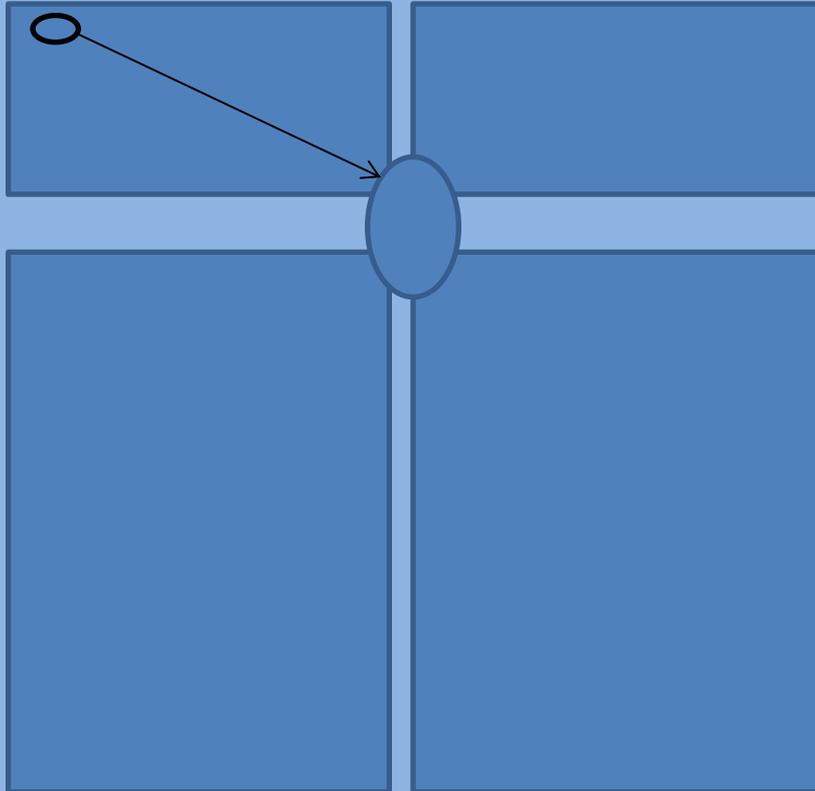


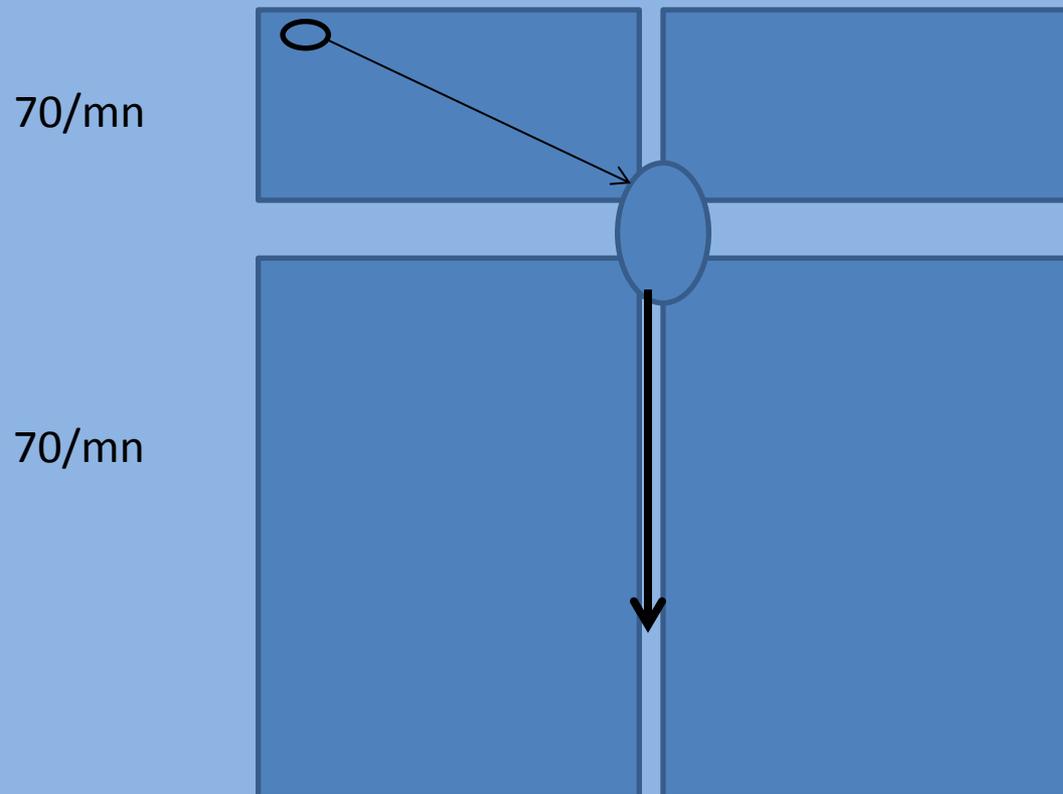
Les Tachycardies

A Bourdeloie J Taieb

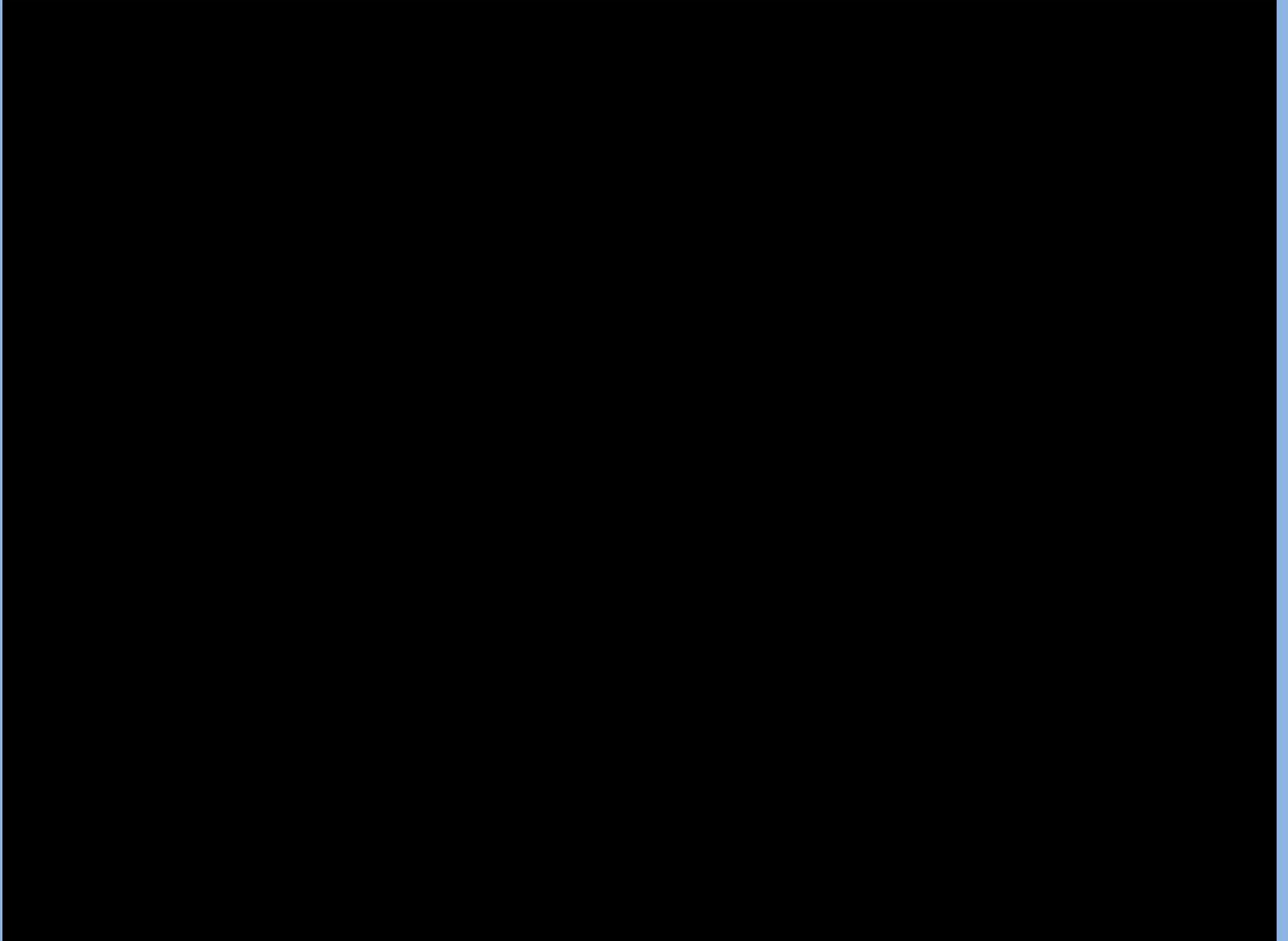
CH Aix en Provence



groupe de rythmologie du CNCH



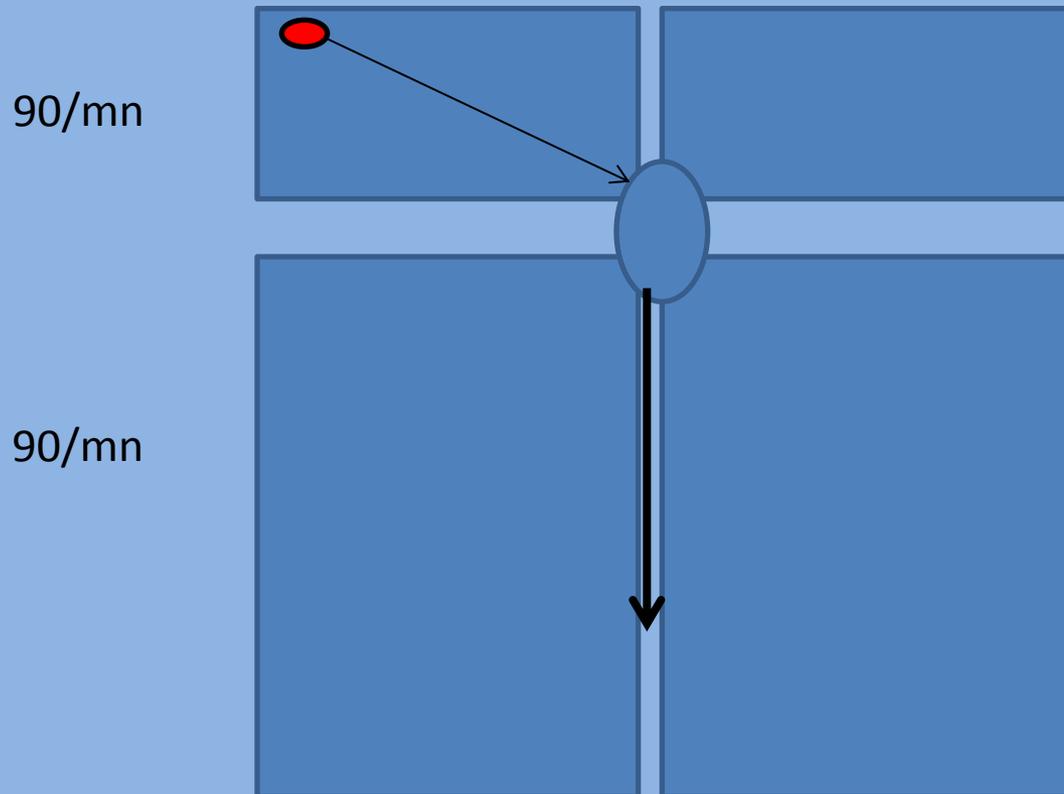
Rythme sinusal



Tachycardies = accélération du
rythme cardiaque

Tachycardie sinusale: nœud sinusal superactif

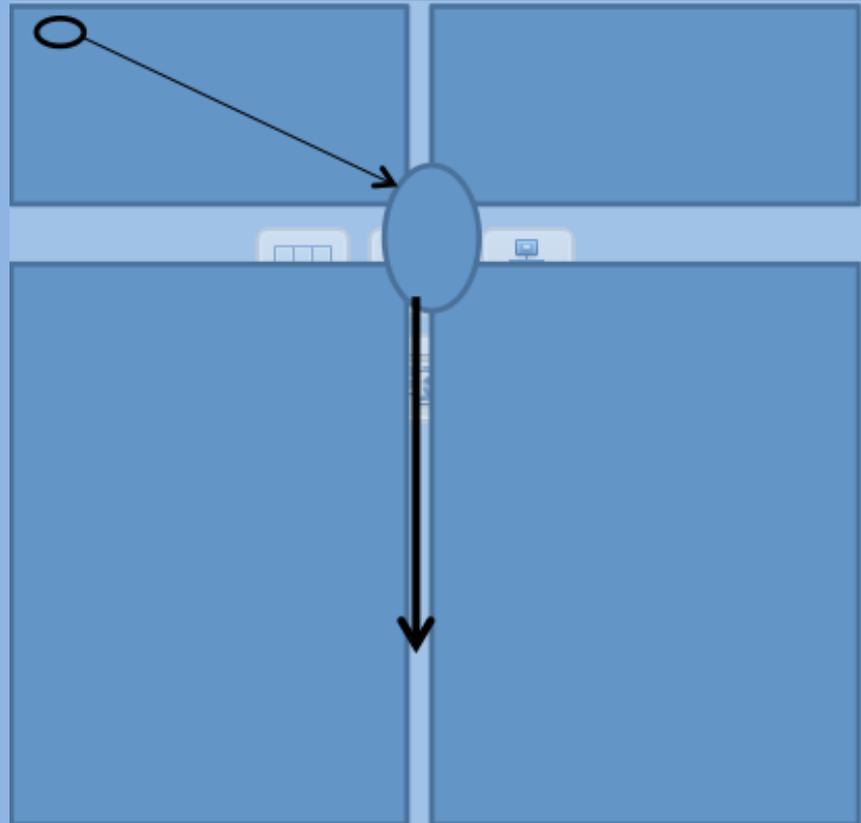
- par réaction à un stress physiologique
- Pathologique inapproprié



Tachycardie sur un court circuit ou foyer actif

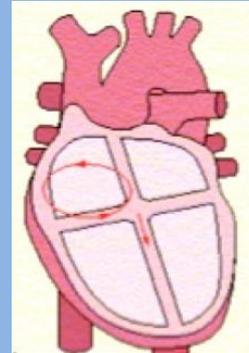
3 étages

- Atrial
- Jonctionnel
- Ventriculaire

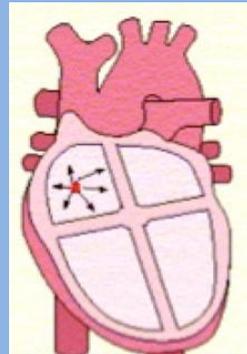


Tachycardies atriales

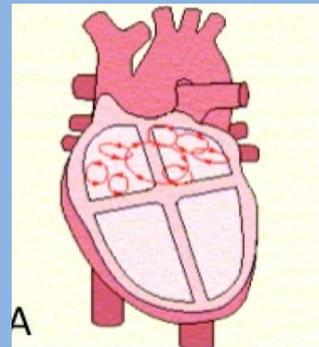
- Macroreentrée flutter



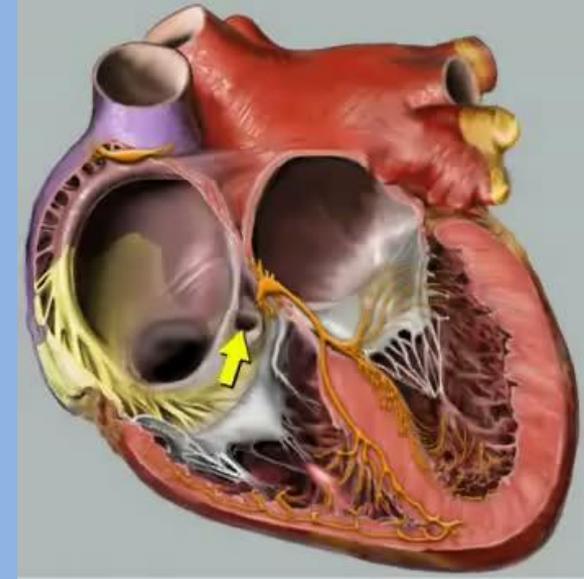
- Focales



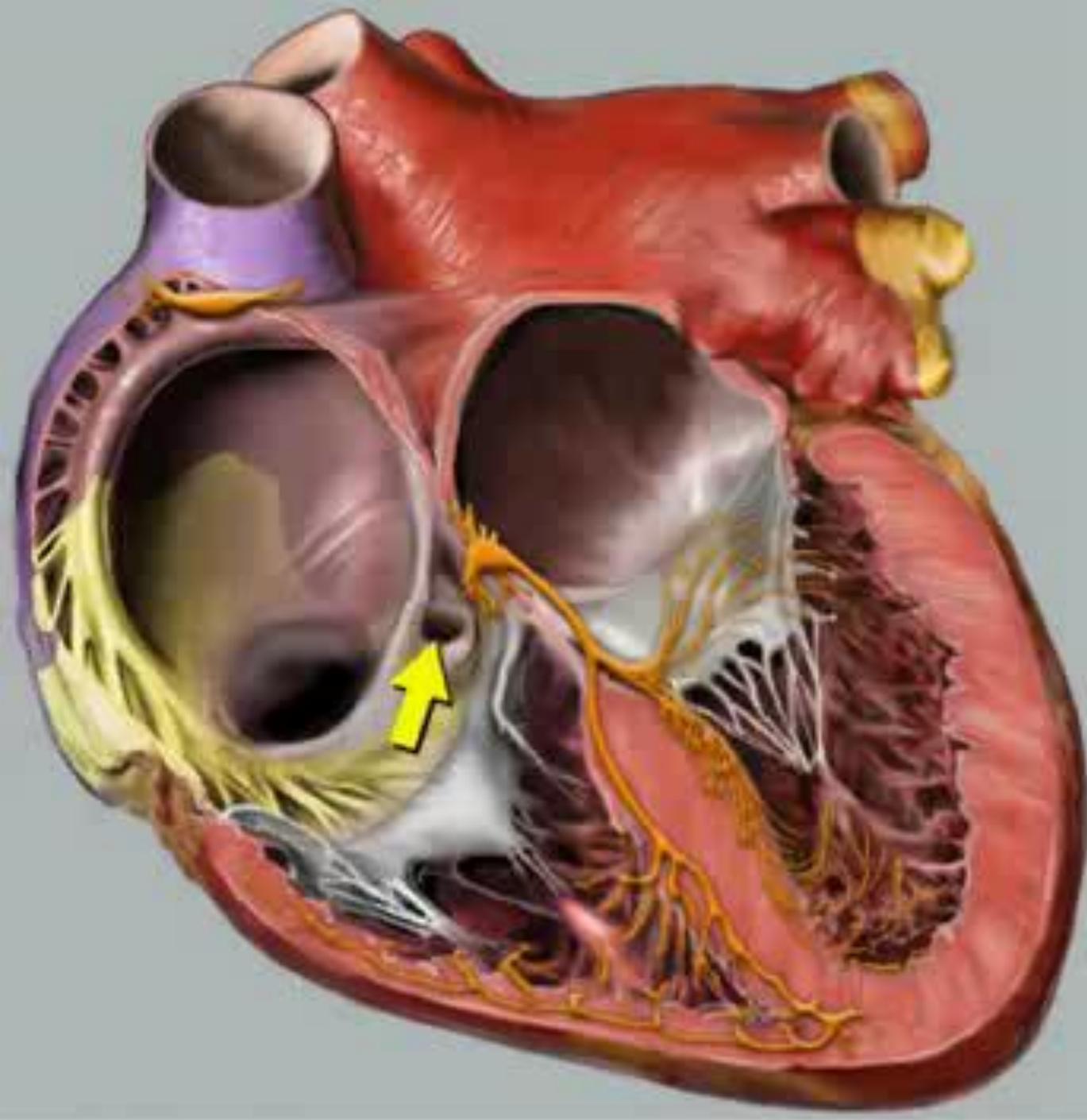
- Fibrillation auriculaire



Flutter Mécanisme



- Macroréentrée intra auriculaire
- septum dépolarisé de bas en haut
- descente le long de la paroi latérale par la cristaterminalis puis gagne le fond de l'OD.
- Traversée de l'isthme cavotricuspidien

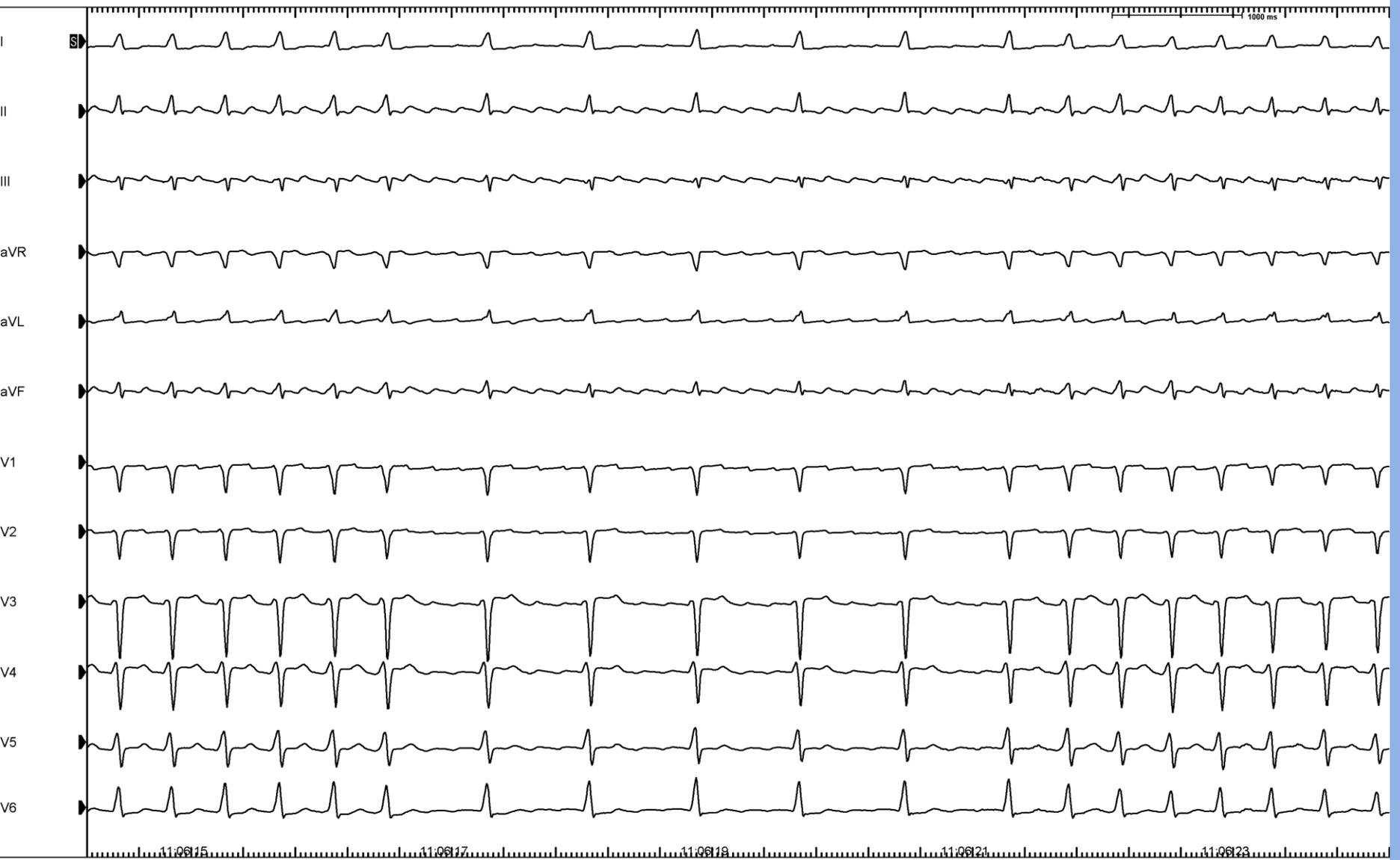


L'électrocardiogramme

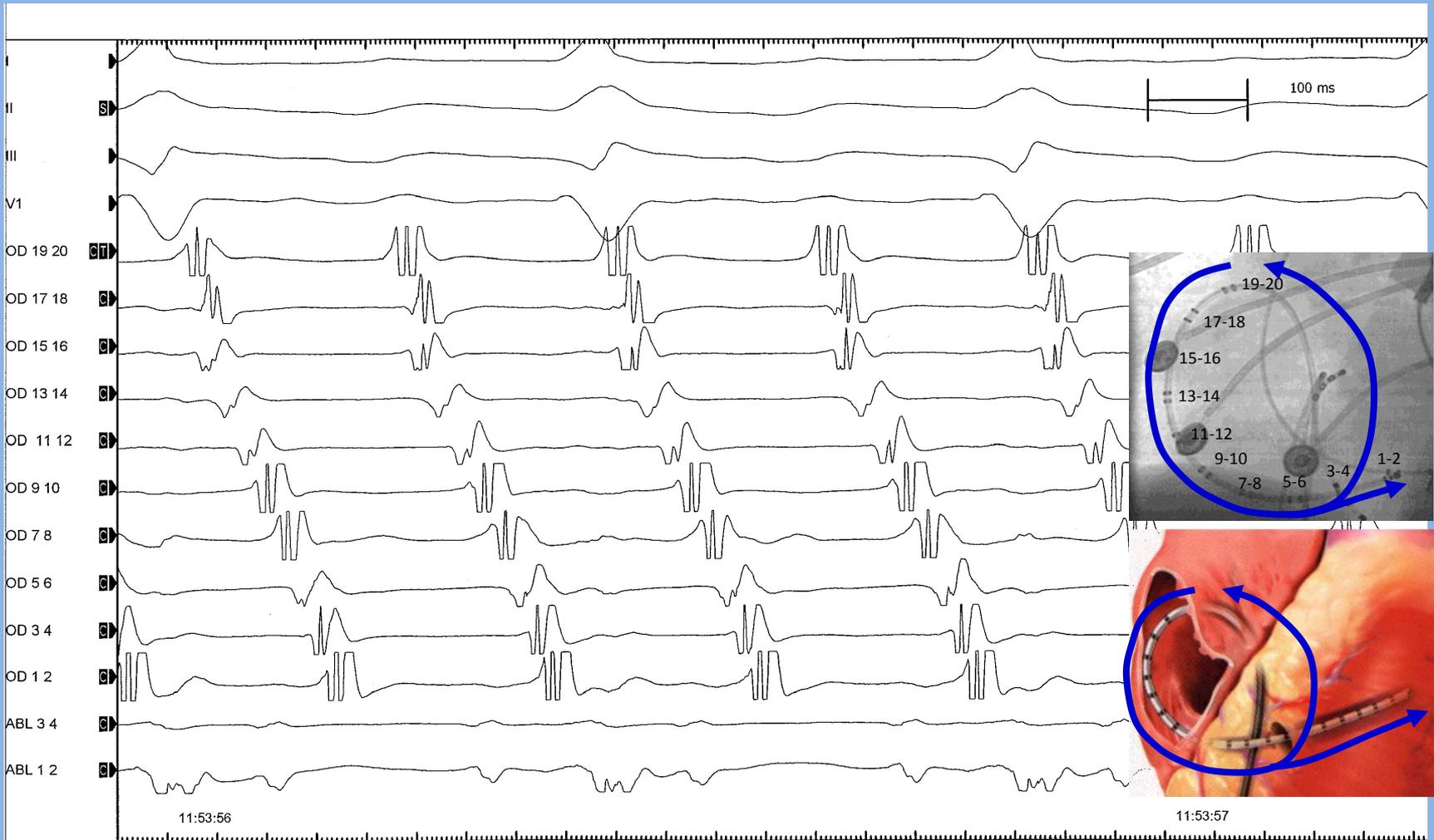
l'activité auriculaire(300/mn) se lit dans les dérivations D2,D3,et AVF

les ondes de flutter sont diphasiques sans retour à la ligne isoélectrique faisant évoquer des « toits d'usine ».

Massage sinocarotidien

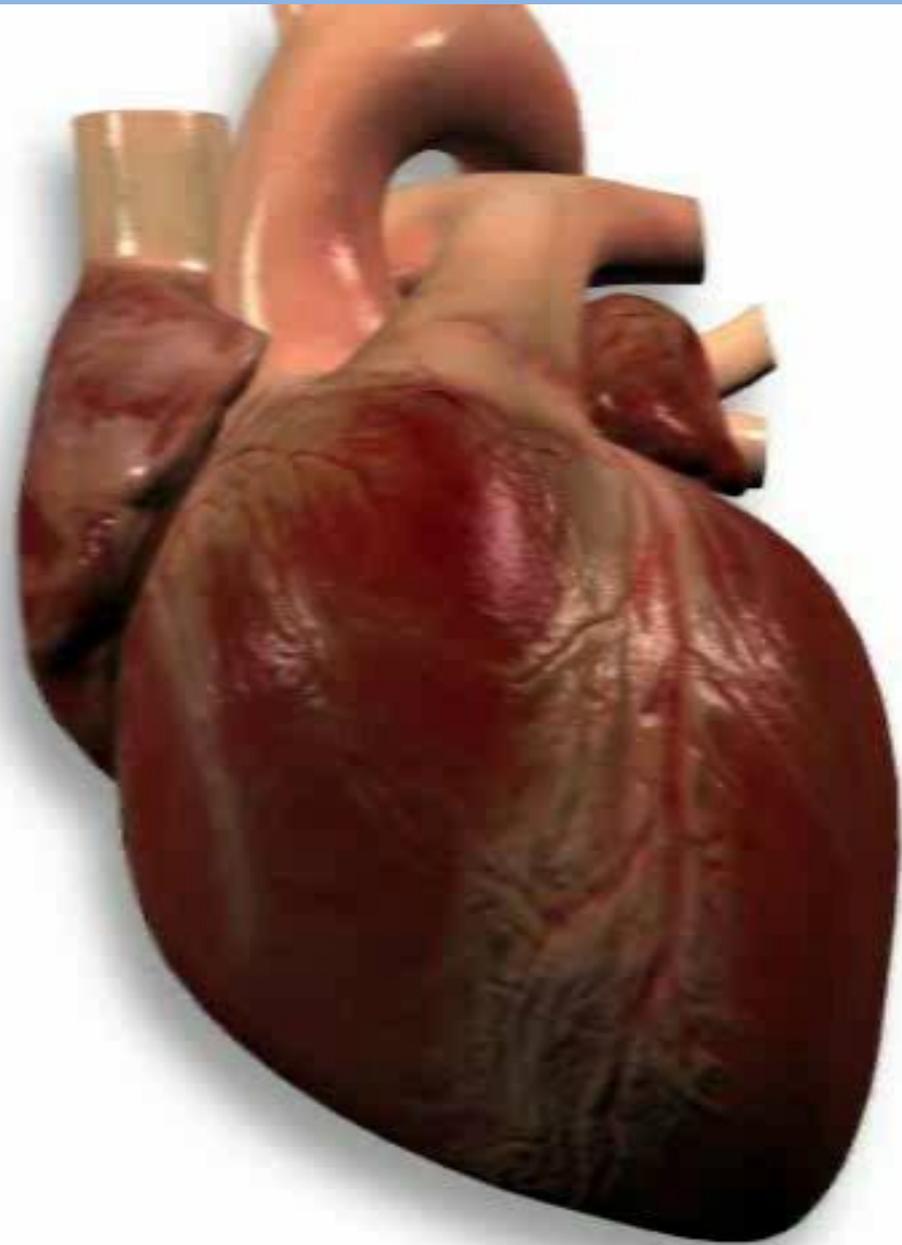


Activation de l'OD en flutter



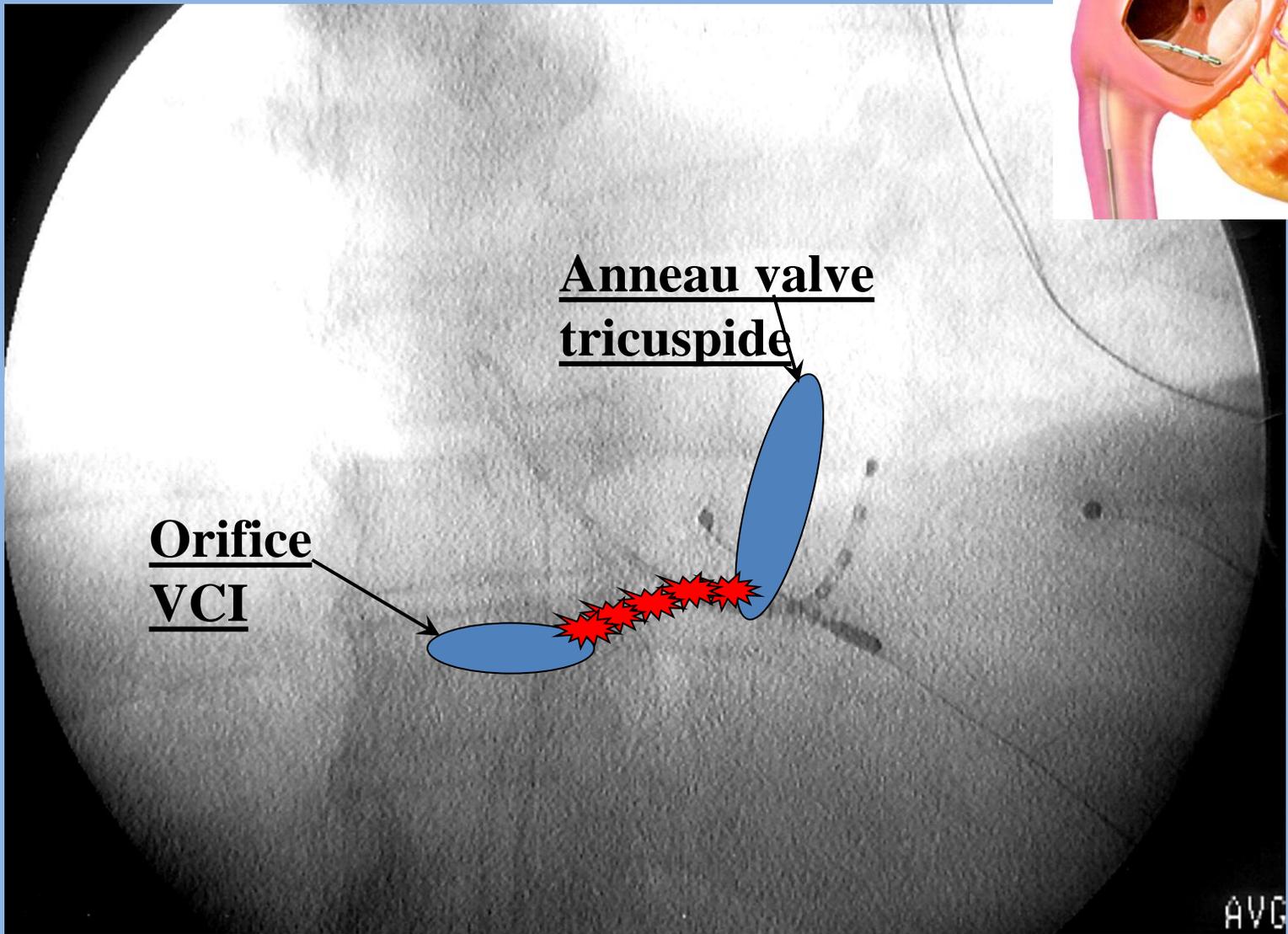
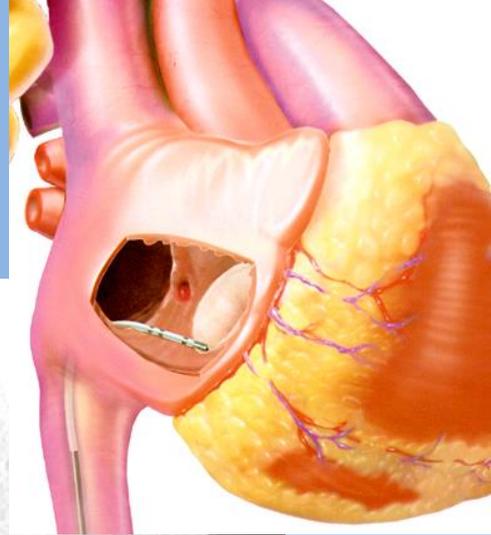
TRAITEMENT

- L'ablation endo cavitaire est le traitement de première intention.
- L'ablation est réalisée au niveau de l'isthme cavotricuspidien , voie de passage nécessaire au flutter.
- Cette voie est facilement accessible à la sonde qui est montée par la veine cave inférieure.



TROIS CRITERES DE REUSSITES

- Pendant l'ablation : passage en sinusal pendant le tir
- Non inductibilité par rafale, extrastimuli
- bloc de conduction dans l'isthme

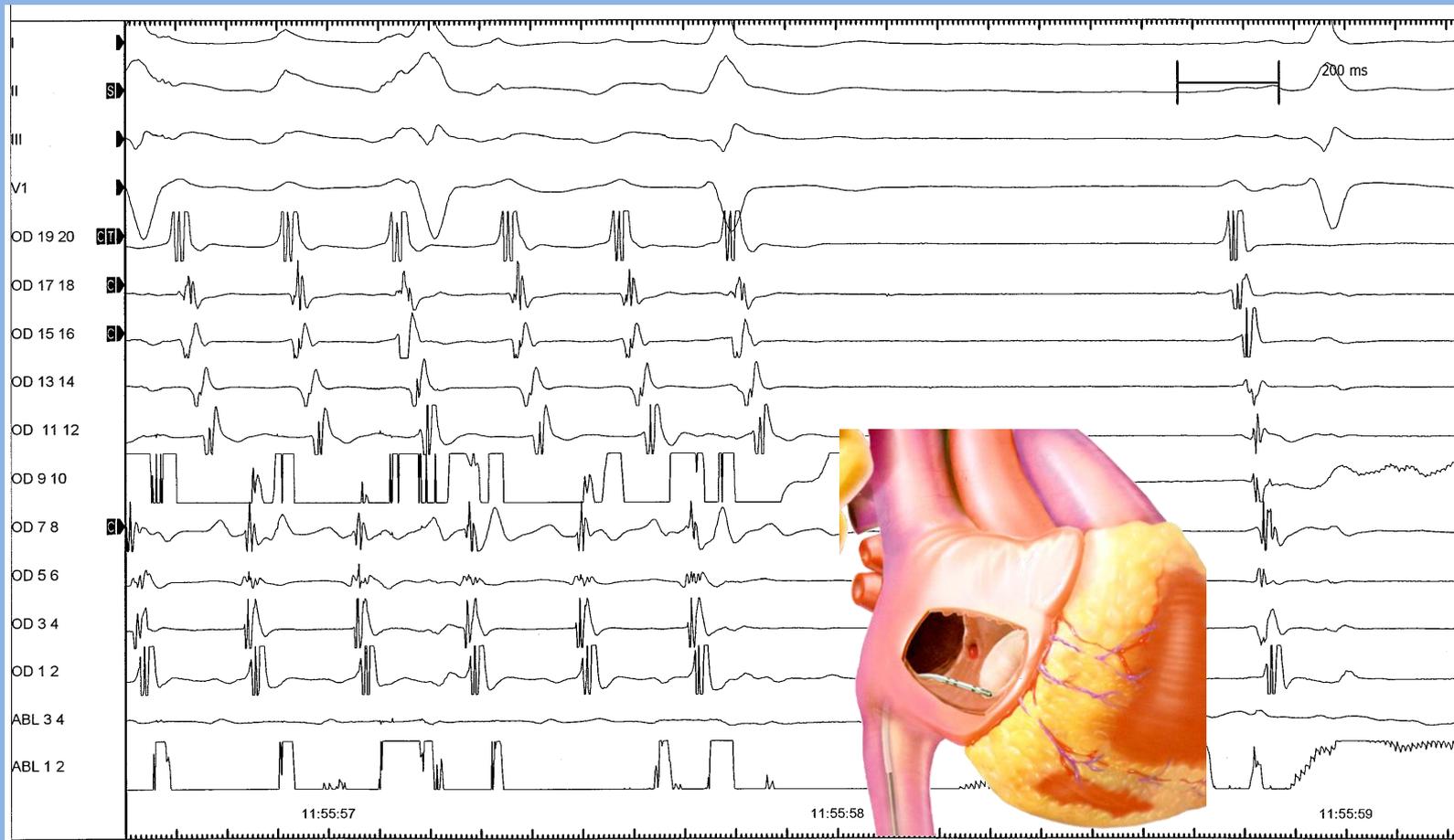


Orifice
VCI

Anneau valve
tricuspide

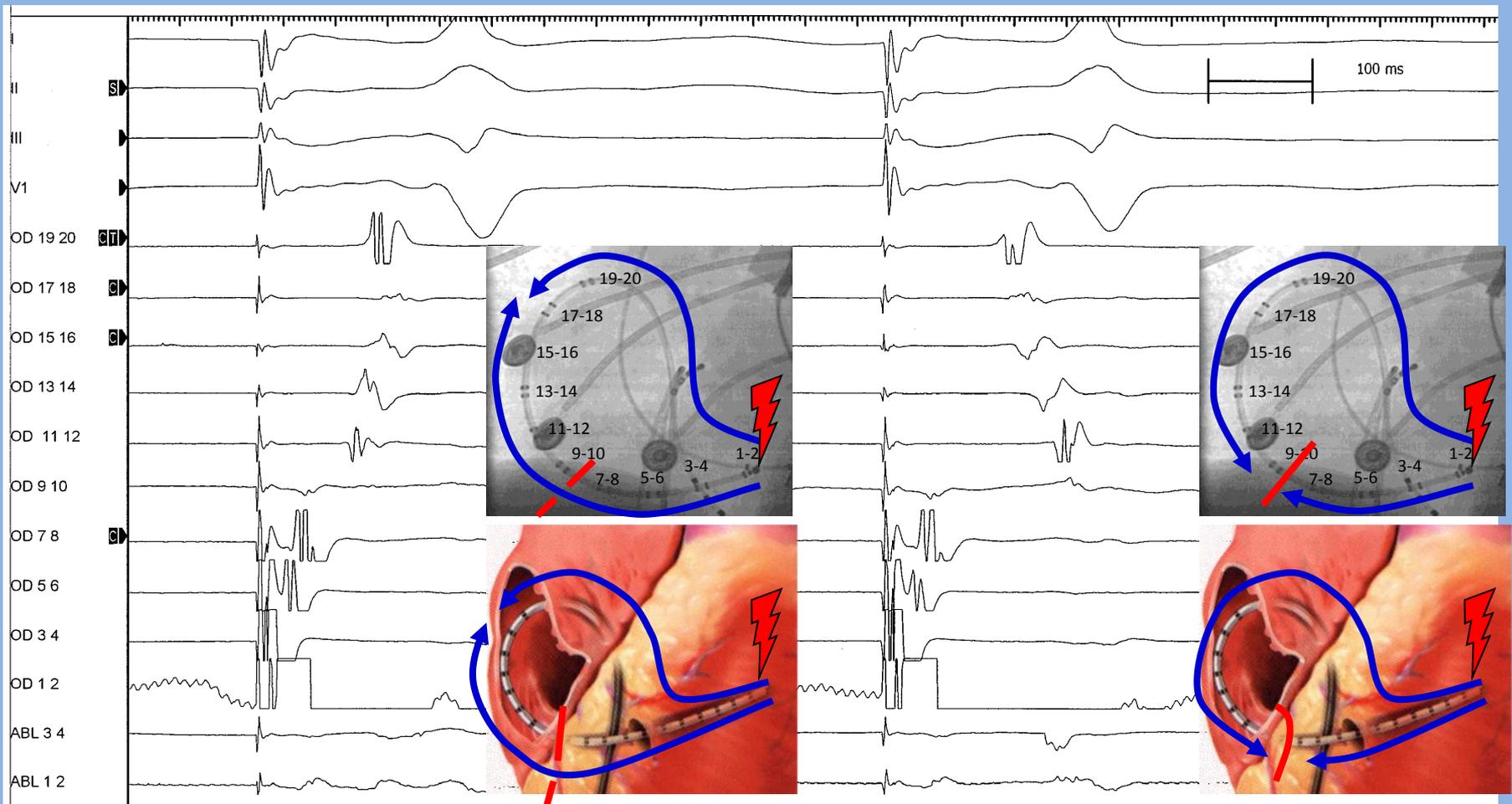
AVC

Arrêt du flutter en cours de tir

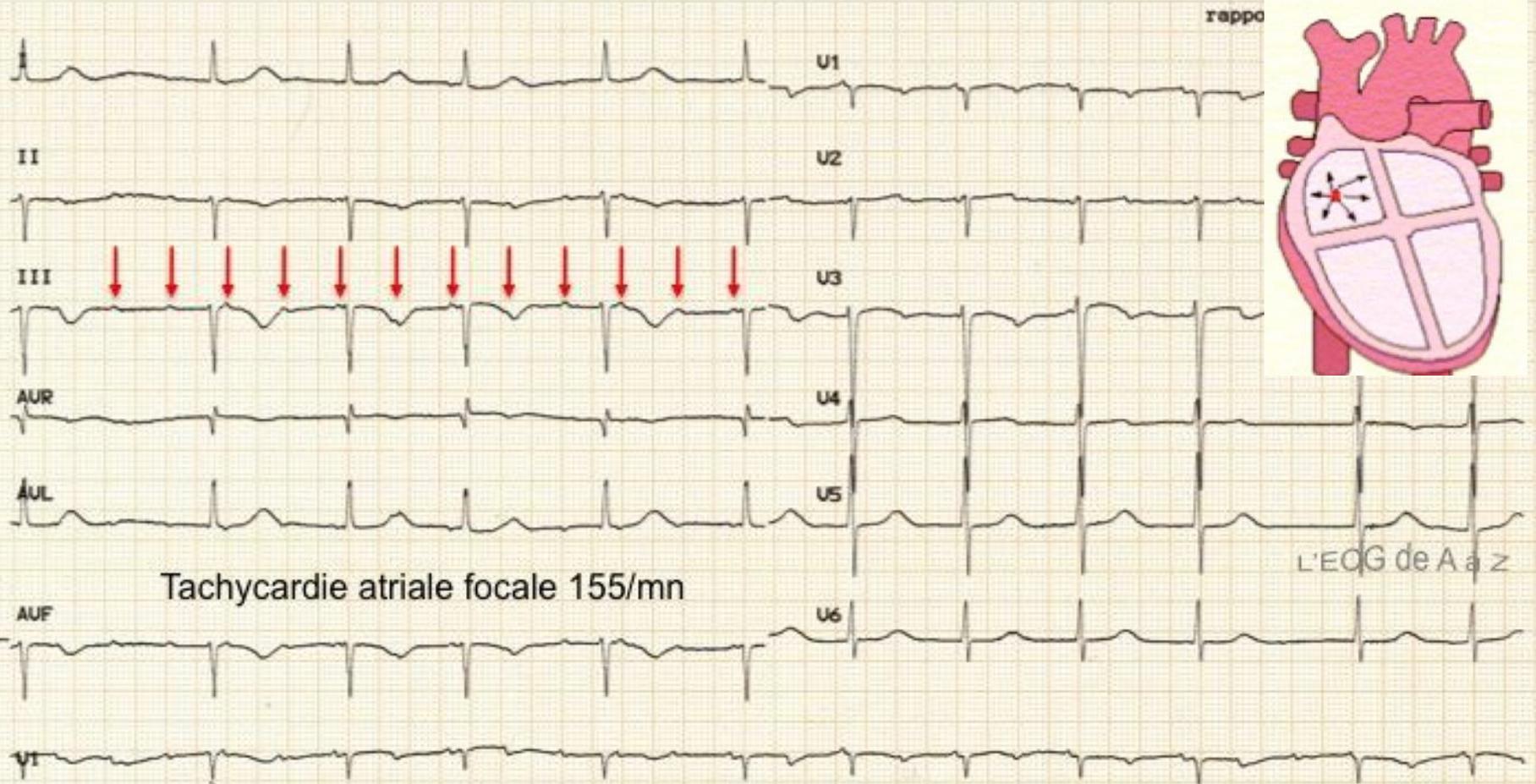


Bloc Succes

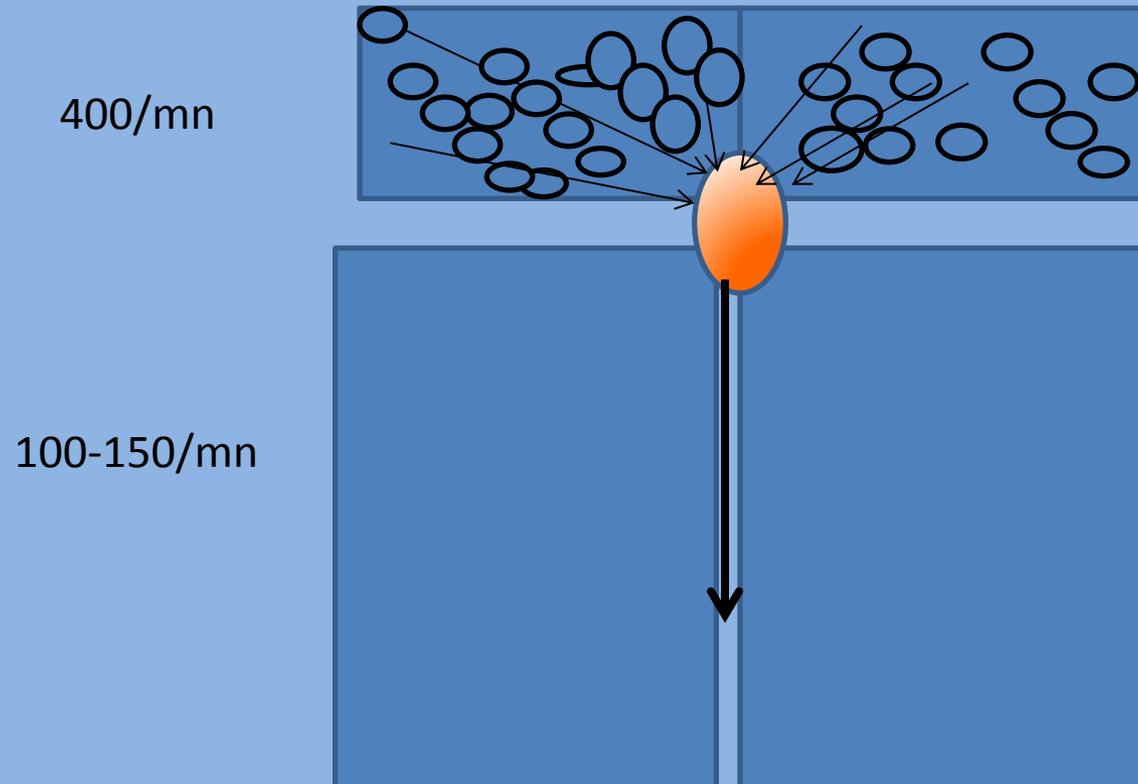
Mise en évidence de l'apparition d'un bloc de conduction isthmique en cours de tir



Tachycardie atriale focale



Fibrillation Atriale

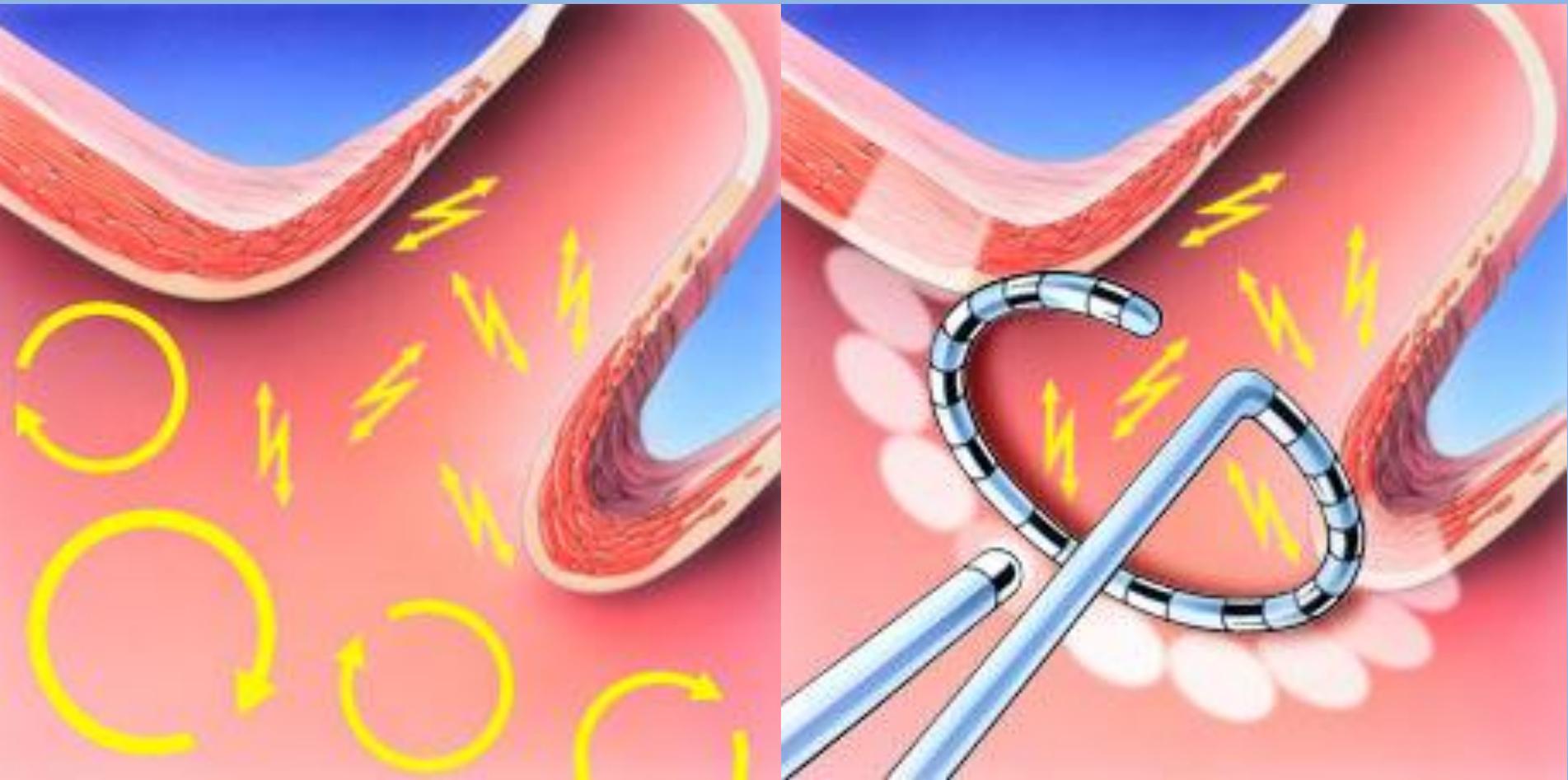


Fibrillation atriale

- Rôle NAV qui filtre les influx atriaux
- ECG: QRS irrégulier et trémulation ligne base

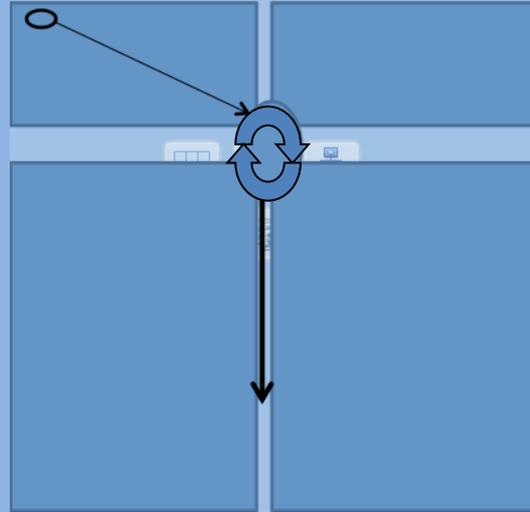


Paroxystique: initiation dans veines pulmonaires

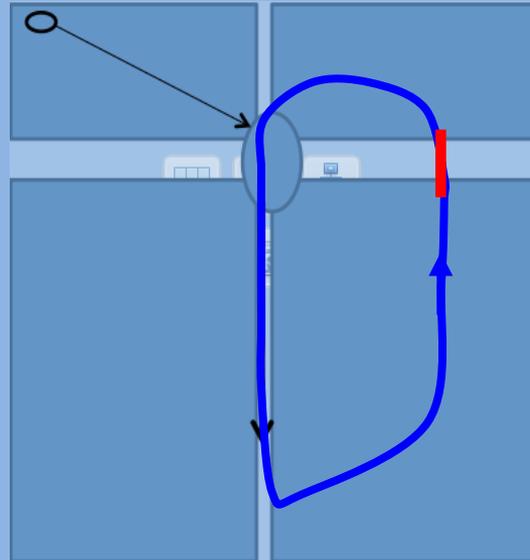


Tachycardies jonctionnelles

– Rentrée intranodale

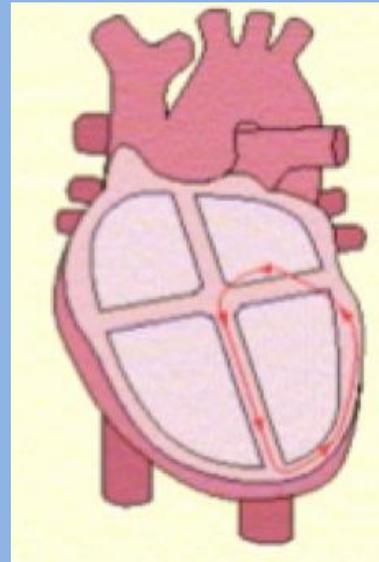
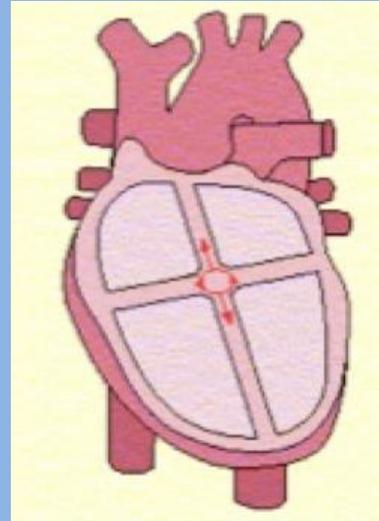


– Reentrée sur Kent



Tachycardies jonctionnelles

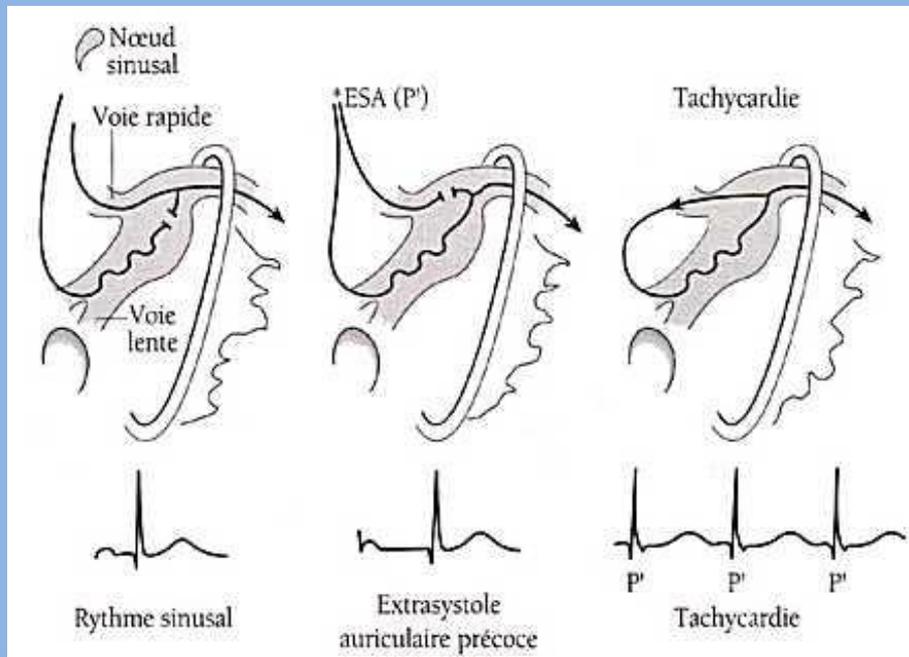
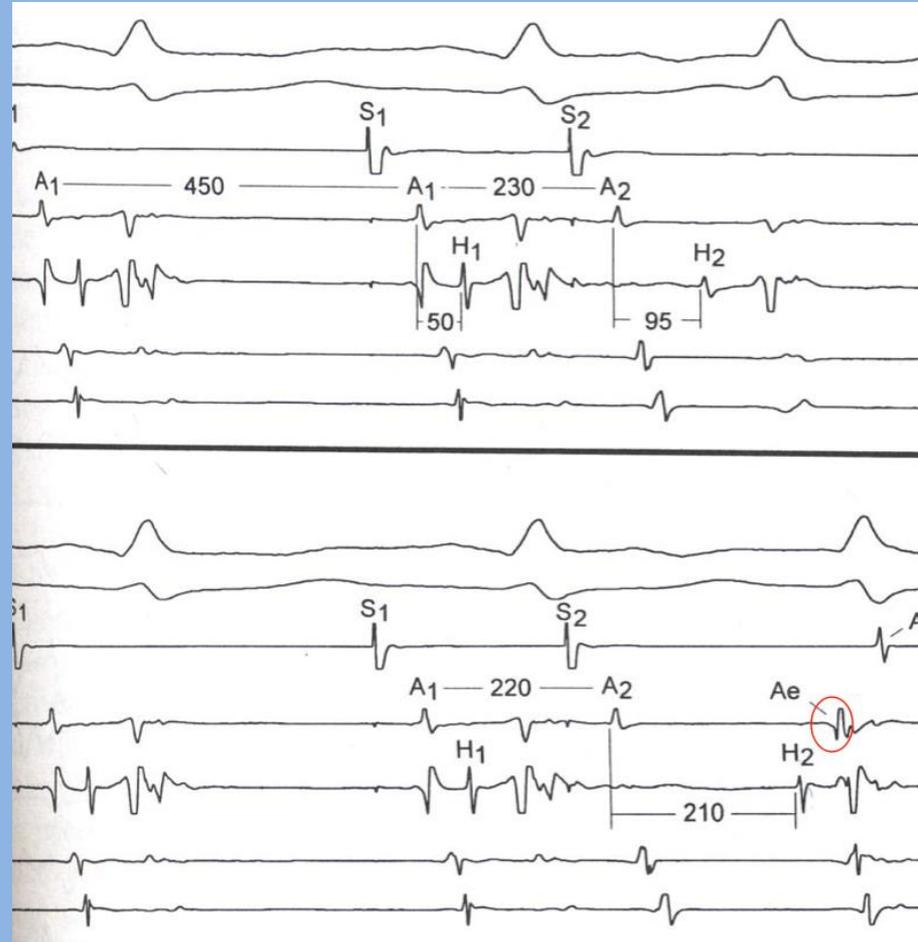
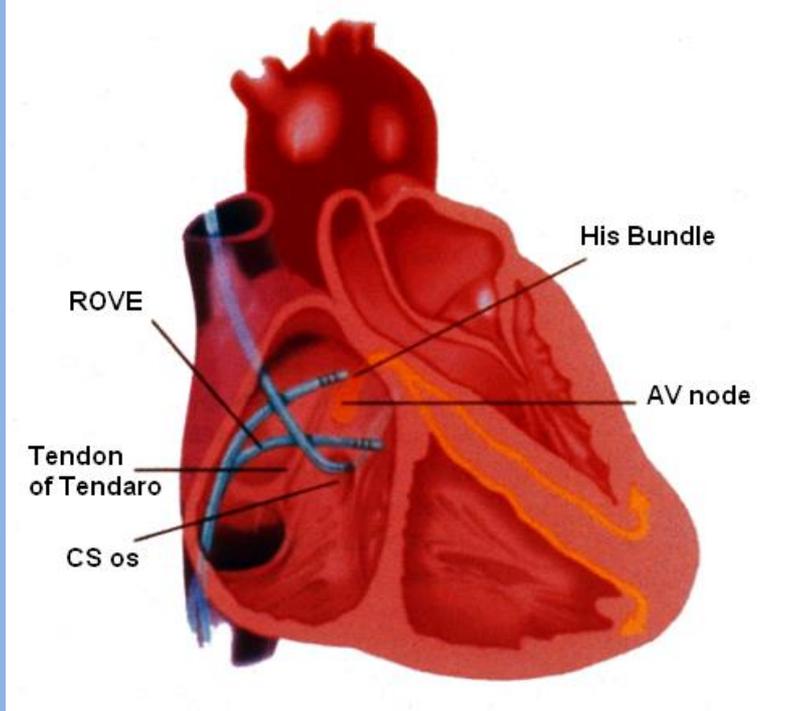
- NAV inclus dans le circuit
 - Dualité nodale: TRIN
 - Kent patent ou caché



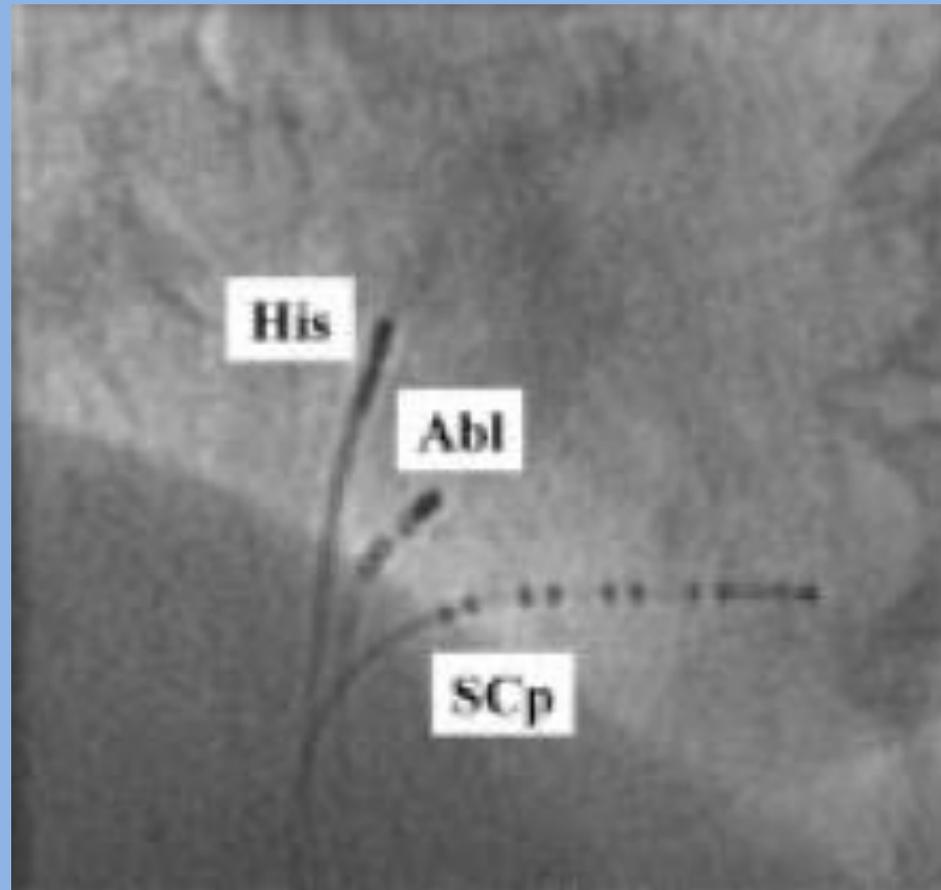
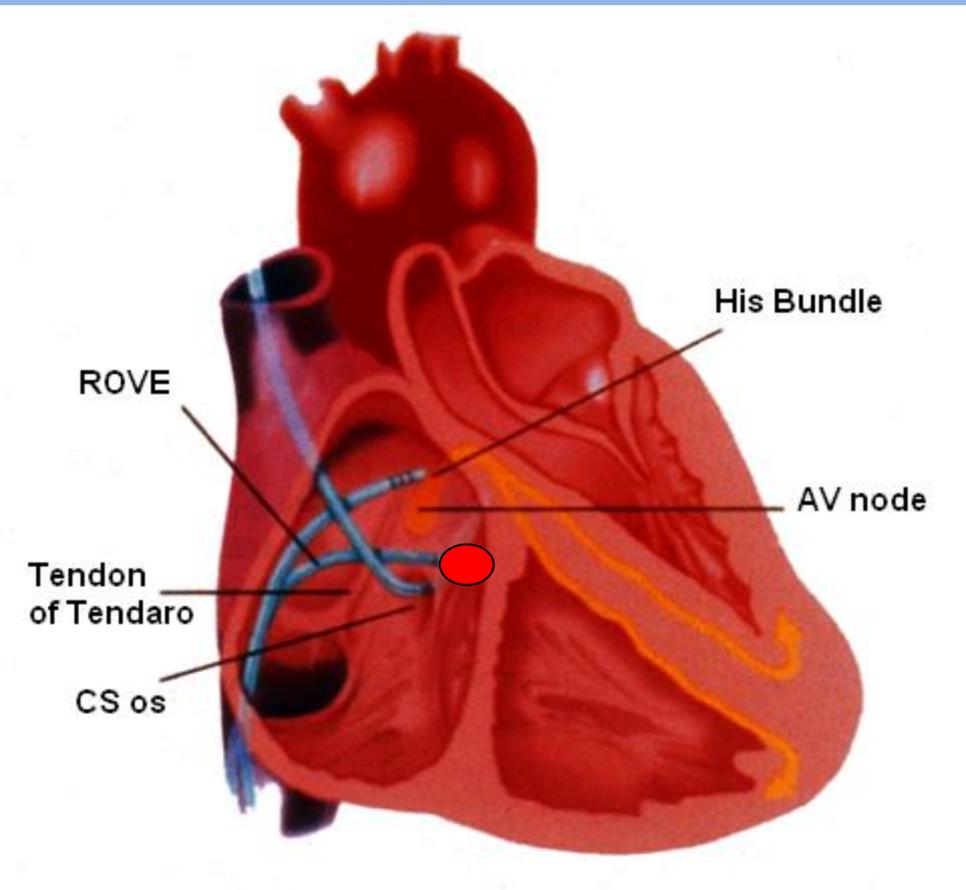


Tachycardie jonctionnelle (1/1)





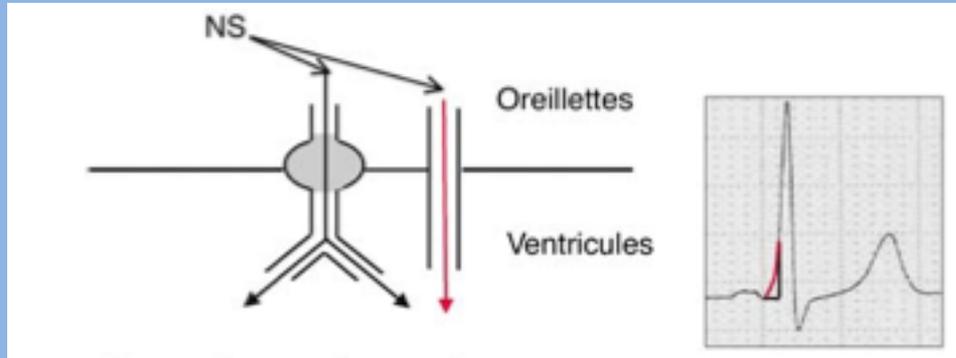
ABLATION TRIN



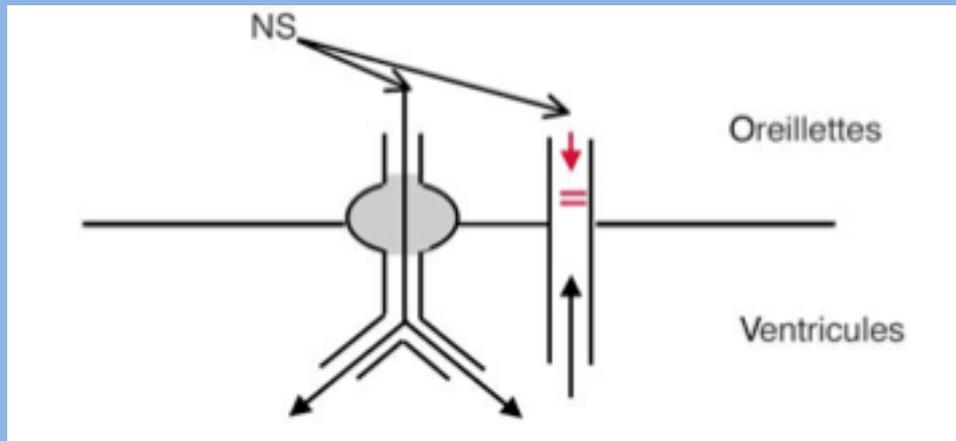
Source: Scheinman, M.M. Emerging Technologies in Antiarrhythmic Therapy; Creative Medical Communications, Inc., NY 1992: 1-33.

TJ sur kent

Kent anterograde
Sd WPW



Kent caché:
seulement retrograde



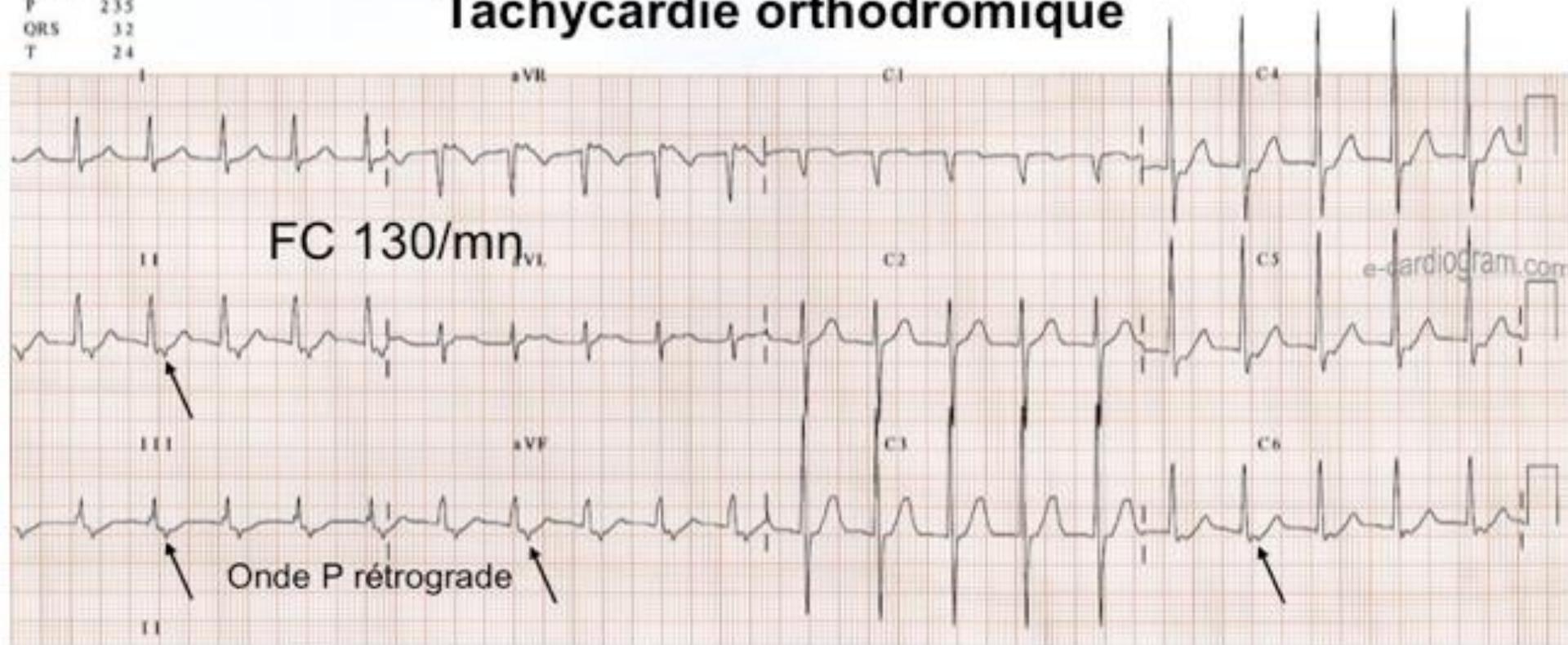
Tachycardie orthodromique

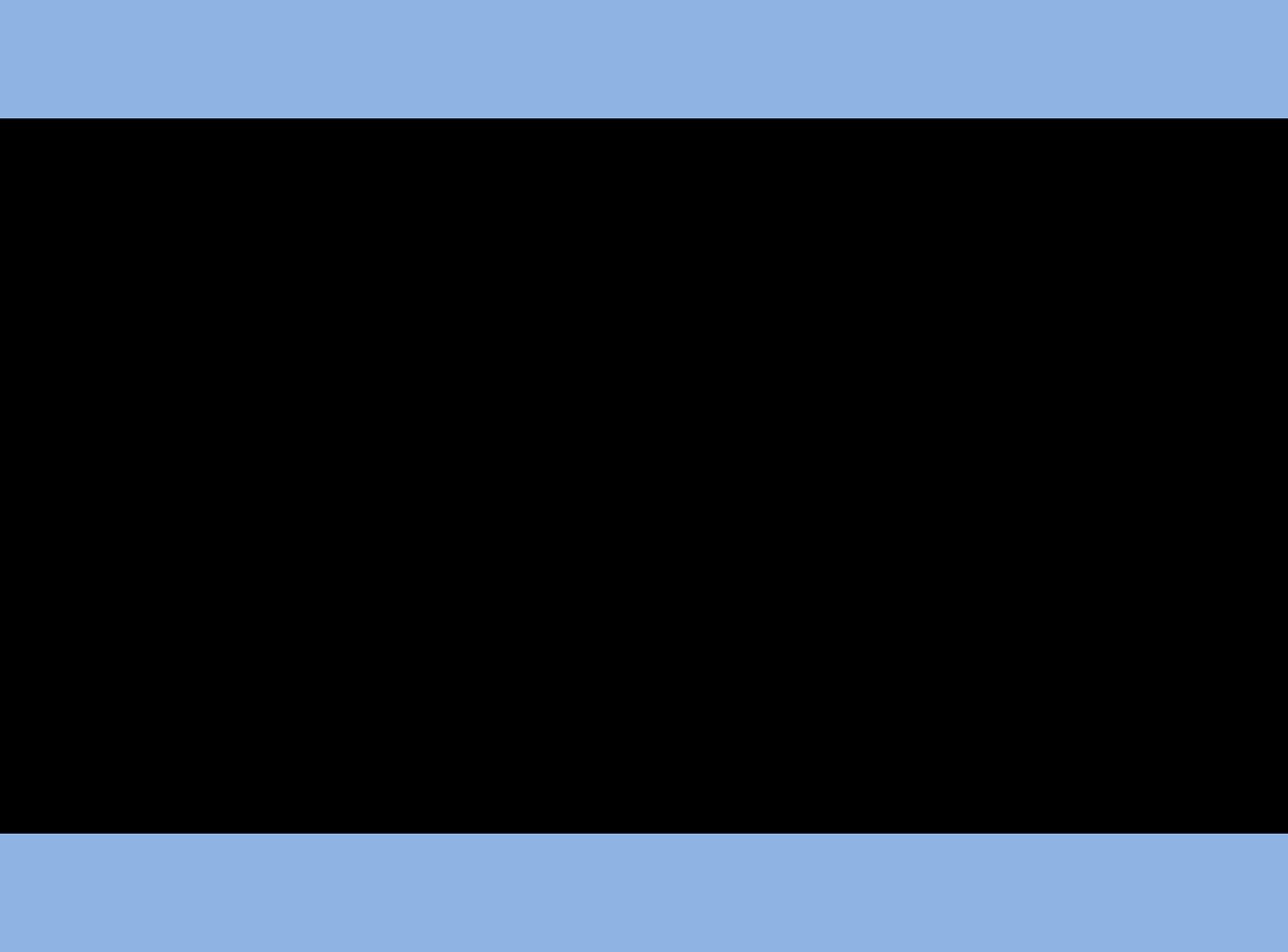
--Axe--
P 235
QRS 32
T 24

FC 130/mn_{VI}

Onde P rétrograde

e-cardiogram.com

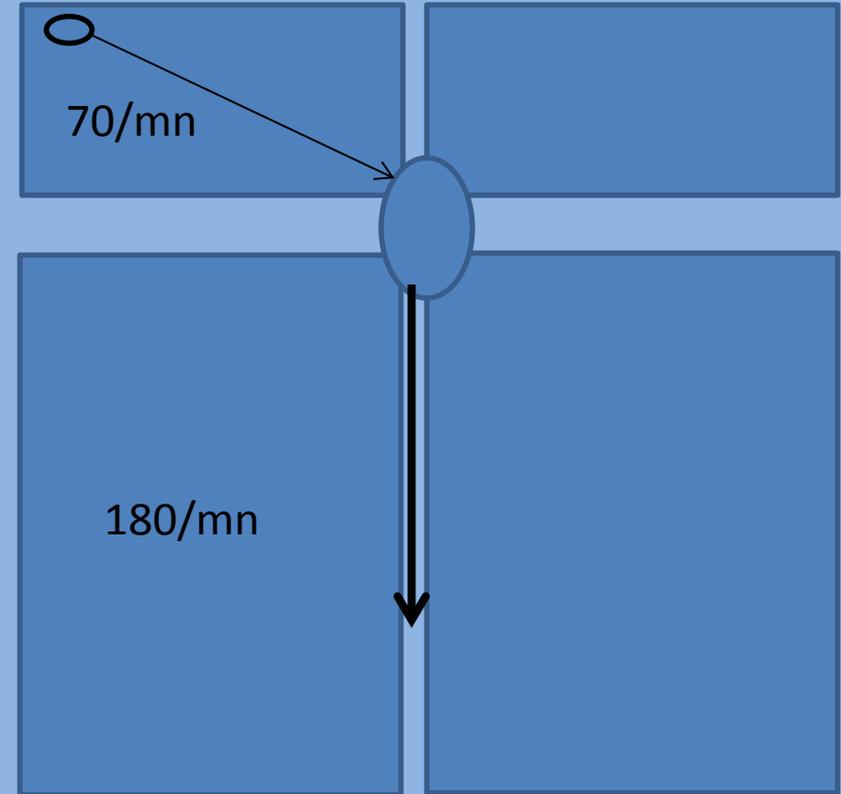
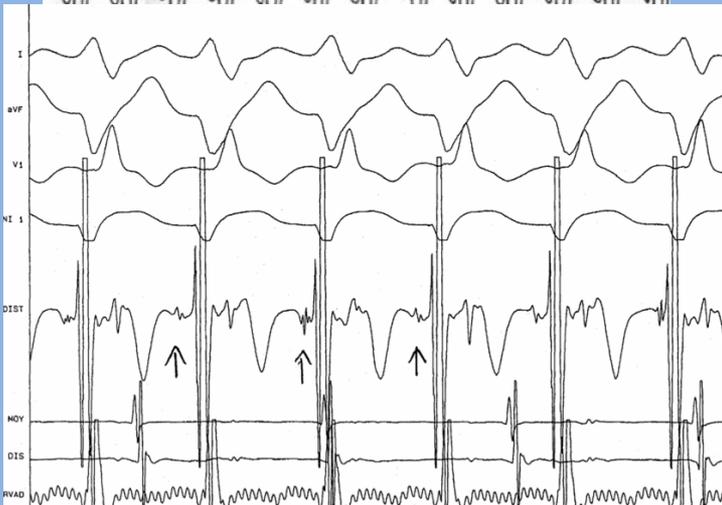
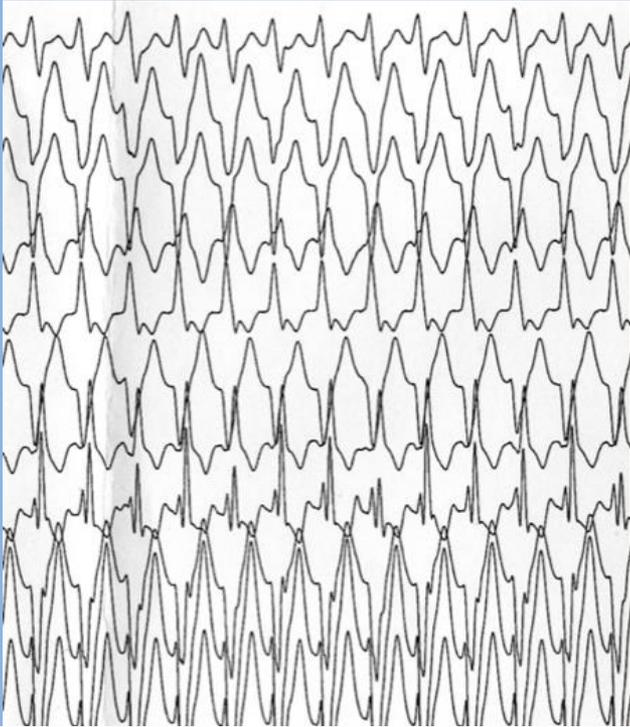








Tachycardies ventriculaires



Tachycardies ventriculaires

- Cicatricielle

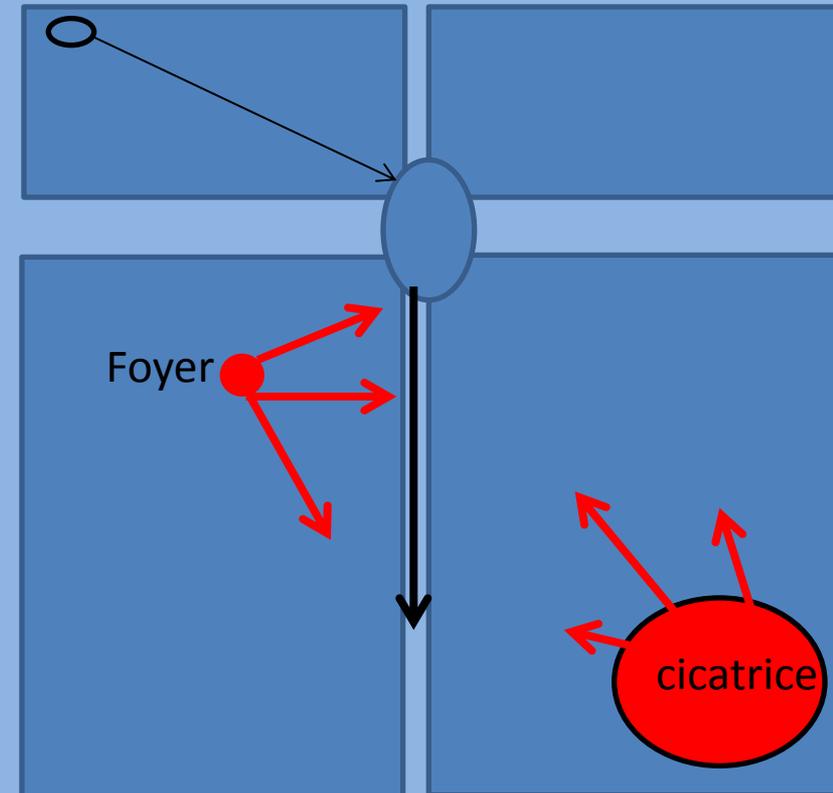
- Post IDM +++
- CMD
- DVDA

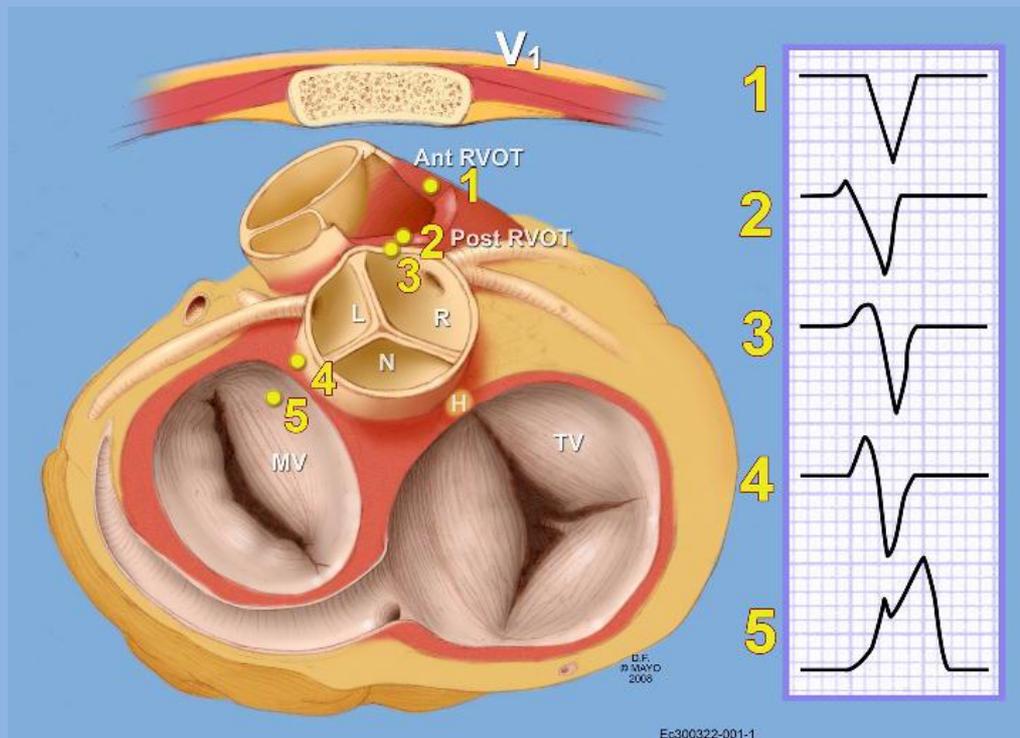
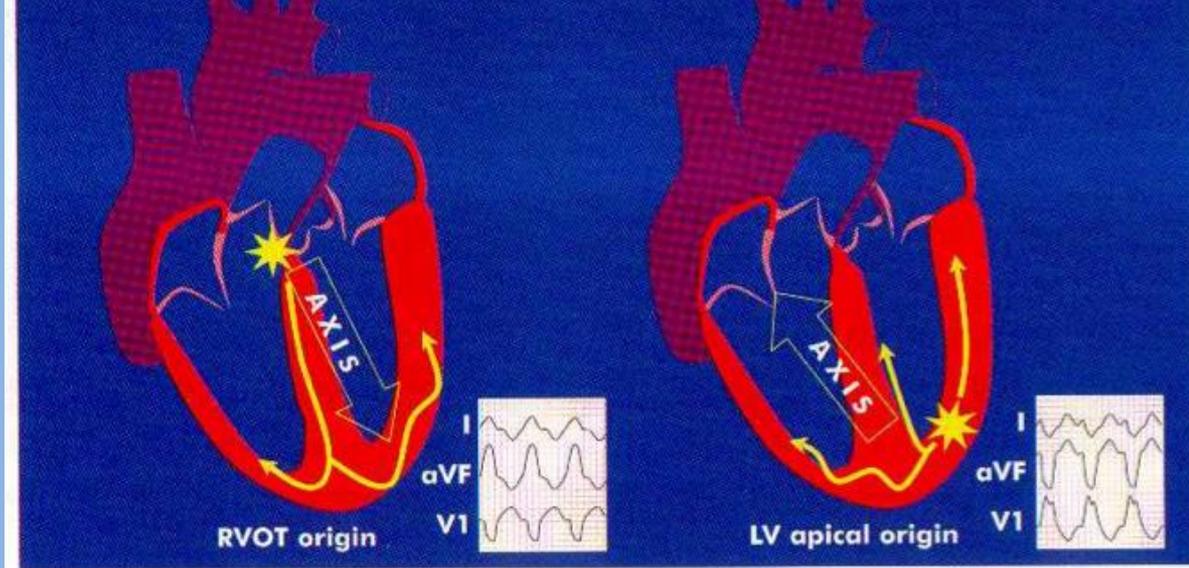
- Focale

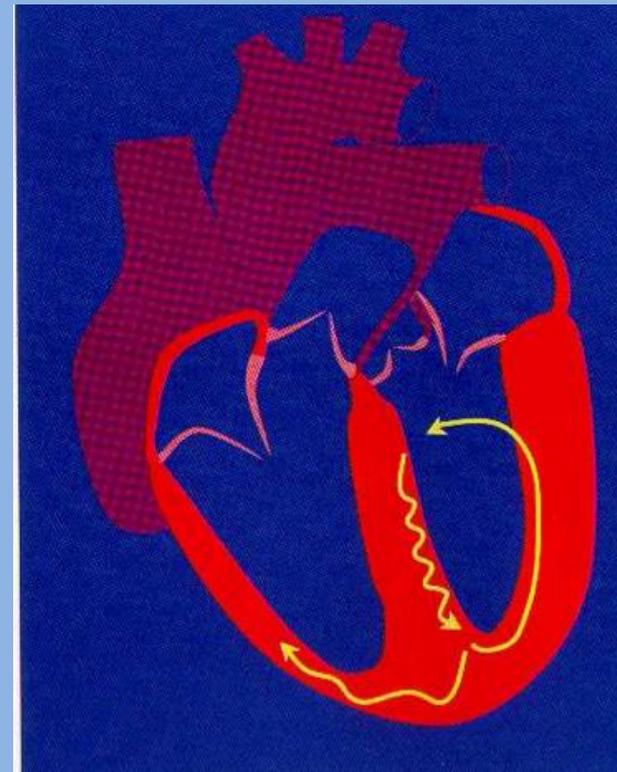
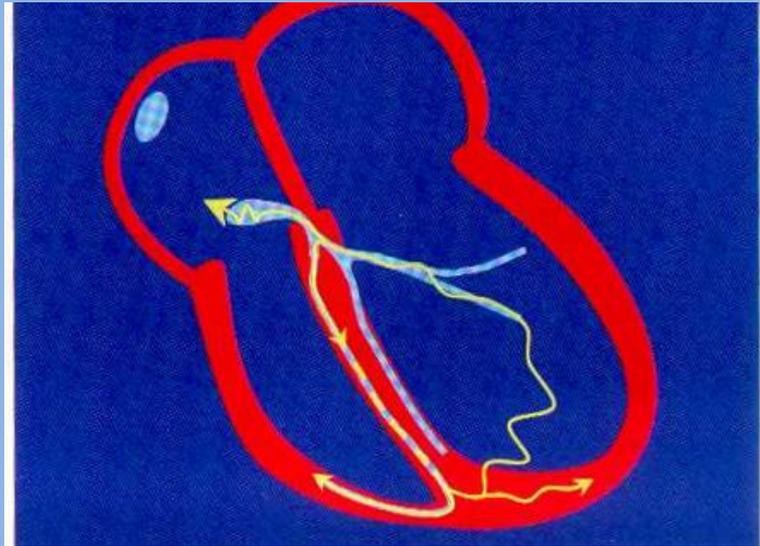
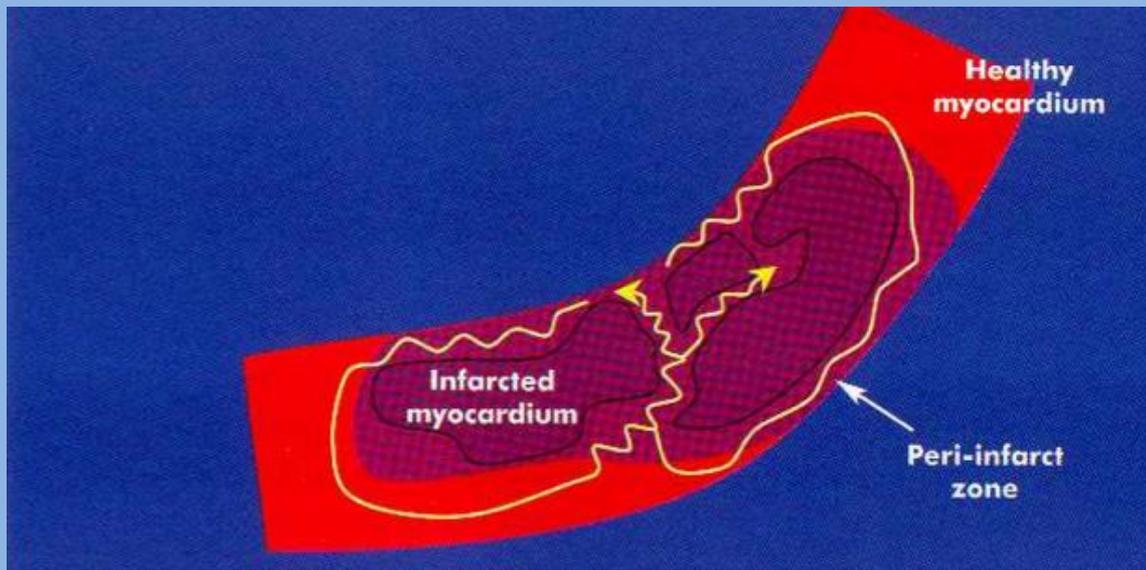
- Siege infundibulaireDt ++

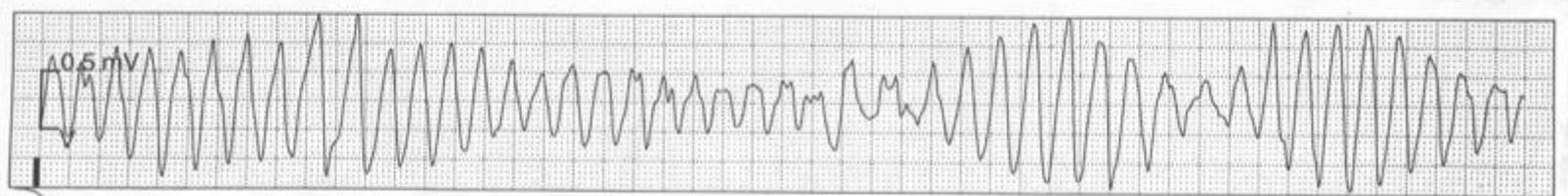
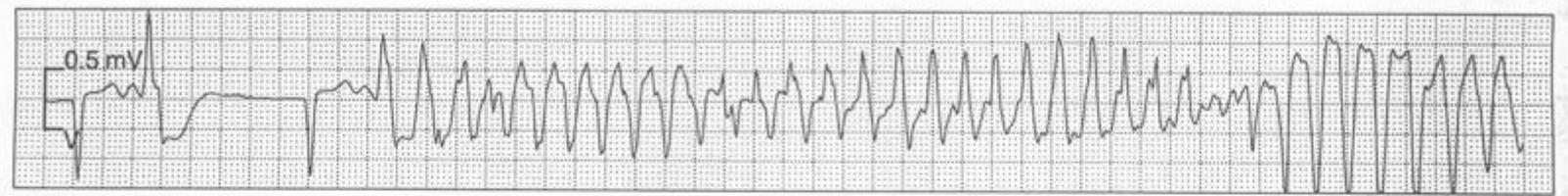
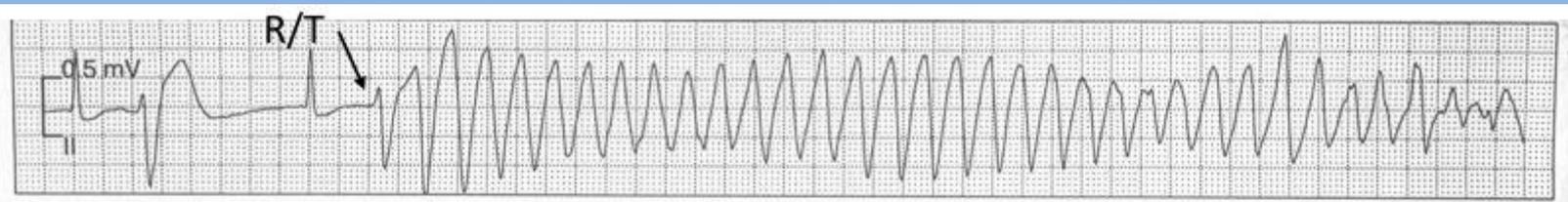
70/mn

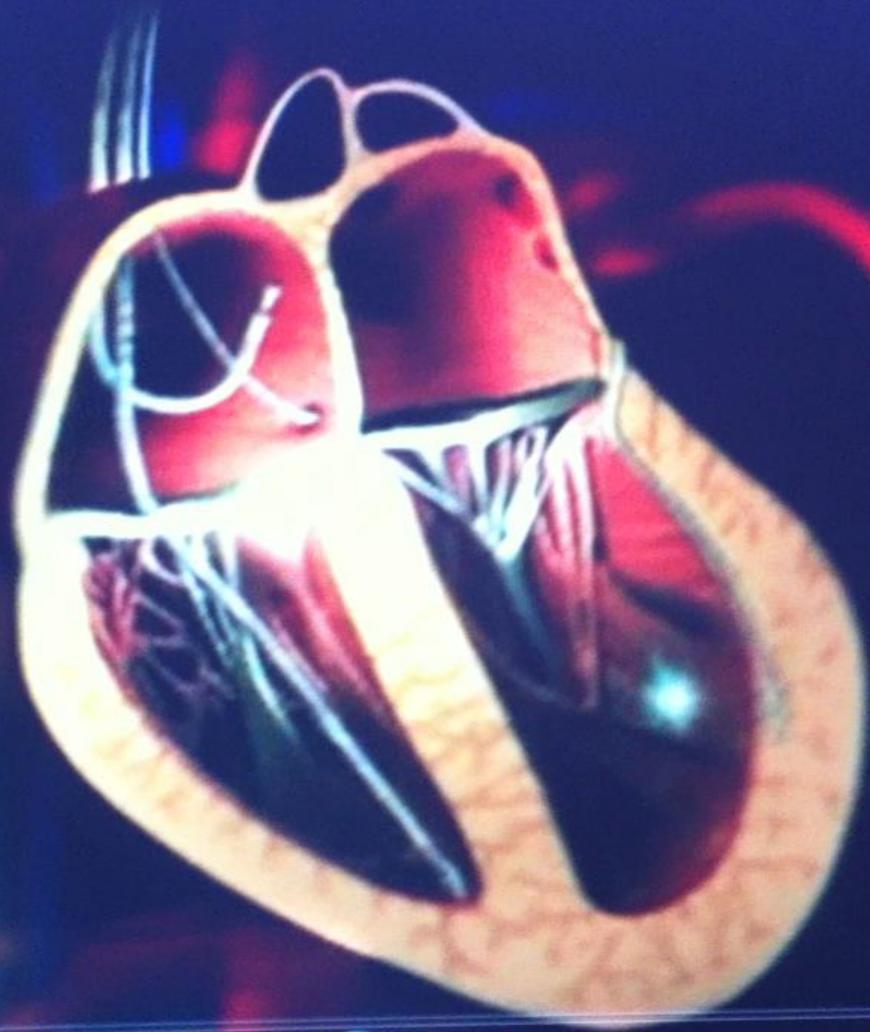
180/mn











Conclusion

- Comprendre les mécanismes est indispensable pour faire un diagnostic et choisir la thérapeutique
- L'ECG de surface est la pierre angulaire du raisonnement
- Les manœuvres vagales et les explorations endocavitaires précisent très souvent les mécanismes