Abstracts From Other Journals

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Adherence to Guidelines for Atrial Fibrillation Management of Patients Referred to Cardiology Departments:
Studio Italian© Multicentric Sul Trattamento della Fibrillazione Atriale (SITAF)
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Abstract:
Aim: The purpose of this study was to evaluate adherence to national guidelines on the non-pharmacologic (ablative) treatment of atrial fibrillation (AF).
Methods and Results: This prospective, observational, transversal study enrolled 1256 consecutive inpatients and outpatients referred to 43 Cardiology Departments between 1 and 31 October 2008 for the management of AF as a primary diagnosis. A rhythm-control strategy (cardioversion, antiarrhythmic medication, pace-maker implantation, substrate ablation, alone or in combination) was prescribed in 865 (69%) of the patients and a rate-control strategy [drugs, atrioventricular junction ablation and pace-maker implantation (Ablate and Pace)] in 285 (23%). Specifically, substrate catheter ablation was indicated by the attending cardiologist in 187 (14.9%) patients and Ablate and Pace in 29 (2.3%). According to guideline indications, substrate catheter ablation would have been indicated in 183 (14.6%) patients, but only 105 (57%) of these were correctly identified by the attending cardiologist (K statistics for agreement for indications 0.49). Atrioventricular junction ablation and pace-maker implantation would have been indicated in 108 (8.6%) patients, but only 29 (27%) of these were correctly identified by the attending cardiologist (K statistics for agreement for indications 0.06).

Conclusion: About a quarter of patients referred to cardiology departments for AF management have potential indications for non-pharmacological treatment according to the guidelines. Substrate catheter ablation was offered by the attending cardiologist in a percentage similar to that expected, but concordance with guideline indications was moderate. Atrioventricular junction ablation and pace-maker implantation was largely underused.

Key words: Atrial fibrillation, Guidelines, Rhythm-control, Rate-control

European Utilization of the Implantable Defibrillator:
Has 10 years changed the “enigma”?
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Abstract:
The correct rate of implantation for implantable cardioverter defibrillator (ICD) and CRT-D devices is not known, but practice surveys suggest persistent under-utilization of these treatments on both sides of the Atlantic. Although recent clinical trial results and the implementation of current guidelines appear to have encouraged a growth of the rate of implantation in most countries, there remains a remarkable trans-Atlantic difference which has not changed much for more than 10 years. For every European ICD implant, there are four implants in the USA after adjustment for the size of the populations. Since very large variations in the implantation rates also occur between and within European Countries, an opportunity is afforded to explore the possible cause of these differences. It seems very unlikely to be explained simply by guideline discrepancies, financial constraints, or differences in disease prevalence. Instead, it is more likely to be attributable to a relative paucity of electrophysiologists, and their associated resources. In turn, the failure to establish effective educational programmes, screening, and referral pathways contributes to far fewer patients. It seems unlikely that adequate equity of access to this potentially lifesaving treatment will be provided until adequate registries, audits, and gap analyses are undertaken throughout Europe.

Key words: Implantable cardioverter defibrillator (ICD), Sudden death, Primary prevention, ESC guidelines, Cost-effectiveness

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Low Efficacy of Atrial Fibrillation Ablation in Severe Obstructive Sleep Apnoea Patients

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Abstract:

Aims: Atrial fibrillation (AF) ablation efficacy varies according to patients’ clinical characteristics. Although the association of obstructive sleep apnoea (OSA) and AF is well established, data on AF ablation efficacy in OSA are scarce. The aim of this study was to clarify the effect of OSA on the outcome of AF ablation.

Methods and Results: A series of 174 consecutive patients without polysomnography submitted to circumferential pulmonary vein ablation were included in the study. All patients were assessed by Berlin Questionnaire (BQ) and underwent an echocardiogram and a clinical evaluation. Patients with a high BQ score, indicating high risk for OSA, participated in a sleep study. Diagnoses were classified according to the apnoea-hypopnoea index (AHI) as mild (AHI < 10/h), non-severe (AHI < 30/h), or severe (AHI ≥ 30/h) OSA. Follow-up consisted of outpatient visits and 24 or 48 h Holter monitoring at 1, 4, and 7 months, and every 6 months thereafter. Any episode of AF or left atrial (LA) flutter was considered recurrence. Fifty-one (29.3%) patients had high BQ scores. The sleep study showed that 17 (9.6%) and 25 (14.4%) of these patients had non-severe and severe OSA, respectively. One-year arrhythmia-free probability after a single ablation procedure was 48.5% in outpatient visits and 24 or 48 h Holter monitoring at 1, 4, and 7 months, and every 6 months thereafter. Any episode of AF or left atrial (LA) flutter was considered recurrence. Fifty-one (29.3%) patients had high BQ scores. The sleep study showed that 17 (9.6%) and 25 (14.4%) of these patients had non-severe and severe OSA, respectively. One-year arrhythmia-free probability after a single ablation procedure was 48.5% in patients with low risk for OSA (low BQ score or AHI < 10/h), 30.4% in the non-severe OSA group (10 < AHI < 30/h) and 14.3% in the severe OSA group (AHI ≥ 30). Anteroposterior LA diameter [hazard ratio (HR) = 1.046, 95% confidence interval (CI): 1.005–1.089; P = 0.029] and severe OSA (HR = 1.870, 95% CI: 1.106–3.161; P = 0.019) were the independent predictors of arrhythmia recurrence.

Conclusion: In patients with AF ablation, the presence of severe OSA is an independent predictor for AF ablation failure.

Keywords: Obstructive sleep apnoea, Atrial fibrillation, Catheter ablation

Sentinel Lymphadenectomy for the Staging of Clinical Axillary Node-negative Breast Cancer Before Neoadjuvant Chemotherapy

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Abstract:

Background: Several authors reported sentinel lymph node biopsy (SLNB) after neoadjuvant chemotherapy (NC). Nevertheless, the ideal time of SLNB is still a matter of debate.

Methods: We evaluated the feasibility and the accuracy of SLNB before NC using a combined procedure (blue dye and radio-labelled detection) before NC. Axillary lymph node dissection (ALND) was performed after completion of NC in a homogeneous cohort study with clinically axillary node-negative breast cancer.

Results: Among the 20 women who had metastatic SLNB (65%), 4 (20%) had additional metastatic node on ALND. By contrast, all the 11 women who had no metastatic SLNB had no involved nodes in the ALND. The SLN identification rate before NC was 100% with any false negative.

Conclusions: SLNB before NC is a feasible and an accurate diagnostic tool to predict the pre-therapeutic axilla status. These findings suggest that ALND may be avoided in patients with a negative SLNB performed before NC.

Keywords: Sentinel node, Neoadjuvant chemotherapy, Breast cancer