Ventricular fibrillation (VF) is the most common cause of sudden death, and atrial fibrillation, the most prevalent clinical arrhythmia, accounts for nearly one third of strokes in the elderly. Fibrillation results when an electrical wavebreak induces reentry and triggers a cascade of new wavebreaks. In the diseased heart, the increased predisposition to wavebreak—reentry—fibrillation has traditionally been ascribed to increased tissue heterogeneity caused by structural and electrical remodeling associated with disease processes. However, recent evidence indicates that dynamic factors operate synergistically with tissue heterogeneity, as well as among themselves, to promote wavebreak. Unlike tissue heterogeneity (which refers to local structure and fixed electrophysiological dispersion), dynamic factors create functional electrophysiological dispersion that destabilizes wave propagation. Dynamic factors are related to cellular membrane voltage ($V_m$) and $Ca$. The former include action potential duration (APD) and conduction velocity (CV) restitution, short-term cardiac memory, and electrotonic currents. The latter are related to $Ca$ cycling between the sarcoplasmic reticulum (SR) and cytoplasm. Although dynamic factors can vary in different regions of the heart and exacerbate tissue heterogeneity, dynamic instability also has global aspects. Suppressing dynamic instability may be a promising therapeutic target if it can be accomplished without exacerbating tissue heterogeneity. In this review, we provide a brief overview of how dynamic factors synergistically interact with preexisting tissue heterogeneity to promote fibrillation.

Electrical Waves and Wavebreak
Cardiac excitation can be viewed as an electrical wave, with a wavefront corresponding to the AP upstroke (phase 0) and a waveback corresponding to rapid repolarization (phase 3). The wavelength, i.e., the distance between the wavefront and waveback, is defined as the product of APD and CV (Figure 1A). Normally, when a wave propagates through tissue, wavefront and waveback never touch. If they do, their point of intersection defines a wavebreak, sometimes called a phase singularity. When wave propagation fails simultaneously along the full length of the wavefront, the electrical wave extinguishes everywhere and no harm is done. However, if the wavebreak is spatially localized, reentry may result. Reentry begins at a localized wavebreak because the curvature of the wavefront at that point is very high. The high curvature produces a source-sink mismatch (i.e., too little depolarizing current with respect to the number of locally coupled unexcited cells), which slows conduction of the propagating wave near this point,1 causing the wave to rotate around the wavebreak point. If this wavebreak rotates around an anatomically defined circuit (such as a scar), it is called anatomic reentry. However, the wavebreak point can also

Abstract—Reentry occurs when the electrical wave propagating through the atria or ventricles breaks locally and forms a rotor (also called a scroll wave or functional reentry). If the waves propagating outward from a rotor develop additional wavebreaks (which may form new rotors), fibrillation results. Tissue heterogeneity, exacerbated by electrical and structural remodeling from cardiac disease, has traditionally been considered the major factor promoting wavebreak and its degeneration to fibrillation. Recently, however, dynamic factors have also been recognized to play a key role. Dynamic factors refer to cellular properties of the cardiac action potential and $Ca$ cycling, which dynamically generate wave instability and wavebreak, even in tissue that is initially completely homogeneous. Although the latter situation can only be created in computer simulations, its relevance to real (heterogeneous) cardiac tissue has been unequivocally demonstrated. Dynamic factors are related to membrane voltage ($V_m$) and $Ca$. $V_m$ factors include electrical restitution of action potential duration and conduction velocity, short-term cardiac memory, and electrotonic currents. $Ca$ factors are related to dynamic $Ca$ cycling properties. They act synergistically, as well as with tissue heterogeneity, to promote wavebreak and fibrillation. As global properties, rather than local electrophysiological characteristics, dynamic factors represent an attractive target for novel therapies to prevent ventricular fibrillation. (Circulation. 2005;112:1232-1240.)

Key Words: fibrillation ■ calcium ■ action potentials ■ antiarrhythmia agents ■ death, sudden
Tissue Heterogeneity and Wavebreak

Tissue heterogeneity can cause wavebreak by several mechanisms. When a wave travels into a region with a long refractory period (eg, longer APD), wavebreak will occur if the tissue has not yet recovered excitability from the previous wave. Wavebreak can also occur if there is a source-sink mismatch between the wavefront and the excitable tissue in front of it, so that the density of the depolarizing diffusive current is too low to bring the excitable tissue to threshold. This may occur at anatomic source-sink mismatches, such as papillary or pectinate muscle insertions, or when excitability is depressed regionally due to ischemia or drugs.

Figure 1. The cardiac impulse as an electrical wave, with a wavefront (black) corresponding to the upstroke of the AP, and a waveback (gray to white), corresponding to repolarization. Wavelength (λ) is the product of APD and CV. A, Uniform wave. B, Wave with wavebreak instability due to APD local prolongation. C, Wave with wavefront instability due to local CV slowing.

Tissue heterogeneity, due to electrophysiological, structural, or functional dispersion, can also contribute to wavebreak. In the normal heart, wavebreak is typically induced by electrical pacing, but it is also possible for spontaneous wavebreak to occur in the presence of disease processes that increase heterogeneity, such as infarction, fibrosis, or structural remodeling. This can lead to drug-induced wavebreak, which is often associated with the use of antiarrhythmic drugs that prolong APD or CV.

Dynamic Factors and Wavebreak

Although the normal heart exhibits electrophysiological and structural heterogeneity, fibrillation in the normal heart also depends on dynamic factors. Dynamic factors produce functional dispersion of electrophysiological properties, arising purely from the dynamic properties of Vm and Cai cycling on APD and wavelength, as demonstrated in computer simulations in which all cells in the tissue have identical initial conditions. This happens because the normal electrical wave is inherently unstable at very rapid heart rates. Because wavelength is the product of APD and CV, factors regulating APD and CV are critical for wave stability. These can be divided into Vm and Ca, factors. The former include APD restitution, CV restitution, short-term cardiac memory, and electrotonic currents. The latter include Ca, cycling dynamics and spontaneous SR Ca release.

V_m-Related Dynamic Factors

APD Restitution

When heart rate increases, APD shortens physiologically to preserve a sufficient diastolic interval (DI) for ventricular filling and coronary flow (Figure 2A). This relation defines an APD restitution curve (Figure 2B). If the APD restitution...
curve has a steep slope, then APD (and hence, wavelength) is sensitive to small changes in DI. During a rotor, small perturbations in DI will create large changes in APD and wavelength. If these wavelength oscillations are self-amplifying (e.g., APD restitution slope >1), then the wavelength oscillations are unstable and cause the rotor to break up. This has been clearly demonstrated in 2D and 3D cardiac tissue simulations in which every cell is assigned identical properties; yet when a rotor is induced, it breaks up spontaneously into multiple wavelets as a result of dynamically induced functional heterogeneities\textsuperscript{16–18} (Figure 2C-D). These theoretical predictions have been borne out by experiments\textsuperscript{19–24} demonstrating that reducing the slope of the APD restitution curve prevented VF in the normal ventricle (Figure 2E-F). Based on these findings, it has been proposed that drugs that flatten the APD restitution slope may be antifibrillatory by increasing dynamic wave stability (Figure 2D).

As the concept of dynamic stability has been examined more intensely, it has become apparent that APD restitution is not the sole source of dynamic wave instability. Several additional dimensions of instability have been identified, including CV restitution, short-term cardiac memory, electrotonic currents, and especially Ca cycling. They interact synergistically with each other, as well as with tissue heterogeneity. Their physiological importance in promoting VF in real cardiac tissue is just beginning to be explored.

CV Restitution
Whereas self-amplifying oscillations in wavelength caused by a steep APD restitution slope are manifested primarily in the waveback (i.e., repolarization) of the wave (Figure 1B), self-amplifying oscillations in the wavefront can also cause wavebreak (Figure 1C) when coupled with a steep APD restitution curve or tissue heterogeneity. Because wavefront position is directly controlled by CV, this situation arises dynamically when CV has a strong dependence on the preceding DI (i.e., “broad” CV restitution). Recently, we described a type of VF due to this mechanism\textsuperscript{24} in response to the calcium channel blocker D600 (Figure 3). At concentrations selective for L-type calcium channel blockade, D600 flattened the APD restitution slope and converted VF to ventricular tachycardia (VT) (Figure 3B). However, at higher concentrations, which also blocked cardiac sodium channels and decreased excitability, D600 converted VT back to VF.
(Figure 2C), but with altered features. Whereas optical mapping showed that the original type 1 VF before D600 was typical for multiple-wavelet fibrillation, the new type 2 VF in the setting of low excitability was slower, and optical activation maps indicated a mother rotor mechanism of VF. That is, a stable mother rotor acted as a focal periodic source, and wavebreak occurred due to fibrillatory conduction block as waves from the mother rotor were unable to conduct 1:1 into the surrounding tissue. The mother rotor typically was anchored to a papillary muscle near the left ventricular apex.25 Thus, in type 2 VF, broad CV restitution drives wavebreak by causing the wavefront to become unstable, and a steep APD restitution slope is not required.

These findings help to resolve the controversy over the 2 current leading hypotheses of VF. Type 1 VF corresponds to multiple-wavelet fibrillation, as originally proposed by Moe and colleagues,7 in which continual wavebreak is the engine driving fibrillation. Type 2 VF corresponds to the mother rotor mechanism recently emphasized by Jalife and colleagues (Zaitsev et al8 and Samie et al26). Clinically, both forms of VF may be important, with type I VF typically occurring when VF is first induced and being replaced by type 2 VF as acute ischemia reduces tissue excitability and amplifies static tissue heterogeneities. Clinical studies suggest that flattening the APD restitution slope (measured by pacing protocols) increases wave stability during VF and prevents type 1 VF in the normal ventricle.19–24

Electrotonic Currents
In addition to membrane ion channels, electrotonic current flow, proportional to the voltage difference and gap junction conductance between adjacent cells, influences APD, CV, and wavelength. In 3D tissue, fiber rotation and other heterogeneities affecting current diffusion can generate electrotonic currents, which cause filaments of meandering scroll waves to twist, leading to wavebreak.18,30 Decreasing Vander flatter by flattening the APD restitution slope or other means still prevents wavebreak by this mechanism. Electrotonic currents also play an important role in the development and evolution of repolarization alternans (see next section).

Ca2+-Related Dynamic Factors
Ca2+ cycling is increasingly recognized as an important regulator of dynamic wave instability. In mammalian hearts, most of the calcium that activates contraction is released from intracellular stores in the SR by the process of calcium-induced calcium release (CICR).31 With CICR, a small amount of calcium flowing into the cell via L-type calcium channels triggers calcium-release channels (ryanodine receptors) in the SR membrane to open and release the larger SR calcium pool into the cytoplasm. Cytoplasmic calcium is then pumped back into the SR via an SR Ca-ATPase (ie, SERCA pump) or transported across the sarcolemmal membrane by Na-Ca exchange. Under normal physiological conditions, regulation of contractile force by Ca2+ in the beating heart is tightly controlled by Vm such that the Ca2+ transient is effectively slaved to the AP. However, CICR constitutes an excitable medium in its own right and can exhibit independent dynamics. For example, when isolated rabbit ventricular myocytes are paced at rapid rates under AP clamp conditions, Ca2+ transients develop alternans and more complex periodicities, despite the fact that the Vm waveform is fixed29 (Figure 4A). Accumulating evidence suggests that Ca2+ alternans is the predominant cause of APD alternans in intact tissue.32,33 Theoretical34,35 and experimental36 studies suggest that a steep relation between calcium release from the SR and SR load is the underlying mechanism of Ca2+ alternans in isolated cells and hence, also in tissue.

The SR is also capable of spontaneously releasing calcium when the former becomes calcium overloaded.51 Rapid pacing is one modality for inducing SR calcium overload and can produce triggered activity due to delayed and early afterdepolarizations.31 When repolarization reserve is reduced, as in the long-QT syndromes, early afterdepolarizations may both initiate and reinitiate reentry. In the latter case, theoretical studies37 suggest that when rotors self-extinguish by colliding with a border, early afterdepolarizations arising from spontaneous SR calcium release may then perpetuate reentry. Traveling Ca2+ waves due to regenerative CICR are also
observed in the setting of Ca overload and can propagate intercellularly from myocyte to myocyte. Actual subcellular Ca, rotors due to CICR have been described in cardiac myocytes.

Once released, Ca influences APD (and hence, wavelength) through calcium-sensitive ionic currents, including the L-type calcium current, the Na-Ca exchange current, and calcium-activated nonselective and chloride currents. Ca release has opposing effects on APD: it tends to shorten APD by potentiating calcium-induced inactivation of the L-type calcium current but tends to prolong APD by enhancing the inward current through electrogenic Na-Ca exchange. Depending on which effect predominates, a larger Ca transient can cause the APD to prolong (positive coupling) or shorten (negative coupling) (Figure 4B and 4C). Conversely, these same currents influence the amount of calcium stored in the SR, so that the coupling between Vm and Ca is bidirectional. This coupling raises the possibility that under pathophysiological conditions, Ca release may alter the AP sufficiently to promote wavebreak, as has been observed in 2D cardiac tissue simulations. Experimentally, we found that the Ca and Vm waveforms, which tracked each other closely during pacing and VT, became desynchronized during VF. These observations all support that idea that during tachycardia and fibrillation, Ca dynamics may contribute independently to initiation and destabilization of reentry.

Also, Ca cycling and APD restitution are interrelated. In rabbit ventricular myocytes, a normal Ca transient was required for a steep APD restitution slope and APD alternans, because removing the influence of the Ca transient on membrane ionic currents during the AP by any of several means caused the APD restitution slope to become flat and/or APD alternans to disappear. Thus, Ca influences wave stability by multiple mechanisms.

**Dynamics of Repolarization Alternans**

Repolarization alternans, detected clinically as microvolt T-wave alternans, predicts increased arrhythmia risk in patients with diseased hearts. Repolarization alternans plays a special role in the dynamics of arrhythmogenesis because it is a direct measure of wave instability: repolarization alternans reflects beat-to-beat variations in APD and hence, wavelength, as the wave travels through cardiac tissue. There are 2 forms of repolarization alternans—concordant and discordant.

**Concordant Repolarization Alternans**

In this less-arrhythmogenic form of repolarization alternans, successive waves alternate between long and short wavelengths. Although APD and refractoriness vary from beat to beat, the refractory period of each individual beat is relatively uniform, so that dispersion of refractoriness is not markedly increased. However, in heterogeneous tissue, this dynamic modulation of refractoriness, if localized, can lead to wavebreak and rotor formation. Concordant repolarization alternans can be caused by either Vm or Ca dynamics. When heart rate increases and DI shortens to a point at which the APD restitution slope becomes >1, APD begins to alternate. Because APD affects the filling of SR calcium stores, this will also cause the Ca transient amplitude to alternate. Alternatively, if heart rate increases to a point at which Ca cycling causes the Ca transient to alternate, then APD will alternate secondarily due to calcium-sensitive membrane currents affecting APD.

If the coupling between Ca and Vm is positive, then the repolarization alternans is electromechanically concordant. In this case, the Vm and Ca dynamics sensitize each other to alternans; ie, APD alternans will occur even though the slope of the APD restitution slope is still <1, because the Ca

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**Figure 4.** Ca cycling and wavelength. A, Primary Ca alternans, during pacing of a rabbit ventricular myocyte with an AP clamp to prevent the AP from alternating. Ca still alternates. B, Positive coupling, in which a large Ca transient (red) prolongs APD (black) by increasing the inward current during the AP plateau (mainly via Na-Ca exchange). C, Negative coupling, in which a large Ca transient shortens APD by decreasing the inward current during the AP plateau (mainly via enhancing calcium-induced inactivation of the L-type calcium current).
instability is also synergistically promoting alternans. If the Ca-Vm coupling is negative, then repolarization alternans will be electromechanically discordant. In this case, Vm and Ca dynamics oppose each other; thus, APD may fail to alternate even though the APD restitution slope is $>1$. When both Vm and Ca systems exhibit dynamic instability and coupling is negative, more complex forms of repolarization alternans, such as quasiperiodicity, may also arise. This interaction between Vm and Ca instabilities is another reason why a simple criterion such as an APD restitution slope $>1$ may fail to accurately predict the onset of APD alternans or wave stability.

**Discordant Repolarization Alternans**

In spatially discordant repolarization alternans, APD alternates out of phase in different regions of tissue (Figure 5). Separating the regions with long-short and short-long APD alternans is a nodal line, along which no alternans is present. This form of repolarization alternans is highly arrhythmogenic because during propagation of the same wave, the spatial APD variation produces long and short wavelengths in different regions of the same tissue. This increases dispersion of refractoriness, so that a premature beat arising in the region of short wavelength may block as it propagates into the region of long refractoriness. For example, if the heart is paced from the short APD region, then as wave No. 1 propagates into the region of lengthening APD, its lengthening waveback will encroach on the DI of wave No. 2, causing its wavelength to shorten. However, this prolongs the DI encountered by wave No. 3, causing its wavelength to increase, and so forth. Thus, the waveback of a wave will oscillate as it propagates through the tissue, producing spatially discordant alternans.

A number of mechanisms have been identified that cause spatially discordant repolarization alternans, all requiring dynamic factors. When a spatial repolarization gradient, such as the normal base-to-apex APD gradient in the ventricles, is present, then concordant repolarization alternans, arising from either a steep APD restitution slope or unstable Ca cycling, can be converted to discordant APD alternans. For example, if the heart is paced from the short APD region, then as wave No. 1 propagates into the region of lengthening APD, its lengthening waveback will encroach on the DI of wave No. 2, causing its wavelength to shorten. However, this prolongs the DI encountered by wave No. 3, causing its wavelength to increase, and so forth. Thus, the waveback of a wave will oscillate as it propagates through the tissue, producing spatially discordant alternans.

However, simulations show that preexisting tissue heterogeneity is not necessary for spatially discordant alternans. Another mechanism arises purely from dynamic factors and occurs when CV restitution is engaged during spatially concordant APD alternans. During spatially concordant repolarization alternans, if wave No. 1 has a long wavelength, then wave No. 2 will encounter a short DI and therefore, have a short wavelength. If the short DI also engages CV restitution, wave No. 2 will slow and its DI will lengthen. As this happens, the wavelength of wave No. 2 will increase, thereby shortening the DI encountered by wave No. 3. Thus, as the wave is subjected to a varying DI, due to the wave in front of it slowing down and speeding up, its wavelength will change as it propagates through the tissue. In the normal heart, CV slows only at very short DI values ($<10$ ms). However, sodium channel–blocking drugs and acute ischemia both broaden the range of DI over which CV varies. These effects
facilitate discordant repolarization alternans, which may have contributed in part to the disappointing results of the CAST study.49

Additional mechanisms for spatially discordant alternans involving dynamical factors have been described recently, eg, premature beats delivered during spatially concordant alternans48 and negative Cai-Vm coupling.49a They are currently under investigation, and their clinical relevance is uncertain at the present time. Negative Cai-Vm coupling producing discordant electromechanical alternans has been observed experimentally.50

Interactions Between Tissue Heterogeneity and Dynamics Factors

Figure 6 summarizes interactions between tissue heterogeneity and dynamic factors in regulating wave stability. The vertical axis corresponds to dynamic factors related to Vm (APD and CV restitution properties, short-term cardiac memory, and electrotonic currents) and Cai (SR dynamics), whereas the horizontal axis reflects structural and electrophysiological tissue heterogeneity in normal and diseased hearts. In the gray area (low-risk/VT zone), the combined level of tissue heterogeneity and dynamic factors makes wavebreak difficult to induce. In addition, once induced, a rotor remains stable and does not break up into a fibrillation-like state. Increasing tissue or dynamic heterogeneity sufficiently along any axis, however, will move the heart out of the gray zone and into the high-risk/VT zone. In this zone, the initial wavebreak becomes progressively easier to induce, eventually allowing physiological triggers such as spontaneous extrasystoles to initiate reentry. Once induced, a rotor has a high probability of developing subsequent wavebreaks, resulting in fibrillation.

The normal heart lies in the white zone, because, if a rotor is induced, it has a high probability of degenerating into VF.51 Vm-Cai dynamics are therefore unstable enough to cause spiral/scroll wave breakup.15 Fortunately, tissue heterogeneity, though significant, is not extreme enough to allow physiological premature ventricular extrasystoles to induce rotors, which require a large electrical stimulus superseding the VF threshold or very rapid pacing. Disease states, genetic abnormalities, or drugs that increase tissue heterogeneity and dynamic instability move the heart farther away from the gray zone, so that initiation of unstable reentry by physiological stimuli becomes increasingly probable.

Implications for Antifibrillatory Therapy

As implicit in Figure 6, preventing fibrillation by pharmacological or gene-based therapy will involve moving the heart from the high-risk/VF zone into the low-risk/VT zone. Tissue heterogeneity itself is a difficult therapeutic target, because it is governed by disease-related structural and electrical remodeling that alters electrophysiological properties locally. Electrophysiological dispersion in this setting is often exacerbated by antiarrhythmic drugs, owing to differential sensitivity to drug effects. Dynamic factors, on the other hand, are cellular properties that can potentially increase wave stability on a global scale. If a therapy can be designed whose net effect increases dynamic wave stability more than it exacerbates tissue heterogeneity, it should be possible to reduce the occurrence of wavebreaks that initiate rotors. Standard antiarrhythmic drugs (classes 1 through 4) were developed primarily to prevent initiation of VT by suppressing the triggering events or altering the properties of reentrant circuits, with little regard for how they affected dynamic wave stability. This may in part explain their failure to prevent
sudden cardiac death in large clinical trials. With improved understanding of the role of dynamic factors in causing wave instability, it may someday be possible to develop effective drug or gene-based therapies that can reduce our present reliance on devices as the only effective strategy to abort sudden cardiac death due to VF. A similar therapeutic strategy holds promise for atrial fibrillation.

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