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Chronic Atrioventricular Nodal Vagal Stimulation
First Evidence for Long-Term Ventricular Rate Control in Canine Atrial Fibrillation Model

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Background—We have previously demonstrated that selective atrioventricular nodal (AVN) vagal stimulation (AVN-VS) can be used to control ventricular rate during atrial fibrillation (AF) in acute experiments. However, it is not known whether this approach could provide a long-term treatment in conscious animals. Thus, this study reports the first observations on the long-term efficacy and safety of this novel approach to control ventricular rate during AF in chronically instrumented dogs.

Methods and Results—In 18 dogs, custom-made bipolar patch electrodes were sutured to the epicardial AVN fat pad for delivery of selective AVN-VS by a subcutaneously implanted nerve stimulator (pulse width 100 μs or 1 ms, frequency 20 or 160 Hz, amplitude 6 to 10 V). Fast-rate right atrial pacing (600 bpm) was used to induce and maintain AF. ECG, blood pressure, and body temperature were monitored telemetrically. One week after the induction of AF, AVN-VS was delivered and maintained for at least 5 weeks. It was found that AVN-VS had a consistent effect on ventricular rate slowing (on average 45 ± 13 bpm) over the entire period of observation. Echocardiography showed improvement of cardiac indices with ventricular rate slowing. AVN-VS was well tolerated by the animals, causing no signs of distress or discomfort.

Conclusions—Beneficial long-term ventricular rate slowing during AF can be achieved by implantation of a nerve stimulator attached to the epicardial AVN fat pad. This novel concept is an attractive alternative to other methods of rate control and may be applicable in a selected group of patients. (Circulation. 2005;112:2904-2911.)

Key Words: atrioventricular node ■ fibrillation ■ heart rate ■ hemodynamics ■ vagus nerve

Atrial fibrillation (AF) is recognized as the most common clinically significant cardiac arrhythmia. Current data estimated that 2.3 million Americans have AF.1,2 Because the prevalence of AF increases with age1,2 and because of the aging population, the number of AF patients is estimated to increase 2.5-fold during the next 50 years.1

Currently, there are 2 broad strategic treatment options for AF: rhythm control and rate control. Although rhythm control (restoring and maintaining the sinus rate) is thought to be ideal, it cannot be achieved or maintained in a large number of patients, rendering rate control (controlling ventricular rate while AF continues) the only realistic long-term solution in a majority of patients.3,4 Recent clinical trials (AFFIRM and RACE)5,6 demonstrated that rate control is at least as good as rhythm control for most patients with AF. Thus, rate control can be considered a “primary approach” in treating these AF patients.7,8

The strategy of rate control during AF essentially deals with efforts to utilize and adjust the filtering properties of the atrioventricular node (AVN)9 because the AVN is the only normal structure responsible for the conduction of atrial impulses to the ventricles. Drug therapy (calcium channel antagonists, β-blockers, and digitalis) is the most common approach in rate control. However, drug therapy is not effective in some patients and may not be well tolerated in others because of side effects. AVN modification can be used to control the ventricular rate. Because of the limited success rate and high probability of complete AV block, it is currently recommended only when AVN ablation with pacemaker implantation is intended.10 The latter option results in a lifelong pacemaker dependency. In addition, there are hemodynamic drawbacks because of the retrograde ventricular contraction.11,12 Recently, lesions encircling rather than destroying the AVN were shown to result in acceptable junctional escape rhythm.13,14 However, this technique needs further refinements and verification.
Recently, a novel strategy, selective AVN vagal stimulation (AVN-VS), has emerged for rate control during AF. We have previously demonstrated that AVN-VS could be used to achieve desired predetermined ventricular rate slowing with improved hemodynamics in acute experiments. Moreover, ventricular rate slowing by AVN-VS provided better hemodynamic benefit than AVN ablation and right ventricular pacing. However, it is unknown whether AVN-VS could be used as a long-term therapy during AF. Thus, the purpose of this study was to determine the long-term effects of VS in slowing ventricular rate and the safety and tolerability of this novel therapeutic strategy in conscious animals during AF.

Methods
This study was approved by the Institutional Animal Care and Use Committee and was in compliance with the Guide for the Care and Use of Laboratory Animals published by the National Institutes of Health.

Animal Model: Surgical Preparation and Device Implantation
A total of 18 adult mongrel dogs (body weight, 21 to 35 kg) underwent device implantation. Each dog received an atrial pacemaker for induction and maintenance of AF, a vagal nerve stimulator, and a telemetric device (TL11-M2-D70-PCT, Data Science International DSI) for monitoring ECG, blood pressure, and temperature.

The surgical procedures for implantation of these devices are briefly described. All dogs were premedicated with thiopental sodium (20 mg/kg IV), intubated, and ventilated with room air supplemented with oxygen by a respirator (NARKOMED 2, North American DRAGER). Anesthesia was then maintained with 1% to 2% isoflurane throughout the experiment. Normal saline at 100 to 200 mL/h was infused to replace spontaneous fluid losses. Standard surface ECG leads (I, II, III) were monitored with a rectal probe (TM-2400, Electromedics, Inc), and an electric heating pad under the animal and operating room lamps were used to maintain body temperature of 37°C.

Under sterile surgical procedures, dogs underwent a right lateral thoracotomy at the fourth intercostal space. With ribs and lungs retracted, the pericardium was opened. A custom-made bipolar patch electrode (St Jude Medical) was sutured on the AVN fat pad, located at the junction of the inferior vena cava and the left atrium. This electrode was connected to a nerve stimulator.

We used 2 types of nerve stimulators: ITREL II 7424 nerve stimulator (Medtronic Inc) or a modified Photon ICD (St Jude Medical). Both devices could deliver a synchronized mode of stimulation with an output (10 V) available in the ITREL II and the Photon ICD nerve stimulators.

We also implanted a telemetric device (TL11-M2-D70-PCT) subcutaneously at the back area. At the end, the pericardium and the chest were closed in layers. A drain chest tube was used, and negative pressure in the pleural cavity was reestablished. All incisions were closed, and the dogs were carefully monitored during their recovery. Standard postoperative care was performed daily until the incisions were healed (~2 weeks).

Study Protocol and Conscious Monitoring
After recovery, AF was induced and maintained for the entire duration of the study by the atrial pacemaker, which delivered high-rate pacing at 600 bpm (1-ms impulses, 2 to 3 V). One week later, while the AF was maintained, nerve stimulation was initiated and delivered for at least 5 weeks (in 2 dogs the AVN-VS was maintained for 6 months). We titrated AVN-VS voltage output, attempting to slow the average ventricular rate toward the sinus rate level observed before AF induction (121±13 bpm). The adjustments were done typically within the first few days. When sinus rate target was not achievable, the output of the device was set to the maximum output (10 V) available in the ITREL II and the Photon ICD nerve stimulators.

We observed the dogs daily but collected ECG and blood pressure data every other day between 10 AM and noon. During monitoring, the dogs were kept unrestrained in a moderate-sized cage (or lying on a couch during echocardiography). A typical episode of data collection consisted of the following steps. First, we recorded ECG and blood pressure signals with the ongoing VS. Then the VS was turned off, and after a 10-minute stabilization period another set of data was collected to determine the intrinsic ventricular rate during AF. After this brief interruption, VS was reinitiated. In the first 6 animals, we also collected data immediately after VS reinitiation and verified that the heart rate returned to the level at the start of the observations. The duration of each recording step permitted collection of at least 500 beats for subsequent analysis. The reported electrophysiological data are averages from 3 daily observations in a given week.

In 5 dogs implanted with the Photon ICD, we compared the effectiveness of 2 modes for delivery of the nerve stimulation: continuous and synchronized. In these cases, data were collected with consecutive delivery of continuous and synchronized modes of AVN-VS at 10-V output. For the rest of the time, continuous mode was maintained.

Conscious Echocardiographic Measurements
Left ventricular function was assessed weekly by transthoracic echocardiography. Left ventricular end-diastolic volume (LVEDV) and left ventricular end-systolic volume (LVESV) were determined by 2-dimensional guided M-mode echocardiography (SystemFive, General Electric-Vingmed). Left ventricular ejection fraction (LVEF) was calculated with the use of the Teichholz equation. Left ventricular cavity dimensions and LVEF were calculated from an average of 7 to 15 heart cycles during AF.

Daily Animal Status Monitoring
Since there are no generally accepted objective criteria for assessing the degree of pain/discomfort in animals, we followed accepted recommendations based on the recognition of a departure from the normal behavior and appearance of the animals. Any noticeable behavioral changes, including activity, appetite, and/or any signs of pain and distress in the animals, would be recorded on the animals’ log chart by our technician and the Biological Resource Unit staff personnel.

Statistical Analysis
Data are presented as mean±SD. The ventricular rate changes at different time courses during AF (without VS) were evaluated by single-factor repeated measurements of ANOVA followed by the Tukey honestly significant difference (HSD) test. The ventricular rate and hemodynamic parameters with and without AVN-VS for each week were compared by paired t test. The analysis was performed with the use of statistical software (STATISTICA version 5.1, StatSoft Inc). All statistical tests were 2-sided, and a probability value <0.05 was required for statistical significance.
Results

Of the 18 dogs, successful experiments were performed on 15 (body weight, 27±2 kg; range, 23 to 31 kg). One dog died suddenly 6 days after AF induction before initiation of AVN-VS. The other 2 dogs had lead/device problems requiring premature termination of the study. A total of 15 dogs completed the study protocol with at least 5-week AVN-VS, and in the first 2 dogs the AVN-VS period was extended to 6 months. In all dogs, the long-term AVN-VS was maintained with the use of the continuous mode of VS, whereas the synchronous mode was used during the tests. The intensities of AVN-VS were 9.4±1.3 V. In 3 dogs, VS was titrated (6.0 to 8.0 V), and the averaged ventricular rate was maintained within 10% of the sinus rate. In all other dogs, the target was not reached, and the VS output was set to 10 V.

AVN-VS Effects on Ventricular Rate During AF

Figure 1 shows ECG and blood pressure tracings recorded by a DSI telemetric device at the end of 5 weeks of AVN-VS in 1 dog. The top panel shows ECG and blood pressure tracings taken when the VS was temporarily turned off, and the bottom panel shows tracings taken when continuous mode AVN-VS was on (output at 7.0 V). Clearly, VS decreased ventricular rate from 205 bpm (top panel) to 122 bpm (bottom panel). Note that the slower rate was associated with more stable blood pressure readings.

Figure 2 shows another example when AVN-VS was delivered during a synchronized mode test. In this case, ventricular rate was decreased from 246 bpm (top panel) to 148 bpm (bottom panel) by AVN-VS at 10.0 V. Note the AVN-VS artifacts at the end of each QRS when VS was on.

The composite data for the ventricular rate in all 15 dogs are shown in Figure 3. Several important observations are as follows: (1) The average sinus rate before AF induction was 121±13 bpm (filled circle) and increased to 270±33 bpm immediately after AF was initiated by high-rate right atrial pacing (week −1). (2) The intrinsic ventricular rate gradually decreased to a level of 251±50 bpm 1 week after AF induction, just before initiation of AVN-VS (week 0, filled triangle). (3) When AVN-VS was initiated, the ventricular rate decreased sharply to 180±37 bpm (week 0, open circle). (4) In the subsequent 5 weeks, AVN-VS treatment had a consistent effect in slowing the ventricular rate. This is evident from the comparison of data obtained in the presence, and during the temporary cessation, of the nerve stimulator. Thus, the average rates were (in bpm) 182 versus 217 (week 1), 172 versus 218 (week 2), 165 versus 209 (week 3), 157 versus 195 (week 4), and 153 versus
192 (week 5) (Figure 3; compare open symbols with AVN-VS versus filled symbols without AVN-VS; paired t test, $P < 0.01$ for each week).

We kept 2 of the dogs for 6 months under the same experimental conditions and confirmed the presence of significant vagal effect throughout the observation period. For example, the average ventricular rate in these 2 dogs stayed in the range of 150 to 135 bpm.

Of interest, the data illustrated in Figure 3 revealed that the intrinsic ventricular rate (ie, the rate observed when AVN-VS was temporarily turned off) had a tendency to slow down as the study progressed. As seen in Figure 3, the intrinsic ventricular rate (without AVN-VS) decreased from $270 \pm 33$ bpm when AF was initiated (week 1) to $192 \pm 50$ bpm at the end of the fifth week of AVN-VS treatment (ANOVA with HSD test, $P < 0.001$). Although at any point the intrinsic ventricular rate (without AVN-VS, filled symbols) was always faster than that observed with VS (open symbols), the 2 processes were “parallel” and resulted in an average VS-induced slowing of $45 \pm 13$ bpm.

AVN-VS Effects on Blood Pressure During AF

As shown in Figures 1 and 2, more stable blood pressure was associated with the slower ventricular rate achieved by AVN-VS. Figure 4 summarizes the averaged blood pressure responses in all dogs. AF decreased both the systolic and diastolic pressures compared with those during sinus rate (filled circles at sinus rate and filled triangles at week 1; paired t test, $P < 0.001$). The values for systolic blood pressure during the AVN-VS treatment period (open circles) remained higher than the values observed at initiation of AF ($97 \pm 21$ mm Hg, week 1). However, intermittent removal of AVN-VS (solid triangles versus open circles) indicated that the direct effect of AVN-VS on the averaged SBP during AF had statistical significance only during the initial 2 weeks ($P < 0.05$). Similarly, AVN-VS had no direct effect on the averaged diastolic blood pressure during AF (bottom panel).

AVN-VS Hemodynamic Effects Derived From Echocardiography

Echocardiographic averaged data of LVEF, LVEDV, and LVESV are shown in Figure 5. As expected, AF significantly decreased LVEDV and LVEF and increased LVESV compared with values observed during sinus rhythm (closed circles versus closed triangles; $P < 0.05$). In weeks 0 to 5, AVN-VS did not affect LVESV (bottom panel) but had a
direct effect on LVEDV (middle panel, except week 1) and significantly improved LVEF (top panel) \( (P < 0.05 \text{ as marked for each week}) \).

**Continuous Mode Versus Synchronized Mode of AVN-VS**

In 5 dogs implanted with Photon ICD, we compared the effects of AVN-VS using the continuous versus synchronized mode. In these 5 dogs, the intrinsic ventricular rate during AF without VS was 216 ± 50 bpm. When programmed to the same output of 10 V, the continuous AVN-VS mode (train of stimuli with duration of 100 μs, at 20 Hz) decreased ventricular rate to 174 ± 42 bpm, while in the synchronized mode (bursts consisting of 20 impulses, 1 ms in duration, and delivered after each QRS), ventricular rate was decreased to 177 ± 43 bpm. Thus, the achieved rates were not different (paired \( t \) test, \( P > 0.05 \)).

**Safety and Tolerability of AVN-VS**

The procedure was well tolerated by all animals. There were no signs of distress or discomfort associated with AVN-VS. All studied dogs with VS remained healthy, and their body weight, temperature, and vital signs were normal.

**Discussion**

**Major Findings**

This study demonstrated for the first time that long-term ventricular rate slowing during AF could be achieved by implantation of a “nerve pacemaker” attached to the epicardial AVN fat pad. Rate control by AVN-VS during AF was associated with hemodynamic improvement. Furthermore, the epicardial approach of AVN-VS to control ventricular rate during AF was a well-tolerated modality in this animal model and did not produce any noticeable side effects.
desensitization of the muscarinic receptors,30 ie, the uptake in the synaptic cleft is a slow process, and this is the main source of choline in vitro.31 Indeed, direct acetylcholine injection was shown to maintain the cholinergic effect over a prolonged period of time.32 One should expect that in vivo, where there is normally an unlimited pool of choline provided by the plasma,33 the synthesis of acetylcholine during repetitive VS should be unhampered.17 Nevertheless, it remained imperative to determine whether AVN-VS could provide long-term therapeutic effects and whether it is safe and tolerated by conscious animals.

To our knowledge, this is the first study to explore the feasibility of employing AVN-VS for long-term control of ventricular rate in AF. Our results clearly demonstrated that the epicardial AVN fat pad stimulation could be used in chronically instrumented animals, producing sustained long-term effects in controlling ventricular rate and improving hemodynamic status. In addition, this novel approach was not associated with any noticeable side effects.

The present dog study may have important clinical implications. Since a similar fat pad in humans has been identified, AVN-VS could be applied to control ventricular rate in some AF patients. Future advancement of technology (as with epicardial ablation35) may permit avoidance of open chest surgery and may provide a means for transcutaneous lead implantation for epicardial nerve stimulation.

**AVN Remodeling During AF and Chronic AVN-VS**

It appeared that chronic application of AVN-VS was accompanied by progressive slowing of the intrinsic ventricular rate, ie, the steady state rate during AF when the vagal stimulator was temporarily turned off (Figure 3). The direct effect of VS remained almost unchanged (45±13 bpm) and disappeared promptly with termination of the stimulation as a result of fast acetylcholine hydrolysis.28

Although the exact mechanism(s) responsible for the intrinsic ventricular rate slowing is not known, it is likely related to the filtering function of the AVN during AF and/or to the AF pattern itself. The atrial activation pattern could change during a prolonged high atrial rate because of atrial remodeling36–38 and affect conduction through the AVN.39 Whether this proposed mechanism is also dependent on the presence of chronic VS that might affect the atrium remains speculative.

Although the atrial component is a significant functional and structural determinant of AVN conduction,40 it is reasonable to speculate that AVN itself might also undergo some remodeling during AF. For example, it is known that AF induces significant remodeling in the sinus node function.41,42 We have previously demonstrated in rabbits that chronic AF increased basic AVN conduction times and refractory periods.43 Such AVN electrophysiological remodeling would be favorable for reducing the intrinsic ventricular rate during chronic AF. Again, the potential role of persistent VS in the process of AVN remodeling remains unknown.

Finally, there is evidence that electric stimulation of the atria and sympathetic ganglia induces nerve sprouting.44,45 It is possible that long-term ganglionic AVN-VS might also induce nerve sprouting and changes in the autonomic balance, thus affecting AVN conduction. Unfortunately, this study was not designed to differentiate and elucidate such possible mechanisms.

**VS: Synchronized Versus Continuous Mode of Delivery**

Previously we had explored 2 modes of VS in acute studies: continuous and synchronized.12,15,16 The appeal of the latter is in its perceived safety because it is delivered during the ventricular refractory period and the arrhythmic consequences of ventricular capturing are minimized. There are energy considerations as well. As with any electric stimulation, the impulses used for AVN-VS must have amplitude above a certain threshold (in our experiments it was typically 2.5 to 3.5 V), and the vagal effects are determined by the overall intensity. Thus, at a given amplitude, the effect of the VS would be proportional to the duration and frequency of the impulses. Therefore, the synchronized mode allows the “bundling” of substantial energy in a short burst containing relatively long (1 ms) and high-frequency (160 Hz) impulses that are delivered discretely after the QRS complex. In contrast, the energy delivered during the continuous mode of VS at the same amplitude is homogeneously distributed in time and delivered by a sequence of brief (100 µs) impulses.

![Figure 5. Echocardiographic measurements of LVEF, LVEDV, and LVESV taken at the same times as indicated in Figure 3. All symbols and marked statistical differences are as in Figure 3. See text for details.](image-url)
with a total energy of 4 J. In the synchronized mode (third tracing), the nerve stimulator would deliver only 2 bursts but not 14 impulses. If we assume the amplitude of 10 V and lead impedance of 1 kΩ, this segment is 0.14 J. In the synchronized mode (third tracing), the nerve stimulator would deliver only 2 bursts but with a total energy of 4×10⁻³ J.

On the basis of the aforementioned considerations, we were expecting that the synchronized mode of delivery of the AVN-VS would produce much stronger vagal effects. However, this study showed that the 2 modes (at the same programmed amplitude of 10 V) produced similar effects in slowing the ventricular rate. This unexpected outcome was partially due to design limitations of the Photon ICD in this mode (Figure 6). Efforts that seek to reduce fibrosis, such as steroid-eluting electrodes, may enhance the efficacy of VS. In addition, while we have developed algorithms for a feedback-controlled delivery of VS,¹⁶ such a sophisticated feature is not yet available in chronic implantable nerve stimulators. Future devices would be able to deliver individualized therapy by maintaining predetermined levels of ventricular rate slowing. Similarly, they would permit more detailed evaluation of the VS therapy in the presence of increased sympathetic tone (eg, controlled exercise). Finally, although no side effects were observed in these dogs, because of the nature of animal studies, the clinical tolerability of this approach needs future investigations.

**Study Limitations**

AVN-VS had consistent long-term effects, but the ventricular rate slowing was less dramatic than in our previous acute studies.¹²,¹⁶ Even though direct comparison is not warranted, a thick fibrous socket that formed around the patch vagal electrode in the chronic experiments might have reduced the efficacy of current delivery, even though the measured impedance of the electrode remained unchanged (1017±306 Ω at implantation versus 922±258 Ω at the end of the experiments). Efforts that seek to reduce fibrosis, such as steroid-eluting electrodes, may enhance the efficacy of VS. In addition, while we have developed algorithms for a feedback-controlled delivery of VS,¹⁶ such a sophisticated feature is not yet available in chronic implantable nerve stimulators. Future devices would be able to deliver individualized therapy by maintaining predetermined levels of ventricular rate slowing. Similarly, they would permit more detailed evaluation of the VS therapy in the presence of increased sympathetic tone (eg, controlled exercise). Finally, although no side effects were observed in these dogs, because of the nature of animal studies, the clinical tolerability of this approach needs future investigations.

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**References**


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**Figure 6.** Schematic illustration of the delivery of AVN-VS in continuous (Cont VS) vs synchronized (Sync VS) mode. Top tracing, Right ventricular (RV) ECG signal. Second tracing, Continuous train of impulses with duration of 100 μs, 20 Hz. Third tracing, Each AVN-VS burst is synchronized with the QRS and consists of 20 impulses with duration 1 ms, 160 Hz. Bottom tracing, The real burst delivered by Photon ICD during bench testing in synchronized mode. See text for details.
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CLINICAL PERSPECTIVE

Symptoms of atrial fibrillation (AF) are commonly due to a rapid ventricular response. Achieving control of the ventricular rate is important for control of symptoms and to prevent tachycardia-induced ventricular dysfunction. Rate control often requires a combination of medications that depress AV nodal conduction, including β-adrenergic blockers, calcium channel blockers, and digoxin. When these fail or are not tolerated, AV junction ablation with permanent pacemaker implantation is sometimes required, despite concern that ventricular pacing has the potential to adversely affect ventricular function. We have explored a novel nondestructive, nonpharmacological strategy for ventricular rate control during AF. Specifically, we investigated the feasibility of using chronic, selective vagal stimulation for controlling ventricular rate during AF in dogs. This new therapy was well tolerated by the animals, achieved significant slowing of ventricular rate over prolonged periods of time, and produced the desirable hemodynamic consequences of slowing the rate in AF. This study provides the basis for the development of novel neural stimulators for future clinical evaluation of this therapy.