Cardiac resynchronisation therapy for chronic heart failure

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Chronic heart failure is common, affecting about 900,000 people in the United Kingdom and with a prevalence of about 6-10% in people aged over 65 years; despite modern drug treatment, it carries a high morbidity and a 10% annual mortality. About a third of patients with chronic heart failure have a left ventricular ejection fraction ≤35%, up to 40% of whom are at risk of worse outcomes and more severe heart failure identified by conduction delay (QRS duration on a surface electrocardiogram of >120 ms).

A recent addition to therapeutic algorithms for chronic heart failure is cardiac resynchronisation therapy (also known as biventricular pacing). Cardiac resynchronisation therapy is a well proved treatment for patients with heart failure who have left ventricular systolic dysfunction and conduction delay, and it can reduce symptoms and admission to hospital and improve quality of life and prognosis. Clear mortality benefits have moved it from a treatment for intractable symptoms to one that, alongside β blockers, angiotensin converting enzyme inhibitors, and aldosterone antagonists, is now a routine therapy for patients with current or previous severe chronic heart failure.

Identifying suitable patients is straightforward; there is no upper age limit of benefit; the implant technique is of low risk; and the treatment is highly cost effective. This article reviews the evidence and indications for cardiac resynchronisation therapy, discusses the clinical features that should alert general physicians and general practitioners to patients who may benefit from this therapy, and considers future directions for such therapy for heart failure (“device therapy”) in the UK.

What is cardiac resynchronisation therapy?

Cardiac resynchronisation therapy is a form of cardiac pacing that aims to improve the coordination of the atria and both ventricles. Pacing leads are placed into the right atrial appendage, at the right ventricular apex, which is also the anterior wall of the left ventricle, and, via a lateral tributary of the coronary sinus, into the left ventricular posterolateral wall (fig 1). Venous access is through the subclavian vein as for normal pacing, and the procedure is usually done under local anaesthetic through an infraclavicular incision. The target vein on the lateral wall is identified by retrograde balloon venography of the coronary sinus (fig 2; see videoclip 1 on bmj.com). The leads are connected to a subcutaneous generator, which can then be programmed to deliver simultaneous left ventricular and right ventricular pacing. To over-ride intrinsic conduction, the atrioventricular delay is set shorter than the intrinsic PR interval. In selected patients cardiac resynchronisation therapy can be combined with additional protection from sudden cardiac death by implantation of an automatic implantable cardioverter defibrillator.

How does cardiac resynchronisation therapy work?

Conduction system disease is common in patients with chronic heart failure and can be identified by a broad QRS complex on a surface electrocardiogram (fig 3). This is commonly accompanied by dyssynchronous, inefficient cardiac contraction, increased mitral regurgitation, and regional ischaemia, all of which contribute to further adverse remodelling and a downward spiral of cardiac function (see videoclip 2 on bmj.com). By pacing both sides of the left ventricle, thereby improving the coordination of left (and right) ventricular contraction, cardiac resynchronisation therapy...
improve cardiac output, reduce mitral regurgitation during rest and exercise, and improve regional perfusion defects (see videoclip 3 on bmj.com).

What is the evidence for cardiac resynchronisation therapy?

Early double blind randomised controlled clinical trials of cardiac resynchronisation therapy (achieved by implanting a full system but randomly allocating patients to having the left ventricular lead switched off) found that during biventricular pacing there were improvements in cardiac function, left ventricular dimensions, mitral regurgitation, and exercise capacity. The largest study (CARE-HF), published in 2005, randomised 813 patients either to optimal drug treatment or to optimal drug treatment plus cardiac resynchronisation therapy. Over the 29 month follow-up period, 30% of those receiving only the drug treatment died, compared with 20% of those also receiving biventricular pacemakers (absolute risk reduction of 10 percentage points). Biventricular pacing was associated with lower mortality resulting from both heart failure and sudden death. Every nine devices implanted (for cardiac resynchronisation) prevented one death and three admissions to hospital over the follow-up period (fig 4). Morbidity related to the implanted device was uncommon (about 10%), and there was only one death related to the device (this was caused by deteriorating heart failure owing to lead displacement). An economic analysis using a model populated by data from the CARE-HF study showed that cardiac resynchronisation therapy is cost effective, with an estimated cost per quality of life year gained of about £7000 (€7500; $10 000).

Who is suitable for cardiac resynchronisation therapy?

Before the publication of the CARE-HF study, cardiologists tried to select patients most likely to have a symptomatic response. Since the publication of data showing mortality benefits, selection has become much easier.

American and European guidelines recommend cardiac resynchronisation therapy for patients with New York Heart Association (NYHA) classes III and IV heart failure (table), an ejection fraction ≤35%, and a QRS duration of ≥120 ms. Guidelines published by the National Institute for Health and Clinical Excellence (NICE; www.nice.org.uk/TA120), differ slightly and include patients with “recent or persistent” moderate or severe (classes III and IV) heart failure despite optimal drug treatment, and a QRS duration of >150 ms. In the UK, patients with a shorter QRS duration (120-149 ms) should have confirmation of mechanical dyssynchrony by echocardiography. Current UK guidelines also

<table>
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<th>Class</th>
<th>Symptoms</th>
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<tr>
<td>I</td>
<td>No limitation: ordinary physical exercise does not cause undue fatigue, dyspnoea, or palpitations</td>
</tr>
<tr>
<td>II</td>
<td>Slight limitation of physical activity: comfortable at rest, but ordinary exercise results in fatigue, palpatations, or dyspnoea</td>
</tr>
<tr>
<td>III</td>
<td>Marked limitation of physical activity: comfortable at rest, but less than ordinary activity results in symptoms</td>
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<tr>
<td>IV</td>
<td>Unable to carry out any physical activity without discomfort; symptoms of heart failure are present even at rest, with increased discomfort with any physical activity</td>
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require the presence of sinus rhythm, but patients with atrial fibrillation probably fare no worse than those in sinus rhythm provided that intrinsic conduction can be suppressed pharmacologically or by atrioventricular node ablation. Although randomised controlled trials have focused on patients with left bundle branch block, guidelines do not distinguish between patients with right and left bundle branch block, and patients with right bundle branch block and important symptoms may be considered for biventricular pacing.

Age is unrelated to improvements in mortality and morbidity from heart failure treatments, including cardiac resynchronisation therapy (but not implantable cardioverter defibrillators), so advanced age alone should not affect a decision on whether to refer for possible cardiac resynchronisation therapy.

Electrocardiography, a simple non-invasive test that can be performed and interpreted by non-specialists and repeated easily, means that non-specialists can screen their patients with chronic heart failure for the potential to benefit from cardiac resynchronisation therapy.

**Do all patients with conduction delay benefit from cardiac resynchronisation therapy?**

Between 60% and 70% of patients with chronic heart failure who have left bundle branch block show an improvement in symptoms after biventricular pacing. The degree of improvement in any individual is unpredictable, although an improvement by one class of the NYHA classification of heart failure is common.

The consequence of a perceived “failure to respond” of 30-40% before the publication of the CARE-HF study was the development of many echocardiographic measures of mechanical dyssynchrony, which in observational studies seemed to identify patients with a greater likelihood of an improvement in symptoms and cardiac function. None of these measures has proved useful when applied in a larger multicentre trial, probably because the presence of dyssynchrony at baseline identifies patients with a better overall prognosis, because dyssynchrony is not
fixed, and because dysynchrony measures have poor inter-observer reproducibility and cannot be assessed in all subjects. The best predictor of symptomatic response remains a surface electrocardiogram showing a QRS duration of ≥120 ms.

Now that we know that biventricular pacing brings mortality benefits, cardiac resynchronisation therapy also now focuses on mortality and morbidity outcomes (and is no longer just a treatment primarily for symptoms). This shift in indication implies that in any individual it is impossible to say whether they have had no response at all to biventricular pacing, as this might manifest merely as a stabilisation or slowing of the condition (fig 5). Even “non-responders” deteriorate when the device is temporarily switched off, implying an underlying progression of the disease. Hence a failure to improve after cardiac resynchronisation therapy in an individual is not equivalent to a failure to respond. Whether patients with a short QRS duration (<120 ms) experience a mortality benefit from biventricular pacing remains unknown.

**What are the complications of cardiac resynchronisation therapy?**

Major morbidity and death as a consequence of biventricular pacing are rare. Failure to implant the left ventricular lead is <5% in large series, and lead displacement after successful implantation is about 1%. The course of the left phrenic nerve over the posterolateral wall of the heart occasionally leads to uncomfortable diaphragmatic stimulation. If this is identified during implantation the lead can be repositioned; if it occurs after implantation, the discomfort can often be limited by reprogramming. The serious though uncommon (around 1%) major complication of the procedure—infected and the attendant risks of extraction—is closely related to procedure time and hence to the experience of the cardiologist doing the procedure. Patients with a biventricular pacemaker should not drive for one week after the implantation (one month if combined with an implantable cardioverter defibrillator).

**Should every patient also receive an implantable cardioverter defibrillator?**

The use of implantable cardioverter defibrillators in patients with ischaemic heart disease and severe heart failure without a previous arrhythmic event (primary prevention) remains controversial. Subgroup analysis of large trials suggests mortality benefits from these devices only in patients with mild chronic heart failure (NYHA class I or II). The current NICE guidelines recommend that patients with symptoms “no worse than class III,” left ventricular dysfunction (left ventricular ejection fraction <30%), and conduction delay with a QRS duration of >120 ms should receive a cardioverter defibrillator (www.nice.org.uk/Guidance/TAG5). The NICE guidelines for cardiac resynchronisation therapy and for implantable cardioverter defibrillators overlap therefore only in patients with class III heart failure. Despite this, many cardiologists think that a single procedure is prudent in patients with class II symptoms as many will deteriorate over the lifetime of the device. Such patients often therefore
Biventricular pacing is considered in patients with left bundle branch block, 
right bundle branch block, 
or with prior myocardial infarction. 

Increased mortality and higher chance of lead failure are associated with 
right ventricular pacing compared to biventricular pacing. 

The findings of three primary prevention trials and a subsequent meta-analysis of use of implantable cardioverter defibrillators in patients with non-ischaemic cardiomyopathy were neutral, 
and although there was a trend towards improved outcomes in the device arm of non-ischaemic subgroups of larger trials, 
no consensus yet exists on whether these patients should receive implantable cardioverter defibrillators.


evaluated biventricular pacing in young patients in whom lead complications and inappropriate discharges are more frequent, biventricular pacing alone might be sufficient.

What about patients with existing pacemakers?

Left ventricular dysfunction and heart failure are common in patients with standard right ventricular pacemakers. 
Right ventricular pacing induces dysynchrony that is the same as seen with intrinsic left bundle branch block, 
and can induce new or worsen existing left ventricular dysfunction. 
The risk of hospital admission for heart failure is directly related to the percentage of paced beats required. 
No randomised controlled trial of upgrading right ventricular pacemakers to biventricular pacemakers has been performed, 
but the frequency and magnitude of increases in left ventricular ejection fraction and improvements in symptoms are the same in patients with previous right ventricular pacemakers as in those with intrinsic left bundle branch block.

Are the indications for cardiac resynchronisation therapy expanding?

The UK indications for cardiac resynchronisation therapy are likely to broaden in the future to include patients with a QRS duration of ≥120 ms whether or not there is echocardiographic dyssynchrony. 
Patients with less severe heart failure symptoms (NYHA classes I and II) have improvements in left ventricular function and exercise capacity of a similar magnitude to those in patients with NYHA classes III and IV symptoms, 
and the relative risk reduction from cardiac resynchronisation therapy in the CARE-HF study was larger in patients with less severe heart failure. 
Further, severity and nature of symptoms at baseline do not seem to be a good marker of prognostic benefit. The MADIT-CRT study examining “early” cardiac resynchronisation therapy in patients with mild or no symptoms of heart failure and who are also having a cardioverter defibrillator implanted has completed recruitment and will report in 2009. 
Symptoms may soon be less frequently used to identify patients suitable for biventricular pacing. 
Randomised studies with hard end points are needed in patients with a QRS duration of <120 ms.

SUMMARY POINTS

Consider cardiac resynchronisation therapy for any patient with chronic heart failure if they have, or have recently had, moderate or severe symptoms of heart failure; if their left ventricular ejection fraction is ≤35%; and if their QRS duration is ≥120 ms or 120-149 ms with dyssynchrony measured on echocardiography. 
Cardiac resynchronisation therapy can improve symptoms and prognosis.

Advanced age does not reduce the effectiveness of the therapy.

All healthcare professionals involved in the management of heart failure need to be aware of the potential benefits of cardiac resynchronisation therapy and who to refer.

Evaluation of the QRS duration and heart rhythm on the electrocardiogram should be part of the standard management of any patient with heart failure and repeated at least yearly.

receive a device capable of both defibrillation and biventricular pacing. In contrast, the decision to implant a cardioverter defibrillator in a patient with class III symptoms must be considered carefully. Although such devices reduce sudden death in these patients, there is an increased frequency of deaths from heart failure, such that overall mortality is unchanged. In addition, implantable cardioverter defibrillators are associated with a higher complication rate than cardiac resynchronisation therapy alone, including inappropriate discharges (with an associated increased mortality) and a higher chance of lead failure. Therefore, frank discussions are needed with patients with NYHA class III symptoms, those aged over 75 years, 
and those with very poor ventricular function (<10%) about how and where they might like to die.

ADDITIONAL EDUCATIONAL RESOURCES

For patients
- Arrhythmia Alliance (www.hearthrhythmcharity.org.uk/)—UK charity with patient orientated information on arrhythmias and their treatment
- Leeds Institute of Genetics, Health and Therapeutics (www.leeds.ac.uk/light/research/cdr/Clinical%20Research%20Section.html)—Information about the Leeds heart failure clinic and research currently under way
- St Jude Medical (www.sjm.com/procedures/procedure.aspx?name=Cardiac+Resynchronization+Therapy+(CRT))—Information about cardiac resynchronisation therapy
- Boston Scientific (www.bostonscientific-international.com/procedure/ProcedureLanding.bsci://navRelId/1000.1002/method/Procedure/id/10084822/seo.serve)—Cardiac pacemaker company with patient information about pacemakers and the implantation procedure

For healthcare professionals
- Cardiac resynchronisation therapy for the treatment of heart failure (www.nice.org.uk/Guidance/TA120)—Guidelines from the National Institute for Health and Clinical Excellence
- Medtronic (www.medtronic.com/physician/hf)—Website by a manufacturer of devices with images and explanations
- Cardiac Network Device Survey Group (www.devicesurvey.com/)—Website providing yearly updated survey of UK implant rates for pacemakers, implantable cardioverter defibrillators, and cardiac resynchronisation therapy.
Who should refer patients for possible cardiac resynchronisation therapy and when?

All individuals involved in the care of patients with chronic heart failure must be aware of the indications, potential benefits, and cost effectiveness of device therapy. A systematic approach to the long term follow-up of patients with chronic heart failure both in the community and by general physicians is required to identify patients needing treatment in a timely fashion. Mortality after hospital admission with heart failure is particularly high. Patients with a recent or persistent episode of moderate or severe heart failure should have 12 lead electrocardiography at follow-up and those with a QRS duration of ≥120 ms (three or more small squares on a standard recording at 25 mm/s) should be referred for consideration of cardiac resynchronisation therapy. Patients with chronic heart failure who are not initially considered suitable for biventricular pacing should be reassessed with electrocardiography after each exacerbation, or yearly if stable, as conduction delay develops as chronic heart failure progresses.

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Patient consent obtained.

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