LETTERS TO THE EDITOR

doi:10.1093/europace/euv279 Published online 31 October 2015

Non-documented but induced supraventricular tachycardia: a new challenge or a new light?

We have read the article published by Lauschke et al.¹ with a great enthusiasm. In their article, they have reported the electrophysiological study (EPS) results of patients with suspected but not electrocardiogram (ECG)-documented. Briefly, supraventricular tachycardia (SVT) has been induced during EPS in 89% of patients with pre-procedural ECG documentation, and 64% of patients with suspected SVT and without ECG documentation. The success rates of ablation and symptomatic improvement in both groups namely, with and without ECG documentation have been reported to be high and comparable. Accordingly, they have provided a justification for using EPS for patient with the suspicion of SVT but without ECG documentation.

Indeed, a significant proportion of patients in clinical practice may not have ECG recordings of the index tachycardia (non-documented SVT), or only have recordings of limited diagnostic value and it is a grey area and a big challenge for guiding the therapy in those patient groups. In this regards, Lauschke et al.’s report would certainly add a new approach to treat patients with suspected SVT. Although this is the first prospective registry, we have also reported several cases in which SVT has been suspected and successful ablation of slow pathway have been performed in both documented dual AV node physiology and documented atrioventricular nodal re-entrant tachycardia recently.²–⁴ Since empirical slow pathway ablation would have increased the rate of symptomatic improvement in ECG-documented patient group, it would be valuable to see the rate of dual AV node physiology in both ECG-documented and non-document patient groups.

Although further prospective clinical studies are needed, a subtle inference of this study is that the prevalence of SVT might be higher than the ECG-based reported prevalence in the literature.⁵ Since Lauschke et al.’s report has shown that in non-ECG documented but suspected patients might have inducible SVT in EPS, the prevalence of SVT needs to be revised in further studies.

In conclusion, we strongly agree with the authors that patients with suspected but non-documented SVT may have inducible SVT and obtain a clinical benefit from EPS. To identify those patients and to refer for EPS merely necessitates, a high suspicion index of SVT and individual approaches to patient symptoms.

References


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doi:10.1093/europace/euv308 Published online 31 October 2015

Non-documented but induced supraventricular tachycardia: a new challenge or a new light?—author’s reply

With great interest we read the letter by Yetkin and Tandogan.¹ He pointed to an interesting question regarding the rate of dual atrioventricular (AV) nodal physiology in patients with or without an electrocardiogram (ECG)-documented supraventricular tachycardia.² Since we focused on inducible tachycardias, we did not evaluate the rate of dual AV nodal physiology in the absence of an inducible atrioventricular nodal reentrant tachycardia (AVNRT). We acknowledge that there is a subgroup of patients without an ECG documentation despite a typical clinical history which show the combination of dual AV nodal physiology and non-inducibility of AVNRT during an electrophysiological study. In this setting, it remains unclear whether these patients would benefit from slow pathway ablation. In our institution, we do not ablate in this setting. Further data from registries or prospective studies are needed to answer this question.

Conflict of interest: none declared.

References


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