Methods: Inclusion criteria: Consecutive patients aged > 18 years, who underwent successful RF ablation in the PS region. Exclusion criteria: Failed ablation, Ablation at the left sided endocardium, Ablation deep inside the main CS, beyond 3 cm of the CS ostium (left free wall epicardial pathways). The cases were divided into two groups: Group En: Endocardial ablation; Group Ep: Ablation within the CS/CSD/epicardial surface.

Definition: RPB is defined as monophasic tall R in V2 larger than V1 and V3 along with either (i) R/S < 1 in V3, or (ii) S wave in V3 > 4 mV.

Results: Among 66 cases [Age: 32 ± 12 year, 40 males], 53 were ablated endocardially and 13 cases epicardially (12 inside a CS diverticulum, one in epicardium after gaining pericardial access). The baseline characteristics were comparable. RPB was present in 10/13 of Group Ep, but only in 6/53 cases of Group En. The sensitivity and specificity of RPB for epicardial location were 83% and 94% respectively, while the positive predictive value (PPV) was 77%. The negative predictive value (NPV) was 89% and the accuracy was 87%.

Conclusion: Among the patients who underwent ablation for PS accessory pathways, RPB was more often observed on the preexcited ECGs in patients having epicardial APs. This pattern may indicate the need for mapping within the CS/CSD or or epicardium.

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ISOELECTRIC OR BIPHASIC DELTA WAVE IN V1 IS A NEW ACCURATE PREDICTOR FOR EPICARDIAL LOCATION OF POSTEROSEPTAL ACCESSORY PATHWAY

CE-542-03

CANNON A WAVE VALIDATION AS A DIAGNOSTIC TOOL IN PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIAS

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Background: Atrioventricular nodal re-entrant tachycardia (AVNRTs) and orthodromic reciprocating tachycardias (ORTs) are major mechanisms of paroxysmal supraventricular tachycardias. Cannon A waves, rapid and regular pulsations with bulging of the internal jugular veins, is traditionally associated with AVNRTs.

Objective: The aim was to assess the diagnostic utility of the cannon A wave in cases of paroxysmal supraventricular tachycardias.

Methods: We prospectively included 100 patients with paroxysmal supraventricular tachycardias. Videos of the jugular venous pulse were obtained after tachycardia induction. Two independent experts visualized the videos in a blindly manner and classified patients into two groups whether de sign was present or not. Central venous pressure (CVP) was continuously monitored.