A 70-year-old woman was admitted to hospital due to recurring symptomatic sustained ventricular tachycardias (VTs). She was diagnosed with ischaemic cardiomyopathy with low ejection fraction (20%). She also had left bundle branch block and chronic heart failure in New York Heart Association class III. Blood electrolyte levels were normal. Coronary angiography showed a preserved effect of previous angioplasty. *Clostridium difficile* infection was identified. Increasing levels of C-reactive protein and procalcitonin were observed. Despite treatment with metoprolol (100 mg per day) and amiodarone (1200 mg per day), VTs kept recurring; they had morphology of right bundle branch block with right axis deviation and cycle length of 240 ms. Ablation was performed using an anatomical visualisation system (CARTO). Potential map of the left ventricle revealed a large scar region. During left ventricular mapping VTs of the same morphology were induced with programmed ventricular stimulation (PVS). Areas of low conduction were removed. After ablation of late potentials, PVSs demonstrated non-induction of VT. No arrhythmias were observed directly after the ablation, but an iatrogenic third-degree atioventricular block occurred. The patient required temporary stimulation with antiarrhythmic medications, sedatives, and invasive methods is required. The OPTIC study showed that prevention of VT recurrence in patients with ICDs is effective with a combination of amiodarone and β-blockers [1]. In this case, no such identifiable cause was found. In such situations treatment with antiarrhythmic medications, sedatives, and invasive methods is required. The OPTIC study showed that prevention of VT recurrence in patients with ICDs is effective with a combination of amiodarone and β-blockers [2]. In our patient, amiodarone with metoprolol did not prevent VT recurrence. The next step in the treatment is ablation, which not only should act as an effective treatment — both ATP and CVs were successful treatments in the case of VT recurrence. The dual-coil lead was implanted because the can was not placed under the skin but externally. The defibrillation dipole was programmed from coil to coil in order to ensure appropriate defibrillation impedance and prevent skin burning during CV. It proved to be an effective treatment — both ATP and CV were successful. Programming of the VT zone was performed, although it was not line with the guidelines because previous VTs caused immediate deceleration of the patient.

**References**


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**Conflict of interest:** none declared

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