

Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:

<https://reachmd.com/programs/cme/individualizing-management-strategies-for-psvt-incorporating-patient-preference/68795/>

Released: 10/01/2026

Valid until: 10/01/2027

Time needed to complete: 1h 05m

ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Individualizing Management Strategies for PSVT: Incorporating Patient Preference

Announcer:

You're listening to GLC on ReachMD. This activity is provided by Global Learning Collaborative and is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Brian Rose, PA-C:

Welcome to this educational activity from GLC. I'm Brian Rose, and I'm here with Jennifer Carlquist and Sean Pokorney. Today, we'll discuss individualizing management strategies for patients with PSVT, or paroxysmal supraventricular tachycardia.

Jennifer, when do you refer a PSVT patient for ablation?

Jennifer Carlquist, PA-C:

So I'll actually refer patients to electrophysiology when they are very symptomatic or having a lot of episodes, and I'm referring them to EP for a couple reasons. I'm going to do it early after we've officially diagnosed them so that they can make that relationship with EP, because eventually they may need an ablation. And a lot of patients actually do end up needing an ablation, and everything we're going to do in the meantime is going to be a bridge or a Band-Aid. We're going to try things like calcium channel blockers or beta-blockers to help their symptoms until they can see EP.

But some patients are quite resistant to this in the beginning, so I like to give them sort of the lay of the land, like what can they expect, what does an ablation look like if they end up going there. I like to prep them for this, so when they talk about this with EP, they sort of have a baseline understanding.

So what I'll tell them is something like this: You have an electrical short circuit in your heart, and this is an electrical problem. And what we need to do is get in there and either freeze or burn the area that's shorting out, and that will make it so the electricity can't go down that route and cause problems for you anymore. It's a curative procedure, and it has a very good recovery time, and you won't have to live your life in fear of these episodes happening over and over and limiting your activities of daily living.

So, Brian, what do you do for these patients?

Brian Rose, PA-C:

I agree with a lot of what you said, Jennifer. I definitely stay very consistent with the guideline recommendation that ablation is first line, and I'm not EP but I have the benefit of practicing with a lot of EPs in my group. So I tend to refer early on in that patient's journey. Nonetheless, I'm still treating them with AV nodal agents and starting pill-in-a-pocket etipamil for these individuals, and possibly even antiarrhythmic if indicated.

But I do want them to see EP fairly early in that patient journey. I also will discuss statistics with them and really the success rate of ablation, which I think sometimes can ease any trepidation that they may have about an EP referral.

Sean, do you agree on the timing of ablation?

Sean Pokorney, MD:

Yeah, no, absolutely. I think that ablation and the optimal timing for ablation is really dependent on the patient's wishes, and this is where engaging patients in shared decision-making is so critical.

As a proceduralist, as you mentioned, as you both mentioned, the rates of cure with ablation, EP study ablation for PSVT are quite high. I mean, 90% to 95% of these patients are cured and will not continue to have episodes. There are some risks with these procedures. You can have access site bleeding-related issues, and there's a little bit less than 1% risk of pacemaker if you look at the nationwide data for AVNRT, for example. And many of these patients are quite young, and that's a serious consideration for many of them.

And as a proceduralist, we never want to be doing procedures on patients that don't want to be there because there always are inherent risks with any of our procedures. And so, again, this is where it's really important to engage with patients and understand the impact that PSVT is having on their quality of life, the frequency of episodes, the duration of episodes, and severity of symptoms.

And again, it's important for them to understand what the options are. They can continue with AV nodal blocking agents and have episodes at the same cadence, or it may progress to more frequent episodes over time. Oftentimes, those patients end up in the emergency department and require adenosine, which is very uncomfortable for them, and they lose that sort of control in their life.

Some patients may choose to have etipamil, which is a way for these patients to use a nasal spray to potentially terminate these episodes at home on their own. Again, the benefit of that is they have that control over their disease state. They hopefully will not end up in the emergency department. We've demonstrated in the clinical trial data there's a reduction in emergency department visits with the use of etipamil. So again, very beneficial for many of our patients.

At the same time, the etipamil doesn't prevent the episodes. So if patients have more frequent episodes, if even shorter episodes are debilitating for them, then those are patients that really may prefer to go on to ablation as opposed to some patients may be less bothered by the episodes. They have 1 episode a year, maybe 2 episodes a year, and I think that those would be patients that would be great candidates for etipamil if they're going to be using it relatively infrequently, only a handful, a number of times a year, and feel like they can mentally handle the episodes when they do have them.

So those are some of the considerations that I think about when I'm talking to patients about ablation.

Brian Rose, PA-C:

Jennifer, is that the same for you, or do you have anything else to add?

Jennifer Carlquist, PA-C:

Yeah, I really like the fact of what you talked about, Dr. Pokorney, about basically putting the patient in the driver's seat of what's going to happen next and shared decision-making. And I also just want to echo the sentiment that you talked about, where you need to make sure that it's not anxiety, right? They may feel anxious because of their arrhythmia, right? And I think that's a really important question that we want to ask them when we're first seeing them is do you feel anxious and then your heart races, or is your heart racing and then you feel anxious? Because those are 2 completely separate things. And I do feel that a lot of these patients do get sort of written off as anxious, especially because a lot of our patients are young.

But the great thing is, what I like to do with them once we get them the diagnosis is, like I said, educate them. But then I actually, if they're young and they are able to open up the notes tab in their phone, I'll actually tell them, "Write this down," and I'll tell them exactly instructions. So when you get an episode and you're panicking, this is what you're going to do step-by-step, and I include a YouTube video in there of a certain vagal maneuver that I like. Even though, as Dr. Pokorney said, they're not always effective, it's something they can do. And then, of course, now we have other tools that we can say, hey, we also have Cardamyst, and you can use that and hopefully abort an ER visit and also decrease their healthcare cost. And then just get them to EP so they can get their ablation, which is

ultimately, a lot of times, the answer.

Sean Pokorney, MD:

Yeah, I would say, Jennifer, we hear this from our patients over and over again that oftentimes these patients that have been dealing with PSVT for several years and they've been working with vagal maneuvers and other things and they end up having an ablation procedure, sometimes they're fearful of the risks of the procedure. Sometimes it's a cost issue to get invasive procedures done or inconvenience in their work and family life that leads them to delay it. And I would say that the vast majority of those patients end up saying, "Wow, I wish I'd done this several years ago." So I think getting them in to have those conversations early is important, but it's still ultimately up to them when the timing is best for them. And again, we would much rather be in the position of a patient saying to us, "I wish I'd done this several years ago," instead of saying, "I wish I hadn't done this" or "I wish I'd waited."

And so, again, I do think it's really important to make sure that patients know the different options, that they know the realistic outcomes of the procedure. Again, 90% to 95% chance that you're cured, but also knowing the risks of up to a slightly less than 1% risk of a pacemaker, because that's pretty impactful for many of these patients. Again, it's a very low-risk procedure with a very high cure rate. But again, things can happen during procedures, even access site issues, and so we certainly want patients to be aware of all those considerations and know that there are alternatives, including medical therapy.

Brian Rose, PA-C:

Shifting gears briefly away from ablation, Sean, how do we manage some of these more acute episodes of PSVT? And what are some of the emerging therapies that we're seeing out in the world?

Sean Pokorney, MD:

Yeah, so I'd say the most promising therapy is etipamil or Cardamyst, which was FDA-approved in December of 2025 and became available clinically in early 2026. It's a nasal spray. A canister comes with 2 sprays. You do 1 spray in each nostril. It's important to counsel patients not to shake the canister and not to snort the medication. It's absorbed in the nasal mucosa, and you actually want them to let it sit in the nasal mucosa to absorb.

And what the data show is that about 60% to 65% of patients will be able to terminate their episodes of SVT within 30 minutes with utilization of that medication. And now you can have a second canister and actually reapply the medication 10 minutes later if the episodes do not terminate.

And so this is a way for patients to control these episodes acutely without ending up in the emergency department, with high success rates—really, almost 2.5-fold more successful than vagal maneuvers and pill-in-the-pocket medications. And so, again, that's probably the best way to acutely manage episodes outside of going to the emergency department and getting adenosine.

Brian Rose, PA-C:

We've heard about timing of ablation and the importance of referral, as well as utilization of emerging therapies like etipamil for outpatients. These are all tools for PSVT patients.

This concludes our episode, and we will see you next time.

Announcer:

You have been listening to GLC on ReachMD. This activity is provided by Global Learning Collaborative and is part of our MinuteCE curriculum.

To receive your free CE credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.