Background—Dynamically induced heterogeneities of repolarization may lead to wave-front destabilizations and initiation of ventricular fibrillation (VF). In a computer modeling study, we demonstrated that specific sequences of premature stimuli maximized dynamically induced spatial dispersion of refractoriness and predisposed the heart to the development of conduction block. The purpose of this study was to determine whether the computer model results pertained to the initiation of VF in dogs in vivo.

Methods and Results—Monophasic action potentials were recorded from right and left ventricular endocardium in anesthetized beagle dogs (n=11) in vivo. Restitution of action potential duration and conduction time and the effective refractory period after delivery of the basic stimulus (S_1) and each of 3 premature stimuli (S_2, S_3, S_4) were determined at baseline and during verapamil infusion. The effective refractory period data were used to determine the interstimulus intervals for a sequence of 4 premature stimuli (S_2S_3S_4S_5) for which the computer model predicted maximal spatial dispersion of refractoriness. Delivery of CL_VF was associated with discordant action potential duration alternans and induction of VF in all dogs. Verapamil decreased spatial dispersion of refractoriness by reducing action potential duration and conduction time restitution in a dose-dependent fashion, effects that were associated with reduced inducibility of VF with CL_VF.

Conclusion—Maximizing dynamically induced spatial dispersion of repolarization appears to be an effective method for inducing VF. Reducing spatial dispersion of refractoriness by modulating restitution parameters can have an antifibrillatory effect in vivo. (Circulation. 2008;118:1123-1129.)

Key Words: electrophysiology ■ ventricular fibrillation ■ verapamil

Clinical Perspective p 1129

Our group has demonstrated in a computer modeling study that in the presence of a steeply sloped APD restitution, the delivery of multiple premature stimuli produces spatial gradients of repolarization that can precipitate propagation failure.7 Recently, Otani8 developed a theory in which APD restitution interacts with CV restitution to produce this type of conduction block. The purpose of the present study was to determine whether the predictions generated by these computer models are relevant to the development of VF in canine myocardium in vivo. Our hypothesis was that maximizing dynamic heterogeneity by delivering a set of premature stimuli that cause conduction block in the computer model would suffice to predictably induce VF in vivo. We further tested this hypothesis by determining whether calcium channel blockade, which has been shown previously to suppress the development of VF in vitro by decreasing the slope of the APD restitution relation,9,10 reduces spatial dispersion of refractoriness and the inducibility of VF in vivo.

Methods

Two separate sets of experiments were performed in 2 groups of beagle dogs (Marshall Farms, North Rose, NY), group A (n=8) and group B (n=3). Experiments conducted on group A were performed...
to test the predictions resulting from the empirical modeling studies of Fox et al.,7 namely that premature stimulus combinations such as the "short-long-short-short" combination induce conduction block. Because the results obtained in group A dogs agreed well with the predictions of Fox et al., a more rigorous set of experiments were conducted in group B dogs using the predictions generated by the detailed theoretical model of Otani.8

Premature Stimulus Intervals Theoretically Predicted to Produce Block

Group A

In the modeling study by Fox et al.,7 APD and CV restitution functions measured in canine ventricular myocardium in vitro were used to construct a 1-dimensional coupled-maps computer model. The model was used to generate predictions regarding which combinations of premature stimuli were most (and least) likely to induce conduction block. The combinations generated by the computer model were delivered to the dogs in group A, as described below, to test whether the predictions were accurate.

Group B

For these experiments, predictions regarding which combinations of premature stimuli were most (and least) likely to produce conduction block were generated using the theoretical model of Otani.8 This model also relies on APD and CV restitution relations to generate predictions. Rather than use previously recorded in vitro data for the APD restitution relation as in the group A dogs, we measured APD restitution from each ventricle in vivo at the time of the study. Because CV restitution could not be measured in vivo, the CV restitution relation determined previously in vitro was used for the modeling.7

The predictions for this set of experiments were generated by running a coupled-maps model (Reference 8, Equations 17 through 19) using all possible combinations of $\Delta DI_1$, $\Delta DI_2$, $\Delta DI_3$, and $\Delta DI_4$ between 0 and 70 ms in 1-ms increments, where $\Delta DI_i = DI_{i+1} - DI_{i-1}$, $DI_0$ is the DI preceding stimulus $S_i$ for $i =$ 2, 3, 4, and 5; and $DI_{n+1}$ is the shortest DI allowing conduction of the subsequent premature beat. The simulations generated the following: all combinations of $\Delta DI_1$ and $\Delta DI_2$ that produced block of the $S_i$ wave; all combinations of $\Delta DI_1$, $\Delta DI_2$, and $\Delta DI_3$ that produced block of the $S_i$ wave; and the largest value of $\Delta DI_i$ that produced block of the $S_i$ wave for every combination of $\Delta DI_1$, $\Delta DI_2$, and $\Delta DI_3$.

Experimental Preparations

Animals in both experimental groups were prepared identically. Adult beagle dogs (2 to 3 years of age) of either sex (n = 11) that weighed on average 12.5 kg (range, 6 to 18 kg) and were maintained on standard chow were used. General anesthesia was induced with pentobarbital (30 mg/kg bolus IV) and maintained by continuous-rate infusion at 7 mg · kg$^{-1}$ · h$^{-1}$.11 Animals were ventilated to maintain oxygen tension at >100 mm Hg, arterial oxygen saturation at >96%, and carbon dioxide tension at 35 to 42 mm Hg and were given intravenous lactated Ringer’s solution to maintain hydration and electrolyte balance. Arterial blood pressure and ECGs were recorded continuously.

Monophasic action potentials (MAPs) were recorded from the right ventricle (RV) and left ventricular (LV) endocardium with MAP catheters (7F, EP Technologies Inc, San Jose, Calif) introduced through transfemoral venous and arterial access. Ventricular stimulation was performed through the MAP catheter using rectangular pulses of 2-ms duration at twice the diastolic threshold. Data were digitized at 1000 Hz with 12-bit resolution and were recorded on an electrophysiology recording system (Biopac Systems, Inc, Goleta, Calif). Filter settings were 0.05 Hz for high pass and 500 Hz for low pass. Data analysis was performed with custom-written analysis programs in the MATLAB language.

After measurements were taken during control conditions, each dog in group A was given verapamil at continuous-rate infusions of 0.1 mg · kg$^{-1}$ · h$^{-1}$ ($V_{bolus}$), 0.3 mg · kg$^{-1}$ · h$^{-1}$ ($V_{ bolus}$), and 1.0 mg · kg$^{-1}$ · h$^{-1}$ ($V_{bolus}$), with each dose preceded by a bolus dose of 0.1 mg/kg. Measurements were obtained at steady state and 30 minutes after each increase in dose.

At the end of the study, the dogs were euthanized with an intravenous injection of sodium pentobarbital. All experimental protocols and procedures were approved by the Institutional Animal Care and Use Committee of the Center for Animal Research and Education at Cornell University (Ithaca, NY).

Pacing Protocols

Three pacing protocols were used for the group A experiments: (1) a protocol to establish the effective refractory periods (ERPs) after delivery of 1 to 4 premature stimuli, (2) a protocol to establish APD restitution during constant pacing, and (3) a protocol to test whether the premature stimulus intervals predicted by the computer model—induced conduction block were generated using the theoretical model of Otani.8 This protocol was delivered at progressively shorter $S_iS_i$ intervals until $S_i$ failed to capture ($S_iS_i$). The $S_iS_i$ interval was then set to $S_iS_i$+40 ms, and an $S_i$ stimulus was delivered at progressively shorter $S_iS_i$ intervals until it failed to capture ($S_iS_i$). The procedure was then repeated to find $S_iS_i$+50 ms and $S_iS_i$+5 ms, and $S_iS_i$+5 to 10 ms.

For the second protocol, the dynamic pace-down protocol,12 drive trains of 50 stimuli were delivered at a constant $S_iS_i$ interval. The $S_iS_i$ interval of each drive train was decreased by 20 ms starting at 340 ms until 2:1 block occurred or VF was induced, in which case the dogs were immediately defibrillated with 50 to 100 J.

In the third protocol, a set of 4 appropriately timed premature stimuli designed to maximize dynamically induced spatial heterogeneity of refractoriness (CI,e), as predicted by the Fox et al.7 study, were delivered. The sequence of stimuli was as follows: $S_iS_i$+5 ms, $S_iS_i$+50 ms, $S_iS_i$+5 ms, and $S_iS_i$+5 to 10 ms.

For the group B experiments, a dynamic pace-down protocol was conducted, as in Group A. The APD and DI data subsequently were used to calculate an APD restitution function and predictions regarding which sequences of premature stimuli were expected to induce VF and which were not. Because the testing of thousands of stimulus combinations in an in vivo experiment was clearly impractical, we took the following approach. Each premature stimulus from each combination tried was categorized according to whether the preceding DI was short ($S_i$) ($\Delta DI$ between 0 and 5 ms), intermediate (l) ($\Delta DI$ between 5 and 40 ms), or long (L) ($\Delta DI$ between 40 and 60 ms). The $DI_{bolus}$ values used to calculate the $\Delta DI$ were determined separately for each combination of the preceding stimuli. Subsequently, stimulus combination categories were formed. For example, the SLSS category contains all combinations of stimuli for which $\Delta DI_1$, $\Delta DI_2$, and $\Delta DI_3$ are between 0 and 5 ms and $\Delta DI_4$ is between 40 and 60 ms. We attempted to test all 4 two-premature-stimuli combination categories, all 8 three-stimuli categories, and 14 of 16 possible categories involving 4 premature stimuli.

Determination of the APD Restitution Function

The APD restitution relation was determined by plotting APD (measured at 95% of repolarization [APD$\text{R}$]) as a function of the preceding DI of the last action potential at each paced cycle length.12 For the group A experiments, the maximum slope of the restitution relation was determined using a 4-parameter, sigmoidal function of the form $APD=b(1+\exp[-(DI-c)/d])$. For the group B dogs, the restitution relation was fit by solving the standard nonlinear least-squares problem using the functional form $APD=a+b\exp(-DI/c)$.

Interventricular Conduction Time and Dispersion

The conduction time (CT) between the RV and LV during the dynamic restitution protocol (CT) was determined for group A dogs. CT was defined as the maximum difference in RV to LV CT during stimulation at the longest and shortest cycle lengths of the dynamic restitution protocol. CT was used as a surrogate parameter for CV, which could not be determined directly because the conduction path length between RV and LV MAP recording sites was not known. As an index of spatial dispersion of refractoriness,
As shown in Table 1, delivery of this SLSS pattern (CLVF) resulted in discordant APD alternans (APDdiff) was determined. The APD restitution relation, ΔCT, APDdiff, and VF inducibility were assessed under control conditions and 30 minutes after administration of each dose of verapamil in group A dogs.

### Statistical Analysis

In group A dogs, we used a linear mixed-effect model with dog as a random effect to assess the dependence of hemodynamic and electrophysiological parameters on verapamil dosage. We coded the control, low, medium, and high doses as a categorical factor and report the significance of the factor as a whole. We note that the mean responses for these factors all exhibit a monotonic relationship to dose level. We report the absolute value, presented as mean±SEM, and the probability value for the factor. In group B dogs, we applied a likelihood-ratio test to logistic regression to assess the significance of the association between our theoretical predictions to induce VF and the outcome in the experiments. All statistical analyses were performed with JMP version 7 (SAS Institute Inc, Cary, NC). A value of \( P<0.05 \) was considered statistically significant.

The authors had full access to and take responsibility for the integrity of the data. All authors have read and agree to the manuscript as written.

### Results

#### Induction of VF In Vivo With Dynamic Premature Stimulation

For the group A experiments, the theory predicted that the highest incidence of local conduction block should occur for (1) an \( S_1S_2 \) interval very close to \( S_{S_{min}} \) (2) an \( S_2S_3 \) interval 50 ms longer than \( S_{S_{max}} \) (3) an \( S_3S_4 \) interval very close to \( S_{S_{min}} \) and, (4) an \( S_4S_5 \) interval 5 to 10 ms longer than \( S_{S_{max}} \). As shown in Table 1, delivery of this SLSS pattern (CLVF) resulted in induction of VF in all 12 trials of group A dogs under baseline conditions. We also tested combinations of \( S_1 \) through \( S_5 \) sequences that should not, as predicted by the computer model, lead to local conduction block (CLNoVF). VF was not inducible with these premature stimulus combinations in 6 of 9 trials (Table 1).

Delivery of CLVF resulted in discordant APD alternans between RV and LV. As shown in Figure 1A, a short-long-short-long MAP APD sequence at the site of stimulation (RV) was associated with an opposite long-short-long-short APD sequence at the MAP recording site in the LV, followed by VF. There was significant spatial dispersion of refractoriness between the 2 recording sites during premature stimulation, as evidenced by an APDdiff value of 153 ms for the example shown in Figure 1A.

In the group B experiments, there was excellent agreement between the theoretical predictions and the experimental results, as illustrated by Figures 2 through 4. Nearly all stimulus combinations predicted not to produce block did not cause VF, as evidenced by the large number of green disks (indicating no induction of VF) appearing well away from the sequences predicted to cause VF in all 3 figures. Only 3 episodes of VF were not predicted by the theory, as represented by 1 red disk (indicating VF induction) located away from the sequences predicted to cause block in Figure 3 and 2 red disks in Figure 4. Conversely, 11 episodes of VF occurred when the theory indicated that VF was likely (1 episode in Figures 2, 3 episodes in Figure 3, and 7 episodes in Figure 4).

The mechanism for induction of conduction block is illustrated in Figure 5 with results from the theoretical model. As shown in Figure 5A, when the stimulus intervals were made as short as possible, the largest \( S_1–S_2 \) interval that produced block was 14 ms longer than the \( S_2 \) ERP (A). In contrast (Figure 5B), when the \( S_1–S_2 \) interval was longer (25 ms above ERP) while the \( S_2–S_3 \) and \( S_3–S_4 \) intervals were kept short (1 ms above ERP), a substantially longer \( S_3–S_4 \) interval was capable of producing block (25 ms above ERP).
The longer S₂–S₃ interval led to a substantial spatial gradient in the excitable period (the white, wedge-shaped region) between the S₂ and S₃ ERPs. This gradient was amplified and inverted during each subsequent action potential by the steep APD restitution function, yielding increasingly steep spatial gradients in the excitable periods between S₁ and S₂ and between S₂ and S₃. The latter was expressed largely through slow propagation of the S₄ wave back, which allowed the S₅ wave to catch up and run into it, even when the S₅ stimulus was 25 ms after the end of the S₄ ERP. The robustness of this mechanism likely accounts for the 100% success rate in producing VF with SLSx stimulus combinations, in contrast to the lower predicted and actual success rates in producing VF with a SSSx combination.

A statistical analysis was performed to determine whether an agreement existed between the experimental results and the theory. Each attempt to induce VF (n=105) was categorized by (1) the dog and (2) the ventricle in which the attempt was performed, (3) whether <25% or >25% of the stimulus combinations in the stimulus combination category used were predicted to produce block, and (4) whether VF induction was actually successful in the experiment. Table 2 summarizes these data. We then applied logistic regression to these data for the event of VF induction using dog, ventricle, and theoretical prediction as covariates. When the likelihood-ratio test was applied to this method, neither the effect of dog (P=0.42) nor the effect of ventricle (P=0.25) was statistically different from 0. However, the effect of the theoretical prediction was significantly different from 0 (P<0.0001). The coefficient of prediction was 2.2.
Effects of Verapamil on Inducibility of VF

Tables 3 and 4 summarize the effects of verapamil on selected hemodynamic and electrophysiological parameters. The statistical analysis using a linear mixed-effect model yielded a probability value for the overall effect of dose. As Table 3 shows, verapamil significantly decreased arterial blood pressure and spontaneous heart rate and prolonged atrioventricular CT (as reflected by prolongation of the PR interval) as the dosage was increased. MAP recordings had a more triangular shape during verapamil infusion, which was associated with a significant prolongation of steady-state APD₉⁵ during constant pacing at a cycle length of 400 ms.

Verapamil significantly reduced the maximum slope of the dynamic APD restitution relation of the left ventricle and decreased the maximum difference in RV and LV CTs during stimulation at long and short cycle lengths (ΔCT). The changes in restitution parameters were associated with a tendency toward decreased spatial heterogeneity of refractoriness (APD₉⁵diff), but changes in the latter did not reach statistical significance (Table 4). In addition, inducibility of VF with CL_VF was reduced in a dose-dependent fashion by verapamil (Table 1).

An example of simultaneous MAP recordings from RV and LV during high-dose verapamil infusion and delivery of CL_VF is shown in Figure 1B. Compared with control conditions (Figure 1A), there was no discordant alternans between the RV and LV, and the duration of the premature action potentials was more uniform, as reflected by a markedly decreased APD₉⁵diff value of 32 ms. VF was not inducible by delivery of CL_VF during high-dose verapamil infusion in this dog.

Table 2. Percentage of Stimulus Combination Categories That Did or Did Not Produce VF in 2 Divisions of Stimulus Combination Categories Defined by the Fraction of Combinations in Each Category That Was Predicted Theoretically to Yield Conduction Block

<table>
<thead>
<tr>
<th>Experimental Outcome</th>
<th>&lt;25% of Combinations</th>
<th>&gt;25% of Combinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>VF inducible</td>
<td>8 (9/97)</td>
<td>75 (6/8)</td>
</tr>
<tr>
<td>VF could not be induced</td>
<td>92 (89/97)</td>
<td>25 (2/8)</td>
</tr>
</tbody>
</table>

Numbers in parentheses indicate the number of categories (trials) for which VF could or could not be induced.

Discussion

New Findings

In this study, we demonstrated in a computer model that maximizing dynamically induced spatial dispersion of refractoriness most often led to conduction block after a premature stimulus pattern of short-long-short-short. The predictions from the computer model with respect to which patterns of premature stimulation would cause conduction block were tested in canine myocardium in vivo. Delivery of CL_VF predicted by the computer model to cause block, resulted in discordant APD alternans, followed by VF induction. Delivery of a premature stimulus combination that did not produce conduction block in the computer model typically did not induce VF in vivo.

A second important finding of this study is that modulation of APD restitution parameters via calcium channel blockade reduced spatial dispersion of repolarization and thereby reduced VF inducibility after premature stimulation. Verapamil reduced the slope of the APD restitution relation and decreased the magnitude of APD alternans, effects that inhibited the development of spatially discordant alternans and inducible VF. This result is in agreement with our previous in vitro studies and earlier work demonstrating reduced MAP alternans in canine hearts in vivo after verapamil infusion.13

Table 3. Effects of Dosage (Coded as Control, Low, Medium, and High) of Verapamil on Hemodynamic and Electrophysiological Parameters

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>V₀</th>
<th>V_med</th>
<th>V₉⁵</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPₚ₀₂₅ mm Hg</td>
<td>164±14</td>
<td>142±7</td>
<td>131±6</td>
<td>129±10</td>
<td>0.0375</td>
</tr>
<tr>
<td>BPₚ₅₀ₐ₅ mm Hg</td>
<td>98±8</td>
<td>82±8</td>
<td>71±5</td>
<td>59±7</td>
<td>0.038</td>
</tr>
<tr>
<td>BPₚ₇₅ₐ₅ mm Hg</td>
<td>127±6</td>
<td>105±8</td>
<td>96±6</td>
<td>93±7</td>
<td>0.0013</td>
</tr>
<tr>
<td>HR, bpm</td>
<td>140±6</td>
<td>105±4</td>
<td>97±5</td>
<td>83±5</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PR, ms</td>
<td>94±8</td>
<td>119±7</td>
<td>147±9</td>
<td>207±10</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>APD₉⁵ RV, ms</td>
<td>214±4</td>
<td>223±9</td>
<td>238±9</td>
<td>238±8</td>
<td>0.0086</td>
</tr>
<tr>
<td>APD₉⁵ LV, ms</td>
<td>220±4</td>
<td>241±10</td>
<td>240±8</td>
<td>245±10</td>
<td>0.0371</td>
</tr>
</tbody>
</table>

BP indicates arterial blood pressure; HR, heart rate; PR, PR interval of the ECG; and APD₉⁵, APD at 95% repolarization in the RV and LV during steady-state pacing at a cycle length of 400 ms. Data are mean±SEM. Probability values show significance of factor as a whole.
ever, detailed mapping studies of the ventricles would be prevented conduction block and the initiation of VF. How-
disorder is that wave break can arise purely on a dynamic basis secondary to spontaneous wavelength oscil-
lations.3–5 These oscillations develop because of fundamental restitution properties of the myocardium, namely that APD shortens and CV slows progressively as the pacing rate is increased. If the pacing rate is rapid enough to engage CV restitution, then successive waves will decelerate or accelerate, depending on how close they are to the wave back of the preceding wave, thereby causing spatially heterogeneous oscillations in wavelength that result in discordant APD alternans.14–17

Our computer model demonstrates that a short-long-short APD sequence at the site of premature stimulation is associated with a long-short-long sequence at the opposite end of the fiber. Discordant APD alternans enhances spatial dispersion of refractoriness, which may eventually cause local conduction block because additional premature beats may impinge on the wave back of the preceding wave. The results obtained from the computer model subsequently were validated in vivo; the cycle lengths that caused conduction block in the computer model (CL\text{cp}) were associated with discordant APD alternans and induction of VF.

### Antifibrillatory Effects Through Modulation of Restitution Parameters

Experimental studies have demonstrated that drugs such as bretylium, verapamil, and diacetyl monoxime, which flatten APD restitution and thereby suppress APD alternans, have antifibrillatory effects in vitro.9,10 It is important to note that although verapamil decreased the slope of the dynamic restitution relation in the present study in vivo, the slope was not decreased to \(<1\) even at verapamil doses that had significant negative inotropic and dromotropic effects. Because the slope of the APD restitution relation remained \(>1\) after verapamil infusion, APD alternans was not eliminated by verapamil. However, verapamil reduced the magnitude of APD alternans, which was reflected in a decrease in APD dispersion during premature stimulation and a corresponding decrease in the difference in CTS. It seems likely that the reduced spatial dispersion of refractoriness prevented the development of discordant APD alternans, which, in turn, prevented conduction block and the initiation of VF. However, detailed mapping studies of the ventricles would be required to confirm this hypothesis and to eliminate the possibility that verapamil prevented the induction of VF by some other mechanism such as suppression of triggered activity.

### Implications

Our study provides additional mechanistic insights for the well-recognized clinical observation that induction of rapid ventricular tachycardia and VF is often preceded either by a long-short-long18 or a short-short-short sequence of ventricular premature beats.10 Because of APD and CV restitution properties, a short-long-short sequence of premature beats maximizes spatial dispersion of refractoriness by inducing discordant APD alternans, which may eventually result in local conduction block. Local conduction block, in turn, is a prerequisite for the initiation of reentrant arrhythmias.

Our results further suggest that suppression of discordant APD alternans by drugs that appropriately modulate APD and CV restitution parameters may be a promising antiarrhythmic strategy, recognizing that several events may be required for the induction and subsequent maintenance of VF. Here, we address only one of these events: Are the necessary ingredients present to block some portion of a propagating wave? Although wave block may be a necessary condition for creating wave break, it is not sufficient. Heterogeneity in the direction perpendicular to propagation also is required; otherwise, the entire wave would block at once and no wave break would occur. Accordingly, it is likely that the intrinsic heterogeneity of refractoriness contributed to the onset of VF in our experiments. It therefore follows that suppression of intrinsic heterogeneity also would be expected to prevent the induction of VF, an expectation supported by previous studies in which postpolarization refractoriness was shown to reduce both dispersion of refractoriness and the inducibility of VF.10

### Study Limitations

The primary limitations of the study were related to the fact that we obtained MAP recordings from only 2 sites, 1 in each ventricle. Consequently, we were not able to map the sequence of activation, which prevented us from determining CV as opposed to CTS. In addition, we were not able to determine the site of local conduction block, which would have required high-resolution mapping of the propagation wave fronts in the RV and LV.

A more general limitation of the study is that it was conducted in normal beagle dogs in the absence of overt heart disease. Given that sudden cardiac death occurs most often in patients with heart disease, the relevance of the present results to patients at risk for sudden cardiac death remains to be established. However, recent demonstrations that APD restitution is steep in some ventricular regions and is associated with the development of APD alternans in patients who lack structural heart disease20,21 and that the incidence and magnitude of alternans are greater in patients who do have structural heart disease21 suggest that studies of dynamically induced APD heterogeneity in normal dogs are likely be relevant to the clinical situation. If so, circumstances that
maximize dynamical heterogeneity may increase the risk for VF.

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**Disclosures**

None.

**References**


**CLINICAL PERSPECTIVE**

Our study demonstrates a novel mechanism of induction of ventricular fibrillation in vivo in intact normal beagle dogs. This work may contribute to our understanding of the mechanisms leading to the development of ventricular fibrillation in the structurally normal heart. For example, in patients with idiopathic ventricular fibrillation, focal ectopic ventricular activity originating in the Purkinje network is thought to trigger the onset of ventricular fibrillation. Our work also may be clinically relevant to patients with channelopathies, ie, long-QT syndrome, in which typically a short-long-short sequence of premature stimuli induces ventricular tachycardia and fibrillation. We showed in our study that such specific patterns (called CLVF, cycle lengths inducing VF) can indeed lead to ventricular fibrillation by creating conduction block and wave break, depending on the restitution properties of the action potential duration and conduction velocity. In that regard, a potential therapeutic application of our work is to specifically target the restitution parameters with drugs so that CLVF would no longer lead to ventricular fibrillation. We showed that the calcium channel blocker verapamil exerts antifibrillatory effects by altering restitution parameters but not at clinically relevant dosages. However, we postulate that other drugs may prove to have antiarrhythmic effects by altering the restitution parameters of a patient and thus may prevent the induction of ventricular fibrillation rather than by suppressing the premature stimuli.
Dynamic Mechanism for Initiation of Ventricular Fibrillation In Vivo
Anna R.M. Gelzer, Marcus L. Koller, Niels F. Otani, Jeffrey J. Fox, Michael W. Enyeart, Giles J. Hooker, Mark L. Riccio, Carlo R. Bartoli and Robert F. Gilmour, Jr

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