Some Clinical Advances on Brugada Syndrome

Hu Kangxin¹, Pan Jie²*, Yao Wenliang¹

¹Clinical Department, Nanchang City Institute of Medical Science, Nanchang, China
²Literature Department, Nanchang City Institute of Medical Science, Nanchang, China

Email address:
hupei7758521@163.com (Hu Kangxin), panjie29@163.com (Pan Jie), 475644902@qq.com (Yao Wenliang)

To cite this article:

Abstract: Brugada syndrome is an inherited arrhythmogenic disorder that exhibits ECG ST-segment elevation with a negative T-wave in the right precordial leads (V₁-V₂), with normal heart structure, predisposing to VF and SCD. Its symptoms include syncope, nocturnal agonal respiration and cardiac arrest. Recently, researchers on Brugada syndrome have archived some advances, for example, regarding to exposing concealed Brugada 1 type ECG, besides pharmacological provocation, there are two other methods: putting right precordial lead on the second intercostal space or Holter monitoring; early repolarization (J-wave) has important value in prognostic judgment of Brugada syndrome; radiofrequency catheter ablation was generally applied only in epicardium of RVOT in the past, while it has been applied in endocardium of RVOT today. Therefore, the endocardium of RVOT can be considered as an alternative site in the treatment of recurrent VF in Brugada syndrome.

Keywords: Brugada Syndrome, Early Repolarization, Drug Provocation Test, Radiofrequency Catheter Ablation

1. Introduction

Brugada syndrome (BrS) is an inherited arrhythmogenic disorder that exhibits ECG ST-segment elevation and a negative T-wave in the right precordial leads (V₁-V₂), with normal heart structure, predisposing to VF and SCD. Its symptoms include syncope, nocturnal agonal respiration and cardiac arrest. Recently, researchers on Brugada syndrome have archived some advances, for example, regarding to exposing concealed Brugada 1 type ECG, besides pharmacological provocation, there are two other methods: putting right precordial lead on the second intercostal space or Holter monitoring; early repolarization (J-wave) has important value in prognostic judgment of Brugada syndrome; radiofrequency catheter ablation was generally applied only in epicardium of RVOT in the past, while it has been applied in endocardium of RVOT today. Therefore, the endocardium of RVOT can be considered as an alternative site in the treatment of recurrent VF in Brugada syndrome.

2. Some Diagnosing Problems

2.1. Brugada ECG Patterns [1]

There are 3 types of ECG patterns: (1)Type 1: Electrocardiogram of right ventricular lead (V₁-V₂) shows coved ST-segment elevation ≥2 mm, with the T-wave inversion, V₁-V₃ no equipotential separation; (2)Type 2: ST segment elevation, gradually becoming inferior oblique shape, followed by positive or bi-directional T-wave, saddle shape, J-wave amplitude higher than 2 mm; (3)Type 3: right ventricular lead ST segment elevation ≤1 mm, coved shape or saddle, or both. By now, only type 1 ECG pattern has diagnostic value to BrS, type 2 or 3 is not considered to be of any significance to the diagnosis. Even type 1 ECG pattern, due to the incomplete penetrance and the dynamic character of ECG, sometimes can be concealed. ECG diagnosis of BrS may face difficulties. For this there are 3 ways to overcome them.

2.2. Methods to Reveal Concealed Type 1 ECG Pattern

The following 3 methods are available for clinical use:
(1) Place ECG right ventricular lead high in the chest (until 2nd intercostal space) Antzelevitch and Nof [2] placed the right lead at high position (up to 2nd intercostal space), regardless of whether there is a drug challenge, the sensitivity of ECG determining BrS phenotype increased. Because only in high intercostal space position, ECG recording is easy and noninvasive. So this method is recommended as the alternative method for sodium channel blockers provocation test revealing type 1 ECG pattern. Only when this method failed, drug provocation test is considered. But the generalization of type 1 ECG diagnosing BrS caused by this method should also be taken into account.
(2) 12-lead 24-hour Holter monitoring (12L-Holter) Cerrato, et al [3] found the diurnal fluctuation of BrS ECG, and type 1 ECG was common at 12 o'clock noon until 6 pm. They think type 1 ECG pattern is measured more often by 12L-Holter than by regular ECG habitual trace. This means 12L-Holter may cancel 20% patients with non-risk-free sodium channel blocker drug provocation test. Therefore, 12L-Holter should be considered as the first-line screening test.

(3) Drug provocation test According to the opinion of Antzelevitch and Brugada [4], the drugs and their dosage used in provocation test are as follows: Ajmaline: 1mg/kg/5min, intravenous; Flecaïnide: 2mg/kg/10min; Propafenone: 10mg/kg/10min. The commonly used drugs are Ajmaline and Flecaïnide in foreign countries and Propafenone in the domestic [5]. Now brief introductions are as follows: (A)Ajmaline: Considering the research results so far, UzielBo-Zyczkowski, et al [6] applied Ajmaline because of its highest sensitivity and specificity as well as the drastical reduce of complications in the same time test. Another reason to choose Ajmaline was its short half-life (near 10min), which was convenient for a short time post-test observation on patients in hospital not more than 1 day. Conte, et al [7] think that 1.8% of patients with this drug test can produce sustained supraventricular arrhythmias (sVAs), but none of them occurs sudden cardiac death or further fatal ventricular arrhythmias later. (B) Flecaïnide: Compared with Ajmaline, its effect is slightly inferior. Because Ito is the basic mechanisms of pathogenesis of BrS [2], it is believed that the inhibition of Ito by Flecaïnide becomes the basis of this difference. Drubner, et al [8] used a single oral dose of 400mg Flecaïnide and suggested that BrS typical coved ECG pattern (type 1) do not occur atrioventricular block or atrial tachyarrhythmia. Calvo, et al [9] (2015) suggested that ECG changes have time dependence on the reaction of Flecaïnide. Recording for a long time (10–90min), the rate of type 1 ECG pattern has a progressive increases. However, there are some

### 12L-Holter

The ECG change characteristics of BrS has been described above, and will not be repeated here. Early repolarization(ER) is characterized by J-point elevation, QRS terminal fuzzy, with or without ST-segment elevation, J-point and/or ST-segment elevation 0.1mV from at least two adjacent lead baseline [12, 13]. J-wave syndrome is an immediate deflection after the QRS wave on surface electrocardiogram. When R is covered partly, it seems to be J-wave elevation or ST-segment elevation [14]. Because of the significant features of J-wave forming BrS and early repolarization syndrome (ERS), both of BrS and ERS have the common Ito-mediated J-waves electrocardiographic findings, clinical consequences,
risk factors and the same arrhythmia platform. Thus, Antzelevitch [12, 15] advocated that these syndromes should be classified under the heading of J-wave syndrome, although this 3 types are different in the wave amplitude and the lead placement sites of abnormal J-wave. It should be noted that J-wave>0.1mV accompanied by decline or horizontal ST segment is a malignant ER mode [16], which can be differentiated from BrS in the ECG.

It should be emphasized that ER (J-wave) is of great value in the prognosis judgement of BrS. Kawata, et al [17] think that ER (permanent or intermittent) occurring in lower (II, III, aVF) and lateral (I, avL, V4-V6) lead is the independent predictor factor of fatal arrhythmia events for BrS. Talkaqi, et al [18] evaluated the value of J-wave and J-wave morphology in the prognosis of BrS. They found that patients with the lower or lateral lead J-wave or with horizontal ST segment elevation had higher rate of cardiac events than those without J-wave. Multivariate analysis showed that symptoms, the V2 lead QRS>90ms and the lower, lateral lead J-wave and/or horizontal ST segment morphology after J-wave are important to predict the heart accident of BrS.

Although the first expert consensus, BrS ECG diagnosis has been confirmed, because of the dynamic and concealed characteristics of ST segment, and the appearance of BrP, so the BrS diagnosis cannot solely rely on ECG. Confirmed diagnosis must be combined with one of the following 4 conditions [1, 2]: (1) family history, and family members younger than 45 have had sudden cardiac death or the family has type 1 ECG pattern; (2) arrhythmia related symptoms, such as syncope, and epileptic seizures and nocturnal agonal respiration; (3) ventricular arrhythmia as polymorphic ventricular tachycardia(PVT) or VF; (4)programmed electric stimulus can induce VT/VF.

4. Some Progress in Treatment of BrS

Until 2015, the unanimous view [1, 2, 19, 20] is: the countermeasures against BrS sudden cardiac death is the implantable cardioverter defibrillator (ICD). But ICD therapy is accompanied by inappropriate electrical shocks caused by ventricular bradycardia attack and instrument complications [20]. Because ICD has such shortcomings, it has been reported in the literature [19, 21] that radiofrequency catheter ablation method is used to treat inappropriate shock or ICD-rejecting patients of BrS with VF. Nedemanee, et al [22] noted that amplitude of abnormal ECG was higher in epicardial than that in endocardium of right ventricular outflow tract, so that radiofrequency catheter ablation was applied in epicardial location. In 89% of patients with BrS, ECG pattern had been normalized. Sunsaneewitayakul, et al [23] noticed when using equipotential mapping, late activation zone(LAZ) as electrical activity was recorded from J point to RVOT endocardial surface ECG lead V1 and V2 + 60ms interphase. Radiofrequency catheter ablation of endocardium LAZ was used to modify Brugada ECG pattern of VF storm patients. VF did not recur during the follow-up period. It seems to be considered that RVOT endocardial is an alternative location for radiofrequency catheter ablation treating recurrence of VF in patients with BrS.

When it is not easy to get ICD areas or radiofrequency catheter ablation cannot be carried out, drug treatments are available: 1)Ito blockers: (1)Quinidine: The existence of significant Ito is the basic mechanisms of BrS, so using quinidine is a wise "transitional treatment"("Bridging therapy"). The disadvantages of oral quinidine include gastrointestinal adverse reactions, delayed rectifier current (Ikr and Iks) quickly and slowly activated by quinidine block, easily occurring acquired long QT syndrome. Another point to mention is the efficacy of quinidine decreases if its dosage is too large. Because in high plasma concentrations, quinidine also blocks inward sodium current (INa), INa may fight the increases of repolarization spatial diffusion and the blocking effects of Ikr and Iks that trigger torsades de points(TdP). (2)Tedisamil: Without significant inward current block effect like quinidine, it may be more effective than quinidine. 2)Isoproterenol: This drug can reduce vagus nervous tension, increase heart rate, and thus help reduce Ito current. It is effective in acute and chronic treatment of patients with VF storm. 3)Cilostazol: a kind of phosphodiesterase III inhibitors. It has the potential to enhance calcium current (ICa), decrease the Ito secondary to the increase of heart rate, and can make the ST segment of BrS normalize and prevent VF. 4) Dimetyl lithospermate B (dmLSB) [21, 24]: It is extracted from salvia miltiorrhiza for traditional Chinese medicine herbal remedy. Fish, et al [24] reported that dmLSB slows INa inactivation, leading to the increase of early action potential inward currents, and has antiarrhythmic effects on BrS. It is worthy of further study and application of medical workers in China.

References


