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irrespective of inducibility or hemodynamic tolerance. Because of this risk, the coronary arteries with arteriography are essential to localize the ablation electrode relative to the position of the coronary arteries. Although some of these conditions can be optimized prior to an elective procedure, this is often not possible for more emergent procedures. It is well suited for mapping of the epicardial surface. Kobayashi Y. Dong J.Z. et al.Catheter ablation of premature ventricular contractions originating in the aortic sinus cusp or great cardiac vein: two QRS morphologies with one origin.Crossref PubMed Scopus (4) Google Scholar).Initial mapping should include the LVOT and SVs (S9.2.7.33Yamada T. Prospective evaluation of a therapeutic strategy based on clinical, holter, hemodynamic, and electrophysiological findings.Crossref PubMed Google Scholar).Ablation is generally performed for monomorphic VT that recurs despite antiarrhythmic therapy, particularly with ICD shocks. Several observations can be made based on available data:Recommendation-Specific Supportive TextRecommendation-Specific Supportive TextThe use of amiodarone might be reasonable to lower the risk of new-onset AF after epicardial VT ablation in patients with evidence of acute pericarditis. In particular, significant pulmonary regurgitation after prior transannular patching with subsequent RV enlargement is a common finding in repaired tetralogy of Fallot () and might require surgery or transcathaneous valve replacement. Ablation at one region can abolish more than one VT. et al.Association of regional epicardial right ventricular electrogram voltage amplitude and late gadolinium enhancement distribution on cardiac magnetic resonance in patients with arrhythmogenic right ventricular cardiomyopathy: implications for ventricular tachycardia ablation.). In particular, a pulmonary homograft can cover parts of the infundibular septum in patients with tetralogy of Fallot, preventing isthmus transection from an RV approach (S9.11.3.18Kapel G.F. Reichlin T. When used prophylactically, the pLVAD has been shown to prevent AHD and has a lower 30-day mortality (4.2% vs 58%). et al.Management of ventricular tachycardia in the setting of a dedicated unit for the treatment of complex ventricular arrhythmias: long-term outcome after ablation.Crossref PubMed Scopus (111) Google Scholar.). In the Multicenter Thermocool Ventricular Tachycardia Ablation Trial, 35% of 1-year mortality was due to heart failure (S10.3.35Stevenson W.G. Wilber D.J. Natale A. Monomorphic sustained VT approachable by catheter or surgical ablation typically occurs in patients with ventricular incisions, surgical scars, and patch materials. et al.Irrigated radiofrequency catheter ablation guided by electroanatomic mapping for recurrent ventricular tachycardia after myocardial infarction: the multicenter thermocool ventricular tachycardia ablation trial.Crossref PubMed Scopus (473) Google Scholar). The low-voltage areas are typically adjacent to the tricuspid valve annulus and in the free wall of the RVOT. Ultrasound-guided femoral arterial and venous access has been widely implemented in electrophysiological procedures in an effort to reduce vascular complications. Considering the higher risk for procedural complications with an epicardial approach (), careful patient selection is warranted. Rubio-Guivernau J.L. et al.Noninvasive identification of ventricular tachycardia-related conducting channels using contrast-enhanced magnetic resonance imaging in patients with chronic myocardial infarction: comparison of signal intensity scar mapping and endocardial voltage mapping.Crossref PubMed Scopus (122) Google Scholar); and the signal intensity method (full-width at half maximum technique), which uses >50% of the maximal signal intensity within a region of interest to define scar. Litovsky S.H. McElderry H.T. Kay G.N. Efficacy of an anatomical approach in radiofrequency catheter ablation of idiopathic ventricular arrhythmias originating from the left ventricular outflow tract.Crossref PubMed Scopus (14) Google Scholar). Training requirements vary from country to country, but irrespective of local differences, appropriate advanced training and continued lifelong learning are strongly recommended for all clinical cardiac electrophysiologists who perform catheter ablation for VAs.As the field of catheter ablation for VAs continues to evolve with introduction of new approaches, technology, and application in higher-risk and more complex patients (ie, adults with VADs and CHD), trainees and practicing operators specializing in these ablations are expected to continue to maintain their core and specialized competencies as outlined in the 2017 ACC/HRS Lifelong Learning Statement of Clinical Cardiac Electrophysiology Specialists (). The prevalence of epicardial VT in patients with NICMs appears to be significantly higher than for VT following MI (, S6.3.4.43Soejima K. Therefore, in some clinical scenarios, initiation or continuation of medical therapy instead of an ablation procedure may be the most appropriate option, even when a class I recommendation for ablation is present. Most electrophysiologists of the writing committee perform pacing in a bipolar manner, starting with an output of 10 mA at 2 ms pulse width. Larger series have demonstrated that this technique's efficacy can be limited by the availability of suitable target vessels, its procedural risk, and the risk of collateral injury (S9.1.9.2Kumar S. Ablation can be performed during sinus rhythm, targeting the substrate based on electrogram characteristics and pace mapping (see Section 8) and/or during mappable monomorphic VTs. These ablation strategies have not been directly compared in patients with ARVC and are complementary and often combined. SchaliJ M.J. Bartelings M.M. et al.Catheter ablation of ventricular tachycardia after repair of congenital heart disease: electroanatomic identification of the critical right ventricular isthmus.Crossref PubMed Scopus (198) Google Scholar.).Isthmus dimension and conduction properties likely determine the susceptibility to arrhythmias. Ramirez R.J. et al.Characterization of the arrhythmogenic substrate in ischemic and nonischemic cardiomyopathy implications for catheter ablation of hemodynamically unstable ventricular tachycardia.Crossref PubMed Scopus (153) Google Scholar. ,). However, scar-related circuits (particularly in patients with a nonischemic substrate) can have intramural component(s) that might not be recorded on the surface. AF is reported to occur in 4.1%–19.5% (S10.1.2.16d'Avila A. A focal origin is confirmed by mapping that shows spread of activation away in all directions from the site of earliest activation relative to the QRS onset. Isolated cardiac involvement has been increasingly recognized; a longitudinal study in Finland found that nearly two-thirds of 110 patients with histologically confirmed cardiac sarcoidosis had isolated cardiac involvement. Proclemmer A. It is important to note that quantification of the border zone still awaits histologic validation. Tedrow U.B. Koplan B.A. et al.Reentrant ventricular tachycardia originating from the periaortic region in the absence of overt structural heart disease.Crossref PubMed Google Scholar.). Viable but denervated myocardium has been shown to be particularly sensitive to development of arrhythmias (S5.4.49Kammerling J.J. Green F.J. Watanabe A.M. et al.Denervation supersensitivity of refractoriness in noninfarcted areas apical to transmural myocardial infarction.Crossref PubMed Google Scholar. S5.4.50Simoes M.V. Barthel P. Pace N. Attili A. Mazzanti A. Hadjis T. Antunes S. Mathuria et al. Radiofrequency catheter ablation of ventricular tachycardia guided by nonsurgical epicardial mapping in chronic Chagasic heart disease.Crossref PubMed Scopus (97) Google Scholar. S2.2.4.27Kapel G.F. Sacher F. Adequate preprocedural planning and standardization of procedural steps are crucial in this population with advanced heart disease. Tsiachris D. Tchou and Mehdiard () described 3 categories of BBRVT (Table 5). CMR has been reported to identify patients at increased risk for adverse outcomes in the presence of frequent PVCs (S3.2.3.1Aguaro G.D. Pingitore A. The reported sensitivity and specificity of these criteria to predict successful epicardial ablation in NICM can exceed 90% (). Dhalal A. Under these circumstances, unipolar voltage mapping can be used to extend the field of view of endocardial mapping (S8.5.2.15Hutchinson M.D. Gerstenfeld E.P. Desjardins B. Remp T. Nogami () and Talib et al. del Castillo S. Radiofrequency catheter ablation of ventricular tachycardia after myocardial infarction.Crossref PubMed Google Scholar). There have been many important contributions related to VT ablation, the details of which will be further highlighted elsewhere in this document.Catheter ablation has an important role in reducing or preventing VAs both in patients with heart disease and in those with idiopathic VTs not associated with SHD. Radiofrequency catheter ablation using cooled electrodes: impact of irrigation flow rate and catheter contact pressure on lesion dimensions.Crossref PubMed Google Scholar. S9.1.9.10Yokoyama K. Pilleggi F. Increased tissue heterogeneity within the scar demonstrated by CMR has helped to identify critical sites that can be selectively targeted (), resulting in decreased VT recurrences. et al.Italian Sudden Death Prevention GroupPrevention of sudden cardiac death after a first myocardial infarction by pharmacologic or surgical antiadrenergic interventions., ,).Surgical CSD can be considered for high-risk patients with contraindications for beta blockers, for patients with symptomatic long QT syndrome when beta blockers are not effective, or when ICD therapy is contraindicated or declined (, , ,). Packer D. Monahan K. Page K. Klein et al. et al.Outcomes of pre-emptive and rescue use of percutaneous left ventricular assist device in patients with structural heart disease undergoing catheter ablation of ventricular tachycardia.Crossref PubMed Scopus (27) Google Scholar. S5.1.3.7Iwasawa J. The latter is particularly true for patients with NICMs, including idiopathic DCM (, S6.3.4.14Hutchinson M.D. Gerstenfeld E.P. Desjardins B. Baser K. However, scars commonly exist intramyocardially and/or subepicardially in an area with an associated thick layer of subendocardial myocardium. et al.Endocardial and epicardial ablation guided by nonsurgical transthoracic epicardial mapping to treat recurrent ventricular tachycardia.Crossref PubMed Google Scholar.). A careful understanding of the potential procedural complications that might arise from either the patient's underlying medical conditions or the electrophysiology procedure itself is necessary. Isthmus 3 between the pulmonary annulus and the VSD patch or septal scar is the most common cause of VT and occasionally requires ablation from both the RV and LV sides of the septum or SV for transection (S9.11.3.18Kapel G.F. Reichlin T. Use of intracardiac ultrasound has also been suggested for detecting scars, but data are limited (). Jazayeri M.R. Akhtar M. Yang B. Chaithiraphan S. et al.Irrigated radiofrequency catheter ablation guided by electroanatomic mapping for recurrent ventricular tachycardia after myocardial infarction: the multicenter thermocool ventricular tachycardia ablation trial.Crossref PubMed Scopus (473) Google Scholar. S10.4.6Marchlinski F.E. Haffajee C.I. Beshai J.F. et al.Long-term success of irrigated radiofrequency catheter ablation of sustained ventricular tachycardia: post-approval THERMOCOOL VT trial.Crossref PubMed Scopus (48) Google Scholar. S10.4.9Tanner H.

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