Targeting Viable Myocardium in Cardiac Resynchronization Therapy Using a Multipolar Left Ventricular Lead

Khalid Abozguia, PhD; Francisco Leyva, MD, FRCP, FACC

An 81-year-old man with 3-vessel coronary heart disease and a left ventricular (LV) aneurysm, who had been deemed unsuitable for coronary revascularization, was referred for cardiac resynchronization therapy. He was in New York Heart Association class III, and he had a LV ejection fraction of 20% and a left bundle-branch block (QRS duration of 148 ms). Late gadolinium enhancement cardiovascular magnetic resonance showed an apical aneurysm and transmural enhancement in 11 of 17 myocardial segments, including the mid and apical segments of the LV free wall (Figure 1).

At implantation, coronary sinus venography revealed a single posterolateral tributary as the only adequate vessel for LV lead deployment. A conventional bipolar LV lead (QuickSite XL model 1058T, St. Jude Medical) was deployed in a distal portion of this tributary, but unfortunately, unacceptable pacing thresholds (≥7 V at 0.5 ms) were obtained. More proximal lead positions were anatomically unstable. A multipolar LV lead (Quartet, St. Jude Medical) was subsequently advanced into this tributary, with its tip deployed in a distal portion.

As shown in Figure 2, the multipolar LV lead straddled an area of myocardial scar. Importantly, there was a marked variation in the pacing thresholds from the proximal to the distal poles, ranging from 1 V over nonscarred myocardium to ≥7.5 V over scarred myocardium (pole to right ventricular coil, at 0.5 ms). Interestingly, there was also a marked variation in the QRS duration as well as in QRS morphology on the surface ECG, which was right bundle-branch block-like in the proximal poles (A and B), subtending viable myocardium, and left bundle-branch block-like in the distal poles, subtending myocardial scar (C and D).

It is well recognized that scarring in the vicinity of a pacing stimulus leads to prolongation and fragmentation of the QRS complex and reduced myocardial excitability. It has also been shown that pacing viable myocardium during cardiac resynchronization therapy is associated with a better symptomatic response and clinical outcome in comparison with pacing scarred myocardium. This case illustrates how, combined with late gadolinium enhancement cardiovascular magnetic resonance, multipolar LV leads can be used to electronically optimize LV pacing parameters in the vicinity of myocardial scars.

Acknowledgments

We are grateful to Jeremy Weaver for his assistance in the documentation of pacing parameters.
Disclosures
Dr Levya received sponsorship from St. Jude Medical, Medtronic Inc, and Sorin.

References
Targeting Viable Myocardium in Cardiac Resynchronization Therapy Using a Multipolar Left Ventricular Lead

Khalid Abozguia and Francisco Leyva

Circulation. 2011;123:e617-e618
doi: 10.1161/CIRCULATIONAHA.110.017400

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/123/22/e617

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org//subscriptions/