Determinants of LV $\frac{dP}{dt_{\text{max}}}$ and QRS duration with different fusion strategies in cardiac resynchronisation therapy

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INTRODUCTION

Cardiac resynchronisation therapy (CRT) is very useful in selected patients; however, responder rates rarely exceed 70%. CRT causes improved electrical synchrony (shortened QRS duration (QRSd)) and mechanical function (higher left ventricular (LV) $\frac{dP}{dt_{\text{max}}}$) once inserted. Research groups have therefore used LV $\frac{dP}{dt_{\text{max}}}$ and QRSd to guide different approaches to improve CRT, including fusion of intrinsic conduction with paced wavefronts and LV pre-excitation. The objective of this study was to analyse how fusion determines LV $\frac{dP}{dt_{\text{max}}}$ and QRSd to understand better how these measurements reflect resynchronisation and should be interpreted if they were to be used for acute haemodynamic...
assessments or for the prediction of long-term response from CRT. We applied biventricular stimulation with different fusion strategies, including fusion with intrinsic right ventricle (RV) activation, different degrees of fusion within the LV by LV pre-excitation/post-excitation and fusion from the LV activation site with single-point and multipoint pacing (MPP) in order to analyse the effect of different fusion strategies on LV dP/dtmax and QRSd.

MATERIAL AND METHODS
Ethics statement
This study was an acute single-centre observational, experimental haemodynamic study approved by the Regional Committees for Medical and Health Research Ethics in Norway and conducted following the Declaration of Helsinki principles. We obtained written, informed consent from all patients.

Study population
Patients with heart failure admitted for CRT implantation according to current European Society of Cardiology/American Heart Association guidelines were asked to participate in the study. Inclusion criteria were sinus rhythm, New York Heart Association (NYHA) functional class II and III heart failure on optimal medical therapy, QRSd larger than 130 ms and a left ventricular ejection fraction of less than 35%. Exclusion criteria were age less than 18 years and above 80 years, ongoing atrial fibrillation and complete atrioventricular block. We successfully positioned the quadripolar LV lead in what we determined was the optimal lateral branch of the coronary sinus in each patient. LV pacing (LVP) was set up in an extended bipolar configuration with the cathode on the LV electrode and the anode on the RV defibrillation coil. Therefore, MPP was limited to simultaneous pacing from the distal LV electrode to RV coil and proximal LV electrode to RV coil, a configuration that is superior to other MPP configurations.

Pacing interventions: groups, electrode configurations and pre-excitation/post-excitation classes
The atrial pacing (AP) rate was set 10% higher than baseline sinus rhythm, and AP-QRS interval was measured. We paced the RV at baseline in DDD-mode with AV delay at 80% of the measured AP-QRS interval. We used the AP-QRS interval to calculate the AP-left ventricular paced interval in the fusion with intrinsic RV activation group (FUSION) to pace the LV relative to QRS-onset (figure 1). The FUSION group was the only one to allow intrinsic RV activation. In the NO FUSION with intrinsic RV activation group, the AV-delay to RV pace (RVP) was set to 80% of the AP-QRS interval to avoid intrinsic RV activation (figure 1). We applied LVP from three different electrode configurations within each intervention group (FUSION/NO FUSION). LVP was paced first from the distal electrode (DIST), then from the proximal electrode (PROX), and finally combined DIST+PROX (MPP). Figure 1 shows representative electrograms from one patient and illustrations of the two main groups (FUSION/NO FUSION) with the different electrode configurations (DIST, PROX, MPP) and illustrated ideal...
electrical wavefronts from intrinsic activation and pacing electrodes in models of the heart. In the biventricular pacing mode, LVP was then performed relative to either calculated AP-QRS-onset (FUSION) or relative to the RVP (NO-FUSION) to achieve LV pre-excitation/post-excitation. The off-set between LV and RV activation was set by pacing the LV with a different extent of LV pre-excitation/post-excitation in four pre-excitation/post-excitation classes (PCs):

- PC1. LVP earlier than 50 ms before QRS (FUSION) or RV pace onset (NO FUSION).
- PC2. LVP within 50 ms before QRS (FUSION) or RV pace onset (NO FUSION).
- PC3. LVP within 50 ms after QRS (FUSION) or RV pace onset (NO FUSION).
- PC4. LVP later than 50 ms after QRS (FUSION) or RV pace onset (NO FUSION).

With this, we have two main groups (FUSION/NO FUSION) with three different electrode configurations (DIST, PROX, MPP), each paced repeatedly with four different degrees of LV pre-excitation/post-excitation (PC1–4) within each main group in each patient. Therefore, AV-delay was obligate different between the groups, with AV-delay being shorter in the NO FUSION group to avoid intrinsic RV activation compared with the FUSION group. The AV-delay shortened even more when we paced the LV before RV or QRS-onset, as in PC1 and PC2. Therefore, we measured actual AV-delay within each beat, to be included in the analyses, as the interval from AP to the first ventricular activation; LVP, RVP or QRS-onset. Figure 1 shows that the initial portion of the QRS complex is unchanged in the FUSION group before pacing onset. In the NO FUSION group, there is an immediate change in QRS compared with intrinsic QRS morphology. We confirmed a stable AV-delay visually when pacing with FUSION with intrinsic RV activation and post-excitation of LV (PC3, PC4) with every electrode configuration (figure 1) to confirm intrinsic QRS-onset before LVP and an unchanged intrinsic AV-delay. All biventricular pacing interventions were performed similarly in every patient, alternating FUSION and NO FUSION with each electrode configuration and PC. QRS morphology was visually inspected, compared with successive paced beats and fully paced beats to confirm stable fusion and LV pre-excitation/post-excitation during interventions. We averaged all measurements from 8 to 10 consecutive beats during each pacing intervention.

Data collection, pacing set-up and measurements
We collected electrophysiology signals and ECGs with the BARD Pro EP recording system, with Clearsign Amplifier (Boston Scientific). Pressures were measured via femoral artery access from the left ventricle with the Millar Micro-Cath pressure sensor catheter (Millar, USA) and collected with the PCU-2000 Pressure Control Unit (Millar, USA). We allowed pressures to stabilise with pacing before measuring the resulting LV dp/dtmax. Signals were collected in real-time from the recording system to a data acquisition unit (PowerLab, ADInstruments, UK) for analyses in the LabChart Pro V.8.0 software. We performed pacing with the EPS 320 cardiac stimulator (Micropace EP, USA). We determined QRS-onset as the first fluctuation above the isoelectric line that resulted in a complete QRS complex and QRsd from onset Q to global end of S wave from all ECG leads.

Statistical analysis
We used linear mixed models (SPSS V.26.0) that include fixed and random effects for the repeated measurements and used the Hotelling Lawley test and the GLIMMPSE sample size calculator (Glimmpse V.3.0.0 (samplesizeshop.org)) to confirm power >80% for a type I error of 5%. We chose compound symmetry as covariance type for both fixed and random effects, with each subject selected as random effects, with Bonferroni correction for comparison of main effects. The model with covariates that provided the lowest Akaike’s information criteria was selected. The statistical output provides the estimated marginal means±SEM for each fixed-effects group, considering random effects and covariates. It allowed us to analyse the effects of and the interactions between the modes of pacing (NO FUSION and FUSION), electrodes used (DIST, PROX, MPP) and pre-excitation (PC1–4). We used general linear models to compare groups with no repeated measures. Numbers from descriptive statistics are means±SD. A p value of less than 0.05 was considered statistically significant.

RESULTS
Baseline patient characteristics
We included 19 patients in sinus rhythm and a standard indication for a CRT device in the study. Mean age 64±10 years, 32% females, 42% ischaemic, 84% Left bundle-branch block (LBBB), 16% Intra-ventricular conduction disease (IVCD), QRsd 170±12 based on 12-lead ECG, Ejection Fraction (EF) 29%±4%, NYHA class 2.4±0.5 (mean±SD). Q-LV distal was 127±19 ms, and Q-LV proximal was 133±20 ms (mean±SD), with a linear relationship between the two (β=0.82, R=0.86, p<0.01). Paced rate, QRsd, AV-delay and LV dp/dtmax with AP, NO FUSION and FUSION are presented in table 1. Online supplement figure 1 shows the electric intervals between the RV and LV electrodes and the interval from onset of QRS complex to LV electrodes (QLV).

The effects of stimulation on LV dp/dtmax
We analysed the overall effect of LV pacing with biventricular stimulation (NO FUSION) on LV dp/dtmax and compared this to LV pacing with fusion with intrinsic RV activation (FUSION). We found that LV dp/dtmax was higher with NO FUSION (709±46 mm Hg/s) than with FUSION (746±46 mm Hg/s, p<0.01). The increase in the two groups from baseline represents a 10% and 7% increase, respectively. We then evaluated the effect of electrode configuration at PC3, including both NO FUSION and FUSION, and found that LV dp/dtmax was
lower with the proximal electrode than with the distal electrode, which again was lower than MPP (753±48 mm Hg/s vs 758±48 mm Hg/s vs 770±48 mm Hg/s, *p < 0.01). We included the delay between LV stimulation and RV stimulation/activation (VV-delay in ms) as a continuous variable in the model and found a significant effect of VV-delay on LV dP/dt max (estimate −0.34 ms/(mm Hg/s), *p < 0.01). Therefore, we expected pre-excitation classes (PC) to have different effects on LV dP/dt max. Figure 2A,B shows the average timing of pre-excitation/post-excitation in each PC. Overall, regardless of fusion with intrinsic RV activation or not, LV pre-excitation of less than 0 ms (PC1 and PC2) was associated with a higher LV dP/dt max (779±46 mm Hg/s).

### Table 1  Baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>Paced rate</th>
<th>QRS duration</th>
<th>AV-delay</th>
<th>LV dP/dt max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial paced (both groups)</td>
<td>76±12/min (n=180)</td>
<td>171±10 ms* (n=184)</td>
<td>223±22 ms* (n=184)</td>
<td>657±159 mm Hg/s* (n=180)</td>
</tr>
<tr>
<td>NO FUSION</td>
<td>77±12/min (n=2906)</td>
<td>155±14 ms (n=2931)</td>
<td>168±36 ms* (n=2912)</td>
<td>776±205 mm Hg/s* (n=2906)</td>
</tr>
<tr>
<td>FUSION</td>
<td>76±12/min (n=2932)</td>
<td>157±19 ms (n=2988)</td>
<td>195±35 ms (n=2962)</td>
<td>754±204 mm Hg/s (n=2932)</td>
</tr>
</tbody>
</table>

The table includes the pooled data with all pacing modes and VV-delays. Values are mean±SD. Significance are based on linear mixed models with estimated marginal means not presented in the table. Abbreviations: AV-delay: atrioventricular-delay, VV-delay: Interventricular delay.

*P<0.01 compared with the other groups.

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**Figure 2**  Left ventricular pacing relative to QRS onset or right ventricle (RV) pace onset, pre-excitation/post-excitation classes (PC1–4). (A) FUSION group. The panel displays biventricular activation with LV pacing and fusion with intrinsic RV conduction. In the illustrated example, LV pacing pre-excites the LV before intrinsic QRS onset (pre-excitation/post-excitation class 2, PC2). Fusion with native conduction is evident by the change in QRS morphology from that of intrinsic activation (stippled blue line) and with the sensed RV EGM in the RV channel (red) appearing after LV pace and early in the QRS complex. (B) NO FUSION group. The panel displays biventricular activation of the LV with postexcitation of the LV, with RV pace before LV pace. Biventricular pacing is evident by the change in QRS morphology after LV pace compared with the QRS morphology resulting from RV pace only (stippled blue line). Pre-excitation/post-excitation classes (PC): The boxes indicate the timing of LV pacing within each pre-excitation/post-excitation class with the average time differences between LVP and intrinsic QRS onset or RV pace onset.
versus post-excitation (757±46 mm Hg/s). PC2 was found to provide higher LV dP/dt max than PC3 (779±46 mm Hg/s vs 759±46 mm Hg/s, p<0.01). Pre-excitation (PC1 and PC2) was associated with higher LV dP/dt max than with no pre-excitation (PC3 and PC4) within both groups (NO FUSION and FUSION, table 2). Finally, we tested the interaction of NO FUSION and FUSION with all electrode configurations and PC. Figure 3 shows LV dP/dt max at all different electrode configurations and PCs with FUSION/NO FUSION compared with AP. Online supplemental figure 2 shows the relationship between LV dP/dt max and LV dP/dt max.*

### The effects of stimulation on QRSd

We found no difference in QRSd between NO FUSION and FUSION (156±2 ms vs 155±2 ms). However, QRSd significantly shortened from baseline with both FUSION and NO FUSION (table 1). We noted a weak significant association between LV dP/dt max and QRSd (β=−2140 mm Hg/s², R²=0.03, p<0.01), however, with substantial differences between patients (figure 4). In the linear mixed models, the β-coefficient of the association between LV dP/dt max and QRSd was −360 mm Hg/s², p<0.01. The linear mixed model takes the individual intercept into account, explaining the lower β-coefficient compared with the linear regression model. We normalised the average changes across all pacing modes and electrode configurations and plotted them against the fusion classes. It then becomes evident that LV dP/dt max peaks with pre-excitation, while QRSd reaches its nadir close to the onset of QRS or RV-pace (figure 5). Finally, we tested the interaction between FUSION/NO FUSION, electrode configurations and PCs on QRSd (figure 3). Online supplemental figure 3 displays a scatterplot of the relationship between QRSd and LV dP/dt max and how QRSd was measured.

### The impact of AV-delay on LV dP/dt max and QRS duration

Table 1 presents the measured AV-delays in different groups. Stimulation of the LV before or after the QRS onset in the FUSION group resulted in a significant correlation between the degree of LV pre-excitation/post-excitation (ms) and AV-delay (ms) (R=0.73, p<0.01). The association between the degree of LV pre-excitation (ms) and AV-delay (ms) in the NO FUSION group was weak (R=0.29, p<0.01). The association between AV-delay and degree of pre-excitation/post-excitation could potentially affect the results, as AV-delay have a known impact on dP/dt max. We, therefore, studied the relationship between AV-delay and dP/dt max in the patients. We included all the data from the study in the regression analyses and found a quadratic relationship between AV-delay and dP/dt max (figure 6). Figure 6 shows how LV dP/dt max trends towards lower values at ultrashort and long AV-delays; however, even at ‘optimal’ AV-delays, 150–180 ms, a broad span in LV dP/dt max of almost 1000 mm Hg/s is observed between the patients. We also examined the relationship between AV-delay and LV dP/dt max in the mixed models with MPP (FUSION and NO FUSION) and PC3 only to avoid confounding effects.
of pre-excitation/post-excitation and to test the within-subjects changes. We found no impact of AV-delay on LV dP/dt\textsubscript{max} (p=0.09). We included AV-delay as a covariate in the mixed models reported in this study and observed no additional AV-delay effects that would change the results. We also measured the delay from AP to LV pace and compared it to LV dP/dt\textsubscript{max} and found no significant relationship (online supplemental figure 4).

**DISCUSSION**

Besides that from resynchronisation, fusion strategies may have an independent impact on LV dP/dt\textsubscript{max} and QRSd. As an example, we know that LV dP/dt\textsubscript{max} increases to a similar extent, with full LV pre-excitation and biventricular stimulation (resynchronisation). The reason must be independent of resynchronisation. LV-only pacing without fusion with intrinsic conduction introduces more dyssynchrony compared with biventricular pacing.\(^{16,17}\) Therefore, since LV dP/dt\textsubscript{max} is equally high with LV-only and biventricular pacing, the measurement lacks the ability to confirm resynchronisation as a diagnostic biomarker.\(^{18}\) When measured as an increase from baseline, LV dP/dt\textsubscript{max} may not increase to the most considerable extent in positions were QRSd shorten the most.\(^{8}\) The fact that LV dP/dt\textsubscript{max} does not necessarily reflect better resynchronisation may also explain why MPP that increase LV dP/dt\textsubscript{max} and shorten QRSd acutely failed to show a clinical benefit compared with conventional BIVP in the MOre REsponse to Cardiac Resynchronization Therapy with Multi-Point Pacing (MORE-CRT).
study. The predictive value of an increase in LV \( \frac{dp}{dt_{max}} \) from baseline for determining the response to CRT is weak. It seems that fusion and LV pre-excitation, inevitably linked to CRT, contribute independently to a rise in LV \( \frac{dp}{dt_{max}} \) and a change in QRSd. It is essential to understand the measurements’ respective value as biomarkers if one would use them for acute prediction of long-term response during CRT implantation.

This study was designed to provide knowledge on how different fusion strategies and LV pre-excitation/post-excitation determine QRSd and LV \( \frac{dp}{dt_{max}} \) to provide information on the two’s potential utility as biomarkers for the prediction of long-term response to CRT. We show that the two parameters have different determinants, and with LV \( \frac{dp}{dt_{max}} \), LV pre-excitation is likely to provide a better response, while simultaneous pacing with multiple activation wavefronts are likely to decrease QRSd the most. The latter is in keeping with better electrical resynchronisation.

Patient characteristics and Q-LV measured from the LV electrodes seen in this study are typical for patients with LBBB, and as expected, LV \( \frac{dp}{dt_{max}} \) increased with biventricular stimulation compared with AP or RV pace and QRSd shortened. A significant correlation between VV-delay and LV \( \frac{dp}{dt_{max}} \) revealed itself when we changed VV-delay (pre-excitation/post-excitation) within each patient during biventricular stimulation. LV pre-excitation was associated with higher LV \( \frac{dp}{dt_{max}} \). Although LV \( \frac{dp}{dt_{max}} \) increased the most with LV pre-excitation, we found that QRSd shortened the most when pacing the LV close to the onset of QRS or RV-pace. Simultaneous activation of LV and RV is likely to cause a narrower QRS complex. Overall, FUSION, MPP and pacing close to QRS and RV-pace onset (PC3) provided the shortest QRSd, similar to what has been documented by others. Hence, LV \( \frac{dp}{dt_{max}} \) and QRSd show different response patterns to LV pre-excitation/post-excitation (figure 5). Univentricular LV stimulation without intrinsic activation of the RV can increase LV \( \frac{dp}{dt_{max}} \) to values above what is seen with standard biventricular pacing. The reason for this is still unclear, but contractility itself is not likely to be affected by LV-only stimulation. The increase in LV \( \frac{dp}{dt_{max}} \) with LV pre-excitation may relate to stimulation of a larger ventricular mass in the LV electrode region. The distal electrode resulted in higher LV \( \frac{dp}{dt_{max}} \) than the proximal electrode. The distal electrode is also likely to capture more myocardium before reaching the mitral valve annulus’s boundaries compared with the proximal electrode, and MPP may capture even more. The amount of myocardium captured over time may partly explain a higher LV \( \frac{dp}{dt_{max}} \) when pacing with different electrode configurations (see illustrations in figure 1).

To achieve LV pre-excitation/post-excitation, we needed to pace with different AV-delays. We know that the AV-delay influences LV \( \frac{dp}{dt_{max}} \), under otherwise similar haemodynamic conditions; however, in this study, the effect of LV pre-excitation on LV \( \frac{dp}{dt_{max}} \) was stronger than that resulting from a change in AV-delay. AV-delay was shorter in the NO FUSION group; however, LV \( \frac{dp}{dt_{max}} \) was higher with LV pre-excitation in both groups, also when corrected for AV-delay. We changed AV-delay along a wide range of intervals; however, the association between LV \( \frac{dp}{dt_{max}} \) and LV pre-excitation was unaffected by AV-delay. The significance of LV pre-excitation in LBBB patients as a determinant of LV \( \frac{dp}{dt_{max}} \) was therefore confirmed, in keeping with recent clinical, animal and computational experiments. We also showed that LV \( \frac{dp}{dt_{max}} \) increased, resulting from even subtle LV pre-excitation (PC2). LV pre-excitation can also be achieved by pacing LV at multiple sites. Pacing the LV with pre-excitation in time (PC1–2) and in space (MPP), or both, increased LV \( \frac{dp}{dt_{max}} \) (figure 3). In our study, we found that LV \( \frac{dp}{dt_{max}} \) was higher in the NO FUSION group compared with the FUSION group in contrast with what has been found in similar studies. The different degrees of LV pre-excitation between the groups were different in our study compared with the intervals investigated by van Gelder et al, and may explain the differences found. Besides, beneficial haemodynamics to determine the optimal response, other than LV \( \frac{dp}{dt_{max}} \), resulting from intrinsic activation of the RV may not be recognised using LV \( \frac{dp}{dt_{max}} \). LV pacing only has not proven beneficial compared with biventricular stimulation on long term. A recent multicenter controlled trial prospective controlled trial showed an increase by 13% in beneficial remodelling (ie, ESV reduction) after 6months’ follow-up when using LV \( \frac{dp}{dt_{max}} \) for LV lead optimisation compared with a standard approach in CRT, but still with a 27% non-responder rate. Subanalyses of the Radi-CRT study also showed no differences in long-term response among patients with non-ischaemic aetiology, indicating that the effect from selecting electrodeposition based on a higher LV \( \frac{dp}{dt_{max}} \) would mainly benefit patients with an ischaemic aetiology. Twenty-eight per cent of patients without a <10% increase in LV \( \frac{dp}{dt_{max}} \) experienced long-term reverse remodelling, while 16% with a >10% increase in LV \( \frac{dp}{dt_{max}} \) did not experience long-term reverse remodelling. Therefore, it is quite clear that an increase in LV \( \frac{dp}{dt_{max}} \) from one pacing site to another carries information that leads to an increased response rate, but an increase in LV \( \frac{dp}{dt_{max}} \) from baseline does not necessarily reflect better resynchronisation to predict long-term outcomes. Interpretation of a higher LV \( \frac{dp}{dt_{max}} \) as being haemodynamically superior, reflecting better resynchronisation, with one approach compared with a different approach, may not be warranted.

Fusion-optimised intervals leading to shorter QRSd, shortening of QRSd and a reduction in QRS area are associated with improved remodelling and mortality. QRSd incorporates essential elements (eg, left ventricular
activation time) of dyssynchrony. Our study MPP provided shorter QRSd than pacing from single electrodes, suggesting that shortening of QRSd in our study also reflects the shortening of the left ventricular activation time. If shortening of QRSd were to be the sole target for a response; however, our data suggest that this will come at the cost of not optimising LV dP/dt\textsubscript{max} and vice versa. Concurrently, QRSd may not shorten to the most considerable extent with CRT when pacing LV from sites that reflect the maximal mechanical response. Even if shortening of the QRSd with pacing is the desired response, it is still not a perfect measure for long-term prediction. Figure 3 shows that with the shortest QRSd, LV dP/dt\textsubscript{max} increased, on average, only by 7%. Our study shows how LV dP/dt\textsubscript{max} may paradoxically increase in situations where QRSd gets longer.

Clinical implications

This study points out that mechanical function assessment, with LV dP/dt\textsubscript{max} and electrical activation, with QRSd, may provide conflicting results. We expect that electrical activation and mechanical action is positively concordant with successful resynchronisation. Our study shows that pre-excitation of the LV is associated with a higher dP/dt\textsubscript{max} and longer QRSd than less pre-excitation. LV pre-excitation rather than the effect from resynchronisation may determine an increase in LV dP/dt\textsubscript{max} from baseline. Therefore, a higher percentage increase in LV dP/dt\textsubscript{max} from baseline values should not be interpreted as a better result when assessing the effect of resynchronisation.

Limitations

The lack of direct insight into LV activation time intervals and exact electrical propagation in the tissue are limitations in this study. LV activation time, propagation and activated area over time would be better measures of the effect of fusion and resynchronisation than QRSd. MPP may promote better resynchronisation in the presence of a scar. Therefore, the presence of scar could potentially explain improvements in LV dP/dt\textsubscript{max} with MPP and LV pre-excitation but would not concurrently explain the associated prolongation of QRSd. We did not clearly identify the presence of scar in our patients, despite that 43% of the patients had ischaemic heart disease. The knowledge of myocardial scar location and different study design could have brought insight into the effect of a scar on both LV dP/dt\textsubscript{max} and QRSd. Multisite pacing with a larger electrode separation could have provided an even more apparent LV pre-excitation effect. Placement of the RV and LV electrodes in close proximity could have affected the degree of fusion and pre-excitation resulting from LV activation. Of the patients in this study, 16% were classified as not having true LBBB, and fusion with intrinsic conduction in such patients may be different from fusion with LBBB. We did, however, document a long Q-LV in all patients (online supplemental figure 1). The RV paced to LV sensed interval is presented in relation to QRSd in the supplement. Stimulation from within a scar resulting in delayed myocardial activation may have affected the degree of pre-excitation and lead to misclassification of LV pre-excitation. We did not, however, find a bias in the paced to sense RV-LV and LV-RV intervals (online supplemental figure 1).

CONCLUSION

Biventricular pacing increases LV dP/dt\textsubscript{max} and shortens QRSd depending on different degrees of fusion of electrical wavefronts in the heart. LV pre-excitation determines an increase in LV dP/dt\textsubscript{max} and a longer QRSd, while MPP and LV pacing timed with RV activation shorten QRSd with lower resulting LV dP/dt\textsubscript{max}. In this study, LV dP/dt\textsubscript{max} is therefore determined mainly by LV pre-excitation, while QRSd is determined by optimal resynchronisation.

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Supplemental material:

Figures captions:

**Supplemental Figure 1. Electrical intervals related to the left ventricular distal and proximal electrodes.**

Not all patients included in this study were considered to have true left bundle branch block when evaluated retrospectively (16%). In patients without LBBB there is a potential for conduction through the left bundle branch with early activation of the left lateral wall. In this study we found the Q-LV interval to distal (1) and proximal (4) LV electrodes to be in keeping with what is seen in LBBB patients (left hand panel). Positioning of the leads were also confirmed to be remote from the RV pacing site with similarity between distal and proximal electrodes as seen in the middle and right hand panel, with a sequence of distal to proximal activation as expected and seen in all panels.

**Supplemental Figure 2. Relationship between maximum and minimum left ventricular pressure first order derivative.**

An interesting phenomenon with regards to the filling phase of the left ventricle is the overall strong relationship between maximum and minimum LV pressure derivative. The relationship is strong and present both on a group level (left hand panel) and on an individual level (right hand panel). The relationship shows that a higher dP/dt is associated with improved relaxation. This is interesting also because relaxation in the left heart chamber is dispersed so that delayed activated segments may also have delayed onset of relaxation as such hamper the early passive filling of the heart. Preexcitation of the left lateral wall may provide an earlier onset of relaxation as the LV is given more time to relax compared to the later activated segments, and together with a lower dP/dt provide improved filling characteristics. This warrants further investigations that should include other relaxation parameters derived from pressure measurements.

**Supplemental Figure 3. Manual measurements of QRS duration using multiple ECG channels and EGM from both right and left electrodes.**

LV dP/dt\(_{\text{max}}\) was measured automatically from each and subsequent beats, hence multiple measures of LV dP/dt\(_{\text{max}}\) at each level of QRS duration (left hand panel, individual patients marked up with colors). QRS duration was measured manually (right hand panel) from summed up QRS complexes confirmed to
be identical by morphology inspection at each change in pacing (either from FUSION, Preexcitation Class or electrode configuration).

Supplemental Figure 4. Atrium to left ventricular paced interval in relationship with LV dP/dt\(_{\text{max}}\).

The interval between RV pace and LV pace can be modified within a CRT device to promote pacing at one site earlier than the other adjusting a VV-delay. In our study the VV-delay was captured within the Preexcitation Classes (PC). When modifying the VV-delay one is also modifying the AV-delay to the respective ventricles, so that with a delayed ventricular stimulation, this ventricle will also experience a delayed AV timing compared to the counterpart. We measured the AV-delay to the earliest ventricular activation in this study and may therefore have missed a relationship between Atrium - LV activation and LV dP/dt\(_{\text{max}}\). We have therefore, in this supplement, analyzed the delay from atrial pace to left ventricular pace and compared this in a scatterplot to LV dP/dt\(_{\text{max}}\). No significant relationship was found.
Grouped Scatter of QLV1 by QLV2 by Patient

Grouped Scatter of RVpLV1s by RVpLV4s by Patient

Grouped Scatter of LV1pRVs by LV4pRVs by Patient
Grouped Scatter of QRSw by Max dP/dt (mmHg/s) by Patient

Example of summed ECG from multiple channels, 11 beats overlaid to confirm stability before manual measurement of QRS duration.
Scatterplot showing the relationship between mean maximum LV pressure derivative and the atrial to LV paced interval with all different modes of biventricular pacing pooled (FUSION and NO FUSION)