13th Annual
New Frontiers in
Heart Failure Therapy

Integrating Devices & Pharmacotherapy

Martha Ferrara, FNP-C CCDS
Arrhythmia Clinic
CASE PRESENTATION

question:

Best clinical approach for this patient

PVC ablation or Bi-V ICD?

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CASE Presentation:

1. 6/2007
   • Patient is a 54 year old male presenting with chest discomfort, shortness of breath, CHF

2. Stress Test: Abnormal

3. Cardiac Cath: LAD 50% stenosis, LVEF: 15%

4. EKG: LBBB
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Follow Up:


2. Medications:
   Digoxin QD, Lasix QD, Altace QD, Aldactone QD, ASA QD, Zocor QD, Coreg BID

3. Boston Scientific Bi-V ICD-Contak Renewal H 219 RF
   implanted in 8/2007

4. NIPS testing on 9/2007. He had c/o cough at the time and Altace discontinued

5. Latitude Monitoring Ordered
Bi-V ICD Interrogation History:

1. December 20, 2007: normal, Bi-V pacing 69% (initial interrogation)
2. September 22, 2008: normal, Bi-V pacing 88%
   a. EKG Sinus rhythm with ventricular bigeminy
      *Pt. refused Amiodarone therapy*
3. May 27, 2009: VT~ATP, Bi-V pacing 90%
4. July 21, 2010: 3 VT episodes~ATP, Bi-V pacing 72%
   ^Toprol increased 200 mg daily^
5. December 11, 2011: VT~ATP, Bi-V pacing 82%
   **Of note: Echo 2/2011 LVEF: 30%**

Dates


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1. July 3, 2012: Bi-V pacing 73%. PVCs Counter: **4.3 million**
   ***average 20,000/24 hour period***

2. Recommendation: holter monitor to quantify PVC burden

3. EP referral consult for discussion of findings
   HOLTER August 2012:
   PVCs 15% (13,000), SVT 25% (? fusion & pseudo-fusion beats and may actually represent ventricular ectopy, short NSVT runs)
EKG September 2012

EKG (un-paced):
- sinus rhythm
- LBBB
- ventricular bigeminy
- PVCs: MM, RBBB configuration, superior axis

MUGA
8/2012:
LVEF: 19%
**CLINICAL DATA:**
Patient less energy than last year

**RECOMMENDATION**
1. PVC ablation recommended
2. Second Opinion repeat holter
   11/27/2012: 25% PVCs. Agrees with PVC RFA
3. CARDIOLOGIST:
   what difference will an ablation make if activity level and energy level steady and un-certain if EF would change?
Conclusions: Frequent PVC is an uncommon yet significant cause of CRT non-response. Radiofrequency ablation of PVC foci improves LV function and New York Heart Association class and promotes reverse remodeling in CRT non-responders. PVC ablation may be used to enhance CRT efficacy in non-responders with significant PVC burden.¹

¹. J Am Coll Cardiol 2012;60:1531–9
Goals for Patient
1. Reverse Re-modeling
2. Reduce Mortality
3. Maximize ICD Therapy Benefit