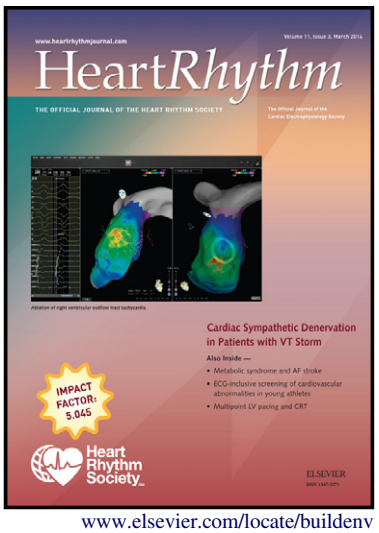

Finding the optimal ablation site in ventricular tachycardia through a single electrogram: Is it too good to be true?

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Finding the optimal ablation site in ventricular tachycardia through a single electrogram: Is it too good to be true?

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Catheter ablation for ventricular tachyarrhyhthmias (VT) has steadily improved in patients with ischaemic cardiomyopathy and in fact, international guidelines recommend its use as an adjunct to anti-arrhythmic therapy in patients experiencing appropriate ICD shocks.[1,2] The procedure, however, is not without its challenges. Ablation of a VT circuit is dependent on multiple factors, the most important being the identification of a critical isthmus of slow conduction that facilitates re-entry. Slow conduction through surviving fibers of any infarct zone may produce late or isolated diastolic potentials as well as fractionated electrograms that may or may not play a role in a given VT. Studies characterising the spatial relationship between late diastolic potentials and the components of re-entrant VT circuits (entrance, mid-isthmus, exit and outer loops) based on timing alone[3,4] have found it difficult to distinguish a critical ablation site from bystander sites.[5] Strict entrainment criteria have been invoked to