**Prognostic Value of Endocardial Voltage Mapping in Patients With Arrhythmogenic Right Ventricular Cardiomyopathy/Dysplasia**

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**Background**—Endocardial voltage mapping (EVM) identifies low-voltage right ventricular (RV) areas, which may represent the electroanatomic scar substrate of life-threatening tachyarrhythmias. We prospectively assessed the prognostic value of EVM in a consecutive series of patients with arrhythmogenic right ventricular cardiomyopathy/dysplasia (ARVC/D).

**Methods and Results**—We studied 69 consecutive ARVC/D patients (47 males; median age 35 years [28–45]) who underwent electrophysiological study and both bipolar and unipolar EVM. The extent of confluent bipolar (<1.5 mV) and unipolar (<6.0 mV) low-voltage electrograms was estimated using the CARTO-incorporated area calculation software. Fifty-three patients (77%) showed ≥1 RV electroanatomic scars with an estimated burden of bipolar versus unipolar low-voltage areas of 24.8% (7.2–31.5) and 64.8% (39.8–95.3), respectively (P=0.009). In the remaining patients with normal bipolar EVM (n=16; 23%), the use of unipolar EVM unmasked ≥1 region of low-voltage electrogram affecting 26.2% (11.6–38.2) of RV wall. During a median follow-up of 41 (28–56) months, 19 (27.5%) patients experienced arrhythmic events, such as sudden death (n=1), appropriate implantable cardioverter defibrillator interventions (n=7), or sustained ventricular tachycardia (n=11). Univariate predictors of arrhythmic outcome included previous cardiac arrest or syncope (hazard ratio=3.4; 95% confidence interval, 1.4–8.8; P=0.03) and extent of bipolar low-voltage areas (hazard ratio=1.7 per 5%; 95% confidence interval, 1.5–2; P<0.001), whereas the only independent predictor was the bipolar low-voltage electrogram burden (hazard ratio=1.6 per 5%; 95% confidence interval, 1.2–1.9; P<0.001). Patients with normal bipolar EVM had an uneventful clinical course.

**Conclusions**—The extent of bipolar RV endocardial low-voltage area was a powerful predictor of arrhythmic outcome in ARVC/D, independently of history and RV dilatation/dysfunction. A normal bipolar EVM characterized a low-risk subgroup of ARVC/D patients. (Circ Arrhythm Electrophysiol. 2013;6:167-176.)

**Key Words:** arrhythmogenic right ventricular cardiomyopathy-dysplasia ■ cardiac arrhythmias ■ electrophysiology ■ electroanatomic voltage mapping ■ risk

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**Clinical Perspective on p 176**

Advances in our understanding of pathobiologic processes leading to RV lesion and the related electric instability may provide novel predictors of arrhythmic outcome. Pathological and molecular genetic studies showed that the hallmark lesion of ARVC/D is the fibro-fatty scar, which is characterized...
by genetically-determined myocardial loss and fibrofatty replacement and may provide a substrate for life-threatening re-entrant ventricular tachyarrhythmias.\textsuperscript{4,11–14} The assessment of mechanical consequences of myocardial fibrofatty scar has been traditionally based on imaging techniques such as echocardiography and angiography.\textsuperscript{15,16} Among the techniques now available for direct imaging of ventricular myocardial lesion, endocardial voltage mapping (EVM) is an emerging tool that has the ability to accurately identify and quantify RV regions with low-amplitude electric signals (ie, electroanatomic scar areas), which reflect myocardial replaced tissue.\textsuperscript{17–24} Although the technique has been demonstrated to enhance the accuracy for diagnosing ARVC/D, its value for arrhythmic risk stratification remains to be established. Hence this study was designed to prospectively evaluate the prognostic value of RV EVM in a cohort of ARVC/D patients during a long-term follow-up.

**Methods**

**Study Population**

The study population included 69 consecutive patients (47 males; median age 35 years [28–45]) with ARVC/D who were referred at the Division of Cardiology of the University of Padova, Italy for risk stratification. All patients underwent detailed cardiac evaluation including family history, physical examination, 12-lead ECG recording, signal-averaged ECG; 24-hour Holter monitoring, exercise stress testing, echocardiography and cardiac catheterization including RV and left ventricular (LV) cineangiography in the right and left anterior oblique view, and coronary angiography. Technical equipment, protocols, and reference values of each investigation have been reported in details elsewhere.\textsuperscript{20,21,24} All patients met the International Task Force (ITF) criteria (2 major criteria or 1 major criterion plus 2 minor criteria or 4 minor criteria) for diagnosis of definite ARVC/D. Diagnosis was established according to the original ITF criteria\textsuperscript{24} and confirmed using the recently revised criteria.\textsuperscript{26} All patients underwent intracardiac electrophysiological study with PVS for assessing VT/VF inducibility and high density EVM for imaging and quantification of abnormal RV EVM. The study was approved by the institutional review board, and all patients gave their informed consent.

**Electrophysiological Study**

All antiarrhythmic drugs were discontinued 5 half-lives (6 weeks for amiodarone) before the electrophysiological study. Programmed ventricular stimulation protocol included 3 drive cycle lengths (600, 500, 400 ms) and 3 ventricular extrastimuli while pacing from 2 RV sites (apex and outflow tract). Programmed ventricular stimulation was considered positive if either a VF or sustained VT (ie, one that lasted ≥30 seconds or required termination because of hemodynamic compromise) was induced. Programmed ventricular stimulation was repeated after intravenous isoproterenol infusion in those patients with effort induced non sustained VT (16 of 53, 26%).

**Electroanatomic Voltage Mapping**

At the time of electrophysiological study, all patients underwent detailed EVM by the CARTO system (Biosense-Webster) during sinus rhythm, as previously reported.\textsuperscript{18,20,21,27} A 7-F Navi-Star (Biosense-Webster) catheter, with a 4-mm distal tip electrode and a 2-mm ring electrode with an interelectrode distance of 1 mm, was introduced into the RV under fluoroscopic guidance and used as the mapping/ablation catheter. The catheter was placed at multiple sites on the endocardial surface of RV free wall (infero-basal, antero-lateral free wall, apex, and RV outflow tract) and septum to reconstructed the 3-dimensional geometry of the RV chamber. Bipolar electrogram signals (filtered at 10–400 Hz and displayed at 100 mm/s speeds on the CARTO system) and unipolar signals (filtered at 1–240 Hz and displayed at 100 mm/s speeds on the CARTO system) were recorded and analyzed simultaneously with regard to amplitude, duration, relation to the surface QRS, and presence of multiple components.

Duration of an endocardial bipolar electrogram was measured as the time from the earliest electric activity to the artifact produced by the decay of the amplified filtered signal. Bipolar signals were recorded between the distal electrode pair, unipolar signals between the distal tip of the ablation catheter (cathode) and the Wilson central terminal.

In our study the following tools were used to avoid false low-voltage recordings: (1) adequate catheter contact was confirmed by concordant catheter tip motion with the cardiac silhouettes on fluoroscopy; (2) a recording was accepted and integrated into the map when the variability in cycle length, local activation time stability, and maximum beat-to-beat difference of the location of the catheter (automatically detected by the CARTO system) were <2%, <3 ms, and <4 mm, respectively (these parameters, combined with the stability of the impedance reading, were used to exclude low amplitude signals attributable to poor endocardial catheter contact); (3) in the presence of a low voltage area, ≥3 additional points were acquired in the same area to confirm the reproducibility of the voltage measurement.\textsuperscript{20} Particular attention was paid to validate the acquisition of endocardial points from the RV infero-basal region, because of the recognized risk of poor tissue contact in this area. Because of the potential high mapping error and to avoid overestimation of low-voltage RV areas resulting from inclusion of normal annular fibrous tissue, the immediate perivalvular areas (ie, within 1.5 cm of the valvular locations on postprocessing measurement) were excluded in the analysis of endocardial low voltages.

Values of normal RV endocardial voltages were established by RV EVM in 6 reference patients without structural heart disease, who underwent electrophysiological study for evaluation of supraventricular tachycardia. RV septal endocardial sites (23±5) were excluded and only RV free-wall electrogram recordings (207±16 points sampled), either bipolar or unipolar, were analyzed. Normal bipolar electrograms were sharp with ≤3 rapid deflections; the mean electrogram duration was 34.8±1.2 ms and the mean amplitude 5.3±0.9 mV, with 95% of all electrogram signals ≤6.0 mV and >1.47 mV.

In addition, we analyzed the amplitude of unipolar electrograms, which was 10.2±0.6 mV with 95% of all unipolar signals recorded having an amplitude >5.96 mV.

Then in the present study the reference values used to define normal RV electrogram amplitude was set at 1.5 mV for bipolar signals and 6.0 mV for unipolar signals, which were the values above which 95% of all bipolar and unipolar electrogram voltages from the endocardium of normal RVs were included.

We considered normal bipolar electrocardiograms those with sharp and ≤3 spikes, amplitude ≥1.5 mV, and duration ≥70 ms. We defined as fragmented electrograms those characterized by multiple deflections (>3), amplitude ≤1.5 mV, and duration >70 ms.

Normal amplitude electrograms (bipolar >1.5 mV and unipolar >6.0 mV) were represented in the electroanatomic CARTO map by the color purple, whereas low-amplitude signals were represented by nonpurple range of colors. Color red indicated dense scar, which was arbitrarily defined as bipolar signal amplitude <0.5 mV and unipolar signal amplitude ≤5.5 mV, according to previously reported criteria.\textsuperscript{20–23} An EVM was considered abnormal in the presence of a single or multiple RV low voltage areas ≥1 cm² including ≥3 adjacent points with a bipolar signal amplitude <1.5 mV and an unipolar signal amplitude <6.0 mV.

Complete endocardial maps were obtained in all patients to ensure reconstruction of a 3-dimensional geometry of the RV chamber and to identify areas of abnormal electrograms in the RV free wall. The septum was excluded from the analysis (Figure I in the online-only Data Supplement). Regions showing low-amplitude signals were mapped with greater point density to delineate the extent and borders of endocardium electroanatomic scar areas.

The extent of low-voltage areas was estimated by using a CARTO-incorporated area calculation software (CARTO, Biosense Webster Inc,
Follow-Up
The follow-up data were obtained prospectively during regular out-patient visits at 6- to 12-month intervals. Routine ICD interrogation and ECG recordings at the time of symptoms were used to document the occurrence of spontaneous VT during follow-up. The study outcome was the index combined end point of major arrhythmic events such as sudden death (SD), cardiac arrest attributable to VF, sustained VT, or appropriate ICD intervention. Sudden death was defined as any natural death occurring instantaneously or within one hour from symptoms onset.

Sustained VT was defined as tachycardia originating in the ventricle with rate >100 beats/min and lasting >30 seconds or requiring an intervention for termination. Appropriate ICD intervention was defined as a device shock or anti-tachycardia overdrive pacing delivered in response to a ventricular tachyarrhythmia and documented by stored intracardiac ECG data. Ventricular fibrillation and VT were defined as a ventricular tachyarrhythmia with a cycle length ≤240 ms or >240 ms respectively. Implantable cardioverter defibrillator were routinely programmed to include a monitoring zone that identified VT with a rate >160 bpm.

Statistical Analysis
Results are summarized as mean±standard deviation (SD) or median with 25 to 75 percentiles for normally distributed and skewed variables, respectively. Normal distribution was assessed using Shapiro–Wilk test. Paired and unpaired Rank Sum test were used for skewed continuous variables.

Table 1. Clinical Characteristics of Overall Sample and According to Results of Bipolar EVM

<table>
<thead>
<tr>
<th></th>
<th>Overall Sample n=69</th>
<th>Abnormal Bipolar EVM n=53 (77%)</th>
<th>Normal Bipolar EVM n=16 (23%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>35 (28–45)</td>
<td>36 (28–46)</td>
<td>34 (28–44)</td>
<td>0.42</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>47 (68)</td>
<td>36 (68)</td>
<td>11 (69)</td>
<td>1</td>
</tr>
<tr>
<td>Family history of sudden death (&lt;35 y)</td>
<td>16 (23)</td>
<td>15 (28)</td>
<td>1 (6)</td>
<td>0.12</td>
</tr>
<tr>
<td>Family history of ARVC/D</td>
<td>12 (17)</td>
<td>11 (20)</td>
<td>1 (6)</td>
<td>0.34</td>
</tr>
<tr>
<td>History of cardiac arrest or syncope</td>
<td>22 (32)</td>
<td>20 (37)</td>
<td>2 (12)</td>
<td>0.07</td>
</tr>
<tr>
<td>Right precordial T-wave inversion (V1-V3)</td>
<td>49 (71)</td>
<td>41 (77)</td>
<td>8 (50)</td>
<td>0.04</td>
</tr>
<tr>
<td>Positive SAECG</td>
<td>34 (49)</td>
<td>29 (54)</td>
<td>5 (31)</td>
<td>0.13</td>
</tr>
<tr>
<td>Premature ventricular beats &gt;1000/24 h</td>
<td>59 (85)</td>
<td>45 (85)</td>
<td>15 (94)</td>
<td>0.72</td>
</tr>
<tr>
<td>Nonsustained VT</td>
<td>44 (63)</td>
<td>33 (62)</td>
<td>11 (69)</td>
<td>0.81</td>
</tr>
<tr>
<td>Sustained VT</td>
<td>9 (13)</td>
<td>8 (15)</td>
<td>1 (6)</td>
<td>0.72</td>
</tr>
<tr>
<td>RVEDV, ml/m²</td>
<td>80 (63–97)</td>
<td>82 (65–99)</td>
<td>77 (58–90)</td>
<td>0.09</td>
</tr>
<tr>
<td>RVFAC, %</td>
<td>40 (38–41)</td>
<td>40 (28–30)</td>
<td>40 (28–31)</td>
<td>0.82</td>
</tr>
<tr>
<td>LVEDV, ml/m²</td>
<td>46 (55–75)</td>
<td>65 (55–77)</td>
<td>55 (55–65)</td>
<td>0.94</td>
</tr>
<tr>
<td>LVEF, %</td>
<td>50 (45–60)</td>
<td>50 (46–60)</td>
<td>49 (43–58)</td>
<td>0.26</td>
</tr>
<tr>
<td>Multiregional RV-WMA*</td>
<td>25 (36)</td>
<td>22 (41)</td>
<td>3 (19)</td>
<td>0.01</td>
</tr>
<tr>
<td>Inducibility at PVS</td>
<td>34 (49)</td>
<td>26 (49)</td>
<td>8 (50)</td>
<td>1</td>
</tr>
<tr>
<td>VT</td>
<td>28 (41)</td>
<td>22 (42)</td>
<td>6 (38)</td>
<td>0.93</td>
</tr>
<tr>
<td>VF</td>
<td>6 (9)</td>
<td>4 (8)</td>
<td>2 (13)</td>
<td>0.91</td>
</tr>
<tr>
<td>ICD implantation</td>
<td>31 (44)</td>
<td>29 (54)</td>
<td>2 (12)</td>
<td>0.004</td>
</tr>
</tbody>
</table>

Categorical variables are presented as number of patients (%). Continuous values are expressed as median with 25 and 75 percentiles. ARVC/D indicates arrhythmogenic right ventricular cardiomyopathy/dysplasia; EDV, end diastolic volume; EF, ejection fraction; FAC, fractional area change; ICD, implantable cardioverter defibrillator; LV, left ventricle; PVS, programmed ventricular stimulation; RV, right ventricle; SAECG, signal averaged ECG; SD, standard deviation; VF, ventricular fibrillation; VT, ventricular tachycardia; and WMA, wall motion abnormalities.

*Multiregional WMA=akinesia, diskinesia, or bulging in ≥2 RV regions.
Twenty-two (32%) patients had a history of cardiac arrest or syncope. Ventricular tachycardias were documented in 53 (76%) patients and included sustained VT (n=9, 13%) or nonsustained VT (n=44, 63%). There were 15 morphologies of sustained VT, all with a left bundle branch pattern, with a superior axis in 8, inferior axis in 4, and undetermined axis in 3. Right ventricular dilatation/dysfunction were observed at echocardiography/angiography in all patients. Multiregional wall motion abnormalities (akinisia, diskinasia or bulging involving ≥2 RV regions) were found in 25 (36%) patients. Thirty-four (49%) patients were inducible at programmed ventricular stimulation to either sustained monomorphic VT (n=23) or VF (n=11). Among 8 noninducible patients, 2 experienced exercise induced arrhythmic events during follow-up.

At enrolment, 57 (82%) patients with VT or frequent premature ventricular beats were empirically treated with antiarrhythmic drug therapy, which consisted of sotalol (n=22), amiodarone either alone (n=9) or in combination with beta blockers (n=14), beta blockers (n=7), and flecainide (n=5).

**Electroanatomic Voltage Mapping**

Endocardial voltage mapping was successfully acquired during sinus rhythm in all patients, with a mean number of sites sampled of 195±22.

**Bipolar EVM**

An abnormal bipolar RV EVM was recorded in 53 (77%) patients. Patients with and without evidence of abnormal bipolar EVM had similar baseline clinical characteristics, except for multiregional RV wall motion abnormalities, which was significantly more prevalent in the abnormal bipolar EVM group. In patients with an abnormal bipolar EVM the median RV low-voltage area was 39.1 cm² (13.2–67.8) with a median percent RV area of 24.8% (7.2–31.5; Figure 1). The involved RV regions were infero-basal in 49 (71%) patients, antero-lateral in 28 (40%), RV outflow tract in 25 (36%), and apex in 15 (22%) (Figure I in the online-only Data Supplement).

Mean bipolar amplitude of local electrograms recorded from within RV electroanatomic scar areas was significantly lower than that sampled from unaffected RV areas (0.38±0.11 vs 5.2±0.6 mV; P<0.001). Similarly, bipolar electrograms from low-voltage areas had a longer mean duration (78.9±18 vs 33.5±7.8 ms; P<0.001) and more often extended beyond the offset of the surface QRS (64% vs 7%; P<0.001), compared with electrograms sampled from regions with preserved electrogram voltage (Figure 2). Fragmented bipolar electrograms (ie, signals with >3 deflections, amplitude ≤1.5 mV, and duration >70 ms) were recorded in 47 of 53 (88%) patients with an abnormal bipolar EVM.

In 16 patients (23%), EVM was normal, with preserved bipolar endocardial electrogram amplitude (4.8±1.3 mV) and duration (35.3±0.8 ms; Figure 2).

**Unipolar EVM**

In the 53 patients (77%) with abnormal bipolar EVM, unipolar EVM recorded significantly more extensive RV electroanatomic scar involvement with a median RV low-voltage area of 68.5 cm² (22.9–98.7) and median percent RV area of 64.8% (39.8–95.3) compared with low voltages obtained by bipolar EVM (P<0.009; Figure 1).

In all 16 patients (23%) with normal bipolar EVM, the use of unipolar EVM technique unmasked ≥1 regions of low-voltage unipolar electrogram abnormality 37.3 cm² (12.1–48.9); 26.2% (11.6–38.2; Figure 1).

**Follow-Up**

During a median follow-up of 41 (28–56) months, 19 patients (27.5%) reached the composite arrhythmic end point, with a 6.7% annual rate of major arrhythmic events. Eleven patients (16%) had an episode of sustained VT; 7 (10%) experienced ≥1 appropriate ICD interventions, either against VF (n=4) or VT (n=3), and 1 (1.4%) died suddenly. Among the 4 patients who experienced VF, 1 underwent orthotopic heart transplantation because of intractable recurrent VF storms (Figure 3).
Table 2 shows the clinical characteristics of patients with or without major arrhythmic events during follow-up. Patients who experienced arrhythmic events significantly more often had a history of cardiac arrest or syncope (73% vs 16%; \( P=0.001 \)), and abnormal bipolar EVM (100% vs 68%; \( P=0.003 \)).

Figure 4A shows Kaplan–Meier analysis of survival from the index combined end point of sustained VT, appropriate ICD intervention, and SCD for the overall population, stratified by bipolar EVM findings. Overall, the annual event rate was 11.4%/y in patients with an abnormal bipolar EVM and 0%/y with a normal bipolar EVM (logrank: \( P=0.02 \)).

Electrophysiological Study

Overall, the annual event rate was 6.1%/y in patients who were inducible at PVS and 7.1%/y in those who were noninducible (logrank: \( P=0.46 \); Figure 4B). Of 34 patients who were inducible at PVS, 23 (68%) did not experience major arrhythmic events during the follow-up (ie, false positives), whereas 8 of 35 (23%) noninducible patients had malignant events (ie, false negatives). The type of ventricular tachyarrhythmia which was inducible at the time of PVS (either VT or VF) did not predict either the presence of bipolar electroanatomic scar or the occurrence of arrhythmic events during follow-up. Patients with and without events during follow-up had a similar prevalence of RV fragmented bipolar electrograms (79% vs 64%).

Predictors of Events

Univariate and multivariable analysis for predictors of adverse events during follow-up are listed in Table 3. Univariate predictors of events were a previous history of cardiac arrest or syncope and extent of abnormal bipolar EVM. The overall arrhythmic risk increased with percentage of abnormal bipolar EVM (HR, 1.7 per 5% abnormal EVM increase; 95% CI, 1.5–2.0; \( P<0.001 \); Figure 5). At multivariable analysis the amount of abnormal bipolar EVM was an independent predictor of events (HR, 1.6 per 5% increase of abnormal EVM percentage; 95% CI, 1.2–1.9; \( P<0.001 \)). The amount of abnormal bipolar EVM was a predictor of events (HR, 1.4 per 5% increase of abnormal bipolar EVM percentage; 95% CI, 1.1–1.9; \( P=0.004 \)) even in the subgroup of 55 patients without previous sustained VT (n=9) and previous cardiac arrest (n=5).

According to c-statistic, the best cut-off value for abnormal bipolar EVM % area was 27.8% (c=0.74).

Discussion

The present study was designed to evaluate the value of the presence and extent of RV electroanatomic scar areas for predicting arrhythmic outcome in a consecutive series of ARVC/D patients. The major study findings were the following: (1) abnormal bipolar EVM was of independent prognostic significance, with the arrhythmic risk being proportional...
with the increased extent of RV low-voltage areas; (2) abnormal bipolar EVM appeared to be superior in predicting major arrhythmic events over a long-term follow-up to classic clinical risk factors such as clinical history, arrhythmic background and ventricular dilatation/dysfunction; and (3) a normal bipolar RV EVM characterized a low-risk subgroup of ARVC/D patients.

These study results suggest that EVM should supplement the traditional intracardiac electrophysiological studies for prognostic evaluation of ARVC/D patients.

Diagnostic Utility of EVM

Endocardial voltage mapping has the ability to identify areas of scar tissue by recording and spatially associating low amplitude electrograms to generate a 3-dimensional electroanatomic ventricular map. The technique has been clinically validated in electrophysiological labs where it is increasingly used for substrate-based mapping and catheter ablation of scar-related VT, in either ischemic or nonischemic cardiomyopathies. In ARVC/D patients, RV bipolar low-voltage area was demonstrated to correlate with the histopathologic finding of fibrofatty myocardial replacement at endomyocardial biopsy. Previous studies showed that EVM provides additional value for ARVC/D diagnosis. EVM has been recently reported to be significantly more sensitive than contrast-enhancement-cardiac magnetic resonance to identify RV scar lesion.

In the present study, an abnormal bipolar EVM was demonstrated in the majority of ARVC/D patients, confirming data from previous studies. Regional distribution of bipolar

### Table 2. Characteristics of Patients With and Without Arrhythmic Events During Follow-Up

<table>
<thead>
<tr>
<th></th>
<th>Events n=19 (28%)</th>
<th>No Events n=50 (72%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>34 (23–42)</td>
<td>37 (28–47)</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>14 (74)</td>
<td>36 (72)</td>
</tr>
<tr>
<td>Family history of sudden death (&lt;35 y)</td>
<td>6 (32)</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>History of cardiac arrest or syncope</td>
<td>14 (73)</td>
<td>8 (16)</td>
</tr>
<tr>
<td>Nonsustained VT</td>
<td>10 (53)</td>
<td>34 (68)</td>
</tr>
<tr>
<td>Sustained VT</td>
<td>6 (32)</td>
<td>6 (12)</td>
</tr>
<tr>
<td>RVEVD, ml/m²</td>
<td>80 (55–103)</td>
<td>80 (64–96)</td>
</tr>
<tr>
<td>RVFAC, %</td>
<td>39 (40–41)</td>
<td>39 (38–40)</td>
</tr>
<tr>
<td>LVEVD, ml/m²</td>
<td>59 (54–71)</td>
<td>65 (55–80)</td>
</tr>
<tr>
<td>LVEF, %</td>
<td>50 (45–58)</td>
<td>50 (45–60)</td>
</tr>
<tr>
<td>Fragmented bipolar electrograms</td>
<td>15 (79)</td>
<td>32 (64)</td>
</tr>
<tr>
<td>Inducibility at PVS</td>
<td>11 (58)</td>
<td>23 (46)</td>
</tr>
<tr>
<td>VT</td>
<td>9 (47)</td>
<td>19 (38)</td>
</tr>
<tr>
<td>VF</td>
<td>2 (11)</td>
<td>4 (8)</td>
</tr>
<tr>
<td>Antiarrhythmic drug therapy</td>
<td>15 (79)</td>
<td>42 (84)</td>
</tr>
<tr>
<td>Abnormal bipolar EVM</td>
<td>19 (100)</td>
<td>34 (68)</td>
</tr>
<tr>
<td>Abnormal unipolar EVM</td>
<td>19 (100)</td>
<td>50 (100)</td>
</tr>
</tbody>
</table>

Categorical variables are presented as number of patients (%). Continuous values are expressed as median with 25 and 75 percentiles. Abbreviations as in Table 1.

![Figure 4. Kaplan–Meier analysis of freedom from adverse events stratified by the presence of abnormal bipolar endocardial voltage mapping (EVM; A) and programmed ventricular stimulation (PVS) findings (B).](http://circep.ahajournals.org/contents/63/2/A64.10041f4.jpg)
low-voltage regions, with predominant involvement of the antero-lateral and infero-basal RV regions, resembled that observed in autopsy hearts of ARVC/D patients who died suddenly or underwent heart transplant, in whom the most severe atrophy and wall aneurysms were characteristically localized in the antero-infundibular wall and underneath the tricuspid valve.2,11

Prognostic Value of Abnormal EVM

The available data based on autopsy series or observational clinical investigations suggest that predictors of SCD in ARVC/D patients include the young age at the time of diagnosis, previous cardiac arrest or syncope, VT, severe RV/LV dysfunction, and inducibility at PVS.5,6,14 Our previous retrospective analysis of clinical history of ARVC/D patients undergoing EVM suggested that demonstration of bipolar low-voltage areas may be associated with a greater arrhythmic risk in ARVC/D patients.20 We previously found that during the time interval from onset of symptoms to the invasive study, 55% of patients with evidence of abnormal bipolar EVM required an ICD because they experienced malignant ventricular tachyarrhythmias, whereas all but 1 patient with preserved myocardial voltage values remained stable on antiarrhythmic therapy.20 The present study confirms and extends such previous observations by showing that an abnormal EVM identifies patients at increased risk of major arrhythmic events during a prospective long-term follow-up. We found that the amount of abnormal bipolar EVM was of independent prognostic significance, with the arrhythmic risk being proportional with the increased amount of abnormal bipolar EVM. At univariate Cox regression analysis, an abnormal bipolar EVM was a significant predictor for the composite arrhythmic end point, yielding an HR of 1.7 for every 5% increase in abnormal EVM; the other variable that was found to predict adverse arrhythmic outcome included history of cardiac arrest or syncope (HR=3.4). However, the extent of abnormal EVM appeared to be superior to classic clinical risk factors, because at multivariable analysis it remained the only independent predictor of malignant arrhythmic outcome in our patients population (HR=1.6 per 5%). It is noteworthy that according to the c-statistic method based on survival data, 27.8% abnormal bipolar low-voltage area was the best cut-off value to discriminate between patients with and without major arrhythmic adverse events during follow-up.

Arrhythmogenic Substrate

Unlike traditional imaging techniques such as echocardiography and ventriculography, which disclose RV mechanical
dysfunction (either regional or global) caused by fibro-fatty myocardial replacement, EVM has the ability to accurately identify and quantify low-amplitude RV regions which represent the electric consequences of RV scar lesions.17-30

Ventricular tachyarrhythmias in ARVC/D are frequently the result of a scar-related macro-reentry circuit, similar to that observed in the postmyocardial infarction setting.2,3 Voltage mapping-guided catheter ablation of VT by linear radiofrequency lesions connecting or encircling electroanatomic scar areas has proven to successfully interrupt the arrhythmic reentry circuit in ARVC/D patients.19-21 In the majority of patients with an abnormal bipolar EVM, we recorded fragmented bipolar electrograms (ie, >3 deflections, amplitude ≤1.5 mV, and duration >70 ms) from within the electroanatomic RV low-voltage. As shown by previous studies on scar-related electric activity in either ischemic or nonischemic heart disease, these electrographic abnormalities are the result of complex anisotropic propagation of the electric wavefront through scar tissue, which predisposes to the genesis of re-entrant ventricular tachyarrhythmias.31-35 Accordingly, we found that EVM provided prognostic value additional to traditional imaging techniques such as echocardiography and angiography, because demonstration of an electroanatomic scar area implies that the RV lesion acts as an arrhythmogenetically active myocardial substrate. This explains why the presence and amount of electroanatomic scar areas were stronger predictors of adverse arrhythmic outcome than traditional hemodynamic RV parameters such as RV dilatation/dysfunction.

Prognostic Value of Normal EVM

Failure to detect endocardial low-voltage areas in about one fourth of our patients fulfilling ITF criteria for ARVC/D remains to be explained. It is relevant that in our study unipolar EVM unmasked the presence of large regions of confluent abnormal unipolar electrograms in patients with a normal bipolar EVM as well as identified a greater amount of low-amplitude electrogram area in those with an abnormal bipolar EVM. The most likely explanation for the discordant unipolar and bipolar EVM is that fibro-fatty scar involvement of outer RV wall layers (ie, epi- and midmyocardium) is detected better with unipolar mapping technique.24,35 Indeed, because the wavefront of RV fibrofatty myocardial replacement in ARVC/D progresses from the epicardium to the endocardium, scar tissue in nonadvanced ARVC/D may be confined to epicardial/midmural layers, sparing (or reaching focally) the endocardial region.11 In our study, voltage mapping was limited to the endocardial side of the RV free wall and may have underestimated or missed nontransmural low-voltage areas. Previous studies showed that unipolar EVM recording may accurately predict the location and extent of epicardial electroanatomic scar involvement as evidenced by direct epicardial bipolar voltage mapping.24,35 Polin et al24 validated the use of unipolar EVM to identify confluent areas of signals with an amplitude <5.5 mV as a strategy for approximating the degree and location of epicardial bipolar voltage abnormality in ARVC/D patients with only limited endocardial bipolar voltage changes. It has been suggested that unipolar EVM provide a larger antenna than bipolar EVM to detect fibro-fatty substrate involvement of epi- and midmyocardium which is commonly present in ARVC/D patients.

It is noteworthy that in our ARVC/D study population major arrhythmic events occurred exclusively in the group of patients with RV electroanatomic scar involvement on bipolar EVM (Figure 3). Specifically, ARVC/D patients with a preserved bipolar voltages through the RV had an uneventful arrhythmic outcome, regardless of the amount of low amplitude ECG areas evidenced by unipolar EVM.

Voltage Mapping-Enhanced Electrophysiological Study

The results of this study confirm previous data showing that traditional electrophysiological study is of limited value for risk stratification of ARVC/D patients.6-9 We found that the positive predictive value of PVS for major arrhythmic events was only 32%. On the other hand, a negative PVS could not indicate better prognosis because approximately one fourth of noninducible patients experienced malignant events.

By contrast, Bhonsale et al10 reported that nonsustained VT and inducibility at PVS were significant predictors of appropriate discharges in ARVC/D patients who received an ICD for primary prevention. The discrepancy between our study findings and those reported by Bhonsale may be related to differences in patient populations, which in the latter study also included subjects with a probable (non definite) ARVC/D diagnosis, and to different arrhythmic study end points (ie, composite arrhythmic end-point versus appropriate ICD intervention alone).

The addition of EVM to traditional intracardiac electrophysiological study provides significant added value for arrhythmic risk assessment. Although recording of low-voltage, polyphasic, and abnormally wide scar-related electrograms do not necessarily require the use of electromagnetic mapping techniques, the ability of RV EVM to generate a 3-dimensional reconstruction of RV electroanatomic scar regions by spatially associating the abnormal local electrograms offers the potential not only to determine the presence but also to quantify the amount of RV myocardial tissue replaced by scar tissue, which was the most powerful predictor of adverse arrhythmic outcome in our study.

At variance with our results, Santangeli et al16 found that fragmented electrograms were the only variable independently associated with arrhythmic events during follow-up in a series of 32 patients with ARVC/D undergoing bipolar EVM, while the extent of electroanatomic scar was not predictive of outcome. The discrepancy between study results may be explained by a different abnormal bipolar signals definition and the different patient populations, with the Santangeli study including a highly selected group of ARVC/D patients, all showing an abnormal bipolar EVM and receiving a prophylactic ICD because of inducible sustained monomorphic VT.

Study Limitations

Although the study cohort was relatively large for ARVC/D, a small number of patients and outcomes were analyzed, linked predominantly to relatively low disease prevalence and low event rate. The small number of events limits both the power
to detect associations and the ability to control completely for all potential confounders in the multivariable models. Nonetheless, we believe that our study results and statistical analysis indicate important trends that are of clinical relevance for arrhythmic risk stratification and management of ARVC/D patients. Further studies with larger number of patients and longer follow-up are needed to confirm the value of bipolar EVM for predicting long-term clinical outcome of ARVC/D patients.

The different rate of ICD implantation (54% of patients with an abnormal bipolar EVM versus 12% of those with normal bipolar EVM) may represent a study bias with regard to arrhythmia detection. However, ICD were routinely programmed to include a monitoring zone that identified VT with a rate >160 bpm; this lessens the potential limitation of not homogeneous distribution of ICD, because slower, asymptomatic VTs remained equally undetected in both patient subgroups, regardless of ICD monitoring.

Conclusions

The results of the present study indicate that RV EVM has an important prognostic value in ARVC/D patients and that the arrhythmic risk is related to regional extent of RV scar lesions. RV EVM should supplement the traditional intracardiac electrophysiological studies for characterization of the arrhythmic substrate and risk stratification of patients with ARVC/D.

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Disclosures

None.

References

Arrhythmogenic right ventricular cardiomyopathy/dysplasia (ARVC/D) is characterized by areas of fibrofatty scar that can provide a substrate for life-threatening ventricular tachycardias. In voltage maps, these areas have low amplitude electrograms. This study prospectively assessed the presence and extent of RV low voltage regions in electroanatomic voltage maps (EVM) in a consecutive series of ARVC/D patients. An abnormal bipolar-EVM and greater size of the abnormal area predicted arrhythmia risk and appeared to be superior to several clinical risk factors. A normal bipolar EVM identified a low-risk subgroup of ARVC/D patients. Thus, although invasive, voltage maps can help assess arrhythmia risk in patients with ARVC/D.
Prognostic Value of Endocardial Voltage Mapping in Patients With Arrhythmogenic Right Ventricular Cardiomyopathy/Dysplasia

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Supplemental online figure legend: Anatomic representation of regional distribution of bipolar low-voltage areas in the RV free-wall. The septum was excluded from the analysis. RVOT = right ventricular outflow tract.