Dear Readers,

We have another great issue of the Journal this month. As I contemplated what my topic should be this month, the article by Dr. Will Sauer and colleagues from the University of Colorado entitled “Use of Isoproterenol for Assessment of Anterograde Accessory Pathway Conduction Properties in Sedated Asymptomatic Patients with Ventricular Pre-excitation” particularly impressed me.

This article has caused me to rethink my approach to the asymptomatic patient with the Wolff–Parkinson–White syndrome. Could many of the patients with asymptomatic ventricular pre-excitation that I previously considered “low-risk” for sudden cardiac arrest actually be “high-risk” patients in a catecholaminergic state?

While the number of patients with asymptomatic WPW studied in this article was limited, remarkably an isoproterenol infusion not only enhanced accessory pathway conduction in most patients but also allowed induction of supraventricular tachycardia or atrial fibrillation in many patients.

Does this mean these patients are at increased risk for sudden cardiac arrest? While the results of this study are provocative, unfortunately, we just do not know what these findings mean clinically. Certainly, our young and active patients with asymptomatic WPW could easily find themselves in a hyper-adrenergic state.

While on the subject of WPW, I have been very concerned lately that we are training a generation of EP fellows that may have limited experience in ablating accessory pathways. Recently, I have been evaluating many young applicants for new EP positions within Intermountain Healthcare. While most have extensive experience in device implantations and atrial fibrillation ablation procedures, surprisingly many of them have not had adequate training in ablating accessory pathways.

It is amazing just how much has changed in just the last 10-15 years. We have gone from where most EP fellows spent the majority of their time in the EP lab treating SVT or WPW patients to one where most have never seen some of the more unusual accessory pathways. What will this new generation of EPs do when they encounter their first septal or Mahaim fiber tachycardia in practice? Will they recognize the pathway? Will they be able to safely treat the patient?

For many new EP fellows coming out of training today they will need to be carefully mentored for a number of years after training until their skills are polished and they have seen these unusual pathways in practice. I am particularly concerned for new EP fellows taking jobs where they will be isolated as the sole EP for their hospital.

When I meet with EP fellows at various conferences, I am often asked what they should look for in their first job. My advice is always for them to carefully select a position where they can receive the appropriate mentorship and hone their skills. Unfortunately, I have seen too many cases over the years where the first job out of training did not end well. While many EP fellows coming out of fellowship in June will have difficulties finding jobs, it is my sincere hope that they can each find a position that will enable them to fully develop their skills.
As part of developing the skills of physicians treating patients with heart rhythm disorders, I hope that this edition of the Journal will continue to be a valuable resource. As always, I look forward to hearing what is on your mind.

Warm regards,

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