At our institution, most patients eligible for LVR undergo a preoperative EP study. In patients with spontaneous or inducible ventricular tachycardia (VT), we perform endocardial resection and cryoablation. In patients with preoperative clinical VT, we perform an EP study before hospital discharge, and in patients with inducible-only VT, we perform an EP study 3 to 6 months after the operation. In case of postoperative clinical or inducible VT, we recommend ICD implantation. We have recently reported our experience in a series of 53 consecutive patients undergoing LVR and surgical intervention for VT.³ The success rate in terms of VT control was 90%. This finding is comparable to the results previously reported by Di Donato and colleagues⁴ and Mickleborough and associates.⁵

Treat the cause, not the symptoms.

ICD firing is associated with a certain amount of discomfort for the patient. ICDs indisputably save lives, but the price can be high both in terms of money and patient well-being. Therefore the aim must be to eliminate the need for ICD. By adding specific antiarrhythmic surgical procedures, such as endocardectomy and cryoablation, in patients undergoing LVR, we have a potentially curative treatment option at our disposal. In our view an EP study is necessary after LVR when surgical intervention for VT has been included to identify surgical failures in which ICD therapy is warranted.

In our opinion patients scheduled for LVR should be assessed for ventricular arrhythmias, and if present, specific arrhythmia surgery should be performed concomitantly, and the postoperative result should be verified by means of EP studies. With this protocol, implantation of an ICD will not be needed in most patients after LVR including surgical intervention for VT.

Ulrik Sartipy, MD

Anders Albåge, MD, PhD

Dan Lindblom, MD, PhD

Department of Cardiothoracic Surgery

and Anesthesiology

Karolinska Institutet

Karolinska University Hospital

S-171 76 Stockholm, Sweden

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doi:10.1016/j.jtcvs.2005.11.048

Reply to the Editor:

As stated in the article, 30 patients had implantable cardioverter-defibrillators inserted preoperatively, and the indication for the majority of these patients was secondary prevention, having had either a documented ventricular arrhythmia or aborted sudden death. Of these 30 patients, 2 had aborted sudden cardiac death, 3 had sustained ventricular tachycardia, and the remainder presumably had positive electrophysiologic (EP) studies. For groups 2 and 3 of our series, we do not have accurate data on who underwent EP studies preoperatively.

Dr Sartipy's group performs EP studies preoperatively. This approach is used to guide endocardial resection or cryoablation. Many of our patients (13%) underwent cryoablation for arrhythmias. However, the main indication for left ventricular reconstruction (LVR) was heart failure, rather than intractable arrhythmias.

LVR definitely has a role in the treatment of ventricular arrhythmias, but in patients with severe left ventricular dysfunction, border zones between scar and viable myocardium might provide arrhythmic substrate. In addition, patients in our series had evidence of marked left ventricular remodeling, with arrhythmic substrate in areas remote to the site of LVR.

Against that, the Coronary Artery Bypass Graft Patch Trial¹ failed to show a reduction in mortality when patients with markers for increased risk of ventricular arrhythmia un-

derwent implantable cardioverter-defibrillator implantation at the time of coronary artery bypass grafting. This has been attributed to a reduction in the risk of arrhythmic death as a result of revascularization.² This indicates that perhaps the most important procedure to reduce arrhythmias is surgical revascularization.

Further prospective studies are required to elucidate the optimal strategy in this complex group of patients.

Mina K. Chung, MD

James O. O'Neill, MD, FRCPI

Cardiac Pacing and Electrophysiology

Department of Cardiovascular Medicine/F15

9500 Euclid Ave

Cleveland, OH 44195

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doi:10.1016/j.jtcvs.2005.11.049

Left ventricular assist device in heart failure

To the Editor:

I read with great interest the article by Nicholas C. Dang and colleagues, wherein they report their experience with left ventricular assist device (LVAD) in patients with chronic congestive heart failure.¹ There are various mechanical circulatory devices employed currently as a bridge to transplantation. The authors report their experience with the HeartMate (Thoratec Corp, Pleasanton, CA) device; however, the type of device engaged is not mentioned. It is pertinent to note that of HeartMate LVADs, the single-lead vented electrical devices have been linked with the best posttransplant survival rates.²

Even as vigilance for the predictive factors¹ will help in patient selection, improved clinical outcome should also be sought by careful timing of transplantation following LVAD insertion. By instituting patient support and rehabilitation for at least a month following the implantation, significant normalization of end-organ func-