

Cardiac Electrophysiology Laboratory
St. David's Medical Center

Electrophysiology Study Report

Patient Information

Patient Name Van Slooten, Travis
Study Date 4/27/2023
MRN [REDACTED]
Study Number [REDACTED]
Account Number [REDACTED]
Date of Birth [REDACTED]
Age 50 Years
Gender Male
Race White
Height 180 cm (5'11")
Weight 95 kg (209 lbs)
BSA 2.15 m²

Staff

Duty	Name
Electrophysiologist	Andrea Natale, MD
Monitor	Brandon Doyle, CVT
Monitor	Daniel Valdez, RN
Scrub	Carlos Monreal, RCES
Circulator	Jaime Schaetz, RN

Procedures

Intracardiac echocardiography
Left ventricular visualization
RF ablation for PSVT (AF)
Serial ACTs to achieve ACT 350-400 seconds
Three-dimensional mapping
Transseptal access x2
Left Atrial / Coro Sinus pace/record

Pre-Procedure Diagnoses

Atrial fibrillation / Atrial flutter

Patient History

Two previous cardiac ablations for atrial fibrillation and atrial flutter; cardioversion; Eliquis for CVA prevention; Profound epistaxis; TEE with most recent EF of 61%; CHADSVASC score 3, HASBLED score 3

ASA Score

ASA Classification III provided by anesthesia service.

Anesthesia Type

General

Patient Allergies

NKA

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Pre Procedure Description

The patient was brought to the Electrophysiology lab in the fasting, post absorptive state. Risks, benefits and alternatives of the procedure and general anesthesia were explained to the patient and a written informed consent was obtained. The patient was prepped and draped in the usual sterile fashion. Vascular access was obtained by the modified Seldinger technique and ultrasound guidance in both right and left groins and the right neck. The distal portion of the duodecapolar catheter was advanced into the coronary sinus and the proximal portion was placed along the crista terminalis. Surface ECG leads I aVF and V1, and intracardiac electrograms from the CS, HIS bundle and RVA were displayed in real time and recorded. Intracardiac echocardiography, transseptal puncture, endocardial mapping and radiofrequency ablation was performed as described below.

Heparin boluses (initially, 12,000 units) were given to maintain an ACT 350- 500 sec. An esophageal temperature probe was inserted and maneuvered under fluoroscopy to monitor esophageal temperatures throughout the case.

Vascular Access Sheaths

Sheaths

8F-8.5F MERIT 50
8F-8.5F MERIT 90
7F
11F

Site of Insertion

RIGHT FEMORAL VEIN
RIGHT FEMORAL VEIN
RIGHT INTERNAL JUGULAR
LEFT FEMORAL VEIN

Catheters

<u>Manufacturer</u>	<u>Size</u>	<u>Type</u>	<u>Placement</u>
BIOSENSE WEBSTER	7F	DUO DECAPOLAR	CORONARY SINUS /CRISTA
BIOSENSE WEBSTER	7F	LASSO 10/20 NAV	MAPPING
BIOSENSE WEBSTER	8F	QDOT MICRO J-CURVE	ABLATION/MAPPING
BIOSENSE WEBSTER	10F	ULTRASOUND	RIGHT VENTRICLE /RIGHT ATRIUM

ICE and Three-Dimensional Mapping

A three-dimensional reconstruction of the left atrium was created with the use of the Carto 3 system. The following structures were visualized with ICE: the right atrium, fossa ovale, tricuspid valve, coronary sinus, crista terminalis, RA appendage, LA, mitral valve, left atrial appendage, left superior pulmonary vein, left inferior pulmonary vein, right superior pulmonary vein, right inferior pulmonary vein, aortic valve, left ventricular outflow tract, ascending aorta, pulmonic valve, right ventricular outflow tract and pulmonary artery. ICE was also used to guide transseptal catheterization and rule out complications.

Transseptal

Left atrial instrumentation was achieved by double transseptal punctures. The Baylis transseptal system was used to facilitate the transseptal punctures. Proper placement was confirmed by fluoroscopy, intracardiac echocardiography, contrast injection, left atrial pressure tracings and left atrial pressure.

LA mean pressure 24/9/16 (mmHg)

Post Procedure Description

The patient arrived to the Electrophysiology laboratory in sinus rhythm. After left atrial instrumentation was achieved by double transseptal puncture, the circular mapping catheter was placed in all four pulmonary veins, antrums and along the posterior wall of the left atrium. During mapping, the pulmonary veins remained electrically silent from a previous procedure as well as the left atrial appendage. Electrograms were mapped and ablated at the floor of left atrium, septum of left atrium, and coronary sinus.

A total of 7 minutes of radiofrequency energy lesions were delivered.

At the end of the procedure, access was maintained to accommodate the Watchman/Flex portion of the procedure. The patient tolerated the procedure well and was transferred in stable condition.

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Plan

1. Continue long-term anti-coagulation.
2. Continue home medications as directed.
3. Follow-up in 6-12 weeks.
4. Event recorder upon discharge.

Conclusion

1. The patient arrived to the Electrophysiology laboratory in sinus rhythm.
2. After left atrial instrumentation was achieved by double transseptal puncture, the circular mapping catheter was placed in all four pulmonary veins, antrums and along the posterior wall of the left atrium. During mapping, the pulmonary veins remained electrically silent from a previous procedure as well as the left atrial appendage.
3. Electrograms were mapped and ablated at the floor of left atrium, septum of left atrium, and coronary sinus.
4. A total of 7 minutes of radiofrequency energy lesions were delivered.

Complications

NONE

Radiation dosage (Includes Watchman portion of procedure)

Air Kerma(AK): 209 mGy
Dose Area Product (DAP): 1533.30 uGy*m²
Fluoro time: 34.4 minutes

Number of ACTs performed (Includes Watchman portion of procedure)

Two

Total contrast used

None

Estimated Blood Loss

Less than 20ml

Specimens Collected

None

Post Procedure Diagnosis

Atrial Fibrillation and Atrial Flutter status post radiofrequency ablation


Andrea Natale, M.D.

4/27/2023

Parts of this document were entered by the electrophysiology monitoring staff member under the direction of the physician.


Brandon Doyle, CVT

4/27/2023

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