Effect of Nontransmural Necrosis on Epicardial Potential Fields
Correlation With Fiber Direction
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The effect of nontransmural necrosis on epicardial potential distributions was studied in 13 dogs. In previous studies, left ventricular epicardial pacing generated epicardial potential maps at QRS onset with a negative central area and two positive areas that faced the portions of the wavefront propagating along fibers. Subsequently, the positive areas expanded in a counterclockwise direction by 90° to 120°. In those studies, the rotatory expansion of the positive areas was tentatively attributed to the spread of excitation through deep myocardial layers, where fiber direction rotated counterclockwise from epicardium to endocardium. To test this hypothesis, we tried to interrupt the counterclockwise expansion of the positive area by creating localized, nontransmural necrosis at various depths in the left ventricular wall by injection of formalin or application of laser energy. Epicardial potential maps were obtained from a grid of 12×15 electrodes on a 44×56-mm area. Epicardial pacing from selected sites generated epicardial maps in which some positive areas were missing compared with controls. The direction of the straight line joining the pacing site to the site of missing positivity correlated well with the average fiber direction in the necrotic mass (r=0.82, p<0.01). Angle between epicardial fiber direction and the straight line described above correlated well with the average depth of the necrosis, expressed as percent of the wall thickness (r=0.95, p<0.01). These data support the hypothesis that the counterclockwise expansion of the epicardial positivity occurring after epicardial pacing results from excitation spreading along deep fibers. The findings are consistent with the oblique dipole layer model of the excitation wavefront. The results may be useful for localizing nontransmural necrosis from epicardial maps. (Circulation 1990;82:2115–2127)

Received January 19, 1990; revision accepted July 3, 1990.

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Supported in part by the Nora Eccles Treadwell Foundation, the Richard A. and Nora Eccles Harrison Fund for Cardiovascular Research and the National Institutes of Health grant HL-43276-01.

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some kind of CCW rotation, although the amount of rotation may be different for fiber direction, isochrone pattern, and potential distribution for reasons explained in Frazier et al有一种 and in the “Discussion.” In the present study, we tested the above interpretation by locally destroying some of the superficial or deep fibers that supposedly participated in generating the rotating epicardial positivity. We expected that, for properly selected pacing sites, a subepicardial necrosis would suppress one of the two initial maxima and the initial part of the CCW expansion of the positivity. According to the same reasoning, intramural and subendocardial necrosis would suppress later portions of the expanding epicardial positivity. We also expected that the position of the suppressed positivity within the expanding positive area would rotate CCW with increasing intramural depth of the necrosis, reflecting the loss of deeper and later portions of the rotating intramural positivity. To test the validity of this reasoning, we recorded left ventricular epicardial potential maps while pacing from various epicardial sites before and after inducing nontransmural, small necroses at various intramural depths in the left ventricular wall of exposed dog hearts. The necrosis was produced by laser energy or by formalin injection into the ventricular wall. The results were consistent with our expectation and supported our interpretation of the CCW expansion of the epicardial positivity during QRS.

Methods
Creation of Necrosis and Data Acquisition
Experiments were performed in 13 dogs weighing 20–28 kg and anesthetized with sodium pentobarbital (30 mg/kg). The heart was exposed by a left thoracotomy through the fifth or sixth intercostal space and suspended in a pericardial cradle. Respiration was maintained with a pump respirator. The sinus node was crushed, and the right or left atrial appendage was driven at 360–400-msec cycle lengths. One hundred eighty unipolar silver electrodes were mounted on a nylon sock that covered most of the anterolateral left ventricular surface except the apex (Figure 1A). The electrodes were arranged in a 12×15 grid with 4-mm spacing between columns and rows (Figure 1A, B). The nylon sock also carried 20 pairs of bipolar electrodes that were used for ventricular pacing (see Figure 11). During data acquisition, the sock was kept moist with saline so that a very thin layer of fluid covered the heart surface. Electrograms were simultaneously recorded from the electrode array, multiplexed, and digitized at 1,000 samples/sec with a 192-channel acquisition system. A Wilson central terminal was used as the reference electrode for recording. Control recordings and recordings after inducing the necrosis were obtained during simultaneous pacing of the atrium and of each stimulating electrode on the sock. Stimulation was performed by delivering current pulses of 2 msec at twice diastolic threshold.

Laser energy or formalin was used for inducing nontransmural necrosis. There were three types of necrosis (Figure 2). In two of 13 dogs, a laser-induced necrosis was made on the epicardium. A 0.9-mm diameter quartz core fiber (model 8200, Molelectron Medical) was used for this purpose. Laser energy was supplied by a Nd:YAG (neodymium, yttrium, aluminum, garnet) laser (model 8000, Molelectron Medical). Energy used was 50 and 100 J. In four of 13 dogs, 37% formalin was used for inducing limited intramural necrosis. A small amount of formalin (0.3–0.5 ml) was injected with a very fine needle (Tuberculin needle) from the epicardium in the area covered by the nylon sock. The depth of the injection and the amounts of formalin were such that the necrosis did not extend to the epicardium or endocardium. In seven of 13 dogs, laser energy was used for producing a necrosis on the endocardial surface (Table 1). A 5F catheter introducer was inserted into the left ventricular cavity through the right ventricle and the inter-

FIGURE 1. Panel A: Schematic of the heart showing the position of 180 unipolar electrodes. The 44×56-mm electrode grid is shown with indications for the septal, basal, posterolateral, and apical border of the area explored. Panel B: Display format of the maps.
The same type of laser fiber used for inducing subepicardial necrosis was inserted into the introducer and positioned with the tip touching the endocardial surface. Laser energies of 50–399 J were delivered to induce various extents of subendocardial necrosis. The position of the fiber tip was verified by fluoroscopy.

To avoid the interference of injury currents, we obtained recordings 2 hours after inducing the necrosis, when the ST-T shifts had disappeared almost completely.

**Data Analysis**

The 180 simultaneously recorded signals were gain and baseline adjusted. The electrograms were plotted, and their quality was evaluated. Missing or poor electrograms were replaced by the mean of the signals recorded by the surrounding electrodes. Then, epicardial potential maps were displayed for every msec in the QRS. Maps were displayed in the format shown in Figure 1B. Isopotential contours were drawn at 10 equal voltage intervals for each polarity using linear interpolation. This format facilitates recognition of the extrema.

Two hours after inducing the necrosis, some of the dogs showed a shortened QRS duration, as measured in the power curve, which displays, for every instant, the root mean square value of all voltages simultaneously recorded from the 180 sock electrodes. The amount of shortening ranged from 0 to 12 msec (average, 6.5 msec). The reason for the shortening was unclear. When the shortening was more than 5% of the control QRS duration, we normalized QRS durations. Corresponding “control” and “necrosis” time instants were determined by using the following expression: \( Y = X \) (QRS duration after injury divided by QRS duration in control state) where \( Y \) is time after stimulus (msec) in “necrosis” map sequence, and \( X \) is time after stimulus in “control” map sequence. Fractions of 1 msec were adjusted to the

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**Table 1. Type and Extent of the Necrosis Made by Laser and Formalin**

<table>
<thead>
<tr>
<th>Case</th>
<th>Type of the necrosis</th>
<th>Necrosis size (mm)</th>
<th>Laser energy used (J)</th>
<th>Formalin injected (ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Subepicardial</td>
<td>9</td>
<td>9</td>
<td>3.5</td>
</tr>
<tr>
<td>2</td>
<td>Subepicardial</td>
<td>15</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Intramural</td>
<td>5</td>
<td>5</td>
<td>7.5</td>
</tr>
<tr>
<td>4</td>
<td>Intramural</td>
<td>10</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>Intramural</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Intramural</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Subendocardial</td>
<td>8</td>
<td>7</td>
<td>2.5</td>
</tr>
<tr>
<td>8</td>
<td>Subendocardial</td>
<td>10</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Subendocardial</td>
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<td>9</td>
<td>11</td>
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<td>Subendocardial*</td>
<td>10</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>11</td>
<td>Transmural</td>
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<td>10</td>
<td>15</td>
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<td>Subendocardial</td>
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<td>Subendocardial*</td>
<td>13</td>
<td>14</td>
<td>12</td>
</tr>
</tbody>
</table>

*Part of the papillary muscle was involved.

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**Figure 2. Cardiac sections showing the lesions (black areas) produced by laser (cases 1,2,7–13) or formalin (cases 3–6). All sections are oriented as follows. Top, posteroinferior wall of left ventricle; bottom, anterior wall of left ventricle. Section 11 depicts a portion of the posteroinferior wall of the left ventricle. Sections have been cut approximately midway between apex and base of left ventricle except section 12, which is closer to the base.**
nearest millisecond. This equation enabled us to compare “control” and “necrosis” maps from corresponding phases of activation.

Analysis of the isopotential maps was performed by comparing the location and size of the positive areas before and after necrosis. A procedure for evaluating the missing positivity is described in the “Results.”

**Histopathology**

After the animals were killed, the hearts were fixed in 10% buffered formalin. All hearts were subjected to gross examination for locating the necrotized tissue. The heart was cut into slices along lines parallel to the atroioventricular sulcus. The necrotized regions were revealed by the presence of an area of black or gray tissue. Cubic blocks of normal tissue (10×10 mm×transmural thickness) and blocks including the necrosis with neighboring intact tissue were excised. The specimens were embedded in gelatin and sectioned parallel to the epicardium. The sections were 20 μm thick. Every 25th section was stained with hematoxylin and eosin and photographically enlarged. Fiber directions (relative to one side of the section) were measured at four different sites in each stained section and were averaged. Fiber directions versus intramural depth were plotted on graphs by assigning a value of 0° to the direction of epicardial fibers (Figure 3).

Because fiber direction in the necrotic regions was often difficult to determine, we measured fiber directions (with respect to epicardial fibers) near the outer and inner ends of the necrosis, and we took the mean of the two directions as an index of the average fiber direction in the necrosis (Table 2). We also determined the intramural depth of the inner and outer border of the necrosis, and we took the mean of the two depths as a measure of the depth of the center of the necrosis. This depth was normalized, that is, was expressed as a percentage of the total wall thickness at the site of necrosis excluding the papillary muscle when present (Table 2).

**Results**

**Necrosis Produced by Laser Energy and Formalin**

The epicardial lesions made by laser consisted of a central vaporized core surrounded by a dark necrotic tissue whose border was easy to identify. The lesions on the endocardium did not have the vaporized crater. However, the necrotized tissue was revealed by a darkened endocardial area and by a dark gray region in the wall. These findings were consistent with a previous report11 and enabled the border of most lesions to be identified. In the few cases in which the border of the lesion was not distinct, examinations were performed microscopically. Formalin-induced lesions were similarly revealed by the presence of a dark gray region with a clear-cut border. Diagrams of the lesions made by laser and formalin are shown in Figure 2. Table I shows the dimensions of the necrotic areas.

**Epicardial Potentials**

As shown in previous reports,1–6 epicardial pacing gave rise to epicardial potential distributions at QRS

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**TABLE 2. Angular Position of the Gaps in Positive Area, Depth of Necrosis, and Fiber Direction in Necrosis**

<table>
<thead>
<tr>
<th>Case</th>
<th>Type of necrosis</th>
<th>AP (°) of maxima flanking gap</th>
<th>Angular position (°) of bisection*</th>
<th>Fiber direction (°) at border of necrosis</th>
<th>Depth of necrosis border (mm)</th>
<th>Ventricular wall thickness at necrosis (mm)</th>
<th>Normalized depth of center of necrosis (% of wall thickness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Subepicardial</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>2</td>
<td>Subepicardial</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>Intramural</td>
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<td>35</td>
<td>25</td>
<td>12.5</td>
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<td>58</td>
</tr>
<tr>
<td>4</td>
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<td>100</td>
<td>25</td>
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<td>14</td>
<td>61</td>
</tr>
<tr>
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<td>Intramural</td>
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<td>90</td>
<td>25</td>
<td>12.5</td>
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<td>47</td>
</tr>
<tr>
<td>6</td>
<td>Intramural</td>
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<td>95</td>
<td>25</td>
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<tr>
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<td>Subendocardial</td>
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<td>72.5</td>
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<td>73</td>
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<td>Subendocardial</td>
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<td>100</td>
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<td>63</td>
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<td>Subendocardial†</td>
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<td>70</td>
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<tr>
<td>13</td>
<td>Subendocardial†</td>
<td>40</td>
<td>115</td>
<td>77.5</td>
<td>17</td>
<td>17</td>
<td>65</td>
</tr>
</tbody>
</table>

AP, angular position.
*Angle ASD in Figure 10.
†Part of the papillary muscle was involved.
onset with a negative area close to the pacing site and two positive areas with two maxima located along a line parallel to epicardial fiber directions (Figure 4, 10 msec). Later into QRS, the two positive areas expanded CCW in all the experiments and finally surrounded the central negative area on both sides. As an example, Figure 4 shows a 110° CCW expansion-rotation of the upper positive area. Other examples are given in Figure 5 (total rotation, 120°) (see also Figure 8). In all cases, one or more new maxima appeared in the positive areas as they expanded CCW (Figure 4, 45 msec; Figure 8, control, 48 msec).

The CCW expansion of the positive areas during QRS was always continuous; that is, no negative islands interrupted their progressive CCW expansion, even when multiple maxima developed in a single positive area (Figure 4, 45 msec; Figure 8, control, 48 and 49 msec). We attempted to describe the CCW expansion-rotation of the positivity in a semiquantitative way by measuring the CCW rotation of the maximum around the pacing site during QRS, starting from its initial position just after the stimulus, which was defined as “0°.” The angles, measured as explained above, were called “angular positions of the maximum.” When two or more maxima were present in the positive area at a given time instant (as in Figure 4, 45 msec), their angular positions were averaged. Figure 6 shows the CCW rotation of the maximum during QRS as measured after pacing 108 epicardial sites in 13 dogs. Total rotation was 100 ± 15° (SD). Typical examples of CCW expansion of the positivity are depicted in Figures 4 and 5, which show two series of potential maps obtained while pacing the left ventricular epicardium at site S (Figure 4) and S’ (Figure 5) in the same heart (case 1). At 10 msec after stimulation, two maxima and a single minimum were observed near the pacing site. The straight lines connecting the pacing site with the maxima were nearly parallel to the local direction of the epicardial fiber (arrow). In the negative area, an
array of densely packed negative isopotential lines revealed the approximate position of the wavefront. Positive potentials spatially preceded the wavefront where it propagated along the direction of the epicardial fibers. Conversely, negative potentials were observed in the areas toward which epicardial excitation propagated across fibers. As the wavefront advanced, the upper positive area expanded CCW forming a C-shaped positive ridge (Figure 4, 40–60 msec). At 20, 30, and 40 msec, the angular positions of the upper maximum were 10°, 22°, and 25°, respectively. At 45 msec, a new maximum appeared (Figure 4, 45 msec) so that two maxima were simultaneously present for 2 msec. The averaged position of the maximum at 45 msec was 43°. In most cases, the position of the maximum changed rapidly after 40 msec. For example, in Figure 4, the angular position of the maximum shifted from 25° to 80° between 40 and 50 msec. Then, the maximum moved out of the area explored (60 msec). Another pacing site in the

**FIGURE 5.** Isopotential maps for the same experiment as in Figure 4 but with different pacing site (S'). Total rotation of maximum is 120°.

**FIGURE 6.** Plot of rotation of maximum as a function of time after pacing. Mean values and standard deviations are shown in 10-msec increments. Dotted lines show mean±2SD. Data relate to a total of 108 pacing sites in 13 dogs.
same dog brought about angular positions of the upper maximum of 10°, 80°, 105°, and 115° at 20, 50, 60, and 70 msec, respectively (Figure 5).

Effect of Necrosis

All hearts with subepicardial, intramural, or subendocardial lesions exhibited some loss of positivity compared with controls during the CCW expansion of the positive areas. The missing positivity was replaced by a localized negative area. Loss of positivity in dogs with subepicardial necrosis occurred in the initial stages of QRS (Figure 7; 12 and 15 msec). In dogs with intramural or subendocardial necrosis, the loss of positivity occurred later in QRS and produced a gap in the expanding positive area (Figure 8, 49 msec, right column).

Subepicardial necrosis. In two dogs, a circumscribed subepicardial necrosis was induced by laser energy. When the heart was paced from sites so that the line connecting the pacing site to the center of the necrosis was approximately parallel to the epicardial fiber direction, the relevant positive area did not appear in the early stages of QRS and was replaced by a negative area (Figure 7, 12 msec). A potential maximum appeared later in a different position (Figure 7, 15 msec), and the positive area surrounding the maximum started its CCW expansion from that new position. To evaluate the loss of positivity in these cases, we drew two segments on the maps, joining the pacing site to the site of the missing maximum (Figure 10, subendocardial necrosis, segment S-B) and to the delayed maximum (segment S-C). Segment S-A indicates the direction of the epicardial fibers that, in the case of epicardial necrosis, coincides with S-B. Segments S-B and S-C roughly delimited the area of missing positivity. The value of the angle B-S-C between the two segments (angle β) was taken as an index of the amount of missing positivity (Figure 10). The bisector of the angle between the two segments (segment S-D) was

![Figure 7](http://circ.ahajournals.org/)

**Figure 7.** Isopotential maps during epicardial pacing in a dog heart with subepicardial necrosis (case 1). Map display format is the same as in Figure 4. Left: Control maps. Right: Maps recorded 2 hours after the delivery of laser energy on epicardium. Broken circles indicate the approximate area of the necrosis. Frames are displayed at 12, 15, and 18 msec after stimulus artifact. Two hours after inducing the necrosis, the early maximum was absent at 12 msec. A maximum and a small positive area appeared at 15 msec in a position that shifted CCW compared with control.
Intramural and subendocardial necrosis. In four dogs, an intramural necrosis was induced by injecting a small amount of 37% formalin into the left ventricular wall. In seven dogs, a subendocardial necrosis was created by delivering laser energy on the endocardium by an intracavitary catheter (Figure 2). Only data from four of these seven dogs were used for reasons explained below. In all eight dogs considered here, epicardial maps recorded while pacing from selected epicardial sites showed some loss of positivity compared with controls (Figure 8, 45 msec). The loss of positivity appeared as early as 20 or 25 msec after the stimulus when the outermost border of the necrosis was close to the epicardium (e.g., case 5, Figure 2). Later maps invariably exhibited a gap in the expanding positive area (Figure 8, 49 msec; Figure 9, 56 msec). Such a discontinuity never occurred in normal hearts (see controls in Figures 8 and 9). The negative area was always located along or near a straight line passing through the pacing site and the epicardial projection of the necrosis (Figure 8, 49 msec; Figure 9, 56 msec; Figure 10). The gap persisted for 3–7 msec and changed in shape and size during this time interval. To evaluate the location and amount of missing positivity in a semiquantitative way, we drew two segments joining the pacing site to the two maxima flanking the gap (Figure 10, intramural necrosis). The two segments encompassed an area of decreased or missing positivity. Here again, the angle between the two segments (angle B-S-C or β in Figure 10) was taken as an index of the amount of missing positivity, and the bisector of angle β (segment D in Figure 10) indicated the angular position of the center of missing positivity (angle α). Angle α was greater in dogs with subendocardial necrosis than in dogs with intramural necrosis (Table 2). Also, the gap occurred later in QRS in dogs with subendocardial necrosis (56 msec in Figure 10 versus 49 msec in Figure 8).

The number of pacing sites bringing about a loss of positivity varied between two and five in dogs with intramural necrosis (five sites in Figure 11) and between two and four in dogs with subendocardial necrosis. Because, for a given necrosis, the amount (angle β) and position (angle α) of the missing positivity varied for different pacing sites (Figure 11), we took the widest angle β as an index of the highest

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**Figure 8.** Isopotential maps during ventricular pacing in a dog heart with intramural necrosis (case 3). Left: Control maps at 45, 48, 49, and 54 msec after the stimulus. Right: Maps recorded 2 hours after injecting 37% formalin into intramural space. Broken circles indicate the approximate area of the intramural necrosis as projected onto the epicardium. In control maps, the upper positive area and its maximum moved upward out of the explored area at 30 msec. At 45 msec, a positive area appeared in the upper left portion of the electrode array and expanded downward continuously. After inducing an intramural necrosis, there was no upper left positive area at 45 msec. A positive area appeared in that region at 48 msec, but its downward and CCW expansion was discontinuous. At 49 msec, a second positive area with a maximum appeared on the apical side of the wavefront (left side in the figure). Upper positive area also showed a maximum at 49 msec. Lower maximum was separated from the upper maximum by a negative area.
amount of missing positivity in a particular experiment (see star in Figure 11, relating to a case of intramural necrosis). The corresponding bisector (angle α) was taken as an index of the angular position of the center of missing positivity. In a given dog, the value of angle “α” was stable for the entire duration of the gap (3–7 msec).

All four cases with intramural necrosis and four of seven cases with subendocardial necrosis exhibited the potential patterns described above. Two cases with subendocardial necrosis were discarded because the major necrosis was in the septum (case 12) or in the posterior wall (case 11), areas not sampled by the electrode array. Another case with superficial necrosis in a papillary muscle (case 7) was also discarded. The maps of that case showed some delay in the expansion of the positive area compared with controls but no new negative area.

In summary, four cases (cases 3, 4, 5, and 6) with intramural necrosis, four cases (cases 8, 9, 10, and 13) with subendocardial necrosis, and two cases with subepicardial necrosis were used for statistical analysis.

Histological Findings: Correlation With Potential Patterns

The overall cellular arrangement in the explored area was similar in all the hearts, with some individual variability. Epicardial fiber directions were approximately perpendicular to the left anterior descending coronary artery. Serial sections of the tissue at 0.5-mm intervals at various locations in the explored area showed an epicardial CCW rotation of fiber direction (Figure 3). The total rotation varied between 75° and 125° among specimens. These figures are consistent with data from the literature.9,10 Comparison of electrical and histological findings showed a good correlation between the angular position of the center of missing positivity (angle α) and the average fiber direction in the necrosis (r=0.82, p<0.01) (Figure 12A). A good correlation was also found between the position of the gaps (angle α) and the normalized depth of the center of necrosis (r=0.95, p=0.01) (Figure 12B). This was not unexpected because fiber direction correlates with intramural depth.9,10

Discussion

The pu, poses of this investigation were 1) to describe and interpret epicardial potential patterns associated with ventricular, nontransmural necrosis, 2) to test previous hypotheses on the origin of the CCW expansion of positive epicardial areas observed in normal dogs after epicardial pacing, and 3) to evaluate the possibility of detecting intramural necrosis from epicardial potentials.

In accord with previous observations,5 this study confirmed that pacing the ventricular epicardium of normal exposed dog hearts generated epicardial potential maps at QRS onset with a central negative area and two maxima surrounded by two positive areas. The axis joining the two maxima was parallel to the direction of the subepicardial fibers. We also confirmed the CCW expansion of the positive areas, which occurred in later stages of QRS, from 10 to 70 msec after the stimulus, and which amounted to 100±15° (SD). As previously suggested,5,8 the early pattern with two maxima and the subsequent CCW expansion of the positive areas during QRS may be explained by the oblique dipole layer model of the excitation wavefront.7 This model predicts that positive potentials will be mostly found in those areas toward which the excitation wavefront is spreading along fibers. However, if the epicardial field were only affected by excitation spreading along the epicardial fibers, the positive area should move only along the direction of the subepicardial fibers during
the entire QRS interval and not expand CCW. Conversely, the appearance of new, CCW expanding positive areas later in QRS suggests participation of deep wavefronts in the genesis of epicardial potentials. Counterclockwise rotation of deep elliptical wavefronts after epicardial pacing has been demonstrated by Frazier et al12 as a result of rotating fiber direction with increasing intramural depth. Our results are consistent with the study by Frazier et al in that they show that some features of the epicardial field, namely the potential maxima, also rotate CCW as excitation reaches deeper intramural layers. However, the amount of rotation exhibited by the potential pattern may be different from that of the isochrones, whose rotation as a function of depth lags behind the rotation of the fibers.12 Intramural measurements are needed to define the correlation between the three types of rotation (fibers, isochrones, and potential patterns). Such studies are actually in progress at this institute. Previous studies5,6 showed that epicardial potentials are affected by deep wavefronts and by the direction of deep fibers through which excitation is spreading. In the light of the oblique dipole layer model, the CCW expanding positivity on the epicardium may be interpreted as the epicardial projection of a deep rotating positivity that arises when excitation spreads into deep myocardial layers, where fiber direction rotates CCW from epicardium to endocardium. If this interpretation is correct, we would expect an interruption in the CCW expansion of the epicardial positivity when we destroy a limited amount of intramural fibers and a suppression of the initial positivity when we destroy a limited amount of subepicardial fibers, provided we choose appropriate pacing sites.

The results of this study support the above interpretation of the early epicardial positivity and its subsequent CCW expansion during QRS. Epicardial necrosis actually suppressed the initial positive area and its maximum when the epicardial wavefront spread along fibers into the necrosis (Figure 7). Intramural necrosis brought about a loss of epicardial potentials.12,13 Such results indicate that the necrosis of subepicardial fibers is responsible for the initial positivity of QRS, whereas necrosis of intramural fibers is responsible for the later positivity of the QRS complex. This suggests that the concordance of positivity during the slowing of heart rate is the result of a combined contribution from the epicardium and intramural layers, with the epicardial contribution dominating during periods of rapid heart rate and the intramural contribution dominating during periods of rapid heart rate.
dial positivity that occurred later in QRS and, still later, a localized gap in the CCW expansion of the positivity. The angular position of the gap, determined as explained in the “Results,” rotated CCW with increasing depth of the necrosis and correlated with average fiber direction in the necrotic area (and, by consequence, with the intramural depth of the necrosis) (Figure 12). Also, the gap occurred later in QRS for intramural than for subepicardial necrosis. All these findings are consistent with the previously suggested interpretation of epicardial potentials, based on the oblique dipole layer model of the excitation wavefront. From the viewpoint of possible clinical applications, our results showed that epicardial potential maps exhibit characteristic changes in dogs with nontransmural necrosis. Knowledge of these patterns may be useful for detecting intramural necrosis from epicardial maps, whether directly recorded or computed from body surface measurements with inverse procedures.

In assessing the validity of our conclusions, we must take into consideration the limits inherent in our experimental conditions.

1) Only epicardial potentials were measured in this study. Therefore, our interpretation of the results in terms of intramural events is based on indirect experimental evidence and should be substantiated by three-dimensional transmural mapping of isochrones and potentials, which should be performed before and after inducing the necrosis. Such studies are actually in progress at this laboratory. Also, stimuli of greater strength or deep stimulations would create intramural wavefronts that move directly into the necrosis and may, therefore, provide additional data to test the hypothesis.

2) Only a limited epicardial area was explored. Apical areas, where fiber architecture and myocardial structure are different from those existing in the region we studied, may behave differently. Also, our

**Figure 11.** Cardiac section and display map of locations of pacing sites on the epicardial sock (circles). Solid circles indicate pacing sites that gave rise to a gap in the positive area in a dog heart with intramural necrosis (case 6). Short arrows show directions of lines joining each pacing site to the two maxima flanking the gap. Angle between the two lines (angle B) was largest when site marked by star was paced. Broken circle shows location of intramural necrosis projected onto the epicardial surface. Long arrow shows direction of epicardial fibers over the necrosis.

**Figure 12.** Panel A: Plots of average fiber direction in necrosis versus position of missing positivity (gap) on the epicardium. Panel B: Average depth of the necrosis (in percentage of total wall thickness) versus position of the missing positivity. Fiber direction in necrosis and angular position of the missing positivity are measured with respect to epicardial fiber direction.
procedure is insensitive to lesions in the interventricular septum.

3) Our interpretation of epicardial potentials is based on the assumption that only those portions of a wavefront that propagate along fibers generate positive potentials. According to the oblique dipole layer model, this contention is true if the wavefront is a closed surface or its rim is exposed to air. However, when the wavefront initiated from an epicardial pacing site reaches the endocardium, the wavefront is no longer a closed surface because it opens into the ventricular cavity that contains blood, a conductor of electricity. This situation makes the electrical field more complicated. Although the axial component is still predominant, epicardial potentials after endocardial breakthrough are also affected by the transverse component. This fact must be taken into account when interpreting the maps in the late phases of the QRS.

4) Finally, in our experiments, the gaps in the positive areas often appeared 40 msec after the stimulus or later, at a time when Purkinje involvement had probably occurred. The role of the Purkinje system in determining epicardial potentials after epicardial pacing, both before and after inducing a necrosis, was not investigated in this study and will be addressed in future studies, based on intramural recordings. However, the loss of positivity that invariably preceded the gaps often started well before excitation had reached the endocardium and was, therefore, related to the intramural spread of the primary wavefront.

With regard to the clinical implications, the results of the present study may provide useful criteria for locating nontransmural necrosis. Previous studies showed that subendocardial or intramyocardial regions play a role in the initiation and maintenance of monomorphic ventricular tachycardia. For the treatment of such reentrant tachyarrhythmia, surgical procedures to isolate the arrhythmogenic foci or routes are used. Catheter-mediated destruction of tissue using electrical discharge has also been tried. In these procedures, identification of the tissue as normal or necrotic is extremely important for both choosing the target and knowing the effect of ablation. A classifier based on the magnitude of the epicardial Q waves in dogs was reported by Laxer et al. The classifier detects the epicardial projection of intramural infarctions but does not reveal the depth of the necrosis. The same investigators reported that most of the misclassified electrodes were near the borders of the infarcts. The regions bordering an infarct are often the site of continuous diastolic activity and can induce tachycardia when prematurely stimulated. Identifying the border and the depth of damaged tissue are important issues, still unsolved to date. The method described here may be useful to assess the depth of the necrosis in the wall. However, it must be pointed out that the area of missing positivity is not the necrotic area itself. To locate the necrotic area, both the Q wave criterion and determination of the missing positivity may be necessary. The bisector of the angle that delimits the loss of positivity has been shown to pass through the epicardial projection of the necrosis. This criterion may also help to locate the injury. On the other hand, the geometry of an infarcted area is often irregular, unlike the clear-cut necrosis in this study. Additional studies with actual infarcts will be required to better evaluate the clinical implications of our findings.

This study validates several predictions of the oblique dipole layer model and contributes to our understanding of epicardial potential maps as reflecting intramural events. Although many problems remain unsolved, our study shows the usefulness of epicardial potential maps obtained during epicardial pacing for assessing intramural events and for determining the site and depth of nontransmural necrosis.

Acknowledgments

We thank Michael G. Vincent, MD, and Barbara A. DeLuca, BS, for assistance in the use of laser facilities. We also thank Stacey Garry, MD, and Christine M. Zabawa, BS, for their invaluable help in the processing of histologic specimens. We are grateful for the critical reviews of the manuscript by J. A. Abildskov, MD, and Mary Jo Burgess, MD.

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KEY WORDS • epicardial maps • oblique dipole layer model • intramural necrosis • anisotropy
Effect of nontransmural necrosis on epicardial potential fields. Correlation with fiber direction.
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Circulation. 1990;82:2115-2127
doi: 10.1161/01.CIR.82.6.2115

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