Systolic heart failure is the leading cause of cardiovascular morbidity and mortality in North America, consuming >$20 billion per year of global healthcare expenditures. Therapeutic strategies currently include cardiac resynchronization therapy (CRT), a permanent pacing therapy aimed at correcting dysynchronous mechanical activation of the left ventricle (LV) through simultaneous pacing of the right ventricular (RV) septum and the lateral wall (via a coronary sinus lead). Although CRT has been shown to reduce symptoms and mortality in select patients with heart failure, up to 30% to 40% of candidates may not respond. Reasons for response failure seem multifactorial, with 3 dominant variables implicated to date: (1) lack of LV dyssynchrony, (2) geographic placement of the LV lead, and (3) scar within the LV pacing region. Preliminary evidence similarly suggests absence of RV pacing region (ie, septal wall) scar to be of importance for achieving response. However, the relative and combined influence of these variables on response to CRT has not been well studied.

In this prospective cohort study, we combine findings from late gadolinium enhancement (LGE) MRI and cardiac-gated computerized tomography (CCT) to achieve accurate geographic registration of myocardial scar and lead tip location for both the LV and RV pacing leads. These findings are correlated to CRT response, as assessed by serial echocardiography.

**Background**—Transmural scar occupying left ventricular (LV) pacing regions has been associated with reduced response to cardiac resynchronization therapy (CRT). However, spatial influences of lead tip delivery relative to scar at both pacing sites remain poorly explored. This study evaluated scar distribution relative to LV and right ventricular (RV) lead tip placement through coregistration of late gadolinium enhancement MRI and cardiac computed tomographic (CT) findings. Influences on CRT response were assessed by serial echocardiography.

**Methods and Results**—Sixty patients receiving CRT underwent preimplant late gadolinium enhancement MRI, postimplant cardiac CT, and serial echocardiography. Blinded segmental evaluations of mechanical delay, percentage scar burden, and lead tip location were performed. Response to CRT was defined as a reduction in LV end-systolic volume ≥15% at 6 months. The mean age and LV ejection fraction were 64±9 years and 25±7%, respectively. Mean scar volume was higher among CRT nonresponders for both the LV (23±23% versus 8±14% [P=0.01]) and RV pacing regions (40±32% versus 24±30% [P=0.04]). Significant pacing region scar was identified in 13% of LV pacing regions and 37% of RV pacing regions. Absence of scar in both regions was associated with an 81% response rate compared with 55%, 25%, and 0%, respectively, when the RV, LV, or both pacing regions contained scar. LV pacing region dyssynchrony was not predictive of response.

**Conclusions**—Myocardial scar occupying the LV pacing region is associated with nonresponse to CRT. Scar occupying the RV pacing region is encountered at higher frequency and seems to provide a more intermediate influence on CRT response. (Circ Cardiovasc Imaging. 2013;6:542-550.)

**Key Words:** cardiac computed tomography ▪ cardiac MRI ▪ cardiac resynchronization therapy ▪ dyssynchrony ▪ late gadolinium enhancement ▪ response ▪ cicatrix

**S**ystolic heart failure is the leading cause of cardiovascular morbidity and mortality in North America, consuming >$20 billion per year of global healthcare expenditures. Therapeutic strategies currently include cardiac resynchronization therapy (CRT), a permanent pacing therapy aimed at correcting dyssynchronous mechanical activation of the left ventricle (LV) through simultaneous pacing of the right ventricular (RV) septum and the lateral wall (via a coronary sinus lead). Although CRT has been shown to reduce symptoms and mortality in select patients with heart failure, up to 30% to 40% of candidates may not respond. Reasons for response failure seem multifactorial, with 3 dominant variables implicated to date: (1) lack of LV dyssynchrony, (2) geographic placement of the LV lead, and (3) scar within the LV pacing region. Preliminary evidence similarly suggests absence of RV pacing region (ie, septal wall) scar to be of importance for achieving response. However, the relative and combined influence of these variables on response to CRT has not been well studied.
The linear difference in length from its intersection of the endocardial and epicardial borders. For each segment, the mean of 15 radial measurements was used to provide a mean wall thickness at each of the cardiac phases. Time to maximal wall thickness of the LV paced segment was defined as the time in milliseconds required to reach maximal wall thickness for this segment, identified by CCT analysis.

An experienced investigator, blinded to patient identity, visually scored each myocardial segment to identify those with any myocardial scar, defined as unequivocal signal enhancement of the myocardium not felt to be attributable to image artifact. Quantitative assessment of myocardial scar was performed by trained core-laboratory personnel using a signal-threshold–based analysis, and reported for the entire LV (total percentage scar) and for each myocardial segment. This was performed using a Signal Threshold versus Reference Myocardium approach, as previously described,20,29 where a signal threshold of ≥5 SD above the mean signal of normal myocardium was used to define scar. With respect to the referenced myocardial region, careful attention was paid to avoid tissue-blood and tissue-fat interfaces, and to select only homogeneous regions of signal-nailed tissue.

**CCT Imaging Protocol and Image Analysis**

Cardiac CT imaging was performed using a 64-slice CT scanner (Lightspeed VCT, GE Medical Systems) using standard acquisition protocols.21 As part of an expanded study protocol (although not required for lead localization), contrast enhancement was used with 80 to 100 mL of iodinated contrast agent (Visipaque [iodixanol], Amersham Health, Princeton, NJ) administered. Typical imaging parameters were the following: slice=thickness 0.625 mm, tube voltage=120 kV, and tube current=550 mA, followed by a 40-mL saline flush. Image reconstruction was performed using retrospective ECG-gating to obtain the optimal phase for lead visualization with overlapping 0.75 mm cross-sectional images reconstructed at 0.5 mm and image matrix of 512×512 pixels.

Segmental assignment of the LV and RV lead tips was performed by a blinded interpreter using a 3-dimensional (3D) multiplanar reconstruction (Osirix, Version 3.7.1), as shown in Figure 2. To minimize artifact related to the CRT lead system, we reconstructed images using a 2.5-mm slice thickness and displayed this data set using 3D multiplanar reconstruction, averaging signal of 4 consecutive slices (maximum intensity projection thickness=10 mm). The tips of the LV and RV lead were separately localized on axial images, and orthogonal short- and long-axis projections were generated. Using a radial grid manually overlaid on the short-axis view to mark standard segmental agglomerations according to the AHA 16-segment model (6 basal, 6 middle, and 4 apical),22 the segmental positions of the LV and RV leads were determined. The corresponding long-axis view was used to determine its basal, middle, or apical position (equal division of the LV into 3 zones). For the LV lead, pacing lead polarity (ie, ring to tip versus tip to ring) was incrementally considered to ensure that the pacing portion of the lead was scored.

**Figure 1.** Example of quantitative wall motion analysis applied to a midventricular short-axis cine image. End-systolic and end-diastolic phases shown to illustrate changes in radial spokes representing wall thickening. The mean length of 15 spokes per myocardial segment was used to determine the mean wall thickness at each phase of the cardiac cycle.
median baseline NYHA was 3 (interquartile range, 3–3). Referral pathogenesis was ICM in 25 patients (42%) and DCM in 35 patients (58%). Baseline non-LGE MRI findings revealed a mean LV ejection fraction of 25.3±7.1%. No significant differences in septal to LV paced segment mechanical delay was identified between ICM and DCM cohorts (P=0.22). Mean segmental time to maximal wall thickness values for all 16 myocardial segments are graphically shown in Figure 3. Univariate analysis showed the following to be associated with nonresponse to CRT: lower glomerular filtration rate (P=0.04), higher NYHA class (P=0.04), ICM (P=0.01), and right bundle-branch block (P=0.02). No dyssynchrony measure was predictive of CRT response.

**Definition of Response to CRT**

The primary outcome, echocardiographic response to CRT, was defined as a reduction in the LV end-systolic volume ≥15% at 6 months postimplantation. Predefined thresholds for the following clinical variables were used to define secondary clinical end points: NYHA functional class improvement by ≥1 class, 6-minute walk test increase by ≥30 m or by 10%, and quality of life score improvement (reduction) by ≥10 points.

**Interobserver and Intraobserver Reproducibility**

Interobserver and intraobserver reproducibility measures for scar analysis in this population have been reported separately from our laboratory. To assess reproducibility of dyssynchrony measurement, 10 randomly selected cases underwent blinded evaluations by 2 investigators followed by a repeat evaluation by the first investigator on a separate day.

**Statistical Methods**

Continuous variables are expressed as the mean±SD, whereas medians with 25th and 75th percentiles are provided for non-normally distributed data. Categorical variables are expressed as simple proportions. Univariate analysis to test for differences between responders and nonresponders to CRT was performed using the Mann–Whitney U test for continuous variables and the Fisher Exact Test for categorical variables. Similar analyses were performed for improvement in NYHA, 6-minute walk test, and quality of life. All end points were assessed at 6 months post-CRT device implantation. We constructed a multivariate logistic regression model to assess the incremental association of MRI and baseline clinical variables to predict the occurrence of nonresponse to CRT using backward stepwise selection (P<0.10 for entry and P>0.05 for removal). Because of the number of events, we limited covariates to comply with the general rule that 10 events should be available for each variable tested. Reproducibility analyses were performed using both linear regression analysis and Bland and Altman analysis. Sample size calculations were performed a priori based on available literature, and adequate power was ensured for the selected primary outcome. All statistical tests were 2-tailed, and P value <0.05 was regarded as significant. S-Plus (version 8.0, Insightful Software, Seattle, WA) was used to perform the statistical analyses.

**Baseline Patient Characteristics**

Sixty of the 63 enrolled patients (95%) completed study follow-up and were included in final analysis. Three patients did not complete initial (3 months) follow-up; 2 dying—one because of heart failure and the other because of device-unrelated sepsis—and 1 patient voluntarily withdrawing from the study. Baseline patient characteristics are summarized in Table 1. The mean age was 64±9 years with 16 (27%) being female. The median baseline NYHA was 3 (interquartile range, 3–3). Referral pathogenesis was ICM in 25 patients (42%) and DCM in 35 patients (58%).

Baseline non-LGE MRI findings revealed a mean LV ejection fraction of 25.3±7.1%. No significant differences in septal to LV paced segment mechanical delay was identified between ICM and DCM cohorts (P=0.22). Mean segmental time to maximal wall thickness values for all 16 myocardial segments are graphically shown in Figure 3. Univariate analysis showed the following to be associated with nonresponse to CRT: lower glomerular filtration rate (P=0.04), higher NYHA class (P=0.04), ICM (P=0.01), and right bundle-branch block (P=0.02). No dyssynchrony measure was predictive of CRT response.

**Echocardiographic Imaging Protocol and Image Analysis**

Standard 2D echocardiography was performed at baseline, 3, and 6 months using a 3.5 MHz transducer (S5-1, Philips, Bothell, WA) on commercially available equipment (ie33, Philips, Eindhoven, The Netherlands). Digitally captured images were stored for offline analysis using the Xcelera software suite version 3.1 (Philips, Eindhoven, The Netherlands). All imaging was performed at end-expiration. The LV end-diastolic volume and LV end-systolic volume were determined using the biplane method of discs method (modified Simpson’s technique) by an experienced, blinded echocardiographer.

**CRT Device Implantation**

CRT devices with defibrillator capability were implanted in the standard fashion in all patients. The LV pacing lead was inserted transvenously into the coronary sinus and positioned according to standard clinical practice. The RV septal lead was routinely placed to the api- cal septal segment in accordance with the conventional practice of the site. V-V intervals were set to 0 ms with A-V intervals programmed to the manufacturer nominal settings. These settings were not adjusted during the first 6 months of therapy.

**CRT Lead Tip Locations by CCT**

The primary end point was met in 42 patients (70%) at 6 months. Secondary end points were achieved as follows: improvement ≥1 NYHA class in 37 patients (62%), increase in 6-minute walk test ≥30 m or by 10% in 37 patients (62%), and a reduction in MLWH score ≥10 in 39 patients (65%).

**Results**

**Scar Burden and Distribution by LGE-MRI**

Analysis of LGE imaging confirmed a higher prevalence and total burden of myocardial scar in those with ICM versus...
those with DCM (Table 2). Overall, 25 patients with ICM (100%) and 27 patients with DCM (77%) showed any visible scar by LGE-MRI. Similarly, the mean total scar burden was significantly higher among those with ICM versus DCM (26.2±14.5% versus 5.9±7.2%; P<0.001). Segmental scar analysis, shown in Figure 3, revealed the burden of scar to be highest among the septal wall segments, irrespective of cardiomyopathy pathogenesis.

The prevalence of transmural scar (≥50% wall thickness) within the LV paced segment was 7%, with a prevalence of 22% for the RV paced segment. The prevalence of significant pacing region (paced segment plus adjacent segments) scar, defined as ≥25% scar by volume, was 13% for the LV pacing region and 37% for the RV pacing region. Patient examples are shown in Figure 4.

### Pacing Site Scar and Response to CRT

Total scar burden was not statistically different between those achieving and not achieving the primary outcome (Table 2). This finding was consistent for both ischemic and nonischemic cohorts.

The results of segmental scar analysis among responders and nonresponders are shown in Table 2. The mean scar volume of the LV pacing region was significantly lower in responders versus nonresponders (P=0.01) with a similar finding identified for the RV pacing region (P=0.04). Thirty-four patients had no significant scar (<25%) in either the LV or RV pacing regions. Of these patients, 19% failed to achieve CRT response at 6 months (ie, response rate 81%). Twenty-two patients had significant scar in the RV pacing region with 45% of this group having nonresponse (ie, response rate 55%). Eight patients had significant scar in the LV pacing region with 75% having nonresponse (ie, response rate 25%). Among these patients, 4 had significant scar in both the LV and RV pacing regions, 100% having nonresponse to CRT at 6 months. The relationship between pacing region scar and CRT response is graphically shown in Figure 5.

LV pacing region scar ≥25% was the strongest independent predictor of CRT nonresponse after adjustment for cardiomyopathy pathogenesis with an odds ratio of 7.2 (95% confidence interval, 1.2–43.8; P=0.03). By multivariate analysis,

### Table 1. Non-MRI Baseline Patient Characteristics, Presented for the Total Population and for Those With and Without Response to CRT (Defined as a ≥15% Reduction in LVESV at 3 or 6 Months)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total Population (n=60)</th>
<th>ICM (n=25)</th>
<th>DCM (n=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Response (n=42)</td>
<td>No Response (n=18)</td>
<td>P Value</td>
</tr>
<tr>
<td>Age, y</td>
<td>64±9</td>
<td>63±10</td>
<td>66±8</td>
</tr>
<tr>
<td>Female</td>
<td>16 (27%)</td>
<td>14 (33%)</td>
<td>2 (11%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>34 (57%)</td>
<td>25 (59%)</td>
<td>9 (50%)</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>19 (32%)</td>
<td>13 (31%)</td>
<td>6 (33%)</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>37 (62%)</td>
<td>25 (59%)</td>
<td>12 (67%)</td>
</tr>
<tr>
<td>Smoking</td>
<td>22 (37%)</td>
<td>14 (33%)</td>
<td>8 (44%)</td>
</tr>
<tr>
<td>Any previous revascularization</td>
<td>14 (23%)</td>
<td>9 (21%)</td>
<td>5 (28%)</td>
</tr>
<tr>
<td>GFR, mL/min per 1.73 m²</td>
<td>68±16</td>
<td>71±17</td>
<td>61±12</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>9 (15%)</td>
<td>5 (12%)</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>QRS morphology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QRS duration, ms</td>
<td>159±21</td>
<td>162±20</td>
<td>151±23</td>
</tr>
<tr>
<td>LBBB</td>
<td>48 (81%)</td>
<td>36 (86%)</td>
<td>12 (71%)</td>
</tr>
<tr>
<td>RRBB</td>
<td>5 (8%)</td>
<td>1 (2%)</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>Nonspecific delay</td>
<td>6 (10%)</td>
<td>5 (12%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>NYHA functional class</td>
<td>2.8±0.5</td>
<td>2.7±0.6</td>
<td>2.9±0.2</td>
</tr>
<tr>
<td>Class II</td>
<td>18 (30%)</td>
<td>17 (40%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Class III</td>
<td>39 (65%)</td>
<td>22 (52%)</td>
<td>17 (94%)</td>
</tr>
<tr>
<td>Class IV</td>
<td>3 (5%)</td>
<td>3 (7%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACE inhibitor</td>
<td>43 (72%)</td>
<td>31 (74%)</td>
<td>12 (67%)</td>
</tr>
<tr>
<td>ARB</td>
<td>20 (33%)</td>
<td>13 (31%)</td>
<td>7 (39%)</td>
</tr>
<tr>
<td>ACE inhibitor or ARB</td>
<td>57 (95%)</td>
<td>40 (95%)</td>
<td>17 (94%)</td>
</tr>
<tr>
<td>ß-Blocker</td>
<td>54 (90%)</td>
<td>38 (90%)</td>
<td>16 (89%)</td>
</tr>
<tr>
<td>Diuretic</td>
<td>50 (83%)</td>
<td>34 (81%)</td>
<td>16 (89%)</td>
</tr>
</tbody>
</table>

Continuous data are expressed as mean±SD, categorical data as n (%). ACE indicates angiotensin-converting enzyme; ARB, Angiotensin Receptor Blocker; CRT, cardiac resynchronization therapy; DCM, dilated cardiomyopathy; GFR, glomerular filtration rate; ICM, ischemic cardiomyopathy; LBBB, left bundle-branch block; LVESV, left ventricular end-systolic volume; NYHA, New York Heart Association; and RRBB, right bundle-branch block.
when LV and RV pacing region scars were entered into the same model, only LV pacing region scar remained predictive with an odds ratio of 7.7 (95% confidence interval, 1.3–46.3; P=0.03).

Secondary end points were achieved with high frequency among those with no scarring of LV or RV pacing regions. Among these patients, a reduction of NYHA class ≥1 was achieved in 82% of patients, an increase in 6MHW ≥30 m in 82%, and a reduction in MLWH score ≥10 in 96% of patients. Although a trend toward reduction in these outcomes was seen among those with scar of LV and RV pacing regions, these differences were not statistically significant.

Interobserver and Intraobserver Reproducibility
Good interobserver reproducibility was seen for the measurement of dyssynchrony by SD16-time to maximal wall thickness (TmWT) for all patients, ischemic cardiomyopathy (ICM), and dilated cardiomyopathy (DCM) patients. Shown using the AHA 16-segment model divided into septal and nonseptal segments relevant to the right ventricular and left ventricular pacing leads, respectively.

**Discussion**
In this prospective, multimodality imaging study analyzing the effects of regional scar in relation to lead tip localization on CRT response, the primary findings were as follows: (1) Scar in the LV pacing region was observed in a minority of patients but was associated with a low CRT response; (2) Scar occupying the RV pacing region was seen more commonly and was associated with intermediate CRT response; (3) Presence of scar in both pacing regions was associated with no response, whereas absence of scar in these regions was associated with the highest response rate.

The overarching goal of CRT is to advance electromechanical activation of the lateral wall, such that it becomes physiologically synchronous with the septal wall. If accomplished, this therapy can realize substantial improvement in stroke volume and cardiac performance. Studies to date evaluating optimal patient selection and CRT delivery have focused primarily on characteristics of the posterolateral wall, suggesting scar in this region to be associated with lower rates of LV remodeling. Such findings led to the recent reporting of the first randomized control trial of targeted LV lead placement in CRT. In this study, a reported 15% improvement in CRT response was observed when LV leads were targeted to dyssynchronous but nonscarred myocardial segments; the latter defined by surrogate echocardiographic markers of viability. Our current study presents the most comprehensive evaluation of scar burden relative to lead tip delivery to date and confirms that scar within the LV pacing region, encountered in 1 out of 8 cases, is an important impediment to CRT response. Scar within the RV pacing region is more common, being encountered in 1 out of 3 cases. This finding did not provide an independent influence on CRT response among those also having LV pacing region scar. However, a reduction in CRT response was appreciated among the whole population when significant RV pacing region scar was present.

The potential relevance of RV pacing region scar was highlighted in a recent study by Duckett et al that evaluated the feasibility of achieving a midseptal RV pacing position among 50 consecutive patients receiving CRT. In this study, a more conventional apical position was conceded to in those patients with poor R-wave pacing amplitudes (≤5 mV) and identified that these patients had a 67% prevalence of septal scar by LGE imaging versus 33% in those where adequate voltages were achieved. Septal wall scar by LGE imaging was associated with a lower rate of LV remodeling at 6 months (20% versus 56%; P=0.02) within the context of this lead placement strategy. Segmental characterization of LV lead position, LV dyssynchrony, or LV pacing region scar were not evaluated. By comparison, our current study shows that the delivery of both LV and RV pacing leads to nonscarred myocardium provides a robust 81% response rate to CRT, versus 55% when significant scar is present in the RV pacing region, 25% when in the LV pacing region, and 0% when present in both pacing regions.

The septal-predominant distribution of myocardial injury found among this referral population is not unexpected. ICM patients are anticipated to be at higher likelihood of both heart failure and left bundle-branch block when irreversible injury is realized in the LAD-territory (ie, septal wall). Similarly, patients with DCM preferentially demonstrate nonischemic fibrosis of the septum in advanced stages of disease, a finding associated with worse prognosis. Irrespective of pathogenesis, mechanisms relating septal scar to nonresponse in CRT can be envisioned. First, electromechanical advancement of the lateral wall is aimed at reducing afterload effects on the septum, and re-engaging its contribution to stroke volume. Such contribution may not be enlisted if the septum is substantially injured, limiting its capacity to augment stroke
Volume. Second, the aim of RV paced stimulation to activate the LV myocardium simultaneous to paced stimulation of the lateral wall may be violated by interposed scar. An introduction of electromechanical dispersion can, therefore, be theorized. This latter concept presents 1 plausible role for directing RV lead tips to alternate and viable geographic targets, similar to that proposed for the LV lead. Indeed, the concept of midseptal or RV outflow tract pacing has been shown to be both feasible\(^{39-42}\) and potentially of clinical value.\(^{24,42}\) In a study by Haghjoo et al.,\(^{40}\) patients otherwise receiving optimal LV pacing (ie, those with LV leads delivered to the posterolateral wall) had significantly higher CRT response rates when the RV lead was placed to the high (basal) septum compared with conventional apical placement (70% versus 30%; \(P=0.01\)). Furthermore, Duckett et al.\(^{24}\) showed that midseptal pacing was associated with improved response rate compared with apical pacing (70% versus 30%; \(P=0.01\)). However, whether the selective placement of the RV lead to viable myocardial targets improves outcomes in this population remains to be evaluated.

**Clinical Implications**

Our findings add justification for lead navigation approaches to optimal myocardial targets in CRT. Several studies to date, inclusive of the current study, demonstrate that characteristics of the LV pacing region strongly influence response to CRT\(^{21,36,37,43-45}\) and support that lead delivery to viable targets may be a prerequisite for response to occur. We found that without image-guidance the delivery of this lead to a scarred myocardial region occurs in 13% of cases with 75% of these patients failing to respond. Navigation strategies to guide the LV lead to viable targets is, therefore, of potential importance for this cohort. Although the role of RV lead navigation to optimal septal targets remains uncertain, recognition that scar within this region may contribute to response failure justifies expanded exploration within larger cohort studies.

**Study Limitations**

This study must be considered in recognition of several limitations. First, this was a single-center cohort study and was not sufficiently sized to evaluate clinical outcomes beyond the surrogate of LV remodeling at 6 months. Second, although not the focus of the current article, the MRI-derived measure of mechanical dyssynchrony used in this study, adopted from Marsan et al.,\(^{21}\) has not undergone rigorous clinical validation versus other measures of dyssynchrony, such as tissue Doppler or strain imaging. Finally, signal-threshold–based scar quantification is inherently dependent on user-selected regions for referencing of normal myocardium. In this study, we used a Signal Threshold versus

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**Table 2. Baseline MRI Characteristics of the Study Population and for Those With and Without Response to CRT, Stratified According to Cardiomyopathy Pathogenesis**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total Population (n=60)</th>
<th>ICM (n=25)</th>
<th>DCM (n=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Response</td>
<td>No Response</td>
<td>Response</td>
</tr>
<tr>
<td>LV volumes/mass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LV EF, %</td>
<td>26±6</td>
<td>24±9</td>
<td>0.48</td>
</tr>
<tr>
<td>LV EDV, mL</td>
<td>275±78</td>
<td>320±68</td>
<td>0.02*</td>
</tr>
<tr>
<td>LV ESV, mL</td>
<td>206±71</td>
<td>245±64</td>
<td>0.03*</td>
</tr>
<tr>
<td>LV mass, g</td>
<td>191±41</td>
<td>229±66</td>
<td>0.03*</td>
</tr>
<tr>
<td>LV mass–indexed, g/m²</td>
<td>96±20</td>
<td>105±27</td>
<td>0.28</td>
</tr>
<tr>
<td>SD16-TmWT, ms</td>
<td>151±48</td>
<td>144±51</td>
<td>0.88</td>
</tr>
<tr>
<td>Septal to LVp segment delay, ms</td>
<td>323±159</td>
<td>303±192</td>
<td>0.54</td>
</tr>
<tr>
<td>LVp region scar, %</td>
<td>13±16</td>
<td>17±11</td>
<td>0.08</td>
</tr>
<tr>
<td>LVp region segment delay, ms</td>
<td>8±14</td>
<td>23±23</td>
<td>0.01*</td>
</tr>
<tr>
<td>RVp region ≥50% scar</td>
<td>24±30</td>
<td>40±32</td>
<td>0.04*</td>
</tr>
<tr>
<td>RVp region ≥25% scar</td>
<td>12±19</td>
<td>5±28</td>
<td>0.33</td>
</tr>
<tr>
<td>RVp region ≥25% scar</td>
<td>12±29</td>
<td>10 (56%)</td>
<td>0.05</td>
</tr>
</tbody>
</table>

*Data expressed as mean±SD. CRT indicates cardiac resynchronization therapy; DCM, dilated cardiomyopathy; EDV, end-diastolic volume; EF, ejection fraction; ESV, end-systolic volume; ICM, ischemic cardiomyopathy; LV, left ventricular; LVpD, left ventricular paced segment delay; RV, right ventricular; RVp, right ventricular paced; and SD16-TmWT, standard deviation of the time to maximal radial wall thickening obtained from all 16 segments.

*Statistically significant.

†Defined as the presence of ≥1 myocardial segment with unequivocal scar, as determined by an experienced, blinded investigator.
technique, limited analysis to a Signal Threshold versus Reference Myocardium–based approach.

Conclusions
Scar within the LV and RV pacing regions is associated with a lower response rate to CRT at 6 months. Strategies aimed at the selective placement of pacing leads to nonscarred myocardial targets seem justified.

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Disclosures
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References

Figure 4. Late gadolinium enhancement images of patients found to have significant scar (bright signal within myocardium) within the left ventricular pacing region scar (A) and right ventricular pacing region (B). Examples provided for both ischemic and non-ischemic patterns of injury. Left column shows the 4-chamber view (highlighted in red). Middle column shows a representative short-axis view. Right column shows the corresponding signal threshold–based scar analysis with division into the AHA segment model. Red line corresponds to approximate position of the 4-chamber view.

Figure 5. Six-month response rate to cardiac resynchronization therapy (CRT) among patients with (1) both leads delivered nonscarred pacing regions, (2) only the right ventricular (RV) lead delivered to a scarred pacing region, (3) only the left ventricular (LV) lead delivered to a scarred pacing region, or (4) both the LV and RV leads delivered to scarred pacing regions. CRT response was defined as a reduction in LV end-diastolic volume by ≥15% by serial echocardiography. LVPR indicates LV pacing region; and RVPR, RV pacing region.
CLINICAL PERSPECTIVE

Myocardial scar is recognized to predict clinical response to cardiac resynchronization therapy (CRT), with an emerging paradigm of image-guided CRT lead delivery to nonscarred myocardial targets. For such a paradigm to evolve, a more detailed understanding of how the spatial distribution of scar within the left ventricle (LV) and its relationship to lead electrode placement must be established. Such explorations require consideration of scar surrounding the LV pacing region and the right ventricular pacing region because the latter may provide unique obstacles to improvements in LV remodeling. In this study, we spatially registered findings of late gadolinium enhancement scar imaging and cardiac computed tomography lead imaging to characterize geographic influences of scar on the achievement of LV remodeling in patients receiving standard CRT lead placement. We identified that patients without significant scar in targeted LV or right ventricular pacing regions achieved LV remodeling criteria (≥15% reduction in LV end-systolic volume) by 6 months in 81% of cases. When scar was present in the right ventricular pacing region, this response rate was significantly reduced to 55%, and when present in the LV pacing region reduced further to 25%. If scar was present in both pacing regions, no patient responded to CRT. These findings support that myocardial scar has a graded influence on LV remodeling that is weighted on its geographic distribution. Accordingly, targeted CRT lead delivery seems justified if also considering scar beyond the LV pacing region when anticipating clinical response.

Influence of Pacing Site Characteristics on Response to Cardiac Resynchronization Therapy

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