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1 **Left ventricular wall thickness assessed by cardiac computed tomography and CRT**
2 **outcomes.**

3

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1 **ABSTRACT**

2 **Aims.** Up to 30% of selected heart failure patients do not benefit clinically from cardiac
3 resynchronization therapy (CRT). Left ventricular (LV) wall thickness (WT) analyzed using
4 computed tomography (CT) has rarely been evaluated in response to CRT and mitral
5 regurgitation (MR) improvement. We examined the association of LVWT and the ability for
6 reverse LV remodeling and MR improvement after CRT.

7 **Methods.** 54 patients scheduled for CRT underwent pre-procedural CT. Reduced LVWT was
8 defined as $WT < 6\text{mm}$ and quantified as a percentage of total LV area. End points were 6-
9 month clinical and echocardiographic response to CRT (NYHA class, LV ejection fraction
10 (LVEF), LV end-diastolic volume (LVEDV) and LV end-systolic volume (LVESV)), MR
11 improvement and 2-year major adverse cardiac events (MACE).

12 **Results.** Patients were divided in 3 groups according to the percentage of $LVWT < 6\text{mm}$ area:
13 $\leq 20\%$; 20-50% and $\geq 50\%$. At 6 months, 75%, 71% and 42% of the patients experienced
14 NYHA improvement in the $\leq 20\%$, 20-50% and $\geq 50\%$ group respectively. Additionally, $\leq 20\%$
15 group presented higher LVEF, LVEDV and LVESV positive response rate (86%, 59% and
16 83% respectively). Both 20-50% and $\geq 50\%$ groups exhibited a lower LVEF, LVEDV and
17 LVESV positive response rate (52% and 42%; 47% and 45%; 53% and 45%, respectively).
18 Additionally, $\geq 25\%$ of $LVWT < 6\text{mm}$ inclusive of at least 1 papillary muscle insertion was the
19 only predictor of lack of MR improvement. Lastly, $\geq 50\%$ group experienced significantly
20 lower 2-years MACE survival free probability.

21 **Conclusion.** WT evaluated using CT could help to stratify the response to CRT and predict
22 MR improvement and outcomes.

23

24 **KEY WORDS:** Cardiac resynchronization therapy, response to cardiac resynchronization
25 therapy, mitral regurgitation, computed tomography, left ventricular wall thickness

1 **CONDENSED ABSTRACT**

2 CRT-recipients with a low percentage of left ventricular wall thickness (LVWT) <6mm
3 ($\leq 20\%$) significantly improved their echocardiography parameters. Patients with $\geq 25\%$ of
4 LVWT<6mm inclusive of at least 1 papillary muscle insertion was the only predictor of no
5 mitral regurgitation improvement. Patients with $\geq 50\%$ of LVWT<6mm experienced poor 2-
6 years outcomes.

7

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1 **What's New?**

2 -Left ventricular wall thickness (LV WT) measured computed tomography could be
3 associated with the response to CRT.

4 -CRT candidates with a low percentage of LV WT<6mm ($\leq 20\%$) significantly improved their
5 clinical status and echocardiography parameters compared to the groups with a larger
6 proportion of reduced LV wall thickness.

7 -An area $\geq 25\%$ of LVTW<6mm that including the insertion of at least 1 muscle limits the MR
8 improvement after CRT implantation.

9 -Patients with $\geq 50\%$ of LV WT<6mm experienced poor outcomes 2-years post CRT
10 implantation

11

1 **ABBREVIATIONS**

2 Cardiac resynchronization therapy = CRT

3 Computed tomography = CT

4 Heart failure = HF

5 Left ventricular = LV

6 Left ventricular ejection fraction = LVEF

7 Left ventricular end-diastolic volume = LVEDV

8 Left ventricular end-systolic volume = LVESV

9 Mitral regurgitation = MR

10 Mitral valve = MV

11 Wall thickness = WT

12

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1 INTRODUCTION

2 Cardiac resynchronization therapy (CRT) improves mortality, morbidity and quality of
3 life in selected heart failure (HF) patients (1; 2). Indeed, CRT implantation has been
4 associated with left ventricular (LV) reverse remodeling and secondary mitral regurgitation
5 (MR) improvement (1; 3). However, up to 30% of device recipients do not benefit clinically
6 from CRT (2). Among the factors influencing the response to CRT, LV morphology and
7 mitral valve (MV) geometry have been previously described. Indeed, LV fibrosis and MV
8 apparatus geometry (analyzed using cardiac magnetic resonance or echocardiography
9 respectively) have been strongly correlated with poor LV function and MR enhancements
10 after CRT implant (3, 4-5). Nonetheless, data regarding the impact of LV myocardial analysis
11 using computed tomography (CT) on LV and MR functions after CRT are scarce.

12 Dual-source CT is an ideal noninvasive modality that provides pertinent information
13 to guide the CRT implantation procedure (6). Indeed, previous studies have demonstrated that
14 CT can visualize the coronary venous anatomy, detect the presence of myocardial scar and
15 evaluate the LV mechanical dyssynchrony to guide physician for an optimal LV lead pacing
16 site (7-8). However, there is a paucity of data regarding the impact of LV wall thickness (WT)
17 evaluated using CT on response to CRT. In this study, we sought to examine the association
18 between LV WT and LV reverse remodeling and MR improvement after CRT in a
19 prospective cohort.

20

21 METHODS

22 **DESIGN OF THE STUDY.** The rationale and design of the Dual-Source Computed
23 Tomography to Improve Prediction of Response to Cardiac Resynchronization Therapy
24 (NCT01097733) have been previously published (9). Briefly, 54 refractory HF patients with
25 New York Heart Association (NYHA) functional class II-IV, LV ejection fraction (LVEF)

1 $\leq 35\%$ and electrocardiographic QRS duration >120 ms were prospectively enrolled for a CRT
2 implantation procedure between 2010 and 2014. The CT scan protocol was previously
3 described (9). Of note, the distinction between ischemic and non-ischemic etiology was based
4 on the medical record of each patient and especially on the history of angina/myocardial
5 infarction and coronary angiography findings. Patients with normal coronary angiography or
6 with minor coronary lesion ($< 50\%$ stenosis) not explaining the cardiomyopathy were
7 classified as a non-ischemic.

8 After CRT implantation, patients returned for regular clinic visits at 1, 3, 6 months,
9 and annually thereafter. At each follow-up visit, NYHA Class, global assessment, 6-minute
10 walk distance and 12-lead ECG were assessed. At the 6-month follow-up visit, a repeat echo
11 and assessment for CRT response was performed. Study clinical follow-up ended at 2 years.
12 Of note, the impact of LVWT on the response to CRT was assessed among the 54 enrolled
13 patients and the impact of MR improvement was specifically evaluated among the patients
14 with mild to severe MR at baseline ($n=38$). The study protocol was approved by the
15 institutional review board and all patients provided written informed consent.

16
17 **LEFT VENTRICULAR WALL THICKNESS ANALYSIS.** All CT images were
18 retrospectively analyzed using the ADAS-VT software (Galgo Medical, Barcelona, Spain) by
19 an experienced observer, blinded to the clinical data. The performance and the inter- and
20 intra-observatory reproducibility of the software has been previously described (10-11). To
21 create the model, CT images were exported in DICOM format and integrated in the software.
22 A total of four landmarks were manually placed (center of the aortic annulus, center of the
23 mitral annulus, LV apex and center of the tricuspid annulus). To adjust the model, the
24 contours of the LV endocardium and epicardium were then manually drawn in 3 LV short
25 axis slices. Then, endocardial and epicardial borders were delimited with a semiautomatic

1 segmentation algorithm. Lastly, a manual adjustment of the LV endocardial and epicardial
2 borders was required to fit the surface to the CT images in the short-axis, two chambers and
3 coronal planes. A 3D visualization of the LV was then created and WT was defined using a
4 color threshold. As previously described, normal LV WT was defined as an end-diastolic
5 $WT > 6\text{mm}$ and $WT < 6\text{mm}$ suggested reduced LV WT (9-10; 12). For quantitative analysis, the
6 extent of total $WT < 6\text{mm}$ burden was quantified as a percentage of total LV area. In this work,
7 10 CT images were used to evaluate the intra- and inter-observer variance. The intraclass
8 correlation coefficient was 0.97 (0.89-0.99) and 0.95 (0.82-0.99) for the intra-observer and
9 inter-observer variability for the total percentage of LV $WT < 6\text{mm}$, respectively.

10 Additionally, the LV was automatically segmented in 17 segments and each segment
11 was considered with reduced WT in case of $WT < 6\text{mm}$ area location. Depending on this
12 segmentation, the LV was divided in 3 regions: postero-lateral (segments 4-5-10-11-15-16),
13 antero-lateral (1-6-7-12-13) and septal (2-3-8-9-14). Patients were considered to have a
14 thinned region if there was at least 1 segment with reduced WT in each region.

15 Regarding the MV apparatus analysis, papillary muscles (PM) were manually tagged
16 on DICOM images and then automatically segmented and extracted by the ADAS-VT
17 software. Importantly, the implantation base of the PM was carefully tagged to accurately
18 evaluate the WT below the insertion base. After this segmentation, each PM was added and
19 superimposed on the 3D LV model. PM was considered as inserted in a reduced WT area if
20 the majority of the PM was implanted in a region with a $WT < 6\text{mm}$.

21
22 **END POINTS.** End-points included the clinical/echocardiographic response to CRT
23 at 6-months, QRS duration decrease at 6 months, MR improvement at 6 months and the
24 occurrence of major adverse cardiac events (MACE) during 2-years of follow-up.

1 The clinical response to CRT endpoints included: 1) change in the NYHA class at 6
2 months; and 2) change in HF clinical status at 6 months using the patient global assessment.
3 Of note, the global assessment score is a 7-point rating scale, allowing for the evaluation of
4 the patient's own perspective of overall health compared with a previous point in time (13).
5 Patients exhibited HF clinical status response in case of markedly or moderately
6 improvement.

7 The echocardiographic response to CRT endpoints included: 1) change in left
8 ventricular end-systolic volume (LVESV). LVESV response was defined as reduction in
9 LVESV by $\geq 15\%$; 2) change in left ventricular end-diastolic volume (LVEDV). LVEDV
10 response was defined as reduction in LVEDV by $\geq 10\%$; and 3) LVEF improvement at 6
11 months. LVEF response was defined as improvement in LVEF by $\geq 5\%$ (14).

12 The intrinsic QRS durations at baseline (pre-CRT) were compared with the
13 biventricular-paced QRS durations at 6 months; the delta QRS was defined as the intrinsic
14 QRS duration (ms) at baseline minus the biventricular-paced QRS at 6 months.

15 Positive MR improvement at 6 months was defined as improvement by ≥ 1 class
16 among patient with mild to severe MR at baseline. Of note, the MR was graded semi-
17 quantitatively in an integrative fashion as none (0), trace (1), mild (2), moderate (3) or severe
18 (4). All measurements were performed in accordance with the current guidelines (15).

19 For the end point of 2-year MACE, we included the composite end point of death, LV
20 assist device implantation, cardiac transplantation, and HF hospitalization.

21
22 **STATISTICAL ANALYSIS.** Qualitative variables are summarized with frequencies
23 (percentage); continuous data as mean \pm standard deviation or median (interquartile range)
24 depending on their distribution, which was assessed using the Kolmogorov-Smirnov test.
25 Categorical variables were compared using the χ^2 tests or Fisher's exact test. Continuous

1 variables were compared using Student's *t*-test or the Mann-Whitney U-test for two-group
2 comparisons. ANOVA tests or Kruskal-Wallis tests were used to compare continuous
3 variables among three or more groups. Multivariable analysis and odds ratio (OR) was
4 determined using logistic regression. For the purposes of the multivariable analysis, variables
5 with *p*-values <0.05 in univariate analysis were included. Of note, for the predictor of
6 response to CRT, we used the LVESV parameter to define responder and non-responder
7 patients (responder was defined as reduction in LVESV by $\geq 15\%$). Additionally, for the
8 predictor of MR improvement, a receiver-operator curve (ROC) analysis was used to
9 categorize LVWT by selecting clinically-relevant cut-off, which were the closest to the
10 optimal cut-off according to the maximum Youden's index (sensitivity + specificity). Survival
11 rates were summarized using Kaplan–Meier estimates, and log-rank tests were used to
12 compare groups. A *p*-value <0.05 was considered statistically significant. The analyses were
13 performed with the SPSS statistical package, version 11.0 (SPSS Inc., Chicago, IL).

14

15 **RESULTS**

16 **BASELINE CHARACTERISTICS.** Among the 54 patients enrolled in the DIRECT
17 study, the mean area of LV WT<6mm was 62.6 ± 53.7 cm² per patient ($30.2 \pm 19.5\%$ of the total
18 LV area). To assess the impact of LV WT on the response to CRT, patients were divided into
19 3 groups according to the percentage of LV WT<6mm related to the total LV area: $\leq 20\%$
20 (low group=21 patients); 20-50% group (moderate group=21 patients) and $\geq 50\%$ group (high
21 group=12 patients). Of note, to define these 3 groups, we used the tertiles of total percentage
22 of LV WT<6mm. Illustrative examples of patients with $\leq 20\%$; 20-50% and $\geq 50\%$ of LV
23 WT<6mm are shown in **Figure 1**. Baseline characteristics of the 3 groups were detailed in
24 **Table 1**. Briefly, there was no difference regarding the age, gender, body mass index and
25 atrial fibrillation history. All groups have a mean QRS duration > 150 ms without statistical

1 difference in the QRS duration or morphology. Of note, there was a statistically increased
2 gradient of NT-proBNP level between the 3 groups. Regarding the echocardiography
3 parameters, $\leq 20\%$ group had higher LVEF at baseline without difference in LVEDV or
4 LVESV but a non-significant increase in dilated LV from the $\leq 20\%$ to the $\geq 50\%$ group was
5 noted. Additionally, the low LVWT area group had thicker inter-ventricular septum.
6 Regarding the LVWT <6 mm area location, there was a significant gradual number of postero-
7 lateral segments with reduced LVWT from the $\leq 20\%$ to the $\geq 50\%$ group.

8 Of note, supplemental baseline characteristics between patients with ischemic or non-
9 ischemic etiology are presented in the **supplementary material (Table 1)**. Briefly, ischemic
10 group was significantly older with worse renal function before CRT implantation.
11 Importantly, both groups were similar according to the echocardiographic parameters and CT
12 analysis at baseline.

13
14 **LEFT VENTRICULAR WALL THICKNESS AND RESPONSE TO CRT.** At 6
15 months, 76%, 71% and 42% of the patients experienced an improvement in NYHA class by
16 ≥ 1 in the low, moderate and high groups respectively (**Table 2**). Additionally, a majority of
17 patients included in the low and moderate groups (80% and 65% respectively) had a
18 significant improvement of their global assessment, whereas 42% in the $\geq 50\%$ group
19 experienced no change of worst global assessment (**Figure 2, panel A**). However, despite a
20 high rate of clinical response in the low and moderate LV WT area group, the 6-minute walk
21 distance was only significantly improved in the low group (**Figure 2, panel B**).

22 Electrocardiographic and echocardiographic response is described in **Figure 3** and
23 **Table 2**. Compared to baseline, biventricular pacing had significantly decreased the QRS
24 duration in the $\leq 20\%$ group (164.0 ± 14.3 vs. 145.7 ± 15.3 , $p=0.001$). In the 20-50% group,
25 although we noted a QRS duration reduction (162.2 ± 26.7 vs. $148.9.1 \pm 27.8$, at baseline and 6-

1 months respectively), this improvement was not statistically significant ($p=0.140$). Lastly,
2 $\geq 50\%$ group experienced no electrical remodeling, with no change in QRS duration at 6-
3 months.

4 Regarding the echocardiographic response to CRT, patients in low LVWT area group
5 have a significant improvement between baseline and 6 months in LVEF (27.2 ± 5.7 vs.
6 $40.6\pm 9.5\%$, respectively; $p<0.001$) and LVESV (146.6 ± 82.9 vs. 93.3 ± 35.0 , respectively;
7 $p=0.015$). Using the responder criteria for LVESV ($\geq 15\%$ relative reduction), LVEDV ($\geq 10\%$
8 relative reduction), and LVEF ($\geq 5\%$ absolute increase), positive echocardiographic responses
9 to CRT were observed in 86%, 52%, and 81% of patients, respectively. Patients in the
10 moderate area group experienced only LVEF significant improvement with a positive LVEF,
11 LVEDV and LVESV response rate of 52%, 52% and 48% respectively at 6 months. Lastly,
12 patients with $\geq 50\%$ of LVWT >6 mm experienced a lower rate of response to CRT at 6
13 months with 42%, 42% and 25% of LVEF, LVEDV and LVESV improvement using the CRT
14 response definition.

15 Multivariate analysis for the predictor of response to CRT (based on the LVESV
16 reduction at 6-months) showed that the total percentage of reduced WT area was the only
17 predictors of response to CRT (OR 1.04 (1.003-1.08), $p=0.032$) (**Supplemental material,**
18 **Table 2**).

19 Additionally, the response to CRT was evaluated depending on the underlying
20 cardiomyopathy (**Supplemental material, Table 3**). Importantly, both etiologies in the $<20\%$
21 group had significant LVEF improvement and LVESV reduction. In the 20-50% and $>50\%$
22 groups, there was no significant LVEF improvement and LV volumes reduction in both
23 patient cohorts, i.e. with ischemic and non-ischemic cardiomyopathy. However, there is a
24 trend toward less response in the ischemic group using the LVEF, LVEDV and LVESV
25 criteria.

1 Changes in LVEF, LVEDV and LVESV from baseline to 6 months were also
2 evaluated depending on the location of the thinned WT in the postero-lateral, antero-lateral
3 and septal regions. Results are presented in the **supplementary material (Table 4)**. Briefly,
4 only patients with normal antero-lateral region experienced significant LVEF improvement
5 from baseline to 6 months. Similarly, there was a non-significant trend toward a higher
6 LVEDV and LVESV reduction in patients with normal postero-lateral region.

7
8 **MITRAL REGURGITATION IMPROVEMENT.** Among the 54 patients, 38
9 (70.4%) had mild to severe MR at baseline and a total of 16 (42.1%) experienced MR
10 improvement by ≥ 1 class at 6 months. Characteristics of patients with or without MR
11 improvement were described in the **Table 3**. Importantly, no difference was recorded
12 regarding the LV dilation in both groups. However, patients without MR improvement had
13 significantly higher NT-pro BNP level at baseline. Interestingly, patients without MR
14 improvement had larger LVWT<6mm area (41.5 ± 19.4 vs. $22.4 \pm 16.1\%$, $p=0.003$) associated
15 with a higher number of PM inserted in the reduced LV WT area. ROC analysis for total
16 percentage of LVWT<6mm demonstrated that an optimal cut-off value of 25% differentiated
17 patients with or without MR improvement (C-statistic of 0.77 (95%IC:0.62-0.92))
18 **supplementary material (Figure 1)**. In multivariable analysis, an area $\geq 25\%$ of
19 LVWT<6mm including at least 1 PM insertion was the only predictor of no MR improvement
20 at 6 months (OR 16.82 (95%CI:1.72-164.2), $p=0.015$). Illustration of PM insertion in reduced
21 LVWT is depicted in **Figure 4, Panel A/B**.

22 Lastly, as described in the **Figure 4, Panel C**, patients with MR improvement had
23 significant lower rate of basal segments with reduced WT (0.9 vs. 1.7, $p=0.045$), especially in
24 the lateral location. Additionally, results showed a trend toward fewer reduced WT segments

1 in mid and apical locations among the 16 patients with MR improvement. Of note, patients
2 with MR improvement exhibited a lower rate of postero-lateral WT<6mm segments.

3

4 **LEFT VENTRICULAR WALL THICKNESS AND MACE OUTCOMES.**

5 Among the 54 CRT recipients, MACE occurred in 9 (16.7%) patients after 2-years of follow-
6 up. Among those, all experienced at least one HF hospitalization, one was subsequently
7 implanted with a LV assist device and cardiovascular death occurred in 5 patients. None of
8 these CRT recipients underwent heart transplantation. Of note, 4 patients who died were in
9 the $\geq 50\%$ group and death occurred 10.0 ± 6.8 months after CRT implantation. First MACE
10 occurred after a mean time of 10.9 ± 5.9 months after CRT implantation and low and moderate
11 area groups had higher MACE-free survival probability than the high area group (**Figure 5**).

12

13 **DISCUSSION**

14 **MAIN RESULTS.** Our study is amongst the first to evaluate the role of CT in
15 quantifying the extent of LV wall thickness in prognosticating response to CRT. The main
16 results of this study are: 1) LV WT could help to stratify the response to CRT and predicts
17 MR improvement. 2) CRT candidates with a low percentage of LV WT<6mm ($\leq 20\%$)
18 significantly improved their clinical status and echocardiography parameters compared to the
19 groups with a larger proportion of reduced LV wall thickness. 3) Patients without MR
20 improvement had larger LVWT<6mm area associated with a higher number of PM inserted in
21 the reduced LV WT area. 4) Lastly, patients with $\geq 50\%$ of LV WT<6mm were at higher risk
22 of MACE.

23

24 **LEFT VENTRICULAR MORPHOLOGY AND RESPONSE TO CRT.** Among
25 the factors influencing the response to CRT, LV myocardial morphology has been

1 investigated in HF patients. Indeed, among 97 non ischemic patients, those with midwall
2 fibrosis detected by CMR via late gadolinium enhancement were less likely to exhibit LV
3 reverse remodeling (16). Similarly, Taylor *et al.* evaluated the impact of CMR among 89 CRT
4 candidates and showed that LV lead deployment over non-scarred segments was associated
5 with better response and clinical outcomes after CRT (5). However, data regarding LV CT
6 analysis and CRT benefit are unclear (9). Variability in the measurement of WT (i.e. end-
7 diastole or end-systole) can impact its predictive value. WT measured during maximal systolic
8 thickening could possibly underestimate the real burden of reduced WT area compared to
9 end-diastole measurement. Indeed, a recent editorial has suggested that the quantification of
10 reduced WT is more accurate during the end-diastole (12). In our study, we observed a graded
11 enhanced response to CRT with increasing WT. Similarly, WT as a marker for adverse events
12 in CRT recipients has been evaluated among the patients enrolled in the MADIT-CRT study
13 (17). In this work, relative WT at baseline was the best echocardiographic predictor for
14 ventricular tachyarrhythmia events compared with commonly used echocardiographic
15 measurements and rightfully suggested that WT can mirror the extent of LV fibrosis and
16 scarring on one hand and the extent of the remodeling process on the other hand (17). In the
17 current study, advanced deleterious remodeling process could explain poor response to CRT
18 in patients with a larger baseline area of WT < 6mm. Indeed, moderate (20-50%) and high
19 ($\geq 50\%$) groups had both numerically higher LVEDV and LVESV at baseline compared to the
20 low area patients. However, the moderate group experienced more favorable response to CRT
21 than the high group and higher fibrosis and more scar response in these patients may explain
22 that they less likely experienced LV reverse remodeling. Notably, we found that patients
23 within the $\geq 50\%$ group had no QRS reduction after CRT compared to baseline ECG, thereby
24 explaining the LV function improvement, as previously described (18).

25

LEFT VENTRICULAR WALL THICKNESS AND MITRAL

REGURGITATION IMPROVEMENT AFTER CRT. In our current study we observed that PM insertion site is probably crucial. Indeed, patients without MR improvement had larger LVWT<6mm area associated with a higher number of PM inserted in the reduced LV WT area. This result possibly highlighted the critical link between the LV morphology at the site of MV apparatus insertion and suggests that normal WT could promote a MV apparatus remodeling after CRT. Our result is supported by previous work that demonstrated that the lack of scar at the PM insertion sites using echocardiography was associated with MR improvement (19). Lastly, we observed that patients without MR improvement had larger area of reduced WT in the basal segments. Similarly, previous study showed that CRT enhanced the mitral annular deformation by resynchronizing LV basal segments (20). Consequently, normal WT adjacent to the MV annulus could potentially improve mitral annulus deformation in CRT recipients, leading to a decrease of the annular diameter.

COMPUTED TOMOGRAPHY AS A TOOL TO PREDICT OUTCOMES IN

CRT CANDIDATES. In our study we show that patient with $\geq 50\%$ area of LVWT<6mm had poor 2-years outcomes compared to $\leq 20\%$ and 20-50% groups. Of note, this result is consistent with a previous study that demonstrated that CRT patients with low relative WT at baseline had significantly higher risk for ventricular arrhythmias and death (17). Additionally, advanced deleterious remodeling process could explain the worse outcomes in patients with a larger area of WT<6mm. Indeed, we showed that this subgroup of patients had lower LVEF and higher NT-pro BNP level at baseline.

CLINICAL IMPLICATIONS. These results bring important information and could

be helpful in daily clinical practice. First, in contrast to other cardiac imaging technique, CT

1 provides some benefit. Indeed, compared to CMR, CT can be much more easily and quickly
2 performed in patients previously implanted with a device (pacemaker or implantable
3 cardioverter defibrillator) and who require an up-grade to CRT. Additionally,
4 echocardiography measurement requires a relatively high image quality, depends more
5 heavily on operator experience and cannot provide an extensive description of the WT
6 compared to CT. Second, LV WT using CT analysis could stratify the response to CRT in HF
7 patients, depending on the total area with WT<6mm ($\leq 20\%$; 20-50% and $\geq 50\%$) and may
8 assist the physician to optimize the HF management. Indeed, patient with low or moderate
9 percentages of LV WT<6mm ($\leq 20\%$ and 20-50%) experience few MACE events during 2-
10 years of follow-up compared to patients with a larger area of LV WT<6mm, who exhibited
11 33.3% of cardiac death. Physicians should consequently carefully manage this last group
12 associated with probably low chance of long-term CRT benefit expected but only temporary
13 HF status stabilization.

14

15 **LIMITATIONS.** The limited sample size makes our study hypotheses generating,
16 and will require validation in larger studies. The relationship between wall thickness and
17 fibrosis is difficult to define and will require evaluation through studies using multi-modality
18 imaging (i.e. CMR and CT). Lastly, due to the small number of MACE events, we were not
19 able to provide a multivariate analysis to evaluate the impact WT on the outcomes.

20

21 **CONCLUSION**

22 LV WT evaluated using cardiac CT could help to stratify the response to CRT and MR
23 improvement in HF patients. This needs to be further validated in a larger cohort of patients
24 receiving CRT.

25

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4

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1 **FIGURES**

2

3 **Figure 1: Example of left ventricular wall thickness segmentation using the ADAS**
4 **software in patients with $\leq 20\%$, 20-50% and $\geq 50\%$ of LV WT $<6\text{mm}$, respectively. Panel**
5 **A: Antero-posterior view; Panel B: Postero-anterior view; Panel C: Lateral view; Panel D:**
6 **Inferior view.**

7

8 **Figure 2: Clinical response to CRT from baseline to 6 months.** Panel A: Global
9 assessment at 6 months; Panel C: 6-minute walk distance evolution between baseline and 6
10 months.

11

12 **Figure 3: Electrocardiographic and echocardiographic response to CRT from baseline**
13 **to 6 months.** Panel A: QRS duration change from baseline to 6 months. Panel B: Individual
14 changes in LVEF from baseline to 6 months. Panel C: Change in LVEDV and LVESV from
15 baseline to 6 months.

16 LVEF=Left ventricular ejection fraction; LVESV=Left ventricular end-systolic volume;
17 LVEDV=Left ventricular end-diastolic volume.

18

19 **Figure 4: Panel A and B Illustrative examples of WT segmentation and PM insertion.**
20 **Star=Anterior PM insertion; Arrow=Posterior PM insertion.** Panel A: patient with 45%
21 of LVWT $<6\text{mm}$ and PM insertion in normal WT area who experienced MR improvement at 6
22 months. Panel B: patients with 46% of LVWT $<6\text{mm}$ and posterior PM inserted in reduced
23 WT area without MR improvement. **Panel C: LV segmentation and location of each**
24 **reduced WT segments in patient with or without MR improvement.**

25 MR=Mitral regurgitation; WT=Wall thickness

1 **Figure 5: MACE free survival probability.**

2 MACE=Major adverse cardiac event.

3

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1 **Table 1: Baseline characteristics**

2 ACEI=Angiotensin-converting enzyme inhibitor; ARB=Angiotensin II receptor blocker;

3 ICD=Implantable cardioverter defibrillator; LBBB=Left bundle branch block; LV=Left

4 ventricular; LVEF=Left ventricular ejection fraction; LVEDV=Left ventricular end-diastolic

5 volume; LVESV=Left ventricular end-systolic volume; NT-proBNP=N-terminal pro-brain

6 natriuretic peptide; RBBB=Right bundle branch block; WT=Wall thickness.

7

	≤ 20% (n=21)	20 – 50% (n=21)	≥ 50% (n=12)	p Value
Computed tomography analysis				
-LV area with WT<6mm, cm ²	9.8 (4.4-16.4)	34.9 (24.9-43.3)	55.4 (53.2-59.9)	<0.001
-Postero lateral LV segments with WT<6mm	1.0 (0.0-2.0)	2.0 (1.0-3.0)	4.0 (2.5-4.5)	<0.001
-Antero lateral LV segments with WT<6mm	0.0 (0.0-1.0)	2.0 (1.0-2.0)	3.0 (1.5-3.0)	<0.001
Age, yrs	63.1±10.4	63.2±13.5	60.7±10.1	0.810
Ischemic cardiomyopathy	8 (38.1)	8 (38.1)	4 (33.3)	0.956
Male gender	14 (66.7)	17 (80.9)	9 (75.0)	0.570
Body mass index, kg/m ²	30.9±6.8	27.5±5.2	30.0±3.9	0.148
Hypertension	12 (57.1)	9 (42.9)	6 (50.0)	0.651
Diabetes mellitus	9 (42.9)	3 (14.3)	1 (8.3)	0.034
Atrial fibrillation	4 (19.0)	1 (4.8)	3 (25.0)	0.227
Previous device				
-Pacemaker	3 (14.3)	1 (4.8)	0 (0)	0.269
-ICD	6 (28.6)	7 (33.3)	10 (83.3)	<0.001

NYHA, functional class				0.556
-II	3 (14.3)	5 (23.8)	1 (8.3)	
-III	17 (80.9)	16 (76.2)	11 (91.7)	
-IV	1 (4.8)	0 (0)	0 (0)	
6-minute walk distance, m	268.3±130.7	341.1±116.9	276.1±131.7	0.177
Baseline medication				
-Beta blockers	20 (95.2)	19 (90.5)	11 (91.7)	0.833
-ACEI/ARB	13 (61.9)	18 (85.7)	11 (91.7)	0.076
-Spironolactone	8 (38.1)	5 (23.8)	7 (58.3)	0.141
-Diuretics	13 (61.9)	13 (61.9)	10 (83.3)	0.381
Electrocardiogram				
-Intrinsic QRS duration, ms	164.0±14.3	162.2±26.7	152.7±20.6	0.346
-QRS morphology				0.559
-LBBB	16 (76.2)	16 (76.2)	8 (66.6)	
-RBBB	1 (4.8)	2 (9.5)	2 (16.7)	
-Undetermined BBB	1 (4.8)	2 (9.5)	2 (16.7)	
-Paced QRS	3 (14.3)	1 (4.8)	0 (0)	
Laboratory parameters				
-Creatinine, mg/dL	1.0±0.9	1.1±0.9	1.1±1.0	0.416
-NT-proBNP, pg/mL	361.0 (188.2-1113.0)	908.0 (630.7-1738.0)	1730.0 (1179.5-3438.5)	<0.001
Echocardiography				
-LVEF, %	27.2±5.7	26.4±6.8	21.2±6.7	0.031
-LVEDV, ml	208.3±93.0	235.7±96.2	265.4±81.8	0.149
-LVESV, ml	146.6±82.9	172.5±79.3	202.6±69.4	0.145
-Left atrial diameter, mm	41.1±6.6	44.5±5.7	45.2±4.2	0.082

-Interventricular septum, mm	10.6±1.3	9.4±1.5	9.4±1.9	0.036
-Posterior wall thickness, mm	10.4±2.3	10.3±2.0	10.0±1.7	0.836
-Mitral regurgitation, class				0.490
-I	8 (38.1)	7 (33.3)	1 (8.3)	
-II	9 (42.9)	7 (33.3)	4 (33.3)	
-III	3 (14.3)	4 (19.0)	6 (50.0)	
-IV	1 (4.8)	3 (14.3)	1 (8.3)	
LV lead location				
-Non-apical location	19 (90.5)	21 (100)	10 (83.3)	0.190
-Postero-lateral location	14 (66.7)	16 (76.2)	12 (100)	0.084
Biventricular pacing at 6 months, %	99.0 (98.0-99.0)	99.0 (96.5-99.0)	98.0 (96.2-99.0)	0.392

Table 2: Echocardiographic and clinical response to CRT

LVEF=Left ventricular ejection fraction; LVEDV=Left ventricular end-diastolic volume; LVESV=Left ventricular end-systolic volume.

Group	Parameters	Baseline	6 months	Change	p value	Response definition	Response rate at 6 months (%)
≤ 20% (n=21)	LVEF, %	27.2±5.7	40.6±9.5	+ 13.5±8.0	<0.001	≥5% absolute increase	86% (n=18)
	LVEDV, ml	208.3±93.0	157.3±54.2	- 14.6±25.6	0.100	≥10% relative reduction	52% (n=11)
	LVESV, ml	146.6±82.9	93.3±35.0	- 28.6±25.2	0.015	≥15% relative reduction	81% (n=17)
	NYHA I/II/III/IV, %	0/14/81/5	30/50/20/0	+ 1.0±0.7	<0.001	≥1 class improvement	76% (n=16)
20 – 50% (n=21)	LVEF, %	26.4±6.8	31.3±7.8	+ 4.9±5.6	0.036	≥5% absolute increase	52% (n=11)
	LVEDV, ml	235.7±96.2	202.7±70.8	- 5.6±35.4	0.236	≥10% relative reduction	52% (n=11)
	LVESV, ml	172.5±79.3	140.5±61.4	- 10.8±34.3	0.173	≥15% relative reduction	48% (n=10)
	NYHA I/II/III/IV, %	0/24/76/0	23/48/29/0	+ 0.7±0.7	0.004	≥1 class improvement	71% (n=15)
≥ 50% (n=12)	LVEF, %	21.2±6.7	24.2±5.4	+ 3.1±4.1	0.230	≥5% absolute increase	42% (n=5)
	LVEDV, ml	265.4±81.8	246.9±69.8	- 5.6±21.6	0.557	≥10% relative reduction	42% (n=5)
	LVESV, ml	202.6±69.4	190.9±58.6	- 5.5±23.1	0.669	≥15% relative reduction	25% (n=3)
	NYHA I/II/III/IV, %	0/8/92/0	17/42/33/8	+0.6±0.9	0.038	≥1 class improvement	42% (n=5)

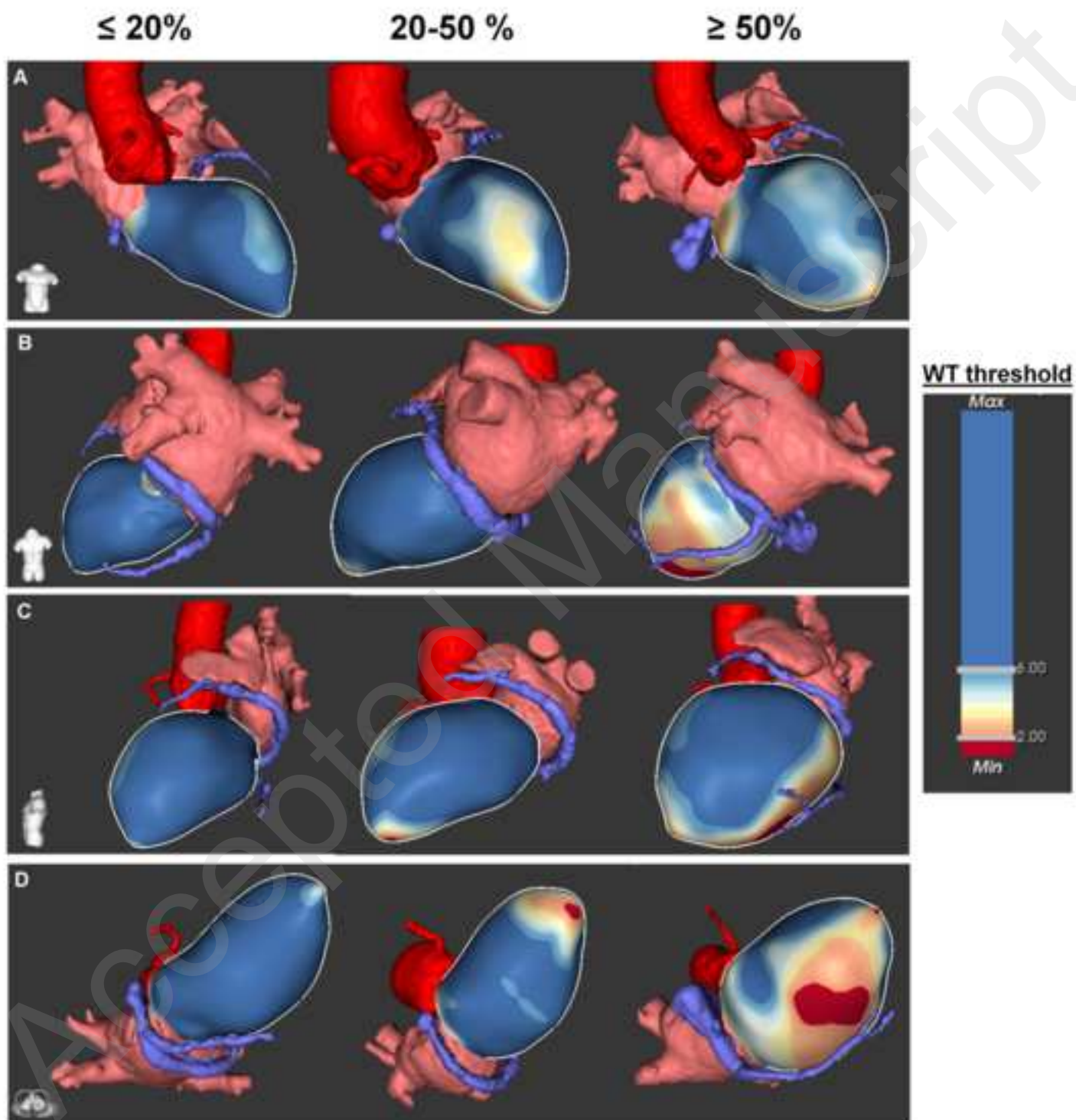
Table 3 Baseline characteristics between patients with or without MR improvement

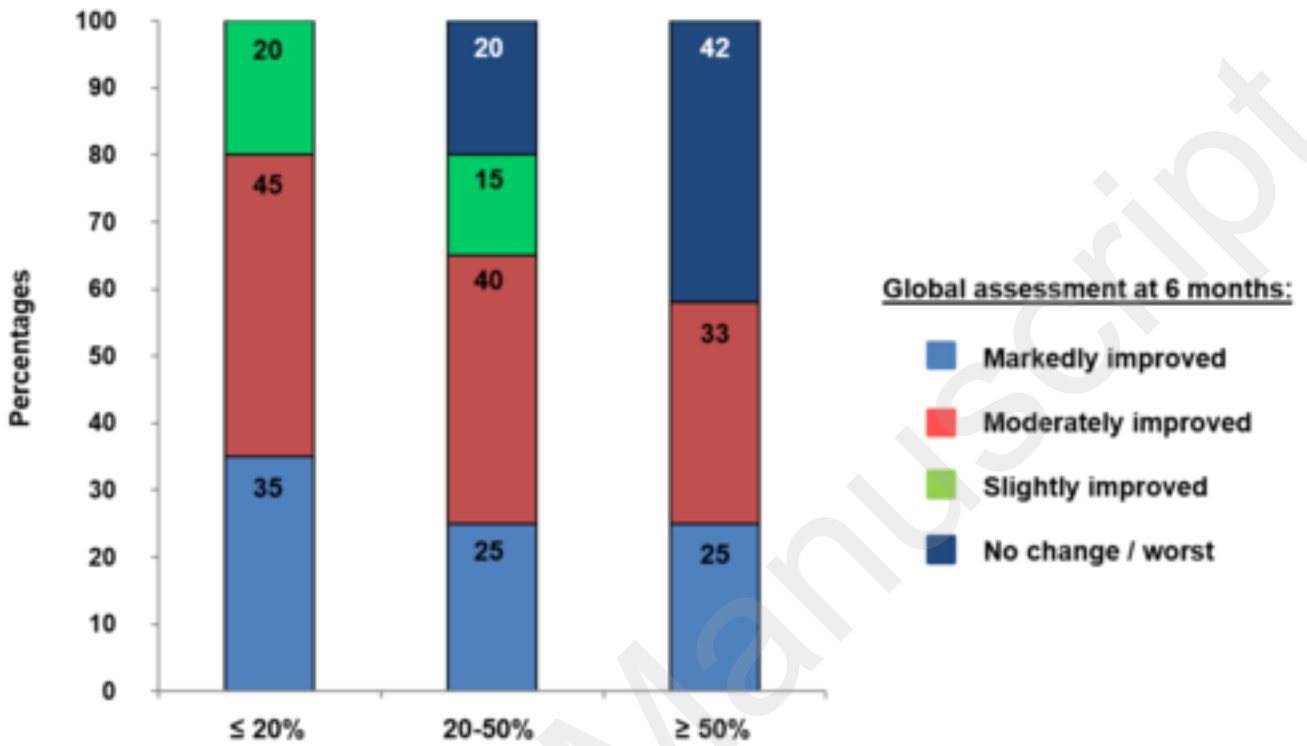
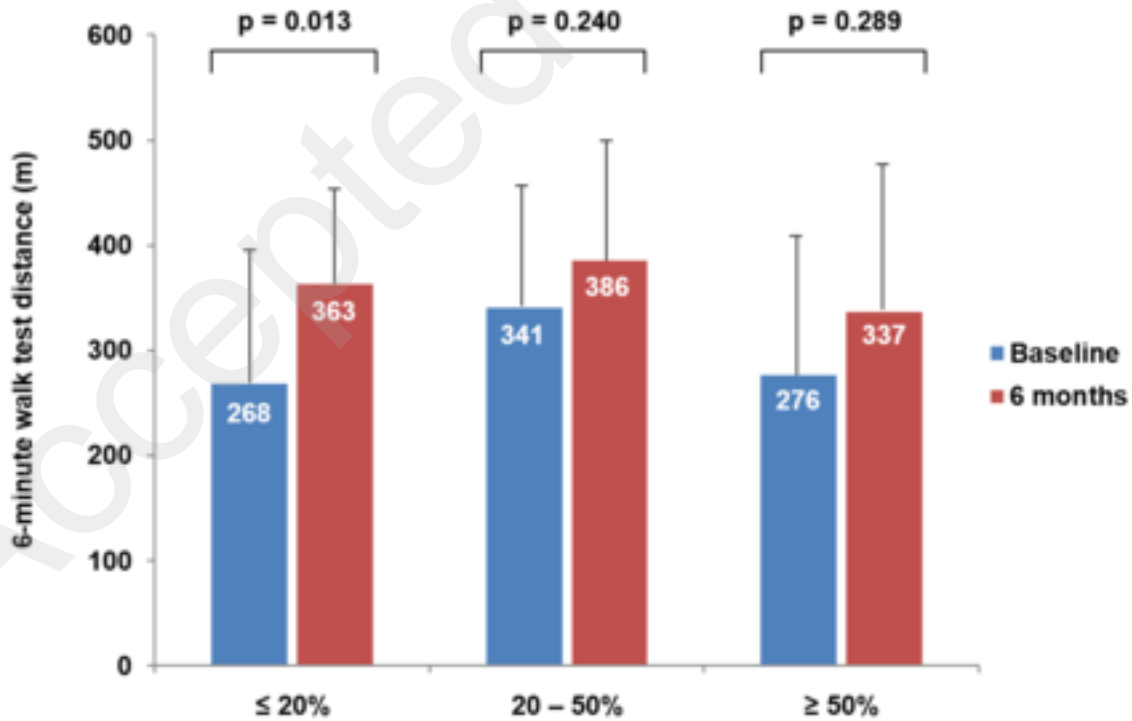
ACEI=Angiotensin-converting enzyme inhibitor; ARB=Angiotensin II receptor blocker; ICD=Implantable cardioverter defibrillator; LBBB=Left bundle branch block; LV=Left ventricular; LVEF=Left ventricular ejection fraction; LVEDV=Left ventricular end-diastolic volume; LVESV=Left ventricular end-systolic volume; NT-proBNP=N-terminal pro-brain natriuretic peptide; RBBB=Right bundle branch block; WT=Wall thickness.

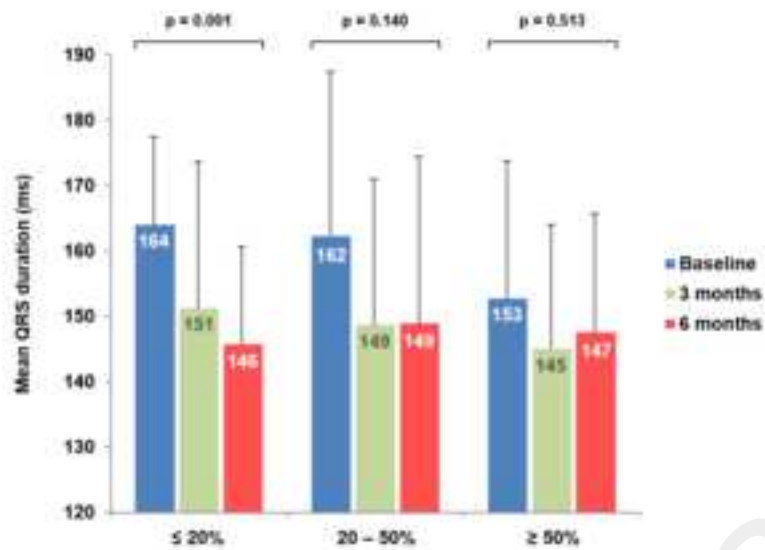
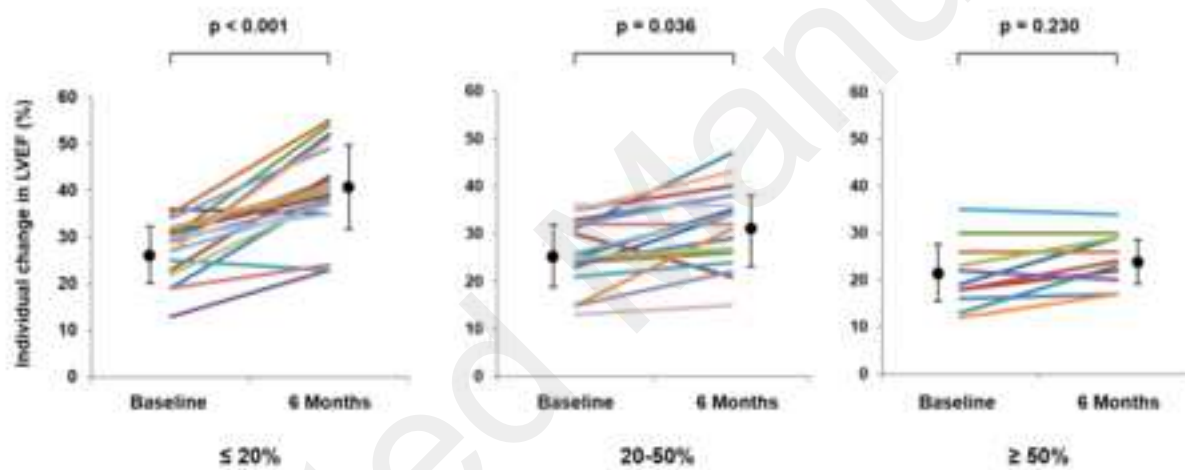
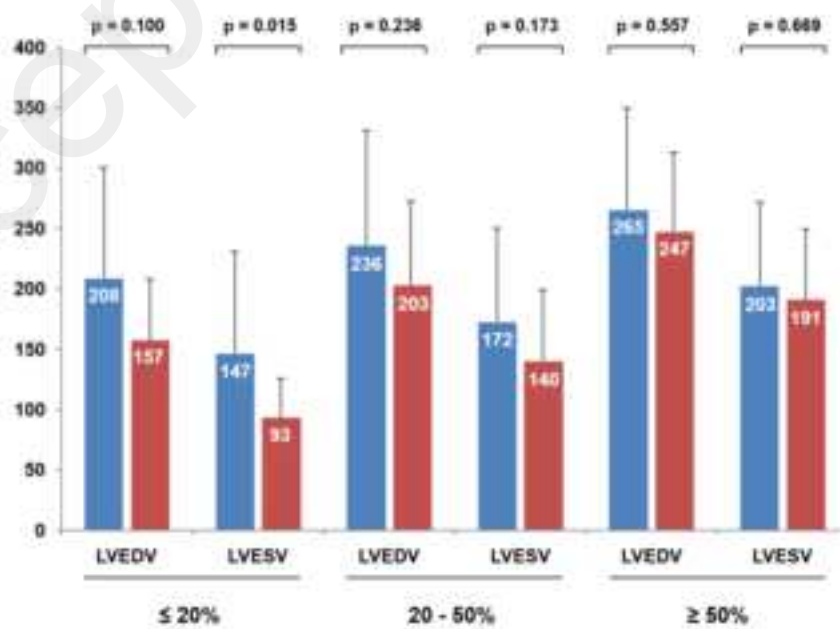
	MR improvement by ≥ 1 class (n=16)	No MR improvement (n=22)	p Value
Age, yrs	59.5 \pm 10.1	65.7 \pm 10.2	0.073
Male gender	12 (75.0)	16 (72.2)	0.829
Ischemic cardiomyopathy	5 (31.2)	8 (36.4)	0.553
Body mass index, km/m²	28.3 (23.5-34.4)	27.4 (26.0-30.6)	0.657
Hypertension	4 (25.0)	12 (54.5)	0.137
Diabetes mellitus	1 (8.3)	4 (33.3)	0.374
Atrial fibrillation	2 (12.5)	4 (18.2)	0.981
NYHA, functional class			0.425
-II	4 (25.0)	3 (13.6)	
-III	12 (75.0)	19 (86.4)	
-IV	0 (0)	0 (0)	
Baseline medication			
-Beta blockers	15 (93.7)	19 (86.4)	0.624

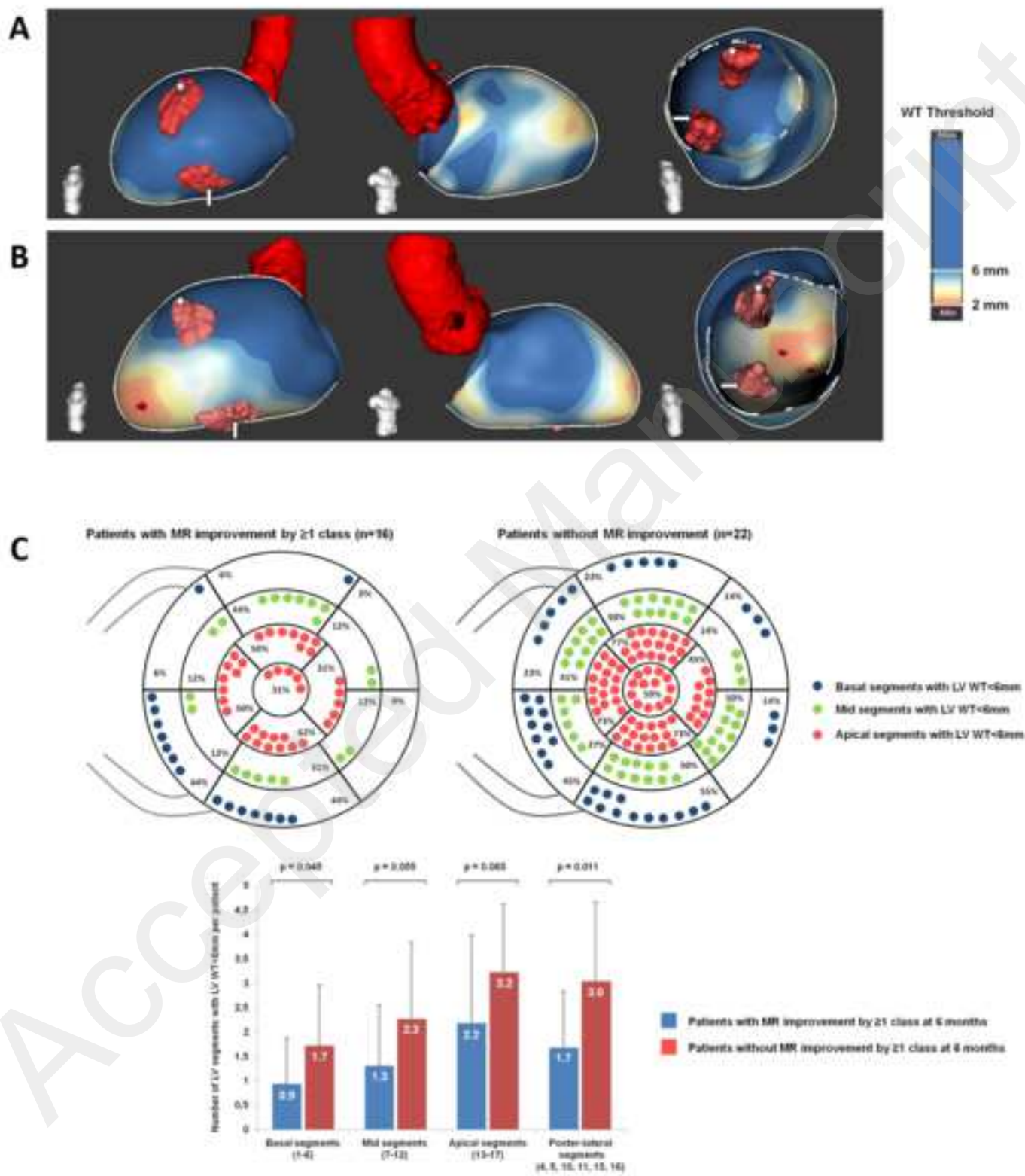
-ACEI/ARB	10 (62.5)	17 (77.3)	0.471
-Spironolactone	6 (37.5)	10 (45.4)	0.875
-Diuretics	10 (62.5)	18 (81.8)	0.267
Electrocardiogram			
-QRS duration, ms	171.5±25.6	162.7±20.7	0.251
-LBBB morphology	11 (68.7)	14 (63.6)	0.985
Laboratory parameters			
-Creatinine, mg/dL	1.0±0.2	1.1±0.2	0.460
-NT-proBNP, pg/mL	813.0 (365.5-1243.5)	1651 (1100.0-3248.0)	0.007
Echocardiography			
-LVEF, %	26.2±7.0	23.5±7.4	0.268
-LVEDV, ml	246.8±90.2	241.6±106.0	0.873
-LVESV, ml	167.0 (124.0-251.0)	157.0 (107.2-206.0)	0.477
-Left atrial diameter, mm	45.9±4.9	43.2±6.2	0.144
-Inter ventricular septum, mm	9.7±1.7	9.8±2.2	0.867
-Post wall thickness, mm	9.5±2.5	10.1±1.5	0.428
-Mitral regurgitation, class			0.547
-II	10 (62.5)	10 (45.5)	
-III	4 (25.0)	9 (40.9)	
-IV	2 (12.5)	3 (13.6)	
LV computed tomography analysis			
-Total of LV WT<6mm, %	22.4±16.1	41.5±19.4	0.003
-Papillary muscle inserted in LV WT<6mm			
-0	13 (81.3)	6 (27.3)	0.004
-1	3 (18.7)	14 (63.6)	

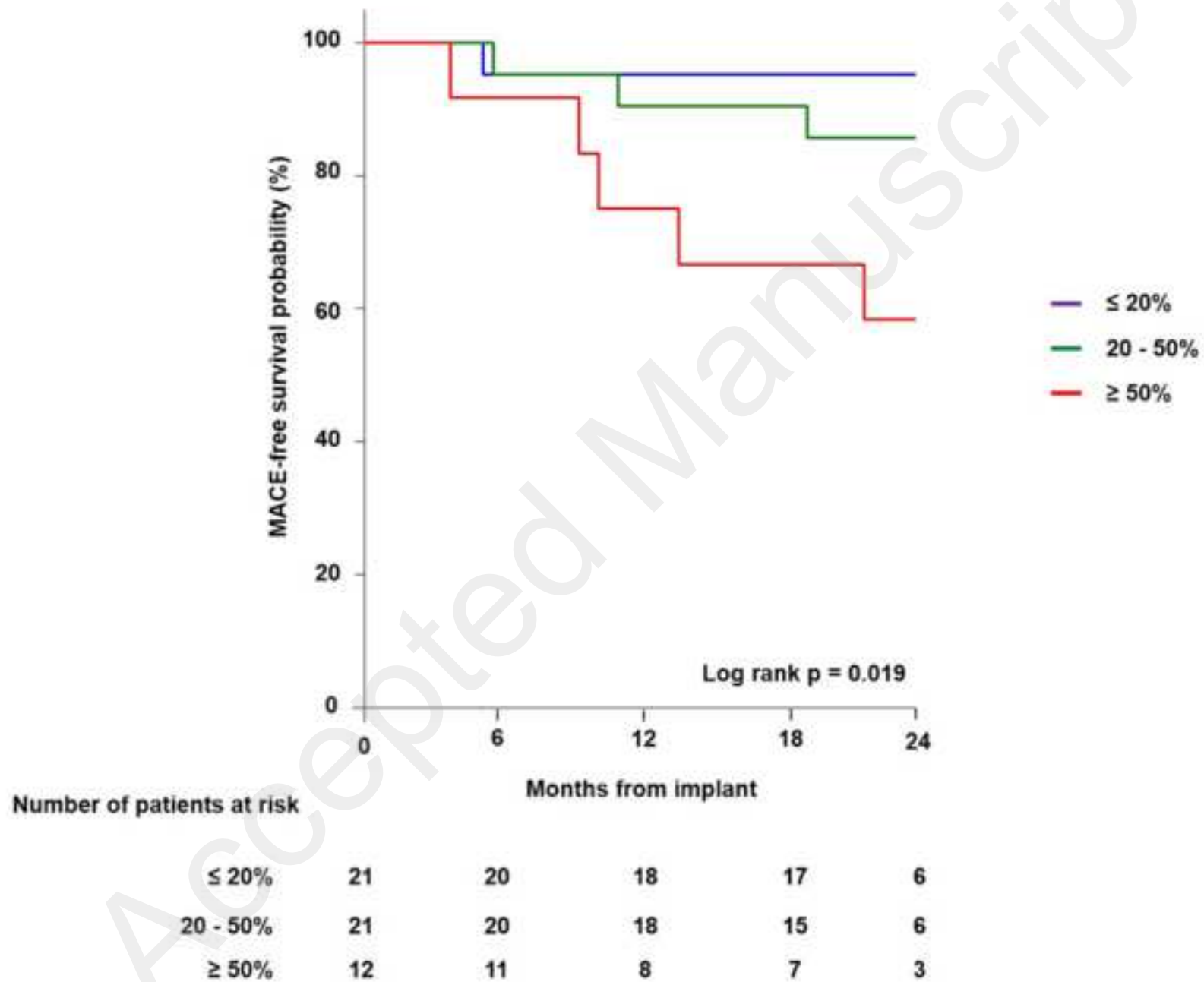
-2	0 (0)	2 (9.1)	
-Posterior MV pillar	3 (100)	13 (59.1)	0.031
-Anterior MV pillar	0 (0)	5 (22.7)	0.061
LV lead location			
-Non-apical location	15 (93.7)	19 (86.4)	0.624
-Postero-lateral location	14 (87.5)	21 (95.4)	0.562
Biventricular pacing at 6 months, %	99.0 (98.0-99.0)	98.0 (96.7-99.0)	0.388
Bi-ventricular pacing QRS duration at 6 months, ms	155.3±22.8	152.1±21.1	0.664




A**B**

A**B****C**







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