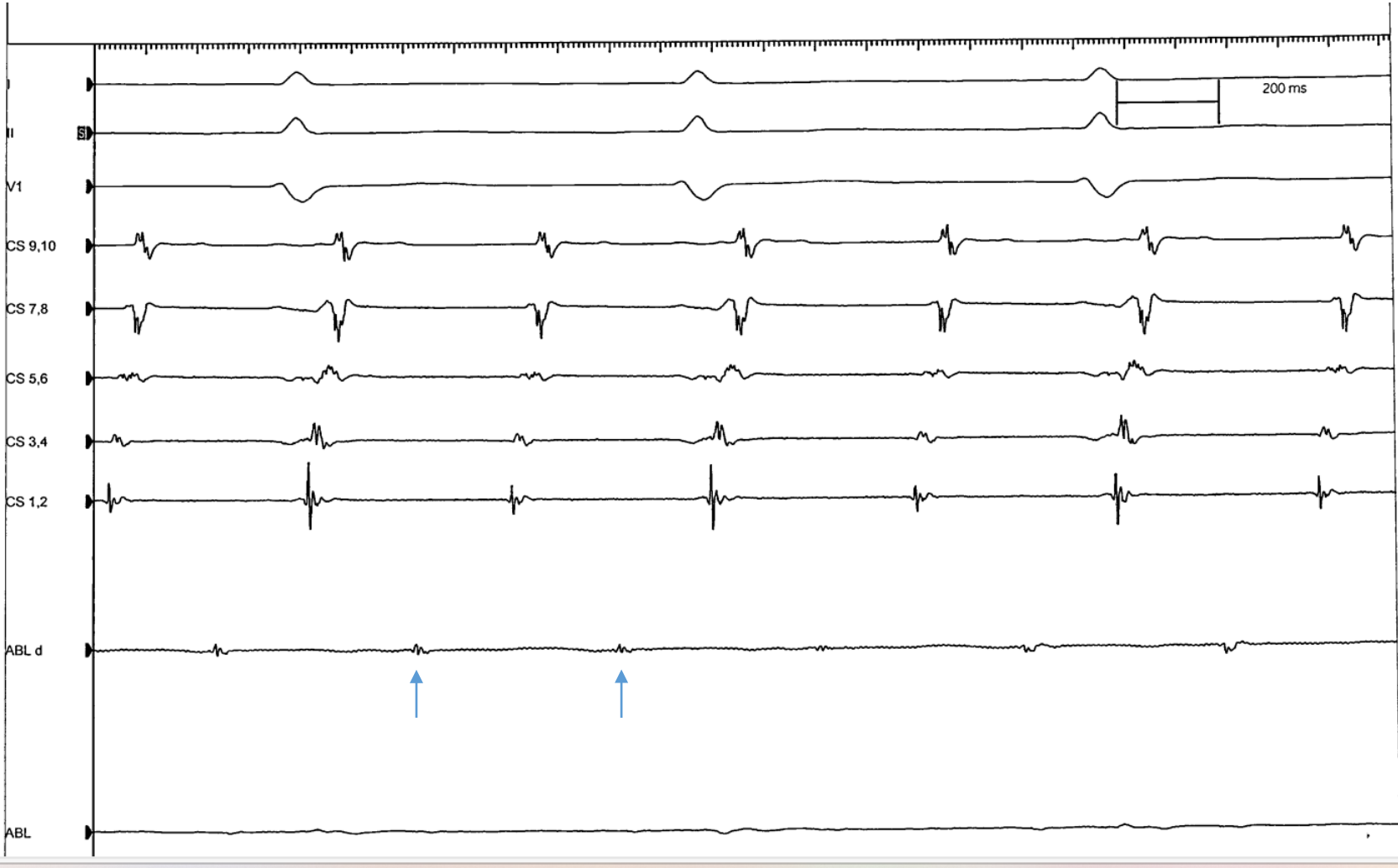
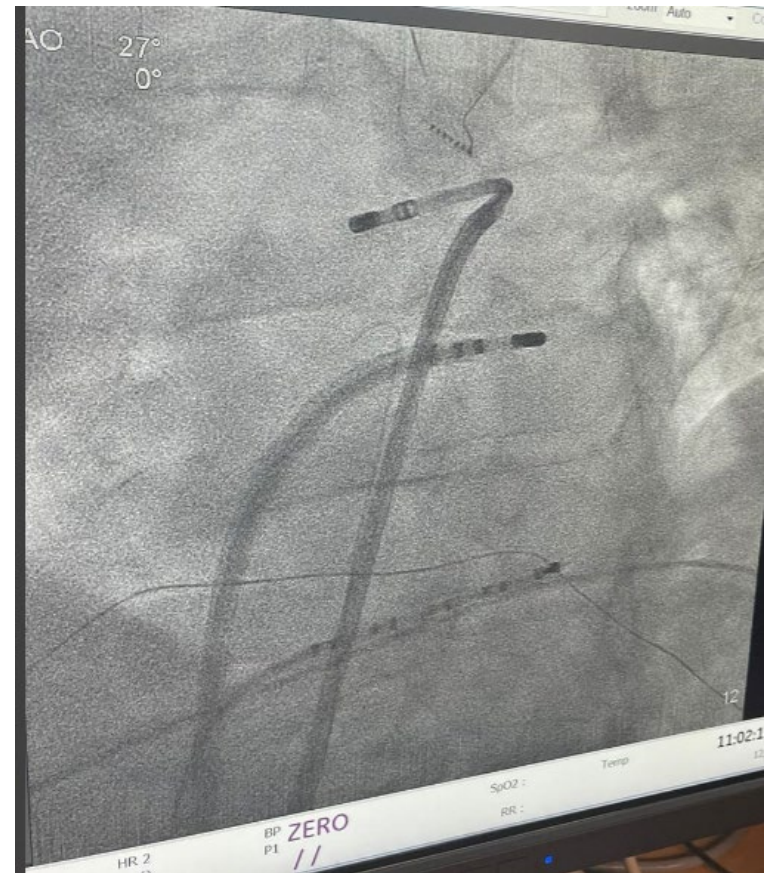
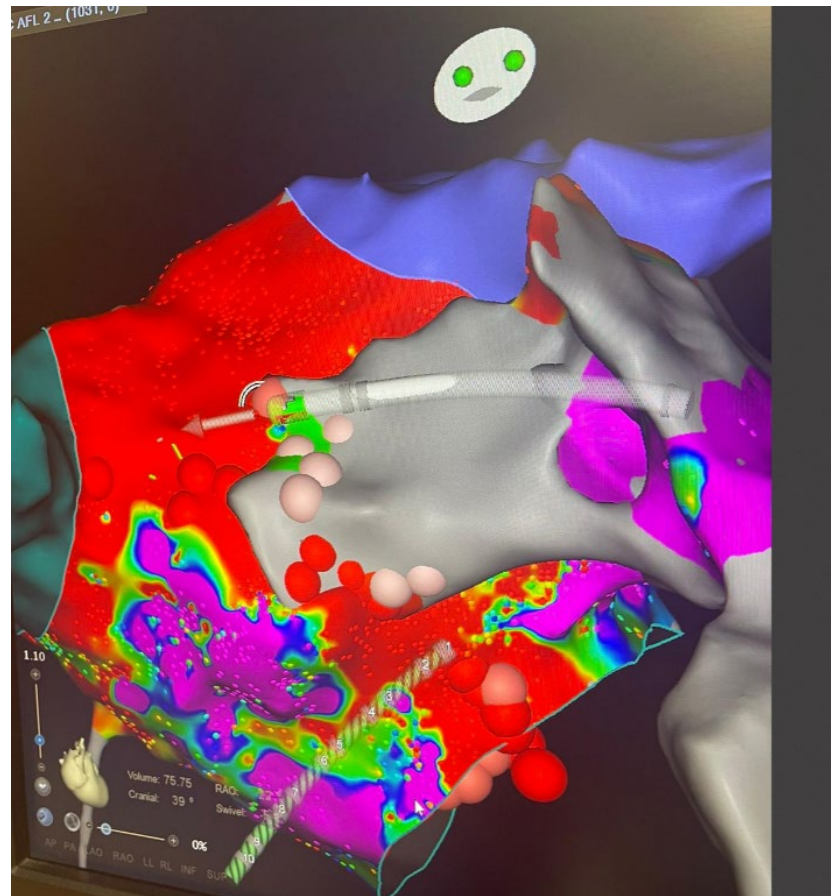
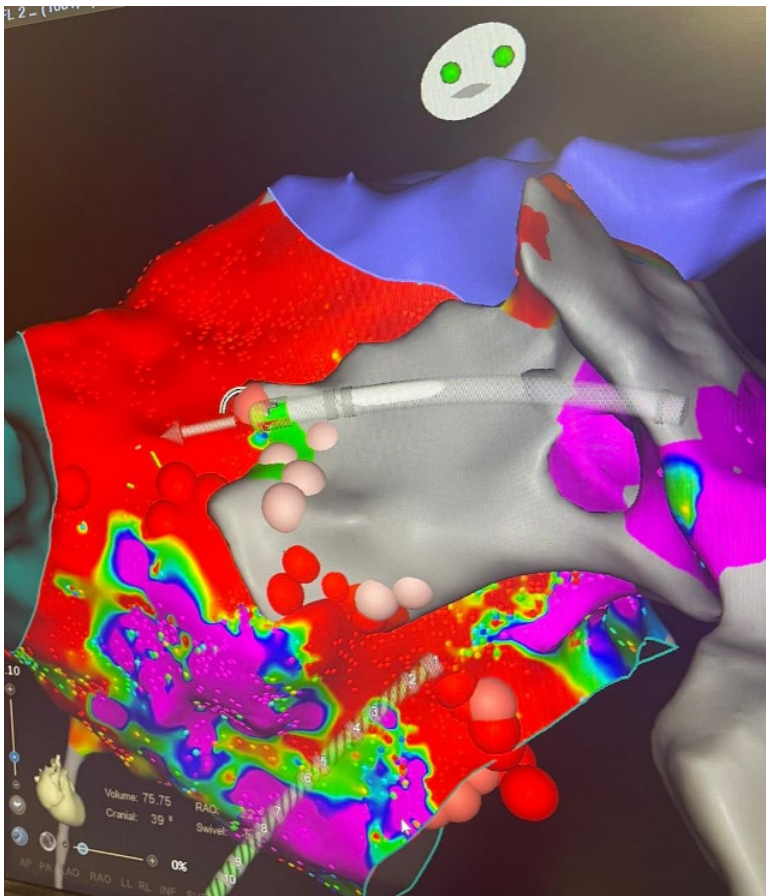


Coherent map of AFL showed that
AFL isthmus was in ant LA scar
but no endocardial signals:



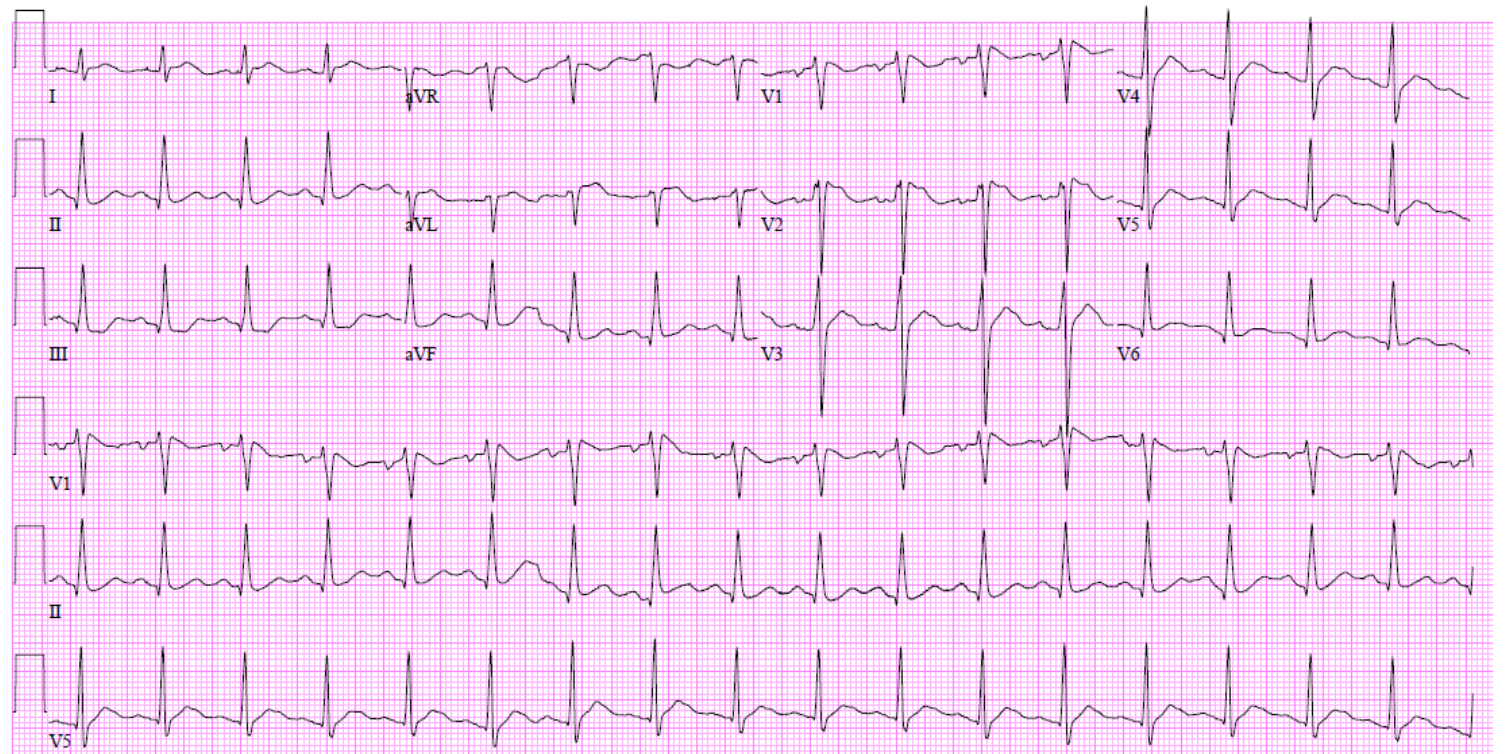
Epicardial mapped showed a mid atrial flutter circuit signal on the opposite endo area. RF at that side >>> NSR



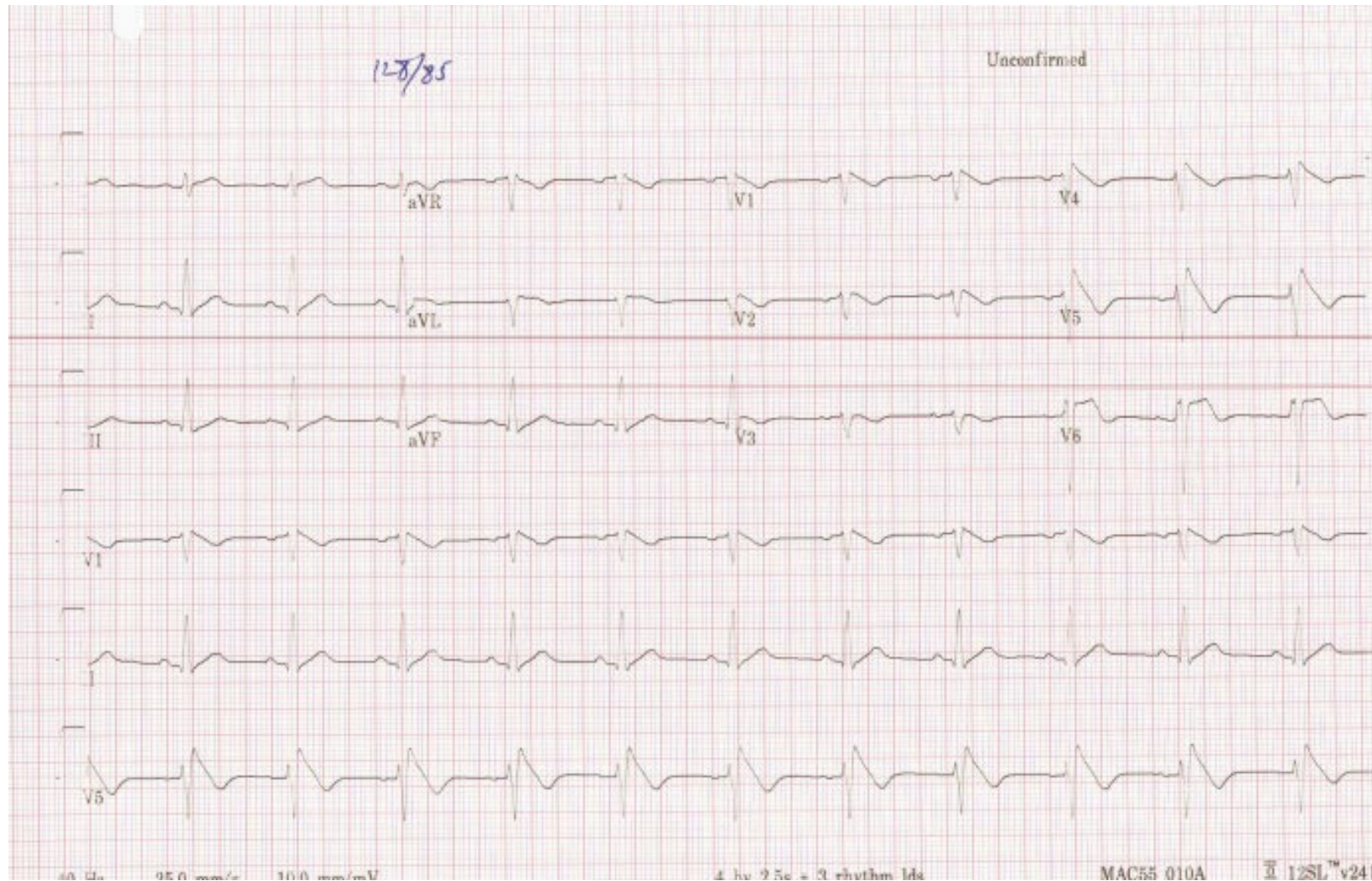


OHSCA:

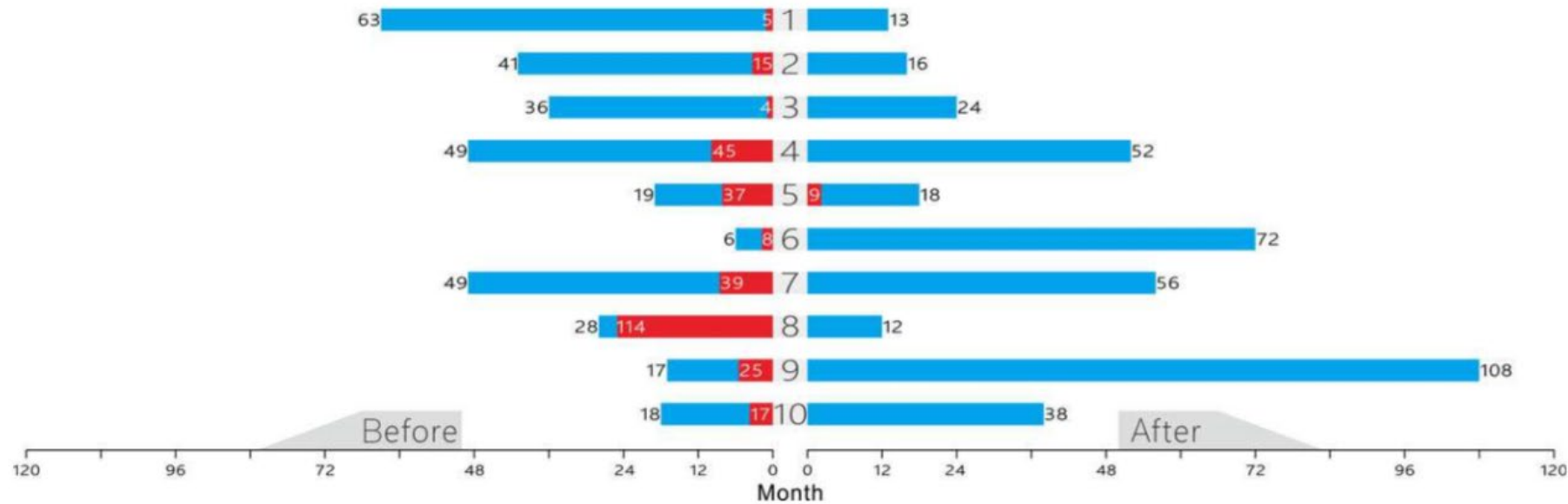
- 27 yo
- Presented with OHSCD while sitting after “heavy meal”.
- NL ECHO, NL cMRI
- Baseline ECG:



High leads (V2= V1; V5= V2) Ajmaline ECG during hospitalization:



Quinidine in pts w/ Brugada Syndrome



- **However:**
 - GI side effects in up to 60% & d/c in 25%
 - Difficult to obtain in many parts of the world

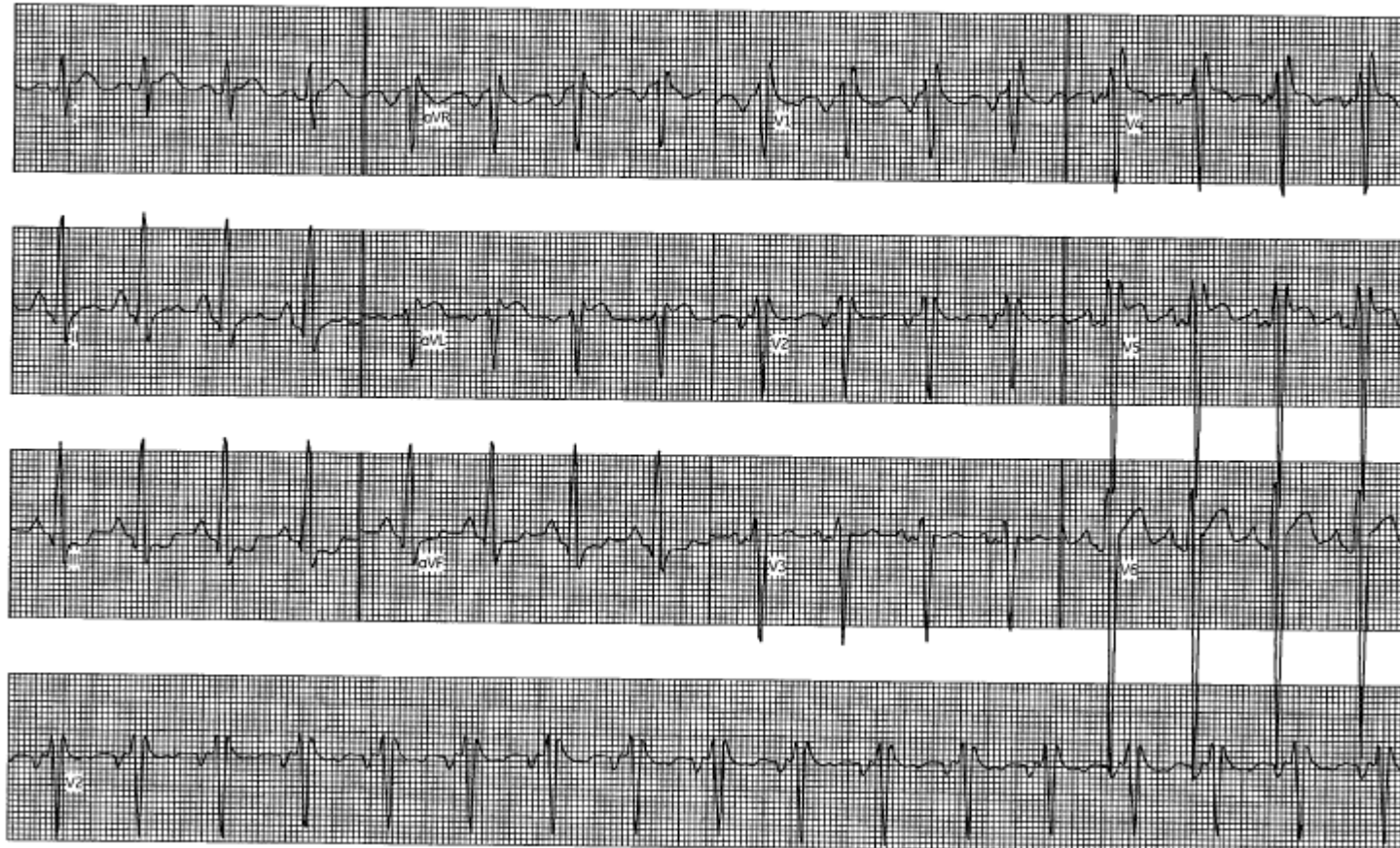
Baseline ECG:

Age: 30 Years
Gender: Male
Height:

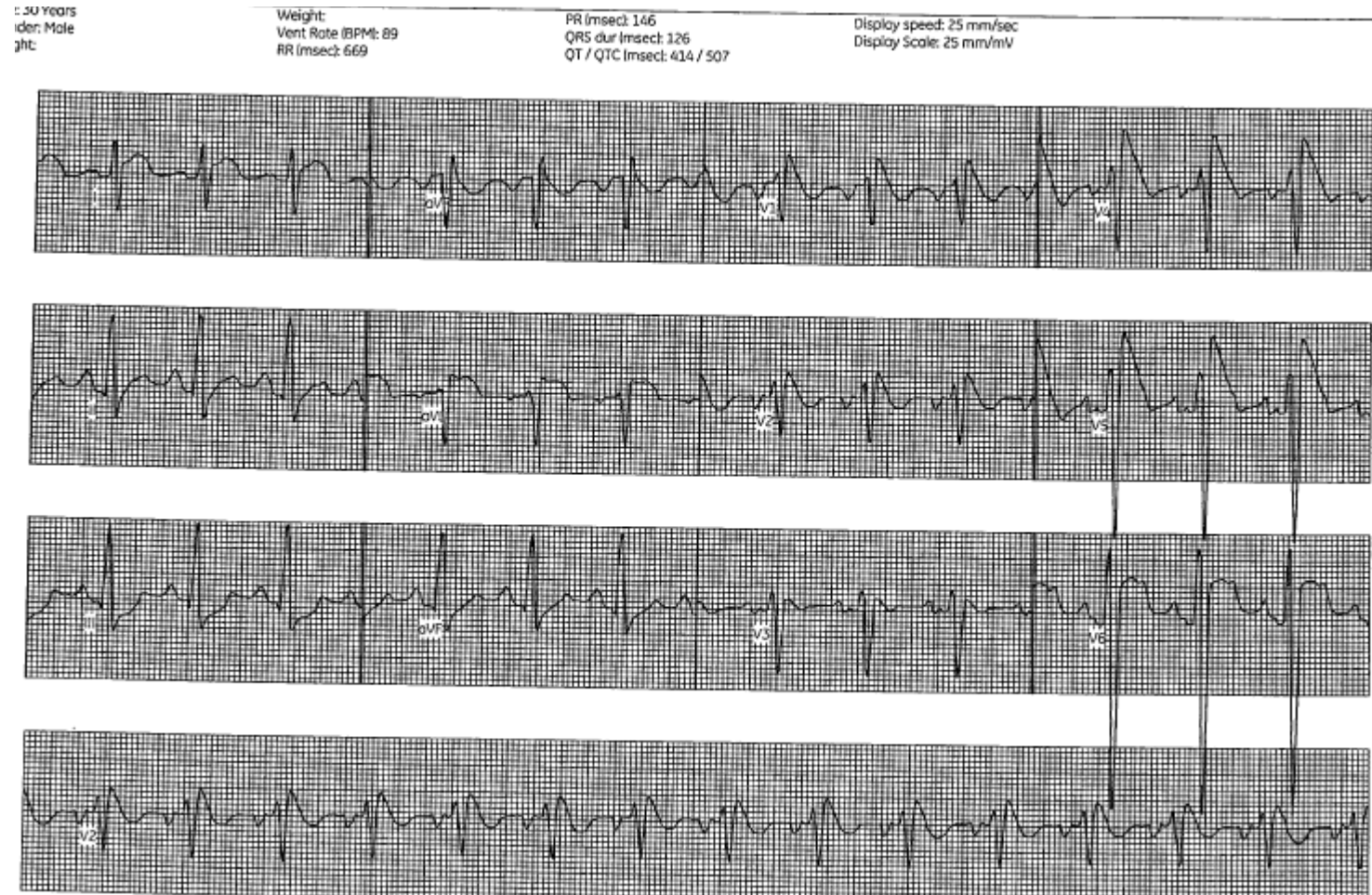
Weight:
Vent Rate (BPM): 101
RR (msec): 591

PR (msec): 150
QRS dur (msec): 102
QT / QTc (msec): 281 / 365

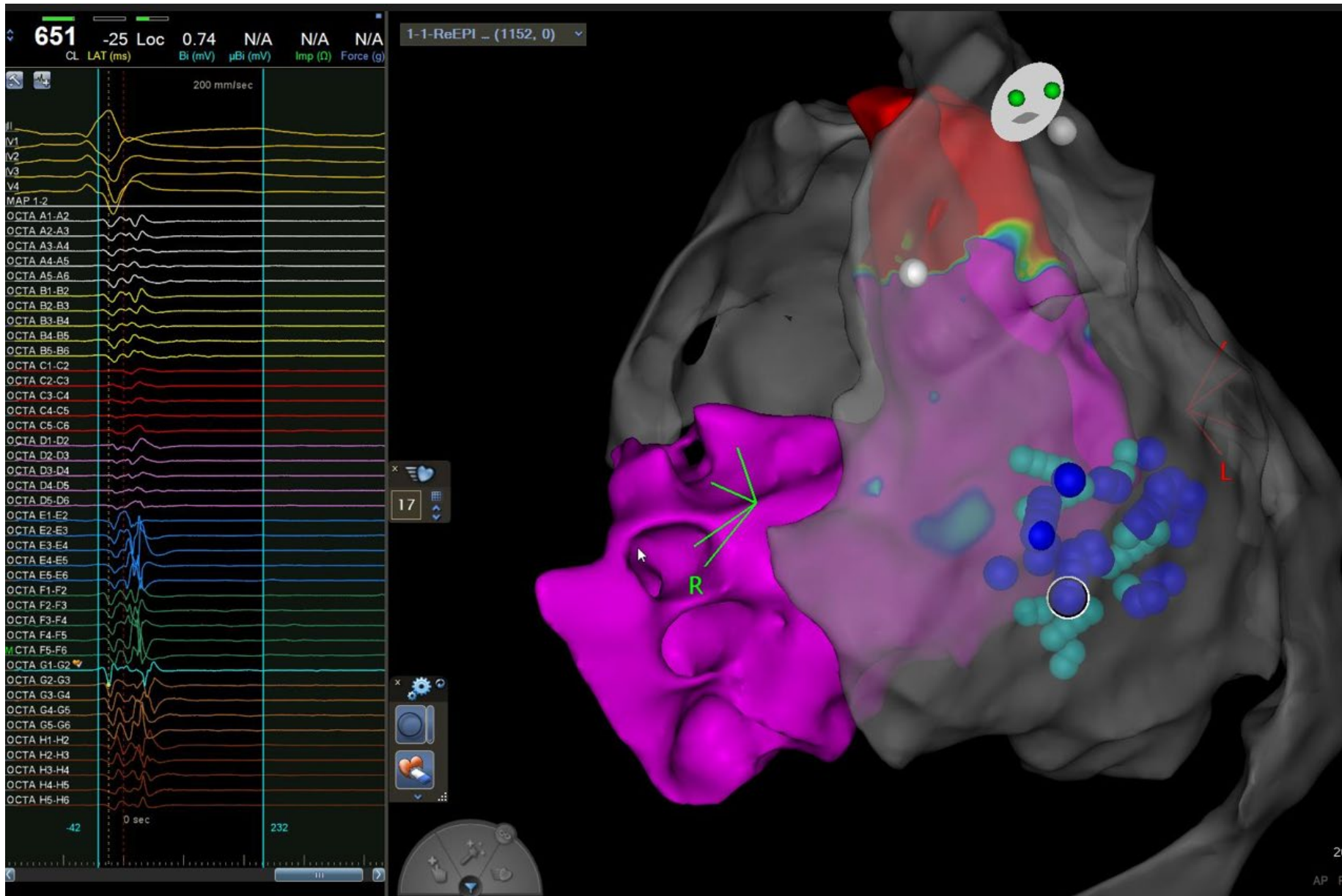
Display speed: 25 mm/sec
Display Scale: 25 mm/mV



Baseline post Ajmaline High lead ECG V2= V1; V5= V2:



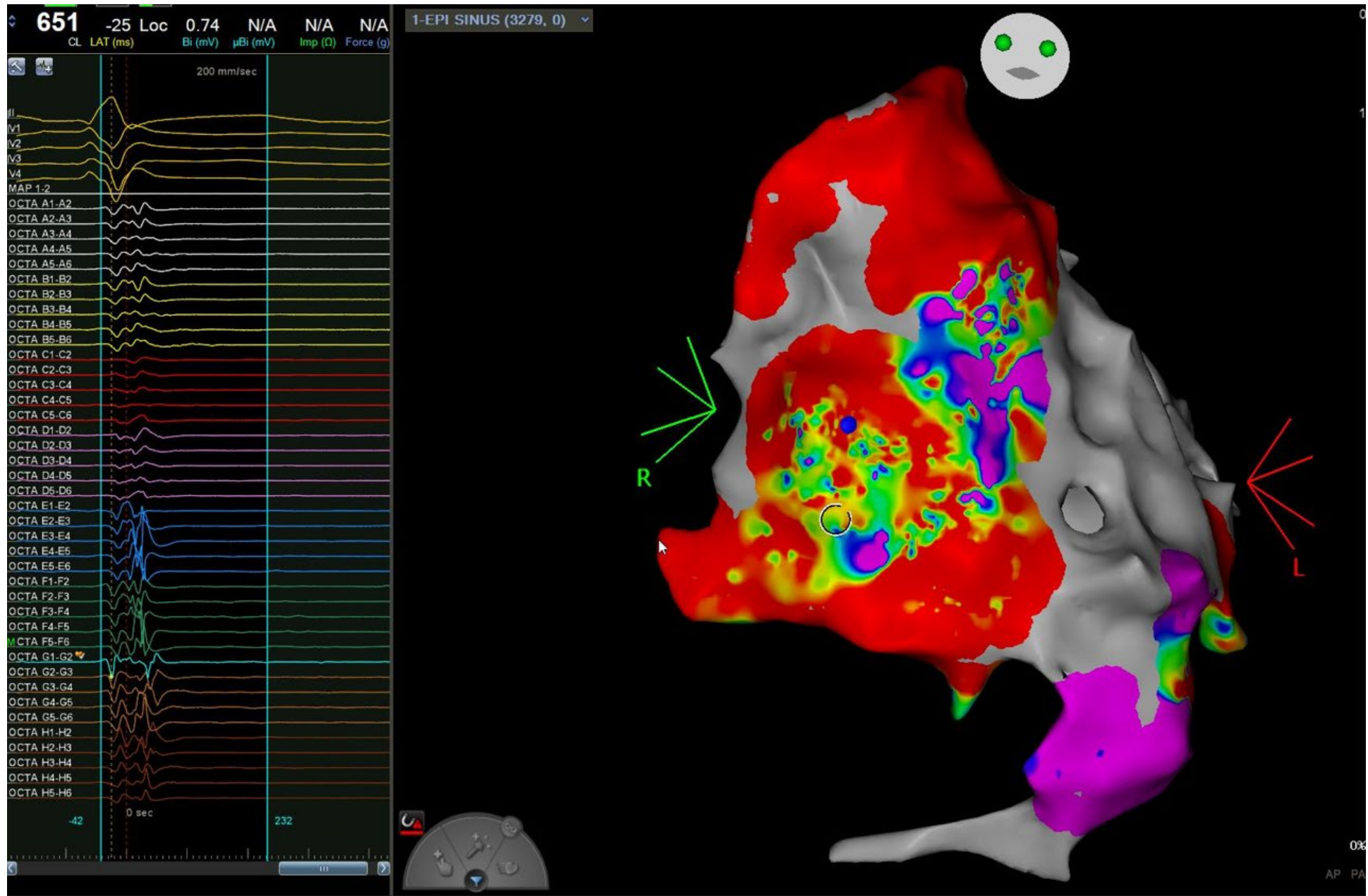
Pre Ajmaline and pre ablation Endo RVOT map:



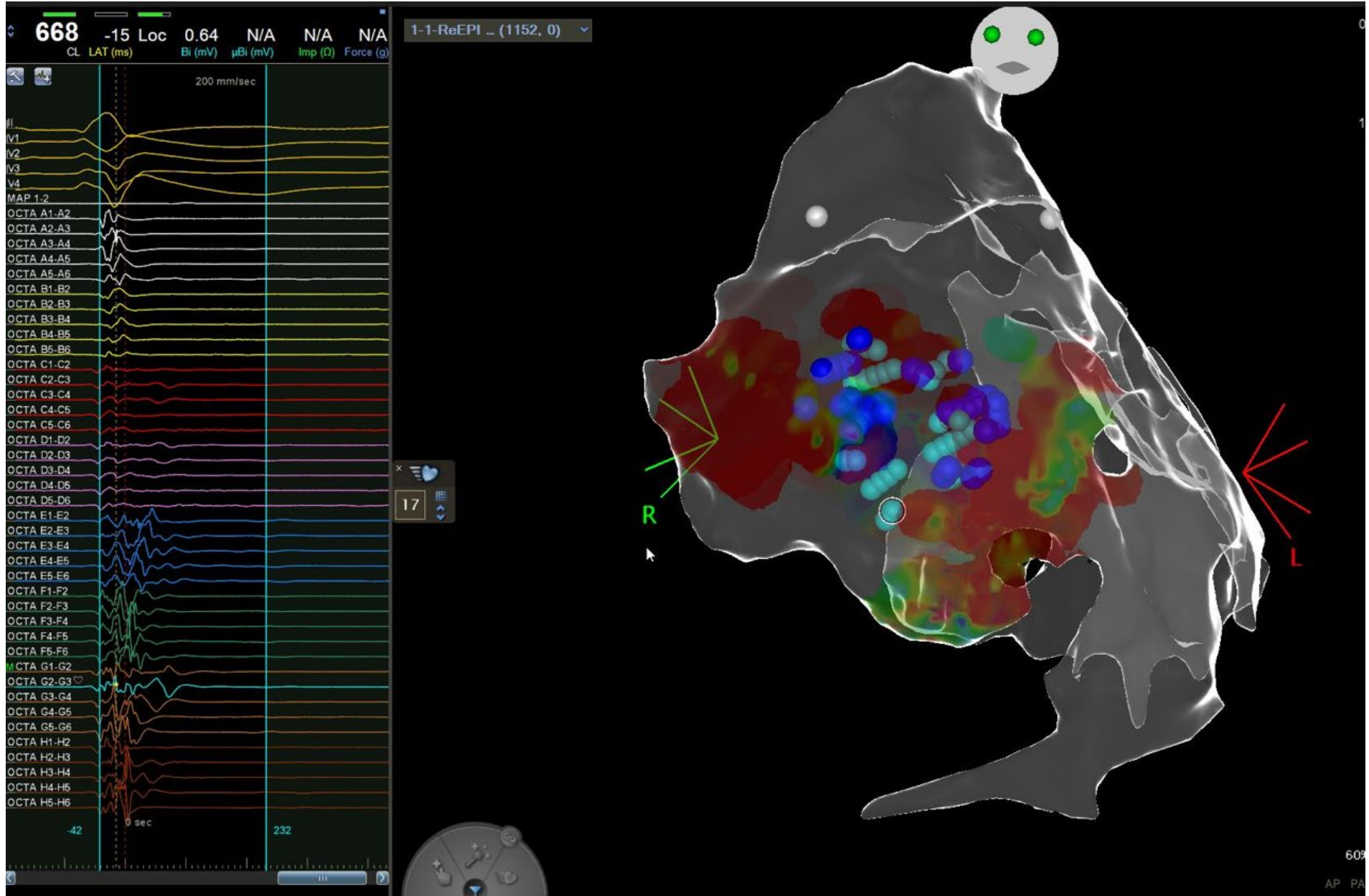
Abnormal EGMs

1. amplitude <1.5 mV
2. associated wide duration (>80 ms)
3. multiple (>3), or delayed components extending beyond the end of the QRS complex

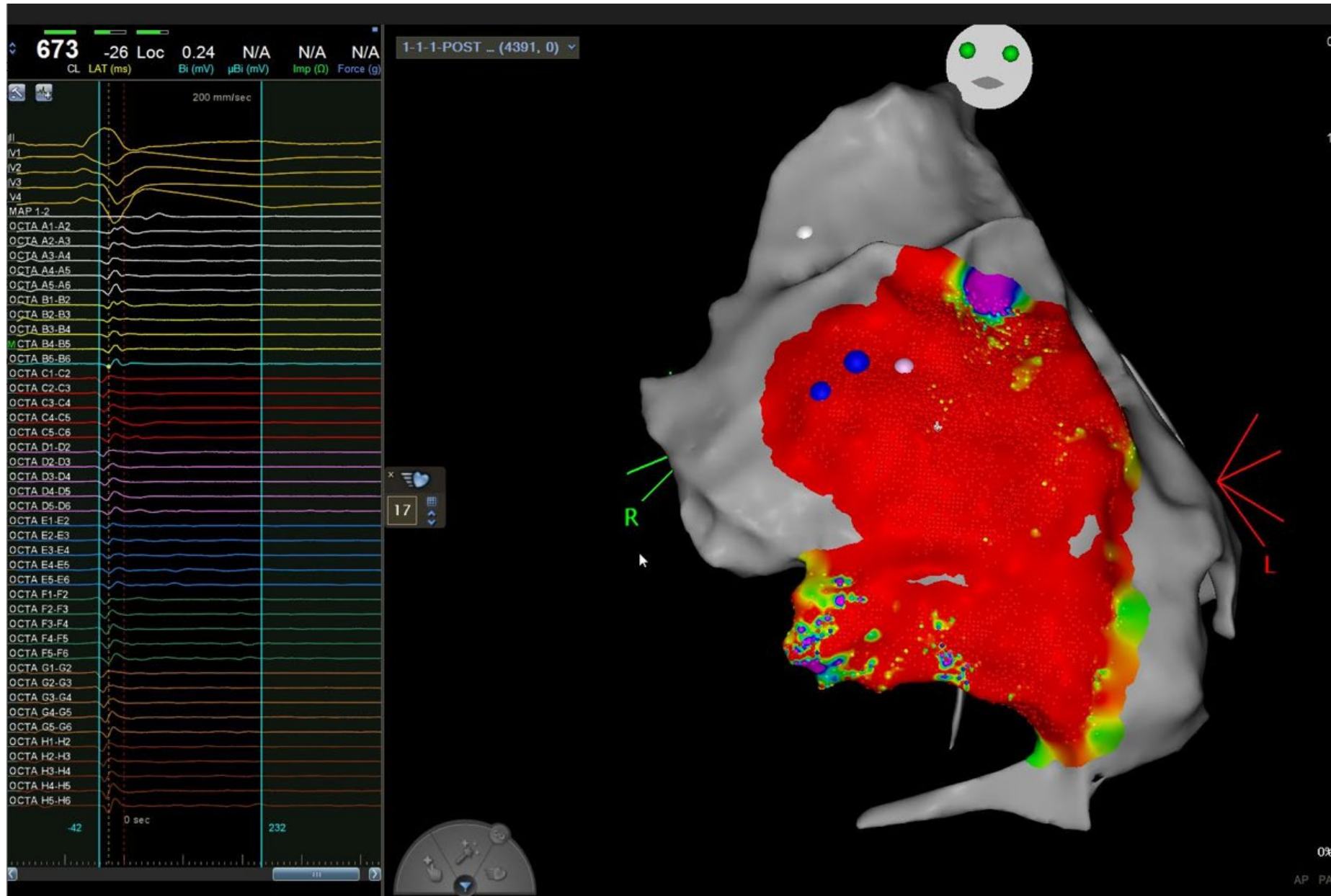
Pre Ajmaline and pre ablation EPI RVOT map:



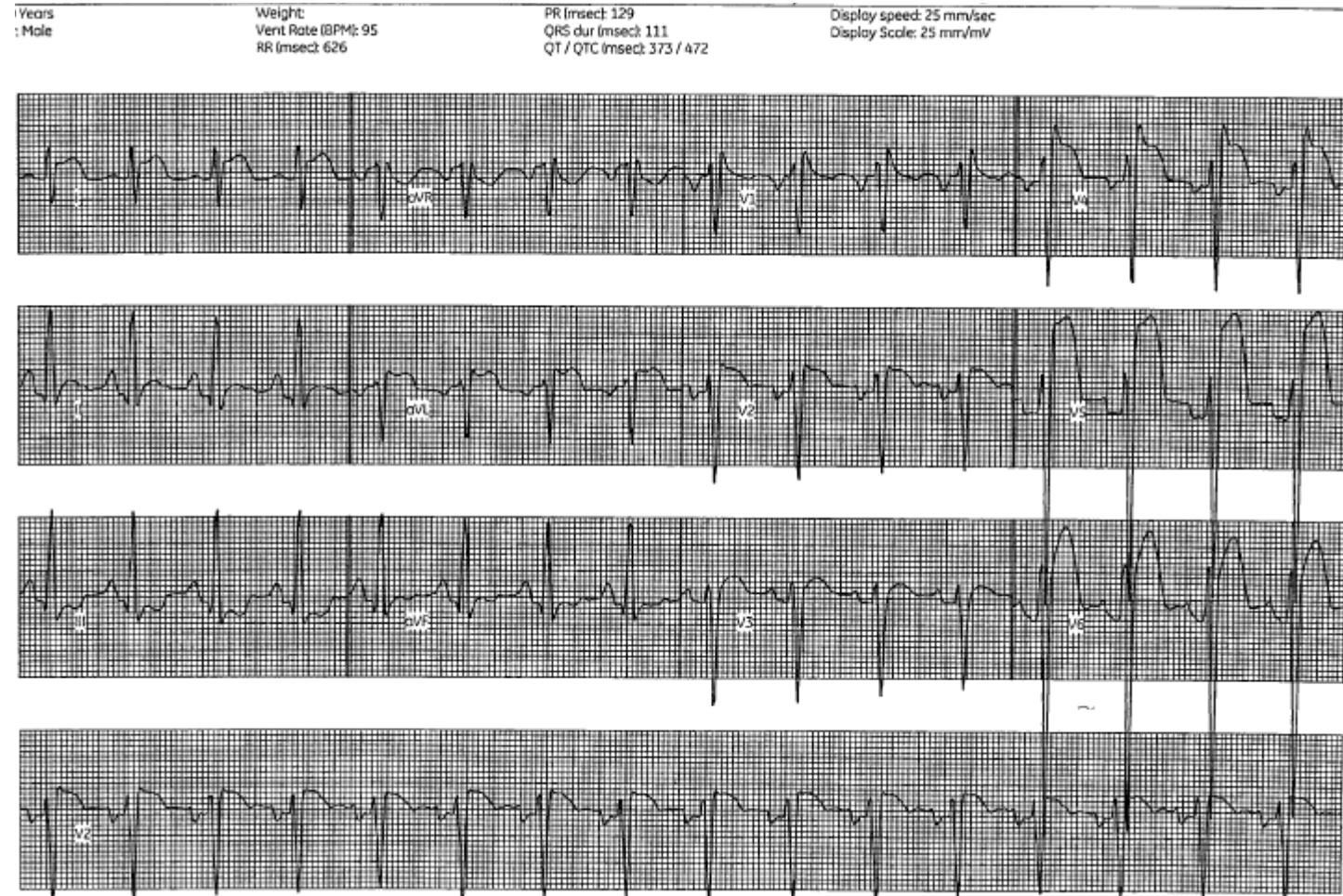
Post Ajmaline and pre ablation EPI RVOT map:



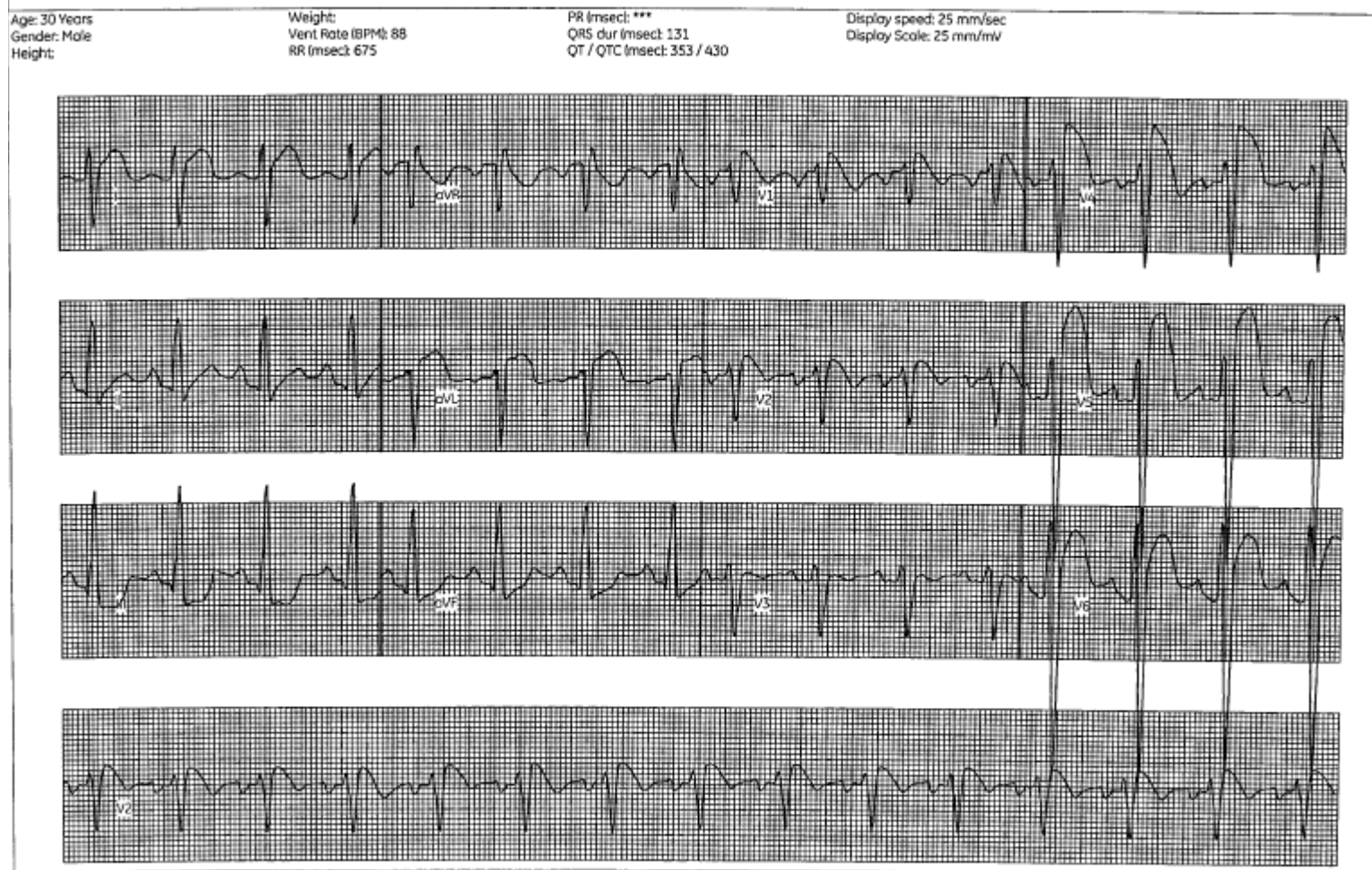
Post Ajmaline and Post ablation EPI RVOT map:



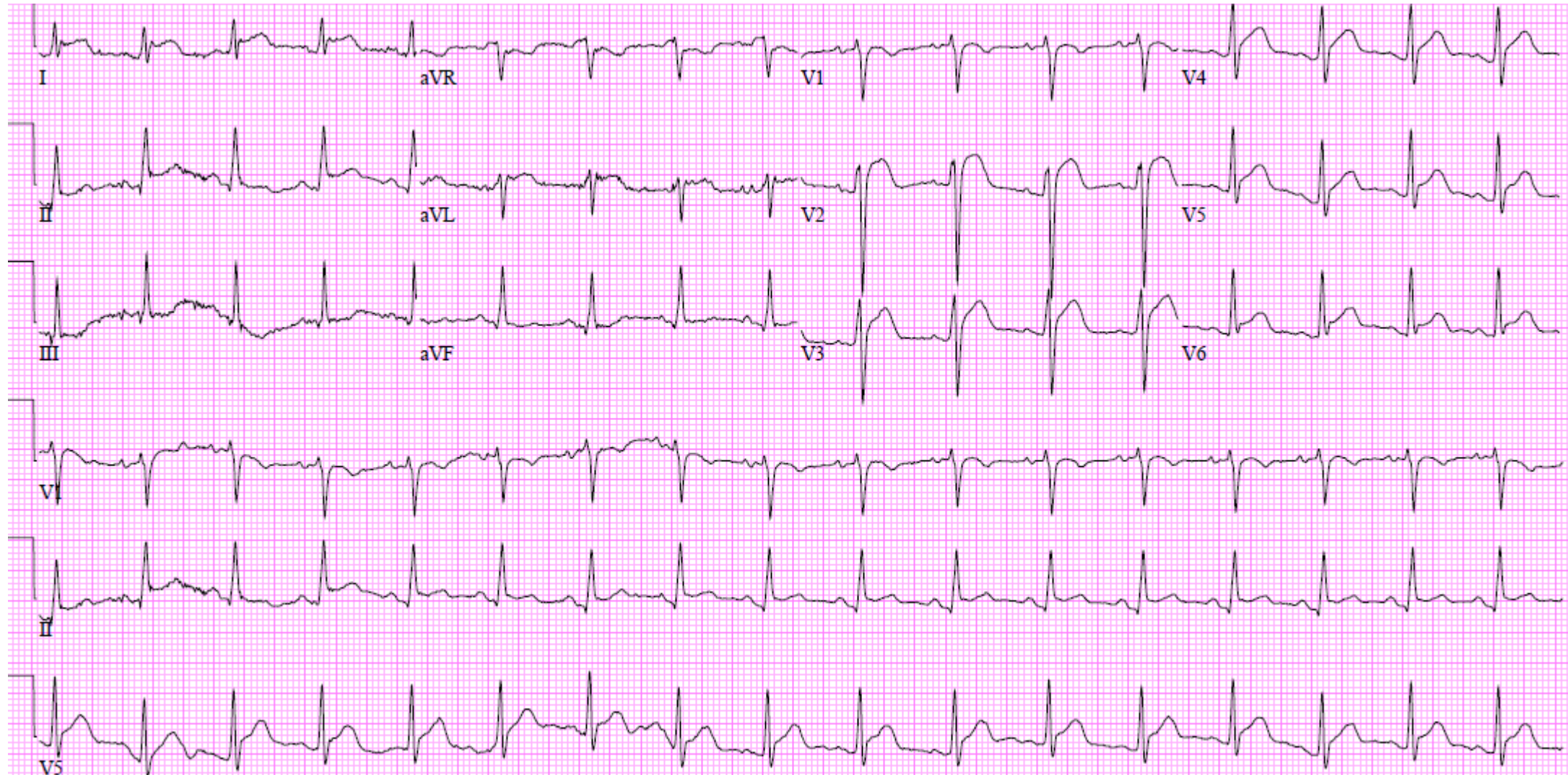
Post RFA High lead ECG V2= V1; V5= V2:



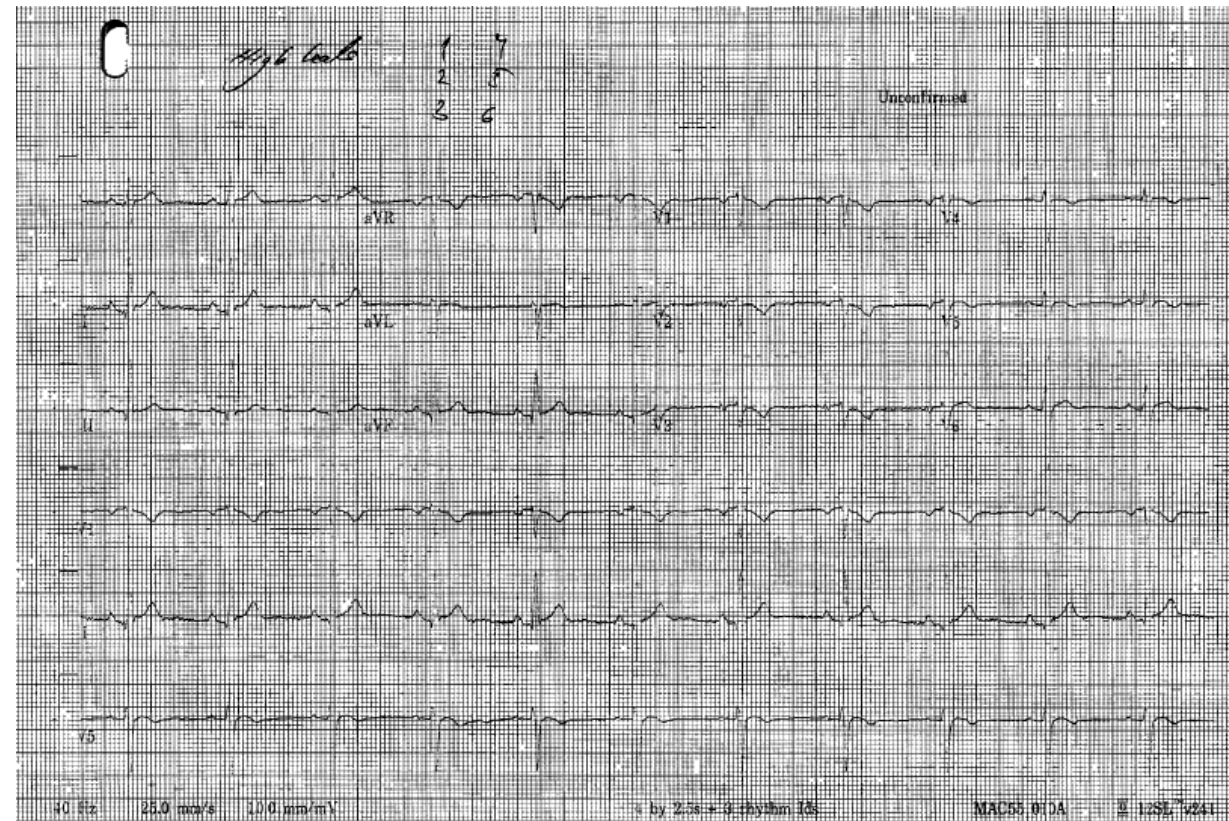
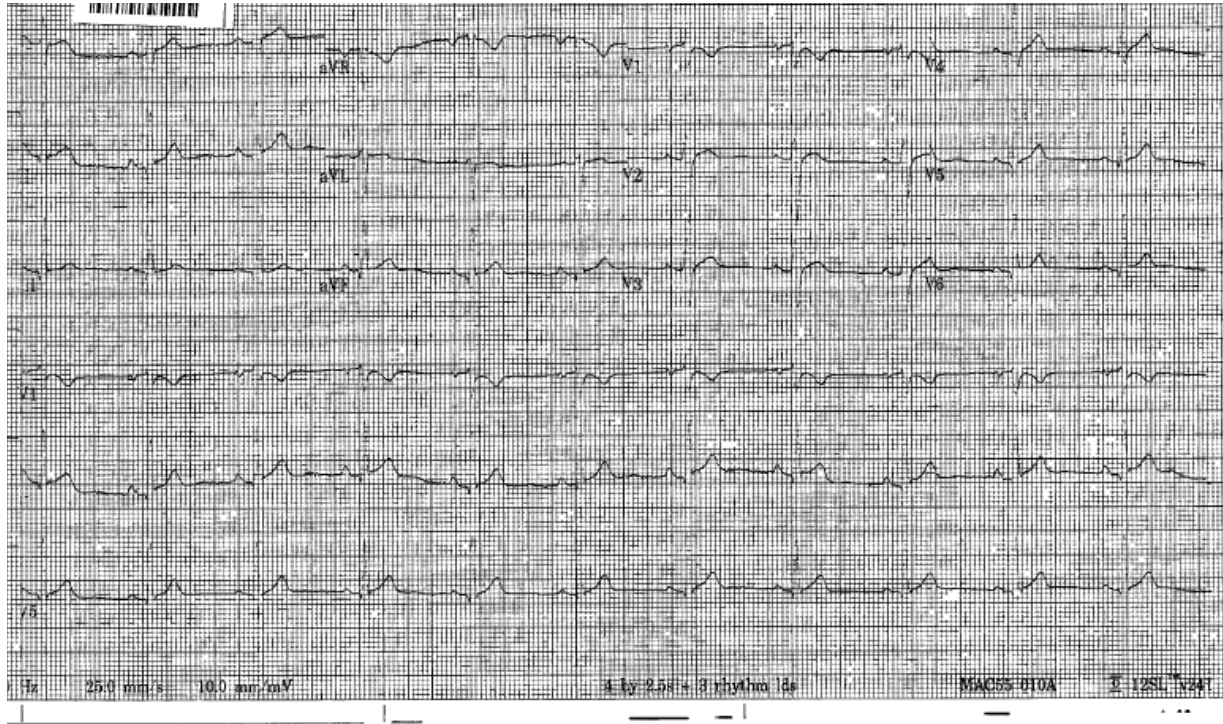
Post RFA post Ajmaline High lead ECG V2= V1; V5= V2:



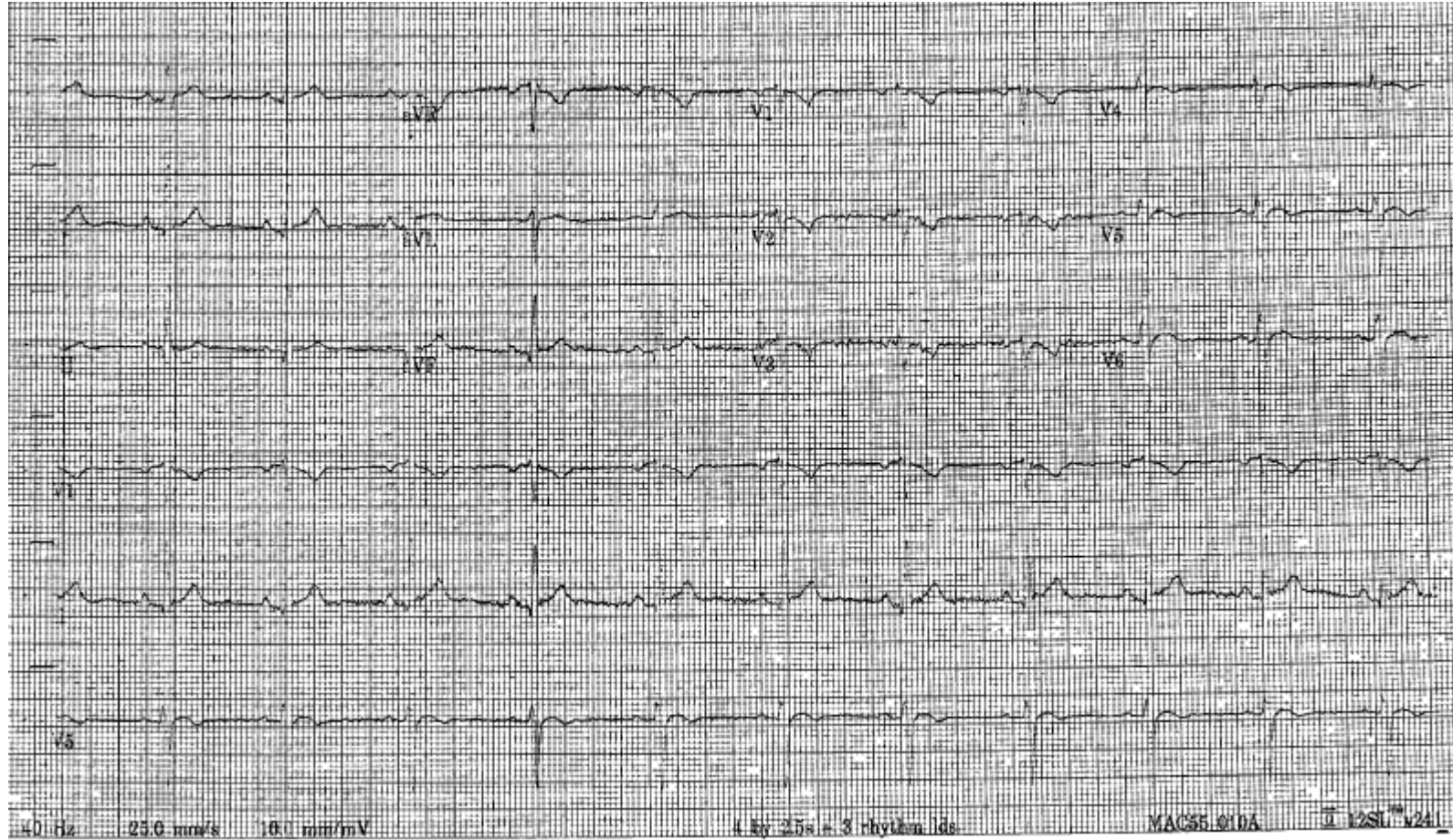
ECG on day 1 post RFA:



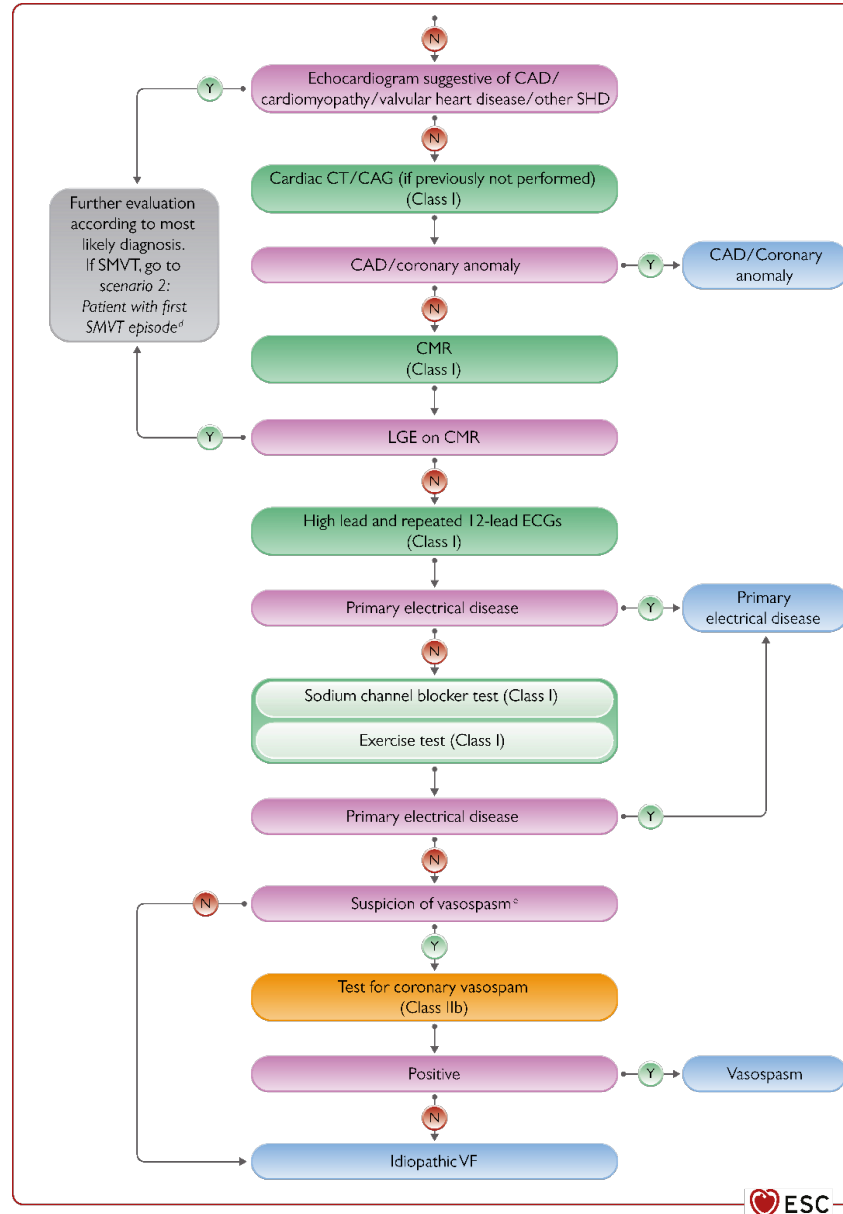
Baseline and highleads ECG 1 month later:



Ajmaline+ high leads ECG 1 month later:



DISCUSSION:



Electrical Substrate Elimination in 135 Consecutive Patients With Brugada Syndrome

Carlo Pappone, MD, PhD*; Josep Brugada, MD, PhD*; Gabriele Vicedomini, MD;
Giuseppe Ciconte, MD; Francesco Manguso, MD, PhD; Massimo Saviano, MD;
Raffaele Vitale, MD; Amarild Cuko, MD; Luigi Giannelli, MD; Zarko Calovic, MD;
Manuel Conti, MD; Paolo Pozzi, Eng; Andrea Natalizia, PhD, Eng; Simonetta Crisà, Eng;
Valeria Borrelli, PhD; Ramon Brugada, MD, PhD; Georgia Sarquella-Brugada, MD, PhD;
Marco Guazzi, MD; Alessandro Frigiola, MD; Lorenzo Menicanti, MD; Vincenzo Santinelli, MD

Circulation A&E, 2017

Procedural Details:

- Median procedure time: 169 min
- Median RF time: 18 min
- No complications

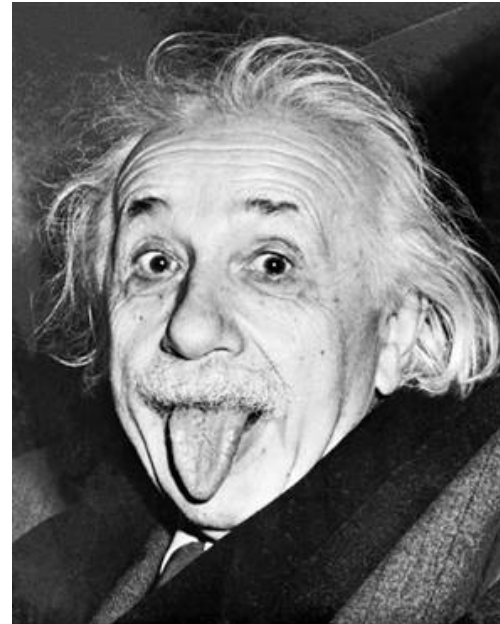
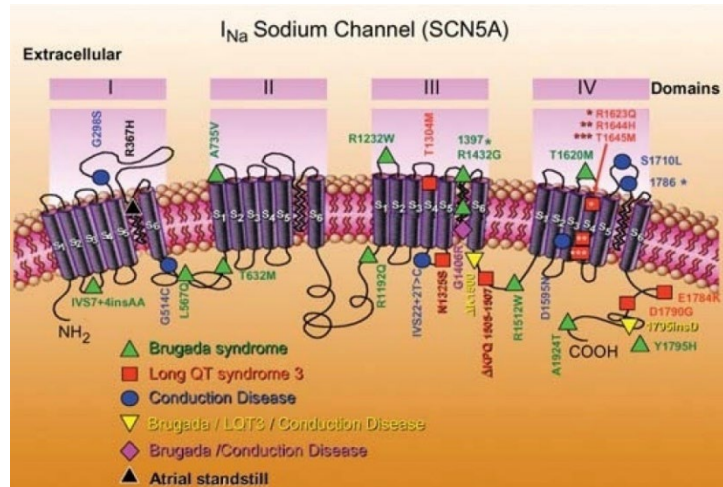
Outcome:

- ECG Normalization in 100%
- Noninducibility for VT/VF at end of Ablation in 100%
- Persistent ECG normalization during median 10 months of FU in 133/135 pts (99%) despite repeat Ajmaline testing
- Recurrent Arrhythmia in only 2/135 pts (1%)

Summary

- The arrhythmogenic electrophysiological substrate in BrS resulting in the ECG phenotype and the vulnerability to VF seems located in the anterior RV epicardium.
- Epicardial substrate ablation targeting sites with prolonged fragmented signals identified after administration of Na-Channel-Blockers can normalize the resting ECG and minimize (or even prevent) further ventricular arrhythmias.
- A prospective RCT comparing Ablation vs. Standard Rx after 1st ICD shock is under way (BRAVE study).
- For now, ablation is a welcome therapeutic option in selected symptomatic BrS patients.

Catheter Ablation in pts w/ Brugada Syndrome



«A question that sometimes drives me hazy: am I
or are the others crazy?»

- Albert Einstein -