Coronary Stent Immobilization During Angioplasty by Transcoronary Ventricular Pacing Via a Guidewire

Garikoitz Lasa, a Mariano Larman, a Koldo Gaviria, a Juan Carlos Sanmartín, a Mario Sádaba, b and José Ramón Rumoroso b

a Servicio de Hemodinámica y Cardiología Intervencionista, Policlinica Gipuzkoa, San Sebastián, Guipúzcoa, Spain
b Servicio de Hemodinámica, Hospital de Galdakao, Galdakao, Vizcaya, Spain

ORIGINAL ARTICLES

Introduction and objectives. In some patients, cardiac contractions cause the coronary artery segment adjacent to a stent to move in such a way that accurate stent positioning is difficult. A number of techniques have been described for immobilizing the stent at the target site by inducing periods of either asystole or tachycardia. This study shows how pulsatile motion can be controlled by means of rapid ventricular pacing via an angioplasty guidewire.

Methods. The study involved 27 consecutive patients in whom excessive stent movement during angioplasty complicated accurate stent implantation. In these selected patients, myocardial tachycardia was induced by transcoronary ventricular pacing via an angioplasty guidewire with the aim of reducing the pulsatile motion of the stent.

Results. At baseline, the median displacement was 4.08 mm (interquartile range, 2.75 mm). During pacing at 100 and 150 beats per minute, the median displacement was 1.39 mm and 0.54 mm, respectively (interquartile range, 1.66 mm and 0.54 mm, respectively). Trans coronary myocardial pacing was effective in 96% of cases. No complications associated with pacing were reported.

Conclusions. Transcoronary ventricular pacing via an angioplasty guidewire was an effective and safe method for achieving stent immobilization in cases where there was excessive pulsatile motion.


INTRODUCTION

Coronary stent angioplasty is the treatment of choice for coronary artery disease in a large proportion of cases. However, stent placement is not free of difficulties or complications and correct implantation can be hindered by the stent’s
Tachycardia was induced in all cases and angiographic controls obtained while pacing at 100 and 150 beats/min. The stent was then relocated in the desired position (Figure 1) using the same principles applied when permanent pacemakers are functioning in monopolar mode. The guidewire therefore acts as a negative electrode or cathode (the role performed by the distal end of the pacemaker electrode) and the skin acts as the positive electrode or anode (the role performed by the pacemaker casing). The battery of the temporary external pacemaker is connected to the clips, which act as extension leads. The battery has 2 wires or poles (anode and cathode, positive and negative, or red and black, respectively), and the clip acting as the cathode is connected to the guidewire. The clip acting as the anode is connected to the Abbocath needle which is inserted under the skin. Our usual practice is to traverse the subcutaneous tissue with the Abbocath for 1 cm in the previously anesthetized area close to the introducer (Figure 2). Pacing begins at a slightly higher frequency than patient’s baseline (5 V). When there is no evidence of failure to capture in a 10-15 s interval, the frequency is increased to 100 and 150 beats/min and a control angiography is performed at both frequencies. The frequency giving the best response is selected. When failure to capture is observed at 5 V, the voltage is increased to 10 V and the same procedures are followed.

We performed a descriptive analysis of the study variables. Qualitative variables were described in terms of frequency distributions. Quantitative variables showing a normal distribution were described using means (standard deviations [SD]) and those with a non-normal distribution were described using medians [interquartile range] or the 25-75 percentile. The Kolmogorov-Smirnov test was used to test the normality of the distributions. Mean observed deviations were compared using Student
Lesions were ostial in 14% of cases (in any of the coronary vessels) and bifurcation lesions were present in 74% of cases. The mean vessel diameter was 3.01 (0.82) mm and mean lesion length was 13.24 (5.97) mm. The presence of calcium was noted in 22% of cases, angulation in 37%, tortuosity in 29%, and thrombus in 18%. Balloon predilatation was performed in 59% of patients. The median minimal luminal diameter prior to stent implantation was 1.22 [0.62] mm. Drug-eluting stents were implanted in 48% of cases (Table 1). Median displacement was 4.08 [2.75] mm at baseline, 1.39 [1.66] mm during stimulation at 100 beats/min, and 0.54 [0.54] mm during stimulation at 150 beats/min. Differences were statistically significant at P<.001 (Table 2). In 62% of cases, 10 V pacing was used due to failure to capture at 5 V. Assuming an acceptable outcome as one in which displacement is <1 mm, stimulation at 100 beats/min achieved success in 37% of cases, whereas stimulation at 150 beats/min achieved success in 96% of cases. Implantation was considered successful in all cases. The only case in which stimulation at 150 beats/min did not achieve a successful result in 18%, and the distal segment in 3%. Lesions were ostial in 14% of cases (in any of the coronary vessels) and bifurcation lesions were present in 74% of cases. The mean vessel diameter was 3.01 (0.82) mm and mean lesion length was 13.24 (5.97) mm. The presence of calcium was noted in 22% of cases, angulation in 37%, tortuosity in 29%, and thrombus in 18%. Balloon predilatation was performed in 59% of patients. The median minimal luminal diameter prior to stent implantation was 1.22 [0.62] mm. Drug-eluting stents were implanted in 48% of cases (Table 1). Median displacement was 4.08 [2.75] mm at baseline, 1.39 [1.66] mm during stimulation at 100 beats/min, and 0.54 [0.54] mm during stimulation at 150 beats/min. Differences were statistically significant at P<.001 (Table 2). In 62% of cases, 10 V pacing was used due to failure to capture at 5 V. Assuming an acceptable outcome as one in which displacement is <1 mm, stimulation at 100 beats/min achieved success in 37% of cases, whereas stimulation at 150 beats/min achieved success in 96% of cases. Implantation was considered successful in all cases. The only case in which stimulation at 150 beats/min did not achieve a successful result in 18%, and the distal segment in 3%. Lesions were ostial in 14% of cases (in any of the coronary vessels) and bifurcation lesions were present in 74% of cases. The mean vessel diameter was 3.01 (0.82) mm and mean lesion length was 13.24 (5.97) mm. The presence of calcium was noted in 22% of cases, angulation in 37%, tortuosity in 29%, and thrombus in 18%. Balloon predilatation was performed in 59% of patients. The median minimal luminal diameter prior to stent implantation was 1.22 [0.62] mm. Drug-eluting stents were implanted in 48% of cases (Table 1). Median displacement was 4.08 [2.75] mm at baseline, 1.39 [1.66] mm during stimulation at 100 beats/min, and 0.54 [0.54] mm during stimulation at 150 beats/min. Differences were statistically significant at P<.001 (Table 2). In 62% of cases, 10 V pacing was used due to failure to capture at 5 V. Assuming an acceptable outcome as one in which displacement is <1 mm, stimulation at 100 beats/min achieved success in 37% of cases, whereas stimulation at 150 beats/min achieved success in 96% of cases. Implantation was considered successful in all cases. The only case in which stimulation at 150 beats/min did not achieve a successful result in 18%, and the distal segment in 3%. Lesions were ostial in 14% of cases (in any of the coronary vessels) and bifurcation lesions were present in 74% of cases. The mean vessel diameter was 3.01 (0.82) mm and mean lesion length was 13.24 (5.97) mm. The presence of calcium was noted in 22% of cases, angulation in 37%, tortuosity in 29%, and thrombus in 18%. Balloon predilatation was performed in 59% of patients. The median minimal luminal diameter prior to stent implantation was 1.22 [0.62] mm. Drug-eluting stents were implanted in 48% of cases (Table 1). Median displacement was 4.08 [2.75] mm at baseline, 1.39 [1.66] mm during stimulation at 100 beats/min, and 0.54 [0.54] mm during stimulation at 150 beats/min. Differences were statistically significant at P<.001 (Table 2). In 62% of cases, 10 V pacing was used due to failure to capture at 5 V. Assuming an acceptable outcome as one in which displacement is <1 mm, stimulation at 100 beats/min achieved success in 37% of cases, whereas stimulation at 150 beats/min achieved success in 96% of cases. Implantation was considered successful in all cases. The only case in which stimulation at 150 beats/min did not achieve a successful result
placement of a second, parallel guidewire,5 or the administration, balloon inflation at the main branch, ventricle,3,4 induction of asystole through adenosine via transvenous catheter stimulation of the right stabilizes the stent. The best known are rapid pacing to increase the rate of complications resulting from situations can lead to a suboptimal outcome and use of voltages >10 V. Stimulation was equally effective using either hydrophilic or non-hydrophilic guidewires (Wisp and BMW respectively, Abbott Laboratories, Illinois, USA). Symptomatic electrical stimulation of the diaphragm occurred in 11% of cases and electrical sensation at the puncture site in 7% of cases.

**DISCUSSION**

Intracoronary stent displacement can lead to anomalies in the implantation of the device and have serious consequences, particularly in the treatment of ostial and bifurcation lesions. Poor positioning of the stent can mean it fails to cover all plate segments and can lead to the presence of stent cells at the main branch when treating ostial injuries or proximal segments of lateral branches. It can also lead to the presence of prosthetic material in healthy coronary segments. In some cases, poor positioning of the stent may mean a second stent is needed to cover the entire target plate. Some studies have indicated an association between stent length and thrombosis and restenosis rates, so that the greater the length of the stent, the greater the risk of complications.1,2 In practice, therefore, the smallest feasible amount of prosthetic material is used to cover the stenotic segment. Any of these situations can lead to a suboptimal outcome and increase the rate of complications resulting from poor implantation.

Various techniques have been described to stabilize the stent. The best known are rapid pacing via transvenous catheter stimulation of the right ventricle,3,4 induction of asystole through adenosine administration, balloon inflation at the main branch, placement of a second, parallel guidewire,5 or the Szabo technique,6 among others. Right ventricular pacing using catheters is not without complications. Ventricular perforation and cardiac tamponade are serious complications of this procedure.7 It can also cause complications, such as bruising or fistulae, at the vascular access. Other disadvantages of this technique are the increased procedure time required and the greater use of material resources. Using adenosine to induce asystole periods also has some disadvantages. First, the duration of the induced asystole is short and unpredictable. This can lead to the emergence of a heartbeat during implantation with subsequent displacement of the stent and the occurrence of complications or an undesirable final outcome. Secondly, adenosine should be used with caution in asthmatic patients. Both of these aspects limit the technique’s practical usefulness. Balloon inflation at the main branch and the placement of a second parallel guidewire are alternative techniques that have shown limited effectiveness and applicability.

Angioplasty guidewire pacing has been described as a technique for controlling bradyarrhythmias during cardiac catheterization or angioplasty.8-10 Transcoronary stimulation using guidewires is not susceptible to the adverse effects associated with these techniques.11,12 We did not observe any complications associated with this mode of stimulation. Tachycardia was induced safely and effectively and, using a temporary pacemaker, achieves the same results as right ventricular pacing, thus avoiding the need for central venous catheterization. In comparison with drug-induced asystoles, transcoronary pacing has a longer-lasting effect and avoids possible side effects from these drugs. The time required to commence stimulation is significantly less than in the case of transvenous stimulation and is similar to that required for the administration of adenosine. In a small number of patients, the technique produces electrical stimulation of the diaphragm or a mild electrical sensation at the puncture site which is somewhat unpleasant, but its short duration means it is well-tolerated. Self-limiting coronary spasms associated with similar techniques have been described, but we did not observe any cases here. In contrast to slow stimulation (100 beats/min), rapid stimulation (150 beats/min) was effective in 96% of cases (P<.001) and stent deployment was considered successful in all cases. It was not necessary to use more than one guidewire to improve capture, nor to use pacing voltages >10 V. We observed some capture defects but these were resolved after repositioning the guidewire or slightly increasing the threshold for stimulation.

In terms of study limitations, the number of patients included was small and the results were obtained in a single center. We also did not analyze the final disposition of the stent or the occurrence of clinical events, and we did not undertake patient follow-up.
CONCLUSIONS

Transcoryonary ventricular pacing via an angioplasty guidewire was an effective and safe method for achieving stent immobilization in cases where there was excessive pulsatile motion. This method is simpler, cheaper, and safer than those described previously in the literature. It can be applied in any interventional cardiology unit without the need for additional material or a long learning period.

REFERENCES