We agree with Dr. Olde Nordkamp and colleagues that careful history taking remains crucial for appropriate risk stratification and management of patients with long-QT syndrome (LQTS) (as well as other subjects with unexplained syncope). As Dr. Olde Nordkamp and colleagues note, this point was also emphasized in our report in our discussion of the clinical implications of our findings (1). However, we think that the comment regarding the fact that the vast majority of syncopal episodes in patients with LQTS are associated with a vasovagal mechanism may mislead readers to underestimate the clinical importance of the development of syncope in patients with LQTS. In this regard, it is important to note that the sources Dr. Olde Nordkamp and colleagues cite regarding a high frequency (41%) of syncopal episodes in general population (obtained from questionnaire data in a relatively small sample of medical students) may be an overestimation, as data from other studies suggest that the frequency of syncope before age 18 years is much lower (approximately 15%) (2,3). Furthermore, estimation of the frequency of vasovagal syncope in nonselected patients is difficult, because in most studies, these events are not thoroughly investigated, and this information may not take into account the true penetrance of LQTS (or other arrhythmogenic disorders) in the general population (4).

Information regarding the circumstances of syncopal events in patients with LQTS in the registry was obtained prospectively and carefully validated by study specialists. Our data consistently show that among patients with LQTS, syncope is the most powerful predictor of subsequent fatal or near fatal events. Importantly, the present study shows that children and adolescents with LQTS who experienced syncope had a pronounced 7- to 15-fold increase in the risk for subsequent aborted cardiac arrest of sudden cardiac death (1). These findings contrast those in the general population, in which vasovagal events were shown to be associated with a benign clinical course (3), and strongly suggest that the majority of syncopal episodes in patients with LQTS should be considered arrhythmic in nature until proven otherwise.

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References


Surgical Ablation for Atrial Fibrillation

Not All Energy Sources Are Created Equal

We read the recent report by Onorati et al. (1) with great interest. We agree with the investigators that the effect of surgical lesion pattern has been poorly investigated and had hoped that this report would clarify the success of different lesion patterns in patients undergoing concomitant surgery for atrial fibrillation. Unfortunately, we believe that the report has several inherent flaws that make the results inconclusive.

Most important, the left atrial group combined patients whose lesions were created using different types of energy sources. Myriad new ablation technologies have been introduced in the past decade, and the ability of each to create transmural linear lesions varies. Bipolar radiofrequency (RF) ablation appears more reliable in creating transmural lesions than monopolar RF ablation (2). The most likely reason that a change from monopolar RF to bipolar RF ablation occurred after December 2003 was the improvement in technology and thus outcomes. Fourteen of 32 patients undergoing the limited approach had lesions created using monopolar RF ablation. The “extensive” approach began in August 2004, after bipolar RF ablation was introduced. This suggests that the outcomes were inherently biased toward the “extensive group,” the group with the better energy source. Even in the 18 patients who underwent left atrial with bipolar RF ablation, the freedom from atrial fibrillation in this series was 53%. We recently reported our results in 175 patients using a left atrial-only approach, with freedom from atrial fibrillation of 81% (3). It is difficult to account for this disparity in results.

We congratulate Onorati et al. (1) for attempting to address a critical question: Does a more extended lesion set improve sinus