Pacemaker (Medtronic InSync III) located in the left subclavicular portion. Postoperative period was uncomplicated. After 2 months pacing and sensing parameters remained excellent and significant clinical improvement was observed in all patients.

Patients' characteristics and results (b-before, a-2 months after CABG + CRT)

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age (years)</th>
<th>Conduction disorders on ECG (b)</th>
<th>QRS width (ms)</th>
<th>LV pacing threshold at implant (V)</th>
<th>LV sensing threshold at implant (mV)</th>
<th>6-min walk test (m)</th>
<th>NYHA class</th>
</tr>
</thead>
<tbody>
<tr>
<td>RM</td>
<td>68</td>
<td>AVB (LAH) 120</td>
<td>0.0</td>
<td>17</td>
<td>275</td>
<td>35</td>
<td>I</td>
</tr>
<tr>
<td>SN</td>
<td>57</td>
<td>none</td>
<td>0.5</td>
<td>15</td>
<td>325</td>
<td>45</td>
<td>II</td>
</tr>
<tr>
<td>KJ</td>
<td>58</td>
<td>LAH</td>
<td>100</td>
<td>20</td>
<td>350</td>
<td>45</td>
<td>III</td>
</tr>
</tbody>
</table>

Conclusion: CRT can be regarded as important supplement to surgical revascularization in still growing population of patients with severe heart failure and systolic dysynchrony, for optimization of treatment results.

BIVENTRICULAR PACING VIA THE FEMORAL ROUTE: DESCRIPTION OF A NOVEL APPROACH

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Purpose: Cardiac resynchronisation benefits patients with heart failure. Occasionally, the procedure is not possible from a superior approach. We encountered a patient with inaccessible subclavian veins and describe the implantation of a biventricular (biv) pacemaker via the femoral approach. Methods & Results: A transverse incision was made 2cm above the right inguinal ligament and access to the femoral vein obtained. A long splittable Safesheath guiding catheter was advanced into the right atrium. Initial attempts at gaining access to the coronary sinus with 6F Amplatz catheters were unsuccessful, however, we were able to engage the coronary sinus ostium with a 6F multipurpose catheter. Sinography identified an ideal posterolateral tributary of the great cardiac vein into which an over-the-wire left ventricular lead was negotiated. Catheter support during left ventricular lead placement was excellent (panel A). Extra length active fixation leads were positioned in the right interventricular septum and in the right atrial appendage (panel B). After fixing to the deep inguinal fascia, the leads were reflected and tunnelled up into a mid abdominal pocket where a biv generator was implanted. Conclusion: Our experience shows that anterior cannulation of the coronary sinus may offer particular advantages, e.g. ability of the catheter to straighten out curves leading to the coronary sinus. We therefore recommend that the femoral route be considered where subclavian access is not possible, or where the morphology of the coronary sinus precludes catheter approach from a superior approach.

INITIAL EXPERIENCE WITH A NEW S-SHAPED BIPOLAR LEAD FOR LEFT VENTRICULAR PACING

W. Dünschel, L. Padeletti, D. Gra, F. Gjestvang, D. Kalusche on behalf of the European QuickSite™ T Investigators

AHC, Chemnitz, Germany; Carghi Frenze, Italy; NCM, Nantes, France; St. Herlantyekszus, Kristianstad, Norway; Brainzentrum Bad Krozingen, Germany.

Purpose: This study evaluated the safety and efficacy of the new QuickSite™ T 1056 T (St. Jude Medical, Sylmar, USA) left ventricular (LV) lead. QuickSite™ T 1056 T is a polyurethane/silicon, 6 French, S-shaped, bipolar, Fast Pass™ coated, steroid eluting lead, which can be implanted using either a stylet-driven or an over-the-wire approach.

Method: 55 patients, candidates for Cardiac Resynchronization Therapy (CRT), were recruited in 18 European centers.

Results: Lead implantations were attempted in 55 patients. 51 implants were successful (overall success rate: 92.7%). When compared to the existing QuickSite™ T 1056 K (unipolar) lead, the QuickSite™ T 1056 T handling characteristics were classified as superior by more than one third of responding physicians (36%) and similar by 61%.

48 patients received an Epic/Epic®/Atlas®+ HF CRT DeBriillator (CRT-D devices with independent ventricular channels and no LV sensing), 3 a Frontier CRT pacemaker (CRT-P device without independent channels).

At implant and over the follow-up period, the electrical characteristics of the lead were good (Table 1).

![Diagram](https://example.com/diagram.png)

**Table 1:** Electrical characteristics of RVOT leads are good and are similar for CRT and NON-CRT patients. Implantation is successful in all patients and complications may occur, but are at a low acceptable level.