Endo-Epicardial Versus Only-Endocardial Ablation as a First Line Strategy for the Treatment of Ventricular Tachycardia in Patients With Ischemic Heart Disease

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Background—Epicardial ablation has shown improvement in clinical outcomes of patients with ischemic heart disease (IHD) after ventricular tachycardia (VT) ablation. However, usually epicardial access is only performed when endocardial ablation has failed. Our aim was to compare the efficacy of endocardial+epicardial ablation versus only endocardial ablation in the first procedure in patients with IHD.

Methods and Results—Fifty-three patients with IHD, referred for a first VT ablation to our institution, from 2012 to 2014, were included. They were divided in 2 groups according to enrollment time: from May 2013, we started to systematically perform endo-epicardial access (Epi-Group) as first-line approach in consecutive patients with IHD (n=15). Patients who underwent only an endocardial VT ablation in their first procedure (Endo-Group) included patients with previous cardiac surgery and the historical (before May 2013; n=35). All late-potentials in the scar zone were eliminated, and if VT was tolerated, critical isthmuses were also approached. The end point was the noninducibility of any VT. During a median follow-up of 15±10 months, the combined end point (hospital or emergency admission because of a ventricular tachycardia or reablation) occurred in 14 patients of the Endo-group and in one patient in the Epi-group (event-free survival curves by Grey-test, P=0.03). Ventricular arrhythmia recurrences occurred in 16 and in 3 patients in the Endo and Epi-Group, respectively (Grey-test, P=0.2).

Conclusions—A combined endocardial–epicardial ablation approach for initial VT ablation was associated with fewer readmissions for VT and repeat ablations. Further studies are warranted. (Circ Arrhythm Electrophysiol. 2015;8:882-889. DOI: 10.1161/CIRCEP.115.002827.)

Key Words: ablation ◼ chronic ischemic heart disease ◼ electrophysiology

Methods

Patient Population

The present analysis includes all patients with IHD referred to our institution from 2012 to 2014 for a first ablation procedure of sustained monomorphic VT.

Since May 2013, we decided to prospectively perform both endo and epicardial access as a first-line approach, in all consecutive patients with IHD referred for their first VT ablation procedure, except for contraindications. Baseline characteristics, safety, and outcome of this Epi-Group were compared with patients who underwent only an endocardial VT ablation in their first procedure (Endo-Group).

The Endo-Group finally included the following:

− Patients with previous cardiac surgery in whom epicardial access was contraindicated.
− The historical cohort of consecutive patients with IHD referred to our institution for a first VT ablation from 2012 to May 2013.
− A small number of patients from May 2013 to 2014 who underwent only endocardial ablation, despite not having...
WHAT IS KNOWN:

- Epicardial ventricular tachycardia (VT) ablation in patients with ischemic heart disease improves outcomes in terms of VT recurrences.
- However, ventricular access is performed in selected patients, either as a second option when a previous endocardial ablation has failed or as a first option only in selected patients (for instance when the VT are suspected to have an epicardial origin in the ECG).

WHAT THE STUDY ADDS:

- Endo-epicardial access as a first step in consecutive, unselected patients with ischemic heart disease who undergo VT ablation is feasible. However, an increased risk of pericardial effusion must be taken into account.
- It is noteworthy the significant number of patients in which epicardial targets were found in a first procedure.
- In this study, we compared endocardial versus endo-epicardial ablation as a first line therapy in unselected patients. Although we could not demonstrate a significant reduction of VT recurrences with this approach, it may improve clinical outcomes (hospital admission because of VT or need of reablation).

contraindications to epicardial ablation, because of physician preference (usually related to the lack of experience in epicardial access during the learning curve of the technique).

- This study was approved by the Institutional Review Board and all patients signed an informed written consent.

VT Ablation

The procedure was performed under local anesthesia and conscious sedation. A quadripolar diagnostic catheter was introduced via the right femoral vein to the right ventricular apex. The left ventricle was accessed retrogradely through the aortic valve, via a transseptal puncture, or both. Electroanatomical left ventricle maps were obtained using CARTO 3 (Biosense Webster, Diamond Bar, CA) or EnSite NavX (St Jude Medical, St Paul, MN). For ablation 3.5 to 4 mm saline-irrigated tip ablation catheters (Navistar Thermocool, Celsius Thermocool [Biosense Webster] or CoolFlex [ST Jude]) were used. Simultaneous recordings of ventricular bipolar electrograms (band-pass filtered 30–500 Hz) and 12-lead surface ECG were stored digitally (Prucka Cardiolab; GE Medical Systems, Milwaukee, WI). The procedures were performed under intravenous anticoagulation with sodium heparin (initial bolus of 50–100 IU/kg followed by a 1000 IU/h perfusion adjusted to maintain the partial time of thromboplastine activated above 250 s).

If the VT was not incessant, VT was induced with programmed stimulation (high rate pacing and extrastimuli test using 2 pacing cycles, ≤3 extrastimuli, from the right and, if necessary, left ventricle) and number of morphologies was recorded.

Isovoltage maps of the left ventricle’s endocardium and also epicardium in the Epi-Group were constructed. The voltage thresholds used to consider dense scar and border zone were 0.5 and 1.5 mV, respectively. Regions with late potentials inside or in the borders of a scar were annotated using color tags. A first attempt of VT induction was always performed. Points with QRS morphology during pace-mapping identical to that during documented VT were also annotated. When VT was present or induced and it was hemodynamically well tolerated, activation maps and entrainment-mapping techniques were performed trying to characterize the arrhythmia circuit. Radiofrequency energy was delivered in the power control mode through the irrigated tip catheters using a Stocart or Irvine generator with power set to 30 to 50 W and irrigation set to 17 to 30 mL/min. Radiofrequency lesions were created either during VT or sinus rhythm in the regions identified or supposed to be critical for the sustenance of clinical or inducible VTs. The end-point was the elimination of all late potentials in the endocardial scar and also in the epicardial scar in the Epi-Group. Lack of inducibility of any VT after ablation was considered acute procedural success; partial success was defined as inducibility of faster, nonclinical VT. In patients with induced, not tolerated VT before ablation that needed more than 2 DC shocks to be cardioverted, postprocedure inducibility was not systematically tested.

Pericardial Access

The pericardium was accessed percutaneously using the technique described by Sosa et al once the venous and arterial accesses were gained and before start of intravenous anticoagulation. As stated before, pericardial access was not performed in patients with previous cardiac surgery.

Before epicardial ablation, coronary angiography was performed to avoid coronary artery damage. Epicardial phrenic nerve capture was tested with bipolar pacing from the ablation catheter. When epicardial position of the ablation catheter was too close to a coronary artery or when phrenic capture was obtained from it, the catheter was slightly moved trying to avoid damage of such structures. If imminent damage was suspected, radiofrequency was not delivered.

Clinical Outcome and Follow-Up

All patients without previous implantable cardioverter defibrillator (ICD) implant were implanted before discharge except for one patient in the Epi-group with important pulmonary comorbidity. All patients were followed in the outpatient clinic at 3 months and then every 6 months after ablation.

End Points

Primary end points were the following:

1. VT recurrence that included an ICD appropriate therapy (antitachycardia pacing or shock) or a documented, slow, symptomatic VT not detected by the ICD.
2. A combined end-point that included hospital or emergency admission because of a new episode of VT or the need of a second ablation procedure.

Statistical Analysis

Continuous variables were expressed as median and interquartilic range. Discrete variables were summarized as percentages. Baseline characteristics were compared between Epi-Group and Endo-Group using nonparametric tests (Fisher’s exact test and Mann–Whitney Test for categorical and continuous variables, respectively). An adapted version of Cox regression, that takes into account the effect of all-cause mortality as competing event,10 was used to examine the univariated association between baseline variables and both end points (VT recurrence and the combined end-point).

The univariate effect of the combined epicardial ablation strategy (Epi-Group) on the incidence of the end-points (VT recurrence and combined end-point) was analyzed by the Fine and Gray18 event-free survival curves.

The interaction in the Epi-Group prognosis of those variables that significantly differed in baseline characteristics between groups (in
particular previous cardiac surgery) was also studied, and for that purpose, a second sensitivity analysis excluding patients with previous cardiac surgery was performed. A multivariate test was not considered because none of the candidate covariables had $P < 0.15$ in the univariate analysis and because of the small sample size. Estimated survival curves in both groups (Endo- and Epi-groups) were assessed by Kaplan–Meier analysis and differences between strata were assessed by Log-rank test. Univariate Cox-regression model was performed to find whether there were any baseline characteristics that predicted mortality for any cause. After that, a second sensitivity analysis excluding patients with previous cardiac surgery was performed. A 2-sided $P$ value of $<0.05$ was considered to be statistically significant for all analyses. Statistical analyses were performed using STATA 13.1 (StataCorp. 2013. Stata Statistical Software: Release 13.1. College Station, TX: StataCorp LP).

Results
From January 2012 to December 2014, 53 patients with IHD were referred for their first VT ablation procedure. Thirty-five patients underwent only endocardial ablation:
- Twelve patients because they had had previous cardiac surgery.
- Twelve patients included from January 2012 to May 2013 when a combined procedure, endo and epicardial access, was not performed as a first attempt yet.
- Eight patients from May 2013 that underwent only endocardial ablation, 7 because of physician decision as it is explained in methods and 1 patient because of skin lesions in the subxifoid area that contraindicated subxifoid access.
- Three patients in whom epicardial access failed (2 of them because of the existence of pericardial adhesions).

Figure 1 shows a flow chart where the incorporation of patients is depicted.

Table 1 shows a comparison of the baseline characteristics between both groups. There were no significant differences except for previous cardiac surgery, given that all operated patients were in the Endo-Group.

Clinical Follow-Up
Complete clinical follow-up was available for all but 1 patient that was lost after moving to another country. The median follow-up was 397 (interquartile range 233–637) days in the Endo-Group and 324 (interquartile range 174–454) days in the Epi-Group ($P=0.38$).

Ablation Procedure
Among the 15 patients in the Epi-Group, epi and endocardial ablation targets with subsequent radiofrequency delivery were found in 11 patients (Figure 2). In 2 patients, only endocardial targets were found although there were epicardial dense scars, and in 2 patients only epicardial targets were encountered. Phrenic nerve capture and the proximity of coronary arteries did not prevent any radiofrequency delivery.

There were no significant differences in acute complete success of ablation, 20 (57%) versus 6 (40%) patients in

<table>
<thead>
<tr>
<th>N</th>
<th>Endo-Group</th>
<th>Epi-Group</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>66 (61–78)</td>
<td>67 (64–78)</td>
<td>0.82</td>
</tr>
<tr>
<td>Sex: Male</td>
<td>33 (94%)</td>
<td>14 (94%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Ejection fraction</td>
<td>32 (28–41)</td>
<td>30 (22–41)</td>
<td>0.38</td>
</tr>
<tr>
<td>QRS duration</td>
<td>144 (107–156)</td>
<td>119 (100–153)</td>
<td>0.46</td>
</tr>
<tr>
<td>Hypertension</td>
<td>25 (71%)</td>
<td>13 (86%)</td>
<td>0.30</td>
</tr>
<tr>
<td>Creatinin</td>
<td>1.08 (0.88–1.44)</td>
<td>1.19 (0.94–1.54)</td>
<td>0.45</td>
</tr>
<tr>
<td>Dyslipemia</td>
<td>23 (65%)</td>
<td>11 (73%)</td>
<td>0.74</td>
</tr>
<tr>
<td>Smoker</td>
<td>6 (17%)</td>
<td>3 (20%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Ex smoker</td>
<td>16 (46%)</td>
<td>7 (47%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>11 (31%)</td>
<td>5 (33%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Previous atrial fibrillation</td>
<td>11 (31%)</td>
<td>4 (27%)</td>
<td>0.22</td>
</tr>
<tr>
<td>History of heart failure admission</td>
<td>11 (31%)</td>
<td>3 (23%)</td>
<td>0.72</td>
</tr>
<tr>
<td>Previous ICD</td>
<td>22 (63%)</td>
<td>10 (67%)</td>
<td>0.96</td>
</tr>
<tr>
<td>Secondary prevention</td>
<td>13 (56%)</td>
<td>5 (50%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Resynchronization Therapy</td>
<td>6 (18%)</td>
<td>2 (14%)</td>
<td>0.80</td>
</tr>
<tr>
<td>Previous Cardiac Surgery</td>
<td>11 (31%)</td>
<td>0</td>
<td>0.03</td>
</tr>
<tr>
<td>Bypass</td>
<td>11 (31%)</td>
<td>0</td>
<td>0.03</td>
</tr>
<tr>
<td>Valvular</td>
<td>1 (3%)</td>
<td>0</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Values are expressed as a median (interquartile range) or n (percentage). ICD indicates implantable cardiac defibrillator; and VT, ventricular tachycardia.
Endo- and Epi-Group, respectively ($P=0.69$). Induction of a nonclinical tachycardia occurred in 7 (20%) versus 5 (33%) in Endo and Epi-Group. Ablation failure, that is induction of the clinical tachycardia, occurred in 2 patients (6%) in the Endo-Group and in 1 patient (7%) in the Epi-Group. Induction was not tried in 6 (17%) and in 3 patients (20%) of the Endo- and Epi-Group, respectively.

The rest of the variables related to the procedure are displayed in Table 2. There were no significant differences between groups. The mean radiofrequency delivery time in the endocardium was significantly shorter in the Epi-Group. However, total delivery time did not differ between the 2 groups.

**Complications**

There were 4 local groin complications; 2 pericardial effusions in the Epi-group, 1 during the endocardial mapping, before ablation, that needed drainage and finally required cardiac surgery (this effusion was suspected to be produced by endocardial mapping), and another that occurred during epicardial mapping and that needed drainage (this second patient underwent a second only-endocardial procedure because of pericardial adhesions).

**VT Recurrence**

During follow-up, 16 (46%) patients of the Endo-Group had VT recurrence. Remarkably 5 of these patients had slow symptomatic VT that were undetected by the ICD, 4 needed a hospital admission because of this symptomatic slow VT, and 1 had a slow VT episode before discharge after ablation.

In the Epi-Group, 3 (20%) patients had VT recurrences: 1 patient with a few episodes reverted with antitachycardia pacing and 2 patients with an isolated VT episode requiring an ICD shock. No slow, undetected VTs were registered.

Although a trend toward more VT recurrences in the Endo-Group was observed (Figure 3A), no independent predictors of VT recurrence were found (Table 3).

As it is displayed in Figure 3A, the majority of recurrences occurred in the first 3 months in both groups (2 of 3 in the Epi-Group and 10 of 16 in the Endo-Group).

**Combined End-Point (Hospital or Emergency Admission or Reablation)**

The need of admission because of VT recurrence occurred in 13 (34%) patients of the Endo-Group (12 had a hospital admission and 1 patient attended the emergency department). One patient of the Epi-Group attended the emergency department during follow-up. A second VT ablation procedure was indicated in 10 (29%) patients of the Endo-Group and in none of the Epi-Group.

The occurrence of the combined end point (hospital or emergency admission because of VT or reablation) was significantly lower in the Epi-Group (Figure 3B). Baseline

![Figure 2. Epicardial (left) and endocardial (right) bipolar maps using Carto (A) and NavX (B). The pink (A) and red marks (B) inside the scar identify late potential zones.](image-url)
characteristics between groups were comparable except for previous cardiac surgery, so the interaction was studied and a second analysis excluding those patients was performed. Survival curves analysis showed a trend toward better outcomes excluding these patients ($P=0.06$; Figure 4).

No other predictors of the combined end point were found in the univariate analysis (Table 3).

**Mortality**

Eleven patients (31%) of the Endo-Group died during follow-up. Causes of death were heart failure (6 patients) and lung cancer, intestine occlusion, pneumonia, sepsis, and endocarditis over a resynchronization therapy device with rapid heart failure after removal of the system (1 patient each).

In the Epi-Group, only 1 patient died during follow-up because of tracheomalacia secondary to a previous prolonged intubation. There were no significant differences in the estimated cumulative risk of mortality between groups (log Rank, $P=0.17$).

In the univariate analysis mortality was associated to previous cardiac surgery. Excluding this subgroup, there were no significant differences in the estimated cumulative risk of mortality between groups (log Rank=0.49).

**Discussion**

The main findings of this single-center experience are that a systematic combined access, endocardial and epicardial, in consecutive, unselected patients with IHD who undergo their first VT ablation procedure improve clinical outcome in terms

**Table 3. Predictors of VT Recurrence and the Combined End-Point (Hospital or Emergency Department Admissions Because of VT and Need of Reablation)**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Unadjusted Hazard Ratio for VT Recurrence</th>
<th>P Value</th>
<th>Unadjusted HR for the Combined End-Point</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ejection fraction*</td>
<td>0.82 (0.50, 1.36)</td>
<td>0.45</td>
<td>0.78 (0.45, 1.35)</td>
<td>0.38</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>1.37 (0.84, 2.14)</td>
<td>0.23</td>
<td>1.13 (0.61, 2.12)</td>
<td>0.46</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.67 (0.25, 1.76)</td>
<td>0.42</td>
<td>2.59 (0.46, 14.72)</td>
<td>0.28</td>
</tr>
<tr>
<td>Smoker</td>
<td>1.08 (0.66, 1.76)</td>
<td>0.76</td>
<td>1.50 (0.81, 2.93)</td>
<td>0.19</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.82 (0.35, 2.15)</td>
<td>0.69</td>
<td>0.97 (0.30, 3.13)</td>
<td>0.96</td>
</tr>
<tr>
<td>Age</td>
<td>0.97 (0.92, 1.01)</td>
<td>0.16</td>
<td>0.96 (0.90, 1.03)</td>
<td>0.28</td>
</tr>
<tr>
<td>Creatinine†</td>
<td>1.05 (0.94, 1.18)</td>
<td>0.37</td>
<td>0.99 (0.86, 1.14)</td>
<td>0.92</td>
</tr>
<tr>
<td>First VT episode</td>
<td>1.70 (0.68, 4.14)</td>
<td>0.25</td>
<td>1.41 (0.58, 12.14)</td>
<td>0.51</td>
</tr>
<tr>
<td>QRS duration†</td>
<td>1.08 (0.92, 1.28)</td>
<td>0.33</td>
<td>1.05 (0.88, 1.27)</td>
<td>0.54</td>
</tr>
<tr>
<td>Anti-arrhythmic drug</td>
<td>2.07 (0.75, 5.73)</td>
<td>0.15</td>
<td>1.77 (0.55, 5.43)</td>
<td>0.35</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; HR, hazard ratio; and VT, ventricular tachycardia.

*For each 10% increase.
†For each 0.1 mg/dL increase.
‡For each 10 ms increase.
of readmission because of VT and reduce the need of reablation when compared with only endocardial ablation.

To our knowledge, all the published studies that assess the acute success and clinical outcomes of epicardial ablation of sustained monomorphic VT in IHD include patients who have a previous failed only-endocardial ablation procedure, so the epicardial access remains consigned to a second step.5–8 In these studies, a bias toward enriched epicardial substrates may be present, given that prior endocardial ablation had failed.

This study systematically includes unselected, consecutive patients who underwent epicardial access in their first procedure. The only reason to accede or not to the epicardium, except for contraindications, was the date of the procedure. Only a previous study by Di Biase et al11 compared a systematic endo-epicardial strategy in IHD patients with electrical storm to an historical endo-ablation cohort. This study showed that an endo-epicardial approach reduced the number of VT recurrences. However, the main limitation of the study of Di Biase et al was that the ablation technique differed between groups: scar homogenization in the epi-group versus limited substrate ablation in the historical cohort. Our series includes not only electrical storms but all patients with sustained monomorphic VTs, and the same ablation technique was used in both groups.

This systematic endo-epicardial approach in IHD patients could be justified by some arguments: (a) different data point to increased electrophysiologists confidence with the technique that probably reflects the improvement in terms of security and the awareness of the extent of epicardial involvement;6 (b) epicardial and intramural re-entry circuit locations are well recognized in the literature12–14 and are an important cause of failure of endocardial ablation;6 (c) improvements in outcome have been demonstrated when patients undergo an endo-epicardial ablation in a second procedure after a first only endocardial ablation has failed; (d) clinical and EKG characteristics have failed to reliably identify endocardial or epicardial components of VT circuit in IHD.15

So we speculated that an appropriate choice of a combined endo-epicardial approach as a first line mapping, and ablation strategy may avoid a substantial number of repeated procedures and improve ablation outcome, as it has been demonstrated. Although we also observed a trend toward a reduction in ICD therapies with the endo-epicardial approach, we failed to demonstrate a significant difference. However, all hospital admissions because of VT and all reablation procedures during follow-up occurred in the Endo-Group.

It must be emphasized that epicardial targets were found in 13 of 15 patients in the Epi-Group, and 2 of them had only epicardial targets. Although it is true, on the one hand, that the presence of abnormal electrograms that may not participate in reentry could overestimate epicardial isthmuses and only the number of terminated VT in the epicardium may be more real, it is also true, on the other hand, that most tachycardias are not hemodynamically tolerated and cannot be mapped. Moreover, as Jais et al demonstrated, elimination of all late potentials is associated with a superior clinical outcome.16

Surprisingly, acute success did not differ between groups in our series. Tung et al5 when compared only-endo versus endo-epicardial ablation mainly in ischemic patients with previous failed procedures reported a similar finding. Procedural end points may therefore be unreliable as well. Lack of inducibility of VT after ablation does not unequivocally predict a better outcome after ablation.17,18 Although noninducibility has been related to reduced mortality and VT recurrences,19 it is known that VT ablation does o’t improve

Figure 4. Event-free survival curves for VT recurrences (left) and the composite end-point (right), excluding patients with previous surgery. VT indicates ventricular tachycardia.
survival, so we can speculate that noninducibility can be seen as a well prognosis marker that may not be achieved in all patients.

In other series, VT ablation has failed to demonstrate a survival improvement.\(^1\)\(^2\)\(^\text{21}\) In our study, a reduction in terms of hospital admission because of a VT or need of reablation or even a trend toward less VT recurrences in the Epi-Group did not associate with a mortality reduction. The only predictor of mortality was previous cardiac surgery. As it is shown in Table 3, previous cardiac surgery was not a predictor of VT recurrence or the combined end-point. However, as this subgroup of patients were all allocated in the Endo-Group, further statistical analysis was performed removing this subgroup. Even then endo-epicardial ablation as a first step still showed a trend toward a better outcome in terms of hospital admissions and reablations.

A curious finding was that 5 patients in the Endo-Group and none in the Epi-Group had a recurrence in the form of slow VT undetected by the ICD. There are few studies including patients with slow VT that show that these patients have a worse prognosis in terms of VT recurrence and even mortality.\(^1\)\(^2\)\(^\text{23}\)

Finally but not less important is that 2 patients had significant pericardial bleeding in the Epi-group, a percentage already described in the literature,\(^6\)\(^\text{24}\) so it must be emphasized that the procedure should be performed by experienced operators with surgical back-up.

Limitations

The major limitations of our study are the following:

1. It is not a randomized study; however, the patients who underwent epi+endo-ablation were unselected, and the assigned access depended in most of them only on the time period. Moreover, there were no significant differences in baseline characteristics, but for previous surgery, between both groups.

2. No surgical epicardial ablation was performed, so patients with previous surgery were included in the Endo-Group. However, the interaction of previous surgery for the combined end-point was not significant.

3. It reflects only the practice in a single center but, just because of this, the ablation technique is homogeneous in all the patients.

4. The sample is small and the follow-up period in the Epi-Group is short, especially when compared with the Endo-Group. Thus, our series must be taken as a hypothesis-generating study or as a feasibility study.

5. The composite end point (hospital or emergency admission because of VT or reablation) is not a hard end-point and could be somehow subjective.

Conclusions

A combined endocardial and epicardial approach in the first ablation procedure for monomorphic sustained VT is feasible. It is not associated, in our limited series, to a significant reduction in VT recurrence. However, it is associated with a significant reduction in hospital and emergency admissions because of VT recurrence and with the need of reablation in IHD patients. Further studies are warranted.


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_Circ Arrhythm Electrophysiol_. 2015;8:882-889; originally published online June 8, 2015;
doi: 10.1161/CIRCEP.115.002827

_Circulation: Arrhythmia and Electrophysiology_ is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1941-3149. Online ISSN: 1941-3084

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