Tackling tricky right atrial tachycardias

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Disclosures

• Fees, travel and sponsorship from Medtronic, St Jude, Boston Scientific, Bayer.
Case 1

• 51 year old

• Severe LV dysfunction

• “Palpitations probably years ago – just got used to them doc”
Basic intervals
Termination <2s
V pacing post RFA
Normal A curve
Wenckebach at 530ms
ORIGINAL ARTICLE

Permanent form of junctional reciprocating tachycardia in adults: peculiar features and results of radiofrequency catheter ablation

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Figure 4  Schematic representation of successful radiofrequency catheter ablation site for each of 49 patients (60° left anterior oblique view).
Case 2: Listed as AVNRT
S1 600 S2 400
HV times with high rate and normal SR
Is earliest best?

EDITORIAL COMMENT

What Is the Optimal Approach to Ablation of Para-Hisian Atrial Tachycardias?*

Steven M. Markowitz, MD

The operator faces practical choices after mapping the RA and identifying a para-Hisian focus: either cautiously ablate in the paranodal region, access the LA, or map the aortic root. This study and the previous reports provide convincing evidence that mapping the NCC is the preferred option. The approach
Case 3

• 43 year old female, referred from another centre, 3 previous ablations

• Previous Sinus mode modification for inappropriate sinus tachycardia

• Then developed a refractory tachycardia, arising from septum, resulting in CS mouth ablation, a cryo PVI and a CTI line over a 5 year period (using Carto)
Baseline ECG
BCL 280; Orion mapping
My “EP instinct” was that this was a gap in the crista terminalis
About 60ms ahead of surface P wave; not a very exciting signal *per se* though
Termination within 5 seconds
Case points

• Better mapping = better outcomes

• End our obsession with “double potentials” and “fragmentation”