro re-entry atrial flutter may have a tachycardia cycle length less than 15 % and therefore this is not such as good discriminator.

Roof Dependent Left Atrial Flutter

In order to map roof dependent left atrial flutter the catheter is positioned anterior to the roof and then more inferiorly close to the anterior mitral annulus. This is repeated by positioning the ablation catheter along the roof in the posterior direction and then towards the coronary sinus which generally marks the general direction of the posterior mitral annulus. If the activation is in the reverse direction i.e. earlier inferior

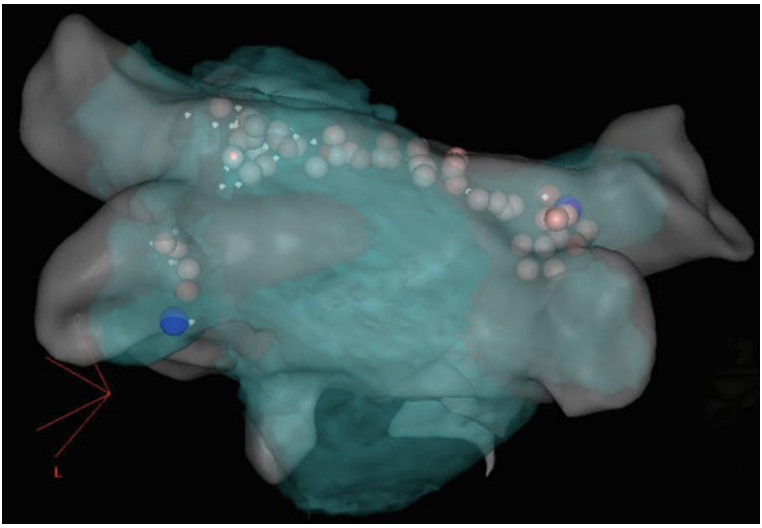

Fig. 8.14 Electroanatomic map showing a linear lesion joining the left superior pulmonary vein to the right superior pulmonary vein. This resulted in termination of the macro re-entrant atrial flutter. Further pacing demonstrated block across this line

than superior on the anterior wall and earlier superior to inferior on the posterior wall or vice versa then this is likely to be a roof dependent atrial flutter. If entrainment is performed in the anterior and posterior regions of the roof then a PPI-TCL of less than 30 ms further helps to confirm roof dependent atrial flutter. In the setting of a prior roof line or PVI with WACA mapping of fractionated potentials in the region of the roof is also helpful.

A roof line connecting the LSPV and the RSPV should be performed in the setting of a macro re-entry atrial tachycardia circulating around the PV's and involving the roof. In order to perform this the sheath is directed towards the right superior pulmonary vein while the catheter is flexed over to the left superior PV (Fig. 8.13). Using 30–35 W the catheter flexion can then be slowly released staying at each point for approximately 30–60 s. A superior and a PA view help to ensure that the line is performed along the roof rather than the posterior wall. In order to evaluate the roof line the LAA is paced during sinus rhythm. Roof line block is demonstrated by the presence of double potentials along the line during pacing as well as caudocranial activation of the posterior wall (Fig. 8.14).

Mitral Isthmus Dependent Atrial Flutter

This is a relatively common cause of post PVI atrial arrhythmias and generally occurs as a result of slow conduction inferior to the LIPV from a prior mitral isthmus ablation or PVI. In this arrhythmia CS activation is either proximal to distal or distal to proximal. It is useful to use the ablation catheter to map the anterior mitral

annulus. If CS activation is proximal to distal then anterior activation should be from lateral to septal. If the CS activation is distal to proximal then the anterior mitral annular activation should be from septal to lateral as shown in Fig. 8.15.

A posterior mitral isthmus line may be performed which connects the LIPV to the posterior mitral annulus close to the coronary sinus. A deflectable sheath is used and the ablation catheter is positioned at the ventricular side of the lateral mitral annulus with an AV ratio of either 1:1 or 2:1 [56].

During proximal CS pacing the catheter and sheath are then rotated clockwise towards the left inferior PV with delivery at 30 W for 90–120 s applied at each location. The catheter is moved whenever there is splitting of the local electrograms. The mitral isthmus varies in thickness along its length being thinner at the annular end and thicker at the medial end.

In order to prove block for a posterior mitral isthmus line pacing is performed from the CS and activation is measured in the LAA. Normally pacing from the distal CS should result in a shorter conduction time to the LAA than pacing from a less distal pole. In the event of posterior mitral isthmus block the more distal location will take longer to travel to the LAA. The presence of double potentials along the entire ablation line with coronary sinus pacing is also a useful endpoint.

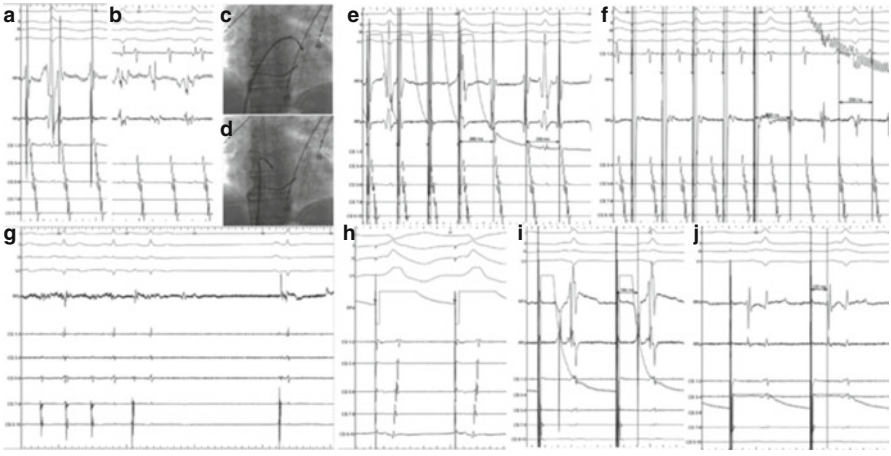

Fig. 8.15 Mitral isthmus dependent atrial flutter in a patient with a prior PVI. In panel **a**, the activation of the coronary sinus can be seen to be distal to proximal. The mapping catheter is anterolateral. As the mapping catheter is moved along the anterior wall to the septum in panel **b**, the direction of activation is clearly septal to lateral. This is compatible with perimitral flutter. Panels (**c**, **d**) demonstrate the catheter positions in panels (**a**, **b**), respectively, in an anteroposterior view. Entrainment maneuvers are performed from the distal CS (panel **e**) and septally, on the mitral annulus (panel **f**), with a return cycle length on both occasions being within 20 ms. A mitral line from the lateral mitral annulus to the left inferior pulmonary vein is performed, resulting in termination of the tachycardia (panel **g**). The completeness of the line is now checked with pacing from the line (panel **h**) demonstrating proximal to distal activation of the coronary sinus and a longer delay from close to the line (panel **i**) than distally to the line (panel **j**), confirming bidirectional block (Courtesy of Weerasooriya et al. [62], Wiley Brothers)

If block is not achieved then the line should be remapped and ablated further. In some cases ablation has to be performed at 20 W from the coronary sinus in order to block epicardial activation. An alternative approach is to perform an anterior mitral isthmus line joining the anterior mitral annulus to the LSPV.

CFAE Mapping and Ablation

CFAE's are defined as local electrograms which are fractionated with at least two components and with cycle lengths less than 120 msec recorded during AF and lasting for at least 10 s [57]. These are frequently recorded during AF within the regions of the LA close to the pulmonary vein antral regions and therefore may be ablated and electrically isolated during a pulmonary vein isolation.

In persistent atrial fibrillation CFAE's may be located anywhere within the left and right atrium with a potential propensity for the septum, inferoposterior wall of the LA and the LAA.

There are various theories as to what CFAE's actually represent with suggestions such as anchor points in rotors, regions of conduction slowing or autonomic activation. The long term results of CFAE ablation are not impressive and certainly this does not appear to represent a very effective strategy for the treatment of persistent AF.

Rotor Mapping

A rotor is defined as an unexcited core termed a phase singularity resulting in reverberations which radiate at very high velocity into the surrounding tissue [58]. Phase singularities are surrounded by different phases of the cardiac action potential and may be considered useful targets for ablation as they may be considered regions of tissue which can support rotors. They may occur on the endocardium, mid myocardium or epicardium or indeed span all layers. The theory is that following initiation of atrial fibrillation from pulmonary vein and non pulmonary vein sources rotors result in maintenance of atrial fibrillation.

Rotors differ from re-entry circuits in several ways. In a rotor the core is the active component with secondary spiral activity. The rotor core is functional and does not appear to be related to a detectable structural obstacle. Rotors are not stationary and may move over a considerable area [59]. Spiral waves also collide with each other altering the overall activation pattern. Additionally there does not appear to be a close correlation between rotors and CFAE's [59].

Some of these features actually make mapping of rotors very complex. Rotor activation is complex, can change during the mapping process and may involve different the endocardium, myocardium and epicardium. There are currently two systems which may be used for mapping rotors. These involve either invasive mapping using a multi-electrode basket catheter called the Focal Impulse and Rotor Modulation system and a non invasive multi electrode vest which is superimposed on a cardiac CT.

Focal Impulse and Rotor Modulation of Atrial Fibrillation

This system uses a 64 electrode basket with eight splines which is positioned in either the right, left or both atria as shown in Fig. 8.16. If the patient is in atrial fibrillation the unipolar electrograms are recorded and exported for analysis. If the patient is in sinus rhythm atrial fibrillation is induced with rapid atrial pacing and the signals are then recorded and analyzed after 10 min of sustained atrial fibrillation. It is extremely important that there is excellent electrode contact. The correct size of basket should be chosen and this can be difficult in large atria. Catheter orientation should be optimized on fluoroscopy and with the aid of a 3 dimensional mapping system in order to record vital areas of the left atrium including the pulmonary veins and the left atrial appendage as well as septal, roof, anterior and posterior activity.

The signals are then processed using RhythmView™ (Topera Inc.). This system is based on restitution monophasic action potential data acquired during rapid atrial pacing and atrial fibrillation. This displays the activation signals on a 2 dimensional image where the operator can then visualize potential rotors or focal sources. The image of each atria is opened so that for the right atrium the tricuspid annulus is inferior with the septal component to the right of the image and the lateral component to the left. For the left atrium the mitral annulus is at the bottom of the image

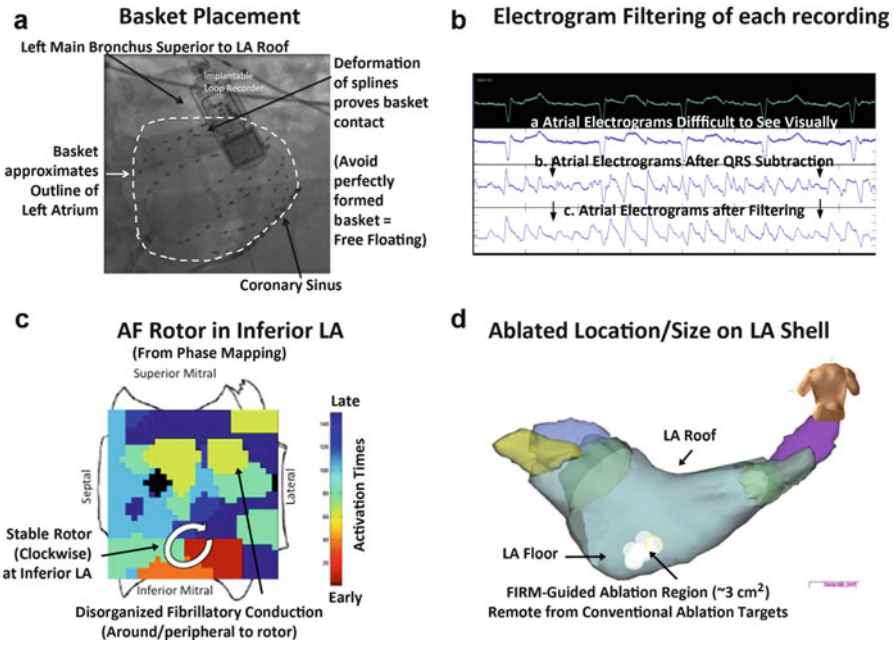

Fig. 8.16 Approach to FIRM (Focal Impulse and Rotor Mapping) guided ablation of atrial fibrillation (Courtesy of Dr Sanjiv Narayen)

and is divided. The electrodes of interest where a rotor core is felt to exist can then be referenced off an electroanatomic system and ablation can then be performed.

It has been shown that focal sources and rotors may be recorded in almost all patients with atrial fibrillation. Approximately one third of these can be recorded in the right atrium [60] and more than one half of all rotors are recorded outside of the regions where a wide area circumferential ablation would be performed [61]. Results suggest that the addition of ablation of rotors using this technique increases the success when compared with pulmonary vein isolation alone.

A. **Baskets placed in left atrium** (**shown**) and also in right atrium to map both chambers sequentially. Good positioning results in deformation of the highly compliant basket, proving electrode contact, and splines that approximate the LA roof and floor. In contrast, a spherical shape when deployed indicates an undersized basket with poor contact.
B. **Electrogram filtering** using well-established methods enables detection of sometimes difficult to visually identify atrial signals.
C. **Rotor during human AF in left atrium**, revealed by spatial phase mapping of filtered atrial electrograms, depicted as clockwise 'snapshot' (isochrone) where early and late activation meet, surrounded by fibrillatory disorganization. Phase mapping is used since activation mapping during of dynamically changing activation in AF is challenging. Intraprocedurally, diagnosis is actually made from animated 'FIRM movies' which better convey rotor precession and their dynamic interaction with the fibrillatory milieu.
D. **FIRM-guided ablation zone**, in inferior left atrium guided by map, typically of $\approx$3 cm^2 areas.

Non-invasive Multi Electrode Mapping

Using this technique a 252 electrode vest (CardioInsight, © Medtronic plc 2015) is applied to the patient during AF. This is used to record unipolar surface potentials. Anatomic data is then acquired by performing a noncontrast cardiac CT with the vest in place so that each electrode position can be calculated relative to the cardiac chambers. The system then performs a calculation in order to calculate and display electrical data on the surface of the heart from the surface unipolar electrograms. Activation sequences are then calculated by looking at the most negative dV/dT. This can then be displayed on a 3 dimensional reconstruction of the right and left atria using colors to animate various phases of depolarization and repolarization as shown in Fig. 8.16. This can be analyzed for focal sources as well as rotors. There are several advantages of this system. Since it simultaneously maps both atria and therefore can help to differentiate between active rotors and passive activation. It also does not rely on contact to record the electrograms. Given that data is acquired prior to an ablation there may be a question of changes in activation or changes related to the ablation itself.

Important Points to Remember

1. AF is classified as paroxysmal, persistent, longstanding persistent or permanent. Paroxysmal AF is defined as two or more episodes of AF each of which terminate within seven days and commonly within 24 h. Persistent AF is sustained generally for greater than seven days (or less if a cardioversion was performed in this time) and requires chemical or electrical cardioversion for termination of the arrhythmia. Longstanding persistent refers to cases in which AF has been present for more than one year and previously may have been designated as being permanent; however, an electrical cardioversion or ablation strategy is being pursued and therefore sinus rhythm may be achieved. Permanent AF also continues for more than seven days and cannot be terminated anymore thus a rhythm control strategy has been unsuccessful or not appropriate.
2. The main cardiovascular causes of AF are hypertension, coronary artery disease and valvular heart disease, metabolic causes of AF include thyroid dysfunction and diabetes mellitus while lifestyle risk factors include obesity, excessive alcohol and obstructive sleep apnea. AF is frequently seen in an acute setting in post operative patients as well as those who have infection, or in association with pulmonary embolism, pericarditis and myocarditis. AF may also occur in association with other supraventricular arrhythmias, such as AV nodal re-entry tachycardia, AV re-entry tachycardia and atrial flutter.
3. PVI is considered to be a reasonable strategy in patients with paroxysmal AF in whom medication has been ineffective, poorly tolerated or in cases of patient preference. This may be performed using a point by point technique or a ‘single shot’ device. PVI may also be useful in patients with persistent AF as a method of isolating the potential triggers.
4. Electrograms recorded from the ostia of the pulmonary veins show an initial non circumferential lower amplitude atrial signal followed by an isoelectric period followed by sharp pulmonary vein potentials. Depending on the overlap between the left atrium and the surrounding structures as well as the orientation of the mapping catheter there is a variable delay between the farfield electrogram and the pulmonary vein potentials. For the LSPV and to a lesser degree the LIPV farfield electrograms from the LAA may be recorded. These can be separated from the PV potentials by pacing from the LAA or the distal CS. For the RSPV farfield electrograms may be recorded from the SVC. If the signal is within 30 msec of the onset of the p wave then these are likely to represent SVC farfield.
5. Entrance block may be observed either during normal sinus rhythm or with atrial pacing during sinus rhythm. The circular catheter is positioned in the PV antra just distal to the line of ablation.
6. In order to prove exit block the ablation catheter can be positioned in the same pulmonary vein as the circular mapping catheter. Although pacing

can be performed from either the ablation catheter alone or the circular catheter alone it is often easier to discern pulmonary vein potentials from a separate catheter which has closely spaced poles without superimposed pacing arterfact.

7. An additional useful technique to help prove an intact line around the pulmonary veins is to assess for unexcitability to pacing. Following ablation the catheter is positioned along the line during sinus rhythm at an output of 10 mA and a pulse width of 2 ms. If lack of local capture occurs the catheter is moved a further 5 mm along the line and pacing repeated. If local capture occurred then further ablation was performed in this region and pacing performed at the same output.
8. In some cases non pulmonary vein triggers may contribute to AF. Potential locations include the superior vena cava, coronary sinus, crista terminalis, fossa ovalis, ligament of Marshall and left atrial appendage.
9. Post PVI atrial arrhythmias may involve the CTI, gaps around the PV's, the mitral annulus or the LA roof. Activation mapping using the ablation catheter relative to a stable CS electrogram may help to distinguish these.
10. Newer mapping techniques including the potential mapping of rotors may help to further understand the mechanism for AF.

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Chapter 9
Ventricular Tachycardia

Benedict M. Glover and Pedro Brugada

Abstract Ventricular tachycardia is defined as an arrhythmia which originates from the ventricles consisting of at least three or more consecutive beats at a rate of greater than 100/min and independent of AV or atrial conduction. If this terminates spontaneously within less than 30 s it is defined as non-sustained. If it lasts greater than 30 s or requires treatment for termination it is defined as sustained. Most commonly VT is associated with structural heart disease such as scar related re-entry in patients who have had a prior MI. Occasionally it may be associated with a structurally normal heart and is termed idiopathic. This is most commonly seen in the right ventricular outflow tract, coronary cusps, coronary veins or around the valve annuli.

ECG Criteria

One of the most important issues is to record an ECG during tachycardia in order to help make a diagnosis as to whether the arrhythmia is ventricular or supraventricular and if ventricular where the exit site may be located. As shown in Fig. 9.1 several criteria exist in order to help make this differentiation.

The Brugada criteria uses a straightforward and stepwise approach. This was developed by examining 348 cases of VT and comparing these with 170 cases of SVT with abberancy [1]. No patients were receiving anti-arrhythmic drugs. The first step looks at the absence of an RS in all of the precordial leads. If this is the case

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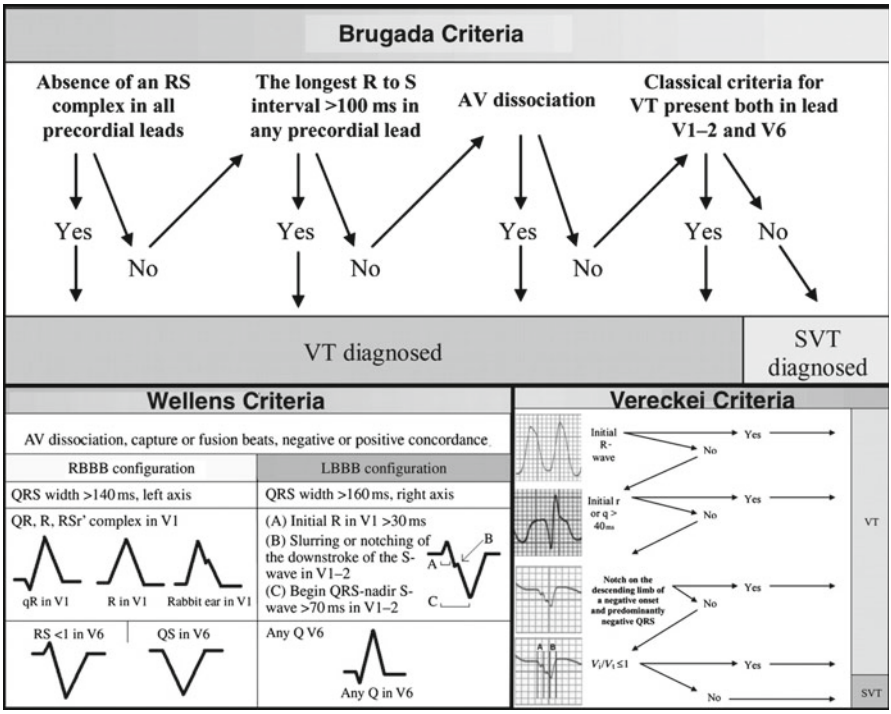

Fig. 9.1 Brugada Criteria, Wellens Criteria and Vereckei Criteria for the diagnosis of VT (Reproduced with permission from Alzand and Crijns [15]. Oxford University Press)

then VT is diagnosed. If not then the longest RS interval is examined and if greater than 100 ms VT is diagnosed. If not the presence of AV dissociation is looked for. As VA conduction may occur in almost half of all cases of VT it is important not to confuse 1:1 VA conduction with a supraventricular arrhythmia with 1:1 A:V conduction or 2:1 VA conduction during VT with AV dissociation.

If this is not seen then the classical Wellens criteria for VT in leads V1 or V2 as well as V6 are looked for [2]. These include a QR, R or RSr' in V1 or V2 with an RS less than 1 in V6 or a QS in V6 in a RBBB morphology or an R in V1 greater than 30 ms with notching of the S wave and an onset of QRS to S wave of greater than 70 ms in V1 or V2 with a Q wave in V6 in a LBBB morphology.

Another interesting algorithm has also been developed in which inly lead aVR is analysed [3]. As shown in Fig. 9.1 the presence of an initial R-wave, the width of an initial r- or q-wave greater than 40 ms, the presence of notching on the initial downstroke of a predominantly negative QRS complex and a V_i/V_t less than or equal to 1 are more indicative of VT.

Scar Related VT

Macro re-entry scar related monomorphic re-entry VT requiring treatment is a common indication for catheter ablation. Although this is most commonly the result of coronary artery disease other potential causes include infiltrative conditions and

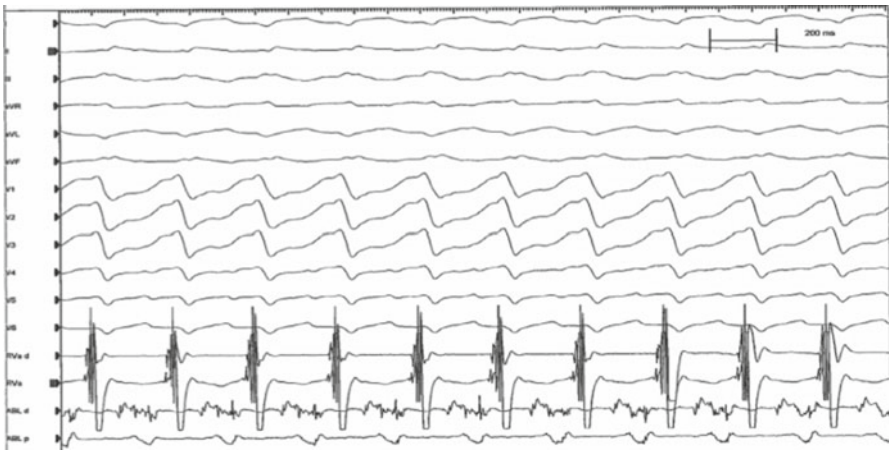

Fig. 9.2 Mapping during scar related re-entry VT showing long fractionated signals on the distal ablation catheter (ABL d) during diastole most likely indicative of a critical isthmus. Ablation in this region resulted in termination of the tachycardia with no further inducible tachycardia

dilated cardiomyopathy. As anti-arrhythmic drugs are often only moderately effective and often have significant side effects catheter ablation represents a reasonable alternative. Of course the potential complications of catheter ablation should also be considered. These include vascular injury, thrombo-embolism, hemodynamic instability and compromise, damage to the conduction system and cardiac tamponade.

Mechanism

Most scar related VT is a macro re-entry circuit. This is composed of an area of slow conduction with functional unidirectional conduction block as well as a structural barrier which is generally scar. Like all re-entry circuits the tachycardia can be entrained and reset if pacing is performed close to the circuit at a cycle length slightly shorter than the tachycardia cycle length with a closely matched post pacing interval minus tachycardia cycle length. There is generally an isthmus which is characterized by electrical activity during diastole. This is often the region which is targeted for catheter ablation. Pacing from this location results in a long stimulation to onset of QRS with a good pace map at the exit site. It is the exit site which determines the QRS morphology. Following this the waveform either propagates around the outer loop of the scar or an inner loop within the scar (Fig. 9.2).

Mapping and Ablation of Scar Related VT

In general it is reasonable to induce VT at the start of the procedure in order to have some procedural endpoint following ablation. Performing activation mapping and

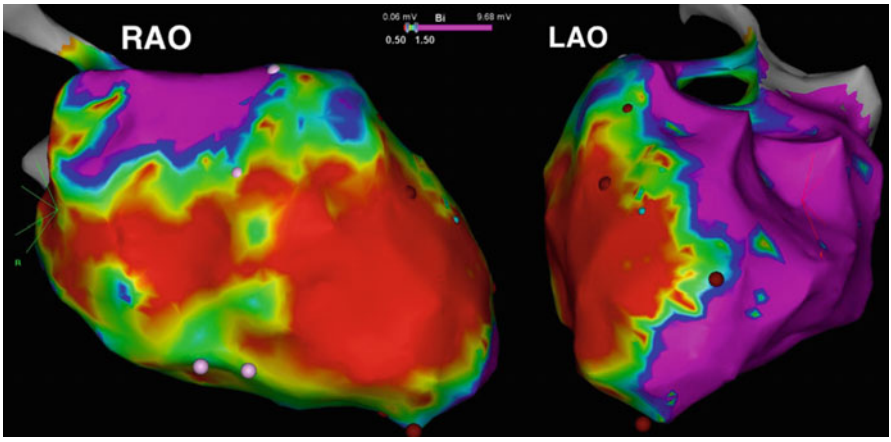

Fig. 9.3 Substrate mapping in a patient with monomorphic ischemic VT. Scar is seen in the LV septum, anterior wall and apex with heterogeneous tissue around this. This is clearly seen in the RAO image on the left and LAO image on the right

ablation of VT can result in significant hemodynamic compromise and may have adverse effects in itself. It is therefore our practice to map the substrate and target fractionated, low amplitude or delayed electrograms. In general **scar is defined as a bipolar voltage less than 1.5 mV and dense scar is a voltage less than 0.5 mV**. As shown in Fig. 9.3 scar is shown as red along the LV septum, anterior wall and apex with a region of heterogeneous tissue around this colored yellow, green and blue and higher voltage areas are seen in pink.

The targeting of **local abnormal ventricular activities** (**LAVA**) which represent poorly coupled fibers surrounded by appears to be an effective strategy [4].

The classical features of LAVA during sinus rhythm are:

- High frequency often double (or more) potentials separated by either a low amplitude baseline
- Separate from and often (but not always) following ventricular far-field
- May require pacing at the site in order to distinguish LAVA from ventricular farfield.

As well as exposing LAVA, which may be within the farfield, ventricular pacing at different outputs may result in different morphologies which means that the pacing substrate is complex. This is shown in Fig. 9.4.

The interesting concept is that although later potentials do tend to be significant and generally should be targeted the timing of these potential relative to the QRS is not just dependent on local conduction but on the anatomic location being earlier closer to the endocardial septum and latest being closer to the posterobasal epicardium which is activated at least 30 ms after [5].

It is therefore a reasonable strategy to perform pacing in order to separate out local fractionated potentials from farfield ventricular activation.

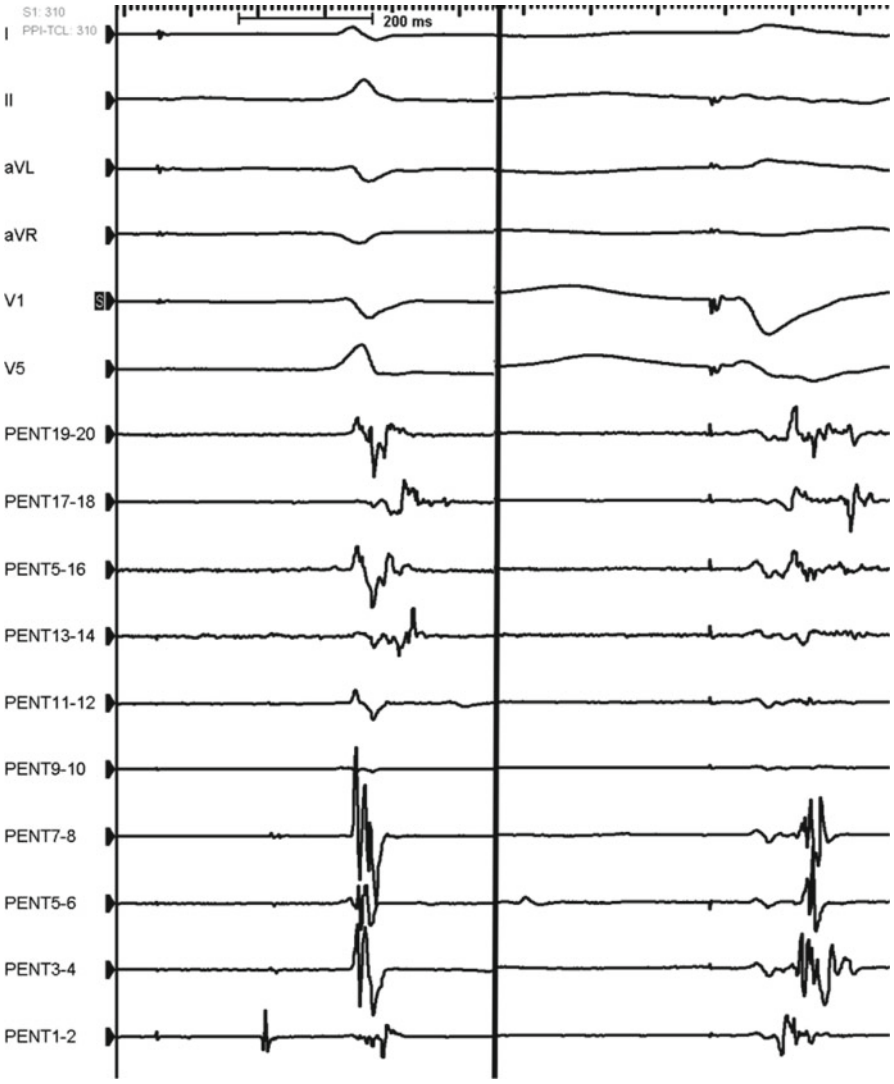

Fig. 9.4 LAVA potentials exposed during pacing from the RV apex (*circled on the right*). The pentarray catheter (PENT 1–20) is positioned in the inferior wall of the left ventricle. The first beat on the left occurs following an atrial paced beat in which fractionation is noted in PENT 13–20. On the right pacing is performed from a catheter in the RV apex which expose higher frequency split potentials in PENT 15–20 and 3–4 which were targeted for ablation

Pace mapping particularly along the critical isthmus is also a very helpful strategy. A long stimulus to QRS with a good pace map is often a reasonable sign of being close to the isthmus. In cases of septal VT we perform this on both the right and left septum. This is shown in Fig. 9.5 in which the patient has extensive scar along the LV septum, anterior wall, inferior wall and apex. A pace map on the RV

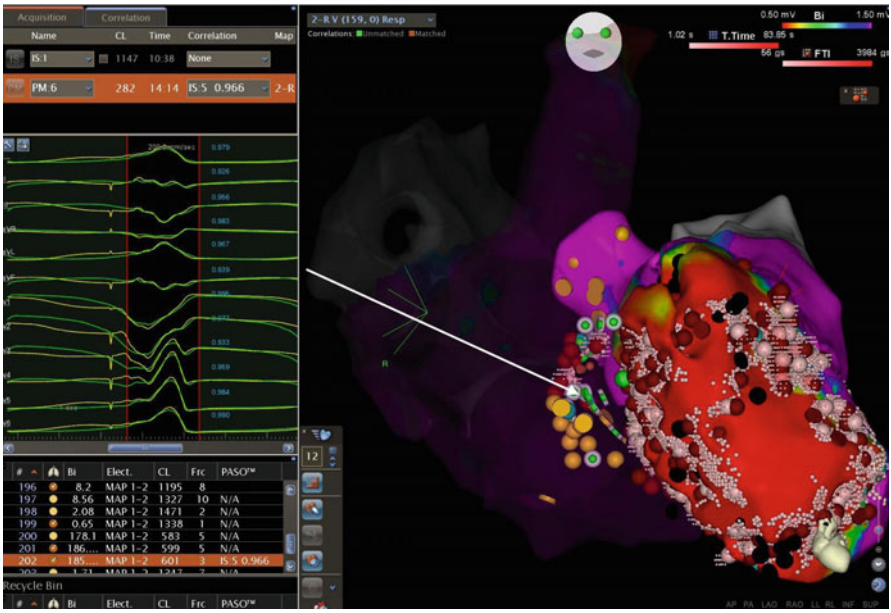

Fig. 9.5 Substrate map showing extensive scarring of the left ventricle involving the septum, anterior wall, inferior wall and apex. VT could be easily induced and terminated with ablation at 50 W along the septum (exact point *green dot*). Despite this VT could be re-initiated and therefore pace mapping was performed on both sides of the septum. The pace map shows a very good match with the clinical VT on the right side of the septum. Despite the appearance of relatively normal signals ablation was performed in this region with no further inducible tachycardia. The *arrow points* to the area with the best pace map and indicates that the exit site was likely on the right side and that ablation was required on both sides of the septum. (*Yellow dots* were regions with less good pace map matches and *black dots* were LAVA potentials which were also targeted)

septum in which the voltages were normal revealed an excellent pace map as shown. Ablation was therefore performed on both sides of the septum which successfully targeted the circuit which was likely deep septal.

If tolerated and a distinct region has been mapped such as the isthmus then VT can be induced and the signals examined during tachycardia or ablation can be performed looking for tachycardia termination. Additionally if the arrhythmia is tolerated entrainment can be performed in order to assess the location of the catheter relative to the circuit.

At the end of the procedure further testing can be performed in order to examine for tachycardia induction.

Epicardial Access and Ablation

Scar related monomorphic VT circuits may involve the endocardium, mid myocardium and epicardium. This is more commonly but not exclusively seen in non-ischemic VT. Certain cases may require epicardial access in order to successfully

target the critical components of the circuit. This may be determined according to the underlying substrate, by using imaging which may help visualize scar distribution, in cases where ablation was unsuccessful from the endocardium and in cases where the ECG may exhibit certain characteristics.

ECG Characteristics Suggestive of Epicardial Involvement

In general the QRS during VT originating from or involving the epicardium results in a significantly wider QRS due to the greater distance from the His Purkinje system. For epicardial VT with a RBBB morphology thought to have an exit site in the region of the left ventricle several parameters can be measured which may suggest epicardial involvement.

These include the following parameters [6]:

1. **The onset of the QRS to a pseudo-delta wave of greater than 34 ms**. A pseudo-delta wave is defined as an early rapid deflection on the upstroke of the QRS complex.
2. **An intrinsicoid deflection time of greater than 85 ms**. The intrinsicoid deflection time is the time from the onset of the QRS to the peak of the R wave measured in V2.
3. **The RS complex duration** defined as the earliest ventricular activation to the nadir of the first S wave in any precordial lead of **greater than or equal to 121 ms**.

For VT originating from the epicardial surface of the RV these parameters do not appear to be helpful [7].

The presence of a Q wave or a QS in the local site of activation provides a more useful indicator. Therefore an inferior origin tends to have a Q or QS in leads II, III and aVF. None of these parameters are useful in determining whether an outflow tract tachycardia is endocardial or epicardial. An example of an ECG in a patient with VT with an epicardial focus involving the LV inferior wall is shown in Fig. 9.6.

Epicardial VT Ablation

Although this procedure can be performed with sedation it is generally uncomfortable for the patient and general anesthesia should be considered. A sterile field is prepared inferior to the sternum and fluoroscopy with or without the addition of echo can be used for imaging.

Epicardial Access

A 17 Guage Tuohy needle is introduced at a 45° angle initially until it has passed through the diaphragm and then a slightly steeper angle. The direction of the needle can be visualized in the RAO view aiming towards the medial one third of the RV

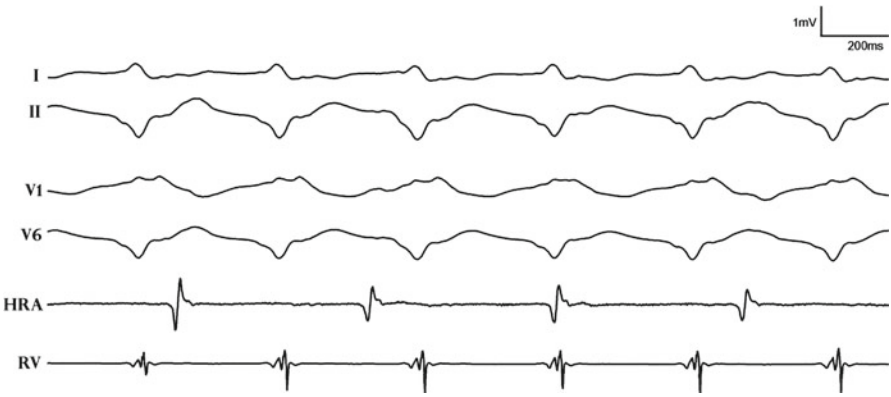

Fig. 9.6 ECG of VT originating located in the epicardial surface of the LV inferior region. V1 and V6 are indicative of a left ventricular origin while lead I and II indicate an inferior origin. The QRS is broad with a pseudodelta wave seen on lead V1. There is clear dissociation seen between the RV and RA activation

(where there are no major coronary vessels) while the depth is most easily seen in a left lateral projection.

As the tip of the needle enters the epicardial space a sensation of a 'give' is felt followed by a cardiac pulsation. Although contrast can be injected this should be minimized as it often then obscures the view. A more straightforward approach is to advance a long wire into the pericardial space. If this is truly in the pericardial space it should not follow the course of any cardiac chamber. If this is in the RV it will tend to pass towards the RVOT and into the pulmonary truck often with significant ectopy. Another option is to record the pressure from the needle which will change from a flat line as the needle is advanced through tissue to a sudden negative pressure as the tip of the needle passes into the pericardial space. Entering the right ventricle will demonstrate an RV pressure waveform. In general as long as only the needle tip and wire enter the ventricle this should not result in a major problem and a fresh attempt can be made with close hemodynamic monitoring.

As soon as it is confirmed that the needle and wire are in the epicardium then a sheath and dilator can be introduced. In general a short deflectable sheath can be used. We also tend to introduce a second wire through the sheath in case access is lost.

It is important that a catheter is left in the sheath and if removed that it is replaced with a wire in order to avoid laceration of the ventricular wall with the tip of the sheath.

The relevant anatomy pertaining to epicardial access is shown on anatomical image and the CT image in Fig. 9.7.

In approximately 10 % of patients epicardial access is not possible. This is particularly common in patients who have had prior cardiac surgery as well as some patients with a prior history of pericarditis. In these cases a surgical window can sometimes be made.

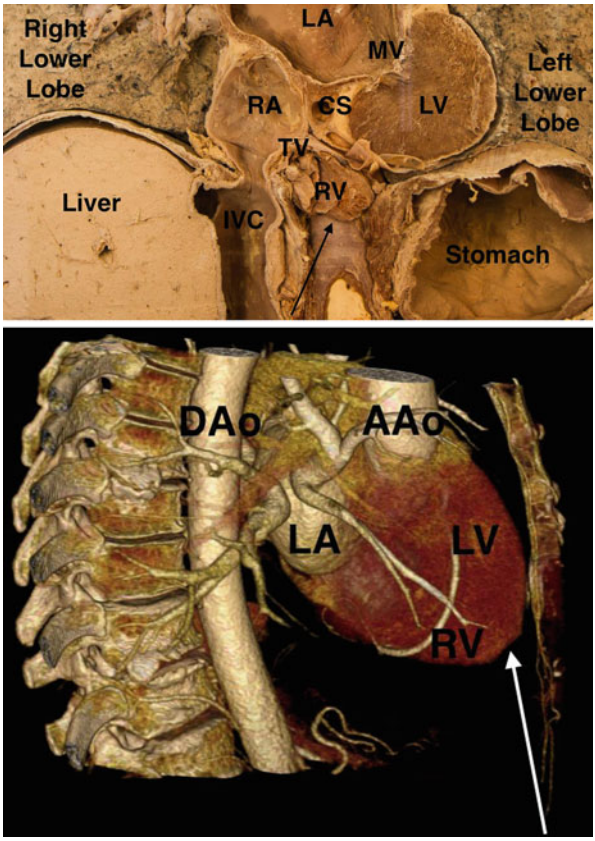

Fig. 9.7 Anatomical image showing the relevant anatomy from an anterior coronal view in epicardial access (*top image*) and a lateral sagittal view shown on a CT (*bottom image*). The *arrow* in the *top image* shows the direction in which the needle should be advanced towards the middle one third of the RV. The angulation of this is seen in the CT image below this in which the arrow shows the course of the needle (*LA* left atrium, *RA* right atrium, *TV* tricuspid valve, *MV* mitral valve, *CS* coronary sinus, *IVC* inferior vena cava, *AAo* ascending aorta, *DAo* descending aorta)

Epicardial Mapping and Ablation

An irrigated catheter is used for mapping and ablation. The general principles of mapping are the same as for endocardial mapping. The main issue which may arise, is the differentiation of scar from epicardial fat. In generally fat greater than 5 mm results in a reduction in the amplitude of the local electrogram. The degree of fractionation is helpful and is generally reasonably specific for local scar rather than fat. If a region of low amplitude signals follows the distribution of a coronary vessel then it is likely to represent epicardial fat. An example of a voltage map recorded on the epicardium and showing scar along the inferior wall of the LV is shown in Fig. 9.8 along with the region of ablation performed.

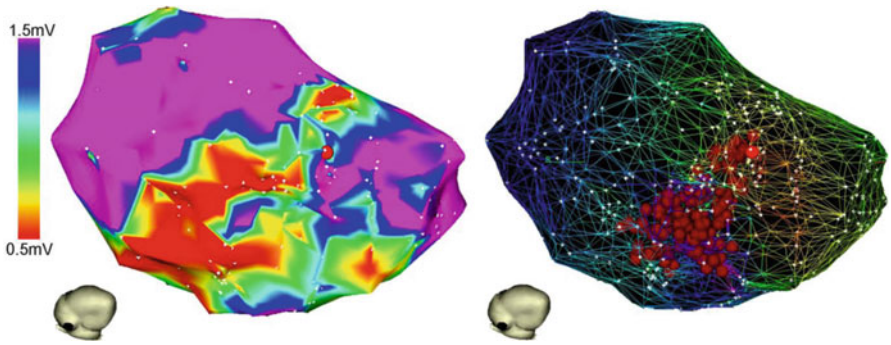

Fig. 9.8 Voltage Map of VT along the epicardial surface of the LV inferior wall. *On the image on the left red* represents dense scar surrounded by heterogeneous zones and normal voltages are shown in *pink*. The *image on the right* shows the points recorded with ablation shown as *red dots* along the critical isthmus

The fact that ablation catheters deliver circumferential radiofrequency energy means that there is always a degree of damage to surrounding structure. This is generally the pericardium and pleura which accommodate this with no major problems. The main structures to be cautious of when delivering RF to the epicardial surface are the coronary arteries and the phrenic nerves. In general either a CT is merged at the start of the procedure with the locations of the coronary arteries or a coronary angiogram is performed prior to ablation. A **minimum distance of 5 mm** should be maintained between the site of ablation and the coronary artery in order to prevent coronary artery spasm or acute thrombosis.

As there is no flow in the pericardium irrigation is used at a rate of 10 ml/min. This should be aspirated from the side arm of the sheath to prevent cardiac tamponade. RF can be delivered at a power ranging from 25 to 50 W.

Epicardial Ablation: The Difficult Case

The difficulties in epicardial mapping and ablation relate to either general issues relating to mapping which are similar to those of endocardial ablations and additional technical issues. One of the first issues is that of gaining access with minimal complications. Maintaining a relatively shallow angle while beneath the diaphragm minimizes the risk of hepatic laceration and subdiaphragmatic injury. Perforation of a subdiaphragmatic vessel should be suspected in a patient with significant hypotension and no evidence of a pericardial effusion.

Another technical issue is that of phrenic nerve proximity to a region where ablation is required. In general the phrenic nerve can be pushed away from the ablation catheter by injecting air through the pericardial sheath. This should be aspirated immediately if defibrillation is required and after ablation has been performed.

Although some centers use local non steroidal drugs in the pericardial space post procedure we tend to manage the majority of cases with simple analgesia.

Idiopathic VT

Bundle Branch Re-entry

Under normal circumstances antegrade conduction through the His Purkinje network is relatively rapid. The fact that the tissue remains refractory for more prolonged periods of time therefore generally prevents re-entry from occurring between the right and the left bundle branches. In cases where conduction is slowed or transiently blocked in either the antegrade or retrograde directions re-entry may occur. As shown in Fig. 9.9 this may result in antegrade conduction down the right bundle with retrograde conduction up the left bundle resulting in a left bundle branch block morphology during VT. The reverse may also occur with antegrade conduction down the left bundle and retrograde conduction up the right bundle resulting in a right bundle branch block morphology during VT.

EP Study and Ablation for Bundle Branch Re-entry VT

In patients with bundle branch re-entry the baseline ECG during normal sinus rhythm often shows first degree AV block with some variant of intraventricular conduction delay or an incomplete bundle branch block.

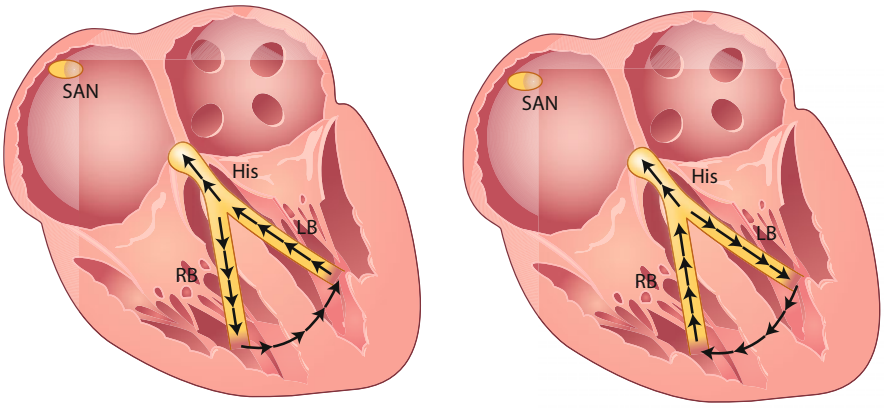

Fig. 9.9 Showing the potential circuits involved in BBR. *Top image* shows the more common scenario where antegrade conduction occurs along the right bundle and retrogradely along the left bundle and below the less common antegrade conduction along the right bundle with retrograde conduction along the right bundle

The baseline EP study demonstrates a **prolonged HV interval during sinus rhythm of greater than 60 ms** [8]. Tachycardia may be induced with either atrial or ventricular pacing. The morphology is more commonly a LBBB than a RBBB. The diagnosis is generally made by the presence of a **His signal before every QRS** with a HV interval slightly shorter than during sinus rhythm. The His signal is generally followed by the right bundle potential or less commonly a left bundle potential depending on the direction of the circuit. As these are all vital components in the circuit a change in either the H-H, RB-RB or LB-LB intervals prolongs the tachycardia cycle length. Entrainment may be possible by pacing from the right ventricular apex. A difference of less than 30 ms is suggestive of bundle branch re-entry [9].

In general ablation of the right bundle branch is performed. In order to map this the His is located and a more distal location with a right bundle electrogram and no atrial signal is chosen along the anterobasal region.

Fascicular Re-entry VT

Fascicular re-entry VT is sometimes referred to as either verapamil sensitive or Belhassen VT. Whereas in Bundle Branch Re-entry VT the His activation occurs before left bundle activation in fascicular re-entry His activation tends to occur after left bundle activation and with a much shorter HV interval during tachycardia. The QRS in fascicular VT although prolonged, is generally less than 140 ms and therefore is not as prolonged as many other types of VT. Upper septal re-entry tends to be narrower and may even be confused with SVT. Three different types of fascicular VT exist.

The most common type is **left posterior fascicular** in which the antegrade component to the circuit involves slowly conducting decremental verapamil sensitive Purkinje fibers extending from the base of the interventricular septum towards the LV apex. The retrograde circuit then propagates along the posterior fascicle with an exit site in the inferoposterior septum resulting in a **RBBB morphology with a superior directed axis**.

Less commonly is **left anterior fascicular** in which the retrograde activation occurs along the anterior fascicle with an exit along the anterolateral wall of the LV resulting in a **RBBB** morphology QRS during tachycardia with an inferior directed axis.

In **upper septal VT** the left posterior and left anterior fascicles both act as the antegrade limbs resulting in a relatively narrow QRS often with a **RBBB** morphology although occasionally there is a LBBB pattern with an inferior or normal axis. Diagrammatic representation of these is shown in Fig. 9.10.

EP Study and Ablation for Fascicular VT

EP evaluation and catheter ablation may be performed successfully in the majority of patients. Given that the circuit is located in the left ventricle access can be achieved either retogradely across the aortic valve or through a transseptal approach.

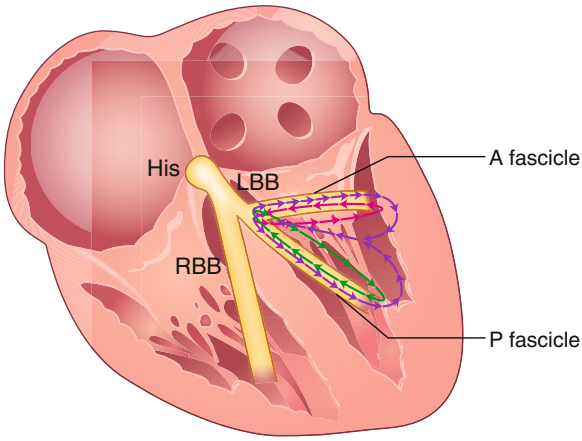

Fig. 9.10 Demonstrating the circuits involved in fascicular VT utilizing the posterior fascicle as the retrograde limb (*green*) and the anterior fascicle as the retrograde limb (*pink*) as well as the uncommon upper septal fascicular re-entry (*purple*)

The risks are therefore similar to those for all left ventricular ablations with the additional potential risk of the development of LBBB and AV block.

One of the interesting and diagnostic features of this type of VT is that it can be induced and entrained by performing atrial pacing. If pacing is insufficient for the induction of VT then isoprenaline can often be helpful.

During normal sinus rhythm and during tachycardia a sharp high frequency Purkinje potential can be recorded prior to the onset of the QRS which represents depolarization of the fascicle. During sinus rhythm a lower frequency potential may be recorded after the QRS which is known as a **pre-purkinje potential**. This term is used for this potential as during tachycardia it represents activation of the verapamil sensitive antegrade limb of the circuit and therefore occurs before the purkinje potential. As the mapping catheter is moved further from the base of the interventricular septum towards the LV apex the pre-purkinje potential becomes later. The area of slow conduction tends to occur at the junction of the fascicle and the antegrade limb where the purkinje potential is at its earliest and the pre-purkinje potential is at its latest.

Ablation is generally performed during tachycardia as termination with ablation with no further initiation is a reasonable endpoint. A region close to the exit site can be targeted approximately one third from the LV apex where the **purkinje potential precedes the QRS by approximately 20 ms**. The pre-purkinje potential tends to occur after the QRS in this region. An alternative approach where the earliest pre-purkinje potential can be targeted until VT is terminated and in which case the potential then becomes late. This appears to be associated with a slightly higher risk of AV block or LBBB.

If VT cannot be induced nor sustained and the suspicion is that of a left posterior fascicular VT then a linear lesion can be made 1 cm proximal to the exit site. The exit site can be identified by careful pace mapping. If the linear lesion is successful the purkinje potential jumps from before to after the QRS complex.

The Difficult Case

Several issues may make ablation of this arrhythmia difficult. In general from a practical perspective the two major issues are difficulty with initiation of the tachycardia and ensuring that the correct diagnosis has been made.

Although atrial and ventricular pacing should initiate the tachycardia if this is not possible the administration of intravenous isoprenaline may be helpful.

In cases where ablation appears to be unsuccessful it is important to review the diagnosis. It is possible to have a focal arrhythmia originating from the purkinje network which also results in a RBBB morphology QRS with either a superior or inferior directed axis. Being focal it tends not to be initiated or entrained from pacing in the atrium or ventricles. In mapping this unusual VT the earliest site of activation should be targeted. Another possibility is that of mitral annular VT which may have a RBBB morphology with a superior axis.

Given the relatively narrow QRS and the fact that initiation may occur with atrial pacing, fascicular VT may also be confused with SVT. This is most easily differentiated by the presence of AV dissociation.

Outflow Tract VT

The most common locations for premature ventricular complex's (PVC's) are within the right and left ventricular outflow tracts. Isolated PVC's in the setting of normal left ventricular function are generally of minimal significance. Indications for ablation include PVC induced left ventricular dysfunction or significant symptoms where pharmacological therapy is ineffective or not tolerated. Non-sustained and sustained focal VT may also originate from the outflow tracts and like PVC's is more commonly found on the right ventricular outflow tract (RVOT) compared with the left ventricular outflow tract (LVOT). Although RVOT extrasystoles are more common in females there is an approximate equal gender distribution in LVOT extrasystoles.

Outflow tract tachycardia generally occur more commonly at rest than with exercise and are often suppressed with an increase in the sinus rate. A proportion of cases are exercise induced occurring either at peak exercise or during the recovery phase.

Anatomy and ECG Features

The RVOT runs from the superior aspect of the tricuspid annulus at the inferior aspect to the pulmonary valve at the superior end. The LVOT includes the coronary cusps superior to the aortic valve and extends inferiorly to the aortomitral continuity and the superior aspect of the mitral annulus. The majority of foci in both outflow tracts tend to be relatively close to the annulus of either valve which may result in anisotropy and arrhythmogenesis.

Given that both the right and left ventricular outflow tracts are superior structures the ventricular activation tends to be from superior to inferior resulting in a positive QRS axis in leads II, III and aVF and negative in aVR and aVL.

The differentiation between tachycardia's originating from the right versus the left ventricular outflow tracts based on the ECG can occasionally be more complex. The majority of outflow tract tachycardia's originate from the superior and anterior septal RVOT making it difficult at times to know if these are originating from the left or the right side. In approximately 15 % of cases the origin is the LVOT. Occasionally the origin may be the right ventricular infundibulum, superior to the pulmonary valve, the aortomitral continuity or with close to the anterior interventricular vein.

As shown on the CT image in Fig. 9.11 the right ventricular outflow tract is anterior to the left ventricular outflow tract and as it becomes more superior moves to the left of the LVOT so that the pulmonary valve is actually left of the aortic valve. As a result of this basic fact, ventricular activation from the RVOT generally spreads from anterior to posterior. This results in a negative QRS in V1 with a LBBB type pattern on the ECG. If the precordial transition occurs at lead V4 or later then the origin is almost certainly RVOT.

The difficulty arises when the precordial transition occurs at or close to V3 and where there may be a predominantly negative QRS in the early precordial leads with an R wave. A small R wave may be present in posterior and superior RVOT foci as

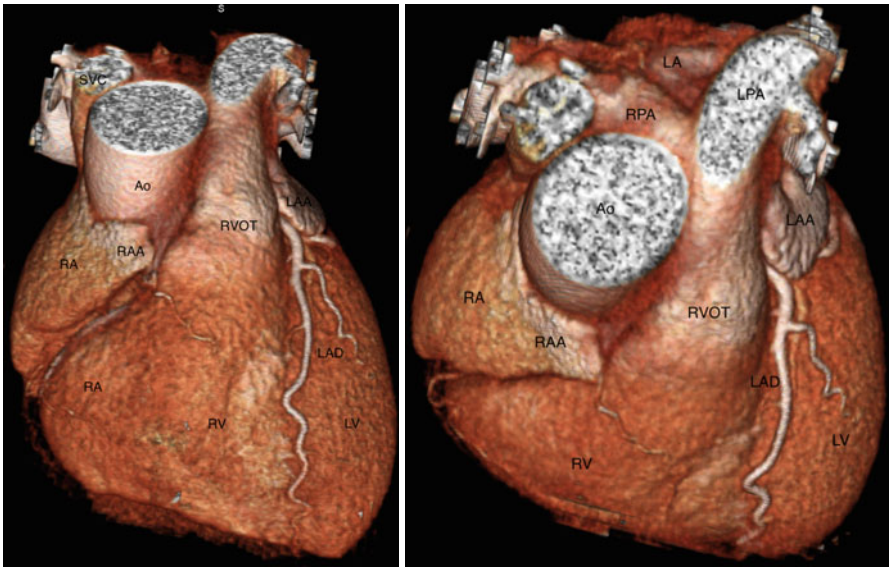

Fig. 9.11 CT Image showing the Relationship of the RVOT and LVOT. The figure on the *top* shows an anterior view in which the RVOT is anterior and to the left of the LVOT. The image at the *bottom* shows a superior view (*Ao* aorta, *RA* right atrium, *RAA* right atrial appendage, *RV* right ventricle, *LAA* left atrial appendage, *SVC* superior vena cava, *LV* left ventricle, *LAD* left anterior descending artery, *LPA* left pulmonary artery, *RPA* right pulmonary artery)

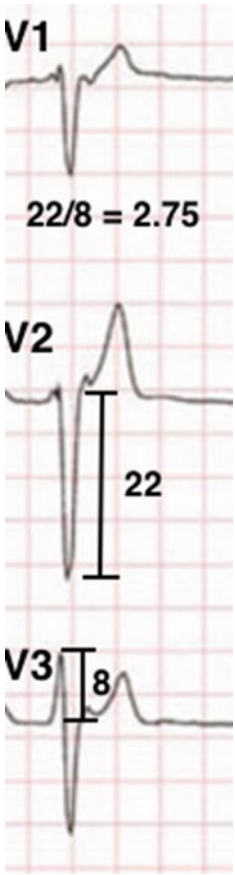

Fig. 9.12 Measurement and calculation of the V2S/V3R ratio for an outflow tract PVC. The S wave in lead V2 is 22, while the R wave is 8 resulting in a V2S/V3R of 2.75 which is indicative of an RVOT origin

well as the anterior LVOT where it tends to be slightly higher in amplitude. In order to help estimate the location several algorithms have been developed.

The V2S/V3R Index is useful in helping to differentiate between a RVOT and LVOT origin in outflow tract PVC's with a LBBB type morphology [10]. As shown in Fig. 9.12 using this simple calculation the amplitude of the S wave in lead V2 is divided by the amplitude of the R wave in lead V3. A value of less than or equal to 1.5 has been shown to be suggestive of a LVOT origin while a value greater than 1.5 represents a likely RVOT origin.

Having ascertained whether the origin is located in either the RVOT or LVOT further ECG analysis can be performed to help estimate the specific location within the specific outflow tract.

As demonstrated in Fig. 9.13 a lateral lead such as Lead I may be useful in further ascertaining the origin of an outflow tract tachycardia. In an RVOT tachycardia a negative QRS in lead I is more indicative of a more superior origin close to or above the pulmonary valve. A positive QRS in lead I indicates a more rightward inferior structure such as the RVOT freewall. Septal and anterior origins often are biphasic in lead I.

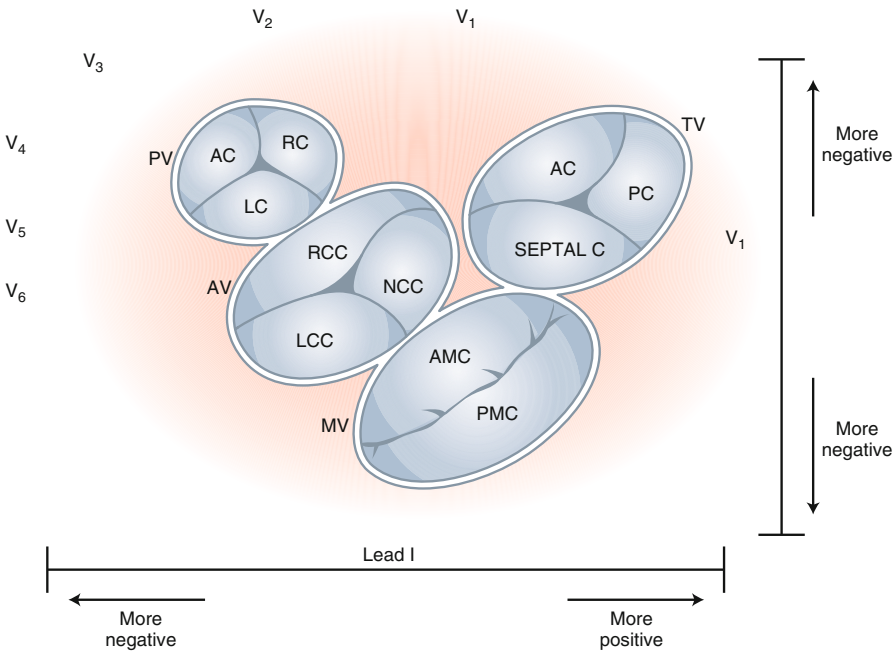

Fig. 9.13 Showing the anatomic relationship of the precordial lead V1 and lead I to the outflow tracts (*PV* pulmonary valve, *AC* anterior cusp, *RC* right cusp, *LC* left cusp, *AV* aortic valve, *RCC* right coronary cusp, *LCC* left coronary cusp, *NCC* non coronary cusp, *MV* mitral valve, *AMC* anterior mitral cusp, *PMC* posterior mitral cusp, *TV* tricuspid valve, *AC* anterior cusp, *PC* posterior cusp, *Septal C* septal cusp)

One further important point to examine on the ECG in more detail is leads aVR and aVL. These are almost always negative for all outflow tract tachycardias. However if aVL is isoelectric or positive the inferior portion of the RVOT close to the Bundle of His and right bundle should be considered.

Outflow Tract Tachycardia: EP Study and Ablation

Indications

The two main indications for the ablation of outflow tract tachycardias are either symptoms which cannot be effectively treated with pharmacological agents or frequent arrhythmias resulting in left ventricular dysfunction. For minimal symptoms often no treatment is required. Pharmacological therapy is often of moderate efficacy if symptoms persist and includes beta blockers, flecainide and calcium channel blockers. Acute termination can be performed with the administration of intravenous adenosine which acts by blocking the beta adrenergic activation of intracellular calcium [11].

Risks

The most common risks of ablation of the outflow tracts are vascular complications in the groin. This is more likely for arrhythmias on the left side which generally require arterial access. For left sided ablations heparin should be administered during the procedure in order to minimize the small risk of thrombo-embolism. Coronary artery damage in the mapping and ablation of aortic cusp tachycardias is a potential risk and therefore it is generally recommended that the coronary arteries are visualized prior to delivering ablation by performing a coronary angiogram. This should also be performed prior to ablation in the cardiac veins which generally run beside the coronary arteries.

On the right side the risks depend on the location of ablation. If the focus is inferior and septal then damage to the His is a possibility. For ablations in the more superior posterior RVOT it must be remembered that the left main coronary artery is often only 5 mm from the site of the ablation catheter [12].

Tamponade is a possibility in either outflow tract however the RVOT is relatively thin in many regions and care must be taken not to use excess power or force.

Procedure

Initiation and Catheter Positioning

In general, if possible all anti arrhythmic drugs should be discontinued for at least 5 half lives prior to the procedure. A single catheter can be used to map and ablate or else a reference catheter can be positioned in either the RV apex or the outflow tract which may help in mapping the level of the focus. For RVOT tachycardia's this is advanced into the right ventricle and then clockwise rotated in order to access the outflow tract. A curl in the tip of the catheter often makes advancement less traumatic with a lower chance of right ventricular outflow tract perforation.

In order to access the LVOT the catheter is generally advanced via the femoral artery with a curve placed on the catheter as it is advanced around the aortic arch. Occasionally trans-septal access can be performed if additional stability is required. The epicardium can often be mapped in this location from the coronary veins.

It is important to try to induce the arrhythmia at the start of the procedure in order to examine the activation sequence of the arrhythmia and map for the earliest and most interesting sites. Activation mapping of outflow tract tachycardias has been shown to result in higher success compared with pace mapping. In general intravenous sedation should be minimized. If there is difficulty with spontaneous initiation of the arrhythmia rapid atrial pacing can be performed provided AV conduction is intact, otherwise ventricular pacing can be carried out. By increasing the ventricular rate this may initiate some outflow tract arrhythmias. If this is unsuccessful isoprenaline or epinephrine can be infused.

Mapping

Activation mapping is superior to pace mapping. It is important to use both the bipolar electrogram looking for early signals relative to the onset of the QRS complex and a unipolar signal which should show only a QS wave with no R wave during ectopy. The earlier the signal the better and success is generally noted when the onset of the local electrogram is at least 10 ms ahead of the onset of the QRS. It is unusual for this to be much earlier than 60 ms ahead of the surface QRS. Following the determination of an early site it is useful to pacemap using the minimal output in order to compare with the morphology of the intrinsic beat. A good pacemap is an additional useful parameter prior to delivery of ablation.

Ablation

Following the mapping of an early region of activation and a good pacemap ablation can be performed in either of the outflow tracts. In general a 4 mm tip catheter is used. For the RVOT if a non irrigated catheter is used then the power is generally set at 40 W with a target temperature of 55 C for a period of 60 s. If an irrigated catheter is used power can be set at 30 W in the RVOT up to a maximum of 35 W.

In the LVOT ablation is typical performed using an irrigated catheter with a power of 25–30 W. Care must be taken in the left and right coronary cusps to ensure that ablation is performed at least 8 mm from the coronary ostia. Of note when mapping the coronary cusps it may be difficult to pacemap and high outputs may be required making this relatively unreliable. Activation mapping in this region is more reliable. During ectopy from this region the electrogram is often biphasic and the earliest component of the first signal should be recorded as the earliest activation. If ablation is performed in the cardiac venous system then power is generally limited to 20–25 W using an irrigated catheter. The issues in these regions may include the possibility of coronary artery damage and a minimum distance of 1 cm should be kept from the coronary artery to the ablation catheter as well as the possibility of impedance rises due to poor flow.

During the delivery of RF in a successful region there is often an episode of non sustained VT or frequent unifocal ventricular ectopy in the first 10–15 s followed by normal rhythm for the remainder of the ablation. The presence of ST segment elevation in the unipolar electrogram is generally a good sign of local tissue injury.

Endpoints and Success

In general it is reasonable to monitor the patient for 30 min following ablation. If there is a recurrence of ectopy with the same morphology then further mapping and ablation should be performed. It is possible that the exit site of an ectopic foci may be shifted by ablation and therefore all the leads on the ECG should be examined in order to ensure this. If pharmacological agents were required fro initiation of the ectopy at baseline then these should be administered following ablation.

The overall acute success for catheter ablation for outflow tract tachycardia is approximately 90 %. Following the procedure ectopy may recur even after 1 year. The two predictors of recurrence are less early local signals targeted for ablation as well as pace mapping being used as the mapping strategy [13].

The Difficult Case

Lack of Spontaneous Ectopy

One of the most common arises from the inability to induce the tachycardia at the start of the case. All anti-arrhythmic agents and beta blockers should be ideally stopped for 5 half lives prior to the procedure. Intravenous sedation should be minimized and if there is no spontaneous ectopy rapid atrial or ventricular pacing can be performed or isoprenaline or epinephrine can be infused at the start of the case. These agents should ideally be stopped during ablation in the RVOT as they may result in hypercontractility of this region which may in theory increase the risk of perforation. If there are very infrequent episodes of ectopy then careful pacemapping can be performed using the minimum output to result in local capture with time spent ensuring that the morphology matches the spontaneous beat very closely.

Lack of Early Sites

If there are no focal regions of early activation but rather a general area either on time with or slightly ahead of the onset of the QRS then the other outflow tract should be mapped. If there are still no particularly early sites then it is useful to map the cardiac venous system.

Continuation of the Arrhythmia Despite Ablation

There are several potential reasons for this. The most likely is that the exact focus has not be accurately mapped and ablated. It is also possible that contact with the catheter is poor and it is useful to flex the catheter in order to alter the angle on the endocardial surface. If the focus is slightly deeper it is possible that the endocardial exit site has shifted with a subtle change in the QRS morphology on the 12 lead ECG. It is also possible that an entirely different PVC is present and a decision must be made as to whether this is significant enough to required further mapping and ablation in another region.

Inability to Deliver Ablation in the Cardiac Venous System

This is not uncommon. The most likely reason for not being able to deliver RF in the cardiac venous system is the proximity to the coronary arteries. It is sometimes possible to perform the ablation in a site which is slightly further from the earliest activation and still achieve success.

Another potential problem with ablation in the cardiac venous system is a significant rise in impedance due to low flow with an inability to deliver sufficient power. This can be overcome by moving the catheter to a slightly different location or different angle as well as increasing the rate of infusion of the irrigation through the ablation catheter.

Mitral Annular VT

This is a less common location for ectopy when compared with the outflow tracts. The ECG typically shows a RBBB pattern with very early precordial transition with in V1 or between V1 and V2 an a positive concordance in the precordial leads due to the relative posterior locations of the mitral annulus relative to the ECG lead positions. For anterolateral origins leads II, III and aVF tend to be positive and leads I and aVL tend to be negative. For posterior or posteroseptal foci leads II, III and aVF tend to be negative and positive in leads I and aVL. More septal origins tend to be narrower than LV free wall locations. Mapping and ablation of a mitral annular PVC is shown in Fig. 9.14.

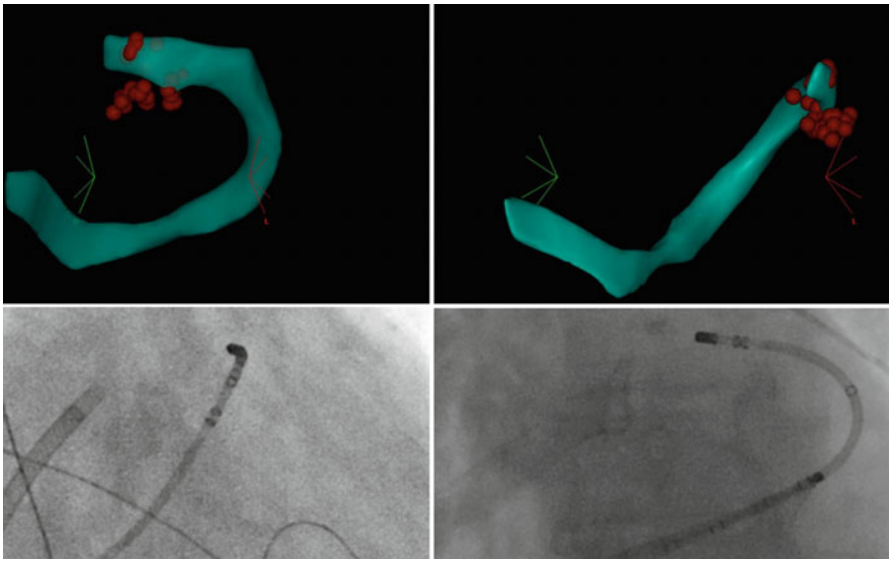

Fig. 9.14 Ablation of a mitral annular PVC resulting in LV dysfunction. This was mapped to the anterior mitral annulus however ablation in this region did not result in termination of ectopy. The ablation catheter was then positioned in the anterior cardiac vein where ablation was successful in terminating ectopy. The successful site of epicardial ablation is shown in the electroanatomic maps on the top of the image (LAO on the *left* and RAO on the *right*) and fluoroscopically (LAO on the *left* and RAO on the *right*). Pace mapping was also used to help confirm the location prior to ablation. These images are shown at the bottom of the figure in which the epicardial map was much closer in morphology to the intrinsic beat when compared with a similar endocardial location

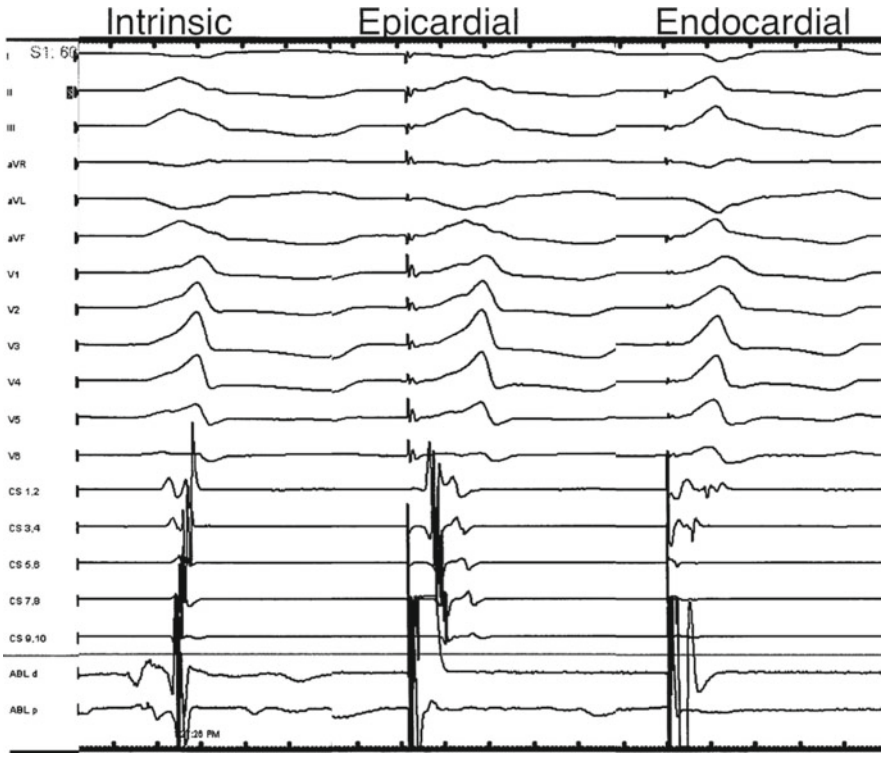

Fig. 9.14 (continued)

Important Points

1. Ventricular tachycardia is defined as an arrhythmia which originates from the ventricles consisting of at least three of more consecutive beats at a rate of greater than 100/min and independent of AV or atrial conduction.
2. The majority of scar related VT is composed of an area of slow conduction with functional unidirectional conduction block as well as a structural barrier which is generally scar.
3. The isthmus is characterized by electrical activity during diastole and is generally the focus for ablation.
4. Scar is defined as a bipolar voltage less than 1.5 mV and dense scar is a voltage less than 0.5 mV.
5. The classical features of LAVA during sinus rhythm are:

   High frequency often double or more potentials separated by either a low amplitude baseline
   Separate from and often but not always after ventricular far-field
   May require pacing at the site in order to distinguish LAVA from ventricular farfield.

6. VT with a RBBB morphology may have an epicardial component if the following features are present:

   The onset of the QRS to a pseudo-delta wave of greater than 34 msec. A pseudo-delta wave is defined as an early rapid deflection on the upstroke of the QRS complex.
   An intrinsicoid deflection time of greater than 85 msec. The intrinsicoid deflection time is the time from the onset of the QRS to the peak of the R wave measured in V2.
   The RS complex duration defined as the earliest ventricular activation to the nadir of the first S wave in any precordial lead of greater than or equal to 121 msec.
   The presence of a Q wave or a QS in the local site of activation provides a more useful indicator. Therefore an inferior origin tends to have a Q or QS in leads II, III and aVF.

7. For VT originating from the epicardial surface of the RV these parameters do not appear to be helpful.
8. Bundle branch re-entry may occur in cases where conduction is slowed or transiently blocked in either the antegrade or retrograde directions re-entry may resulting in a LBBB morphology or less commonly a RBBB morphology.
9. Fascicular re-entry may occur with antegrade or retrograde conduction in the anterior fascicle of the left bundle an conduction in the opposite direction in the posterior fascicle. Either of these activation sequences results in a right bundle branch block type morphology during VT with a superior directed axis.
10. Outflow Tract ectopy is common and may occur in either the RVOT or less commonly the LVOT. Given that both the right and left ventricular outflow tracts are superior structures the ventricular activation tends to be from superior to inferior resulting in a positive QRS axis in leads II, III and aVF and negative in aVR and aVL.
11. Ventricular activation from the RVOT generally spreads from anterior to posterior. This results in a negative QRS in V1 with a LBBB type pattern on the ECG. If the precordial transition occurs at lead V4 or later then the origin is almost certainly RVOT.
12. If the precordial transition occurs at or close to V3 and where there may be a predominantly negative QRS in the early precordial leads with an R wave. A small R wave may be present in posterior and superior RVOT foci as well as the anterior LVOT where it tends to be slightly higher in amplitude. In order to help estimate the location several algorithms have been developed.
13. The V2S/V3R Index is useful in helping to differentiate between a RVOT and LVOT origin in outflow tract PVC's with a LBBB type morphology. A value of less than or equal to 1.5 has been shown to be suggestive of a LVOT origin while a value greater than 1.5 represents a likely RVOT origin.

14. Lead I may be useful in further ascertaining the origin of an outflow tract tachycardia. In an RVOT tachycardia a negative QRS in lead I is more indicative of a more superior origin close to or above the pulmonary valve. A positive QRS in lead I indicates a more rightward inferior structure such as the RVOT freewall. Septal and anterior origins often are biphasic in lead I.
15. If aVL is isoelectric or positive the inferior portion of the RVOT close to the Bundle of His and right bundle should be considered.
16. The mitral annulus This is a less common location for ectopy when compared with the outflow tracts. The ECG typically shows a RBBB pattern with very early precordial transition with in V1 or between V1 and V2 an a positive concordance in the precordial leads due to the relative posterior locations of the mitral annulus relative to the ECG lead positions. For anterolateral origins leads II, III and aVF tend to be positive and leads I and aVL tend to be negative. For posterior or posteroseptal foci leads II, III and aVF tend to be negative and positive in leads I and aVL. More septal origins tend to be narrower than LV free wall locations.

Mitral annular PVC's can be ablated with a success as high as that of outflow tract tachycardia [14]. Mapping can be performed using either a transseptal or retrograde approach. It is also worth mapping within the coronary sinus as the focus may be epicardial.

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Chapter 10
Anti-arrhythmic Drugs

Benedict M. Glover and Paul Dorian

Abstract Anti-arrhythmic drugs (AAD's) alter the electrical properties of the heart principally by either prolonging the cardiac action potential, decreasing conduction velocity, reducing focal automaticity or a combination of these effects. Despite the fact that a large number of AAD's were initially developed for ventricular arrhythmias the most common current indication is actually AF.

Although the majority of these drugs act relatively specifically on certain receptors the overall general distribution of these receptors throughout the ventricular and atrial myocardium may result in unwanted effects such as Torsades de Pointes (TdP) predominantly with class IA and class III drugs, prolongation of AV conduction, QRS widening and monomorphic VT with class IC drugs.

A meta-analysis of 44 trials involving 11,322 patients showed that all AAD's were associated with an increased risk of proarrhythmia with the exception of amiodarone and propafenone (Lafuente-Lafuente et al. Arch Intern Med 166:719–28, 2006). Although amiodarone is a very useful agent in the treatment of both atrial and ventricular arrhythmias its use is often limited as a result of its potential long term non-cardiac side effects which limit its use (Rothenberg et al. Heart Dis Stroke 3:19–23, 1994).

More recently, "atrial selective" AAD's have been developed which may have improved efficacy with better side effect profile. Additionally some drugs (such as renin-angiotensin aldosterone inhibitors and anti-inflammatory agents) may affect the underlying substrate and be indirectly antiarrhythmic.

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Table 10.1 Classification of current anti-arrhythmic drugs as well as inotropic effects on the ventricle and potential pro-arrhythmic effects

Class	Examples	Mechanism	Inotropic effect	Pro-arrhythmia
Ia	Procainamide Quinidine	Inhibition of intermediate Na^+ channel	Negative	QRS widening and VT
Ib	Lidocaine Mexilitine	Inhibition of fast Na^+ channel	Negative	VT
Ic	Flecainide, propafenone	Inhibition of slow Na^+ channel	Negative	1:1 AV conduction
II	B blockers	B Adrenoceptor blockade	Negative	Bradycardia
III	Amiodarone Sotalol	K^+ channel blockade	Neutral	Sotaolol: bradycardia, ↑QT, torsades
IV	Ca channel blockers	Ca^{2+} channel blockade	Negative	Bradycardia

Mechanisms of Action: An Overview

Although the majority of AAD's have multiple effects on either the AP directly or by autonomic modulation, their actions can generally be classified into groups according to the predominant mechanism or resulting electrophysiological effect. This classification is called the Vaughan Williams system which was subsequently modified by Singh and Harrison (Table 10.1). It should be remembered that most AAD's have properties belonging to more than one group.

Drugs with Class I action act by blocking the fast sodium channels that are responsible for phase 0 of the AP thus affecting its slope and amplitude. These drugs are subdivided according to the rate of binding and dissociation from the sodium channel. Class IB mechanism of action is associated with the most rapid onset of action and dissociation, IA has intermediate activities and IC the slowest (Fig. 10.1).

These differences result in clinically relevant differences as a function of heart rate- drugs with slowest rates of binding and unbinding have "rate dependent properties" and the effect increases at high heart rates, not seen with the class 1b mechanism of action. As well as their effects on the slope of rapid depolarization, class I agents also have different effects on the repolarization (and APD) and thus refractory periods. Class IA property is generally associated with an increase, Class IB with a shortening (invitro) and Class IC have no effect on the APD.

Class II mechanism of action is the property of blocking beta adrenergic receptors. The primary consequence is to antagonize the effect of circulating, neurally or locally released catecholamines, with effects on all cardiac tissues and to prolong the phase 2 and 3 (after chronic use) of the AP and thus lengthen the effective refractory period.

Class III agents such as sotalol and amiodarone prolong the APD principally by inhibition of the potassium channels.

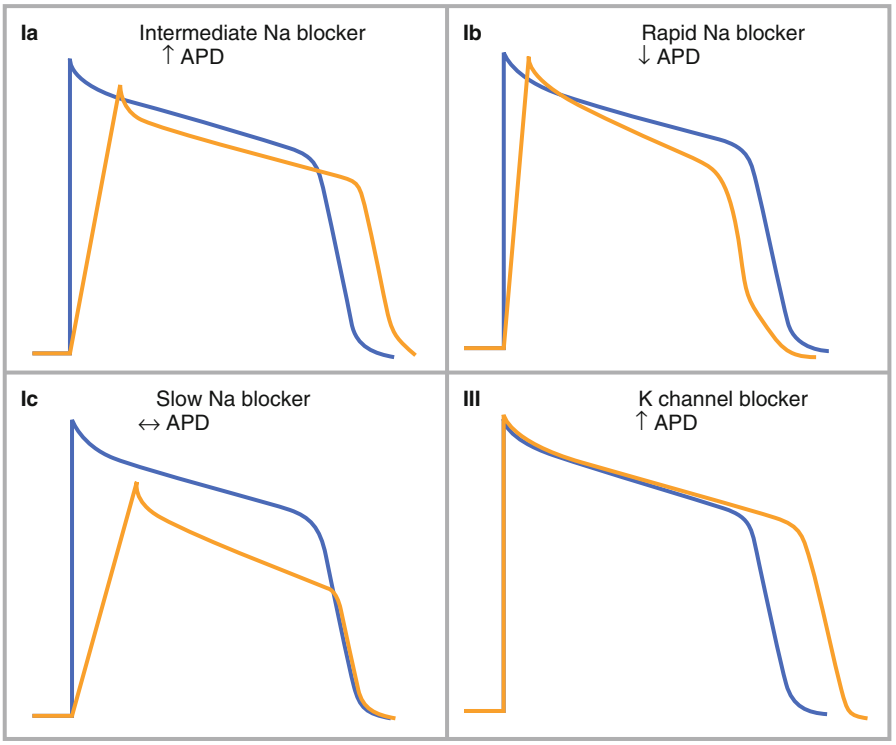

Fig. 10.1 Schematic of the effects of Class Ia, Ib, Ic and Class III AAD's on the cardiac AP

Class IV action inhibits the slow calcium current and therefore depress phase II and III of the AP in certain tissues primarily the SN and AV nodes.

Class IA Antiarrhythmics

Procainamide is conjugated to the active metabolite N-acetylprocainamide at a rate determined by whether the patient is a rapid acetylator [3, 4]. Although it was previously used for the treatment of atrial and ventricular arrhythmias its use is now largely reserved for the treatment of VT. It is also used for the acute management of haemodynamically stable pre-excited AF in the WPW syndrome (Class IIb indication) [5]. Proarrhythmia occurs in up to 9 % of cases [6] and like all class IA drugs its use has been severely restricted due to the associated risk of TdP particularly in patient with bradycardia and left ventricular hypertrophy (LVH) [7]. In general terms the risk of TdP for all class IA and some class III AAD's include a long baseline QT interval, a family history of Td, female gender, bradycardia, renal impairment (for renally excreted drugs) and a low potassium or magnesium [8].

Procainamide can also increase the ventricular rate in patients with uncontrolled AF or flutter (Class IA effect). This occurs as a result of slowing the fibrillation or flutter rate as well as increasing the likelihood that a given impulse will pass through the AV node due to the direct vagolytic action of procainamide. Thus, conduction through the AV node must be slowed and the ventricular response controlled before therapy with procainamide is initiated in these disorders. Nearly all patients will develop a positive antinuclear antibody, with a lupus-like syndrome in approximately one-third of patients taking the drug for more than one year [9]. Severe neutropaenia has been reported with long term use of oral procainamide [10]. There is limited evidence to suggest that procainamide is comparable to or superior to lidocaine in terminating monomorphic VT [11]. It is also commonly used for pharmacological testing in Brugada risk stratification.

Quinidine has similar properties and side effects to procainamide but owing to its additional effect on the the transient outward current there has been a some limited interest in this drug in patients with Brugada syndrome. Although there is some evidence to support a degree of efficacy in maintaining sinus rhythm following an electrical cardioversion for AF [12] it carries significant pro-arrhythmic side effects with an increased associated mortality [13]. The incidence of TdP reported with quinidine use varies from 0.5 to 8 % [14] and like all class IA drugs the QT prolongation tends to occur early and therefore it is recommended that it should be initiated in the hospital under continuous ECG monitoring [15]. Modest QT prolongation is relatively common while excessive prolongation is unusual and generally indicates toxicity. Like all AAD's in this group it is contraindicated in the presence of structural heart disease and LVH and is not a first-line agent for the long-term management of any atrial arrhythmia. One of the more common reasons for discontinuation of the drug is gastrointestinal side effects such as nausea, reduced appetite, an abnormal bitter taste and abdominal discomfort are relatively common occurring in approximately one third of patients.

Although the use of quinidine in cases of asymptomatic Brugada syndrome [16, 17] seems counterintuitive given that other sodium channel blockers are used for provocation; it is thought that the potential beneficial effect may be due to blockade of the transient outward current Ito thus preventing phase II reentry and VF [18]. Discontinuation of quinidine therapy due to predominantly gastrointestinal side effects may occur in approximately one third of patients. A registry of patients with asymptomatic Brugada is currently looking at the effects of quinidine in this population. Overall quinidine is generally not readily available throughout the world except in exceptional circumstances.

Disopyramide has marked anticholinergic effects and thus in theory may prove useful in vagally mediated AF [5]. The evidence for disopyramide in AF however is very weak involving a small study involving 90 patients following a successful electrical cardioversion from AF to sinus rhythm [19]. Following 1 month 70 % of patients receiving disopyramide were in sinus rhythm versus 39 % in the placebo group. It is considered a second or third line agent for suppression of atrial and ventricular arrhythmias and conversion of AF to normal sinus rhythm. Due to its negative inotropic effect it has been used in the treatment of hypertrophic cardiomyopathy

in order to reduce the outflow tract gradient and improve symptoms [20]. Other than the proarrhythmic and negative inotropic effects characteristic to this group the other main adverse effects are related to its anticholinergic effects, including urinary retention, blurred vision, constipation and dry mouth. This drug is therefore rarely used clinically.

Class IB Antiarrhythmics

The two main drugs in IB are lidocaine and mexiletine both of which act predominantly on the ventricular myocardium.

Lidocaine is a short acting intravenous antiarrhythmic which has been used extensively for the management and prophylaxis of ventricular arrhythmias. The initial clinical data for the use of lidocaine was in its ability to suppress PVC's and prevent VF after an acute myocardial infarction [21]. However this practice stopped after data showed an associated increased mortality most likely related to bradyarrhythmias and hypotension [22]. Although one trial has shown an increased prehospital survival with lidocaine [23] other randomised trial comparing lidocaine with amiodarone have shown amiodarone to be superior in terms of return of spontaneous circulation [24] as well as a lower rate of asystole [25]. As a result of this the ALS (UK) guidelines recommend the use of lidocaine only as an alternative if amiodarone is not available.

Mexiletine is structurally similar to lidocaine but has a much higher oral bioavailability and thus is available in an oral preparation. Its main activity occurs in the His Purkinje and ventricular myocardium with minimal effects on the sinus node, atrium and AV node [26, 27]. The most frequent side effects are related to GI disturbances and CNS toxicity. Cardiovascular side effects include hypotension, sinus bradycardia, and worsening of ventricular arrhythmias in 10–15 % of cases [27]. Use of mexiletine has been reported to be associated with an increased mortality [28] but may be used in patients who cannot tolerate amiodarone.

Class IC Action AAD's

The class IC drugs flecainide and propafenone have the slowest onset of action in sodium inhibition and have no effect on action potential duration.

Both flecainide and propafenone have been shown to be relatively similar in terms of efficacy in the management of symptomatic paroxysmal AF in two randomized control trials [29, 30]. Additionally in cases of recent onset AF flecainide has been shown to be effective in termination of the arrhythmia in 90 % of cases [31]. Oral flecainide has been shown to be as effective as the intravenous preparation for acute chemical cardioversion although obviously with a slower onset of action [32].

This fact combined with the large degree of use dependence has lead to the regimen called 'pill in the pocket' in which patients with symptomatic paroxysmal AF self administer a single oral dose of flecainide (generally with a beta blocker) for chemical cardioversion. Although this has been shown to be effective in 94 % of cases with no significant adverse effects, patients in this group were very carefully selected and this strategy is not ideal for many patients with paroxysmal AF [33]. In general if this strategy is to be used patients are usually tested with the identical regimen in hospital to assess for side effects and potential arrhythmias. Despite this 5 % of patients still experience problems such as presyncope, syncope and sinus arrest [34].

Despite the efficacy of class IC drugs their use has been largely limited by safety concerns. They may occasionally convert AF to atrial flutter with 1:1 AV conduction and thus a paradoxical increase in ventricular response rate. This tachycardia occasionally looks like VT particularly when there is QRS widening (also due to the drug) and since they have minimal effects on AV conduction it is recommended that they be used in the presence of an AV nodal blocker such as a beta blocker. However the major concerns regarding these drugs arose from a series of trials showing an increase in cardiovascular mortality in patients with ventricular arrhythmias in the setting of coronary artery disease and other structural heart disease The Cardiac Arrhythmia Suppression Trial (CAST) compared flecainide, encainide, moricine and placebo for the suppression of PVC's in post MI patients [35]. The trial which enrolled 1498 patients was prematurely terminated after showing an increased mortality in patients receiving flecainide and encainide (subsequently withdrawn) primarily due to arrhythmias.

Although propafenone may have a relatively better side effect profile given its additional beta adrenergic blocking effects the Cardiac Arrest Survival in Hamburg (CASH) study, in which 349 survivors of cardiac arrest due to documented VT were randomised to either an ICD, amiodarone, propafenone or metoprolol, showed a significant increase in mortality in patients receiving propafenone [36].

For these reasons, these drugs are contraindicated in the setting of prior myocardial infarction or a history of VT, and relatively contraindicated in the setting of structural heart disease.

Class II Antiarrhythmics

These drugs act by inhibiting sympathetic activity, primarily through beta-adrenergic blockade. This class is subdivided based on the specific adrenergic blockade profile, and associated properties. Propranolol is a first-generation non-selective beta-blocker with equal affinity for the β1 and β2 receptors. At high doses, propranolol may also block sodium channels. Propranolol, although useful in reducing ventricular rate in AF has not been shown to be useful as an atrial anti-arrhythmic' [37].

Metoprolol and bisoprolol are second-generation beta-blockers, which preferentially inhibit β2 receptors and may have more useful atrial antiarrhythmic effects

than propranolol. Bisoprolol has been shown to be similar to sotalol in maintenance of sinus rhythm at 12 months following an electrical cardioversion [38]. Metoprolol, has also been shown to be superior to placebo in maintenance of sinus rhythm as well as a slower ventricular rate during a recurrence [39].

Beta adrenergic blockers have been shown to reduce mortality, likely largely to a reduction in arrhythmic death in most cases, in patients with long QT syndrome [40], survivors of cardiac arrest [41], post myocardial infarction [42] and in patients with impaired LV systolic function [43].

Class III

Class III action AAD's block the potassium channels, thereby prolonging repolarization, the APD, and the refractory period. These changes are manifested on the surface ECG by prolongation of the QT interval. This group includes sotalol, amiodarone, dofetilide, vernakalant and ibutilide.

Sotalol consists of 2 isomers called D and L each of which contribute to the anti-arrhythmic properties. The D isomer blocks the rapid component of the delayed rectifier potassium current (IKr channel) during phase 3 of the AP and thus prolongs the AP duration. The L isomer also prolongs the cardiac AP as well as having a degree of Beta Adrenergic blocking activity. Although a preparation of the D isomer has been developed it has been shown to be associated with an increase in the risk of mortality in patients with impaired LV function and a recent MI or heart failure with a history of prior MI [44]. Therefore that the beta adrenergic blocking effects may also confer an advantage.

Sotalol has been shown to be effective in maintaining sinus rhythm and reducing the incidence of episodes of AF, although not as effectively as amiodarone. The CTAF study randomised patients with a history of AF to sotalol, amiodarone or propafenone [45]. After a mean follow-up of 16 months similar percentages of patients receiving sotalol and propafenone had a recurrence of AF while significantly fewer receiving amiodarone had an AF recurrence.

In clinical practice sotalol is generally used for the control of paroxysmal AF as second or third line agent after flec/propafenone and amiodarone. It has also been shown to reduce the recurrence of sustained ventricular arrhythmias [46, 47] but less than amio (OPTIC study) and can also be considered after amiodarone in terms of reducing ICD discharges.

The most significant risk associated with sotalol is the risk of TdP particularly at slower heart rates. The actual risk of TdP has been reported as approximately 2.5 % at a median follow up of 164 days [48]. This risk is increased in females, patients with a history of heart failure, patients with renal impairment and at high doses of sotalol (greater than 320 mg per day) [48].

Amiodarone was first used as an anti-anginal drug in the 1960s, and its anti-arrhythmic properties were first reported in 1970. The predominant mode of action is class III by blocking the IKr and IKs channels. This results in a reduction in

dispersion of refractoriness, re-entry and proarrhythmia and overall a prolongation of myocardial repolarization homogeneously. Additionally it also blocks sodium channels (Class I effects) and thus reduces conduction velocity, has non selective beta adrenergic blocking effects (Class II) and inhibits the L type calcium channel (Class IV). It causes use dependent potassium channel blockade meaning that as the heart rate increases the refractory period increases incrementally [49].

The onset and mode of action depends on the type of administration. If given intravenously the onset of action is several hours and there is minimal AP prolongation except in the AV node. The oral preparation takes several days and the overall effects are more pronounced after chronic usage.

Amiodarone has been shown to be the most efficacious AAD in the treatment of both AF and VT. The Canadian Trial of AF in which patients with at least one episode of AF were randomized to various antiarrhythmic medications showed that 35 % of patients randomized to amiodarone had a recurrence of AF versus 63 % of patients randomized to either sotalol or propafenone [44]. There was no significant difference in the maintenance of sinus rhythm between those who received either sotalol or propafenone. Given its multichannel effects and minimal negative inotropic effects it is considered relatively safe in patients with impaired LV function and is recommended as first line therapy for the treatment of ventricular arrhythmias unless there is a contraindication [22]. Although amiodarone prolongs the QT interval the risk of torsades de pointes VT is less than 1 % [50].

The most common and significant side effects which limit the longterm use of amiodarone are generally non cardiac and adverse effects have been reported to be as high as 15 % within the first year of treatment and 50 % during long term therapy [50]. It is therefore important that the patient is monitored for side effects as shown in Fig. 10.2.

Amiodarone induced hypothyroidism is more common than thyrotoxicosis. Within the first 3 months of therapy there is an increase in thyroid stimulating hormone (TSH), free T4 and a reduction in free T3. TSH then normalises while T4 and T3 may remain abnormal. The importance of this is that it is generally not useful to check thyroid function within the first 3 months and following this the most useful measure is TSH [50]. Amiodarone induced thyrotoxicosis is less predictable and can occur relatively suddenly at any time during treatment. It can be due either to aggravation of pre-existing thyroid disease or thyroiditis, although often it is difficult to distinguish between these. It is generally recommended that all patients being commenced on long term amiodarone therapy should have baseline TFT's which should be rechecked after 3 months to establish a new baseline and then every 6 months or sooner if clinically indicated [50].

Lung toxicity has been reported as occurring in up to 2 % of patients [50]. Risk factors for pulmonary fibrosis are a prior history of lung disease and a daily dose of amiodarone greater than 400 mg per day [51]. It may present anytime from 1 week following initiation of the drug and is relatively unpredictable and therefore although pulmonary function tests are frequently performed they of limited value.

These and other non cardiac side effects of amiodarone have subsequently lead to the development of the noniodinated benzofuran derivative dronedarone.

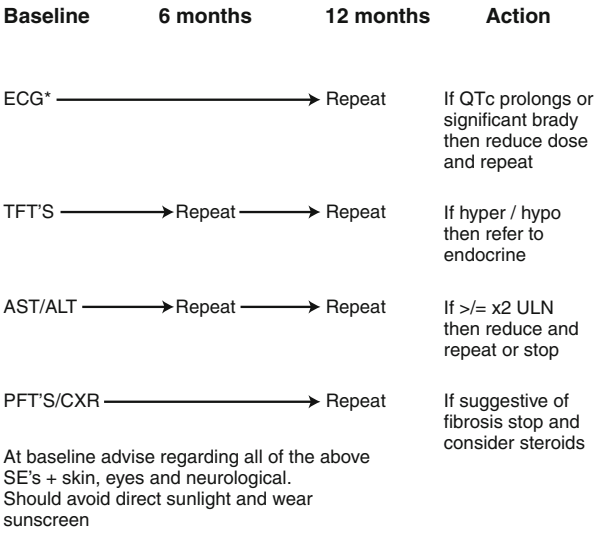

Fig. 10.2 Suggested monitoring for the side effects of long term amiodarone (* Evidence of QTc prolongation, sinus node or AV node conduction abnormalities should prompt close monitoring)

The dose of dronedarone was established in the Dronedarone Atrial Fibrillation Study after Electrical Cardioversion (DAFNE) [52]. Three different doses (800, 1200, or 1600 mg) of dronedarone daily were compared with placebo in patients following a successful electrical cardioversion. 800 mg per day delayed the time to recurrence of AF; 35 % dronedarone versus 10 % placebo at 6 months. Higher doses of dronedarone resulted in better ventricular rate control in patients who converted to atrial fibrillation. Dronedarone was not associated with any thyroid, pulmonary or ocular side effects. Although higher doses of dronedaone were associated with increases in the QT interval, there were no cases of torsades de pointes. The most important side effects associated with the use of dronedarone were gastrointestinal disturbance. Based on these results the dose of 400 mg twice daily was chosen. This dose was studied in patients with either atrial fibrillation or atrial flutter in the twin studies called The European Trial in Atrial Fibrillation or Flutter Patients Receiving Dronedarone for the Maintenance of Sinus Rhythm (EURIDIS) and the American-Australian-African Trial with Dronedarone in Atrial Fibrillation or Flutter Patients for the Maintenance of Sinus Rhythm (ADONIS) [53]. These trials randomised patients with a history of paroxysmal atrial fibrillation or atrial flutter to receive either dronedarone or placebo. Dronedarone increased the time to first recurrence of atrial fibrillation from 53 days in the placebo group to 116 days for those patients receiving dronedarone. Additionally in patients who had a recurrence of atrial fibrillation dronedarone significantly reduced the ventricular rate. A post hoc analysis revealed a 27 % reduction of relative risk of hospitalization and death with dronedarone treatment.

The effect of dronedarone in ventricular rate control for patients with permanent AF was studied in the Efficacy and Safety of Dronedarone for Control of Ventricular Rate (ERATO) [54]. The addition of dronedarone (800 mg per day) to standard rate-control therapy reduced the ventricular rate by 11.7 beats per minute after 2 weeks of treatment and by a mean of 24.5 bpm during exercise.

Dronedarone was studied in patient with moderate to severe left ventricular impairment irrespective of the rhythm in the Antiarrhythmic Trial with Dronedarone in Moderate-to- Severe Congestive Heart Failure Evaluating Morbidity Decrease (ANDROMEDA) [55]. Patients had a left ventricular ejection fraction less than 35 % and had been hospitalized with new or worsening heart failure. They also had to have had at least one episode of shortness of breath on minimal exertion or at rest (NYHA III or IV) or paroxysmal nocturnal dyspnoea within the month prior to admission. There was no restriction related to renal function.

After a median follow up period of 2 months, a significantly higher mortality rate was reported with dronedarone treatment (8.1 %) as compared with placebo (3.8 %). The worse the left ventricular function the higher the risk of death. This has lead to the avoidance of dronedarone in patients with severe LV dysfunction and heart failure.

To help address some of these issues a further study was carried out looking at patients with stable AF and at least one cardiovascular risk factor. The Assess the Efficacy of Dronedarone for the Prevention of Cardiovascular Hospitalization or Death from Any Cause in Patients with Atrial Fibrillation/Atrial Flutter (ATHENA) [56] had the composite primary end point of all-cause mortality and cardiovascular hospitalization. 4628 patients with a history of paroxysmal or persistent AF/atrial flutter were randomised to dronedarone 400 mg twice a day versus placebo with 12 months of follow-up. The use of dronedarone was associated with a significant 27 % reduction in the primary end point of death or cardiovascular hospitalization. The most frequently reported adverse effect of dronedarone was gastrointestinal, principally nausea and diarrhoea that in several cases led to drug discontinuation. The reduction in hospitalisations was a major reason for dronedarone gaining clinical approval in North America and more recently lead to a second draft guidance by National Institute for Clinical Excellence (NICE) revising its original recommendation that the drug should not be used to treat AF. It is therefore recommended that dronedarone should be considered as a second-line treatment in patients with additional cardiovascular risk factors whose AF has not been controlled by first-line therapy (usually including beta blockers).

Class IV

Verapamil and diltiazem block the L-type calcium channel and principally prolong the atrioventricular nodal refractory period. The VERDICT study showed no benefit in maintenance of sinus rhythm of verapamil over digoxin [57]. Two large trials which examined the use of verapamil in the maintenance of sinus rhythm following an electrical cardioversion both showed verapamil combined with quinidine was similar in efficacy to sotalol with a higher incidence of TdP in the sotalol group [58, 59]. Due to its negative inotropic effects verapamil should be used cautiously in patients with left ventricular dysfunction. As verapamil also suppresses sinus node automaticity it should also be avoided in sick sinus syndrome. Both verapamil and

diltiazem are similar in efficacy and side effects (other than constipation associated with verapamil). Calcium channel blockade may be a reasonable choice of drug for ventricular rate control in patients with preserved LV function and can be considered as an alternative to B blockers.

AAD's Not in the Vaughan Williams Classification

Some drugs such as digoxin, adenosine and ivabradine do not fit into the traditional Vaughan Williams classification.

Digoxin acts directly on the myocardium in order to increase the concentration of intracellular sodium and thus account for its positive inotropic effects. Of interest however this as well as its vagotonic effects actually shortens the atrial effective refractory period and therefore may actually increase the potential to develop AF in patients who are in sinus rhythm [60]. Its role in AF is therefore principally to slow AV conduction (through its vagotonic effects) and thus reduce the ventricular rate. It is not an ideal drug for acute ventricular rate control as the onset of action is 4–6 h and may not be as effective if the rate is partially sympathetically-driven. It continues to have an important role in the management of AF and is particularly effective when combined with a beta adrenergic blocker due to synergistic effects [5]. Recent data suggests that it may have deleterious effects and therefore its use if now relatively limited.

Adenosine is a metabolite of adenosine triphosphate which results in slowing of AV nodal conduction, shortening of the atrial myocardial refractory period and depression of sinus node automaticity [61]. Adenosine is highly effective in terminating supraventricular arrhythmias in which the AV node forms part of the reentrant circuit such as AV nodal reentry and orthodromic reciprocating tachycardia.

Additionally it can be used for diagnostic purposes such as transiently slowing AV conduction in SVT to identify the underlying rhythm and may also be helpful in differentiating SVT from VT (although very rarely adenosine may terminate a specific type of VT). Side effects such as facial flushing (due to cutaneous vasodilation), dyspnoea, and chest pressure have been reported to occur in about 30 % of patients [62]. Given the short half life of adenosine these side effects generally last less than 60 s. The downside to the short duration of action is that in some cases arrhythmias recur after several minutes after termination with adenosine [63].

Ivabradine is a novel selective inhibitor of the If channel in the SA node. It therefore reduces the sinus rate with no effect on either the AV node or intraventricular conduction times [64]. Although its principle clinical use is for symptom relief in patients with chronic stable angina it may also have a role in patients with an inappropriate sinus tachycardia. A recent study examining its use in 18 symptomatic patients with an inappropriate sinus tachycardia (defined as a nonparoxysmal tachyarrhythmia with a P-wave morphology and endocardial activation identical to sinus rhythm and an excessive increase of heart rate in response to minimal physical activity and emotional stress, and nocturnal normalization) showed a significant reduction

in heart rate on Holter and exercise stress tests [65]. Although this was a small study there may be a role for this drug in these patients where other drug therapies can be relatively ineffective and ablation therapy may carry some significant risks.

The Future: Novel AAD's

Given the significant cardiac and non-cardiac side effects associated with current AAD's there has been a huge interest in the development of novel 'atrial selective' drugs for the treatment of AF. These drugs can be broadly divided into amiodarone derivatives such as dronedarone, PM101 and budiodarone, selective Iks blockers such as HMR1556, atrial repolarization-delaying agents such as vernakalant and sodium channel blockers such as ranolazine.

Mention it is approved for angina (US) and being tested for AF (with dronedarone) and ICD shocks (NIH sponsored RAID study).

Atrial Repolarization Delaying Agents: Vernakalent

Vernakalant predominantly targets early-activating K+ channels and frequency-dependent Na+channels in the atria. It has been shown to have an efficacy of 52 % in the acute conversion of recent onset AF compared to a 4 % success rate with placebo [66]. More recently the results of the AVRO trial comparing vernakalant with amiodarone was presented. This randomised double blind multicentre superiority trial in 254 adult patients with AF showed that vernakalant has a higher efficacy for the conversion of AF as well as a greater rate of symptom relief (51.7 % converted with vernakalant versus 5.2 % with amiodarone). Treatment with vernakalant resulted in a rapid conversion to sinus rhythm, with a median conversion time of 11 min. Additionally it is well tolerated and appears to be relatively safe with no cases of ventricular arrhythmias or drug related deaths. This drug is currently under consideration for clinical approval in Europe and North America. The main side effects associated with its use appear to be dysgeusia (30 %), transient sneezing (17 %), hypotension (5 %) and bradycardia (5 %).

Sodium Channel Blockers: Ranolazine

Ranolazine has been shown to be effective as an anti-anginal agent when added to standard medical therapy most likely through various mechanisms but predominantly through its ability to inhibit the inward sodium current. In a similar mechanism it has been postulated that this may have anti-arrhythmic effects in the atria where rapid atrial rates during AF may result in oxidative stress and atrial myocardial

ischaemia. The Metabolic Efficiency with Ranolazine for Less Ischaemia in Non-ST-elevation acute coronary syndrome— Thrombolysis in Myocardial Infarction (MERLINTIMI 36) trial compared ranolazine with placebo in 6560 patients hospitalized with acute coronary syndromes. A significant reduction in tacharrhythmias (SVT and VT) was noted in patients commenced on ranolazine versus placebo on 7 day continuous cardiac monitoring [67]. There was no effect on sustained arrhythmias such as AF and VT and no overall effect on mortality or recurrent ischaemia. Further clinical studies are required to assess the clinical utility of ranolazine as an AAD.

Important Points

1. Anti-arrhythmic drugs alter the electrical properties of the heart principally by either prolonging the cardiac AP, decreasing conduction velocity, reducing focal automaticity or a combination of these effects.
2. The Vaughan Williams classification categorizes anti-arrhythmic drugs into groups according to their main mechanism of action. These are:

   Class I action block the fast sodium channels which are responsible for phase 0 of the action potential thus affecting its slope and amplitude. These drugs are subdivided according to the rate of binding and dissociation from the sodium channel. Class IB mechanism of action is associated with the most rapid onset of action and dissociation, IA has intermediate activities and IC the slowest.

   Class II action block beta adrenergic receptors prolonging the phase 2 and 3 (after chronic use) of the action potential and thus lengthen the effective refractory period.

   Class III agents prolong the action potential duration principally by inhibition of the potassium channels.

   Class IV action inhibits the slow calcium current and therefore depress phase II and III of the AP in certain tissues primarily the SN and AV nodes.

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Index

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