

Europe encompasses a very large but diverse EP community, including physicians with various backgrounds and specialties coming from many countries and centres, with inherent differences regarding clinical practice, implementation of guidelines and their legal implication, access to modern therapies, and health economic systems.

Ideally, patient registries can capture such differences in patient management and thereby improve quality of care. Registries are, however, often associated with significant efforts and cost for the healthcare community, and seldom gives a quick insight into the clinical practice or their adoption to guidelines. As the Scientific Initiative Committee of the European Heart Rhythm Association (EHRA), we have continued to publish the so-called 'EP wires'. These are surveys, consisting of short questionnaires with 15–25 questions, accessible via the Internet for centres which voluntarily has declared their interest to participate in EHRA's, Electrophysiology (EP) Network. The aim with these EP Wire surveys is to provide a quick insight into current clinical practice and adoption to guidelines in the EP community in Europe. Well aware of and recognising the limitations with these surveys, it is our believe that by spreading the results and demonstrating regional and/or geographical differences regarding use or access to modern therapies, it may hopefully improve the situations for many of our patients and colleagues. Such surveys may also recognize unmet needs for education.

The aim of this specific EP Wire survey was to provide insight into current practice regarding the management of paediatric arrhythmias in Europe. The survey was based on a questionnaire sent via the Internet to the EHRA, EP Network Centres. We did not intend to analyse practice among paediatric EP centres exclusively. Furthermore, surveys can only reflect the past and what is asked for in a limited number of centres. We do, however, welcome the participation of paediatric EP centres and the EP network can be reached on our website.

Our results are based on the non-paediatric EP community and in the results we stated: 'Catheter ablation of paediatric arrhythmias was exclusively performed by paediatric electrophysiologists in only 2.56% of the centres, while EP teams were multidisciplinary in 15.36% of hospitals or the same teams performed ablations in both children and adult patients (82.05%)'. This means that most centres do perform paediatric ablation, even if they may not be the 'centres only specialized in paediatric arrhythmias'. We believe it is quite common in Europe.

Given the limitations with both surveys and registries, the former being based on physician's perception and the latter most often being on a

voluntary basis, we still believe that many of these EP wires and registries contribute to an increased awareness of differences in healthcare and educational needs.

Correct that none of the authors are paediatric cardiologist, and electrophysiologists only but many with wide experience in paediatric catheter ablation procedures and related publications.³ The volume of ablation procedures performed is the key for a high quality. We believe that our survey supports the need for a continued collaboration with the paediatric EP community and we welcome a corresponding survey, or a Registry, involving ALL centres performing paediatric ablations.

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Left atrial appendage closure to prevent stroke in patients with atrial fibrillation: a call for the heart team approach

With great interest we read the EHRA/EAPCI expert consensus statement on catheter-based left atrial appendage (LAA) occlusion.¹ It is important to emphasize that the seminal efforts to address the LAA originate from open-heart surgery, specifically Madden's seminal report on surgical LAA amputation in 1949, which has driven innovation and the development of less invasive catheter-based approaches to achieve LAA closure.

Current data have led to early clinical adoption of this seemingly attractive therapy. In this regard, the incorporation of surgically applied epicardial closure devices may offer an interesting adjunct for selected patients. Unfortunately, the expert panel just states that '... In addition, a number of other minimally invasive surgical and percutaneous devices including the AtriClip, Cardioablate, and Aegis, are at various stages of advanced animal studies or first in man experiments ...'.¹

We believe it is important to also include the surgical devices in this statement. The clinical experience with these surgically placed devices is substantial and can be found in many peer reviewed journals. First, the AtriClip has been implanted in humans since 2007. Over 40 000 devices have been sold since CE mark and FDA approval. Data on this effective device are substantial.^{2,3} Next, the long-term imaging controlled data on the AtriClip further substantiate these positive results of complete and durable closure, presenting the first data on durability of LAA closure.³ Second, there is another epicardial closure device, the Tiger-Paw (MAQUET Medical Systems USA, Wayne, NJ, USA) approved by the FDA yielding similar short-term safety and efficacy results as the aforementioned AtriClip (Atricure, West Chester, OH, USA).⁴ Third, and most importantly, thoracoscopic LAA amputation with 3 months computed tomography control with a linear stapler has been reported in a stand-alone fashion by Ohtsuka *et al.*⁵ LAA stapler amputation has long been an integral part of surgical minimal invasive atrial fibrillation ablation. The results are summarized

in two review papers, reporting on over 1000 patients also highlight feasibility, safety and efficacy of routine surgical LAA amputation.⁶

Before any type of intervention, important anatomical and morphological considerations are mandatory to more accurately predict in which patients a complete and durable transcatheter closure is not likely to be achieved. In these cases, referral for minimally invasive surgical LAA closure should be considered as an option. We believe that only a more focused collaboration between cardiologists and cardiothoracic surgeons (the heart team approach) in regard to device and patient selection would enable a 100% successful LAA closure in all-comers. In regards to stroke prevention obviously more data, and ideally a prospective randomized trial would be necessary.

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