The Substrate Maintaining Persistent Atrial Fibrillation

Michel Haïssaguerre, MD; Matthew Wright, MBBS, PhD; Mélèze Hocini, MD; Pierre Jaïs, MD

Complex fractionated atrial electrogram (CFAE) ablation is one successful approach for treating patients with persistent atrial fibrillation (AF), along with strategies that incorporate pulmonary vein isolation and linear lesions. In this issue of Circulation: Arrhythmia and Electrophysiology, Oral et al investigate the effect of right atrial CFAE focused ablation in patients with long-lasting persistent fibrillation. All patients had CFAE ablation in the left atrium and coronary sinus, and patients who did not convert to either sinus rhythm or atrial tachycardia were randomized to either additional right atrial CFAE ablation or to no further ablation. Patients were followed up for more than 1 year with similar outcomes in both groups, which suggests that right atrial CFAE ablation has no incremental benefit to targeting CFAE in the left atrium in persistent AF. Oral et al do acknowledge some limitations in their study design, which may have given a false-negative result.

Does the right atrial substrate play an important role in persistent AF, and how do we distinguish patients in whom the right atrium needs to be targeted as part of a catheter ablation strategy from those in whom the right atrium is unimportant?

Does CFAE Represent the Atrial Substrate?
The Heart Rhythm Society/European Heart Rhythm Association/European Cardiac Arrhythmia Society expert consensus document on catheter and surgical ablation of AF suggests that areas with CFAEs potentially represent AF substrate sites, ie, the atrial, venous, and ganglionic tissue that is critical in perpetuating or “driving” AF. Is this widely held assumption that CFAEs are related to the substrate correct? CFAEs are defined as electrograms displaying >2 deflections that are fractionated or have a short cycle length <120 ms, in their maximal form giving continuous electrical activity. Twenty years ago, such split potentials were observed after premature stimuli in patients with or without AF, and the split potentials indicated local slow conduction. That split potentials are caused by nonuniform or slow atrial propagation, resulting in different activations between myocardial fibers sensed by the recording electrode, is supported by multiple prior studies, notably those by Spach and Allessie. Underlying myocardial fibers have poor electrical coupling and can be separated by fibrous tissue, causing activation to spread into a maze of micropathways. Fractionation is critically dependent on both the direction of wavefront progression and its cycle length. In animal experiments, Kalifa et al demonstrated that the fractionation was located at the boundary of high-frequency sources because of wavebreak related to local tissue architecture. In humans, high-density mapping during AF demonstrated that the formation of CFAE was preceded in 91% of mapped sites by shortening of the atrial cycle length, which further supports the key role that cycle length plays in the generation of CFAE.9 In practice, diffuse fractionation will accompany short AF cycle length (AFCL) (commonly ≈150 ms in persistent AF); more limited fractionation will occur in paroxysmal AF because of the longer AFCL (typically >170 ms); and little fractionation is observed when AFCL is long.

Therefore, the mechanism by which CFAE ablation can prolong AFCL or terminate AF is unknown. On the basis of their physiopathology, we may hypothesize that some fractionated areas act like a reservoir of microreentrant activities, continually refueling the fibrillatory process.

In animal experiments, the AF substrate involves wandering wavelets, macroreentries, and focal sources. In humans, no study has demonstrated the feasibility of individually discriminating these mechanisms. Noncontact mapping, allowing simultaneous acquisition of beat-to-beat activity in the whole chamber, is theoretically the ideal tool to map AF; however, so far it has not proved practical in the clinical setting. Studies that use frequency domain analysis are limited by methodological issues, notably with regard to fractionation, and so far they also have not been helpful in persistent AF. Time domain analysis is difficult because of irregularity of cycle, definition of early versus late activation, and ambiguity in ascribing local activation during fractionated activity. In addition, a perpetuating source may act intermittently or may be rendered “invisible” when the surrounding tissue has been rendered refractory by other coexisting sources (see below).

Identification of AF sources has been reported to be feasible with high-density mapping during specific conditions, either perioperatively or during organized AF.11 These studies have demonstrated atrial activation spreading from focal point sources or from small areas harboring localized reentry, displaying fractionated or nonfractionated electrograms at the source location.

Indirectly, by evaluating the impact of CFAE on AFCL, we have learned that all anatomic areas are not equal in their contribution to maintenance of AF. Regions that have the greatest influence are the pulmonary veins, the base of the left
atrial appendage, and the inferior left atrium–coronary sinus interface. Interestingly, these regions have the common feature of being annexed to the main body of the left atrium by numerous connections. Their arrhythmogenic potential may be due to local structural discontinuity or to dynamic “ping-pong” interaction between the 2 structures that continuously refuel the AF process. In support of this hypothesis, it is striking that isolation of the pulmonary veins often leads to cessation of pulmonary vein tachycardia, distal to the isolation site, which suggests that the connection to the left atrium was necessary for the continuation of venous firing, and vice versa.

**Fibrillatory Cycle Length as a Marker of Substrate Burden**

It is well known that the extent of AF substrate correlates with the duration of AF and the volume of the left atrium. Furthermore, AFCL, a measurement of fibrillation rate, strongly correlates with acute termination of AF both by catheter ablation and pharmacological or electrical cardioversion and hence can be used as a marker of AF substrate burden. That AFCL is not simply a surrogate of the local refractory period is evidenced by the prolongation of AFCL at remote sites during ablation. Additional insights have been gained by computer modeling of AF. In a model based on the assumption that AF is due to multiple sources, AFCL progressively decreases with the addition of more focal sources, up to a threshold. In this computer simulation, although all sources are continually firing, not all of them can be “seen” at any given time, and thus several snapshots in time are necessary to be able to visualize and map all of the sources (Figure 1). Initially, AFCL changes only minimally, as another source can take over from the one that has been ablated. Then, as more sources are eliminated, the AF becomes more organized, and the AFCL prolongs to the point of conversion to either sinus rhythm or atrial tachycardia, when only 1 or 2 sources are present (Figure 2). This correlates well with what we have observed during catheter ablation of persistent AF. The shorter the baseline AFCL, the more ablation is required to prolong the AFCL and to reach the critical point at which conversion to either sinus rhythm or atrial tachycardia occurs, typically around 200 ms.

**Multiple Sources as a Major Mechanism in Human AF**

The evidence from catheter ablation supports the hypothesis that AF involves multiple sources. Source is used in a broad sense to indicate a localized origin of atrial wavefronts,
AF ablation success rates with a number of different strategies—pulmonary vein isolation, electrogram-based ablation, and linear lesions—are continually improving. The combination of these approaches has led to unprecedented success in treating persistent AF, particularly when procedural termination of AF is achieved. Such patients have better outcomes than patients without termination, as observed in the study by Oral et al. Intuitively, AF termination means that all actively participating elements have been eliminated; in our opinion, this represents the optimal end point. After restoration of sinus rhythm, assessment and completion of pulmonary vein isolation and linear block are necessary to ensure long-term maintenance of sinus rhythm.

This extensive ablation approach is associated with significant alteration of atrial tissue, and although extensive scarring and low-voltage areas result (~40% of left atrial surface), mechanical function is restored. In patients who had no atrial function in AF, restoration of mechanical function is a great improvement, and we can expect it to affect their embolic risk, ventricular function, and quality of life. Nevertheless, we should do better. In addition to improving ablation catheters, further effort should be directed to identifying the sources or other mechanisms that are active in any particular patient, either by refining the present mapping tools or by developing new techniques. One challenge is to decipher CFAEs and link them to the underlying substrate to obtain an effective cure of AF with the minimum degree of ablation in each individual patient.

Disclosures
None.

References


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