

SURGICAL CORRECTION OF HOCM AFTER FAILED TRANSCORONARY ABLATION.

K.Borisov, L.A.Bockeria, A.F.Sinyov. Moscow, Russia.

Objective: The elimination of the outflow obstruction with a myocardial infarction may lead to impaired ventricular function and predispose patients to sustained ventricular arrhythmias. In some HOCM patients the level of obstruction may be in the mid-left ventricular cavity.

Methods: We present a 5 cases of HOCM surgical correction after failed transcatheter ablation of septal hypertrophy (TASH) in symptomatic patients. The level of obstruction was in the mid-left ventricular cavity and thickness of IVS was maximal in middle part. Follow-up (1 year after TASH) showed no any symptomatic improvement and all patients had severe symptoms and functional limitations (NYHA class 3). Ventricular arrhythmias were registered by Holter monitoring after TASH in all patients. All patients were operated on using our technique. The excision of the hypertrophied area of the interventricular septum causing midventricular obstruction was performed from conal part of right ventricle in upper third part of IVS and in middle part anteriorly of the moderator band but without penetration into the left ventricular cavity. This excision of IVS implies avoiding the damage of His bundle right branch.

Results: Follow-up echocardiography showed a significant decrease of intraventricular gradient after surgery from $83,2 \pm 11,8$ to $7,1 \pm 4,8$ mmHg, the septal thickness in middle part of IVS was reduced $30,3 \pm 3,1$ versus $16,2 \pm 2,3$ mm. Significant symptomatic improvement (NYHA class 1) was noted postoperatively in all patients. Ventricular arrhythmias were not registered. Sinus rhythm was noted in all pt.

Conclusion: This method is a safe and effective technique for surgical correction of HOCM with severe hypertrophy and complications.