



**Extrasistolia ventricolare refrattaria con origine nel “LV Summit”: l’importanza dell’utilizzo delle nuove tecnologie nel laboratorio di elettrofisiologia.**

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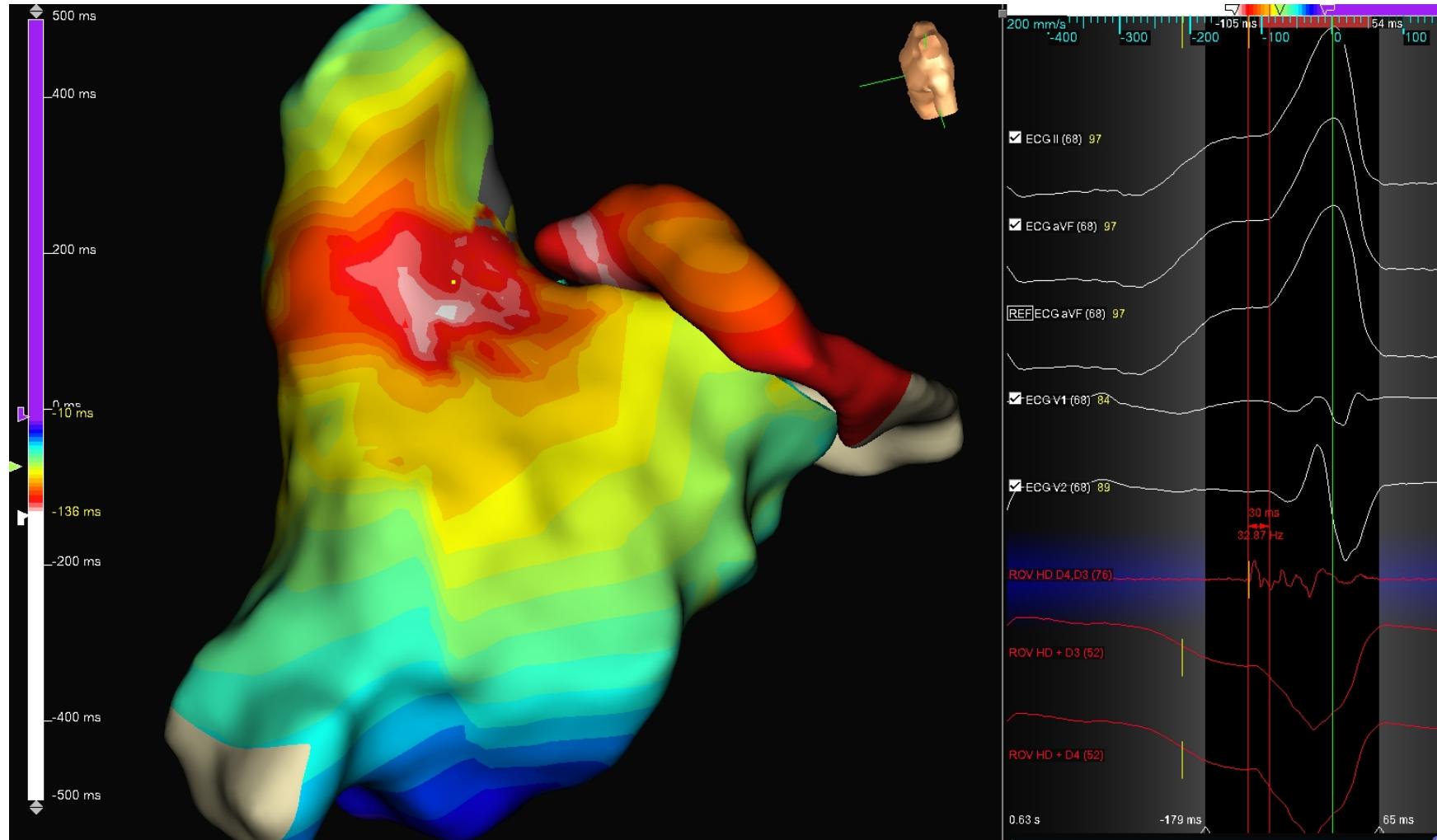
# P.B., 76 years old.

## Anamnesis:

- 2014 BPAC for stable angina
- Paroxysmal atrial fibrillation
- Ventricular Extrasystolia symptomatic for effort dispnea and asthenia
- 24hrs EKG holter: **45% extrasistolic burden**
- Ineffective medical treatment:
  - Beta Blocker
  - Amiodarone
  - Mexiletine

**LV summit morphology:** RBBB, inferior axis, MDI= 0,66





## BIPOLAR ACTIVATION MAP

(EnsiteX, Advisor Hdgrid mapping catheter, Abbott TM).

- **-30 ms** precocity
- **QS morphology** of unipolar electrogram



**SUBVALVULAR LVOT**  
**GREAT CARDIAC VEIN**



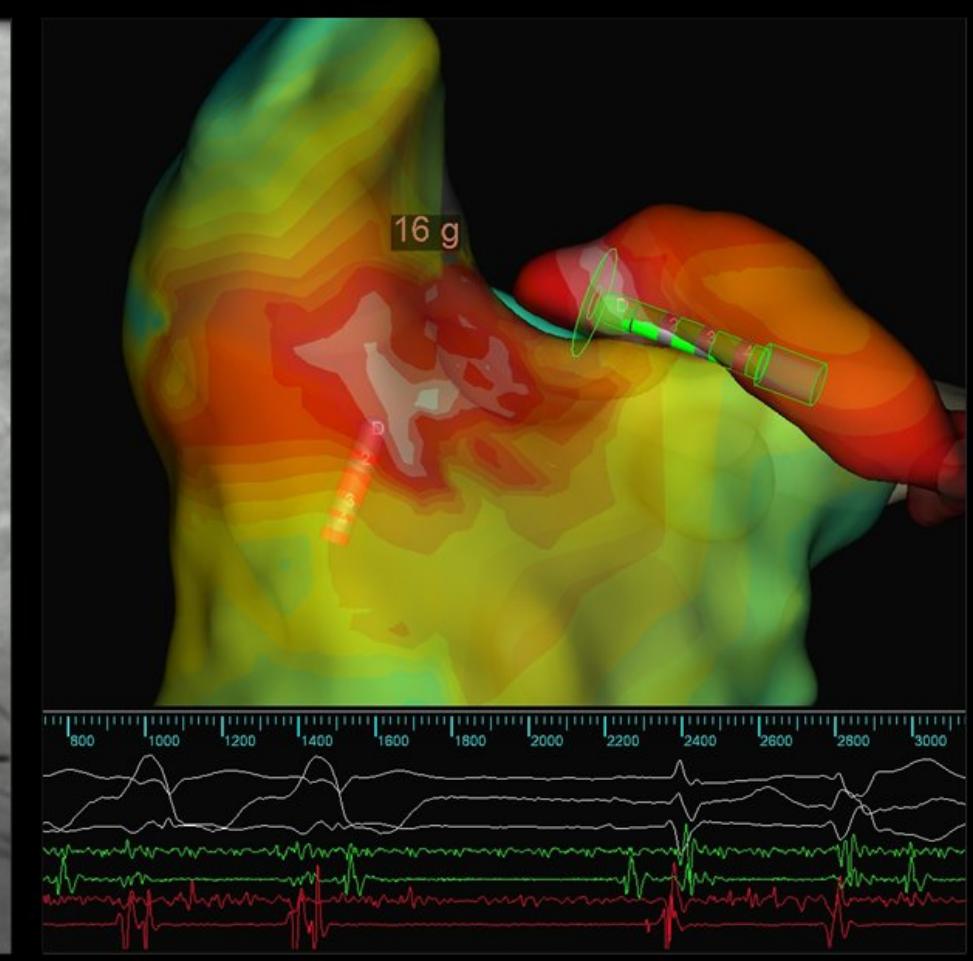
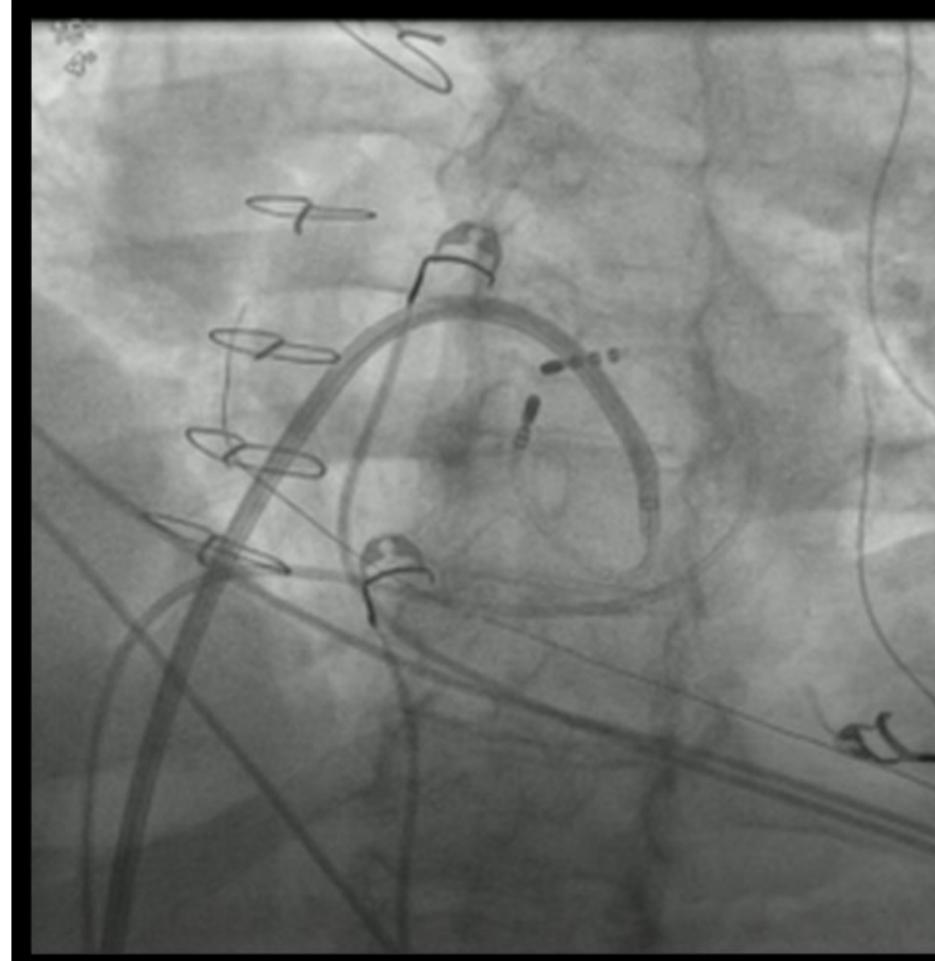
Ineffective unipolar ablation  
Induction of Sustained monomorphic ventricular tachycardia

## BIPOLAR ABLATION

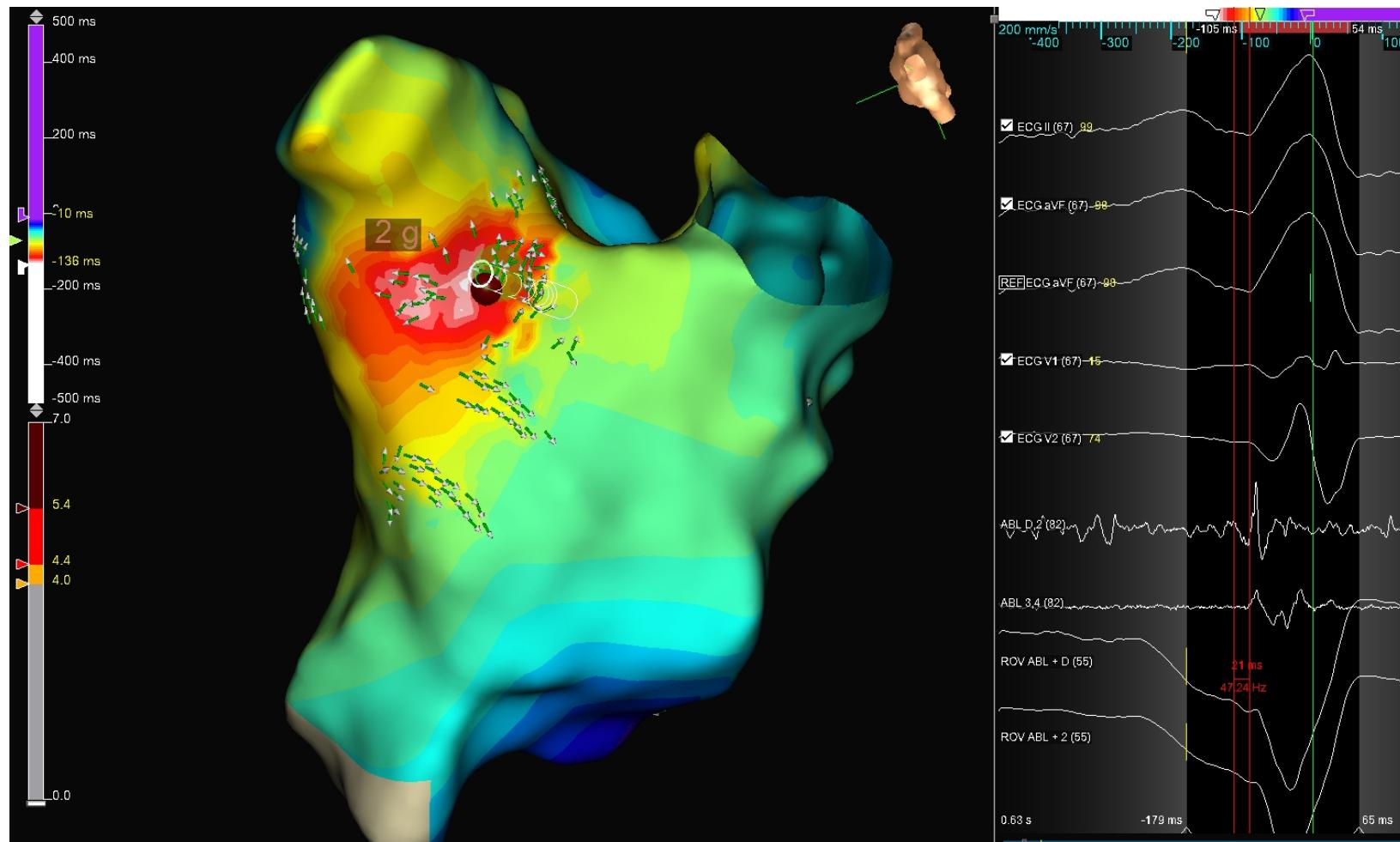
- Tacticath (Abbott TM), connected to RF source -> GCV
- Flexability (Abbott TM), connected to the passive electrode -> LVOT

Two RF application:

- 20W
- 240 s
- 25°



## VENTRICULAR TACHYCARDIA TERMINATION



## OMNIPOLAR MAPPING

### Subvalvular LVOT:

- -20 ms precocity
- -QS morphology of unipolar EGM



### Conventional unipolar ablation:

- 40W, 40°C, 180 sec



### Complete PVCs suppression.

3 months follow up: <1%  
extrasystolic burden

In *conclusion* this case highlights the importance of an appropriate procedural planning combined with the use of new technologies: indeed, both were essential to achieve the procedural and clinical success.



Thank's for  
your  
attention