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Reply

Catheter Ablation to Treat Sustained Ventricular Tachycardia in Patients With Chagas Cardiomyopathy and Implantable Cardioverter-Defibrillator



We would like to thank Drs. Scanavacca and Sosa for their letter regarding our review (1), which outlined an important aspect related to the management of patients with Chagas heart disease (CHD) and malignant arrhythmias. Patients with CHD have a higher risk of death than idiopathic dilated cardiomyopathy (2), possibly related to the higher frequency and severity of ventricular arrhythmia in CHD subjects when compared with other structural heart diseases (3,4). The higher number of shocks observed in CHD patients is related to the higher incidence of ventricular tachycardia (VT) and fibrillation in implantable cardioverter-defibrillator (ICD) patients (4) and to the higher risk of death (5). Amiodarone, which has been largely used in CHD (6), in association with beta-blockers, may prevent shocks in ICD patients but not in all patients, and only at the cost of an increased risk of drug-related adverse effects (7). As Dr. Scanavacca and Dr. Sosa correctly point out, ablation therapy emerges as the first-line treatment for those receiving frequent ICD therapies due to incessant and recurrent VT in spite of amiodarone and beta-blocker therapy in CHD.

However, several aspects of this treatment option in CHD should be better elucidated. Dr. Scanavacca and Dr. Sosa's group have to be praised for the introduction of the technique of nonsurgical transthoracic epicardial catheter ablation to treat recurrent VT in CHD patients (8), which is now used for VT ablation of other etiologies (9). CHD patients frequently have epicardial VT breakthroughs (8,10) and a combined epicardial/endocardial substrate mapping, and ablation has been proposed as a first-line therapy for preventing VT recurrences and appropriate ICD therapies (8,10). Indeed, the use of extended substrate modification in patients with ischemic cardiomyopathy—with routine approach to endocardial and epicardial surface—was more effective in preventing VT recurrences than the limited (traditional) substrate ablation (9). This is a hypothesis that deserves to be tested in CHD in a prospective, randomized trial.

CHD is now a global health problem, but most infected patients are poor people born in rural, endemic areas in Latin America; thus, few randomized studies have been performed for treatment of CHD complications (11,12). Globalization of knowledge and evidence-based medicine should be matched by attempts to provide solutions for regional and neglected pathologies in addition to global health problems (13).

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