Correspondence

Letter by Fenici et al Regarding Articles, "Wolff-Parkinson-White Syndrome in the Era of Catheter Ablation: Insights From a Registry Study of 2169 Patients" and "The Asymptomatic Wolff-Parkinson-White Patient: Time to be More Proactive?"

To the Editor:

We read with much interest the article by Pappone et al[1] and the accompanying editorial,[2] which revive the long-lasting debate about the appropriate clinical approach to asymptomatic Wolff-Parkinson-White (WPW) patients, balancing between the need to prevent sudden cardiac death and the need to avoid invasiveness and potential complications of unnecessary catheter ablation (CA).

We agree with the editorial statements that "Current data including the present study cannot justify a more aggressive ablation approach in the asymptomatic WPW patient," that "it is yet to be convincingly demonstrated as superior in the real world to the natural history in asymptomatic WPW patients," and that "ablation provided at the asymptomatic stage has not been demonstrated to produce outcomes superior to those of early treatment at the symptomatic stage."

On the other hand, in Italy, sports physicians and cardiologists are charged with the responsibility of and consequent risk of lawsuit and liability linked to mandatory risk assessment whenever asymptomatic WPW patients need fitness certification to practice agonistic sport or for law enforcement or military professions. Consequently, as a result of an increasing trend toward a "defensive medical approach," routine electrophysiological screening is favored. In fact, although electrophysiological risk markers may lack accuracy in identifying high arrhythmogenic–risk patients,[2] probably because the occurrence of sudden cardiac death is attributable more to the incidental concomitance of multiple factors (eg, silent myocarditis, autonomic imbalance, drug effects) than to antegrade conduction properties of the accessory pathway, their high negative predictive value is somehow reassuring when one has to sign a fitness certification.

In this regard, electrophysiological screening is certainly a useful add-on that can reinforce the predictivity of other noninvasive markers generally accepted as associated with favorable long-term prognosis of asymptomatic subjects. However, if electrophysiological screening is performed invasively, "having the catheters inside the patient" a bias toward enhanced use of ablation is reasonably conceivable, but can be avoided if risk assessment is performed noninvasively with transesophageal atrial pacing[3] (TEAP).

Although reasonable statistics may be questionable because of the very low incidence of sudden cardiac death events, on the basis of our 28 years of electrophysiological follow-up of 318 WPW patients (overall, 922 TEAPs)[4] initiated when safe CA was not yet available to minimize invasivity for risk assessment and to treat surgically only those patients identified as truly being at high arrhythmogenic risk, we think that an intermediate approach might be suggested.

Briefly, at the first TEAP, 59 of 318 patients were classified as being at high arrhythmogenic risk according to the criteria in the literature.[4] Although only 34 underwent surgery or CA, no adverse events occurred in patients treated with antiarrhythmic drugs (average follow-up, 12.3±5.2 patient years). Two sudden cardiac deaths (0.06%/y of follow-up), occurring before CA was available, in 2 symptomatic patients correctly identified at high arrhythmogenic risk with TEAP would have been avoidable if surgery was accepted or antiarrhythmic drugs were not self-discontinued. Follow-up TEAP identified accessory pathway conductivity enhancement in 10 borderline patients (3.1%) and guided appropriate treatment. No worsening was observed after evidence of electrophysiological stability after >8 years.

We believe that low-cost, ambulatory TEAP is preferable for initial risk assessment of asymptomatic WPW, for follow-up after unsuccessful CA, and to prevent cardiologists from "excessive use of force" (in ≈150 "good asymptomatic guys") to catch, in 10 years, only 1 safely identifiable[5] "bad guy."

Disclosures

None.

Riccardo Fenici, MD
Donatella Brisinda, MD, PhD
Angela Venuti, MD
Clinical Physiology
Biomagnetism Center
Catholic University of Sacred Heart
Rome, Italy

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Riccardo Fenici, Donatella Brisinda and Angela Venuti

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