HEART AND VASCULAR INSTITUTE

Johns Hopkins Arrhythmia Service

A guide for patients and their families
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Welcome to Johns Hopkins Arrhythmia Service. Our service exists to provide patients with timely as well as accurate diagnoses and therapies. We do this by using advanced technologies and by working as a team with you, your family and your physician to help you return to normal daily activities as soon as possible.

The Arrhythmia Service began in the early 1970s with two goals: to provide leading-edge clinical care for patients with abnormal heart rhythms (arrhythmias), and conduct research to determine the cause of arrhythmias and develop therapies for patients who have arrhythmia-associated problems.

As the first such service in Maryland and one of the first in the United States, the Johns Hopkins Arrhythmia Service rapidly took on a leadership role. An early success was the development and use of the first implantable cardioverter defibrillator (ICD). In 1980, Levi Watkins, M.D., first implanted this device, invented by Michel Mirowski, M.D., and Morton Mower, M.D., in a patient who had experienced numerous episodes of life-threatening arrhythmias. Since then, ICDs have saved hundreds of thousands of lives and ICD implantation is currently recognized as the most effective treatment to prevent sudden cardiac death. Doctors in our Arrhythmia Service also focus their efforts on catheter ablation, a minimally invasive technique that can cure a number of arrhythmias. Other areas of major interest include the causes and treatment of atrial fibrillation, stroke prevention, evaluation and management of syncope, diagnosis and treatment of inheritable arrhythmias such as arrhythmogenic right ventricular dysplasia, prevention and treatment of both common and rare problems that may cause sudden cardiac death, device therapy for monitoring and treatment of congestive heart failure, and further improving pacemaker and ICD lead extraction therapy. Now, more than four decades after setting out on this journey, the Johns Hopkins Arrhythmia Service has grown dramatically. Our 14 clinical electrophysiologists evaluate nearly 10 thousand patients in the outpatient setting and perform more than 4000 interventional electrophysiology and device procedures each year.

Our physicians, nurses and technologists are available to explain tests and procedures to you and your family, answer questions, and guide you as you proceed through the diagnostic and treatment process. Some of your questions may be answered by the information we have assembled here for you, but don’t hesitate to ask more questions. Understanding your care is an important part of a complete recovery.

Sincerely,

Hugh Calkins, M.D.
Nicholas J. Fortuin, M.D., Professor of Cardiology
Professor of Medicine
Director, Arrhythmia Service and Electrophysiology Laboratory
Director, Johns Hopkins ARVD/ARVC Program

“Johns Hopkins is dedicated to providing the best clinical care possible for all of our patients—everything we do starts from that simple fact.”

Hugh Calkins, M.D.
Electrophysiology is the study of electrical activity in the heart—that is, how the heart beats. Our doctors are cardiologists who specialize in the electrical system of the heart. Cardiac electrophysiologists (arrhythmia specialists) rely on a patient’s medical history and the results of a variety of procedures to diagnose heart rhythm abnormalities. Once the electrical disorder is diagnosed, the arrhythmia specialist works with your doctor to determine the risk posed by the heart rhythm abnormality and recommend treatment. Together you, your primary care doctor or general cardiologist, and the arrhythmia specialist decide on the most appropriate treatment for you.
The heart is a four-chambered muscle that pumps blood, which carries oxygen and nutrients throughout the body. The two upper chambers of the heart, the right atrium and the left atrium, receive and collect the blood, and the lower chambers, the right and left ventricles, pump the blood. Specifically, the right atrium receives oxygen-depleted blood from the body and the right ventricle pumps it through the pulmonary artery to the lungs, where it picks up oxygen. At the same time, the left atrium receives oxygen-rich blood from the lungs and the left ventricle pumps it through a large artery, called the aorta, to the rest of the body.

“I take pride in our ability to tackle not just routine cardiac procedures but rare and complex ones as well.”

Ronald Berger, M.D., Ph.D.
Co-Director of Cardiac Electrophysiology
Blood is pumped through the heart via muscle contractions, which must be electrically stimulated. In a normally functioning heart, the electrical signal starts in the upper right chamber of the heart in the sinus node, often referred to as the heart’s natural pacemaker. This signal causes the upper chambers, the atria, to contract and squeeze blood into the lower chambers, the ventricles. The signal then travels to the atrioventricular (AV) node, located between the atria and the ventricles, where it is delayed for a fraction of a second. This delay allows the ventricles to fill completely with blood. The electrical impulse then travels rapidly through the bundle of His and then the right and left bundle branches.
Once the lower chambers are filled, the electrical impulse moves through a network of specialized fibers (the right and left bundles) that stimulate the ventricles to contract and pump blood to the lungs and the rest of the body. Normally, the heart’s electrical system triggers the heart to beat in this precise sequence approximately 60 to 100 times each minute while resting. This is referred to as normal sinus rhythm. The heart rate will normally increase to above 100 times per minute with exercise.
What Are Arrhythmias?

An arrhythmia is an abnormality in the timing or pattern of the heartbeat. Arrhythmias may cause the heart to beat too rapidly, too slowly or irregularly. They are common and may cause a wide variety of symptoms, such as a racing, skipping or fluttering sensation (called palpitations) in your chest.

Cardiac arrhythmias also may cause lightheadedness, fainting, chest pain, shortness of breath, fatigue or no symptoms at all. Many types of arrhythmia are merely nuisances; other types may be serious problems because they cause the patient to develop heart failure, pass out or even die suddenly when the heart beats too slowly or too rapidly to pump blood to the body.

Our electrophysiology labs are equipped with state-of-the-art 3-D electroanatomic computerized mapping equipment and biplane fluoroscopy to facilitate complex catheter ablations and reduce the amount of X-ray exposure. The doctor routinely meets with the patient beforehand to explain the procedure and answer any questions.
THERE ARE FOUR MAJOR KINDS OF ARRHYTHMIAS

1. Irregular or Extra Heartbeats
(also referred to as atrial premature beats or ventricular premature beats)

Each year our heart beats about 100,000 times. Most of these heartbeats occur with a very regular timing. However, irregular or extra beats can happen when an electrical signal starts someplace other than the sinus node and causes the heart to beat irregularly. Depending on the precise timing of the extra beat, a patient may experience an “extra beat,” a “skipped beat,” a “forceful beat” or a “fluttering sensation.” Many patients are completely unaware that they are experiencing extra heartbeats. Even completely healthy people have irregular or extra heartbeats, especially as they get older. Usually, they are nothing to be concerned about. In some cases, however, irregular or extra beats can cause bothersome symptoms, can be the first sign of underlying heart disease, or may lead to heart failure or sustained rapid rhythms.
2. Supraventricular Tachycardia

Supraventricular tachycardia (SVT) is a series of rapid heartbeats that begin in or involve the upper chambers (atria) of the heart. SVT can cause the heart to beat very rapidly or erratically. As a result, the heart may beat inefficiently, and the body may receive an inadequate blood supply. There are three major types of SVT.

Atrial Fibrillation

Atrial fibrillation results from the rapid and uncoordinated firing of electrical impulses from multiple sites in the upper chambers, which causes ineffective atrial contractions. Some of these impulses travel to the ventricles, resulting in irregular, erratic (chaotic) and rapid heart rhythm. Atrial fibrillation is the most common type of SVT, affecting nearly 5 million people in the United States alone. Atrial fibrillation occurs most commonly in patients over 50 years of age and those who have other types of heart disease. Sometimes, atrial fibrillation occurs in young, otherwise healthy individuals. Atrial fibrillation can cause a wide variety of symptoms and can increase the risk of developing a stroke. As a result, patients who have atrial fibrillation often require treatment with medications or catheter ablation procedures. Treatment with a blood thinner such as Coumadin or one of the newer anticoagulant medications is also recommended to lower the risk of stroke.

For patients with atrial fibrillation who are at high stroke risk but cannot take blood thinners due to bleeding risks, new devices to occlude the atrial appendage can be implanted percutaneously or through minimally invasive surgical techniques. These devices reduce stroke risk and eliminate the need for a lifelong blood thinner.
Atrial Flutter and Atrial Tachycardia

“Typical atrial flutter” results from a single “short circuit” in the right atrium. This short circuit causes the atria to beat at about 300 beats per minute while the lower chambers of the heart (the ventricles) beat at a slower rate (often 75 to 150 beats per minute). Like atrial fibrillation, atrial flutter occurs most commonly in elderly patients and those with other types of heart disease. It also can cause a wide variety of symptoms and increase the risk of developing a stroke. Treatment options include various types of medications as well as catheter ablation, which cures the problem in most patients.

Less commonly, a patient may have “atypical atrial flutter,” which results from a short circuit in an unusual location such as the left atrium or near scar tissue. Some patients have atrial tachycardia, a rapidly firing focus that may originate from either atria. These arrhythmias also usually warrant medical therapy or complex catheter ablation.
Paroxysmal Supraventricular Tachycardia

Paroxysmal supraventricular tachycardia (PSVT) is another type of “short circuit” arrhythmia. It may result from either atrioventricular nodal re-entrant tachycardia (AVNRT) or from an accessory pathway, which may occur as part of Wolff-Parkinson-White syndrome.

PSVT may occur at any age and commonly occurs in patients who have no other types of heart disease. Patients with PSVT typically describe a rapid, or racing, regular heartbeat (between 130 and 230 beats per minute) that starts and stops abruptly. It is commonly misdiagnosed as a panic attack. Except for some patients with Wolff-Parkinson-White syndrome, PSVT generally is not a dangerous arrhythmia. However, it can result in debilitating symptoms. Treatment options include a variety of drugs or catheter ablation, which cures the problem in most patients.

With AVNRT, a small extra pathway exists in or near the AV node. If an electrical impulse enters this pathway, it may start traveling in a circular pattern that causes the heart to abruptly start beating fast and irregular.
Wolff-Parkinson-White syndrome occurs when there is an extra connection between the atria and ventricles (accessory pathway). The presence of this second connection between the atria and ventricles is a setup for developing a “short circuit” arrhythmia: Electrical impulses may start traveling in a circular pattern and cause the heart to beat too rapidly (AVRT: atrioventricular reciprocating tachycardia). Under rare circumstances, patients with Wolff-Parkinson-White syndrome can develop an extremely rapid heart rhythm abnormality that may be life-threatening.
3. Ventricular Tachycardia

Ventricular tachycardia (VT) is a series of rapid heartbeats that originate in the lower chambers of the heart (the ventricles). As a result, the heart may beat inefficiently, and the body may receive an inadequate blood supply. Ventricular tachycardia most often occurs when the heart muscle has been damaged by a heart attack or some other disease, creating abnormal electrical pathways in the ventricles.

This type of tachycardia may last only a few beats and cause no problems; however, it may continue and lead to life-threatening arrhythmias and cardiac arrest. Treatment options include medications, catheter ablation or placement of an implantable cardioverter-defibrillator (ICD).
4. Bradycardia

Bradycardia is a slow heart rate, when the heart beats less than 60 times per minute. In some patients who are otherwise healthy, the heartbeat may slow to less than 60 beats per minute while resting or sleeping. This usually causes no symptoms and does not require treatment. In other patients, bradycardia may occur due to age-related wear and tear on the heart or some other heart condition, and may cause undue fatigue, lightheadedness or fainting (syncope). There are two basic types of bradycardia.

Sick sinus syndrome occurs when the sinus node (the heart’s own pacemaker) fails and does not reliably trigger heartbeats. This is very common in elderly persons but may occur at any age.

Heart block is a complete or partial interruption of the electrical impulses on their way to the ventricles and results in a slow, unreliable heartbeat. Heart block may be present at birth, may result from other types of heart disease (after a heart attack for example) or may be due to age-related wear and tear on the heart’s electrical system.

Permanent pacemakers can be implanted to prevent patients from experiencing symptoms due to a slow heart beat.
If an abnormal heart rhythm is suspected, your doctor may recommend one or more tests to diagnose the arrhythmia and determine if it is causing your symptoms. These tests may include an electrocardiogram (ECG, also identified as an EKG), a Holter monitor, an event monitor, an exercise stress test, a tilt table test or an electrophysiology (EP) study.

EP studies involve positioning electrode catheters (wires) into the heart from a large vein in the leg guided by fluoroscopic imaging (X-ray).
Electrocardiogram

An electrocardiogram (ECG) is a simple test that traces the electrical activity of your heart. During an ECG, you lie flat on a table, connected to an ECG machine with wires taped to your chest, arms and legs. The test is painless and takes only a few minutes. The ECG produces a printout that doctors can examine to diagnose arrhythmias or other types of heart condition.

Holter Monitoring

Holter monitoring is a continuous ECG recording, usually for 24 to 48 hours, while you go about your normal daily activities. It is useful to detect arrhythmias that may not occur during a resting ECG. During Holter monitoring, wires are connected to your chest and attached to a small recording device that you carry with you. If you experience any symptoms, you are asked to push a button and record your symptoms so your heart rhythm at the time of your symptoms can be determined. An arrhythmia specialist will later analyze the electrical recordings to determine what your heart rhythm was at the time you experienced the symptoms and whether any asymptomatic abnormal heart rhythms occurred while you were wearing the Holter monitor.

Event Monitors

Event monitors are similar to Holter monitors but they do not record the heart rhythm continuously. Event monitors only record the heart rhythm when an abnormally fast or slow heartbeat occurs or when you activate them. They typically are used for one or two months, during which you are instructed to trigger the device and record your symptoms if they occur. Once a recording is obtained, the ECG tracing can be transmitted over the phone to a monitoring station that will analyze the ECG recording and send it to your arrhythmia specialist for interpretation.

Implantable Monitor

The implantable monitor is a small device that is inserted under the skin (similar to a pacemaker) and functions like an event monitor. It has a battery that lasts more than three years and is inserted in the left chest wall under the collarbone. This device is typically recommended for patients who have passing-out spells every three to 12 months and for whom other tests have not determined a cause. It is also used in patients who have had an unexplained stroke, and no evidence of atrial fibrillation is detected with short term monitoring. No wires are implanted into the heart—this minor procedure is performed on an outpatient basis.
Exercise Stress Test

Some arrhythmias only occur while a patient is exercising. Because of this, your doctor may recommend an exercise stress test (or treadmill test). During this test, you briskly walk or jog on a treadmill while hooked up to an ECG machine. This allows your arrhythmia specialist to determine if you are experiencing any arrhythmias while exercising and if you have evidence of a blocked heart artery.

Echocardiogram and Transesophageal Echocardiogram

An echocardiogram is a noninvasive, painless test that allows cardiologists to see if your heart is functioning normally, or if it is enlarged or weakened or has a damaged valve. Ultrasound waves are directed through the chest to the heart. The echoes of the sound waves are processed and used to produce images of the heart. Additionally, a transesophageal echocardiogram (TEE) may be performed by having you swallow the ultrasound probe (following numbing medication to the throat and appropriate sedation). The TEE provides close-up images of the heart from the esophagus. This technique is an excellent way to search for blood clots in the atria. Your physician may request that you have a TEE prior to an electrical cardioversion or catheter ablation. Most patients tolerate this test quite well.

MRI Scan

Magnetic resonance imaging (MRI) is a painless means of evaluating the heart’s structure and function. It can sometimes detect rare heart conditions (such as arrhythmogenic right ventricular dysplasia and cardiac sarcoidosis) and involves no radiation. MRI scans are obtained routinely prior to many types of catheter ablation procedures, including catheter ablation for treatment of ventricular tachycardia and catheter ablation of atrial fibrillation. It is also now possible to use MRI imaging to guide some types of catheter ablation procedures in order to avoid radiation exposure.

CT Scan

Computed tomography (CT) scanning is performed by taking high-resolution X-ray images using a multislice scanner. This advanced imaging can detect coronary artery disease, evaluate congenital heart disease, and may be used to evaluate a patient’s heart prior to a complex catheter ablation procedure.

PET Scan

A positron emission tomography (PET scan) is a noninvasive technique to identify inflammation in the heart or body. It is an important tool to diagnose cardiac sarcoidosis.
Tilt Table Test

A tilt table test can help diagnose an abnormality of blood pressure regulation causing “fainting,” which is referred to by a variety of names including neurally mediated syncope, neurocardiogenic syncope or vasovagal syncope. Tilt table testing is also useful for diagnosing postural orthostatic tachycardia syndrome (POTS).

During the tilt table test, an intravenous (IV) line is placed in your arm and ECG wires are attached to your chest. You then lie flat on a table for 10 to 15 minutes while your heart rate and blood pressure are monitored. At that point, the table is tilted upright so you are in an almost standing position. You are asked to remain still for 30 to 45 minutes while your heart rate and blood pressure are monitored. If you have a normal response, you may receive medication through the IV and have the test repeated. If your symptoms are provoked by the tilt test, the team notes your heart’s rhythm and your blood pressure before returning the tilt table to the flat position. You will recover quickly after the test and should be able to return home soon after.

Magnetic Resonance Imaging in Patients with Implanted Cardiac Pacemakers and Defibrillators

Magnetic resonance imaging is a useful diagnostic test for patients with various kinds of medical problems. In the past, MRI was not allowed in patients with implanted cardiac pacemakers and defibrillators. Thanks to the research efforts of several physicians and researchers, including those at The Johns Hopkins Hospital, MRI can now be safely performed in many patients with implanted cardiac devices. Several thousand patients with implanted pacemakers and defibrillators have safely undergone MRI at The Johns Hopkins Hospital, where this procedure is now considered the standard of care.

Patients with implanted cardiac pacemakers and defibrillators who need an MRI procedure must have their device fully tested and reprogrammed to MRI-safe settings before entering the MRI room. During the procedure, the patient’s ECG is continuously monitored by a doctor or nurse who has been specially trained in both MRI safety and cardiac device management. Following the MRI, the pacemaker or defibrillator is retested to ensure that no damage to the device occurred during the MRI procedure, and the patient’s original device settings are restored.

Please contact the scheduling office to arrange an MRI for a patient who has a pacemaker or ICD.

“I’m keen on developing the new technology necessary to forgo radiation exposure for many cardiac procedures.”

Henry Halperin, M.D., M.A.
Electrophysiology Study

Some arrhythmias are difficult to diagnose and may require an electrophysiology (EP) study. An EP study is often used to evaluate patients who have “fainted” or have experienced an abnormal rapid heart rhythm. This test may be recommended for patients who have impaired heart function and intermittent extra heartbeats, even if they are not experiencing symptoms. In other circumstances, patients with an inherited cardiac condition may undergo an EP study as part of their risk assessment. In these cases, the EP study may identify patients who are at high risk of developing a serious arrhythmia indicating the need for preventive treatment.

In an EP study, the electrophysiologist inserts several intravenous (IV) lines into large veins. The electrophysiologist then passes several electrical catheters through the IVs and guides them into the heart using X-ray imaging. This allows the electrophysiologist to examine the electrical activity inside your heart to determine if and why the rhythm is abnormal. Once that is known, your physician can prescribe the most effective treatment.

Electrical catheters are inserted into a vein in the leg and are positioned to record the electrical activity inside the heart.
Your doctor will discuss preparation for the test. In general, you should not eat or drink after midnight the night before the study. Check with your doctor about taking your normal medications. During the study, you will lie on an X-ray table with a blood pressure cuff on your arm, a clip on your finger to monitor your oxygen level, and wires on your legs, arms and chest to check your heart rate. The nurse will give you medication for sedation and to minimize discomfort before and during the procedure.

The sites where the doctor will work will be cleaned and shaved. You will be covered with sterile drapes from your shoulders to your feet. Then the doctor will numb the area on your leg or neck where the wires will be inserted. The wires will be passed through the veins toward the heart. You may feel pressure, but you should not feel any sharp pain. Once the catheters are in position, they are connected to a computer that produces internal ECGs.
The catheters are used to record and stimulate electrical activity. You may feel your heart beating faster than normal, a skipped beat, or familiar symptoms such as dizziness or palpitations. The EP study usually lasts one to three hours.

Once the study is complete, the wires and IVs are removed and pressure is applied to the numbed area for five to 10 minutes to prevent bleeding. You then must rest in bed for three to four hours with your leg(s) straight. You can eat and drink when you are awake. During recovery, your nurse will record your blood pressure, check the area where the IVs were, and monitor your heart rhythm regularly. If you are an outpatient, you may leave after a short recovery period, but you will need someone to drive you home. You should avoid heavy lifting or other vigorous activities for three days after the procedure.

Depending on the results of your EP study, your doctors may recommend a change in medication, catheter ablation, implantation of a pacemaker or defibrillator to manage your heart’s rhythms, or more diagnostic tests.
Catheter Ablation

Catheter ablation is a procedure that is used to destroy (ablate) areas of the heart that are causing arrhythmias. In a radiofrequency ablation, electrophysiologists pinpoint the area and then use radio wave energy to “cauterize” the tiny part of the heart muscle causing the abnormal heart rhythm. Catheter ablation plays an important role in the management of most types of cardiac arrhythmias.

The procedure is done in the EP lab under the direction of a team of highly trained doctors, nurses and technologists. Using X-rays as guides, the doctor will pass several small catheters through veins in the groin or neck and position them in the area that is interfering with the heart’s normal electrical activity. A diagnostic EP study (previously described) is always performed as part of the catheter ablation procedure to accurately diagnose the heart rhythm abnormality. Threedimensional mapping, using a previously acquired MRI or CT scan, may sometimes be required as determined by your physician. If one of the many arrhythmias that are curable with ablation is identified, a catheter is guided to the site of the abnormal heart rhythm. Thermal energy (extreme heat) or cryoenergy (extreme cold) is then passed through the catheter to this site to destroy the problem-causing tissue. This procedure typically lasts three to five hours.

“Catheter ablation plays an important role in the management of all types of cardiac arrhythmias.”

Hiroshi Ashikaga, M.D., Ph.D.
You should avoid eating or drinking anything after midnight the night before the study except for your normal medications, unless otherwise directed by your doctor or nurse. Once you are at the EP lab, a nurse will place an IV in your hand or arm so you can receive fluids and medications.

During the procedure, you will lie on a padded X-ray table. You will have a blood pressure cuff on your arm, a clip on your finger to monitor oxygen, and wires on your legs, arms and chest to check your heart rate. The nurse will give you pain medication and a sedative. The amount of sedation is adjusted for patient comfort. The area of your chest and groin where the doctor will work will be cleaned and shaved, and you will be covered with sterile drapes from your shoulders to your feet. The doctor will give you a small needle to numb the area where the catheters will be inserted.

“Our team of electrophysiology physician Assistants will work closely with your electrophysiologist while you are recovering in the hospital. We will review your home medications and post-procedure activity instructions with you prior to your discharge. We will be available to answer all of your questions.”

Nikki Chokshi, P.A.-C.
Lead Electrophysiology Physician Assistant
Once the problem area of the heart is “knocked out,” the catheters will be removed and pressure will be applied to the area to stop any bleeding. After the procedure, you need to rest in bed for three to six hours without bending your leg(s). Your nurse will take your blood pressure regularly, check the area where the wires were and monitor your heart rhythm. You may experience soreness as the anesthetic wears off, so do not hesitate to ask for pain medication. Tell your doctor or nurse immediately if you notice bleeding, swelling or undue discomfort in the area where the catheters were inserted. Most catheter ablation procedures are performed on an outpatient basis. However, depending on the specific procedure and the time it is performed, you may spend one or two nights in the hospital. Avoid heavy lifting or excessive exercise for three days after the procedure.

Catheter ablation is a safe therapy; however, any invasive procedure carries unique risks. These risks will be reviewed with you before the procedure.
Anti-arrhythmic Medications

Antiarrhythmic medications are commonly used to treat heart arrhythmias. These medications alter the electrical properties of the heart either directly by affecting the electrical currents in the heart, or indirectly by blocking the effects of adrenaline or improving blood flow to the heart. There are many types of anti-arrhythmic medications. The most common are beta blockers, calcium channel blockers and digoxin. Other frequently prescribed anti-arrhythmic drugs (in alphabetical order) include amiodarone, disopyramide, dofetilide, dronedarone, flecainide, propafenone and sotalol. Although anti-arrhythmic medications are effective in treating many types of heart arrhythmias, they can also cause a variety of minor and major side effects.

After completing your evaluation, your doctor will decide if you would benefit from treatment with an anti-arrhythmic medication. The risks and benefits will be discussed. Your doctor will also discuss with you whether anti-arrhythmic therapy is your only treatment option or if others such as catheter ablation or device therapy, are feasible. It is important to be sure that your new anti-arrhythmic medication does not interact with any medications you may currently receive. Please feel free to ask any questions you might have.

“I’ve trained at several prominent institutions in the country but chose to stay at Hopkins for its camaraderie and unrivaled patient care.”

AV Kolandaivelu, M.D.
Cardiac Pacemakers

A pacemaker is used primarily to correct some types of bradycardia, or slow heart rhythms. The pacemaker is implanted in the body, usually below the collarbone, where it monitors the heart rhythm and triggers an electrical impulse if the heart is beating too slowly. The pacemaker is composed of a small, titanium-encased pulse generator that contains a lithium battery and electrical circuitry attached to one, two or three leads (wires) that are inserted into the heart. Pacemaker pulse generators are checked two or three times each year and must be replaced about every 10 years.

Pacemaker implantation takes about one to three hours in the electrophysiology lab. A 1- to 2-inch incision is made beneath the collarbone and a small “pocket” is created for the pulse generator under the skin. The leads are inserted into the heart through a large vein that runs under the collarbone. Once the leads are positioned in the heart, they are attached to the pulse generator. During the procedure, the nurse will give you pain medication and a sedative to be certain you are comfortable.

One of the new developments in pacemaker therapy that we offer at Johns Hopkins is a “leadless” pacemaker. This new pacemaker, which is the size of a AAA battery, is implanted into the heart from the leg. No incision is needed under the collarbone and there are no wires. One of our electrophysiologists will discuss all of the options in pacemaker therapy, including placement of a “leadless” pacemaker.

You will receive detailed follow-up instructions before you leave the hospital. It is important that you follow these instructions and call your doctor or nurse with any questions.

You will also need to carry a pacemaker ID card with you. It contains useful, manufacturer-specific details regarding your device for medical personnel.
Implantable Cardioverter Defibrillators (ICDs)

ICDs are commonly used to treat patients who may experience or have experienced a potentially dangerous ventricular arrhythmia. These devices continuously monitor the heartbeat and automatically deliver a small electrical shock to the heart if a sustained rapid heart rhythm occurs. The shock may cause momentary discomfort, which is described by some patients as being “kicked in the chest.” ICDs also function as pacemakers and can be used to treat both slow and fast heart rhythm abnormalities. ICDs must be checked every three to four months and replaced every four to eight years.

The ICD is composed of a titanium-encased pulse generator (the size of a small box of raisins) that contains a lithium battery, electrical circuitry and capacitors attached to one, two or three leads (wires) that are inserted into the heart. It monitors heartbeats and, when appropriate, generates a small electrical impulse to pace the heart or a large electrical impulse to shock the heart.

One of the new advances in ICDs is the development of a totally subcutaneous ICD, with which leads are not inserted into your heart. Our electrophysiologists will discuss whether this type of ICD is the best option for you.

The technique used to insert an ICD is almost identical to implanting a pacemaker. It is performed in the electrophysiology lab and takes two to three hours. A 2-inch incision is made beneath the collarbone and a small “pocket” under the skin is created for the pulse generator. The leads are inserted into the heart through a large vein that runs under the collarbone. Once the leads are positioned in the heart, they are attached to the pulse generator. During the procedure, the nurse will give you pain medication and a sedative to be certain you are comfortable.

You will receive detailed follow-up instructions before you leave the hospital. It is important that you follow these instructions and call your doctor or nurse with any questions. You will also need to carry an ID card with you, which can inform
medical personnel of important, manufacturer-specific
details regarding your device. You may also need to
show your ID card to security personnel because the
device may set off security devices in airports and other
high-security areas.

The risks associated with placement of an ICD are
low and will be discussed in detail with you before
the procedure.

Cardiac Resynchronization Therapy

New technology has been developed for patients
with both advanced heart failure and mechanical
“dyssynchrony.” Dyssynchrony occurs when the right
side of the heart beats out of step with the left side
of the heart as identified on electrocardiogram (or
echocardiogram). Resynchronization therapy devices
consist of a pacemaker or an ICD connected to
three wires that are placed in the right atrium, right
ventricle and coronary sinus—a large vein behind the
left ventricle (see diagram). With pacing from three
distinct locations “in synchrony,” the weakened heart
can often beat more effectively, resulting in improved
quality of life and length of life. The surgical techniques
and potential complications are similar to those of
conventional pacemaker or ICD insertions, albeit higher
due to the added complexity of placing the special
third wire on the left side of the heart. Johns Hopkins
has played an important role in the development of
resynchronization therapy for the treatment of heart
failure patients.

“Some physicians
dread tough cases, but
I’ve always relished a
clinical challenge—I
wouldn’t be here
otherwise.”

Joe Marine, M.D., M.B.A.

“T’ve worked in the device
clinic for nearly three
decades. I very much
enjoy getting to know
each of my patients
after their procedure
and monitoring their
implanted devices over
time.”

Misty Capps
Device Support Tech
Ventricular Tachycardia (VT) Ablation Program

Ventricular tachycardia can be treated with medications, catheter ablation, and/or with an implantable defibrillator. Catheter ablation involves using computerized mapping to identify the site of origin of the VT or premature ventricular contractions (PVCs). Once identified, ablation energy is applied to treat this arrhythmia. For some types of VT we have to apply ablation energy to the outside of the heart using an epicardial approach. Johns Hopkins has a specialized program focused on performing this procedure. We commonly use computerized mapping techniques combined with CT or MRI imaging to achieve the best outcomes. When you meet with one of our electrophysiologists they can provide more details on the procedure and the anticipated outcomes for a particular type of ventricular tachycardia.

Device Lead Extraction Program

Although pacemakers and ICD pulse generators need to be replaced every four to 10 years, the leads (wires) that connect the device to the heart usually remain in place forever. Under rare circumstances, these leads will have to be removed. The most common reason for this is the development of an infection on the leads. This type of infection is nearly impossible to treat with antibiotics, so it may be necessary to remove (extract) the leads. Lead failure is another reason why an implanted lead may need to be removed from the body. Leads that have been in place less than six months usually can be removed without much difficulty or risk. However, leads that have been in place for many years may require a special laser-cutting sheath to free them from the wall of the heart. Although similar to having a pacemaker or ICD implanted, lead extraction is more difficult and is associated with a greater chance of complications. In the unlikely event that you require this procedure, you will be provided with more details about the procedure that are unique to your case.

Johns Hopkins offers the largest and most experienced comprehensive program focused on lead extraction in this region of the country. Lead extraction procedures are all performed in our new state-of-the-art hybrid operating room with cardiac surgical backup.

No matter where the VT is arising from, we will identify the precise site of origin and treat the arrhythmia with radiofrequency catheter ablation.”

Harikrishna Tandri, M.D.

“One of my main interests is removal of infected or failed pacemaker and defibrillator leads. I have performed more than two thousand of these procedures.”

Charles Love, M.D.
Director of the Johns Hopkins Cardiac Rhythm Device Service
Cardioversion

Cardioversion is a common procedure to shock the heart back into rhythm. Most patients who undergo a cardioversion procedure have either atrial fibrillation or atrial flutter. The procedure is done in the electrophysiology lab under the direction of a team of highly trained doctors, nurses and technologists.

You should avoid eating or drinking anything after midnight the night before the study except for your normal medications, unless otherwise directed by your doctor or nurse. Most patients who undergo this procedure are placed on a blood thinner, such as coumadin, for at least four weeks before and following cardioversion.

In some situations, your doctor may recommend that you have a special type of echocardiogram, called a transesophageal echocardiogram, immediately before your cardioversion to be certain there are no blood clots in your heart.

Once at the EP lab, a nurse will place an IV in your hand or arm so you can receive fluids and medications. During the procedure, you will lie on a padded table. You will have a blood pressure cuff on your arm, a clip on your finger to make sure you are getting enough oxygen, and ECG electrodes and two large patches on the chest. The electrodes and patches monitor the heart rhythm and, once you are fully asleep, deliver a safe, controlled shock to the chest to restore normal rhythm.

During recovery, your nurse will record your blood pressure and monitor your heart rhythm regularly. You can eat and drink when you are awake. If you are an outpatient, you may leave after a short recovery period, but you will need someone to drive you home. You can resume full activities one day following the procedure.
Arrhythmia Device Clinics

Inserting the hardware of pacemakers, defibrillators, biventricular pacemaker-defibrillators and implantable monitors is only part of complete care. The other part is monitoring and programming the device software over the long term. This aspect is crucial for optimizing the performance of many of today’s remarkably sophisticated pacemakers and ICDs. Battery status and the intracardiac leads are routinely checked to remedy any potential problems that might be of future clinical concern. As well, clinical episodes with recorded arrhythmias can be found quickly and reviewed accurately, such as with ICD shocks. In addition to “interrogating” patients’ devices in the hospital or clinic, Johns Hopkins is rapidly adopting technology that facilitates reliable, useful and secure web-based “remote anlaysis” from a patient’s home or workplace, even from out of state, to reduce frequent in-person check-ups.

Pacemakers routinely require computer programmer checks every three to six months. Defibrillators are normally checked every three or four months. Implantable monitors are often checked every three months or as symptoms dictate. If concerns arise over a device’s performance or a new clinical development occurs (such as syncope or ICD shocks), an appointment is expedited.

Johns Hopkins is dedicated to maintaining comprehensive, timely and effective device follow-up. Fully dedicated arrhythmia device clinics are located at both The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. Several Johns Hopkins community cardiology clinics also provide periodic arrhythmia device checks.

“Implantable arrhythmia devices shouldn’t restrict lives but improve them, and their follow-up should be timely and convenient.”

Jonathan Chrispin, M.D.
Pediatrics

The pediatric electrophysiology program at The Johns Hopkins Hospital specializes in the evaluation and treatment of heart rhythm disorders and syncope (fainting) in children. Although the range of diagnostic tests and treatment options available to children with arrhythmias is similar to those for adults, we recognize that children are not merely “small adults.”

The pediatric electrophysiology program provides the same high-quality care as the adult program and has physicians and nurses who are specially trained in the care of children with rhythm disorders.

Successful treatment of irregular heart rhythms in children requires that doctors understand the types of arrhythmias seen in children as well as developmental issues that may affect them. Pediatric electrophysiologists also have an in-depth knowledge of the types of heart rhythm problems often associated with congenital heart disease. The special needs of children and their families are addressed throughout the evaluation and treatment process, with extra attention given to age-appropriate explanations and ways to make children comfortable during procedures.

“Children are not just small adults. They have special needs, both physical and emotional, and careful planning is crucial to ensure that they get the great care they deserve.”

Jane Crosson, M.D.

Children get a special walk-through before their procedure to make the high-tech electrophysiology lab less intimidating. Nurses and technologists are adept at helping young patients relax, and Jane Crosson, a pediatric electrophysiologist at Hopkins, is always available to check in before the procedure.
Clinicians are increasingly recognizing uncommon forms of heart disease as common causes of arrhythmias in often young and athletic persons. Some of these diseases have been characterized on a genetic basis, including hypertrophic cardiomyopathy (HCM) and arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C), which may be inherited in either a familial manner or maybe a spontaneous occurrence. Johns Hopkins is playing a leading role in performing research, diagnosis, counseling and treatment of these complex genetic conditions, and Johns Hopkins has established the Center for Inherited Heart Diseases to help facilitate the genetic and clinical evaluation of patients with inherited types of heart disease. In addition to this program, Johns Hopkins has programs focused on ARVD/C and HCM.

**Hypertrophic Cardiomyopathy Program**

Hypertrophic cardiomyopathy (often called HCM) is a condition associated with the abnormal thickening of part or all of the heart muscle. It often affects young people and may not cause many symptoms but can result in sudden death. People with HCM have unique needs and require specialized care over a wide range of medical expertise targeted toward relieving symptoms, preventing complications and exploring surgical options.

Special facilities available through the Johns Hopkins hypertrophic cardiomyopathy clinic include access to specialists in HCM management, echocardiography, magnetic resonance imaging and spectroscopy, genotyping and genetic counseling, noninvasive risk assessment for sudden death, defibrillator implantation, percutaneous alcohol septal ablation, surgical myectomy and cardiac transplantation. Patients and relatives are also offered voluntary enrollment in a variety of ongoing research projects.
Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy Program

Arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C) is a rare inherited heart condition primarily affecting the lower right heart chamber (ventricle). Over time, the healthy heart muscle is replaced with fatty, fibrofatty and scar tissue that often results in abnormal heartbeats called premature ventricular complexes (PVCs) or ventricular tachycardia (VT). ARVD/C most commonly presents in young, apparently healthy and especially athletic people. The most common symptoms are palpitations and syncope (fainting). Less common are heart failure and sudden cardiac death. ARVD/C is a genetic condition and results from an abnormality in the protein structures that connect heart muscle cells together, which causes abnormalities in cell-to-cell communication and structural support.

Diagnosing ARVD/C is often very difficult because there is no single test that can either establish or exclude this condition. An evaluation might include the following: ECG, echocardiogram, cardiac MRI, Holter monitor and electrophysiology study. Approximately 50–60 percent of patients diagnosed with ARVD/C will have an identifiable genetic mutation. There is no known cure for ARVD/C; however, there are treatment options with the primary goal of preventing sudden cardiac death, managing arrhythmias and slowing structural disease. The majority of patients diagnosed with ARVD/C are treated with an implantable cardioverter defibrillator (ICD). Catheter ablation also plays a very important role in the management of ventricular arrhythmias.

The Johns Hopkins Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy Program was founded in 1999 to provide specialized evaluation and care of patients. An appointment may involve diagnosis, second opinion and/or management guidelines. Genetics counselors are available to work with patients and their families to determine the genetic cause of their ARVD/C and identify and screen at-risk family members. They also provide genetics counselling using telemedicine. The program also focuses on research that will help address the many unanswered questions about ARVD/C. Visit www.ARVD.com or contact the genetics counselors at 410-502-7161 for more information or to schedule an appointment.

“Our team of cardiac genetics counselors will meet with you during your visit to Hopkins. We specialize in determining if genetics testing is needed and helping to interpret the results.”

Brittney Murray, M.S., C.G.C.
Atrial Fibrillation and Atrial Tachyarrhythmia Center

The Johns Hopkins Hospital has established a center focused on the evaluation and treatment of patients with atrial fibrillation (AF) and complex atrial tachyarrhythmia.

Catheter ablation of atrial fibrillation is performed in a catheterization laboratory that uses catheters inserted from the leg. The most commonly used approach for catheter ablation of AF involves the creation of continuous circumferential lesions around the two right and the two left pulmonary veins in the left atrium. The endpoint is the electrical isolation of the pulmonary veins (see figure 1-3).

Cryoballoon ablation is another treatment option. Information from your CT or MRI scan will be imported into a special system to allow for precise 3-D mapping (see figure 3).

The success rate for these procedures depends on various clinical factors. In general, younger patients with a normal-size left atrium, normal heart function and intermittent atrial fibrillation (i.e., those who are not in atrial fibrillation all the time) can expect the highest success rate. Lower success rates are expected in older patients, those with other types of heart disease and those who are in chronic AF.

Some patients need a second ablation procedure six or more months after their first one. These “redo” procedures can significantly improve the overall success rates of AF ablation.

Another option available at the Johns Hopkins Heart and Vascular Institute is surgical ablation. This procedure can be performed through small incisions in your chest wall and requires a three- to four-day hospital stay.

Your electrophysiologist will provide information about the pros and cons of the various catheter and surgical ablation options and will answer any questions you may have about atrial fibrillation, atrial flutter, atrial tachycardia and their management.
Atrial fibrillation (AF) can cause blood to stagnate and clot, significantly elevating the risk of stroke. To combat this possibility, those with AF are often prescribed blood thinners. However, many patients are not willing or able to take blood-thinning medication due to risk of bleeding, risk of falls and/or patient preference.

Fortunately, nonpharmacologic options can also significantly reduce an AF patient’s risk of stroke. Decades ago, cardiac surgeons found that if they closed off the left atrial appendage (LAA)—a windsock-shaped outpouching in the muscle wall of the left atrium that collects blood and drains into the heart—by stapling, tying and other means, patient stroke risk shrank to baseline.

The three cardiac implant devices highlighted to the right offer safer and more reliable means to achieve the same goal. To make the best recommendations for treatment with these devices, Johns Hopkins initiated the Left atrial appendage occlusion program to help determine which option is optimal for each patient. As part of the program, a multidisciplinary team—including imaging experts, electrophysiologists, interventional cardiologists, cardiac surgeons and others—examines the patient and determines the best options. Prior to making this decision, a CT scan will be performed to determine the precise size and shape of your left atrial appendage. This information is critical to deciding which of the three options is best.

Once one of the devices is in place, permanent use of blood thinners is not necessary to prevent strokes that are associated with atrial fibrillation.

WATCHMAN: Shaped like a small umbrella, this device is delivered via catheter to block the opening to the LAA. This device is only suitable for patients whose LAA is a certain size and shape. Patients must take blood thinners for several weeks after surgery, a disqualifier for those at high risk of life threatening bleeding.

AtriClip: Using minimally invasive thoroscopic techniques, surgeons place this bobby pin-shaped clip at the base of the LAA, preventing blood from entering and clots from forming. No blood thinners are required after the procedure. Patients who have had prior cardiac surgery are not candidates for this approach.

LARIAT: This device is a catheter-implanted suture delivery loop that ties off the LAA. This procedure doesn’t require postoperative blood thinners. It’s not suitable for patients whose LAAs are very large or in certain positions. Patients who had prior cardiac surgery are not candidates for this approach.

From left, Kaushik Mandal, Ronald Berger and Hugh Calkins.
If you have questions about atrial fibrillation or catheter ablation, you can:

- Schedule an appointment to see an electrophysiologist at Johns Hopkins.
- Contact one of our electrophysiology faculty.

Minimally Invasive Ablation of Atrial Fibrillation and Ventricular Tachycardia

The Johns Hopkins Minimally Invasive Cardiac Surgical Program, under the direction of Kaushik Mandal, M.D., M.P.H., offers minimally invasive surgical radiofrequency ablation for patients who suffer from atrial fibrillation. This program is also one of the leading programs in the world to offer bilateral minimally invasive sympathectomy for treatment of refractory ventricular arrhythmias.

New surgical technology now takes the place of traditional invasive procedures, and permits cardiac surgeons to perform procedures through much smaller incisions made between the ribs on each side of the chest without use of a heart-lung machine. Using a fiberoptic camera to visualize the heart through these small incisions, the surgeon makes a series of lesions on the outside of the heart.

During the procedure, surgeons often remove the left atrial appendage because it is widely believed that this is where blood clots tend to form in patients with atrial fibrillation. Removing this source of clots is intended to significantly reduce the risk of stroke and, in many cases, reduce or eliminate the need for long-term coumadin anticoagulant therapy.

Most of these operations take three to four hours. The minimally invasive approaches used usually result in a relatively short postoperative hospital stay averaging three to four days. Since it often takes several months for the procedure to take full effect, patients are generally placed on a short course of anti-arrhythmic drugs (e.g., amiodarone, beta blocker) and coumadin. Most patients are able to resume normal activities two to four weeks after surgery.

For answers to questions or to arrange a consultation with Kaushik Mandal, please contact the cardiac surgery office at 410-955-9510 Monday through Friday, 8:30 a.m.–5:00 p.m.

“In properly selected patients, I have found that bilateral sympathectomy can be an extraordinarily effective treatment for refractory ventricular tachycardia and ventricular fibrillation.”

Kaushik Mandal, M.D., M.P.H.
Arrhythmia Service at The Johns Hopkins Hospital

The Sheikh Zayed Tower and the Charlotte R. Bloomberg Children’s Center

Many patients at our East Baltimore campus will stay in our newest facilities, which represent a $1.1 billion investment in patient care. The Sheikh Zayed Tower and the Charlotte R. Bloomberg Children’s Center bring an astonishing level of service and innovation to our East Baltimore medical campus. Replacing half of the original hospital, the two new 12-story patient care towers occupy five acres. The hospital’s entryway features one continuous airport-style canopy, shielding you from bad weather as you arrive. All areas of the hospital, including the adult and pediatric emergency rooms, are accessible through this single entrance.

At The Johns Hopkins Hospital, we use state-of-the-art technologies and innovations, many of which our researchers and clinicians have pioneered.

Our technology enhances patient care in three ways:

- greater precision and safety
- a more comfortable patient experience
- improved coordination and smoother work flow

For example, repeated alarms, beeps and overhead pages are familiar to anyone who has stayed in a hospital. Yet these noises can disturb patients and distract staff members. Patients who stay in the Sheikh Zayed Tower and the Bloomberg Children’s Center enjoy a quieter, more peaceful environment. New technology eliminates overhead paging, advanced building materials absorb sound, and thoughtfully designed floor plans reduce the foot traffic and noise that occur at busy nursing stations.
Electrophysiology Program in the Sheikh Zayed Tower

The Johns Hopkins electrophysiology program is based at the new Sheikh Zayed Tower of The Johns Hopkins Hospital. This new state-of-the-art facility provides the latest advances in technology to achieve the best possible outcomes for our patients.

Unique features include:

- four advanced electrophysiology procedure rooms, each equipped with biplane fluoroscopy and electroanatomic mapping systems
- operating room level airflow and sterile technique
- a hybrid operating room/electrophysiology room to facilitate procedures that require surgical back-up or a combined surgical and electrophysiology approach
- a dedicated room for cardioversion and tilt table test procedures
- an interventional MR imaging room—this unique facility allows electrophysiology procedures to be performed with nonfluoroscopic MR imaging
- 10 pre-procedure rooms for pre-procedure evaluation, located adjacent to the electrophysiology procedure rooms
- Ten post-procedure rooms for post-procedure recovery, located adjacent to the electrophysiology procedure rooms
- 20 private hospital rooms, each with a private bath and a sleeping couch for family members to stay overnight
- the electrophysiology rooms are adjacent to the cardiac surgical operating rooms.
- the cardiac intensive care unit and cardiac surgical intensive care unit are on the same floor

A patient discusses device options with an electrophysiologist in one of the consultation rooms in the Sheikh Zayed Tower.
The Arrhythmia Service provides arrhythmia consultation and device follow-up at the Johns Hopkins Bayview Medical Center. If you live near Bayview you may prefer to have your outpatient consult with a Johns Hopkins arrhythmia specialist at this location. Please discuss this with your doctor.

“We are pleased to be able to offer arrhythmia consultative services and device follow-up on the Bayview campus.”

David Spragg, M.D.

Johns Hopkins Bayview Medical Center
4940 Eastern Ave.
Baltimore, MD 21224-2780
Office: 443-997-0274
hopkinsmedicine.org/johns-hopkins_bayview

Driving directions from the north and east:
Take Interstate 95 south to Eastern Avenue (Exit 59) and turn right. Follow Eastern Avenue west for approximately 1 mile. Entrance to the campus is on the right, on Bayview Boulevard.

Driving from the south:
Take Interstate 95 north through the Fort McHenry Tunnel to Eastern Avenue (Exit 59). Turn left onto Eastern Avenue and proceed west approximately 1 mile. Entrance to the campus is on the right, on Bayview Boulevard.
The Johns Hopkins Arrhythmia Service now provides a full range of electrophysiologic services at Howard County General Hospital, including patient consultation, electrophysiologic studies, catheter ablation, pacemaker implantation and other device implantation. If you live in or near Howard County, you may prefer to have your procedure performed at this hospital in Columbia. Please discuss this with your doctor.

Howard County General Hospital
5755 Cedar Lane
Columbia, MD 21044
www.hcgh.org
Several physicians from the Johns Hopkins Arrhythmia Service also attend arrhythmia clinics at Johns Hopkins cardiology locations outside of Baltimore. If you prefer to have your arrhythmia consultation at one of the sites listed below, please discuss this with your doctor.

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
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<tbody>
<tr>
<td>Columbia</td>
<td>Johns Hopkins Cardiology—Columbia</td>
<td>443-997-0270</td>
<td>410-630-7455</td>
</tr>
<tr>
<td>Lutherville</td>
<td>Johns Hopkins Cardiology—Green Spring</td>
<td>443-997-0270</td>
<td>410-630-7455</td>
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<tr>
<td>Odenton</td>
<td>Johns Hopkins Cardiology—Odenton</td>
<td>443-997-0270</td>
<td>410-630-7455</td>
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<tr>
<td>Towson</td>
<td>Johns Hopkins Cardiology—GBMC</td>
<td>443-849-8989</td>
<td>443-849-8988</td>
</tr>
<tr>
<td>White Marsh</td>
<td>Johns Hopkins Cardiology—White Marsh</td>
<td>443-997-0270</td>
<td>410-630-7455</td>
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</tbody>
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Appointments

There are several ways to make appointments for arrhythmia services. The most direct way is for your physician to call the Hopkins Access Line (HAL) at 800-765-5447 and ask for any one of the Johns Hopkins electrophysiology doctors. Your doctor can also call the cardiovascular access team (scheduling line) at 443-997-0270 to expedite an outpatient clinician appointment or consultation. Your doctor also may call one of the EP doctors directly. If you prefer to schedule the appointment yourself, you may call the cardiovascular access team at 443-997-0270 or contact one of our electrophysiologists directly.

Johns Hopkins USA: For Our Out-of-Town Guests

Johns Hopkins USA provides one point of contact for our out-of-town patients. Our staff members can help you identify the appropriate physician or specialist, coordinate multiple medical appointments, arrange second opinions and obtain general information on Johns Hopkins’ numerous services. In addition, Johns Hopkins USA staff members can provide information regarding transportation, lodging and other travel needs. Call 855-695-4872 to talk with Hopkins USA or visit the website at www.hopkinsmedicine.org/jhusa.

Johns Hopkins Medicine International

The professional staff members of Johns Hopkins Medicine International coordinate all aspects of international patients’ medical care, paying special attention to personal, cultural, and travel-related needs. The staff members will arrange consultations, second opinions or treatments and coordinate appointments in a time-efficient manner. The staff members also provide medical record reviews before the patient travels to the United States, language interpreters, cost estimates and assistance with travel arrangements. For more information, call 410-502-7683. From outside the country, call +1-866-823-7712, or visit the website, www.hopkinsmedicine.org/international.

All patients are admitted to private rooms in Zayed.
Services for You and Your Family

Accommodations Office
The Johns Hopkins Hospital has arranged special rates (and shuttle service in some instances) at several local hotels for patients and their families. A full-service travel agency is available to help with air, hotel or ground transportation. It is open Monday through Friday 9 a.m. to 2 p.m. Please call 800-225-2201 or 410-464-6816 for assistance.

Communication
Please let us know if you have specific needs concerning language, hearing or vision. Ask your care provider to arrange for an interpreter if you are deaf or hearing impaired, or if English is not your primary language.

Foreign Language Interpreters
To arrange for a foreign language interpreter, contact or speak to a staff member. Interpreter service is available 24 hours a day seven days a week, 410-614-4685.

For the Hearing Impaired
To schedule a sign language interpreter, call the Patient Relations Department Monday through Friday between 8:30 a.m. and 5 p.m., at 410-955-2273. During other times, your nurse can schedule an interpreter for you, or contact the security office at 410-955-5585.

TTY service is available in the Patient Relations Office, 410-955-2273.

Assistive devices are available upon request by calling 410-614-4685. Televisions have closed captioning. All fire and smoke alarms include a strobe light. When an interpreter is not available, NexTalk devices can be obtained.

Guest Services
For assistance with directions, hotels and local attractions, call 410-614-5100 or visit the reception desk in the Arcade, Zayed Tower, main level, Room M2123. Services are available Monday through Friday 8 a.m. to 4:30 p.m.

Parking for Patients and Visitors
Use the McElderry Street Garage, which is open 24 hours a day seven days a week and is conveniently located adjacent to the Outpatient Center. Be sure to take your parking ticket with you because you must pay for parking before you return to your vehicle.

Parking Coupons
Patients and visitors who need parking over an extended period of time should consider buying parking coupons, which are sold in books of five or 10 at a discounted rate. Parking coupons do not expire, but we do not offer a refund for unused coupons. They are for use in the garages only. You may buy coupon books at:

- Cashier’s Office, Nelson 161, Monday through Friday 7:30 a.m. to 5 p.m.
- McElderry Garage, Monday through Friday 4 to 9 p.m. / Saturday and Sunday 7 a.m. to 11:30 p.m.
- Orleans Garage, 24 hours a day seven days a week including Saturdays, Sundays and all holidays
- Satellite Cashier—Zayed lobby, Monday through Friday 5:30 a.m. to 1:30 p.m.
- Outpatient Cashiers Office, Monday through Friday 5:30 a.m. to 5 p.m.
- Weinberg Building (first floor at admitting/registration) Monday through Friday 7 a.m. to 5 p.m.
Shuttle Service
On-call service is available 24 hours a day, seven days a week within the perimeters of the East Baltimore medical campus. Scheduled shuttle service to the Johns Hopkins Bayview medical campus operates on weekdays only from 6:30 a.m. to 7:30 p.m. For information on departure/arrival times, call the Transportation Office at 410-502-6880 (Monday through Friday, 6 a.m. to 11 p.m.).

Valet Parking
Valet parking is available at the Hospital’s main entrance on Orleans Street; the Outpatient Center (Outpatient Center Circle); and the Weinberg Building on Jefferson Street (Sidney Kimmel Cancer Center). Phone: 410-955-5333.

Pastoral Care
The Pastoral Care staff provides sensitive spiritual support, sacramental ministries, advance directive consultation and other services for patients and their family members. Your observance of the rituals and sacraments of your faith will be respected, and your religious needs will be accommodated as fully as possible.

Religious services are available in the hospital, including Catholic mass, Jewish minyan, Protestant worship and Muslim prayer. For specific times and locations, please call 410-955-5842.

Two interfaith chapels are open 24 hours a day for private prayer and meditation. One is located on the first floor of the hospital in the corner of the Children’s Center lobby. The other is in the Harry and Jeanette Weinberg Building off the main lobby.

A chaplain is in the hospital at all times. To request a visit from a chaplain or a clergyperson of a particular faith on a weekday, please call 410-955-5842. Your nurse will assist you at night and on the weekend.

Patient Information
Family and friends may dial 410-502-4000 for your room location and a brief description of your condition. If you wish this information to be withheld, please inform your nurse.

Patient Representatives
The Patient Relations Department can help you with any questions, concerns or needs that you may have regarding your stay in the hospital.

Patient representatives can:
- investigate concerns and complaints and facilitate their resolution
- address questions and special needs
- arrange for sign language interpreters and assistive devices for the hearing impaired
- serve as liaisons between your family and the health care staff in the operating room and intensive care waiting rooms

To speak with a patient representative, call 410-955-2273 Monday through Friday between 8:30 a.m. and 5 p.m.
Pharmacy

Pharmacies are conveniently located on the hospital campus.

Arcade Outpatient Pharmacy
1800 Orleans St.
Sheik Zayed Tower, Main Level, Room M2125
Monday through Friday 8 a.m. to 10 p.m.
Saturday and Sunday 8 a.m. to 6 p.m.
Call 443-287-9200 or fax 443-287-9230

Weinberg Outpatient Pharmacy
Johns Hopkins Kimmel Cancer Center
Monday through Friday 9 a.m. to 7 p.m.
Saturday and Sunday 10 a.m. to 6 p.m.
Call 410-955-5747 or fax 410-502-1511

Johns Hopkins Outpatient Center Pharmacy
601 N. Caroline St.
Main Level
Monday through Friday 8 a.m. to 6:30 p.m.
Call 410-955-3733 or fax 410-614-3733

Monument Street Outpatient Pharmacy
1810 E. Monument St.
Monday through Friday 8 a.m. to 7 p.m.
Saturday 9 a.m. to 4 p.m.
Call 410-502-5735 or fax 410-502-5734

Registration

Our goal is to help you get settled and feel comfortable as quickly as possible. On the day of your admission to the hospital, you will meet with a patient service coordinator.

Please have the following items with you:

- your orange hospital plate (if you were issued one during a prior visit)
- your health insurance card
- personal identification (such as a driver’s license or picture ID)
- HMO/PPO referral forms (if required)
- medical records, X-ray films or prior test results (if your physician has requested them)
- a copy of your advance directives

You will be given an identification bracelet with your name and Hopkins history number. Please confirm that the information is correct. Do not take the bracelet off until you have been discharged from the hospital. If the bracelet comes off before then, notify your nurse and ask for a new one.

Please send home any valuables. But if you must keep valuables at the hospital, we urge you to place them in a hospital safe.

Telephone and Television

Our telephone and television services are available to you 24 hours a day. To request service, dial 2-7250 from your bedside phone and follow the instructions. The daily charge for these services can be billed to your home telephone bill or to a personal credit card. If you prefer, you may purchase a prepaid TV rental card from the kiosk in the main admitting office.

To make calls from your bedside phone:

- When calling a Hopkins number from your room or any on-campus phone, use only the last five numbers. For example, if you want to reach 410-955-5000, dial 5-5000.
- When calling a number in the Baltimore area, dial 9 and the full telephone number, including the area code.
- For long-distance calls, you must use a calling card or personal credit card. Prepaid calling cards are available in the gift shop in the Nelson Lobby. The hospital does not accept collect calls.
Coming to The Johns Hopkins Hospital and the Outpatient Center

From Washington, D.C., Virginia and the I-95 access at Baltimore-Washington International Airport
Take Interstate 95 North to Exit 53 (I-395 North) into downtown Baltimore. Continue straight on I-395 (stay left at fork; turns into Howard Street). Turn RIGHT onto Pratt Street. Continue on Pratt for approximately 1.5 miles to Broadway; turn LEFT on Broadway.

FOLLOW INSTRUCTIONS FOR HOSPITAL PARKING (ORLEANS GARAGE) OR OUTPATIENT CENTER PARKING (MCELDERGY GARAGE).

From Philadelphia, New York and Northeastern Baltimore Suburbs
Take I-95 South to Baltimore; merge onto I-895 South. Take Exit 14/Moravia Road; turn LEFT onto Moravia Road at the traffic light at the end of the exit. Turn RIGHT onto the U.S. 40 West/Pulaski Highway.

FOLLOW INSTRUCTIONS FOR HOSPITAL PARKING (ORLEANS GARAGE) OR OUTPATIENT CENTER PARKING (MCELDERGY GARAGE).

From York, Central Pennsylvania and Northern Baltimore Suburbs
Take I-83 South into Baltimore. At the end of the freeway, turn LEFT onto Fayette Street. Continue on Fayette Street to Broadway and turn LEFT.

FOLLOW INSTRUCTIONS FOR HOSPITAL PARKING (ORLEANS GARAGE) OR OUTPATIENT CENTER PARKING (MCELDERGY GARAGE).

From Annapolis and Maryland’s Eastern Shore
From Route 50, take I-97 toward Baltimore and follow I-97 to the Baltimore Beltway (I-695) toward Towson. Take the Beltway to the Baltimore-Washington Parkway (I-295) North. Follow I-295 into Baltimore (it becomes Russell Street). Turn RIGHT on Pratt Street. Stay on Pratt for approximately 1.5 miles to Broadway; turn LEFT on Broadway.

FOLLOW INSTRUCTIONS FOR HOSPITAL PARKING (ORLEANS GARAGE) OR OUTPATIENT CENTER PARKING (MCELDERGY GARAGE).

Outpatient Center Parking (McElderry Garage) from U.S. 40 West:
Continue on U.S. 40 West approximately 3.5 miles to North Caroline Street; turn RIGHT onto McElderry Street. The entrance to Outpatient Parking at the McElderry Garage is on the right. After parking your car, follow the sidewalk to the Outpatient Center.

Hospital Parking (Orleans Garage) from Broadway:
From Broadway, turn RIGHT onto Orleans Street. Turn RIGHT into the Orleans Garage (at the Orleans Garage traffic light). After parking, take the elevator to Level 4 (Main Level) and proceed across the enclosed pedestrian bridge to the main hospital.

Outpatient Center Parking (McElderry Garage) from Broadway:
From Broadway, turn LEFT onto Orleans Street. Turn RIGHT onto North Caroline Street. Turn RIGHT onto McElderry Street (first traffic light). The entrance to Outpatient Parking at the McElderry Garage is on the right. After parking your car, follow the sidewalk to the Outpatient Center.

From Frederick and Western Maryland
Take I-70 East. Merge onto I-695 South/Baltimore Beltway outer loop via Exit 91A toward I-95 South/Glen Burnie. Take Exit 11A-11B for I-95 North/I-95 South toward Baltimore/Washington; keep left at the fork and merge onto I-95 North. Take I-95 North to Exit 53 (I-395 North) into downtown Baltimore. Continue straight on I-395 (stay left at fork; turns into Howard Street). Turn RIGHT onto Pratt Street. Continue on Pratt for approximately 1.5 miles to Broadway; turn LEFT on Broadway.

FOLLOW INSTRUCTIONS FOR HOSPITAL PARKING (ORLEANS GARAGE) OR OUTPATIENT CENTER PARKING (MCELDERGY GARAGE).
Your Notes and Questions
Johns Hopkins Arrhythmia Service Physicians

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Harikrishna Tandri, MD

Gordon Tomaselli, MD  
Chief of Cardiology

Referral Contact Information

Electrophysiology Service Main Phone Number and Phone Tree  410-955-7405
For all other calls concerning arrhythmia management and electrophysiology service.

Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (ARVD/C) Program  410-502-7161
For physicians and patients to schedule an appointment or consultation for ARVD/C.

Cardiovascular Access Team (Scheduling Line)  443-997-0270
For physician referral for outpatient consultation. Also for patients to schedule outpatient clinical appointments (arrhythmia, general cardiology, pacemaker and implantable defibrillator clinics).

Hopkins Access Line (HAL)  800-765-5447
For physician-to-physician communication, hospital transfers and referrals.

Johns Hopkins USA  855-695-4872
To schedule appointments and obtain help with travel needs for out of town guests.

Johns Hopkins Medicine International  410-502-7683 +01-410-614-4334
(In the United States) (Outside the United States)
To schedule appointments and make travel arrangements for international guests.

Outpatient Pediatric Appointments  410-955-6666
To schedule an appointment with a pediatric electrophysiologist or general pediatric cardiologist.

Arrhythmia Research Office and Nurse  410-502-0517
For information about research related to arrhythmias and treatment.

The Johns Hopkins Hospital

Main Phone Number  410-955-5000
Patient Information  410-502-4000

Johns Hopkins Bayview Medical Center

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