



REVIEW ARTICLE

Atrial fibrillation ablation beyond pulmonary veins: The role of left atrial appendage

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KEYWORDS

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Abstract The role of pulmonary vein isolation in patients with non-paroxysmal atrial fibrillation (AF) is only modest. Several studies have demonstrated the role of the left atrial appendage (LAA) in initiating and maintaining of this arrhythmia. We review in this article the incremental benefit in free-arrhythmia recurrence of LAA electrical isolation in patients undergoing procedures for persistent AF or long standing persistent AF either using radiofrequency ablation, cryoablation or Lariat device implantation. Likewise, acute complications, anticoagulation and the risk of ischemic stroke after LAA electrical isolation (LAAEI) are analyzed. LAAEI in addition to standard ablation appears to have a substantial incremental benefit to achieve freedom from all atrial arrhythmias in patients with persistent AF and long standing persistent atrial fibrillation (LSPAF) without increasing acute procedural complications and without raising the risk of ischemic stroke.

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Introduction

Atrial fibrillation (AF) is the most common arrhythmia in the elderly population (>65 years). Several antiarrhythmic medications have been used to control this arrhythmia with limited efficacy and numerous short and long-term side effects. Likewise, several arrhythmogenic mechanisms have been proposed for AF and in turn many ablation strategies have been tested. Most of these studies have been small observational single center experiences, which have not been validated or replicated worldwide. As elegantly

demonstrated in the landmark study by Haissaguerre and colleagues, pulmonary veins (PV) play an extremely important role in the initiation and maintenance of AF.¹ It has been established by several studies that wide antral pulmonary vein isolation (PVI) is more efficacious than ostial PVI in achieving freedom from any atrial tachyarrhythmia recurrence at long-term follow-up.² It is now well known that the role of the PVs is more pronounced in paroxysmal AF than in persistent AF or long-standing persistent AF (LSPAF). Persistent AF or LSPAF is a complex arrhythmia and frequently requires extensive catheter ablation (CA) targeting thoracic veins other than the PVs and some times large areas of atrial myocardium. Several studies reporting results on CA of persistent AF have been published to date. Most of these studies are observational with very different methodologies and end

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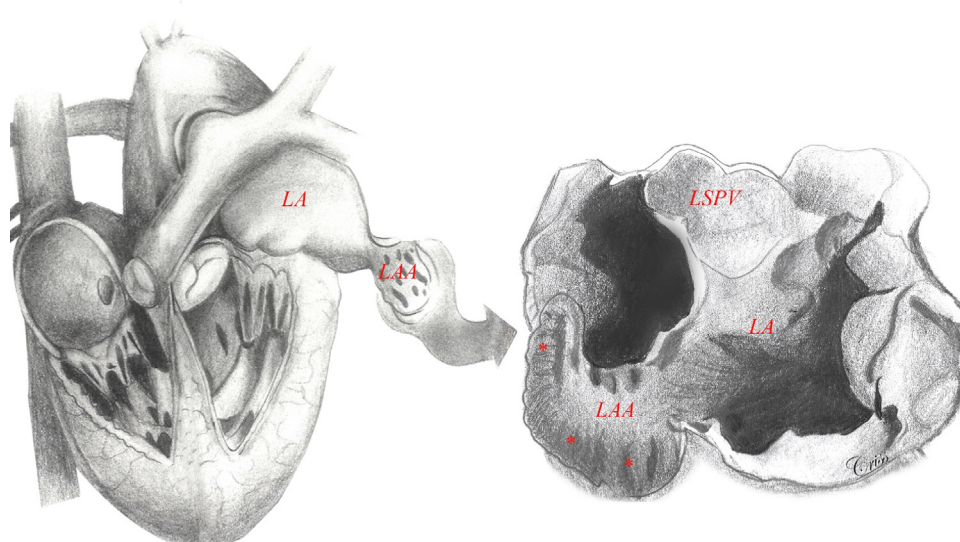


Figure 1 Left atrial appendage anatomy (classic ‘chicken wing’ morphology). The LAA is a remnant of the primordial embryonic left atrium, hence the presence of pectinate muscles. Note the close relationship between the LAA and the LSPV, which is very important in the setting of LAAEI during ablation for AF. Asterisks show heavy trabeculations (pectinate muscles). Abbreviations: LA: left atrium; LAA: left atrial appendage; LSPV: left superior pulmonary vein.

points using different ablation strategies and targets. As a result, there has been an astonishing variation in success rates at short- and long-term follow-up within and between techniques, suggesting that the optimal ablation approach for persistent AF and LSPAF is still to be elucidated.³

Although the STAR AF (Substrate and Trigger Ablation for Reduction of Atrial Fibrillation) trial was the first randomized control trial (RCT) showing that complex atrial fractionated electrograms (CFAEs) ablation guided by automated mapping software could have an additive benefit over PVI alone,⁴ more recently the results from the STAR AF II trial have been published.⁵ In this large multicenter RCT, participants with persistent AF received PVI vs. PVI plus CFAEs ablation vs. PVI plus empiric linear ablation (i.e. atrial roof line and a line along the mitral valve isthmus). Surprisingly, after following these patients for 18 months, freedom from AF occurred in 59% of the PVI group, 48% of the PVI plus CFAEs group, and 44% of the PVI plus lines group with no statistical difference among groups ($p=0.15$). Freedom from AF after two procedures occurred in 72% of the PVI group, 60% of the PVI plus CFAE group, and 58% of the PVI plus lines group ($p=0.18$).⁵ Empirical isolation of the posterior left atrial (LA) wall might also have a role in patients undergoing AF ablation. From an embryologic, anatomic, and electrophysiological standpoint, the posterior wall should be considered an extension of the PVs and its isolation has been proven to improve outcomes in paroxysmal and non-paroxysmal AF patients.⁶ We recently published data from the AATAC multicenter RCT, in which patients with persistent AF and left ventricular ejection fraction $<40\%$ were randomly assigned to undergo CA for AF or receive amiodarone.⁷ After a minimal follow-up of 24 months, 70% of patients in RFA group were recurrence free after average 1.4 procedures in comparison with 34% in the amiodarone group, $p<0.001$. More importantly, higher success was reported in patients undergoing PVI and posterior wall isolation in comparison with PVI

alone (79% and 36%, respectively, $p<0.001$). There was no significant difference between PVI alone and amiodarone, which suggest that posterior wall isolation might be necessary to achieve better results.⁷ However, there is no large RCT proving this concept.

Left atrial appendage

Embryologically, the left atrial appendage (LAA) is a remnant of the primordial embryonic LA, which explains its trabecular appearance (Figure 1). It was not until the mid-1950s that the LAA, previously considered a trivial and non-functional anatomic cardiac structure, was identified as the main location of thrombus formation in AF (i.e., 93% in non-valvular AF).⁸ Ever since, the LAA has become the interest of several investigators who have looked deeper into it in different angles including understanding its anatomy, physiology and role on initiation and maintenance of AF.

Left atrial appendage electrical isolation

We always believed that this structure deserved special consideration when mapping and ablating patients with persistent AF and LSPAF. In 2005, Takahashi et al. reported a case of a patient with paroxysmal AF, in whom multiple foci were identified in the LAA after PVI. The patient was successfully treated by CA by disconnecting this structure from the LA.⁹ The arrhythmogenic role of the LAA was not well known until 2010 when our group initially reported on the prevalence of triggers firing from the LAA and the optimal strategy to eliminate these foci to increase the procedural success rate. Nine hundred eighty-seven consecutive patients underwent redo CA for AF (29% paroxysmal, 71% non-paroxysmal) in that study. All patients had demonstrated isolated PVs. The study not

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