Safety and efficacy of steerable versus non-steerable sheaths for catheter ablation of atrial fibrillation systematic review and meta-analysis

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ABSTRACT

Objectives With the development of radiofrequency (RF) ablation technology, in recent years, more and more patients with atrial fibrillation (AF) have been treated with RF ablation. Steerable sheaths (SS) have been widely used in RF ablation of AF. The aim of this meta-analysis was to compare the efficacy and safety of AF ablation using SS and non-steerable sheaths (NSS).

Methods From the beginning to March 2022, we conducted a comprehensive, systematic search of the databases PubMed, MEDLINE, EMBASE, Web of Science and the Cochrane Library to finish the study. For categorical and continuous data, we used ORs and mean difference to calculate the effect. We also estimated the 95% CI.

Results Five studies of RF ablation of AF were selected, three prospective and two retrospective, involving 282 SS and 236 NSS ablation patients. The rate of recurrence of AF or atrial arrhythmias was 27.3% versus 42.8% (OR: 0.52, 95% CI 0.36, 0.76; z=3.41, p=0.0006) and acute pulmonary vein (PV) reconnection (8.7% vs 17.4%, OR: 0.47, 95% CI 0.23, 0.95; z=2.10, p=0.04). In the SS group and the NSS group, the total ablation time (p=0.25), fluoroscopy time (p=0.26) and total operative time (p=0.35) were not significantly different.

Conclusions Compared with the use of NSS, the use of SS for RF ablation of AF can effectively reduce the recurrence rate of AF and the occurrence of acute PVs reconnection events. However, there is no advantage in shortening the total RF time, fluoroscopy time, total surgical time and reducing complications.

INTRODUCTION

Description of the condition

Since Haïssaguerre et al reported that the rapid impulse issued by the ectopic excitation centre in the pulmonary vein triggered and driven atrial fibrillation (AF) through the electrical connection with the atrium,1 Ablation of the electrical connection site was the radical treatment of AF, which laid the theoretical basis for the treatment of AF by pulmonary vein vestibular electrical isolation (PVI). With the development of technology, radiofrequency (RF) ablation is widely used in the treatment of AF, which greatly reduces the recurrence of AF, effectively prevents the occurrence of heart failure and embolism events, prolongs patients’ life and improves their quality of life.2–4 In clinical practice, pulmonary vein reconnection still occurs in large numbers after the first ablation due to non-continuous ablation line, focal non-transmural lesions and tissue oedema caused by ablation head displacement, which greatly increases the recurrence rate of AF.5–7 Therefore, stable, repeatable and reliable attachment to the ablation target during the ablation process has become one of the keys to the success of ablation,8–12 which goes beyond the use of traditional fixed curve sheaths. In prior practice, steerable sheaths (SS) have been widely used in RF ablation of AF and improved catheter navigation, catheter stability and LA wall contact, so as to provide stable transmural ablation lesions and reduce reconnection of pulmonary veins to reduce...
METHOD

Search strategy

We conducted and reported this systematic review according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guideline criteria. This systematic review was conducted pursuant to a forward-looking agreement and was not registered with any external entity. Two researchers (XJ and YZ) searched three databases: PubMed, MEDLINE, EMBASE, Web of Science, the Cochrane Library. It was limited to English literature, and there are no specific date, sex and age restrictions. The coverage dates for this review began from each database’s inception and ended on 22 March 2022. The search strategy consisted of four core components, which were linked using the AND operator: (1) clinical trials (eg, therapeutic studies, human cohort trials); (2) AF (eg, paroxysmal AF and persistent AF); (3) sheath (eg, SS, navigable vascular sheaths, NSS, fixed curve sheaths); (4) RF ablation (eg, pulmonary vein isolation, pulmonary vein vestibule isolation and circumferential pulmonary vein isolation). MESH and keywords were identified for each of the four keywords to complete the search and were reviewed by an independent expert (consultant) from an external institution. In addition, we manually reviewed the reference lists of previously included trials and retrieved key articles to further complete the relevant study.

Study selection

The title and abstract of the study were independently selected by two researchers (XJ and YZ). The disagreement was decided by the third examiner (MX). All studies considered to meet the screening criteria for title and abstract were reviewed in full by two independent reviewers (XJ and YZ) using the same criteria. The participation of the third reviewer (MX) in the discussion was used to resolve the inconsistency. Articles were filtered and identified according to the following inclusion criteria: (1) all AF catheter ablation relevant clinical studies were original articles published in English; (2) full text and complete data could be provided (if the data is incomplete, complete data can be provided after contacting the author); (3) case–control study (including prospective cohort study or retrospective cohort study design); (4) the primary end points of the study were recurrence of AF and atrial arrhythmias, and surgical complications. (5) The secondary end points were acute PVs reconnection, ablation time, fluoroscopy time and total procedure time. (6) The object of study was human being, but not animal or tissue. The exclusion criteria were as follows: (1) case reports, conference abstracts and animal experiments; (2) studies reporting incomplete or irrelevant data; (3) studies that did not use SS; (4) studies using methods other than RF ablation (such as cryoablation and pulse ablation).

Data extraction, results and quality assessment

The standardised protocol and reporting forms were used to extract data on study characteristics (year of publication, study design, authors, year of publication), study questions (sample size, AF type, sheath type, duration, baseline characteristics) and results (outcomes, key findings). Two paired reviewers (XJ and YZ) independently extracted this information from each study and resolved any disagreements through discussion. The primary end points were the rate of recurrence of AF and atrial tachyarrhythmias after surgery and perioperative and FU complications. Secondary endpoints included PVs acute reconnection, ablation time, fluoroscopy time and total procedure time. Risk bias was assessed independently by two reviewers (XJ and YZ) using the Newcastle Ottawa Scale for the quality of the selected studies. Any disagreement was then resolved through the participation and discussion of the third reviewer (MX).

Statistical analysis

All extracted data were summarised and analysed by using Review Manager V.5.3 software (Copenhagen: Nordic Cochrane Centre, Cochrane Collaboration, 2014). We used OR and respective 95% CIs to compare differences for dichotomous variables and calculated weighted mean difference (WMD) or standard mean difference and respective 95% CIs to analyse continuous variables. A Cochrane’s Q p value <0.05 was considered significant. With a 95% CI, the statistic I² was interpreted as follows: ≤50% reflected high heterogeneity between studies and <50% indicated low heterogeneity. In the case of low heterogeneity, we used the fixed effects model; when heterogeneity was significant, a random effects model was used. In addition, we actively explore whether there is inherent heterogeneity potential among the included studies, and further consider the study design, population, race, age, method and other sources of variation. When heterogeneity is found in the included studies, a random effects model is selected and further subgroup analysis is conducted based on the sources of heterogeneity to explore the possibility of heterogeneity sources. Study possible publication bias was assessed by funnel plot.

Patient and public involvement

Patients were not involved in this study.

RESULTS

Study and data selection

The results of the detailed search process were shown in figure 1, 333 potentially relevant records were obtained.
in our search strategy, of which 175 were excluded as duplicates. Of the remaining, 149 studies were excluded after title and abstract reviewed. After detailed assessment of the full text, further four studies were excluded due to the following: two uncontrolled trials, one using (VIZIGO, Biosense Webster Inc, Irvine, CA, USA) bi-directional sheath, one reporting duplicate date. In the end, we selected five studies in this meta-analysis.

Study characteristics and quality assessment of included studies

From the selected studies, there were 518 subjects, of which 282 (54.4%) in the SS group and 236 (45.6%) in the NSS group. The characteristics of the five studies were summarised in online supplemental table 1. The incidence of paroxysmal AF was 69%, and Piorkowski et al., Rajappan et al., Deyell et al. and Masuda et al. included all subtypes of AF. Steering sheaths used in selected studies included non-steerable transseptal sheath (Mullins, Cook Inc, Bloomington, IN, USA), a conventional NSS (Swartz SL0, St Jude Medical), controlled SS (Agilis, St. Jude Medical, St. Paul, MN, USA). The follow-up in the three studies was 6 months after the first surgery, but 12±2 months in the study by Masuda et al. and 3 months in the study by Deyell et al. There were no significant differences between the two groups in terms of mean age, proportion of males, hypertension ratio, duration of AF, mean left atrial (LA) diameter and proportion of underlying cardiac disease.

Main clinical outcomes

The main endpoint included in the study was the ECG recording of AF recurrence time ≥30 s 3–12 months after RF ablation. Piorkowski et al, Rajappan et al, Deyell et al and Masuda et al reported statistically significant differences in the recurrence rate of atrial tachyarrhythmia after AF ablation surgery. The heterogeneity test of these five studies shows that ($\chi^2=4.04$, df=4, $I^2=1\%$, p=0.4), there was no significant heterogeneity between the studies, and a fixed effects model was used for analysis. Summary analysis showed that there was a significant difference in the recurrence rate of AF after the first surgery between SS and NSS ablation treatments (OR=0.52, 95% CI 0.36, 0.76, z=3.41, p=0.0006) (figure 2A).

Another primary endpoint is the incidence of perioperative and follow-up complications in both groups. Among the included literature, four articles reported the occurrence of complications, with 225 cases in the SS group and 203 cases in the NSS group. Heterogeneity testing showed that ($\chi^2=0.97$, df=3, $I^2=0\%$, p=0.81), there was no significant heterogeneity between the studies, and a fixed effects model was used for analysis. There was no
statistically significant difference between the two groups (OR=1.03, 95% CI 0.42, 2.56, z=0.07, p=0.94) (figure 2B). Inguinal and femoral vein haematoma are the most common intraoperative and postoperative complications. Piorkowski et al reported that one patient in the rotatable sheath group experienced a perioperative stroke during follow-up with minimal residual material; one patient had a pseudoaneurysm in the femoral artery pathway, which must be resolved by surgery. In the NSS group, two patients developed cardiac tamponade requiring pericardial puncture, and one patient developed phrenic nerve paralysis, which was relieved during follow-up.

Secondary clinical outcomes
Acute pulmonary vein reconnection is one of the secondary clinical outcomes. Three of the five studies mentioned acute pulmonary vein reconnection, and heterogeneity test showed that ($\chi^2=0.35$, df=2, $I^2=0\%$, p=0.84), with no significant heterogeneity between studies. A fixed effects model was used for analysis, and summary analysis showed that the SS group was superior to the NSS group in reducing the risk of PV reconnection (OR=0.47, 95% CI 0.23, 0.95, z=2.10, p=0.04) (figure 3A). Piorkowski et al reported that compared with the NSS group, the SS group had less acute Pulmonary vein reconnection (11.1% vs 20.0%), which was similar to the research results published by Deyell et al and Masuda et al. The study by Rajappan et al did not involve a description of acute reconnection of PV.

Among the included literature, five articles reported ablation time and fluoroscopy time respectively, with small heterogeneity between each study. Fixed effect models were used for analysis, and after summary analysis, it was found that the SS group was not superior to the NSS group in reducing ablation time (WMD=−3.6, 95% CI −9.77, 2.57, z=1.14, p=0.25) (figure 3B). The SS group was not superior to the NSS group in reducing fluoroscopy time (WMD=−3.32, 95% CI −9.10, 2.47, z=1.12, p=0.26) (figure 3C). In addition, five articles were included to report the total programme time, and heterogeneity testing showed that ($\chi^2=7.44$, df=4, $I^2=46\%$, p=0.11), with significant heterogeneity between studies. A random effects model was used for analysis, and summary analysis showed that there was no statistically significant difference between the two groups (WMD=−3.11, 95% CI −9.63, 3.42, z=0.93, p=0.35) (figure 3D). The results showed that the SS group was not superior to the NSS group in reducing total programme time.

Risk of bias in included studies
For the analysis of AF recurrence rate, the funnel plot was symmetric, so we think there was no significant publication bias (figure 4).

DISCUSSION
This meta-analysis showed that there was no significant difference in clinical complications between AF ablation with SS and NSS, suggesting that both SS and NSS are safe and effective for AF ablation. There was no statistically significant difference in ablation time between SS and NSS for RF ablation of AF, Mhanna et al obtained positive results after excluding Piorkowski 2008, with a p value less than 0.05. They believe that using the SS shortened the surgical time, which we believe is evidence of a lack of robustness in the results. Due to rigorous considerations, we still believe that using the SS does not have an advantage in shortening the surgical time of AF RF

Figure 2  Forest plot of the primary outcomes. (A) Recurrence of atrial fibrillation and atrial arrhythmias and (B) complications. M-H, Mantel-Haenszel; NSS, non-steerable sheaths; SS, steerable sheaths.
ablation.\textsuperscript{18} However, in reducing the incidence of AF, rapid atrial arrhythmia and pulmonary vein connection, SS have significant advantages over fixed curved sheaths.

RF catheter ablation has developed as the recommended treatment for AF, and circumferential pulmonary vein antrum isolation is considered to be the cornerstone for the treatment of paroxysmal and persistent AF.\textsuperscript{1–4} However, similar to other long LA ablation lines, continuous and transmural ablation of these lesions is often difficult to achieve. Therefore, in clinical practice, due to the following reasons: (1) incomplete isolation of pulmonary veins; (2) distant pulmonary vein isolation; (3) the occurrence of pulmonary vein reconnection lead to the occurrence of AF and atrial arrhythmia in a large number of patients, which greatly reduces the success rate of RF ablation.\textsuperscript{6, 19, 20} Therefore, the duration and transmural lesions of PVI are critical to reduce AF recurrence. But
during actual manipulation, it is a major challenge for the interventionalist to attempt a complex 3D ablation line in the pulmonary vein vestibule in an organ which moves with the respiratory rate, requiring a stable catheter and adequate tissue contact in order to achieve the desired ablation goal (transmural ablation with long duration). In recent years, steerable transseptal sheaths and fixed curve sheaths have been widely used in clinical RF ablation. The SS is convenient to enter and contact the ablation target, which is conducive to the continuity, maintenance and transmurality of the ablation target, and has been paid more and more attention and used in clinical practice.  

Second, the pressure to find gaps in the complex 3D PV anatomy to improve provides the basis for reliable pacer and voltage mapping. In addition, precise navigation of the ablation head ally leading to acute reconnection of pulmonary veins (usually anterior to the left and right sided PVs).  

Sardu et al’s study mentioned that excessive inflammation can lead to changes in the electrolytic dissection of the atrial myocardium. Sardu et al believed that the persistence of abnormal calcium treatment can activate ion channel and trigger calcium dependent signalling pathways. The miR-106b-25 cluster mediated posttranscriptional regulation of ryanodine receptor type-2 is a potential molecular mechanism involved in the pathogenesis of paroxysmal AF. Moreover, intracellular calcium treatment in patients with AF is related to the increased incidence of abnormal spontaneous sarcoplasmic calcium release events, which can be attributed to the imbalance of ryanodine receptor type-2, leading to the delay and trigger mechanism after depolarisation, and ultimately promoting atrial remodelling and the development of AF into a more lasting form.  

The study by Rajappan et al further showed that the use of the SS for right inferior pulmonary vein ablation could reduce CT registration time as well as ablation time. This may be due to the fact that the right lower pulmonary vein is relatively more difficult to place and attach by using the fixed curved sheath, while the SS can use the inverted U technique to quickly attach to PVs, which can build 3D models flexibly. This also greatly reduces the impact of the learning curve and manipulation experience of young interventionalists on RF ablation.

In addition, research by Janosi et al and Guo et al found that compared with the standard, non-visualisable SS, visualisable SS significantly not only reduces the LA procedure time, RF delivery and fluoroscopy exposure, but also but also significantly improved CF and initial PVI rate. This greatly improves the safety of the surgery.

Access with a larger transseptal sheath and ablation with more catheter tip pressure often raise safety concerns for the interventionalist during the procedure. In complications, there is no higher overall complication rate with SS. However, thicker sheaths have a direct correlation to single complications such as femoral vein injury and haematoma. Continuous monitoring and data collection, interpretation and alarm settings may help clinical doctors in timely treatment management and medication adjustment, as well as early detection of AF recurrence and timely intervention to reduce stroke and other related AF complications.

**Limitations**

There are some limitations to this study. First, all included studies are partly retrospective or non-randomised observational cohort studies. Second, in these studies, the force-time index or other ablation index are not mentioned. This data is reproducible in some clinical ablation treatments and is gaining increasing acceptance. If available, it will provide a firmer basis for clinical selection of SS. Finally, our sample size was small, with a minimum follow-up of 3 months and a maximum follow-up of 12 months. Therefore, the effect of selective sheath on AF recurrence in long-term follow-up is uncertain. To confirm the findings of our study, we need more randomised studies with larger sample sizes and longer follow-up.

**Conclusion**

Compared with traditional fixed sheath, catheter ablation of AF with SS has better efficacy, which can effectively reduce the recurrence rate of AF and the occurrence of acute PV reconnection. However, it cannot shorten the procedure time and reduce complications.
Contributors XJ and MX designed the meta-analysis and selected studies. MX was responsible for the revision of the manuscript and overall content as the guarantor. YZ and YW collected and analysed the data statistically. All authors contributed to the writing of this manuscript. MX was responsible for the revision of the manuscript and overall content as the guarantor.

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Ethics approval Not applicable.

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REFERENCES


## Table 1 Baseline characteristics of included studies

<table>
<thead>
<tr>
<th>First author (year)</th>
<th>Study design</th>
<th>Sample size</th>
<th>Age</th>
<th>Male n(%)</th>
<th>PAF</th>
<th>AF duration</th>
<th>LA size</th>
<th>Hypertension n(%)</th>
<th>Structural heart disease n(%)</th>
<th>Follow-up (month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christopher Piorkowski M.D. 2011[13]</td>
<td>Prospective observational</td>
<td>63</td>
<td>60</td>
<td>57±9</td>
<td>62±9</td>
<td>44 (70)</td>
<td>35 (58)</td>
<td>46</td>
<td>55</td>
<td>43±6</td>
</tr>
<tr>
<td>Christopher Piorkowski M.D. 2008[14]</td>
<td>Retrospective observational</td>
<td>83</td>
<td>83</td>
<td>55±9</td>
<td>55±9</td>
<td>61 (73)</td>
<td>61 (73)</td>
<td>52</td>
<td>54</td>
<td>36 ± 13</td>
</tr>
<tr>
<td>Kim Rajappan 2009[15]</td>
<td>Prospective observational</td>
<td>27</td>
<td>27</td>
<td>57±10</td>
<td>54±10</td>
<td>19</td>
<td>20</td>
<td>50%</td>
<td>50%</td>
<td>53±31</td>
</tr>
<tr>
<td>Marc W. Deyell 2020[16]</td>
<td>Retrospective observational</td>
<td>52</td>
<td>33</td>
<td>56.6±13.1</td>
<td>61.2±11.7</td>
<td>36</td>
<td>20</td>
<td>69.4%</td>
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<td>NA</td>
</tr>
<tr>
<td>Masaharu Masuda 2016[17]</td>
<td>Prospective observational</td>
<td>57</td>
<td>33</td>
<td>67 ± 11</td>
<td>66±11</td>
<td>39 (68)</td>
<td>24 (73)</td>
<td>67%</td>
<td>29 ± 36</td>
<td>25±26</td>
</tr>
</tbody>
</table>

SS steerable sheath, NSS non-steerable sheath, PAF paroxysmal atrial fibrillation, AF atrial fibrillation, LA left atrium, N/A not available/applicable.