Differentiation of Papillary Muscle From Fascicular and Mitral Annular Ventricular Arrhythmias in Patients With and Without Structural Heart Disease

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Background—Idiopathic left ventricular arrhythmias (VAs) and those caused by structural heart disease can originate from the papillary muscles, fascicles, and mitral annulus. Differentiation of these arrhythmias can be challenging because they present with a right bundle branch block morphology by electrocardiography. We sought to identify clinical, electrocardiographic, and electrophysiological features that distinguish these left VAs in patients with and without structural heart disease.

Method and Results—Patients undergoing catheter ablation for papillary muscle, fascicular, or mitral annular VAs were studied. Demographic data and electrocardiographic and electrophysiological findings were analyzed. Fifty-two VAs in 51 patients (32 [63%] male; mean age 61 ± 15 years) with papillary muscle (n=18), fascicular (n=15), and mitral annular (n=19) origins were studied. Patients with papillary muscle VAs were older and had higher prevalence of left ventricular dysfunction (67% versus 13% of fascicular VA patients [P=0.009]) and coronary artery disease (78% versus 37% of mitral annular VA patients [P=0.036]). Papillary muscle VAs were distinguished electrocardiographically from fascicular VAs by longer QRS durations and lower prevalence of r< R’ in QRS morphology, and from mitral annular VAs by lower prevalence of positive precordial lead concordance. Using a stepwise electrocardiographic algorithm, the accuracy rates for the diagnosis of papillary muscle VAs, fascicular VAs, and mitral annular VAs were 83%, 87%, and 89%, respectively.

Conclusions—Specific electrocardiographic characteristics, including QRS morphology and precordial lead morphology, can help distinguish between papillary muscle, fascicular, and mitral annular VAs. (Circ Arrhythm Electrophysiol. 2015;8:616-624. DOI: 10.1161/CIRCEP.114.002619.)

Key Words: electrocardiography ■ fascicular ■ mitral valve annulus ■ papillary muscle ■ ventricular arrhythmia

The left ventricular anterior and posterior papillary muscles (Pap) give rise to ventricular arrhythmias (VA) in both structurally normal and abnormal hearts.1-4 VAs originating from the papillary muscles have been shown to exhibit distinct clinical and electrocardiographic features.1-6 Given that papillary muscles are anatomically complex structures, catheter ablation of Pap VAs can be challenging and are associated with lower success rates than ablation of left ventricular fascicular arrhythmias.6 Studies on the differentiation of Pap VAs from other idiopathic left VAs, such as mitral annular (MA) VAs, are lacking. In this study, we characterize the clinical, electrocardiographic, and electrophysiological features of left Pap VAs in patients undergoing catheter ablation and compare these features to those of left fascicular and focal mitral annular VAs. We sought to identify an electrocardiographic algorithm to distinguish left Pap VAs from fascicular and MA VAs.

Methods

Study Population

The subjects comprised 51 consecutive patients undergoing catheter ablation of symptomatic VA (31 [61%] presenting as premature ventricular contractions (PVCs) and 20 [39%] as sustained or non-sustained ventricular tachycardia (VT)) arising from either the left ventricular papillary muscles, left ventricular fascicles, or mitral annulus at the Weill Cornell Medical Center. This study was approved by the Institutional Review Board of Weill Cornell Medical College.

Electrocardiogram Characteristics (12-Lead and Holter Monitor)

All patients had standard 12-lead electrocardiogram (ECG) recordings made at the time of electrophysiological testing using the Prucka CardioLab (GE Healthcare, Waukesha, WI) recording system using low-frequency and high-frequency filters of 0.05 and 150 Hz, respectively. Measurements were performed with electronic calipers at...
WHAT IS KNOWN

- Idiopathic left ventricular arrhythmias and those caused by structural heart disease can arise from the papillary muscles, left fascicular system, and the mitral annulus. Proper differentiation of these arrhythmias is critical for guiding catheter ablation, but remains challenging.

WHAT THE STUDY ADDS

- Our study suggests that the use of a stepwise algorithm that examines electrocardiographic parameters, such as QRS duration, precordial lead transition, and V1 electrocardiogram morphology, can help differentiate ventricular arrhythmias arising from the papillary muscles, fascicles, and mitral annulus.

uniform lead gain at a sweep speed of 100 mm/s. The following VA ECG characteristics were recorded: bundle branch block morphology (right or left), axis (right or left, inferior or superior), QRS duration, morphology of the QRS complex in V1 (R, R', r, qR, Q, qR', qrR', Rs, rS, RsR, R'sR', rS', and variable; see Table I in the Data Supplement). Lead V1 VA QRS morphology was classified as rR' if 2 distinct positive deflections were present, and the amplitude of the first positive deflection was less than the second positive deflection. Lead V1 VA QRS morphology was classified as Rs2s if the amplitude of the R wave was greater than amplitude of the S wave or if no S wave was present. VA ECGs were defined as having positive precordial concordance if Rs>s in all 6 precordial leads. These criteria were adjudicated by 2 observers (S.J. Al’Aref and J.W. Cheung) with initial interobserver agreement on V1 QRS complex morphology adjudication of 92% and on all other variables of 100%. Discrepancies were resolved by consensus.

Electrophysiological Study and Catheter Ablation

After written informed consent was obtained, electrophysiological testing was performed. Patients were locally anesthetized with 0.25% bupivacaine and sedated with midazolam and fentanyl. The ventricular stimulation protocol included up to triple ventricular extrastimuli at ±2 paced cycle lengths from the right ventricular apex and right ventricular outflow tract. Isoproterenol infusion (≤20 μg/min) was given in 45 (87%) cases to assess for arrhythmia facilitation as characterized by increase in PVC frequency or VT inducibility. The presence of multiple morphologies of PVCs or VT during the electrophysiology study was recorded.

Electroanatomic mapping (CARTO, CARTO XP, or CARTO 3; Biosense Webster, Diamond Bar, CA) was performed in all cases, using the Biosense Navistar 4 mm (n=8), Biosense Navistar 8 mm (n=1), Biosense Thermocool Navistar irrigated 3.5 mm (n=26), Biosense Thermocool SF irrigated 3.5 mm (n=11), and Biosense Thermocool RMT irrigated 3.5 mm (n=8) ablation catheters (Biosense Webster, Diamond Bar, CA). For 1 MA VA ablation case, both a Biosense Navistar 4 mm and Biosense Navistar 8 mm nonirrigated ablation catheter were used, and for 2 Pap VA cases, both Biosense Thermocool RMT irrigated 3.5 mm and Biosense Thermocool SF irrigated 3.5 mm ablation catheters were used. Remote magnetic navigation mapping (Stereotaxis, St. Louis, MO) was performed in 8 (16%) cases based on operator preference. For Pap and MA VAs, sites for ablation were determined by the earliest sites of VA activation as characterized by electroanatomic mapping, local activation >20 ms pre-VA QRS onset, polarity switch between proximal and distal ablation electrogram recordings, QS unipolar electrograms during VA, or pace mapping. During mapping of 6 (11%) VAs (4 Pap VAs and 2 MA VAs), pace mapping was the primary modality used to identify the site of VA origin because of presence of infrequent VA ectopy during the procedure. This was performed by identifying sites of near 12/12 lead ECG pace map match as confirmed visually by the operator. In all Pap VA cases, catheter positions and relationship to papillary muscle location were assessed using intracardiac echocardiography (Acuson, Siemens, Mountain View, CA). Mitral annular VAs were defined by the presence of both atrial and ventricular electrograms at the site of VA origin. The presence of fractionation, fascicular, or Purkinje potentials at the site of earliest VA activation was annotated. In cases of ablation of fascicular VAs, the location of the left anterior and posterior fascicles as identified by the presence of sharp fascicular potentials either during sinus rhythm or VA was recorded. Sites with diastolic potentials consistent with slowed Purkinje conduction were targeted for ablation. Overall, acute success of ablation was defined as complete abolition of targeted PVCs and, if applicable, lack of VT inducibility during a postablation observation period of at least 30 minutes. Post-ablation clinical follow-up was available for 42 (82%) patients. All available follow-up clinical histories, ECGs, and Holters were reviewed for arrhythmia recurrence.

Cardiac Magnetic Resonance Imaging

Cardiac magnetic resonance (CMR) imaging before catheter ablation was performed in 14 (27%) patients. Myocardial scar/infarction was assessed via use of a inversion recovery gradient echo pulse sequence, which was performed 10 to 30 minutes after administration of gadolinium-based contrast (0.20 mmol/kg), during which inversion times were tailored to null viable myocardium (typical inversion time 250–350 ms). Myocardial scar/infarction within each of the papillary muscles was identified based on regional enhancement within each of the papillary muscles, in accordance with previously established methods.

Follow-Up

All dates of follow-up either in the hospital or in the office after ablation were recorded. Medical records were reviewed to assess for documentation of recurrent arrhythmias. For patients who underwent PVC ablation, Holter reports before and after ablation were analyzed. Results from repeat electrophysiology studies and catheter ablation procedures performed for recurrent clinical VA were reviewed.

Statistical Analysis

Statistical analysis was performed using SPSS version 19 (SPSS Inc., Chicago, IL).

Continuous variables were expressed as the mean±standard deviation or median (interquartile range [IQR]): 25th percentile, 75th
percentile) based on normality of distribution. For pairwise comparisons of categorical variables, the Fisher exact test was used, and for comparisons of >2 groups of categorical variables, the Chi-square test was used. For comparisons of >2 groups of normally distributed continuous variables, 1-way analysis of variance was performed. For comparisons of 2 groups of normally distributed continuous variables, Student’s t test was performed. If significant differences were found, a post hoc analysis using the Scheffe test was performed. Comparisons were considered statistically significant based on a P value of <0.05.

Results

Clinical Characteristics

Fifty-one patients (32 [63%] male; mean age 61±15 years; range 27–89 years) comprised the study population. The distribution of 52 VAs among the study patients are summarized in Figure 1, which included 18 (35%) Pap VAs (Figure 2), 15 (29%) fascicular VAs (Figure 3) and 19 (36%) MA VAs (Figure 4). Among the Pap VAs, 9 (50%) VAs arose from each papillary muscle. Of the 19 MA VAs, 6 (32%) were mapped to epicardium and ablated within the coronary venous system. Of note, one patient had both Pap VA and fascicular VA, both of which were targeted with ablation and were therefore included in the analysis.

Baseline clinical characteristics of patients with Pap VAs, fascicular VAs, and MA VAs are detailed in Table 1. Patients with Pap VAs were older than fascicular VA patients (age 68±10 versus 53±17 years; P=0.018). Patients with Pap VAs had a higher prevalence of left ventricular dysfunction (defined as left ventricular ejection fraction <50%) than fascicular VA patients (67% versus 13%; P=0.009), as well as a higher prevalence of coronary artery disease than MA VA patients (78% versus 37%; P=0.036). With respect to baseline medical therapy for VAs, a higher proportion of patients with Pap VAs were on β-blocker therapy, and a higher proportion of patients with fascicular VAs were on calcium channel blocker therapy.

CMR was performed median 17.5 days (IQR, 4.5, 33 days) before ablation in 6 (42% of all patients undergoing CMR) Pap VA patients, 4 (29%) fascicular VA patients, and 4 (29%) MA VA patients. No myocardial scar was detected

Figure 2. Anatomic and electrophysiological localization of papillary muscle premature ventricular contraction (PVC). A, Intracardiac echocardiographic view showing contact between the ablation catheter and the base of the posteromedial papillary muscle during radiofrequency ablation of focal left ventricular arrhythmia (red star marking the contact point). B, An electroanatomical map in cranial RAO projection with clipped view showing the positions of the anterolateral (AL Pap) and posteromedial (PM Pap) papillary muscles (in purple) as outlined by intracardiac echocardiography (CARTO, Biosense Diamond Bar, CA). Activation map reveals site of origin of PVC at the base of the posteromedial papillary muscle (red star). C, Surface electrocardiogram 12 leads, distal bipolar (MAP 1–2), and unipolar (MAP 1) intracardiac electrograms recorded from the early site are shown. Local activation precedes QRS by 21 ms.
in the patients with fascicular VAs and MA VAs. One patient with Pap VA had isolated posteromedial papillary muscle scar, which correlated with the site of VA origin, whereas 2 of the 5 remaining Pap VA patients had evidence of LV chamber wall scar (n=1 inferoseptal, n=1 lateral), but no evidence of scar within the papillary muscle themselves.

**Electrocardiographic Characteristics**

The ECG characteristics of the Pap VAs, fascicular VAs, and MA VAs are summarized in Table 2. Every patient’s VA had a right bundle branch block morphology in lead V1. Compared with patients with fascicular VAs, the presenting clinical arrhythmia in patients with Pap VAs was more likely to be PVC than VT (78% versus 33%; \( P=0.010 \)). The QRS durations of Pap VA and MA VA were significantly longer than that of fascicular VA (Table 2). Among MA VAs, epicardial MA VAs tended to have longer QRS durations when compared with endocardial MA VAs (173±26 ms versus 148±25 ms; \( P=0.06 \)). When compared separately in a pairwise fashion, both epicardial and endocardial MA VAs had longer QRS durations than fascicular VAs (173±26 ms and 148±25 ms versus 127±24 ms; \( P=0.035 \) and \( P=0.001 \), respectively). Fascicular VAs had a significantly higher prevalence of an r′<R′ pattern in V1 (80% versus 6% of Pap VAs; \( P<0.001 \) and versus 42% of MA VAs; \( P=0.038 \)). All mitral annular VAs had RzS in lead V6 (100% versus 22% of Pap VAs; \( P<0.001 \) and versus 11% of fascicular VAs; \( P<0.001 \)). Representative ECG examples of Pap, fascicular, and MA VAs are shown in Figure 5.

With respect to VA localization based on ECG axis, 9 of 11 (82%) Pap VAs with superior axis were localized to the posteromedial papillary muscle, 11 of 12 (92%) fascicular VAs with superior axis were localized to the left posterior fascicle, and 4 out of 4 (100%) MA VAs with superior axis were localized to the posterior half of the mitral annulus. Among all VAs with an inferior axis, 7 of 7 (100%) Pap VAs originated from the anterolateral papillary muscle, 2 of 3 fascicular VAs from the left anterior fascicle, and 15 of 15 (100%) MA VAs from the anterior half of the mitral annulus.

A proposed stepwise algorithm summarizing the ECG findings of Pap VAs, fascicular VAs, and MA VAs demarcated on the basis of inferior and superior axis morphologies.
are displayed in Figure 6A and 6B. A comparison of the ECG features among the inferior and superior axis VA subgroups are detailed in Table II in the Data Supplement. Among VAs with an inferior axis, the presence of VA QRS ≤ 130 ms was associated with 100% sensitivity and 100% specificity for differentiating fascicular VAs from Pap and MA VAs. The presence of positive precordial concordance had an 87% sensitivity and 71% specificity for differentiating MA VAs from Pap VAs. Among VAs with a superior axis, the presence of R ≥ S in lead V5 was associated with 100% sensitivity and 100% specificity for differentiating MA VAs from Pap and fascicular VAs. The combined use of the 2 stepwise algorithms for all study left VAs yielded accuracy rates of 83%, 87%, and 89% for the diagnosis of Pap VAs, fascicular VAs, and MA VAs, respectively.

Electrophysiological Study Findings
The electrophysiological findings are summarized in Table 3. Compared with patients with fascicular VAs, patients with Pap VAs were significantly less likely to have inducible VT during electrophysiological study (67% versus 22%; P=0.015).

<table>
<thead>
<tr>
<th>Table 1. Baseline Clinical Characteristics of Papillary Muscle VA Patients Compared With Fascicular and Mitral Annular VA Patients</th>
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<tbody>
<tr>
<td>Pap VA (n=18)</td>
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<tr>
<td>-------------</td>
</tr>
<tr>
<td>Age, mean, y</td>
</tr>
<tr>
<td>Male sex, n (%)</td>
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<tr>
<td>Hypertension, n (%)</td>
</tr>
<tr>
<td>Diabetes mellitus, n (%)</td>
</tr>
<tr>
<td>Coronary artery disease, n (%)</td>
</tr>
<tr>
<td>Prior myocardial infarction, n (%)</td>
</tr>
<tr>
<td>Heart failure, n (%)</td>
</tr>
<tr>
<td>Left ventricular EF &lt;50%, n (%)</td>
</tr>
<tr>
<td>Beta-blockers, n (%)</td>
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<tr>
<td>Calcium channel blockers, n (%)</td>
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<td>Anti-arrhythmic drugs, n (%)</td>
</tr>
</tbody>
</table>

EF indicates ejection fraction; MA, mitral annular; Pap, papillary; and VA, ventricular arrhythmia.

*All displayed P values are based on 3-way comparisons; pair-wise P values are denoted as follows:
†P<0.05 for Pap VA vs fascicular VA.
‡P<0.05 for Pap VA vs MA VA.
§P<0.05 for fascicular VA vs MA VA.

<table>
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<tr>
<th>Table 2. Electrocardiographic Characteristics of Papillary Muscle VA Patients Compared With Left Ventricular Fascicular or Mitral Annular Arrhythmias</th>
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<tbody>
<tr>
<td>Pap VA (n=18)</td>
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<tr>
<td>Presenting VA: PVC, n (%)</td>
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<tr>
<td>VA QRS duration, mean, ms</td>
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<tr>
<td>Positive precordial concordance, n (%)</td>
</tr>
<tr>
<td>V1 morphology (R≥S), n (%)</td>
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<tr>
<td>V1 Morphology (r&lt;R′), n (%)</td>
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<tr>
<td>V1 Q wave, n (%)</td>
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<tr>
<td>V1 QRS morphologies (n)</td>
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<tr>
<td>Variable (3)</td>
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<tr>
<td>qR′ (3)</td>
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<tr>
<td>rR′ (1)</td>
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<tr>
<td>Variable (1)</td>
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<tr>
<td>QR (1)</td>
</tr>
</tbody>
</table>

MA indicates mitral annular; ms, millisecond; Pap, papillary; PVC, premature ventricular contraction; and VA, ventricular arrhythmia.

*All displayed P values are based on 3-way comparisons; pair-wise P values are denoted as follows:
†P<0.05 for Pap VA vs fascicular VA.
‡P<0.05 for fascicular VA vs MA VA.
§P<0.05 for Pap VA vs MA VA.
The rates of VT inducibility among patients who presented with VT and not PVCs as their clinical arrhythmia were 3 of 4 (75%) among Pap VA patients, 10 of 10 (100%) among fascicular VA patients, and 6 of 7 (86%) among MA VA patients. Fascicular and Purkinje potentials were found more frequently at the site of successful ablation of fascicular VA when compared with Pap VA (100% versus 22%; \( P < 0.001 \)) and when compared with MA VA (100% versus 0%; \( P < 0.001 \)) (Figure 3). There were no significant differences in electrophysiological study findings with respect to presence of polymorphic VA morphologies, isoproterenol VA facilitation, and timing from electrogram to QRS onset at site of successful ablation. Acute ablation success rates for Pap VAs, fascicular VAs, and MA VAs were 83%, 100%, and 95%, respectively.

**Discussion**

The left ventricular papillary muscles have been shown to be a source of ventricular ectopy in patients with and without structural heart disease. Given the distinct challenges that arrhythmias from the papillary muscles can present during catheter ablation, the recognition of specific ECG patterns that can distinguish these arrhythmias from other idiopathic left VAs is important. We found a higher prevalence of structural heart disease among patients with Pap VAs compared with patients with fascicular VAs and MA VAs. Moreover, we identified VA QRS duration, \( V_1 \) QRS pattern, and precordial lead concordance as specific features that can help localize these VAs. This is the first study, to our knowledge, that compares.
Pap VAs in patients with and without structural heart disease to both fascicular VAs and MA VAs.

**Clinical and Electrophysiological Features of Papillary Muscle Ventricular Arrhythmias**

In our study, patients with Pap VAs were older and had more structural heart disease as manifest by a higher prevalence of decreased ejection fractions and coronary artery disease. Unlike patients with fascicular VAs, over 75% patients with Pap VA in our study were not inducible for sustained VT at electrophysiological study. Moreover, the majority of patients with Pap VA presented with PVCs and not VT as their clinical arrhythmia. In the only previous study to compare patients with and without structural heart disease with Pap VAs to fascicular VAs, an increased prevalence of structural heart disease was seen among patients with Pap VAs, although this difference did not reach statistical significance because of low overall number of Pap VAs (n=9).

Although some cases of Pap VAs may be directly associated with scar because of myocardial infarction, others can occur in apparently structurally normal hearts. Focal myocardial scarring confined to the papillary muscle as detected by CMR was present in one patient without prior history of myocardial infarction in our series, which is a phenomenon that has been described previously. Increased myocardial fibrosis caused by aging, hypertension, and coronary artery disease may predispose patients to Pap VAs. Anatomic disruptions of existing areas of maximal refractoriness at the Purkinje–ventricular tissue interface may lead to focal reentry. However, it should be noted that in our study, 5 of the 6 Pap VA patients who had CMRs before ablation did not have evidence of scar at the site of arrhythmia origin. Therefore, the underlying mechanisms behind Pap VAs are likely heterogeneous.

### Table 3. Electrophysiological Characteristics of Papillary Muscle VA Patients Compared With Fascicular and Mitral Annular Arrhythmias

<table>
<thead>
<tr>
<th></th>
<th>Pap VA (n=18)</th>
<th>Fascicular VA (n=15)</th>
<th>MA VA (n=19)</th>
<th>P Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inducible sustained VT, n (%)</td>
<td>4 (22)</td>
<td>10 (67)</td>
<td>7 (37)</td>
<td>0.032†</td>
</tr>
<tr>
<td>Isoproterenol facilitation, n/total (%)</td>
<td>9/15 (60)</td>
<td>8/14 (57)</td>
<td>5/17 (29)</td>
<td>0.340</td>
</tr>
<tr>
<td>EGM pre-QRS potential, mean, ms</td>
<td>23±6</td>
<td>26±13</td>
<td>25±9</td>
<td>0.673</td>
</tr>
<tr>
<td>Fascicular/Purkinje potential, n (%)</td>
<td>4 (22)</td>
<td>15 (100)</td>
<td>0 (0)</td>
<td>&lt;0.001†‡</td>
</tr>
<tr>
<td>Pleomorphic VA, n (%)</td>
<td>4 (22)</td>
<td>2 (13)</td>
<td>1 (5)</td>
<td>0.319</td>
</tr>
<tr>
<td>Successful radiofrequency ablation, n (%)</td>
<td>15 (83)</td>
<td>15 (100)</td>
<td>18 (95)</td>
<td>0.178</td>
</tr>
</tbody>
</table>

EGM indicates electrogram; MA, mitral annular; VA, ventricular arrhythmia; VT, ventricular tachycardia.

*All displayed P values are based on 3-way comparisons; pair-wise P values are denoted as follows:

†P<0.05 for Pap VA vs fascicular VA.

‡P<0.05 for fascicular VA vs MA VA.
Distinguishing Electrocardiographic Characteristics of Papillary Muscle, Fascicular, and Mitral Annular Arrhythmias

We identified several electrocardiographic hallmarks of papillary muscle, fascicular, and mitral annular VAs. Specifically, VA QRS duration, V1 r and R’ amplitudes, and precordial transition can help distinguish these 3 categories of VAs. In our study, fascicular VAs were distinguished by shorter QRS durations and the presence of a V1 rR’ amplitude pattern. The shorter QRS duration likely reflects the proximal exit of fascicular VAs from the His–Purkinje system, which occurs in contradistinction to the distal Purkinje exit of Pap VAs and the myocardial exit of MA VAs. Moreover, the presence of a V1 rR’ amplitude pattern among fascicular VAs that mimics typical right bundle branch aberration⁹ is another manifestation of His–Purkinje network activation. With fascicular VAs, we postulate that the left ventricle is depolarized more rapidly via the Purkinje system than with Pap and MA VAs, which results in unopposed late activation of the right ventricular outflow tract, leading to a large R’ amplitude in lead V6. Furthermore, we found that all mitral annular VAs ECG patterns had R2≥ in lead V5. This reflects the more basal location of MA VAs compared with fascicular and Pap VAs. Specifically, anterior MA VAs display positive precordial concordance because of the positive electric forces of ventricular activation directed toward the apical V6 lead. In comparison, because the papillary muscles and the midfascicular system lie in the midsegment of the heart in the long axis orientation, positive concordance is not seen in the precordial VA ECG leads.

Although we were able to identify specific ECG patterns that were more commonly seen in one left ventricular origin than another, there was still considerable overlap in these patterns among the different groups. We therefore proposed a stepwise approach as outlined in Figure 6 that achieves a high sensitivity and specificity (83% to 100%) for distinguishing among these forms of left VAs. However, not all patients were accurately differentiated using our ECG algorithm. For example, there was one group of Pap and MA VA patients that could not be differentiated completely on the basis of positive precordial lead concordance. This may have been explained in part by presence of anterolateral Pap VAs that had exit sites close to the mitral annulus. Another group of Pap and fascicular VA patients was not completely differentiated on the basis of V1 r and R’ ratio, which may reflect variations in VA exit along the septum (eg, more distal exit from the Purkinje network may yield a more atypical right bundle branch block pattern).

Only one previous study to date has compared all 3 categories of Pap VA, fascicular VA, and MA VA ECG patterns, but the study excluded patients with structural heart disease and only included MA VA patients with posteroesophal and anterolateral mitral annular sites of origin.⁸ The ECG algorithm developed in our study helps differentiate left ventricular VA subtypes and can be applied more broadly to patients with and without structural heart disease and may be used in patients with mitral annular VAs of any location.

Study Limitations

First, as this is a single-center retrospective study of relatively uncommon VAs, the clinical and ECG hallmarks identified here may not be generalizable to all patients with Pap, fascicular, and MA VAs. A prospective validation cohort study, ideally with multicenter participation, would address this limitation. Second, given that patients with and without structural heart disease were included, considerable heterogeneity in VA mechanism may exist. The impact of the absence or presence of structural heart disease on our ECG findings did not seem to be significant. For example, VA QRS durations were longer among patients with Pap and MA VAs when compared with fascicular VAs in patients with and without structural heart disease were analyzed separately (data not shown). Third, CMRs were not routinely done in all study patients, which precludes definitive conclusions regarding the prevalence of focal papillary scar in patients with Pap VA. Finally, in 6 patients, pace-mapping was performed to identify the VA site of origin. Given the limited spatial resolution of pace-mapping,¹⁰ some decrease in the accuracy in the VA localization in these cases may have been possible.

Conclusions

A stepwise ECG approach that incorporates QRS duration, V1 QRS morphology, and precordial lead transition can help distinguish the Pap, fascicular, and MA VAs. An understanding of the distinguishing clinical, ECG, and electrophysiological features of these 3 categories of left ventricular VAs can help facilitate mapping and ablation of these arrhythmias.

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Disclosures

Dr J.W. Cheung has received speaker honoraria from St Jude Medical and fellowship grant support from Biosense Webster and St Jude Medical. Dr S.M. Markowitz has received consulting fees from Boston Scientific and St Jude Medical. Dr C.F. Liu has received speaker honoraria from St Jude Medical. The other authors report no conflicts.

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SUPPLEMENTAL MATERIAL
Supplemental Table 1.

ECG QRS morphology of study ventricular arrhythmias in lead V₁ were characterized as follows with Q, R, S, and R’ waves as defined using previously published criteria:¹,²

I. *Monophasic subtypes*
   a. R: single positive deflection (R)
   b. Rr’: Initial positive deflection (R) amplitude ≥ second positive deflection (r’) amplitude with no negative deflection below baseline
   c. rR’: Initial positive deflection (r) amplitude < second positive deflection (R’) amplitude with no negative deflection below baseline

II. *Biphasic subtypes*
   a. qR: initial negative deflection (q ≥ 0.1 mV amplitude) followed by monophasic single positive deflection (R) with q amplitude < R amplitude
   b. QR: initial negative deflection (Q ≥ 0.1 mV amplitude) followed by monophasic single positive deflection (R) with Q amplitude ≥ R amplitude
   c. qRr’: initial negative deflection (q ≥ 0.1 mV amplitude) followed by positive deflection (R) amplitude ≥ second positive deflection (r’) amplitude with no negative deflection below baseline with q amplitude < R amplitude
   d. qrR’: initial negative deflection (q ≥ 0.1 mV amplitude) followed by positive deflection (r) amplitude < second positive deflection (R’) amplitude with no negative deflection below baseline with q amplitude < R amplitude
   e. Rs: initial positive deflection (R) amplitude ≥ negative deflection (s) amplitude
   f. rS: initial positive deflection (r) amplitude < negative deflection (S) amplitude

III. *Triphasic subtypes*
   a. RSr’: Initial positive deflection (R) amplitude ≥ second positive deflection (r’) amplitude separated by negative deflection below baseline (S) with amplitude ≥ dominant R deflection amplitude
   b. Rsr’: Initial positive deflection (R) amplitude ≥ second positive deflection (r’) amplitude separated by negative deflection below baseline (s) with amplitude < dominant R deflection amplitude
   c. rSR’: Initial positive deflection (R) amplitude < second positive deflection (r’) amplitude separated by negative deflection below baseline (S) with amplitude ≥ dominant R deflection amplitude
   d. rsR’: Initial positive deflection (R) amplitude < second positive deflection (r’) amplitude separated by negative deflection below baseline (s) with amplitude < dominant R deflection amplitude

IV. *Variable*
   a. QRS complexes exhibiting variability that precluded morphology adjudication. In this study all cases of variable VA V₁ QRS morphology consisted of cases where alternating Rr’ and rR’ morphologies were seen in lead V₁
References


**Supplemental Table 2.**

**Inferior axis VAs (total n = 25)**

<table>
<thead>
<tr>
<th></th>
<th>Pap VA (n = 7)</th>
<th>Fascicular VA (n = 3)</th>
<th>MA VA (n = 15)</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting VA: PVC, n (%)</td>
<td>6 (86)</td>
<td>3 (100)</td>
<td>9 (60)</td>
<td>0.24</td>
</tr>
<tr>
<td>VA QRS duration, mean (msec)</td>
<td>154 ± 15</td>
<td>108 ± 15</td>
<td>164 ± 23</td>
<td>0.001†,‡</td>
</tr>
<tr>
<td>Positive Precordial Concordance, n (%)</td>
<td>2 (29)</td>
<td>1 (33)</td>
<td>13 (87)</td>
<td>0.015‡,§</td>
</tr>
<tr>
<td>V₅ Morphology (R ≥ s), n (%)</td>
<td>4 (58)</td>
<td>1 (33)</td>
<td>15 (100)</td>
<td>0.06</td>
</tr>
<tr>
<td>V₁ Morphology (r &lt; R'), n (%)</td>
<td>0 (0)</td>
<td>2 (67)</td>
<td>7 (47)</td>
<td>0.052</td>
</tr>
<tr>
<td>V₁ Q wave, n (%)</td>
<td>2 (29)</td>
<td>0 (0)</td>
<td>4 (27)</td>
<td>0.58</td>
</tr>
</tbody>
</table>

Pap = papillary; MA = mitral annular; VA = ventricular arrhythmia; PVC = premature ventricular contraction; msec = millisecond.

*All displayed p values are based on three-way comparisons; pair-wise p values are denoted as follows: †p < 0.05 for Pap VA vs. fascicular VA; ‡p < 0.05 for fascicular VA vs. MA VA; §p < 0.05 for Pap VA vs. MA VA

**Superior axis VAs (total n = 27)**

<table>
<thead>
<tr>
<th></th>
<th>Pap VA (n = 11)</th>
<th>Fascicular VA (n = 12)</th>
<th>MA VA (n = 4)</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting VA: PVC, n (%)</td>
<td>8 (73)</td>
<td>2 (17)</td>
<td>4 (100)</td>
<td>0.003†,‡</td>
</tr>
<tr>
<td>VA QRS duration, mean (msec)</td>
<td>153 ± 34</td>
<td>132 ± 25</td>
<td>132 ± 9</td>
<td>0.18</td>
</tr>
<tr>
<td>Positive Precordial Concordance, n (%)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>NA</td>
</tr>
<tr>
<td>V₅ Morphology (R ≥ s), n (%)</td>
<td>0 (0)</td>
<td>1 (8)</td>
<td>4 (100)</td>
<td>&lt;0.001‡,§</td>
</tr>
<tr>
<td>V₁ Morphology (r &lt; R'), n (%)</td>
<td>1 (9)</td>
<td>10 (83)</td>
<td>1 (25)</td>
<td>0.001†,‡</td>
</tr>
<tr>
<td>V₁ Q wave, n (%)</td>
<td>1 (9)</td>
<td>0 (0)</td>
<td>2 (50)</td>
<td>0.031‡</td>
</tr>
</tbody>
</table>

Pap = papillary; MA = mitral annular; VA = ventricular arrhythmia; PVC = premature ventricular contraction; msec = millisecond.

*All displayed p values are based on three-way comparisons; pair-wise p values are denoted as follows: †p < 0.05 for Pap VA vs. fascicular VA; ‡p < 0.05 for fascicular VA vs. MA VA; §p < 0.05 for Pap VA vs. MA VA