Methods for Determining the Refractory Period and Excitable Gap During Persistent Atrial Fibrillation in the Goat

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Background—Recently, the temporal excitable gap during atrial fibrillation (AF) has been identified as a vulnerable parameter for cardioversion of AF. In this study, we evaluated 5 methods to measure the refractory period (RP<sub>AF</sub>) and the excitable period (EP<sub>AF</sub>) during persistent AF.

Methods and Results—In 11 goats instrumented with 83 epicardial atrial electrodes, persistent AF (43±34 days) was induced with a median AF cycle length (CL) of 98±14 ms. To measure RP<sub>AF</sub>, premature stimuli were applied to the center of the electrode array on the right or left atrium. The RP<sub>AF</sub> measured by mapping of premature stimuli was 70±12 ms (“gold standard”). The RP<sub>AF</sub> determined during entrainment of AF was 77±17 ms (R²=0.88, P<0.01). Statistical analysis of the effects of synchronized stimuli (each coupling interval ×100) on the AFCL histogram yielded an RP<sub>AF</sub> of 70±13 ms (R²=0.94, P<0.01). A further simplification was to apply slow fixed-rate pacing (1 Hz) during AF. For each stimulus (n=250 to 500), the paced AFCL was plotted against its coupling interval, and capture was determined by statistical shortening of the AFCL (RP<sub>AF</sub> 71±17 ms, R²=0.84, P<0.01). The 5th percentile of the AFCL histogram as an index of RP<sub>AF</sub> was 77±12 ms (R²=0.90, P<0.01).

Conclusions—During persistent AF with an AFCL of 98±14 ms, the RP<sub>AF</sub> determined by mapping of synchronized premature stimuli (gold standard) was 70±12 ms, with an excitable period of 28±8 ms. Although the indirect methods to measure RP<sub>AF</sub> all correlated well with the gold standard, slow fixed-rate pacing seems to be the most attractive technique because of the ease of acquiring the data and the clear graphic result. (Circulation. 2001;104:957-962.)

Key Words: fibrillation • electrophysiology • excitation

It was recently suggested that the temporal excitable gap during atrial fibrillation (AF) is a critical determinant for perpetuation and termination of AF.1,2 In the presence of a short excitable gap, fibrillation waves are more likely to die out by encountering refractory tissue. Conversely, a short excitable gap may also promote the formation of new wavelets because of an increase in the likelihood of intratrial conduction block. Thus far, determination of the excitable gap may also promote the formation of new wavelets during persistent AF. Five methods were evaluated in a goat model of persistent AF using mapping as “gold standard.”

Methods

The goat model of AF was described previously.4 In 11 goats (51±8 kg), 2 plaques (3.5×2.5 cm, 30 electrodes, distance 4 mm) were sutured to the free wall of the right atrium (RA) and left atrium (LA). One strip (6×1 cm, 23 electrodes, distance 6 to 10 mm) was pulled along Bachmann’s bundle and sutured to both atrial appendages. The leads were tunneled subcutaneously to the neck and exteriorized by three 30-pin connectors. A subcutaneous silver plate served as indifferent electrode. After the goats had recovered from surgery, persistent AF was produced by a fibrillation pacemaker.4 After amplification (×300) and filtering (1 to 500 Hz), all unipolar atrial electrograms were stored on tape. Local activation times were determined automatically by a custom-made algorithm detecting the maximal negative slope of the fibrillation electrograms. The goats were studied after 43±34 days of AF at a median AF cycle length (CL) of 98±14 ms. A central pair of electrodes on the RA (n=7) or LA (n=4) was used for stimulation. Biphasic stimuli of 2 ms were generated by a constant-current stimulator equipped with an amplifier recording a bipolar electrogram from the pacing electrodes (Medtronic SF3111). The minimal current required for regional entrainment of AF was taken as the threshold for stimulation.7

Methods to Measure RP<sub>AF</sub>

Figure 1 illustrates the 5 methods to measure RP<sub>AF</sub>. Mapping was used as the gold standard. Single premature stimuli of 4× threshold were synchronized to the fibrillation waves at the pacing site. Capture was verified by activation maps around the pacing site. In
case of capture, the atrium was activated in a radial fashion from the site of pacing. A second method to measure RP AF is to apply premature stimuli during regional entrainment of AF with an interval equal to the median AFCL. The S1-S2 interval was changed in steps of 2 ms. Capture was determined by the latency and morphology of an electrogram recorded 4 mm from the pacing site. In case of capture, the premature electrogram showed a morphology and latency similar to that during entrainment. The longest S1-S2 interval that failed to capture the atria was taken as the RP during entrainment of AF.

A third method to measure RP AF is to determine the statistical effect of synchronized premature stimuli on the AFCL histogram. Each coupling interval was repeated 100 times. The shortest coupling interval resulting in a statistically significant difference in AFCL histogram was taken as the RP AF. During fixed-rate pacing, EP AF could be directly measured from the histogram of the interval between the stimulus and the first response (S-AF). Whereas during subthreshold pacing, the S-AF intervals were equally distributed, pacing at 4 X threshold caused a gap in the S-AF histogram. The longest S-AF interval occurring less frequently than expected (95% CI) was taken as the EP AF.

A fifth method to estimate RP AF is to determine the 5th percentile of the AFCL histogram, constructed from 100 consecutive AF cycles from a unipolar RA or LA electrogram.

Excitable Gap During AF
The term “excitable gap” refers to both the excitable tissue between fibrillation waves (spatial excitable gap) and the time window of excitability during the AF interval (temporal excitable gap). We used the term excitible period (EP AF) to indicate the temporal excitable gap. With all 5 methods, EP AF can be calculated as the difference between the median AFCL and RP AF. During fixed-rate pacing, EP AF could be directly measured from the histogram of the interval between the stimulus and the first response (S-AF). Whereas during subthreshold pacing, the S-AF intervals were equally distributed, pacing at 4 X threshold caused a gap in the S-AF histogram. The longest S-AF interval occurring less frequently than expected (95% CI) was taken as the EP AF.

Results
Mapping of the Refractory Period During AF
Figure 2 shows an example of the RP AF determined by mapping. In the upper panel, a stimulus was applied 70 ms after the pacing site was activated. The activation map shows that the stimulus did not capture the atrium. A stimulus with a slightly longer interval of 75 ms (lower panel) resulted in capture, as evidenced by radial spread of activation from the pacing site. When stimuli with the same coupling interval were repeated 20 X, however, sometimes capture occurred and sometimes not. In Figure 3, we plotted the percentage of capture at different coupling intervals. At short coupling intervals (<65 ms), the atrium was never captured. Prolonging the interval from 65 to 90 ms resulted in a progressive increase in the probability of capture. A coupling interval >90 ms resulted in 100% capture. The S-shaped curve shows that the RP AF is not a deterministic but a probabilistic variable. We arbitrarily defined the RP AF as the shortest coupling interval that captured the atrium >20% of the time. This value represents the shortest of a wider range of refractory periods during AF. In all goats, the RP AF measured in this way was 70±12 ms. The temporal variation in RP AF (5% to 95% capture) was 19±4 ms.

Refractory Period During Entrainment of AF
Figure 4 shows an example of the RP during entrainment of AF. Entrainment was performed at the LA with an S1-S2
interval of 110 ms (median AFCL 113 ms). The unipolar electrogram recorded next to the pacing site shows 8 entrained beats followed by a single premature stimulus (S₂). During entrainment, the activation maps revealed radial spread of activation. An S₂ stimulus of 90 ms did not capture the atrium, whereas an S₂ stimulus with a coupling interval of 92 ms did capture the atrium (radial spread). For determination of the RPₐf, capture was verified by the morphology of the unipolar electrogram next to the pacing site. In case of no capture, the electrogram showed a clear R wave and a variable time interval between the stimulus and the next activation. In case of capture by the premature stimulus, the latency and electrogram morphology were similar to those during entrainment of AF (no R wave). The RP during entrainment, defined as the longest S₁-S₂ interval that did not capture the atrium, was 77±17 ms (6 goats).

Measurement of the RPₐf by Synchronized Stimuli
The response to synchronized stimuli was determined statistically by applying a premature stimulus 100 times. For each coupling interval, a histogram of the paced AFCL was reconstructed from a neighboring electrogram. In Figure 5, an example is given of a premature stimulus with a coupling interval of 50 ms. The control AFCL histogram (sampled 1 second before each premature stimulus) shows a normal distribution with a median AFCL of 80 ms. In contrast, the paced AFCL histogram showed a bimodal distribution. Because of capture, 39% of the AF cycles were now <60 ms. The Wilcoxon 2-sample test revealed a significant difference between the 2 histograms (P<0.05). Premature stimuli with a coupling interval of <50 ms did not result in statistically different AFCL histograms. In 11 goats, the RPₐf measured by the shortest coupling interval yielding a statistically different AFCL was 70±13 ms. This value represents the shortest of a range of refractory periods during AF.

Measurement of the RPₐf by Fixed-Rate Pacing
An alternative way to determine RPₐf is to stimulate the fibrillating atria at a slow fixed rate of 1 Hz, resulting in a series of randomly applied premature stimuli. In Figure 6, the

![Figure 3](image1.png)  
**Figure 3.** Probability of capture of AF by premature stimuli. S-shaped curve shows temporal variation in RPₐf.

![Figure 4](image2.png)  
**Figure 4.** Measurement of RP during entrainment of AF. Electrogram was recorded 4 mm from pacing site. premature stimulus with coupling interval of 90 ms did not capture atrium, whereas an S₁-S₂ interval of 92 ms captured atria (no R wave; short latency).

![Figure 5](image3.png)  
**Figure 5.** Determination of RPₐf by statistical analysis of paced AFCL histogram close to pacing site. During administration of premature stimuli with a coupling interval of 50 ms (n=100), histogram showed a shift to left due to capture of part of stimuli.

![Figure 6](image4.png)  
**Figure 6.** Determination of RPₐf by slow fixed-rate pacing (1 Hz). During 250 consecutive stimuli, paced AFCL is plotted against its coupling interval. Shaded column indicates range of refractory periods during AF.
AFCL at an electrode close to the pacing site is plotted for all coupling intervals during 4 minutes of fixed-rate pacing \( (n = 240) \). Two populations of data points can be clearly distinguished. At shorter coupling intervals, AFCL shows the normal variation (median 88 ms). At longer coupling intervals, the normal variation in AFCL was lost, and because of capture, the paced AFCL was now determined by the coupling interval of the stimulus. At intermediate coupling intervals (48 to 69 ms), only part of the stimuli captured the atrium, illustrating the temporal variation in RPAF (shaded column). In all goats, the range of temporal variation of the RP AF was 24\( \pm \)6 ms. The shortest coupling interval producing a significant shortening of AFCL, as determined by the Kolmogorov-Smirnov test, was 71\( \pm \)17 ms. This method was applied only in the last 6 of 11 goats, because it was developed during evaluation of the other techniques in the first 5 goats.

With fixed-rate pacing, EP\(_{AF} \) can be directly visualized (Figure 7). During 16 to 17 minutes of 1 Hz pacing, all poststimulus intervals \( (n = 1000) \) were plotted in a histogram. During subthreshold pacing, the S-AF intervals were equally distributed, with a mean incidence of 10.7\( \pm \)2.9 (95% CI between 4.9 and 16.5). When stimulus strength was set at 4\times \) threshold, the S-AF intervals were no longer equally distributed. Now, a high incidence \( (n = 368) \) of short S-AF intervals was observed, representing the latency between stimulus and response during capture. At the same time, the incidence of S-AF intervals between 5 and 30 ms markedly decreased. These intervals disappeared because they were shortened by capture of the premature stimuli. The distribution of S-AF intervals >35 ms did not change during pacing. The upper limit of the excitable period was determined by the longest S-AF interval that occurred less frequently than the 95% CI. In 6 goats, EP\(_{AF} \) measured in this way was 27\( \pm \)4 ms. This value represents the longest of a range of excitable periods during AF. Because of variation in AFCL and RP\(_{AF} \), during many cycles EP\(_{AF} \) will actually be shorter. This is illustrated in Figure 7 by the atrial responses that still occurred during the measured excitable period.

**p5 AFCL Value as an Index of the RP\(_{AF} \)**

In 11 goats, the median AFCL measured at the RA or LA was 98\( \pm \)14 ms. The 95th and 5th percentiles of the AFCL were 120\( \pm \)16 and 77\( \pm \)12 ms. The 5th percentile (p5) value was used as an index of RP\(_{AF} \). This is based on the assumption that the shortest AF cycle lengths have no or only a very short excitable period.

**Comparison of the Different Measurements of the RP\(_{AF} \)**

In Table 1, the values of RPAF as obtained by the 5 methods are listed for all goats. The RP\(_{AF} \) measured by mapping is

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**TABLE 1. RP\(_{AF} \) Values Obtained by Different Methods**

<table>
<thead>
<tr>
<th>Goat</th>
<th>Site</th>
<th>AFCL (Median)</th>
<th>Refractory Period During AF, ms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RA</td>
<td>105</td>
<td>Mapping: 75</td>
</tr>
<tr>
<td>2</td>
<td>RA</td>
<td>107</td>
<td>...</td>
</tr>
<tr>
<td>3</td>
<td>LA</td>
<td>88</td>
<td>...</td>
</tr>
<tr>
<td>4</td>
<td>RA</td>
<td>88</td>
<td>65</td>
</tr>
<tr>
<td>5</td>
<td>LA</td>
<td>93</td>
<td>70</td>
</tr>
<tr>
<td>6</td>
<td>LA</td>
<td>86</td>
<td>65</td>
</tr>
<tr>
<td>7</td>
<td>RA</td>
<td>90</td>
<td>70</td>
</tr>
<tr>
<td>8</td>
<td>RA</td>
<td>127</td>
<td>95</td>
</tr>
<tr>
<td>9</td>
<td>LA</td>
<td>103</td>
<td>75</td>
</tr>
<tr>
<td>10</td>
<td>RA</td>
<td>113</td>
<td>80</td>
</tr>
<tr>
<td>11</td>
<td>RA</td>
<td>80</td>
<td>50</td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td>98 (73)</td>
<td>70 (77)</td>
</tr>
<tr>
<td>SD</td>
<td></td>
<td>14 (15)</td>
<td>12 (17)</td>
</tr>
</tbody>
</table>

| \( R^2 \) | 0.88* | 0.94* | 0.84* | 0.90* |

Numbers in parentheses indicate mean and SD of goats 6 through 11; \( R^2 \), correlation of the RP\(_{AF} \) measured by the different techniques compared with mapping.

*P<0.01.
TABLE 2. Comparison of Different Techniques to Measure the RP$_{AF}$

<table>
<thead>
<tr>
<th>Techniques</th>
<th>Equipment</th>
<th>Time, min</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mapping</td>
<td>High-density mapping</td>
<td>60</td>
<td>&quot;Gold standard&quot;</td>
<td>Only in exceptional circumstances</td>
</tr>
<tr>
<td>Entrainment</td>
<td>Programmed electrical stimulation</td>
<td>15</td>
<td>Conventional S$_1$-$S_2$ pacing</td>
<td>Not always possible</td>
</tr>
<tr>
<td></td>
<td>Multipolar catheter</td>
<td></td>
<td>Also in paroxysmal AF</td>
<td></td>
</tr>
<tr>
<td>Synchronized Stimuli</td>
<td>Stimuli synchronized to pacing site</td>
<td>30</td>
<td>Statistical determination of RP$_{AF}$</td>
<td>Complex</td>
</tr>
<tr>
<td>Fixed-Rate Pacing</td>
<td>Fixed-rate pacemaker</td>
<td>15</td>
<td>Easy to use</td>
<td>Takes 15 minutes</td>
</tr>
<tr>
<td></td>
<td>Multipolar catheter</td>
<td></td>
<td>Direct measurement of EP$_{AF}$</td>
<td></td>
</tr>
<tr>
<td>p5 AFCL</td>
<td>Recording of atrial electrogram</td>
<td>3</td>
<td>No pacing required</td>
<td>Reliability questionable</td>
</tr>
</tbody>
</table>

Considered the gold standard. All methods yielded an RP$_{AF}$ between 70 and 80 ms. During entrainment, the RP was 4±5 ms longer than the RP$_{AF}$ determined by mapping (77±17 versus 73±15 ms, P=0.12). The correlation between the values obtained by entrainment and mapping was 0.88 (P<0.01). The RP$_{AF}$ determined by synchronized stimuli yielded the same values as obtained by mapping (70±13 versus 70±12; R=0.94; P<0.01). The RP$_{AF}$ measured by fixed-rate pacing also gave a similar result (71±17 versus 73±15 ms; R=0.84; P<0.01). The 5th percentile of the AFCL histogram was 7±4 ms longer than RP$_{AF}$ measured by mapping (77±12 versus 70±12 ms, P<0.05), with a correlation coefficient of 0.90 (P<0.01). Although the study was not designed to compare measurements in RA and LA, AFCL and RP$_{AF}$ were consistently longer and showed more variation in the RA (P=0.33 to 0.47).

**Discussion**

**Refractory Period During Atrial Fibrillation**

The present study shows that the refractory period during AF exhibits a considerable temporal variation. Measurement of RP$_{AF}$ by mapping or fixed-rate pacing revealed a time window of 20 to 25 ms during which premature stimuli sometimes captured the atrium and sometimes not (Figures 3 and 6). This probabilistic nature of RP$_{AF}$ is probably a result of beat-to-beat variations in AFCL and direction of propagation. Also, fragmentation of fibrillation waves and electrotonic modulation of the action potential by dissociated neighboring wavelets may cause temporal variation in RP$_{AF}$. The RP$_{AF}$ measured by mapping was defined as the coupling interval resulting in >20% capture. The other methods also determined the shortest refractory period during AF. The values obtained by the 5 methods ranged between 70±12 and 77±17 ms (70% to 80% of median AFCL). Although these measurements of the refractory period ignore the existing temporal variation, they may be useful to explore the effects of changes in RP$_{AF}$ on perpetuation and termination of AF. In addition, they might be of value to evaluate the spatial variation in refractory periods during AF. The observed greater variability in AFCL and RP$_{AF}$ in the right atrium may be associated with a more complex geometry, allowing 3D propagation during AF.

**Excitable Period During Atrial Fibrillation**

In the present study, EP$_{AF}$, calculated as the difference between AFCL (98±14 ms) and RP$_{AF}$ (70±12 ms), was 28±8 ms. The EP$_{AF}$ measured during fixed-rate pacing was 27±4 ms (Figure 7). EP$_{AF}$, however, must also show a considerable temporal variation. In our experiments, the p5 and p95 AFCL were 77±12 and 120±16 ms. This variation in AFCL (43±8 ms) cannot be completely explained by the variability in RP$_{AF}$ (19±4 ms). This implies that at short AF cycles, the excitable period may become as short as 7 ms, whereas during long cycles, the excitable period might be as long as 50 ms. This beat-to-beat variability in EP$_{AF}$ may play a role in perpetuation of AF.

The excitable period during AF might be explained by the different types of reentry during AF. In case an impulse circulates around an anatomic obstacle, EP$_{AF}$ is determined by the difference between the conduction time around the obstacle and the refractory period within the reentrant circuit. In case of functional reentry, EP$_{AF}$ is caused by the
curvature of the circulating waveform at pivot points. Because of the high curvature, the excitatory current generated by the turning waveform may not be enough to make a rapid 180° turn,15–17 and the resulting conduction delay creates an excitable period in the returning limb of the turning waveform.18 In addition, when functional reentrant circuits are drifting through the myocardium, the excitable gap will be shortened or lengthened by the Doppler effect.19,20 In case of random reentry, an excitable period will arise at areas remote from the site of reentry because of the anterograde and retrograde conduction time to the site of reentry.1 Conversely, the excitable period will be shortened by epicardial break-through of wave fronts propagating in one of the pectinate muscles.10 The resulting short circuit of epicardial reentry may play an important role in perpetuation of AF, not only because of the 3D nature of the reentrant process but also by narrowing its excitable gap.

We recently suggested that EPAF might be a critical determinant for termination of AF. Cardioversion of persistent AF by class I drugs was associated with a dose-dependent widening of EPAF.2 We speculated that widening of the EPAF decreases the number of head-tail interactions between fibrillation waves, resulting in less dissociation and a higher degree of organization of the multiple wavelets. Cardioversion of AF would occur if multiple wavelets would fuse into a single wave front whose circulating pathway is ultimately interrupted. The possibility cannot be excluded, however, that under other circumstances, cardioversion of AF might be due to closure of the excitable period. Measurement of RP and EP during pharmacological cardioversion of AF by the methods developed in the present study may further elucidate the significance of the excitable period for termination of AF.

**Limitations**

In the present study, epicardial mapping was used to determine RP and EP. Because no endocardial recordings were made, the 3D structure of the atrial wall, which might play a role in the activation during AF,10 was not taken into account. Also, the study was not designed to determine differences in AFCL, RP, and EP at different atrial sites. Variation in atrial architecture and underlying geometric discontinuities may cause spatial variability in the RP and EP during AF. Future clinical studies measuring RP and EP with the use of catheter will be needed to elucidate differences between RA and LA. Another limitation is that measurements of RP were not compared with monophasic action potential recordings. Therefore, it remains unknown whether the EP is due to a diastolic interval between the successive action potentials during fibrillation. Because in the present study, RP was measured by chronically implanted epicardial electrodes, clinical application of these methods must await validation by use of multipolar endocardial catheters.

**Acknowledgment**

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**References**


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