



VT Ablation Supported by TandemHeart

University of Virginia Medical Center

The patient was a 61 year old male, H/O ischemic cardiomyopathy, EF15% +/-, Bi-V ICD, bilateral femoral arterial stents, VT, VT ablation. The patient was brought to the EP lab for a redo VT ablation with TandemHeart Support. The initial case, without TandemHeart support, was too unstable with means in the low 50s. The original EP study and Carto Map showed primarily epicardial origination. The physicians decided to do an epicardial ablation while being support on the TandemHeart.

Before draping of the patient, general anesthesia was administered. The patient was then draped and Dr. Lim put in the venous and arterial sheaths. A new arteriogram of the lowers showed an occluded LFA stent. Their only access was to use the RFA. Once the sheaths were inserted Drs. Mahapatra and Ailawadi attempted to gain epicardial access subxiphoid. Due to the difficult anatomy of the patient, they were unable to gain access. Dr. Ailawadi then performed a pericardial window to gain access. Once this was accomplished, Dr. Lim proceeded to insert the cannulas for the TandemHeart System. The cannulae were inserted on the right with a 15 Fr. arterial return cannula. The transeptal puncture took Dr. Lim approximately one minute from the SVC. The pump was deaired without difficulty. Support was initiated at 7000 rpms at 3.6 lpm flow with a MAP of 94. Initial epicardial mapping showed some very early activity. Once VT was initiated, flows remained at 3.5-3.7 lpm. The rate was 173 with a cycle length of 340 msec and a MAP of 90. The initial VT was broken 1hr 20 min later after multiple RF lesions. The second VT was slower at a rate of 145 and a cycle length of 400 msec and MAP of 92. At this time a new map was done and it was determined that the VT was endocardial. Even though the rate was decreased to 140, it was still present. Further mapping showed that it was endocardial. The patient will be rescheduled for a further ablation.

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