

RF ablation under sequential VRA or VCS pacing

We hypothesized that sequential VA pacing can attenuate the dislodgment of the catheter tip during RF ablation. As shown in Table 1, in all patients, there was no significant difference between values obtained before and after elimination of the accessory pathway in either projection. All accessory pathways were successfully eliminated without dislodgment of the ablation catheter.

Typical examples of intracardiac electrograms recorded during RF ablation of a left-

sided accessory pathway is shown in Fig. 6. After obtaining a stable catheter position with appropriate localization of the accessory pathway as judged by the earliest retrograde atrial activation on the local electrogram during RV pacing, sequential VRA pacing was initiated before the application of RF current. In this case, sequential VRA pacing was performed at a pacing drive cycle length of 500 ms and a VA interval of 60 ms. During sequential VRA pacing, after no change in the local activation sequence at the distal coronary sinus (CS₁₋₂) was confirmed, implying that conduction was through the accessory pathway, RF current was applied while monitoring the change in the

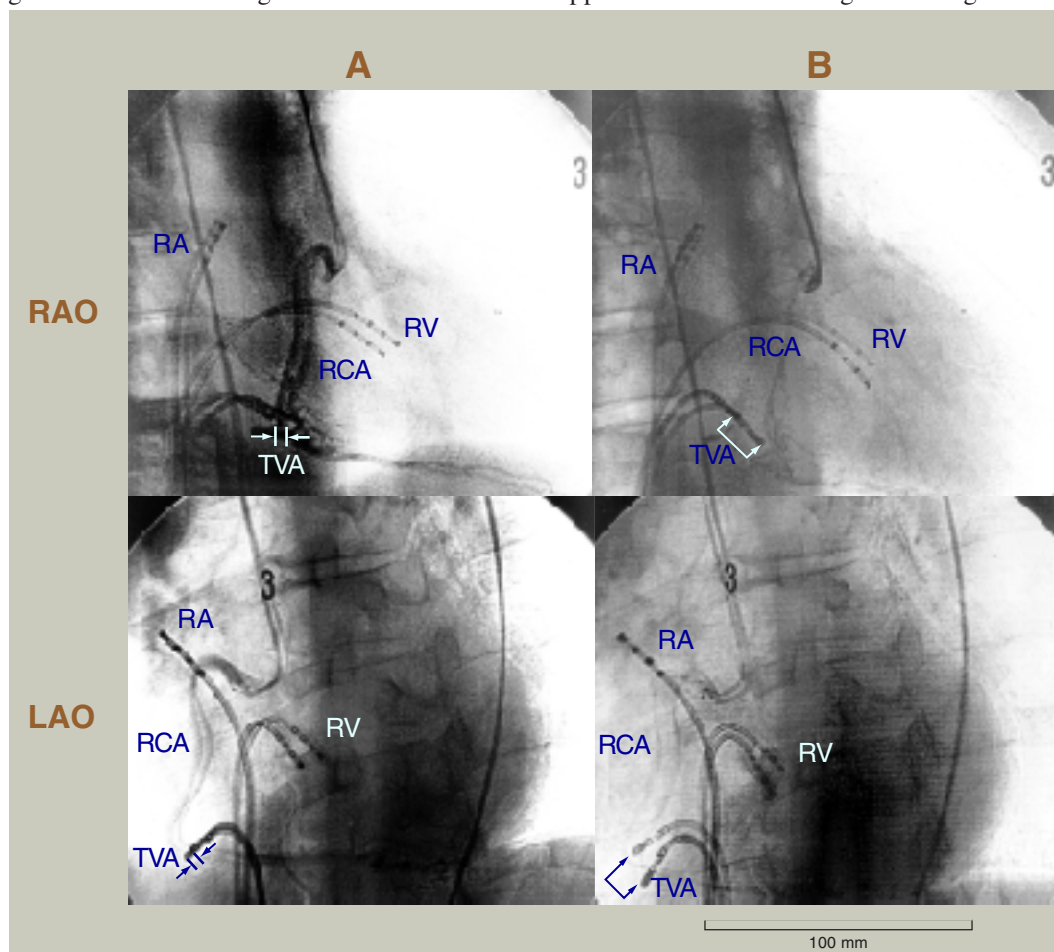


Fig. 5. The fluoroscopy images of the right coronary artery angiogram in the 30° right anterior oblique (RAO) and 45° left anterior oblique (LAO) projections during sequential ventriculo-atrial pacing (A) and right ventricular pacing when a fusion beat occurred (B). Two images of the diastolic and systolic phases are superimposed during each pacing attempt. See the text for details. RA, catheter in the right atrium; RCA, right coronary artery; RV, catheter in the right ventricle; TVA, catheter on the tricuspid valve annulus.