Atrial Pacing Thresholds Measured in Anesthetized Patients with the Use of an Esophageal Stethoscope Modified for Pacing

Christine Z. Pattison, M.D.,* John L. Atlee III, M.D.,† Edwin L. Mathews, M.D.,* Nedijlka Buljubasic, M.D.,‡ Jeffrey J. Entress, M.D.*

Traneseophageal atrial pacing (TAP) with the use of standard, thermistor-equipped, esophageal stethoscopes, modified for pacing by incorporation of a 4-French, bipolar TAP probe (pacing esophageal stethoscope [PES]), was evaluated in 100 adult patients under general anesthesia. A commercially available TAP pulse generator supplied 10-50 ms pulses with current variable between 0 and 40 mA. Pacing distances (in centimeters) were measured from the infraesophageal ridge to midway between PES electrodes (1.5-cm interelectrode distance). Pacing thresholds (milliamperes) were measured at the point of a maximum-amplitude P-wave (P$_{MAX}$) in the bipolar esophageal electrogram and points 1 cm proximal or 1, 2, or 3 cm distal to P$_{MAX}$. TAP (70-100 beats per min) was used for sinus bradycardia $\leq$ 60 beats per min (36 patients) or atrioventricular (AV) junctional rhythm (2 patients) and blood pressure changes with TAP documented. In male patients (n = 49), P$_{MAX}$ was 32.7 ± 0.3 cm (mean ± SE) and minimum pacing threshold 5.1 ± 0.4 mA (range, 1–13 mA) at 33.6 ± 0.3 cm (range, 30–37 cm). In female patients (n = 51), P$_{MAX}$ was 30.4 ± 0.4 cm and minimum pacing threshold 4.4 ± 0.4 mA (range, 2–14 mA) at 31.1 ± 0.4 cm (range, 26–40 cm). TAP produced an average 13–16 mmHg increase in systolic, diastolic, or mean arterial pressure in patients with sinus bradycardia or AV junctional rhythm. There were no subjective patient complaints (epigastric discomfort, dysphagia) that could be attributed to TAP; objective evaluation (esophagoscopy) was not performed. It is concluded that TAP is widely applicable to anesthetized adults; low TAP thresholds can be obtained by first determining P$_{MAX}$ and positioning the PES electrode 1 cm or less distal to P$_{MAX}$ and TAP can be used to increase blood pressure in patients with sinus brady-}

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* Assistant Professor of Anesthesiology.
† Professor of Anesthesiology.
‡ Research Assistant.

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Address reprint requests to Dr. Atlee: Department of Anesthesiology (MCMC), Medical College of Wisconsin, 8700 West Wisconsin Avenue, Milwaukee, Wisconsin 53226.
trode catheter (TAPCATH®; Arzco Medical Electronics, Inc., Vernon Hills, IL), as shown in figure 1. The TAPCATH® probe was approved for investigational use in humans by the Food and Drug Administration (Food and Drug Administration Investigational Device Exemption G900151). The TAPCATH® is 105 cm long and equipped with two, 2.5-mm-wide, stainless steel electrodes spaced 1.5 cm apart. A 14-G angiocatheter was inserted into the proximal end of the stethoscope, and the TAPCATH®, with wire stylet, was advanced to the level of the acoustic diaphragm of the stethoscope. A second 14-G angiocatheter was inserted into the most proximal diaphragmatic perforation of the esophageal stethoscope and used to “catch” the tip of the TAPCATH®. The TAPCATH® was advanced through the angiocatheter so that the electrodes were exposed at the level of the acoustic diaphragm, and the angiocatheter was removed. The distal end of the TAPCATH® was next tucked into the third diaphragmatic perforation, leaving the bipolar electrodes exposed at the surface of the stethoscope. Finally, the wire stylet was removed from the TAPCATH®. The esophageal stethoscope, so-modified for pacing (pacing esophageal stethoscope [PES]), was then ready for insertion.

**Determination of Pacing Thresholds**

After anesthetic induction and tracheal intubation, the PES was inserted transorally into the esophagus and advanced to record a maximum-amplitude, bipolar P-wave ($P_{\text{MAX}}$, by visual inspection) in the esophageal electrocardiogram (ECG). The bipolar esophageal ECG was recorded by substituting the proximal and distal TAPCATH® electrode pins for the right arm and left leg electrode terminal inputs, respectively, and selecting the surface ECG lead II position, as shown in figure 2. The distance (in centimeters) from the intralveolar ridge to a point midway between the bipolar TAPCATH® electrodes at $P_{\text{MAX}}$ was recorded. $P_{\text{MAX}}$ served as the reference point for later measurements of pacing distances (in centimeters) and thresholds (in milliamperes).

Pacing thresholds were determined with patients supine and an FDA-approved TAP pulse generator (model 7A; Arzco Medical Electronics, Inc., Vernon Hills, IL) powered by four 9-V batteries. Rectangular pulses lasting 10 ms were used for TAP, with current variable between 0 and 40 mA. The paced rate was set from 15 to 20% above the spontaneous rate and stimulation begun at 40 mA. Current was decreased until atrial capture was just lost and the current output value (in milliamperes) at loss of capture recorded as the threshold current for $P_{\text{MAX}}$.

To find the minimum pacing threshold (Thmin), pacing thresholds and distances were also recorded at points referenced to $P_{\text{MAX}}$, including 1 cm proximal ($P_{\text{MAX}} - 1$) and 1, 2, and 3 cm distal ($P_{\text{MAX}} + 1, 2, 3$). These points were selected based on previous studies that suggested that Thmin should be 1–2 cm distal to $P_{\text{MAX}}$, as well as information supplied by the manufacturer (Arzco). A Thmin was always recorded at one or more of these points ($P_{\text{MAX}}$ or referenced). If Thmin was observed at only one point, the range for Thmin was arbitrarily 1 cm; if at two adjacent points, the range for Thmin was 2 cm, and so forth. Because, in many patients, Thmin was observed at two or more points, the distance to Thmin was recorded as the average of the intralveolar ridge-to-electrode distances to respective points of Thmin. Thus, if, for example, Thmin was 5 mA at 30 cm ($P_{\text{MAX}}$), 31 cm ($P_{\text{MAX}} + 1$), and 32 cm ($P_{\text{MAX}} + 2$), the range for Thmin would have been tabulated as 3 cm and distance to Thmin as 31 cm.

If patients were later turned from the supine position to the lateral decubitus or prone position, pacing thresholds were redetermined at the same point(s) at which Thmin had been obtained previously.
The PES was left at a Thmin position for the duration of anesthesia but not used for pacing unless sinus bradycardia ($\leq 60$ beats per min) or AV junctional rhythm developed. If pacing was used to treat sinus bradycardia or AV junctional rhythm, blood pressure changes with pacing were noted. Measurements of systolic, diastolic, and mean arterial pressure (noninvasive or direct) during spontaneous rhythm and with TAP were also included. Because three patients were also monitored with thermodilution pulmonary artery catheters, cardiac output and pulmonary artery wedge pressure were recorded before and during TAP for these patients.

**DATA ANALYSIS**

Unless otherwise stated, data are shown as mean $\pm$ standard error of the mean. Paired (two-tailed) and unpaired t tests were used for statistical comparisons, with $P \leq 0.05$ considered significant. Simple regression was used for linear correlations, including distance to $P_{\text{MAX}}$ or Thmin with patient height, age, or body surface area (BSA).

**Results**

**PATIENT DEMOGRAPHICS**

The average age, height, weight, and BSA and median ASA physical status for patients of this study are provided in table 1. There was no difference in age or ASA physical status between male and female patients, but height, weight, and BSA were less in women ($P < 0.05$).

**PACING THRESHOLDS**

Pacing thresholds (in milliamperes), distances (in centimeters), and range for Thmin (in centimeters) are provided in table 2 for supine patients, and changes in Thmin in patients with position changes are shown in table 3.

Pacing thresholds were not less in female compared with male patients, but distances to Thmin, $P_{\text{MAX}}$, and points referenced to $P_{\text{MAX}}$ were less in women compared with men (table 2). The range for Thmin (approximately 2 cm) was the same in both groups of patients (table 2). Thmin was located approximately 1 cm distal to $P_{\text{MAX}}$ in both male and female patients (table 2); changing the patient from supine to the right, but not left, lateral decubitus or prone positions increased Thmin. Finally, although there was a statistically significant linear correlation between patient height and distance to Thmin or $P_{\text{MAX}}$ in male but not female patients, respective R values were low in both patient groups: 0.378 and 0.363 (men) and 0.250 and 0.249 (women).

**PACING FOR BRADYCARDIA**

Twenty-one of 49 male (43%) and 17 of 51 female patients (33%) required TAP for sinus bradycardia (36 patients) or AV junctional rhythm (2 female patients). Blood pressure changes with TAP compared with spontaneous rhythm are shown in table 4 and indicate that an average 13–16-mmHg increase in systolic, diastolic, or mean arterial pressure can be expected with pacing. The effect of TAP rate changes on blood pressure was not tested. In three patients with sinus bradycardia and pulmonary artery catheters, hemodynamic changes with TAP

<table>
<thead>
<tr>
<th>Table 1. Patient Demographics</th>
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<tr>
<td><strong>Men</strong></td>
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<tr>
<td>n</td>
</tr>
<tr>
<td>Age (yr)</td>
</tr>
<tr>
<td>Height (cm)</td>
</tr>
<tr>
<td>Weight (kg)</td>
</tr>
<tr>
<td>BSA (m$^2$)</td>
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<tr>
<td>ASA</td>
</tr>
</tbody>
</table>

BSA = body surface area; ASA = median ASA physical status.

* $P \leq 0.05$. 

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are listed in table 5. All three patients showed improvement in cardiac output. Finally, the ASA physical status of patients who underwent TAP for bradycardia or AV junctional rhythm (ASA physical status 2) was not different from that of patients without these rhythm disturbances.

**Discussion**

The transesophageal atrial pacing thresholds we observed were similar to those obtained by Chung et al. (4.6–9.3 mA). Chung et al. used a bipolar, transvenous pacing lead with an interelectrode distance of 2.9 cm (compared with our 1.5 cm), and their distance to site of minimum pacing threshold (36 ± 7 cm [standard deviation], 11 patients) was somewhat greater than the average distances (men, 34 cm; women, 31 cm) in our patients. These discrepancies might be explained by differences in interelectrode distance, proximal reference point for measurements, distinction as to sex of patients, and numbers of patients between the two studies. Finally, TAP thresholds in our study and that of Chung et al. are considerably less than TAP stimulation parameters for thresholds previously reported for adult patients. Backofen et al. (37 patients) used pulse widths of 20 ms and currents of 25 mA (interelectrode distance not specified), and Buchanan et al. (11 patients) found TAP current thresholds of 18 mA for a pulse width of 10 ms.

At least in theory, minimizing TAP thresholds should reduce the risk of esophageal damage with protracted use of TAP. We did not perform endoscopy to evaluate our patients for evidence of esophageal injury, and there were no subjective patient complaints (e.g., epigastric discomfort or dysphagia). Continuous TAP has been performed for as long as 60 h without evidence of esophageal injury, and two recent reviews did not mention thermal, electrical, or other injury to the esophagus as a direct consequence of TAP. Nevertheless, until more complete data are available, if extended durations (>3–4 h) of pacing are anticipated, one should consider alternative routes for pacing, including transvenous pacing.

Factors that have been evaluated for minimizing pacing thresholds include stimulus duration, stimulation site, and interelectrode distance. These are considered below.

**Stimulus Duration**

Gallagher et al. found that pulse widths between 5 and 10 ms minimized current requirements. This range was confirmed for anesthetized patients in the subsequent study by Chung et al. Benson remarked that pulse widths exceeding 10 ms should have little effect on reducing TAP thresholds in most patients. Exceptions might be those patients in whom TAP thresholds exceed 14 mA for a pulse width of 10 ms. In that case, pulse widths of 15 or 20 ms could reduce TAP thresholds substantially.

**Stimulation Site**

Several studies have suggested that the site of minimum TAP thresholds could be located by finding the site of the maximum-deflection P-wave in the esophageal ECG. This might be a unipolar or bipolar esophageal ECG, because P-wave amplitudes correlate well with

| Table 3. Pacing Thresholds at Thmin after Position Changes in Men or Women Patients |
|-------------------------------|-----------|-----------|-----------|
| Position          |         | Pacing Thresholds (mA) |         |         |         |
|                  | n        | Supine   | New Position |
| RLD              | 4        | 6.3 ± 1.4 | 9.0 ± 2.0   |
| LLD              | 2        | 5.0 ± 2.0 | 5.0 ± 2.0   |
| Prone            | 1        | 5.0       | 55.0       |

RLD = right lateral decubitus; LLD = left lateral decubitus.

Table 3. Pacing Thresholds at Thmin after Position Changes in Men or Women Patients

| Table 4. Effects of TAP on Blood Pressure in Patients with Sinus Bradycardia or AV Junctional Rhythm |
|--------------------------------------------------------|---------------------|---------------------|---------------------|
| Men (n = 21)                                           |                     |                     |                     |
| SBP                      | DBP | MBP | Rate |
| Before TAP                | 102 ± 5 | 56 ± 3 | 74 ± 4 | 55 ± 1 |
| After TAP                 | 118 ± 5* | 69 ± 4* | 88 ± 4* | 85 ± 2* |

| Women (n = 10)                                          |                     |                     |                     |
|SBP                      | DBP | MBP | Rate |
|Before TAP                | 100 ± 4 | 58 ± 3 | 73 ± 3 | 57 ± 2 |
|After TAP                 | 115 ± 4* | 71 ± 3* | 88 ± 3* | 80 ± 1* |

SBP, DBP, MBP = systolic, diastolic, and mean arterial pressures (mmHg), respectively. Rate = heart rate (beats per min).

* P < 0.05 versus before.
TABLE 5. Cardiac Output and Pulmonary Artery Wedge Pressure before and after TAP in Three Men Patients with Sinus Bradycardia

<table>
<thead>
<tr>
<th>Patient</th>
<th>Before TAP CO</th>
<th>Before TAP PWP</th>
<th>After TAP CO</th>
<th>After TAP PWP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.8</td>
<td>13</td>
<td>7.3</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>3.6</td>
<td>8</td>
<td>4.5</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>3.5</td>
<td>12</td>
<td>4.9</td>
<td>10</td>
</tr>
<tr>
<td>Mean ± SEM</td>
<td>4.0 ± 0.4</td>
<td>11 ± 1.5</td>
<td>5.6 ± 0.9</td>
<td>12 ± 2.5</td>
</tr>
</tbody>
</table>

the two techniques. In available studies of anesthetized patients, Backofen et al. did not examine the relation between maximum P-wave amplitude and minimum pacing threshold. Buchanan et al. also did not examine it, although they inserted their cardioesophagogoscope to a depth determined by the greatest P-wave deflection. Chung et al. used surface landmarks to initially position the TAP electrode, which was then withdrawn by 1-cm increments until a minimum pacing threshold was obtained. None of the foregoing studies in anesthetized patients provide a reproducible and convenient way to locate the site of minimum TAP thresholds. Our study, in agreement with findings in nonanesthetized patients, suggests that minimum pacing thresholds can be obtained 1 cm or less distal to $P_{MAX}$.

**INTERELECTRODE DISTANCE**

An esophageal pacing probe with sliding electrodes (1–8 cm spacing) was used by Gallagher et al. to evaluate the effect of interelectrode distance on TAP thresholds. In seven patients, the threshold current for 10-msec pulse widths was slightly lower for interelectrode spacing of 3 cm. Benson et al. concluded that, for interelectrode spacing of 1.5–2.8 cm, interelectrode distance was not a critical factor for minimizing pacing thresholds. Nishimura et al. found that TAP thresholds were lowest for interelectrode spacing of 2.4 cm. Neither we nor others who have reported TAP thresholds for anesthetized patients have determined the effect of interelectrode distance on minimizing TAP thresholds. Nevertheless, our results and those of Chung et al. suggest that TAP thresholds for a stimulus duration of 10 ms are lowest and nearly the same for interelectrode distances between 1.3 and 2.9 cm. Much higher (approximately threefold) TAP thresholds can be expected with 10-cm interelectrode spacing.

We found that TAP thresholds increased when patients were turned from the supine to prone or right (not left) lateral decubitus positions. To our knowledge, the effect of position changes on TAP thresholds has not been examined previously. More detailed knowledge of this might be of interest to anesthesiologists who contemplate using TAP for intraoperative management of bradycardia and supraventricular tachyarrhythmias amenable to pacing therapy. The distance between the left atrium and esophagus is said to be less than 1 cm in supine adults. Based on inspection of anatomic drawings depicting relations between the posterior wall of the heart and esophagus, we surmise that this distance would increase least in the left lateral decubitus compared with other, non-supine positions.

There was a surprising high overall incidence of sinus bradycardia or AV junctional rhythm in our patients; comparable data are not available. TAP produced substantial hemodynamic improvement in our patients, with increases in blood pressure similar to those previously reported with TAP for bradycardia in anesthetized patients having cardiovascular surgery. Additional studies are required to compare TAP with existing methods for treating bradycardia, including drugs and noninvasive transcutaneous ventricular pacing. We believe that TAP might be preferable to the latter for treating hemodynamically deleterious bradycardia in patients with intact atrioventricular conduction and not in atrial fibrillation, because TAP preserves atrial transport function. Preserved atrial contraction should be most critical in patients with impaired ventricular relaxation.

In conclusion, TAP appears widely applicable in anesthetized, adult surgical patients. It can be established easily with acceptably low pacing thresholds if pacing electrodes are positioned 1 cm or less distal to the maximum-amplitude P-wave in the esophageal ECG. Finally, TAP can be expected to improve hemodynamics in patients with sinus bradycardia or AV junctional rhythm.

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**References**


