Ablacija ventrikulske tahikardije u bolesnika sa strukturnom bolešću srca

Ablation of ventricular tachycardia in patients with structural heart disease – single centre experience

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Uvod: Ablacija ventrikulske tahikardije (VT) u strukturnoj bolesti srca (SHD) je učinkovita metoda za sprečavanje recidiva VT-a, poboljšanje kvalitete života i redukciju terapije ugrađenim kardioverter defibrilatorom (ICD).¹

Pacijenti i metode: Uključeni su bolesnici sa postojanom VT koji su bili podvrgnuti radiofrekventnoj ablaciji od prosinca 2014. do rujna 2016. godine u Kliničkom bolničkom centru Sestre milosrdnice. Elektrofiziološka studija provedena je u skladu s lokalnim protokolima. Procijenjena je stopa akutnog uspjeha, komplikacije i bolnički ishodi. Također, klinički podaci i podaci iz memorije ICD-a evaluirani su tijekom praćenja.

Rezultati: Ukupno 36 bolesnika je referirano radi ablacije postojane VT. Osam bolesnika (22 %) nije imalo SHD, a 28 (78 %) bolesnika imalo je SHD. 16 bolesnika (57 %) imali su ishemijsku bolest srca (IHD), a 12 (43 %) imalo je neishemijsku bolest srca (NIHD). Dvoje bolesnika s IHD (12,5 %) je imao stabilne VT koje su mapirane tijekom tahikardije i abkirane, a 14 (87,5 %) je imalo nestabilne VT te je učinjena modifikacija supstrata. U bolesnika s IHD svi pacijenti imali neinducibilne kliničke VT ili bilo koje VT na kraju postupka. Nije bilo komplikacija vezanih uz postupak. Nakon medijana praćenja od 7 mjeseci (4-14) bio je jedan recidiv te je ponovljen postupak. U bolesnika s NIHD 4 (33 %) je imalo "bundle branch reentry" VT, 2 je imalo fokalne VT iz papilarnog mišića i aortnog kuspisa. 2 bolesnika su imala VT koje su abkirane u području lateralnog mitralnog anulusa. Četiri bolesnika (33 %) imalo je ili polimorfnu VT ili nestabilne VT koje se nije moglo mapirati, a nije verificiran niti patološki supstrat endokardno.

Zaključak: Rezultati i iskustva su usporedivi s onima u većim studijama. Ablacija postojanih VT u bolesnika s SHD je učinkovita metoda za prevenciju VT i redukciju terapija ICDom. Međutim, treba biti izvedena u velikim centrima sa standardiziranim protokolima za ablaciju, nadzor i skrb bolesnika.

Background: Ablation of ventricular tachycardia (VT) in structural heart disease (SHD) is an effective tool to prevent VT recurrence, improve quality of life and reduce therapy with implantable cardioverter defibrillator (ICD).¹

Patients and Methods: Patients treated for sustained VT who underwent radiofrequency ablation from December 2014 until September 2016 in University Hospital Center "Sestre milosrdnice" were included. Electrophysiology studies were performed according to local protocols. Acute success rates, complications and hospital outcomes were evaluated. Also, clinical data and implantable cardioverter defibrillator data were evaluated during the follow up.

Results: Total of 36 patients were referred for ablation of sustained VT. Among those, 8 (22%) had no overt SHD while 28 (78%) had SHD. 16 patients (57%) had ischemic heart disease (IHD) while 12 (43%) had non ischemic heart disease (NIHD). 2 patients with IHD (12.5%) had stable VTs that were mapped and ablated while 14 (87.5%) had unstable VTs and substrate modification was performed. In patients with IHD all patients had non inducible clinical VT or any VT at the end of the procedure. There were no procedure related complications. There was one in hospital death (6.2%) due to severe, prolonged cardiogenic shock four days post ablation. After median follow up of 7 months (4-14) there was one re-do procedure. In patients with NIHD 4 (33%) had bundle branch reentry VT, 2 had focal VTs originating from papillary muscle and aortic cusp. 2 patients had VT that was ablated at lateral mitral annulus. 4 (33%) patients had either polymorphic VT or unstable VTs that could not be mapped with no identifiable substrate endocardially.

Conclusion: Results and experience are comparable to those reported in larger studies. Ablation of sustained VT in patients with SHD is a useful tool to prevent VT recurrence and reduce ICD therapies. However, it should be performed in high-volume centers with standardized protocols for ablation, monitoring and care.

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LITERATURE

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