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Atrioesophageal fistula in the era of atrial fibrillation ablation: a review.

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Abstract

The purpose of this review is to understand the epidemiology, clinical features, etiopathogenesis, and management of atrioesophageal fistula (AEF) after atrial fibrillation (AF) ablation. The incidence of AEF after AF ablation is 0.015%-0.04%. The principal clinical features include fever, dysphagia, upper gastrointestinal bleeding, sepsis, and embolic strokes. The close proximity of the esophagus to the posterior left atrial wall is responsible for esophageal injury during ablation. Prophylactic proton pump inhibitors, esophageal temperature monitoring, visualization of the esophagus during catheter ablation, esophageal protection devices, and avoidance of energy delivery in close proximity to the esophagus play an important role in preventing esophageal injury. Early surgical repair or esophageal stenting are the mainstay of treatment. Eliminating esophageal injury during AF ablation is of utmost importance in preventing AEF. A high index of suspicion and early intervention is necessary to prevent fatal outcomes.