**Cardiac Resynchronization**

**INTRODUCTION:**

This gentleman had cardiac evaluation at another cardiac center in 10 months back. 24-hour Holter at that time showed one episode of non-sustained ventricular tachycardia. This was followed by a second episode of non-sustained ventricular tachycardia on the Holter recording at the previous cardiac center. At the present cardiac center, he was referred for further evaluation and management of this arrhythmia.

**PHYSIOLOGICAL TESTING:**

Angiography revealed normal coronary arteries. The patient was referred to our hospital for further evaluation and management of this arrhythmia.

**THERAPY:**

The most appropriate therapeutic option was to use a cardioverter device, the second best option of biventricular pacing with a left infraclavicular incision. Subclavian vein catheterization was performed after transvenous implantation of atrial synchronized biventricular pacing through a left infraclavicular incision. Subclavian vein catheterization was performed after transvenous implantation of atrial synchronized biventricular pacing through a left infraclavicular incision.

**CASE REPORT:**

Patient was taken up for transvenous implantation of atrial synchronized biventricular pacing through a left infraclavicular incision. Subclavian vein catheterization was performed after transvenous implantation of atrial synchronized biventricular pacing through a left infraclavicular incision.

**DISCUSSION:**

Resynchronization therapy using an atrial synchronized biventricular pacing system is an effective treatment option for patients with atrioventricular conduction disturbances and left ventricular dysfunction. The success rate of this procedure is high, with a low rate of complications. However, long-term follow-up is necessary to evaluate the durability of the pacing system and the improvement in cardiac function.

**CONCLUSION:**

Resynchronization therapy using an atrial synchronized biventricular pacing system is an effective treatment option for patients with atrioventricular conduction disturbances and left ventricular dysfunction. The success rate of this procedure is high, with a low rate of complications. However, long-term follow-up is necessary to evaluate the durability of the pacing system and the improvement in cardiac function.
The sutures in the valve have to be coiled out, and in the aorta, they have to be tied in. The leaflets are held in place with care, so as to avoid a purse string effect. The suturing procedure takes not more than 10 minutes, and the learning curve is very short or negligible. VAO can also be used in calcified aortas or the distal anastomosis first, an option that is not possible with the distal anastomosis first. We have had no postoperative ischemia, or perioperative events with the use of VAO.

Most emboli are noted with two full weeks of treatment and the risk of embolization is high and surgery may be indicated. The optimal timing of surgery for ACS remains indecisive. Various studies have showed the success rate of > 95%, although the incidence of procedure related mortality in acute MI patients declined considerably with the increasing use of fibrinolytic agents (DVI) for acute MI. Prophylactic anticoagulation is done on a stopped heart than on a beating heart. This deleterious effect is due to the acute event. The early invasive strategy incorporates coronary angiography for all stable patients within 48 hours of presentation. The conservative strategy of prolonged clinical symptoms (≥3 months), cyanotic congenital heart disease, previous infection, and embolisation are common. Valve surgery is a must as Antibiotic prophylaxis is mandatory for left sided infective endocarditis. Valve replacement is mandatory for left sided infective endocarditis. Prosthetic or previously damaged aortic or mitral valves. Infection is subclinical and is identified on echo. Echo may be useful in diagnosis of culture negative IE. TEE is the investigation of choice to look for and assess annular abscesses, fistula or leaflet perforation. All these are picked up by Staphylococcus epidermidis. Late onset prosthetic valve infective endocarditis during the first two months after surgery is frequently caused by Staphylococcus aureus – as this is more common in IV drug abusers. Staphylococcus aureus is a frequent cause of infective endocarditis in immunocompromised patients. The need for revascularization is based on diagnosing the culprit lesion and has shown to reduce the clinically relevant morbidity, especially for the elderly: a review of studies on patients older than 64, 69 or 74 years.

Staphylococcus species and HACEK organisms are important causative factors. Most emboli are noted with two full weeks of treatment and the risk of embolization is high and surgery may be indicated.

Studies of our patients in this series, to confirm their long-term patency. We are planning to follow up these patients and to repeat coronary angiography, the risk of embolization is high and surgery may be indicated. The one-year follow-up angiography showed a perfectly patent curve is very short or negligible. VAO can also be used in calcified aortas or the distal anastomosis first. We have had no postoperative ischemia, or perioperative events with the use of VAO.

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