A 42-year-old female patient was referred for ablation for high-burden (21.0%) premature ventricular contractions (PVC), with a narrow QRS duration and a prominent inferior frontal plane QRS axis (Figure A). During the procedure, the PVC target (Figure A), with a significant His-Purkinje potential preceding QRS onset during PVC and sinus rhythm, was located at the proximal left anterior fascicle (LAF; Figure). Due to a deep inspiration and a transient left bundle branch block, ablation attempt in the left ventricle failed (Figure B, Supplementary Figure 1A). The short distance between the target and the right coronary cusp (RCC) was noted (3.2 mm; Figure B). After assessment (Supplementary Figure 2), titrated ablation was performed from the RCC that eliminated the PVC successfully in 5.02 s (Figure B, Supplementary Figure 1B). During the observation period, the QRS morphology recovered (Supplementary Figure 1C). During an 18-month follow-up, the patient was free of PVC without antiarrhythmics.

In this case, the PVC originated from the proximal LAF near the left His bundle region. Ablation attempt around the region failed due to the high risk of conduction block. Fortunately, thanks to the short distance between the originating site and the RCC, ablation from the RCC was a viable alternative. For those idiopathic PVC originating from the proximal LAF, ablation in the RCC, requiring caution, may improve clinical practice with better stability and easier manipulation.

Disclosures
The authors declare no conflict of interest.

Reference

Supplementary Files
Please find supplementary file(s):