During the past decade, catheter ablation of atrial fibrillation (AF) has emerged as an important treatment option for patients with symptomatic AF refractory to anti-arrhythmic drug therapy. The 2012 Heart Rhythm Society/European Heart Rhythm Association/European Cardiac Arrhythmia Society Expert Consensus Document on Catheter Ablation of Atrial Fibrillation provides a Class 1 Level of Evidence A recommendation for catheter ablation of AF in patients with paroxysmal AF who have failed treatment with at least 1 anti-arrhythmic medication and a Class 2 Level of Evidence B recommendation for patients with paroxysmal AF who have not failed anti-arrhythmic drug therapy.1

A 6.3% overall complication rate (not including serious complications, such as pulmonary vein stenosis and atrial esophageal fistula) and one in-hospital death for every 238 patients undergoing AF ablation is not in keeping with the results of previous studies. The incidence of in-hospital complications of catheter ablation of AF among 93,801 AF ablation procedures performed by operators doing <25 AF ablation procedures per year and in hospitals with annual AF ablation volumes <50 were operator volume <25 and annual hospital volume <50 were associated with a higher rate of complications.

In writing this editorial, I am charged with helping to interpret the results of this study in the context of both my own experience with catheter ablation and the considerable body of previously published literature on AF ablation. I would like to focus my comments by addressing three questions. First, are the findings of this study valid? Second, are the findings of this study important? Third, what are the clinical implications of this study for both patients considering having the procedure performed operators who perform this procedure and for hospitals that grant privileges to physicians to perform this procedure?

It is my opinion that the results of this study are valid. Although it is easy to criticize the many assumptions needed to perform this analysis (including the absence of a procedure code for AF ablation), to identify the limitations inherent to data derived from administrative data bases, and to argue that these findings are outdated (>3 years old), I believe that strength comes from numbers and that the results of this study are valid. It is striking that the overall complication rate (6.3%) is virtually identical to the 6% and 4.5% complication rates reported in the 2005 and 2010 Worldwide Surveys by Cappato et al.3,4 The complication rate is also very similar to the complication rates reported in recent analyses of the California State Inpatient Database and a Claims Database of Medicare Beneficiaries.5,6 It is also reassuring to me that several of the conclusions of this study, such as the increased risk of complications in women and in the elderly, are well aligned with data I and others have published from our single-center ablation registry.7,8

I believe that the results of this study are unique, important, and sobering. The uniqueness of this study rests in its size and scope, as well as the fact that these are “real-world” data obtained from smaller hospitals and lower volume operators. More than 80% of the 93,801 AF ablation procedures were performed by operators with an annual AF ablation volume <25. The importance of this study results from the significance of these findings. As physicians, we are all bound by the phrase “Primum non nocere,” for “first, do no harm.” As electrophysiologists, we perform AF ablation procedures to improve quality of life.

A 6.3% overall complication rate (not including serious delayed complications, such as pulmonary vein stenosis and atrial esophageal fistula) and one in-hospital death for every 238 patients undergoing AF ablation is not in keeping with the results of this study are sobering on many fronts. First, it appears that complication rates of AF ablation when viewed broadly are not falling and in fact may be increasing.
in which our complication rate has dropped from 11.1% to 1.6% over a 10-year period, with no deaths. Furthermore, in the past 5 years, there have been no complications with a permanent sequelae. Second, complication rates were age related, increasing to 9.4% in patients older than 80 years old. To the extent that advanced age is the most powerful predictor of AF, the clinical implications of this finding should be clear to all. Third, complication rates were dramatically and powerfully affected by both operator volume and hospital AF ablation volume. Although perhaps predictable, the clinical impact of this finding is enormous because >80% of AF ablation procedures were performed by operators performing <25 AF ablation procedures per year. This annual AF ablation volume is below the volume recommended in the 2012 Heart Rhythm Society/European Heart Rhythm Association/European Cardiac Arrhythmia Society Expert Consensus Document that recommends that electrophysiologists should perform at least 50 AF ablation procedures during training and then should perform “several procedures for AF per month if they intend to remain active in this area.”

Finally, what are the implications of the results of this study for interested parties? First, the results of this study should remind electrophysiologists of the complexity of AF ablation procedures and the very significant risk associated with these procedures, especially when performed by inexperienced low volume operators. The successful complication-free performance of AF ablation procedures requires successful execution of a large series of detailed steps. These steps include proper patient selection, detailed attention to anticoagulation strategies before, during, and after the procedure, successful performance of a single or double transeptal puncture, careful sheath management to prevent thrombi and air embolization, precise catheter manipulation, and vigilant patient follow-up. At each of these steps, both technical skill and clinical judgment is required. In my opinion, only those operators who have a serious commitment to the field of AF ablation should perform these procedures. Even if adequately trained during an electrophysiology fellowship, it is not possible to maintain the skills and clinical judgment needed to safely perform this procedure with case volumes less than the recommended minimum of “several per month.”

Second, the results of this study should be considered by hospital committees that grant clinical privileges. Although there is an inherent conflict between the desire of hospitals to perform more revenue-generating procedures and the granting of clinical privileges, in the long term, the public is not well served if these privileges are granted to operators who do not have the skills and commitment to perform these procedures safely. Third, the results of this study should be carefully considered by industrial partners who manufacture technology used for AF ablation. Clearly there is room for both the perfection of current ablation technologies to make them more “user friendly” and the development of new ablation technologies, but it is notable that high volume operators appear to be able to use currently available ablation technology safely and effectively. Finally, the results of this study need to be considered by patients who are making the final decision concerning who will perform their ablation procedure and where it will be performed.

At the end of the day, I think this paper is a welcome addition to the literature. Not only does it provide new and important information concerning complications of AF ablation, but it also helps launch an important discussion among those interested in this rapidly growing field.

Disclosures
None.

References

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Hugh Calkins

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