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VIRTUAL LAF CONFERENCE

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SUBJECT: *Future of Catheter Ablations*

Many LAFers are utilising meds and/or supplements and/or lifestyle changes in the hope that they might stave off an ablation - presumably for a few years or more - until such time as ablation techniques have improved presumably to the stage where procedures are 99% effective (>12mths no meds) with near-enough 0% mortality/complications. Such a scenario will obviously arrive at the more highly regarded EP labs first. Ganglionated Plexi Ablation in conjunction with the more usual PVI certainly appears to be an interesting development in this regard.

How far does this group consider we are away time-wise from such a scenario as abovementioned and why??

Mike F.

"...stave off an ablation - presumably for a few years or more - until such time as ablation techniques have improved"

Not me, buddy. My ambition is to keep the afib boogies flapping their leathery wings in somebody else's life and just keep right out of this one!

For that matter, are any other surgical procedures 99% effective? Is that a reasonable expectation?

PeggyM

Peggy,

I'm certain that AFlutter ablations are close to 99% successful these days.

As per Hans' last data/survey, the best centres are now in the high 80s% and the tech is still improving: as such, I think mid-to-high 90s% isn't an unreasonable expectation in a few years time.

Oh, and thanks for the replies - I think you are the only person who has noticed that the CR is still around!!

Cheers,

Mike F.

Mike

I guess I am as skeptical as Peggy regarding 99% efficacy being possible.
I had my first and only ablation in Oct 2008 after just over 6 months of very symptomatic afib. One of my major factors for pursuing so quickly was a "gut feel" that the longer afib progressed the less likely that an ablation would be successful. I used sotalol for 8 weeks post ablation and nothing since. I did have one breakthrough in July that required me using my PIP propafanone which I attribute to dehydration due to several days of diarrhea. I continue to use the essential trio and believe they are a key to my "success". Perhaps an ablation in and of itself is not a "silver bullet" but one part of a program including nutrients and minerals that allows the heart to stay in NSR. I hope so.... BTW, my ablation was done by Dr Blair Halperin in Portland, Oregon.

Cyndie

I had two ablations, did not fix either my fibrillation or flutter.

Maze procedure fixed both immediately. Wonderful to wake up from the surgery with a stable pulse!!

Steve D

Mike,

Even considering substantial technological advances in catheter development etc. I firmly believe that catheter ablation is more an art than a science. A few electrophysiologists "have it", but most don't. Having done a lot of procedures is certainly important, but there is, in my opinion, much more to it than that. I think future technological developments will primarily benefit those EP's that do not have the "magic touch". The ones that do already achieve better than 90% success (in some cases with more than one procedure). So, should you wait for further improvements? That is a little bit like asking if you should have waited to see if someone better than Michelangelo would come along to paint the Sistine Chapel!!

Hans

Cyndie, i have found immodium very effective, even in the "house brand" varieties from Walmart and Riteaid. Also, it helps to take an extra glass of K gluconate in water every second diarrhea episode or so, to counteract the loss of K via the diarrhea. Best to you.

PeggyM

Hi Hans,

I have a hard time thinking of ablation as an "art", or "magic touch"- "some have it & others do not". My opinion is that successful ablations occur simply because of "experience". And what, most likely, experience teaches these EPs with the "magic touch" is simply how to be aggressive. Most likely aggressiveness is the key-not art or magic touch. Just know where, when and how much to burn. Maybe that might be the "ART" part; however aggressive burning somehow doesn't seem like art, just a surer way to stop future impulses from getting through. The greater the burn, the larger the scar-maybe to the point of having the majority of the inside of the atrium burnt up. Maybe those are the "successful" ablations. How are we to know? Maybe the sloppier the better, & those who are trying to be "artists" by being too careful by not applying enough frying juice are those who aren't having successful ablations. Maybe those of us who have had "successful" ablations are just lying in wait for our "burnt up" atrium's to give out prematurely. Sometimes I wonder, but am still thankful I went the ablation route.

Jim

Hi Hans

I believe we all recognise that the experience of the EP is one of the largest factors in the success of an ablation. However even with the best EP's, a high % of patients have repeat ablations (myself included, a LAF that has had 3 ops at Bordeaux and now contemplating another "touch up"). All of this is down to the difficulty of the procedure itself and the environment (inside the heart) it is performed in.
Having looked back thru previous posts for this year, I don't see a lot of discussion about the exmaze procedure? Some of their published results are almost to good to be true (87%+ success rate, no drugs) and if this is the standard of this op plus all the other benefits (no fluoroscopy, totally measured control of heat used for ablation, less risk of heart wall damage, no risk of esophageal injury, etc), then isn't it time to contemplate this as the potential replacement for current "within heart" ablation techniques?
I'd be interested in your comments of the exmaze technique and how you see it possibly replacing ablation as we know it now. In particular, I muse that the exmaze is a simpler procedure therefore enabling less skilled EP's to perform it successfully....

Allan

Hello Allan,

As far as I know the EX-maze procedure is fairly new. It was only in 2007 that Dr. Kiser reported on the first 12 patients who had undergone the procedure. I believe some European Centers report success rates of 85% (35 out of 41 patients). So, in my opinion it is a bit early to comment on whether this procedure will eventually replace catheter ablations. Please note that the EX-maze is performed by cardiothoracic surgeons, not electrophysiologists (EPs). Unfortunately, cardiothoracic surgeons have the habit of defining success as free of afib with or without drugs. A recent survey of over 200 Cox maze procedures claimed a success rate of 91%. However, reading the "small print" it was clear that only 67% of patients were actually free of afib without drugs. Also, all my surveys have shown that it is the skill of the person doing the procedure that is all important irrespective of which procedure is used.

Hans

Hi Hans

I guess the best of both worlds is the morphing of the stand alone exmaze into the even newer "Convergent Procedure". If their reports are true and the type of patient they are dealing with are "chronic" AF sufferers, which catheter ablation has not had a high success rate with in the past, their results for 2009 look very promising.
Maybe this bodes well for us LAF sufferers in the not to distant future although the point is still well noted, the success of the catheter ablation side of this procedure is still hugely dependant on the skill of the EP!

Allan

Allan,

The "skill" factor is also very important for the maze and mini-maze procedures. According to my 2008 Ablation/Maze survey top-ranked cardiothoracic surgeons had complete success rates (no afib, no meds) of 88% and 62% for the maze and mini-maze procedures respectively. The corresponding success rates for other than top-ranked surgeons were 33% and 50%.

Hans

I have a difficult time imaging that success could be defined as still using drugs. What am I missing?

Jackie

Jim - When I watched the many video clips of EPs doing ablations at the AF Summit held here in Cleveland about 5 years ago, I definitely came away with the idea there is some "art" involved... but more so... a high degree of skill, knowledge and experience.

The way they showed the burns being laid down was awesome because they decided when to stop the energy or the power by observing the microbubbles that were seen on the ICE guidance monitoring equipment that was also inside the heart. As the microbubbles (a result of heated tissue) reached a certain quantity or density, the energy was stopped so that the tissue didn't overheat and cause damage in the area. Too much heat in a thin area would result in tamponade...so aggressive burning? Maybe, but call it art or knowledge/experience and skill - it's what defines or distinguishes aggressive burning and a safe, successful ablation from a catastrophe.

Anytime anyone goes into a heart for any reason, they need skill and a huge amount of knowledge and experience to back it up.

You and I were fortunate that we had successful and safe Natale ablations.

Regards, Jackie

Hans,

I'm guessing that you are aware of the ablation and cryo-balloon-inside -the-PVs combo that Schilling and his team are currently doing at the London AF centre??

http://www.dailymail.co.uk/health/article-1184278/Pioneering-procedure-cure-faulty-heartbeat.html

What do you think??

Mike F.

Hans

If the addition of the cyro procedure inside the PVs shows such great results then we need to work out why.
Since they also perform a full PVI as part of the op then one must ask how the removal of already neutralised triggers can make such a big difference.

Allan

Mike,

Yes, I am aware of Dr. Schilling's work with a cryoballoon producing lesions inside the pulmonary veins where using RF ablation would result in stenosis. I am still not convinced that cryo lesions are durable. I think it is a bit like wart removal. If you freeze it it tends to come back. If you ablate it it likely won't. Nevertheless, it is a promising approach, but I think we need long-term (4-5 years) results before "pronouncing" on its merits.

Hans

Two ablations. Both worked relatively well after a few months until some new trigger set me off again:
1) prostrate exam. magnesium depletion in prep? (this prompted second ablation)
2) pneumonia recently has me mostly in a-fib for several weeks now.

Is there any known relationship between pneumonia (or other pulmonary events) and a-fib? Seems logical but I've not heard of one.

I am trying to determine next step now. Any suggestions?

Mike K

Hello Mike,

Both viral and bacterial infections are known triggers for afib episodes. Hopefully you'll return to sinus rhythm once your pneumonia is a thing of the past.

Hans

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