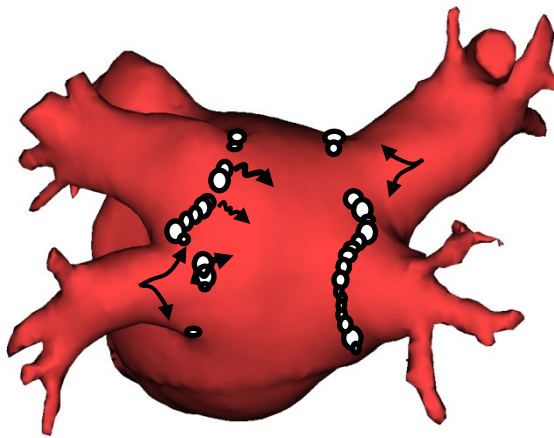
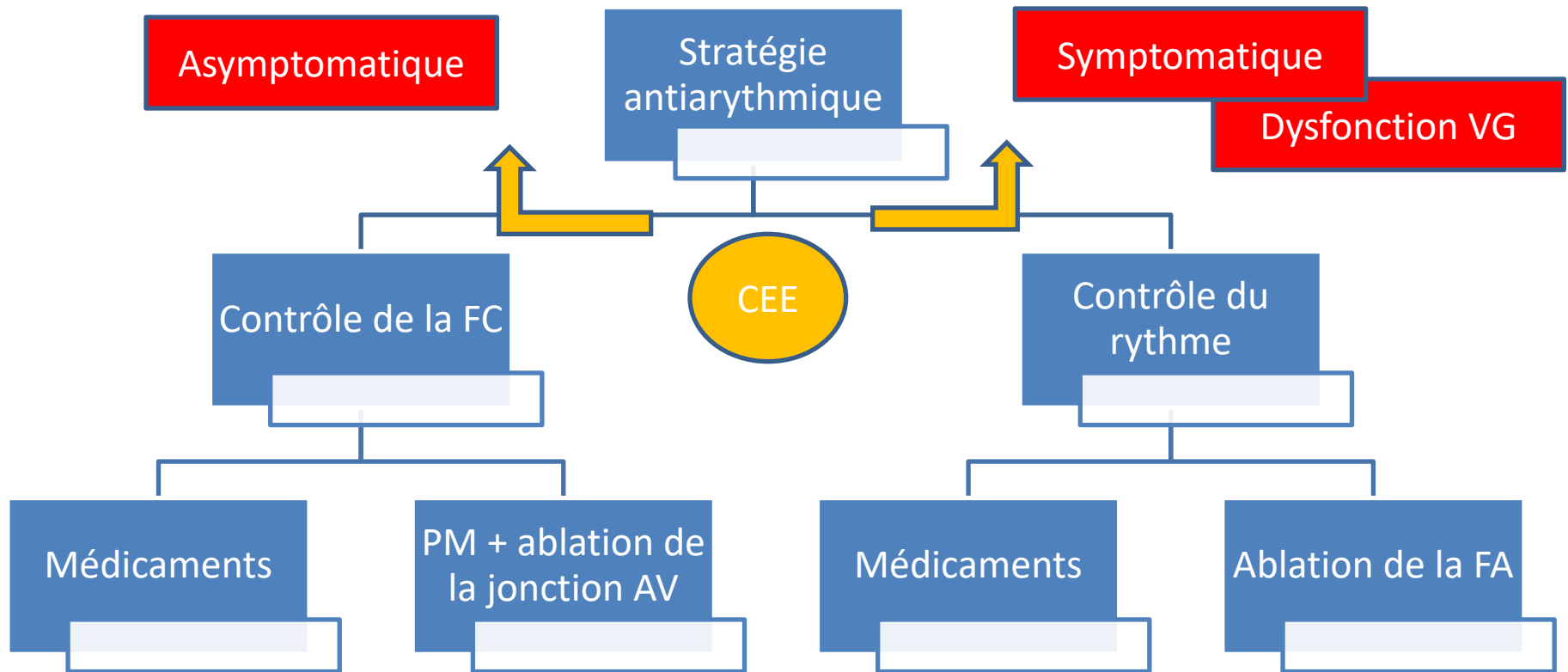

Ablation de FA pour qui ? Comment ?

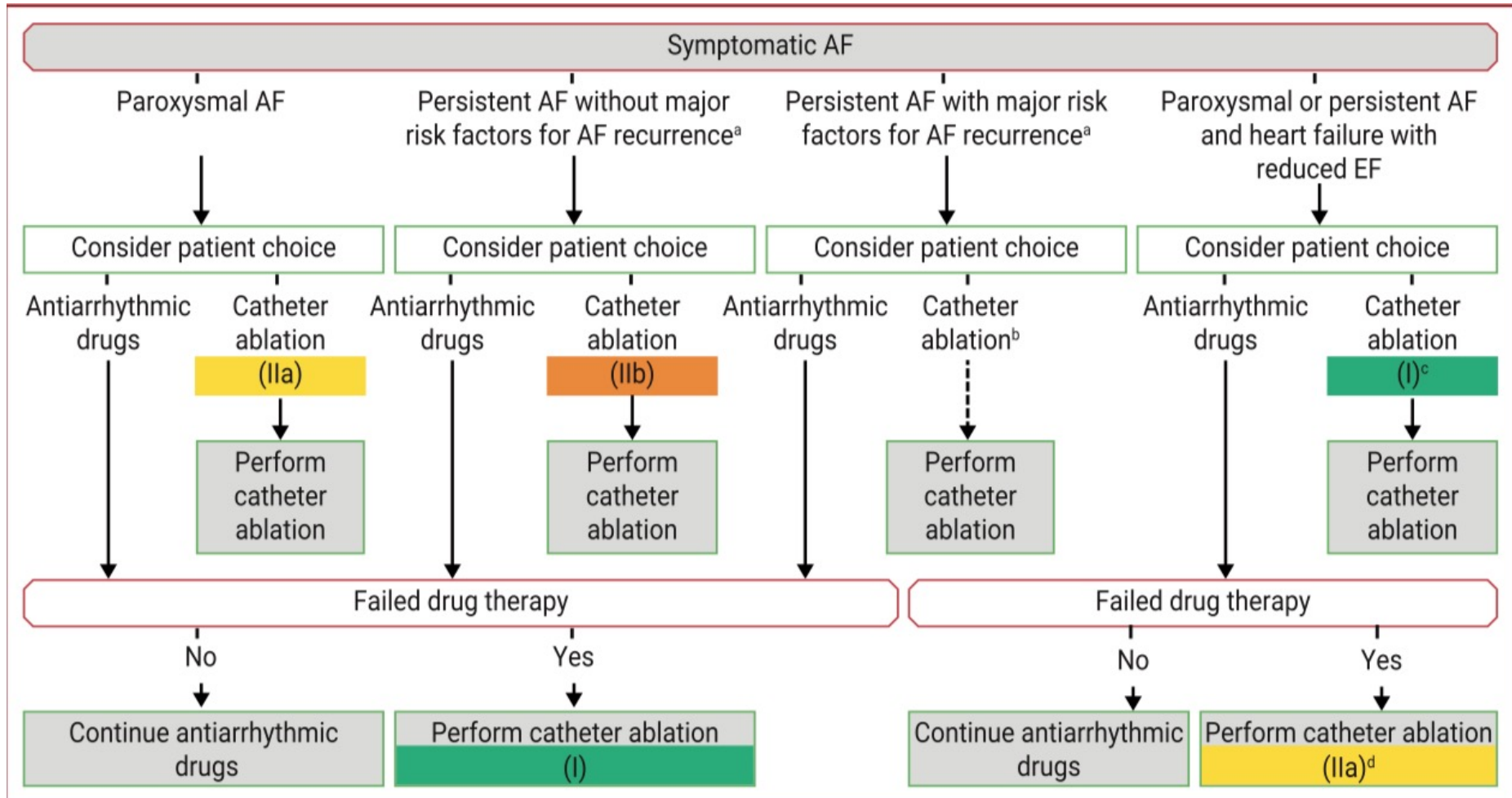


Dr Behaghel Albin

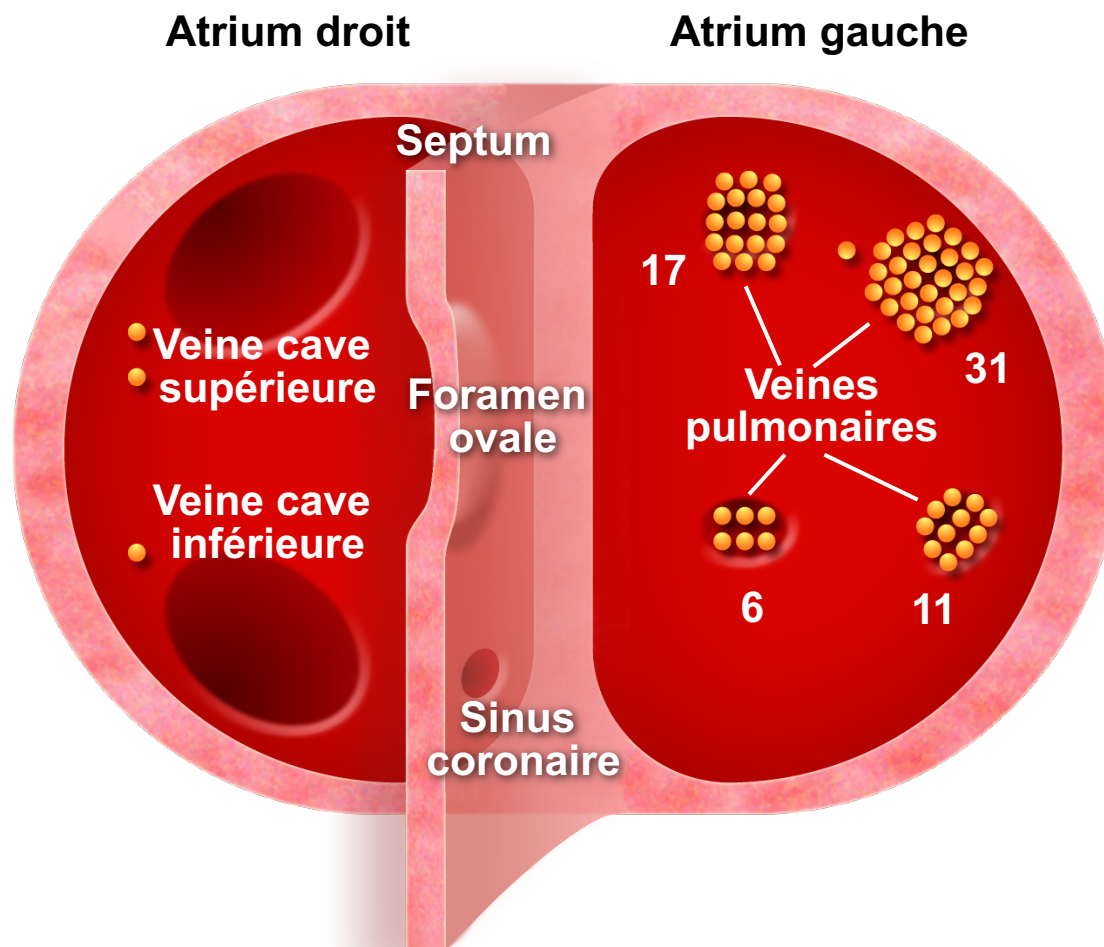
Pour Qui ?



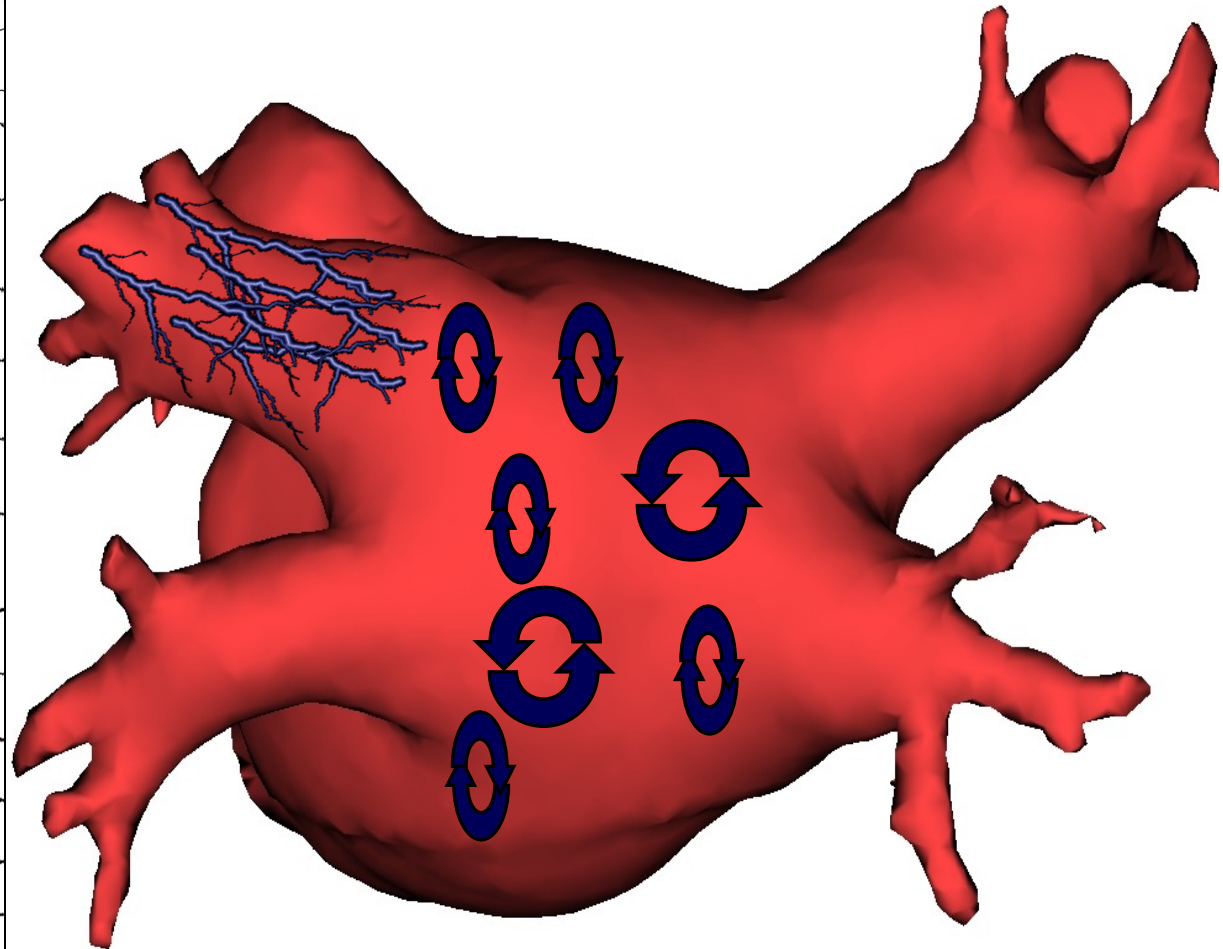
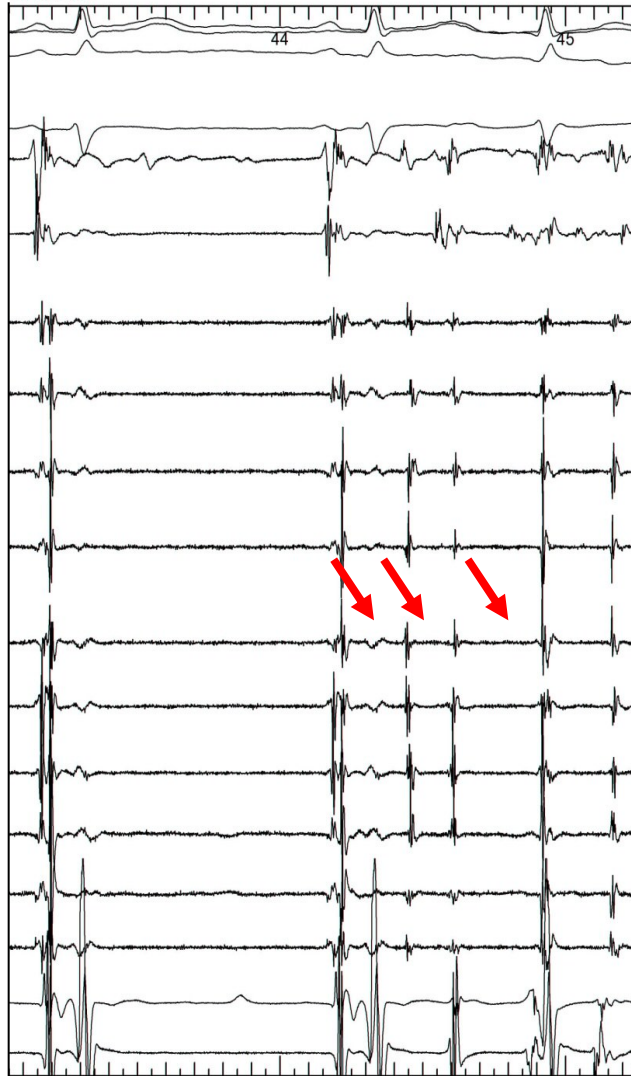
Pour Qui ?



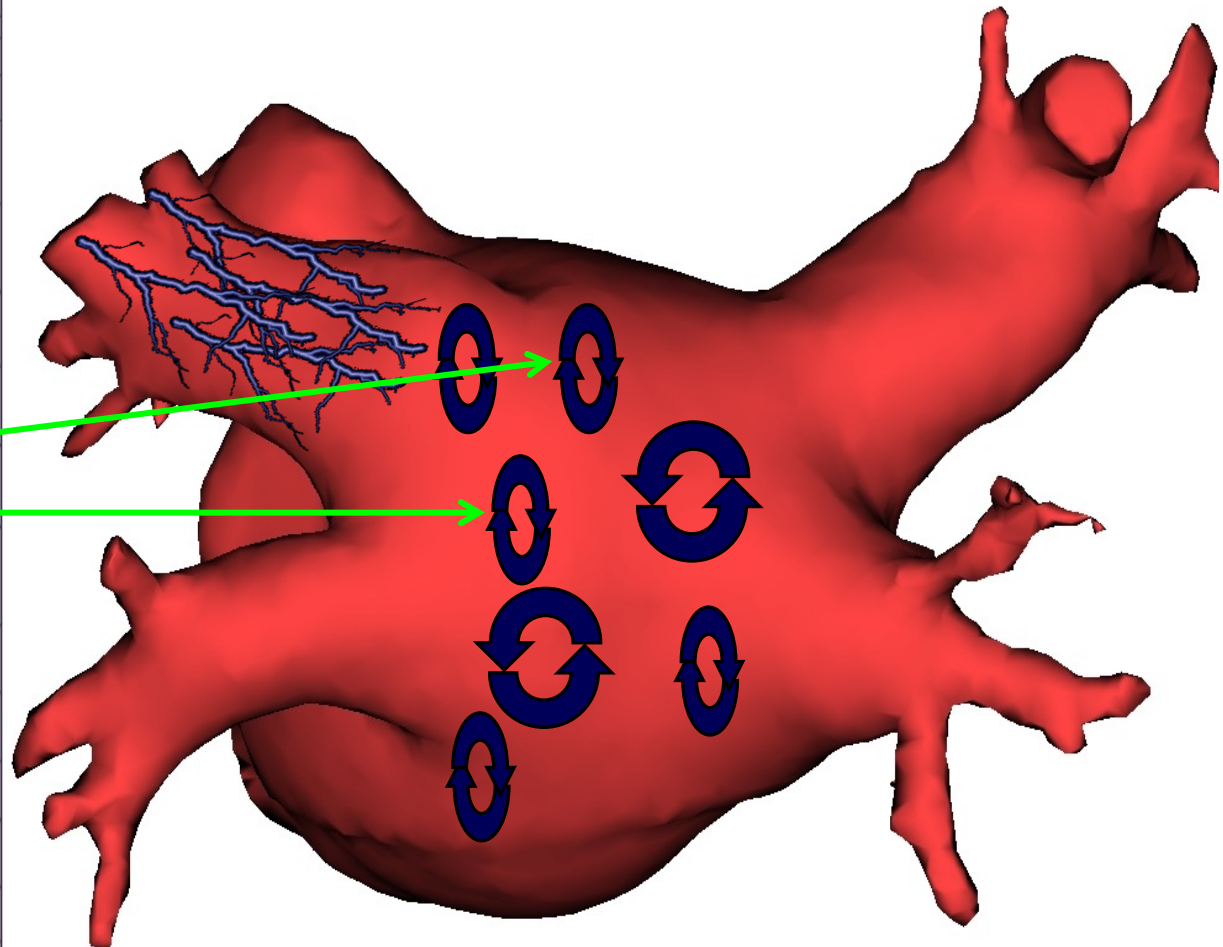
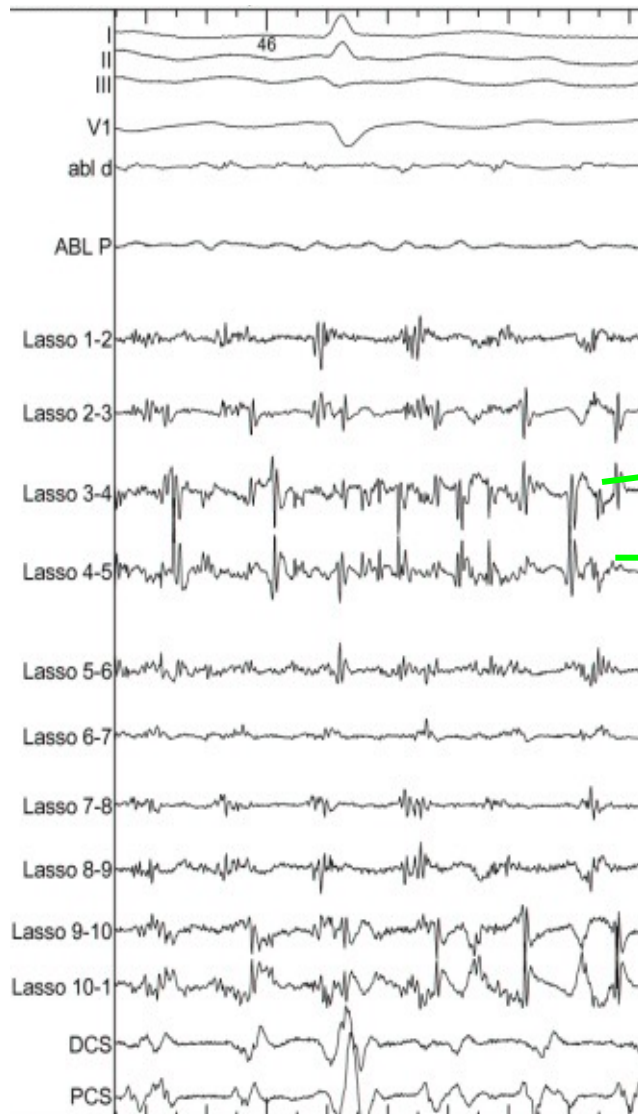
Comment?



Comment ?

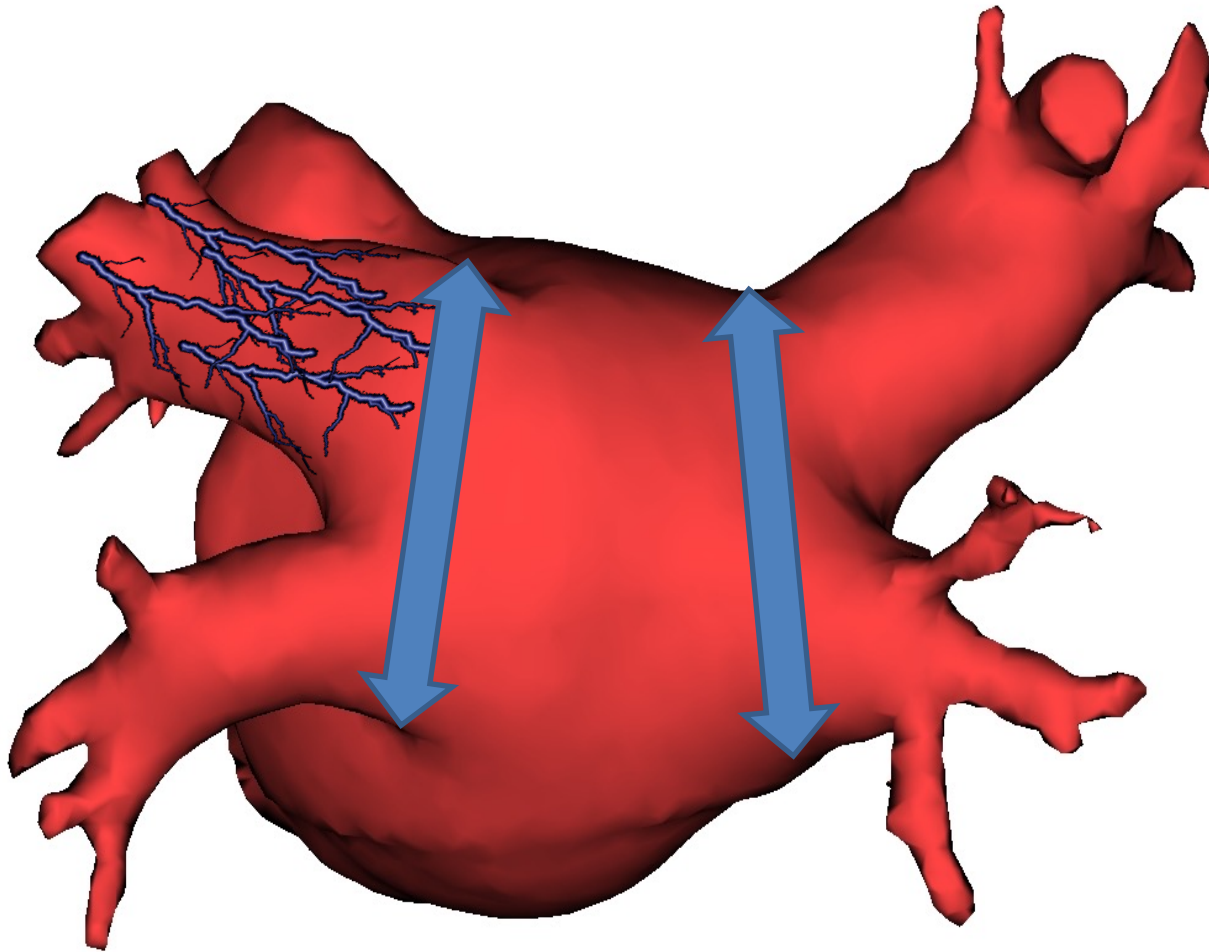


Comment ?



Comment ?

Créer une barrière entre les VP et l'OG

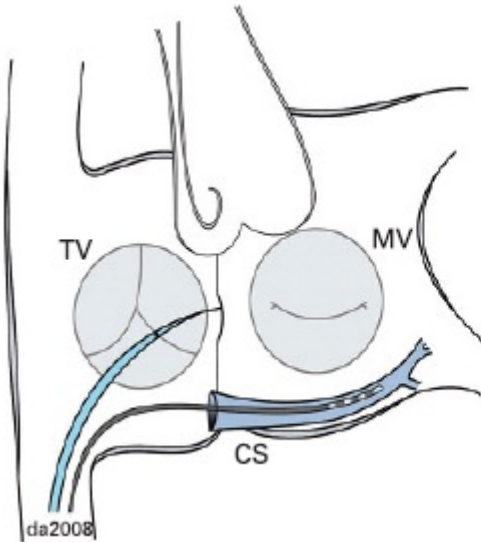


Comment ?

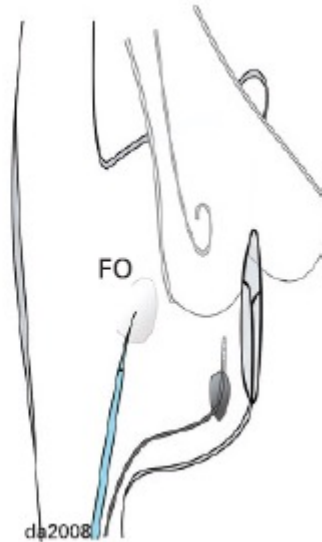


- Sous **anesthésie générale**
- **ETO avant intervention**
- Durée entre **1h30 et 2h30**
- Arrivée le matin ou la veille au soir
- Sortie le lendemain
- Abord veineux fémoral droit (2-3 ponctions)
- **Avant l'intervention :**
 - Consultation d'explication
 - Scanner des oreillettes
 - Consultation anesthésie
 - Bilan biologique
- **Après l'intervention :**
 - ETT le lendemain
 - Consultation avec cardiologue à 1 mois
 - Holter ECG à 2 mois et demi
 - Consultation avec opérateur à 3 mois
 - Centre opérateur ouvert 24h/24h

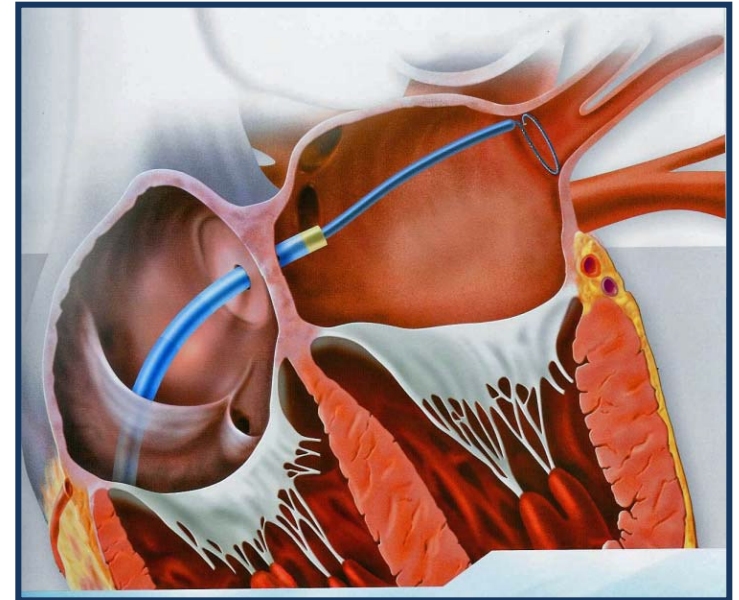
Comment ?



OAG

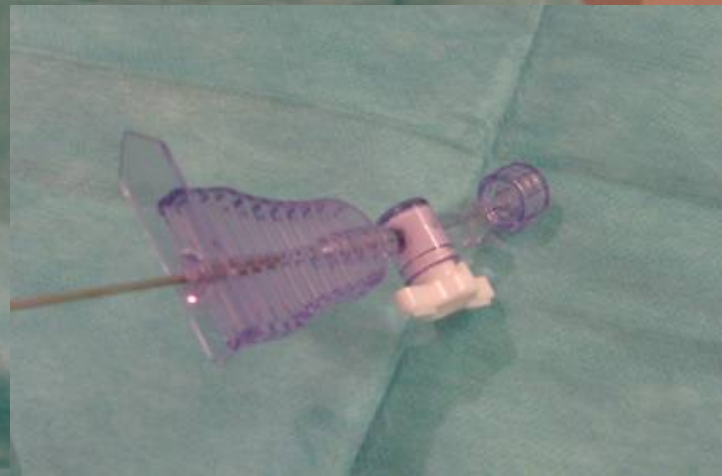


OAD



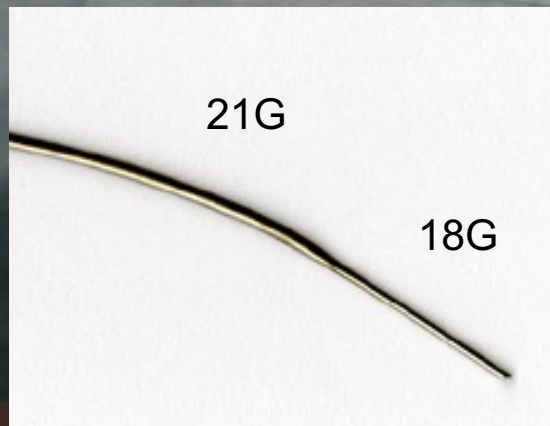
- Maintien du traitement anticoagulant jusqu'à l'intervention
- Pas de prise d'AOD le matin
- Bolus d'héparine avant la ponction transeptale
- Mesure ACT toutes les 15 minutes
- Reprise anticoagulant le soir même

KT transseptal Equipement

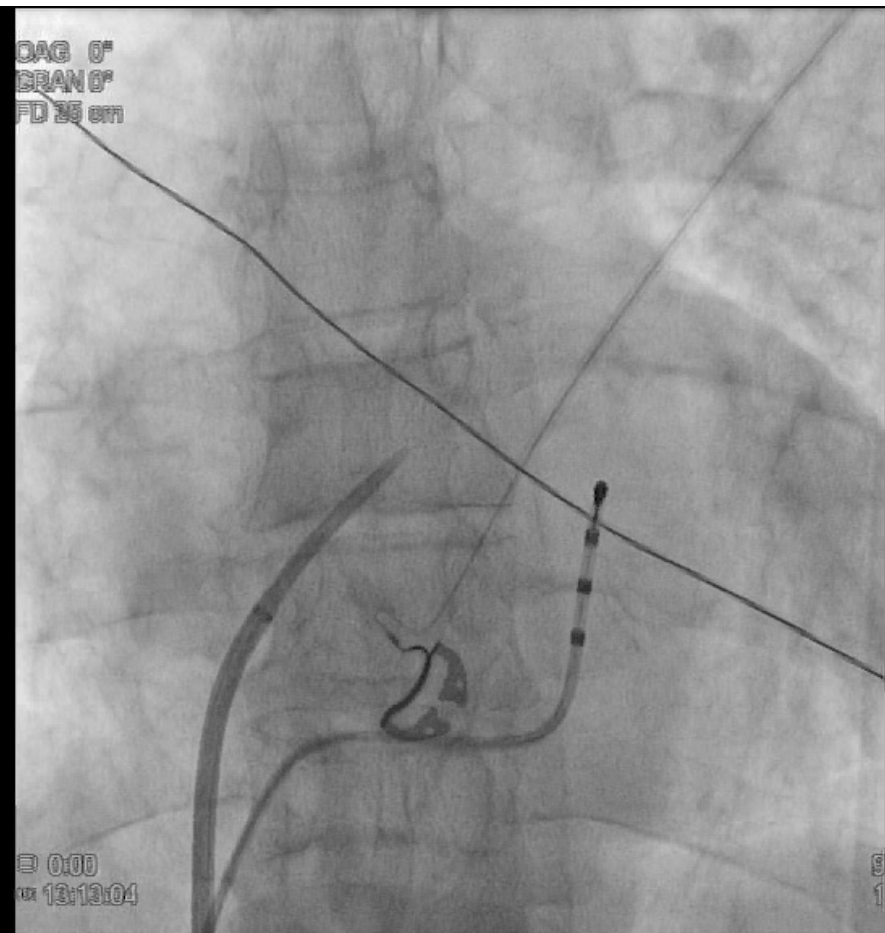
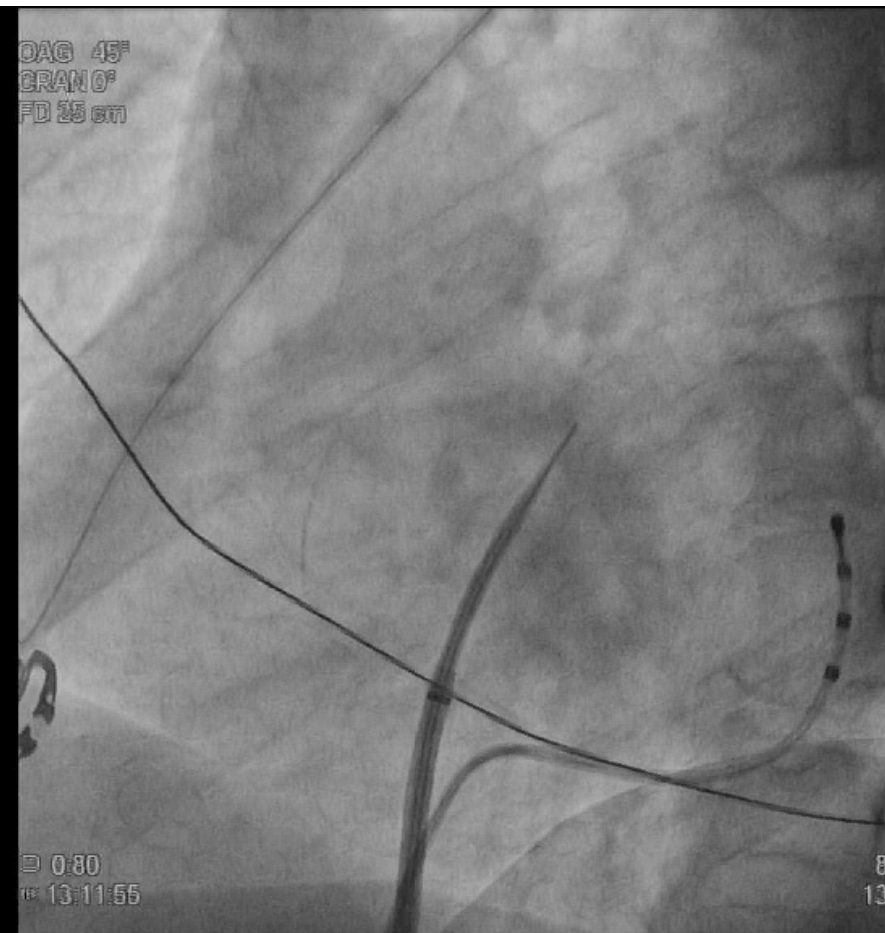


Gaine (+ dilatateur) Swartz SL0 8F, 67 cm (85 cm), St JM

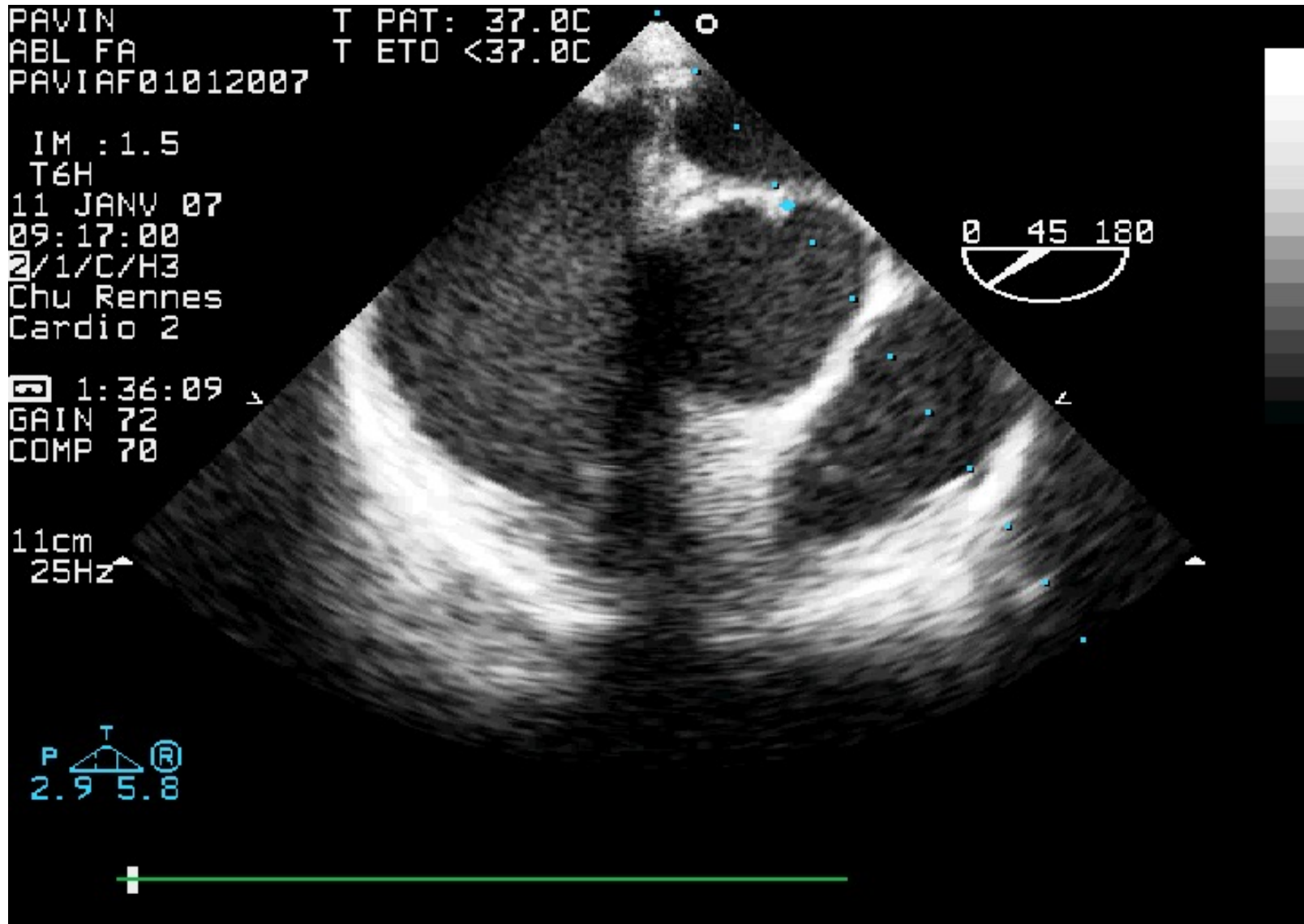
Aiguille de Brockenbrough BW 71 cm (89 cm)



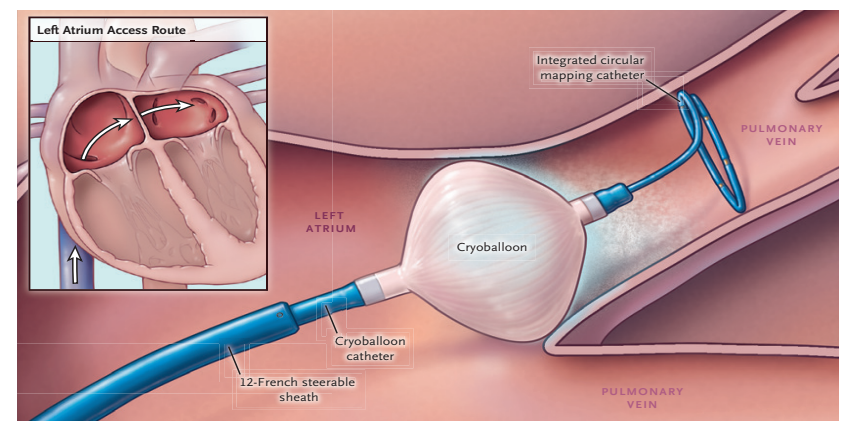
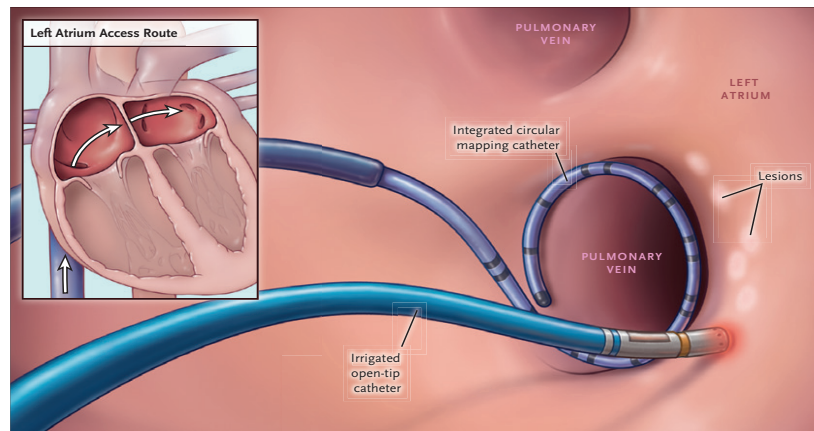
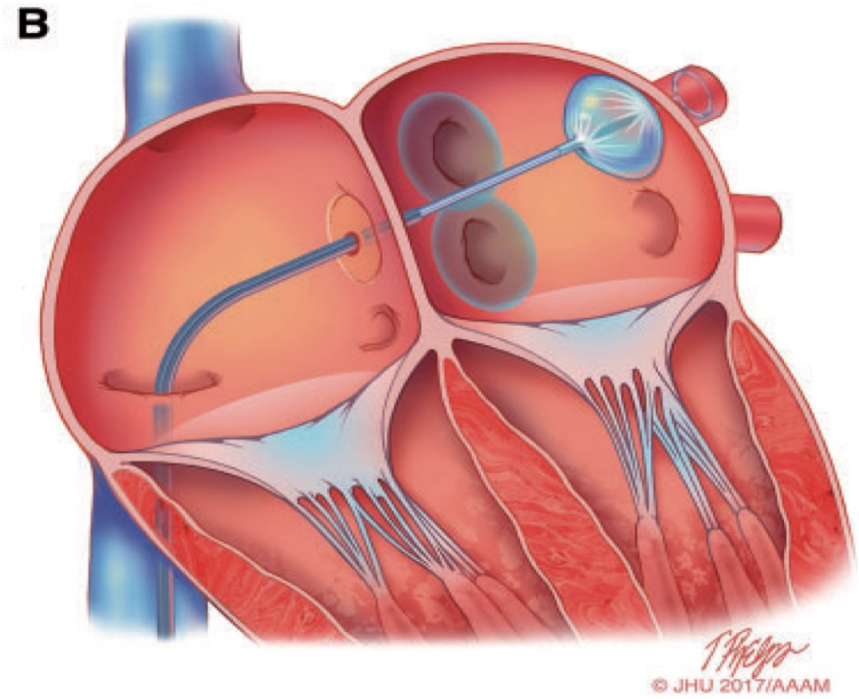
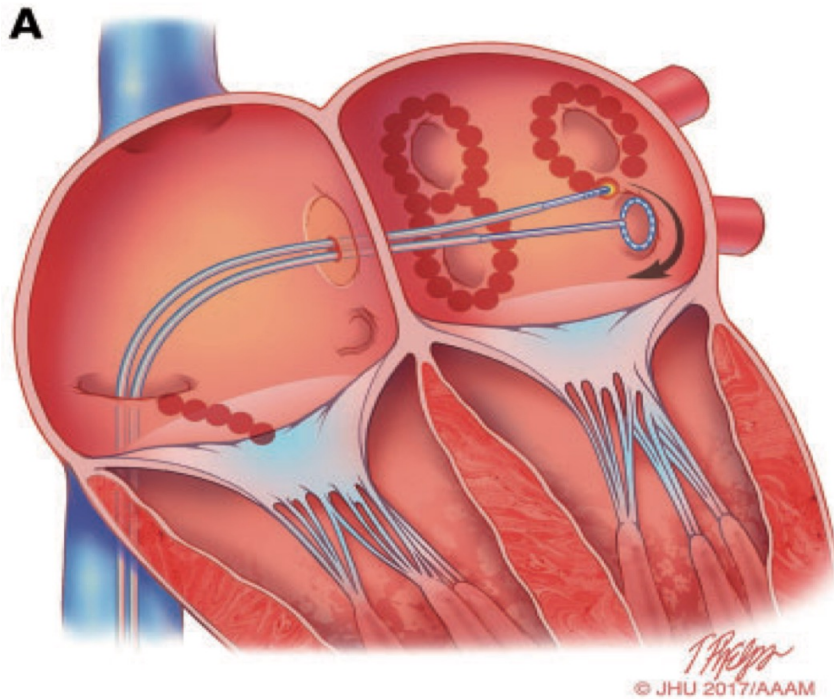
Guide J 0.032" 180 cm



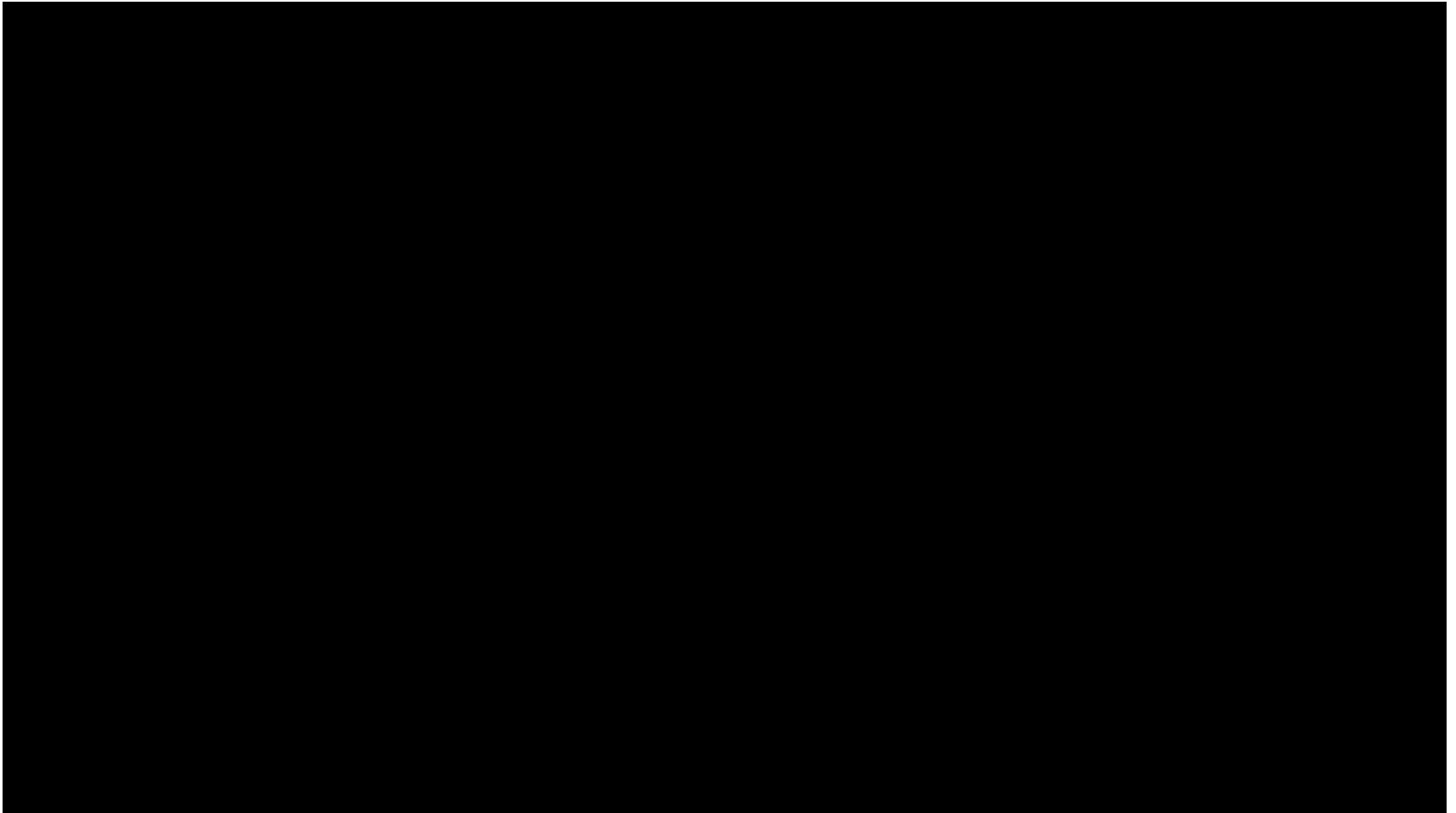
Echographie transoesophagienne



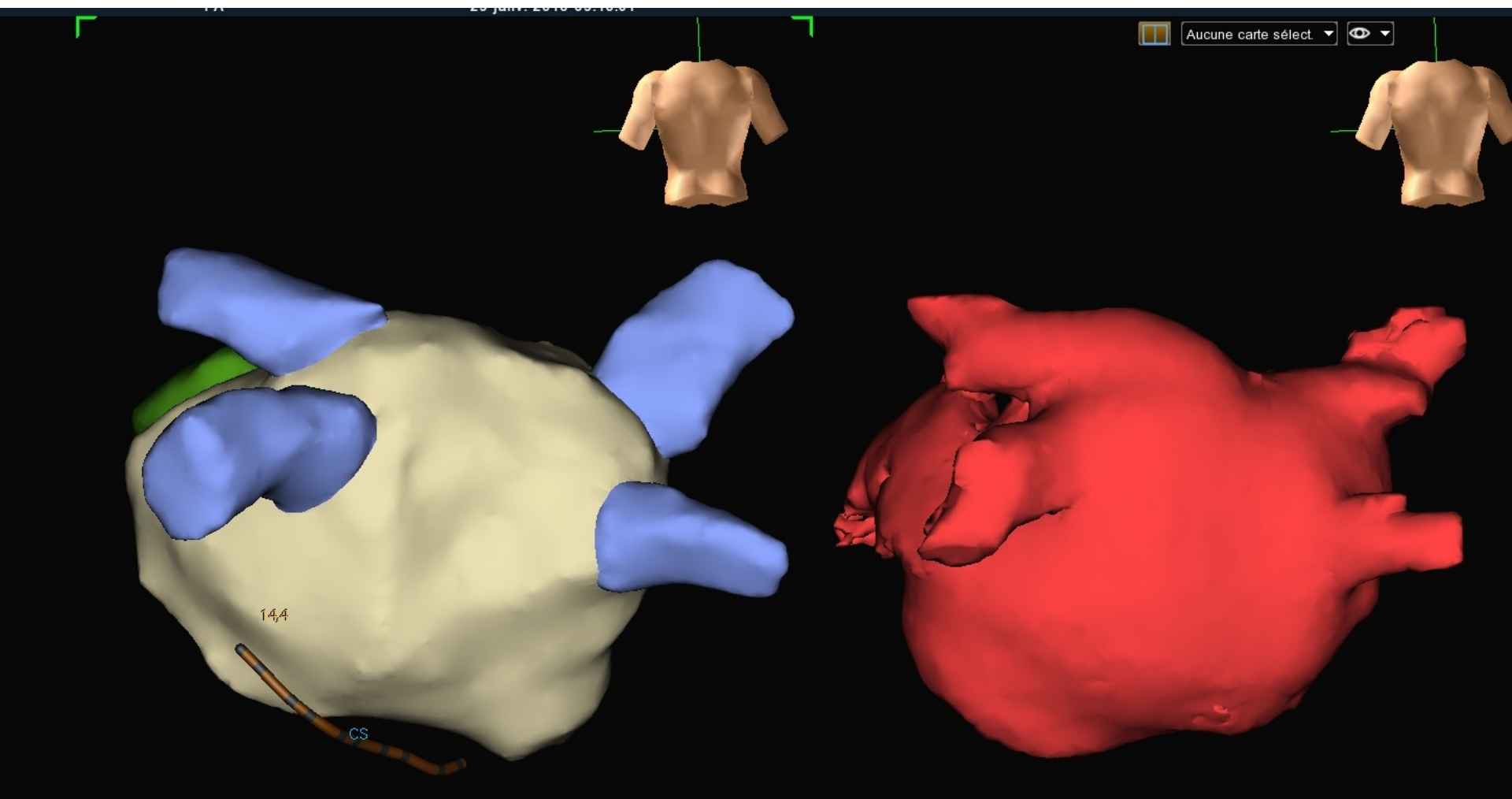
Comment ?

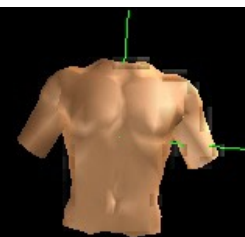
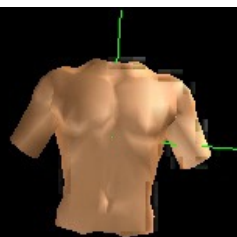
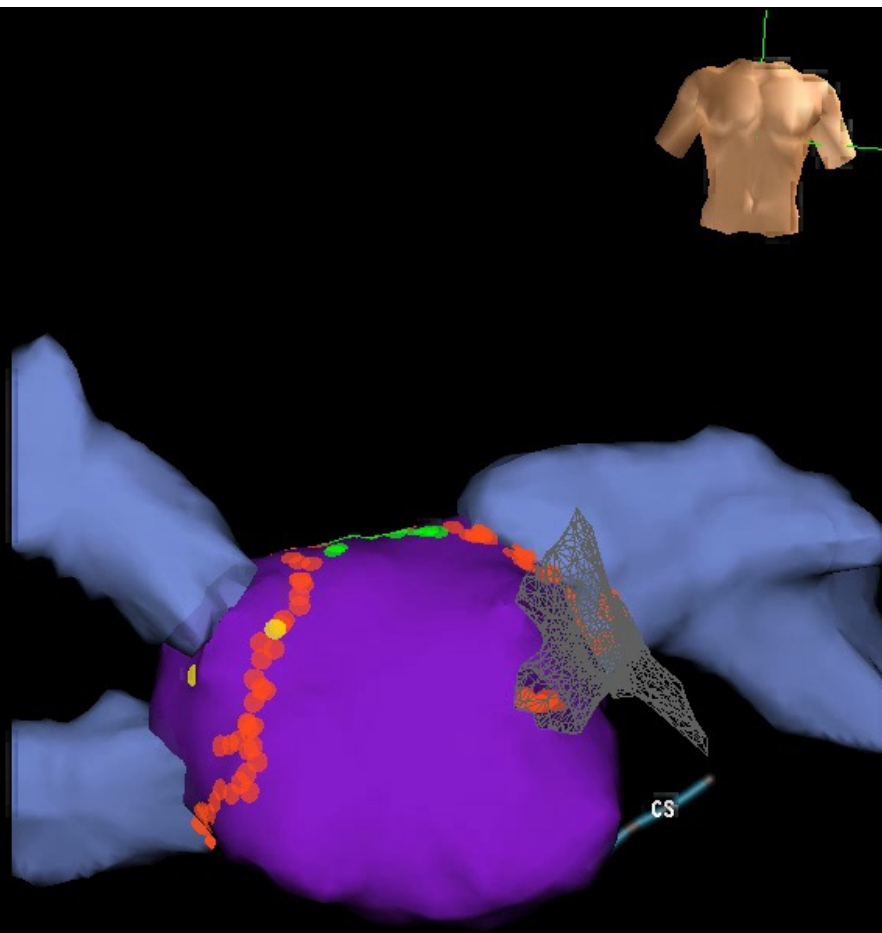


Isolation des veines pulmonaires en cryothérapie

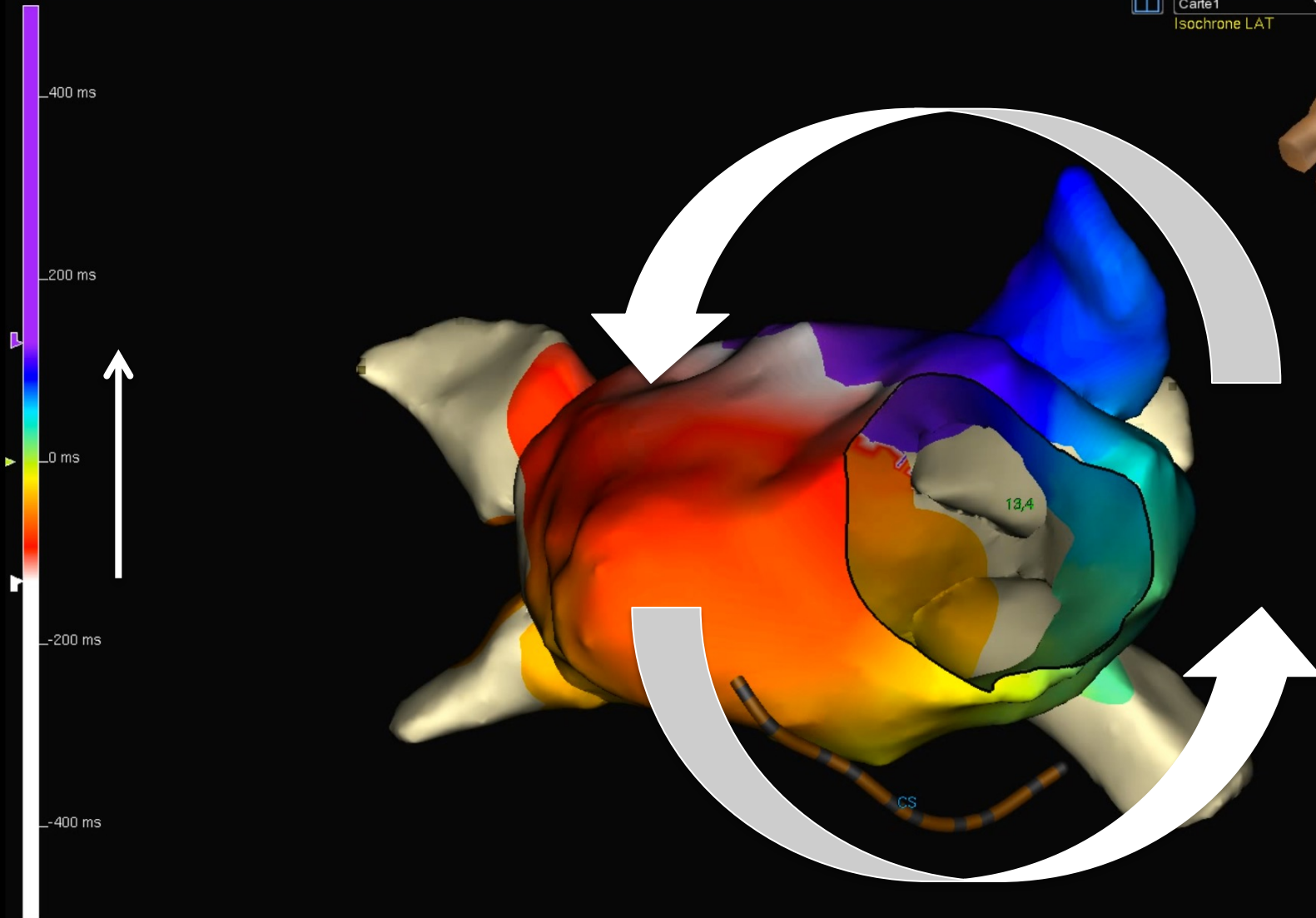


Isolation des veines pulmonaires en radiofréquence





☐ Carte1
Isochrone LAT

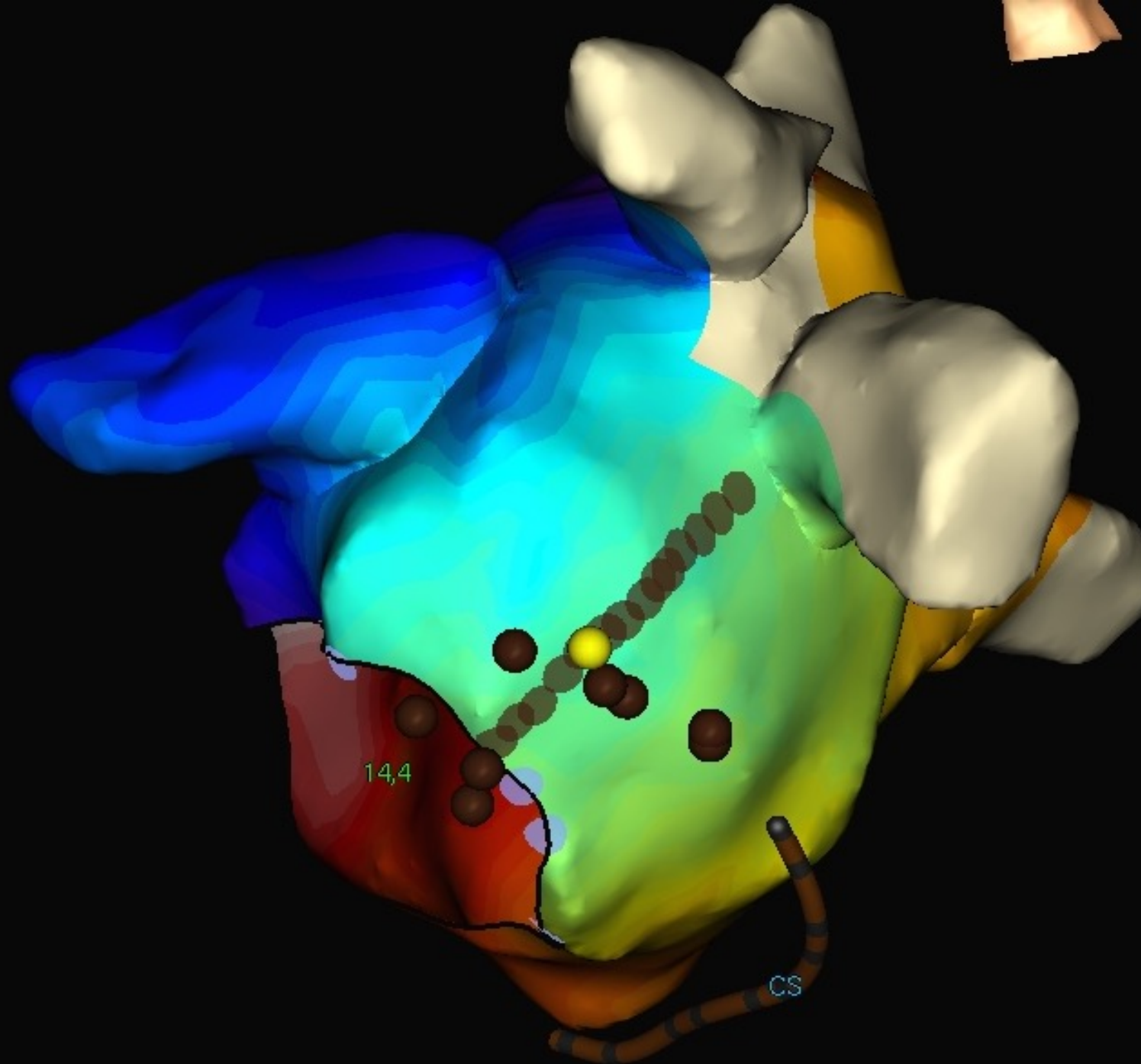




Carte1

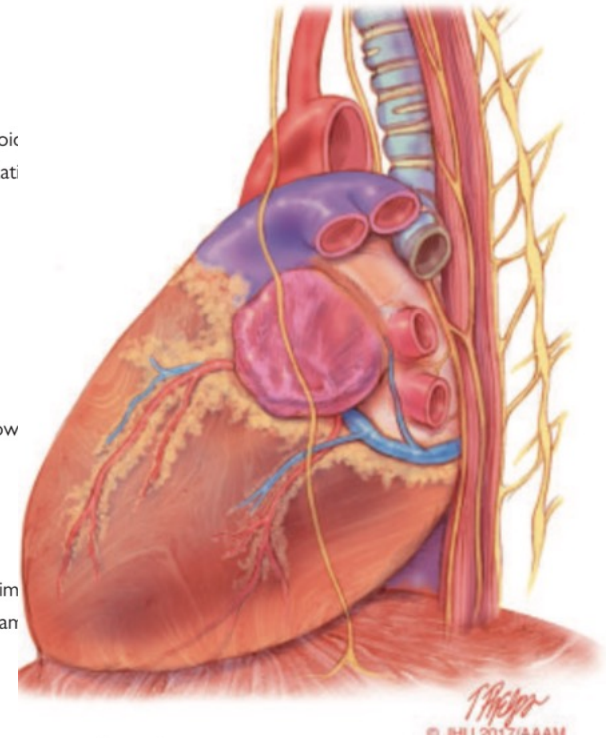
Isochrone LAT





Comment ?

| Complication | Incidence | Selected prevention techniques | Diagnostic testing | Selected treatment options |
|------------------------------------|----------------|---|---|--|
| Air embolism | <1% | Sheath management | Nothing or cardiac catheterization | Cardiac catheterization |
| Asymptomatic cerebral emboli (ACE) | 2% to 15% | Anticoagulation, catheter and sheath management, TEE | Brain MRI | |
| Atrial esophageal fistula | 0.02% to 0.11% | Reduce power, force, and RF time on posterior wall, monitor esophageal temp, use proton pump inhibitors; avoid energy delivery over esophagus | CT scan of chest, MRI; avoid doscopy with air insufflati | |
| Cardiac tamponade | 0.2% to 5% | Cather manipulation, transseptal technique, reduce power, force, and RF time | Echocardiography | |
| Coronary artery stenosis/occlusion | <0.1% | Avoid high-power energy delivery near coronary arteries | Cardiac catheterization | |
| Death | <0.1% to 0.4% | Meticulous performance of procedure, attentive postprocedure care | NA | |
| Gastric hypomotility | 0% to 17% | Reduce power, force, and RF time on posterior wall | Endoscopy, barium swallow tric emptying study | |
| Mitral valve entrapment | <0.1% | Avoid circular catheter placement near or across mitral valve; clockwise torque on catheter | Echocardiography | |
| Pericarditis | 0% to 50% | None proven | Clinical history, ECG, sedim tion rate, echocardiogram | |
| Permanent phrenic nerve paralysis | 0% to 0.4% | Monitor diaphragm during phrenic pacing, CMAP monitoring, phrenic pacing to identify location and adjust lesion location | CXR, sniff test | |
| Pulmonary vein stenosis | <1% | Avoid energy delivery within PV | CT or MRI, V/Q wave scan | Angioplasty, stent, surgery |
| Radiation injury | <0.1% | Minimize fluoroscopy exposure, especially in obese and repeat ablation patients, X-ray equipment | None | Supportive care, rarely skin graft |
| Stiff left atrial syndrome | <1.5% | Limit extent of left atrial ablation | Echocardiography, cardiac catheterization | Diuretics |
| Stroke and TIA | 0% to 2% | Pre-, post-, and intraprocedure anticoagulation, catheter and sheath management, TEE | Head CT or MRI, cerebral angiography | Thrombolytic therapy, angioplasty |
| Vascular complications | 0.2% to 1.5% | Vascular access techniques, ultrasound-guided access, anticoagulation management | Vascular ultrasound, CT scan | Conservative treatment, surgical repair, transfusion |



> 100 actes /an

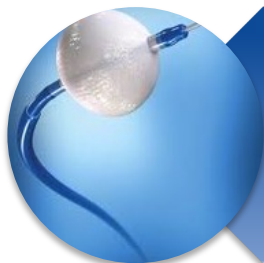
Comment ?

- Taux de succès : 80-85 %
 - Récidive de FA fréquentes dans le premier mois (période de cicatrisation)
 - AAR/CEE
- 2^{ème} ablation nécessaire dans 20-30% des cas (cibler les reconnections desVP)
- Facteurs de risques d'échecs
 - FA persistante de longue durée > 1 an
 - Absence de trémulation de la ligne de base en V1
 - Oreillette gauche très dilatée
 - Syndrome d'apnée du sommeil non appareillé
- Traitement des facteurs de risque
 - HTA
 - SAOS
 - Obésité

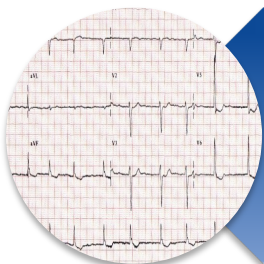
Conclusion



Stratégie de contrôle du rythme
Patients symptomatiques ou retentissement VG



ETO
Isolation des VP par cryo ou RF
Suivi



Complications rares
Taux de succès 80-85%
Parfois nécessité d'une seconde procédure