CARDIOVASCULAR PATHOLOGY: SURGERY AND INTERVENTIONS.

Proceedings of the Third Moscow International Course

May 16–17, 2015

Editors
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Content

Opening Remarks

Leo A. Bockeria.

Dear colleagues,

Let me welcome you here in Bakoulev Center for Cardiovascular Surgery in Moscow for the third time. It is a great privilege for us to have such a wonderful team as it was also before. In my view, we have a very interesting program and here are the people in the audience, who would like to learn the new trends in cardiovascular surgery, interventional cardiology, electrophysiology. So you have an opportunity to share your knowledge and experience with the younger professionals.

Welcome again and I wish to all of us to have these two days applying new knowledge not only in medicine, but also around the city, around the country and culture.

Marko Turina.

Ladies and Gentlemen. Welcome to the III-d Moscow International Course: Cardiovascular pathology: surgery and interventions. We have invited a group of international experts to share with the most actual information on the treatment of cardiovascular pathology. Within two days a series of lectures and presentations will be presented. As in previous years we thank professor Leo Bockeria for the organization of this Course and financial support for this Course.

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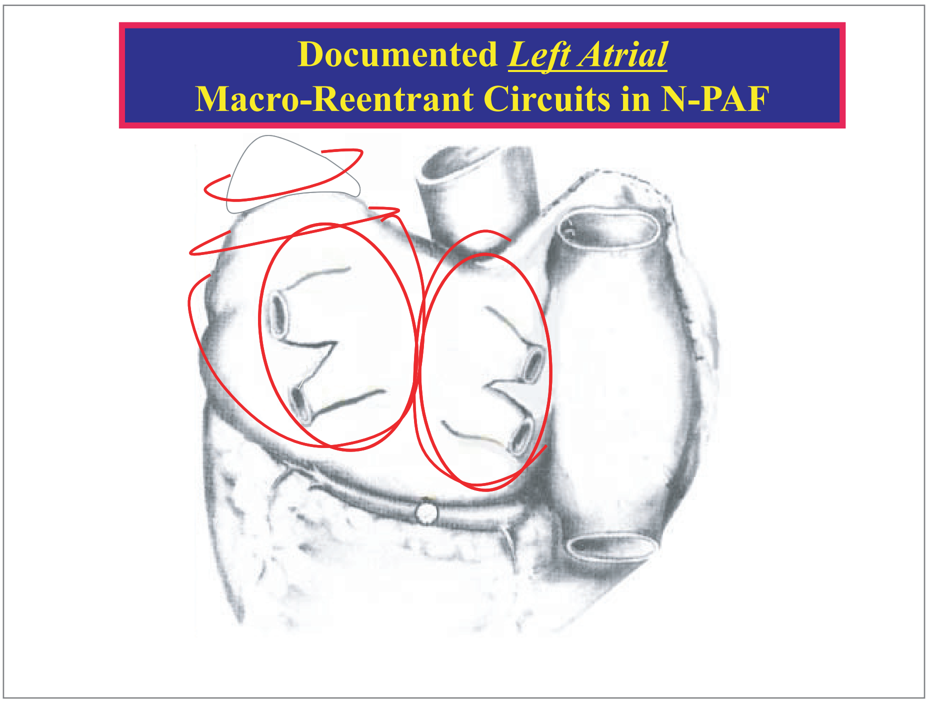

Fig. 27

Firstly a box lesion around the pulmonary veins, a lesion up to the left atrial appendage and a clip on it are performed. (Fig. 28)

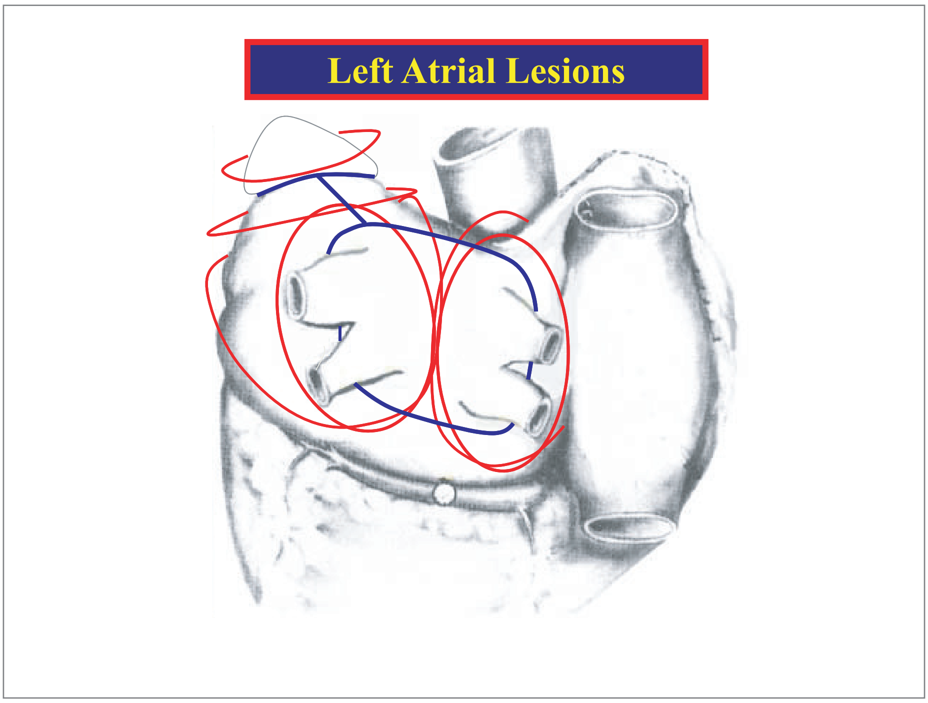

Fig. 28

Then some radiopaque vascular clips are put. If there is a reentrant circuit around here, a cardiologist has to go to the coronary sinus, make a lesion between those clips and solve the problem. (Fig. 29)

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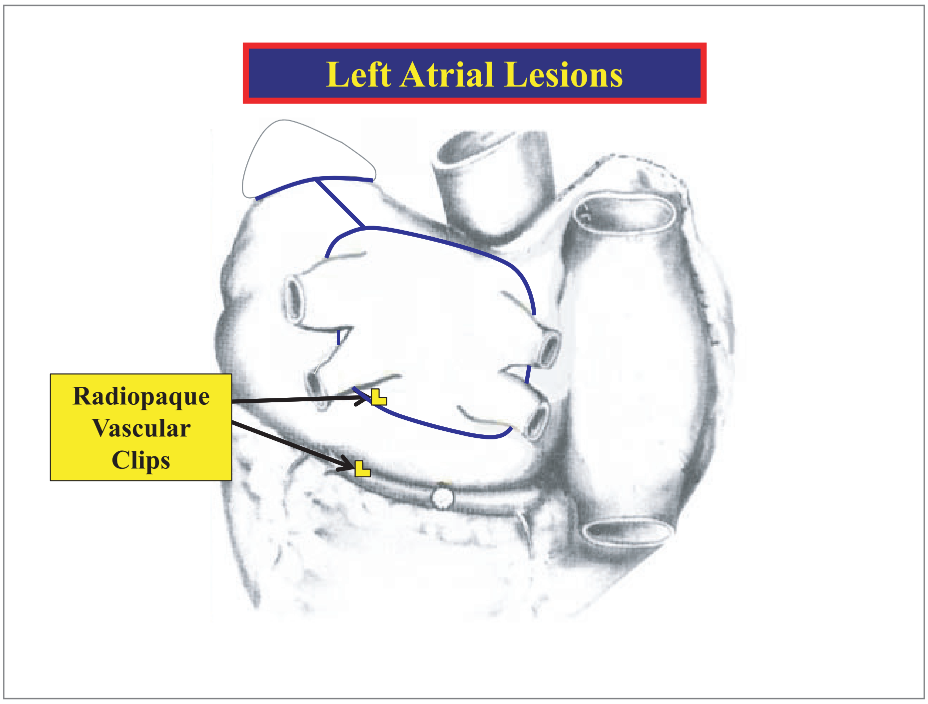

Fig. 29

On the right side we documented right atrial macro-reentrant circuits. I have shown Haissaguerre this slide and asked if he agrees with the documented reentrant circuits and he said "yes". Now almost all of them use the cavo-tricupid isthmus. (Fig. 30, 31)

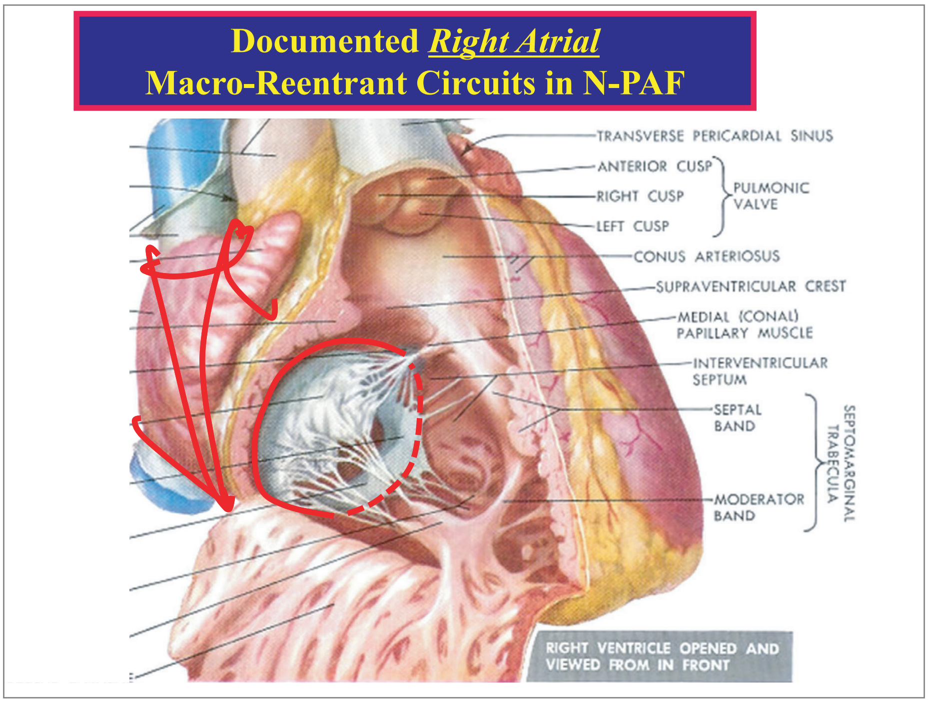

Fig. 30

So the initial thoracoscopic procedure would be the box lesion in the left, lesion up to the left atrial appendage, put a radiopaque vascular clip, SVC to IVC lesion up to the right atrial appendage and stop. Notice that this is not the complete Maze procedure. (Fig. 32)

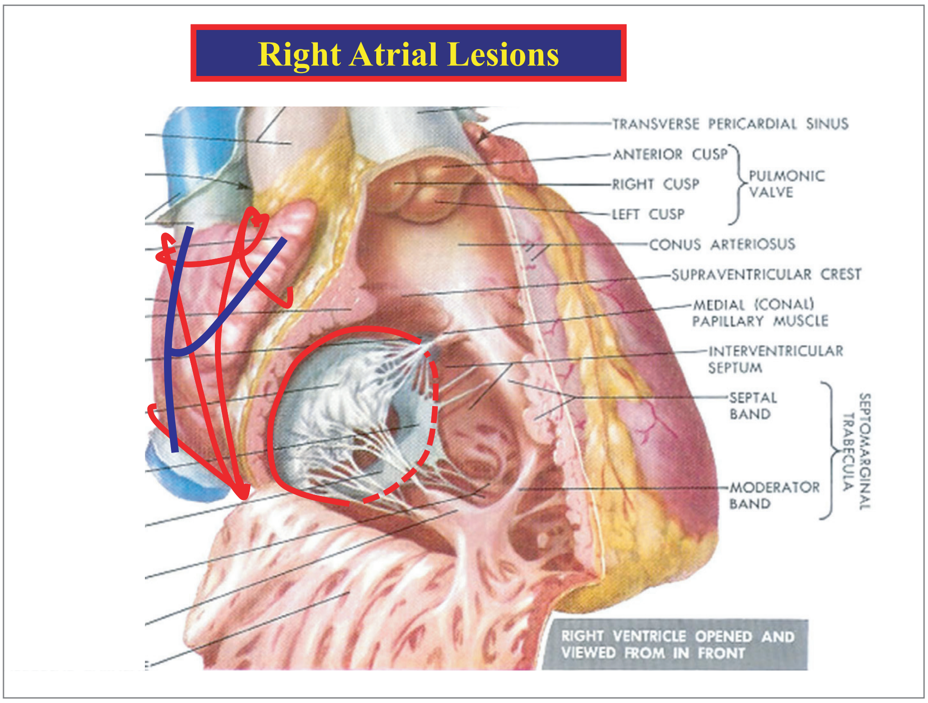

Fig. 31

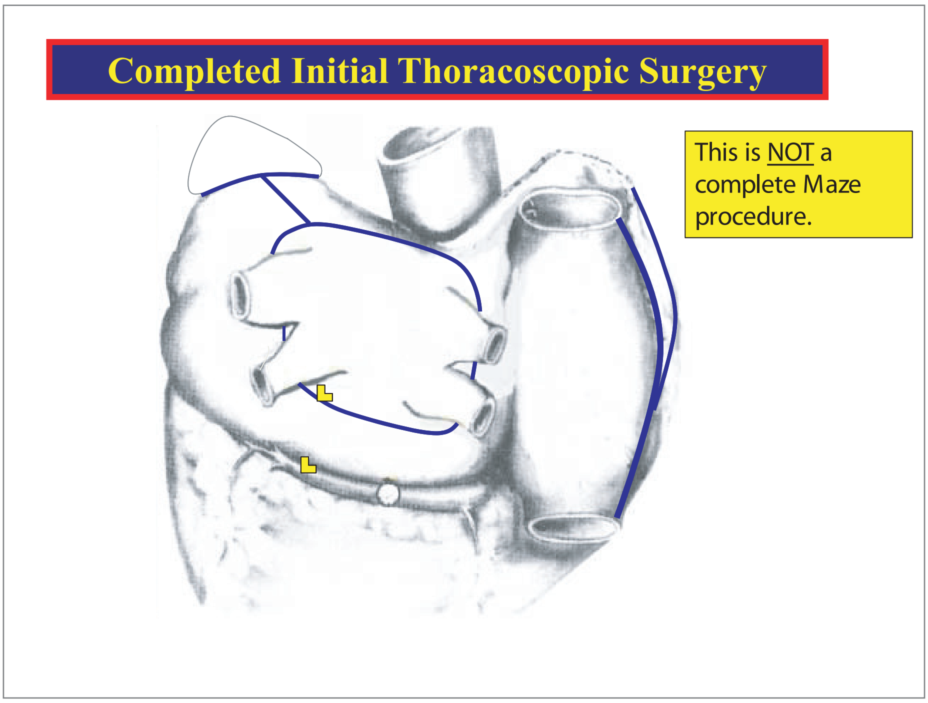

Fig. 32

After 6 weeks to 3 months the follow-up catheter ablation is performed. If a patient has perimitral flutter a lesion onto a coronary sinus with a catheter between the radiopaque clip and the myocardium inside is performed. That is the left sided Maze. (Fig. 33, 34)

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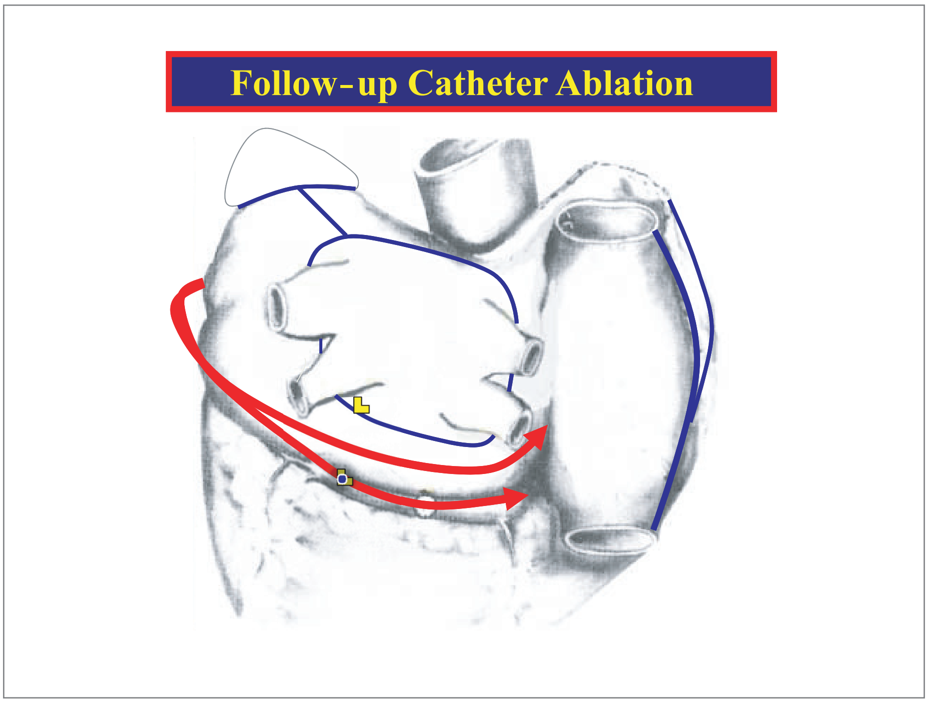

Fig. 33

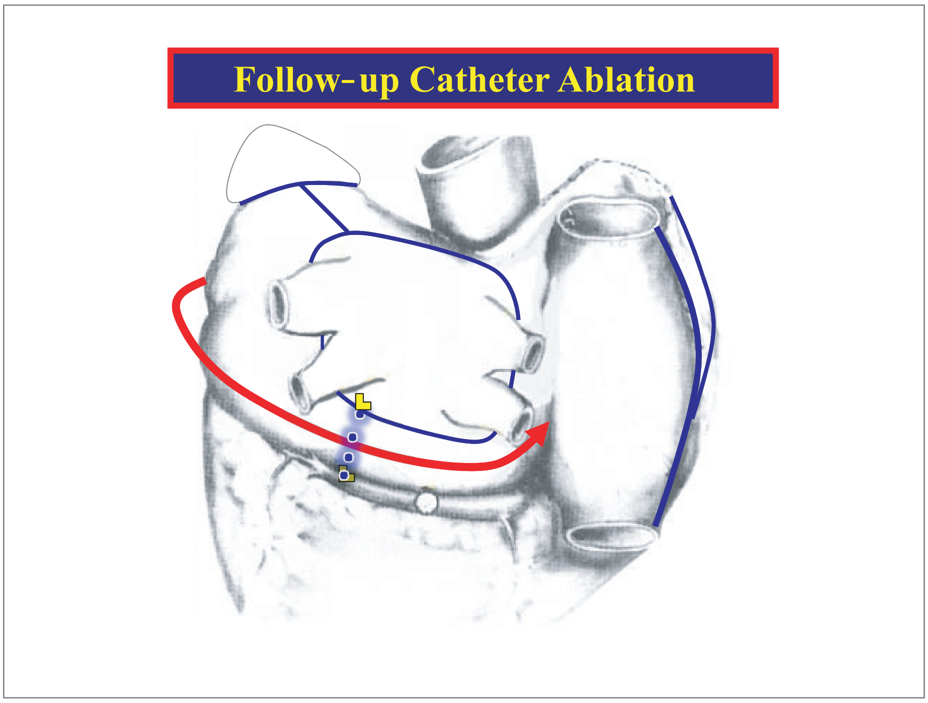

Fig. 34

If a patient has anything on the right side, the cavo-tricuspid isthmus line is performed. (Fig. 35)

The initial thoracoscopic surgery and follow-up catheter ablation. That in fact is a complete Maze procedure. (Fig. 36)

So the promises of hybrid Maze procedure are:

– Outcomes for the catheter ablation of AF will not improve until better catheter tools are developed.

– New off-pump thoracoscopic procedures make surgery a viable option as the initial treatment for stand-alone AF, provided there is an obligatory follow-up catheter ablation.

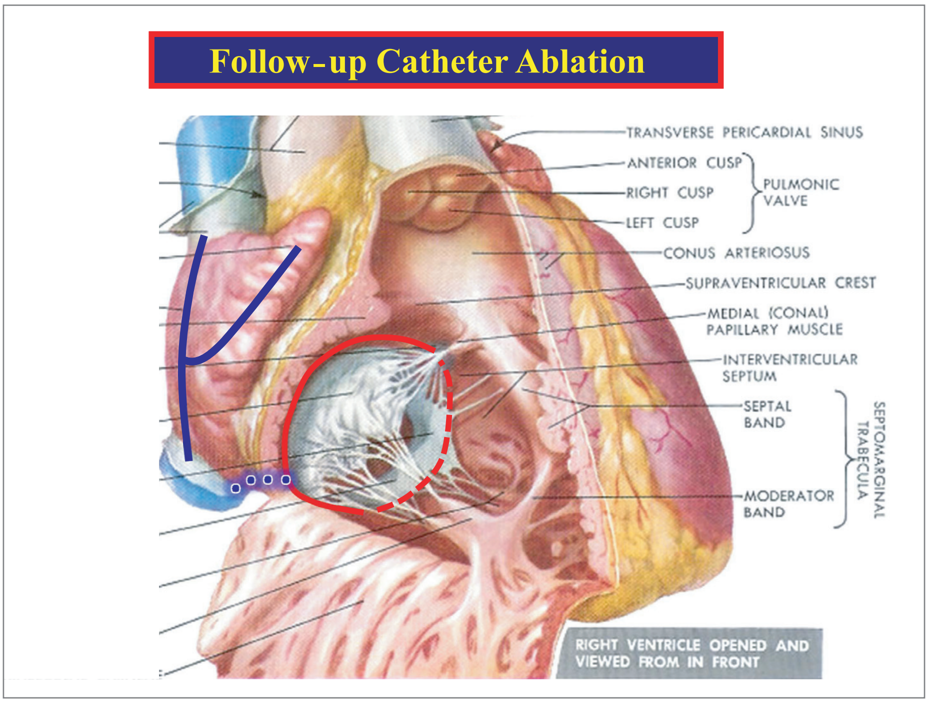

Fig. 35

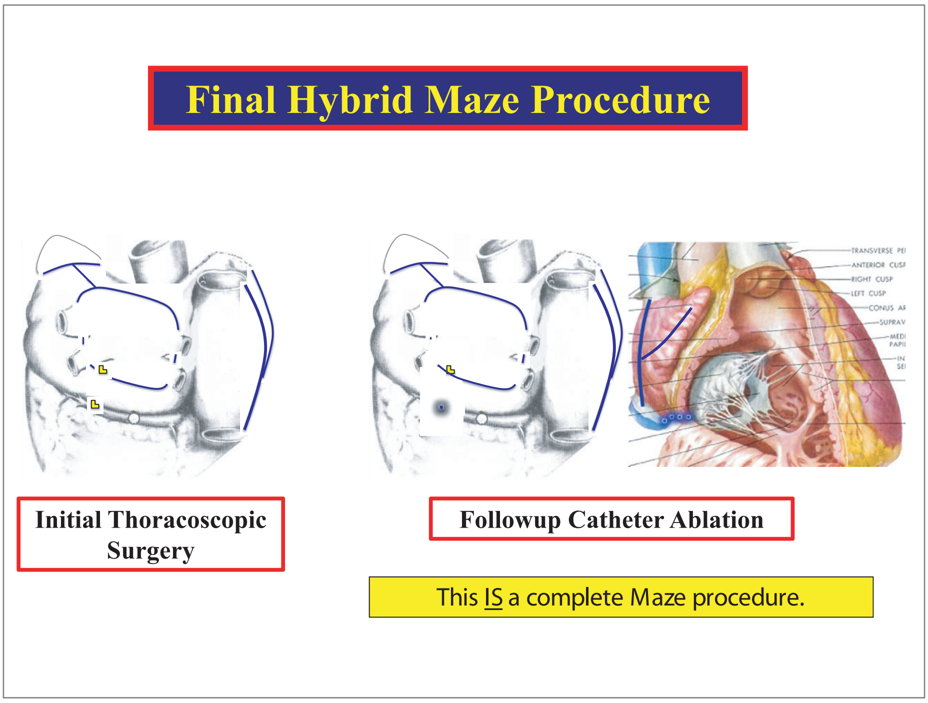

Fig. 36

– New "Hybrid Non-Maze Procedures" are based on EP mapping, a concept that has failed in the past. The risk is that these map-guided procedures will fail with time.

– "Hybrid Maze Procedures" should produce outcomes equal those for the open-heart surgical Maze Procedure.

Thank you.

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