A 68-year-old woman with troublesome palpitations and intolerant of several antiarhythmics was referred for ablation of frequent (>25,000 in 24 h) symptomatic premature ventricular complexes (PVCs) with an inferior axis, positive QRS polarity in leads II, III, and aVF, and a dominant R-wave in V1 with the absence of S waves from V4 to V6 suggesting a left ventricular outflow tract origin (A) (1). Activation and pace mapping at a site between the aortic and mitral annulus found an early local electrogram and a perfect pace map to the clinical ectopy (B to E). A coronary angiogram marked the proximity of the left main stem to the site of successful ablation (B to E).

Sites of left ventricular outflow tract ectopy include the aortic sinus cusps, especially the left coronary cusp, the anterolateral mitral annulus, and rarely, the aortomitral continuity region. A coronary angiogram should be performed before ablation and the use of cryoablation should be considered.

REFERENCE