

Site of origin:

- RVOT – 14 cases: anteroseptal-11; posteroseptal-2 and free wall-1
- LVOT – 4 cases: Left coronary cusp-1 and aorto mitral continuity-3
- **Follow-up:** 2 patients had symptomatic recurrence – 1 case redo RFA
- **Complication:** Nil

Summary

- Frequent PVC's, NSVT and sustained VT occurs even in structurally normal heart.
- Drug refractory arrhythmias or intolerant patients can undergo RF ablation safely.

Clinical and angiographic profile of patients with complete heart block



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100 patients who came to the emergency department with complete heart block were included in this prospective study. Commonest age group is above 60 years mostly males with chest pain in 60%, shortness of breath in 30% and giddiness in 20% of patients, 43% are known hypertensives.

Blood pressure at the time of admission is 100/70 mm of Hg, heart rate around 40%, tachypnoea 5%.

On auscultation crepts in 5% patients, creatinine levels elevated in 5%, hypokalemia in 15%, echo showed regional wall motion abnormality in 30%. Severe and mild LV dysfunction 15% and 12% patients, good LV function in 3%. Degenerative complete heart block seen in 34% patients, diphtheric 15%, hypokalemic 15%, dilated cardiomyopathy 2%. MI in 34% patients commonly inferior wall MI. On Coronary angiogram RCA – 41%, LAD – 23%, LCX – 23%, LCX and LAD 8%, Triple vessel disease – 8%. 10% patients had cardiogenic shock and 26% died.

Correlation of head-up tilt table test time interval with risk of recurrent syncope



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Background: The head-up tilt table test (HUTT) is a widely used method for investigation of syncope, presyncope, dizziness and palpitations related to orthostatic intolerance and dysautonomia. Time required for positive response has a probable relationship to the sensitivity of neural reflex mechanism underlying syncope. Multiple studies have addressed the role of this test in syncope with regard to its diagnostic utility in terms of sensitivity and specificity but none have focused the implication of time required for positive response in relation to risk of recurrent syncope.

Aim: To correlate HUTT time interval with recurrence of syncope in Indian population.

Methods: We evaluated 68 patients with history of syncope who were referred to HUTT clinic. They were divided into two groups. Group A included patients with recurrent syncope defined as 3 or more episodes of syncope and group B included those with less than 3 episodes of syncope. We analyzed the time required for the test to become positive in both the groups.

Results: Of the 68 patients studied, 22 (32.35%) were included in group A and 46 (67.65%) were included in group B. HUTT was positive in 41 patients (60.29%). The positivity rate was 100% in group A and 41.3% in group B. Pattern of positive hemodynamic response was predominantly type 1 (mixed response) in both groups. Median time interval for positive response in group A was 12.5 min (25th to 75th IQR = 10.5 to 14.0) in comparison to 30.0 min (25th to 75th IQR = 20.0 to 35.0) in group B. Using binary logistic regression analysis, an inverse association was found between recurrent syncope and time interval for positive response ($r = -0.282$, $p = 0.002$) which was statistically significant. Receiver operating characteristics (ROC) curve showed that time interval of less than 19.5 min had 94.5% sensitivity and 97.89% specificity for recurrence of syncope. No patient experienced technical difficulty or complications during the test.

Conclusion: HUTT time interval of less than 19.5 min predicted recurrence of syncope. Hence can serve as an important clinical predictor of future recurrence of syncope.

Novel technique of transfemoral venous pacing in a case of inferior vena cava stenosis



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Background: Temporary transvenous pacing is simple, life saving, invasive procedure commonly performed in cath labs for treatment of bradyarrhythmias, yet at times may present with difficulty due to unexpected anatomical variations. We present a novel technique for transfemoral venous pacing in cases with Inferior Vena Cava (IVC) stenosis.

Method: A 68-year-old lady and a diagnosed case of rheumatic heart disease and dilated cardiomyopathy with atrial flutter presented with dry cough and worsening dyspnea for 7 days. Her initial ECG showed frequent VPC's and digoxin levels were found to be 3.4 ng/ml. Patient developed junctional bradycardia with hypotension during hospital stay and temporary transvenous pacing by femoral route was planned. RV pacing was initially attempted using 6F and subsequently 5F pacing leads, but the temporary pacing lead could not be negotiated beyond the D8 level which was confirmed by a contrast venogram. Then 6F armored sheath was passed over a terumo wire into the RA and then through the armored sheath, a 6F pacing lead was placed at the RV apex and armored sheath was then pulled back into the IVC. Armored sheath and pacing lead were anchored to the thigh. Procedure was successful and uneventful and pacing lead and sheath were removed after 4 days without complications.

Conclusions: Even after extensive search in various databases like PUBMED, MEDLINE, EMBASE and Cochrane library, no mention of similar technique has been described. Hence this case highlights a successful novel technique for temporary pacing, when faced with difficult temporary pacing lead manipulation in cases of IVC stenosis, in life threatening situations.