Letters to the Editor

Long-Duration Self-Limiting Idiopathic Ventricular Fibrillation

To the Editor:

A 26-year-old woman, with no relevant personal or family history, experienced 3 resting syncopal episodes with tonic convulsions in a period of 2 months. The physical examination, electrocardiogram, echocardiogram, programmed stimulation, and a provocation test with flecainide were normal or negative. A subcutaneous Holter was implanted (Reveal® Plus Medtronic, Inc.) which was consulted a fortnight later after a new syncope with the same features. Ventricular fibrillation (VF) was substantiated (Figure, A) initiated by a ventricular extrasystole (VE) (Figure, B, arrows). In the minute prior to the event, a large density of VE from the same focus with fixed coupling (Figures, A and B). The VF was maintained for almost 3 minutes and spontaneously ceased (Figure, C), the VE disappeared in the following minutes (Figure, A). An ablation of the VE was attempted which set off the VF, but its reproduction was not possible during the electrophysiological study. The implanting of a defibrillator was decided on. Two months later, the patient underwent treatment with beta blockers and no clinical events were registered.

The VF that occurs in the absence of structural heart disease or electrocardiographic alterations is found in 5%-10% of survivors of sudden death,1-3 and is known as idiopathic VF (IVF). It is recurrent, it can be self-limiting and manifests managed to finally control the patient's symptoms, which she tolerated well at a resting heart rate of 63 beats/min and showed no side effects; allowing her to resume her working routine and the care of her children without limitations. An improvement of 47 points in the quality of life evaluation was noted according to the MLWHF questionnaire. In the first 3 months, only 2 episodes of palpitations have occurred, coinciding with a fever and with the use of nasal decongestants, respectively. A new ergometry was performed: clinically negative, without surpassing 80% of the MHR and with a functional capacity of 13.7 MET.

To conclude, Ivabradine could represent an efficient alternative to beta blockers in the treatment of inappropriate sinus tachycardia prior to invasive studies. Prospective and random studies allow for an evaluation of its long term efficiency and safety.

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in syncoes.1 Just as in atrial fibrillation, which can appear as a result of a focal mechanism with fibrillatory conduction, in some VF a trigger is identified that is a VE which sets off an arrhythmia. In the IVF, the VE has the same morphology and identical coupling interval and originates in the right ventricular outflow exit tract or in the Purkinje fibres.4,5 Besides in the IVF, it has been observed in patients with channelopathies (long QT and Brugada syndromes) and in certain patients with post-myocardial infarction scarring.6,7

In the treatment of IVF, medication is ineffective and until recently the handling of survivors was limited to the implanting of a defibrillator. Recently, Haissaguerre et al1 performed a radio frequency ablation of the VE which set off the IVF in 27 patients, with a rate of clinical success of 89% during a follow-up of 24 (28) months. This treatment has been included in the latest guidelines for sudden death secondary prevention.8 A limitation of this technique is that the VE cannot be reproduced to perform the ablation.

The peculiarity of this case is the clear documentation that a VF of close to 3 minutes can spontaneously end without causing death or sequelae and the inter-relation between the VF and the appearance and disappearance of its trigger.

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