Myocardial Lesion Depth With Circular Electroporation Ablation

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Background—Recently, we demonstrated the feasibility and safety of circular electroporation ablation in porcine pulmonary vein ostia, but the relationship between the magnitude of the application and lesion dimensions is still unknown.

Methods and Results—An in vivo porcine study was performed on left ventricular epicardium submerged under 10 mm of blood, using devices that mimic a 20-mm-diameter 7F circular ablation catheter. Model D contained 10 separate electrodes, whereas model M consisted of 1 circular electrode. Ablations were performed at 50, 100, and 200 J with model D and at 100 J with model M. Lesion dimensions were measured after 3-week survival. All applications resulted in smooth voltage waveforms demonstrating the absence of vapor globe formation, arcing, and a pressure wave. Applications up to 100 J with model D resulted in separate lesions under the electrodes. At 200 J, continuous deep circular lesions were created despite the use of separate electrodes. There was a significant relationship between applied current and median lesion depth, with a slope of 0.17 mm/A. At 100 J, there was no difference in lesion depth or width between models D and M. The electrodes and ablation site directly after ablation showed no signs of thermal damage.

Conclusions—In an epicardial porcine model with blood around the application site, continuous circular lesions, deep enough for electric pulmonary vein isolation, were created with a single circular 200-J application. Lesions were continuous despite the use of separate electrodes. Lesion depth increased with the magnitude of the application. (Circ Arrhythm Electrophysiol. 2012;5:581-586.)

Key Words: atrial fibrillation • catheter ablation • ventricular tachycardia • electroporation

A strong electric field can permanently permeabilize a cell membrane, and this may lead to exhaustion of metabolic energy and tissue necrosis.1 This was part of the ablative effect of direct current (DC) catheter ablation used between 1980 and 1990.2 Typically, 300 to 400 J was applied via the 2-mm distal electrode of a nondeflectable catheter. However, these shocks caused electroporation and a cascade of events initiated by sufficient electrolysis at the electrode surface to create an electrically isolating vapor globe. This led to a spark (arching), an explosion, and a pressure wave. The spark even left a melted footprint on the platinum electrode surface.

Clinical Perspective on p 586

At the end of the 1980s, low-energy DC ablation was developed.3 Several studies4,5 demonstrated that an energy level lower than the arcing threshold could successfully create myocardial lesions without the previously mentioned hazardous adverse effects. Recently, Lavée et al6 demonstrated epicardial nonthermal electroporation ablation of myocardial tissue. We recently presented the first results of a feasibility study using irreversible electroporation (IRE) ablation inside pulmonary vein (PV) ostia.6 To pave the way for clinical electric PV isolation using electroporation technology, the relationship between delivered energy and lesion size in this setting needs to be known, but the fairly thin myocardium of PV ostia precludes assessment of this relationship.

The purpose of our porcine study was to investigate the relationship between the magnitude of the IRE application and the dimensions of the lesion using a circular arrangement of ablation electrodes in a tissue-blood environment.

Methods

All studies were performed with approval from the Animal Experimentation Committee of the University Medical Center Utrecht, Utrecht, the Netherlands.

Study Protocol

The study was performed in 5 pigs (weight, 60–75 kg). Calcium carbasalate (80 mg/d) and clopidogrel (75 mg/d; first dose, 300 mg) therapy was started 3 days before the procedure and continued until

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procedure-related arrhythmias. The animals were intubated and anesthetized according to standard procedures. The thorax was opened via a medial sternotomy. A 10-cm-long incision was made in the pericardial sack, and its edges were lifted and attached to surrounding instrumentation to create a pericardial cradle. A Starfish Heart Positioner (Medtronic Inc; Minneapolis, MN) was used to raise the apex and to keep the pericardium at least 10-mm free from the ablation site. Before ablation, one of the devices was fixated to the basal left ventricular area.

Cine basal left ventricular epicardium with 3 sutures. Thereafter, the pericardial space is filled with heparinized blood and the application is delivered.

Figure 1. The 2 custom devices used for ablation. Type D has 10 metal 2-mm-long and 7F-diameter contacts mimicking a decapolar circular ablation catheter with all electrodes interconnected. Type M has one 7F circular electrode. Both devices are 20 mm in diameter and have a spacer to ensure at least 10 mm of blood above the ablation area within the pericardial space.

Figure 2. Decapolar device D is temporarily fixated to the porcine basal left ventricular epicardium with 3 sutures. Thereafter, the pericardial space is filled with heparinized blood and the application is delivered.
The 3-week survival period was uneventful, except in 1 animal that experienced a period of sickness and fever, presumably due to pericarditis. At removal of the hearts, the pericardium was adhered to the epicardium in most animals. Visual inspection of tissue surrounding the heart did not reveal any lesions. The 3 sutures that had held the ablation devices and whitish colorization of the lesion(s) allowed identification of the 4 circular application areas, even when superficial epicardial damage due to pericardial adhesion obscured the epicardial aspect of the lesions. Except for some 50-J ablation sites, the original position of the 10 electrodes of device D could not be identified, because those ablations had resulted in 1 continuous whitish ablation ring on the epicardial surface.

Lesion Characteristics

Tangential sections of lesions obtained with device D at 50 J always showed separate lesions under the presumed electrode contact sites (Figure 3). Tangential sections of decapolar 100-J applications showed separate lesions at 2 of 5 ablation sites, a mixed pattern with deeper lesions under the electrodes and shallower lesions between electrodes at 2 ablation sites, and 1 continuous lesion at 1 ablation site. Tangential sections of lesions obtained at 100 J with device M always showed continuous lesions. Tangential sections of lesions obtained after a single 200-J application via decapolar device D were also continuous. In 3 of 5 lesions obtained at 200 J, a surviving central island was present in at least 1 of the histological sections (Figure 4).

In all sections along each circular ablation line, a lesion was found, except at 4 sites (1 at 50 J, D; 2 at 100 J, M; and 1 at 200 J, D) where epicardial fat, thicker than the median lesion depth of those particular lesions, was present. The relationship between delivered peak current and median lesion depth along each circular lesion is shown in Figure 5 and Table. This relationship is significant, with a slope of 0.17 mm/A ($P=0.001$; 95% CI, 0.09–0.25). When all sections of 200-J (D) lesions are combined, the 5th and 95th percentiles of all observed lesion depths are 2.9 and 8.7 mm, respectively (Figure 6). The corresponding values for 50- and 100-J applications via device D are 0.8 to 4.6 and 1.2 to 5.5 mm, respectively.

Ablations at 100 J via devices D and M resulted in average peak currents of 24.3±1.3 and 25.7±1.6 A, respectively ($P=0.14$). Median lesion depths and widths were not significantly different between these 2 types of ablation ($P=0.49$ and $P=0.27$, respectively). The 5th and 95th percentile range of all lesion depths observed in sections of 100-J applications via device M was 0.5 to 5.3 mm.

Of 102 histological sections, 3 showed an exceptionally narrow and deep lesion, as if the ablation current had followed a specific path through the myocardium (Figure 7). This path was always perpendicular through the myocardial
wall and not directed toward the indifferent skin electrode. Such lesions were observed at each energy level. The depth/width ratio of these 3 lesions was 11±1, whereas it was 1.0±0.6 for all other lesions. Rootlike extensions that were usually observed at the border of the lesions (Figures 3 and 4) were not included in lesion depth and width.

**Lesion Histological Features**
All lesions showed complete replacement of cardiomyocytes by granulation tissue consisting of fibroblasts with loose collagen fibers and capillaries. Lesions have irregular outer margins, with tiny extensions at their borders (Figure 4).

**Discussion**
This study demonstrates a significant relationship between the magnitude of the application and median lesion depth. In addition, it demonstrates the possibility of creating continuous 20-mm circular lesions with a single ultrashort 200-J DC application via 10 electrodes (7F and 2-mm diameter). At that energy level, voltage waveforms were smooth, demonstrating the absence of vapor globe development and of hazardous adverse effects associated with DC ablation.7

**Lesion Depth**
In this study, 200-J applications delivered via device D resulted in continuous lesions with a median depth of 5.2±1.2 mm. The 0.05 to 0.95 percentile range of lesion depths is 2.9 to 8.7 mm, suggesting that electric PV isolation is a realistic goal for this development.

Myocardial cells do not sense total applied energy, only local current density and impulse duration. Local current density is directly proportional to delivered current at any moment, independent of electrode interface impedance, polarization, and position of the indifferent electrode. Therefore, delivered current (and duration) is the most direct measure of the magnitude of the application (Figure 5). Total peak current delivered with a 200-J application is only twice that of a 50-J application, which was the standard energy level for endocardial cardioversion before the arrival of biphasic defibrillators (Table).

**Unanticipated Lesion Formation**
Three histological sections showed an exceptionally deep and narrow lesion with an =10 times larger depth/width ratio than of the other lesions (Figure 7). Further studies might reveal why the ablative current sometimes finds such an abnormal path through myocardial tissue.

**Thermal Effects**
Blood clots and/or carbonization were never observed on the electrodes or application site. Energetically, 20 J per electrode is <0.7 seconds of radiofrequency (RF) delivery at 30W. Thermally, this energy level cannot explain a 7-mm lesion depth. At the application sites, a whitish tissue colorization, as is common with thermal RF ablation, was never observed acutely. In addition, RF lesions have a fairly sharp demarcation between damaged and healthy myocardium, whereas lesions in the present study have a more irregular border with tiny fibrous extensions.9 The exact local temperature increase
near the electrodes still needs to be investigated, but our data suggest that tissue heating is not the ablative mechanism.¹⁰

**Tissue Contact**

Given the better conductivity of blood than of tissue, electrode-tissue contact will definitely affect lesion depth. Final catheter design and perhaps electric means to measure tissue contact may determine the success of this technique for PV antrum isolation.

**Lesion Width**

The main purpose of our study was to investigate lesion depth and continuity at various energy levels. Lesion width is important too, because we expect that circular IRE ablations must be placed just inside PV ostia to achieve sufficient electrode-tissue contact. Lesion width will then determine how much of the antrum will be ablated, and this may affect clinical success (Table).¹⁰–¹²

**Catheter Configuration**

For 3D localization, mapping, and PV isolation, a circular catheter with multiple electrodes may be more attractive than one with a single circular electrode. The ultimate catheter design will also depend on whether mapping of PV potentials remains important for PV isolation with IRE, but the results of our study suggest that electrode design is not a critical issue as long as electrode size is large enough to prevent arcing.

**Limitations**

The design of the decapolar device did not allow for measurement of individual electrode impedances. Theoretically, impedance differences may cause differences in delivered current between electrodes. However, except for a wedged situation, measurement of electrode impedance with a roving endocardial catheter usually shows little variation. We presumed that the same would be true for the electrodes of device D.

Measurement of lesion size from radial segments could have missed the center and presumably greatest lesion depth and width of separate 50- or 100-J lesions. Tangential sections may also have missed greatest lesion depth. This could have led to an underestimation of lesion depth. Despite this, lesions were always found in all sections along each circular ablation line, except at 4 locations with relatively thick epicardial fat.

Lesion size with IRE will depend on electrode-tissue contact and, thus, on the ultimate catheter design and measures to ensure electrode-tissue contact. Given the major differences between the present model and circular catheter ablation of PV ostia, extrapolation of the results of this study to PV isolation should be performed with great caution. Data of this study, however, suggest that electroporation technology definitely has the potential to facilitate extremely fast PV isolation.¹³,¹⁴ Further studies must address potential complications, such as PV and coronary stenosis, nerve damage, esophageal fistula, and other unwanted adverse effects.¹⁵,¹⁶

**Side Contact**

The plane of the circular ablation device was positioned parallel to the tissue (Figure 2). The plane of a circular ablation catheter positioned against a PV antrum may also be parallel to the tissue. With a circular arrangement of electrodes, the ablation current will preferentially be directed outward. With the catheter hoop positioned inside a PV ostium, an even deeper lesion than what was obtained in the present study may be expected.

**Clinical Implications**

IRE ablation might not be the optimal approach for all other cardiac arrhythmias. RF and cryoablation are much more controllable because they allow monitoring the electrophysiologic response during energy application. However, for electric PV isolation and in cases in which deep transmural lesions are desired, a fast technique that does not require tissue heating may be preferable.

The design used in the present study had a 7F 20-mm-diameter hoop. In clinical use, a different hoop diameter may be required. With identical electrode size and spacing, total applied current should be scaled proportional to the diameter of the ablation hoop to maintain the same lesion depth and safety margin below arcing threshold.

**Conclusions**

The data of this study demonstrate a significant relationship between the magnitude of the application and myocardial lesion depth. In a blood-myocardial tissue environment, continuous 20-mm circular lesions, deep enough for electric PV isolation, can be created with a single 200-J application of a few milliseconds in duration. Tissue heating does not appear to play a role in lesion formation.

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**Disclosures**

Dr Wittkampf is a consultant for St Jude Medical, Atrial Fibrillation division.

**References**

This article presents data of lesions created with a novel energy source that induces irreversible myocyte membrane electroporation, leading to apoptosis. The study demonstrates that a single 6-ms high current application, delivered via a circular arrangement of electrodes in a blood-tissue environment, can create a continuous circular lesion sufficiently deep for pulmonary vein antrum isolation. The data of this study suggest that the application does not cause enough temperature elevation to induce blood or tissue coagulation. The technology would allow for ultrafast nonthermal electric pulmonary vein isolation as an alternative for multiple sequential radiofrequency applications. The ablation technology still relies on electrode-tissue contact. Clinical application will, therefore, require the means to determine electrode-tissue contact to ensure sufficient lesion depth.
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