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LETTERS TO THE EDITORS

Letter in response to the article entitled ''Position paper concerning the competence, performance and environment required in the practice of complex ablation procedures'' by Maury et al.

Lettre en réponse à l'article, « Position paper concerning the competence, performance and environment required in the practice of complex ablation procedures » par Maury et al.

Keywords Atrial fibrillation; Ablation; On-site surgery; French Society of Cardiology recommendations
Mots clés Ablations complexes ; Fibrillation atriale ; Arythmies ventriculaires

To the Editor,

In their article, Maury et al. [1] from the Working Group on Pacing and Electrophysiology of the French Society of Cardiology state that ''≥ 100 catheter ablation procedures for atrial fibrillation or left atrial tachycardia and ≥ 30 for ventricular arrhythmia per year per centre seems a reasonable requirement to maintain expertise'' for various reasons, including that ''complex ablations are very technically demanding procedures, where expertise, skill and mastery are essential to achieve high success rates and minimize complication rates''.

Although we agree that expertise is required for safety reasons, we believe that such high recommended minimum thresholds may encourage centres to extend their indications for atrial fibrillation and ventricular tachycardia ablation. A 2017 German consensus statement recommended a minimum number of 75 atrial fibrillation ablations per year per centre [2]. Further, the previous French Society of Cardiology guidelines (2011) [3] regarding interventional cardiac electrophysiological procedures, which focused on dedicated complex ablations, stated that 50 atrial fibrillation ablations per year per centre (achieved within 2 years) was necessary.

An analysis of in-hospital complications associated with atrial fibrillation ablation in the USA during 2000—2010, which included 93,801 procedures, showed that annual operator (< 25 procedures) and hospital (< 50 procedures) volumes were significantly associated with adverse outcomes [4]. In the same publication, there were little differences between 25—50 and > 50 per operator, nor between 50—100 and > 100 per hospital. In the 2017 HRS/EHRA/ECAS/APHRS/SOLAECE expert consensus statement on catheter and surgical ablation of atrial fibrillation [5], the writing group did not recommend an absolute minimum number of atrial fibrillation ablations per year. Rather, this international document recommended that those performing the procedure should perform ''at least several atrial fibrillation ablation procedures per month to maintain competence''.

Maury et al. [1] also stated that ''surgical pericardial drainage by a thoracic or cardiac surgeon on standby in the medical centre should be available at any time during and after the procedure''. The 2011 version of the French Society of Cardiology guidelines said that immediate surgical back-up should be available for the management of critical complications [3]. This was also stated in the HRS/EHRA/ECAS/APHRS/SOLAECE expert consensus document, which indicated that atrial fibrillation ablation should only be performed in hospitals equipped and prepared to manage these types of emergencies, with access to emergency surgical support when required [5]. Hence, a better recommendation could be the availability of immediate surgery (vascular, thoracic or cardiac), as vascular surgeons would also have the required skills to repair a cardiac wound.

To conclude, we were surprised by the French Society of Cardiology recommendations [1] that advocate much higher numbers of procedures than other guidelines from Germany [2] and HRS/EHRA/ECAS/APHRS/SOLAECE [5], and their surgical back-up recommendations. Minimum numbers of procedures and surgical back-up requirements were already well addressed in previous guidelines (both French [3] and international [5]).

Disclosure of interest

The authors declare that they have no competing interest.

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