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Catheter Cryoablation of Ventricular Ectopy Originating from His Region

Case Presentation

A 47-year-old man with symptomatic frequent PVCs, refractory to pharmacological therapy with betablockers and flecainide in association, was admitted for catheter ablation. A 12-lead electrocardiogram (ECG) of PVCs showed a monophasic R wave in lead 1 and aVL with precordial transition in V4 (Figure 1). Ambulatory ECG recording showed frequent monomorphic PVCs (60,230 ectopic beats; 35% of the total beats).

Figure 1: 12-lead ECG shows frequent clinical PVCs.

After informed consent was obtained, a cardiac electrophysiological study was performed under conscious sedation. Baseline ECG showed normal sinus rhythm with frequent monomorphic PVCs with the same configuration as clinical morphology. Diagnostic catheters was advanced for reference in coronary sinus and His-region. Electrophysiological study with programmed ventricular stimulation did not induce sustained ventricular tachycardias in basal conditions orduring isoproterenol infusion. Bipolar ventricular signal recorded from His-catheter advanced PVC onset by 20msec (Figure 2). Activation mapping was performed using a 8-Fr open irrigated catheter with contact force sensor with an electroanatomic mapping system. Right ventricular (RV) activation mapping focused on PVCs beats showed an early focal activation in the region on the inflow tract. The target site was recognized between “valvular” His-potential region and right bundle branch origin. At the mapping site local bipolar signal recorded from mapping catheter advanced PVC onset by 47 msec with unipolar QS pattern (Figure 2). Pacing mapping conducted from ablator tip demonstrated optimal concordance (12/12 leads) in respect to the ectopic beat (Figure 3). At this site an RF application was performed with low energy (20 W with a target temperature of 45°C) with complete disappearance of ectopic beats but rapid right bundle block creation. Application was then stopped. After 2 minutes conduction damage was resolved but ectopic activity recurred. In order to avoid persistent conduction damage, a 7-Fr cryoablator catheter (Freezor, Medtronic) was advanced for mapping and ablation. An accurate cryomapping was conducted in the target site up to -35°C. Cryoablation up to -80°C were performed for 6 minutes under continuous check for AH and HV prolongation and right bundle block occurrence. Afterwards, the successful result persisted during 30 minute observation (Figure 4). The patient was discharged without complications after two days from the procedure. Ambulatory ECG monitoring showed a PVCs burden of 4% and 2% at 2 months and 1 year of follow-up, respectively. No conduction abnormality was noted during monitorings. The patient, in the absence of antiarrhythmic drugs, remained free from symptoms during a follow-up period of one year.

Keywords: Premature ventricular complexes; Bundle of his; Catheter ablation; Cryothermal ablation
Figure 2: Recordings on ablation site of ablation catheter (ABL) and His catheter (His). Local ventricular activation recorded on His catheter (His p) advanced PVC onset by 20msec. Local ventricular activation of ablation catheter is earlier than onset of PVC by 47ms. Note the His signal (H) recorded at the ABLp in the sinus beat.

Figure 3: Activation mapping of ventricular ectopy (A). Red dots shows location of “valvular” His bundle. There is a perfect match between pacemap from the ablation site (B) respect to spontaneous ectopic beat (C).

Figure 4: Electro anatomical mapping of right heart (A), modified left-lateral view. Red dots are location of “valvular” His. Orange dots are mapping points of right bundle branch signals. Yellow dots are cryoenergy applications in the target site (angiographic LAO and RAO views, image B). Image C is the electrocardiographic final result after successful cryoablation.
Discussion

We reported a successful catheter cryoablation of PVCs originating from the Hisian region without AV conduction damage. Electrocardiographic analysis of ectopic beats shows vertical axis with large positive notched R wave in D1 and pattern QS in AVR with Rs' on AVL; precordial transition was in V4 with QS pattern in V1 and large R wave in V5-V6. Based on the electrocardiographic features we presumed the focus to be near the His-region. Activation mapping indicated the exit-site of ectopics at the proximal RV inflow tract and the presence of His signal recorded on the mapping catheter indicate that the ablation site was near the main penetrating AV conduction bundle. Given the electrophysiological features found on the ablation target site (bipolar and unipolar electrograms, pacemapping and effect of energy delivery), we decided not to perform an additional mapping on the left side of the interventricular septum or non-coronary aortic cusp.

It is interesting to note that in our report irrigated RF delivery permitted to suppress ventricular ectopy but with transient right bundle block creation; after 2 minutes from RF ablation attempt conduction damage was resolved but ectopic activity recurred. At the target site cryothermal energy application led to ectopy suppression without right bundle block creation. While a more superficial lesion together with optimal catheter stability obtained during cryoablation may allow to suppress ventricular ectopy and avoid damage of deeper penetrating structures, irrigate RF energy could have determined a deeper lesion leading to right bundle branch block.

Safety and feasibility of parahisian focal cryoablation for ventricular arrhythmias is well reported in the literature. Several papers described cases of successful ablation procedures using irrigated and non-irrigated RF energy [4,5]. De Biase et al. [5] reported the largest population of 7 cases of ventricular arrhythmias originating from His region treated with successful cryoablation. No complication or failure were mentioned. The average distance from ablation site to critical conduction structures were 4 mm about. In our opinion this case report may be of interest for specialists who are aware of highly unwanted complications during ablation in parahisian region. Furthermore this report shows the importance of changing approach and the ablation setting in difficult situations. As a matter of fact, after transient right bundle block creation we discontinued RF delivery and converted our procedure to the cryothermal setting.

Conclusion

In conclusion, we performed a successful catheter cryoablation of a PVC from the His region under activation and electroanatomical mapping guidance. Careful mapping, early detection of AV conduction damage and cryothermal energy availability are essential in dealing with ablation procedures at the parahisian region.

Ethical Standards

This study complies with the Declaration of Helsinki and our Institutional Ethics Committee approved the study protocol. As mentioned in the text, informed consent from our patient was obtained before the invasive procedure.

References