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Termination of atrial flutter by directed transesophageal atrial pacing during transesophageal echocardiography

Terminierung von Vorhofflattern mit gerichteter transösophagealer Vorhofstimulation bei transösophagealer Echokardiographie

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Abstract

Introduction: The purpose of this study was to evaluate termination of atrial flutter (AFL) by directed rapid transesophageal atrial pacing (TAP) with and without simultaneous transesophageal echocardiography (TEE) performed using a novel TEE tube electrode.

Materials and methods, and Results: A total of 16 AFL patients (age 63 ± 12 years; 13 males) with mean AFL cycle length of 224 ± 24 ms (n = 12) and mean ventricular cycle length of 448 ± 47 ms (n = 12) were analyzed using either an esophageal TO electrode (n = 10) or a novel TEE tube electrode consisting of a tube with four hemispherical electrodes that is pulled over the echo probe (n = 6). AFL could be terminated by directed rapid TAP using an esophageal TO electrode, leading to induction of atrial fibrillation (AF) (n = 6), induction of AF and spontaneous conversion to sinus rhythm (SR) (n = 3), and with conversion to SR (n = 1). AFL could also be terminated by directed rapid TAP using the TEE tube electrode, with induction of AF (n = 3) or induction of AF and spontaneous conversion to SR (n = 3).

Conclusion: AFL can be terminated by directed rapid TAP with hemispherical electrodes with and without simultaneous TEE. TAP with the directed TEE tube electrode is a safe, simple, and useful method for terminating AFL.

Keywords: atrial flutter; esophageal ECG; rapid atrial pacing; transesophageal atrial pacing; transesophageal echocardiography.

Zusammenfassung

Einleitung: Die Terminierung von Vorhofflattern (AFL) mit gerichteter hochfrequenter transösophagealer Vorhofstimulation (TAP) wurde mit und ohne simultane transösophageale Echokardiographie (TEE) mit einer neuen TEE-Schlauchelektrode evaluiert.

Material und Methode und Ergebnisse: 16 AFL Patienten (Alter 63 ± 12 Jahre; 13 Männer) mit einer mittleren AFL-Periodendauer von 224 ± 24 ms (n = 12) und einer mittleren ventrikulären Periodendauer von 448 ± 47 ms (n = 12) wurden mittels Ösophaguslektrode „TO“ (n = 10) oder neuer „TEE-Schlauchelektrode“, die aus einem Schlauch mit 4 halbkugelförmigen Elektroden besteht und über die Echokardiographiesonde gezogen wird (n = 6), analysiert. AFL konnte mit gerichteter hochfrequenter TAP und TO-Elektrode durch Induktion von Vorhofflimmern (AF) (n = 6), Induktion von AF mit spontaner Konversion in den Sinusrhythmus (SR) (n = 3) und Konversion in den SR (n = 1) terminiert werden. AFL konnte mit gerichteter hochfrequenter TAP und TEE-Schlauchelektrode durch Induktion von AF (n = 3) und Induktion von AF mit spontaner Konversion in den SR (n = 3) terminiert werden.

Schlussfolgerung: AFL kann durch gerichtete hochfrequente TAP mit halbkugelförmigen Elektroden mit und ohne simultane TEE terminiert werden. TAP mit der gerichteten TEE-Schlauchelektrode ist eine sichere, einfache und praktikable Methode zur Terminierung von AFL.

Schlüsselwörter: hochfrequente Vorhofstimulation; Ösophagus-EKG; transösophageale Vorhofstimulation; Vorhofflattern.

Introduction

Transesophageal atrial pacing (TAP) for treatment of tachycardias after a transesophageal echocardiography examination is an established therapy for termination of atrial tachycardia and atrial flutter. However, simultaneous directed TAP during transesophageal echocardiography so far has not been possible [1–3, 7, 9, 12, 13]. Simultaneous transesophageal echocardiography and pacing would reduce these transesophageal procedures from two steps to one step, and thus save time and reduce patient discomfort. The purpose of this study was to compare termination of atrial flutter by directed rapid TAP with and without simultaneous transesophageal
Materials and methods

Atrial flutter patients were analyzed using an esophageal TO electrode with one cylindrical and either three or seven hemispherical electrodes on the cardiac side of the probe (TO, Dr. Osypka GmbH, Rheinfelden, Germany) in ten patients and a transesophageal echocardiography tube electrode that is pulled over the transesophageal echocardiography probe, with four hemispherical electrodes on the cardiac side of the transesophageal echocardiography probe (TEE electrode, Dr. Osypka GmbH) in six patients (Figure 1). TAP was analyzed between different pacing dipoles. Bipolar transesophageal atrial pacing with the TEE electrode was analyzed between distal electrodes 1 and 2, electrodes 1 and 3, electrodes 4 and 2, or electrodes 1 and 4. Bipolar transesophageal atrial sensing was analyzed between proximal electrodes 4 and 3, electrodes 4 and 2, electrodes 1 and 3, or electrodes 2 and 3. Finite element simulation of the TAP electrical field was performed using Ansoft Maxwell® 2D simulation software (Figure 2), with measurement of the TAP threshold-evaluated TAP dipole of the novel TEE tube electrode for termination of atrial flutter by simultaneous transesophageal echocardiography and directed TAP [5]. The study was approved by the Ethics Committee of the Friedrich Schiller University of Jena and all patients gave informed consent.

Effective left atrial capture was possible with biphasic constant current pacing from 15 to 20 mA for a stimulus duration of 10 ms (stimulator 8817, FIAB, Florence, Italy) using the TEE electrode in six patients and for 9.9 ms (stimulator 5328, Medtronic, Inc., Minneapolis, MN, USA) with an esophageal TO electrode in ten patients. The esophageal TO electrode with one cylindrical and seven hemispherical electrodes was placed orthogonal to the coronary sinus posterior to the left atrium and to the left ventricle using the EnSite® NavX catheter navigation system (Endocardial Solutions, Inc., St. Paul, MN, USA) in one patient [6].

The electrical pacing response of transesophageal left atrial pacing during atrial flutter was analyzed on the basis of rapid bipolar TAP and bipolar filtered transesophageal atrial ECG with an esophageal TO electrode and the CardioLab® 4.1 system (Prucka Engineering, Inc., Houston, TX, USA; ten patients). TAP was analyzed in ten
Rapid bipolar transesophageal atrial pacing with hemispherical electrodes in a patient with atrial flutter. Atrial flutter was terminated by directed bipolar rapid transesophageal atrial pacing with conversion to sinus rhythm. Transesophageal atrial pacing and conversion to sinus rhythm was recorded using CardioLab® 4.1 system. II, aVF, V1, surface ECG leads; Oes, bipolar filtered transesophageal atrial ECG; TAP, transesophageal atrial pacing; AF, atrial fibrillation; SR, sinus rhythm.

Table 1 Termination of atrial flutter with transesophageal atrial pacing and different electrodes.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Arrhythmia</th>
<th>Electrode</th>
<th>Termination of atrial flutter with transesophageal atrial pacing to</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.K.</td>
<td>59</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TO</td>
<td>Sinus rhythm</td>
</tr>
<tr>
<td>H.W.</td>
<td>47</td>
<td>M</td>
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<td>TO</td>
<td>Atrial fibrillation and sinus rhythm</td>
</tr>
<tr>
<td>S.B.</td>
<td>61</td>
<td>M</td>
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<td>TO</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>C.K.</td>
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<td>F</td>
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<td>TO</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>H.J.</td>
<td>78</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TO</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>G.M.</td>
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<td>TO</td>
<td>Atrial fibrillation and sinus rhythm</td>
</tr>
<tr>
<td>H.H.</td>
<td>81</td>
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<td>TO</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>M.G.</td>
<td>57</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TO</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>W.B.</td>
<td>60</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TO</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>D.K.</td>
<td>69</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TO</td>
<td>Atrial fibrillation and sinus rhythm</td>
</tr>
<tr>
<td>O.W.</td>
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<td>M</td>
<td>Atrial flutter</td>
<td>TEE</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>M.G.</td>
<td>57</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TEE</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>E.K.</td>
<td>63</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TEE</td>
<td>Atrial fibrillation and sinus rhythm</td>
</tr>
<tr>
<td>R.L.</td>
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<td>TEE</td>
<td>Atrial fibrillation and sinus rhythm</td>
</tr>
<tr>
<td>E.W.</td>
<td>80</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TEE</td>
<td>Atrial fibrillation and sinus rhythm</td>
</tr>
<tr>
<td>W.D.</td>
<td>78</td>
<td>M</td>
<td>Atrial flutter</td>
<td>TEE</td>
<td>Atrial fibrillation</td>
</tr>
</tbody>
</table>

TO, Osypka esophageal electrode with one cylindrical and three or seven hemispherical electrodes on the cardiac side of the probe; TEE, Osypka transesophageal echocardiography tube electrode with four hemispherical electrodes that is pulled over the echo probe; M, male; F, female.

Results

Atrial flutter could be terminated by directed rapid TAP using an esophageal TO electrode after a transesophageal echocardiography examination with induction of atrial fibrillation in six patients, with induction of atrial fibrillation and spontaneous conversion to sinus rhythm in three patients, and with conversion to sinus rhythm in one patient (Figure 3). Simultaneous transesophageal echocardiography and TAP reduces two transesophageal procedures to one and thus decreases patient discomfort. Atrial flutter could be terminated by directed rapid TAP using a TEE electrode during a transesophageal echocardiography examination with induction of atrial fibrillation in three patients, and induction of atrial fibrillation and spontaneous conversion to sinus rhythm in three patients (Table 1). The mean atrial flutter cycle length was 224±24 ms in 12 patients. The mean ventricular cycle length was 448±47 ms in 12 patients. The mean age was 63±12 years (3 females, 13 males).

Transesophageal ECG was a bipolar filtered left atrial ECG. The atrioventricular conduction relationship was 2:1 between the transesophageal left atrial and ventricular potential in 12 patients with atrial flutter. The atrioventricular conduction relationship was 3:1 or 4:1 between the transesophageal left atrial and ventricular potential in four patients with atrial flutter (Figure 4).

Bipolar TAP between two hemispherical electrodes was analyzed using a 90-mm and 60-mm TAP dipole. The capture threshold for TAP with the 60-mm dipole was lower than for the 90-mm dipole for a stimulus duration of 10 ms (15 vs. 18±2.1 mA, p=0.02). The minimum rapid TAP cycle length was 50 ms and the maximum stimulus output was an amplitude of 20 mA for a duration of 10 ms. The hemispherical electrical pacing field allowed directed bipolar TAP at the posterior site of the left atrium with low capture threshold and high feeling threshold (Figure 5). Bipolar TAP was possible with short and long TAP dipoles using 6-mm hemispherical elec-
Simultaneous recording of bipolar filtered transesophageal atrial and ventricular ECG and transesophageal echocardiography during atrial flutter. Transesophageal atrial and ventricular ECG was recorded between two hemispherical transesophageal echocardiography electrodes. The atrioventricular conduction relationship was 3:1 and 4:1 between the left atrial and left ventricular transesophageal potential during atrial flutter. Oes, bipolar filtered transesophageal ECG; A, transesophageal atrial potential during atrial flutter; V, transesophageal ventricular potential during atrial flutter.

Figure 5  Low capture threshold and high feeling threshold for transesophageal atrial pacing with a directed 6-mm electrode and different stimulus duration.

Discussion

Previous studies of atrial overdrive pacing in patients with atrial flutter have demonstrated termination of atrial flutter with rapid high-threshold TAP. Termination of atrial flutter with TAP could only be achieved after, but not during, transesophageal echocardiography [8, 10, 11, 14]. This study investigated for the first time directed rapid TAP during simultaneous transesophageal echocardiography for termination of atrial flutter. The atrioventricular conduction relationship ranged from 2:1 to 4:1 between the transesophageal left atrial and left ventricular potential during atrial flutter. Atrial flutter can be terminated by directed rapid TAP with hemispherical electrodes during simultaneous transesophageal echocardiography. Termination of atrial flutter was 100%, with 57% to atrial fibrillation and 43% to sinus rhythm. There was no difference in termination of atrial flutter between the novel TEE tube electrode during simultaneous transesophageal echocardiography and the conventional transesophageal TO electrode. The capture threshold for TAP was lower than the pain threshold using the novel TEE tube electrode during simultaneous transesophageal echocardiography. Transesophageal atrial sensing and pacing was possible with short and long TEE electrode dipoles using hemispherical electrodes. The capture threshold for TAP was lower than the pain threshold using 6-mm hemispherical electrodes (9.8 ± 3.1 vs. 10.9 ± 5 mA for stimulus duration of 9.9 ms), but was higher than the pain threshold for TAP with 10-mm cylindrical electrodes (16.7 ± 3.3 vs. 12.6 ± 5.2 mA for stimulus duration of 11 ± 3.3 ms) [4]. The application of 6-mm hemispherical electrodes allowed TAP with a low capture threshold for termination of atrial flutter. Detection of atrial flutter was possible using bipolar transesophageal atrial ECG with the novel TEE tube electrode during simultaneous transesophageal echocardiography. TAP with the directed TEE electrode is a simple and more efficient, and thus more useful method for termination of atrial flutter. Simultaneous TAP and transesophageal echocardiography reduce these procedures from two to one, and thus save time and reduce patient discomfort.

Our study shows that TAP and transesophageal atrial sensing with a directed TEE tube electrode is a simple and useful method for termination of atrial flutter. Simultaneous TAP, transesophageal atrial sensing and transesophageal echocardiography allow the treatment of atrial flutter during necessary transesophageal echocardiography examinations without an additional study.

Limitations

This was a small non-randomized study. Clinical trials are required to establish this technique for widespread use.

Acknowledgements

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