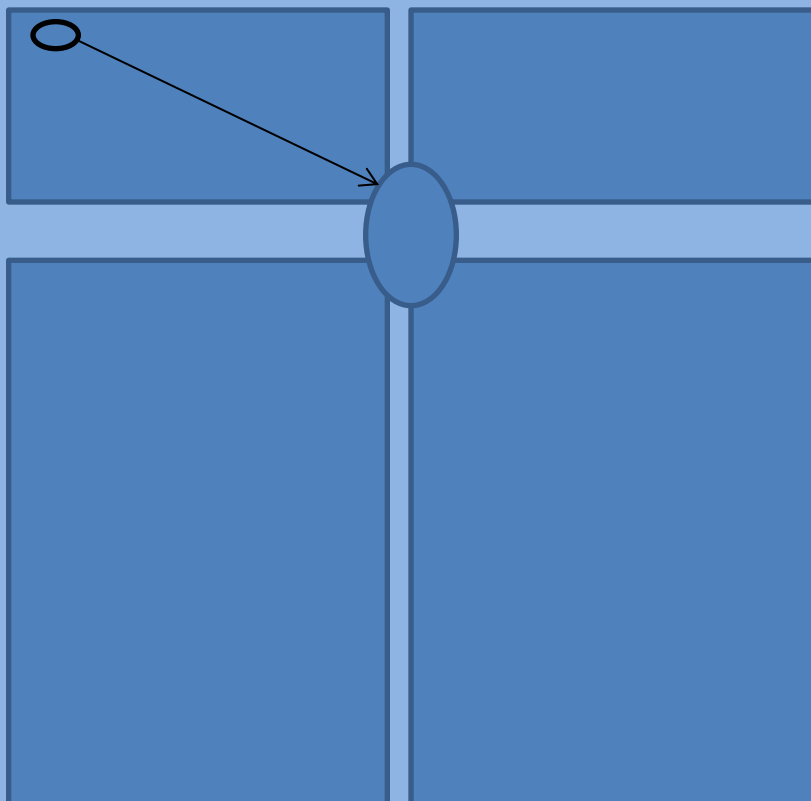


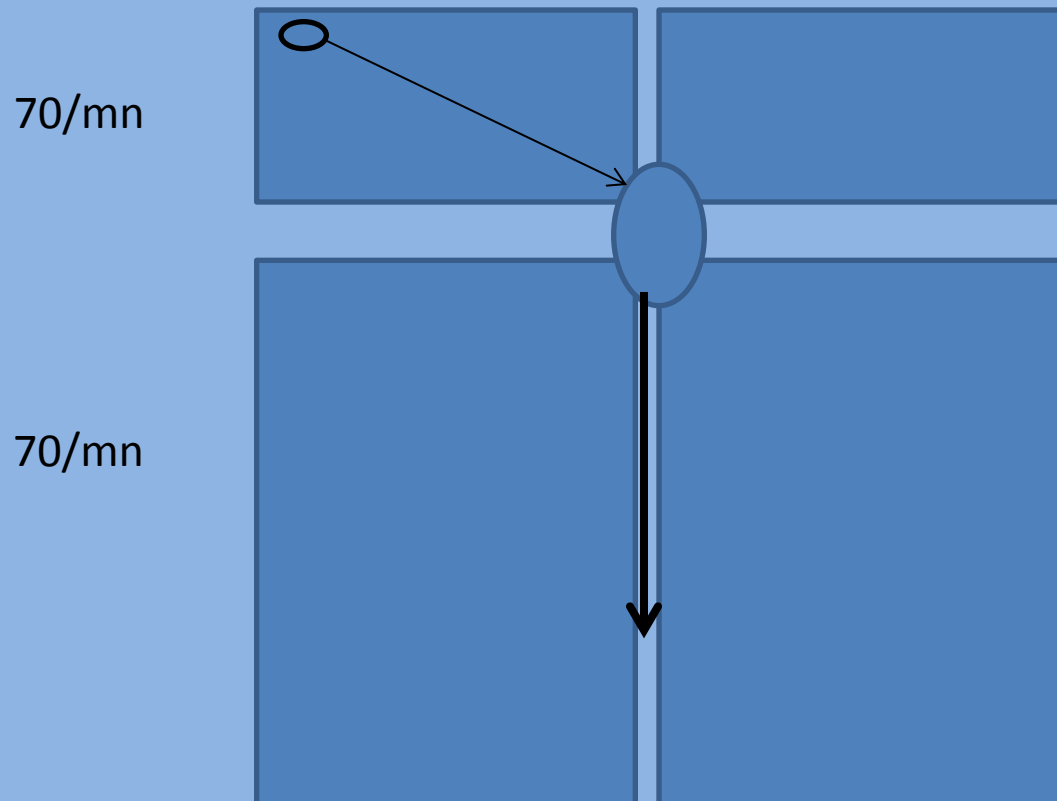
# Les Tachycardies

A Bourdeloie      J Taieb

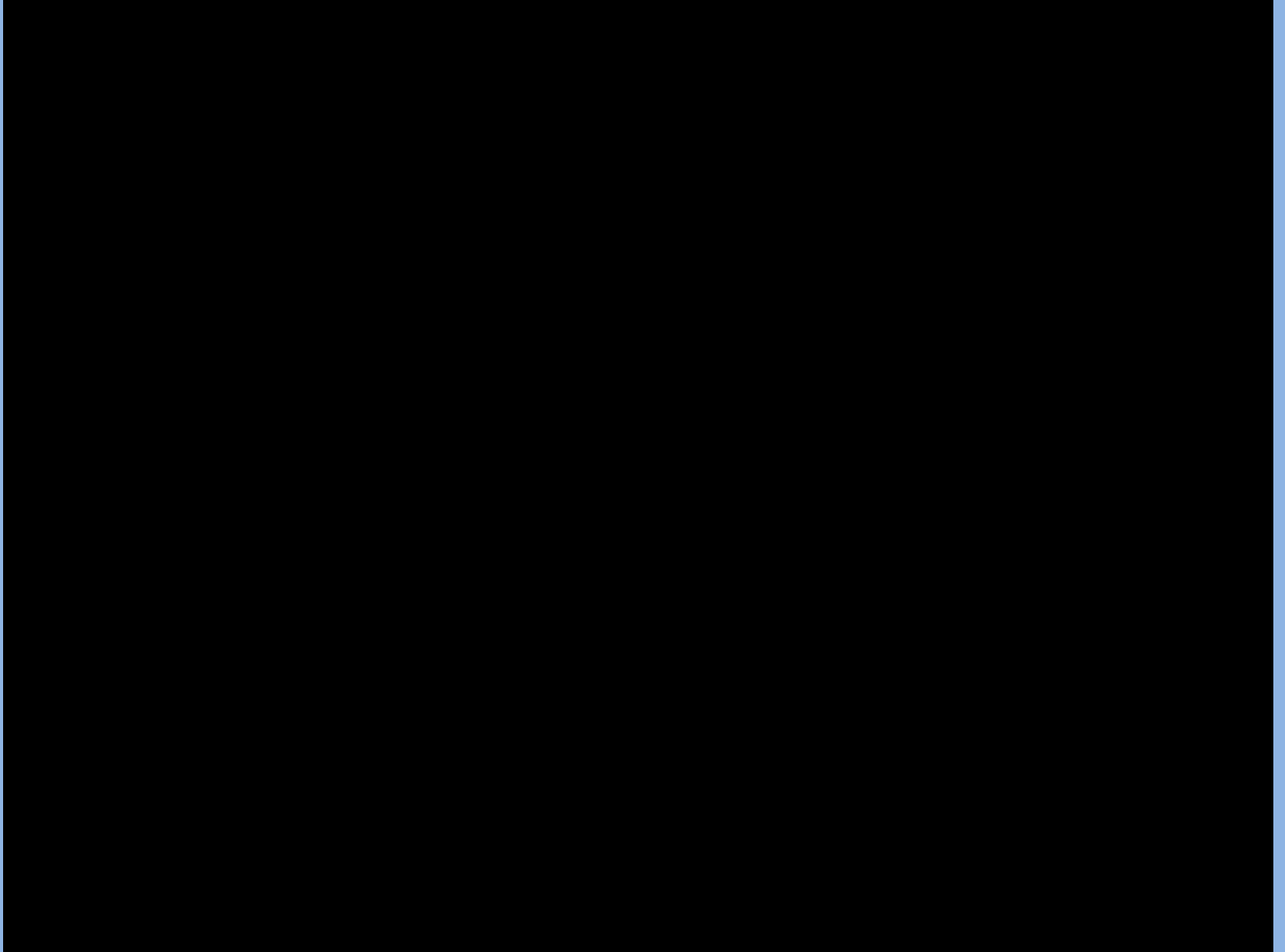
CH Aix en Provence



groupe de rythmologie du CNCH



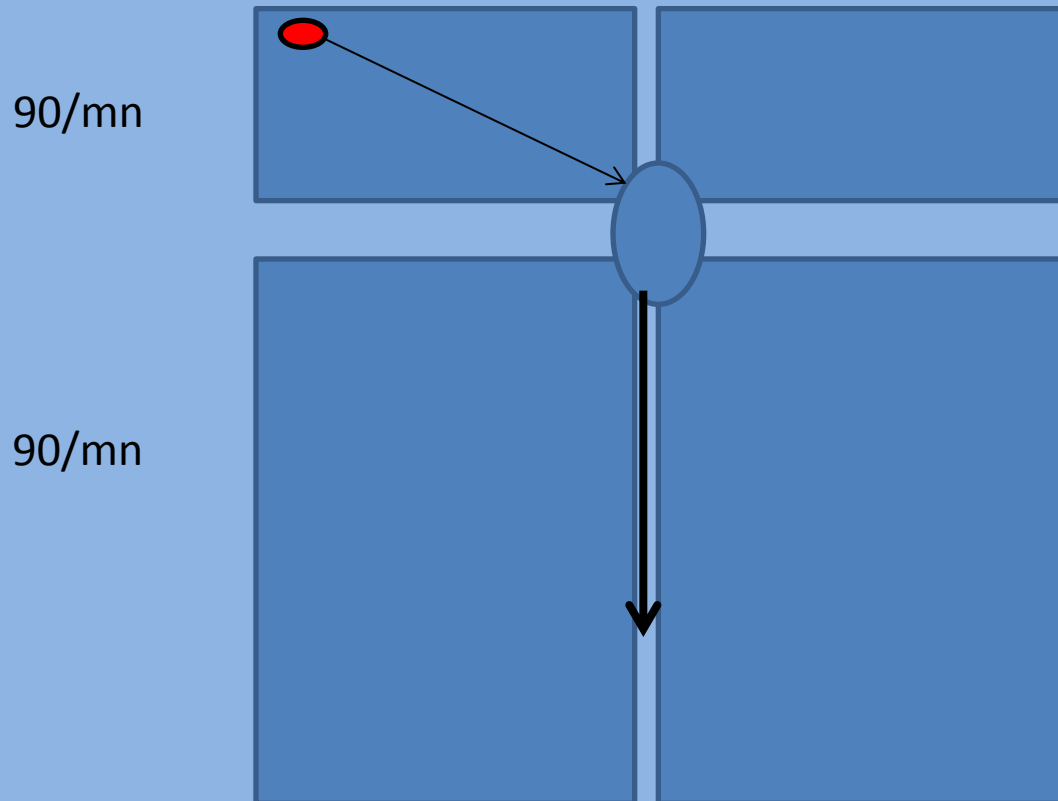
# Rythme sinusal



Tachycardies = accélération du  
rythme cardiaque

# Tachycardie sinusale: nœud sinusal superactif

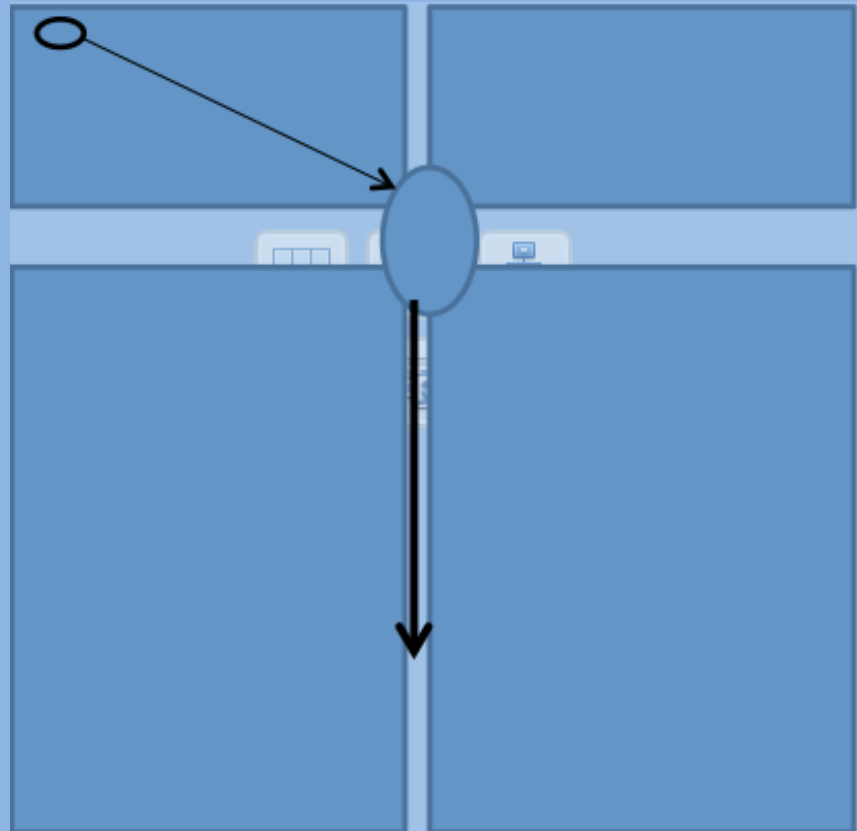
- par réaction à un stress physiologique
- Pathologique inapproprié



# Tachycardie sur un court circuit ou foyer actif

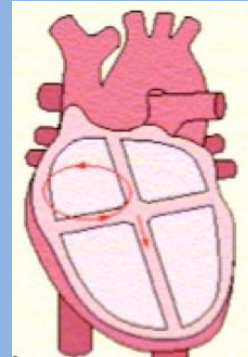
3 étages

- Atrial
- Jonctionnel
- Ventriculaire

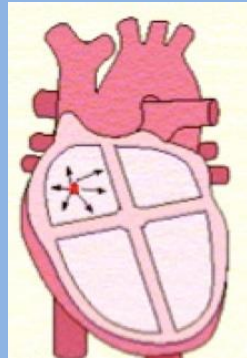


# Tachycardies atriales

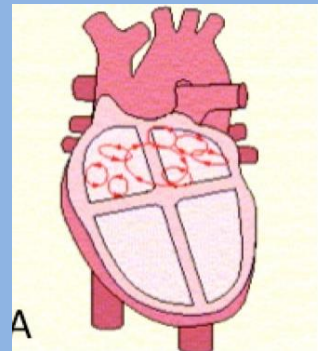
- Macroreentrée flutter



- Focales

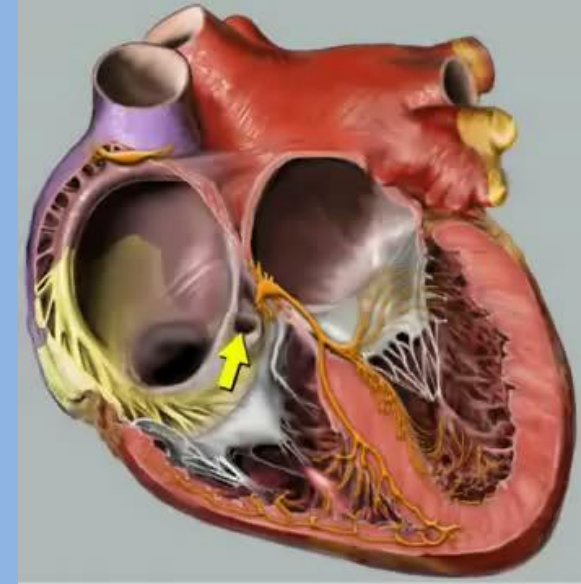


- Fibrillation auriculaire

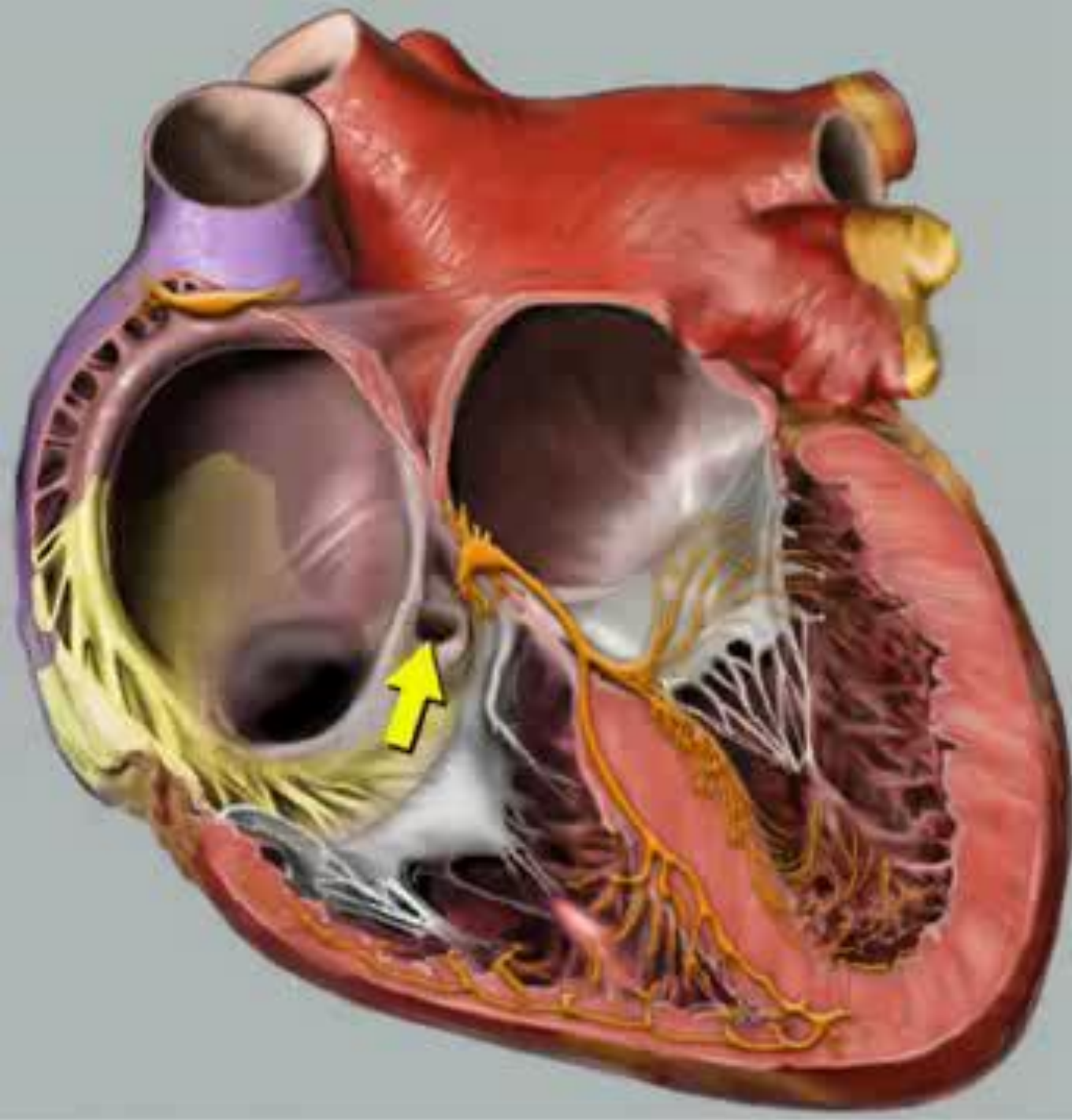




# Flutter Mécanisme



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

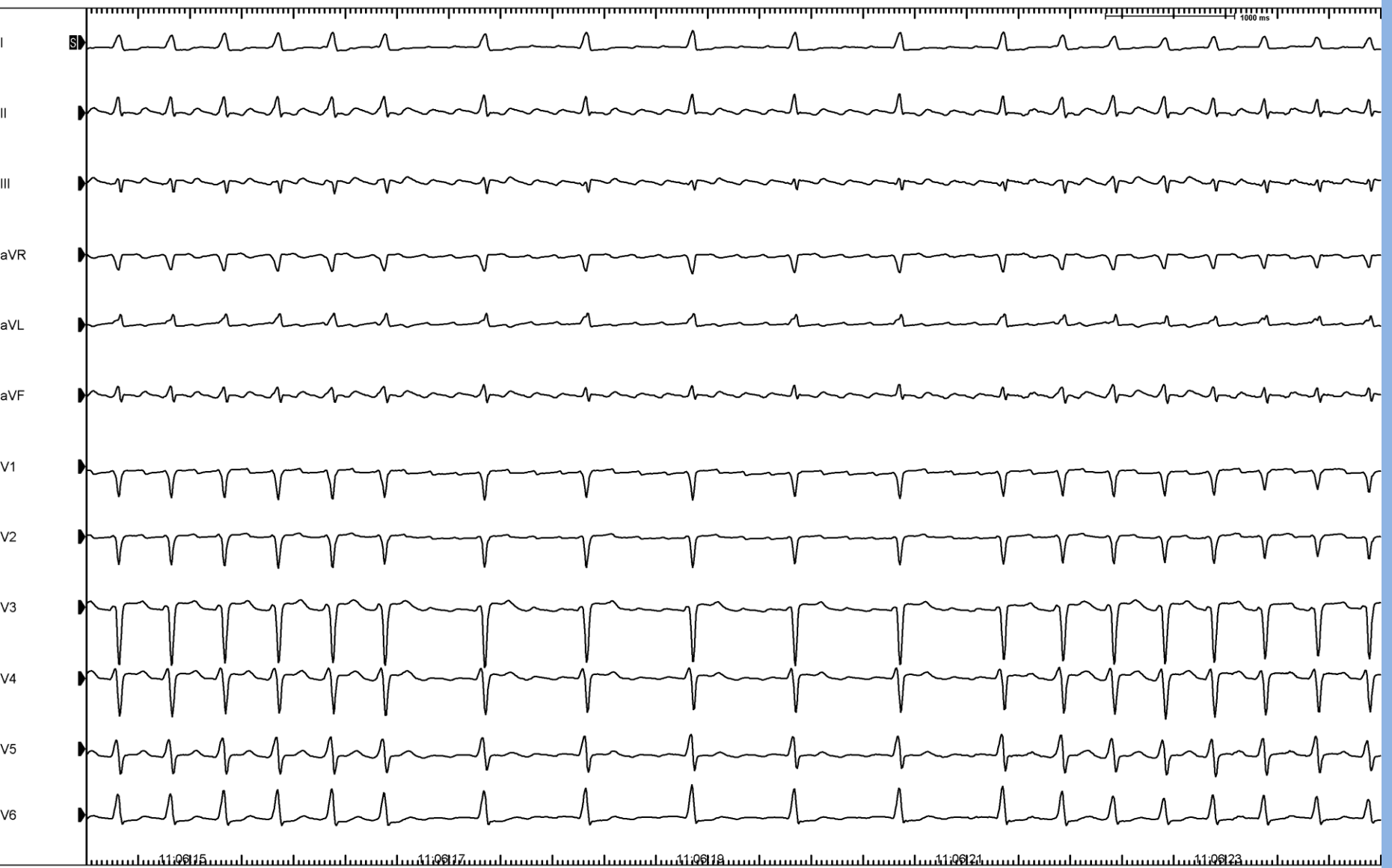


# L'électrocardiogramme

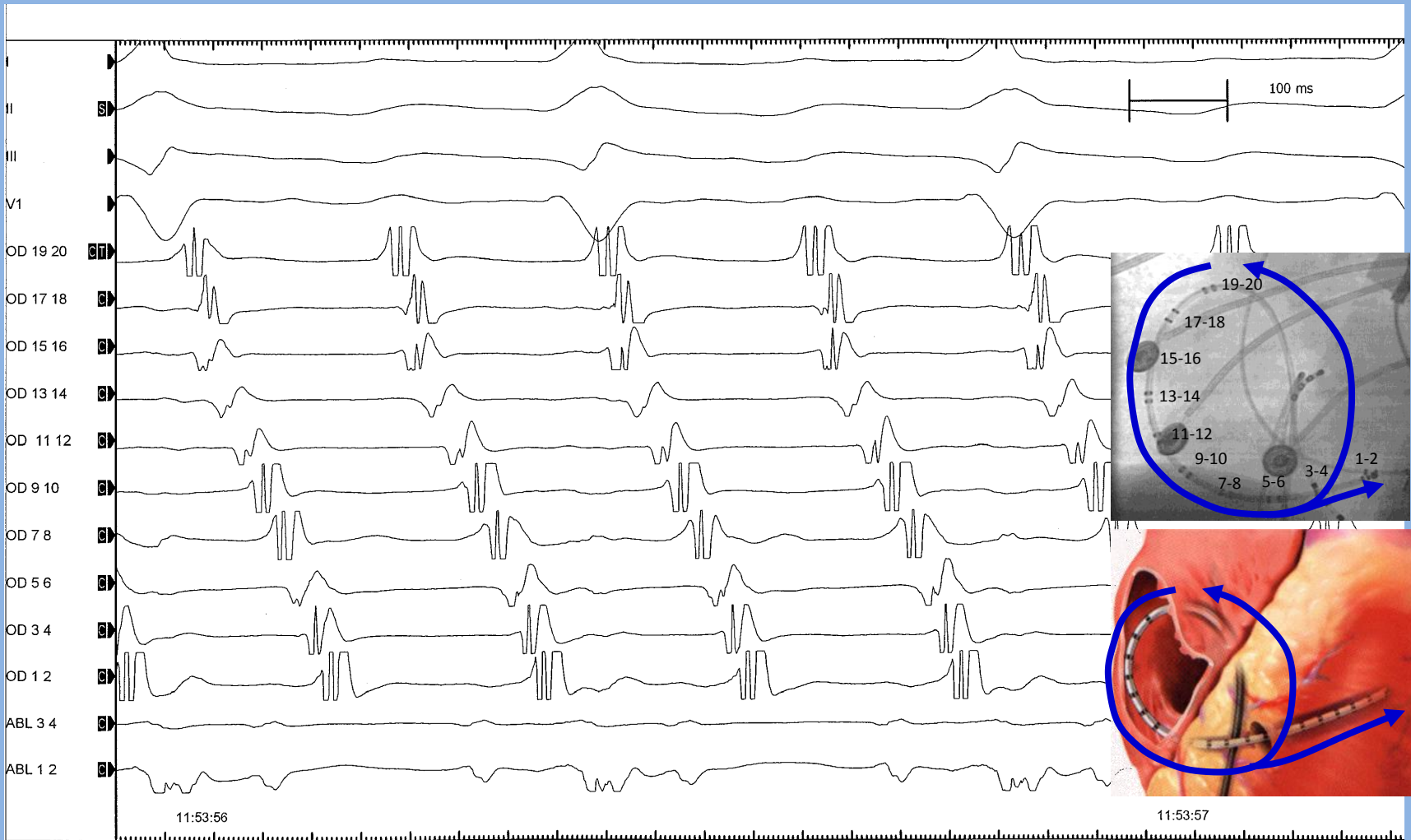
l'activité auriculaire(300/mn) se lit dans les dérivations D2,D3,et AVF

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

# Massage sinocarotidien

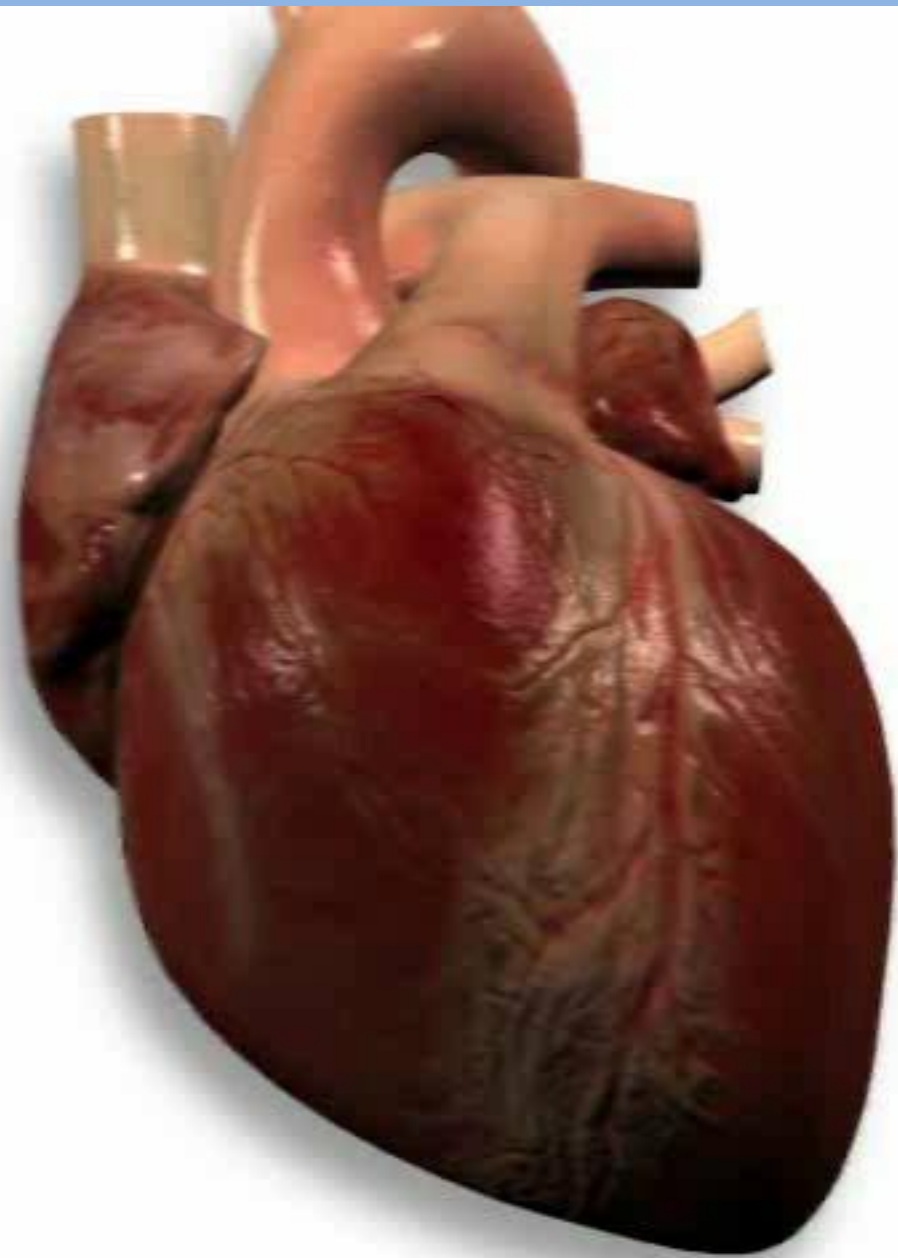


# Activation de l'OD en flutter



# TRAITEMENT

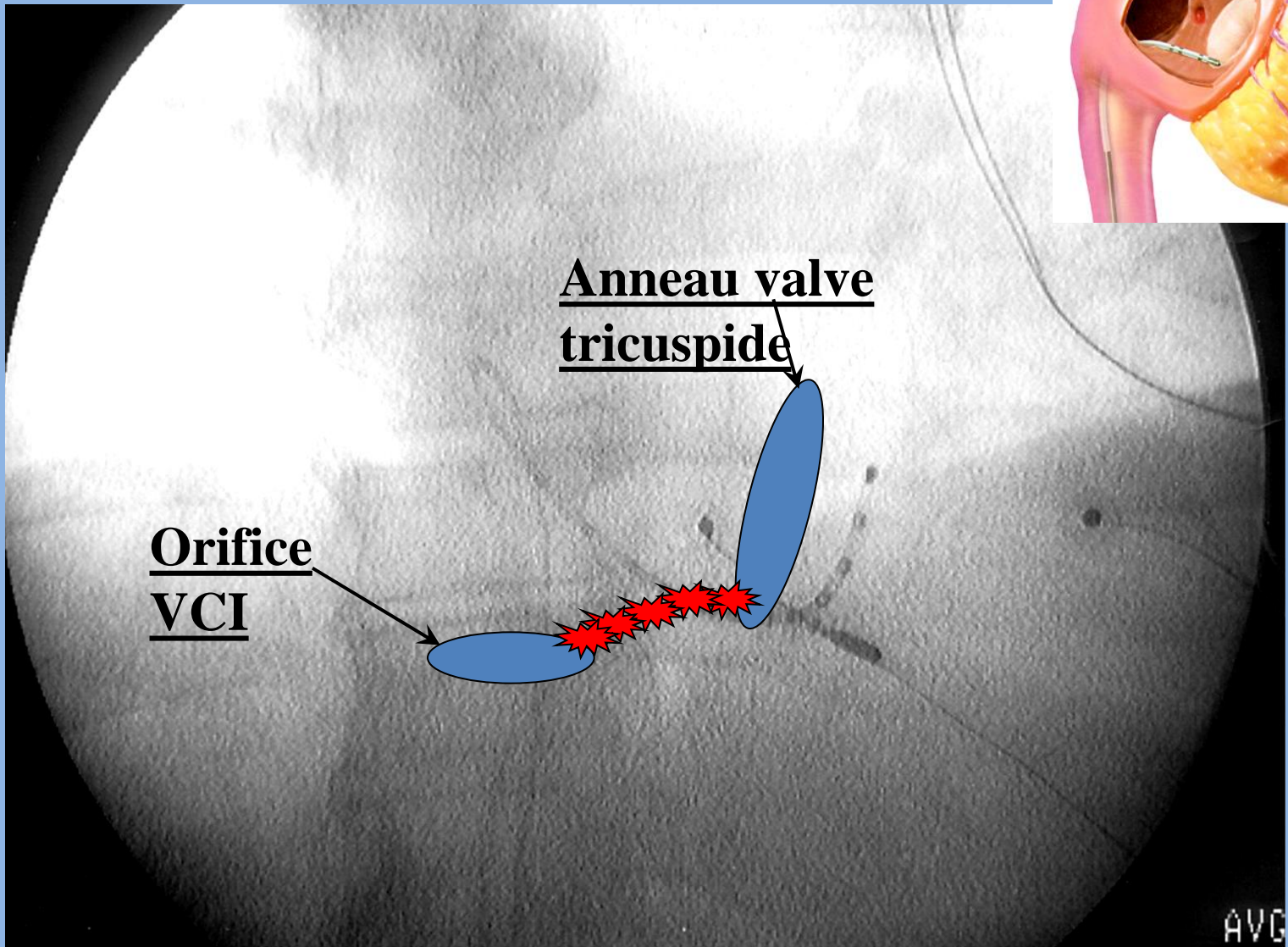
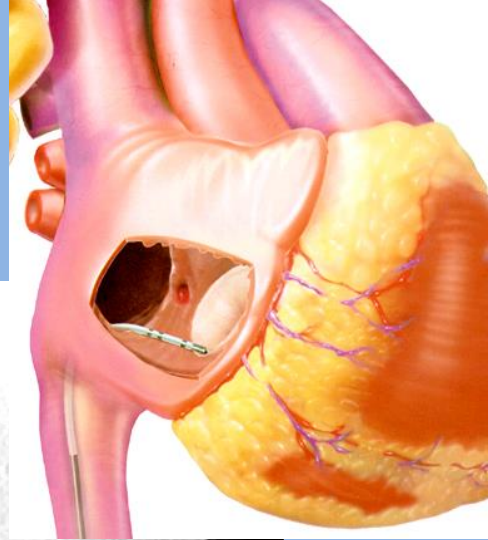
- L'ablation endo cavitaire est le traitement de première intention.
- L'ablation est réalisée au niveau de l'isthme cavotricuspidien , voie de passage nécessaire au flutter.
- Cette voie est facilement accessible à la sonde qui est montée par la veine cave inférieure.



# TROIS CRITERES DE REUSSITES

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



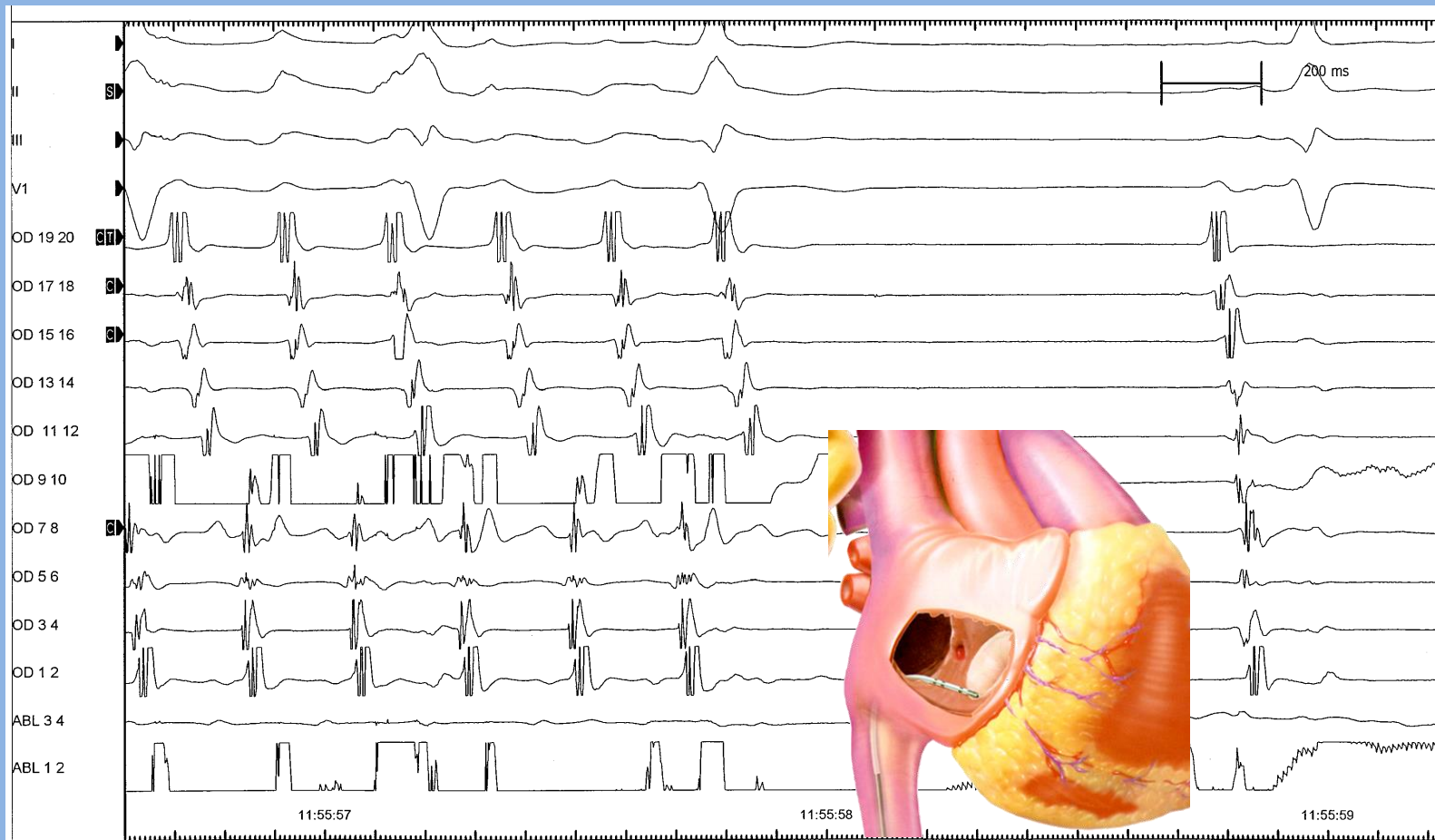


Orifice  
VCI

Anneau valve  
tricuspide

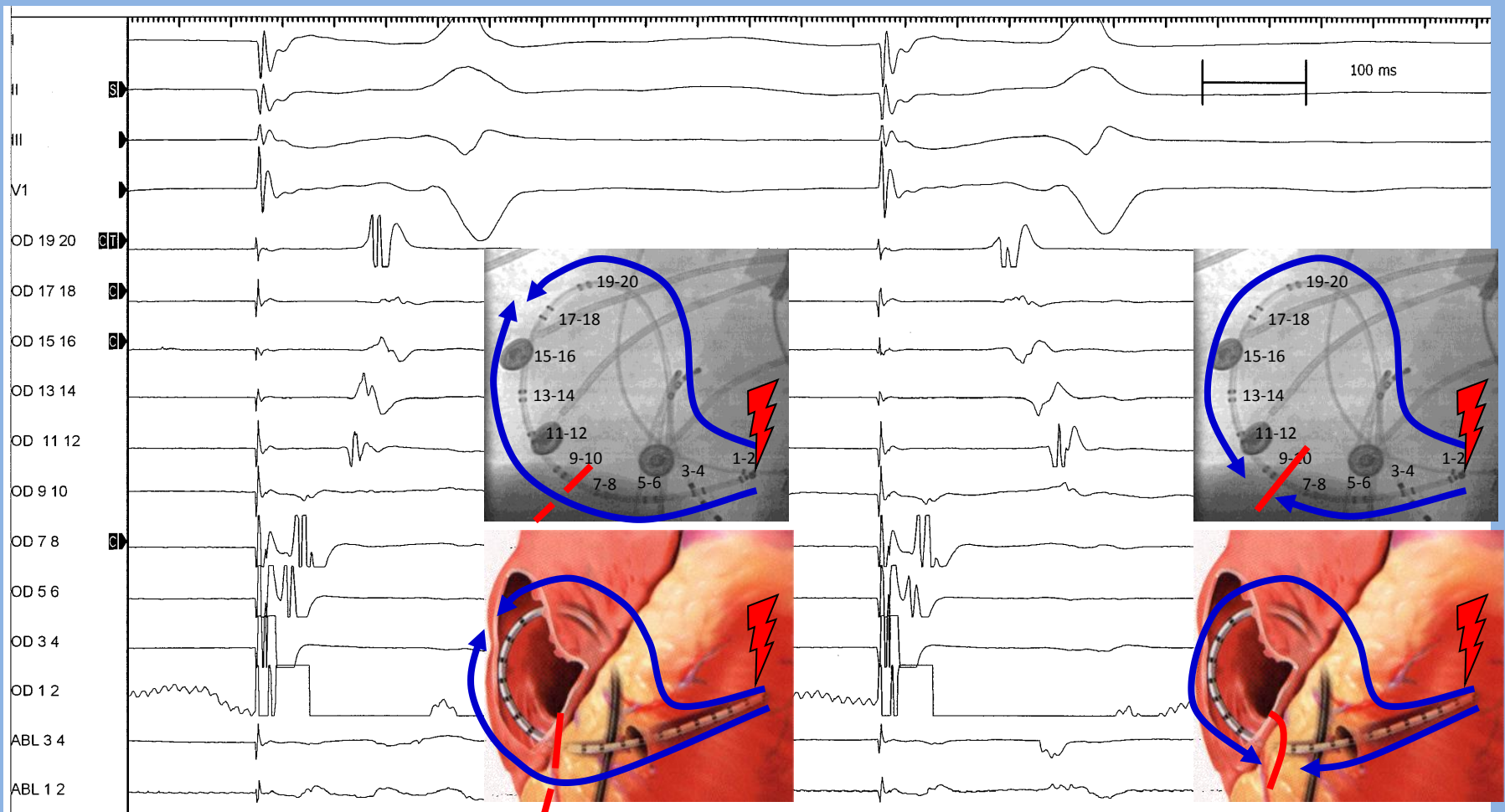
AVC

# Arrêt du flutter en cours de tir



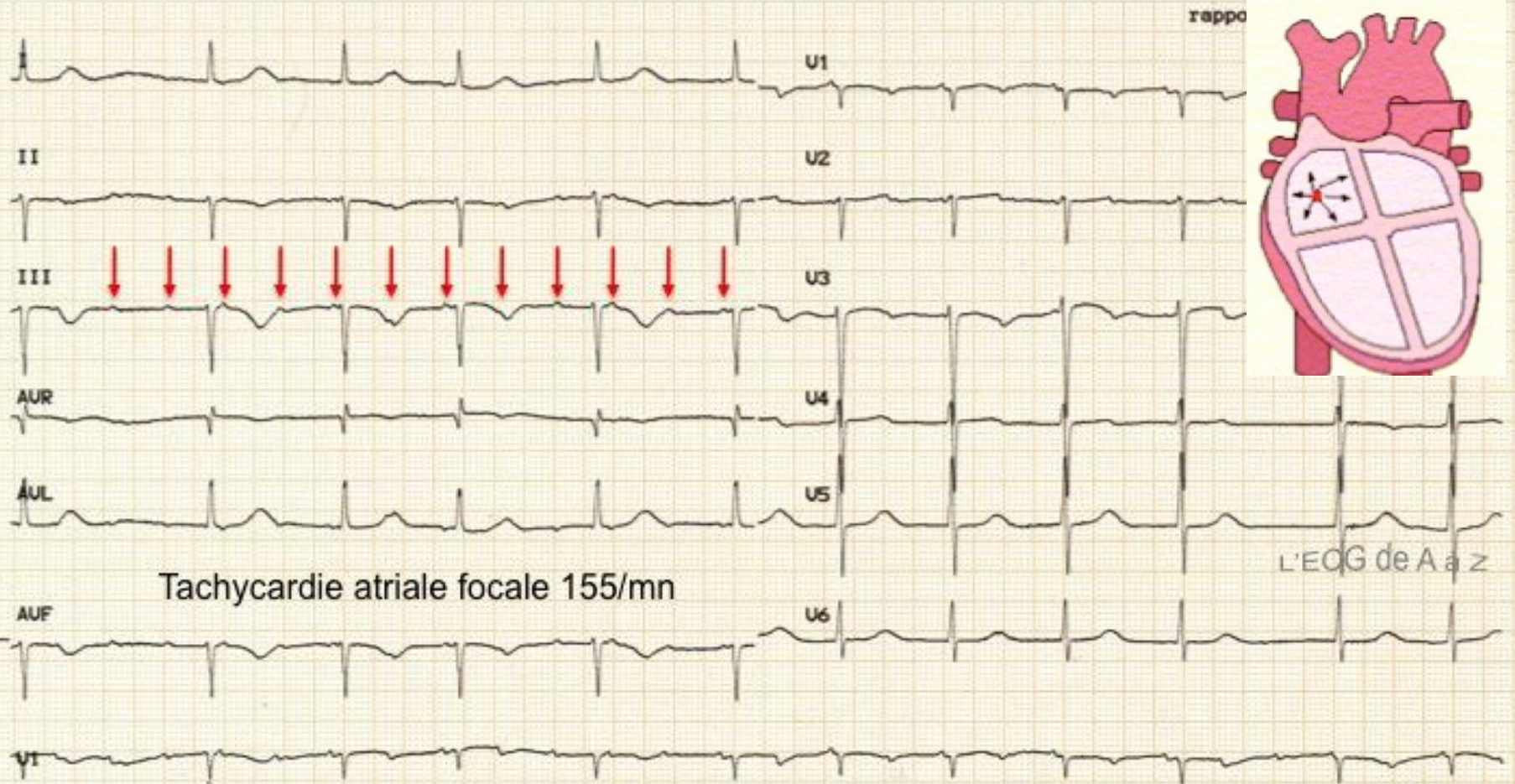
# Bloc Succes

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





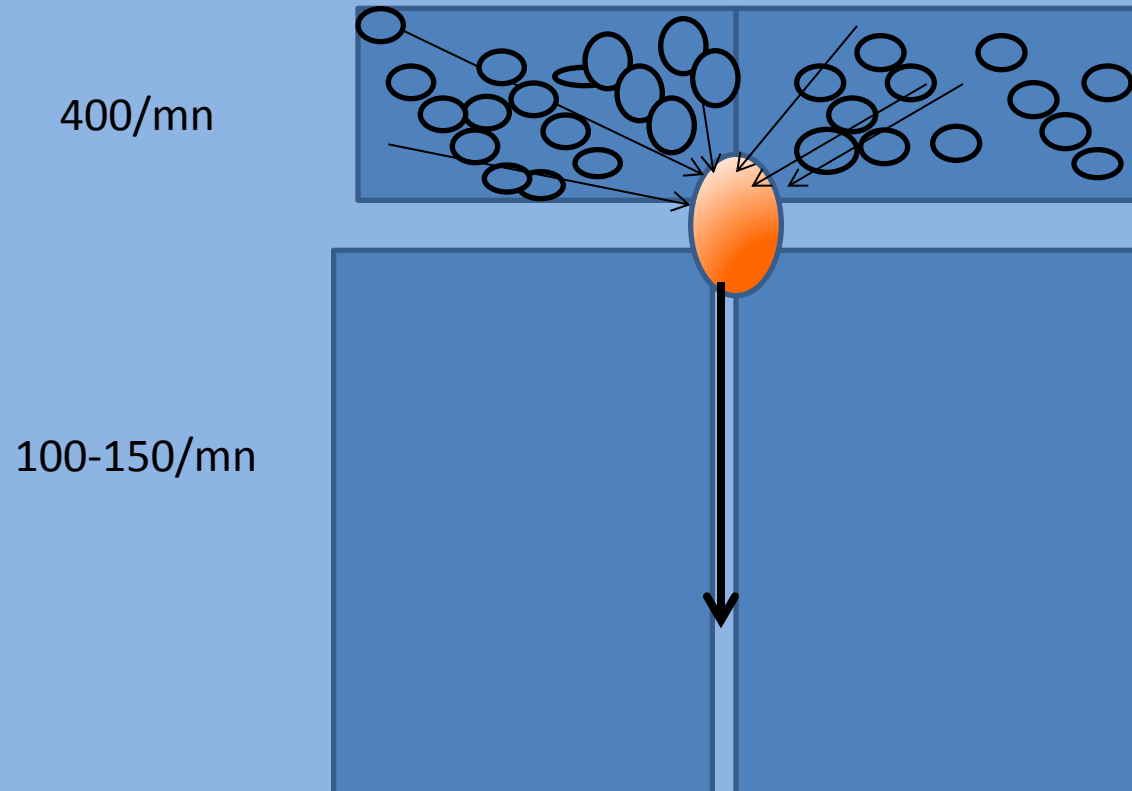
# Tachycardie atriale focale



Tachycardie atriale focale 155/mn

L'EOG de A a Z

# Fibrillation Atriale



# Fibrillation atriale

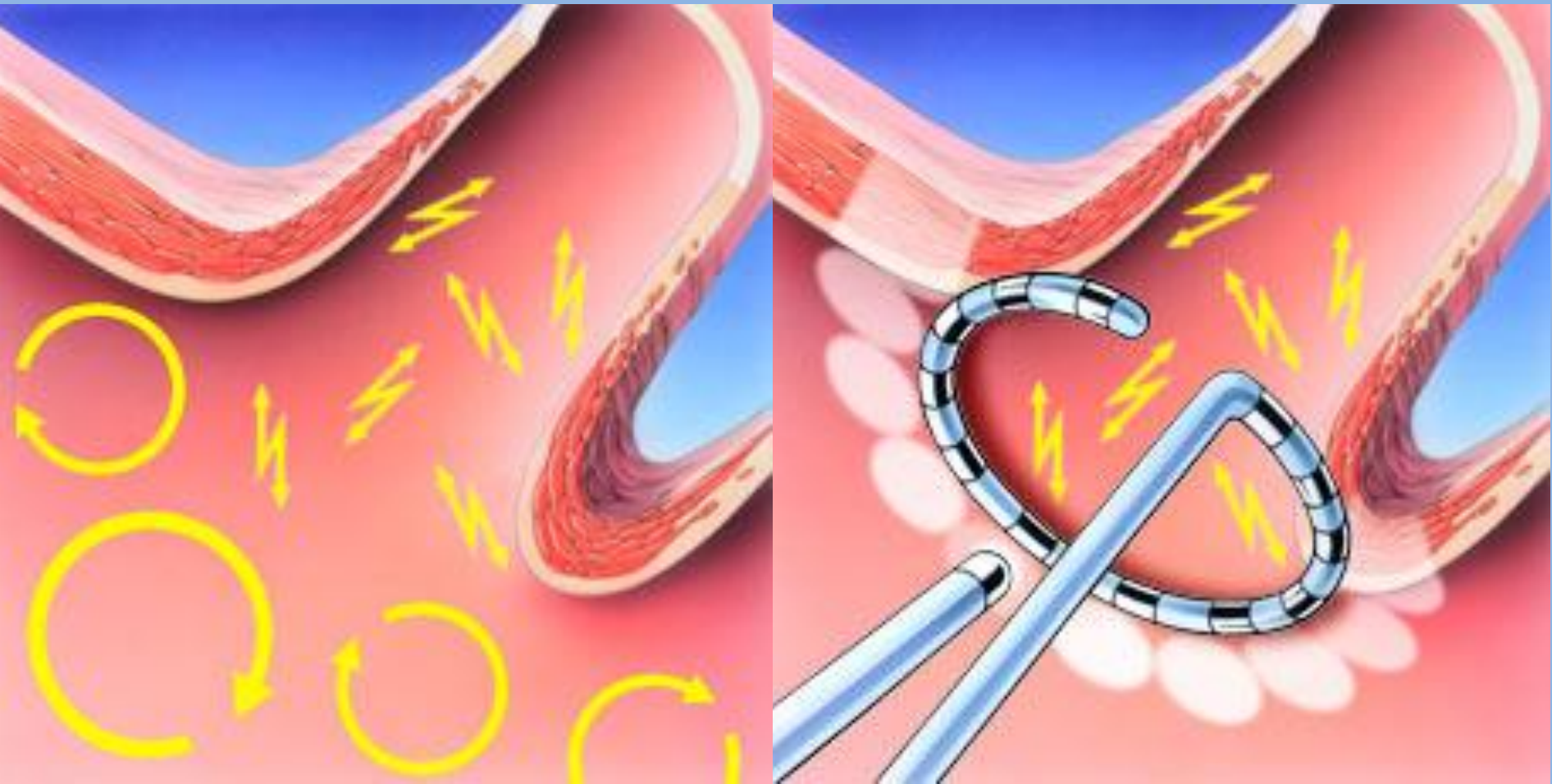
- Rôle NAV qui filtre les influx atriaux
- ECG: QRS irrégulier et trémulation ligne base





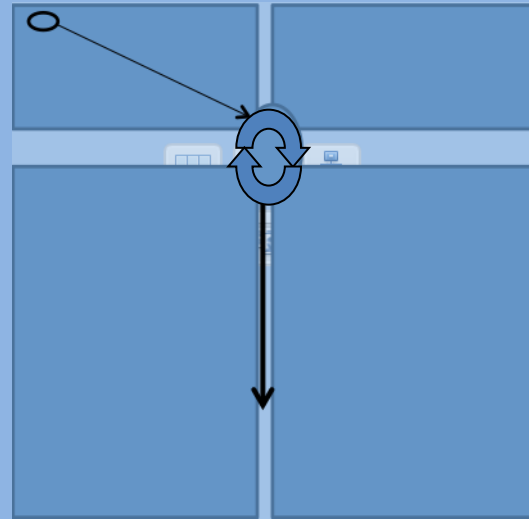


# Paroxystique: initiation dans veines pulmonaires

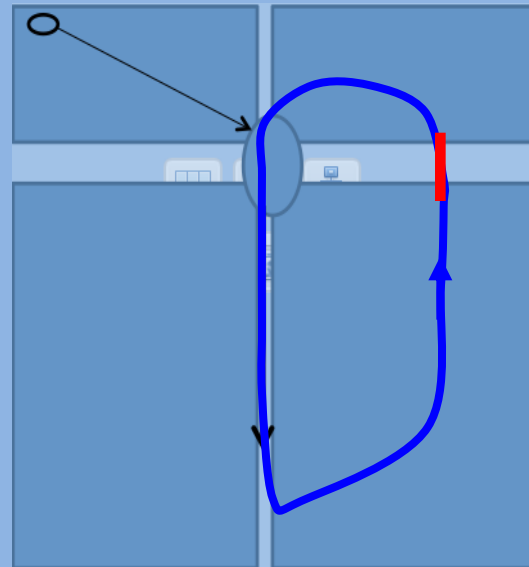


# Tachycardies jonctionnelles

– Rentrée intranodale

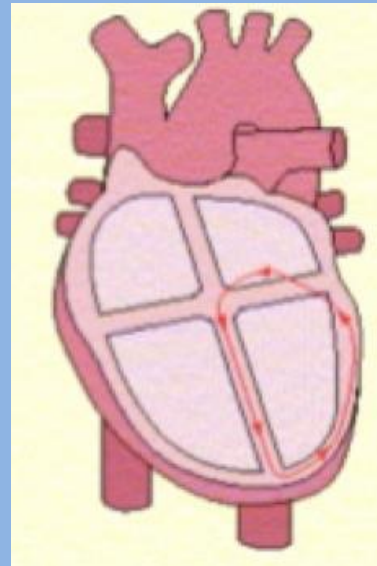
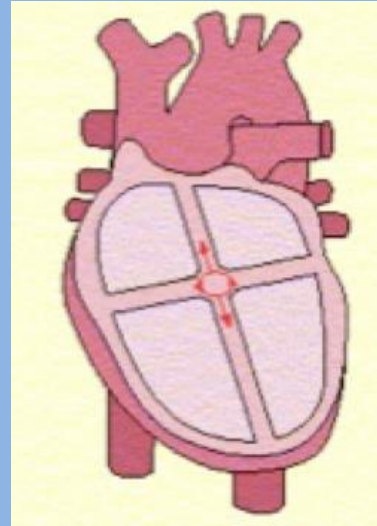


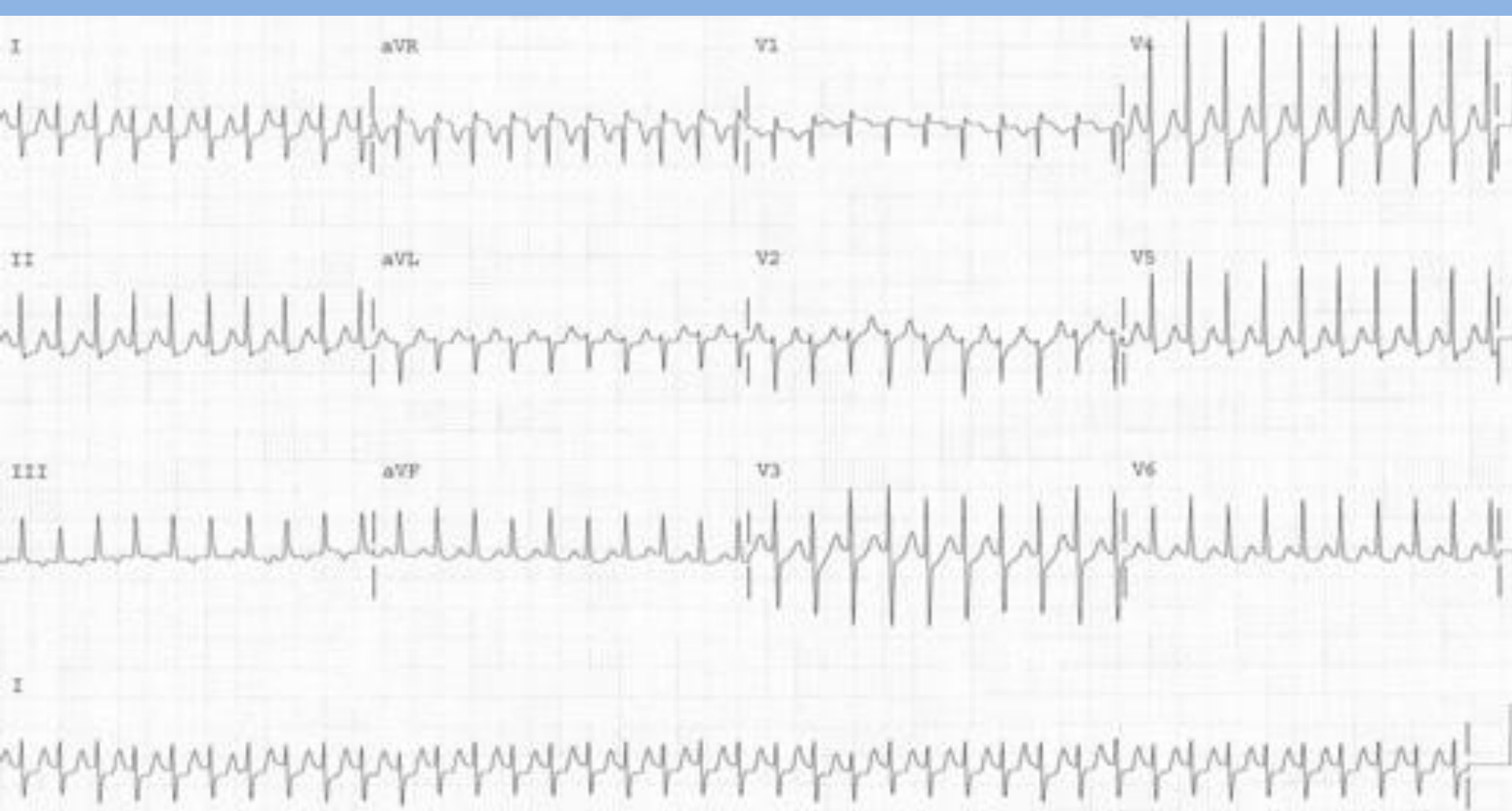
– Reentrée sur Kent



# Tachycardies jonctionnelles

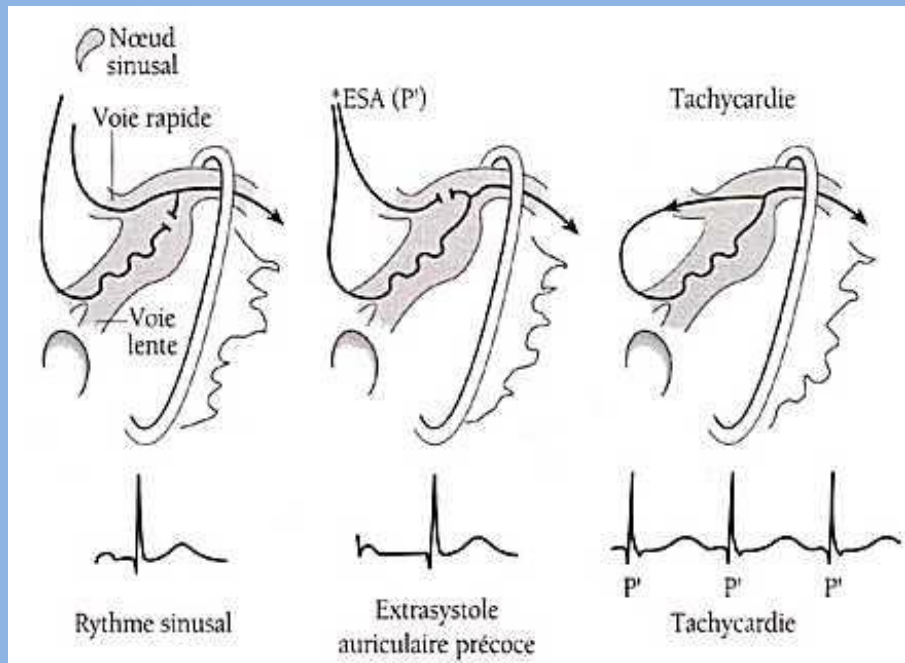
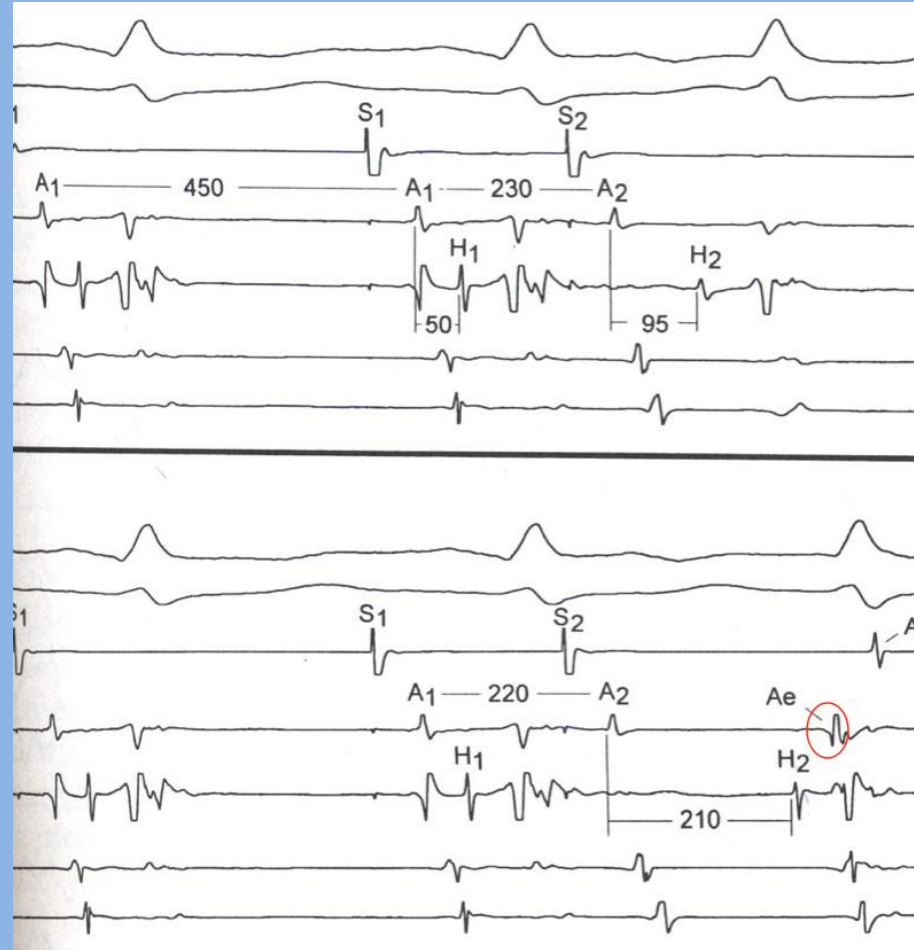
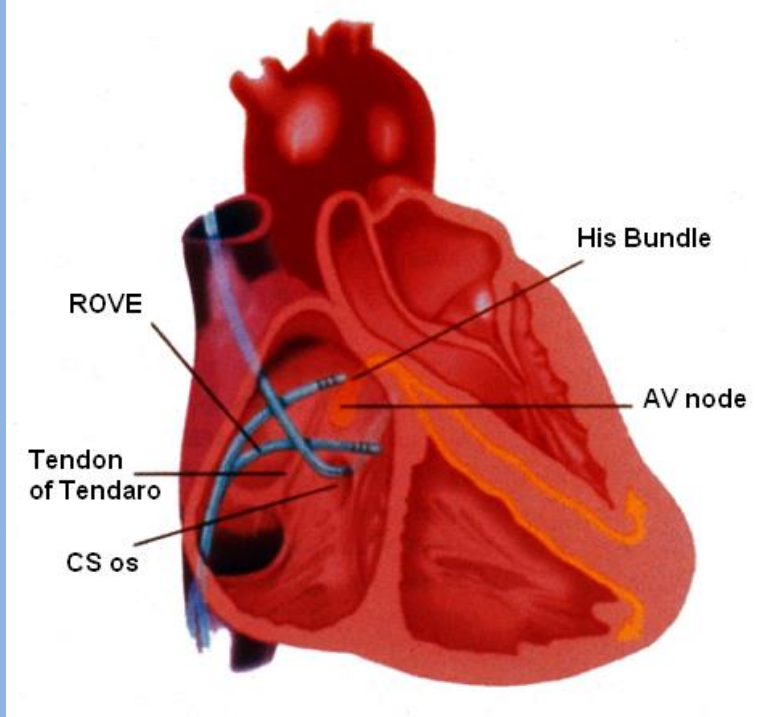
- NAV inclus dans le circuit
  - Dualité nodale: TRIN
  - Kent patent ou caché



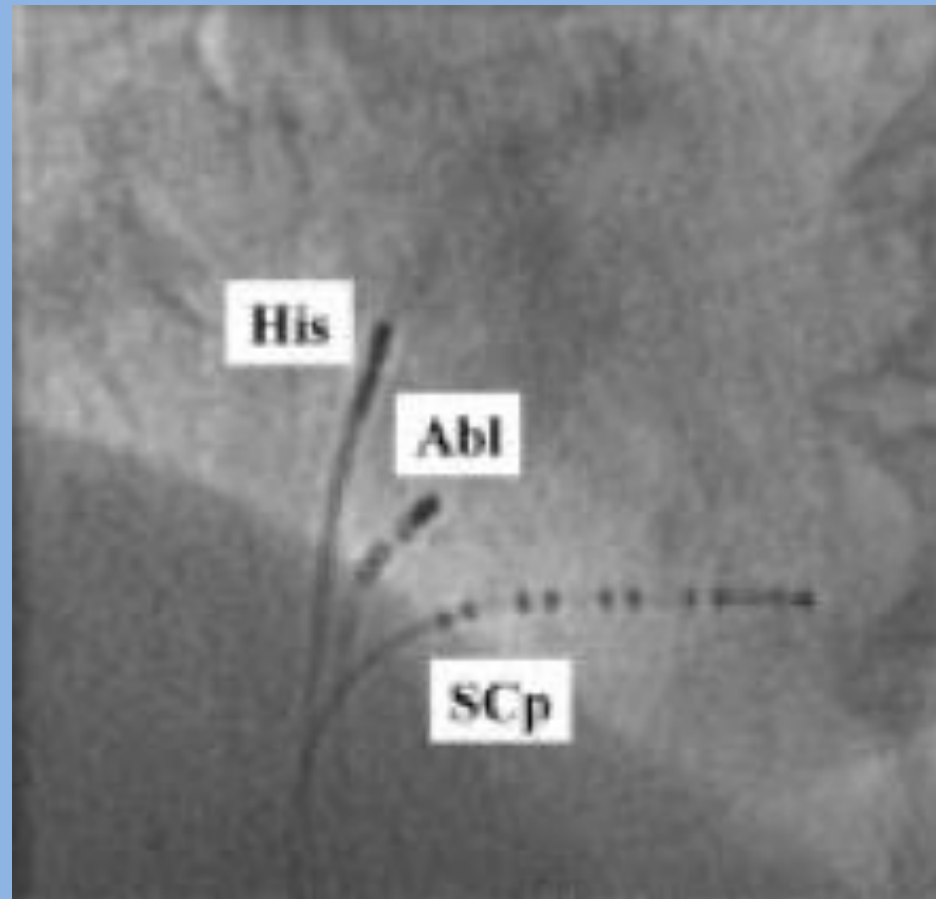
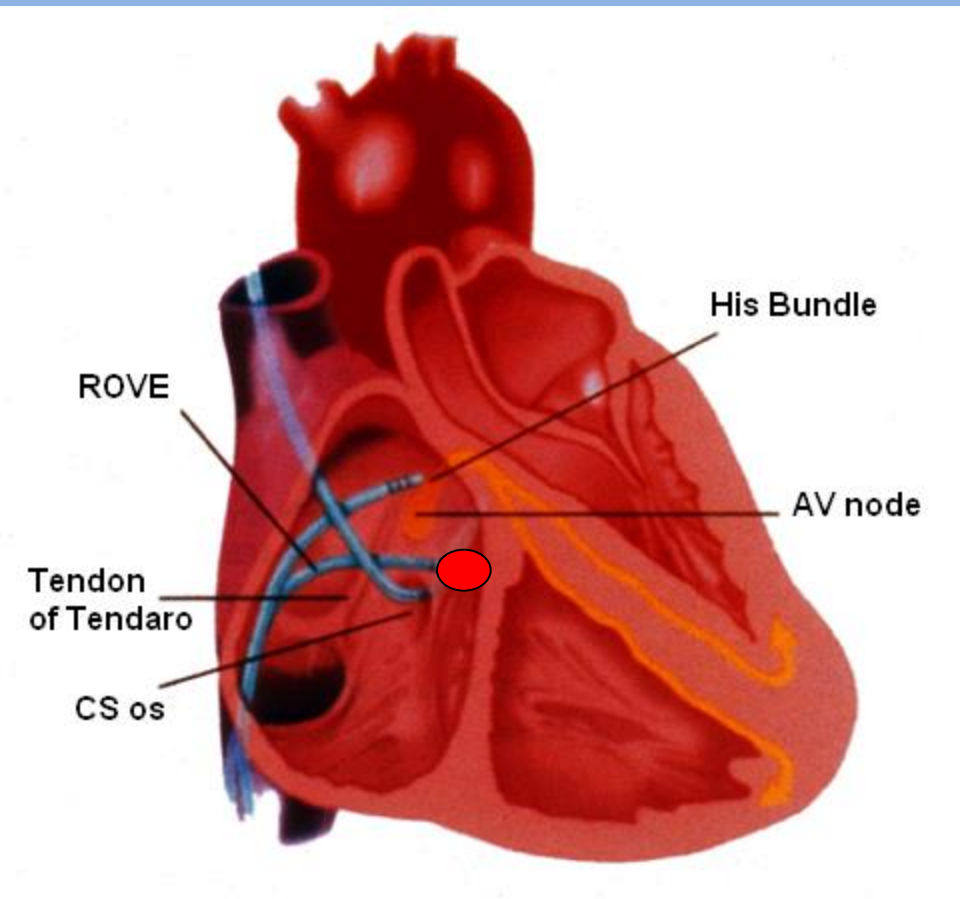


**Tachycardie jonctionnelle (1/1)**





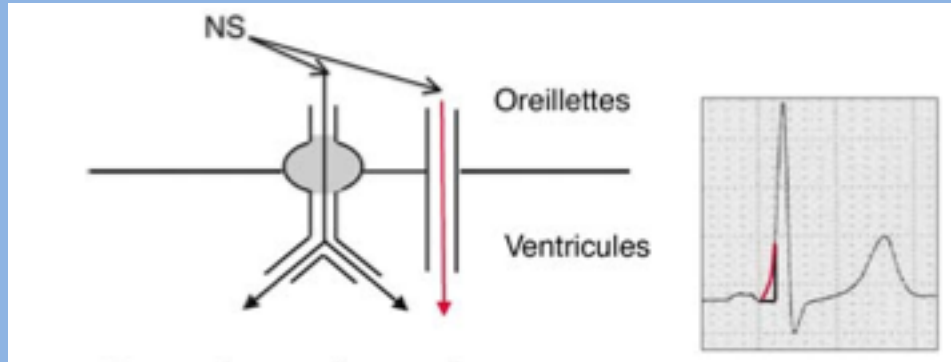
# ABLATION TRIN



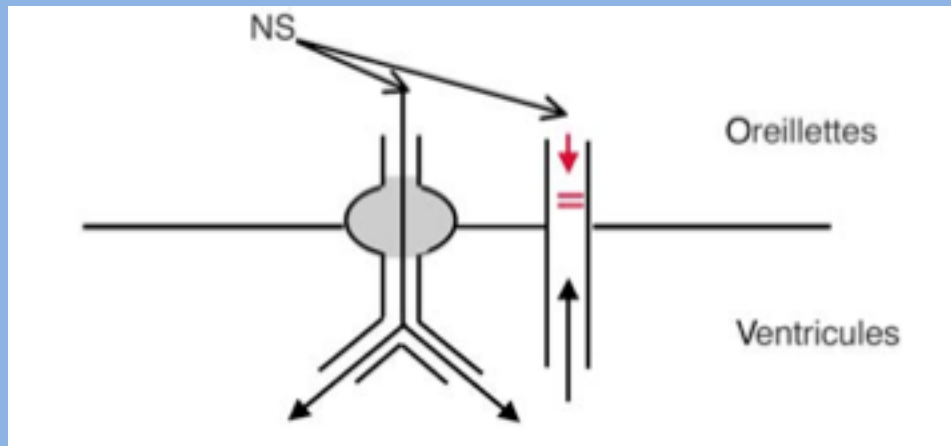
Source: Scheinman, M.M. Emerging Technologies in Antiarrhythmic Therapy; Creative Medical Communications, Inc., NY 1992: 1-33.

# TJ sur kent

Kent anterograde  
Sd WPW



Kent caché:  
seulement retrograde



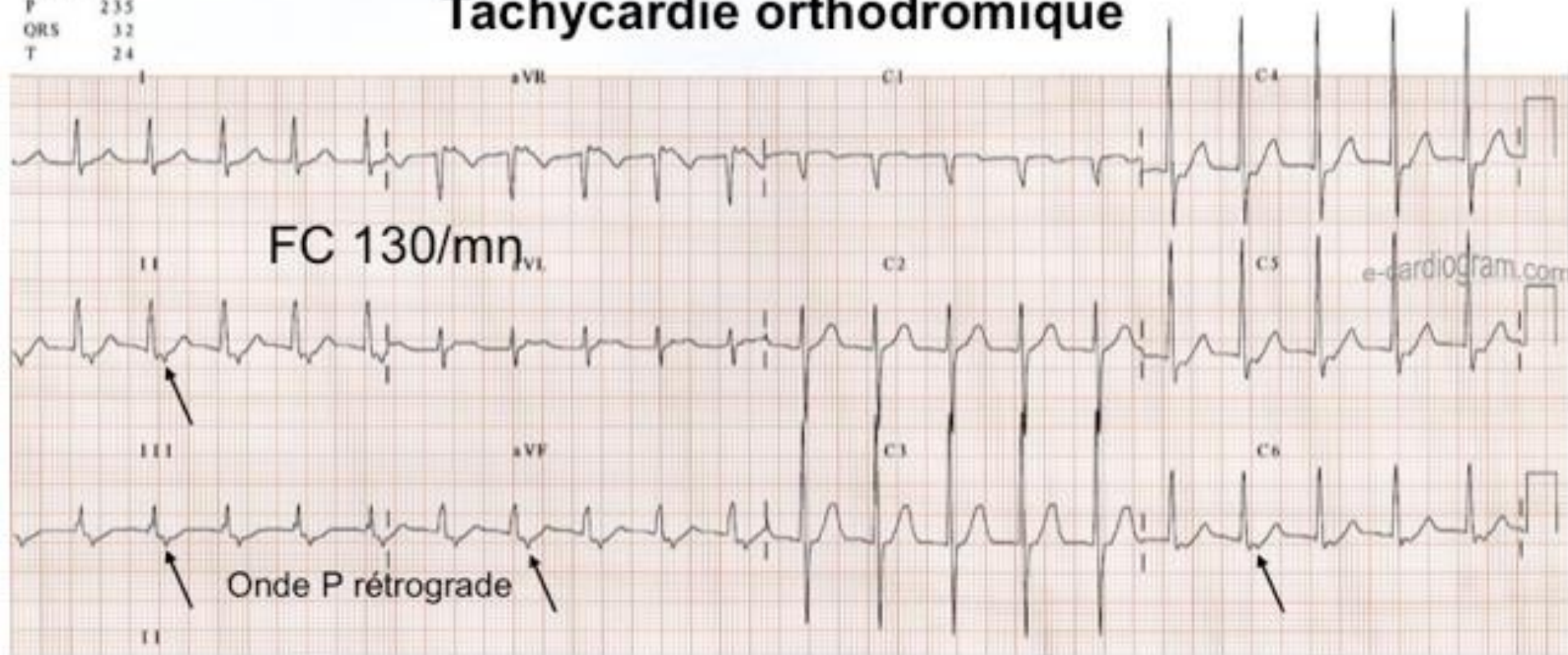
# Tachycardie orthodromique

--Axe--  
P 235  
QRS 32  
T 24

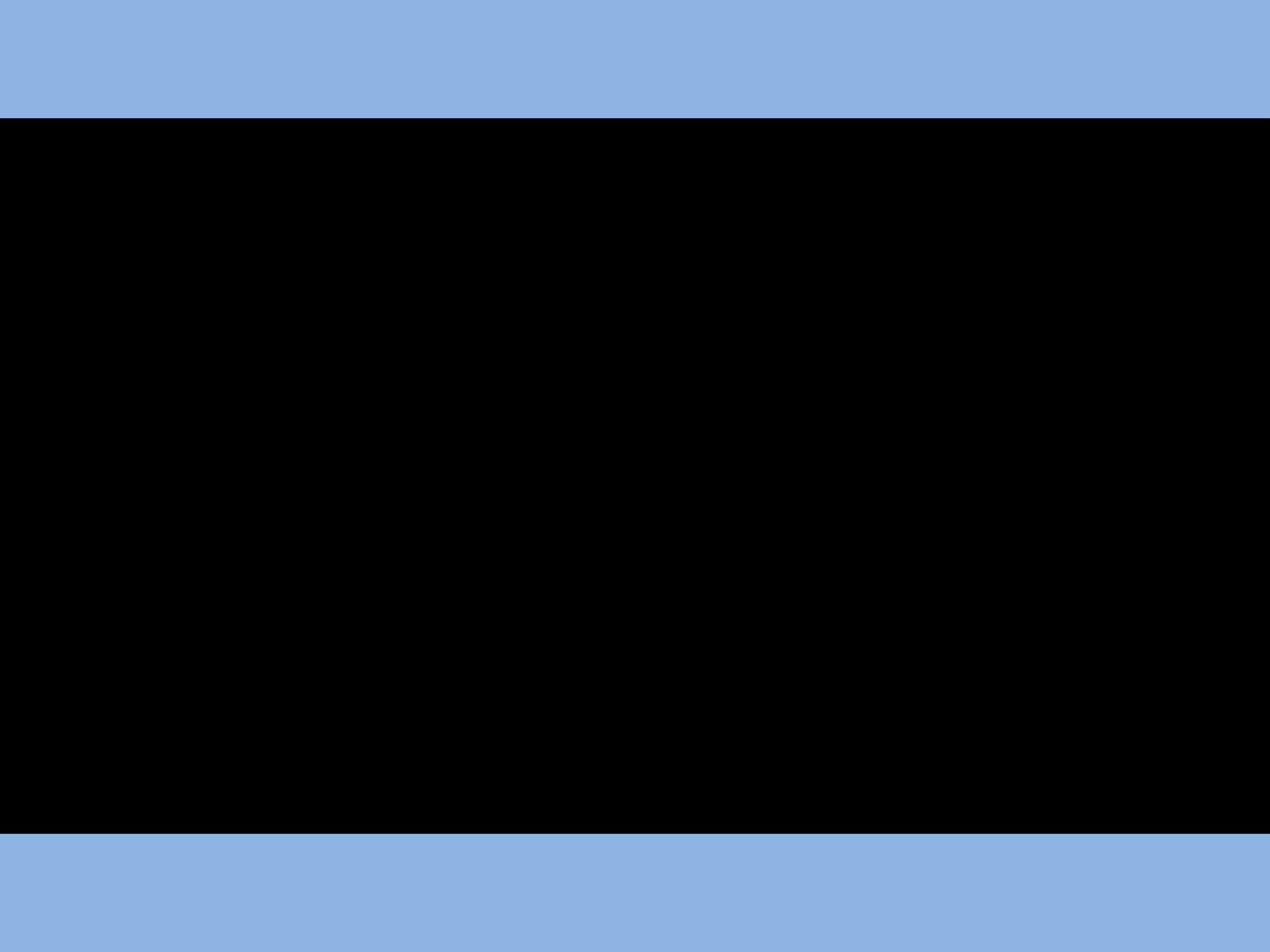
FC 130/mn<sub>VI</sub>

Onde P rétrograde

e-cardiogram.com





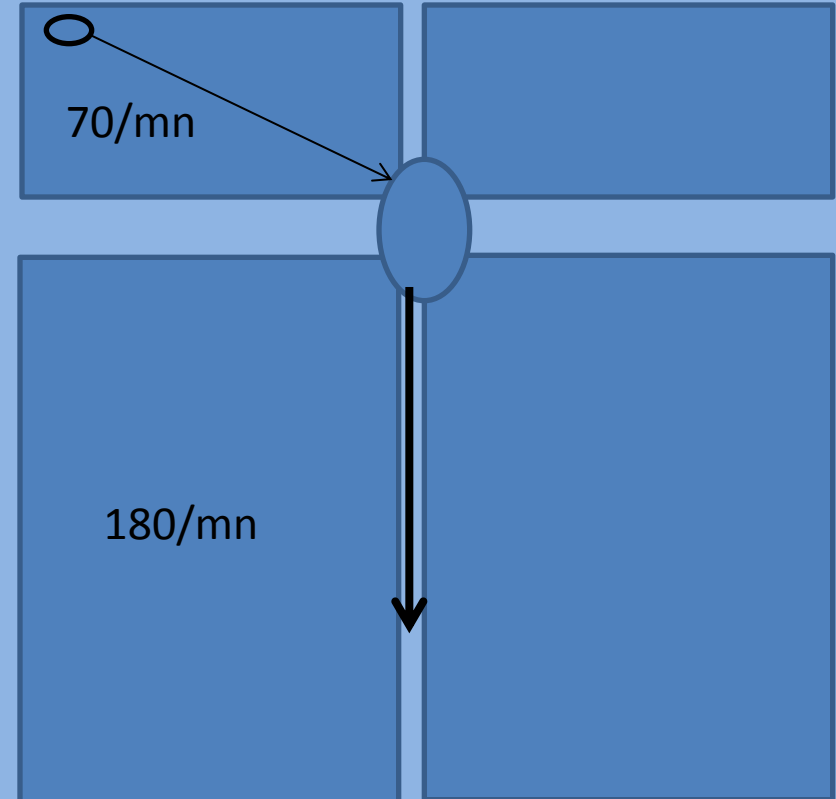
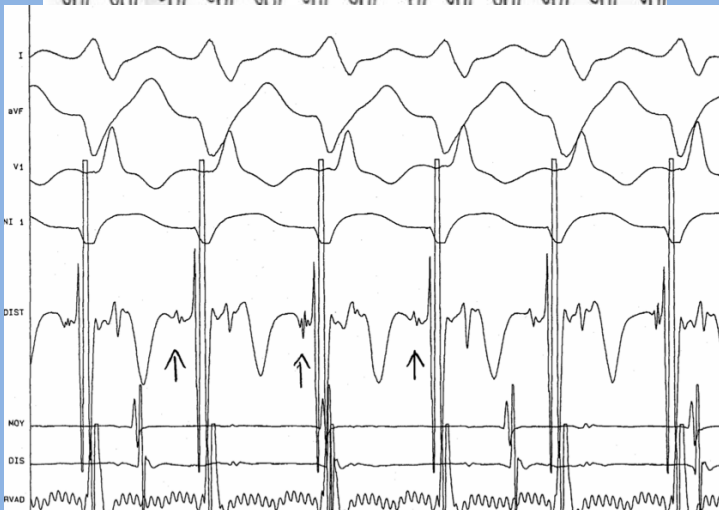
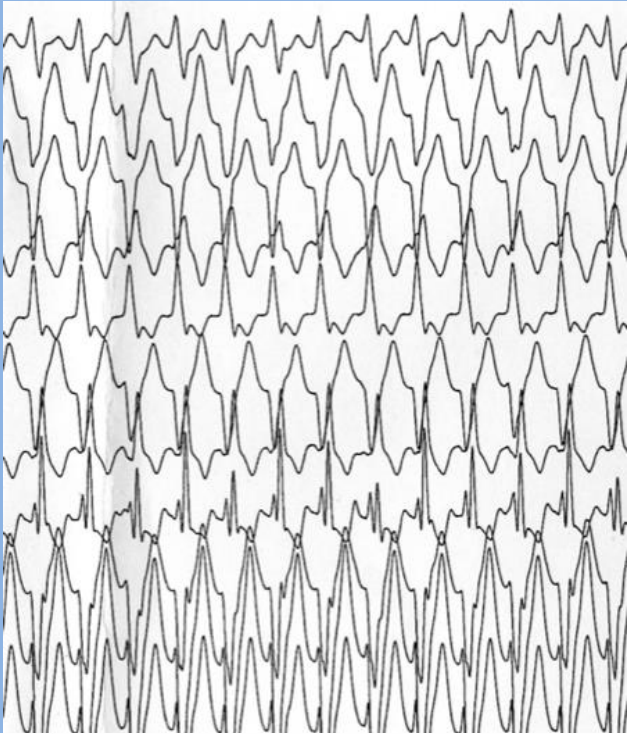








# Tachycardies ventriculaires



# Tachycardies ventriculaires

- Cicatricielle

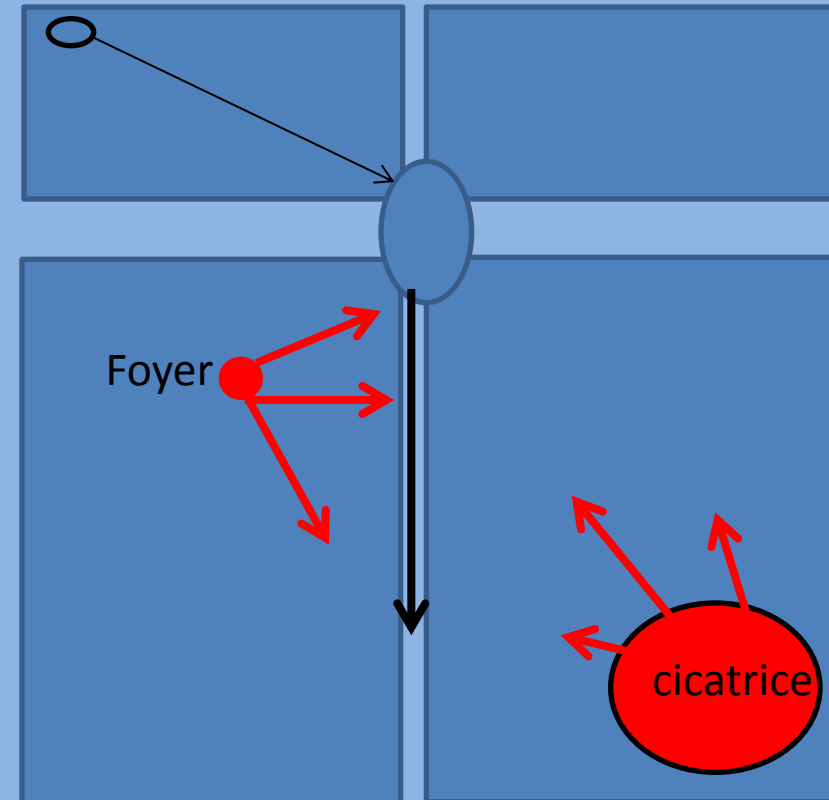
- Post IDM +++
- CMD
- DVDA

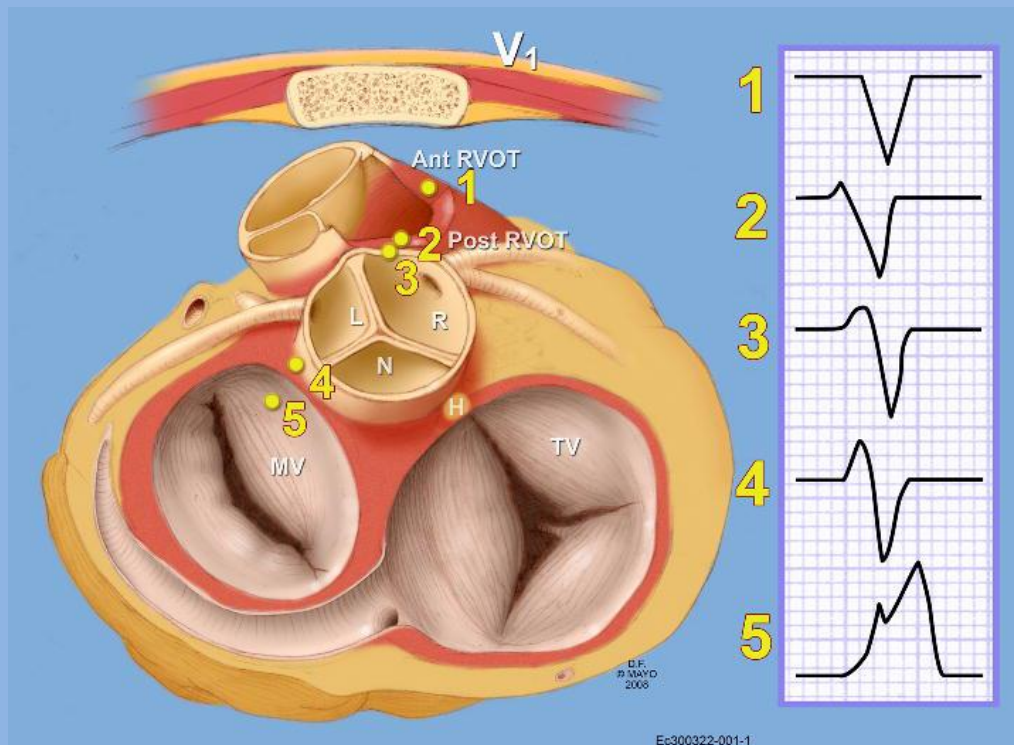
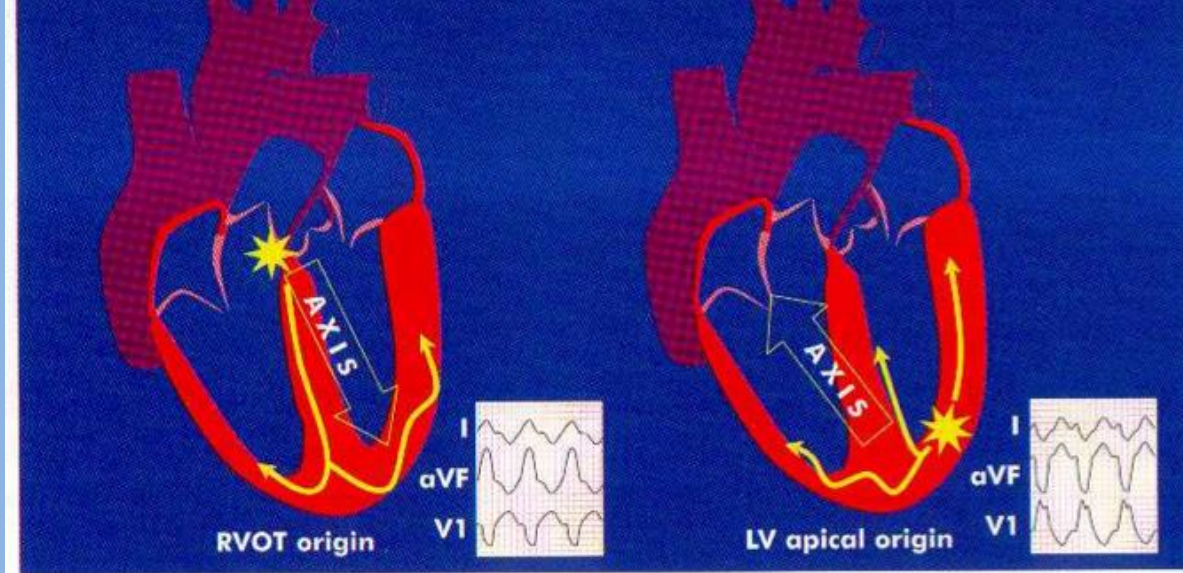
- Focale

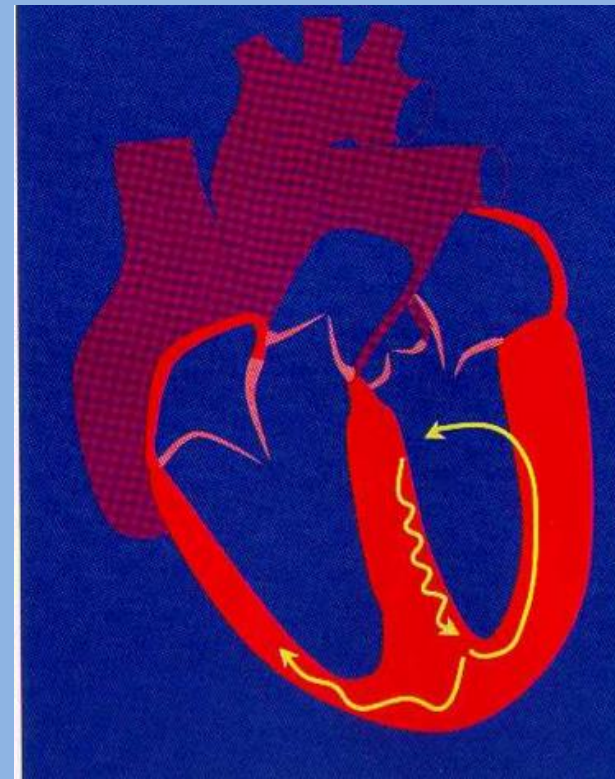
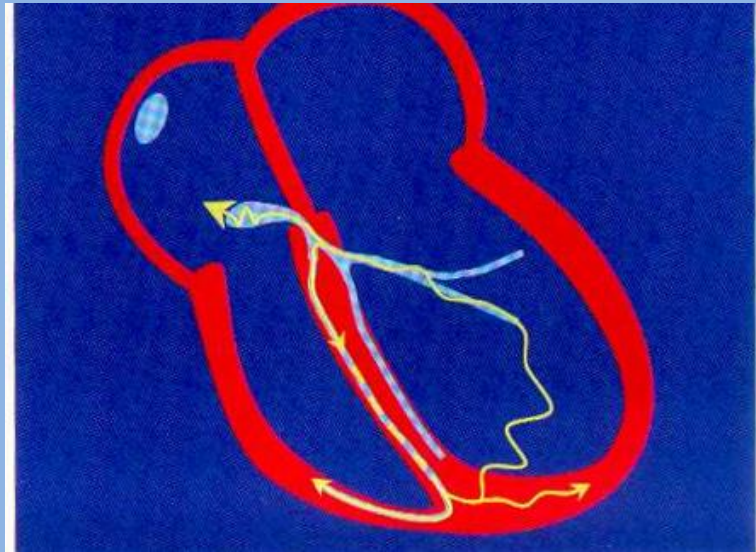
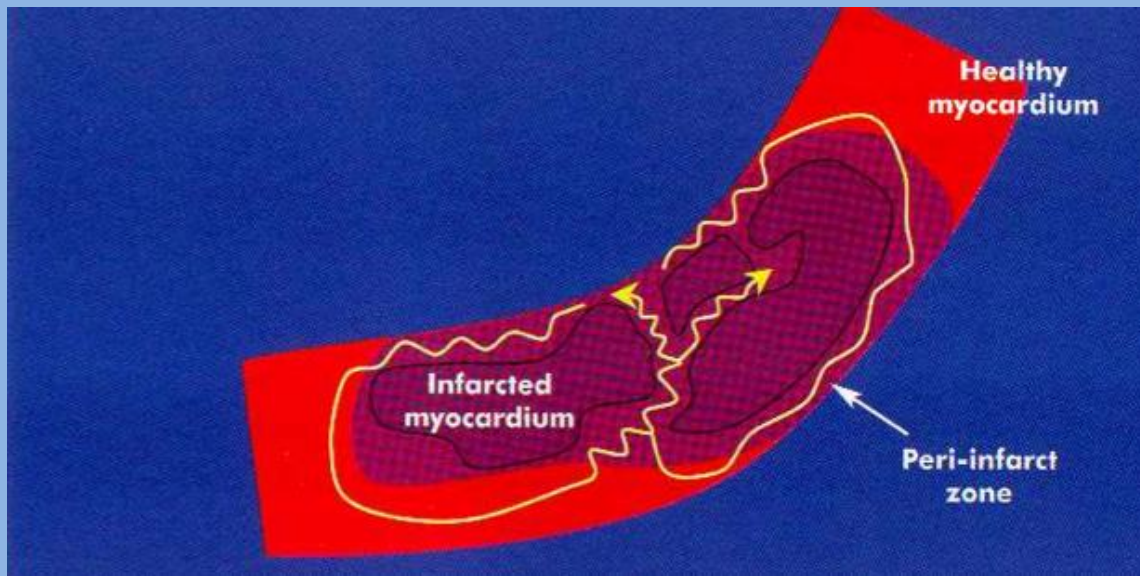
- Siege infundibulaireDt ++

70/mn

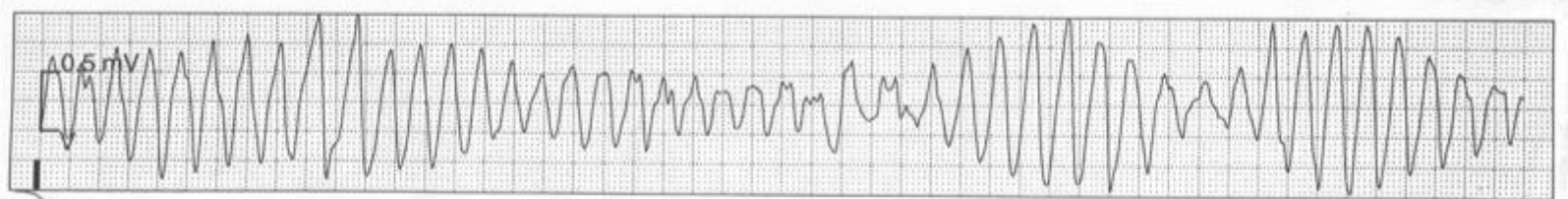
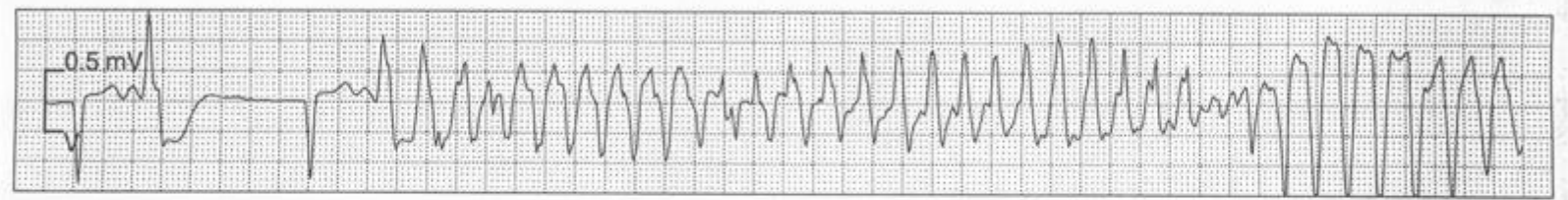
180/mn













# 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