

[MUSIC PLAYING]

PAUL FRIEDMAN: Hello, my name is Paul Friedman, I'm an electrophysiologist at Mayo Clinic, and this will be a one minute update on PVCs, how and when to treat. Premature ventricular complexes are very common, and in the normal heart often require no treatment. Evaluation includes a thorough history, physical, and 12 ECG to see whether there's a suggestion of structural abnormality, severe symptoms, malignant family history, or syncope. When present, a Holter to quantify the number of PVCs and an echocardiogram are obtained.

If there are exertional symptoms, a stress test is helpful. It's useful to divide the PVCs into two groups, multifocal, as shown on the left have multiple morphologies and mandate evaluation for underlying structural heart disease. PVC directed therapy is not typically needed in the underlying disease is treated as typically. On the other hand, unifocal PVCs in which they have a single morphology, may suggest a normal heart with an abnormal electrical focus. Treatment is indicated if it's symptomatic, if there's a drop in ejection fraction, or if there's left ventricular enlargement.

Consider referral to heart rhythm specialists in the presence of syncope, malignant family history, more than 10,000 PVCs a day, or failure to respond to medical therapy, such as beta blockers or calcium channel blockers. Normal heart therapy for PVCs includes Verapamil or other calcium channel blockers, or beta blockers, although these are frequently ineffective. Sodium channel blocking class 1C drugs, such as flecainide and propafenone typically are effective, but as many patients are otherwise healthy or younger, often catheter ablation is preferred.

For the most common right ventricular atrial morphology, catheter ablation success rate can exceed 90%. Whereas for other more difficult to access sites, it may be in the 80% to 90% range. This has been an update on PVC therapy. We look forward to any questions you may have.