Archives of Cardiovascular Disease (2019) 112, 290—291

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LETTER TO THE EDITORS

Reply to the letter about the position paper concerning the competence, performance and environment required in the practice of complex ablation procedures

Commentaire à la lettre en réponse à : « Position paper concerning the competence, performance and environment required in the practice of complex ablation procedures »

Keywords Complex ablation procedures; Atrial fibrillation; Ventricular arrhythmia; French Society of Cardiology
Mots clés Ablations complexes ; Fibrillation atriale ; Arythmies ventriculaires

To the Editor,

Although we fully understand the multiple aftermaths such position papers may provoke, it should be acknowledged that this is their purpose. Expertise, skill and mastery have always been and ever will be mandatory for treating patients, and this is especially crucial in interventional electrophysiology.

The recommended minimal threshold proposed here for performing complex ablations can no longer be considered as ''high'', but should rather be regarded as a reasonable limit based on current (not previous) experience and common sense. We should recall here some of the points stated clearly in the position paper [1], and we do not think that any discussion based on the 2011 guidelines or on even older data is relevant.

First, the threshold of 100 complex atrial ablations per year includes not only procedures for atrial fibrillation, but also for left atrial tachycardia. This is ultimately not so different to the recent German consensus statement [2] referenced by both Amara et al. [3] and us, where the minimal number of 75 yearly procedures was proposed only for atrial fibrillation.

Second, performing 100 procedures per year (i.e., more than two left atrial ablations per week) does not seem to represent a high level of activity in 2018, given the widespread adoption of atrial fibrillation ablation and the availability of refined tools.

Third, these threshold values have been proposed as reasonable landmarks for guidance, and should not be considered as rigid fixed cut-offs. We do not think that this position statement will influence centres with numbers below the threshold to unreasonably expand their indications for complex procedures, as a natural increase is probably expected soon. However, we maintain that centres that achieve much lower activity should be questioned about their ability and legitimacy to carry on performing complex ablations. This would not be the case when each centre accommodates a sufficiently large local population, and if several centres in the same geographic area do not each have a sufficient number of patients, gathering of the activities at one site is strongly encouraged.

Amara et al. [3] mentioned the 2017 HRS/EHRA/ECAS/APHRS/SOLAECE expert consensus statement on catheter and surgical ablation of atrial fibrillation [4]. These recommendations state that physicians should perform ''at least several atrial fibrillation ablation procedures per month to maintain competence''; it should be noted that this concerns the activity of individual physicians, not centres.

Finally, a very recent nationwide data analysis demonstrated that fewer complications occurred in centres performing > 100 versus ≤ 100 left atrial ablations annually [5]. Thus, this threshold value seems to us fully valuable, relevant and reasonable, particularly for the patients.

We also mentioned 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'' [1]. As mentioned by Amara et al. [3], this was also stated in the HRS/EHRA/ECAS/APHRS/SOLAECE expert consensus document, which indicated the need for access to emergency surgical support when required [4]. Emergency surgical support means the availability of surgical pericardial drainage and eventual managing of cardiac perforation, at least transiently, pending specialized definitive correction at a neighbouring centre when transportation is judged safe [1]. Although it remains to be proven that vascular surgeons universally have the required skills to repair a cardiac wound, we acknowledge that this would be sufficient if they are able to do so satisfactorily.

DOIs of original articles: https://doi.org/10.1016/j.acvd.2018.11.010, https://doi.org/10.1016/j.acvd.2018.05.006.

To conclude, this position paper reflects the opinion of experts in the interventional treatment of cardiac arrhythmias in 2018, based on both current or recent scientific data and common sense, in order to achieve better success rates and fewer complications while performing complex ablations, for the sole benefit of the patients.

Disclosure of interest

The authors declare that they have no competing interest.

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Received 14 November 2018;
accepted 15 November 2018
Available online 18 March 2019

https://doi.org/10.1016/j.acvd.2018.11.012