Background and objectives. The information about the practice and results of catheter ablation of cardiac arrhythmias in Europe is limited and there is a lack of multicenter studies and registries. The Spanish Society of Cardiology developed a national registry to define the results of this procedure and the characteristics of the laboratories where it is performed.

Methods. A list of electrophysiology laboratories in Spain was prepared and questionnaires were sent to each of them. The questionnaires were completed with retrospective data about the characteristics of each center, their general activities, and ablation procedures performed during 2001. Data were collected on the results and complications in relation to the arrhythmic substrate or mechanism treated.

Results. Forty-three centers, out of a possible 48, voluntarily participated in the registry. A total of 4,374 ablation procedures were performed in 41 centers. The average number of procedures per center was 106 ± 84 and the rates of success, major complications, and mortality were, respectively, 93%, 1.5%, and 0.1%. About 70% of the procedures were performed to treat patients with AV nodal reentrant tachycardias and accessory pathways or to abolish AV conduction.

Conclusions. The 2001 Spanish National Catheter Ablation Registry is one of the largest reported series of ablation procedures. The results of the registry demonstrate a high success rate and low complication and mortality rates in the practice of catheter ablation in Western Europe.

Key words: Catheter ablation. Electrophysiology. Statistics. Registries.
Cardiología (Andalusian Society of Cardiology),8 which, nevertheless, had the limitation of offering information from a limited geographic area of Spain.

This article presents the results of the National Registry on Catheter Ablation of the Sociedad Española de Cardiología (SEC) of 2001, prepared by the society’s Working Group on Electrophysiology and Arrhythmias, with the participation of most of the electrophysiology laboratories in Spain. This is the first reference of the activity and results of catheter ablation in this country.

METHODS

A census of cardiac electrophysiology laboratories in Spain was made using information available from the working group and its members, as well as facilitated by the catheter ablation manufacturing industry. All the laboratories were sent a questionnaire (Annex 1) as a hard copy and, in some cases, electronic mail. The questionnaire was also made public and could be obtained on the web page of the working group (www.arritmias.org).

The first part of the questionnaire collected general information on the hospital center, the service responsible for ablations, the availability of cardiovascular surgery at the center, the population attended by the center, and the number of patients on the waiting list at the end of 2001. Later, information was collected on the human resources of the laboratory (number of staff physicians, physicians working full-time at the laboratory, research fellows, resident physicians, registered nurses (RN), assistant nurses, and radiology specialists). Information was requested on the characteristics of the radiology laboratory where the procedures were carried out and what activities aside from ablation were performed there, such as implantation of pacemakers, defibrillators or electrical cardioverters. Information was obtained on available technological resources, like the polygraph system or the availability of special mapping techniques (non-fluoroscopic intracardiac navigation systems and intracardiac echography) or therapeutic techniques (cryoablation, ultrasound).

Later, the questionnaire asked about the total number of diagnostic electrophysiological studies, ablation procedures, patients treated by ablation, successful ablation procedures, and complicated ablation procedures performed in 2001. The number of pacemaker and defibrillator implantation and replacement procedures performed in 2001 was investigated. The last item in this section recorded the policy of each laboratory with respect to the prophylaxis of thromboembolism or the time interval before a procedure was considered definitively successful.

Finally, in the last item the number of procedures was recorded and the results were noted in accordance with the arrhythmic substrate or mechanism treated. Ten substrates or mechanisms were contemplated: intranodal tachycardia, accessory pathways, atrioventricular conduction, focal atrial tachycardia, cavotricuspid isthmus, macroreentrant atrial tachycardia or atypical atrial flutter, atrial fibrillation, idiopathic ventricular tachycardia, reentrant ventricular tachycardia associated with a myocardial infarction scar, and reentrant ventricular tachycardia unrelated with a myocardial infarction scar. For each substrate/mechanism, the total number of procedures and patients treated, and the number of procedures performed in patients treated successfully, were recorded. The number of procedures performed with catheters other than the conventional distal 4-mm electrode catheter was also noted (8-mm, irrigated tip, or other).

Success was defined as elimination of the substrate, not just modification of its properties. However, in the case of tachycardia due to intranodal reentry, suppression of the capacity to induce tachycardia was required and the maximum number of permissible inducible nodal echoes at the end of the procedure was recorded. Likewise, the following major complications were recorded: unintended atrioventricular block requiring definitive pacemaker implantation; cardiac tamponade or pericardial effusion that prolonged the hospital stay, whether or not it was evacuated; venous or arterial vascular complication that required a clinical or surgical intervention or prolongation of the hospital stay; cerebrovascular accident or transient ischemic accident, unstable myocardial infarction of recent appearance or unstable angina that required a clinical intervention or prolongation of the hospital stay; the appearance or exacerbation of heart failure related to the procedure, which motivated a clinical attitude or prolongation of the hospital stay, and other complications like pulmonary thromboembolism, pneumothorax, or infections. With respect to mortality, immediate deaths and peri-procedure deaths secondary to clinical or surgical procedures or other complications attributable to ablation were noted.

Finally, in the last substrate/mechanism item, information on some aspects previously mentioned was requested, detailed according to the different variants of the substrate/mechanism. Consequently, intranodal tachycardia was divided into common (I) and uncommon types (II); accessory pathways were classified by
the presence or absence of pre-excitation, and in right,
left, or perihisian; atrioventricular conduction, the ac-
cess was noted, either venous or arterial; focal and ma-
croreentrant atrial tachycardias were classified as right
or left; cavotricuspid isthmus according to whether the
patient presented counterclockwise, clockwise, or in-
ferior vena cava atrial flutter; atrial fibrillations accord-
ing to whether a right atrial or left atrial approach
was used, as well as focal, isolation of pulmonary
veins, or linear; idiopathic ventricular tachycardia ac-
cording to its origin in the right ventricular outflow
tract, left ventricular outflow tract, fascicular, or other
location; postinfarction ventricular tachycardia accord-
ing to whether the patient had an anterior or inferior
scar, and ventricular tachycardia unrelated to a postin-
farction scar, according to whether the patient had
arrhythmogenic right ventricular dysplasias, dilated
cardiomyopathy or another cardiomyopathy, and the
presence or absence of a branch-to-branch reentry me-
chanism. The location of the atrioventricular accessory
pathways and classification of the atrial arrhythmias
were made using the new definitions of the Working
Group on Arrhythmias of the European Society of
Cardiology.9,10

The completed questionnaires were sent to the
Secretariat of the Working Group on Electrophysiology and Arrhythmias, where adminis-
trative personnel assigned them a number (center
code) and removed the upper part of the first page,
which contained the information identifying the cen-
ter. This information was filed separately to safeguard
the confidentiality of the information submitted. The
rest of the form was sent for data analysis to the re-
gistry coordinator (M. Álvarez).

**Statistical analysis**

Numerical results are expressed as mean±standard
development. The qualitative variables and proportions
were analyzed using the χ² test, and the Fisher test,
when necessary. The quantitative variables were
analyzed by means of the Student t test. The success
rates and complication rates were calculated in rela-
tion to the number of patients. A value of P<.05 was
considered statistically significant. The statistical
analysis was made with the SPSS 9.0 statistical pro-
gram.

**RESULTS**

**Infrastructure and resources**

Forty-three (Annex 2) out of 48 possible centers
completed the questionnaire, which was 90% of the
centers that were invited to participate. The character-
istics of the participating centers are shown in Table
1.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University hospital</td>
<td>33 (77)</td>
</tr>
<tr>
<td>Level</td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td>33 (77)</td>
</tr>
<tr>
<td>Secondary-local</td>
<td>3 (7)</td>
</tr>
<tr>
<td>Not specified</td>
<td>7 (16)</td>
</tr>
<tr>
<td>Health care system</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>37 (86)</td>
</tr>
<tr>
<td>Private</td>
<td>6 (14)</td>
</tr>
<tr>
<td>Department responsible</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>41 (96)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Pediatric center</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>32 (74)</td>
</tr>
</tbody>
</table>

Among the material resources of the electrophysio-
logy laboratories, it is significant that 33% of the cen-
ters (n=14) had a digital radiology room. This room
was dedicated exclusively to performing electrophys-
ology procedures in 58% (n=25) of laboratories. The
median number of days of the week dedicated to elec-
traphysiology was 3 days (range, 1 to 5 days). In more
than half of the rooms, definitive pacemaker (60%;
n=26) and automatic defibrillator (56%; n=24) im-
plantations were scheduled. On the other hand, in 58%
of the rooms (n=25), scheduled external electrical car-
dioversions were performed. In 3 rooms, scheduled in-
ternal electrical cardioversions were carried out, in 8,
implantation of event recorders, and in 7, tilt-table stu-
dies.

Intracavitary signals were recorded on digital poly-
graphs in all laboratories. Nevertheless, only 26% of
the centers (n=11) had non-fluoroscopic intracardiac
navigation systems,7 CARTO® systems,3 LOCALISA®,
and 1 ENSITE®. Four laboratories also had intracardiac
echocardiography. Catheter ablation was performed in
all laboratories by radiofrequency, and there was a cr-
yoablation center.

Human resources differed depending on whether the
center was private or public. Private centers, with the
exception of one, did not have research fellows or resi-
dent physicians, and the mean number of staff physi-
cians was 1.8±0.7 (range, 1-3). The human resources
of the publicly financed centers are shown in Table 2.
In public centers, the mean number of physicians work-
ing in the electrophysiology laboratory was 2.2±0.6
(range, 1-4). Nevertheless, the number of physicians
who worked full-time in the electrophysiology labora-
tory was lower (1.6±0.9 per center). In 63% of the
centers (22 of 35 that completed this item), two or
more full-time staff physicians worked in the elec-
trophysiology laboratory. Eleven centers also had re-
search fellows. As far as auxiliary personnel are concer-
Table 2. Human resources of the laboratories of public hospital centers participating in the National Registry of Catheter Ablation of 2001

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Range</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (n=37)</td>
<td>2.2±0.6</td>
<td>1-4</td>
<td>80</td>
</tr>
<tr>
<td>Full-time (n=35)</td>
<td>1.6±0.9</td>
<td>0-4</td>
<td>57</td>
</tr>
<tr>
<td>No. of research fellows (n=37)</td>
<td>0.6±1.3</td>
<td>0-7</td>
<td>21</td>
</tr>
<tr>
<td>No. of resident physicians (n=35)</td>
<td>1±1.5</td>
<td>0-2</td>
<td>36</td>
</tr>
<tr>
<td>No. of RN (n=36)</td>
<td>1.5±0.5</td>
<td>1-2</td>
<td>54</td>
</tr>
<tr>
<td>No. of ARS (n=2)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of auxiliary RNs (n=29)</td>
<td>0.7±0.5</td>
<td>0-2</td>
<td>22</td>
</tr>
</tbody>
</table>

N indicates number of centers that responded; RN, registered nurses; ARS, assistant radiology specialist.

Laboratory practices and general results

Most of the laboratories (n=39) used heparin anticoagulation in the ablation procedures that were carried out by an arterial and/or transeptal approach, whereas only 3 used it in ablation procedures carried out by a venous approach, and 2 in diagnostic electrophysiological studies. The mean interval after an effective radiofrequency application in which a procedure was considered successful was 27±6 min, in 30 laboratories the interval was at least 30 min, and in 9 laboratories, less than 30 min (10, 15, or 20 min).

The total number of diagnostic electrophysiological studies made in 2001 and reported by 36 centers was 6480, a mean of 185±131 studies per center (median, 152; range, 9-725). The total number of ablation procedures performed in 2001 and reported by 41 centers was 4374 (results obtained in 41 centers), which is equivalent to 106±84 procedures per center (median, 89; range, 6-496). The distribution of the number of procedures per laboratory is shown in Figure 1. The overall success rate of catheter ablation procedures was 93%, the complication rate was greater than 1.5%, and the mortality rate was 0.1% (n=4). Two patients died after an ablation procedure on the atrioventricular conduction system, one of them after ablation of the cavotricuspid isthmus and the other after ablation for postinfarction ventricular tachycardia.

Results by arrhythmic substrate/mechanism

Thirty-six centers reported information on results by arrhythmic substrate or mechanism treated, involving 3829 patients who underwent a total of 3969 ablation procedures. The substrate treated (Figure 2) was intranodal tachycardia, followed by accessory pathways, cavotricuspid isthmus, and ablation of the atrioventricular conduction system. Less frequent procedures, performed in similar percentages of patients, were ablation of focal atrial tachycardia, idiopathic ventricular tachycardia, and postinfarction ventricular tachycardia. The substrates treated least frequently were atrial fibrillation, macroreentrant atrial tachycardia/atypical atrial flutter, and ventricular tachycardia due to structural heart disease without previous myocardial infarction. The mean number of dif-

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Different types of substrates/mechanisms treated in a single center (Figure 3) was 7±2 (median, 7; range, 3-10). Only 6 centers (17%) treated all the substrates analyzed. The rates of success and major complications in relation to the arrhythmic substrate/mechanism treated are shown in Table 3 and in Figures 4 and 5.

**Intranodal tachycardia**

One thousand three hundred and twenty-seven ablation procedures were performed in 1303 patients at 35 centers, a mean of 37±32 patients per center (range, 4-187). The peak number of inducible nodal echoes finally used to define a procedure as successful was 1.5±0.7 (range, 0-3). All procedures were performed with conventional ablation catheters, except for two in which an 8-mm distal electrode catheter was used.

The number of patients successfully treated was 1291 (99%). Eight patients (0.6%) suffered major complications, half of them (0.3%) due to unintentional atrioventricular block. No deaths occurred. All the centers had a success rate of more than 90%. In 22 centers (63%), a success rate of 100% with no complications was achieved, whereas 26 centers (74%) reported either a 110% success rate or no complications.

**Accessory pathways**

Thirty-four centers reported 1140 ablation procedures in 1084 patients, a mean of 32±24 patients per center (range, 4-136). The most frequent accessory pathway location was the left free wall (n=547; 54%), followed by the lower paraseptal region (n=245; 24%), right free wall (n=139; 14%), and perihisian region (n=78; 8%). Unconventional catheters were used in 42 procedures (8-mm distal electrode catheter in 15 patients, irrigated-tip catheter in 24 patients), and a non-fluoroscopic navigation system in 3 procedures.

The intervention was successful in 1007 patients (93%) and major complications occurred in 17 (1.6%), the most frequent being vascular arterial complications (n=9). There were no deaths. The success rates in relation to accessory pathway location were 97% in the left free wall; 87% in the lower paraseptal; 93% in the right free wall, and 81% perihisian. A success rate of 90% or more was achieved in 23 centers (68%), no complications occurred in 22 centers (65%), and 16 centers (47%) had success rates of 90% or more without complications.

**Cavotricuspid isthmus**

Thirty-five centers performed 758 procedures in 718 patients, a mean of 20±20 patients per center (range, 1-79). The type of flutter treated was differentiated in 32 centers: counterclockwise in 567 patients, clockwise in 78 patients, and inferior vena cava in 22 patients.

An unconventional ablation catheter was used in 590 procedures, generally an 8-mm distal electrode catheter (n=423), followed by an irrigated-tip catheter (n=150). A non-fluoroscopic navigation system was used in 12 patients.

The procedure was successful in 670 patients (93%) and complications occurred in 9 (1.2%). The most frequent complication was cerebrovascular accident/transient ischemic event (n=4), followed by 2 vascular
complications, complete atrioventricular block, and pericardial effusion. One patient died after the procedure. A success rate of 90% or more was obtained in 23 centers (66%) and there were no complications in 29 (85%). Eighteen centers (53%) had a 90% or better success rate without complications.

**Atrioventricular conduction**

Ablation of the atrioventricular conduction system was attempted in 218 procedures in 211 patients in 31 centers. In each center, 6±5 patients were treated (range, 1-18). In 17 patients, an unconventional catheter was used (in 15, an 8-mm distal electrode, and in 2, an irrigated-tip catheter).

The procedure was successful in 208 patients (98%) and there were 3 (1.4%) major complications; 2 deaths and 1 vascular complication. A success rate of 100% was obtained in 29 centers (93%) and there were no complications in 27 centers (93%). Twenty-six centers (90%) had 100% success without complications.

**Focal atrial tachycardia**

One hundred thirty-seven procedures were performed in 124 patients (4±3 patients per center; range, 1-16) at 30 centers. An irrigated-tip catheter was used in 3 patients and an 8-mm distal electrode catheter in 1 patient. A system of non-fluoroscopic navigation was used in 1 patient.

The procedure was successful in 102 patients (82%) and no major complication occurred. Successful results were obtained in 83% of the tachycardias located in the right atrium (n=95), versus 71% of the tachycardias located in the left atrium (n=21) (P=NS).

**Macroreentrant atrial tachycardia/atypical atrial flutter**

Ablation of this substrate was attempted in only 14 centers, where 45 procedures were carried out in 43 patients, equivalent to 3±3 patients per center (range, 1-9). In 30 patients, the right atrium was treated, and in 14, the left atrium. Eleven centers reported the presence of heart disease (n=19) and/or previous cardiac surgery (n=14) in some of their patients. In 22 procedures, an unconventional ablation catheter was used (in 14, an 8-mm distal electrode catheter and in 2, an irrigated-tip catheter). A non-fluoroscopic navigation system was used in 6 patients.

The procedure was successful in 20 patients (46%) and complications occurred in 5 (12%). The success rate was 57% for tachycardias located in the right atrium and 21% for tachycardias in the left atrium (P<.05). The most frequent complications were vascu-
lar (arterial in 2 patients and venous in 1). One patient had a cardiac tamponade and 1 patient had an embolism.

**Atrial fibrillation**

This substrate was treated in 10 centers, although only 8 contributed sufficient data for analysis. Forty-six procedures were performed in 43 patients (5±7 per center; range, 1-21). The left atrium was treated in 43 procedures and the right atrium in 3.

The procedure was successful in 33 patients (77%) and complications occurred in 7 (16%), in 2 cases cerebrovascular accident/transient ischemic accident and in 2, infarction/transient myocardial ischemia.

**Idiopathic ventricular tachycardia**

In 30 centers, 125 procedures were carried out in 115 patients, equivalent to 4±2 patients per center (range, 1-12). The right ventricular outflow tract was the most frequent location (76%; n=88), followed by fascicular (14%; n=16), left ventricular outflow tract (4%; n=4), and other locations (6%; n=7). In 3 procedures, 8-mm distal electrode catheters were used, and in 2, irrigated-tip catheters.

The procedure was successful in 90 patients (78%), with a single pericardial effusion as the only major complication (0.8%). The success rate was 74% in tachycardia of the right ventricular outflow tract and 81% in tachycardia fascicular.

**Ventricular tachycardia associated with postinfarction scar**

This substrate was treated in 24 centers, where 125 procedures were performed in 99 patients (4±3; range, 1-13). In 21 procedures, 8-mm distal electrode catheters were used, and in 20, irrigated-tip catheters. A non-fluoroscopic navigation system was used in 27 procedures.

The procedure was successful in 70 patients (71%) and complications appeared in 4 patients (4%): 2 arterial vascular complications, 1 heart failure, and 1 death after a procedure.

**Macroreentrant ventricular tachycardia not associated to postinfarction scar**

This substrate was treated only in 16 centers, with 48 procedures performed in 43 patients, 3±1 patients per center (range, 1-6). Fifteen ventricular tachycardias due to a branch-branch reentry mechanism were treated. Seventeen patients had dilated idiopathic cardiomyopathy and 12 patients had an arrhythmogenic right ventricular dysplasia in the 12 centers that completed this data field.

The procedure was successful in 29 patients (67%) and complications appeared in 2 patients (5%): 1 arterial vascular complication and 1 atrioventricular block.

**DISCUSSION**

A national registry of catheter ablation has diverse uses. The first, and probably the most evident, is that it is the most useful reference for an electrophysiology laboratory to evaluate its activity, because registries are usually more representative of local reality than studies published by one or more centers, which often are biased in favor of the procedure. On the other hand, obtaining data from a large number of procedures made over a limited period of time allows us to more accurately understand the possible influence of technological innovations on results. Finally, information from registries can and should be useful for health care managers to confirm how and with what results a given therapy is being used for the needs of health care planning. These uses have been recognized by the SEC, which has long prepared annual registries of activity through the Working Groups on Hemodynamics, Heart Transplantation, and Pacing, which are published in the Revista Española de Cardiología.

**Comparison with previous registries**

Information available on catheter ablation in Spain has been limited until now. In 1994, a panel of experts of the Working Group on Electrocardiology and Arrhythmias of the SEC reported on the number of electrophysiology laboratories in Spain (n=12) and the number of ablation procedures (n=600) that were carried out in 1992. The report also indicated that the number of centers could be insufficient in the future, given the expectations for growth in other countries. Later, the first registry of the activity of the Working Group on Electrocardiology and Arrhythmias for 1995 was published. This registry was prepared by distributing a questionnaire where the number of ablation procedures was recorded, but not their results. The registry showed that in 1995 there were 29 centers in Spain, both public and private, which carried out a mean of 78±66 ablation procedures per center. Finally, the Working Group on Arrhythmias of the Sociedad Andaluza de Cardiología prepared a retrospective registry of four centers that inquired about the activity and results obtained in 2000. However, the activity of a significant number of centers in this autonomous community (33%) was not recorded in the study.

On the other hand, information available on catheter ablation in other countries is limited. As usual, the most complete information comes from the U.S., where the North American Society of Pacing and
Electrophysiology (NASPE) has been compiling retrospective registries since 1989, although only two of them have information about results.\textsuperscript{13,14} In 2000, NASPE published the first and, until now, the only prospective national registry of catheter ablation.\textsuperscript{15} In Europe, the Portuguese Society of Cardiology recently reported the number (n=456) and type of ablation procedures performed at 9 centers, although it does not indicate what percentage of the overall number of centers this figure represents.\textsuperscript{16} This registry did not report the success or complication rates. Finally, other registries have been published that evaluate the ablation of a specific substrate, like the atroventricular node,\textsuperscript{17} or ablation in a particular group of patients, like children and adolescents.\textsuperscript{18}

The success of a registry arises fundamentally from the degree of participation of the hospital centers where the procedure under study is carried out. On the other hand, a registry in which results are analyzed is more useful than one that only reports on the number of procedures. Participation in the National Registry on Catheter Ablation in 2001 was 90%, much greater than in the two retrospective registries of the NASPE mentioned above (which had a participation of about 10% and 7%, respectively).\textsuperscript{13,15} In the registries of the Section in 1995\textsuperscript{7} and the registry of the Portuguese Society of Cardiology,\textsuperscript{15} it is not clear that participation was total, since they did not report on whether all the centers that made ablations had completed the survey. For this reason, it can be concluded that the results of the National Registry on Catheter Ablation of 2001 is representative of the true situation of this procedure in Spain.

Material and human resources

The radiology room where ablation procedures were performed was also used to carry out another type of non-electrophysiological procedures in just under half of the centers (42%). This proportion has not varied significantly since 1995.\textsuperscript{7} This circumstance is probably related with the mean number of days per week assigned for electrophysiological procedures, which was 3.6±1.4. Only 16 centers carried out electrophysiological procedures every day of the week. Both variables—exclusive use of the radiology room for electrophysiology and days assigned to it—are positively related with a larger number of ablation procedures.

The polygraph equipment has improved with time because all of the centers had digital equipment in 2001, whereas fewer than half did in 1995.\textsuperscript{7} Nonetheless, few centers have non-fluoroscopic intracardiac navigation systems, which facilitate the ablation of complex substrates like atrial fibrillation and ventricular tachycardia.\textsuperscript{19}

Most of the public centers, 22 of the 35 (63%) that completed this item, had two or more physicians working full-time, a small increase with respect to the 10 of 21 centers (48%) that met this condition in 1995. Nonetheless, the mean number of physicians working full-time in laboratories of electrophysiology and arrhythmias was 1.6±0.9, a figure that practically has not changed since 1995 (1.6±0.7).\textsuperscript{7}

Results and substrates treated

This registry is important because the number of patients included (n=3783) is similar to that of the largest registries that have been published, like the prospective NASPE registry (n=3357)\textsuperscript{15} and the MERFS study (n=4398).\textsuperscript{20} However, as has been noted, it is more representative than either of these registries because most of the centers in Spain participated.

The success rate of catheter ablation in the present registry (93%) was similar to that reported in other registries and varied, as in other registries, with the substrate treated. More specifically, the success rate (97%) for ablation procedures performed on traditional «substrates» (intranodal tachycardia, accessory pathways, and atroventricular conduction) was similar to that of the NASPE registry\textsuperscript{14} of 1998 and the prospective study of Calkins et al.\textsuperscript{21} The proportion of complex substrates treated can be considered relatively low.\textsuperscript{22} Thus, nearly 70% of the ablation procedures were performed to treat tachycardias due to intranodal reentry by ablating accessory pathways or atroventricular conduction. The success rate of ablation of the cavotricuspid isthmus was 90% or greater, similar to the results of most of the series that have been published. The generalized use of 8-mm distal electrode and irrigated-tip catheters (in more than 70% of procedures) could be an important factor.\textsuperscript{23,24} The success rate of the ablation intervention was slightly higher than 80% in focal atrial tachycardia, slightly lower in atrial fibrillation, and appreciably lower in other atrial arrhythmias. These success rates are not comparable to those of other registries because this distinction was not made in other registries and because the present registry was developed using the new classification proposed by the Working Group on Arrhythmias of the European Society of Cardiology.\textsuperscript{10} The success rate of the ablation of ventricular tachycardia was 73%, and varied with the type of tachycardia (67%-77%). In general, these results were similar to those of the NASPE registry\textsuperscript{15} and to those of the prospective registry of ablation of ventricular tachycardia with irrigated-tip catheters in patients with heart disease.\textsuperscript{25}

The rate of major complications was acceptable (1.5%), similar to that obtained in other registries and lower than in the MERFS study (5.1%).\textsuperscript{20} Some of the complications were associated with the type of substrate treated, such as atroventricular block, in which
4 of the 6 complications took place while attempting the ablation of an intranodal tachycardia. The incidence of this complication in the ablation of this substrate was 0.3%, slightly lower than in the NASPE registry (0.7%) and clearly lower than in the MERFS registry (5.1%). It was significant, however, that atrioventricular block did not occur in any patient who underwent ablation of a perihisian accessory pathway. Arterial vascular complications (9 of 14 patients) and pericardial effusion/caricular tamponade occurred more frequently (4 of 7 patients) in ablation procedures on accessory pathways. Ablation procedures for cavotricuspid isthmus and atrial fibrillation were the only ones that presented transient cerebrovascular or ischemic accidents, whose determinant factors could be the catheterization technique and peri-procedure anticoagulation policy. Likewise, the occurrence of coronary ischemic events in ablation procedures for atrial fibrillation was noteworthy, as this complication did not occur in attempted ablation of other substrates. Although the causes can vary, the most probable cause could be an inadequate technique in the management of vascular sheaths and catheters in the left atrium, since this complication has also been described in percutaneous closure of atrial septal defects.26

The mortality (0.1%) was slightly higher than in the NASPE registry15 (0.03%) and similar to that of the MERFS registry (0.1%).20 The study by Calkins et al21 revealed the existence of three predictors of the risk of death: presence of structural heart disease, impaired left ventricular ejection fraction, and ablation of the atrioventricular conduction system were predictors present in the patients of this registry who died. Finally, it is important to note the absence of mortality in ablation procedures performed on substrates that are usually not associated with structural heart disease, like intranodal tachycardia, accessory pathways, focal atrial tachycardia, atrial fibrillation, and idiopathic ventricular tachycardia.

Limitations

The main limitation of any registry is participation, which can limit its representativity. Nevertheless, the representativity of the present registry is ensured by a participation of about 90% of possible centers. However, some centers with a smaller volume of work did not participate in the SEC registry, probably because the procedures were carried out by physicians who were not specialists in cardiology in most of them.

CONCLUSIONS

The National Registry of Catheter Ablation of 2001 has compiled one of the largest samples to be published in the international literature on ablation procedures and can be considered representative of the activity and results of this procedure in Spain. The effectiveness of this procedure in Spain is high (93%), and the rate of major complications (1.5%) and mortality (0.1%) is low.

REFERENCES

12. Reyes M, Banegas JR, Villar F. Información epidemiológica ac-


ANNEX 1. National Registry on Ablation 2001

Code of center: ____________________________

Hospital: ___________________________________________
Demographic data
Address: ___________________________________________
Province: ____________________________ Zip code: ____________________________
Telephone: ____________________________ Extension: ____________________________ Fax: ____________________________
Contact cell phone: ____________________________ Contact e-mail: ____________________________

National Registry on Ablation 2001 Code of center: ____________________________

Autonomic community: ____________________________
Hospital type*: University / Tertiary / Secondary-local
Public / Private / Military
Department: Cardiology department / Cardiology section (Internal Medicine Department) / Intensive care / Other
Cardiovascular surgery at center: Yes / No
No. of inhabitants in the hospital district: ________________
No. of patients on ablation waiting list on 31/12/01: ________________
No. of patients outside district on ablation waiting list on 31/12/01: ________________
*Circle all applicable options.

Laboratory personnel
No. of staff physicians*: ____________________________ No. of full-time staff physicians*: ____________________________
No. of research fellows/grant holders/year: ____________________________ (e.g., one every 6 months would be: 1/year)
No. of resident physicians/year: ____________________________
No. of assistant nurses/RNs: ____________________________
No. of ARS: ____________________________
No. of auxiliary assistant nurses/RNs: ____________________________
*To avoid counting the same physician in more than one center (public/private activity), indicate in parenthesis the number of physicians already counted in another center (e.g., two physicians, one of which also works in a private center: n=2 (1).

Laboratory information
Number and type of radiology rooms
Conventional _______/ Digital ________
Room dedicated exclusively to electrophysiology/pacemakers: Yes / No
Days of week used for electrophysiology: ____________________________
Are pacemakers implanted in the room? Yes / No
Are automatic defibrillators implanted in the room? Yes / No
Is scheduled cardioversion performed in the room? Yes / No
Other procedures performed in the room: ____________________________
Digitized polygraph: Yes / No
No. of recording channels: ____________________________
Polygraph make and model: ____________________________
Pacer brand and model: ____________________________

Special techniques available
Non-fluoroscopic intracardiac navigation: ____________________________
[ ] Carto [ ] Ensite [ ] Localisa [ ] Other
Describe: ____________________________
Intracardiac echography: Yes / No
Cryoaulation: Yes / No
Ultrasound ablation: Yes / No
Others: ____________________________

Diagnostic activity
Total no. of diagnostic electrophysiology procedures*: ____________________________
No. of electrophysiological studies for syncope/bradyarrhythmia: ____________________________
No. of electrophysiological studies for supraventricular tachycardia: ____________________________
No. of electrophysiological studies for ventricular tachycardia: ____________________________
No. of other electrophysiological studies: ____________________________
No. of studies to evaluate defibrillation by implantable automatic defibrillator: ____________________________
*Procedures performed before ablation are considered diagnostic.

The annex continues in next page
ANNEX 1. Continuation

**Therapeutic activity**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. of patients treated by ablation:</td>
<td></td>
</tr>
<tr>
<td>Total no. of ablation procedures:</td>
<td></td>
</tr>
<tr>
<td>No. of ablation procedures aside from first attempt:</td>
<td></td>
</tr>
<tr>
<td>No. of substrates treated by ablation:</td>
<td></td>
</tr>
<tr>
<td>Total no. of successful ablation procedures:</td>
<td></td>
</tr>
<tr>
<td>Total no. of procedures performed for recurrence:</td>
<td></td>
</tr>
<tr>
<td>Total no. of complications:</td>
<td></td>
</tr>
<tr>
<td>No. of pacemaker implantations/replacements:</td>
<td></td>
</tr>
<tr>
<td>No. of automatic defibrillator implantations/replacements:</td>
<td></td>
</tr>
<tr>
<td>No. of cardioversions scheduled in EPS room/elsewhere:</td>
<td></td>
</tr>
</tbody>
</table>

**Laboratory policy**

<table>
<thead>
<tr>
<th>Policy</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV heparinization for diagnostic electrophysiology studies:</td>
<td>Yes / No</td>
</tr>
<tr>
<td>IV heparinization for transvenous ablation:</td>
<td>Yes / No</td>
</tr>
<tr>
<td>IV heparinization for arterial/transseptal ablation:</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**Usual delay after successful radiofrequency application:** __________

**Comments**

Ablations by substrate (complete an item for each of the following substrates: intranodal tachycardia, accessory AV pathways, AV conduction, focal atrial tachycardia, cavotricuspid isthmus, atypical atrial flutter/macoorientent atrial tachycardia, atrial fibrillation, idiopathic ventricular tachycardia, macoorientent ventricular tachycardia by postinfarction scar, macoorientent ventricular tachycardia unassociated with postinfarction scar)

1. No. of patients/procedures: ______/_______
   - No. of substrates treated by location: ______/_______/_______
2. No. of first procedures/successful non-first procedures: ______/_______
   - No. of patients with successful outcome: ______
   - No. of successful procedures by location: ______/_______/_______/_______
3. No. of procedures in which a nonstandard ablation catheter was used:
   - a. 8-mm ______
   - b. Irrigated-tip ______
   - c. Cryoablation ______
   - d. Other (describe) ______
4. No. of complications:
   - a. AVB requiring pacemaker ______
   - b. Venous/arterial vascular complications ______
   - c. Pericardial effusion/cardiac tamponade ______
   - d. Embolism/CVA/TIA ______
   - e. AMI or ischemia ______
   - f. Congestive heart failure or pulmonary artery stenosis ______
   - g. Peri-procedure death ______
   - h. Other (describe) ______
5. No. of patients with recurrences: ______
   - No. of patients reviewed (approximation): _____________%
6. Comments:

Write «0» in all numeric fields in which no procedure was performed or patient treated.

1. No. of patients/no. of procedures (proced.): number of patients undergoing one or more ablation procedures on each substrate/number of procedures performed on each substrate, including those performed for recurrences. No. of ACP/VT indicates number of accessory pathways/ventricular tachycardias in which ablation was attempted.
2. No. of first proced./successful non-first proced.: number of ablation procedures, differentiating between first procedures and successful procedures performed after failure of a first procedure or recurrence.
3. No. of patients with recurrences: number of patients with a known clinical or electrocardiographic recurrence on a previously treated substrate (including patients successfully treated in later procedures).
4. No. of reviewed patients: approximate percentage of patients for which a reliable evaluation of procedure results at 6 months is available.
ANNEX 2. Electrophysiology laboratories by autonomic communities and provinces participating in the National Registry on Catheter Ablation – 2001

Andalucía
Córdoba
Hospital Reina Sofía
Granada
Hospital Virgen de las Nieves
Málaga
Hospital Virgen de la Victoria
Sevilla
Hospital de Valme
Hospital Virgen del Rocío

Aragón
Zaragoza
Hospital Clínico de Zaragoza
Hospital Miguel Servet

Asturias
Hospital Central de Asturias

Baleares
Hospital Son Dureta

Canarias
Gran Canaria
Hospital Insular

Castilla-La Mancha
Toledo
Hospital Virgen de la Salud

Castilla y León
León
Hospital de León
Valladolid
Hospital Río Hortega
Salamanca
Hospital de Salamanca

Cataluña
Barcelona
Ciudad Sanitaria de Bellvitge
Hospital Clínic de Barcelona
Hospital del Mar
Hospital de la Santa Creu i Sant Pau
Hospital Vall d’Hebron
Centro Cardiovascular Sant Jordi*
Clínica Sagrada Familia*
Hospital Sant Joan de Deu*

Comunidad Valenciana
Alicante
Hospital General de Alicante
Valencia
Hospital General de Valencia
Hospital Clínico de Valencia

Galicia
La Coruña
Hospital Clínico de Santiago de Compostela
Hospital Juan Canalejo
Pontevedra
Hospital Xeral Cies

Madrid
Clínica Puerta de Hierro
Hospital 12 de Octubre
Hospital de Alcorcón
Hospital Clínico San Carlos
Hospital de Getafe
Hospital Gregorio Marañón
Hospital La Paz
Hospital Ramón y Cajal
Clínica USP San Camilo*
Clínica de la Zarzuela*

Murcia
Hospital Virgen de la Arrixaca

Navarra
Clínica Universitaria de Navarra*
Hospital de Navarra

País Vasco
Hospital de Basurto
Hospital de Cruces

*Centers with Principally private care.