Ectopic atrial tachycardia in congenital complete heart block

Varsha Kiron *, Boby John *
Department of Cardiology, Christian Medical College Hospital, Vellore, Tamilnadu 632004, India

Introduction:
- Congenital complete heart block seen 1 in 15000–20000 live births.
- Most common cause is neonatal lupus resulting form maternal anti-Ro/La antibodies crossing transplacentally.
- Other causes include fetal myocarditis, structural heart diseases (CCTGV) and familial conduction system diseases.
- Fetall and neonatal CHB often symptomatic – hydrops fetalis, congestive cardiac failure.
- Childhood and adolescent cases often tend to by asymptomatic and incidentally diagnosed.
- Pacemaker indicated at the earliest in presence of symptoms (class I), and even prophylactically in all individuals with CHB (Class IIa).

Case report:
- 25-year-old lady presented with effort intolerance for the past two years.
- There was no history of syncope/palpitations.
- ECG: Showed sinus rhythm with complete heart block. P wave rate was ~130/min.
- ECHO: Normal LV systolic function; LVIDd = 4.8 cm; LVIDs = 3.4 cm.
- TMT: Maximum heart rate 90/min; Chronotropic incompetence present.
- A permanent pacemaker implantation was done on 22/6/2014: St. Jude Verity DDDR pacemaker

Implication to clinical practice:
- Post-operative corrected TOF patients increasingly encountered in current cardiology practice.
- Radiofrequency ablation needs to be the initial therapeutic option for any sustained arrhythmia.
- Distorted anatomy may complicate the accessibility of pathway through femoral route; transjugular route is useful alternative.
- Heart failure and arrhythmia—two most common problems in post-operative TOF patients, perpetuate each other and hence need prompt therapy.

Effect of pacemaker lead implantation on tricuspid valve and right ventricular function

Department of Cardiology, Lokmanya Tilak Municipal Government Hospital, Sion, Mumbai, India

Introduction: Trivial tricuspid regurgitation (TR) is a common echocardiographic finding in healthy individuals. However, significant TR (grade ≥2) has been shown to be associated with poor prognosis, regardless of the underlying cardiac pathology. Placement of an RV (trans-tricuspid) lead has also been associated with a higher risk of TR. However, the exact incidence of lead-induced