QRS Duration and Early Hemodynamic Instability After Coronary Revascularization Surgery

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Introduction and objectives. The duration of the QRS interval measured by ECG is a marker of ventricular dysfunction and indicates a poor prognosis. Its value in patients undergoing coronary revascularization surgery has not been established.

Methods. The study involved 203 consecutive patients (age, 64[9] years; 74% male) scheduled for elective coronary surgery. The maximum QRS duration measured on a preoperative 12-lead ECG was recorded. Hemodynamic instability was defined as the occurrence of cardiac death, heart failure, or a need for intravenous inotropic drugs or intra-aortic balloon counterpulsation during the postoperative period.

Results. The occurrence of hemodynamic instability (n=94, 46%) was associated with a longer preoperative QRS duration (97.5[21.4] ms vs 88.5[16.9] ms; P=.001). The QRS duration was also longer in patients who developed heart failure (n=23; 104.3[22.9] ms vs 91.1[18.5] ms; P=.002), needed inotropic drugs (n=77; 96.5[20.5] ms vs 90.1[18.2] ms; P=.007) or developed postoperative atrial fibrillation (n=58; 98.2[23.8] ms vs 90.4[17.0] ms; P=.018). Bundle branch block was associated with a greater need for intra-aortic balloon counterpulsation (29% vs 12%; P=.012) or inotropic drugs (58% vs 35%; P=.014) and a higher incidence of hemodynamic instability (69% vs 42%; P=.006). Multivariate analysis identified the following independent predictors of hemodynamic instability: QRS duration (adjusted odds ratio [OR] per 10 ms=1.49; 95% confidence interval [CI], 1.14-1.96; P=.001), the lack of an arterial graft (OR=3.6; CI=1.14-11.6; p=.029) and extracorporeal circulation time (OR per min=1.013; 95% CI, 1.003-1.023; P=.013).

Conclusions. The intraventricular conduction delay, or QRS duration, was associated with a higher risk of postoperative hemodynamic instability following coronary surgery.

Key words: Coronary surgery. QRS interval. ECG. Prognosis. Hemodynamic instability.
duration on the preoperative ECG has been assessed in fewer studies\textsuperscript{18-20} and has been associated with the development of low postoperative cardiac output in the presence of ventricular systolic dysfunction,\textsuperscript{18} heart arrest during the immediate postoperative period,\textsuperscript{19} and long-term adverse events.\textsuperscript{20}

We designed an observational clinical study to evaluate whether the duration of the QRS interval on the preoperative ECG determines the development of hemodynamic deterioration and/or adverse clinical events during the early postoperative period following elective coronary revascularization surgery.

\section*{METHODS}

\subsection*{Study Population}

We performed a prospective study in 203 consecutive patients who underwent elective coronary revascularization surgery between 2002 and 2003 in 2 tertiary hospitals. Emergency procedures, coronary reoperations and combined procedures (coronary and valve surgery, coronary and vascular surgery, or coronary surgery and resection of ventricular aneurysms) were excluded. The day before the surgical intervention, all the patients underwent a preoperative study that included: standard 12-lead resting ECG, with automatic measurement at 50 mm/s (PageWriter 100, Hewlett Packard, Cupertino, California, United States) and the recording of the preoperative clinical characteristics. The preoperative ECG enabled the determination of the maximum duration of the QRS interval and whether there was a His bundle branch block, according to previously described criteria.\textsuperscript{21} The clinical characteristics recorded as preoperative variables were: sex, age, diabetes mellitus, hypertension, dyslipidemia, smoking, family history of ischemic heart disease, preoperative left ventricular ejection fraction (LVEF), acute myocardial infarction, recent acute coronary syndrome (within the preceding 30 days), peripheral arterial disease, coronary angioplasty, previous paroxysmal atrial fibrillation, heart failure, and chronic obstructive pulmonary disease. The additive EuroSCORE scale, the presence of sinus rhythm, the New York Heart Association (NYHA) functional class, the number of diseased coronary vessels per patient, the presence of left main coronary disease, and drug therapy were recorded for each patient. All the patients provided their written informed consent for the study.

\subsection*{Surgical Procedure}

The median sternotomy approach was employed in every case. Left internal mammary artery (LIMA)
and internal saphenous vein were used for the grafts. In those patients who underwent revascularization with extracorporeal circulation, the cardiopulmonary bypass (CPB) was performed with cannulation of ascending aorta and a single cannula in right atrium for venous return. The standard CPB circuit was employed (Cobe Cardiovascular Inc., Colorado, United States), with 40-µ filters (Sorin Biomedica, Saluggia, Italy); a Dideco D903 Avant membrane oxygenator (Dideco srl, Mirandola, Italy) was used. Pulsatile flow was utilized with mean flow velocities of 2.4 L/m²/min. The systemic temperature was lowered to between 28°C and 32°C (moderate hypothermia). Myocardial protection was achieved using antegrade and retrograde hyperkalemic cold blood cardioplegia. In the population that underwent surgery without CPB, the exposure of the vessel in which the graft was to be anastomosed was carried out by means of a CTS stabilizer (Guidant, Indianapolis, Indiana, United States).

Among the operative data, we recorded the use of CPB for the revascularization surgery, the use of arterial grafts, the number of grafts per patient, the myocardial ischemic time (in minutes), and the CPB time (in minutes). For the analysis of the CPB and myocardial ischemic times, they were quantified as zero minutes in the patients who did not undergo CPB.

**Events**

The patients were monitored throughout the first 30 days after the intervention. The major event, hemodynamic instability, was defined as that involving one of the following adverse events: a) cardiac death defined as that secondary to asystole, ventricular fibrillation, acute heart failure, sudden death, or any other cardiac-related death according to the clinical report; b) heart failure defined as the recording of clinical and/or radiological data indicative of left, and/or right heart failure during the postoperative period that required the initiation of treatment with oral or intravenous diuretics or vasodilators; c) the need for intravenous inotropic drugs (inotropic doses, dobutamine over 5 µg/kg/min) in the intensive care unit for more than 24 hours; and d) need for intra-aortic balloon counterpulsation (IABC) at any time during the surgical or postoperative process. We recorded the development of any episode of atrial fibrillation during the postoperative period according to previously described criteria.²² The length of the stay in the intensive care unit (in days) and the total length of the hospital stay (in days) were also recorded.

**Statistical Analysis**

The continuous variables showing a normal distribution are expressed as the mean (standard deviation) and were compared using the Student t test; variables whose distribution was not normal are expressed as medians and quartiles, and were compared by means of with Mann-Whitney U test. Categorical variables are shown as frequencies and percentages and were compared using the χ² test or Fisher’s exact test, as required. For the study of the predictors of the major composite event, logistic regression analysis was performed for every possible baseline risk factor. Multivariate logistic regression analysis (conditional forward step method) included the significant or nearly significant factors (P<.10) in univariate analysis; in addition, the results were adjusted for age, sex, and possible confounding factors (center, number of diseased vessels, history of previous atrial fibrillation, and systolic dysfunction). The statistical analysis was carried out using the SPSS 15.0 software package for Windows (SPSS Inc., Chicago, Illinois, United States). A P value less than .05 was considered to indicate statistical significance.

**RESULTS**

**QRS and Baseline Characteristics**

The mean duration of the preoperative QRS interval was 92.6 (19.4) milliseconds, with a median [interquartile interval] of 90 [80 to 100] milliseconds. Table 1 shows the characteristics of the population distributed according to the median QRS duration (90 milliseconds). The duration of the QRS interval was longer in the patients with a preoperative history of paroxysmal atrial fibrillation (112 [28.3] milliseconds vs 91.4 [18.2] milliseconds; P=.002) and left ventricular systolic dysfunction (LVEF <40%) (100 [18.4] vs 91.4 [19.4]; P=.011). Likewise, a longer QRS duration correlated with a larger number of diseased vessels per patient (P=.015; r=0.171), a larger number of grafts per patient (P=.033; r=0.150), a longer CPB time (P=.016; r=0.201), and a longer myocardial ischemic time (P=.001; r=0.269). Thirty-two patients (16%) presented criteria for complete bundle branch block (CBBB). The QRS categorized as CBBB (over 120 milliseconds) was associated with a greater utilization of CPB for myocardial revascularization (78% vs 56%; P=.020), a larger number of grafts per patient (2.36 [0.941] vs 2.66 [1.12]; P=.059), a longer myocardial ischemic time (44.8 [29.9] vs 26.2 [30.3] minutes; P=.006) and a longer CPB time (93.7 [50.6] vs 56.3 [49.8] minutes; P=.001).

**QRS and Events**

Within the first 30 days, 94 patients (46%) developed the major event or hemodynamic instability; 5
in the presence of CBBB, when fewer arterial grafts were used in the revascularization, when the myocardial ischemic time was longer and when the CPB time was longer. Patients with and without hemodynamic instability did not differ in terms of the preoperative LVEF (60 [50-62] vs 57 [50-61.5]; \(P = .840\)) or the additive EuroSCORE (3 [0-6] vs 4 [0-5]; \(P = .954\)). Moreover (Figure 3), among the patients with preoperative CBBB, there was a significantly higher incidence of hemodynamic instability (69% vs 42%; \(P = .006\)), IABC (29% vs 12%; \(P = .012\)) and use of intravenous inotropics (58% vs 35%; \(P = .014\)) during the postoperative period. The preoperative QRS interval, as the total duration or as CBBB, was not associated with a higher mortality rate (\(P = .301\) and \(P = .792\), respectively).

### Multivariate analysis

After multivariate adjustment in logistic regression analysis for the onset of hemodynamic instability during the early postoperative period (Table 3), the independent predictors were a longer duration

<table>
<thead>
<tr>
<th>TABLE 1. Characteristics of the Population Distributed According to the Median Duration of the QRS Interval</th>
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<tbody>
<tr>
<td>Variables</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
</tr>
<tr>
<td>&gt;70 years, n (%)</td>
</tr>
<tr>
<td>Men, n (%)</td>
</tr>
<tr>
<td>Diabetes mellitus, n (%)</td>
</tr>
<tr>
<td>Hypertension, n (%)</td>
</tr>
<tr>
<td>Hypercholesterolemia, n (%)</td>
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<tr>
<td>Smoking, n (%)</td>
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<tr>
<td>Previous AMI, n (%)</td>
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<tr>
<td>Recent ACS (&lt;1 month), n (%)</td>
</tr>
<tr>
<td>Beta-blockers, n (%)</td>
</tr>
<tr>
<td>Aspirin, n (%)</td>
</tr>
<tr>
<td>Statins, n (%)</td>
</tr>
<tr>
<td>Peripheral vascular disease, n (%)</td>
</tr>
<tr>
<td>LVEF, mean (SD), %</td>
</tr>
<tr>
<td>&lt;40%, n (%)</td>
</tr>
<tr>
<td>Atrial fibrillation, n (%)</td>
</tr>
<tr>
<td>Heart failure, n (%)</td>
</tr>
<tr>
<td>COPD, n (%)</td>
</tr>
<tr>
<td>Additive EuroSCORE, mean (SD)</td>
</tr>
<tr>
<td>Diseased vessels/patient, mean (SD), n</td>
</tr>
<tr>
<td>LMC disease, n (%)</td>
</tr>
<tr>
<td>Surgery with CPB, n (%)</td>
</tr>
<tr>
<td>Grafts/patient, mean (SD), n</td>
</tr>
<tr>
<td>CPB time, mean (SD), min</td>
</tr>
<tr>
<td>Myocardial ischemic time, mean (SD), min</td>
</tr>
<tr>
<td>Use of arterial graft, n (%)</td>
</tr>
<tr>
<td>Hospital 1, n (%)</td>
</tr>
<tr>
<td>Hospital 2, n (%)</td>
</tr>
</tbody>
</table>

ACS indicates acute coronary syndrome; AMI, acute myocardial infarction; COPD, chronic obstructive pulmonary disease; CPB, cardiopulmonary bypass; LMC, left main coronary; LVEF, left ventricular ejection fraction; SD, standard deviation.
of the QRS interval (adjusted odds ratio [OR] per 10 milliseconds = 1.49; 95% confidence interval [95% CI], 1.11-2; \( P = .007 \)), the absence of arterial grafts in coronary revascularization (OR=3.6; 95% CI, 1.4-11.6; \( P = .029 \)) and a longer CPB time (per minute, OR=1.013; 95% CI, 1.003-1.023; \( P = .013 \)). The observation of CBBB on the preoperative ECG was also an independent predictor of hemodynamic instability when the duration of the QRS interval was excluded from the model (OR=6.17; 95% CI, 1.3-27.7; \( P = .017 \)).

DISCUSSION

This study shows that the duration of the QRS interval on the preoperative ECG is associated with a higher risk of hemodynamic instability during the immediate postoperative period in coronary revascularization surgery. The prognostic value of the QRS interval in patients with heart failure or myocardial infarction and ventricular systolic dysfunction is well known. However, the possible prognostic role of the QRS interval on the preoperative ECG has scarcely been explored in coronary surgery. In 2006, Acil et al studied the predictive value of a prolonged QRS interval in the development of postoperative low cardiac output syndrome, but only in patients with preoperative left ventricular systolic dysfunction who underwent revascularization with CPB. In our patients, the systolic function was predominantly preserved (over 40% in 86% of the study group),

Figure 1. QRS duration in patients with and without hemodynamic instability during the early postoperative period. SD indicates standard deviation.

Figure 2. Incidence of hemodynamic instability according to the distribution of the QRS interval by terciles.

Figure 3. Incidence of hemodynamic instability, need for intravenous amines and intraaortic balloon counterpulsation (IABC) in patients with and without complete bundle branch block.
which indicates that the QRS duration may be a risk marker in this population as well. On the other hand, the QRS interval maintained its significance after adjustment for the use of CPB, a fact indicates that its prognostic value is independent of the latter. In 2000, Abdelnoor et al\textsuperscript{19} related a longer duration of the preoperative QRS complex in coronary patients to a higher risk of experiencing cardiac arrest during the immediate postoperative period. In 2005 Biffi et al\textsuperscript{20} related the longer duration of the preoperative QRS interval to death and heart failure over the long term. In our report, the low number of events does not enable us to relate the QRS interval to mortality, but it does show that there is a higher incidence of hemodynamic instability during the immediate postoperative period.

There could be several mechanisms to explain the association between preoperative QRS and a poorer postoperative prognosis in coronary surgery. It could be that it actually masks a greater burden of ischemic myocardial disease and risk factors in these patients.\textsuperscript{23,24} Our results indicate an association with more severe coronary disease, since a longer duration of the preoperative QRS interval is associated with a larger number of diseased coronary vessels, a higher number of grafts per patient and longer myocardial ischemic and CPB times. The fact that the patients with CBBB on the preoperative ECG more often underwent CPB during the operation appears to strengthen this association.

On the other hand, it could also be that the prolongation of the QRS interval is associated with changes in the function and structure of left ventricle.\textsuperscript{25-27} In our study, although we did not observe an inverse relationship between the QRS duration and the LVEF, the QRS interval was longer in patients with impaired systolic function (LVEF under 40%). One important aspect is the fact that the preoperative LVEF is not associated with a higher risk for hemodynamic instability, but QRS duration is, regardless of the degree of ventricular dysfunction. It could be that a more prolonged QRS interval would indicate an early and subtle deterioration of the myocardium, too soon to show an impact on the LVEF, but with a reduced contractile or hemodynamic reserve. On the other hand, there may

### TABLE 2. Clinical Characteristics Associated With the Onset of Hemodynamic Instability

<table>
<thead>
<tr>
<th>Variable (n=203)</th>
<th>Hemodynamic Instability</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (46%)</td>
<td>No (54%)</td>
</tr>
<tr>
<td>Width baseline QRS, ms</td>
<td>92.5 (80-120)</td>
<td>80 (80-98)</td>
</tr>
<tr>
<td>Baseline bundle branch block, n</td>
<td>22 (23)</td>
<td>10 (9)</td>
</tr>
<tr>
<td>Peripheral arterial disease, n</td>
<td>9 (27)</td>
<td>7 (13)</td>
</tr>
<tr>
<td>Preoperative CHF, n</td>
<td>15 (16)</td>
<td>9 (8)</td>
</tr>
<tr>
<td>Use of CPB, n</td>
<td>64 (68)</td>
<td>57 (52)</td>
</tr>
<tr>
<td>Use of arterial graft, n</td>
<td>23 (68)</td>
<td>48 (86)</td>
</tr>
<tr>
<td>Grafts/patient, n</td>
<td>2 (2-3)</td>
<td>2 (2-3)</td>
</tr>
<tr>
<td>Myocardial ischemic time, mean (SD), min</td>
<td>36.3 (29.8)</td>
<td>23.2 (30.8)</td>
</tr>
<tr>
<td>CPB time, mean (SD), min</td>
<td>78 (48.7)</td>
<td>48.3 (50.1)</td>
</tr>
</tbody>
</table>

CHF indicates congestive heart failure; CPB, cardiopulmonary bypass; SD, standard deviation.

### TABLE 3. Logistic Regression Multivariate Analysis of the Onset of Hemodynamic Instability During the Early Postoperative Period

<table>
<thead>
<tr>
<th>Variables</th>
<th>Univariate</th>
<th>Multivariate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>QRS width, 10 ms</td>
<td>.001</td>
<td>1.26 (1.10-1.42)</td>
</tr>
<tr>
<td>Without arterial graft</td>
<td>.042</td>
<td>2.87 (1.016-8.13)</td>
</tr>
<tr>
<td>CPB time, min</td>
<td>.001</td>
<td>1.013 (1.006-1.020)</td>
</tr>
<tr>
<td>Myocardial ischemic time, min</td>
<td>.008</td>
<td>1.014 (1.003-1.025)</td>
</tr>
<tr>
<td>Use of CPB</td>
<td>.022</td>
<td>1.94 (1.09-3.46)</td>
</tr>
<tr>
<td>Preoperative</td>
<td>.095</td>
<td>1.86 (0.372-9.345)</td>
</tr>
<tr>
<td>Peripheral arterial disease</td>
<td>.093</td>
<td>1.89 (0.456-7.812)</td>
</tr>
<tr>
<td>Grafts/patient, n</td>
<td>.077</td>
<td>1.15 (0.408-3.639)</td>
</tr>
</tbody>
</table>

CHF indicates congestive heart failure; CI, confidence interval; CPB, cardiopulmonary bypass; OR, odds ratio.

*Adjusted for age, sex, center, number of diseased vessels, history of previous atrial fibrillation and systolic dysfunction (left ventricular ejection fraction <40%).
be a higher prevalence of ventricular mechanical dysynchrony in these patients, which leads to a decrease in myocardial efficiency.26-30 Probably all these pathophysiological mechanisms contribute to the association between the QRS interval and hemodynamic instability during the postoperative period.

It is interesting that this association between the QRS interval and hemodynamic instability occurred in the presence of a relatively preserved intraventricular conduction; 84% of the patients had a QRS interval of less than 120 milliseconds. This fact indicates a direct and continuous relationship between QRS duration and hemodynamic instability and that, in cases of acute stress, such as myocardial revascularization surgery, minor delays in intraventricular conduction can suffice to lead to a higher risk. Another interesting finding was the association between the QRS interval and a higher prevalence of previous paroxysmal atrial fibrillation and a higher incidence during the postoperative period. This could indicate that changes in ventricular conduction somehow have an impact on atrial conduction, a circumstance that, together with an increase in filling pressures, could enhance the risk of postoperative atrial fibrillation.

In our analysis, a longer CPB time and the absence of arterial grafts in the myocardial revascularization were also found to be independent predictors of hemodynamic instability. Several classical studies have emphasized the short-term and long-term benefits of arterial revascularization in coronary surgery, especially the use of LIMA,31-33 as well as the negative effects on the prognosis of a prolonged CPB time.33,34

This study indicates that an inexpensive and simple method such as preoperative ECG, measuring the QRS interval, can provide important prognostic information. The current mortality risk models, EuroSCORE35 and Parsonnet,36 do not include any electrocardiographic variables. However, the QRS duration could be useful in the development of new models of surgical risk in patients undergoing myocardial revascularization surgery. Additional studies with larger populations will be necessary to define the prognostic role of this variable.

**Limitations**

From our findings, we can only infer that there is an association between a longer duration of the QRS interval on the preoperative ECG and a poorer postoperative course; however, although the longer QRS duration is simply a marker and not a cause of the poorer postoperative course, given the widespread availability of ECG and its routine use in any hospital, it would make financial sense to employ this variable as an indicator of risk. In our study, echocardiographic measurements of ventricular and intraventricular dys synchrony were not obtained, but might have provided additional information on the mechanisms involved. These measurements should be included in future studies in this field.

**CONCLUSIONS**

The prolongation of the QRS interval on the preoperative ECG predicts a higher risk of hemodynamic instability during the early postoperative period in patients who undergo coronary revascularization surgery.

**REFERENCES**