Author's reply

Dear Editor,

We thank Dr. Spartalis for giving us the opportunity to clarify some crucial issues about our work.

As a prerequisite to be included in our analysis, cryoablated patients had to comply with the European Society of Cardiology (ESC) criteria for structural heart disease (SHD). ESC guidelines definition of SHD is mainly based on anamnestic data and does not include any functional cut off. Even if poorly defined by the guidelines, the presence of SHD is relevant to guide the clinical management of these patients, namely the choice of antiarrhythmic and possible other non-pharmacological alternatives for rhythm control. This is the reason why we focused our analysis on this specific population.

This being the premise, we observed that our snapshot of the real world SHD population treated with cryoballoon pulmonary vein isolation did not include patients with advanced heart failure with reduced ejection fraction (HFrEF). As hypothesized in the discussion, this might be due to the general perception that such advanced patients do not benefit from ablation or need more complex ablative approaches. That is why we clearly stated in the results, throughout the discussion and in the limitations section that: (1) our study did not include advanced heart failure (HF) patients and data strictly refer to heart failure with preserved ejection fraction or non-HF SHD (2) for this same reason they are not comparable with studies such as CASTLE-AF and CAMERA-AF, enrolling only advanced HFrEF subjects.

This is the main reason why our results are far better than those cited by Dr. Spartalis in his comments, even if underestimation of the recurrence rate due to non-standardization of follow-up protocols might have played a role as well, as stated in the limitations section.

As underlined by Dr. Spartalis, drug therapy after ablation was left to each center's choice, but was thoroughly described.

Although relevant, and possibly associated with an "upward bias" these limitations are inherent in the retrospective, real world, nature of our study and do not flaw its key observations: within this population of patients with SHD but without significant systolic dysfunction, neither the persistent nature of the arrhythmia, nor the degree of atrial remodeling correlate with the probability of recurrence.

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