Spatiotemporal Organization of the Left Atrial Substrate after Circumferential Pulmonary Vein Isolation of Atrial Fibrillation

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Running title: Mechanism of AF maintenance after pulmonary vein isolation

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Abstract

Background: There is a paucity of data regarding the mechanism of maintaining atrial fibrillation (AF) post pulmonary vein isolation (PVI) in AF patients. The aim of this study was to examine the impact of circumferential PVI on the left atrial (LA) substrate characteristics.

Methods and Results: Seventy-two AF patients (53±11 y/o) underwent mapping and catheter ablation using a NavX system. The bi-atrial characteristics such as the complex fractionated atrial electrograms (CFEs; based on fractionated intervals, FIs) and frequency analysis (based on dominant frequencies, DF) were mapped before and after PVI. PVI with electric isolation was performed in all patients. In the 45 patients who did not respond to PVI, the continuous CFEs (> 8 seconds, 18±18% and 12±17% of the LA sites, before and after PVI, respectively, P=0.02), degree of LA fractionation (mean FI: 75.6±14.3msec vs. 87.3±16.7msec, P=0.001), and mean LA DF (6.92±0.88Hz vs. 6.58±0.91Hz, P=0.001) decreased after PVI. Complete PVI altered the distribution of the CFEs toward the LA anteroseptum, mitral annulus, and LA appendage regions. A persistent presence of continuous CFEs in the vicinity of the DF sites (observed in 53% patients) correlated with a higher procedural AF termination rate for the CFE ablation (63% vs. 23%, P<0.05).

Conclusions: Complete PVI eliminated some CFEs in the LA and altered the distribution of the CFEs. The persistent presence of CFEs before and after PVI in the vicinity of the high frequency sites is important for AF maintenance after PVI.

Key words: atrial fibrillation, electrogram, frequency analysis, left atrium
Introduction

Atrial fibrillation (AF) is the most common type of tachyarrhythmia encountered in clinical practice.¹ Pulmonary vein isolation (PVI) has become the mainstream catheter ablation technique for atrial fibrillation (AF).²³ In the consensus of the catheter ablation therapy for AF, substrate modification is considered to be necessary in patients with non-paroxysmal AF.⁴ A previous study showed that substrate modification with left atrial (LA) linear ablation or complex fractionated electrogram (CFE) ablation in patients with non-paroxysmal AF improved the clinical outcome.⁵⁻⁷,⁸ However, there is a paucity of data regarding the mechanism of AF maintenance in patients who did not respond to PVI. The atrial substrate characteristics before and after PVI may provide important information for these patients. The purposes of this study were (1) to investigate the impact of circumferential PVI with electric isolation on the LA substrate characteristics, and (2) to understand the spatiotemporal organization of the LA substrate after PVI.
Methods

Patient characteristics

This study enrolled 72 symptomatic drug refractory AF patients who received radiofrequency ablation guided by a NavX system (Ensite NavX, St. Jude Medical, Inc., USA). These patients manifested with incessant AF at the onset of the procedure (not pacing or isoproterenol induced AF), and included 33 patients (46%) with paroxysmal AF, 9 (13%) with persistent AF (duration=4.1±1.4 months, range 1-10), and 30 (41%) with long-lasting persistent AF (duration=6.4±5.6 years, range 1-20). The paroxysmal AF patients who were in sinus rhythm (SR) at the beginning of the procedure and who had spontaneous termination of AF before ablation were excluded. Paroxysmal AF was defined as AF with a duration of <7 days, persistent AF as AF which was sustained beyond 7 days, and longstanding AF as continuous AF of greater than a one year duration.\(^4\)

Electrophysiologic study

Each patient underwent an electrophysiological study and catheter ablation in the fasting state, after informed consent was obtained. All antiarrhythmic drugs except for amiodarone were discontinued for at least five half-lives before the procedure. Overall 31% of the patients received amiodarone before the procedure. No patient received amiodarone therapy during electrophysiological procedure to terminate AF. The method of 3D electroanatomic mapping has been described previously.\(^9,10\) Mapping was performed with an irrigated 4-mm tip deflectable catheter (EPT, Boston Scientific Corporation, Natick, MA, USA) inserted into the LA alongside the transseptal sheath without the need for an additional puncture site. A 3D geometry of the LA was then created using the NavX system.

We attempted to find the spontaneous onset of atrial ectopic beats or repetitive episodes of short runs or sustained AF and predict the location of the initiating foci at the baseline, after restoration of SR post procedure, or after an algorithm designed for facilitating the initiation of AF.\(^2,11\) The methods used to provoke...
spontaneous AF were attempted at least twice to ensure reproducibility.\textsuperscript{2,11}

**Signal recording**

After acquiring the LA geometry, a 4-mm tip catheter was selected as the “roving” catheter for sequential contact mapping. Regarding the protocol for sampling in the right atrium (RA) and LA, first, we divided the LA into 7 parts and RA into 7 parts according to previous study.\textsuperscript{12} In each region, at least 10 points were determined. The points in each region were similar in number and were nearly equally distributed. The points designated at the PVs were obtained from the PV ostium and antrum regions outside the PVI lines. The points within the veins were excluded for comparison of the organization of the fibrillation waves before and after PVI in order to investigate the change in the substrate property, rather than the local effect of radiofrequency application. Second, to avoid a too high density in some regions, any mapping site with a distance of <0.5 mm to any of the other nearest sites was deleted by off-line software. The averaged mean distance between any two mapping sites in the LA and RA was 5.4±0.9 and 6.2±0.9 mm, respectively. A previous study showed that the micro-reentrant circuits of the high frequency AF drivers were around 10 mm in diameter.\textsuperscript{13} The density of the mapping points in this study may provide sufficient spatial resolution for detecting the dominant frequency (DF) sites.

**Signal analysis**

The NavX mapping parameters were set to “CFE-mean”, which was an interval-analysis algorithm that measures the average index of the fractionation at each site and produces a color map representative of the CFE distribution. Previously, we demonstrated that the continuous CFEs (>8 seconds) were defined by an averaged fractionated interval (FI) of ≤50 msec over 5 seconds. The continuous CFEs represent the continuous fractionated activity of over one
minute.\textsuperscript{14} The parameters of the automatic algorithm for CFEs have been described previously.\textsuperscript{14} Variable CFEs were defined as having a mean FI between 50-120 msec. The non-CFEs were defined as having an FI of >120 msec. We performed CFE mapping both before and after PVI. The method of the fast Fourier transform (FFT) has been described previously.\textsuperscript{15} A 6.82-second segment of data was exported to an external computer program. The FFT analysis (sampling rate=1200 Hz, resolution=0.14 Hz, with a Hanning window function) was performed from all recording sites. The largest peak frequency of the resulting spectrum was identified as the DF. The RA and LA substrate characteristics were compared quantitatively and qualitatively to investigate the difference in the atrial substrate before and after PVI.

**Catheter ablation**

The stepwise procedure of the catheter ablation of AF involved the following steps:

**Step 1 (Isolation of the PVs):** After a successful transseptal procedure, continuous circumferential lesions were created encircling the right and left PV ostia guided by the NavX system using an irrigated-tip 4-mm ablation catheter. RF energy was applied continuously while repositioning the catheter tip every 40 seconds with a target temperature of 35-40°C and maximum power of 25-30W in the power control mode. When the ablation line was near the posterior LA near the esophagus, a 4-mm-tip catheter was applied with a target temperature of 45-50°C and maximum power of 45-50W in the temperature control mode. The intention was to place the RF lesions at least 1-2 cm away from the angiographically defined ostia. After completion of the circumferential lesion set, the ipsilateral superior and inferior PVs were mapped carefully by a circular catheter recording. Successful circumferential PVI was demonstrated by the absence of any PV activity or dissociated PV activity during AF. After restoration to SR by procedural AF termination or electric cardioversion, PV-LA conduction block was confirmed.
once again. Additional ablation at the sites of the residual PV potentials was
applied from the atrial side of the PV antrum using the electrogram-guided
approach to obtain entrance block.

Step 2 (linear ablation by the anatomic approach): After successful isolation
of all four PVs, additional linear ablation was performed at both the anterior roof
and lateral mitral isthmus. Linear ablation was guided by the NavX system with
the creation of split potentials or an electrogram voltage reduction of >50% after
each application of radiofrequency energy. The RA, cavitricuspid isthmus (CTI)
ablation was performed with an 8 mm-tip ablation catheter with a maximum
power of 70 W, temperature of 70°C, and duration of 120 seconds. Bi-directional
conduction block of the CTI was confirmed after restoration to SR.

Step 3 (continuous CFE site ablation): If AF did not stop after steps 1-2 of the
ablation procedure, an addition CFE-guide substrate ablation was performed
sequentially based on the post-PVI CFE maps. The CFE ablation was confined to
the continuous CFEs in the LA and CS. Considering the possible
complications due to the long procedure time and efficacy of the RA substrate
modification, we did not routinely ablate the CFEs in the RA. The end point of
the CFE site ablation was to obtain a prolongation of the cycle length, eliminate
the CFEs (Thus: Fl>120 msec), or abolish the local fractionated potentials (bipolar
temperature <0.05 mV). The end point of step 3 procedure was elimination of all
continuous CFEs in the LA and CS. If AF terminated during the linear ablation
through the CFE sites, complete linear ablation to an anatomic obstacle or nearest
ablation line was performed to prevent pro-arrhythmias.

Step 4 (non-PV ectopies): After SR was restored from AF either by procedural
AF termination or electric cardioversion, the mapping and ablation was only
applied to spontaneously initiating focal atrial tachycardias and non-PV ectopies
that initiated AF. If any non-PV ectopies initiating AF from superior vena cava
(SVC) were identified, isolation of the SVC was guided by the circular catheter
recordings from the SVC-atrial junction. An AF inducibility test was not
performed in the patients with persistent AF or long-lasting persistent AF.

In this study, if AF became organized during the step 1-3 procedures,
electroanatomic mapping and ablation were performed to terminate the organized tachycardia. The procedural AF termination was defined as AF restored to sinus rhythm during the ablation in steps 1-3. AF induction was not performed in any patients with persistent AF or long-lasting persistent AF.

**Follow-Up of AF Recurrence**

After discharge, the patients underwent follow-up (2 weeks after the catheter ablation, then every 1–3 months thereafter) at our cardiology clinic or with the referring physicians where routine ECGs were obtained during each follow-up, and antiarrhythmic drugs were prescribed for 8 weeks to prevent any early recurrence of AF. When the patients experienced symptoms suggestive of a tachycardia after the ablation, 24-hour Holter monitoring and/or cardiac event recording with a recording duration of one week were performed to define the cause of the clinical symptoms. AF recurrence was defined as an episode lasting more than one minute and that was confirmed by ECGs two months after the ablation (blanking period). The endpoint for the follow-up was clinically documented recurrence of atrial arrhythmias or repeat ablation procedures.

**Statistical analysis**

All continuous data were presented as the mean value±standard deviation (SD). A Chi-square test with Fisher’s exact test was used for the categorical data. The means of continuous data of two groups were compared with the Student’s *t* test. Comparisons of more than two groups were performed with a one-way ANOVA. Pair-*t* test was used for comparison of the substrate properties before and after PVI. Statistical significance was considered when the two-sided *P* value was <0.05.
Results

**Stepwise catheter ablation results**

In the initial ablation step, PVI was performed successfully and electrical isolation was confirmed in all 72 patients. PVI terminated AF, and SR was restored in 20 of 33 patients (61%) with paroxysmal AF, in 5 of 9 patients (56%) with persistent AF, and in 2 of 30 patients (6.7%) with long-lasting persistent AF. The second step involving linear ablation in the remaining 45 patients (63%) resulted in termination of AF in 5 patients (7%). The subsequent step of continuous CFE ablation in the patients with ongoing AF resulted in AF termination in 13 patients (18%). The cumulative rate of procedural AF termination with the stepwise procedure (without anti-arrhythmic medications during the procedure) is shown in Figure 1.

The total procedural time in the paroxysmal AF, persistent AF, and long-lasting AF patients was 111±42, 102±22, and 165±55 min, respectively, P<0.001. The mean procedural time for the step 1-3 procedures was 93±26, 27±16, and 41±17 min, respectively. The mean procedural time to achieve termination was 118±44 minutes (N=45, 63%), and in the other 27 patients (37%), the procedure time required to complete the remaining process was 159±60 min (P<0.001, compared to the patients with procedural AF termination). In 45 patients with termination, radiofrequency ablation resulted in restoration of SR after transient AT in 35 patients (78%). In 10 patients (22%) with procedural AF termination of AF, AF converted to sustained organized atrial tachycardia, including LA atypical AFL in 6 patients (60%), RA CTI flutter in two patients (20%), and focal AT from the LA and CS in two patients (20%). Initiating ectopies from SVC were observed in two patients with paroxysmal AF (6%), and 5 with persistent and long-lasting persistent AF (13%).

**Difference in the LA substrate in the patients that responded and did not respond to PVI**

Table 1 shows the comparison of the substrate characteristics in the patients
who responded to PVI and in those that did not in terms of the procedural AF termination. Patients with a longer AF duration, lower LV ejection fraction, and larger LV dimension were less likely to respond to PVI. In those patients, both the LA and RA substrate were more fractionated in terms of the maximal magnitude of the CFEs (P<0.001), mean degree of the CFEs (P=0.002), and proportion of the continuous CFEs in the LA (P=0.008), compared to the patients who responded to PVI. The frequency analysis showed that the mean DF value in both the LA and RA was higher (P<0.01), and the LA-to-RA DF gradients were less evident.

**LA substrate before and after PVI in the patients who did not respond to PVI**

In 45 patients (13 patients with paroxysmal AF, 7 with persistent AF, and 25 with long-lasting persistent AF) who did not respond to PVI in terms of AF termination, the LA substrate characteristics were assessed before and after PVI. As shown in Table 2 and Figure 2, the LA substrate was less fractionated in terms of the maximal CFEs (shortest FI, P=0.033), mean degree of the CFEs (P=0.001), and proportion of the continuous CFEs (P=0.02) after PVI. The spatial distribution of the continuous CFEs in the LA also differed after PVI (Figure 3). The frequency analysis showed that the mean DF value in the LA was lower with less intra-LA variation of the DF after PVI (P<0.05, Figure 4). The highest DF in the LA was also lower (P=0.012). On the other hand, the highest DF and mean DF of the RA were similar before and after PVI (P=NS).

**Distribution of continuous CFEs after PVI**

In the 45 patients who did not respond to PVI, 53% of the continuous CFE sites in the LA/CS were eliminated by complete PVI. The remaining 47% of the continuous CFE sites could be classified depending on the spatial relationship to the highest DF sites after PVI (Figure 5 and 6).

In 24 of the 45 patients (53%), some CFE regions were compatible with the highest DF sites in the LA/CS after PVI. Overall 25 regions of this type of CFEs (32% of all 84 CFEs after PVI) were identified with an average of 0.6 regions per patient. The mean distance from the highest DF site to the shortest FI sites (center-to-center) was 1.1±0.53 cm (range 0-2 cm, Figure 5). Elimination of those CFEs resulted in procedural AF termination in 15/24 (63%) of the patients.
In 31 of the 45 patients (69%), some CFE regions were observed within homogenous DF substrate or in the periphery of the highest DF sites in the LA/CS (center-to-center distance >2 cm). Overall 53 regions (76% of all 84 CFEs) of this type of CFEs were identified with an average of 1.3 regions per patient (Figure 5, 6). Elimination of those CFEs was associated with a lower rate of termination in 7/31 (23 %) of the patients (P<0.05, compared to the CFEs near the highest DF sites).

**Long-term follow up**

With a mean follow-up of 14±7 months, the rate of SR maintenance with and without drugs was 88%, 78%, and 70% in the patients with paroxysmal AF, persistent AF, and long-lasting persistent AF, respectively (P=0.217). Sinus rhythm was maintained in 87%, 88%, and 80% patients in the patients that underwent the step 1, step 1-2, and step 1-3 procedures with procedural AF termination. In patients without procedural AF termination and who received cardioversion after the step 1-3 procedures, the SR maintenance rate was lower (42%, P<0.01, compared to the other patients).
Discussion

Main findings

This study demonstrated that (1) patients with a less fractionated LA and RA were more likely to respond to PVI in terms of the procedural AF termination. The mean DF values of both atria were lower with evident LA-to-RA gradients of the DF value.(2) The LA substrate after PVI was characterized by a lower mean DF value, less intra-LA DF gradients, and less continuous CFEs.(3) The remaining continuous CFEs after PVI represented the high frequency sources in the vicinity, and could be observed in the homogeneous DF substrate. The continuous CFEs that persisted both before and after PVI in the vicinity of the high DF sites correlated with a higher rate of AF termination during CFE ablation.

Maintenance of AF after PVI

Previous studies demonstrated that AF was maintained by the high frequency sites in the arrhythmogenic veins and elimination of those sites could treat most patients with paroxysmal AF.15,19,20 This study demonstrated that patients who responded to PVI had limited continuous CFEs within the LA. On the other hand, patients who did not respond to PVI and required substrate modification had more continuous CFEs in the LA. Further, a high efficacy of procedural AF termination and long-term AF free survival was observed when achieving procedural AF termination by targeting the continuous CFEs. These results indicate that the continuous CFEs were important for the maintenance of AF after PVI.

In this study, the patients who did not respond to PVI were predominantly non-paroxysmal AF in nature with a lower LV ejection fraction and larger LV dimension. Substrate mapping showed that both atria had higher DF values before PVI with limited left-to-right DF gradients. The remodeled and heterogeneous atrial substrate in these patients may facilitate multiple mechanisms and multiple AF drivers for AF maintainence.8 Complete PVI eliminated some continuous CFEs in the LA, indicating that those CFEs were secondary to the PV activities. This could be also explained by the adrenergic and cholinergic nerves in the ganglionated plexi in the PV vicinity. Complete PVI may interrupt their autonomic
input and interconnections with PV sleeves. After PVI, the remaining continuous CFEs in the LA and CS may drive AF with or without the presence of the high frequency AF sites in the LA.

**Mechanism of the fractionation after PVI**

Substrate mapping and catheter ablation of AF has recently incorporated the analysis of the DF and CFEs. However, the relationships between the DF and fractionation, and spatiotemporal organization of the fibrillation waves after PVI remain unclear. This study demonstrated that a complete PVI reduced some continuous CFEs in the LA. The remaining continuous CFEs after PVI were observed at the high frequency sites, and at the boundaries of the high frequency sites. A recent study by the Sander’s group also had similar finding in human AF. They demonstrated clusters of high DF sites, mostly in the LA, with fractionation observed at or adjacent to these DF sites. This could be explained by the recent observation from a computer stimulation model that showed that increased meandering of AF rotors increased the fractionation. The fractionation may also be observed at the boundaries of the fixed high frequency sources or within the inhomogeneous atrial substrate without the high frequency sources in the vicinity. Those results and the present study indicated that both the stability of the rapid AF sources and inhomogeneous LA substrate contribute to the fractionated electrograms.

**Clinical implication**

This study demonstrated that the intra-atrial DF gradients in the LA before PVI partly resulted from the PV activity. The continuous CFEs post PVI were more localized compared to those observed in the previous studies. These findings indicate that a complete PVI should be performed before the CFE ablation in order to avoid any unnecessary substrate modification. This study also demonstrated that the frequency analysis may not be enough to identify the different sites of interest in the atrial substrate in the patients with non-paroxysmal AF after PVI. Sites with fractionation provide potential targets for selective LA substrate modification in addition to frequency mapping. Fractionated sites in the vicinity of high DF sites were more frequently associated with AF termination.
compared to other CFE sites, suggesting that ablation of these may be beneficial. These data showed that individualized knowledge of the spatial organization of the fibrillation waves, including the fractionation and frequency analysis, may help in the identification of the different mechanisms of AF.

**Limitations**

First, the density of the mapping sites may not have been high enough. A higher density of mapping sites may provide incremental information, particularly on the relationship between the DF sites and continuous CFEs.

Second, oral amiodarone was not discontinued before the electrophysiological study because these patients had very frequent episodes of AF attacks. This may have affected the results of the DF and CFE mapping. However, in this study, each patient served as his/her own control, and the change in the DF and FI after PVI could not be influenced by the amiodarone.

Third, the results of this study are in part based upon the effect of the ablation of the linear lines and continuous CFEs after PVI; therefore, the cumulative effects may have led to restoration of SR. Last, we did not systemically assess the CFE distribution after the LA linear ablation; because the aim of this study was to investigate the effect of complete PVI on the CFEs in the LA.
Conclusions

The atrial substrate characteristics differed in the patients who responded and did not respond to a complete PVI. The fibrillatory activity in the LA was more organized and frequency distribution more homogeneous after a complete PVI. A complete PVI eliminated some CFEs in the LA and altered the distribution of the CFEs toward the LA anteroseptum, mitral annulus, and LA appendage regions. A persistent presence of continuous CFEs before and after PVI in the vicinity of the high frequency Sites was important for the maintenance of AF post PVI.
Funding Sources

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Disclosures

No conflict of interest to disclose.
References


approach for chronic atrial fibrillation--evidence for a cumulative effect.


Figure Legends

Figure 1

The cumulative percentage of patients in which AF terminated with each step of ablation.

Figure 2

Regional distribution of the fractionation interval (FI), representing complex fractionated electrograms in the left atrium (LA) before and after circumferential pulmonary vein isolation (PVI) and the corresponding bipolar electrograms during atrial fibrillation (AF). The complex fractionated electrograms (CFEs) mapping exhibited multiple CFE sites, including the LA lower septum, LA appendage base, and near the mitral annulus region, where fractionated electrograms were observed. After circumferential PVI, the fibrillatory electrograms became organized with an increased FI, whereas the CFEs sites near the mitral annulus region remained fractionated and the radiofrequency ablation successfully terminated AF.

Figure 3:

Regional distribution of continuous CFEs (>8 seconds, with averaged FI<50 msec) before and after PVI in patients who did not respond to the PVI in terms of
the AF procedural AF termination. A complete PVI altered the distribution of the
CFEs toward the LA anteroseptum, mitral annulus, and LA appendage regions.

**Figure 4:**

Regional distribution of the dominant frequency (DF) in the LA before and
after the circumferential PVI. The DF mapping exhibited a heterogeneous DF
distribution in the LA with high DF sites near the LSPV ostium (9.5 Hz). After
PVI, the distribution of the DF value in the LA became homogeneous and the
highest DF sites became less evident, indicating that the mechanism of AF
maintenance after PVI differed from before PVI.

**Figure 5:**

Comparison of the regional distribution of the FI and DF (left panels) in a
patient with non-paroxysmal AF. The CFE map and DF map was obtained after
complete PVI. The local intracardiac bipolar electrogram and their corresponding
frequency spectra during AF were shown in right panels. The continuous CFE
sites in the low LA septum were compatible with the highest DF sites, and were
the location where the radiofrequency ablation successfully terminated AF.
Figure 6:

Comparison of the regional distribution of the FI and DF (left panels) in a patient with non-paroxysmal AF after PVI. The intracardiac bipolar electrogram and their corresponding frequency spectra during AF were shown in right panels. The most fractionated areas (shortest FI, site E) in the LA low posterior wall was in the periphery of the high frequency sites of AF (highest DF site, site C) near the lateral mitral isthmus. CFEs ablation did not terminate AF; however, linear ablation in the lateral mitral annulus crossing the highest DF site successfully terminated AF.
Table 1: Patients characteristics and substrate properties in the patients who responded to the PVI and those that did not in terms of the termination.

<table>
<thead>
<tr>
<th>Clinical and substrate factors</th>
<th>AF did not terminate with PVI</th>
<th>AF terminate with PVI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (Male/Female)</td>
<td>33/12</td>
<td>17/10</td>
<td>0.43</td>
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<tr>
<td>Age (years)</td>
<td>50.5±11.1</td>
<td>55.4±10.3</td>
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<td>Paroxysmal AF/Persistent AF/long-lasting persistent AF</td>
<td>13/7/25</td>
<td>20/2/5</td>
<td>&lt;0.001</td>
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<td>Underlying disease (heart failure, CAD, or VHD)</td>
<td>11/34</td>
<td>3/24</td>
<td>0.34</td>
</tr>
<tr>
<td>Non pulmonary vein ectopy (N,%)</td>
<td>22 (42%)</td>
<td>5 (28%)</td>
<td>0.30</td>
</tr>
<tr>
<td>Echocardiography</td>
<td></td>
<td></td>
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<td>LA diameter (mm)</td>
<td>40.6±6.67</td>
<td>39.3±6.02</td>
<td>0.435</td>
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<tr>
<td>LV ejection fraction (mm)</td>
<td>53.9±9.45</td>
<td>60.5±5.98</td>
<td>0.002</td>
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<td>LV end-diastolic dimension (mm)</td>
<td>52.0±6.64</td>
<td>48.4±4.96</td>
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<td>LV end-systolic dimension (mm)</td>
<td>34.0±8.41</td>
<td>29.2±4.38</td>
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<td>Fractionation analysis</td>
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<tr>
<td>Mean degree of fractionation in the LA (mean FI, msec)</td>
<td>77.1±15.1</td>
<td>93.1±24.3</td>
<td>0.002</td>
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<td>FI of the maximal CFE (msec)</td>
<td>40.3±7.69</td>
<td>47.1±7.91</td>
<td>0.001</td>
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<td>Mean degree of fractionation in the RA (mean FI, msec)</td>
<td>79.8±13.6</td>
<td>107.3±27.1</td>
<td>0.003</td>
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<tr>
<td>Proportion of continuous CFEs (FI&lt;50 msec) in the LA (%)</td>
<td>17.7±14.6</td>
<td>3.8±7.3</td>
<td>0.008</td>
</tr>
<tr>
<td>Proportion of variable CFEs (FI=50-120 msec) in the LA (%)</td>
<td>57.6±16.4</td>
<td>64.4±14.0</td>
<td>0.258</td>
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<td>Frequency analysis</td>
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<tr>
<td>Mean DF of the LA (Hz)</td>
<td>6.92±0.88</td>
<td>6.01±0.71</td>
<td>0.005</td>
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<tr>
<td>Highest DF of the LA (Hz)</td>
<td>10.9±2.06</td>
<td>9.59±2.05</td>
<td>0.012</td>
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<td>Mean DF of the RA (Hz)</td>
<td>6.60±1.00</td>
<td>5.46±0.58</td>
<td>0.001</td>
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<td>Highest DF of the RA (Hz)</td>
<td>8.64±1.37</td>
<td>7.83±1.97</td>
<td>0.282</td>
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<tr>
<td>Mean LA-RA DF gradient (Hz)</td>
<td>0.45±0.85</td>
<td>0.95±0.51</td>
<td>0.162</td>
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</table>

Abbreviations: AF= atrial fibrillation, AFL=atrial flutter, CAD=coronary artery disease, CFE=complex fractionated electrogram, DF=dominant frequency, LA=left atrium, LV=left ventricle, PV=pulmonary vein, SR=sinus rhythm; RA=right atrium, VHD=valvular heart disease.
<table>
<thead>
<tr>
<th>Substrate factors</th>
<th>Before PVI</th>
<th>After PVI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean degree of fractionation (mean FI, msec)</td>
<td>75.6±14.3</td>
<td>87.3±16.7</td>
<td>0.001</td>
</tr>
<tr>
<td>Variation of the fractionation (SD of FI, msec)</td>
<td>39.1±10.3</td>
<td>40.2±11.6</td>
<td>0.626</td>
</tr>
<tr>
<td>FI of the most fractionation site (msec)</td>
<td>44.3±4.46</td>
<td>48.4±7.45</td>
<td>0.033</td>
</tr>
<tr>
<td>Proportion of continuous CFEs (%)</td>
<td>17.7±14.6</td>
<td>11.6±16.9</td>
<td>0.02</td>
</tr>
<tr>
<td>Proportion of variable CFEs (%)</td>
<td>57.5±16.4</td>
<td>58.6±18.4</td>
<td>0.806</td>
</tr>
<tr>
<td>Mean DF of the LA (Hz)</td>
<td>6.92±0.88</td>
<td>6.58±0.91</td>
<td>0.001</td>
</tr>
<tr>
<td>Variation of DF in the LA (SD of DF, Hz)</td>
<td>1.32±0.60</td>
<td>1.00±0.42</td>
<td>0.032</td>
</tr>
<tr>
<td>Mean DF of the RA (Hz)</td>
<td>6.60±1.00</td>
<td>6.27±1.02</td>
<td>0.132</td>
</tr>
<tr>
<td>Variation of DF in the RA (SD of DF, Hz)</td>
<td>1.11±0.60</td>
<td>1.01±0.49</td>
<td>0.626</td>
</tr>
<tr>
<td>Highest DF of the LA (Hz)</td>
<td>10.5±1.62</td>
<td>9.06±1.58</td>
<td>0.012</td>
</tr>
<tr>
<td>Highest DF of the RA (Hz)</td>
<td>8.64±1.37</td>
<td>8.34±1.54</td>
<td>0.575</td>
</tr>
</tbody>
</table>

Abbreviations: FI=fractionation interval; SD=standard deviation.
Procedural termination of AF (%)

- PVI: 38
- PVI + line: 45
- PVI + line + CFE: 64
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