Unipolar Electrogram Morphology to Assess Lesion Formation During Catheter Ablation of Atrial Fibrillation: Successful Translation Into Clinical Practice

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The past decade has seen a significant increase in catheter ablation procedures for atrial fibrillation (AF); however, data on the efficacy of pulmonary vein (PV) isolation (PVI) are soberingly modest, with single and multiple procedure success rates of 54% and 79% for paroxysmal AF, respectively, during long-term follow-up (≥3 years).2 The main mechanism of AF recurrence after catheter ablation is resumption of PV-left atrial (LA) conduction.3 The time-dependent inevitability of recovery of PV conduction has been consistently demonstrated in acute studies showing PV conduction in ≤93% of patients during an intraprocedural waiting period of 60 minutes after PVI.4 Furthermore, late recurrence of AF is associated with conduction recovery in ≥1 PV in >97% of patients who are having a redo procedure.2 Thus, durable PVI is critical if we are to make inroads toward enhancing procedural efficacy.

Gaps in the ablation line5 and failure to produce transmural lesions6 are implicated in recovery of PV conduction. PVI can be achieved after partial completion of a circumferential ring of lesions around the PVs, irrespective of intervening gaps. This is thought to result from a combination of irreversible and reversible atrial injury.7 Reversible atrial injury may stem from incomplete lesion formation that causes temporary electric uncoupling but not cell death ≤3.5 mm away from the lesion boundary, dependent on tissue temperature and tissue geometry.8 With time, tissue at the boundary of the transmural lesion recovers normal conduction during the course of 1 to 4 weeks.4 Thus, lesion gaps that exhibit conduction block frequently go undetected during the index procedure, and block persists for up to several weeks or months thereafter until tissue injury heals. Conduction block may occur in tissue with normal conductivity despite a gap of ≤1.4 mm and in abnormal tissue with a gap as large as 4 mm.9 Complex gap geometry may produce transient unidirectional and rate-dependent block.10

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application continued at each site until the development of a completely positive unipolar signal at that site. The second group of 50 patients was a historical control group who underwent PVI with 30 seconds of ablation at each site. In both groups, continuous and wide circular lesions around the PVs were created and the veins isolated 2-by-2 at the antra. The end point was bidirectional block across the PV-LA junction with a 30-minute waiting period to detect dormant conduction. Patient follow-up was standard with a 12-lead ECG and continuous 24-hour Holter monitor at 1, 3, 6, 9, and 12 months after ablation and every 6 months thereafter.

The pertinent findings of the study were that the unipolar ablation group compared with the controls had a statistically significant (1) reduction in procedural time, x-ray exposure, and total ablation time by 25, 6, and 37 minutes, respectively; (2) reduction in total energy required to achieve PVI by 66 kJ; and (3) 18% absolute reduction in the risk of recurrent AF at a mean follow-up of ≥2 years after the first ablation procedure off antiarrhythmic drugs (88% versus 70%). A mean of only 15±1 seconds of radiofrequency ablation was required to achieve a unipolar R morphology (considered a transmural lesion). Intriguingly, there was a high incidence of recovery of PV conduction (38%) in the unipolar ablation group, which was lower than the control group (53%) but did not reach statistical significance. A similarly high proportion of patients required carina ablation to achieve PVI (30% versus 32%). Of note, patients did not undergo adenosine testing nor pace capture along the line during the index procedure.

Of the 6 patients who had AF recurrence in unipolar RF group, all had evidence of recovery of PV conduction during the index procedure. Interestingly, at the redo procedure, gaps in the ablation line had recovered RS unipolar morphology, and ablation at these sites resulted in PV reisolation. Bortone et al18 are the first to use intraprocedural electrogram morphology as a measure of lesion effectiveness in an attempt to achieve durable PVI. The authors ought to be congratulated in successfully translating findings from an animal study into human practice and for achieving excellent mid-term AF-free survival for their patients. The attractiveness of the technique is clearly the shortened procedural time, radiation exposure, and superiority in outcomes, with the implementation of a reproducible, readily available intraprocedural tool that can be applied universally.

However, as with any new methodology, there are some limitations that need to be stressed. For one, loss of the negative deflection on the unipolar RS morphology is observed with reversible tissue injury, which is true of any of the indirect measurements of lesion transmurality. Additional evidence for the imperfect positive predictive value of the morphology change is the unexpectedly high rate of PV conduction recovery in the study group. We have found that rendering the ablation line unexcitable14,20 has reduced the intraprocedural rate of PV conduction recovery to <5%, although conduction recovery should be nil for a perfect lesion set.

These observations also highlight limitations of the ovine model on which the electrogram-based criteria for transmurality for this study are fundamentally based. In the Otomo study,19 only thin atrial tissue was tested, which makes the method particularly relevant to ablation at the thin posterior wall of the LA adjacent to the esophagus, where limiting RF energy is critical. However, it is not clear that unipolar electrogram morphology criteria apply to lesions in thicker tissue. We have shown, from independent studies at 2 centers, that median impedance decrease nearly doubles with an average contact force >20 g at the ablation catheter tip compared with poor contact and is consistent across different force-sensing platforms.21,22 In the study by Bortone et al,18 the control group had RF ablation performed for an empirical 30 seconds at each site without any feedback on electrogram abatement or impedance changes, presumably without adjustment of the catheter to improve contact. In fact mean impedance change was identical in the unipolar ablation and the control group, which is hard to explain because catheter adjustments made in the study group should have resulted in better contact and a higher average impedance decrease. Finally, the study was not randomized, and the use of a historical control introduces considerable selection bias; thus, results can only be interpreted as hypothesis generating.

We welcome the findings of Bortone et al18 because they represent an important step forward in la quête ultime for permanent PV isolation during catheter ablation for AF. More than any technique or technology or combination thereof, it is more important to appreciate that during and after RF application, if one pays meticulous attention to closing gaps and to scrutinizing the available lesion-specific information at your fingertips, more patients will have persistent PVI that will result in fewer recurrences of AF.

Disclosures

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