

Cardiac Rhythm Management

Heart Failure Therapy

Lumax 740 Family of ICDs and CRT-Ds

# Lumax 740 Family of ICDs and CRT-Ds

## Technical Manual



## **CAUTION**

Federal (U.S.A.) law restricts this device to sale by, or on the order of, a physician.

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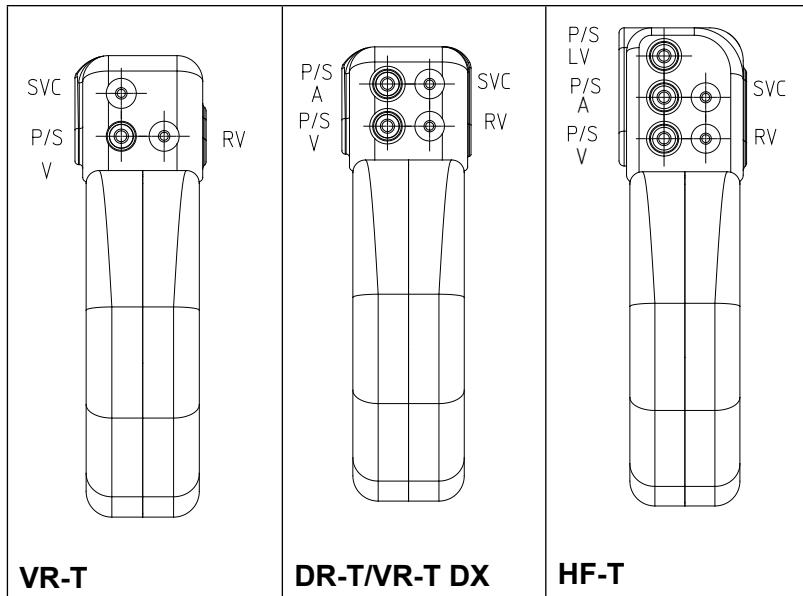
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**Figure 1: Lumax ICDs and CRT-D**

<b>Table 1: Lumax Specifications</b>	
Battery Voltage	3.2 Volts
<b>Maximum Shock Energy</b>	
740 Models	40 Joules programmed
Defibrillation Lead Ports	Two DF1 (3.2 mm)
<b>Pacing Lead Ports</b>	
VR-T Models	One IS-1 (3.2 mm)
DR-T/VR-T DX Models	Two IS-1 (3.2 mm)
HF-T Models	Three IS-1 (3.2 mm)
<b>Materials</b>	
Housing	Titanium
Header	Epoxy Resin
Sealing Plug	Silicone
<b>X-ray Identification Lumax 740</b>	
Inside Housing	RH

Detailed technical specifications are provided in [Section 13](#).

## 1. General

### 1.1 System Description

The Lumax family of Implantable Cardioverter Defibrillators (ICDs) and Cardiac Resynchronization Therapy Defibrillators (CRT-Ds) detect and treat ventricular tachyarrhythmias and provide rate adaptive bradycardia pacing support. The HF-T version of Lumax provides Cardiac Resynchronization Therapy (CRT) through biventricular pacing. Both CRT-Ds and ICDs detect and treat ventricular tachyarrhythmias and provide rate adaptive bradycardia pacing support. They are designed to collect diagnostic data to aid the physician's assessment of a patient's condition and the performance of the implanted device.

The Lumax family of devices provides therapy for ventricular tachyarrhythmias with a sophisticated range of programmable anti-tachycardia pacing (ATP), and/or defibrillation therapy features. The shock polarity and energy may be programmed to tailor the therapy to appropriately treat each patient's tachyarrhythmias. The ICDs/CRT-Ds provide shock therapies with programmable energies from 2 to 40 joules.

The Lumax family of ICDs/CRT-Ds includes the following members:

- Lumax HF-T - provides three chamber rate-adaptive bradycardia pacing support including biventricular pacing via the right and left ventricular pacing lead. The CRT-D uses the atrial and right ventricular sensing/pacing leads to provide enhanced atrial and ventricular tachyarrhythmia discrimination through BIOTRONIK's SMART Detection™ algorithm. In addition, Lumax HF-T also has BIOTRONIK's Home Monitoring system. The Home Monitoring System enables automatic exchange of information about a patient's cardiac status from the implanted device to the physician remotely.
- Lumax DR-T - provides dual chamber rate adaptive bradycardia pacing support. The ICD uses atrial and ventricular sensing/pacing leads to provide enhanced atrial and ventricular tachyarrhythmia discrimination through BIOTRONIK's SMART Detection® algorithm. In addition, it also has BIOTRONIK's Home Monitoring® system. The Home Monitoring System enables automatic exchange of information about a patient's cardiac status from the implanted device to the physician remotely.
- Lumax VR-T - provides single chamber rate adaptive bradycardia pacing support as well as tachyarrhythmia detection and therapy. In addition, it also has BIOTRONIK's Home Monitoring system. The Home Monitoring System enables automatic exchange of information about a patient's cardiac status from the implanted device to the physician remotely.
- Lumax VR-T DX – provides ventricular rate adaptive bradycardia pacing support that can include atrial tracking with a single pass ICD lead and also has BIOTRONIK's Home Monitoring system. The DX system uses a BIOTRONIK DX ICD lead with two atrial sensing electrodes to provide enhanced atrial and ventricular tachyarrhythmia discrimination through BIOTRONIK's SMART Detection® algorithm. The Home Monitoring System enables automatic exchange of information about a patient's cardiac status from the implanted device to the physician remotely.

The 740 designation for each of the above-described models denote the maximum programmable shock energy of 40 joules.

The Lumax 740 models also feature a third programmable shock path for delivery of defibrillation/cardioversion shocks. The shock path is programmable between the different shock coils (SVC/RV) and/or the device housing. [Section 5.2.7](#) provides further details on the available shock configurations. The Lumax 740 HF-T models also feature an additional left ventricular (LV) pacing polarity for HF-T devices from LV-tip to housing (unipolar).

Additionally, the Lumax 740 models feature Ventricular Capture Control of ventricular pacing thresholds. This feature is separately programmable for the right (RV) and left (LV) ventricle.

[Section 7.2.1.12](#) provides further details.

The Lumax 740 models also provide RF Telemetry (SafeSync) to ease implantation and follow-up procedures. In addition, these devices include Thoracic Impedance monitoring and Atrial NIPS that can be used for an EP study to induce an arrhythmia or to burst pace a patient out of a stable tachyarrhythmia.

Lumax 740 models will present with automatic Far-Field IEGM to provide a means to generate the surface ECG-like signal without the need for attaching the surface electrodes to the patients.

All Lumax models have two DF-1 defibrillation/cardioversion ports. Additionally, the Lumax HF-T models have three IS-1 pacing/sensing header ports, the Lumax DR-T and Lumax VR-T DX models have two IS-1 pacing/sensing header ports and the Lumax VR-T models have only one IS-1 pacing/sensing header port. IS-1 refers to the international standard whereby leads and generators from different manufacturers are assured a basic fit [Reference ISO 5841-3:1992]. DF-1 refers to the international standard for defibrillation lead connectors [Reference ISO 11318:1993].

External devices that interact with and test the implantable devices are also part of the ICD/CRT-D System. These external devices include the ICS 3000 Programming and the Implant Module System Analyzer or Pacing System Analyzer for acute lead testing. The ICS 3000 or Renamic programmer is used to interrogate and program the ICD/CRT-Ds.

The Lumax 740 models also feature SafeSync Telemetry (RF-Telemetry) via the Renamic programmer or the ICS 3000 programmer in combination with the SafeSync Module (an external communication module).

BIOTRONIK conducted the TRUST study to evaluate the safety and effectiveness of Home Monitoring. With the TRUST study, BIOTRONIK was able to show the following with regards to Home Monitoring:

- BIOTRONIK Home Monitoring information may be used as a replacement for device interrogation during in-office follow-up visits.
- A strategy of care using BIOTRONIK Home Monitoring with office visits when needed has been shown to extend the time between routine, scheduled in-office follow-ups of BIOTRONIK implantable devices in many patients. Home Monitoring data is helpful in determining the need for additional in-office follow-up.
- BIOTRONIK Home Monitoring-patients—who are followed remotely with office visits when needed—have been shown to have similar numbers of strokes, invasive procedures and deaths as patients followed with conventional in-office follow-ups.
- BIOTRONIK Home Monitoring provides early detection of arrhythmias.
- BIOTRONIK Home Monitoring provides early detection of silent, asymptomatic arrhythmias.
- Automatic early detection of arrhythmias and device system anomalies by BIOTRONIK Home Monitoring allows for earlier intervention than conventional in-office follow-ups.
- BIOTRONIK Home Monitoring allows for improved access to patient device data compared to conventional in-office follow-ups since device interrogation is automatically scheduled at regular intervals.

## 1.2 Indications for Use

### ICDs:

The Lumax Family of Implantable Cardioverter Defibrillators (ICDs) is intended to provide ventricular antitachycardia pacing and ventricular defibrillation, for automated treatment of life-threatening ventricular arrhythmias.

The VR-T DX ICDs are part of a system that includes both a BIOTRONIK DX ICD lead and an Lumax DX ICD.

### CRT-Ds:

The Lumax CRT-Ds are indicated for use in patients with all of the following conditions:

- Indicated for ICD therapy
- Receiving optimized and stable Congestive Heart Failure (CHF) drug therapy
- Symptomatic CHF (NYHA Class III/IV and LVEF  $\leq$  35%)
- Intraventricular conduction delay (QRS duration  $\geq$  130 ms)

## 1.3 Contraindications

The Lumax devices are contraindicated for use in patients with the following conditions:

- Patients whose ventricular tachyarrhythmias may have transient or reversible causes such as:
  - Acute myocardial infarction
  - Digitalis intoxication
  - Drowning
  - Electrocution
  - Electrolyte imbalance
  - Hypoxia
  - Sepsis
- Patients with incessant ventricular fibrillation (VF) and ventricular tachycardia (VT)
- Patients whose only disorder is brady arrhythmias or atrial arrhythmias

## 1.4 Warnings and Precautions

**MRI (Magnetic Resonance Imaging)** - Do not expose a patient to MRI device scanning. Strong magnetic fields may damage the device and cause injury to the patient.

**Electrical Isolation** - To prevent inadvertent arrhythmia induction, electrically isolate the patient during the implant procedure from potentially hazardous leakage currents.

**Left Ventricular Lead Systems** – BIOTRONIK CRT-Ds may be implanted with any legally marketed, compatible LV lead. Compatibility is defined as:

- IS-1 pacing connector
- Active or passive fixation technology
- Insertion and withdrawal forces as specified by ISO 5841-3 (IS-1)

The following LV leads were evaluated in the OPTION CRT/ATx study with BIOTRONIK's CRT-Ds:

- Guidant-EASYTRAK® IS-1 Lead
- Guidant-EASYTRAK LV-1 Lead
- Guidant-EASYTRAK 2 Lead
- Guidant-EASYTRAK 3 Lead

- Medtronic-Attain® OTW Lead
- St. Jude-Aescula™ Lead
- St. Jude-QuickSite® Lead
- Biomed-Myopore™ Epicardial Lead
- Medtronic-Epicardial 5071 Lead
- Medtronic-CapSure® EPI Lead
- BIOTRONIK-ELC 54-UP Lead

The following LV leads were bench tested for compatibility with BIOTRONIK's CRT-Ds:

- Guidant EASYTRAK 4512 (unipolar) Lead
- Guidant EASYTRAK 4513 (bipolar) Lead
- Guidant EASYTRAK 3 4525 (bipolar) Lead
- Medtronic Attain OTW 4193 (unipolar) Lead
- Medtronic Attain OTW 4194 (bipolar) Lead
- Medtronic Attain LV 2187 (unipolar) Lead
- St. Jude Medical QuickSite 1056K (unipolar) Lead
- ELA SITUS® OTW (unipolar) Lead
- BIOTRONIK Corox OTW 75-UP Steroid #346542 (unipolar) Lead
- BIOTRONIK Corox+ LV-H 75-BP #341885 (bipolar) Lead

**ICD Lead Systems** – BIOTRONIK ICDs/CRT-Ds maybe implanted with any legally marketed, compatible ICD lead. Compatibility is defined as:

- IS-1 pacing and sensing connector(s)
- DF-1 shock coil connector(s)
- Integrated or dedicated bipolar pacing and sensing configuration
- Active or passive fixation technology
- Single or dual defibrillation shock coil (s)
- High energy shock accommodation up to 40 joules
- Insertion and withdrawal forces as specified by ISO 5841-3 (IS-1) and ISO 11318:1993 (E) DF-1

The following leads were evaluated in a retrospective study with BIOTRONIK's ICDs/CRT-Ds:

- Medtronic Sprint™ Lead 6932
- Medtronic Sprint Lead 6943
- Medtronic Sprint Quattro™ Lead 6944
- Medtronic Transvene™ RV Lead 6936
- St. Jude (Ventrifex) TVLTM- ADX Lead 1559
- St. Jude SPL® SP02 Lead
- Guidant ENDOTAK® DSP Lead
- Guidant ENDOTAK Endurance EZ Lead, ENDOTAK Reliance Lead
- Guidant (Intermedics) Lead 497-24.

The following leads were bench tested for compatibility with BIOTRONIK's ICDs/CRT-Ds:

- Guidant ENDOTAK Endurance Lead "CPI 0125"
- Guidant ENDOTAK Reliance Lead 0148
- Medtronic Sprint Lead 6932
- Medtronic Sprint Lead 6942
- Medtronic Sprint Lead 6943

- Medtronic Sprint Lead6945
- Medtronic Sprint Quattro Lead 6944
- St. Jude Riata® Lead 1571/65
- St. Jude SPL SPO1 Lead.

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

**Unwanted Shocks** – Always program ICD Therapy to OFF prior to handling the device to prevent the delivery of serious shocks to the patient or the person handling the device during the implant procedure.

**Rate-Adaptive Pacing** – Use rate-adaptive pacing with care in patients unable to tolerate increased pacing rates.

**Blanking after RV pace** – Extending this value too long may lead to delays in arrhythmia detection. Consult Technical Services prior to extending this value.

**Short Pacing Intervals** – Use of short pacing intervals (high pacing rates) with long atrial and/or ventricular refractory periods may result in intermittent asynchronous pacing and, therefore, may be contraindicated in some patients.

### 1.4.1 Sterilization, Storage, and Handling

**Device Packaging** - Do not use the device if the device's packaging is wet, punctured, opened or damaged because the integrity of the sterile packaging may be compromised. Return the device to BIOTRONIK.

**Re-sterilization** - Do not re-sterilize and re-implant explanted devices.

**Storage (temperature)** - Store the device between 5° to 45°C (41°-113°F) because temperatures outside this range could damage the device.

**Storage (magnets)** - To avoid damage to the device, store the device in a clean area, away from magnets, kits containing magnets, and sources of electromagnetic interference (EMI).

**Temperature Stabilization** - Allow the device to reach room temperature before programming or implanting the device because temperature extremes may affect initial device function.

**Use Before Date** - Do not implant the device after the USE BEFORE DATE because the device may have reduced longevity.

### 1.4.2 Device Implantation and Programming

**Blind Plug** - A blind plug must be inserted and firmly connected into any unused header port to prevent chronic fluid influx and possible shunting of high energy therapy.

**Capacitor Reformation** - Infrequent charging of the high voltage capacitors may extend the charge times of the ICD/CRT-D. The capacitors are reformed automatically at least every 90 days. For further information, please refer to [Section 2.4.3](#), Capacitor Reforming.

**Connector Compatibility** – ICD/CRT-D and lead system compatibility should be confirmed prior to the implant procedure. Consult your BIOTRONIK representative regarding lead/pulse generator compatibility prior to the implantation of an ICD/CRT-D system. For further information, please refer to [Appendix A](#).

**ERI (Elective Replacement Indicator)** - Upon reaching ERI, the battery has sufficient energy remaining to continue monitoring for at least three months and to deliver a minimum of six maximum energy shocks. After this period (EOS), all tachyarrhythmia detection and therapy is disabled. Bradycardia functions are still active at programmed values until the battery voltage drops below 1.75 volts.

**Magnets** - Positioning of a magnet over the ICD/CRT-D will suspend tachycardia detection and treatment. The minimum magnet strength required to suspend tachycardia treatment is 1.8 mT. When the magnet strength decreases to less than 1 mT, the reed contact is reopened.

**Programmed Parameters** – Program the device parameters to appropriate values based on the patient's specific arrhythmias and condition.

**Programmers** - Use only BIOTRONIK ICS 3000 or Renamic programmers to communicate with the device.

**Sealing System** - Failure to properly insert the torque wrench into the perforation at an angle perpendicular to the connector receptacle may result in damage to the sealing system and its self-sealing properties.

**Defibrillation Threshold** - Be aware that changes in the patient's condition, drug regimen, and other factors may change the defibrillation threshold (DFT) which may result in non-conversion of the arrhythmia post-operatively. Successful conversion of ventricular fibrillation or ventricular tachycardia during arrhythmia conversion testing is no assurance that conversion will occur post-operatively.

**Manual Shocks** – User-commanded shocks may be withheld if the ICD/CRT-D is already busy processing a manual command or the Battery Status is low.

**Charge Time** - When preparing a high energy shock the charge circuit stops charging the capacitors after 20 seconds, and delivers the stored energy as shock therapy. After the device reaches ERI the stored energy may be less than the maximum programmable energy for each shock.

**Programming Wand Separation Distance** – The wand (with magnet) must not be placed closer than 2 cm to the device (implanted or out of the box). Programming wand (with magnet) distance closer than 2 cm may damage the device.

**Shipment Mode** – The shipment mode is a factory set mode that controls the charge current of automatic capacitor reformations. This mode controls the charge current to avoid temporary low battery readings. The shipment mode is automatically deactivated as soon as electrophysiological tests (e.g., Impedance measurement) are initiated by the programmer.

**Shock Therapy Confirmation** – Programming CONFIRMATION to OFF may increase the incidence of the ICD/CRT-D delivering inappropriate shocks.

**Shock Impedance** - If the shock impedance is less than twenty-five ohms ( $25 \Omega$ ), reposition the lead system to allow a greater distance between the electrodes. Never implant the device with a lead system that has measured shock impedance of less than twenty-five ohms ( $25 \Omega$ ). Damage to the device may result.

**Negative AV Hysteresis** – This feature insures ventricular pacing, a technique which has been used in patients with hypertrophic obstructive cardiomyopathy (HOCM) with normal AV conduction in order to replace intrinsic ventricular activation. No clinical study was conducted to evaluate this feature, and there is conflicting evidence regarding the potential benefit of ventricular pacing therapy for HOCM patients. In addition, there is evidence with other patient groups to suggest that inhibiting the intrinsic ventricular activation sequence by right ventricular pacing may impair hemodynamic function and/or survival.

### 1.4.3 Lead Evaluation and Connection

**Capping Leads** - If a lead is abandoned rather than removed, it must be capped to ensure that it is not a pathway for currents to or from the heart.

**Gripping Leads** - Do not grip the lead with surgical instruments or use excessive force or surgical instruments to insert a stylet into a lead.

**Kinking Leads** - Do not kink leads. This may cause additional stress on the leads that can result in damage to the lead.

**Liquid Immersion** - Do not immerse leads in mineral oil, silicone oil, or any other liquid.

**Short Circuit** - Ensure that none of the lead electrodes are in contact (a short circuit) during delivery of shock therapy as this may cause current to bypass the heart or cause damage to the ICD/CRT-D system.

**Far-Field Sensing** - of signals from the atrium in the ventricular channel or ventricular signals in the atrial channel should be avoided by appropriate lead placement, programming of pacing/sensing parameters, and maximum sensitivity settings. If it is necessary to modify the Far Field Blanking parameter, the parameter should be lengthened only long enough to eliminate far-field sensing as evidenced on the IEGMs. Extending the parameter unnecessarily may cause under sensing of actual atrial or ventricular events.

**Suturing Leads** - Do not suture directly over the lead body as this may cause structural damage. Use the appropriate suture sleeve to immobilize the lead and protect it against damage from ligatures.

**Tricuspid Valve Bioprostheses** - Use ventricular transvenous leads with caution in patients with a tricuspid valvular bioprostheses.

**Setscrew Adjustment** – Back-off the setscrew(s) prior to insertion of lead connector(s) as failure to do so may result in damage to the lead(s), and/or difficulty connecting lead(s).

**Cross Threading Setscrew(s)** – To prevent cross threading the setscrew(s), do not back the setscrew(s) completely out of the threaded hole. Leave the torque wrench in the slot of the setscrew(s) while the lead is inserted.

**Tightening Setscrew(s)** – Do not over tighten the setscrew(s). Use only the BIOTRONIK supplied torque wrench.

**Sealing System** – Be sure to properly insert the torque wrench into the perforation perpendicular to the connector receptacle. Failure to do so may result in damage to the plug and its self-sealing properties.

### 1.4.4 Follow-up Testing

**Defibrillation Threshold** - Be aware that changes in the patient's condition, drug regimen, and other factors may change the defibrillation threshold (DFT), which may result in non-conversion of the arrhythmia post-operatively. Successful conversion of ventricular fibrillation or ventricular tachycardia during arrhythmia conversion testing is no assurance that conversion will occur post-operatively.

**Resuscitation Availability** - Ensure that an external defibrillator and medical personnel skilled in cardiopulmonary resuscitation (CPR) are present during post-implant device testing should the patient require external rescue.

**Safe Program** – Within the EP Test screen, pressing the “Safe Program” key on the programmer or programmer head immediately sends the safe program to the ICD/CRT-D.

## 1.4.5 Pulse Generator Explant and Disposal

**Device Incineration** – Never incinerate the ICD/CRT-D due to the potential for explosion. The ICD/CRT-D must be explanted prior to cremation.

**Explanted Devices** – Return all explanted devices to BIOTRONIK.

**Unwanted Shocks** – Always program ICD Therapy to OFF prior to handling the device to prevent the delivery of serious shocks to the patient or the person handling the device during the procedure.

## 1.4.6 Hospital and Medical Hazards

**Electromagnetic interference (EMI)** - signals present in hospital and medical environments may affect the function of any ICD/CRT-D or pacemaker. The ICD/CRT-D is designed to selectively filter out EMI noise. However, due to the variety of EMI signals, absolute protection from EMI is not possible with this or any other ICD/CRT-D.

The ICD/CRT-D system should have detection and therapy disabled (OFF) prior to performing any of the following medical procedures. In addition, the ICD/CRT-D should be checked after the procedures to assure proper programming:

**Diathermy** - Diathermy therapy is not recommended for ICD/CRT-D patients due to possible heating effects of the pulse generator and at the implant site. If diathermy therapy must be used, it should not be applied in the immediate vicinity of the pulse generator or lead system.

**Electrocautery** - Electrosurgical cautery could induce ventricular arrhythmias and/or fibrillation, or may cause device malfunction or damage. If use of electrocautery is necessary, the current path and ground plate should be kept as far away from the pulse generator and leads as possible (at least 6 inches (15 cm)).

**External Defibrillation** - The device is protected against energy normally encountered from external defibrillation. However, any implanted device may be damaged by external defibrillation procedures. In addition, external defibrillation may also result in permanent myocardial damage at the electrode-tissue interface as well as temporary or permanent elevated pacing thresholds. When possible, observe the following precautions:

- Position the adhesive electrodes or defibrillation paddles of the external defibrillator anterior-posterior or along a line perpendicular to the axis formed by the implanted device and the heart.
- Set the energy to a level not higher than is required to achieve defibrillation.
- Place the paddles as far as possible away from the implanted device and lead system.
- After delivery of an external defibrillation shock, interrogate the ICD/CRT-D to confirm device status and proper function.

**Lithotripsy** - Lithotripsy may damage the ICD/CRT-D. If lithotripsy must be used, avoid focusing near the ICD/CRT-D implant site.

**MRI (Magnetic Resonance Imaging)** - Do not expose a patient to MRI device scanning. Strong magnetic fields may damage the device and cause injury to the patient.

**Radiation** - High radiation sources such as cobalt 60 or gamma radiation should not be directed at the pulse generator. If a patient requires radiation therapy in the vicinity of the pulse generator, place lead shielding over the device to prevent radiation damage and confirm its function after treatment.

**Radio Frequency Ablation** - Prior to performing an ablation procedure, deactivate the ICD/CRT-D during the procedure. Avoid applying ablation energy near the implanted lead system whenever possible.

## 1.4.7 Home and Occupational Hazards

Patients should be directed to avoid devices that generate strong electromagnetic interference (EMI) or magnetic fields. EMI could cause device malfunction or damage resulting in non-detection or delivery of unneeded therapy. Moving away from the source or turning it off will usually allow the ICD/CRT-D to return to its normal mode of operation.

The following equipment (and similar devices) may affect normal ICD/CRT-D operation: electric arc or resistance welders, electric melting furnaces, radio/television and radar transmitters, power-generating facilities, high-voltage transmission lines, and electrical ignition systems (of gasoline-powered devices) if protective hoods, shrouds, etc., are removed.

## 1.4.8 Cellular Phones

Testing has indicated there may be a potential interaction between cellular phones and BIOTRONIK ICD/CRT-D systems. Potential effects may be due to either the cellular phone signal or the magnet within the telephone and may include inhibition of therapy when the telephone is within 6 inches (15 centimeters) of the ICD/CRT-D, when the ICD/CRT-D is programmed to standard sensitivity.

Patients having an implanted BIOTRONIK ICD/CRT-D who operate a cellular telephone should:

- Maintain a minimum separation of 6 inches (15 centimeters) between a hand-held personal cellular telephone and the implanted device.
- Set the telephone to the lowest available power setting, if possible.
- Patients should hold the phone to the ear opposite the side of the implanted device. Patients should not carry the telephone in a breast pocket or on a belt over or within 6 inches (15 centimeters) of the implanted device as some telephones emit signals when they are turned ON, but not in use (i.e., in the listen or stand-by mode). Store the telephone in a location opposite the side of implant.

Based on results to date, adverse effects resulting from interactions between cellular telephones and implanted ICDs/CRT-Ds have been transitory. The potential adverse effects could include inhibition or delivery of additional therapies. If electromagnetic interference (EMI) emitting from a telephone does adversely affect an implanted ICD/CRT-D, moving the telephone away from the immediate vicinity of the ICD/CRT-D should restore normal operation. A recommendation to address every specific interaction of EMI with implanted ICDs/CRT-Ds is not possible due to the disparate nature of EMI.

## 1.4.9 Electronic Article Surveillance (EAS)

Equipment such as retail theft prevention systems may interact with pulse generators. Patients should be advised to walk directly through and not to remain near an EAS system longer than necessary.

## 1.4.10 Home Appliances

Home appliances normally do not affect ICD/CRT-D operation if the appliances are in proper working condition and correctly grounded and shielded. There have been reports of the interaction of electric tools or other external devices (e.g. electric drills, older models of microwave ovens, electric razors, etc.) with ICDs/CRT-Ds when they are placed in close proximity to the device.

## 1.4.11 Home Monitoring®

BIOTRONIK's Home Monitoring system is designed to notify clinicians in less than 24 hours of changes to the patient's condition or status of the implanted device. Updated data may not be available if:

- The patient's CardioMessenger is off or damaged and is not able to connect to the Home Monitoring system through an active telephone link
- The CardioMessenger cannot establish a connection to the implanted device
- The telephone and/or Internet connection do not operate properly
- The Home Monitoring Service Center is off-line (upgrades are typically completed in less than 24 hours)

**Patient's Ability** - Use of the Home Monitoring system requires the patient and/or caregiver to follow the system instructions and cooperate fully when transmitting data.

If the patient cannot understand or follow the instructions because of physical or mental challenges, another adult who can follow the instructions will be necessary for proper transmission.

**Use in Cellular Phone Restricted Areas** - The mobile patient device (transmitter/receiver) should not be utilized in areas where cellular phones are restricted or prohibited (i.e., commercial aircraft).

## 1.5 Potential/Observed Effects of the Device on Health

### 1.5.1 Potential Adverse Events

The following are possible adverse events that may occur relative to the implant procedure and chronic implant of the CRT-D:

- Air emboli
- Allergic reactions to contrast media
- Arrhythmias
- Bleeding
- Body rejection phenomena
- Cardiac tamponade
- Chronic nerve damage
- Damage to heart valves
- Device migration
- Elevated pacing thresholds
- Extrusion
- Fluid accumulation
- Hematoma
- Infection
- Keloid formation
- Lead dislodgment Lead fracture/ insulation damage
- Lead-related thrombosis
- Local tissue reaction / fibrotic tissue formation
- Muscle or nerve stimulation
- Myocardial damage
- Myopotential sensing
- Pacemaker mediated tachycardia
- Pneumothorax
- Pocket erosion
- Thromboembolism
- Under sensing of intrinsic signals
- Venous occlusion
- Venous or cardiac perforation

In addition, patients implanted with the ICD/CRT-D system may have the following risks. These are the same risks related with implantation of any ICD/CRT-D system:

- Acceleration of arrhythmias (speeding up heart rhythm caused by the CRT-D)
- Dependency
- Depression
- Fear of premature battery depletion (fear that battery will stop working before predicted time)
- Fear of shocking while awake
- Fear that shocking ability may be lost
- Anxiety about the CRT-D resulting from frequent shocks
- Imagined shock (phantom shock)
- Inappropriate detection of ventricular arrhythmias
- Inappropriate shocks
- Potential death due to inability to defibrillate or pace
- Shunting current or insulating myocardium during defibrillation with external or internal paddles

There may be other risks associated with this device that are currently unforeseeable.

For the observed adverse events and information on clinical studies, please see the Clinical Study Summary pamphlet, which is provided with this Technical Manual.

## 1.6 Patient Selection and Treatment

### 1.6.1 Individualization of Treatment

- Determine whether the expected device benefits outweigh the possibility of early device replacement for patients whose ventricular tachyarrhythmias require frequent shocks.
- Determine if the device and programmable options are appropriate for patients with drug-resistant supraventricular tachyarrhythmias (SVTs), because drug-resistant SVTs can initiate unwanted device therapy.
- Direct any questions regarding individualization of patient therapy to your BIOTRONIK representative or BIOTRONIK technical services at 1-800-547-0394.

The prospective patient's size and activity level should be evaluated to determine whether a pectoral or abdominal implant is suitable. It is strongly recommended that candidates for an ICD/CRT-D have a complete cardiac evaluation including EP testing prior to device implant to gather electrophysiologic information, including the rates and classifications of all the patient's cardiac rhythms. When gathering this information, delineate all clinically significant ventricular and atrial arrhythmias, whether they occur spontaneously or during EP testing.

If the patient's condition permits, use exercise stress testing to do the following:

- Determine the maximum rate of the patient's normal rhythm.
- Identify any supraventricular tachyarrhythmias.
- Identify exercise-induced tachyarrhythmias.

The maximum exercise rate or the presence of supraventricular tachyarrhythmias may influence selection of programmable parameters. Holter monitoring or other extended ECG monitoring also may be helpful.

If the patient is being treated with antiarrhythmic or cardiac drugs, the patient should be on a maintenance drug dose rather than a loading dose at the time of pulse generator implantation. If changes to drug therapy are made, repeated arrhythmia inductions are recommended to verify pulse generator detection and conversion. The pulse generator also may need to be reprogrammed.

Changes in a patient's antiarrhythmic drug or any other medication that affect the patient's normal cardiac rate or conduction can affect the rate of tachyarrhythmias and/or efficacy of therapy.

If another cardiac surgical procedure is performed prior to implanting the pulse generator, it may be preferable to implant the lead system at that time. This may prevent the need for an additional thoracic operation.

## 1.6.2 Specific Patient Populations

**Pregnancy** - If there is a need to image the device, care should be taken to minimize radiation exposure to the fetus and the mother.

**Nursing Mothers** - Although appropriate biocompatibility testing has been conducted for this implant device, there has been no quantitative assessment of the presence of leachables in breast milk.

**Geriatric Patients** - Most (about 71%) of the patients receiving a CRT-D or ICD in the clinical studies were over the age of 60 years (see Clinical Studies Summary pamphlet).

**Handicapped and Disabled Patients** - Special care is needed in using this device for patients using an electrical wheel chair or other electrical (external or implanted) devices.

## 1.7 Patient Counseling Information

The implanted devices are subject to random component failure. Such failure could cause inappropriate shocks, induction of arrhythmias or inability to sense arrhythmias, and could lead to the patient's death.

Persons administering CPR may experience the presence of voltage on the patient's body surface (tingling) when the patient's CRT-D/ICD system delivers a shock.

A patient manual is available for the patient, patient's relatives, and other interested people. Discuss the information in the manual with concerned individuals both before and after pulse generator implantation so they are fully familiar with operation of the device. (For additional copies of the patient manual, contact the BIOTRONIK at the address listed in this manual.)

## 1.8 Evaluating Prospective CRT-D/ICD Patients

The prospective ICD/CRT-D implant candidate should undergo a cardiac evaluation to classify any and all tachyarrhythmias. In addition, other patient specific cardiac information will help in selecting the optimal device settings. This evaluation may include, but is not limited to:

- an evaluation of the specific tachycardia rate(s)
- the confirmation and/or evaluation of any supraventricular arrhythmias or bradyarrhythmias
- the evaluation of various ATP and cardioversion therapies
- the presence of any post-shock arrhythmias, and
- an evaluation of the maximum sinus rate during exercise.

If a patient's drug regimen is changed or adjusted while the CRT-D/ICD is implanted, additional EP testing may be required to determine if detection or therapy parameter settings are relevant and appropriate.

Empirical changes to the detection or therapy parameters should be assessed based on patient safety. Some changes may necessitate a re-assessment of sensing, pacing, or arrhythmia conversion treatment. Thorough technical knowledge of BIOTRONIK CRT-D/ICDs, additional CRT-D/ICD experience, and individual medical judgment will aid in determining the need for additional testing and follow-up.

## 2. Device Features

The Lumax 740 family feature set is presented under the following sub-headings: Tachyarrhythmia Detection, Tachyarrhythmia Redetection / Acceleration, Tachyarrhythmia Therapy, Tachyarrhythmia Termination, Bradycardia Therapy, EP Test Functions and Special Features. The features apply to all members of the Lumax family except where specifically referenced differently.

### CAUTION

**Programmed Parameters** – Program the device parameters to appropriate values based on the patient's specific arrhythmias and condition.

### 2.1 Master Switch Behavior

The Master switch behavior in the Lumax 740 family of ICDs is different than in previous generations of BIOTRONIK ICDs. Programming the Lumax 740 devices does not automatically turn the tachycardia detection/therapy ON. The Master Switch must be turned ON and the Status Indicator must show Enabled.

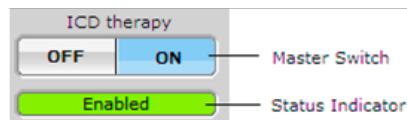


Figure 2: Master switch

Three colors are used for the Status Indicator of the Master Switch:

Green = full detection and therapy options available

Yellow = limited detection and therapy options available

Red = no therapy options are available or the status is unclear

[Figure 3](#) shows the different message options that are available with the Lumax 740 series ICD.



Figure 3: Master switch options

The following sections provide a summary of the Master Switch options and behavior.

#### 2.1.1 Enabled

Tachyarrhythmia detection is enabled, as shown in [Figure 4](#).

All tachyarrhythmias will be detected according to the permanent programmed detection criterion including atrial monitoring episodes.

All tachyarrhythmias will be treated as therapy sequences are programmed.

This status should be confirmed upon completion of a follow-up or implant unless otherwise indicated.



Figure 4: Master switch enabled

### 2.1.2 Disabled

Tachyarrhythmia detection is disabled, as shown in [Figure 5](#).

All tachyarrhythmias will be disregarded by the device detection.

No programmed therapy will be delivered.

The user is able to deliver emergency and manual shocks or manual ATP.



Figure 5: Master switch disabled

### 2.1.3 Temporarily Active

Temporarily active, as shown in [Figure 6](#), is used for the temporary DFT test.

Tachyarrhythmia detection is enabled for temporary VF zone only.

All VF tachyarrhythmias will be treated with shock therapy sequences as programmed in the temporary program on the DFT screen.

The user is able to deliver emergency and manual shocks or manual ATP.



Figure 6: Master switch temporarily active

### 2.1.4 Temporarily Inactive

Temporarily inactive, as shown in [Figure 7](#), is used for temporary testing such as Sensing, Pacing threshold, Retrograde conduction and Impedance test as well as at Atrial NIPS

All tachyarrhythmias will be disregarded by the device detection.

The user is able to deliver emergency and manual shocks or manual ATP.



Figure 7: Master switch temporarily inactive

## 2.1.5 Unknown

The programmer does not know the status of the Master Switch because telemetry interference during an ongoing ICD session interrupts the connection; e.g. slipping wand or EMI. This may also be seen when initial wand placement over the device occurs as the programmer is establishing contact with the device.



Figure 8: Master switch unknown

### WARNING

**Unwanted Shocks** – Always program ICD Therapy to OFF prior to handling the device to prevent the delivery of serious shocks to the patient or the person handling the device during the implant procedure.

## 2.2 SafeSync RF Telemetry

The Lumax 740 models offer "wandless" communication between the device and the programmer by using radio frequency (RF) telemetry, in addition to the currently available telemetry used by applying the programming head (PGH) over the implanted device. This function is called SafeSync Telemetry.

SafeSync Telemetry can be used with the Renamic programmer or with the ICS 3000 programmer (using the SafeSync Module, an external communication module).

Prior to initiating a session, look at the upper right hand corner of the programmer screen to determine if RF is enabled. If RF is turned OFF in the programmer will display a green dot above the ICD therapy message. Additionally, no device picture is shown below the master switch. An example of this is shown on the left side in [Figure 9](#). When RF is ON, communication bars like that seen on cell phones and a picture of a device transmitting information is shown below the master switch, as seen in the right side of [Figure 9](#).



Figure 9: Examples of RF OFF and RF ON

### 2.2.1 Establishing SafeSync RF Telemetry contact:

To initiate a session using SafeSync, place the wand over the device until the message "Programming head can be removed" shown in [Figure 10](#) appears. Once the message appears (typically < 2 seconds) the wand can be removed.

The strength of communication between the programmer and the device is demonstrated by the symbol, found at the upper right hand portion of the programmer screen. The more bars with light green, the better the communication. Conversely, the fewer the green bars, the poorer the communication. To ensure adequate signal strength, place the Renamic programmer or SafeSync Module within 3 meters (9 feet) of the device. Ideally, there should be no obstacles between the patient and the programmer.

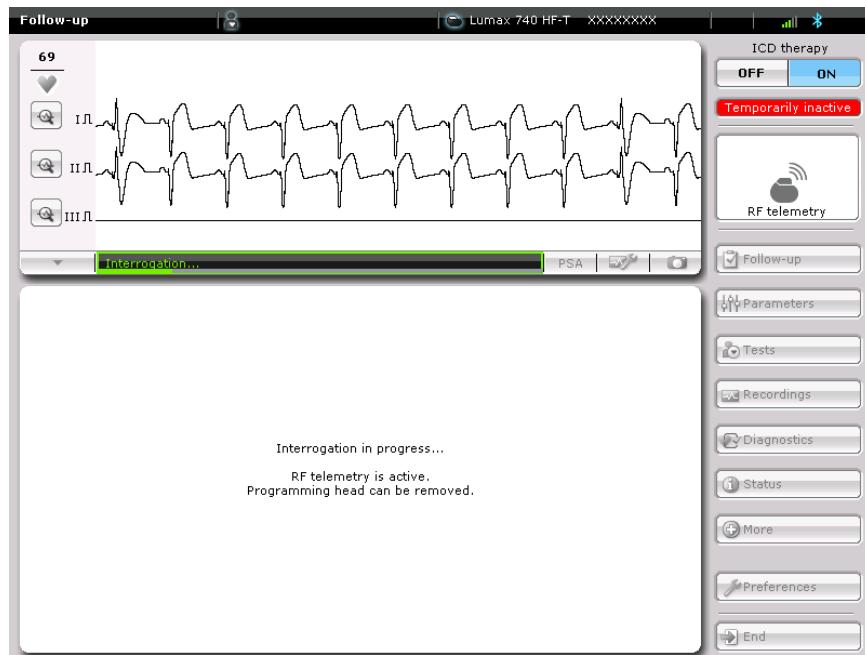


Figure 10: Session initiation message

Once RF telemetry has been established, the programming head wand cannot be used again for the duration of the RF telemetry session. In order to indicate this to the user, the LED on the programming head wand will start blinking with an orange light. This notifies the user that there is an active RF telemetry session

## 2.2.2 Economy Mode

To conserve device battery, the system provides an Economy mode. After five minutes of programmer inactivity, the RF telemetry is suspended. When the telemetry is suspended, the IEGMs will not be present on the programmer screen. Each touch of the programmer screen resets the timer.

When the Economy mode screen appears, the patient name will be displayed in the dialog box. In the example shown in [Figure 11](#), "Patient name" appears. This message prevents potential confusion if more than one patient is in distance of the programmer.

To reactivate RF telemetry, simply press the "Close" button on the screen. The IEGMs will reappear. To conserve the device battery, consider closing the Economy mode box, which ends the Economy Mode, only when you will make a change in the programmer interface.

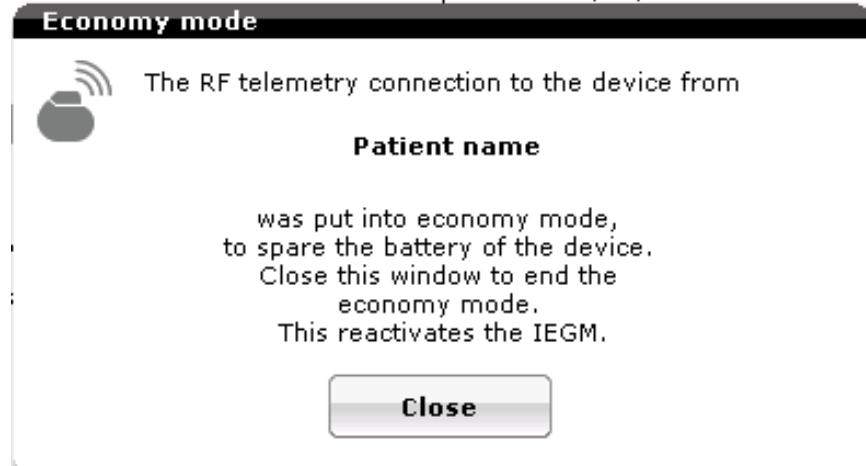


Figure 11: Economy mode message

### 2.2.3 Ending a follow-up session

When ending a follow-up session, end the session by pressing the “End” button on the screen as shown in [Figure 12](#). This ends the RF telemetry link to the device and prevents the possibility of errant programming.

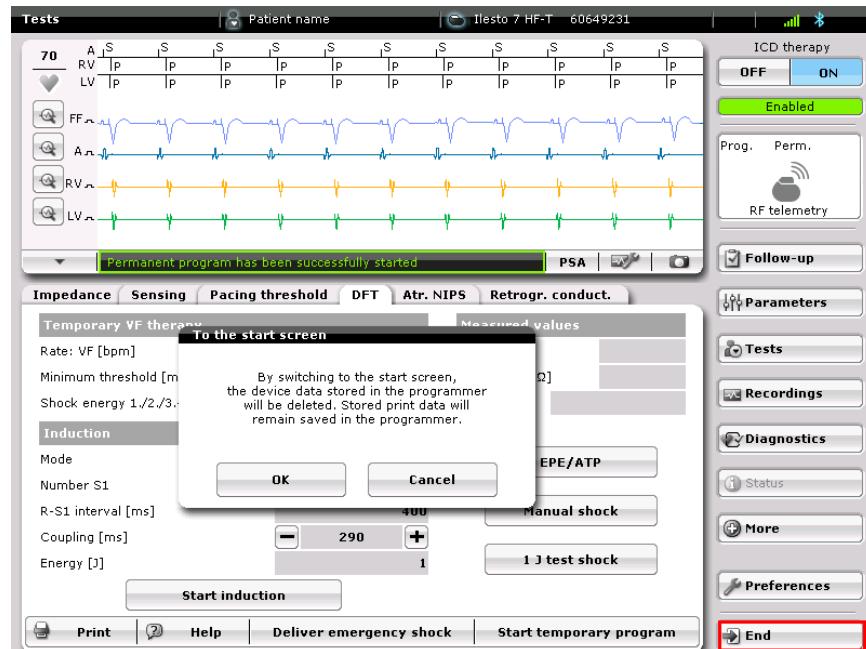


Figure 12: End session

### 2.2.4 Switch between RF and wand

To switch between RF and wand (PGH) telemetry, go to the Lumax tab under the More section. To disable RF telemetry, press the PGH button. If a session is active, a message stating “RF telemetry is deactivated” will appear.

To activate RF telemetry, place the wand on the device and press the RF button. A message stating that “RF telemetry is active. Programming head can be removed.” will appear on the screen.

## Chapter 2 Device Features

Lumax 740 Technical Manual

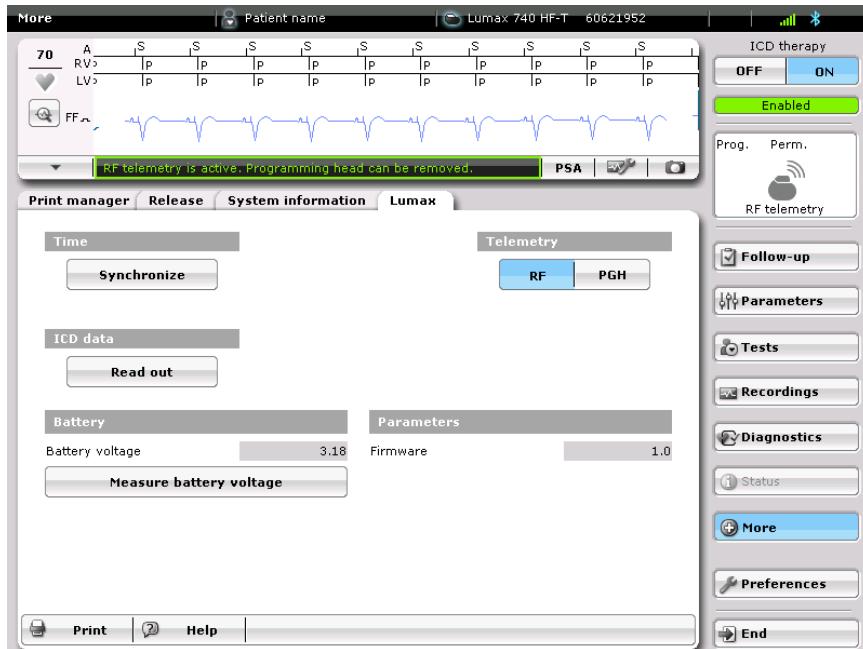


Figure 13: Switch between PGH and RF telemetry

### 2.2.5 Power Consumption Consideration:

SafeSync Telemetry requires somewhat more power than telemetry via the programming head. Power consumption during a three hour implantation procedure corresponds to approximately ten days of service time and consumption during 20-minute follow-up corresponds to approximately three days. As a result:

- Do not establish SafeSync Telemetry sessions unnecessarily.
- After 5 minutes without input, SafeSync Telemetry switches to the economy mode. In order to re-establish telemetry from the economy mode, select “Close” in the pop-up window with the patient’s name as shown in [Figure 11](#). To conserve the device battery, consider closing the Economy mode box, which ends the Economy Mode, only when you will make a change in the programmer interface.
- Check the battery capacity of the device at regular intervals.

## 2.3 Cardiac Resynchronization Therapy (CRT)

### HF-T version only

For Cardiac Resynchronization Therapy (CRT), a sensing/pacing lead is placed in the right atrium, while an ICD lead is placed in the right ventricle. The third lead is positioned to pace the left ventricle. When connected together, this system provides coordinated, simultaneous stimulation of the right and left ventricles. This resynchronization therapy is designed to coordinate the contraction of both ventricles, which allows the heart to contract more efficiently. As a result, patients with Congestive Heart Failure and intraventricular conduction delay may have a greater ability to complete physical activities thus improving their quality of life.

As a result of the device design and header configuration, ventricular pacing pulses can be delivered between the right / left ventricular lead tip electrodes simultaneously (cathode) and at programmed intervals. In some configurations the ring of the right ventricular lead works as LV anode. Ventricular sensing primarily uses the poles of the right ventricular lead tip and ring. This design avoids sensing

of ventricular activity twice during a single cardiac cycle (double counting) in patients with a wide QRS complex. However, for diagnostic purposes and LV pacing protection the Lumax HF-T devices can be programmed to sense in the left ventricle.

### Atrial Channel

The Lumax ICDs/CRT-Ds pace and sense in bipolar configuration, between the atrial lead's tip and ring electrodes. A bipolar atrial lead must be used to ensure reliable sensing of atrial activity.

### Ventricular Channel

The Lumax HF-T devices can be programmed to pace in both the right and left ventricle (as well as RV only). The Lumax HF-T primarily senses in a bipolar configuration in the right ventricle. However, for diagnostic purposes and LV pacing protection the Lumax HF-T devices can be programmed to sense in the left ventricle.

Potential Ventricular lead configurations are provided in [Table 2](#).

Table 2: Lead configurations		
	Configuration	Explanation
Sensing	<b>RV Only</b> (mandatory)	Sensing takes place between the tip and ring electrodes of the right ventricular lead.
	<b>LV Only</b> (optional)	Sensing takes place between the tip and ring electrodes (bipolar) or the tip electrode of the left ventricular lead and the CRT-D housing (unipolar).
Pacing	<b>RV &amp; LV Together (BiV)</b>	Pacing configuration of the RV lead is fixed between tip and ring electrode of the right ventricular lead. Pacing configuration of the LV lead is programmable between the tip and ring electrodes of the left and right ventricular leads and between the housing. See <a href="#">Figure 14</a>
Pacing	<b>RV Only</b>	Pacing takes place between the tip and ring electrodes of the right ventricular lead.

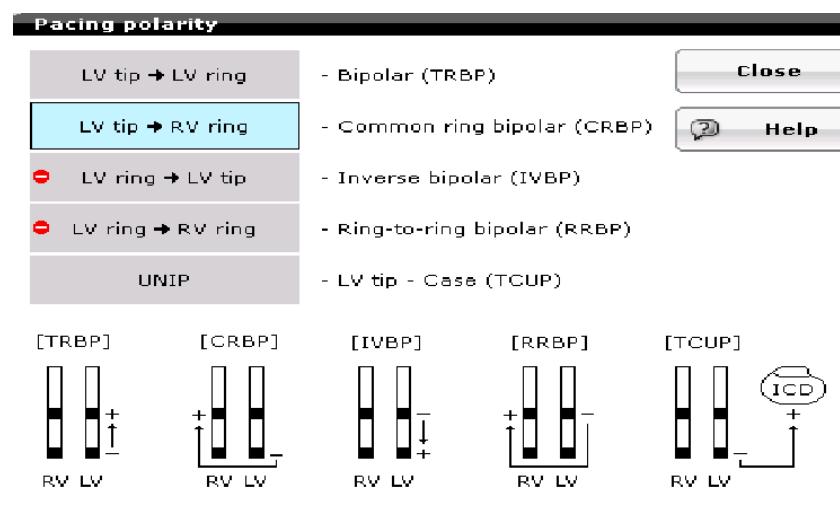


Figure 14: Programmable BiV pacing configurations

For CRT to be effective, ventricular pacing must occur. Therefore, AV delays must be programmed short enough to override intrinsic ventricular contractions. Additional information to further optimize AV delays can be obtained with echocardiography.

CRT can be programmed ON or OFF via the programmer using the [**Ventricular Pacing**] parameter. Ventricular Pacing Configuration allows standard right ventricular [**RV**] (CRT = OFF) pacing or Cardiac Resynchronization Therapy [**BiV**] (CRT = ON).

The Lumax HF-T CRT-D can provide triggered biventricular pacing. This is a functional expansion of the basic ventricular modes (DDD(R); DDI(R); VDI(R); VDD(R); VVI(R)) used for biventricular pacing. The “RVs triggering” was designed to ensure CRT is delivered even when rapid intrinsic activation interferes with pacing, such as in the case of conducted atrial fibrillation. This function triggers LV pacing (LVP) after intrinsic sensing (RVs) in the right ventricle. Triggered pacing can be programmed to react to only normal RV sensed events or to right ventricular extrasystoles as well as normal RV sensed events. The maximum trigger rate is normally limited by the programmed UTR (+20 bpm), but can also be programmed to function up to a separate and higher maximum trigger rate.

### V-V Delay Programming

V-V delays should be programmed based on optimization of the echocardiographic parameter Aortic Valve Velocity Time Integral, evaluating the full range of available delays, as was performed in the clinical study demonstrating the safety and effectiveness of this feature. RV pre-excitation may cause a decline of LV function.

The V-V delay features for the Lumax HF-T devices include the ability to program the following parameters “first chamber paced,” which allows either the right or the left ventricle to be paced first, and “VV delay” for setting a delay between the left and right ventricular pacing pulses (programmable range: 0 ms ... (5 ms) ... 100 ms).

Suggested optimization procedure:

During the V-V clinical study, the assessment was performed by determining the V-V delay setting associated with the largest VTI value. The VTI of the aortic flow is measured in the apical 5 chamber view.

Prior to the V-V delay optimization procedure, each patient underwent an optimization of AV timing. Following the AV timing adjustment, this standardized procedure was followed for the optimization of V-V delay:

1. Program the Lumax HF-T “Initially Paced Chamber” parameter to either RV or LV based on preference
2. Assess the VTI measurement at the following V-V delays (additional V-V settings may be utilized at the physician’s discretion):
  - 100 ms
  - 80 ms
  - 60 ms
  - 40 ms
  - 20 ms
  - 0 ms

#### NOTE:

Use the average VTI parameter over a 3 beat cycle and wait 10 to 15 seconds between changing V-V delay settings. Also, attempt to measure the VTI parameter within the same patient respiratory cycle.

3. Record the VTI measurement associated with each V-V delay setting

Repeat steps 1-3 for the remaining “Initially Paced Chamber” parameters

Select permanent “Initially Paced Chamber” and “V-V delay after Vp” to reflect the maximum VTI measurement for final programming.

## 2.4 Special Features

The Lumax includes several special features to improve ease of use and provide additional information to the user.

### 2.4.1 Thoracic impedance

The thoracic impedance is measured between the distal shock-coil of the RV lead and the ICD housing. Up to 1,024 measurements are done every hour and these measurements are then averaged. The 24 measurements per day are stored in the device and transmitted via Home Monitoring. The Home Monitoring website then displays a trend of the daily average. The same trend of daily TI averages is displayed on the programmer upon interrogation of the ICD. The TI trend does not replace assessments that are part of standard of care for the clinical practice. The clinical value of this feature has not been established for the management of patients.

#### NOTE:

Pocket and or lead revisions may affect the TI trend data. Therefore, the TI trend data should be interpreted cautiously within 6-10 weeks of an implant or revision procedure.

### 2.4.2 Home Monitoring®

Home Monitoring enables the exchange of information about a patient’s cardiac status from the implant to the physician. Home Monitoring can be used to provide the physician with advance reports from the implanted device and process them into a graphical and tabular format that is accessible via the internet platform Home Monitoring Service Center (HMSC). This information helps the physician optimize the therapy process, as it allows the patient to be scheduled for additional clinical appointments between regular follow-up visits if necessary.

BIOTRONIK conducted the TRUST study to evaluate the safety and effectiveness of Home Monitoring. With the TRUST study, BIOTRONIK was able to show the following with regards to Home Monitoring:

- BIOTRONIK Home Monitoring information may be used as a replacement for device interrogation during in-office follow-up visits.
- A strategy of care using BIOTRONIK Home Monitoring with office visits when needed has been shown to extend the time between routine, scheduled in-office follow-ups of BIOTRONIK implantable devices in many patients. Home Monitoring data is helpful in determining the need for additional in-office follow-up.
- BIOTRONIK Home Monitoring-patients—who are followed remotely with office visits when needed—have been shown to have similar numbers of strokes, invasive procedures and deaths as patients followed with conventional in-office follow-ups.
- BIOTRONIK Home Monitoring provides early detection of arrhythmias.
- BIOTRONIK Home Monitoring provides early detection of silent, asymptomatic arrhythmias.
- Automatic early detection of arrhythmias and device system anomalies by BIOTRONIK Home Monitoring allows for earlier intervention than conventional in-office follow-ups.

- BIOTRONIK Home Monitoring allows for improved access to patient device data compared to conventional in-office follow-ups since device interrogation is automatically scheduled at regular intervals.

The implanted device's Home Monitoring function can be used for the entire operational life of the implanted device (prior to EOS) or for shorter periods, such as several weeks or months. Home Monitoring is programmable, ON or OFF.

**NOTE:**

When ERI mode is reached, this status is transmitted. All measurements and transmissions are unaffected. When End of Service (EOS) is reached and transmitted, further measurements and transmissions of Home Monitoring data are no longer possible.

#### **2.4.2.1 Transmission of Information**

The implanted device transmits information with a small transmitter, which has a range of about 2 meters. The patient's implant data are sent to the corresponding patient device, the CardioMessenger, at least every 24 hours. The transmissions may also be activated by the detection of a cardiac event, as programmed. The types of transmissions are discussed in [Section 2.4.2.4](#).

The minimal distance between the implanted device and the patient's CardioMessenger must be maintained at 15 cm.

#### **2.4.2.2 CardioMessenger**

The CardioMessenger patient device is designed for use in the home and is comprised of a stationary device or a mobile device that comes with an associated charging station. The stationary device remains on the patient's bedside table at all times. The mobile device can be carried by the patient during his or her occupational and leisure activities. The mobile patient device is rechargeable, allowing for an operational time of approximately 24 hours. CardioMessenger devices receive information from the implanted device and forward it via a telephone or cellular network to the BIOTRONIK Service Center.

For additional information about the CardioMessenger, please refer to the CardioMessenger technical manual.

#### **2.4.2.3 Transmitting Data**

The implant's information is digitally formatted by the BIOTRONIK Service Center and is processed into a tabular format Cardio Report that is accessible via the internet platform Home Monitoring Service Center (HMSC). The Cardio Report is available in two formats; via fax or via BIOTRONIK's secure Internet connection. Reports are available depending on the type of report transmission—periodic or event triggered. This Cardio Report, which is adjusted to the individual needs of the patient, contains current and previous implant data. An Intracardiac Electrogram (IEGM) is included for the latest tachycardia episode (VT/VF). The Internet site allows the physician to "program" the Service Center on how the information is supplied; either by fax, SMS message, on the internet platform and/or via email.

The trigger criteria are specific to the particular device and can additionally be individually customized for each patient. Trigger notifications can be sent to the attending physician via fax, SMS or e-mail.

For more information on registering for Home Monitoring, contact your BIOTRONIK sales representative.

The password protected BIOTRONIK Home Monitoring website can be accessed at the following URL:

### [www.biotronik-homemonitoring.com](http://www.biotronik-homemonitoring.com)

An online help menu is available in order to assist with the use of the Home Monitoring website.

Use of the Internet for reviewing Home Monitoring data must be in conjunction with the system requirements listed in [Table 3](#). Additionally, [Table 3](#) provides system specifications that are recommended for optimizing usage of the Internet.

<b>Table 3: System requirements / recommendations</b>		
	<b>System Requirements</b>	<b>System Recommendations (for Optimal Usage)</b>
Screen Resolution	1024 x 768	≥ 1280 x 1024
Internet Bandwidth	56 kB/sec	≥ 128 kB/sec (DSL, cable modem)
PC	800 MHz Pentium processor, 128 MB RAM	N/A
Internet Browser	MS Internet Explorer 5.5	≥ MS Internet Explorer 6 - or - ≥ Mozilla 1.8 (Firefox ≥ 3.0) - or - Safari 4 or higher
Acrobat Reader	Version 6.1	Version 8 or higher
Communication Channel	Fax (G3) or e-mail	Fax (G3), e-mail or mobile phone

#### **2.4.2.4 Types of Report Transmissions**

When the Home Monitoring function is activated, the transmission of information from the implant can be triggered as follows:

- Daily report – the time period (daily) initiates the transmission (IEGM included if not yet sent)
- Event report – certain event reports can be programmed to have an IEGM included each time that they are transmitted. The IEGM includes comprehensive event details with up to 45 seconds of IEGM.
- Periodic IEGM report – the device records and transmits up to 30-seconds of patient presenting IEGM at the time interval programmed

##### **Daily Report**

The time of daily Home Monitoring Report transmission is programmable. For periodic messages, the time can be set anywhere between 0:00 and 23:00 hours or may be programmed to Standard (default). When the device is set to Standard (Std.), the device transmits a message between 01:00 and 02:00 hours, dependent on the serial number of the device. It is recommended to select a time between 0:00 and 4:00.

##### **Periodic Report with IEGM**

The Lumax ICDs and CRT-Ds can be programmed to transmit IEGMs with the daily Home Monitoring report on a periodic basis with an interval selection of: OFF, Date, 30, 60, 90, 120, 180 days. The selection of Date allows the user to program up to 5 specific transmission dates for Periodic IEGMs.

## Event Report

When certain cardiac and technical events occur, a report is automatically generated. This information is described as an “event report.”

The implant supports the following automatic event triggers:

- Termination of VT/VF Episode (not Termination of a Monitoring episode, SVT episode or Episodes during temporary program)
- Ongoing Atrial Monitoring Episode lasting longer than the programmed time (6, 12 or 18 hours)

The following event triggers are also supported and are only evaluated at daily transmission time.

These event triggers can convert the daily trigger to an event trigger:

- Impedance out-of-range for A, RV, LV, shock lead (painless)
- Daily shock lead impedance out-of-range
- Atrial and Ventricular ATM/VCC change to disable since the last successfully transmitted message
- Special Device Status – ERI/EOS/ROM-Mode
- Master Switch Off
- Emergency Brady Active

The following triggers are also supported:

- First ineffective maximum energy shock detected
- Initial detection SVT
- Percent of ventricular sensing below set limit
- ERI

## Programmer Triggered Report

With the device status screen, it is possible to test the ICD/CRT-D’s Home Monitoring capabilities during device implantation or follow-up. To do this, the CardioMessenger must be within range of the Lumax ICD/CRT-D and powered ON. From the device’s Home Monitoring tab, press the Send test message button.

### NOTE:

Battery voltage and pace/sense lead impedance are measured before the first transmission of the day. Therefore, the first transmission may occur 2 minutes after the programmed transmission time.

### 2.4.2.5 Description of Transmitted Data

The following data are transmitted for the Status Report by the Home Monitoring system, when activated. In addition to the medical data, the serial number of the implant is also transmitted.

#### Device Status and Home Monitoring Settings

Containing device and message identifying values that pertain to the implant and Home Monitoring:

- Implantation Date
- Battery voltage and Date of Measurement
- Device Status
  - Master-switch (e.g., ICD Therapy ON or OFF)
  - Standard error flags
- Current Consumption for ERI calculation (done by the Service Center)
- Date and time of Last Follow-up and Program Counter
- Message Creation Date/Time

- Device Serial Number
- Current ROM/RAM Version Information

## Leads

- Automatic Threshold Monitoring
  - Measured RV pacing threshold
  - Measured LV pacing threshold
  - RV enabled/disabled
  - LV enabled/disabled
- Pacing Impedance (RA, RV, LV/BiV)
  - Mean of 4 daily measurements
- Sensing Amplitude (RA, RV, LV/BiV)
  - Mean of 4 daily measurements
  - Minimum of 4 daily measurements
- Painless Shock Impedance
  - Mean of 4 daily measurements
- Data of last Shock
  - Impedance & Date of last Shock delivered
  - Complete Shock Recording

## Pacing Counters (Brady)

- AV-Sequences
  - Intrinsic Rhythm (AsVs)
  - Conducted Rhythm (AsVp)
  - Atrial Paced Rhythm (ApVs)
  - Complete Paced Rhythm (ApVp)
  - VV sequence (Vx-Vx) [%]
  - Ap, RVp, LVp [%]

## Pacing Counters (CRT)

- LV-RV-Sequences
  - BiVp (RVp-LVp or LVp-RVp)
  - RVs-LVp
  - RVp-noLVp, RVs-noLVp (LV T-wave protection ON)
  - LVp, noLVp (LV pacing only)
- PVC-Triggered Resynchronization
  - VES-LVp (Triggering: RVs+RVES)
  - VES-noLVp (LV T-wave protection ON)

## Atrial Arrhythmia

- Atrial Tachy Episodes (36 out of 48 criteria)
  - Life-Time Counter on AT/AF detections
  - Atrial Burden per Day
  - Ongoing Atrial Episode Time (programmable for 30 min, 6, 12 or 18 hrs)
  - Includes time stamp of last atrial burden, atrial episodes per day and duration of longest atrial episode

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- Mode Switching
  - Number of Mode Switches per Day
- SVT (Discrimination within VT zones)
  - Lifetime Counter of Detections in SVT
  - Number of SVT by SMART
  - Number of SVT without SMART
  - Ongoing SVT episode (current episode open)

### Ventricular Arrhythmia

- Lifetime Counters
  - Detections in VT1, VT2, VF,
  - Initial Detections during Detection Episodes during temporary program (induction)
  - Started + successful ATP in VT
  - Started + successful ATP-One-Shot in VF
  - Started + cancelled + successful Shocks
  - Shock Path
  - Ineffective maximum energy shocks
- Date, Time and Number of last Episode (number as in episode listing in Recordings)
- Other Ventricular Arrhythmia
  - Number of Mean PVC/h per day ("per Day" is referenced to the Monitor Interval Duration)

### Heart Failure Monitoring (all data based on Monitoring Interval)

- Heart Rate
  - Mean atrial heart rate
  - Mean ventricular heart rate
  - Minimal ventricular heart rate at rest
  - Max/mean ventricular heart rate during atrial burden
- Heart Rate Variability
  - Atrial SDANN per day (5 min periods of As-As)
- Patient Activity
  - % Duration per day (from Sensor)
- Thoracic Impedance
  - Hourly mean of up to 1024 measurements/hour

### Transmitted Device Settings

The currently programmed parameters for the following are sent in the data package:

- Leads – (e.g., Pacing Output, Configuration)
- Brady - (e.g., Basic Rate, UTR, AV-Delays, RV Sensitivity)
- CRT - (e.g., Configuration, VES Triggering, VV delay)
- I-OPT - (ON/OFF)
- AV Delay Adjust setting - (ON/OFF)
- Ventricular Tachycardia Detection - (e.g., Zone limits, SMART Detection®, Sustained VT)
- Ventricular Tachycardia Therapy - (e.g., ATP Schemes, Shock energies)
- HM Settings - (e.g., ON/OFF, transmission time (daily), IEGM transmissions ON/OFF, periodic IEGM, ongoing atrial episode, statistics and recordings)

## System Information

Information is also added by the CardioMessenger II to the message from the implant. This information contains the following data:

- Timing delay between reception in the CardioMessenger II and Delivery to a provider
- CardioMessenger II Serial Number
- Technical Parameters for Troubleshooting

### 2.4.2.6 IEGM Online HDs

The Lumax ICDs/CRT-Ds provide the ability to transmit IEGM Online HD (IEGM and marker data) from the most recent SVT / VT / VF / AF episodes as an additional to the current messages.

An IEGM with up to 3 channels (RV, LV, RA or Far-Field) are sent in one message, depending on the number of IEGM channels programmed in the Holter configuration.

If an episode is terminated each IEGM Frame contains up to 30 s of pre-detection IEGM and up to 15 s of pre-termination IEGM .

If the episode is not terminated each IEGM Frame shall contain up to 10s of pre-detection IEGM.

The IEGMs delivered for specific events are as follows:

- For VT/VF therapy episodes both pre-detection and pre-termination parts are sent (max 30 s + 15 s), because HM is triggered after termination detection.
- If AF, SVT, VF, or VT monitoring episodes are terminated, both pre-detection and post-detection parts are sent (max 30 s + 15 s) if the episode is terminated. If it is not yet terminated only a pre-detection part is sent.
- If an ongoing atrial episode fulfills a programmed time duration criteria, a message is triggered to provide the physician with the information early on.
- For the periodic IEGM only one part is available. Such recordings are performed right before a periodic message, and after each interval as configured.

The Lumax ICD/CRT-D transmits the following data from the Episode List with the IEGM message:

- Episode Number,
- Date and time of initial detection,
- Date and time of termination,
- Indication of magnet application (induced episode and forced termination)
- Zone of Initial Detection,
- Number of delivered ATP and shocks during this episode,
- Number of redetections per zone
- SMART Detection® settings (VT zones activated)
- SMART path (for SVT)
- Duration of episode

The IEGM also contains the following rhythm markers: AS, Ars, AP, VS, Vrs, VP, VT1, VT2, VF, and the SMART path rhythm markers Aflut, SVT, Afib, SinT and 1:1.

The IEGM Online HD from the most recent episode is stored in the device in an IEGM data buffer. The firmware updates the IEGM transmission buffer before the first IEGM transmission episode. IEGM data from a VT/VF episode is available after Termination detection of an episode. If the Holter configuration records an SVT IEGM episode, the IEGM data from an SVT episode is available after Termination

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detection of an episode. An IEGM message is transmitted with daily, periodic IEGM, and episode messages (unless already sent). An IEGM is not sent with programmer triggered and ROM/EOS messages.

The Lumax 740 ICD/CRT-D includes a programmable parameter to disable or enable the IEGM transmission. The default value is “enabled.”

#### 2.4.2.7 Scheduling Remote Follow-up

The Lumax 740 ICDs/CRT-Ds provide the ability to automatically schedule remote follow-ups using the programmer. This feature has the following two options:

1. Fixed Follow-up Intervals (using 30-180 day cycles) from the date of the first scheduled transmission:

Periodic IEGM for follow-up					
Cycle duration [days]	90				
Transmission date(s)	1st date	2nd date	3rd date	4th date	5th date
08/19/2011					

2. Selection of 5 sequential dates\* with a minimum time lag of 20 days between any two selected dates.

Periodic IEGM for follow-up					
Cycle duration [days]	Date				
Transmission date(s)	1st date	2nd date	3rd date	4th date	5th date
08/19/2011	10/19/2011	01/19/2012	05/18/2012	08/20/2012	

#### 2.4.3 Capacitor Reformation

Shock charge times may be prolonged if the high voltage capacitors remain uncharged for an extended period of time. Conditioning (or reforming) the capacitors by periodically charging them will help assure shorter charge times for those patients that do not regularly receive shock therapy. The Lumax 740 devices automatically re-form the capacitors after every 3 months and the reformation is performed at midnight. The capacitor reformation clock is reset following an automatic or manual capacitor reform. Any device initiated maximum charging of the high voltage capacitors also resets the automatic reformation clock (i.e., shock therapies).

An automatic or manually initiated capacitor reform fully charges the capacitors and then allows the capacitors to discharge slowly into an internal resistor. No shock will be delivered to the patient. Throughout the re-formation process the ICD/CRT-D will provide bradycardia pacing support and tachyarrhythmia sensing and detection as programmed. If a tachyarrhythmia is detected during capacitor reformation, the process is aborted and therapy is available if required.

#### CAUTION

**Capacitor Reformation** - Infrequent charging of the high voltage capacitors may extend the charge times of the ICD/CRT-D. The capacitors are automatically reformed.

In order to perform a manual capacitor reformation, the user must enter the code “1655” from the Release screen.

Go to More > Release> type 1655 and then press the enter button > Lumax tab.

\* If the 5 dates have been elapsed the standard time interval for periodic IEGM (30 days) will be enabled.

**NOTE:**

In order to display the Manual Cap Reform button, the Code “1655” must be entered from the Release screen prior to entering the Lumax device tab on the MORE page.



Figure 15: Manual capacitor reformation

#### 2.4.4 Asynchronous Pacing Modes

The Lumax 740 models offer the following asynchronous pacing modes for use during medical procedures:

- V00 – asynchronous pacing in the ventricle
- D00 – asynchronous pacing in the atrium and ventricle with a fixed AV delay for conduction between chambers

Tachyarrhythmia detection is deactivated when using these asynchronous modes in the Lumax 740 devices.

The asynchronous modes are intended for use during medical procedures, such as cauterization. In patients with inadequate intrinsic rhythm, the pacemaker should be reprogrammed to an asynchronous mode during the procedure in order to prevent inhibition by electromagnetic interference. Thus, the asynchronous modes V00 and D00 are intended to prevent possible inhibition by electromagnetic interference during invasive intervention (such as during electrocautery).

The patient must be monitored when asynchronous pacing modes are used. The asynchronous modes V00 and D00 can only be set if tachyarrhythmia sensing is deactivated. However, this would leave the patient without sensing and therefore without ICD therapy. Thus, during the use of asynchronous modes:

- Continually monitor the patient
- Keep an external defibrillator ready

## 2.4.5 Far-Field IEGM for Threshold Testing (Leadless ECG)

The Lumax 740 models offer a new feature, leadless ECG, which allows for an alternative to ECG and IEG for the threshold testing without the external/surface ECG leads. The Far-Field IEGM can be used to replace surface ECG leads during threshold testing. There is now an option to select between (near-field) IEGM, conventional surface ECG signals (I, II, or III) or leadless ECG (FF IEGM) as display options automatically. The figure below shows FF option:

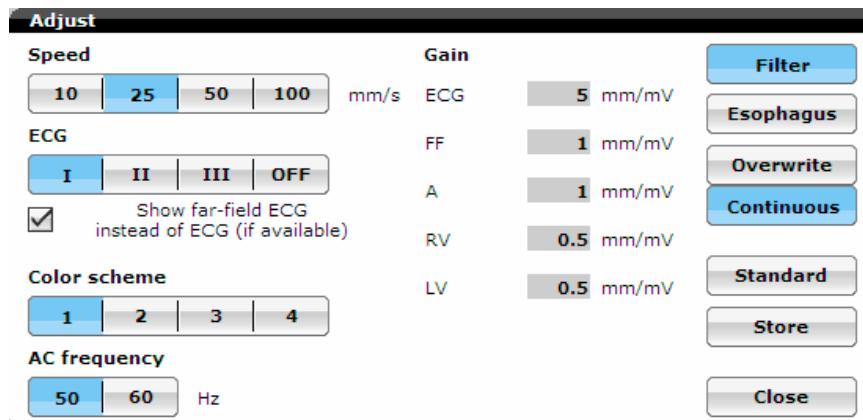


Figure 16: Far-field IEGM option screen

## 2.5 Additional Device Features

### 2.5.1 Real-time IEGM Transmission

The pulse generators provide real time transmission of the intracardiac electrogram (IEGM) to the programmer. IEGMs from the atrium and ventricles can be simultaneously recorded with a bandwidth of 18 to 80 Hz in the atrium and 24 to 100 Hz in the ventricle. Depending on the device, the following channels are simultaneously recorded:

- During single chamber (VR-T) operation, far-field, and RV electrograms are available.
- During dual chamber (VR-T DX, DR-T) operation, far-field, RA, and RV electrograms are available.
- During triple chamber (HF-T) operation, RA, RV, and LV electrograms are available.

A real-time IEGM can be viewed in most programmer screens when the wand is placed over the ICD or when RF Telemetry is established. The surface ECG is continuously displayed in the Overview screen, the Sensing screen and the EP test functions module. Real-time IEGMs are available in the EP tests and sensing / impedance screens. They are then displayed together with surface ECG and markers on the programmer screen and printed on the ECG recorder. Likewise, intracardiac signals and markers identifying atrial/ventricular paced and sensed events are received via the programming wand or RF Telemetry session, and may be displayed on the programmer screen and printed on the ECG recorder.

The IEGM can be printed to document sensing, inductions, and therapy. The printout will show the ventricular markers, one ECG channel, and the atrial and ventricular IEGMs. In the case of a VR-T, VR-T DX or DR-T device, the IEGM will display a far-field electrogram. This far-field signal is measured from the distal shock coil to the can.

[Figure 17](#) shows IEGM marker annotations compared to the ECG box. A pace marker is represented by a full dash. A sense marker is represented by a half-length dash, while a refractory sense marker is represented by a quarter-length dash.

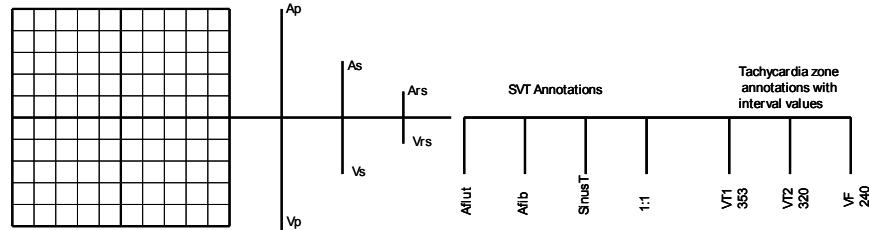


Figure 17: IEGM markers

The FREEZE icon may be used to capture a snapshot of the IEGM. Calipers will appear with the snapshot, allowing the user to measure intracardiac distances. Calipers can be adjusted by touching the vertical dotted lines on the screen ([Figure 18](#)) or by using the arrows on the right side of the screen.



Figure 18: The freeze ECG page

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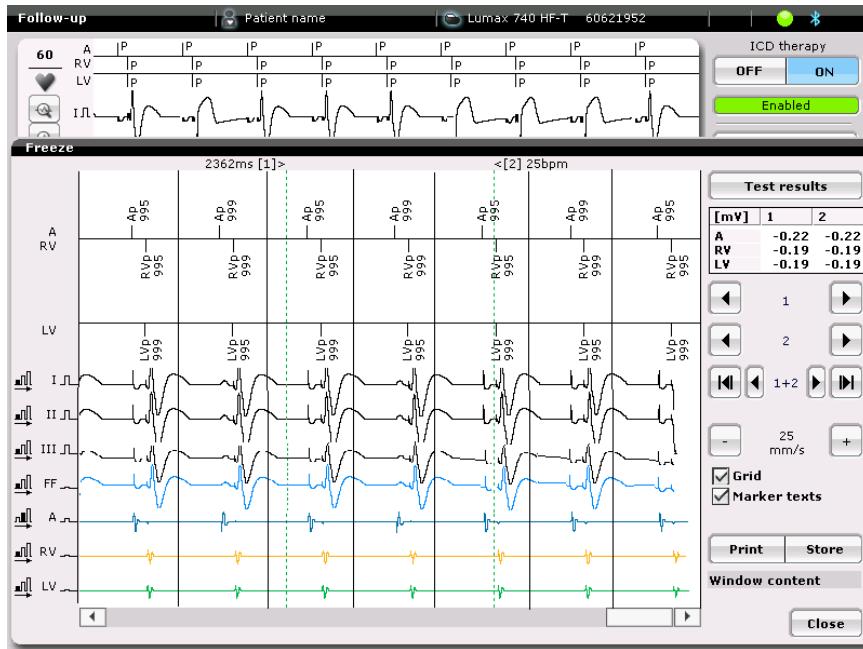


Figure 19: The freeze ECG page with one second gridlines



Figure 20: Window content

The programmer is capable of storing the last 60 seconds of temporary memory when the Freeze icon is selected. This information can be printed by the user. The Print/Save options are opened when pressing on “Window Content,” found on the bottom-right corner of the programmer screen, as shown in [Figure 20](#). When pressing on “Window Content”, the window in appears. Whichever option is selected is the portion that can be printed or stored in the programmer.

There are four choices for printing and storing to the programmer:

1. Window Content – prints only what is visible on the screen
2. All – prints all 60 seconds of information
3. 1-2 Caliper 25 mm/s – prints only the information between the calipers at 25 mm per second paper speed
4. 1-2 Caliper 50 mm/s – prints only the information between the calipers at 50 mm per second paper speed

The IEGMs are printed by pressing the print button in the bottom right hand corner of the screen. The Store button below the Window content stores the frozen information to the programmer for later viewing. The table in the upper right-hand portion of the screen shows the signal amplitude that crosses the calipers. The Close button turns off the freeze and returns the programmer to standard function.

## 2.5.2 Additional Programmer Functions

Additional programmer functions are available to enhance follow-up and troubleshooting for devices. The heart rate is also found in the upper left-hand side of the screen, next to the heart icon.



Figure 21: Main follow-up screen

Immediately to the left of the freeze icon is an adjust icon. This brings up a pop-up menu, allowing the user to change screen sweep speed, display color scheme, ECG display for testing, gains for the ECG and IEGMs, as well as the display mode. Any of these can be changed without rebooting the programmer.

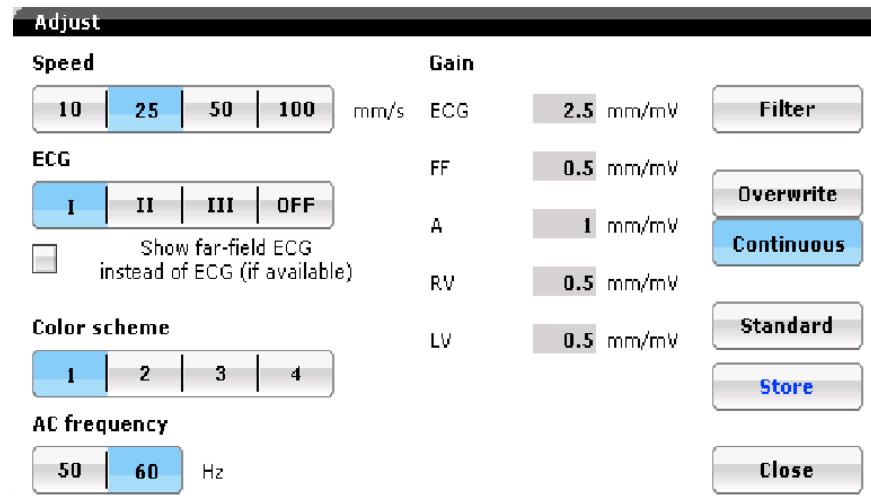


Figure 22: Adjust screen

### 2.5.2.1 Speed

Adjusts the sweep speed of the display.

### 2.5.2.2 ECG

Selects the ECG lead to be visualized during testing. A check box underneath the ECG section allows the user to use the far-field signal instead of the ECG for devices that use a far-field signal.

### 2.5.2.3 Color scheme

Changes the color scheme of the ECG/IEMG display to white-on-black or black-on-white.

### 2.5.2.4 AC Frequency

Allows the user to choose 50 Hz or 60 Hz frequency. Keep at 60 Hz.

### 2.5.2.5 Gain

Another method to adjust the size of the on-screen signal for ECGs, IEGMs and Far-field signals.

### 2.5.2.6 Overwrite / Continuous

Two options are available for choosing how data crosses the screen. The Overwrite mode brings new information in from the right side of the screen. The Continuous mode brings new information in from the left side of the screen.

### 2.5.2.7 Standard

Resets the settings to a standard default.

### 2.5.2.8 Stores

Stores into memory any changes made by the user.

## 2.5.3 Preferences

Preferences may be stored to optimize the programmer's setup for an individual office or clinic. These programmer options can be adjusted via the Preferences button accessed under More. Preferred settings include parameters for the Fast follow-up, threshold and amplitude tests, as well as ECG, Print, and System settings.

### 2.5.3.1 Follow-up Preferences

The Follow-up screen, as shown in [Figure 23](#), allows the user to select which tests are performed automatically by the programmer during a follow-up. Not all devices will have the capabilities shown on this screen.

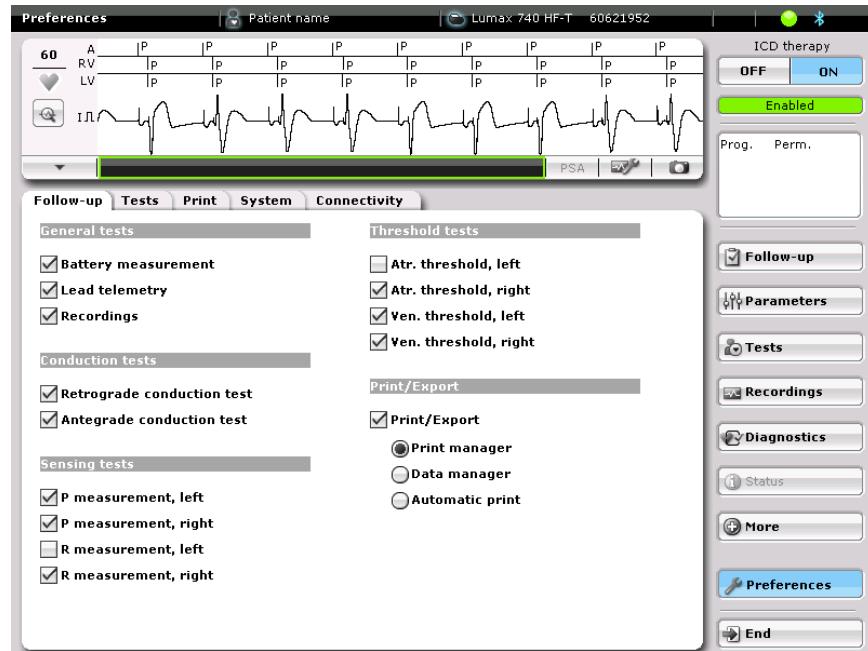


Figure 23: Follow-up preferences screen

### 2.5.3.2 Test Preferences

The Test Preferences screen, shown in [Figure 24](#), allows the user to preset tests in the programmer for follow-up and testing purposes. These values will become the default value each time the programmer is turned on. These values can be manually changed by the user at any time.

Each time the programmer is turned ON, the stored preferences that appear on this page are used for follow-up testing. The user can override the stored preference value at any time by making the desired change in the specific test screen.

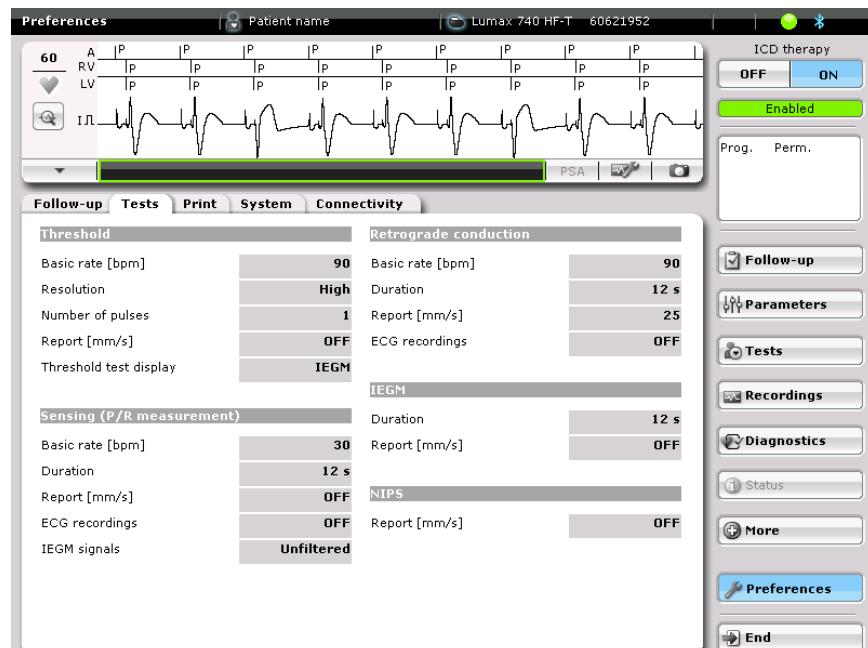
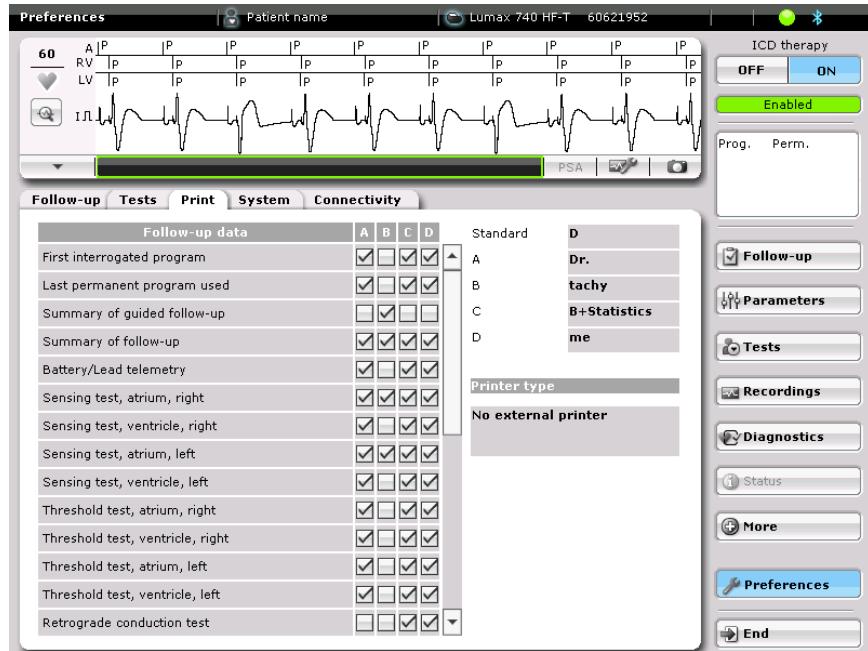


Figure 24: Test preferences screen

### 2.5.3.3 Print Preferences

The print preference screen, shown in [Figure 25](#), permits the user to set up four custom printing scenarios for follow-up data. Each of these can be individually labeled. Simply select the follow-up data to be printed by touching the box to place an “X” in it or by deselecting a box to prevent the data from being printed. These preference selections will be printed when the user prints data from the print manager or data manager.



**Figure 25:** Print preference screen

The four default name choices of Standard, min, B + Statistics and All can be changed by the user to tailor to a specific physician or clinic preference. For example, by pressing Standard, an alphanumeric keyboard appears to let the user change the title name to the print package, as shown in [Figure 26](#).



**Figure 26: Alphanumeric keyboard**

Below the print package names, the user can select the Standard or default print package for a follow-up ([Figure 27](#)). This can be overridden by the user at any time.

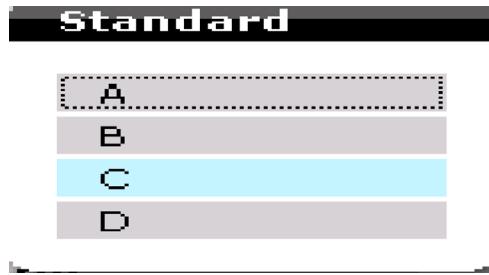


Figure 27: Print package default choices

When connecting an external printer to the programmer, press the Search for button, shown in [Figure 28](#), to allow the programmer to locate and connect to the external printer. Connect the printer first, and then boot-up the programmer to allow the programmer to look for printer drivers during the boot-up process.



Figure 28: Printer type

#### 2.5.3.4 System Preferences

The system preference screen, shown in [Figure 29](#), allows the date and time of the programmer to be set. Additionally, several other basic programmer functions can be set on this screen.

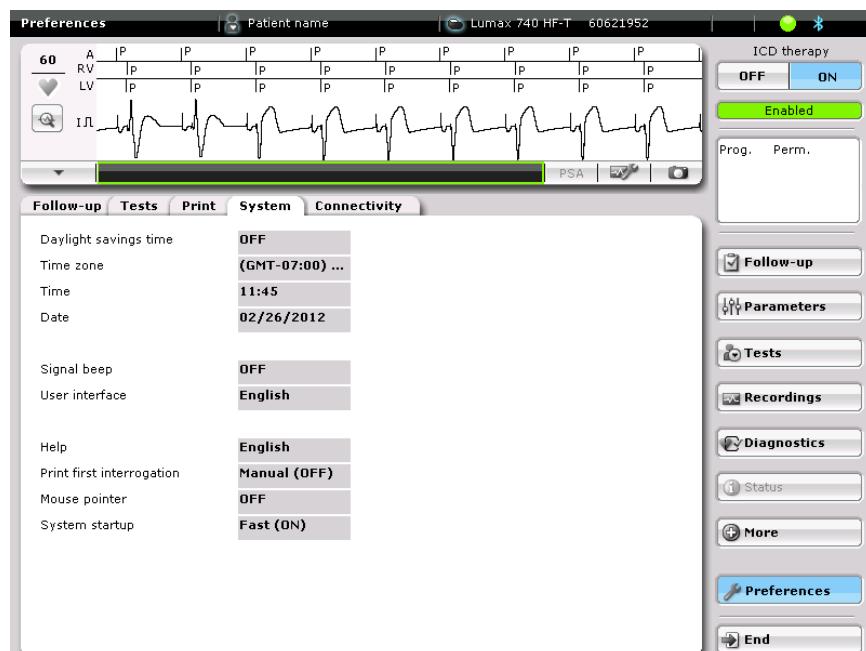


Figure 29: System preference screen

The programmer can adjust its time to daylight saving time (DST) by programming DST ON.

The time zone can be set to the local time by selecting the time zone and choosing the time zone in which the programmer is located ([Figure 30](#)). GMT stands for Greenwich Mean Time.

**NOTE:**

The ICS 3000 programmer displays programmer battery parameters as well as a Start battery maintenance button.



**Figure 30: Time zone**

Signal beep provides an audible tone when selecting parameters or making programming changes when the signal beep feature is ON.

Print 1st interrogation provides an automatic option that prints the permanent parameters when the device is first interrogated. The manual setting requires the user to press the print button if a printout is desired.

For ICS 3000 programmers only:

- Brightness refers to how bright the screen will be when the Operating Module is disconnected from the base. The choices are Bright, Normal and Economy. Selecting bright will use more energy and reduce the time the Operating Module can be disconnected from the base.
- Battery maintenance will take approximately four hours.

### 2.5.3.5 Connectivity

The section provides information regarding Bluetooth information that the programmer may be using as well as the RF telemetry related to SafeSync RF Telemetry device.

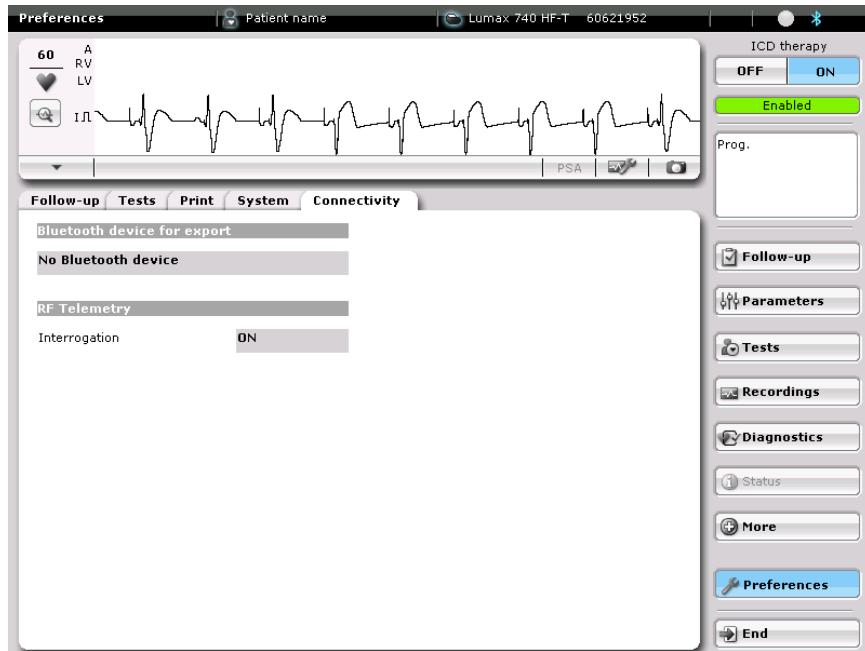


Figure 31: Connectivity screen

#### 2.5.4 Print Manager

The programmer has a print manager, which allows for a simplified printing process. All previous follow-ups for the interrogated device are listed on the left-hand side of the screen below the Print manager tab. The last follow-up is highlighted in orange. The user can simply access any previous follow-up by selecting the data.

The data collected for each follow-up is shown under Follow-up data. By selecting Preview, the user can review data prior to printing. The user has the option to manually override the data to be printed as well as preview data prior to printing.

The user can select the which data is to be printed by selecting the Preference choice. By default, these are named Standard, min, B + Statistics and All. These can be renamed under the preference print screen, as shown in [Figure 32](#).

Selecting the internal printer will send the printouts to the Renamic or ICS 3000 printer, while selecting external will send the report to an attached external printer.

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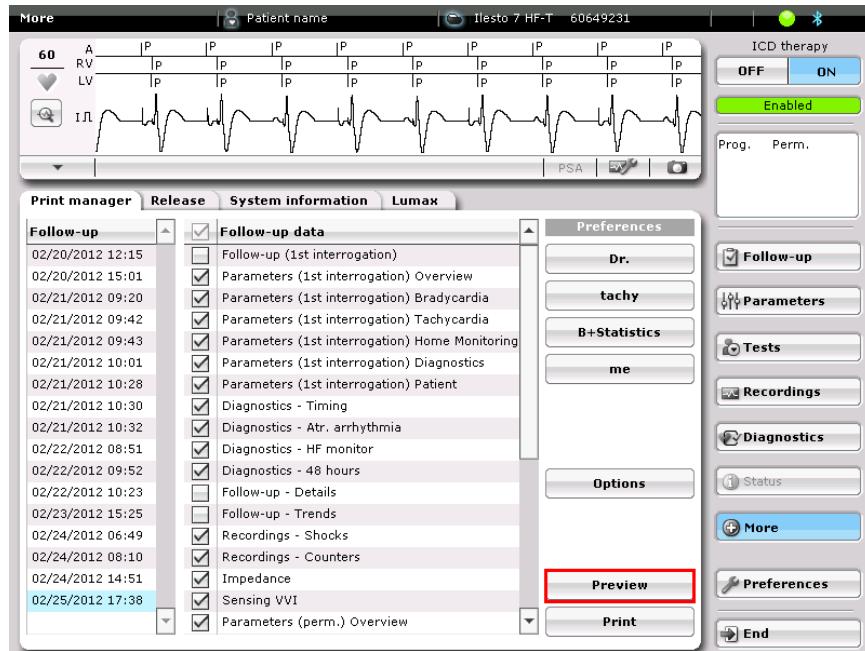


Figure 32: Print manager screen

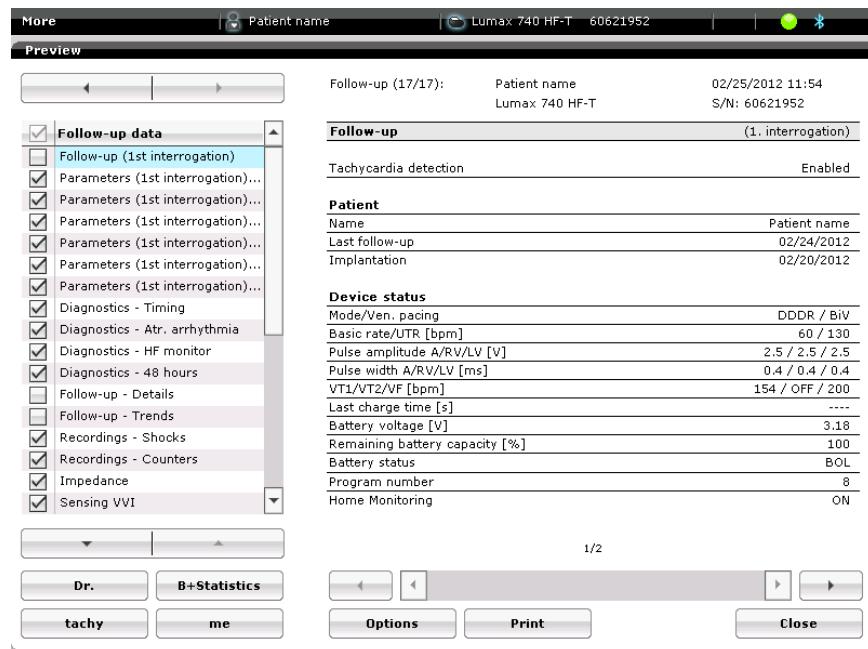
When pressing the Preview button, shown in [Figure 32](#), the screen shown in [Figure 33](#) appears. The upper-left corner of the Preview screen shows arrows to allow the user to view previous follow-ups for that device stored on the programmer. Below the arrows is patient information, along with device serial number and date of the follow-up being viewed.

The data for the currently viewed follow-up is shown on the left side of the screen. The highlighted blue data is what is shown in the center of the screen. Simply pressing any of the follow-up data field choices will display that information.

The user can print the entire follow-up based on the print preference by pressing the print follow-up on the lower right-hand corner of the screen.

Print view only will print the currently viewed data on the programmer screen.

If an external printer is connected, the user can also choose to print to the ICS printer or the external printer by pressing Internal or External.



**Figure 33: Preview screen**

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### 3. Sensing

To ensure that appropriate ICD therapy is delivered, ventricular tachycardia and fibrillation must be distinguished from normal sinus rhythm and supraventricular tachycardias. This is accomplished by proper device sensing.

**NOTE:**

Throughout this technical manual, the default values are shown in bold text.

Table 4: Sensing options in the Lumax 740 ICD/CRT-D devices			
	Right Atrium	Right Ventricle	Left Ventricle*
Sensing Option	Standard (Std)	Standard (Std)	Standard (Std)
	OFF (Inactive)	Enhanced T-wave Suppression (TWS) Enhanced VF Sensitivity (VFS)	OFF (Inactive)
	Range (Default)	0.2 – 2.0 mV (0.4 mV)	0.5 – 5.0 mV (1.6 mV)

#### 3.1 Sensing (Automatic Sensitivity Control)

Because the cardiac signals that the ICD must measure may vary in amplitude with different rhythms, the sensing threshold cannot be static in an ICD. Therefore, the Lumax 740 ICD utilizes Automatic Sensitivity Control (ASC) to automatically adjust the atrial and ventricular sensing threshold. In the Standard setting, each peak R-wave in a single-chamber ICD and P/R-wave in a dual-chamber ICD resets an upper threshold (UT) and a lower threshold (LT). The thresholds decay slightly over time based on a preset sensitivity setting.

Table 5: Programming of sensing options in the Lumax 740 ICD			
Parameter	Right Atrium	Right Ventricle	Left Ventricle*
Upper Threshold†	25%, 50%, 75%	50%, 75%	50%, 75%
Lower Threshold‡	25%	25%, 50%	50%
Upper Threshold duration after sensing	350 ms	110, 150...(50)...350... (50)...500 ms	110, 150...(50)...350... (50)... 500 ms
Upper Threshold duration after pacing	350 ms	110, 150...(50)...400... (50)...500 ms	110, 150...(50)...400... (50)...500 ms
Blanking after atrial pace	100... (10)...140... (10)...350 ms§	50...(10)...100 ms	100 ms
Blanking after RV pace	N/A	100 ... (10) ...120... (10)... 350 ms§	50...(10)...80... (10)...100 ms
Blanking after LV pace	N/A	50...(10)...80... (10)...100 ms	100 ... (10) ...120... (10)... 350 ms§

Default values are in bold.

\* Applies to HF-T devices only

† HF-T devices with LV sensing set to Standard

‡ Lumax VR-T DX default is 75% UT in the right atrium

§ The Upper and Lower Threshold for the Left Ventricular Channel both default to 50%

¶ Requires release code to access

### 3.1.1 Ventricular Sensitivity

In the right ventricle, three different sensitivity settings can be programmed based on patient needs: 1) Standard (Std), 2) Enhanced T-wave Suppression (TWS), and 3) Enhanced VF Sensitivity (VFS). The Standard setting is ideal for most patients. Enhanced T-wave Suppression should be programmed for patients who experience T-wave oversensing during normal sinus rhythm. Enhanced VF Sensitivity should be programmed for patients with fine VF or when signal dropout occurs resulting in significant undersensing of VF events when using the Standard setting. Details of each setting are described in the following sections.

#### NOTE:

With HF-T devices, the settings only apply to the Right Ventricular Channel. Sensitivity choices for the Left Ventricular Channel are Standard and Inactive only.

Table 6: Summary of sensitivity settings

	Standard	TWS	VFS
Upper Threshold	50%	75%	50%
Lower Threshold	25%	25%	25%
UT duration (sense)	350 ms	350 ms	110 ms
UT duration (pace)	400 ms	400 ms	110 ms
High pass filter	24 Hz	32 Hz	32 Hz

#### 3.1.1.1 Standard Sensitivity

In the Standard ventricular setting, each R-wave is measured and used to reset the upper and lower thresholds. The Upper threshold (UT) duration after sensing is set to 50% of the peak R-wave amplitude. Following the Upper threshold duration after sensing, the device sets the lower threshold (LT) to 25% of the measured R-wave for 156 ms. The device will continue to decrement 12.5% of the measured R-wave value every 156 ms until the minimum threshold is reached or until a new R-wave occurs.

The right ventricular minimum threshold is nominally programmed to a default value of 0.8 mV and is programmable from 0.5 mV to 2.5 mV. The MT is a fixed minimum sensing value. The Lumax 740 ICD will not allow sensing below the programmed value.

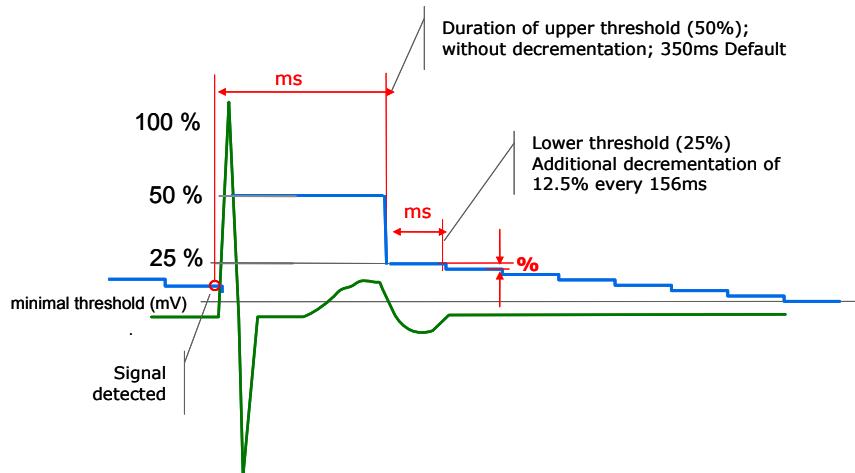


Figure 34: Automatic Sensitivity Control (ASC) with standard sensitivity (right ventricle)

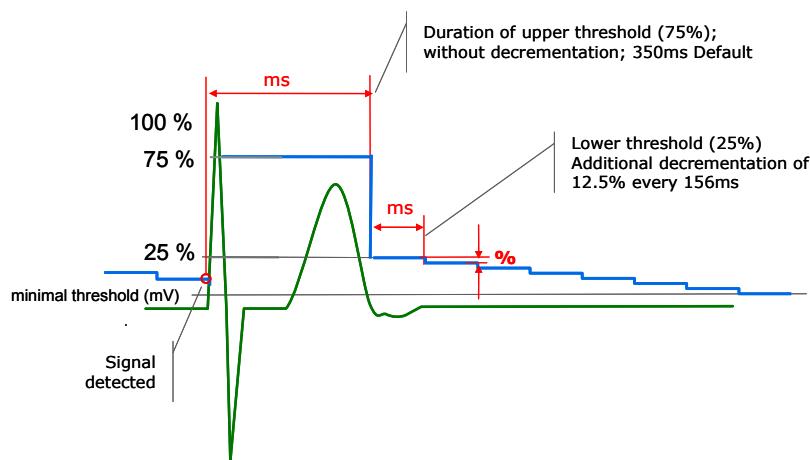
**Figure 34** illustrates ASC with the Standard sensitivity programmed. The R-wave is tracked and determined to be 8.0 mV at its peak. The amplitude is measured in the first 110 ms of the complex. Following the sensed event the upper threshold (UT) is set to 4.0 mV (i.e., 50% of the measured R-wave). After the Upper threshold duration after sensing, the device decreases sensing to the lower threshold (LT), which is 2.0 mV (or 25% of the R-wave amplitude). It remains at the lower threshold for 156 ms and then decrements by 12.5% (or 1.75 mV) every 156 ms. However, the minimum threshold (i.e., maximum sensitivity) is never violated.

The 12.5% decrement is measured from the previous setting. For example, if the lower threshold was 2.0 mV, the next decrement would be 1.75 mV. The one after that would be 1.53 mV ( $1.75 \times 87.5\%$ ) and so on.

The Upper threshold duration after sensing may be extended in patients with T-wave oversensing due to Long QT syndrome.

### 3.1.1.2 Enhanced T-wave Suppression (TWS)

If oversensing of the T-wave complex occurs during normal sinus rhythm, then Enhanced T-wave Suppression may be programmed. With Enhanced T-wave Suppression, two parameters are automatically changed with programming TWS: 1) high pass filtering is increased from 24 Hz to 32 Hz to reduce low-frequency signal components such as T-waves and respiratory artifacts and 2) the upper threshold (UT) is increased to 75% of the measured R-wave.



**Figure 35: Enhanced T-wave suppression**

**NOTE:**

While Enhanced T-wave Suppression can eliminate T-wave oversensing, the setting should be used with caution if the R-wave signal amplitude is small (e.g., less than 4 mV). Detection of VF should be retested when the sensitivity setting is reprogrammed.

**NOTE:**

While Enhanced T-wave Suppression is typically used for oversensing seen after sensed R-waves, this feature can also be used for T-wave oversensing following paced events due to the change in the filtering of the incoming signal.

### 3.1.1.3 Enhanced VF Sensitivity (VFS)

The Enhanced VF Sensitivity was specifically designed to improve VF detection when the VF signal amplitude is small, which can lead to undersensing during detection. Two adjustments are made to ASC with this setting: 1) the Hold of Upper Threshold is decreased to 110 ms, and 2) The high pass filter is changed from 24 Hz to 32 Hz. Both adjustments ensure that the threshold approaches the minimum threshold more quickly compared to the Standard setting. If undersensing is still present, the minimum threshold may also need to be adjusted. As with standard ASC, the minimum threshold value cannot be violated. [Figure 36](#) illustrates Enhanced VF Sensitivity.

**NOTE:**

While Enhanced VF Sensitivity can help with undersensing, the setting should be used with caution, as oversensing of the intrinsic complex may occur. Detection of VF should be retested when the sensitivity setting is reprogrammed.

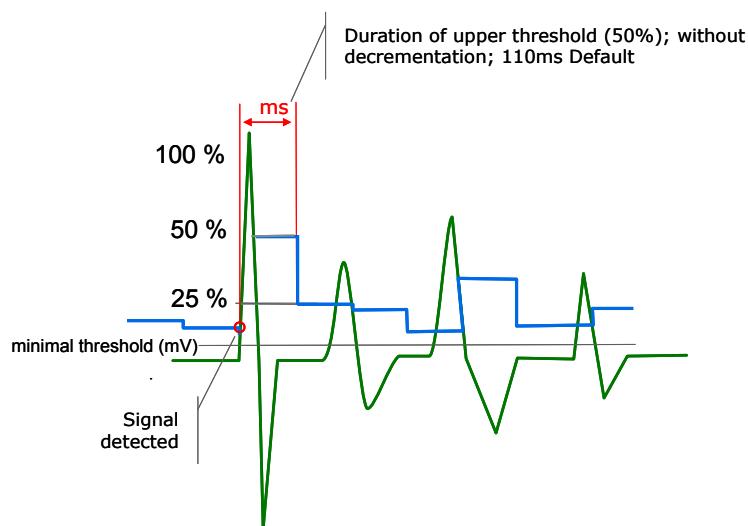


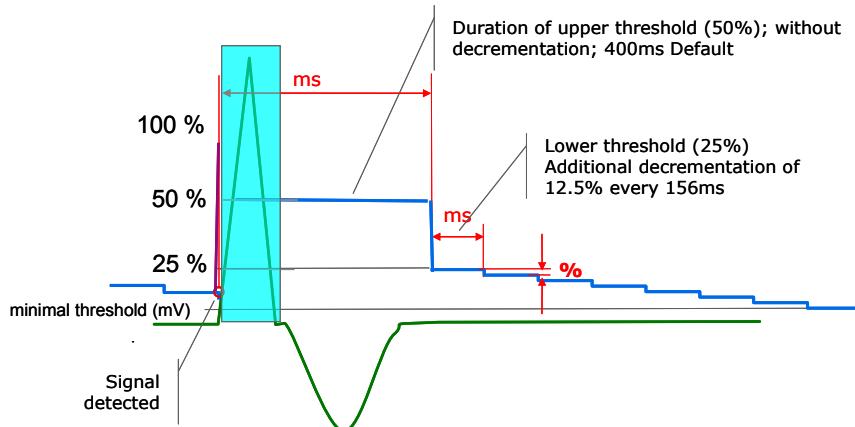
Figure 36: Automatic Sensitivity Control (ASC) with enhanced VF sensitivity

### 3.1.1.4 ASC and Pacing

Typically, the upper threshold (UT) is reset with each sensed R-wave. However, to ensure that pacing does not occur in the presence of ventricular fibrillation (VF), Automatic Sensitivity Control (ASC) behaves differently with paced events. Each paced event is followed by a blanking after RV pace period that is programmable by the user.

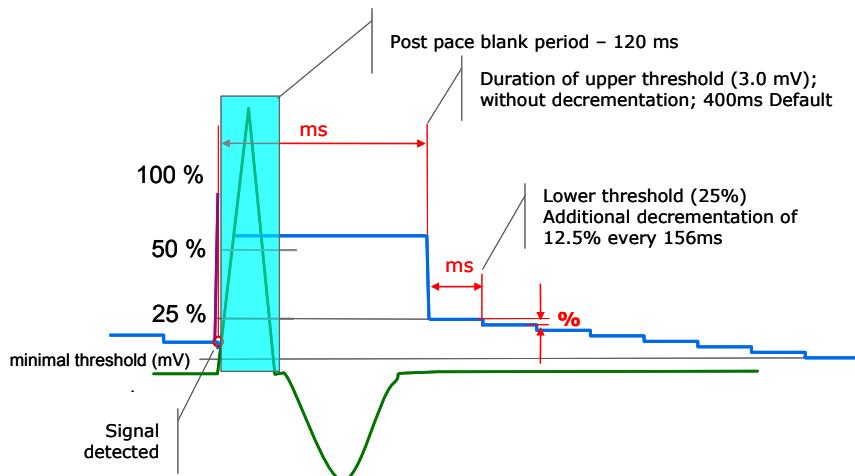
Following the Blanking after RV pace period, the ventricular threshold will default to 50% of the measured event until 400 ms has expired (including the blank post pace period) and then drop stepwise to 25% of the measured event. An example of this behavior is shown in [Figure 37](#).

By default, the blank post pace period is set to 120 ms. The user can program a specific value from 100 ms to a maximum of 350 ms through the use of a release code.



**Figure 37: Automatic Sensitivity Control (ASC) with ventricular pacing - default**

An additional option following post-paced events is available to program the sensing threshold following the blank after RV pacing period to a specific value. When the feature Post pace T-wave is programmed ON, the post pace threshold defaults to 3 mV ([Figure 38](#)). This feature may be used when the patient has small amplitude R-waves (< 4 mV).



**Figure 38: Post pace T-wave suppression**

### 3.1.2 Atrial Sensitivity in Dual-Chamber and HF-T ICDs

The Lumax 740 VR-T DX, DR-T and HF-T ICDs have two sensitivity settings in the atrium: 1) Standard and 2) OFF. The Standard atrial setting is recommended for all patients and works similarly to the ventricular Standard setting. In the Standard setting, each P-wave is tracked and used to reset the upper and lower thresholds. [Figure 39](#) shows an example of atrial ASC. The upper threshold (UT) is set to 50% of the peak P-wave amplitude. The Upper threshold after sense/pace is fixed at 350 ms. Following the Hold of upper threshold, sensing decreases to the lower threshold (LT), which is equal to 25% of the measured P-wave. The lower threshold (LT) decays 12.5% every 156 ms until the Minimum Threshold is reached or until the next event, sensed or paced.

The Inactive setting deactivates the atrial channel for sensing, pacing, SMART® Detection, atrial IEGM, and Holter recording. The Inactive setting may be used in cases in which the atrial lead signal is no longer required.

**NOTE:**

Do not use Inactive setting without consultation.

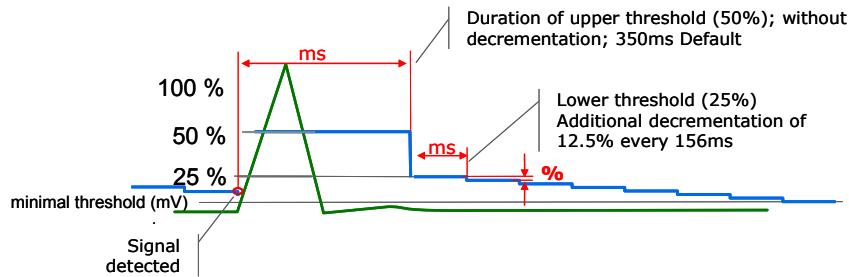


Figure 39: Automatic Sensitivity Control (ASC) in the atrium

### 3.1.3 Left Ventricular Sensitivity in Lumax 740 HF-T ICDs

The Lumax 740 ICD has two sensitivity settings in the left ventricle: 1) Standard and 2) OFF. In the Standard ventricular setting, each R-wave is measured and used to reset the upper and lower thresholds. The Upper threshold (UT) duration after sensing is set to 50% of the peak R-wave amplitude. Following the Upper threshold duration after sensing, the device maintains the 50% value for the lower threshold duration. The device will continue to decrement 12.5% of the measured R-wave value every 156 ms of until the minimum threshold is reached or until a new R-wave occurs.

The sensing threshold is maintained at 50% to reduce the chance of oversensing that could result in the inhibition of LV pacing and thereby affect CRT therapy.

**The Inactive setting deactivates the LV channel for sensing and does not allow diagnostic recording of LV sensing measurements.**

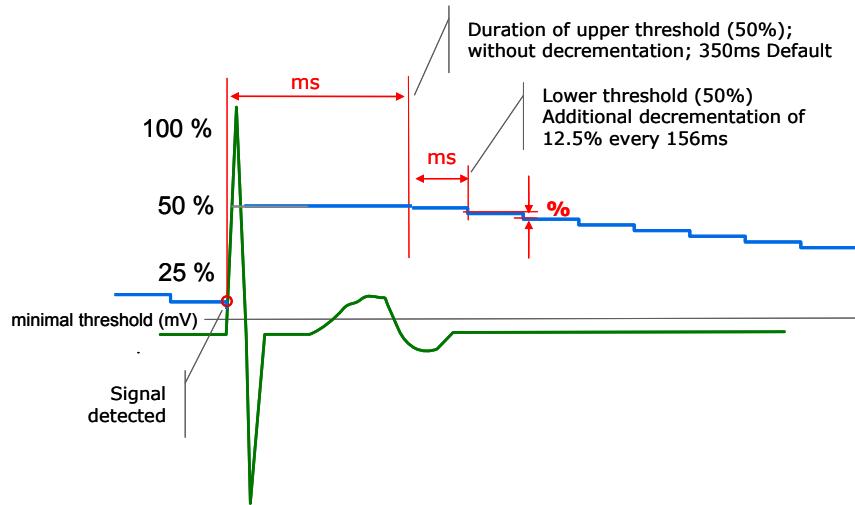
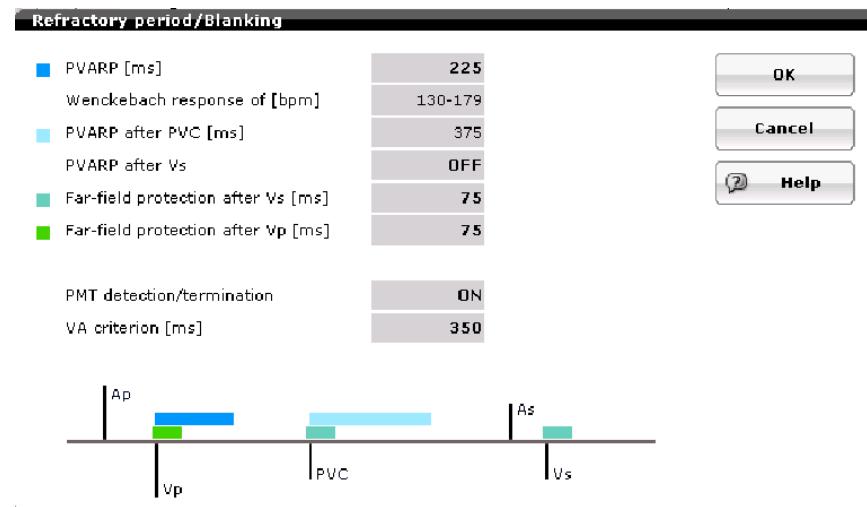


Figure 40: Automatic Sensitivity Control (ASC) in the LV channel

## 3.2 Far-Field Protection

[Figure 41](#) shows the main screen for Far-field Protection. This feature is used to prevent oversensing of crosstalk events to prevent inappropriate therapies or mode switching.



**Figure 41: Far-field parameters screen**

In Lumax 740 ICDs, this parameter is a true blank period, meaning that the signals that occur during this timer are not sensed by the device. As a result, there will be no marker channel events during this time period, and events are not recorded in the device diagnostics.

### 3.2.1 Far-Field Protection after Ventricular Sensed Events

Parameter Range: OFF; 25...(25)...**75**...(25)...225 ms

Far-field protection after Vs is a parameter used to address oversensing in the atrial channel that occurs from ventricular sensed events. Oversensing in the atrial channel can result in inappropriate mode switching and inaccurate statistical counts. In some cases, it can also affect SMART® Detection.

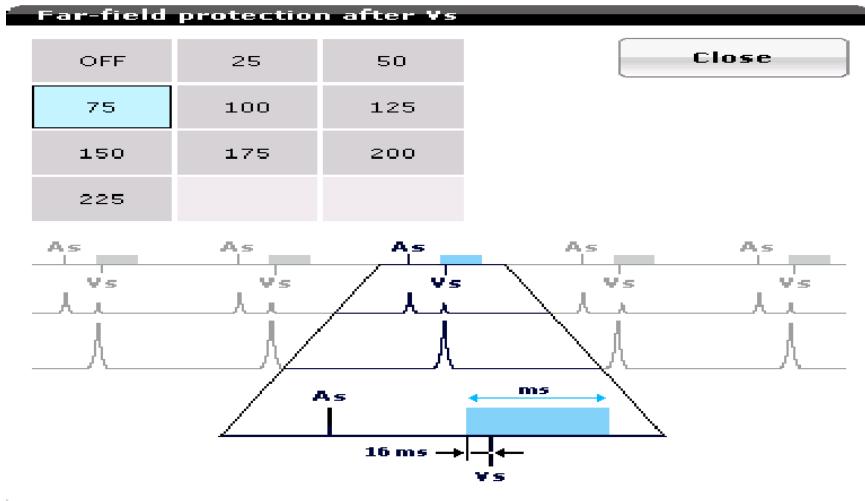
Far-field protection after Vs initiates an atrial blanking period with each ventricular sensed event. As seen in [Figure 42](#), blanking in the atrial channel occurs before and after each ventricular sensed (Vs) event. When the far-field protection parameter is programmed at the default value of 75 ms, 16 ms of blanking is applied before the Vs event and the remaining 59 ms is applied after the Vs event.

When reprogramming this parameter, measure the VA interval and remember that 16 ms is applied before the event when selecting a new value. For example; if the VA interval was measured at 110 ms. The selection of 125 ms would provide 16 ms prior to the event and 109 ms after the event. Therefore, the choice of 150 ms would be more appropriate.

It is important to note that while this parameter will prevent oversensing from ventricular sensed events, it will not alter the morphology of the IEGM.

**NOTE:**

All parameter choices will have 16 ms prior to the event and the remainder post event.



**Figure 42: Far-field protection after Vs.** The picture demonstrates a 16 ms pre-event non-programmable blanking period that is separate (fixed) from the programmable choices.

The Far-field protection parameter is found in the Bradycardia tab.

### 3.2.2 Far-Field Protection after Ventricular Paced Events

Parameter Range: 50, 75...(25)...225 ms

Far-field protection after Vp is a parameter used to address oversensing in the atrial channel that occurs from ventricular paced events. Oversensing in the atrial channel can result in inappropriate mode switching and inaccurate statistical counts.

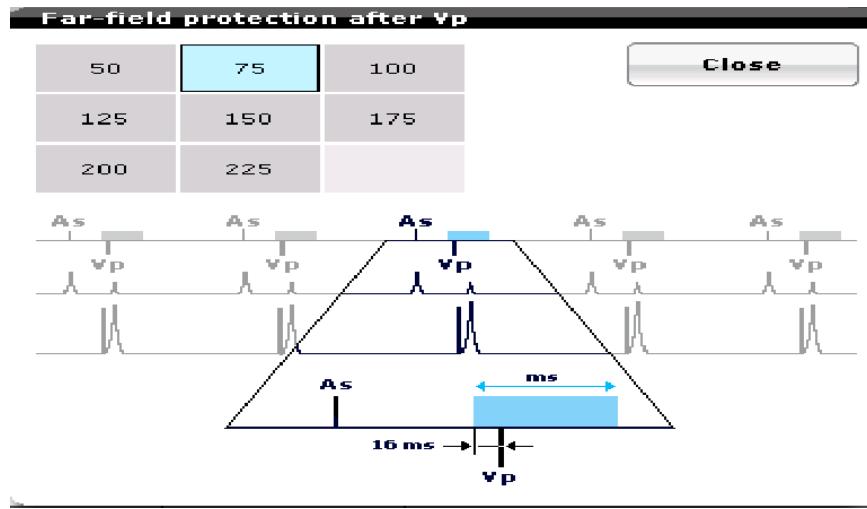
Far-field protection after Vp initiates an atrial blanking period with each ventricular paced event. As seen in [Figure 43](#), blanking in the atrial channel occurs before and after each ventricular paced (Vp) event. When the far-field protection parameter is programmed at the default value of 75 ms, 16 ms of blanking is applied before the Vp event, and the remaining 59 ms is applied after the Vp event.

When reprogramming this parameter, measure the VA interval and remember that 16 ms is applied before the event when selecting a new value. For example; if the VA interval was measured at 110 ms. The selection of 125 ms would provide 16 ms prior to the event and 109 ms after the event. Therefore, the choice of 150 ms would be more appropriate.

It is important to note that while this parameter will prevent oversensing from ventricular paced events, it will not alter the morphology of the IEGM.

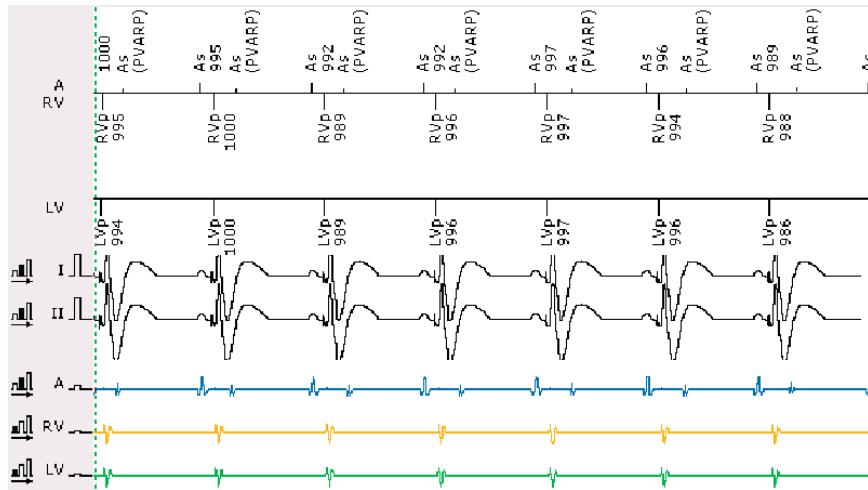
#### NOTE:

All parameter choices will have 16 ms prior to the event and the remainder applied post event.

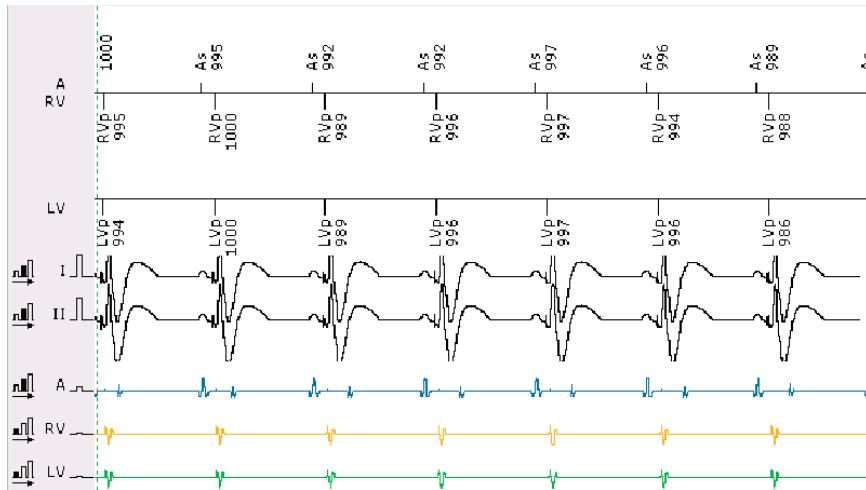


**Figure 43: Far-Field protection after V Pace in the atrial channel. The picture demonstrates a 16 ms pre-event non-programmable blanking period that is separate (fixed) from the programmable choices.**

In [Figure 44](#), intermittent far-field oversensing is occurring on several complexes. (Note the atrial refractory sense (Ars) post ventricular pace (Vp) on complexes 4, 5, 7, 9 & 10.) In [Figure 45](#), the Far-field sensing post-ventricular paced event (Vp) has been corrected by extending the Far-field Protection after Vp. The atrial refractory sense (Ars) markers following the ventricular pace (Vp) markers in the atrial marker channel are gone, which means that the device is no longer sensing the ventricular signal on the atrial channel, even though the complex is still visible on the strip.



**Figure 44: Intermittent atrial oversensing IEGM**



**Figure 45: Atrial channel oversensing corrected IEGM**

#### NOTE:

Should the 75 ms Far-field protection default value not prevent Far-field oversensing, thoroughly analyze the IEGM before making any programming changes. It is important to determine the exact lengthening required to eliminate far-field sensing, as too much blanking can negatively interfere with the X and Z counters for appropriate Mode Switch function, statistics as well as potentially affecting SMART® Detection when addressing oversensing with ventricular sensed events.

### 3.3 Safety Pacing

To protect the patient from inappropriate inhibition of needed ventricular pacing due to oversensing (crosstalk or noise seen as a Vs event), Lumax provides a feature called Safety pacing. Safety pacing provides a ventricular pace (Vp) at an AV Delay of 100 ms (fixed value). As seen in [Figure 46](#), the fourth atrial pace (Ap) is being sensed on the ventricular channel, causing the triggering of Safety Pacing. Note the presence of a Vs event preceding the Vp event. Safety pacing only occurs following an atrial paced event. Safety pacing is not possible following an atrial sense event. The Lumax 740 VR-T DX ICD does not provide safety pacing as atrial pacing is not available.

Should this occur during an implantation, it is advisable to consider relocating the atrial lead. In a chronic system, a common corrective action is to reduce the atrial pacing amplitude, if possible, while maintaining a 2:1 safety margin. One may consider a combination of pulse amplitude and pulse width in order to maintain an adequate pacing safety margin.

If neither of these solutions corrects the crosstalk, the next option is to lengthen the parameter Blanking after A Pace value found in the Details section of the Bradycardia page ([Figure 47](#)). Blanking after A Pacing parameter is programmable from 50 to 100 ms with a default setting of 50 ms.

In the Lumax 740 HF-T device, Safety pacing will provide Biventricular pacing with V-V timing at 0 ms, provided Biventricular pacing is programmed ON.

The Lumax 740 ICD will not display the safety pace value on the AV Delay screen like previous generations of devices.

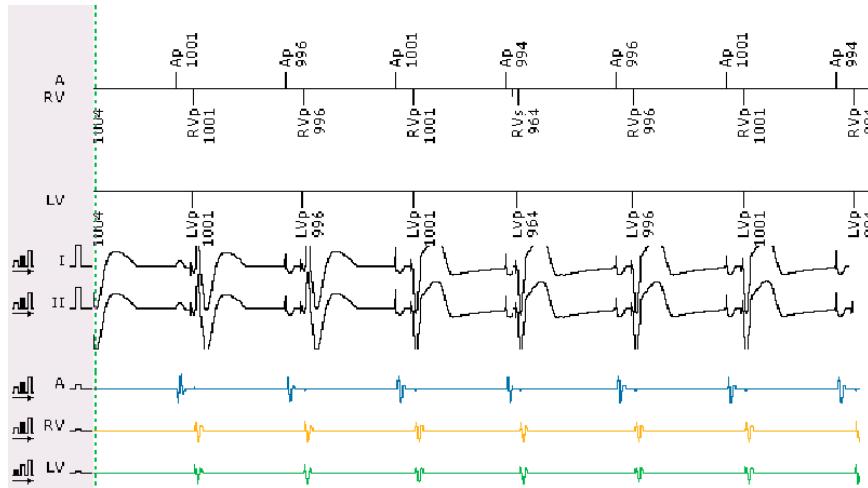


Figure 46: Example of safety pacing

## 3.4 Blanking after pacing

Table 7: Blanking after pacing

Parameter	Right Atrium	Right Ventricle	Left Ventricle*
Blanking after atrial pace	100...(10)... <b>140</b> ... (10)...350 ms <sup>†</sup>	<b>50</b> ...(10)...100 ms	100 ms
Blanking after RV pace	N/A	100 ... (10) ... <b>120</b> ... (10)... 350 ms <sup>†</sup>	50...(10)... <b>80</b> ... (10)...100 ms
Blanking after LV pace	N/A	50...(10)... <b>80</b> ... (10)...100 ms	100 ... (10) ... <b>120</b> ... (10)... 350 ms <sup>†</sup>

### 3.4.1 Blanking after atrial pace

Blank after atrial pace in the Right atrium. When the device delivers an atrial pace, the atrial channel is blanked for 140 ms to prevent oversensing the pace artifact. This feature is not available in the Lumax 740 VR-T DX ICD.

### 3.4.2 Blank after atrial pace in the Right Ventricle

This feature is designed to prevent sensing of the paced atrial artifact from being sensed in the ventricle, resulting in Safety pacing. This screen is found under Sensing details on the Bradycardia screen.

Using the Blank after Atrial Pacing parameter to correct Safety pacing ([Figure 47](#)):

1. To determine the appropriate setting, measure from the Ap to the Vs marker; then add 10 ms to allow for minor variations in duration.
2. If the crosstalk is intermittent, programming to the next higher value should correct the problem.

\* HF-T devices with LV sensing set to Standard

† Requires a release code to access

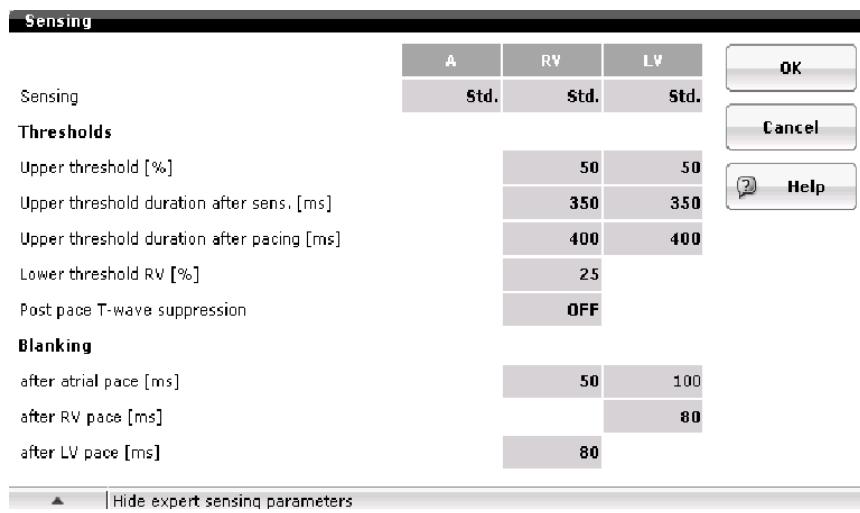


Figure 47: Sensing details screen

**NOTE:**

The sensing details screen, among others, has an arrow in the bottom left corner to open or reduce the window. A message to hide or show additional parameter options is listed to the right of the arrow.

### 3.4.3 Blank after atrial pace in the Left Ventricle

Following an atrial paced event, the left ventricle is blanked for 100 ms (fixed) to prevent oversensing which may lead to inhibition of LV pacing.

### 3.4.4 Blanking after RV pace

Blanking after RV pace in the RV channel. This in-channel blanking period prevents oversensing of the pacing pulse and the depolarized event which could lead to inhibited pacing and changes in device timing. While the default value is 120 ms, the value can be extended to address R-wave double-counting or T-wave oversensing.

Blanking after RV pace in the LV channel. This prevents oversensing in the LV channel which may lead to inhibition of LV pacing.

In the Lumax 740 ICD, this parameter is code protected in the RV channel.

#### CAUTION

**Blanking after RV pace** – Extending this value too long may lead to delays in arrhythmia detection. Consult Technical Services prior to extending this value.

### 3.4.5 Blanking after LV pace (HF-T device only)

#### Blanking after LV pace in the RV channel:

This prevents oversensing in the RV channel which may lead to inhibition of RV pacing if the initially paced chamber is the left ventricle.

### Blanking after LV pace in the LV channel:

This in-channel blanking period prevents oversensing within the LV channel which may lead to inhibition of LV pacing for the subsequent event. This parameter is code protected.

## 3.5 Discrimination after As

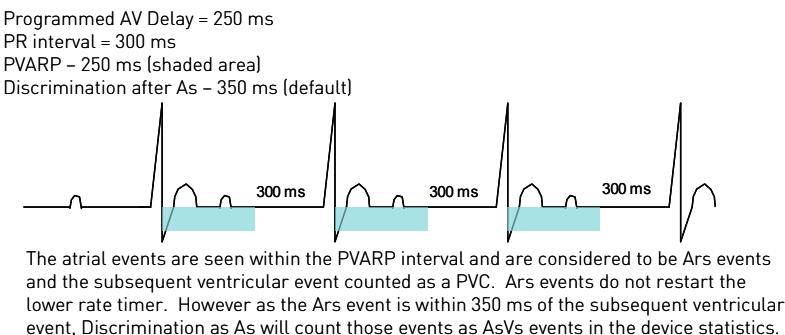
Parameter Range: 250...(50)...**350**...(50)...500 ms

Discrimination after As is a feature used to promote proper device timing and is found in the Sensing details screen via code release. If an RV sensed event occurs within 350 ms of an Ars event, the Lumax assumes the RVs event to be a response to the atrial (Ars) event. As a result, the Lumax will consider the event to be an AsVs event, rather than an Ars event followed by a PVC, and will be annotated that way in the statistics of the ICD. This will provide a more accurate PVC count and event timing.

An example of Discrimination after As is shown in [Figure 48](#).

#### NOTE:

If I-Opt is programmed on in a Lumax 740 DR-T or VR-T DX, the device will use 400 ms as the Discrimination after As value.



**Figure 48: Discrimination after As**



## 4. Detection

### Initial Ventricular Arrhythmia Detection:

To ensure that appropriate ICD therapy is delivered, ventricular tachycardia and fibrillation must be distinguished from normal sinus rhythm and supraventricular tachycardias. This is accomplished by proper device sensing, as well as appropriate detection.

#### Detection activation/deactivation:

Detection is activated and deactivated via the ICD Therapy field in the upper right-hand corner of the programmer screen, under the Master Switch. When the device is disabled, tachyarrhythmia detection and therapy are inhibited and the upper right-hand corner will display “disabled”. Refer to [Section 2.1](#) for more information about the Master Switch.

### 4.1 Ventricular Tachyarrhythmia Detection

The Lumax ICDs/CRT-Ds detect and measure the rate of sensed cardiac signals to discriminate ventricular tachyarrhythmias from supraventricular tachycardias, sinus rhythm or sinus bradycardia. This is accomplished through programmable rate detection parameters in the device. When a tachyarrhythmia is present, the ICD/CRT-D classifies the arrhythmia and delivers the appropriate therapy. If a tachyarrhythmia continues following the first therapy attempt, then the ICD/CRT-D will redetect the tachyarrhythmia and deliver subsequent therapies as necessary.

#### **WARNING**

**Unwanted Shocks** – Always program ICD therapy to OFF prior to handling the device to prevent the delivery of serious shocks to the patient or the person handling the device during the implant procedure.

Classification of cardiac signals is accomplished primarily by measuring the cardiac cycle length (R-R, P-R and P-P). In addition, the ICD/CRT-D can also utilize abrupt changes in rate or irregularity of the cardiac signal to further differentiate ventricular tachyarrhythmias. Each detected ventricular tachyarrhythmia is classified into one of the following zones:

- VT-1 Lower rate ventricular tachycardia
- VT-2 Higher rate ventricular tachycardia
- VF Ventricular fibrillation

Each rhythm class is programmable to a separate rate with the zone limit defining the lowest rate in each class. The upper rate limit of each class is equal to the zone limit of the next higher class, creating a continuous range of rate classes.

#### 4.1.1 Tachycardia Zone Classifications

There are up to three programmable ventricular tachyarrhythmia zones in the Lumax family of ICDs; two ventricular tachycardia zones (VT1 and VT2) and a single ventricular fibrillation zone (VF).

SMART® Detection or Ventricular-Only Detection (i.e., SMART® Detection = OFF) is used only for ventricular tachycardia (VT) detection with an up/down counter. An “X out of Y” detection count is used for VF detection.

#### 4.1.1.1 Ventricular-Only Detection

As the name implies, Ventricular-Only Detection (i.e., SMART® Detection = OFF), uses only information obtained from the ventricular sensing lead. Specifically, ventricular rate (or interval), Stability and Sudden Onset are used for rhythm classification. Therefore, Ventricular-only detection relies on the standard enhancement criteria used in single-chamber ICDs.

In its most basic form, ventricular-only detection uses an interval count and rate/interval cut-off as criteria. This means that any time the rhythm crosses the programmed detection interval, Lumax will classify the event as VT. Detection enhancements such as Onset and Stability can be added to help discriminate VT from SVT. These detection enhancements are sometimes referred to as “therapy inhibitors,” as both interval count and the programmed detection enhancement criteria must be met to classify an arrhythmia.

#### 4.1.1.2 SMART® Detection for dual-chamber AV discrimination

When SMART® Detection is programmed ON, information from the atrial and ventricular chambers of the heart is used for ventricular tachycardia classification. The algorithm is specifically designed to detect VT while withholding therapy upon detection of an SVT. The algorithm performs classification on a beat-to-beat basis. Classification begins after the cycle length is measured and determined to lie within the programmed VT zones. Thereafter, a series of tests is performed to determine if the arrhythmia is atrial or ventricular in origin. SMART® Detection can be programmed in both VT zones (VT1 and VT2) or only in the VT1 zone. SMART® Detection can be programmed in the VT2 zone (only) if a VT1 zone is programmed with SMART® Detection OFF. However, the user is required to use Onset and Stability in the VT1 Zone.

By default, SMART® Detection and SMART® Redetection are ON when a VT Zone is programmed.

#### 4.1.1.3 VF Detection

Initial and redetection in the ventricular fibrillation (VF) zone relies on a single X out of Y detection criterion. The same X out of Y values programmed for initial detection is used for redetection. The Lumax 740 ICD provides 9 options for VF detection/redetection.

Details describing VT and VF detection are shown in [Figure 49](#) and will be discussed in this chapter.

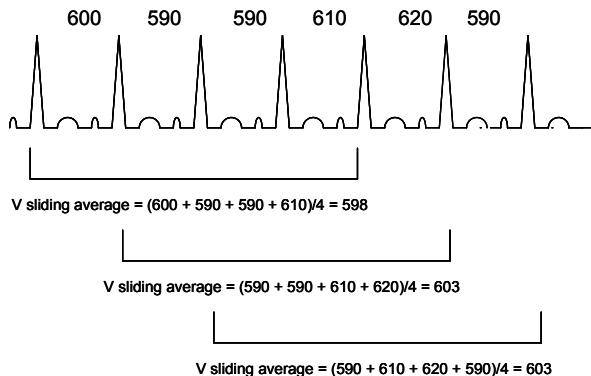
VF	Initial Detection = X of Y (X must be at least 2/3 of Y) Redetection = X of Y (same as initial detection programming)
VT2	Initial Detection = SMART Detection® or Ventricular-only Detection Redetection = SMART Redetection® or Interval count
VT1	Initial Detection = SMART Detection® or Ventricular-only Detection* Redetection = SMART Redetection® or Interval count
Sinus	Sinus events decrement the tachycardia counters by -1

Figure 49: Summary of detection

\* Ventricular-only detection includes interval count, Onset and/or Stability and a Sustained VT Timer

#### 4.1.1.4 Sliding averages

While not a specific criteria of Ventricular-only or SMART® Detection, the Lumax 740 ICD uses 4-beat sliding rate averages for several of its calculations. With SMART® Detection, the devices use sliding averages to compare atrial and ventricular rate to, 1) determine if the atrial and ventricular rates are equal or not, 2) used with Multiplicity to determine the N:1 ratio and 3) Stability, to determine if the atrial and ventricular rates are stable. An example is shown in [Figure 50](#).



**Figure 50: Calculation of sliding averages**

A variant of sliding averages is used in both Ventricular-only and SMART® Detection for Onset. In this case, the devices compare the most recent 4-beat average versus the previous 4-beat average to determine if the Onset criteria was met. This is discussed further in the Onset section of this chapter.

#### 4.1.2 Ventricular-Only VT Detection

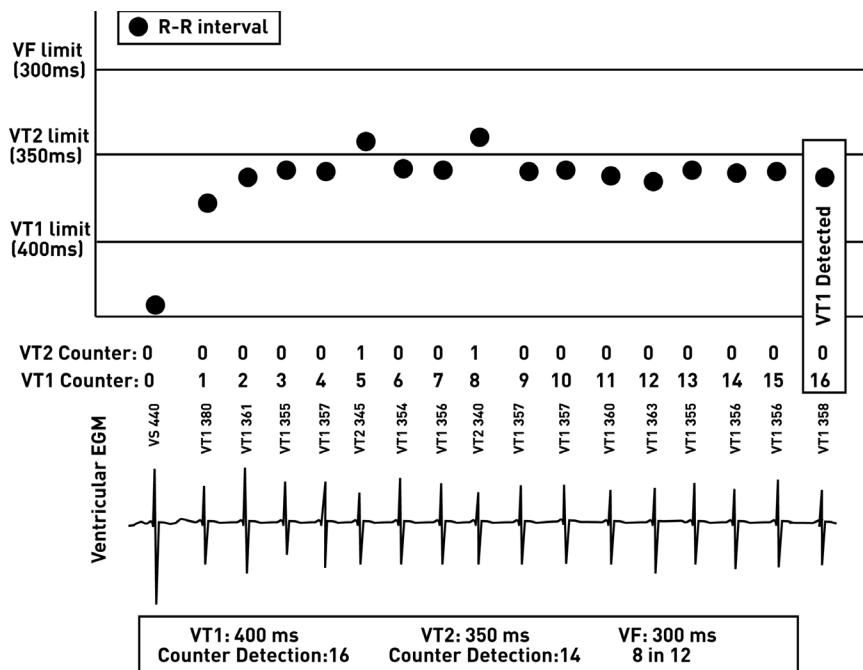
When a VT zone is programmed, the Ventricular-Only Detection algorithm uses a programmable VT Counter and standard detection enhancements used in rate-only ICDs (i.e., Stability and Sudden Onset). As the name implies, Ventricular-only Detection (i.e., SMART® Detection programmed OFF) uses only ventricular information. Detection relies on simple up/down counters (i.e., a VT1 Counter and a separate VT2 Counter), ventricular rate, and single-chamber enhancements.

##### 4.1.2.1 Rate Only

When Rate only is used, detection is met when the programmed number of intervals exceed the programmed detection count.

Each time an interval is faster than the programmed VT zone rate (interval), the VT Counter increments (+ 1). Conversely, the VT Counters decrement by one (- 1) when an interval is slower than the programmed rate for that zone.

All intervals faster than the VT1 detection rate (including VT2 and VF intervals) also increment the VT1 counter. All intervals faster than the VT2 detection rate (including VF intervals) increment the VT2 counter. Intervals slower than the defined detection zones decrement the counter for that zone.



**Figure 51: Rate-only detection of VT1**

An example of rate-only VT1 detection is given in [Figure 51](#). In this case, there are three tachyarrhythmia zones programmed (i.e., VT1, VT2, and VF). VT detection begins with the first short interval (i.e., the first interval that falls into the VT1 zone). The VT1 Detection Counter increments with each interval shorter than the VT1 limit of 400 ms, including intervals that fall into the VT2 zone. The VT2 Detection Counter increments with each interval shorter than the VT2 limit of 350 ms and decrements with each interval longer than the VT2 limit. VT1 detection is declared and therapy delivered when the VT1 Detection Counter reaches the programmed value of sixteen.

#### 4.1.2.2 Stability

Stability is a detection enhancement to assist in determining if a tachyarrhythmia is ventricular tachycardia or atrial fibrillation with a rapid ventricular response. Stability refers to the stability of R-R intervals (not patient hemodynamics). Monomorphic ventricular tachycardia (mVT) demonstrates a stable R-R interval, while in atrial fibrillation the R-R intervals are unstable. Stability is evaluated on a beat-to-beat basis. Stability is used for detection and redetection.

The Stability criterion ([Figure 52](#)) is satisfied for a given ventricular interval when the difference between the current interval and each of the three preceding intervals is less than the programmed Stability limit. The default Stability limit of 24 ms is optimal and should not be reprogrammed. Stability can be programmed independently in the VT1 and VT2 zone.

Reprogramming Stability may result in delivery of inappropriate therapy for supraventricular tachyarrhythmias. Programming a larger value can result in therapy delivery for AFib, while programming a smaller value may result in inhibition of therapy for VTs which may be slightly unstable.

#### NOTE:

Unstable events reset the VT counters to zero and can potentially delay therapy.

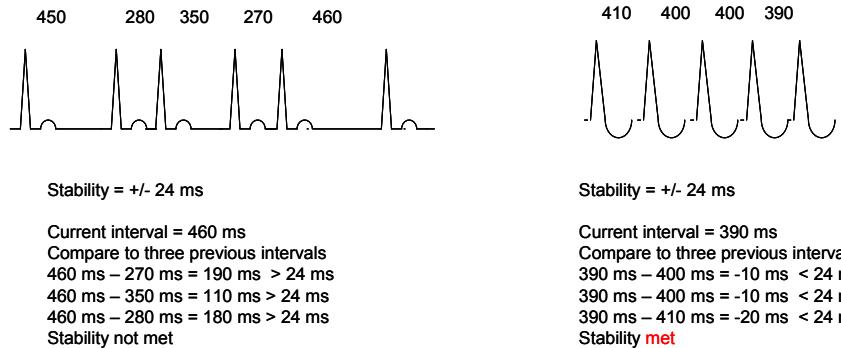


Figure 52: Calculation of stability

#### 4.1.2.3 Sudden Onset

Sudden Onset is a detection enhancement used to determine whether a tachyarrhythmia is ventricular or sinus in origin. Spontaneous ventricular tachycardias typically demonstrate a sudden change in rate, while sinus tachycardias change rate slowly over time. Sudden Onset is programmed to a default value of 20% and is available in the VT1 and VT2 zones in Lumax 740. The Onset value applies to both VT1 and VT2 zones.

In the Lumax 740 ICD, Onset confirmation is activated when the current sliding 4-interval average is faster than the previous 4-interval average by programmed Onset criteria value. Once the first fast event that meets Onset criteria occurs, the device uses that interval and the next three additional intervals to determine a new 4-interval average and compares that new average against the previous 4-interval average. This is designed to prevent single fast events declaring Onset and delivering inappropriate therapy. As shown in [Figure 53](#), Onset is satisfied only when the difference between the current 4-interval average and the previous 4-interval average exceeds the Sudden Onset value.

**NOTE:**

Onset applies to the ventricular chamber only.

**NOTE:**

Once Onset is met, it is declared for the entire episode, including redetection.

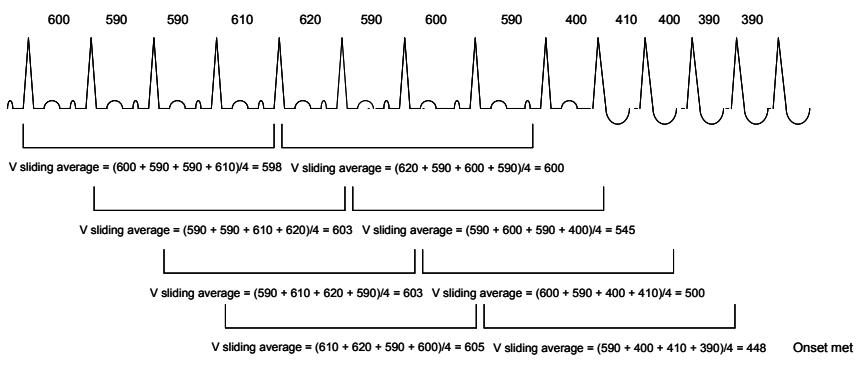


Figure 53: Calculation of onset

## 4.2 Ventricular Tachyarrhythmia Detection Criteria for SMART® Detection

Ventricular-Only Detection algorithm uses a VT Counter and the standard detection enhancements used in rate-only ICDs (i.e., Stability and Onset). SMART® Detection is a much more sophisticated detection algorithm that relies on several key criteria to distinguish supraventricular tachycardias (SVTs) from ventricular tachycardias (VTs). These criteria include: atrial rate, ventricular rate, atrial stability, ventricular stability, sudden onset, multiplicity, as well as AV regularity and AV trend. Each of these terms is defined below as they apply to the Lumax ICD.

As multiple criteria are being used for SMART® Detection, the acronym **STORRM** can be helpful to remember the criteria used for AV discrimination detection.

**S** – Stability

**T** – Trend

**O** – Onset

**R** – Rate

**R** – Regularity

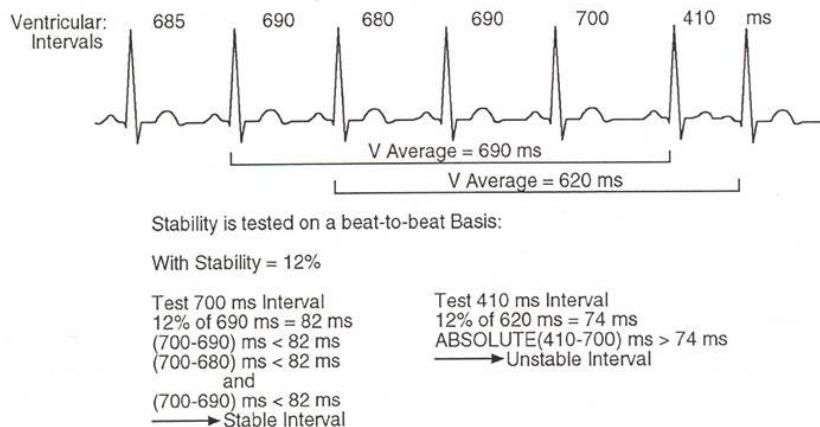
**M** – Multiplicity

Each is described in greater detail throughout the rest of this chapter.

### 4.2.1 Stability

Stability is a key component of SMART® Detection. With SMART® Detection ON, Stability is checked on a beat-to-beat basis in the atrium and the ventricle. Although the calculation for Stability is determined independently in both chambers, the same default of 12% Stability is used for each chamber.

An interval is considered stable when the difference between the current interval and each of the three preceding intervals is less than the Stability limit ([Figure 54](#)).

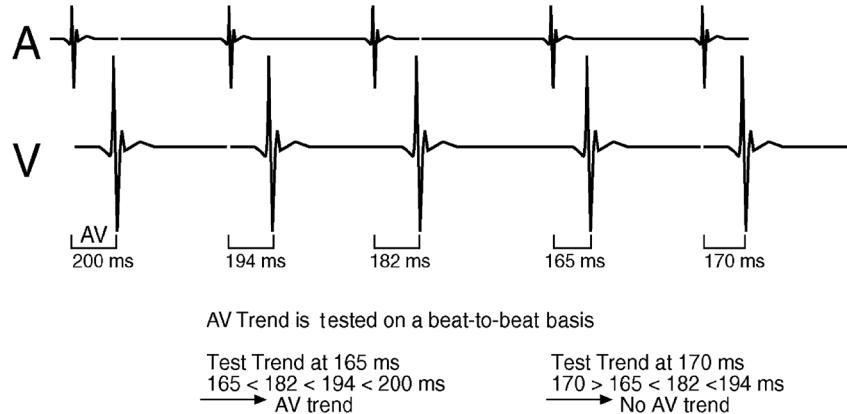


**Figure 54: Calculation of ventricular stability with SMART® Detection**

### 4.2.2 Trend AV

To determine whether a consistent pattern between the atrial and ventricular rhythms (AV association) is present, SMART® Detection measures AV trend ([Figure 55](#)).

When the atrial and ventricular rates are stable and equal, SMART® Detection determines whether an AV trend exists. With each new ventricular interval, the algorithm checks to see whether the four most recently measured AV intervals are in strict increasing or decreasing order (i.e., AV n < AV n-1 < AV n-2 < AV n-3 or AV n > AV n-1 > AV n-2 > AV n-3). This strict order defines AV creep or AV trend indicative of AV dissociation.



**Figure 55: Calculation of AV trend**

#### 4.2.3 Sudden Onset

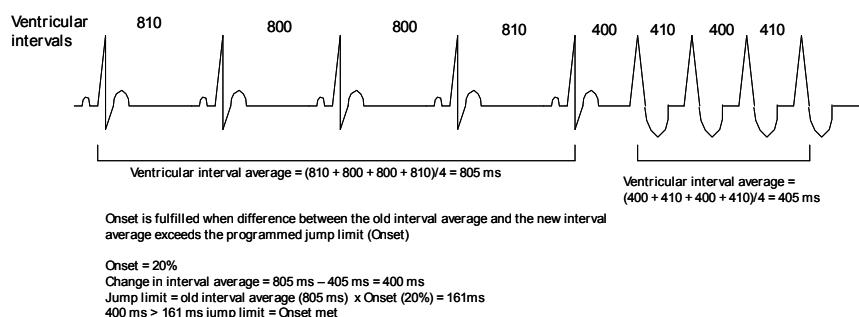
Sudden Onset is used in the SMART® Detection algorithm when the atrial and ventricular rhythms are stable and equal in rate to distinguish ventricular tachycardia from slow onset sinus tachycardia. By default, Sudden Onset is programmed at 20%.

Onset is programmable in the Lumax 740 ICDs. Caution should be used when considering making a programming change.

In the Lumax 740 ICD, Onset confirmation is activated when an event meets the Onset criteria. Once the first fast interval (in a tachycardia zone) meeting Onset criteria occurs, the device uses that interval and the next three additional intervals to determine a new 4-interval average and compares that new average against the previous 4-interval average. This function of Onset is designed to prevent single fast events (PVCs) from declaring Onset and providing inappropriate therapy to the patient. Onset is satisfied only when the difference between the current 4-interval average and the previous 4-interval average exceeds the Sudden Onset value ([Figure 56](#)).

**NOTE:**

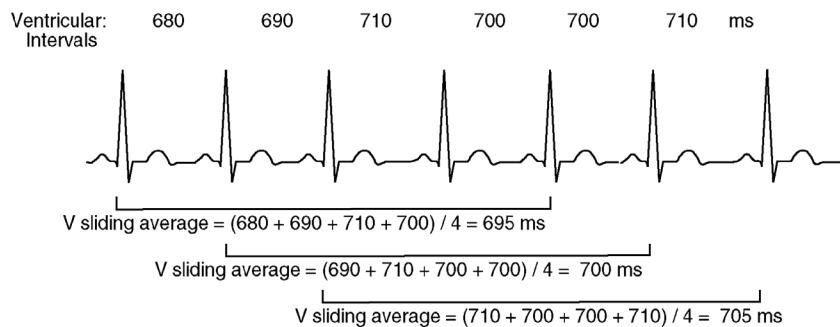
Sudden Onset is applied in the ventricular chamber only.



**Figure 56: Calculation of sudden onset**

#### 4.2.4 Rate (Interval)

SMART® Detection uses a sliding average of intervals ([Figure 57](#)) (both in the atrium and ventricle) to compare the overall atrial and ventricular rates. This is used in SMART® Detection to determine whether the rates in the atrium and the ventricle differ from each other. The sliding average is calculated using the four most recently measured intervals in each chamber of the heart. With each new interval, the average is recalculated, deleting the oldest interval from the average and incorporating the most recently measured interval. In this way, the device has a window over time to assess atrial and ventricular rates.



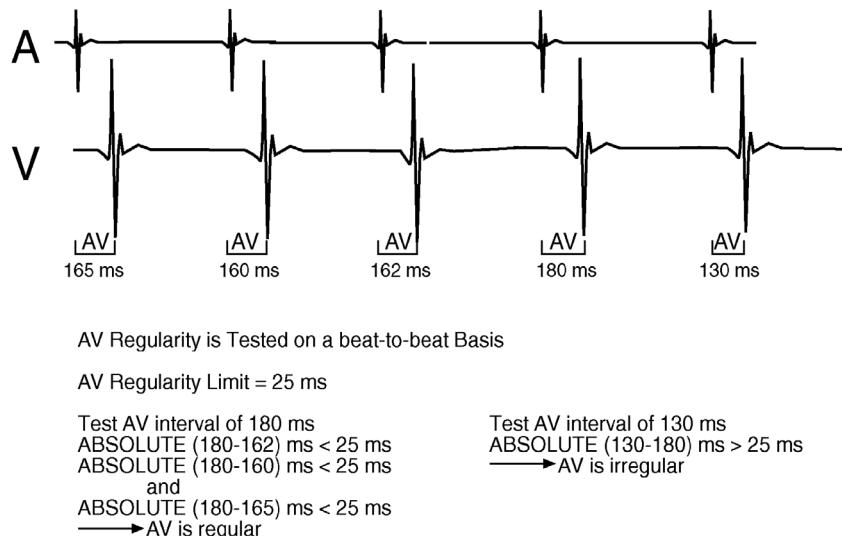
**Figure 57: Calculation of the ventricular sliding average**

#### 4.2.5 Regularity (AV)

To determine whether a consistent pattern between the atrial and ventricular rhythms (AV association) is present, SMART® Detection measures AV regularity ([Figure 58](#)).

An AV interval is determined to be regular if the interval does not differ from the three preceding AV intervals by more than the AV limit. In other words, the device compares the current AV interval against the three previous without averaging. The AV limit is a predetermined value equal to one-half of the Stability limit, or 6%, by default.

In [Figure 58](#), the Stability limit was 50 ms, making the AV Regularity limit 25 ms.



**Figure 58: Calculation of AV regularity**

## 4.2.6 Multiplicity

To determine whether atrial flutter is present, SMART® Detection looks for a consistent N:1 pattern (i.e., 2:1, 3:1, 4:1, etc.). An N:1 pattern, called Multiplicity, is confirmed when the average ventricular interval is found to be a multiple of the average atrial interval (with a tolerance of +/- 12 ms to allow for minor normal variances). Multiplicity, like all SMART® Detection criteria, is evaluated on a beat-to-beat basis.

[Figure 59](#) shows how Multiplicity is evaluated. The ventricular average calculated on the fifth ventricular event is 500 ms. The corresponding atrial average is 250 ms. Consequently, Multiplicity is established for this event. As detection continues, each new interval is tested to determine whether the 2:1 pattern exists. (Remember, the tolerance for multiplicity is 12 ms. For example, if the atrial average is 250 ms then the ventricular interval must be between 488 ms and 512 ms to meet the 2:1 Multiplicity criteria.)

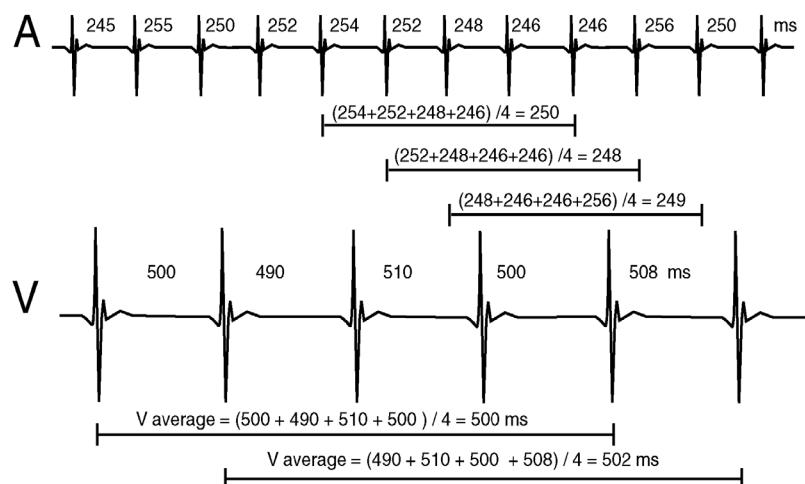


Figure 59: Calculation of Multiplicity

## 4.3 SMART® Detection

SMART® Detection is one of the most sophisticated detection algorithms available for the discrimination of ventricular tachycardia (VT) and supraventricular tachycardia (SVT). SMART® Detection ([Figure 60](#)) is designed to increase detection specificity (i.e., to increase the likelihood that atrial tachycardia is not declared a VT) without sacrificing sensitivity (i.e., the ability to detect and treat all VTs with therapy). This translates into improved patient comfort and care from reduced inappropriate therapies. With SMART® Detection, inappropriate shocks for SVT are minimized without compromising accurate VT detection and therapy. Clinical studies demonstrated that SMART® Detection provided 100% sensitivity and 94% specificity.

Each time an interval is found to lie within one of the programmed VT zones, SMART® Detection follows a series of decisions to determine whether the interval meets the criteria for a VT count or an SVT count. VT criteria affect VT counters, while SVT intervals affect an SVT Counter. VT intervals are labeled with a VT1 or VT2 marker. SVT intervals are marked by one of four labels: AFib for atrial fibrillation, AFLut for atrial flutter, SinusT for sinus tachycardia, or 1:1 for atrial tachycardia.

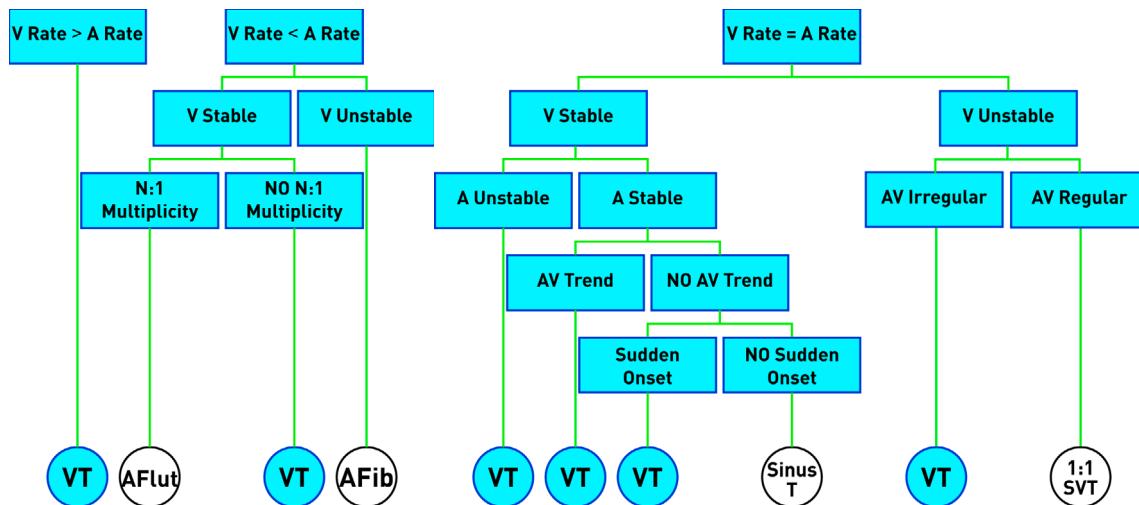


Figure 60: The SMART Detection® decision tree

Most tachyarrhythmias will occur when the ventricular rates are not equal to the atrial rates. Monomorphic VT, atrial flutter, and atrial fibrillation are identified by these portions of the decision tree. When ventricular and atrial rates are equal, discrimination of tachyarrhythmias is more difficult. Additional detection criteria are used to identify biarrhythmias, sinus tachycardia, and VT with retrograde conduction, among other rhythms.

#### 4.3.1 VT Counters with SMART® Detection On

SMART® Detection uses two separate programmable VT Counters (i.e., one counter for VT1 and one counter for VT2). When the VT criteria are met and the interval lies in the VT1 zone, the VT1 counter increments by one (the VT2 counter is unaffected). When VT criteria are met and the interval lies within the VT2 zone, the VT1 and VT2 counter increment by one (i.e., since a VT2 interval is shorter/faster than the VT2 and VT1 limit, both counters increase). VF intervals “freeze” the VT counters.

SVT intervals decrement the VT counters. For initial detection, SMART Branch #2 (Aflutter) decrements the VT counter by one (-1), Branch #4 (Afib) decrements the VT counter by four (-4) and Branches 8 (Sinus Tachycardia) and 10 (1:1 Unstable atrial tachycardia) decrement the VT counter by 1/4. For SMART® Redetection, the same counters are used as in initial SMART® Detection, except for Branch 10, which is decremented by 3/4. A summary of how different SVT events affect the VT counter is shown below.

Table 8: Effects on VT Counters

	Atrial Flutter	Atrial Fibrillation	Sinus Tachycardia	1:1
Initial Detection	-1	-4	-1/4	-1/4
Redetection	-1	-4	-1/4	-3/4

An SVT is declared when the SVT criteria is met. The detection criteria for SVT is twice the VT zone count. For example, if the VT1 zone is set to 16 intervals, it will take 32 SVT intervals in the VT1 zone for an SVT episode to be declared.

## 4.3.2 SMART® Detection decision examples

### 4.3.2.1 Detection of Monomorphic VT or Polymorphic VT (Branch 1)

The easiest case of AV discrimination, the case of monomorphic VT (mVT) or polymorphic VT (pVT), is shown in [Figure 61](#). In this case, discrimination is relatively simple because SMART® Detection can rely solely on the rate criteria.

When an mVT or pVT occurs alone (i.e., without an accompanying atrial arrhythmia or without retrograde conduction), discrimination is based on a comparison of rates - the ventricular rate is faster than the atrial rate. In general, a monomorphic VT has a slow atrial rate, an elevated ventricular rate, and a “regular” QRS morphology and regular R-R intervals. A polymorphic VT has a slow atrial rate and an elevated ventricular rate, but the QRS signal may vary in shape and amplitude.



Figure 61: SMART® Detection of mVT - Branch 1

[Figure 62](#) shows an example of SMART® Detection of a mVT. Detection begins after the device has detected one short (fast) interval. The interval falls into a VT1 zone, and the average atrial rate is less than the average ventricular rate. Therefore, this interval meets the requirement of a Ventricular Tachycardia. The following eleven intervals meet the VT1 criteria for like reasons (the intervals are within a VT1 zone, and the average ventricular rate is faster than the average atrial rate).

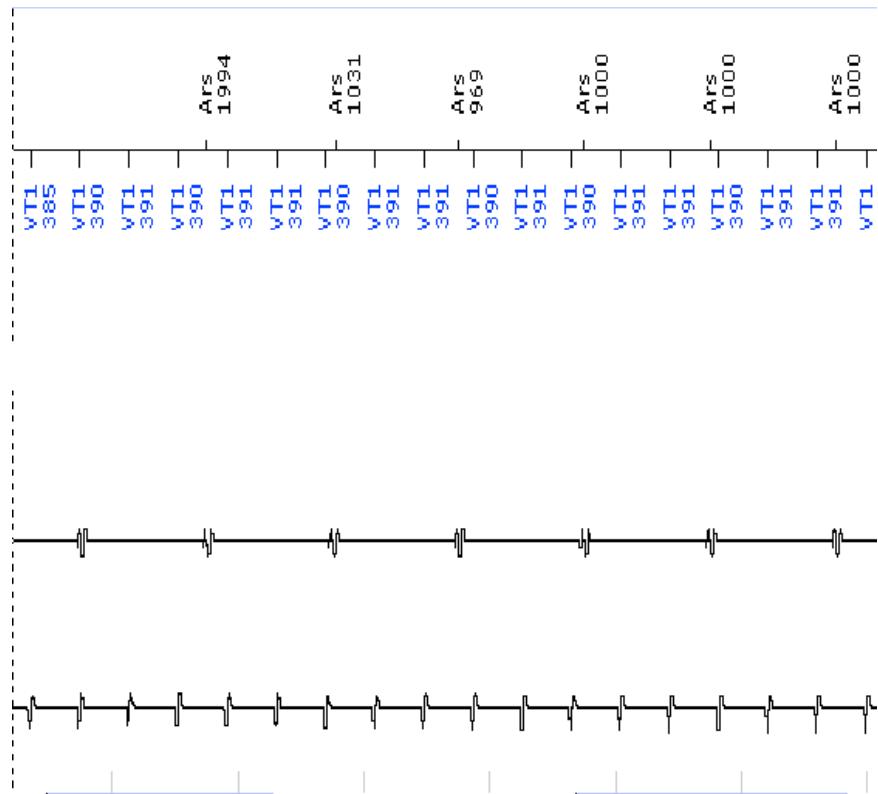


Figure 62: IEGM Sample of VT detection - Branch 1

#### 4.3.2.2 Discrimination of Atrial Flutter (Branch 2)

Typically, VT is difficult for discrimination algorithms to identify when it occurs in the presence of an ongoing atrial arrhythmia. In the worst case scenario, VT could go unrecognized and untreated. However, SMART® Detection distinguishes these arrhythmias by carefully comparing atrial and ventricular rates and analyzing the relationship between intervals to classify VT without delay.

When SMART® Detection measures an interval in the VT zone and determines that the atrial rate is greater than the ventricular rate, a biarrhythmia or a supraventricular tachycardia (SVT) is suspected. To classify the rhythm further, SMART® Detection looks at ventricular stability and multiplicity ([Figure 63](#)).

If the atrial rate is faster than the ventricular rate, and an N:1 relationship exists between the atrial and ventricular rates (i.e., there is a 2:1, 3:1, or 4:1 ratio within a tolerance of +/- 12 ms), then the ventricular interval is classified as an atrial flutter beat and labeled with an AFLUT marker. In other words, the algorithm assumes that the accelerated ventricular rate results from atrial flutter with some degree of AV block. An AFLUT interval will decrement the VT Counter by one (-1).

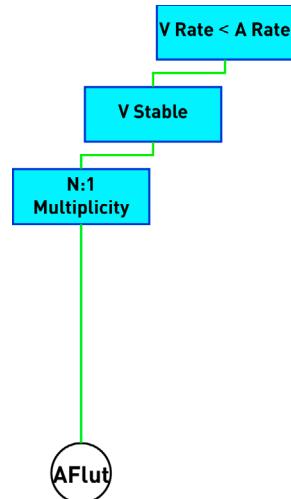


Figure 63: SMART® Detection of atrial flutter - Branch 2

[Figure 64](#) shows an IEGM recording of atrial flutter with 2:1 AV conduction. The 2:1 pattern is maintained throughout the recording; therefore, no VT Counts are identified.

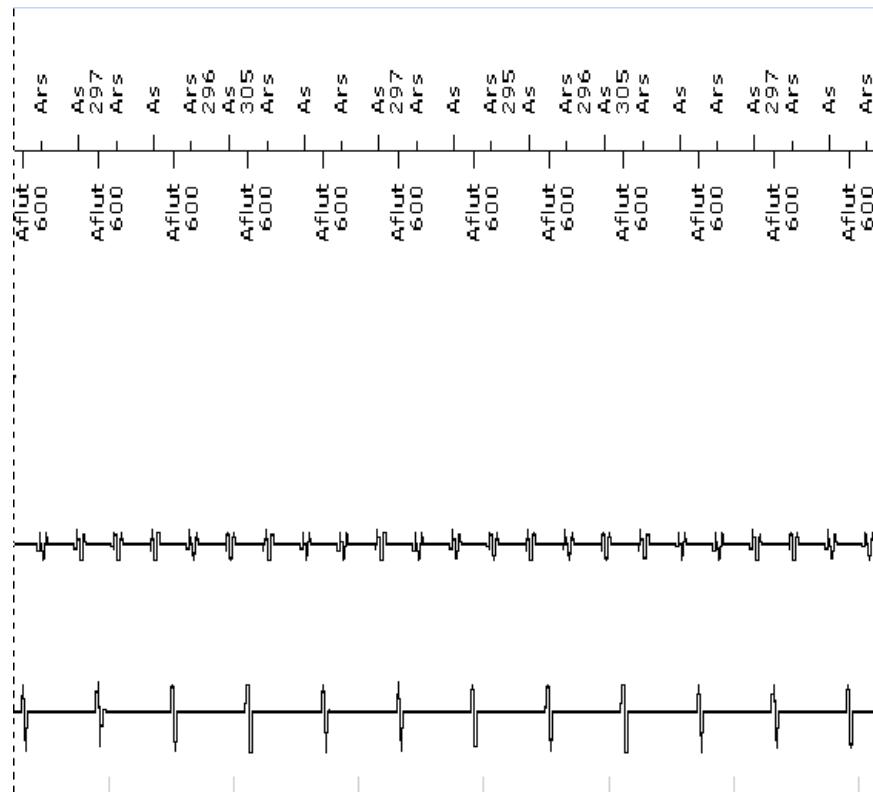


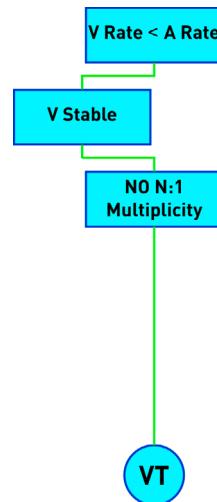
Figure 64: IEGM sample of atrial flutter - Branch 2

#### 4.3.2.3 Atrial Tachycardia or Fibrillation with VT (Branch 3)

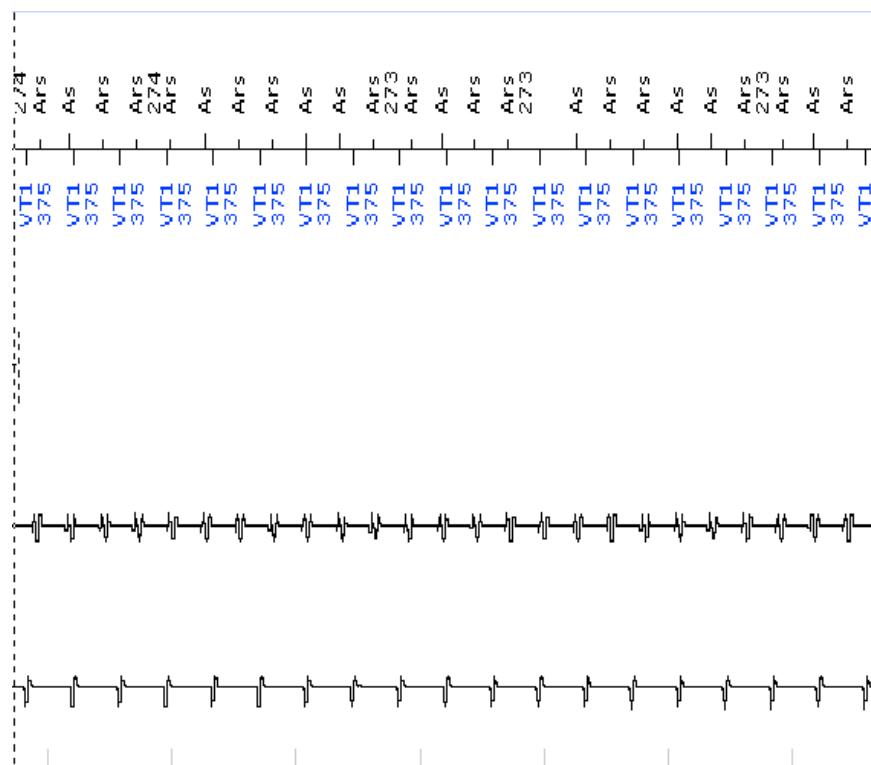
Using SMART® Detection, a biarrhythmia (i.e., a concurrent atrial and ventricular arrhythmia) is identified along several branches of the SMART® Detection decision tree ([Figure 65](#)). The biarrhythmia in this section occurs when the atrial rate is greater than the ventricular rate, the ventricular rate is

stable, and multiplicity cannot be established. When these conditions are met, a VT with concurrent atrial tachycardia or atrial fibrillation is identified. Each beat will be marked with a VT marker ([Figure 66](#)).

This branch uses the same criterion as described for the discrimination of atrial flutter in the previous section. However in this case, N:1 criterion was not met and the device declares the arrhythmia a VT.



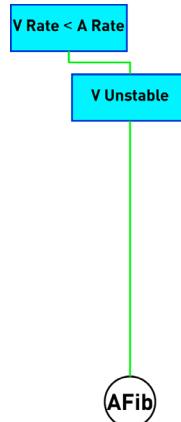
**Figure 65: SMART® Detection VT - Branch 3**



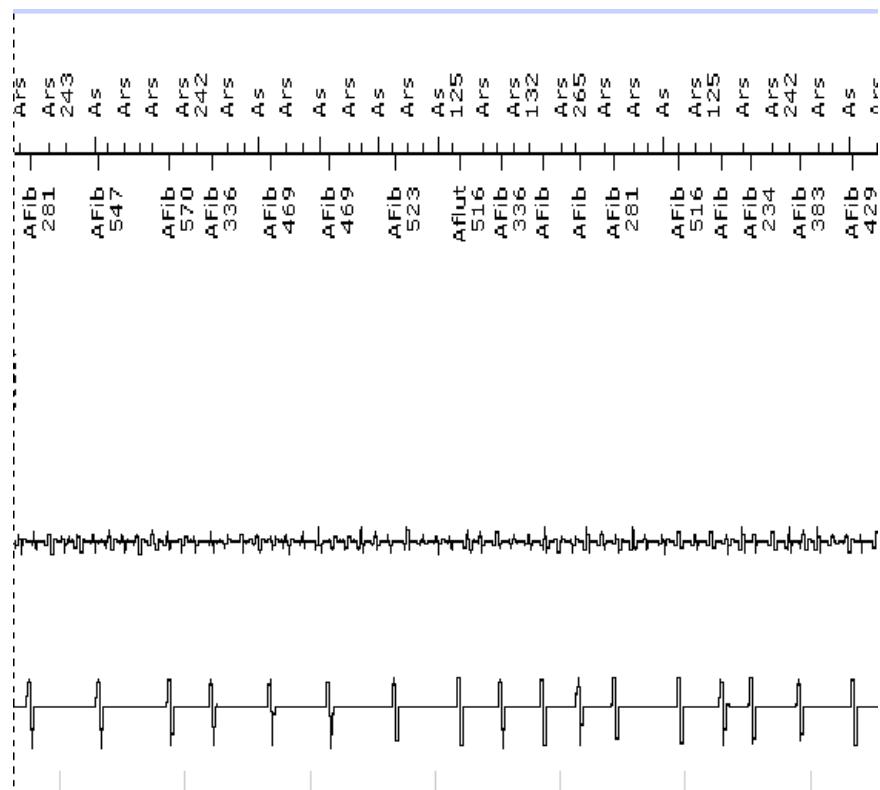
**Figure 66: Example of VT when multiplicity is not met**

#### 4.3.2.4 Atrial Fibrillation (Branch 4)

Atrial fibrillation has more than one focus and by nature is irregular or chaotic with atrial intervals of varying lengths. In turn, these atrial intervals are conducted irregularly to the ventricles. SMART® Detection identifies irregular conduction and declares atrial fibrillation when the atrial rate is greater than the ventricular rate and the ventricular intervals are unstable ([Figure 67](#)). Each ventricular interval is marked with an AFib marker. Therapy is withheld for the episode, and an IEGM is stored ([Figure 68](#)).



**Figure 67: SMART® Detection of atrial fibrillation - Branch 4**



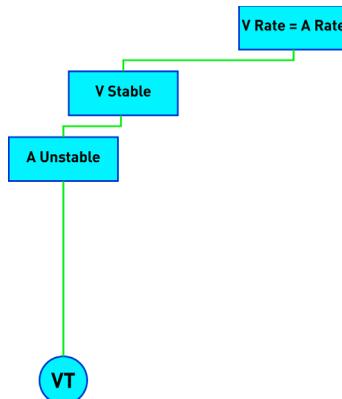
**Figure 68: IEGM sample of atrial fibrillation - Branch 4**

**NOTE:**

An event declared as Atrial Fibrillation will decrease the VT counter by (-4) to reduce the potential of delivering inappropriate therapy.

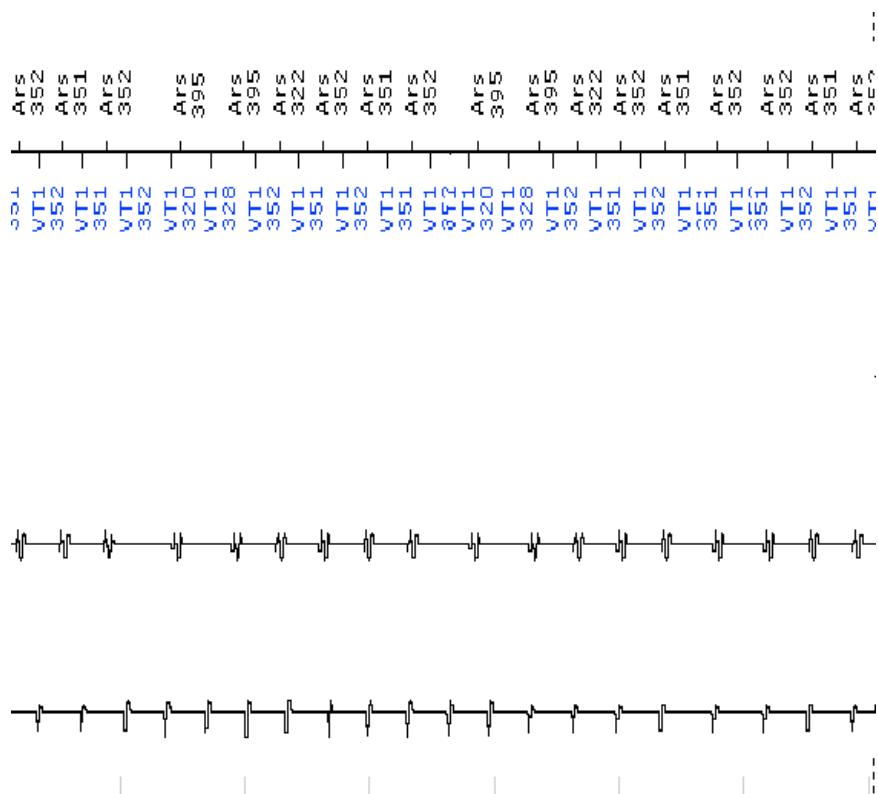
#### **4.3.2.5 VT with an Unstable Atrial Arrhythmia (Branch 5)**

Discrimination of VT is most difficult when atrial and ventricular rates are equal. Therefore, the SMART® Detection branches out to identify six different classification pathways when the atrial and ventricular rates are equal. [Figure 69](#) shows the first of these six possible pathways.



**Figure 69: SMART® Detection of VT - Branch 5**

When SMART® Detection identifies equal atrial and ventricular rates, the algorithm tests stability in both chambers. If the ventricle is stable and the atrium is unstable, the algorithm concludes that the rhythms are disassociated (i.e., independent). In other words, the fast ventricular rate results from a stable VT, while the atrial rate results from an unstable atrial arrhythmia (i.e., multifocal atrial tachycardia). Therapy will be delivered for the VT. An example of this arrhythmia is shown in [Figure 70](#).



**Figure 70:** Example of a biarrhythmia with an unstable atrial arrhythmia

#### 4.3.2.6 Concurrent atrial tachycardia with VT (Branch 6)

When atrial and ventricular rhythms are stable and similar in rate, several different rhythms may exist. If an AV Trend exists, (i.e., successive AV intervals are present in strict increasing or decreasing length), then the user can deduce that the atrial and ventricular rhythms are close in rate, but independent or disassociated. The small but consistent difference between the atrial and ventricular rate causes the AV interval to gradually shrink or expand over time.

[Figure 71](#) shows the SMART® Detection AV trend branch. Since the rhythms are seen as independent, two arrhythmias coexist. SMART® Detection identifies the VT and treats the rhythm. This branch is used when monomorphic VT occurs during slow atrial tachycardia, or with exercise induced VT. An example of this arrhythmia is shown in [Figure 72](#).

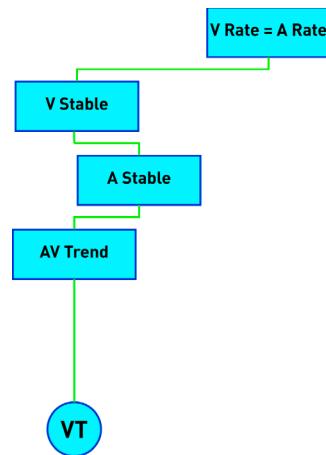


Figure 71: SMART® Detection of VT - Branch 6

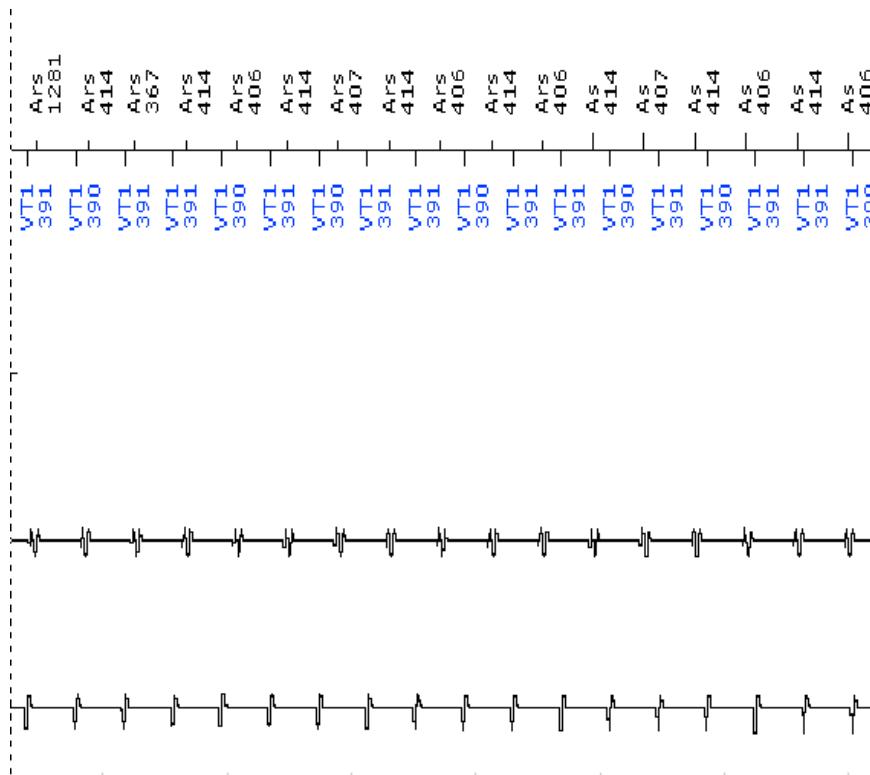


Figure 72: Example of AV trend

#### 4.3.2.7 Distinguishing VT from Sinus Tachycardia (Branch 7 and Branch 8)

When atrial and ventricular rates are similar and stable with no AV trend, SMART® Detection uses Onset to differentiate monomorphic VT (mVT) with 1:1 retrograde conduction from sinus tachycardia (ST). Therapy will be appropriately provided for monomorphic VT with 1:1 retrograde conduction and inhibited for ST.

Monomorphic VT often starts rapidly with a significant rate change occurring over three or four beats. Sinus tachycardia, in contrast, may develop over many seconds such as during exercise. SMART® Detection identifies the rapid change in heart rate with the Sudden Onset criteria to distinguish monomorphic VT with retrograde conduction from Sinus Tachycardia, as shown in [Figure 73](#).

[Figure 74](#) shows an example of VT with retrograde conduction. Intervals classified as Sinus Tachycardia are labeled with a SinusT marker ([Figure 75](#)).

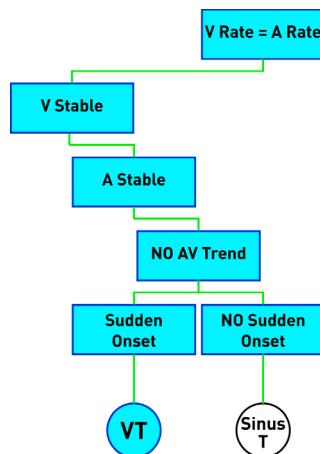
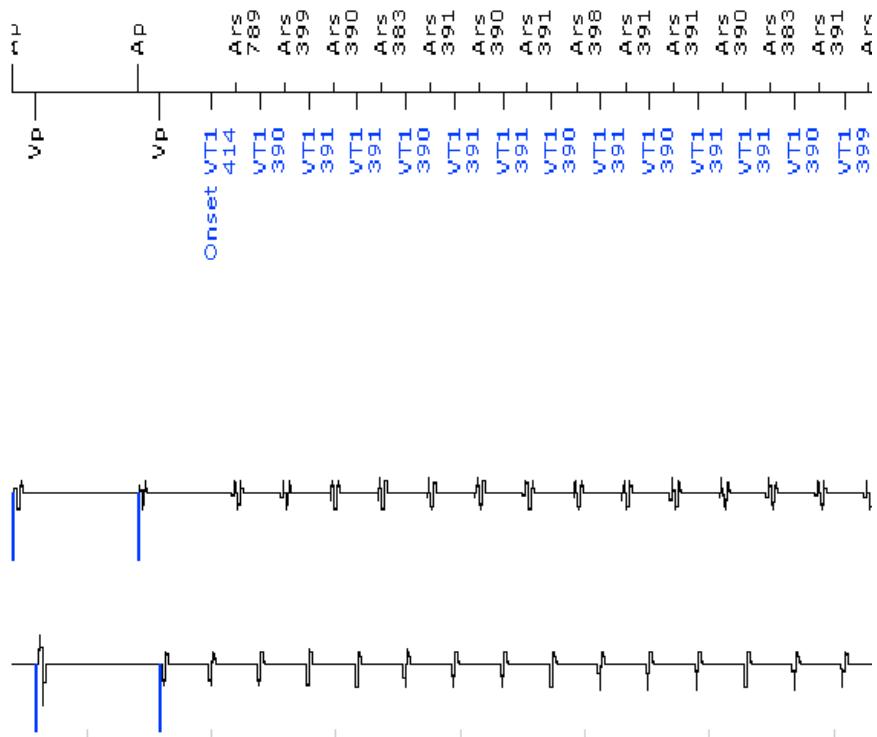
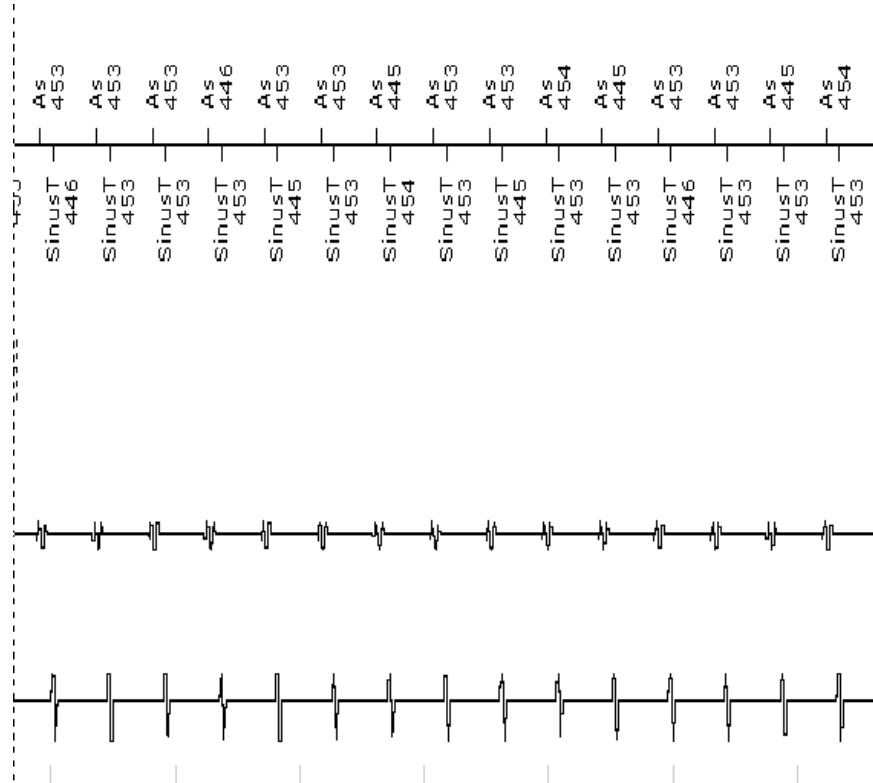


Figure 73: SMART® Detection of VT vs. Sinus T - Branches 7 and 8



**Figure 74: Example of VT with retrograde conduction**



**Figure 75: IEGM sample of sinus tachycardia**

The example in [Figure 75](#) shows a gradual increase in rate due to sinus tachycardia. The Sudden Onset criterion is not met, and therapy is correctly withheld for this episode.

#### 4.3.2.8 Polymorphic VT with Retrograde Conduction (Branch 9)

Usually polymorphic VT occurs at higher rates than monomorphic VT. In addition, the QRS morphology and the rate are variable. When polymorphic VT is conducted back to the atrium on a beat-to-beat basis, instability in the ventricle is introduced into the atrium. Since the retrograde conduction is consistent and the intervals are unstable, the AV intervals become irregular.

As illustrated in [Figure 76](#), SMART® Detection identifies polymorphic VT with retrograde conduction when atrial and ventricular rates are equal, both chambers are stable, and the AV interval is irregular. Therapy is initiated to treat and terminate the polymorphic VT. An example of polymorphic VT with retrograde conduction is shown in Multifocal AT with Antegrade Conduction ([Figure 77](#)).

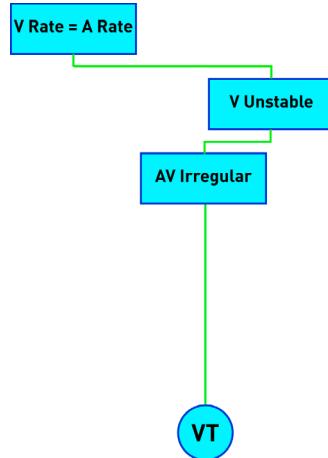


Figure 76: SMART® Detection of VT - Branch 9

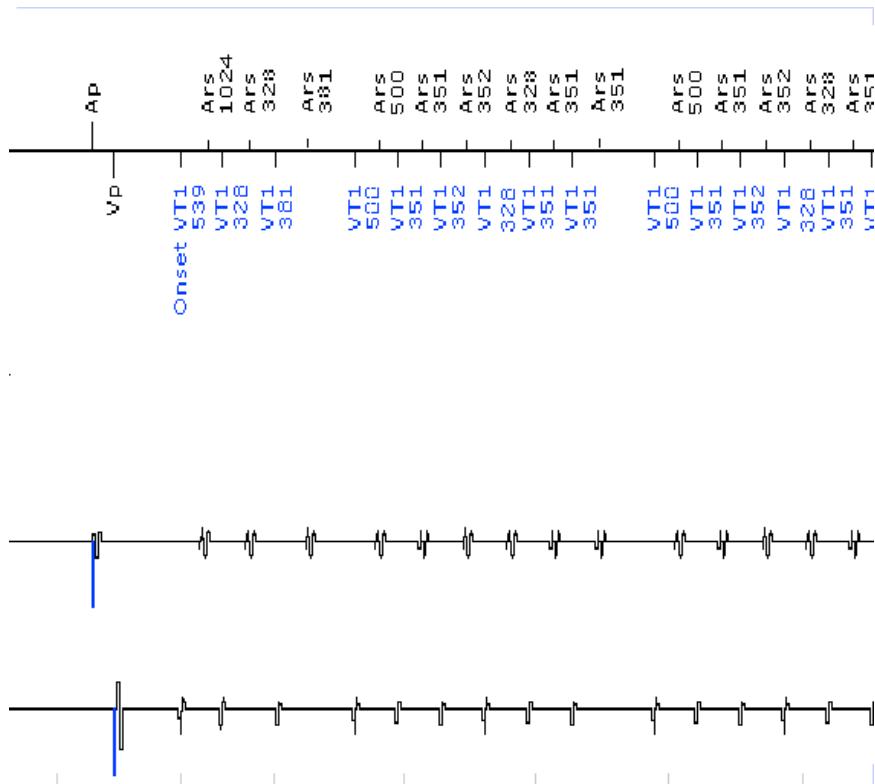
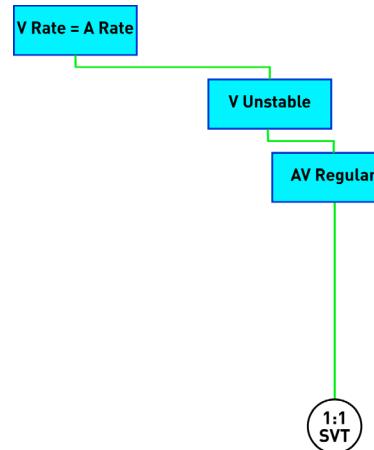


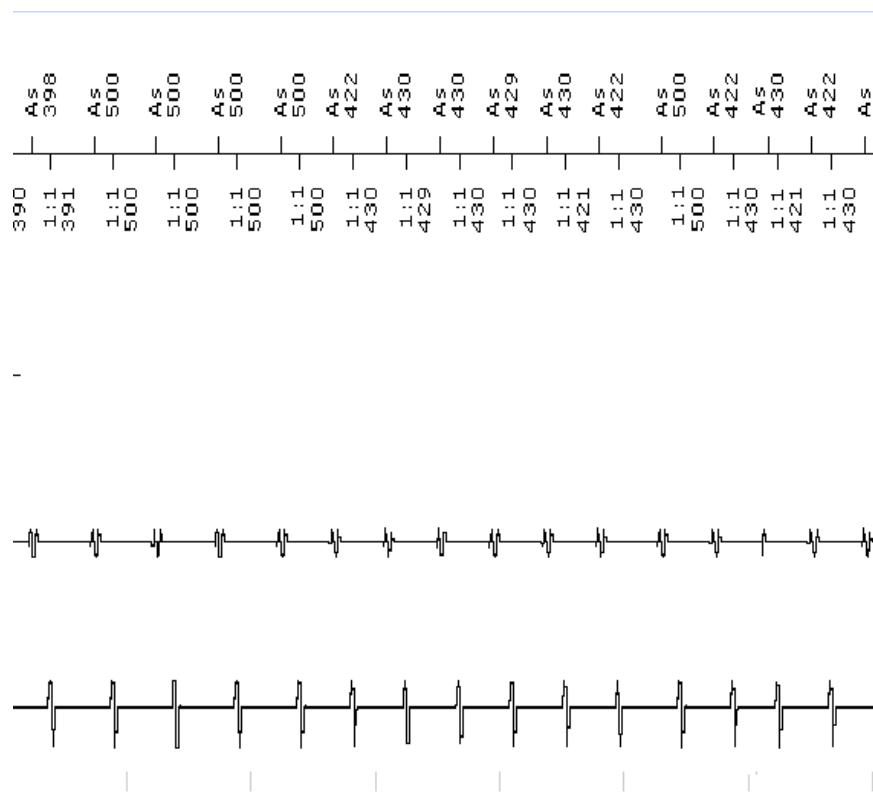
Figure 77: Polymorphic VT with retrograde conduction

#### 4.3.2.9 Multifocal AT with Antegrade Conduction (Branch 10)

In this SMART® Detection branch ([Figure 78](#)), as in the last (Branch 9), the ventricular and atrial rhythms are unstable, while the average atrial and ventricular rates are equal. However, now the AV intervals are regular or stable. This regularity suggests a direct AV association between the atrial and ventricular rhythms. In other words, the rhythm originates in the atrium, and therefore the rhythm is irregular atrial tachycardia with 1:1 antegrade conduction. In this case, each beat is labeled with a 1:1 marker, and therapy is appropriately withheld. An episode of atrial tachycardia is declared after twice the programmed VT Count is met. An example of multifocal AT is shown in [Figure 79](#).



**Figure 78: SMART® Detection of 1:1 SVT - Branch 10**



**Figure 79: Example of multifocal AT**

### 4.3.3 Sustained VT Timer

A Sustained VT timer can be programmed as a “safety net” to override Onset and Stability in initial ventricular-only VT detection. The Sustained VT timer begins with the detection of a fast interval (i.e., an interval that falls into the VT or VF zones). When the timer expires, the rhythm is reevaluated using the single-chamber redetection criteria (i.e., using the Redetection Count without detection enhancements of Onset or Stability). If the redetection criterion is met, therapy is delivered based on what zone the tachyarrhythmia was met. The timer resets with arrhythmia termination. The parameter may be programmed between 1 minute and 30 minutes (default = OFF). A message is provided to show that detection was met due to the Sustained VT timer expiring. This message is shown in

**Figure 80.**

Remark
Initial detection due to sustained VT

**Figure 80:** Episode detail message for Sustained VT

SMART® Detection and Stability must be programmed OFF for the Sustained VT Timer value to appear. It is generally recommended to use the feature only when using Ventricular-Only detection criteria.

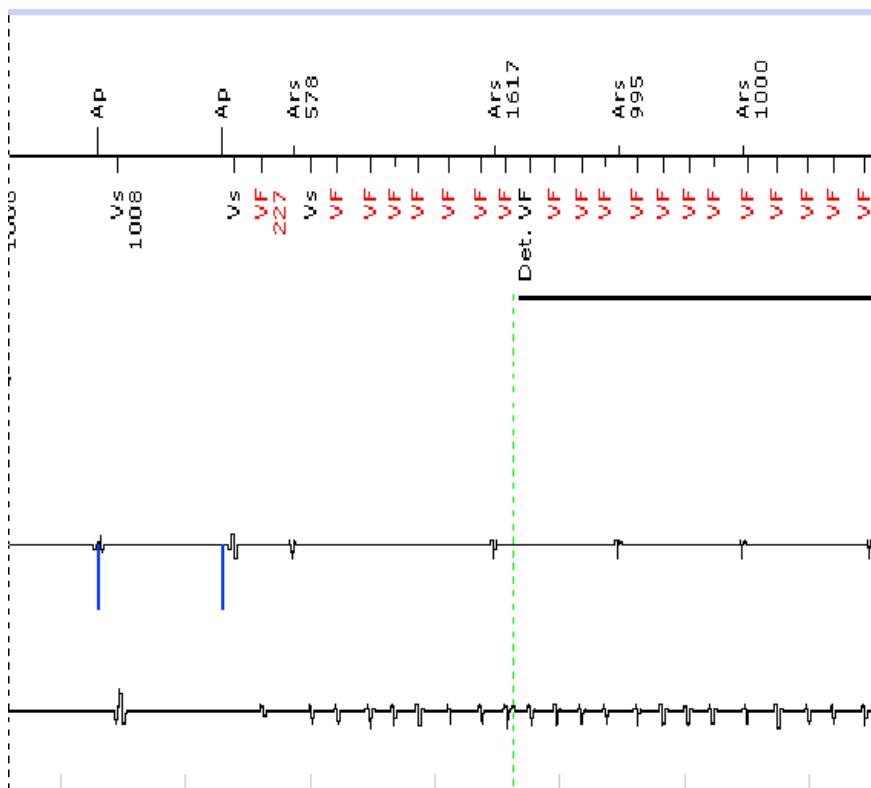
**NOTE:**

When the Sustained VT Timer expires with two VT zones programmed, therapy is based on which VT Redetection Counter is satisfied (i.e., If the VT1 Redetection Counter is met, VT1 therapy is delivered. If the VT2 Redetection Counter is met, VT2 therapy is delivered).

## 4.4 VF Detection

The Lumax ICD has a single VF zone. VF detection is based on the Interval/Rate limit and an “X out of Y” criterion. If X intervals within a rolling window of Y intervals are shorter (i.e., the rate is faster) than the VF detection Interval/Rate limit, then VF is declared and therapy delivered. The default setting for “X out of Y” is 8 in 12. There are nine programmable options available in the Lumax 740 family. The shortest setting is 6 out of 8 intervals and the longest is 24 out of 30 intervals.

Values in which programming is not permitted will have a  symbol in front of the value. This is typically seen when trying to program the “X” value of the “X out of Y” criteria greater than the VT detection count.



**Figure 81: IEGM example of VF detection**

[Figure 81](#) shows an example of VF detection. In this example, the VF zone is programmed 8 out of 12 events at an interval of 300 ms, or 200 bpm. One Vs event is seen after the first VF marker, shown in red. A sliding window of 12 intervals is continuously monitored for VF. VF is declared when eight of twelve intervals are found to be 300 ms or less. The green vertical line shows when the device declared VF. Below the VF markers, a bar appears that shows the device is charging to treat the VF.

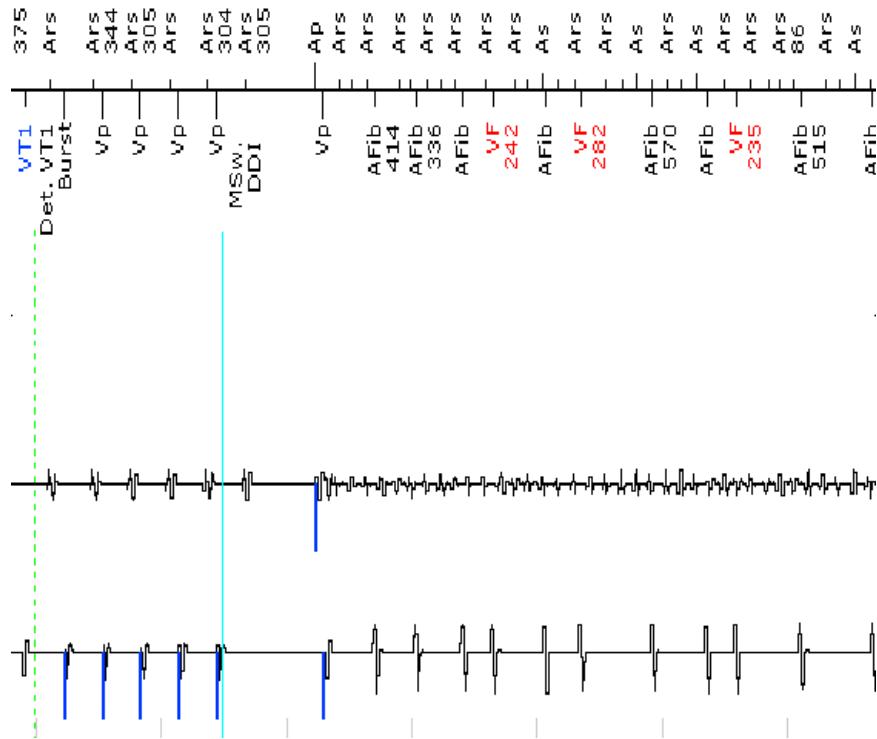
## 4.5 Ventricular Tachyarrhythmia Redetection

Redetection begins after the first therapy in any arrhythmia zone is delivered. Thereafter, the redetection criteria are used to evaluate the cardiac signal until termination is declared or until all programmed therapy has been delivered. VT redetection uses programmable VT1 and VT2 Redetection Counters. The VT Redetection Counters must be programmed to a smaller value compared to initial detection to speed redetection. However, to ensure appropriate detection in the VF zone, the Redetection Counters cannot be programmed below the "X" of the X in Y criteria for VF detection. Nominally, the Redetection Counter is programmed to 12 for the VT1 zone and 10 for the VT2 zone. VT redetection uses the same up/down counters as initial detection. VF redetection uses the same "X out of Y" criteria as initial VF detection.

#### 4.5.1 SMART® Redetection

SMART® Redetection is automatically ON when SMART® Detection is programmed. It is used after VT therapy delivery to withhold further therapy if the delivered VT therapy resulted in an SVT. VT redetection with SMART® Redetection ON is based on the programmable Redetection Count; however, the counters are changed. A VT interval will increment the counter +1, a VF interval “freezes” the counter, and a Sinus interval decrements the counter by -1. SVT events will decrement the counter as in initial SMART® Redetection. The exception of behavior with SMART® Detection ON is Branch #9,

which decrements by 3/4. The Sustained VT timer is not utilized when SMART® Redetection is ON, but rather a Forced Termination timer is used. (See [Section 4.6.1](#).) An Example of SMART® Redetection is shown in [Figure 82](#).



**Figure 82: SMART® Redetection**

**Figure 82** shows a detected VT treated with ATP. The result of the therapy was atrial fibrillation. Because SMART® Redetection is ON, no therapy will be delivered while the AFib continues.

## 4.6 Ventricular Tachyarrhythmia Termination

Tachyarrhythmia termination is based on a non-programmable “X out of Y” termination criterion of 12 in 16. Termination is declared when twelve intervals out of a sliding window of 16 intervals are longer (i.e., the rate is slower) than the lowest programmed cutoff interval/rate limit with therapy. If 12 long intervals are measured before the first window of 16 intervals, termination is declared with the twelfth interval. Following termination, detection starts anew, and all programmed therapy is available for treatment.

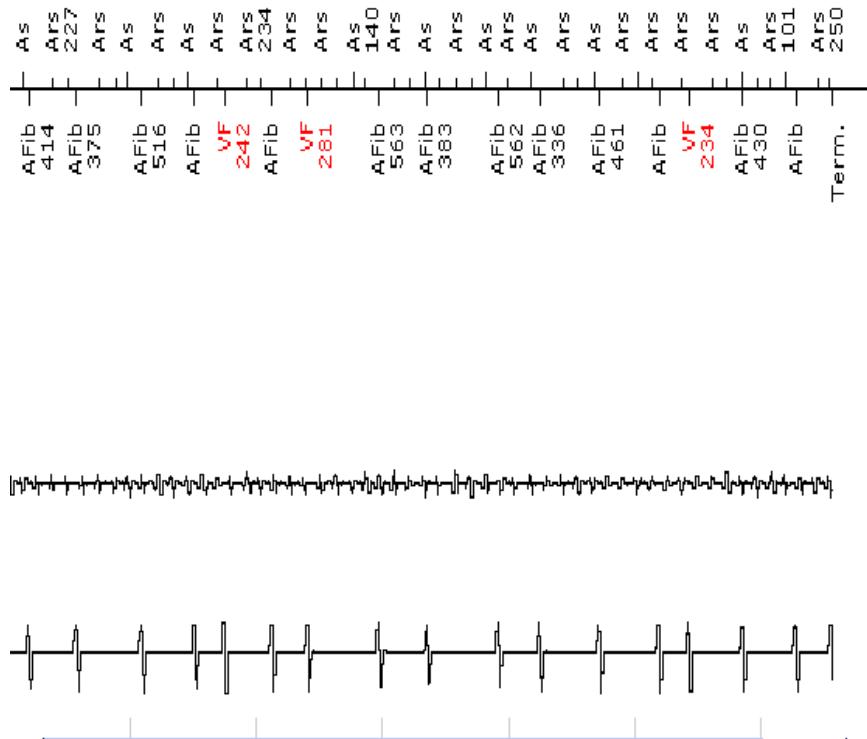
If a VT Monitoring Zone is programmed, intervals in the VT Monitoring Zone count toward termination and do not count towards redetection. For example, a VT Monitoring Zone is programmed to 130 bpm, a VT2 zone at 150 bpm and a VF zone at 200 bpm. Termination of the arrhythmia will occur when 12 of 16 events are slower than the VT 2 zone (150 bpm). This behavior is appropriate, as there is no therapy programmed for a VT Monitoring Zone.

#### 4.6.1 Forced Termination Timer

The purpose of the Forced termination timer is to reset therapies after a successful ventricular arrhythmia termination results in an SVT. In this way, all programmed therapies will be available should the arrhythmia revert back to a VT/VF.

If an SVT occurs after successful termination of VT/VF and SMART® Redetection is used, no therapy will be delivered for the SVT during redetection. If the SVT remains when the Forced Termination timer expires, the device will declare the end of the episode. If the VT/VF returns before the Forced Termination timer expires, the arrhythmia will be treated with the next programmed therapy.

When the Forced Termination timer expires, the current event is logged as terminated and all therapy is reset. A message stating “Term” will appear at the end of the IEGM recording, as shown in [Figure 83](#). The device will then record a new SVT episode provided the SVT IEGM storage is ON.



**Figure 83: Example of forced termination with annotation**

In addition to the annotation of the IEGM, the episode details will also provide a Forced Termination message. An example is shown in [Figure 84](#).

Remark
Forced termination

**Figure 84: Forced termination message in the episode details**

The Forced Termination timer is programmable for 1 – 10 minutes or OFF. Default setting is one minute.

## 4.7 Monitoring Zones

In addition to programming ATP and/or shocks for VT zones, the user may program the Lumax 740 ICD with a monitoring zone in the VT1 zone only. A monitoring zone cannot be programmed in the VT2 zone.

The monitoring zone may be used to look for non-sustained VTs. Monitoring zones are programmed the same as standard VT1 zone programming except that ATPs and therapy energies are not provided. Monitoring zone programs may also include the programming of SMART® Detection as well to look for SVTs that may not be previously known.

To program a VT1 monitoring zone, select the monitoring zone rate or interval and the detection count criteria. Ensure that all ATPs and energies are turned OFF.

**NOTE:**

Trigger pacing in Lumax 740 HF-T CRT-Ds cannot be programmed into a monitoring zone.

There is no reduction in longevity using a monitoring zone.

## 5. Tachyarrhythmia Therapy

The Lumax ICDs/CRT-Ds offer a variety of therapy options that can be tailored to meet a patient's specific anti-tachycardia or defibrillation therapy requirements. Anti-tachycardia pacing (ATP) therapies can be combined with defibrillation therapies to provide a broad spectrum of tachyarrhythmia treatment options.

Lumax 740 ICDs can treat ventricular arrhythmias with anti-tachycardia pacing (ATP) or shock therapy, as well as address bradycardia therapy needs. This chapter will discuss the details of the therapies available in the Lumax 740 ICD.

**Table 9: Therapy programming for a Lumax 740**

Zone	ATP 1 <sup>†</sup>	ATP 2 <sup>†</sup>	Shock 1	Shock 2	Shock 3 - N <sup>th</sup>	Shocks per zone
VT1	OFF, Burst, Ramp	OFF, Burst, Ramp	OFF, 2-40 J	OFF, 4-40 J	OFF, 4*40 J; 6*40J	0, 1, 2, 6 or 8
VT2	OFF, Burst, Ramp	OFF, Burst, Ramp	OFF, 2-40 J	OFF, 4-40 J	OFF, 4*40 J; 6*40J	0, 1, 2, 6 or 8
VF*	OFF, Burst, Ramp	N/A	2-40 J	4-40 J	OFF, 4*40 J; 6*40J	6 or 8

### 5.1 Antitachycardia Pacing Therapy (ATP)

#### 5.1.1 ATP Schemes

##### Burst, Ramp

ATP Enhancements: Add S1, Scan Decrement

In general, all ATP therapies consist of a series of pacing pulses delivered in predetermined (adaptive) intervals. In theory, ATP pulses are delivered to interrupt reentrant tachycardias. As a result, ATP is most effective in terminating slow, monomorphic, re-entrant VTs. An ATP scheme is considered least aggressive (least likely to terminate) and safest (least likely to accelerate the rhythm) when the pulse number is low and the intervals are fixed. Conversely, an ATP scheme is considered the most aggressive (most likely to terminate) and potentially dangerous (most likely to accelerate) when the pulse number is high and the intervals are varied. The device does not differentiate the hierarchy of ATP programming in the device. This allows the user to program ATP therapies to meet a specific patient's needs.

##### NOTE:

Because ATP may not terminate an arrhythmia, ATP therapy should always be programmed together with shock therapy.

The Lumax 740 ICD can be programmed to deliver ATP in the configuration schemes of Burst and Ramp with enhancements Add S1 and Scan decrement. The Lumax 740 ICD allows the programming of two ATP schemes per VT zone, in any combination. The pulse amplitude and pulse width for all ATP pulses is 7.5 V and 1.5 ms respectively, while the pacing mode is VOO. The pacing configuration for ATP can be programmed in either the RV or BiV configuration in HF-T devices. In HF-T devices, the user may program one ATP to deliver RV only pacing and the other to deliver BiV pacing.

\* A single ATP attempt can be programmed in the VF zone (ATP One-shot)

† ATP is delivered in a VOO mode at 7.5 V and 1.5 ms output

The ATP Type, number of Attempts, Number of S1 pulses, and R-S1 Interval parameters define each ATP scheme. In addition, the S1 Decrement, S1-S2 Interval, and Add S1 parameters can be programmed as shown below in [Table 10](#).

**Table 10: ATP programming options**

ATP Type	Burst	Ramp
Attempts	OFF, 1...(1)...10	OFF, 1...(1)...10
Ventricular pacing (HF-T only)	RV, BiV	RV, BiV
Number of S1	1...(1)...10	1...(1)...10
Add S1	ON/OFF	ON/OFF
R-S1 Interval	70...(5)...95%	
S1 Decrement	N/A	5...(5)...40 ms
Scan Decrement	OFF, 5...(5)...40 ms	OFF, 5...(5)...40 ms

## ATP Programming

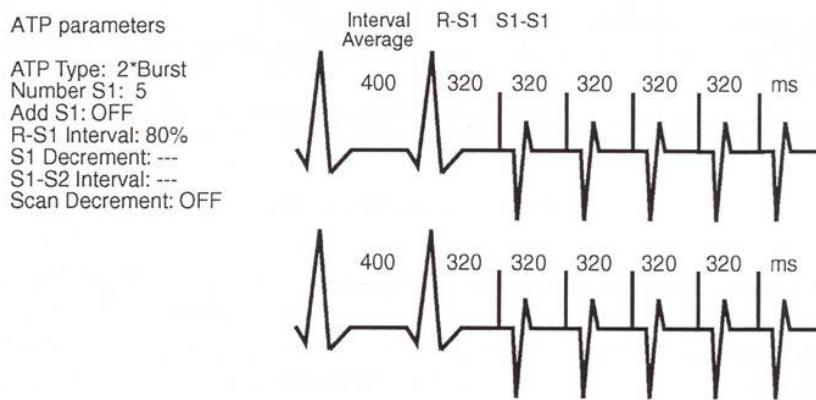
The R-S1 interval is programmed as an adaptive value of the last interval average. The R-S1 interval equals the S1-S1 interval; the S1-S1 interval cannot be programmed independently. If the rate of an arrhythmia increases or decreases between detection and redetection in the adaptive ATP mode, the ATP intervals will adapt to the new arrhythmia interval.

Typically, the ATP interval most likely to cause termination is just shorter (faster rate) than the interval length of the arrhythmia. Therefore, it is often desirable to program ATP intervals that are tachycardia-specific, which is the adaptive mode expressed as a percentage – nominally at 80%. For ATP One-shot, the adaptive percentage is 85%.

### Burst

An ATP Burst scheme is the simplest of ATP forms. It is a series of pulses whose S1-S1 interval is constant. The S1-S1 interval may change between successive trains if the ventricular tachyarrhythmia rate changes.

[Figure 85](#) shows a Burst ATP scheme. The initial S1-S1 interval and the R-S1 interval are calculated to the same value based on the intrinsic R-R average of 400 ms. More precisely, the R-S1 interval and S1-S1 interval are both calculated to 320 ms, or 80% of 400 ms.



**Figure 85: Burst ATP scheme**

## Ramp

An ATP Ramp scheme is a series of pulses whose S1-S1 intervals vary within a single train. To modify the S1-S1 interval, the S1 Decrement is programmed. For example, when the S1 Decrement is programmed to 20 ms, the S1-S1 interval shortens by 20 ms with each successive pulse within the train.

The Ramp scheme in [Figure 86](#) consists of two attempts with five ATP pulses. The R-S1 interval and first S1-S1 are 80% of the R-R average of 400 ms, which equals 320 ms. Since the S1 Decrement is programmed to 10 ms, the second S1-S1 is 10 ms less than 320 ms ( $320 - 10 = 310$  ms). The third S1-S1 interval is 10 ms less than the second interval ( $310 - 10 = 300$  ms). The final interval is 10 ms less than the third interval ( $300 - 10 = 290$  ms).

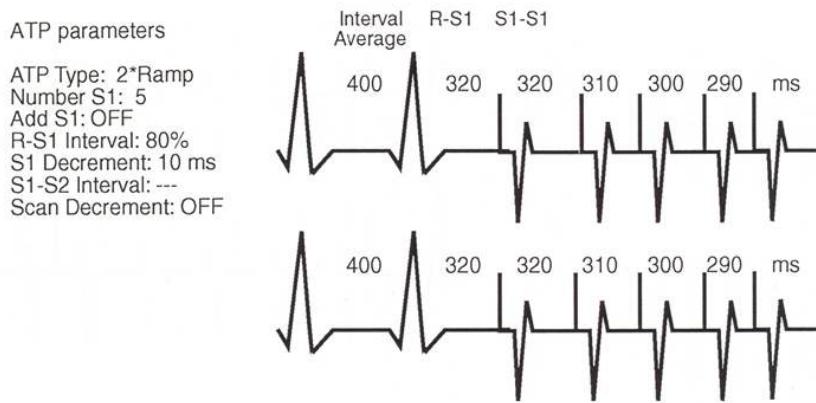


Figure 86: Ramp ATP scheme

## ATP Enhancement - Scan Decrement

The Scan Decrement ATP enhancement can be programmed with each ATP scheme available. When Scan Decrement is programmed with the Burst and Ramp options, the R-S1 and first S1-S1 decrease by the programmed amount between each successive ATP attempt within a given VT episode.

[Figure 87](#) and [Figure 88](#) illustrate a 10 ms Scan Decrement with a Burst and Ramp scheme. For the second Ramp shown, note that the S1 Decrement is based on the newly calculated R-S1 and S1-S1 intervals.

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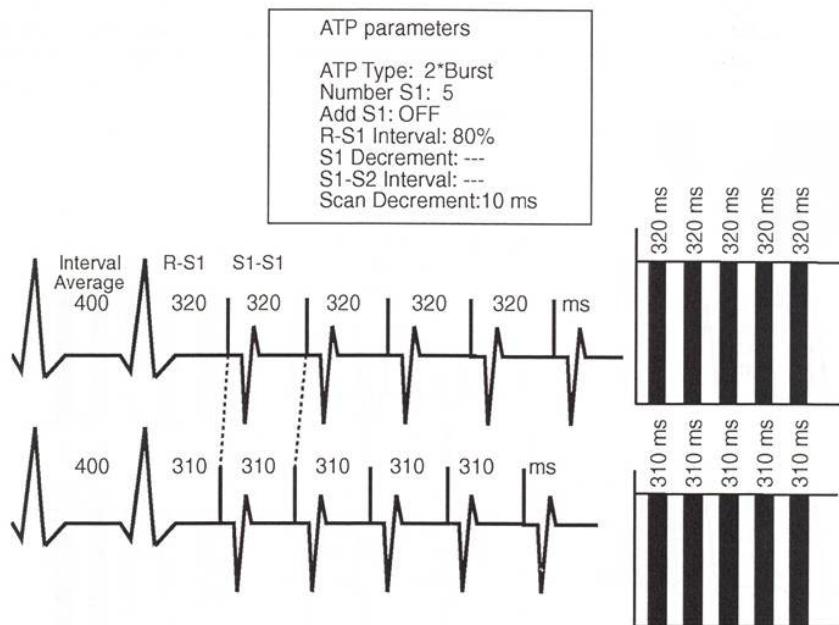


Figure 87: The Scan Decrement programmed with a Burst ATP scheme

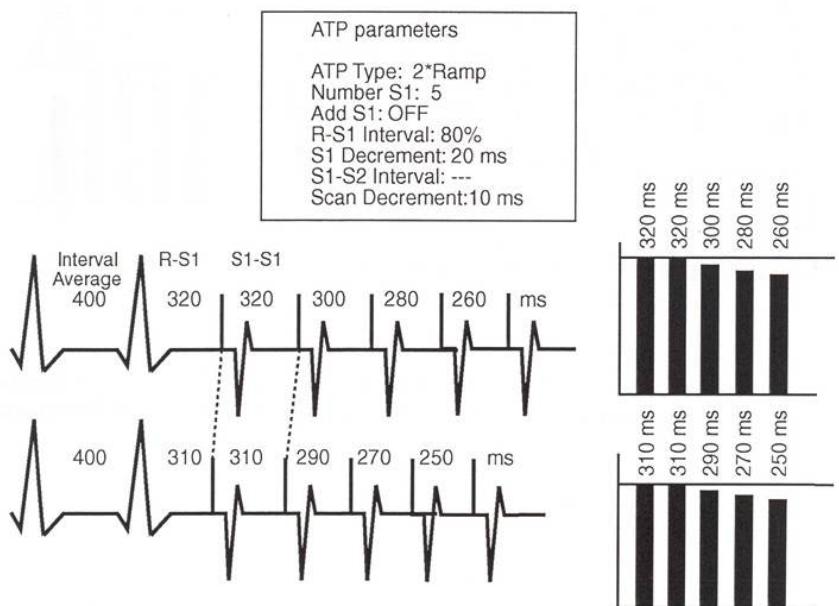


Figure 88: The Scan Decrement programmed with a Ramp ATP scheme

### ATP Enhancement - Add S1

Add S1 is programmed ON by default in the Lumax 740 ICD. When Add S1 parameter is programmed ON, the number of S1 pacing pulses increments by one with each successive ATP delivery. The new S1-S1 interval length is dependent on the programmed ATP parameters and the optional scan parameter (if applicable).

#### 5.1.2 ATP One-Shot

Default **ON** with Burst ATP, S1 to 8 paced events, R-S1 interval at 85%.

ATP One-Shot is a feature that allows the physician to program a single ATP therapy for a stable rhythm in the VF zone prior to charging. The rhythm in the VF zone must be regular (12%), such as a stable monomorphic VT. Once the ATP is delivered, charging begins. During charging, the device looks to see if the arrhythmia has terminated ([Figure 89](#)). If termination has occurred, charging is aborted once three sinus intervals (out of four) occur.

ATP One-Shot allows the user to select different types of ATP to be delivered ([Figure 90](#)). Additionally, the user can select the same options as can be programmed for standard ATP delivery. The minimum pacing interval for ATP One-Shot is 200 ms, the same as the minimum pacing interval for VT ATP.

**NOTE:**

ATP One-shot is disabled after four consecutive unsuccessful attempts. To re-enable ATP One-Shot, simply interrogate the device again with a programmer.

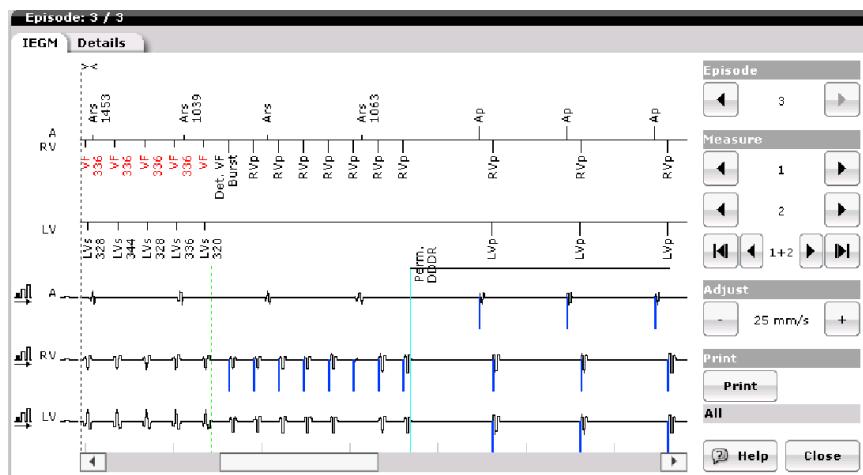


Figure 89: Example of ATP One-shot

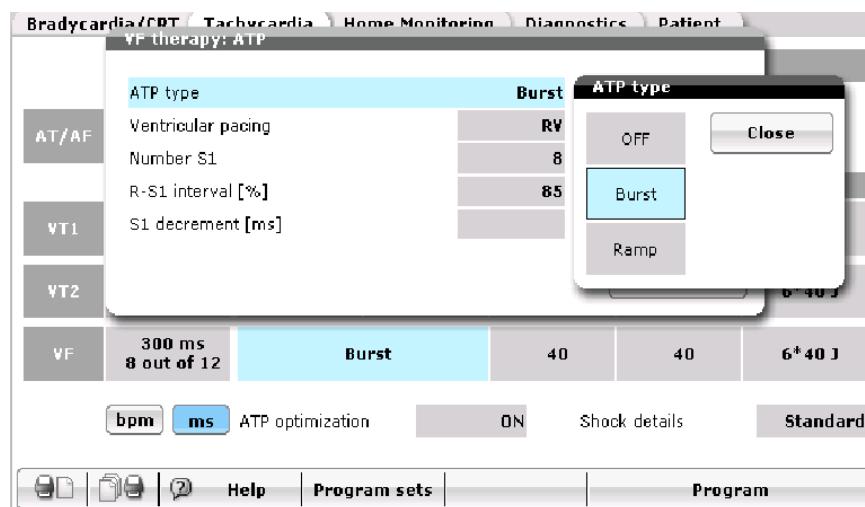


Figure 90: ATP One-Shot type options

### 5.1.3 ATP Optimization

#### ON or OFF

Located on the bottom center of the tachycardia screen and is only programmable when an ATP scheme is programmed.

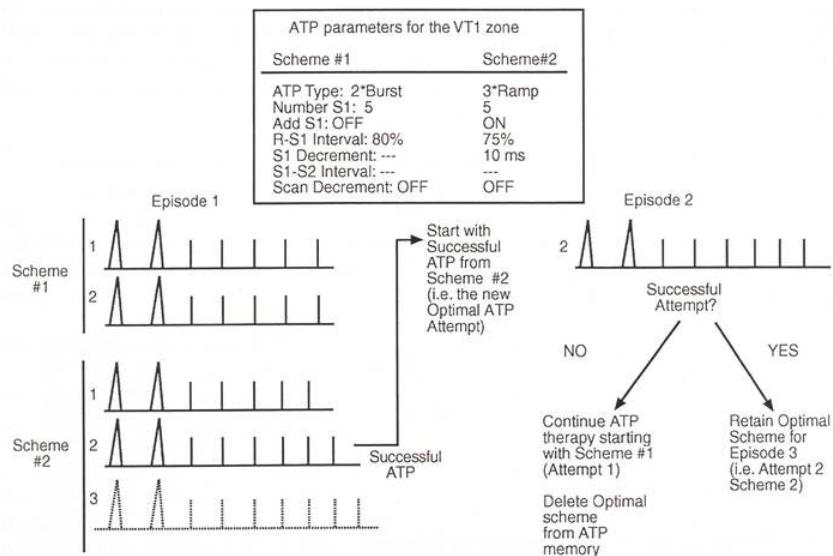
## Chapter 5 Tachyarrhythmia Therapy

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ATP Optimization stores the last successful ATP pacing scheme in device memory and utilizes the stored ATP pacing scheme first for subsequent VT episodes within the same zone. ATP Optimization potentially limits ineffective ATP attempts and reduces time to effective therapy. ATP Optimization applies to all programmed VT zones.

ATP Optimization is programmed in the Tachycardia tab section. The parameter choices will not appear unless an ATP scheme has been programmed. While ATP Optimization cannot be programmed separately for VT1 and VT2, a successful ATP scheme is independently determined for each zone when the parameter is activated. Delivered shock therapy and device reprogramming will reset a stored ATP scheme.

**Figure 91** illustrates ATP therapy progression with ATP Optimization programmed ON. In this case, two ATP schemes are programmed: a Burst scheme with two attempts; and a Ramp scheme with three attempts. During the first VT episode, the device delivers four ATP schemes before the rhythm terminates. The fourth ATP scheme (i.e., the second attempt of the Ramp scheme), therefore, is stored to device memory and becomes the “optimal” ATP attempt. On the following VT episode, ATP therapy begins with the “optimal” ATP attempt - the second attempt in the Ramp scheme. If the “optimal” attempt terminates the episode, the attempt is retained in device memory. If the attempt is unsuccessful and redetection is necessary, then ATP therapy continues beginning with the first attempt in the first ATP Burst scheme (i.e., ATP is re-optimized). Should redetection occur in a different VT zone (i.e., the rhythm accelerates or slows down), then therapy is delivered based on programming for that zone.



**Figure 91: ATP Optimization**

#### NOTE:

The last successful ATP therapy for the zone is stored in memory and is considered an additional ATP scheme. Therefore it is possible to deliver one more ATP than programmed. ATP Optimization is reset in the case of device programming or shock delivery in that zone.

#### NOTE:

In VT zones, the ICD/CRT-D stores successful ATP therapies only. The stored information includes not only the number of the ATP therapy (e.g., ATP2), but also the successful configuration in detail (for example: Burst; R-S1 Interval: 320 ms, S1-S1 Interval: 320 ms; etc.).

### 5.1.4 ATP Help

Found on VT1, VT2, and VF (with ATP One-shot ON) screens

ATP Help is a useful tool to assist the physician in choosing and confirming appropriate ATP programming. When the ATP Help button is pressed, a histogram is displayed on the programmer screen for ATP therapy in the given VT zone. The histogram displays the intervals for each scheme programmed. Placing the cursor over a bar will provide the interval for a given event.

The displayed intervals are based on the programmed zone interval. This interval may be changed to reflect the VT rate for a given patient. To change the interval, select the current VT interval value on the "help" page. A pop-up screen will appear. Choose a specific VT interval. The screen will update to show current values.

An example depicting an ATP Burst and Ramp is shown in [Figure 92](#). To prevent ATP intervals from becoming too short (due to programming of the adaptive parameters) and promoting tachyarrhythmias, a Minimum (ATP) Interval is used. In the Lumax 740 ICD family, the Minimum Interval for the ATP 200 ms for all zones, including the ATP One-shot used in the VF zone.. The Burst is programmed with five S1 pulses and Add S1 programmed ON. The interval lengths are labeled based on a VT rate of 370 ms (as highlighted in the upper center portion of the graph).

The value shown above the cursor indicates the interval based on programming and a specific VT value.

The arrow keys allow the user to move the cursor left and right to view a specific value throughout the ATP schemes.

The thin black horizontal line on the screen indicated the programmed minimum ATP interval of the device.

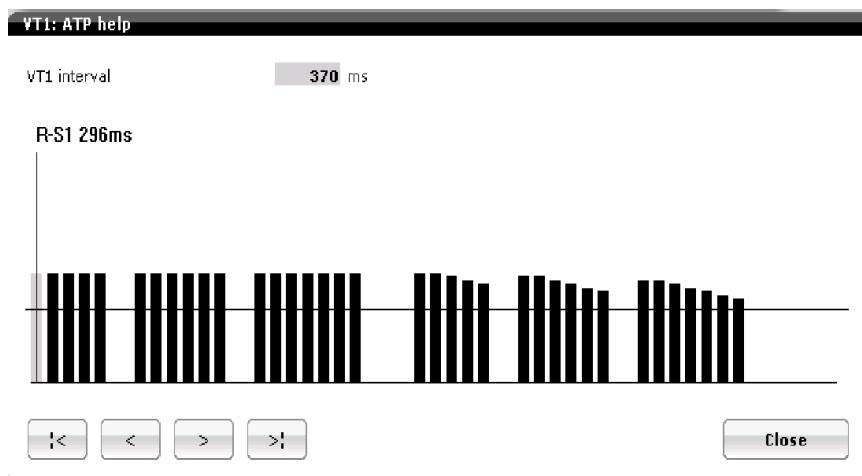


Figure 92: ATP Help

### 5.1.5 Minimum ATP

To prevent ATP intervals from becoming too short (due to programming of the adaptive parameters) and promoting tachyarrhythmias, a Minimum (ATP) Interval is used. In the Lumax 740 ICD family, the Minimum Interval for the ATP 200 ms for all zones, including the ATP One-shot used in the VF zone.

If an ATP pulse within an ATP scheme is calculated such that the S1-S1 interval violates the Minimum Interval (i.e., is shorter than the programmed minimum), the ATP pulse will be delivered at the Minimum Interval and not the calculated interval.

## 5.2 Ventricular Shock Therapy

VT1: OFF, 1,2, 6 or **8** shocks, First two shocks with programmable output

VT2: OFF, 1,2, 6 or **8** shocks, First two shocks with programmable output

VF: 6 or **8**, First two shocks with programmable output †

**Table 11: Shock therapy programming by zone for Lumax 740 ICD/CRT-D**

	VT1	VT2	VF
Programmable shocks per zone	0, 1, 2, 6 or 8	0, 1, 2, 6 or 8	6 or 8
Maximum programmable energy stored (delivered)	40 J (36.9 J)	40 J (36.9 J)	40 J (36.9 J)
Confirmation*	ON/OFF	ON/OFF	ON/OFF
Polarity*	Normal, Reverse, Alternating	Normal, Reverse, Alternating	Normal, Reverse, Alternating
Waveform*	Biphasic/Biphasic 2	Biphasic/Biphasic 2	Biphasic/Biphasic 2
Shock pathway (applies to all zones)	RV→SVC/Can, RV→Can, RV→SVC†		

The Lumax 740 ICD will allow programming of 1-8 shocks in the VF zone for induction testing. This is done through the temporary VF therapy section of the DFT screen.

### 5.2.1 Standard Biphasic Shock Waveform

For the biphasic shock ([Figure 93](#)), the initial charging voltage is 100%, the phase switching voltage is equal to 40% of the initial voltage, and the cutoff voltage is 20% of the initial voltage. The voltage used is automatically calculated based on the programmed shock energy.

Because the waveform is voltage-controlled, the pulse width of each phase varies with the shock lead impedance — the larger the impedance, the longer the pulse width. For a standard biphasic shock waveform, the pulse width maximum limit equals 23 ms for the first shock phase and 17 ms for the second phase.

Sixty percent of the initial voltage is delivered in phase one (i.e.,  $(100 - 40) / 100 = 60\%$  delivered) — also defined as tilt. Fifty percent of the remaining energy is delivered in phase two (i.e.,  $(40 - 20) / 40 = 50\%$  delivered) — also defined as tilt. Therefore, the waveform may be described as a voltage-controlled shock with a (fixed) 60/50 tilt.

\* Confirmation, Polarity and Waveform can be all programmed based on VF zone programming or independently programmed when checking the Configure zones separately box on the Shock details screen.

† Dual coil lead needs be confirmed for this pathway.

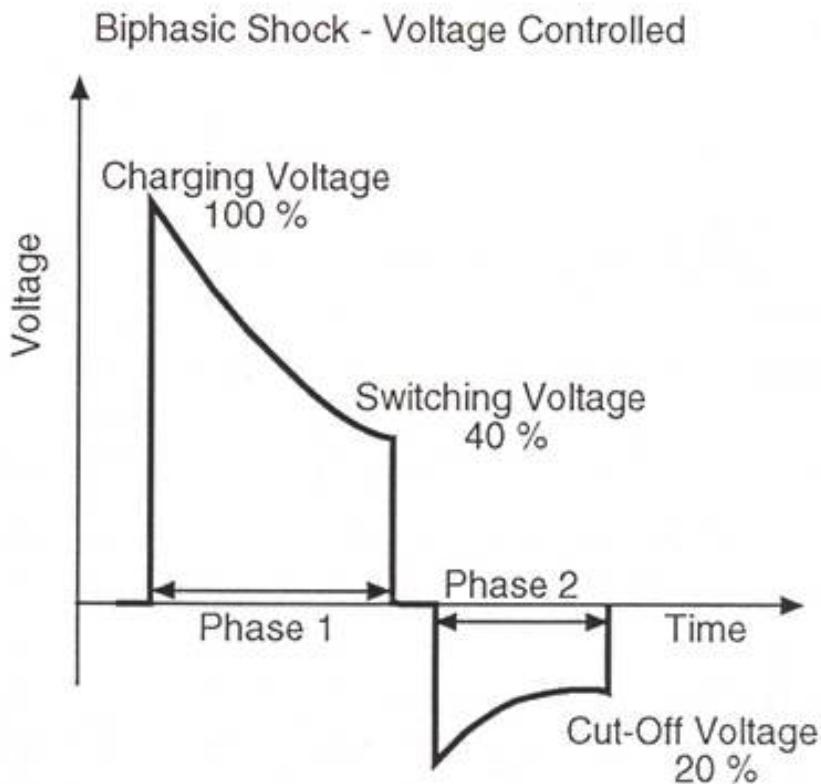


Figure 93: Lumax 740 ICD Biphasic Shock Waveform

### 5.2.2 Biphasic 2 Shock Waveform

For a biphasic 2 waveform ([Figure 94](#)), the initial charging voltage is 100%, the switching voltage is equal to 40% of the initial voltage, and the cutoff voltage for phase 2 is time-controlled at 2 ms. The voltages are automatically calculated based on the programmed energy.

The Biphasic 2 programmable shock waveform option offers an additional option for lowering defibrillation thresholds. A study by Merkely et al. showed have shown that the Biphasic 2 waveform may help lower DFTs in patients on Class III antiarrhythmic drugs\*.

Refer to [Table 12](#) for a summary of shock waveforms offered in Lumax 740 ICDs.

\* Merkely, B., Lubiński, A., Kiss, O., Horkay, F., Lewicka-Nowak, E., Kempa, M., Szabolcs, Z., Nyikos, G., Zima, E., Świątecka, G. and Gellar, L. Shortening the Second Phase Duration of Biphasic shocks: Effects of Class III Antiarrhythmic Drugs on Defibrillation Efficacy in Humans, Journal of Cardiovascular Electrophysiology, Volume 12, No. 7, July 2001: 824-827.

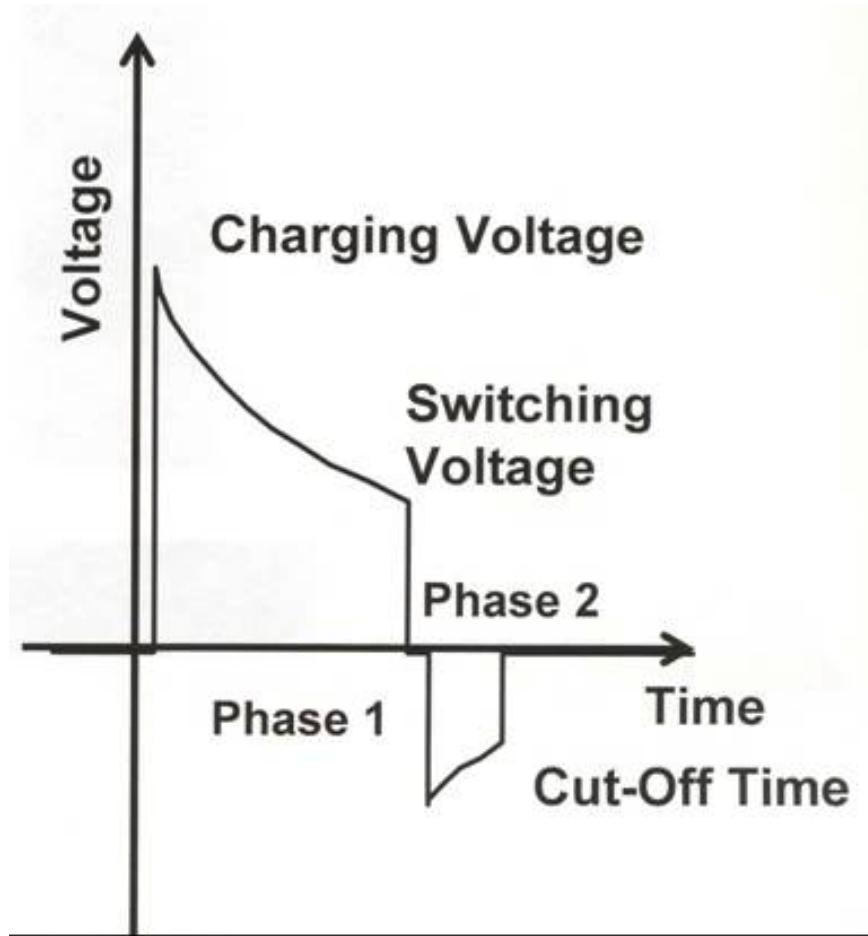


Figure 94: Biphasic 2 shock waveform

Table 12: Lumax 740 Shock Waveforms

Shock Waveform		Phase 1 (Voltage)	Phase 2 (Voltage/Time)
Biphasic	Start	100%	40%
	End	40%	20%
Biphasic 2	Start	100%	40%
	End	40%	2 ms

**NOTE:**

Energy delivery is the same whether Biphasic or Biphasic 2.

### 5.2.3 Maximum Capacitor Charge Time

The maximum capacitor charge time (i.e., capacitor reformations and defibrillation shocks) is 20 seconds. This means that after charging for 20 seconds, the ICD will deliver the energy that is stored on the capacitors, regardless of whether it is fully charged. This could result in delivering less energy for a tachycardia episode than was programmed for the device.

An excessive charge time may be associated with component failure or depleted battery, and the physician or sales representative is alerted that further device analysis is necessary.

## 5.2.4 Uncommitted Shocks (Confirmation ON by default)

Independently programmable by zone when Configure zones separately is selected.

Rhythm classification continues through the charging period when shock Confirmation is programmed to ON. If the device detects three slow intervals (i.e., sinus or brady events) out of four during charge, then the device aborts shock therapy. The device then begins the redetection/termination process. If one fast event is seen after charging but before three slow events is seen, the shock is delivered 30 ms after the tachyarrhythmia event.

Aborted charge energy is slowly released into an internal resistor and may take up to 10 minutes to bleed off. Redetection and shock therapy delivery before the stored energy has bled off may result in a shorter charge time. This is due to a “topping off” of the capacitor as opposed to a full programmed energy charge. The symbol to display the “topping off” of the capacitor is the “^” symbol, which is shown on the shock table page.

Confirmation in Lumax 740 ICDs applies to all shocks within the programmed VT or VF zone. Confirmation can be separately programmable for each therapy zone.

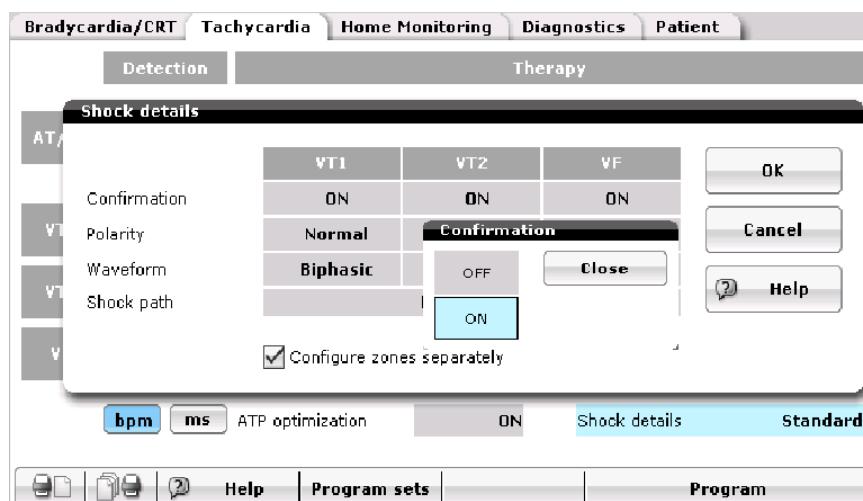


Figure 95: Confirmation

When programmed ON, the first shock in the detected tachycardia zone is uncommitted. Each time a shock is delivered, the next therapy automatically becomes uncommitted. Each time a shock is aborted, the next shock is automatically committed. The device will not allow two aborted shocks in a row to occur. This is a safety feature, should intermittent undersensing of a tachyarrhythmia be present, to prevent therapy inhibition.

[Figure 96](#) shows five different shock scenarios for an uncommitted shock. Shock is delivered in the first three cases, since the abort conditions are not satisfied. In each instance, the shock delivery occurs on a tachyarrhythmia event. The last two examples show aborted shocks.

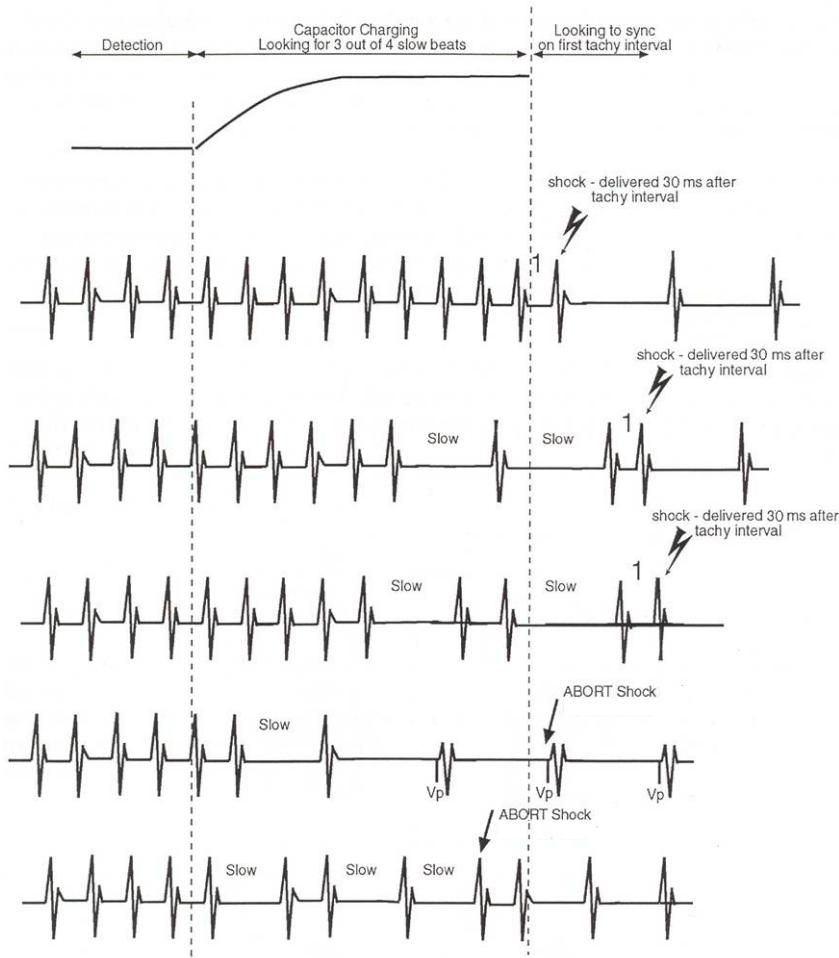
## 5.2.5 Committed Shocks (Confirmation OFF)

Independently programmable by zone when Configure zones separately is selected

A committed shock is a shock delivered after detection and charge. There is no attempt to recheck or verify the rhythm prior to shock delivery. The device tries to synchronize with the first ventricular event (sensed or paced). However, if synchronization is not possible, the device delivers the shock asynchronously within two seconds.

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**Figure 96: Shock delivery with Confirmation programmed ON**

### NOTE:

Pacing events, as well as sinus events, are seen as “slow” events. Therefore, if the rhythm breaks during charging and pacing results, shock therapy aborts after three paced beats.

**Table 13: Lumax 740 Shock Types**

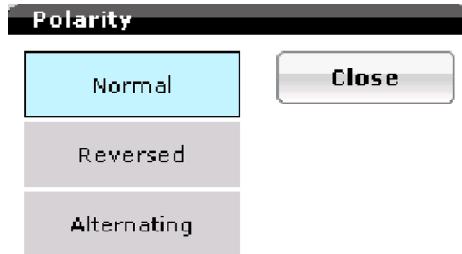
Shock Type	Confirmation	Shock Delivery
Committed	OFF	R-wave synchronization attempted Shock can NOT be aborted/dumped
Uncommitted	ON	R-wave synchronization attempted Shock aborted/dumped if 3 out of 4 intervals are slower than the slowest tachy therapy zone during the charge One fast tachy event after charging is required to deliver energy

### 5.2.6 Shock Polarity

**Normal, Reversed or Alternating**

Independently programmable by zone when Configure zones separately is selected.

The shock polarity refers to the direction of current flow between electrodes during shock delivery. The Shock Polarity parameter is programmable to Normal, Reversed, or Alternating within each tachyarrhythmia zone (e.g., it can be programmed for all shocks within VT1, VT2 and the VF zone). Because the shock polarity can significantly affect defibrillation thresholds in some patients, the DFT may be tested in more than one configuration.



**Figure 97: Polarity choices**

When a single-coil lead is implanted and polarity is programmed to Normal, current flows from the active can — the anode — to the distal shock coil in the ventricular apex — the cathode. When the polarity is programmed to Reversed, the current flows from the shock coil in the ventricular apex to the active can. This reverses the polarity of the two shock phases in the biphasic waveform so the first phase is negative and the second phase positive.

When a dual-coil lead is implanted and the polarity is programmed to Normal, then current flows from the “hot can” to the ventricular apex, as well as from the proximal shock coil to the ventricular apex. The active can and the SVC coil are always electrically tied together. If the configuration is Reversed, current flows in the opposite direction.

When programmed to Alternating, the device starts with Normal polarity and will switch back and forth between Normal and Reversed, as described above, after the first maximum energy shock is delivered.

**NOTE:**

Alternating waveforms begin alternating after the first maximum energy shock therapy is delivered.

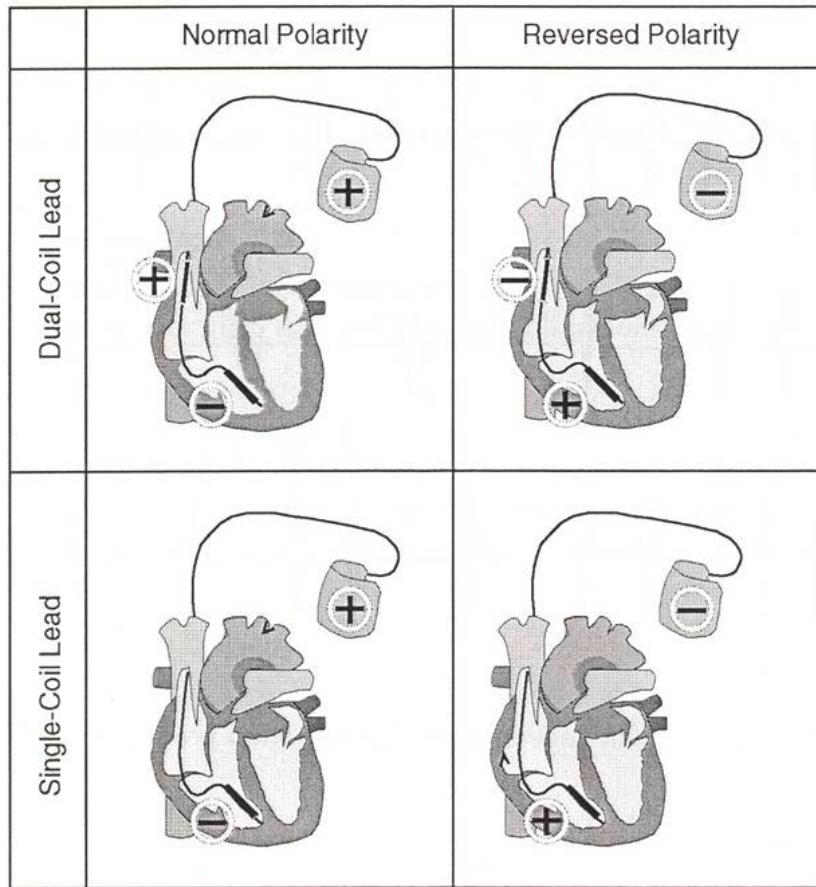


Figure 98: Normal and Reversed shock polarities

### 5.2.7 Shock Pathway Programming for the Lumax 740 series ICD/CRT-D

The Lumax 740 ICD/CRT-Ds allow the user to program different shock vectors to provide additional options for patients with high DFTs. The device provides shock pathway configurations, as seen in [Figure 99](#). If selecting the RV to SVC option, a release button will appear asking the user to select “release”. This is designed to remind and prevent users from selecting this option when a single-coil lead is implanted.

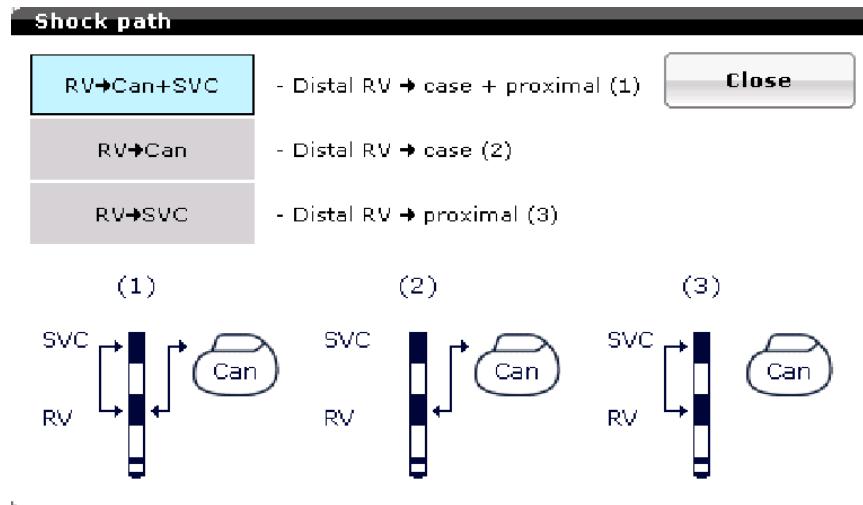


Figure 99: Programmable Shock pathways

### 5.3 Therapy Progression

Progressive Course of Therapy is automatically enabled (ON) whenever a VT Zone therapy is activated.

Therapy within an episode will always be delivered more aggressively with Progressive Course of Therapy. Once shock therapy is delivered, all ATP therapy in the VT zone is suspended, allowing therapy to progress to programmed shock therapy. As illustrated in [Figure 100](#), if shock therapy is delivered and redetection occurs within a slower zone (with the shock energy less than or equal to that of the first shock), then therapy will continue with the next greater output shocks through termination.

The full complement of shocks is available in the lower zone. In the scenario shown in [Figure 100](#), each zone has six shocks programmed. If the 25 joule shock in the VF zone results in a VT1 tachycardia, the device will be able to deliver six shocks in the VT1 Zone for a total of seven shocks for the episode.

Note: ATP therapy MUST be supported by shock therapy in the VT zone to facilitate progressive course of therapy. (For example, if shock therapy was not programmed in the example below, ATP therapy would be skipped upon VT1 redetection leaving no therapy in the VT1 zone. Therapy would continue only with redetection in the VF zone.)

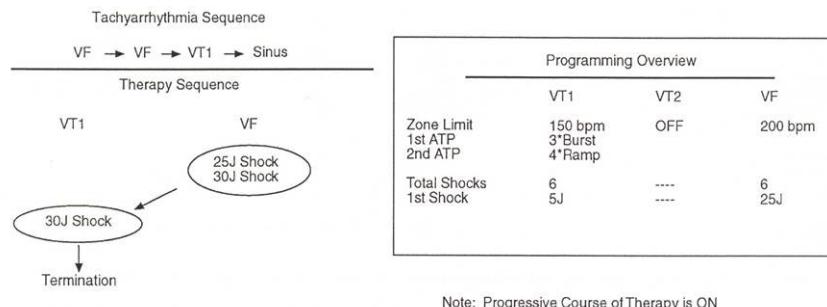


Figure 100: Therapy sequence with Progressive Course of Therapy

## 5.4 Post-Shock Pacing

Nominal: DDI mode, 60 bpm, AV Delay 140 ms, 10-second duration, 7.5 volts @ 1.5 ms (non-programmable), RV pacing.

**Table 14: Post shock pacing**

Post-shock duration	OFF, <b>10 s</b> , 30 s, 1 min, 2 min, 5 min, 10 min
Post-shock mode	<b>DDI</b> , VDI (VVI for Lumax VR-T and VR-T DX)
Post-shock basic rate (bpm)	30 ... (5) ... <b>60</b> ... (5) ... 100 ... (10) ... 160 bpm
Post-shock AV delay (ms)	50 ... (10) ... <b>140</b> ... (10) ... 350 ms (740 DR-T and 740 HF-T)
Post-shock ventricular pacing	<b>RV</b> , BiV (Lumax 740 HF-T)

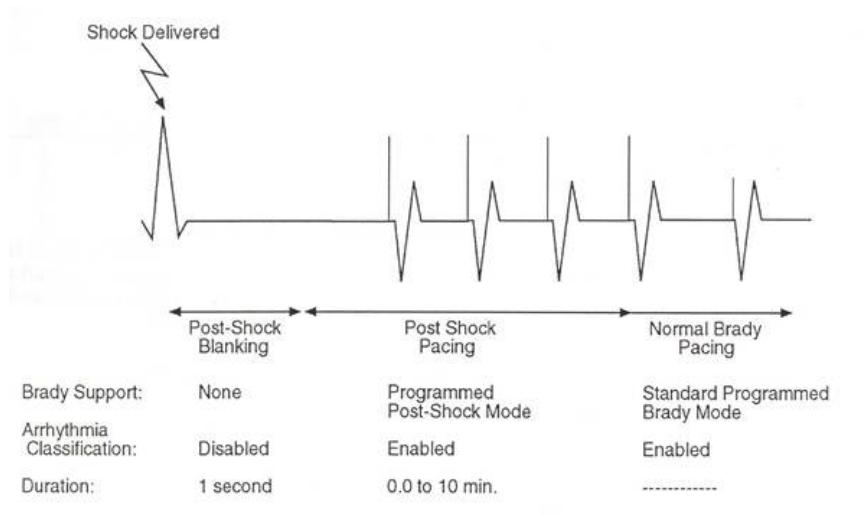
A one-second post-shock blanking period follows each shock delivery (i.e., blanking does not follow aborted shocks). During the blanking period there is no detection, which limits possible polarization effects being sensed as an arrhythmia. At the conclusion of the post-shock blanking period, Post-Shock Pacing begins.

Post-Shock Pacing is delivered in the DDI mode when the Normal Pacing mode is DDD(R), DDI(R), or AAI(R). The Post-Shock mode is VDI when the Normal Pacing mode is VDD(R) or VDI(R). When the Normal Pacing mode is VVI(R), the Post-Shock Mode is VVI.

The Post-Shock Pacing duration is programmable in time between OFF and 10 minutes, with a default of 10 seconds. After the Post-Shock Pacing period is complete, normal bradycardia pacing resumes.

(See [Figure 101](#))

The Lumax 740 HF-T allows biventricular pacing to be programmed during the post-shock period.



**Figure 101: Post-Shock Blanking and Pacing**

### NOTE:

If the Post-Shock pacing rate is programmed higher than the basic rate, the pacing rate will gradually decrease using the sensor rate decrease value once the post-shock pacing time has expired. This prevents sudden drops in pacing rates.

### 5.4.1 Shock Energy

The Lumax ICDs/CRT-Ds are designed to charge to the energy selected on the programmer screen, but similar to all other commercially available ICDs/CRT-Ds, the actual therapy delivered is somewhat less depending on several factors including the shock lead impedance. The first two shock energies in each therapy class are programmable between 2 joules and maximum energy for the first shock and 4 joules and maximum energy for the second shock. The energy of the second shock is always greater than the first shock. The remaining shock energies will be delivered at maximum programmable energy.

Actual energy delivered for each programmable shock energy is approximately equal to the “Energy Delivered” for the high energy Lumax 740 models in [Table 15](#).

**Table 15: Delivered Shock Energy (Lumax 740 HF-T)**

Programmed Energy (joules)	Approximate Delivered Energy (joules)
1	0.9
2	1.8
3	2.7
4	3.7
5	4.5
6	5.4
7	6.5
8	7.3
9	8.3
10	8.8
11	10.0
12	10.9
13	11.6
14	12.7
15	13.4
16	14.4
18	16.3
20	18.0
22	19.9
24	22.3
26	24.2
28	25.9
30	28.1
32	29.6
34	31.4
36	33.7
38	35.2
40	36.9

## CAUTION

**Shock Impedance** - If the shock impedance is less than twenty-five ohms ( $25 \Omega$ ), reposition the lead system to allow a greater distance between the electrodes. Never implant the device with a lead system that has measured shock impedance as less than twenty-five ohms ( $25 \Omega$ ). Damage to the device may result.

**Defibrillation Threshold** - Be aware that changes in the patient's condition, drug regimen, and other factors may change the defibrillation threshold (DFT), which may result in non-conversion of the arrhythmia post-operatively. Successful conversion of ventricular fibrillation or ventricular tachycardia during arrhythmia conversion testing is no assurance that conversion will occur post-operatively.

**Shock Therapy Confirmation** – Programming CONFIRMATION to OFF may increase the incidence of the ICD/CRT-D delivering inappropriate shocks.

## 6. Bradycardia Therapy

The Lumax 740 ICDs/CRT-Ds have independently programmable single, dual and triple chamber and post-shock pacing functions. The post-shock bradycardia parameters may be programmed to higher rates or output values for the period following a delivered shock, without significantly compromising the longevity of the ICD/CRT-D for patients who require chronic bradycardia pacing. The post-shock programmable values are presented [Section 5.4](#) from the normal bradycardia pacing support values.

### 6.1 Bradycardia Pacing Modes

The available bradycardia pacing modes for each member of the Lumax ICD/CRT-D family are listed in [Table 16](#).

Table 16: Lumax Pacing Modes				
Mode	Lumax HF-T	Lumax DR-T	Lumax VR-T	Lumax VR-T DX
DDDR	X	X	N/A	N/A
DDIR	X	X	N/A	N/A
VDDR	X	X	N/A	X
VDIR	X	X	N/A	X
AAIR	X	X	N/A	N/A
VVIR	X	X	X	X
DDD	X	X	N/A	N/A
DDI	X	X	N/A	N/A
VDD	X	X	N/A	X
VDI	X	X	N/A	X
DOO	X	X	N/A	N/A
VOO	X	X	X	X
AAI	X	X	N/A	N/A
VVI	X	X	X	X
OFF	X	X	X	X

The basic rate timer is started by a sensed or paced event. A sensed event outside of the refractory period inhibits pacing and resets the lower rate time; in the absence of a sensed event, a pacing pulse will be delivered at the end of the lower rate interval.

The pacing modes with an “R” indicate rate adaptive pacing controlled by a motion based capacitive sensor. These modes are functionally the same as the corresponding non-rate-adaptive modes, except that the pacing rate is increased based on physical activity.

### 6.2 Basic and Hysteresis Rates

Basic Rate: 30... (5)...**60**...(5)...100... (10)...160 bpm (DR-T and HF-T)

Basic Rate: 30... (5)...**40**...(5)...100... (10)...160 bpm (VR-T and VR-T DX)

Basic rate			
	30	35	40
45	50	55	60
65	70	75	80
85	90	95	100
110	120	130	140
150	160		

Figure 102: Basic Rate

Rate Hysteresis: OFF, -5... (-5)... -65 bpm

Rate hysteresis	
OFF	-5
-10	-15
-20	-25
-45	-65

Figure 103: Rate Hysteresis

Both a Basic Rate and a Hysteresis Rate may be programmed for the normal bradycardia pacing. The Hysteresis Rate, lower than the Basic Rate, is the lowest intrinsic rate permitted before the device begins pacing. With a hysteresis rate programmed, two escape intervals are created. The first escape interval is controlled by the lower rate timer and begins after paced events. The second escape intervals are determined by the hysteresis escape interval and after intrinsic events (Figure 104). The Basic Rate may be programmed between 30 and 160 bpm, while the Hysteresis Rate may be programmed between -5 and -65 bpm (or to OFF).

#### NOTE:

A conflict message appears if the combination of the Basic Rate and the Hysteresis Rate is less than 30 bpm.

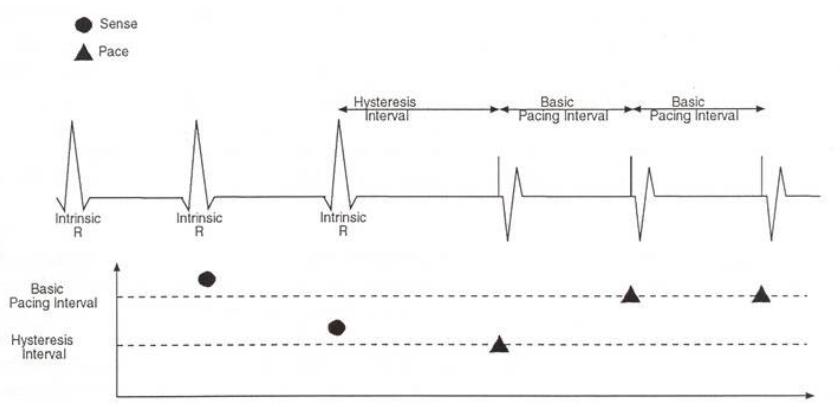


Figure 104: The Basic and Hysteresis intervals with VVI pacing

### 6.2.1 Scan and Repetitive Rate Hysteresis

Scan/Repetitive Hysteresis: OFF; ON at 10 events (non-programmable)

Both Scan and Repetitive Rate Hysteresis are available in the Lumax 740 ICD. These features encourage a patient's own rhythm, periodically allowing for or looking for intrinsic activity.

Scan Rate Hysteresis searches for a spontaneous rhythm during long periods of pacing. The algorithm is activated after 180 consecutive paced events. After this time, the device will pace at the slower hysteresis rate for 10 consecutive beats. If intrinsic activity does not occur above the hysteresis rate, then pacing will continue at the programmed bradycardia rate.

When Repetitive Rate Hysteresis is activated and pacing has been inhibited for at least 180 beats and the rate drops to the hysteresis rate, the device will pace consecutively for 10 beats at the slower hysteresis rate. If intrinsic activity is found, pacing will be inhibited until the rate falls again below the hysteresis rate. If no intrinsic activity is present, pacing will resume at the programmed basic rate.

**NOTE:**

Scan and Repetitive hysteresis are not independently programmable.

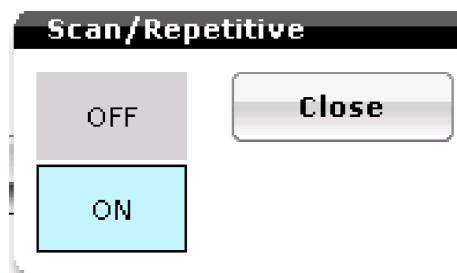


Figure 105: Scan/Repetitive Hysteresis choices

**NOTES:**

If rate adaptation is active, the Hysteresis rate is based on the current sensor-indicated rate and the value of the programmable parameter. If Hysteresis is used in the DDI mode, the AV delay must be programmed shorter than the spontaneous AV conduction time. Otherwise, stimulation in the absence of spontaneous activity occurs at the hysteresis rate instead of the lower rate. Night Rate is the limit for the Hysteresis when Night Mode is active. Programming conflicts arise when the total decrease in rate is below 30 bpm. Care should be exercised to avoid programming a Night Mode rate and hysteresis that are below what is appropriate and may be tolerated by the individual patient.

**NOTE:**

Repetitive and Scan Hysteresis are only available when Hysteresis is selected ON. There is one Standard Hysteresis interval which occurs before the programmable number of Repetitive Hysteresis.

## 6.2.2 Night Rate

**OFF**, 30 ... (5) ... 100 bpm

To reduce the pacing rate to match decreased metabolic needs during sleep, the Lumax 740 ICD can be programmed to Night Rate. When Night Rate is active, the base pacing rate automatically decreases during the programmed nighttime hours. The Night Rate is programmable from 30 to 100 bpm. When Night Rate is started, the base pacing rate will be reduced by the rate sensor decrease value to the Night Rate value.

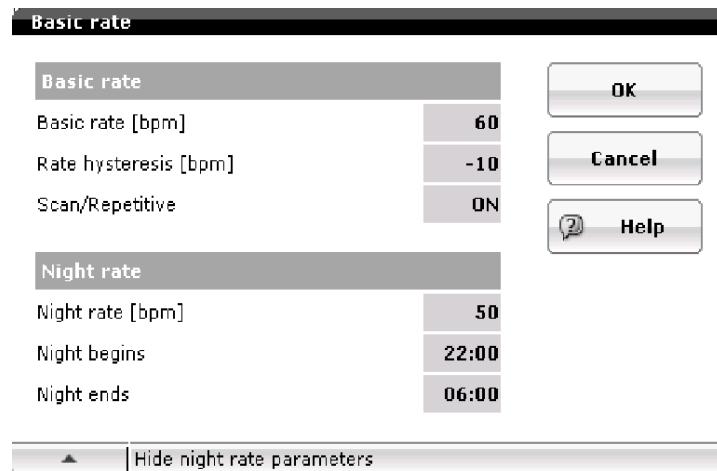


Figure 106: Night rate screen

**NOTE:**

During the Night Program, Rate Hysteresis is limited to the night rate mode. All AV hysteresis options remain as programmed. The Night Program remains in effect in Magnet mode.

**NOTE:**

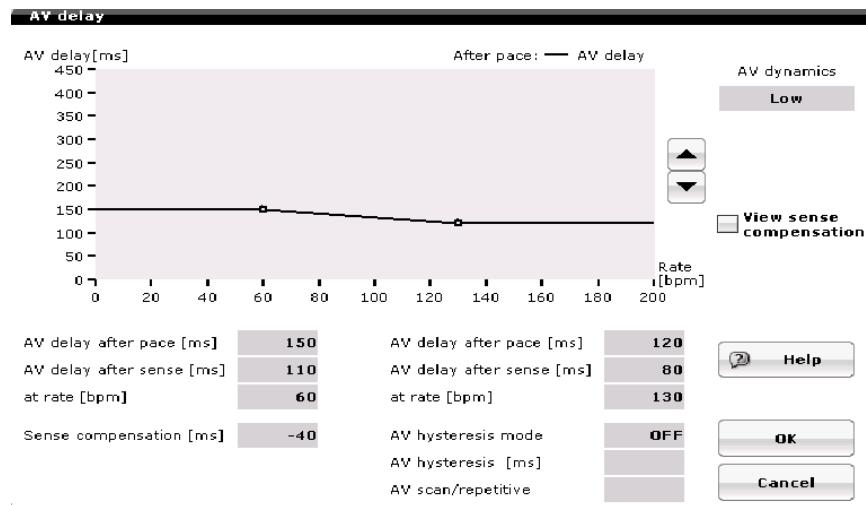
The Night Mode time is based on the programmer clock. Therefore, the programmer time should be checked prior to device programming. If a patient travels across different time zones, the Night Mode time may require adjustment.

### 6.3 Dynamic AV Delay

Table 17: Lumax Dynamic AV Delay

Dynamic AV Delay Default (ms) for Lumax 740 HF-T			
Rate	Low	Medium	High
60 bpm – Lower Rate	150	140	130
130 bpm – Upper Rate	120	100	80
Dynamic AV Delay Default (ms) for Lumax 740 DR-T			
Rate	Low	Medium	High
60 bpm – Lower Rate	180	180	180
130 bpm – Upper Rate	140	100	80

The AV Delay is the interval between an atrial event and the following ventricular event. During normal intrinsic activity, the PR interval (i.e., the intrinsic AV Delay) shortens as the heart rate increases, producing a ventricular filling time that is proportionate to the ventricular ejection time.



**Figure 107: Dynamic AV Delay**

Dynamic AV Delay automatically adjusts the AV interval based on the current heart rate. There are three different pre-defined settings (Low, Medium, and High), as shown in [Table 17](#). In addition, the AV Delay may be Fixed across all heart rate bins, or Dynamic, which allows the user to customize the AV Delay for each heart rate zone — this is referred to as Individual on the programmer screen.

In addition to changing the numerical values, AV Delays and Rates for AV Delay changes can be made on the screen by selecting the small circles ([Figure 107](#)) on the graph with the pen and sliding it up and down to change AV Delay or left to right to change the rate at which AV Delays will change.

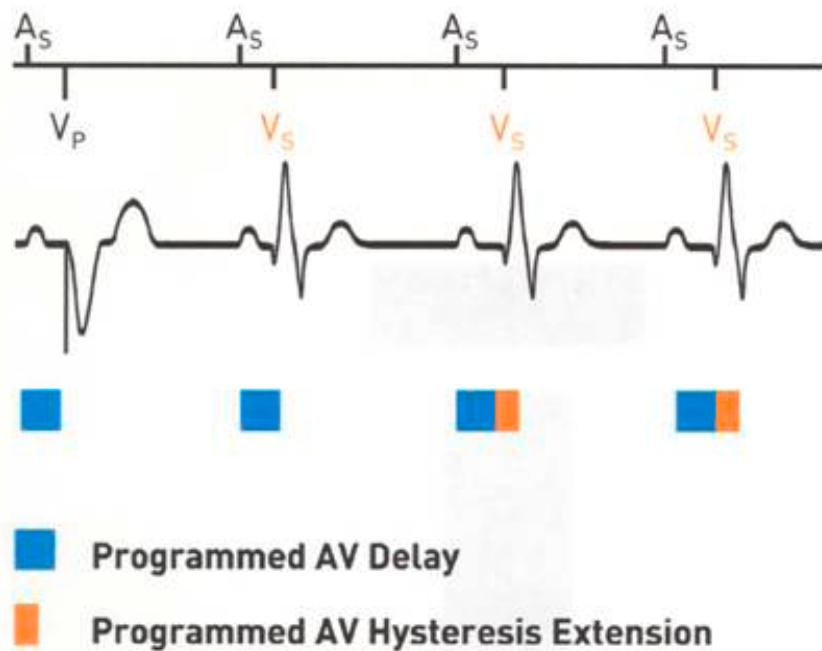
### 6.3.1 AV Hysteresis with Scan/Repetitive

Scan/Repetitive Hysteresis: OFF; **ON** at 5 events (non-programmable)

This function should not be used in Lumax 740 HF-T because it could influence proper CRT pacing negatively.

With AV Hysteresis ON, the AV Delay is extended to the programmed hysteresis delay after every Vs event to encourage intrinsic conduction; see [Figure 108](#):

- If a Vs event is detected, the extended AV delay remains intact.
- If no Vs event is detected, the AV delay returns to its original programmed setting.
- AV Extension programmable: 70, 110, 150 or 200 ms



**Figure 108: AV Hysteresis**

By adding the Repetitive enhancement, the extended AV delay remains in effect for 5 repetitive cycles to help maintain intrinsic conduction. A Vs event triggers the first AV delay extension and starts the counter at zero.

During a Repetitive Sequence (refer to [Figure 109](#)):

- Each Vs event will reset the repetitive counter and initiate the extended AV delay (see green arrow in [Figure 109](#)).
- If no Vs event occurs, the AV delay remains extended until the repetitive count of Vp is met.

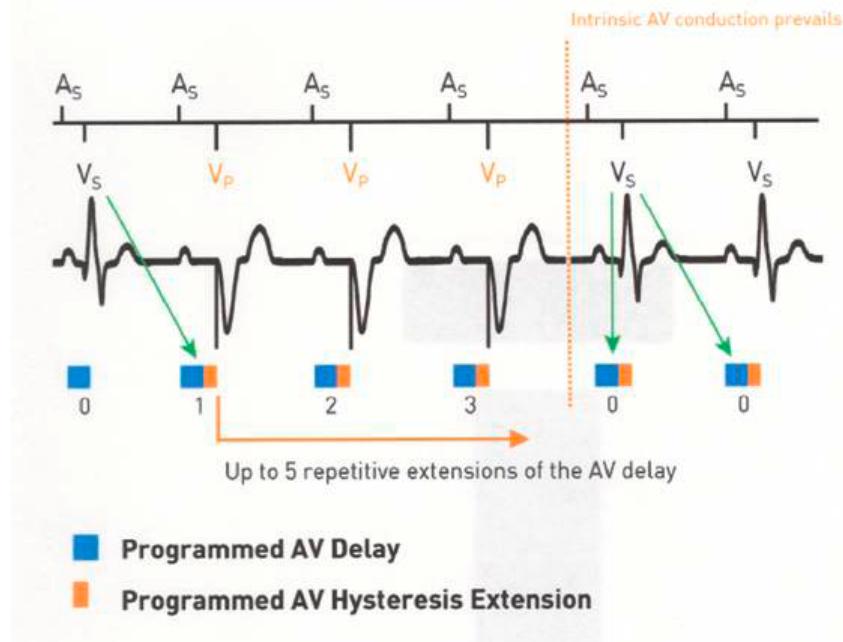


Figure 109: Repetitive Hysteresis

By adding the Scan enhancement, after 180 consecutively paced cycles, the AV delay is extended for 5 pacing cycles

- Each Vs event will reset the scan counter and initiate the extended AV delay (see green arrow in [Figure 110](#)).
- If no Vs event occurs, the AV delay remains extended until the scan count is met.

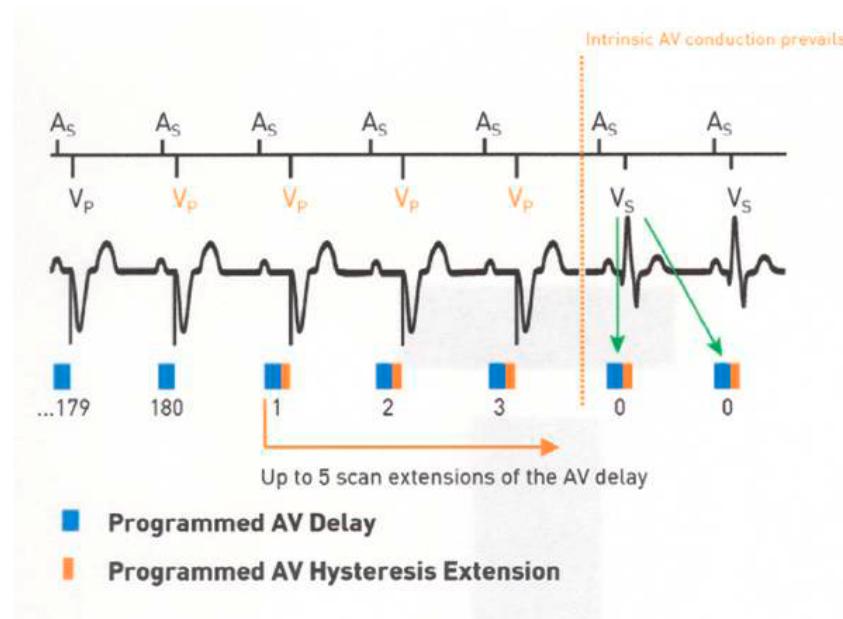


Figure 110: AV Scan Hysteresis

To program Positive AV Hysteresis ON:

1. Press AV hysteresis mode to select Positive hysteresis.
2. Select the AV Hysteresis value desired. The choices are 70, 110, 150, 200 ms.

3. AV scan/repetitive is automatically ON when Positive hysteresis is selected.

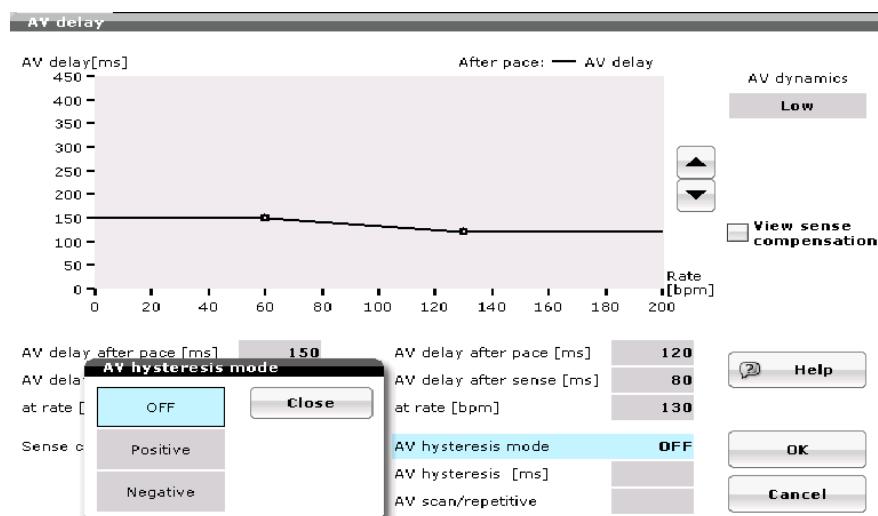


Figure 111: Dynamic AV delay screen with AV hysteresis choices

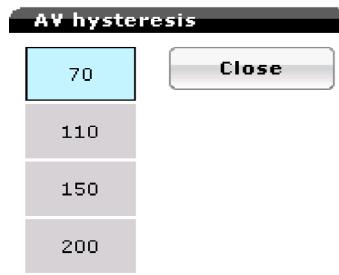


Figure 112: AV hysteresis



Figure 113: AV scan/repetitive

### 6.3.2 Negative AV Hysteresis

AV Hysteresis: 10 ... (10) ... 50...(10)... 150 ms

The intent of Negative AV Hysteresis ([Figure 114](#)) is to reduce the chance of intrinsic activity occurring in patients with Hypertrophic Cardiomyopathy (HCM) or Heart Failure patients when trying to optimize the AV Delay for maximum cardiac output. The feature allows the user to program a shorter AV Delay (10-150 ms) when intrinsic activity breaks through to maintain pacing. After 180 paced ventricular events at the shortened AV Delay, the device returns to the programmed AV Delay. This feature is not required in patients with third-degree heart block or post AV nodal ablation, as there is little risk of intrinsic activity occurring.

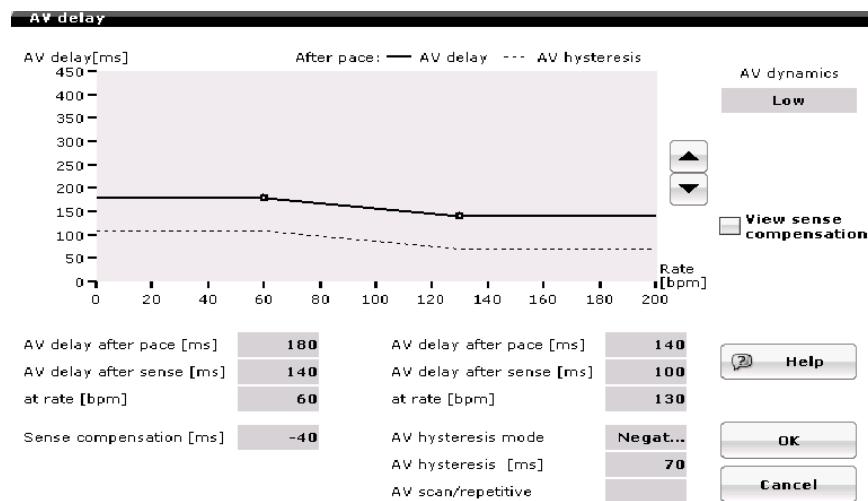


Figure 114: Negative AV Hysteresis

## CAUTION

**Negative AV Hysteresis** – This feature insures ventricular pacing, a technique which has been used in patients with hypertrophic obstructive cardiomyopathy (HOCM) with normal AV conduction, in order to replace intrinsic ventricular activation. No clinical study was conducted to evaluate this feature, and there is conflicting evidence regarding the potential benefit of ventricular pacing therapy for HOCM patients. In addition, there is evidence with other patient groups to suggest that inhibiting the intrinsic ventricular activation sequence by right ventricular pacing may impair hemodynamic function and/or survival.

### 6.3.3 Sense Compensation

OFF, -5 ... (-5) ... **-40**...(-5)... -120 ms

When Sense Compensation is activated, the AV Delay following an atrial sensed event differs from the AV Delay following an atrial paced event. The AV Delay after a sensed event is shortened by a programmed value (i.e., between -5 and -120 ms) to provide a similar PR interval, whether atrial depolarization is accomplished by pacing or intrinsic activity. Sense Compensation is programmed in the AV Delay window.

## 6.4 I-Opt (Lumax 740 DR-T and Lumax 740 VR-T DX)

Programmable from the AV hysteresis parameter screen in the Lumax 740 DR-T and VR-T DX ICDs

Long AVD – 400 ms (fixed)

Scan/Repetitive Hysteresis – ON (fixed - set at 5 events)

I-Opt (intrinsic optimization) is a feature found in the Lumax 740 DR-T and VR-T DX ICDs to promote ventricular intrinsic rhythm. The feature is found under the AV hysteresis parameter. When programmed, the hysteresis AV Delay is set to a fixed value of 400 ms, regardless of programmed AV Delay. It uses the AV Hysteresis functions as described in [Section 6.3](#), with fixed scan and repetitive AV hysteresis values of 5.

### NOTE:

This feature is not available in the Lumax 740 VR-T/HF-T devices.

## Chapter 6 Bradycardia Therapy

Lumax 740 Technical Manual

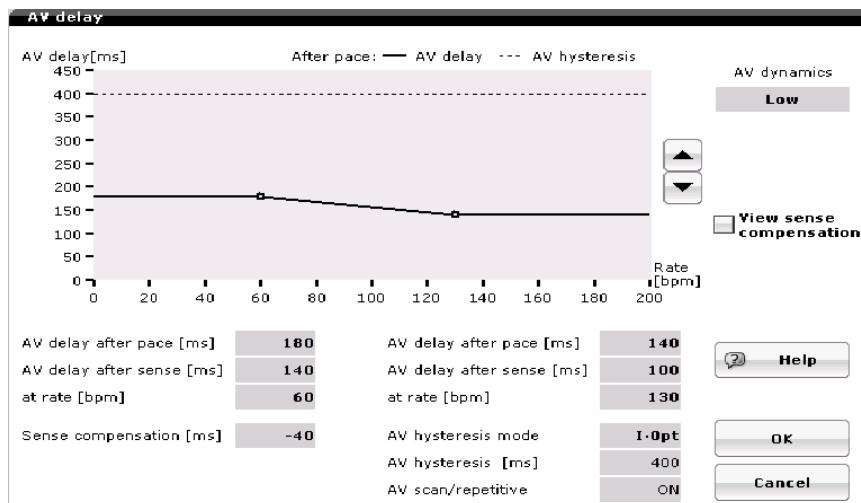


Figure 115: AV Delay Screen with I-Opt ON

## 6.5 Rate Adaptation

The Lumax 740 ICD/CRT-D uses a capacitive accelerometer as its activity sensor. The sensor drives the generator to pace according to a patient's physical demands (i.e., the higher the demand, the higher the pacing rate). The sensor rate can be optimized for each patient by specifying both a Sensor gain and Sensor threshold.

### 6.5.1 Maximum Sensor Rate

80...(10)...**120**...(10)... 160 bpm

The maximum sensor rate is the highest pacing rate that may be achieved with sensor activity and should be programmed based on the patient's activity level. This value must be less than the programmed Upper tracking rate value.

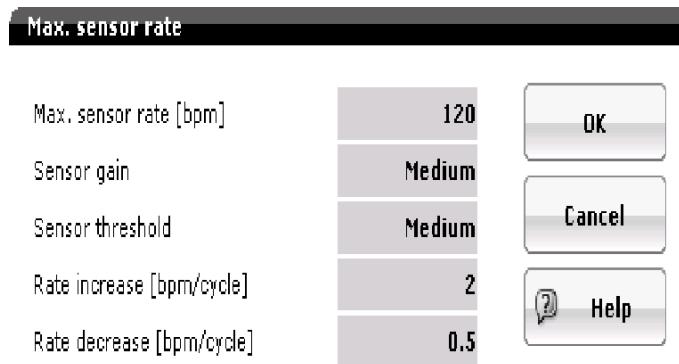


Figure 116: Sensor Parameter Screen

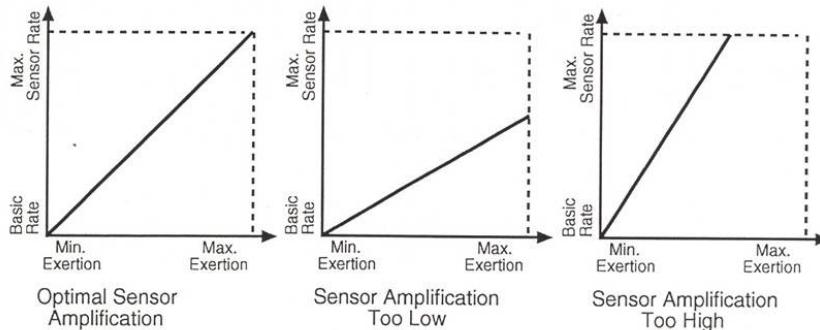
### 6.5.2 Sensor Gain

Auto, Very low (1.3), Low (3), **Medium** (6), High (12), Very High (26)

#### NOTE:

Numbers in parenthesis are not shown on the programmer screen.

The Sensor Gain, also known as response factor, defines how much the sensor signal is amplified before it is transformed to a rate change. The Sensor Gain can be programmed to Auto or to a fixed setting. When the Sensor Gain is Very low (1.3), a great deal of exertion is needed to cause a significant change in sensor output and a subsequent change in the pacing rate. When the Sensor Gain is Very high (26), little exertion is needed to increase the sensor output. Ideally, the gain should be programmed so that the maximum desired pacing rate during exercise occurs at a maximum exertion level as shown below in [Figure 117](#).

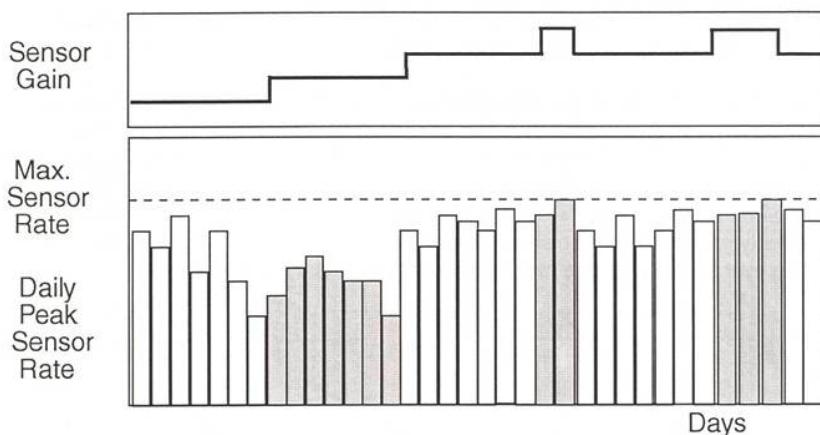


**Figure 117: Sensor Gain**

When the Sensor gain is programmed to Auto, the sensor is designed to adjust the gain setting automatically based on the patient's activity level. The gain will increase in value (more aggressive) if the patient has not reached 90% or more of the maximum sensor rate for 60 minutes in a seven-day period. If the criterion is met, then the sensor gain is reduced by one gain setting. Conversely, if 90% of the maximum sensor rate is reached for 30 minutes within a 24-hour period, the gain decreases by one setting (less sensitive). See [Figure 118](#) for an example of Automatic Sensor Gain.

**NOTE:**

This feature is not recommended for patients who exhibit little or no physical activity as their pacing rate can change dramatically with sudden movement due to the change in sensor gain.



**Figure 118: Auto Sensor Gain**

### 6.5.3 Sensor threshold

Very low, Low, **Medium**, High and Very high

The device ignores all activity that occurs below the sensor Threshold. In other words, the Threshold defines the lowest sensor input that initiates a change in the pacing rate. The basic rate will be used for pacing at rest when the threshold is programmed optimally.

### 6.5.4 Rate Increase/Decrease

The Rate Increase and Rate Decrease parameters work with Sensor Gain to determine how quickly the pacing rate increases or decreases with changes in the sensor output. There are four different Rate Increase settings (1, **2**, 4, or 8 bpm/cycle) and four different Rate Decrease settings (0.1, 0.2, **0.5** or 1.0 bpm/cycle).

## 6.6 Upper Rate Behavior

90 ... (10) ... **130**...(10)... 160 bpm

In atrial-tracking pacing modes (i.e., DDD(R) and VDD(R) modes), the upper tracking rate (UTR) defines the fastest rate that the device tracks an intrinsic P-wave on a 1:1 basis. The upper tracking rate must be slower than the lowest tachyarrhythmia zone.

When the atrial rate surpasses the UTR, one of two different responses may occur, depending on the programmed PVARP value and the AV Delay. Both responses — 2:1 block and (pacing) Wenckebach — prevent the device from pacing the ventricle faster than the programmed UTR.

In the pacing Wenckebach scenario, ventricular pacing is maintained at UTR as the atrial rate exceeds UTR. Ventricular pacing continues at the UTR until the atrial interval falls within PVARP+AV Delay (i.e., until a block mode emerges) or until Mode Switching occurs.

In a 2:1 block scenario, the ventricular pacing rate is half the atrial rate, as every other atrial event falls into the refractory period. The 2:1 ratio between the atrial and ventricular rate is maintained until the atrial rate reaches the Mode Switch Intervention Rate. At a rate greater than this limit, ventricular pacing occurs in a non-tracking mode at the sensor indicated rate or basic rate.

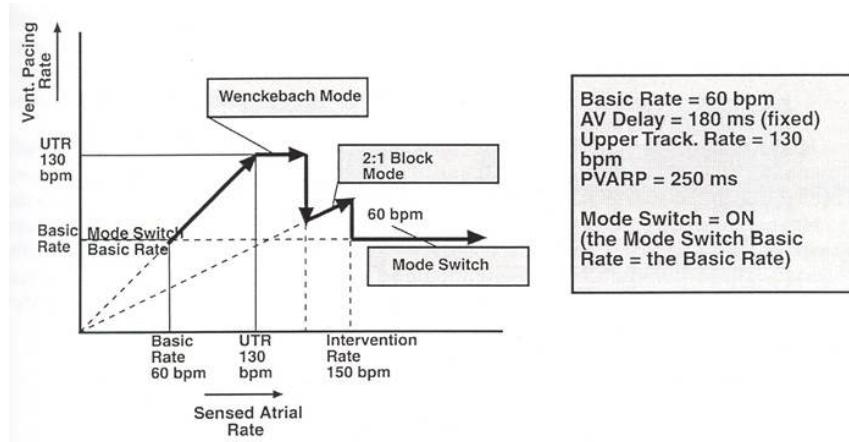


Figure 119: Upper Rate Behavior

[Figure 119](#) shows an example of upper rate behavior in the Lumax 740 ICD. In this case, the Basic Rate equals 60 bpm and the UTR equals 130 bpm. Therefore, the intrinsic atrial rhythm is tracked on a beat-to-beat basis up to 130 bpm. Because the AV Delay is fixed at 180 ms and PVARP equals 250 ms,

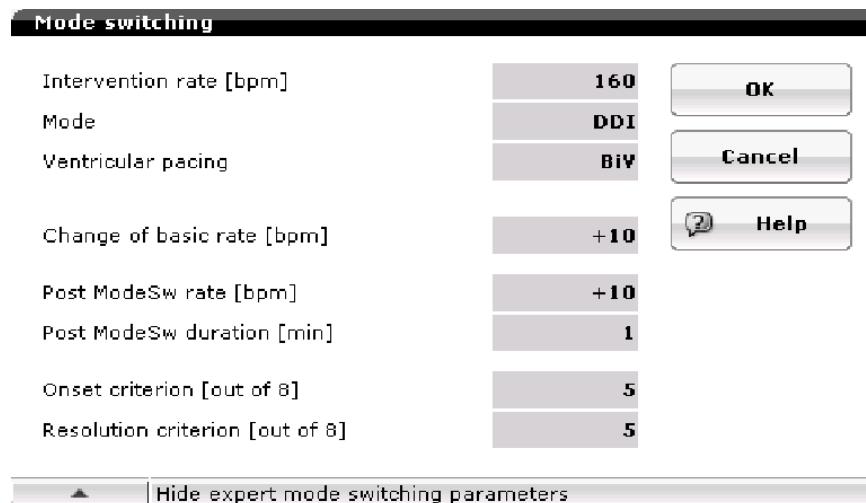
Wenckebach pacing occurs between 130 bpm (i.e. UTR) and 140 bpm (i.e. 140 bpm = 430 ms = 180 ms + 250 ms). Between 140 and 150 bpm, a block pattern emerges in which every other atrial beat is tracked. At 150 bpm, Mode Switch occurs and ventricular pacing begins at 60 bpm.

**NOTE:**

In this example, there is no separate Mode Switch Basic Rate. When Mode Switch occurs, the rate equals the Normal Basic Rate.

## 6.7 Mode Switching

Mode switching parameters are shown in [Figure 120](#).



**Figure 120: Mode Switching Screen**

Mode Switching is designed to avoid tracking of the atrial signal during atrial tachyarrhythmias. In the presence of a high atrial rate, the normal bradycardia mode is automatically reprogrammed to a non-atrial tracking mode.

The Intervention rate is the rate at which Mode Switching will occur. The range is OFF; 120... (10)...**160**...(10)...200 bpm. In other words, based on standard programming it would take 5 out of the last 8 atrial events having a rate of at least 160 bpm to initiate Mode Switching.

**NOTE:**

The Intervention rate will not be used for the atrial diagnostic.

The modes available during Mode Switching are shown in [Table 18](#) below.

**Table 18: Mode Switching**

Programmed Mode	Programmable Mode Switch Mode
DDDR	DDI, DDIR
DDD	DDI, DDIR
VDDR	VDI, VDIR
VDD	VDI, VDIR

Mode Switching is triggered based on the Intervention Rate and Activation/Deactivation criterion. The Intervention Rate defines the minimal atrial rate required for an automatic change to the non-tracking Mode Switch Mode. An "X out of Y" criteria is used to control the time of the mode switch. The X variable can be programmed between 3 and 8. The Y variable is always 8 intervals.

These are shown in the following [Table 19](#).

Table 19: Activation/Deactivation Criterion		
Mode Switch	X value	Y value
Activation Criteria	3, 4, <b>5</b> , 6, 7, 8	8
Deactivation Criteria	3, 4, <b>5</b> , 6, 7, 8	8

The Mode Switching automatically reverts to the Normal Bradycardia pacing mode when the atrial rate falls below the Intervention Rate. The time of reversion is based on the Criteria for Deactivation, an X out of Y criteria. The X value can be defined by the user (i.e., it is programmable between 3 and 8). The Y value is fixed at 8 intervals.

### 6.7.1 Change of Basic Rate

Programmable OFF; +5 ... (+5) ... **+10** ... (+5) ... +30 bpm

When the Lumax mode switches, the basic pacing rate during the Mode Switching is the permanently programming basic rate plus the change in basic rate value. For example, if the Lumax was programmed to a basic rate of 60 bpm, the Mode Switch pacing rate would be 70 bpm.

In Lumax HF-T devices, parameters such as Ventricular pacing, LV T-wave protection and Triggering are programmable.

### 6.7.2 Post Mode Switch Rate and Duration

Post Mode Switch Rate: OFF, +5 ... (+5) ... **+10** ... (+5) ... +50 bpm (above base rate)

Post Mode Switch Duration: **1** ... (1) ... 30 minutes

The Post Mode Switch rate is designed to reduce the likelihood of recurrence of atrial tachyarrhythmias by overdrive pacing the atrium for a programmed period of time. After the time has expired, the pacing rate will decrease to the permanently programmed pacing rate by the rate decrease value.

## 6.8 PMT Protection

ON or OFF

VA criterion: 250 ... (10) ... **350** ... (10) ... 500 ms

Located under the Refractory period/Blanking parameter of the Bradycardia section.

A premature ventricular beat, loss of atrial capture, or a prolonged AV Delay may cause ventricular pacing at an inappropriately high rate due to retrograde conduction. In these cases, retrograde conducted atrial events from ventricular pacing could be tracked and could lead to pacemaker-mediated tachycardia (PMT). PMT Protection is an optional bradycardia algorithm (programmed ON or OFF) designed to “break” PMT.

The PMT termination algorithm looks for eight consecutive AsVp events greater than 100 bpm in which the VA interval is less than the programmed PMT VA criterion (default 350 ms). Additionally, the algorithm looks at stability to determine if the atrial intervals are stable (< 25 ms). If these conditions are met, the PVARP extension is activated. This extension is equal to the programmed VA interval + 50 ms. Thus, a subsequent atrial event that falls within the longer refractory period will not be tracked and PMT will be broken.

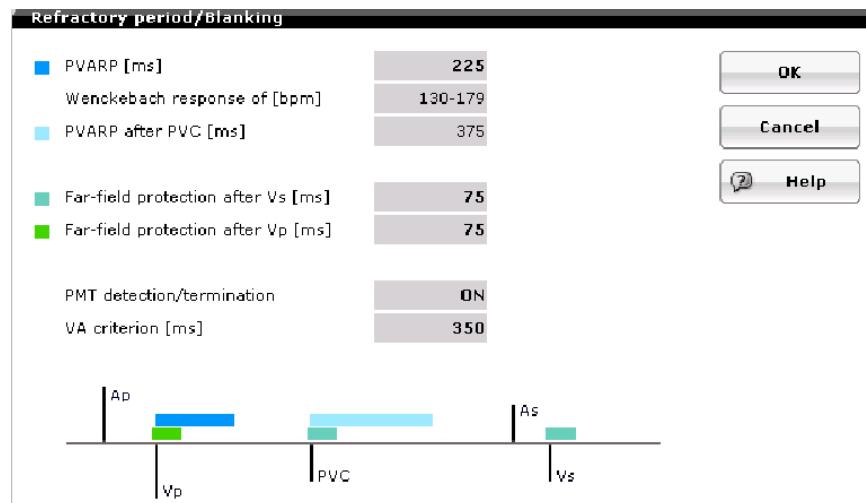


Figure 121: PMT Protection

## 6.9 LV channel programming for pacing polarity

The Lumax 740 HF-T provides 5 choices for LV pacing polarity. The choices are shown in [Figure 122](#). Those choices with a conflict message require the user to confirm the use of a bipolar lead.

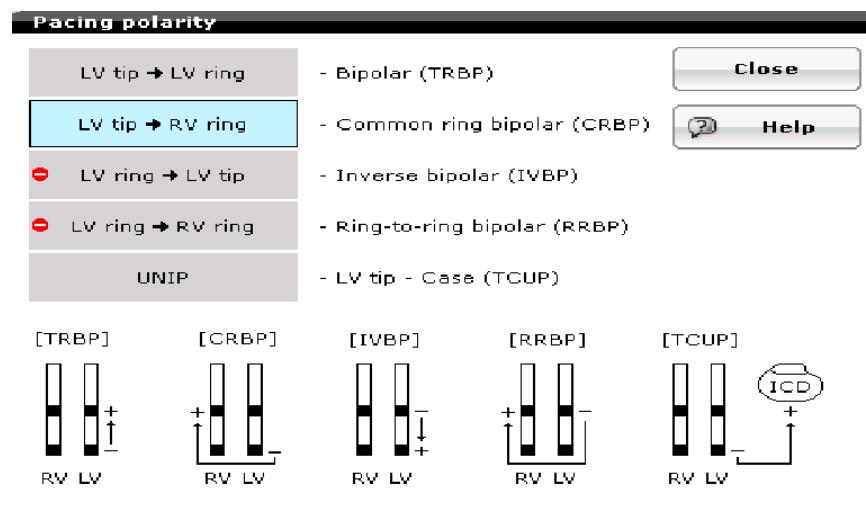


Figure 122: LV pacing polarity choices

The Lumax 740 HF-T allows the user to program bipolar or unipolar sensing. Unipolar sensing is from the LV tip to the ICD housing.

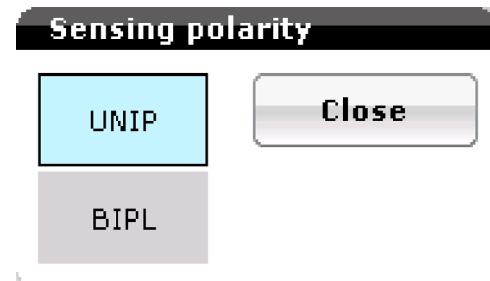


Figure 123: LV sensing polarity choices

## 6.10 Rate Smoothing (non-programmable)

Rate Smoothing is a hidden feature to prevent sudden rate changes and is utilized for Mode Switching, following Post Shock duration and Post Mode Switch Duration. It uses the same attack and decay rates as the sensor, regardless of whether the sensor is turned ON. For example, if the Post mode switch rate is 70 bpm, the basic rate is 60 bpm and the rate decrease is 0.5 bpm/cycle, it would take 20 cycles for the rate to decrease from 70 bpm to 60 bpm.

## 6.11 Bradycardia Noise Mode

Initial Noise interval of 110 ms, retrigger interval of 10 ms

Each ventricular event starts a blanking period. A ventricular sense starts a ventricular sense blanking, and a pace starts a ventricular paced blanking period. During blanking, there is no sensing or rhythm classification. In addition, a sensed event also starts a noise window of 110 ms. The noise window will be retriggered if a sensed event is seen within the window. Continuous retriggering of the noise window will result in asynchronous pacing at the lower rate. The initial noise interval is programmable via a release code from 110 ms to 200 ms, the retrigger interval is fixed. This should only be changed under supervision.

## 7. Programming Overview

### 7.1 General Overview

The Follow-up screen is the first screen displayed following interrogation of the Lumax 740 ICD/CRT-D. It is confirmed the device has been successfully interrogated by the appearance of the patient name, device name and serial number on the right side of the Follow-up header bar located at the very top of the screen. Furthermore, below the ECG/IEGM portion of the screen is an information status bar that provides information related to interrogation (i.e. "Interrogation was successful") and testing status.

The Master switch and device status are shown in the upper right portion of the screen.

The bottom of the screen reveals a Print button for printing a follow-up summary. Pressing the Last follow-up under the Patient section accesses previous follow-up information. The device can store follow-up data for 11 follow-ups. If multiple follow-up procedures are performed in a given day, only one set of follow-up data can be stored per day. The most recent value for a given test will be stored.

The Repeat all tests button repeats follow-up tests. The freeze button (camera icon) freezes 60 seconds of ECG and IEGM data that can be printed or stored into the programmer.

The programmer navigation buttons are found on the right-hand side of the screen and are available at all times from the programming screen. These buttons include: Follow-up, Parameters, Tests (i.e. pacing and defibrillation tests), Diagnostics data, pacing and defibrillation Tests and additional programming options under More. Information with respect to Parameters will be detailed in this chapter.

The programmer interface includes link buttons that take the user directly to specific data or test screens. These include Episodes (if present), Sensing, Threshold, Impedance, Trends and Details (Diagnostics). In addition, picture icons, such as those shown under the Event header take the user directly to data page covered by the icon.

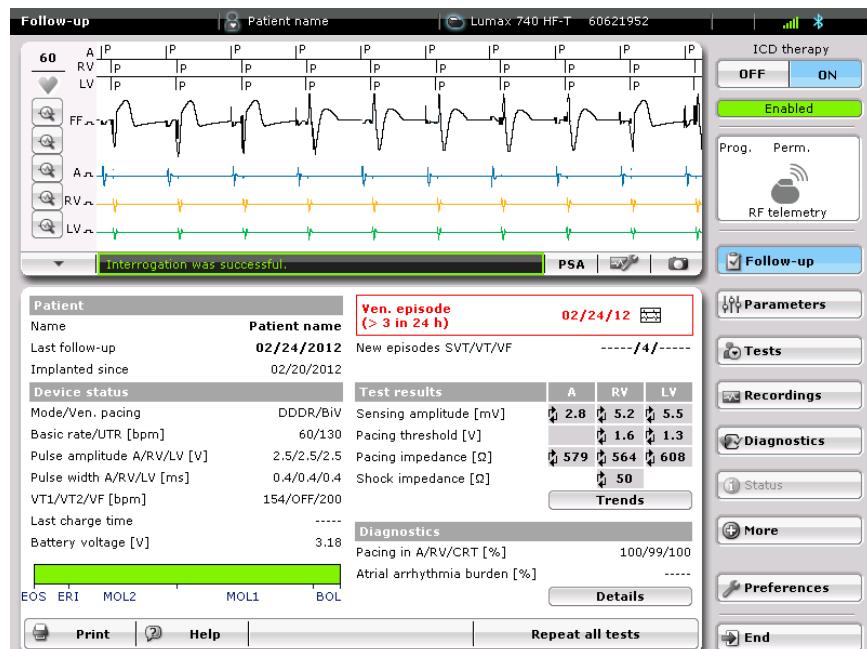


Figure 124: Main Follow-up Page

## 7.2 Parameters Overview

### 7.2.1 Bradycardia/CRT Parameters

The Bradycardia/CRT Screen allows the user to program parameters related to the bradycardia function of the device. Each of these parameters are described in this section.

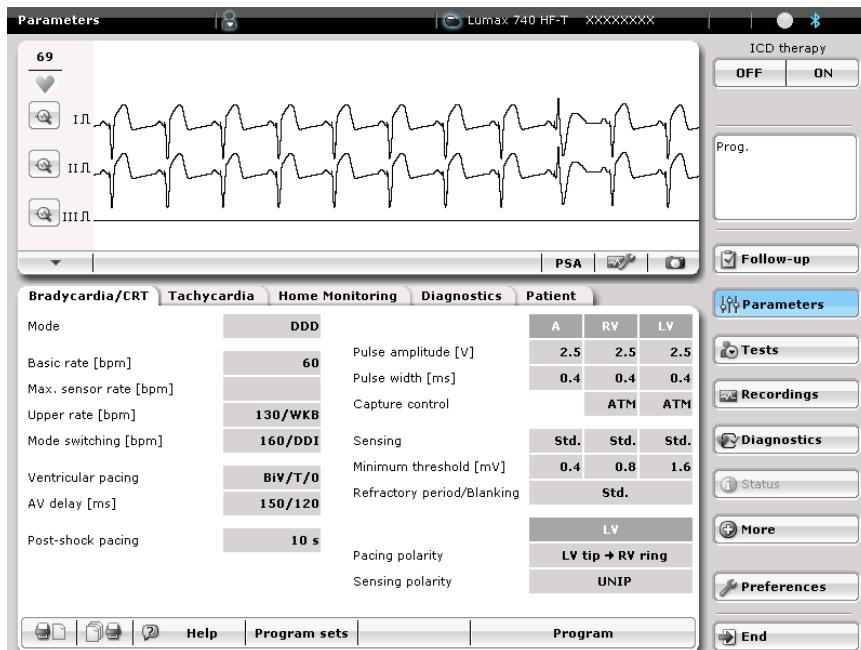


Figure 125: The Bradycardia/CRT screen and Sensing Parameters

#### 7.2.1.1 Mode

[Figure 126](#) shows the available modes for a Lumax 740 DR-T or Lumax 740 HF-T ICD. The Lumax 740 VR-T provides VVI(R), VOO and OFF modes while the Lumax 740 VR-T DX also provides VDD(R) and VDI(R) modes.

The DOO/VOO mode choices require the user to turn OFF detection and therapy as well.



Figure 126: Pacing mode choices in dual-chamber and HF-T ICDs

### 7.2.1.2 Basic Rate and Night Rate

Basic Rate: 30 ... (5) ... **60** ... (5) ... 100 ... (10) ... 160 bpm (Lumax 740 HF-T/DR-T)

Night Rate: **OFF**; 30 ... (5) ... 100 bpm

Night Begins: 22:00

Night Ends: 06:00

**NOTE:**

The clock only appears once a Night Rate is selected.

The basic rate and the night rates cannot be programmed less than 30 bpm. If Night Rate is programmed ON, Rate Hysteresis will not function during that time. Rate response will override the night rate and pace the heart at the sensor indicated rate if the patient becomes active during that time.

The Lumax 740 VR-T/VR-T DX devices have a default basic rate of 40 bpm.

### 7.2.1.3 Rate Hysteresis

Rate Hysteresis: **OFF**, -5 ... (-5) ... -25, -45, -65 bpm

Scan/Repetitive Hysteresis: **ON (10 fixed)**, OFF

**NOTE:**

A combination of Basic Rate and Hysteresis Rate can never be less than 30 bpm. Repetitive and Scan Hysteresis values only appear when a Rate Hysteresis value is selected.

### 7.2.1.4 Ventricular Pacing (HF-T devices only)

There are four sub-parameters found under this menu.

1. Ventricular Pacing – **BiV** or RV
2. LV T-wave protection – **ON** or OFF – When turned ON, inhibits LV pacing in the presence of a sensed LV event with the max trigger rate period. When the feature is turned OFF, the device will not sense intrinsic LV events or withhold pacing. Additionally, no LV sense diagnostic data is collected.
3. Triggering – OFF, **RVs**, RVs + PVC  
When triggering is turned ON, the device will trigger a BiV paced event when an RV sensed event occurs. RVs is a sensed RV event following an AV Delay. PVC is an extrasystolic event that can trigger a BiV pace as long as it does not violate a tachycardia zone or the programmed maximum trigger rate.
4. Maximum Trigger Rate – **UTR + 20**, 90 ... (10) ... 160 bpm  
The user can select a max trigger rate for BiV pacing.

**NOTE:**

Max Trigger rate cannot be programmed into a VT/VF zone. A conflict message will appear informing the user of the conflict.

### 7.2.1.5 V-V Delay after Vp (HF-T devices only)

**0 ...(5)...100 ms**

Allows the user to select either RV or LV pacing first and then program a V-V delay up to 100 ms in 5 ms increments. The user cannot program a V-V delay following a RV sensed event. If the LV pace is selected first, the 2:1 block rate will be lowered as the PVARP timing is based on the RV event only. The programmer will automatically calculate the Wenckebach and 2:1 block rates of the device.

### 7.2.1.6 AV Delay

The Lumax 740 ICD/CRT-D devices provide three preset values for AV Delays; Low, Medium and High. In addition, the user can program a fixed AV Delay as well as a user defined program Individual. Unlike previous generations that used rate bins to determine AV Delay, the Lumax 740 ICDs allow the user to select a Lower Rate AV Delay, as well as an Upper Rate AV Delay, to calculate an AV Delay in a linear fashion. The device automatically calculates what the AV Delay value is for a given heart rate. In Lumax 740 HF-T devices, the AV Delay is calculated based on which chamber is paced first.

#### 7.2.1.6.1 AV Delay Settings

**Table 20: Dynamic AV Delay Default (ms) for Lumax 740 HF-T**

Rate	Low	Medium	High
60 bpm – Lower Rate	150	140	130
130 bpm – Upper Rate	120	100	80
<b>Dynamic AV Delay Default (ms) for Lumax 740 DR-T</b>			
Rate	Low	Medium	High
60 bpm – Lower Rate	180	180	180
130 bpm – Upper Rate	140	100	80

Lower Rate Default = 60 bpm

Upper Rate Default = 130 bpm

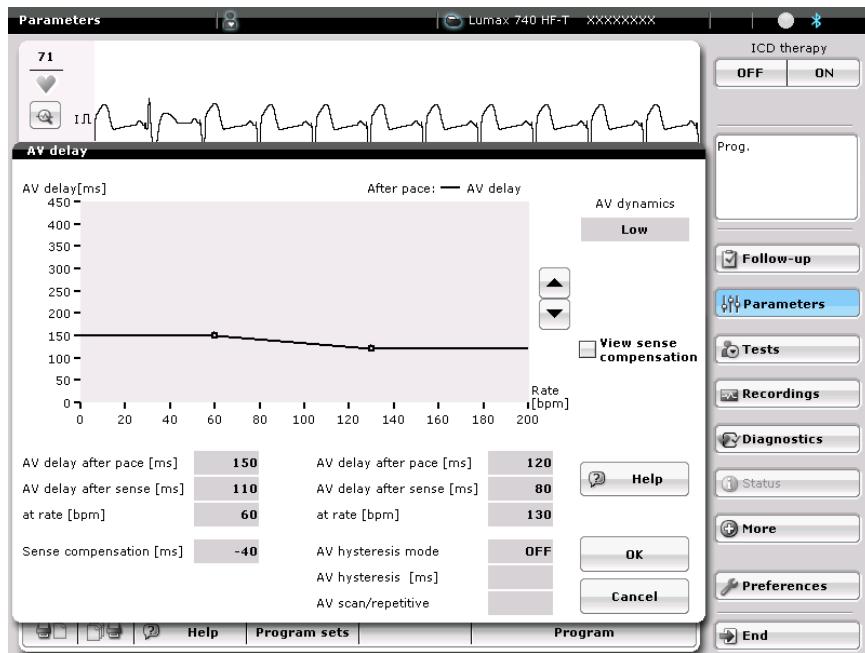


Figure 127: AV Delay screen

### 7.2.1.6.2 Sense Compensation

OFF, -5 ... (-5) ... **-40** ... (-5)... -120 ms

This feature is designed to help ensure that the physiologic AV delay intervals (atrial filling times) are the same from Ap to Vp as it is from As to Vp.

**NOTE:**

Conflicts occur if the AV Delay minus Sense Compensation is less than 40 ms.

### 7.2.1.6.3 Safety Window

Fixed at 100 ms

This parameter refers to the safety pace window, ensuring that non-physiologic events do not inhibit ventricular pacing. This is especially important in pacemaker-dependent patients.

Unlike previous generations of BIOTRONIK ICDs, the Safety window value is not listed on the AV Delay page of Lumax 740 ICD/CRT-Ds.

Safety pacing requires an atrial paced event to occur and does not occur following an atrial sense event. This feature is not available in the Lumax 740 VR-T DX ICD.

### 7.2.1.6.4 AV Hysteresis Mode

OFF, Positive, Negative, I-Opt (Lumax 740 DR-T and VR-T DX ICDs)

Positive: AV Hysteresis – 70, 110, 150, 200 ms

AV Scan/Repetitive - OFF, ON (5)

Negative: AV Hysteresis – 10 ... (10) ... 50...(10)...150 ms

AV Repetitive – 180 (fixed)

I-Opt AV Hysteresis – 400 ms

### AV Scan/Repetitive - ON (5)

The Positive Hysteresis mode is designed to promote intrinsic activity by periodically extending the AV interval looking for intrinsic activity. If intrinsic activity is present, the AV Delay maintains the extended value to allow intrinsic R-waves to occur.

Negative Hysteresis is designed to promote ventricular pacing in the presence of Hypertrophic Cardiomyopathy (HCM) by shortening the AV Delay when a sensed R-wave occurs. This feature can also be used in CRT patients to extend AV Delays to promote better filling times (longer AV Delays) while maintaining pacing.

When Negative hysteresis is programmed ON, the device defaults to AV Repetitive value of 180. This means that the device will shorten the AV Delay to the programmed value for 180 cycles. After 180 cycles, the device will return to the programmed AV Delay value.

I-Opt is a one button feature designed to promote intrinsic activity by periodically extending the AV interval to 400 ms looking for intrinsic activity. If intrinsic activity is present, the AV Delay maintains the extended value to allow intrinsic R-waves to occur. This feature is available in the Lumax 740 DR-T and Lumax 740 VR-T DX ICDs.

#### 7.2.1.7 Upper Tracking Rate

90 ... (10) ... **130** ... (10) ... 160 bpm

##### Wenckebach Response

The Wenckebach response zone is the distribution of rates between the Upper Tracking Rate and the calculated 2:1 response rate. The resulting behavior is a prolongation of the AV interval until a P-wave is not tracked. The ratio of Wenckebach is dependent on the atrial and device programming. When the atrial interval decreases to less than the combined AV Delay/PVARP intervals, a 2:1 response occurs.

The 2:1 response is determined by the following formula:

60,000 ms divided by the ((AV Delay plus PVARP) minus Sense Compensation)

For example:

AV Delay – 200 ms

PVARP – 250 ms

Sense Compensation -30 ms

60,000 ms divided by ((200 ms+ 250 ms) – 30 ms) = 143 bpm

143 bpm is the maximum Wenckebach limit. Once the atrial rate goes faster than 143 bpm, the device will go to a 2:1 response.

##### NOTE:

The Upper Tracking Rate cannot be programmed into a Tachycardia zone if the maximum trigger rate is greater than the Tachycardia zone rate or programmed to UTR +20. This applies only to HF-T devices.

##### NOTE:

The Wenckebach window and 2:1 block rate can be affected if LV pace first is chosen as PVARP is started with the RV paced event. This applies only to HF-T devices.

### 7.2.1.8 Mode Switching

[Figure 128](#) shows the Mode Switch screen. Each of the screen parameters will be discussed below.

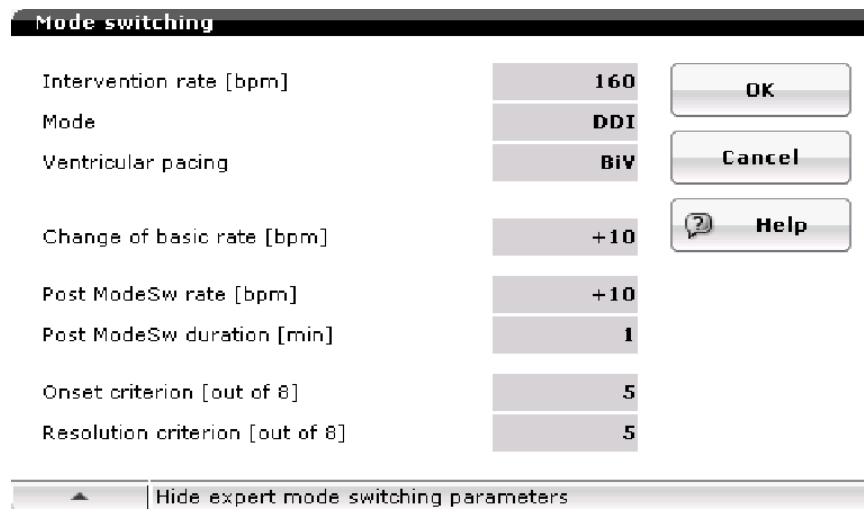


Figure 128: Mode Switch Screen

#### 7.2.1.8.1 Intervention Rate

OFF, 120 ... (10) ... **160** ... (10) ... 200 bpm

The Intervention Rate is the atrial rate above which intervals will count toward Mode Switch. The nominal value is 160 bpm.

#### 7.2.1.8.2 Mode

DDIR, **DDI**

The Mode that the device Mode Switches to when programmed DDD(R). If the device is programmed VDD(R), the device will Mode Switch to VDI(R).

#### 7.2.1.8.3 Onset Criterion

3, 4, **5**, 6, 7 or 8

The number of events out of a sliding window of 8 that must exceed the Intervention Rate in order for the device to Mode Switch.

#### 7.2.1.8.4 Resolution Criterion

3, 4, **5**, 6, 7 or 8

The number of events out of a sliding window of eight that must be below the Intervention Rate for the device to revert to permanently programmed pacing.

#### 7.2.1.8.5 Change of Basic Rate

OFF, +5 ... (+5) ... **+10** ... (+5) ... +30 bpm

The change of basic rate value is the amount added to the Basic Rate when Mode Switching occurs. For example, if the device is programmed to 60 bpm and the Change of Basic Rate is +10, the Mode Switch Rate will be 70 bpm while Mode Switch is present. This is designed to increase the cardiac

output by providing higher pacing rates and reducing patient symptoms during Mode Switch. Once the Mode Switch is terminated, the rate will decrease back to the basic rate or the post mode switch response rate using Sensor rate decrease criteria.

### 7.2.1.8.6 Ventricular Pacing (HF-T device only)

**BiV** or **RV**

The user can select BiV or RV pacing during Mode Switch.

LV T-wave protection – **ON** or OFF – Sets the upper resynchronization rate with the start of the LV sensed or triggered paced event. In other words, it uses the same max trigger rate value as the RV sensed event would use. At nominal settings, it would be UTR +20.

**NOTE:**

LV T-wave protection is programmable in the Ventricular pacing window to provide protection when triggered pacing is programmed. This feature is designed to prevent pacing into the vulnerable period of the left ventricle.

### 7.2.1.8.7 Triggering (HF-T devices only)

OFF, **RVs**, RVs + PVC

When triggering is turned ON, the device will trigger an LV paced event when an RV sensed event occurs. RVs is a sensed RV event following an AV Delay (i.e., Aflutter). RVES is an extrasystolic event (PVC) that can trigger a BiV, pace as long as it does not violate the Maximum Trigger Rate or Tachycardia zone.

### 7.2.1.8.8 Post Mode Switch Response

OFF, +5 ... (+5) ... **+10** ... (+5) ... +50 bpm

This feature is designed to suppress recurrence of atrial arrhythmias immediately after Mode Switching by increasing the pacing rate for a limited (programmable) time.

### 7.2.1.8.9 Post Mode Switch Duration

**01:00** ... (01:00) ... 30:00 minutes

The duration of the Post Mode Switch Response rate change. Once the Post Mode Switch rate expires, the device will decrease the rate to the basic rate using the Sensor decay rate.

### 7.2.1.9 PMT Protection

**ON**, OFF

This algorithm is designed to break a PMT by changing the AV Delay after the device has sensed eight consecutive events in which the Ventricular pace to Atrial sense interval is less than the VA Criterion value. The algorithm requires the following criteria to initiate:

- Rate greater than 100 bpm with Vp
- VA Criterion met
- Stability criteria of 25 ms met

### 7.2.1.9.1 VA Criterion

250 ... (10) ... **350** ... (10) ... 500 ms

The Vp to As interval that the atrial event must be within in order for the PMT algorithm to initiate, along with the rate and stability criteria.

### 7.2.1.10 Max sensor rate

Max. sensor rate		
Max. sensor rate [bpm]	120	OK
Sensor gain	Medium	Cancel
Sensor threshold	Medium	
Rate increase [bpm/cycle]	2	
Rate decrease [bpm/cycle]	0.5	Help

Figure 129: Sensor screen

#### 7.2.1.10.1 Max Sensor Rate

80 ... (10) ... **120** ... (10) ... 160 bpm

This is the maximum atrial paced rate the device will allow. This rate must be at least ten beats lower than the Upper Tracking Rate.

#### 7.2.1.10.2 Sensor Gain

AUTO, Very low (1.3), Low (3), **Medium** (6), High (11), Very high (15)

##### NOTE:

The numbers in parenthesis are not shown on the programmer screen. They are intended to show a correlation to previous device values.

This refers to the rate of increase and decrease. The higher the number, the more aggressive the change in heart rate in response to demand; the lower the number, the less aggressive.

AUTO is designed to tailor the sensor gain to a patient's activity level by making automatic changes based on patient activity level. This feature should not be used in the case of bed-ridden or low-activity-level patients, as the sensor gain can change over time.

Sensor gain will increase in value (more response) if the patient has not reached 90% or more of their max sensor rate for 60 minutes in a seven-day period. Conversely, the device decreases the value (less response) if the patient has reached 90% or more of their max sensor rate for 30 minutes in a 24-hour period.

### 7.2.1.10.3 Sensor Threshold

Very Low, Low, **Medium**, High, Very High

This feature determines how sensitive the accelerometer is to motion to determine rate. This should only be changed when a patient's heart rate does not respond to changes in the Sensor Gain.

### 7.2.1.10.4 Rate Increase

1, **2**, 4, 8 bpm/cycle

The speed of rate increase with sensor activity.

If the Rate Increase is set at the default of 2 bpm, the heart rate increases 2 bpm every new cycle until the sensor pacing rate is met. If the current rate is 60 bpm and the sensor indicated rate is 100 bpm, it would take 20 cycles to achieve a rate of 100 bpm ( $100 - 60 = 40/2 \text{ bpm/cycle} = 20 \text{ cycles}$ ).

### 7.2.1.10.5 Rate Decrease

0.1, 0.2, **0.5**, 1.0 bpm/cycle

The speed of rate decrease as the sensor rate decreases.

If the Rate Decrease is set at the default of 0.5 bpm, the heart rate decreases 0.5 bpm every new event until the sensor pacing rate is met. If the current rate is 100 bpm and the sensor indicated rate is 60 bpm, it would take 80 cycles (events) to achieve a rate of 60 bpm ( $100 - 60 = 40/0.5 \text{ bpm/cycle} = 80 \text{ cycles}$ ).

## 7.2.1.11 Pulse Amplitude and Width

### Pulse Amplitude

0.5 ... (0.25) ... **2.5** ... (0.25) ... 4.0 ... (0.5) ... 6.0, 7.5 V for all chambers

### Pulse Width

**0.4**, 0.5, 0.75, 1.0, 1.25, 1.5 ms for all chambers, as 0.4 ms is required for ATM/VCC.

## 7.2.1.12 Ventricular Capture Control (VCC)

Capture control; OFF, **ATM**, ON

Threshold test start: 2.5 ... (0.5) ... **2.5** ... (0.5) ... 5.0 V

### NOTE:

2.5 V is used when ATM is programmed because ATM starts with the fixed amplitude programmed for the corresponding channel, 3.5 V is used by default when VCC is programmed.

Minimum Amplitude: **1.0** ... (0.25) ... 4.0 V

Safety margin; **1.0** or 1.2 V

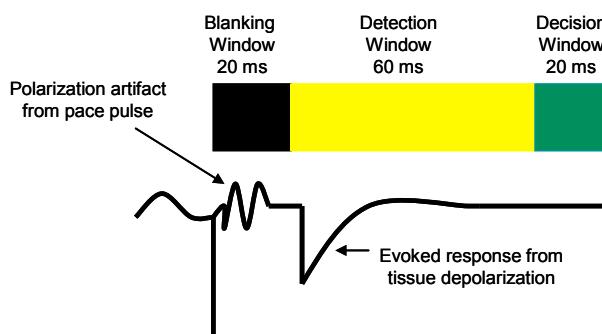
**Table 21: Key numbers for Ventricular Capture Control (VCC)**

<b>Signal Quality Check</b>	Five single-paced events followed by five double-paced events 100 ms apart
<b>AV Delay</b>	The AV Delay is shortened to 15 ms post atrial sense and 50 ms post atrial pace to ensure capture
<b>Back-up pulse</b>	Occurs at 100 ms after the loss of capture event
<b>Back-up pulse output</b>	Current programmed output + 0.1 V at 1.0 ms pulse width. When performing the LV threshold test, V-V delay is set to 50 ms with the LV first. The RV paced event is always delivered throughout the test so an LV back-up pulse is not required
<b>Step down interval</b>	0.6 V until loss of capture, returns to the last captured output and steps down 0.1 V

Active Threshold Monitoring (ATM) allows the user to track the pacing threshold without reprogramming the pacing output. The test is performed in the same manner as Ventricular Capture Control (VCC) except for the final step of reprogramming the pacing output.

### 7.2.1.12.1 Overview of How Ventricular Capture Control Functions

When VCC is programmed ON or to ATM, the device starts by performing a Signal Quality Check (SQC). The purpose of the SQC is to verify that the ventricular capture and non-capture signal are adequate for reliable capture determination. Amplitude and morphology of the ventricular evoked response may vary significantly between patients. This poses a problem for accurately identifying capture versus non-capture morphologies. Also affecting the ability of the capture threshold algorithm is the ability to distinguish between an evoked response (true ventricular systole) and polarization artifacts produced by the pacing lead. The VCC algorithm analyzes signal morphology characteristics to differentiate capture from non-capture by measuring positive and negative signal amplitudes, location and polarity of the zero crossing, and various integrals of the signal at different times. The signal evaluation occurs during a specific window. There is a 20 ms blanking immediately following the paced event. Following the blanking period, a 60 ms detection window and a 20 ms decision window occurs. This is shown in [Figure 130](#).

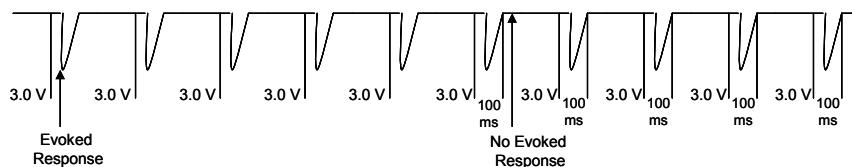
**Figure 130: Signal Evaluation**

### 7.2.1.12.2 Signal Quality Check (SQC) and Capture Threshold Search (CTS)

The first time the VCC or ATM algorithm is activated, an SQC and CTS sequence is initiated. The progression of this sequence is shown by a message displayed at the bottom of the programmer screen. The programmer wand must be in place during the initial SQC/CTS initialization. The SQC/

CTS is initiated as long as the average ventricular rate is less than 110 bpm (the SQC Rate limit). (The preset rate limit is used to avoid overdrive pacing at higher rates, interaction with other pacemaker features that occur at higher rates, and prevent pacing into the intraventricular baseline variations that occur at the end of T-waves.) The SQC begins by setting the pacing amplitude to Threshold Test Start value and shortening the AVD to 15 ms or 50 ms in order to force ventricular pacing. The selection of AVD is determined by the patients' current pacing status. A 15 ms AVD will be used if there is atrial tracking or the patient's intrinsic rhythm is inhibiting the atrial pacing. For the pacemaker dependant patient, a 50 ms AVD provides forced ventricular pacing. In the single-chamber Lumax 740 device, the pacing rate will be set at 10 beats above the intrinsic rate. The SQC is divided into two separate phases, the first to evaluate capture and the second to evaluate lead polarization artifact. In phase 1, five paced cycles are delivered to evaluate capture using the evoked response. In phase 2, the five cycles are for evaluation of the lead polarization artifact in order to differentiate capture from non-capture.

The first ventricular pacing event of SQC is ignored in order to allow the system to stabilize to the altered pacing amplitude. (The cycle that is ignored will have a slightly longer AVD.) On the second to fifth cycles of the capture phase of SQC, capture or non-capture determinations are made. Back-up pulses are delivered if non-capture is present. Immediately following the first phase of SQC, the second phase is started. Five secondary pulses are delivered at 100 ms after each of the next five ventricular paces ([Figure 131](#)). These paces fall into the absolute refractory period of the ventricle. Based on the polarization of the non-capture second paces, the maximum polarization artifact is determined.



**Figure 131: Signal Quality Check**

To pass the SQC phase of VCC initialization, the phase 1 paced events must be retrospectively classified as 'capture' by phase 2. The SQC starts at the Threshold Test Start value and represents the worst-case polarization artifact, and therefore, the resulting worst-case evoked response signal. The criterion for passing the initial SQC is stricter than for the following CTS mode. The stricter SQC criteria ensure that pacing is demonstrated prior to the patient leaving the clinical environment.

If any non-capture events occur during the capture phase or if the polarization amplitude violates the pre-set threshold, the SQC attempt is unsuccessful. If the first SQC attempt is unsuccessful upon initialization, the VCC algorithm is set to pending and repeated. This can continue for up to 32 days after implantation or 2 days after further follow-ups. If VCC is not successfully performed after as previously described, the device will then read "DISABLED". This is necessary because the first running of the SQC and CTS is supervised by a clinician, and the VCC algorithm can be reprogrammed in order to restart VCC and initiate a new sequence. With initial VCC programming, the entire SQC /CTS sequence is evaluated regardless of loss of capture or excessive polarization artifact. The initial SQC/ CTS sequence takes less than one minute.

### 7.2.1.12.3 Capture Threshold Search

The purpose of the Capture Threshold Search (CTS) is to determine the minimum ventricular pacing amplitude that will capture the heart to a resolution of 0.1 V. The pacing threshold is defined as the maximum non-capture voltage at X.X volts + 0.1 V. In the VCC ON mode, the CTS resets the final pacing voltage at completion of the CTS. However, the lowest output that can be set is 1.2 V regardless of the measured output.

**NOTE:**

In the ATM mode, the threshold is recorded in the Ventricular Pacing Threshold histogram, but is not used to adjust the pacing amplitude.

CTS is always initiated following a successful completion of the SQC sequence. The applicable AVD is maintained from the SQC. The pacing amplitude begins at the Threshold Test Start value and decreases by 0.6 V of the currently programmed amplitude every ventricular pacing event. Once the amplitude is lost, the device will return to the last captured value and decrease the output by 0.1 V until the threshold is determined. At the 0.1 V decrement interval, the device will deliver a second paced pulse when a loss of capture occurs to verify the threshold. If the second pulse delivery captures, the device will deliver a third paced pulse. If two out of three paced events capture, the device will step down to the next value. See [Figure 132](#) for an example of Capture Threshold Search.

If a single non-capture is detected, a back-up pulse is delivered 100 ms after the non-capture event at the current programmed output + 0.6 V and 1.0 ms pulse width. The back-up pulse results in a resetting of the lower rate timer (LRT). Once determined, the pacing amplitude is reset to the threshold plus the programmable safety margin (1.0 V standard).

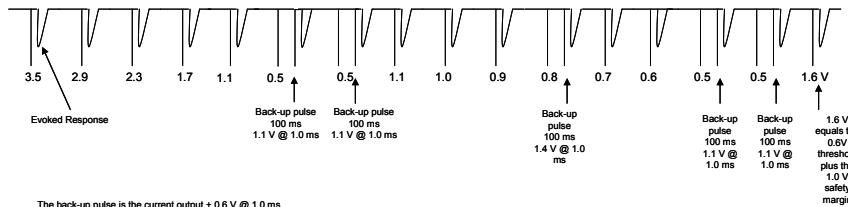


Figure 132: Capture Threshold Search

### 7.2.1.12.4 Key points about ATM/Capture Control

- ATM/VCC is a programmable ON/OFF feature available in the Lumax 740 device family.
- ATM/VCC requires the Pulse Width to be programmed to 0.4 ms or less.
- ATM/VCC measurements are performed once daily, 40 minutes before the programmed HM transmission time. If the first attempt fails, a second attempt will occur 30 minutes later or 10 minutes before the HM transmission.
- A back-up pace pulse occurs up to 100 ms after loss of capture in the RV channel only. The back-up pulse is at +0.6 V above the last output and 1 ms.
- When LV ATM/VCC is performed, the V-V interval is temporarily changed to 50 ms. This means the RV channel will pace 50 ms after the LV channel so a back-up pulse is not required. RV pacing will occur at all times during the test, regardless of whether LV capture occurred.
- ATM/VCC does NOT permanently modify the programmed pacing outputs.
- ATM/VCC will not be performed if the heart rate is 110 bpm or within 10 bpm of the UTR, whichever is higher.

- ATM/VCC is disabled after three days of unsuccessful measurements (after the 28 day initial implantation period) and a medical event Home Monitoring message is sent. ATM/VCC can only be restored through the programmer.
- ATM/VCC in single-chamber ICDs is done by pacing at 10 bpm above the intrinsic rate.
- The AV Delay is shortened to 50 ms following an Ap; 15 ms following an As event.
- When LV ATM/VCC is programmed ON, the LV pacing is only programmable to LV Tip to LV Ring, LV Tip to RV Ring or Unipolar. Conflict messages will appear informing the user if the LV pacing configuration is using the LV ring first.

### 7.2.1.13 Sensing

Chamber	Right Atrium	Right Ventricle	Left Ventricle*
Sensing parameter options	Standard (Std.)	Standard (Std.)	Standard (Std.)
	OFF (Inactive)	Enhanced T-wave Suppression (TWS) <sup>†</sup>	OFF (Inactive)
		Enhanced VF Sensitivity (VFS) <sup>†</sup>	
Minimum threshold	0.2 ... (0.1)... 0.4 ... (0.1) ... 2.0 mV	0.5 ... (0.1)... 0.8 ... (0.1) ... 2.5 mV	0.5 ... (0.1)... 1.6 ... (0.1) ... 5.0 mV

The Standard sensitivity settings are ideal for most patients. However, when special sensing issues arise, the right ventricular sensitivity may be programmed to Enhanced VF Sensitivity or Enhanced T-wave Suppression. (See [Section 3.1.1](#) for details.) The Minimum threshold in the atrium may be adjusted between 0.2 mV and 2.0 mV, while the Minimum threshold in the right ventricle may be adjusted between 0.5 mV and 2.5 mV and up to 5.0 mV in the left ventricle.

Turning the Right Atrial channel to OFF (inactive) disables all atrial related features. In essence, the device will function as a VVI(R) device.

Turning the Left Ventricular channel OFF (inactive) results in the loss of LV sensing and LV statistical information.

Any changes made in the default sensing parameters will result in the term “Ind.” or individual appearing for the chamber in which the changes were made.

**NOTE:**

Enhanced VF Sensitivity and Enhanced T-wave Suppression are available only for the right ventricle. In Heart Failure (HF-T) devices, the Left Ventricular options are Standard or OFF.

### 7.2.1.14 PVARP

Auto, 175 ... (25) ... 225 ... (25) ... 600 ms

PVARP is used to prevent pacemaker mediated tachycardia by not allowing retrograde atrial events to be tracked by the device. Retrograde conduction should be confirmed before making any programming changes. Generally, PVARP should be 15-20 ms longer than the measured retrograde conduction time. Programming PVARP too long could result in non-tracking of antegrade atrial events.

\* Applies to HF-T (CRT) devices only

† These choices are preset programs and will override previous sensing parameter changes

### 7.2.1.14.1 Auto

When Auto is programmed, the PVARP is programmed to 175 ms and the PVARP after PVC is set to 325 ms.

Auto is an option that will automatically adjust the PVARP value when a PMT occurs. Following a PMT, the device will extend PVARP by 50 ms. After seven days of no PMT, the PVARP value will reduce by 50 ms to a minimum value of 175 ms.

### 7.2.1.14.2 PVARP after PVC

PVARP after PVC is nonprogrammable parameter that is used to prevent PMT following PVC events by adding a fixed value of 150 ms to the programmed PVARP for that PVC event. The maximum value is 600 ms. By default, this value is 375 ms.

#### NOTE:

Programming long PVARP values in combination with long AV Delays will result in reduced 1:1 tracking by the device.

## 7.2.2 Tachycardia

### 7.2.2.1 Atrial Detection

100 ... (10) ... **200** ... (10) ... 250 bpm

This parameter allows the user to define a minimal atrial rate to record an atrial arrhythmia IEGM. In order for an atrial IEGM to be recorded, the device needs to detect 36 out of 48 of the most recent atrial events greater than the programmed value. Recording is terminated with 20 out of 24 events are less than the programmed value. This parameter is located on the Tachycardia page of the programmer screen.

### 7.2.2.2 Ventricular Detection

Ventricular detection, redetection, and termination parameters are set up in the Detection screen of the device. This screen is accessed by selecting any of the detection zone buttons that are located immediately to the right of the zone button. The rate limits defining each tachyarrhythmia zone are programmed on the Overview screen or the individual zone screens. VT zones not used are programmed to "OFF." The Detection Counters, Redetection Counters, detection enhancements (i.e., SMART® Detection, Onset and Stability), Sustained VT and Forced Termination timers are located in the Detection screen.

[Figure 133](#) shows an example of the basic Detection screen. In this case, three tachyarrhythmia zones are programmed. A VT1 zone is programmed for ventricular rates between 133 and 154 bpm, a VT2 zone programmed for ventricular rates between 154 bpm and 200 bpm and a VF zone for rates equal to or greater than 200 bpm. In addition, SMART® Detection defaults ON with Onset and Stability of 20% and 12%, respectively. Forced Termination timer defaults to one minute. When Smart Detection is OFF in both VT zones, the Sustained VT timer is active with a default setting of OFF.

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Lumax 740 Technical Manual

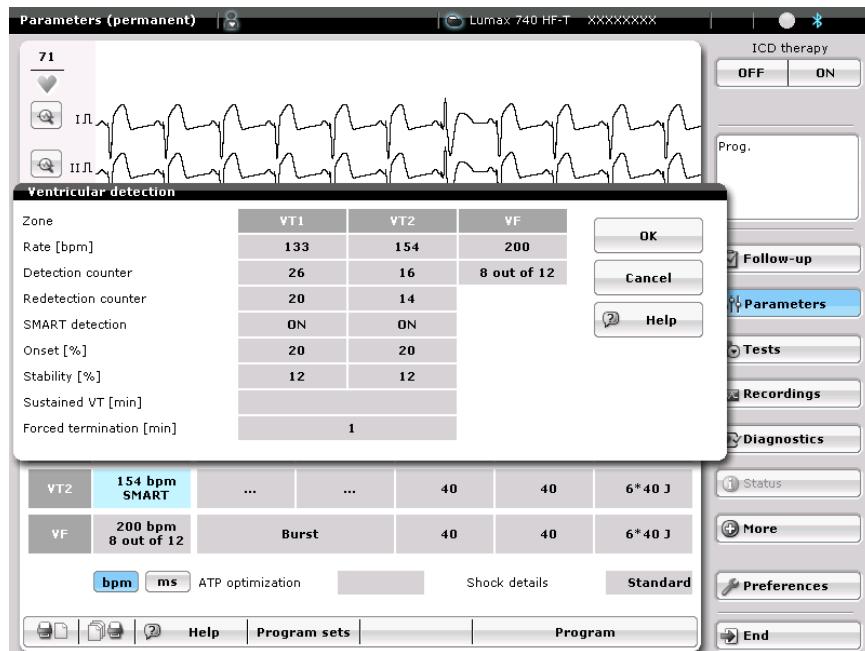


Figure 133: The Detection screen

### 7.2.2.2.1 Detection Rate

VT1: OFF, 100 – 222 bpm or 270 – 600 ms

VT2: OFF, 120 – 222 bpm or 270 – 500 ms

VF: 150 – 250 bpm or 240 – 400 ms; Default **200 bpm (300 ms)**

VT1 is the lowest zone for programming and therefore, when programming multiple zones, the rate must be lower than the VT2 zone or VF zone.

#### NOTE:

When programming a VT zone, a VF zone must be programmed ON.

### 7.2.2.2.2 Detection Counter

VT1: 10 ... (2) ... **16** ... (2) ... 60

VT2: 10 ... (2) ... **14** ... (2) ... 40

VF: 6 out of 8, **8 out of 12**, 10 out of 14, 12 out of 16, 16 out of 20, 18 out of 24, 20 out of 26, 22 out of 30, 24 out of 30

This parameter determines the minimal number of VT events for each zone that must be counted to initiate VT/VF detection and therapy delivery. The VT counters use an up/down counter for criteria. The VF counter uses an X out of Y counter.

The Detection Counter value for a VT1 zone must be greater than the VT2 zone and the "X" value of the VF zone.

### 7.2.2.2.3 Redetection Counter

VT1: 10 ... (2) ... **12** ... (2) ... 30

VT2: 10 ... (2) ... **10** ... (2) ... 30

VF: Same as initial VF detection

This parameter determines the minimal number of VT events for each zone that must be counted to redetect VT/VF and prompt therapy delivery. The Redetection Counter value for a VT1 zone must be greater than the redetection counter of the VT2 zone and the “X” value of the VF zone detection counter.

#### 7.2.2.2.4 SMART® Detection

ON, OFF

This feature can be programmed on in the VT1 zone alone or the VT1 and VT2 zones. SMART® Detection can not be programmed OFF in VT1 and ON in VT2. This feature is discussed in detail in [Section 4.2](#). When SMART® Detection is ON, SMART® Redetection is automatically ON as well.

#### 7.2.2.2.5 Onset

SMART® Detection ON - 4 ... (4) ... **20** ... (4) ... 32%

SMART® Detection OFF – 4 ... (4) ... **20** ... (4) ... 32%

The Onset Value applies to both VT zones.

#### 7.2.2.2.6 Stability

SMART® detection ON – 8 ... (4) ... **12** ... (4) ... 48%

SMART® detection OFF – 8 ... (4) ... **12** ... (4) ... 48 ms

The Stability Value applies to both VT zones.

#### 7.2.2.2.7 Sustained VT

OFF, 1, 2, 3, 5, 20 or 30 minutes

This parameter is the override parameter for SVT detection. If a patient is in an SVT for a period of time, the device will verify the arrhythmia (by rate alone) and deliver therapy after a programmed period of time. This is viewed as a safety net for single-chamber devices that may have difficulty in distinguishing VT from SVT (i.e., Afib with rapid conduction vs. VT).

#### 7.2.2.2.8 Forced Termination Timer

OFF, **1** ... (1) ... 10 minutes

This parameter terminates an SVT episode following VT therapy after a programmed period of time. It will reset all therapy and start a new episode. If the patient is in an SVT when the Forced Termination timer expires, a new SVT episode will begin.

#### 7.2.2.2.9 Programming the VT1 detection lower than the UTR

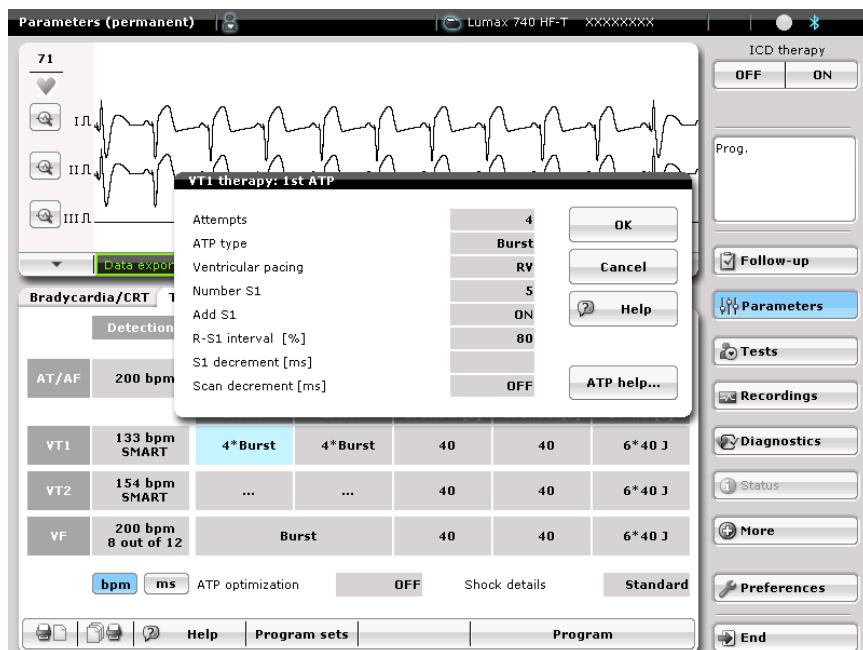
The Lumax 740 ICDs to allow programming of the VT1 zone below the Upper Tracking Rate (UTR) has been retained. The exception is in Lumax 740 HF-T devices that do not allow programming of BiV triggered events higher than a programmed Tachycardia zone. This function is particularly helpful for patients who experience slow, sustained, symptomatic VT (100 bpm – 120 bpm), have active lifestyles in which their sinus rate goes above this rate range, and require a higher UTR. With this programming, more athletic patients have the freedom to exercise at higher heart rates with the continued protection of arrhythmia detection provided by SMART® Detection.

**NOTE:**

Keep in mind the following important information regarding programming: ATP initiated during sinus rhythm can have, in vulnerable patients, a pro-arrhythmic effect and induce a faster VT or VF.

### 7.2.2.3 Therapy

The VT1, VT2, and VF therapies are programmed in separate screens. In each VT zone, two ATP sequences and one shock sequence can be programmed. The therapy is delivered sequentially from ATP1 to ATP2 in VT1 and VT2. Programmed shock therapy follows ATP in each VT zone. In the VT and VF zones, six to eight shocks may be programmed. The first and second shock energies are programmable; the remaining shocks are at maximum shock energy. [Figure 134](#) shows an example of a VT therapy screen.



**Figure 134: VT therapy screen**

#### 7.2.2.3.1 ATP

##### Burst, Ramp

The device allows for two ATP scheme for each zone. There is no hierarchy for ATP programming, allowing the user to program any combination of ATP therapy

#### 7.2.2.3.2 Ventricular Pacing (HF-T devices only)

##### RV, BiV

BiV pacing for ATP may be a better option for therapy if the VT origin is left-sided.

#### 7.2.2.3.3 Number S1

1 ... (1) ... **5** ... (1) ... 10

This sets the number of stimuli delivered for each ATP attempt.

#### 7.2.2.3.4 Add S1

ON, OFF

This parameter adds an additional paced ATP event for each new therapy delivery.

#### 7.2.2.3.5 R-S1 Interval

Adaptive - 70 ... (5) ... **80** ... (5) ... 95%; (85% default for ATP One-Shot)

Applies to all ATP schemes. This sets the paced interval based on the last interval average.

#### 7.2.2.3.6 S1 Decrement

5 ... (5) ... **10** ... (5) ... 40 ms

Used when Ramp ATP is programmed. This parameter sets the amount of decrement between pacing pulses during therapy delivery.

#### 7.2.2.3.7 Scan Decrement

OFF, 5 ... (5) ... 40 ms

This parameter sets the amount of S1 decrement between therapy attempts.

#### 7.2.2.3.8 Minimum Interval

200 ms for all zones, including ATP One-Shot

The minimal pacing interval the device will allow for ATP therapy delivery. This limit prevents the device from pacing too fast and initiating VF. Applies to all programmed schemes within a zone. This parameter is hidden and non-programmable.

#### 7.2.2.3.9 ATP Optimization

ON, OFF

Applies to all programmed schemes within a zone. Stores into memory the last successful ATP to memory and starts with that ATP attempt the next time a VT occurs within that zone. Last successful ATP is defined as the last delivered ATP that terminated a VT.

**NOTE:**

One more ATP therapy may be delivered than programmed with this feature. The device will start with the last successful ATP in memory. If that one should fail, the device starts back at the beginning of the programmed ATP and will deliver all programmed ATP for that scheme. So even though three Ramp therapies were programmed, the device could deliver four; the last successful plus the three programmed ATP.

**NOTE:**

Shock therapy and device reprogramming will clear the ATP Optimization memory.

#### 7.2.2.3.10 ATP Help

Displays the programmed ATP schemes as programmed. The VT interval can be changed to show what the ATP scheme will be, based on a specific interval. This screen cannot be printed.

### 7.2.2.3.11 Shock Therapy

OFF, 1, 2, 6, 8 shocks per VT zone

6 or 8 shocks for the VF zone

The first two shocks for each zone are programmable. The remaining shocks are at maximum output.

ATP therapy should always be followed by shock therapy if ATP therapy is ineffective.

### 7.2.2.3.12 Confirmation

**ON, OFF**

Programmable by zone if the check box Configure zones separately is selected. Otherwise, confirmation in the VT zones will be the same as the VF zone.

When programmed ON, the first shock is uncommitted. If shock therapy is delivered, the next shock is uncommitted. If shock therapy is aborted, the next shock is committed. Shown below are different scenarios of confirmation.

Shock #	1	2	3	4	5	6	7	8
Prior to therapy delivery	U	U	U	U	U	U	U	U
First shock D	D	U	U	U	U	U	U	U
First shock A	A	C	U	U	U	U	U	U
Third shock A	D	D	A	C	U	U	U	U.
Fifth shock A	D	D	D	D	A	C	U	U
A = Aborted								
C = Committed								
D - Delivered								
U = Uncommitted								

A = Aborted  
C = Committed  
D - Delivered  
U = Uncommitted

**NOTE:**

The device can never abort two shock deliveries in a row other than induction testing. Wand application with an induction suspends the rule of aborting two consecutive shocks.

### 7.2.2.3.13 Polarity

**Normal, Reversed, Alternating**

Applies to all shocks in a zone and can be different between zones.

### 7.2.2.3.14 Waveform

**Biphasic, Biphasic 2**

Applies to all shocks within a zone and may be programmed differently for each zone.

### 7.2.2.3.15 Shock path

**RV to proximal Coil/Can, RV to Can, RV to proximal Coil**

In Lumax 740 VR-T DX, the default is RV to Can.

This allows the user to program multiple pathways for patients and is used as an additional tool for patients with high DFTs. The programmer will prompt the user to select a “release” button if selecting the RV to proximal Coil option to ensure that a dual-coil lead is implanted.

### 7.2.2.3.16 ATP One-Shot

Applies to the VF zone only.

This feature allows the delivery of a single ATP before charging only if the fixed 12% Stability Criteria is met during initial detection. If ATP therapy breaks the arrhythmia, the shock charging will abort. The programming of this ATP is the same as described above. This feature is automatically disabled if ATP One-Shot fails in four consecutive attempts.

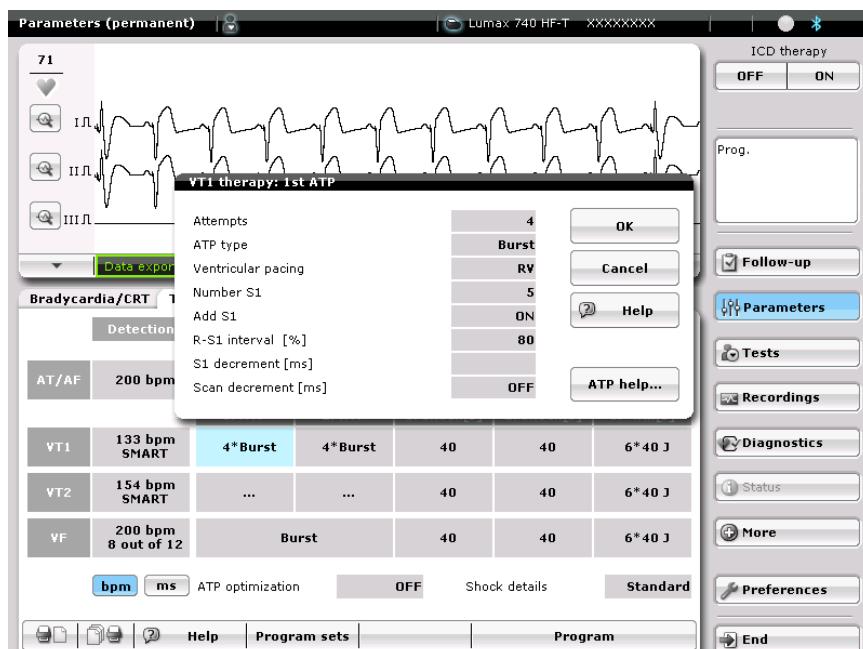
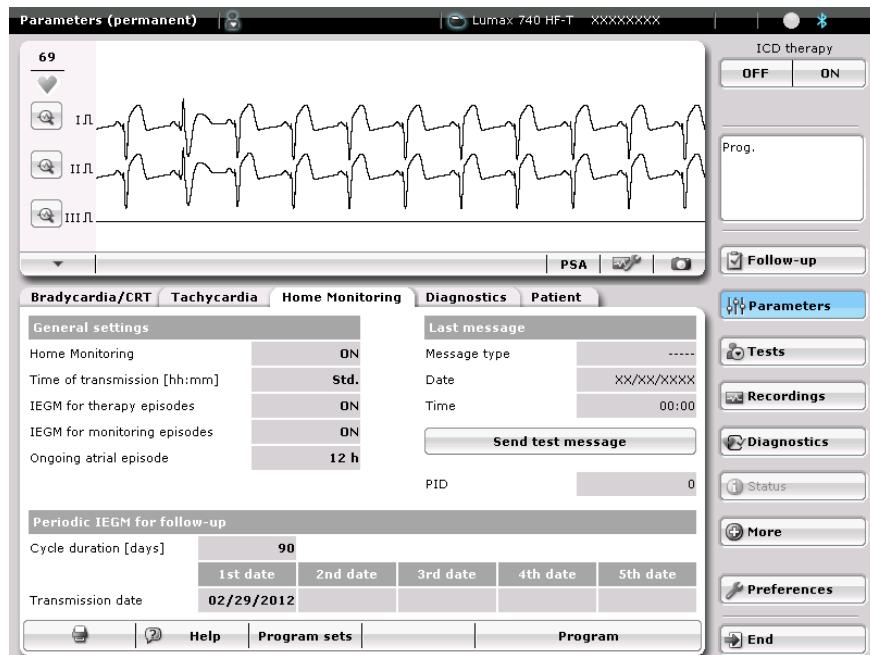


Figure 135: VF Therapy Screen showing ATP One-shot

Table 22: ATP One-Shot programming options

Parameter	Burst	Ramp
Attempts	One Only	
Ventricular pacing	RV, BiV	
Number of S1	1 ... (1) ... <b>8</b> ... (1) ... 10	1 ... (1) ... <b>8</b> ... (1) ... 10
R-S1 Interval	Programmable as an adaptive value of 70 ... (5) ... <b>85</b> ... (5) ... 95%	
S1 Decrement	N/A	5... (5) ... <b>10</b> ... (5) ... 40 ms

## 7.2.3 Home Monitoring®



**Figure 136: Home Monitoring® screen**

The Home Monitoring® screen ([Figure 136](#)) allows the user to set up transmission schedules for Home Monitoring® as well as the recording of IEGM information for Home Monitoring® transmission.

### 7.2.3.1 Home Monitoring®

#### ON, OFF

The user can program the device to transmit or not.

### 7.2.3.2 Time of Transmission

Clock based (24 hour clock) - Standard; 00:00 ... (01:00) ... 23:00 hh:mm

The selection Standard uses the device serial number to calculate a transmission time between 01:00 AM and 02:00 AM. Otherwise, the user can select a time the device transmits information to the Service Center. It is generally recommended that transmissions occur while the patient is asleep as this provides the best chance the patient is in range of the CardioMessenger.

#### NOTE:

Always verify the programmer time prior to programming the transmission time as the device time is based on the current programmer time.

### 7.2.3.3 IEGM for Therapy Episodes

#### ON, OFF

When programmed ON, the device will transmit the IEGM stored during a therapy episode to the service center.

### 7.2.3.4 IEGM for Monitoring Episodes

**ON, OFF**

When programmed ON, the device will transmit the Monitoring Zone IEGM to the Service Center.

### 7.2.3.5 Periodic IEGM

OFF, Date, **30**, 60, 90, 120, 180 days

When programmed to an interval, the device will send a period IEGM to the service center based on the device programming.

The user can program the 1st date of transmission of the Periodic IEGM. The device will then send the next periodic IEGM 30 day (default) after the first transmission provided no other device programming has occurred.

If Date is selected, the user can program up to 5 transmission dates into the device.

### 7.2.3.6 Ongoing Atrial Episode

OFF, 6, **12**, 18 hours

The device will send a message to the service center after a programmed time to alert the physician that the patient is in an ongoing atrial arrhythmia.

## 7.2.4 Diagnostics

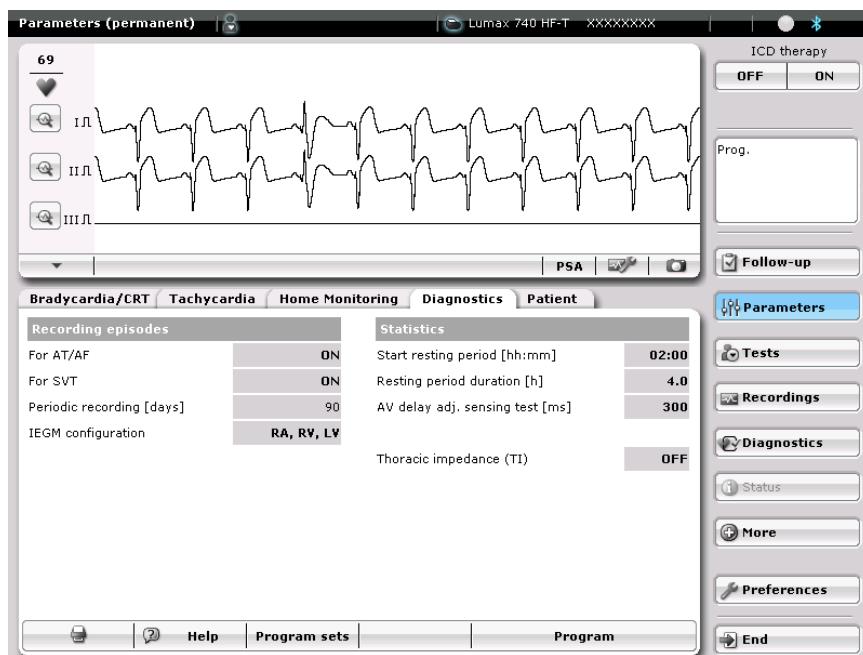


Figure 137: Diagnostics screen

### 7.2.4.1 Recording episodes

**For AT/AF:**

OFF, **ON**, Advanced ON

This allows the user to record atrial tachyarrhythmias into the Holter based on the programmed rate selected in the Tachycardia tab of the device. Selecting Advanced ON doubles the prehistory time of the recording (circa 1 min), allowing the user to view more information related to the onset of the arrhythmia.

**For SVT:**

OFF, **ON**

This parameter stores IEGM data for SMART® Detection SVTs such as AFib, AFlut, SVT and 1:1.

### 7.2.4.2 Periodic recording

OFF, 30, 60, **90**, 120, 180 days

This parameter provides the capability to send periodic IEGMs without enabling Home Monitoring. The default value is 90 days. It can be used as diagnostic support for the normal heart rhythm of the patient at regular in-office follow-ups if needed. If Home Monitoring is ON it displays the value programmed in the Home Monitoring section of the device.

### 7.2.4.3 IEGM configuration (HF-T devices only)

**RA, RV, LV; FF, RV, LV; RA, RF, FF**

This parameter determines the IEGM configuration for the episode recordings in a CRT-D because the storage is limited to 3 channels only. ECG lead (FF) can be used alternatively to RA or LV IEGM.

### 7.2.4.4 Start resting period

Clock based; 00:00 ... (01:00) ... **02:00** ... (01:00) ... 23:00 hh:mm

This parameter determines the Heart Rate at Rest start time, as programmed by the user. Generally, it is recommended to program the time while the patient is at rest or asleep in order to get a more accurate measurement of the true resting heart rate for the patient.

### 7.2.4.5 Resting period duration

0.5 ... (0.5) ... **4.0** ... (0.5) ... 12 h

This parameter determines the duration for the calculation of the mean heart rate at rest calculation. During this time the device will mean the mean heart rate in 10 minutes windows. The lowest value recorded during this time will be displayed on the HF monitor diagnostics.

### 7.2.4.6 AV Delay adjustment sensing test

Off, **300 ms**

Extends the AV Delay during the automatic sensing test to promote intrinsic activity in the ventricle and allow sensing values to be measured. Feature may be turned off in patients with no AV conduction Complete Heart Block or high-grade AV Block.

### 7.2.4.7 Thoracic impedance (TI)

#### ON, OFF

The thoracic impedance is measured between the distal shock-coil of the RV lead and the ICD housing. Up to 1,024 measurements are done every hour and these measurements are then averaged. The 24 measurements per day are averaged and stored in the device and transmitted via Home Monitoring as a single average point per day. The Home Monitoring website then displays a trend of the daily average. The same trend of daily TI averages is displayed on the programmer upon interrogation of the ICD. The TI trend does not replace assessments that are part of standard of care for the clinical practice. The clinical value of this feature has not been established for the management of patients.

## 7.2.5 Patient

This section allows the user to add patient, physician, hospital and lead information. This information is stored in the device and can be accessed with any compatible programmer. The data in this section can be modified at any time.

### 7.2.5.1 Patient Data

#### ID

This section allows the user to input up to a five digit code to serve as a patient identifier. This may be a medical records number or a study number if the patient is enrolled in a study.

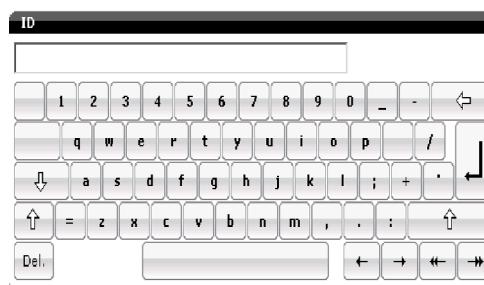


Figure 138: ID Number

#### First Name/Last Name

These sections allow the user to input the patient's first and last name into the memory of the device. This is a free text box, allowing up to 20 characters for the first name, as well as for the last name. Enter the patient's name and select the enter key.



Figure 139: First Name



Figure 140: Last Name

### Date of Birth

This section allows the user to input the patient's birth date. The birth date is entered as MM/DD/YYYY, as shown in [Figure 141](#). When initially accessed, the current day will be displayed. The date can be changed using the following methods:

- Selecting the keypad icon to the left of the OK button will bring up a number keypad allowing the user to manually input the date.
- The day can be selected simply by touching the appropriate day on the screen.
- Pressing the month will bring up a listing of the 12 months, and the user can select the appropriate month.
- Selecting the year will bring up a numeric keypad, allowing the user to enter a year.
- The double arrow will change the year by one value each time it is touched. The left double arrows decrease the value and the right double arrows increase the value.
- The single arrow will change the month by one. The left arrow decreases the value and the right arrow increases the value.

Once the date is entered, select the OK button

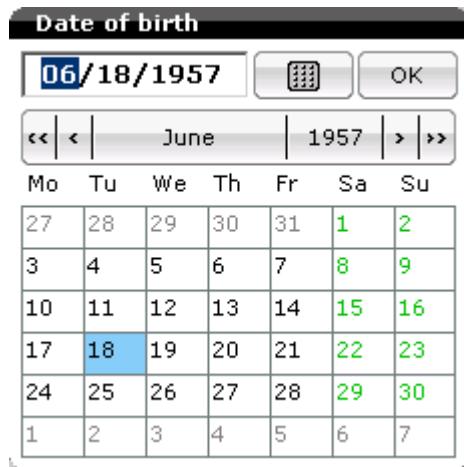


Figure 141: Date of Birth

### Gender

This section allows the user to select the patients gender.



Figure 142: Gender

## Symptom

This section allows the user to select one or multiple symptoms related to the patient. Selecting a symptom will result in a check mark appearing in the box to the left. Once completed, press the OK button. The selection(s) will appear on the main patient page.



Figure 143: Symptom

## ECG Indication

This section allows the user to select one or multiple ECG indications related to the patient. Selecting an ECG indication will result in a check mark appearing in the box to the left. Once completed, press the OK button. The selection(s) will appear on the main patient page.

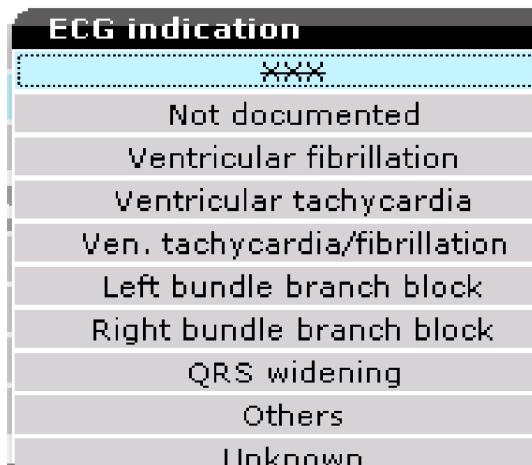
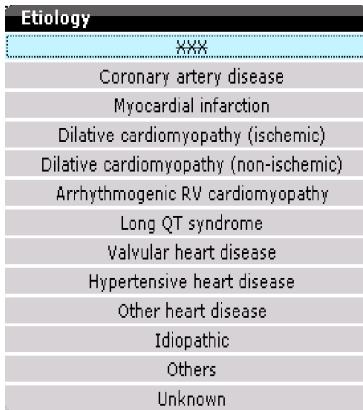


Figure 144: ECG Indication

## Etiology

This section allows the user to select one or multiple etiologies related to the patient. Selecting an etiology will result in a check mark appearing in the box to the left. Once completed, press the OK button. The selection(s) will appear on the main patient page.

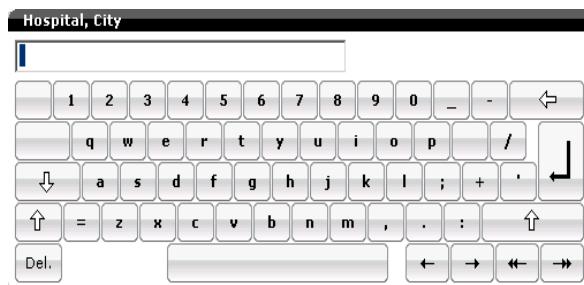
**Figure 145: Etiology**

### Date of Implant

The implantation date is automatically added after implantation when valid impedance values are measured by the device. This refers to the device implantation date. The lead implantation date can be manually entered in the lead section.

### Hospital and City

The hospital name and city name can be added. As with entering the patient's name, up to 20 characters are available to add hospital and city information.

**Figure 146: Hospital, City**

### Physician/Phone

The physician name and phone number can be added. The Physician name can be entered in the left side box and the phone number on the right side box. As with the patient name, up to 40 characters are available to add physician information. It is a good idea to also add the physician's first name also to help prevent confusion.

**Figure 147: Physician information**

## Remark

Free text remarks can be entered into the device. Up to 42 characters (including spaces) can be entered.



**Figure 148: Remark**

## LVEF

This refers to the left ventricular ejection fraction. Here the user can select the LVEF, if known.

XXXX	10	11	12	13	14	15	16	17	18
19	20	21	22	23	24	25	26	27	28
29	30	31	32	33	34	35	36	37	38
39	40	41	42	43	44	45	46	47	48
49	50	51	52	53	54	55	56	57	58
59	60	61	62	63	64	65	66	67	68
69	70	71	72	73	74	75	76	77	78
79	80								

**Figure 149: LVEF**

## NYHA

This refers to the New York Heart Association classification. A value can be entered if it is known.

NYHA	
XXXX	I
II	III
IV	Unknown

**Figure 150: NYHA**

## Lead Information

Lumax 740 series allows atrial and ventricular lead information to be added to the device memory.

### Lead Model

The lead model number can be entered here using both letters and numbers.

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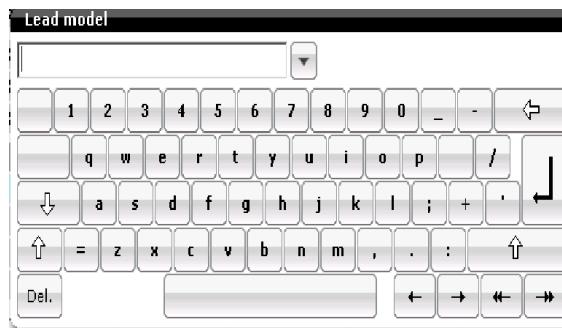


Figure 151: Lead Model

## Manufacturer

This box allows the user to select the lead manufacturer.

Manufacturer		
Biotronik	Boston Scientific	ELA Medical
Guidant	Medtronic	St. Jude Medical
Alpha	American Pacemaker (IMC)	Angeion Corp.
APC	B. Braun Mels.	Biomedica
Biovallees	Braun Celsa	Braun Melsungen
Cardiac Control	Cardiac Control Systems	Cardiac Pacemakers Inc.
Cardio-Pace	CCS	Cook
Coretomic	Cordis	DPI
Elema	Enpath	GEC
Genisis	IMA	Innomedica
Intermedics	LEM	Optima
Oscar	Osypka	Pacesetter
Possis	PSI	Quatrox
Siemens	Somedics	Sulzer
Teletronics	TESLA	TUR
Vasco Med	Vascor	Vascotip
Siemens-Elema	Sorin	Ventrifex
Vitatron		
Other		

Figure 152: Manufacturer

## Serial Number

The device serial number is entered on this screen.

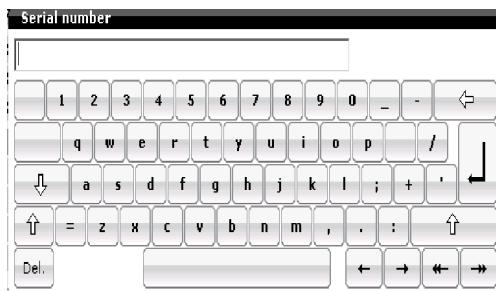


Figure 153: Serial number

## Polarity

The polarity of the lead can be added for the atrial and ventricular leads.

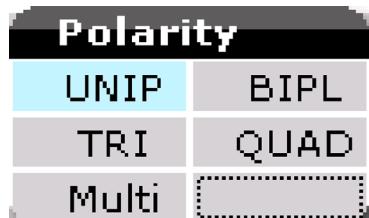


Figure 154: Lead polarity

### Implantation

This box allows the user to enter the implantation date of the leads



Figure 155: Implantation date

### Channels

This box allows the user to choose the channel to which the lead is connected.

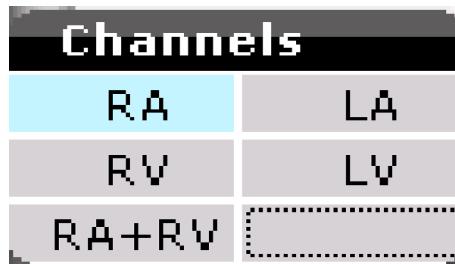


Figure 156: Lead channel

## 7.3 Conflict Manager

Lumax ICD software includes programming rules that result in parameter conflicts when selected values lead to unsafe or illogical parameter combinations. The programmer will not transmit parameters with conflicts present. However, the software includes a Conflict Manager, which displays a Conflict button with each conflict. When the button is selected, a pop-up editing window reveals a short message to guide reprogramming.

An example showing the Conflict Manager is shown in [Figure 157](#). In this case, the VT1 zone and Max Sensor Rate program overlap. To resolve the conflict, the Max Sensor Rate must be programmed to a lower rate relative to the VT1 zone, as indicated by the message. Once the rates are properly adjusted and the Close button is pressed, the pop-up window and the Conflict button disappears, revealing the OVERVIEW screen.

## Chapter 7 Programming Overview

### Lumax 740 Technical Manual



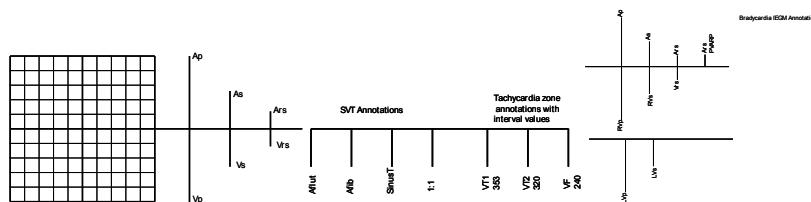
**Figure 157: The Conflict Manager screen**

## 8. Implantation Testing, EP Test Functions and Follow-up

All tests related to an ICD implant and follow-up are located on the Tests screen. These tests include: P/R amplitude measurements, pacing impedance, retrograde conduction test, threshold (pacing), DFT test and ATP test. Additional EP test functions are also available with the Lumax 740 family of ICD/CRT-Ds, including extensive testing of defibrillation thresholds as well as the ability to verify the effectiveness of anti-tachycardia pacing and defibrillation shocks. Each of these tests is described in this chapter.

### Marker Annotations

The Lumax 740 ICD provides multiple-sized marker annotations on ECGs and IEGMs to differentiate events from a bradycardia timing perspective. Shown below are examples of the different marker annotations. The SVT annotations are available on stored episodes only.



**Figure 158: Marker Annotations**

#### NOTE:

In the Lumax 740 devices, unused sensed events can occur in any chamber. They will be annotated as Ars or Vrs events. These events are not used for bradycardia timing cycles. However, these intervals are used for mode switching and/or tachyarrhythmia detection.

#### NOTE:

Tachyarrhythmia detection/therapy is temporarily disabled while the sensing, threshold, retrograde and impedance tests are active. Once the specific test is complete, detection/therapy is active again.

## 8.1 P- and R-Wave Measurements

Sensing test may be performed via the Start or Intrinsic Rhythm buttons.

### 8.1.1 START (test)

The sensing test is performed in a VDI mode with a programmable back-up support pacing when the START button is selected. Atrial values will be given even if the device is programmed in a VVI(R) mode.

When the Tests button is selected, the Sensing screen is revealed, as illustrated in [Figure 159](#). The P- and R-wave amplitudes are automatically measured on command using the Start button. During the tests, the device uses the temporary pacing program to provide backup bradycardia support. The intrinsic amplitudes are measured over several beats and are displayed on the programmer screen when the test is complete. The user has an option to print an IEGM strip during the test via the Report button on the left side of the screen.

## 8.1.2 Intrinsic Rhythm (test)

The sensing test can also be performed by selecting and holding down the Intrinsic Rhythm button. If pressed, the Intrinsic Rhythm test looks for an underlying rhythm but provides no back-up pacing support (ODO or OVO mode) for the duration the button is depressed. This feature should not be used in patient with third degree or high degree AV Block.

### NOTE:

When selecting the Intrinsic Rhythm button, there is no support pacing for the duration the button is depressed. This test should not be performed with pacemaker dependent patients.



Figure 159: The Sensing screen with sensing test in progress

### 8.1.2.1 Back-up pacing mode

OFF, VVI, AAI and VDD

The OFF mode provides no pacing support during the test and should not be used for pacemaker dependent patients.

AAI mode provides no ventricular pacing support and should not be used for patients with high-grade or complete heart block.

VDD mode may be used for pacemaker-dependent patients who suffer from pacemaker syndrome.

### 8.1.2.2 Ventricular Pacing

BiV and RV (BiV for HF-T devices only)

### 8.1.2.3 Basic Rate

30 ... (5) ... 100 ... (10) ... 160 bpm

### 8.1.2.4 AV Delay

100 ms

This is a fixed value available only when the VDD mode is selected.

### 8.1.2.5 LV sensing polarity

Programmed polarity

### 8.1.2.6 Report

OFF, 5, 10, 25 or 50 mm/sec

Report is the paper speed when performing the sensing test.

**NOTE:**

During the sensing test, PVARP is set to 200 ms.

## 8.2 Pacing Lead Impedance

Performed independent of the programmed mode using subthreshold outputs of 135 uA @ 45 us. The user can select the desired LV pacing polarity for the test.

Atrial value may be given even though the device is permanently programmed in a VVI(R) mode.

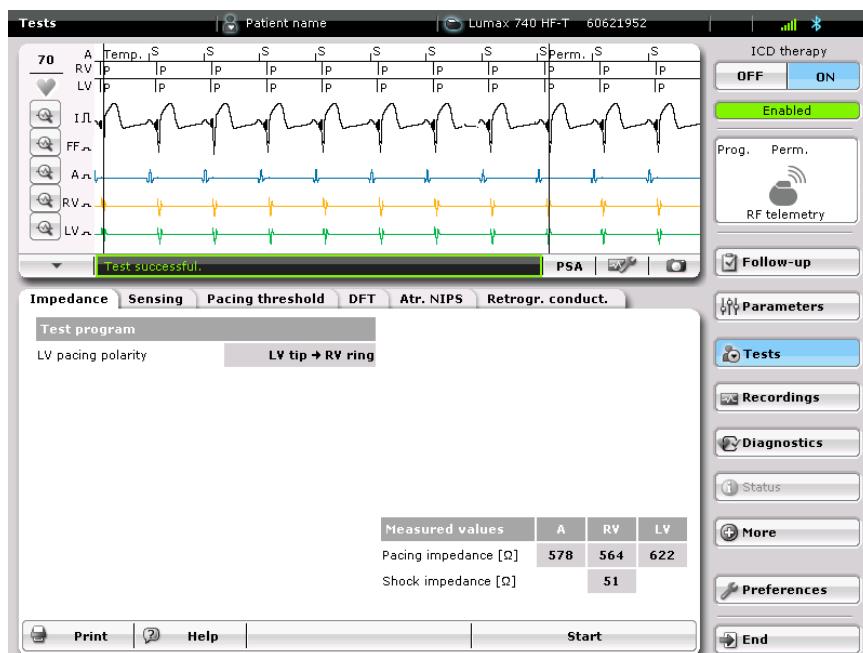


Figure 160: Performing the Impedance Test

Atrial and ventricular pacing lead impedance can be used to determine whether the pacing leads are electrically sound. The pacing impedance is the total resistance to current flow along the lead, across the lead-tissue interface, and into the tissue. A large impedance value (e.g., greater than 3000 ohms) may indicate lead fracture. A small impedance value (e.g., less than 200 ohms) may indicate an insulation break.

The pacing impedances are measured from the Impedance tab found under the Tests button. To measure the impedance, simply press the Start button at the bottom of the screen. The word TEMP (temporary) appears on the marker channel when the test has started and across the bottom of the

screen the phrase “Lead detection in progress. Please wait...” appears with a status bar under the IEGM. Additionally, the device status will be temporarily changed to “Temporarily inactive” while the test is active and returns to “Enabled” when the test is complete. After the button is pressed, a series of subthreshold pacing pulses are delivered. The programmer measures the voltage drop from the leading edge to the trailing edge of the delivered pulses and automatically calculates impedance from the measured voltage drop. The calculated value is immediately displayed on the programmer screen. (See [Figure 160](#).) When the test is complete, the term Perm appears on the marker channels. The impedance test displays the Shock Impedance first and then the atrial and ventricular pacing impedances. Atrial impedance measurements may be difficult in patients with atrial fibrillation at the time of testing. Increasing the sensing threshold value (decrease sensitivity) to force atrial pacing may help in forcing atrial pacing in order to obtain impedance. Be sure to change the sensing threshold back if it is changed for the test.

The Impedance test allows the user to program any LV pacing polarity in order to determine the pacing polarity in different configurations.

### 8.3 Retrograde Conduction Test

The Retrograde conduction test is performed in a VDI mode with a programmable ventricular pacing rate.



**Figure 161: Retrograde conduction test.**

#### 8.3.1 Measuring Retrograde Conduction

The Retrograde Conduction test measurement is initiated from the Retrograde Conduction tab. During the test, the pacemaker operates in VDI mode at a programmable rate that must exceed the heart's intrinsic rate. The V-A interval is measured using the event markers in the IEGM (V pace to A sense). The measurement begins after the Start tab is pressed.

The programmer displays the results as the maximum, minimum, and average retrograde conduction time (RCT), and the measured V-A times are displayed on the marker channel. Generally, if the min, mean and max times are within 25 ms, retrograde conduction is suspected. The timing values shown are equal to the time between the ventricular pace and the first subsequent atrial sense event.

Retrograde conduction from the ventricle to the atrium can be confirmed when a 1:1 relationship at a constant V-A interval is present.

### Requirements for Measurement

1. Telemetry contact (wand or RF) must be maintained with the ICD for the entire measurement duration. If telemetry contact is interrupted, the measuring process will be aborted. This is true for all tests. The values measured up to this point remain displayed.
2. Retrograde conduction can only be measured if ventricular pacing and atrial sensing are present.
3. The ventricular rate for the test MUST be greater than the atrial rate.

#### NOTE:

Retrograde conduction may not be present at all rates. If retrograde conduction is suspected, perform the test at different rates.

### 8.3.2 Programming to prevent PMT

If Retrograde conduction is confirmed, extending the PVARP value by 10-15 ms greater than the RCT interval can cover the retrograde events. Caution should be used, as this will reduce the 2:1 block point for bradycardia pacing.

### 8.4 Pacing Threshold Test

The screenshot shows a software interface for selecting threshold test modes. At the top, a black bar contains the word "Mode". Below it is a grid of six cells representing different combinations of atrial and ventricular modes. The first column is labeled "Atr." and the second column is labeled "RV" and "LV". The rows are labeled "DDD", "DDI", and "VVI". The last row contains the suffix "- AUTO" under each mode. A "Close" button is located in the top right corner of the grid area.

Mode		
Atr. DDD	RV DDD	LV DDD
Atr. DDI	RV DDI	LV DDI
Atr. AAI	RV VVI	LV VVI
	RV DDD - AUTO	LV DDD - AUTO
	RV VVI - AUTO	LV VVI - AUTO

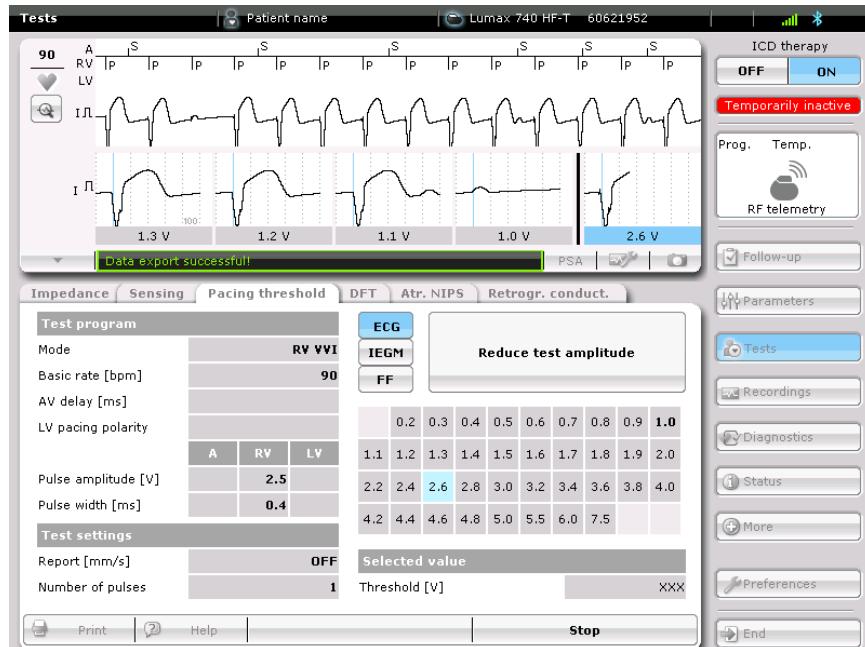
**Figure 162: Threshold Test Choices with Lumax 740 HF-T**

The atrial and ventricular pacing thresholds are determined using the threshold tests found under the Threshold tab, as illustrated in [Figure 163](#), [Figure 164](#) and [Figure 165](#). The right and left (HF-T only) ventricular threshold test can be performed in the DDD, DDI or VVI mode at a user-defined rate between 30 and 160 bpm. The atrial threshold test can be performed in the DDD, DDI or AAI. Auto threshold tests in the RV and LV channels using the same algorithm as the ATM/VCC tests can also be selected. In addition, the atrial IEGM screen can be displayed during the atrial threshold test by toggling the ECG/IEGM button. As with all screens, the patient's intrinsic rate is displayed in the upper right hand corner below the Adjust/Freeze buttons. The intrinsic rate helps the user select the best pacing rate for the test.

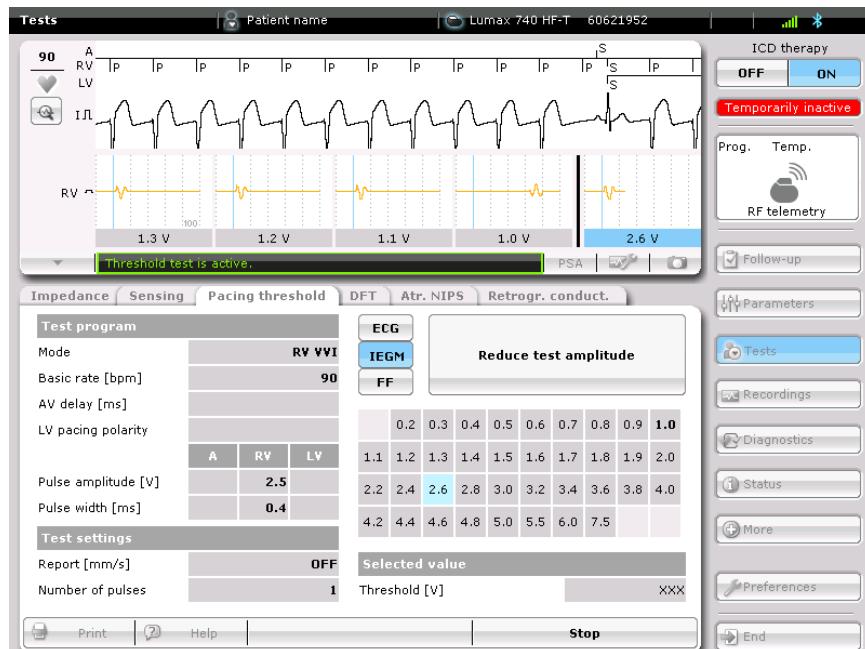
The Lumax 740 devices allow real-time changes during the threshold tests. The user can change any of the values while the test is ongoing.

## Chapter 8 Implantation Testing, EP Test Functions and Follow-up

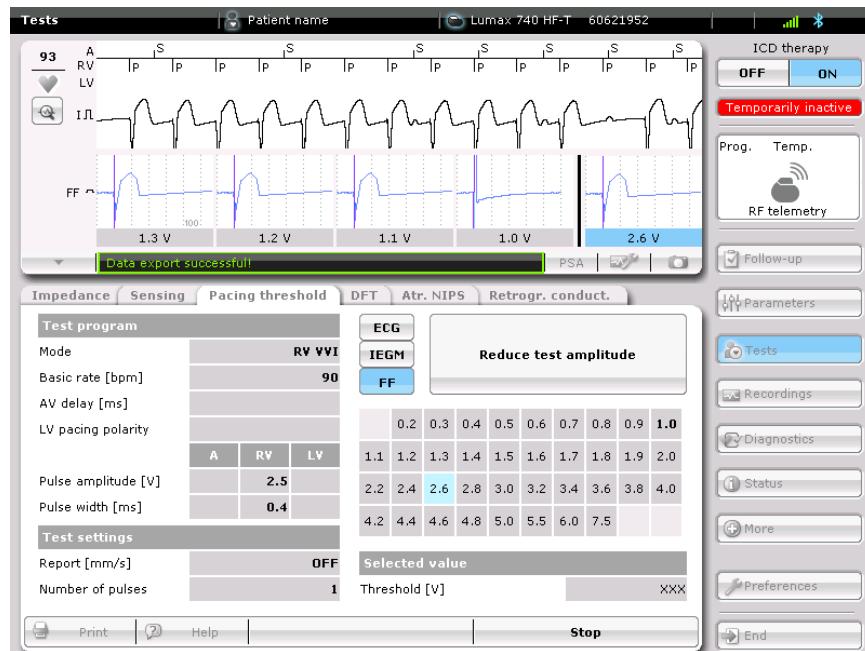
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**Figure 163:** The Pacing Threshold Test using the ECG option



**Figure 164:** The Pacing Threshold Test using the IEGM option



**Figure 165: The Pacing Threshold Test using the far-field option**

As the threshold test begins, the selected pacing parameters are transmitted temporarily to the device. These parameters are default parameters (i.e., the parameters programmed between test parameters) and should be adjusted to guarantee capture. The rate should be programmed above the patient's intrinsic rate to prevent inhibition. Thereafter, test amplitudes can be decremented until capture is lost and the threshold is determined. The test amplitude will change only when new amplitudes are selected and Number of Pulses is programmed to “∞”. Otherwise, a set number of pulses (1-10) will be delivered with each new test amplitude selected before reverting back to the starting value. The default parameters will be reprogrammed between test selections.

When each test is complete, the threshold value is entered into the programmer for future reference. The ECG strip from the entire test is printed if Report is set to a user-defined printer speed. Otherwise an annotated version of the test can be printed after the test by selecting the “Print” button found in the lower left-hand corner of the screen.

## 8.5 Defibrillation Threshold Testing (DFT)

Defibrillation threshold testing is performed from the DFT Test screen. These tests allow the physician to assess defibrillation thresholds and to verify adequate and appropriate detection and sensing during induced arrhythmias. As DFT tests are performed, the ventricular signal is continuously evaluated via the real-time IEGM signal on the programmer screen. The DFT Test screen as it appears when you enter the test page is shown in [Figure 166](#).

## Chapter 8 Implantation Testing, EP Test Functions and Follow-up

### Lumax 740 Technical Manual

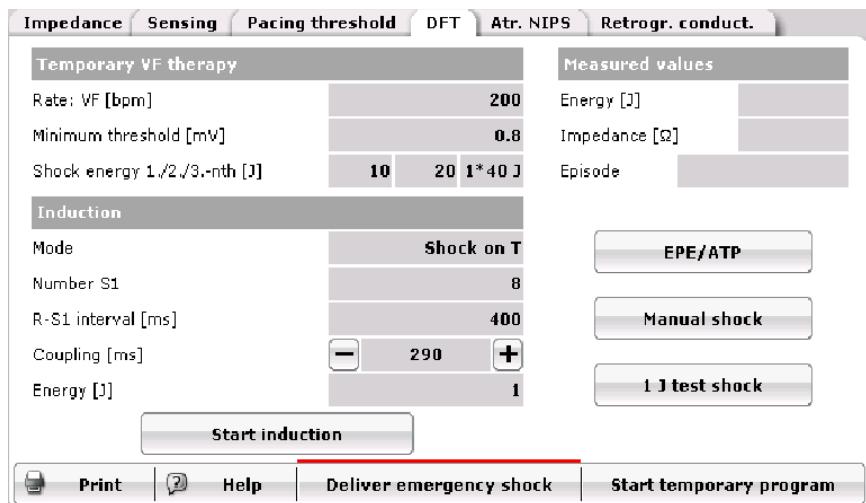


Figure 166: The Lumax 740 DFT Test screen

### WARNING

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

### CAUTION

**Defibrillation Threshold** - Be aware that the changes in the patient's condition, drug regimen, and other factors may change the defibrillation threshold (DFT) which may result in non-conversion of the arrhythmia post-operatively. Successful conversion of ventricular fibrillation or ventricular tachycardia during arrhythmia conversion testing is no assurance that conversion will occur post-operatively.

The DFT Test screen is organized left-to-right in order of use during testing. On the upper left of the screen is the Temporary VF therapy program. This allows the device to use the selected values on the screen without having to permanently program changes to the device. The user can change the VF zone rate, minimum threshold and shock energy output and number of programmed delivered shocks. The user can elect to deliver only two shocks without the need of a release code.

Below the temporary VF therapy section is the Induction section. Here the user can select the induction mode of Shock-on-T or HF Burst, the number of S1 events, the R-S1 interval, coupling interval and energy (Shock-on-T).

In the upper right portion of the screen provides information related to the delivered energy, shock impedance and the date and time of the last recorded episode. A link to the last episode is also provided.

Below the measured values are buttons to access manual ATP (EPE/ATP), deliver a manual shock and deliver a 1-joule test shock. These will be discussed in greater detail throughout the chapter.

### 8.5.1 Induction

The Start induction button is located on the bottom left hand portion of the screen. Two different induction schemes are available: Shock-on-T and HF Burst. If the rhythm is not converted by the device after induction, an emergency shock can be delivered via the Deliver Emergency Shock button found on the bottom center of the screen or Manual shock button located at the right lower portion of the screen. The manual shock energy should be set to a rescue energy level in the case of ventricular undersensing. Manual ATP may also be delivered in the event VT is induced through the EPE/ATP screen.

#### **WARNING**

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

#### **CAUTION**

**Manual Shocks** – User-commanded shocks may be withheld if the ICD/CRT-D is already busy processing a manual command or the Battery Status is low.

#### **NOTE:**

The emergency shock and manual shocks are delivered with confirmation OFF.

### 8.5.2 Shock Lead Impedance

Before an arrhythmia is induced during DFT testing, shock lead connections and lead integrity should be checked. This can be done by performing a painless impedance test from the impedance tab or by delivering a 1-J test shock. As with pacing lead impedance, shock impedance values can indicate poor connector contact, lead fractures, or insulation failures.

Acute shock impedance values should be greater than  $25\ \Omega$  and less than  $100\ \Omega$ , though the programmer will measure up to  $150\ \Omega$ . If the impedance is less than  $25\ \Omega$ , increasing the distance between electrodes through repositioning may increase impedance. However, the device can be damaged if a shock is delivered with very low impedances. Therefore, the pulse generator should not be implanted with a lead system with impedances less than  $25\ \Omega$ . If impedance is greater than  $150\ \Omega$ , shock therapy is likely to be ineffective. No damage will be done to the device during shock delivery in this case; however, the amount of the energy to the patient may not be the programmed amount.

#### **1 J Test Shock**

This test shock may be performed before device testing to ensure shock lead integrity if the painless shock impedance is not performed. After the one-joule (1 J) test shock is delivered, the shock impedance can be viewed and verified by viewing the Measured values portion of the DFT page.

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To ensure the 1-J test shock does not induce VF, the Lumax 740 ICD times the shock after a three pulse pacing train. Pacing is delivered in a VOO mode. The pace train default for the 1-J test shock is 500 ms (default) but is programmable (200-500 ms) if the intrinsic interval is faster ([Figure 167](#)). This may be done to prevent the shock delivery from occurring in the vulnerable period and inducing VT/VF. The shock is delivered into the absolute refractory period of the last paced event.

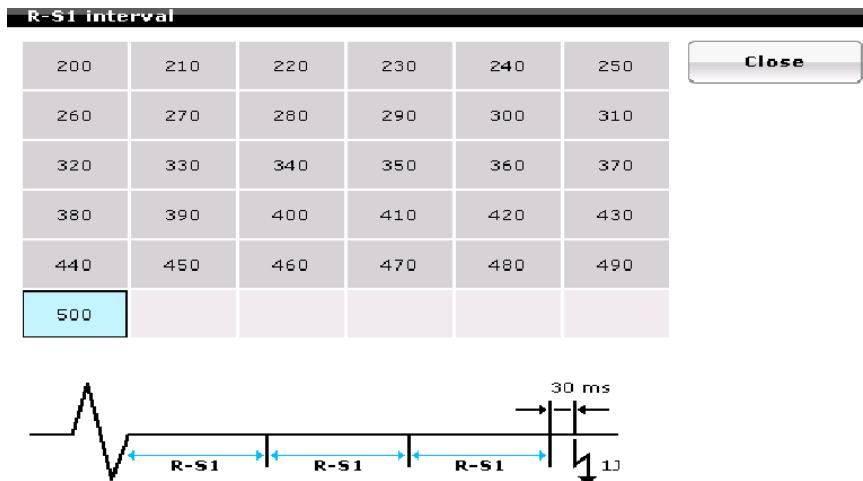


Figure 167: R-S1 interval options for 1 joule test shock

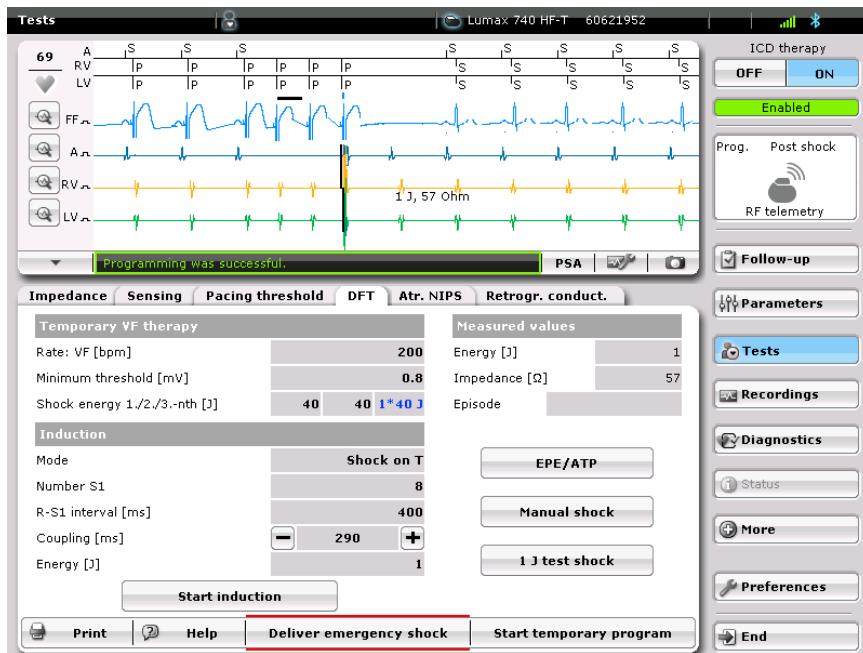


Figure 168: DFT screen with 1 J Test Shock being delivered

As seen in [Figure 168](#), the ICD will deliver three ventricular pacing pulses (500 ms; 7.5 V @ 1.5 ms) as well as a 1-J shock following a 30 ms delay after the third ventricular paced pulse. Should the user try to deliver the test shock while the device ICD therapy is OFF, a caution message is displayed to require the user to activate ICD therapy before the test shock can be delivered. This assures the device is enabled and protects the patient should the 1-J test shock induce VF.

#### NOTE:

When the test shock is administered, VF detection required to be active.

## WARNING

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

## CAUTION

**Defibrillation Threshold** - Be aware that the changes in the patient's condition, drug regimen, and other factors may change the defibrillation threshold (DFT) which may result in non-conversion of the arrhythmia post-operatively. Successful conversion of ventricular fibrillation or ventricular tachycardia during arrhythmia conversion testing is no assurance that conversion will occur post-operatively.

To improve ease of implantation, VT and VF markers displaying tachyarrhythmia detection appear at the level of the marker channel as detection occurs. In addition, a charge bar marks the progress of charging when shocks are delivered. During charging, the marker channels will disappear and will then reappear when charging is complete. The DFT Test screen as it appears after a Shock-on-T induction is shown below in [Figure 169](#).



**Figure 169:** The DFT Test screen during induction testing

### 8.5.2.1 Wand Application

Placing the wand over the ICD closes the reed switch and allows communication — including real-time IEGM transmission — between the device and the programmer. In the Lumax 740 series, unlike previous generations of BIOTRONIK ICDs, wand application does NOT inhibit tachyarrhythmia

detection and therapy. This applies to the standard wand application over the device as well as the RF telemetry mode. If an episode is ongoing during magnet application, detection and therapy will still occur.

When the programmer-initiated session is active, detection remains activated.

**NOTE:**

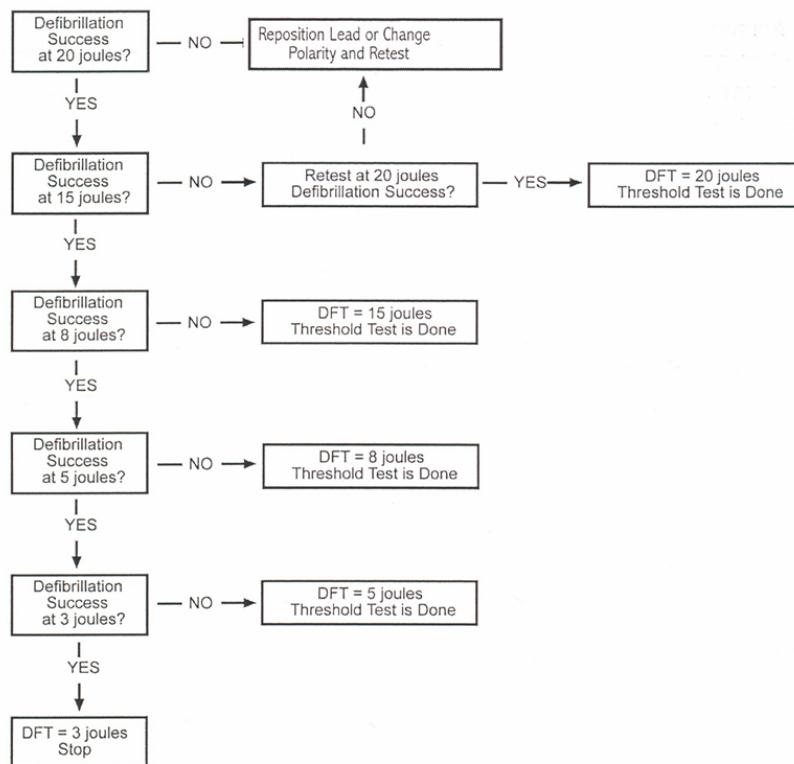
Placing an external magnet over the device will have no effect during the active session.

**NOTE:**

Once initiated, emergency shocks or manual therapies cannot be diverted.

### 8.5.3 Defibrillation Threshold Testing

Before an ICD implant can be completed, a DFT must be assessed. There are two common methods used to evaluate the DFT. The first method is to precisely define the DFT using a step-down test to conversion failure. [Figure 170](#) illustrates step-down DFT testing. The example begins by evaluating conversion efficacy at 20 joules. If a 20-J shock does not successfully convert the induced arrhythmia, the system must be modified (e.g., the lead position or polarity should be changed) until a 10-J safety margin can be met. If the 20-J shock is successful, a second arrhythmia is induced and a conversion is tested at 15 joules. If the 15-J shock is successful, the procedure continues until the induced rhythm cannot be converted. The lowest energy that successfully converts the rhythm defines the DFT.



**Figure 170: Step-down DFT test**

The second testing method is to determine only if an adequate safety margin exists. Standard practice for all ICD implants dictates that an induced fibrillation should be successfully converted twice by a shock that is 10 joules less than the maximum energy output of the device. (See [Figure 171](#).)

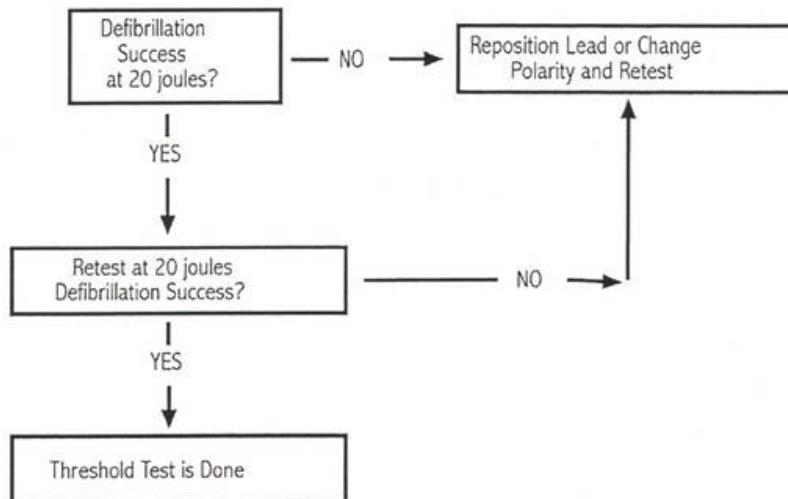


Figure 171: 20-J Safety Margin Test

### 8.5.3.1 Upper Limit of Vulnerability testing with Shock-on-T-wave induction

An alternative to standard DFT testing is the Upper Limit of Vulnerability, which uses defibrillation level energies to determine the DFT for the patient. Shock-on-T-wave energies start at higher energies and step down until VF is not induced, thereby demonstrating the defibrillating threshold for the patient. To ensure that appropriate shock coupling occurs with the higher energies, the Lumax ICD will extend the number of S1 pulses to the end of the charging cycle. This means that even though the number of S1 pulses are programmed to 8 (as shown in [Figure 172](#)), one may see 12 pulses if 15 joules is programmed for ULV testing.

### 8.5.4 Arrhythmia Induction Types

The Lumax 740 devices can be programmed to induce arrhythmias for DFT testing using two different induction schemes: 1) Shock-on-T or 2) HF Burst. Induction success depends on the patient and on the induction type. Shock-on-T is usually most effective for inducing ventricular fibrillation.

The Lumax 740 series provides an on-screen clock located on the induction screen displaying the time since last induction.

**NOTE:**

All induction schemes use a VOO pacing mode.

**WARNING**

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

## CAUTION

**Manual Shocks** – User-commanded shocks may be withheld if the ICD/CRT-D is already busy processing a manual command or the Battery Status is low.

### 8.5.4.1 Shock-on-T

Number S1: 1 – 25 events; Default **8**

R-S1 Interval: 300 ... (10) ... 600 ms; Default **400 ms**

Coupling Interval: 200 ... (10) ... 400 ms; Default **290 ms**

Energy: OFF, 1 joule to maximum output of the device (40 J); Default **1 joule**

The Shock-on-T-wave induction scheme begins with a train of pacing pulses. The number of paced pulses (i.e., Number S1) and the coupling interval (i.e., R-S1 Int.) are programmable. Generally, the coupling interval R-S1 is programmed between 300 and 450 ms with the number of S1 pulses between 4 and 8 pulses.

Following the train, there is a timed shock coupling period and then shock delivery. The shock coupling period and the shock energy are programmable. To increase the probability of induction success, shock coupling should be programmed to target the vulnerable period of the cardiac cycle (i.e., the time just prior to the peak of the T-wave, usually 290 to 310 ms). In cases of a left bundle branch block, one may need to extend the coupling interval to find the vulnerable period to induce VF. The shock energy rarely needs to be reprogrammed from its default value of 1 joule.



Figure 172: Shock-on-T Induction (the shock waveform for induction is biphasic)

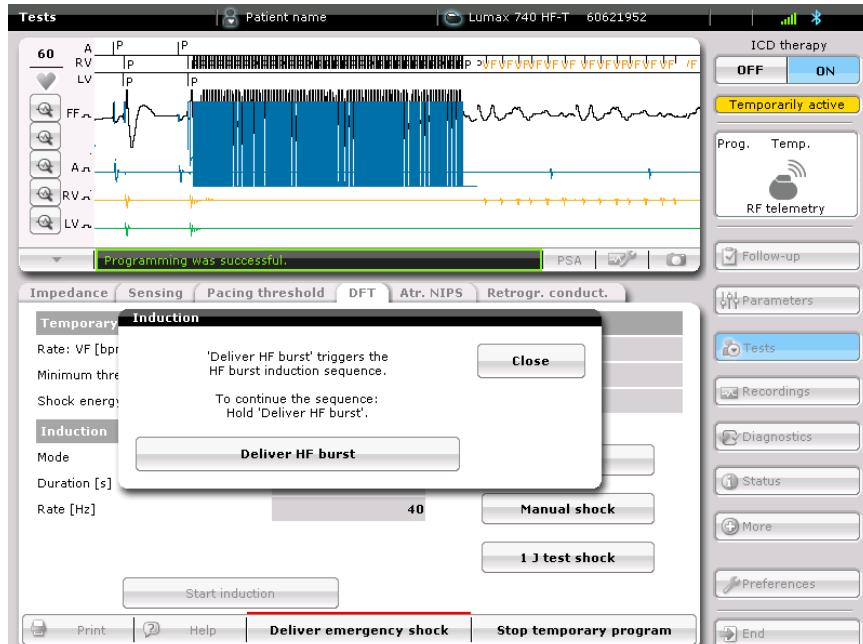
### 8.5.4.2 HF Burst

Duration: 1, 2, 3 or **4 seconds**; Default 4 seconds. HF Burst can be delivered for an extended time by holding the START button down.

Burst Rate: 10 ... (5) ... 40 Hz; Default **40 Hz**

Another type of fibrillation induction can be accomplished using an HF (High Frequency) Burst. This scheme consists of a large number of pulses delivered in rapid succession over a user-defined period of time. (See [Figure 155](#).) The Burst Rate can be programmed between 10 and 40 Hz with durations of 1, 2, 3 or 4 seconds. Hertz (Hz), in this case, means the number of paced pulses delivered per second by the Lumax ICD. If 40 Hz is selected, the device will deliver 40 paced pulses per second to the patient.

The Start button is accessed when the Start VT/VF Induction button is pressed. HF Burst impulses are delivered at the maximum pacing energy of 7.5 V @ 1.5 ms.



**Figure 173: HF Burst induction**

## 8.5.5 Manual Therapy

The new positioning concept of the manual therapy options in the 2nd level no longer makes the confirmation click from previous Lumax devices necessary. Therefore, therapy made within these EPE/ATP windows will be immediately applied without a second confirmation, as in previous Lumax devices.

### 8.5.5.1 Manual ATP

Available in the EPE/ATP section of the DFT screen.

Type: **Ramp**, Burst or Burst + PES;

Ventricular pacing: **RV** or BiV (HF-T only)

Number S1: 1 ... (1)...25; Default **5**

R-S1 Interval: 70% ... (5%) ...95%, 200 ... (10) ...600 ms; Default **80%**

S1 Decrement: 5 ... (5) ... 40 ms (Ramp Only); Default **10 ms**

S1- S2 Interval: 70% ... (5%) ...95%, 200 ... (10) ...600 ms (Burst + PES only); Default **290 ms**

S2- S3 Interval: **OFF**, 70% ... (5%) ...95%, 200 ... (10) ...600 ms (Burst + PES only)

S3- S4 Interval: **OFF**, 70% ... (5%) ...95%, 200 ... (10) ...600 ms (Burst + PES only)

Plus and minus button make it easy to adjust the Sx-Sy intervals for EPE.

### 8.5.5.2 Manual Shock

Energy: 1-**40** joules

Polarity: **Normal** or Reversed

Waveform: **Biphasic** or Biphasic 2

Manual ATP therapy and manual shock therapy can be delivered from the DFT Test screen regardless of the magnet mode. Each therapy type is delivered with the press of the Deliver ATP or Deliver Shock button. Pressing either button will result in a new screen asking the user to confirm therapy delivery. When a manual shock is delivered, the Polarity and Energy may be adjusted to meet the specific needs of the patient or the particular situation at the time of delivery. The manual shock is delivered with Confirmation = OFF.

Burst, Ramp, and Burst + PES ATP therapies are available for manual ATP delivery. (A scheme is shown in [Figure 174](#))

#### WARNING

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

#### CAUTION

**Manual Shocks** – User-commanded shocks may be withheld if the ICD/CRT-D is already busy processing a manual command or the Battery Status is low.

### 8.5.6 Emergency Shocks

A maximum energy emergency shock can be delivered at any time using the Deliver Emergency Shock button at the bottom of the DFT TEST screen. The maximum energy shock is delivered as a committed shock (i.e., Confirmation = OFF) using a biphasic waveform with Normal polarity.

**NOTE:**

After the emergency shock command has been sent by the programmer, the shock CANNOT be aborted.

The Deliver emergency button is located at the center portion of the DFT screen. An ICD icon at the bottom left side of the operating module face can also be pressed to provide an emergency shock. A confirmation message will appear on the screen to confirm therapy delivery.

All emergency shocks will attempt to synchronize to an R-wave.

### 8.5.7 Non-Invasive Programmed Stimulation Testing (NIPS)

To perform NIPS function, the programmer wand must be placed directly over the pulse generator to enable continuous telemetry or wandless telemetry session initiated.

**NOTE:**

High pacing rates and pulse amplitudes, together with long pulse widths may temporarily decrease the amplitude of the pacing pulse. The pacing pulse must be continuously verified with an ECG to assure effectiveness.

### 8.5.7.1 Ventricular NIPS using Burst+PES

Caution should be used when using NIPS. An external defibrillator and other emergency equipment should always be available.

**Burst + PES** (Available in the EPE/ATP section of the DFT screen.)

Pacing: **RV** or BiV (HF-T only)

Number S1: 1 – 25 events; Default **5**

R-S1 Interval: 70% ... (5%) ...95%, 200 ... (10) ...600 ms; Default **80%**

S1-S2 interval: OFF, 200 ... (10) ...600 ms; Default **290 ms**

S2-S3 interval: **OFF**, 200 ... (10) ...600 ms

S3-S4 interval: **OFF**, 200 ... (10) ...600 ms

Plus and minus button make it easy to adjust the Sx-Sy intervals for programmed stimulation.

Re-entrant tachyarrhythmias may be induced using the Burst + PES (Programmed Extra Stimuli) induction scheme. The primary aim of the Burst + PES scheme is to introduce a premature pacing pulse at the precise time needed to enter an established tachycardia re-entrant circuit. This time is often difficult to predict, since the interval needed to initiate the circuit depends on several factors, including: lead position, lead distance from the re-entrant circuit, and cardiac tissue characteristics.

The Burst + PES scheme for induction resembles an ATP burst scheme, as shown in [Figure 174](#). It begins with a series of equally distanced pacing pulses, followed by one to three premature stimulus pulses. The S1-S1 interval and the coupling intervals of the premature stimuli are programmable. These intervals should be programmed to simulate the patient's clinical arrhythmia with each premature interval being shorter than the last. The probability of induction success is greatest with three premature stimuli. However, the arrhythmia induced with three extra stimuli is less likely to be clinically relevant. Therefore, it is standard practice to attempt induction with one or two PES before attempting induction with three premature stimuli.

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Figure 174: Burst + PES induction

### 8.5.7.2 Atrial NIPS

Located under the atrial NIPS tab in the Tests section.

Table 23: Atrial Burst Stimulation

Parameter	Range	Default
Burst Rate Start	30...(10)...800 bpm	250 bpm
Burst Minimum	30...(10)...250 bpm	150 bpm
Burst Maximum	250...(10)...800 bpm	350 bpm
Back-up pacing mode	OFF, VVI at basic rate value	OFF
Basic Rate	30...120 bpm	60 bpm

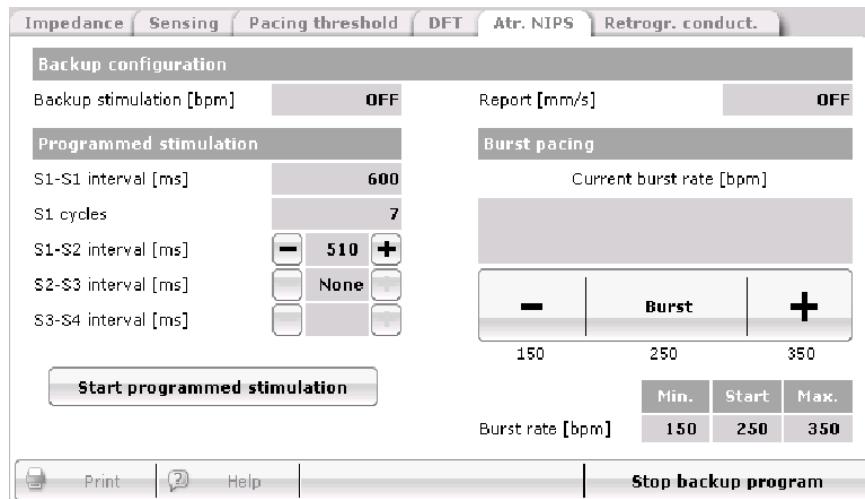


Figure 175: Atrial NIPS Screen

Burst Stimulation, shown in [Figure 175](#), offers a burst of pacing pulses in the atrium up to a rate of 800 bpm. The duration of the burst is as long as the burst key on the programmer is pressed. When the burst key is no longer pressed, the program reverts to the back-up program. Should the wand be removed or the telemetry session ended, the pulse generator reverts to the permanent program.

The upper and lower rates for Burst Stimulation may be adjusted by changing the following parameters:

- Burst rate: the initial rate when burst pacing is started
- Burst minimum: sets the lower rate of burst pacing
- Burst maximum: sets the upper rate of burst pacing

In addition to setting the rate for burst pacing, the following parameters can also be programmed for back-up pacing support:

- Mode: the user can choose either OFF or VVI at the selected rate mode for back-up pacing
- Basic rate: sets the back-up pacing rate in the absence of intrinsic ventricular activity

Burst Stimulation may be stepped up or down from the nominal value to user-defined high or low limits, as long as the selection is touched on the upper right hand portion of the screen. When the Step Up or Step Down key (+ or -) is touched, NIPS is invoked starting at the nominal burst rate and then steps up or down, respectively, in 10 bpm steps. The current value is shown on the screen ([Figure 176](#)). As soon as the step-up or step-down key is released, NIPS terminates. Subsequent inductions resume at the initially programmed burst rate.

Burst may be used to induce or terminate atrial tachycardias. In the case of attempting to terminate atrial fibrillation, one may consider burst pacing for several seconds to increase the odds of success.



**Figure 176: Atrial Burst**

### 8.5.7.3 Programmed Stimulation

Programmed Stimulation offers burst pacing at specifically defined intervals that are user defined. Programmed stimulation offers S1-S1, S1-S2, S2-S3 and S3-S4 individual intervals.

Parameter	Range	Default Setting
S1-S1 (ms)	80...(10)...2000 ms	600 ms
S1 Cycles	0...(1)...10	7
S1-S2	None, 80...(10)...1000 ms	None
S2-S3	None, 80...(10)...1000 ms	None
S3-S4	None, 80...(10)...1000 ms	None

S1-S1: This is the pacing drive train for Programmed Stimulation therapy. The drive train is used to stabilize the rhythm.

S1 Cycles: This is the number of S1 paced events in the drive train. The number used for the drive train is physician dependent.

S1-S2: This represents the coupling interval for the first extrasystole delivered. Sometimes simply referred to as "S2".

S2-S3: This represents the coupling interval for the second extrasystole delivered. Sometimes simply referred to as "S3".

S3-S4: This represents the coupling interval for the third extrasystole delivered. Sometimes simply referred to as "S4".

Plus and minus button make it easy to adjust the Sx-Sy intervals for programmed stimulation.



Figure 177: Atrial Programmed stimulation

## CAUTION

**Short Pacing Intervals** – Use of short pacing intervals (high pacing rates) with long atrial and/or ventricular refractory periods may result in intermittent asynchronous pacing and, therefore, may be contraindicated in some patients.

#### 8.5.7.4 NIPS Additional

Additional information about using NIPS:

- When the battery voltage has reached the Elective Replacement Indicator (ERI) point, the NIPS feature is no longer available.
- NIPS may only be programmed temporarily.

**NOTE:**

High pacing rates and pulse amplitudes, together with long pulse widths may temporarily decrease the amplitude of the pacing pulse. The pacing pulse must be continuously verified with an ECG to assure effectiveness.

To perform NIPS function, the programmer wand must be placed directly over the pulse generator to enable continuous telemetry or wandless telemetry session initiated.

## **Chapter 8 Implantation Testing, EP Test Functions and Follow-up**

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## 9. Diagnostics

### 9.1 Tachycardia Diagnostics

#### 9.1.1 Recording Memory

Various device information is available within the Recording memory. The Recording memory can be configured a number of different ways depending on the physician's preference.

##### 9.1.1.1 Episode List

The ICD/CRT-D stores a variety of useful diagnostic data about tachyarrhythmia episodes, which may be used to optimize tachyarrhythmia detection and therapy parameters. This diagnostic data includes detection counters; therapy counters, last delivered ATP and shock therapy, shock data memory, therapy history, and stored intracardiac electrograms.

Color codes are used for the different zone detections. Red indicates a VF zone event, blue indicates a VT zone event and black indicates a SVT or AT/AF event or Periodic IEGM episode.

The description column provides information related to the type and number of therapies provided or events such as periodic recordings. For example in [Figure 178](#), episodes 10 states "1 shock, induced". This means that one shock was delivered during induction testing.

↓No.	Time	Zone	PP [ms]	RR [ms]	Description	PP [ms]	RR [ms]	IEGM
10	02/25/12 12:12	VF	997	236	1 Shock, induced	998	999	
9	02/25/12 12:09	VF	997	212	1 Shock, induced	998	999	
8	02/25/12 11:59	VF	997	258	induced	997	997	
7	02/25/12 11:56	VTI	997	334	1 ATP	997	997	
6	02/24/12 08:14	VTI	997	334	1 ATP	997	997	
5	02/24/12 07:59	VTI	997	334	2 ATP's	997	997	
4	02/24/12 07:56	VTI	996	337	1 ATP	997	997	
3	02/24/12 07:47	VTI	997	335	1 ATP	997	997	
2	02/24/12 07:44	VTI	996	332	1 ATP	997	997	

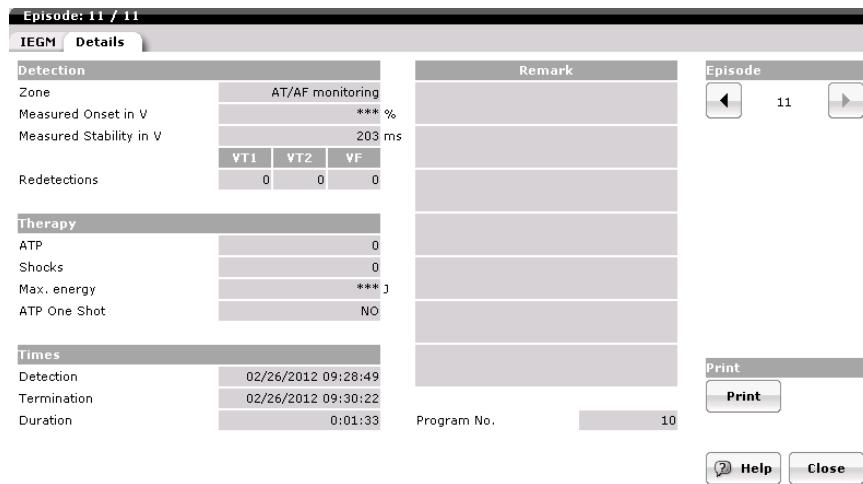
Display episodes  AT/AF  VT/VF  SVT  since last follow-up

Print Help

Figure 178: Episode list

##### 9.1.1.2 Episode Details

Detailed information about each individual episode presented as a table of events ordered from most recently delivered to the first delivered. Each IEGM segment can be viewed from the episode detail sub-menu by selecting the IEGM button (icon). From this screen, an IEGM can be expanded and scrolled to assist in a more accurate IEGM interpretation by enabling a closer examination of specific segments.



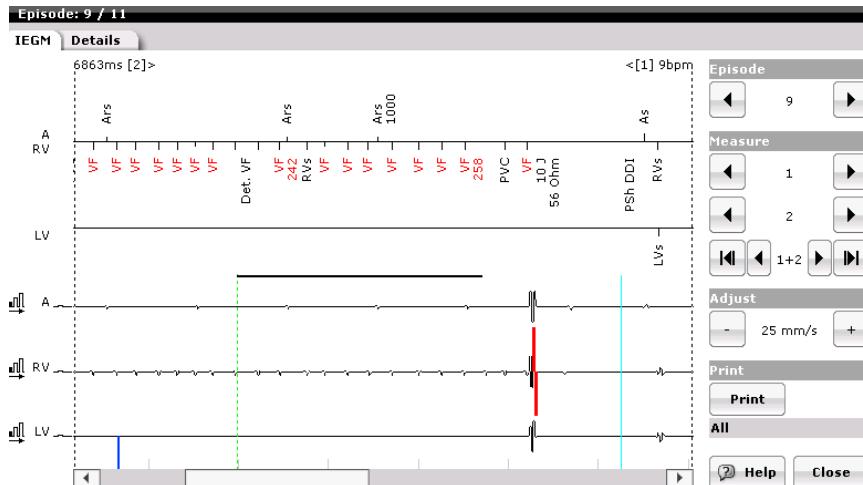
**Figure 179: Episode details**

The Details Icon provides detection and therapy specifics for each episode. The time and date of the episode are noted in the bottom left, along with the duration of the episode and the time of termination. Similarly, the measured stability (in milliseconds) is shown for the last 4 R-R intervals prior to detection in the upper left portion of the panel. The number of redetections in each zone provides acceleration and deceleration information.

### **9.1.1.3 Stored IEGM**

The ICD/CRT-D can store up to 24 minutes of triple chamber intracardiac electrograms (IEGMs) including the history and prehistory of the following events regarding AT/AF, VT/VF and SVTs:

- Time
  - Zone
  - Descriptions
  - Episode details
    - PP and RR intervals (before detection and termination, displayed only in the episode list)
    - IEGMs



**Figure 180: Stored IEGM viewed on the programmer**

The Lumax 740 VR-T ICD provides ventricular and far-field IEGMs and the Lumax 740 DR-T ICD provides atrial and ventricular IEGM recordings as well as far-field recordings. The Lumax 740 HF-T CRT-D provides three channels of electrograms in three programmable offerings: 1) atrial, right and left ventricular IEGMs, 2) atrial, right ventricle, far-field and 3) far-field, right and left ventricle. All ventricular tachyarrhythmia recordings (i.e., VT1, VT2, and VF episodes) are triggered on detection and continue until termination of the episode. A maximum recording time of up to four minutes, including prehistory and termination, is stored. Up to 45 seconds of IEGM, including up to 30 s of prehistory and up to 15 s termination for SVT events, can be stored.

For a VT or VF episode, an IEGM episode in its entirety from pre-history to termination can be viewed on-screen by pressing the IEGM Icon from the Episode List. On-screen annotations include pace/sense markers (e.g., Vp/Vs), zone labels (e.g., VT1, SVT), interval measurements, and therapy markers (e.g., Burst ATP).

SVT episodes will provide IEGMs for the onset of the SVT and termination of the episode. This is done to preserve memory as SVT episodes can last for prolonged periods of time.

#### 9.1.1.4 Shocks

The device history regarding high energy shocks is presented in a table format with the following information:

- Shock Number
- Date
- Time
- Energy
- Charge time
- Impedance
- Type of shock/Remark

Episodes    Shocks    Counters					
No.	Time	Energy [J]	Charge time [s]	Impedance [Ω]	Description
8	02/25/12 12:12	10	2.6	56	
7	02/25/12 12:09	10	2.6	56	
6	02/25/12 12:09	4	1.1	57	Induction shock
5	02/25/12 12:09	1	0.3	61	Induction shock
4	02/25/12 12:00	40	15.3	***	Termination without shock
3	02/24/12 07:34	1	0.3	57	Induction shock
2	02/24/12 07:33	1	0.4	55	Induction shock
1	02/21/12 10:33	1	0.3	57	Manual shock

Total number of charges 8

Print    Help

Figure 181: Shock table

In the Recordings screen, a table summarizing all shock therapy is displayed under the Shocks tab. The table gives the date and time stamp, energy, charge time, and the shock lead impedance for each shock. An additional field (Description) is provided to note induced, manual or aborted therapy. The total number of charges occurring over the life of the device is shown at the bottom on the screen. (See [Figure 181](#).)

Delivered shocks will provide a charge time and a shock impedance value. Aborted shocks will provide a charge time but no impedance value as the energy was not delivered. Aborted energies are not dumped by the device after the episode but rather bleed off over several minutes. If a new episode

resulting in shock delivery occurs before the stored energy bleeds off the device, the user may see “^40” in the energy column for the delivered shock. Additionally, a shorter charge time than expected may be shown.

### 9.1.1.5 Counters

The device history regarding several therapy and detection parameters is presented in the “Counters” screen. For detection and SVT details, this screen contains both the number of events since the last ICD/CRT-D follow-up and totals since the device was implanted. The available parameters include:

#### Detection Episodes (since last follow-up and since implantation)

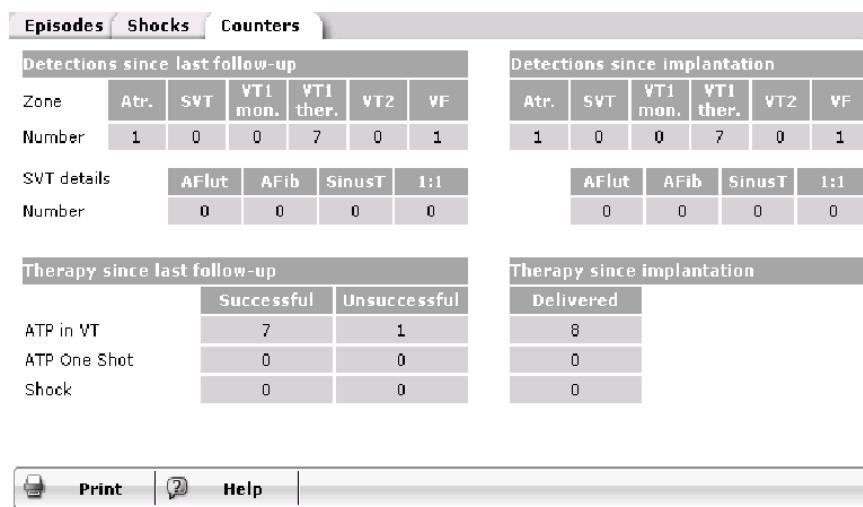
- Atr.
- VT2
- SVT
- VF
- VT1
- VT1 Monitor

#### SVT Details

- AFLut
- Sinus T
- AFib
- 1:1

#### Therapy Episodes (since last follow-up and since implantation)

- Successful ATP Therapies in VT and ATP One-Shot
- Unsuccessful ATP Therapies in VT and ATP One-Shot
- Successful Shock Therapies
- Unsuccessful Shock Therapies
- Delivered ATP Therapies in VT and ATP One-Shot
- Delivered Shock Therapies



**Figure 182: Counters**

Tachyarrhythmia therapy and detection counters are found under the Counters tab shown in [Figure 182](#). Detection counters in the upper panel include the number of initial detections in each tachyarrhythmia zone since the last follow-up and since implantation of the device. Detection counters include VT1, VT2, VF and SVT detections. In the second panel, the SVT detections are classified into

separate types of SVT rhythms based on SMART® Detection. SVT types include AFib (atrial fibrillation - SMART branch 4); AFlut (atrial flutter - SMART branch 2); Sinus T (sinus tachycardia - SMART branch 8); 1:1 SVT (one-to-one atrial tachycardia - SMART branch 10).

The therapy counters appear in the bottom column and give the total number of successful and unsuccessful ATP and shock therapies since the last follow-up. Also included are the therapies delivered since implantation (i.e., over the life of the device). These numbers may help the physician optimize patient therapy

## 9.2 Bradycardia Diagnostics

The Diagnostics button contains data related to bradycardia therapy. This data includes timing data, arrhythmia information, and sensor data. Data is collected for 240 days. After 240 days, the data is overwritten on a first-in, first-out basis.

Diagnostics are not automatically restarted any time a parameter change is made within the bradycardia parameters. This is different from previous BIOTRONIK ICDs. Trends will be marked at the day of follow-up with “F” at a follow-up session without reprogramming or with “P” at a follow-up session with reprogramming. Histogram statistics and counter will be restarted after every follow-up with automatic interrogation. The elapse time for the Histogram statistics is displayed at the follow-up page in the title bar of the sub-dialogue Details (see [Figure 197](#)).

In order to restart statistics, click the Start statistics button at the bottom of the statistics screen on the programmer. With either method, a message at the bottom of the screen will confirm “Programming was successful.”

After diagnostics are restarted, the previous data will still be displayed under the diagnostics screen until the device is reinterrogated by returning to the implant list.

Event messages will appear at Follow-up with a link icon. For example, if 3 VF events occurred in the last 24 hours, an IEGM box will appear. Pressing the IEGMs box will take the user to the episode list.

Breaks in the trend lines on the statistics page represent magnet application. Data is not collected during the time of temporary testing during a follow-up session.

### 9.2.1 Timing Data

Timing is the first tab displayed under Diagnostics. The tab includes four different categories of timing data: event episodes and events (i.e., percent timing sequences and percent atrial, right ventricular and CRT pacing), pacing trends for atrial, right ventricular and CRT pacing, AV histogram and Rate histograms.

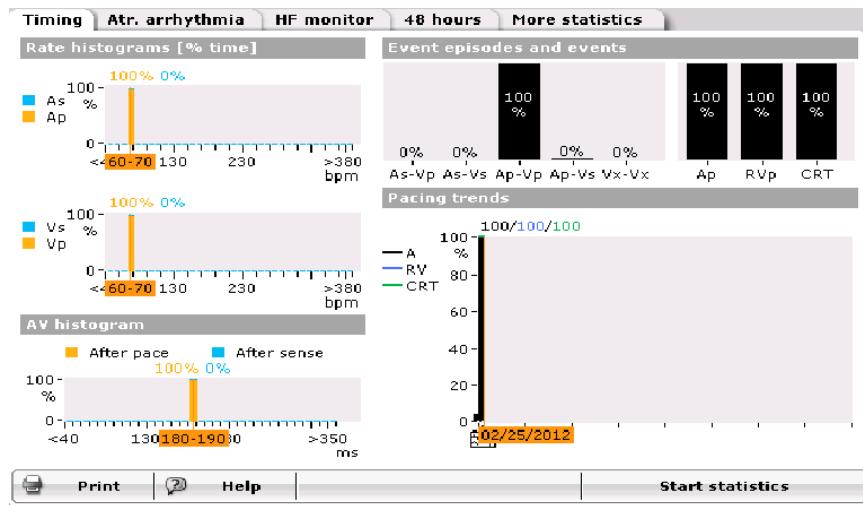


Figure 183: The Timing statistics screen

## 9.2.2 Timing Statistics

The ICD/CRT-D stores a variety of useful diagnostic data of the bradycardia history as described in the following sections.

### 9.2.2.1 Event episode and events

This section presents data collected on the different pacing states of the device; As-Vp, As-Vs, Ap-Vp, Ap-Vs and Vx-Vx. Vx-Vx are ventricular events without an atrial event between.

#### Event episodes (Brady)

- AV-Sequences
- Intrinsic Rhythm (AsVs)
- Conducted Rhythm (AsVp)
- Atrial Paced Rhythm (ApVs)
- Complete Paced Rhythm (ApVp)
- PVC (Vx-Vx)

#### Pacing Counters (Brady)

- Atrial pace percentage
- RV pace percentage
- CRT pace percentage

Each event is recorded into one of these categories and displayed on this screen. The event episodes are not updated when the patient is in Mode Switch due to the change in device timing.

This section also provides the percentages of pacing for each chamber.

### 9.2.2.2 Rate histograms

The Rate histogram shows the amount of pacing and sensing for each chamber at different rates. Touching the screen or using the arrows on the left side of the screen moves the cursor to different heart rate bins and shows the amount of pacing or sensing in each rate bin. The ventricular data is collected from the RV channel.

The heart rate range is divided into 16 segments ranging from less than 40 bpm to greater than 380 bpm.

#### Key Points:

- The Rate Histogram displays the percentage of paced and sensed events in each rate bin listed along the horizontal axis.
- The Rate Histogram is based on Ap, As, Ars, As(PVARP), RVp, RVs, PVC, and RVrs events.
- Atrial and ventricular rates are plotted on two separate graphs: atrium on the top and ventricle on bottom.
- Paced events are shown in orange and sensed events are light blue.
- A high percentage of atrial events in the upper rate bins may indicate atrial arrhythmias, but could also be due to far-field oversensing.
- Atrial or ventricular events below the basic rate may be due to PVCs resetting the basic rate interval or atrial undersensing.

#### 9.2.2.3 AV histograms

The AV histogram shows the amount of pacing or sensing response from the ventricular chamber for each AV interval at different rates. Touching the screen or using the arrows on the left side of the screen moves the cursor to different heart rate bins and shows the amount of pacing or sensing in each rate bin. The ventricular data is collected from the RV channel.

The AV histogram range is adjusted based on the AV delay programming of the device.

#### 9.2.2.4 Pacing trends

The Pacing trends graph shows the amount of pacing in each chamber per day. The pacing percentage values for the selected day are shown at the top of the graph. Moving the vertical cursor presents data for the selected day. The overall pacing percentage for each day is collected and annotated. The trend collects 240 days of data. After 240 day, the oldest data is overwritten first.

#### 9.2.3 Atrial Arrhythmia Data

The Atrial arrhythmia tab provides information related to Atrial Burden and Ventricular reaction. Atrial burden is the amount of time the heart is in an atrial tachyarrhythmia, while Ventricular reaction is the ventricular rate response to the atrial tachyarrhythmia.

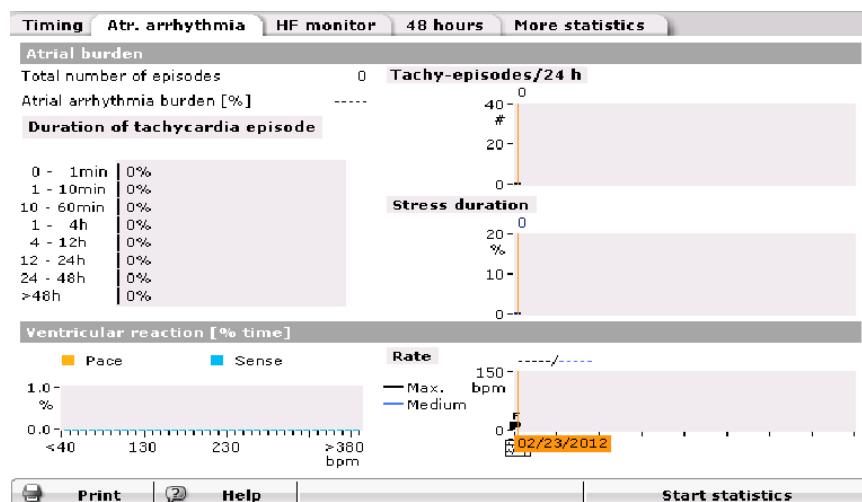


Figure 184: The Atrial arrhythmia screen

### 9.2.3.1 Atrial burden

The Atrial burden section provides information for the following:

#### 9.2.3.2 Total number of episodes

This represents the number of atrial tachycardia episodes that have occurred since the last time the diagnostics were reset. Ongoing atrial episodes are not counted in this number.

#### 9.2.3.3 Atrial arrhythmia burden %

This represents the average daily atrial burden since the last time the diagnostics were reset. Each percentage point represents about 14.4 minutes of data/day.

#### 9.2.3.4 Duration of tachycardia episode

The duration of each episode is placed into the appropriate time bin and displayed as a percentage. For example, if the 0-1 minute bin shows 10%, it means that 10% of all episodes occurred in that bin. It does not represent the duration time.

#### 9.2.3.5 The number of (atrial) tachycardia episodes in a 24-hr period

The field represents the number of (atrial) tachycardia episodes per day. The scalar is automatically adjusted to the maximum number of events to occur in a day.

#### 9.2.3.6 Stress duration per day expressed in a percentage

This field represents the amount of time expressed as a percentage per a given day of an atrial tachycardia. The scalar automatically adjusts to the maximum percentage recorded. Each percentage point represents about 14.4 minutes of data. This value will generally not correspond to the atrial arrhythmia burden percentage.

#### 9.2.3.7 Ventricular reaction

The Ventricular reaction graph provides information of what the mean and maximum ventricular rates are during atrial tachyarrhythmia events. It also provides information as the percentage of paced and sensed events during the atrial tachyarrhythmia events, as well. These graphs auto adjust the value range as new data is acquired.

##### Key Points:

- The Ventricular Reaction diagnostic gives information on the ventricular rate and pacing percentages during an AT/AF episode.
- The diagnostic is based on all Vs, Vp, PVC, and Vrs events.
- Ventricular reaction data will not be plotted continuously since data for this diagnostic is only collected during an AT/AF episode.
- The graph shows the percentage of ventricular events during AT/AF falling into each rate bin. Ventricular paced events are shown lighter in orange and ventricular sensed events are shown darker in light blue.

## 9.2.4 HF Monitor

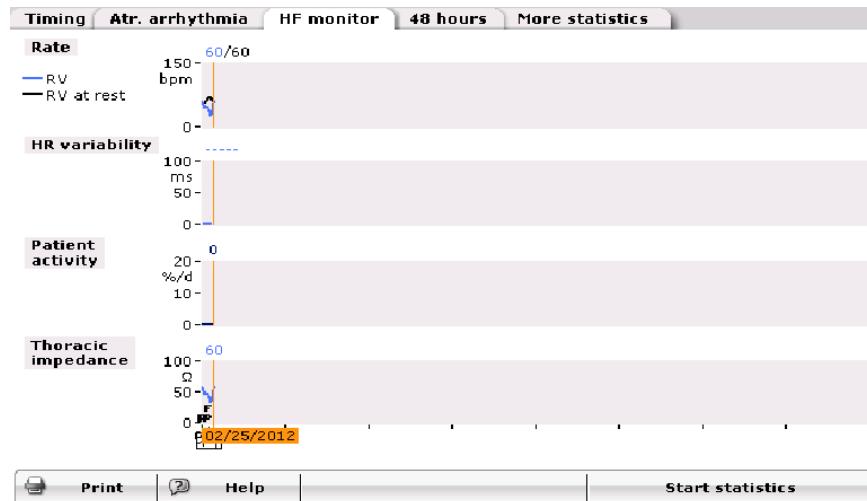


Figure 185: HF Monitor diagnostic

### 9.2.4.1 Rate

The top of the graph in displays Mean Heart Rate and Mean Heart Rate at Rest. Mean Heart Rate is designated by the “RV,” and the Mean Heart Rate at Rest is designated by “RV at Rest”. Mean Heart Rate at Rest is a measurement of the lowest heart rate during a programmed measuring period. The heart rate is calculated based on 10 minute intervals beginning at the programmable Starting Resting Period. The device uses the lowest single average taken during the recording period. For accurate daily measurements, do not program the Starting Resting Period and Resting Period Duration to overlap the transmission time for Home Monitoring periodic transmission.

### 9.2.4.2 HR Variability

In addition, the HF Monitor statistics show the amount of heart-rate variability and patient activity. With Heart Rate Variability, the higher the number the more variability is present. With successful CRT therapy, one would expect both of these statistics to show increased activity.

### 9.2.4.3 Patient Activity

Patient activity is defined as any time the sensor moves off of baseline and not necessarily when sensor pacing occurs such as the case when the patient’s intrinsic rate is greater than the sensor indicated rate.

### 9.2.4.4 Thoracic impedance

The thoracic impedance is measured between the distal shock-coil of the RV lead and the ICD housing. Up to 1,024 measurements are done every hour and these measurements are then averaged. The 24 measurements per day are averaged and stored in the device and transmitted via Home Monitoring as a single average point per day. The Home Monitoring website then displays a trend of the daily average. The same trend of daily TI averages is displayed on the programmer upon interrogation of the ICD. The TI trend does not replace assessments that are part of standard of care for the clinical practice. The clinical value of this feature has not been established for the management of patients.

**Key points:**

- The heart-rate graph reports mean heart rate (indicated by “V” in the key) and resting heart rate (indicated by “Rest” in the key).
  - Mean heart rate reports the average of the ventricular rate over a 24-hour period (based on Vs, Vp, Vrs, and PVCs).
  - The resting heart rate reports minimum ventricular heart rate during the programmed resting period (default beginning at 2:00 AM with a 4-hour duration, programmable under the Diagnostics tab).
  - The minimum ventricular heart rate is determined by taking 10-minute averages during the resting period and reporting the lowest of those averages.
- Variability is based on the P-P interval, and uses only intrinsic P-P intervals, not atrial paced events.
  - Variability is calculated by taking the standard deviation of the 5-minute mean P-P intervals.
- Patient activity is available in both rate adaptive and non-rate adaptive pacing modes.
  - Data is displayed as the percent of the day (24 hour period) the patient is active.
  - Patient activity is present when the device sees motion on the accelerometer.
  - Activity is based on the currently programmed sensor threshold.
  - If the mode is DDD, activity is measured using a mean sensor threshold.
  - Not available in single-chamber devices.
- Thoracic impedance
  - Data is displayed as a single data point per day.
  - Should not be used as a stand-alone parameter to assess CHF in patients.
  - Hypovolemia, COPD and other factors can affect Thoracic impedance calculations.
  - Data collected within the first 30 days of implantation generally should not be used because of issues like small hematomas and expected post-surgical swelling affecting the measurements.

### **9.2.5 48 hours**

48 Hours presents a snapshot of the most recent 48 hours of rate, atrial burden and paced percentages. Each data points shown is a 10 minute average of the data collected. This allows the user to see more detailed, short term data to look for sudden changes rates, burden or pacing percentages.

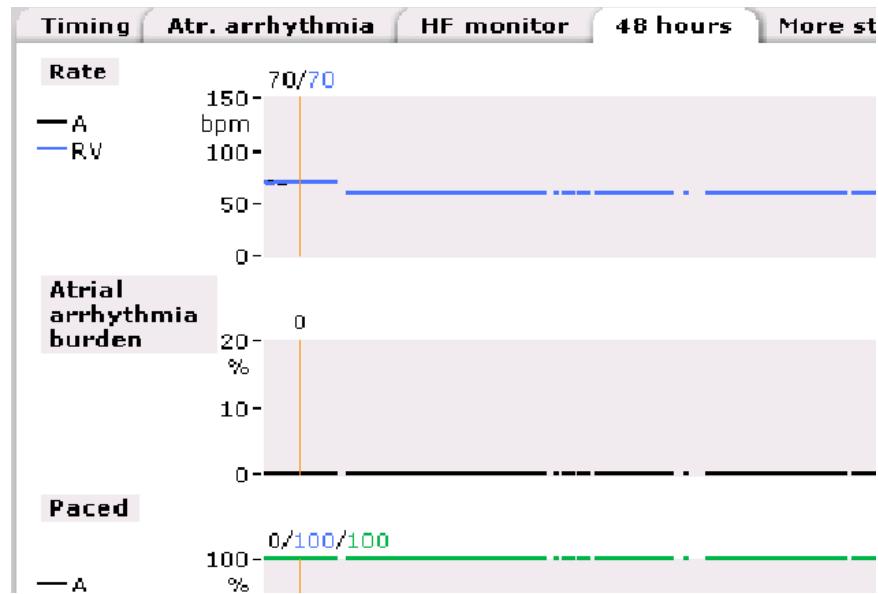


Figure 186: 48 hours

### 9.2.5.1 Rate

The atrial and right ventricular rates are displayed over the last 48 hours prior to interrogation.

### 9.2.5.2 Atrial arrhythmia burden

Presents atrial burden data in 10 minute increments for the last 48 hours prior to interrogation.

### 9.2.5.3 Paced

Presents the paced percentages for all programmed channels.

## 9.2.6 More statistics

### 9.2.6.1 Counters

In the Counters (), the legend is as follows:

As - refers to atrial sensed events

As (PVARP) - refers to atrial event occurring during PVARP

Ars - typically refers to events occurring during the AV Delay or during Mode Switching

Ap - atrial paced events

RVs - refers to RV sensed events

PVC - refers to RV extrasystoles (PVCs)

RVrs - refers to RV refractory sensed events. These are events that occur within 200 ms of the previous RV event and is non-programmable

RVp - refers to RV paced events

LVs - refers to LV sensed events.

LVp - refers to LV pacing

LVrs - refers to LV refractory events. These are events that occur within 200 ms of the previous LV event and is non-programmable

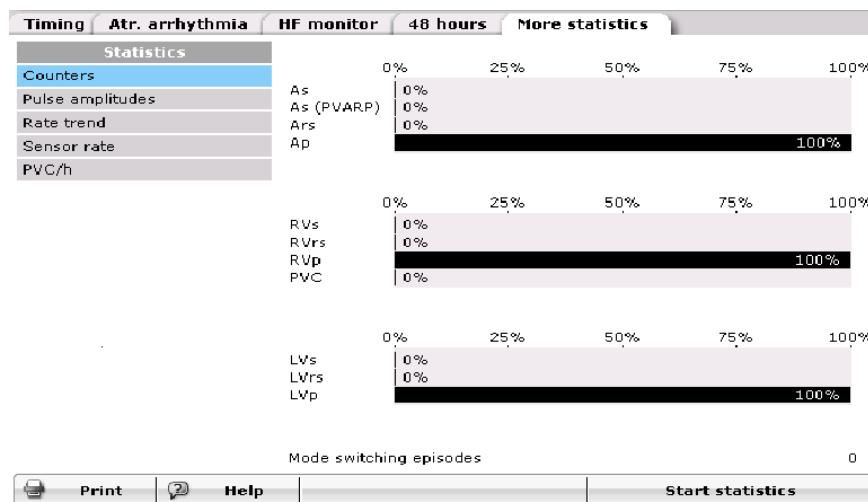


Figure 187: Counters screen

This page provides the percentage of each of the different states of pacing and the percentage of BiV pacing in HF-T devices.

The number of Mode Switching episodes is also listed on this page.

#### Key Points:

- LVs is only enabled when the feature LV T-wave protection is turned ON. If this feature is not enabled, the LV pace will show 100% since the device will not have the ability to sense intrinsic LV events.
- RVrs events are those RV events within 200 ms of the preceding RV sensed event. The 200 ms sensed refractory period is non-programmable. LVrs is also 200 ms.
- PVC = Right ventricular extra systole, defined by the device when the following criteria are met:
  - Two ventricular events with no Ap or As in between
  - An Ars did not occur within 350 ms of the subsequent Vs event
- Ars (PVARP) are those events falling into the PVARP timer and outside the Discrimination after As window. Likely examples of these types of events include non-conducted PAC events or events occurring during Mode Switch.
- Ars events are those events occurring during an AV Delay window.

#### 9.2.6.2 Pulse amplitude

The Pulse amplitude screen, shown in [Figure 188](#), displays the daily threshold measurements taken in the RV and LV chambers. This is measured through the VCC feature and is available if the feature is programmed to VCC. If not, means if programmed to ATM or OFF this diagram shows the fixed programmed amplitude for the LV and RV channel. This measurement is taken once daily 40 minutes prior to the programmed Home Monitoring transmission time. If the test could not be completed, a second attempt 10 minutes prior to HM transmission will occur.

If Home Monitoring is OFF, the device uses the default transmission time.



Figure 188: Pulse amplitudes

#### Key Points:

- Pulse amplitude displays the measured threshold for each day throughout the duration of the statistics.
- Pacing threshold measurements can be programmed to ATM or VCC in the device from the parameters screen under the Bradycardia/CRT tab.
- The test is performed daily, 37 minutes prior to the Home Monitoring transmission time. If the first attempt is unsuccessful, a second attempt will occur 7 minutes prior to the Home Monitoring transmission.

#### 9.2.6.3 Rate trend

The Rate trend statistic shows the heart rate and percentage of pacing in each chamber since the last time the statistics were cleared. The ventricular data is collected from the RV channel.

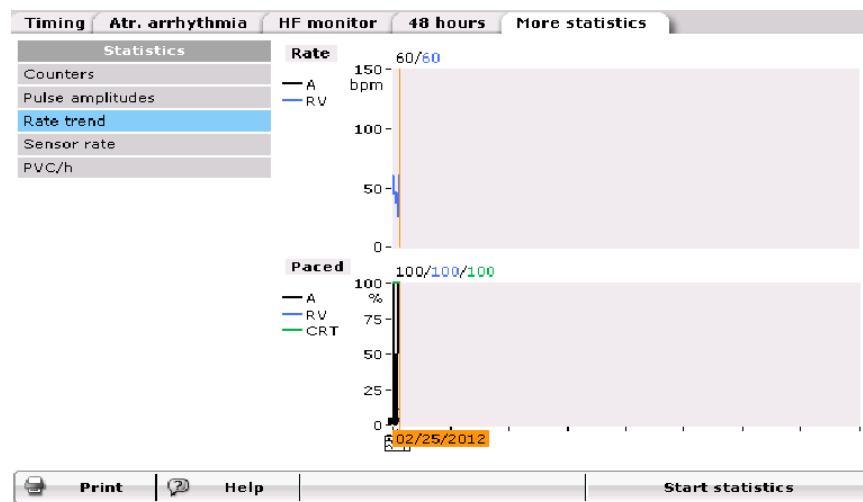


Figure 189: Rate trend

#### Key Points:

- The Term Rate Trend shows the rate of each chamber plotted separately for the duration of the statistics.

- The Rate Trend is based upon As, Ap, Ars, As(PVARP), Vs, Vp, PVC, and Vrs events.
- The Paced Trend shows the percentage of paced events in each chamber for the duration of the statistics.
- This diagnostic is useful to assess any changes to the patient's state of pacing, dependency on the device, or occurrence of arrhythmias.
- An overall increase in average heart rate may indicate worsening heart failure.
- Collects a single data point for each day.
- After 240 days, the oldest data is overwritten.

#### 9.2.6.4 Sensor rate

The Sensor rate page displays sensor histogram data and the rate/sensor trend. The sensor histogram shows the percentage of time the sensor rate lies within given heart rate bins — regardless of whether the sensor is used. The heart rate range is divided into a total of 16 bins in groups of 10 bpm.

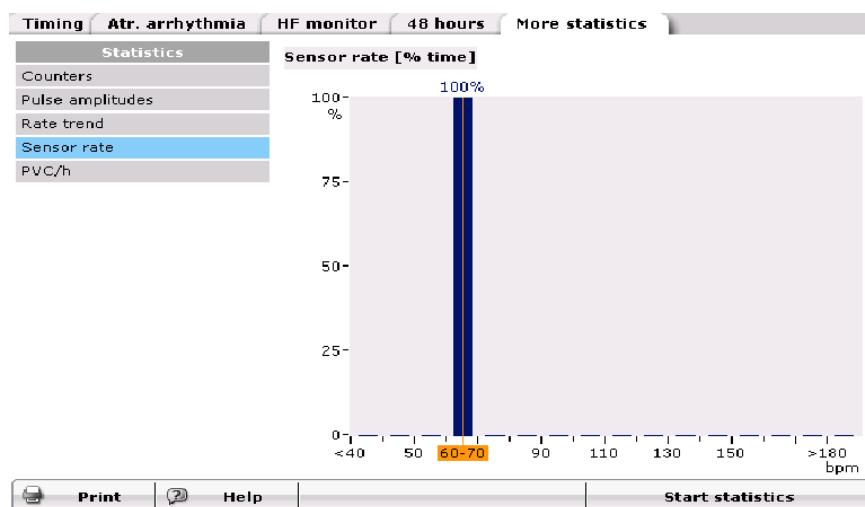


Figure 190: Sensor rate

The Sensor histogram, shown in [Figure 190](#), collects information regarding sensor activity whether the sensor is turned ON or not. In the rate range, the orange line intersects is shown at the bottom of the graph, and the percentage of events of the total that occur in the rate range is shown at the top of the graph.

#### Key Points:

- The Sensor Rate histogram displays the distribution of rates determined by the accelerometer.
- The Sensor Rate histogram is updated in R- and non R-modes.
- The Sensor Rate histogram is updated regardless of whether sensor indicated pacing is inhibited by intrinsic events.

#### 9.2.6.5 PVC/h

The PVC/h statistic shows the average number of PVCs per hour for each 24-hour period. The date the orange line intersects is shown at the bottom of the graph.

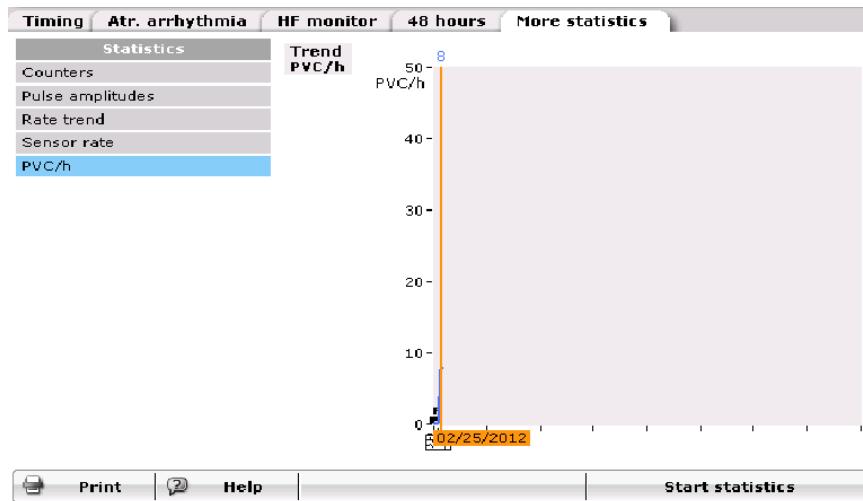


Figure 191: PVC/h graph

**Key Points:**

- The PVC/h diagnostic displays the average PVCs per hour each day throughout the duration of the statistics.
- In order to be counted, PVCs must meet the following criteria:
  - Two ventricular events with no Ap or As in between
  - An Ars occurring more than 350 ms from the subsequent Vs.
- An increase in PVC/h could be an indicator of worsening heart failure.
- An increase in PVC/h may indicate greater susceptibility to ventricular arrhythmias.
- If the patient has a large amount of PVCs causing a low CRT pacing percentage, programming RVES triggering ON may improve the CRT pacing percentage.
- A high number of PVCs may indicate atrial undersensing.
- The scalar will automatically adjust based on the number of PVCs occurring.
- Collects a single data point for each day.
- After 240 days, the oldest data is overwritten



## 10. Sterilization and Storage

The ICD/CRT-D is shipped in a storage box, equipped with a quality control seal and product information label. The label contains the model specifications, technical data, serial number, use before date, as well as sterilization and storage information.

The ICD/CRT-D and its accessories have been sealed in a container and gas sterilized with ethylene oxide. To assure sterility, the container should be checked for integrity prior to opening.

### CAUTION

**Device Packaging** - Do not use the device if the device's packaging is wet, punctured, opened or damaged because the integrity of the sterile packaging may be compromised. Return the device to BIOTRONIK.

**Re-sterilization** - Do not re-sterilize and re-implant explanted devices.

**Storage (temperature)** - Store the device between 5° to 45°C (41° - 113°F) because temperatures outside this range could damage the device.

**Storage (magnets)** - To avoid damage to the device, store the device in a clean area, away from magnets, kits containing magnets, and sources of electromagnetic interference (EMI).

**Temperature Stabilization** - Allow the device to reach room temperature before programming or implanting the device because temperature extremes may affect initial device function.

**Use Before Date** - Do not implant the device after the USE BEFORE DATE because the device may have reduced longevity.

## **Chapter 10 Sterilization and Storage**

Lumax 740 Technical Manual

## 11. Implant, Follow-up and Explantation Procedures

### 11.1 Implant Procedure

#### 11.1.1 Implant Preparation

Prior to beginning the ICD/CRT-D implant procedure; ensure that all necessary equipment is available. The implant procedure requires the selected lead system (including sterile back-ups), the programmer with appropriate software, and the necessary cabling and accessories.

For ICS 3000 and Implant Module based DFT testing, the following cabling and accessories are available:

PK44 - used to connect the Implant Module to implanted lead systems for complete testing of the lead systems during the implant procedure. The following adapters may be necessary:

- Adapters PA-2/PA-3 - The PA-2 adapter is used to connect IS-1 compatible leads to the PK-144 cable. The PA-3 adapter is used to connect DF-1 compatible leads to the PK-44 cable.
- Adapter PA-4 - used to connect the PK-144 cable to sensing and pacing leads while the stylet is still inserted.

Perform an interrogation of the ICD/CRT-D. Ensure programmer operation, nominal device parameters and battery status is appropriate for a new Lumax ICD/CRT-D. Note that the battery status may appear lower than its true value when the ICD/CRT-D is not at body temperature. Program detection and therapy to “Disabled” prior to handling the Lumax ICD/CRT-D.

Sufficient training on the device and its associated components is required prior to implanting the ICD/CRT-D. For additional information, training and training materials contact your BIOTRONIK representative.

## WARNING

**ICD Lead Systems** - BIOTRONIK ICDs/CRT-Ds may be implanted with any legally marketed, compatible ICD lead. Compatibility is defined as:

- IS 1 pacing and sensing connector(s)
- DF-1 shock coil connector(s)
- Integrated or dedicated bipolar pacing and sensing configuration
- Active or passive fixation technology
- Single or dual defibrillation shock coil (s)
- High energy shock accommodation of at least 40 joules
- Insertion and withdrawal forces as specified by ISO 5841 3 (IS-1) and ISO 11318:1993 (E) DF-1

The following leads were evaluated in a retrospective study with BIOTRONIK's ICDs/CRT-Ds:

- Medtronic Sprint™ Lead 6932
- Medtronic Sprint Lead 6943
- Medtronic Sprint Quattro™ Lead 6944
- Medtronic Transvene™ RV Lead 6936
- St. Jude (Ventrifex) TVLTM- ADX Lead 1559
- St. Jude SPL® SP02 Lead
- Guidant ENDOTAK® DSP Lead
- Guidant ENDOTAK Endurance EZ Lead, ENDOTAK Reliance Lead
- Guidant (Intermedics) Lead 497-24.

The following leads were bench tested for compatibility with BIOTRONIK's ICDs/CRT-Ds:

- Guidant ENDOTAK Endurance Lead "CPI 0125"
- Guidant ENDOTAK Reliance Lead 0148
- Medtronic Sprint Lead 6932
- Medtronic Sprint Lead 6942
- Medtronic Sprint Lead 6943
- Medtronic Sprint Lead 6945
- Medtronic Sprint Quattro Lead 6944
- St. Jude Riata® Lead 1571/65
- St. Jude SPL SPO1 Lead

## WARNING

**Left Ventricular Lead Systems** – BIOTRONIK CRT Ds maybe implanted with any legally marketed, compatible LV lead. Compatibility is defined as:

- IS 1 pacing connector
- Active or passive fixation technology
- Insertion and withdrawal forces as specified by ISO 5841 3 (IS-1)

The following LV leads were evaluated in the OPTION CRT/ATx study with BIOTRONIK's CRT-Ds:

- Guidant-EASYTRAK® IS-1 Lead
- Guidant-EASYTRAK LV-1 Lead
- Guidant-EASYTRAK 2 Lead
- Guidant-EASYTRAK 3 Lead
- Medtronic-Attain® OTW Lead
- St. Jude-Aescula™ Lead
- St. Jude-QuickSite® Lead
- Biomed Myopore™ Epicardial Lead
- Medtronic-Epicardial 5071 Lead
- Medtronic-CapSure® EPI Lead
- BIOTRONIK-ELC 54-UP Lead

The following LV leads were bench tested for compatibility with BIOTRONIK's CRT Ds:

- Guidant EASYTRAK 4512 (unipolar) Lead
- Guidant EASYTRAK 4513 (bipolar) Lead
- Guidant EASYTRAK 3 4525 (bipolar) Lead
- Medtronic Attain OTW 4193 (unipolar) Lead
- Medtronic Attain OTW 4194 (bipolar) Lead
- Medtronic Attain LV 2187 (unipolar) Lead
- St. Jude Medical QuickSite 1056K (unipolar) Lead
- ELA SITUS® OTW (unipolar) Lead
- BIOTRONIK Corox+ LV-H 75-BP #346542
- BIOTRONIK Corox OTW 75-UP Steroid #346542 (unipolar)

## CAUTION

**Blind Plug** - A blind plug must be inserted and firmly connected into any unused header port to prevent chronic fluid influx and possible shunting of high energy therapy.

**Connector Compatibility** - ICD/CRT-D and lead system compatibility should be confirmed prior to the implant procedure. Consult your BIOTRONIK representative regarding lead/pulse generator compatibility prior to the implantation of an ICD/CRT-D system. For further information, please refer to [Appendix A](#).

**Programmed Parameters** – Program the device parameters to appropriate values based on the patient's specific arrhythmias and condition.

**Programming Wand Separation Distance** – The wand (with magnet) must not be placed closer than 2 cm to the device (implanted, in the box, or out of the box). Programming wand (with magnet) distance closer than 2 cm may damage the device.

## CAUTION

**Shock Impedance** - If the shock impedance is less than twenty-five ohms ( $25 \Omega$ ), reposition the lead system to allow a greater distance between the electrodes. Never implant the device with a lead system that has a measured shock impedance of less than twenty-five ohms ( $25 \Omega$ ). Damage to the device may result.

**Far-field sensing** of signals from the atrium in the ventricular channel or ventricular signals in the atrial channel should be avoided by appropriate lead placement, programming of pacing/sensing parameters, and maximum sensitivity settings. If it is necessary to modify the Far Field Blanking parameter, the parameter should be lengthened only long enough to eliminate far-field sensing as evidenced on the IEGMs. Extending the parameter unnecessarily may cause undersensing of actual atrial or ventricular events.

### 11.1.2 Lead System Evaluation

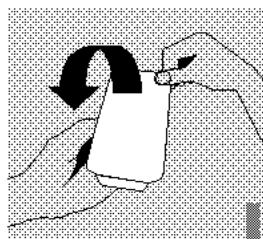
The ICD/CRT-D is mechanically compatible with DF-1 defibrillation lead connectors and IS-1 sensing and pacing lead connectors. IS-1, wherever stated in this manual, refers to the international standard, whereby leads and pulse generators from different manufacturers are assured a basic fit [Reference ISO 5841-3:1992]. DF-1, wherever stated in this manual, refers to the international standard [Reference ISO 11318:1993].

Refer to the appropriate lead system technical manual.

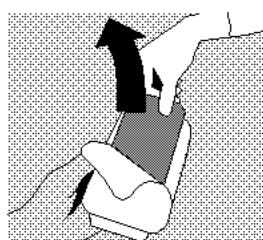
### 11.1.3 Opening the Sterile Container

The Lumax ICD/CRT-Ds are packaged in two plastic containers, one within the other. Each is individually sealed and then sterilized with ethylene oxide.

Due to the double packing, the outside of the inner container is sterile and can be removed using standard aseptic technique and placed on the sterile field.



Peel off the sealing paper of the outer container as indicated by the arrow. Do not contaminate the inner tray.



Take out the inner sterile tray by gripping the tab. Open the inner tray by peeling the sealing paper as indicated by the arrow.

### CAUTION

**Device Packaging** - Do not use the device if the device's packaging is wet, punctured, opened or damaged because the integrity of the sterile packaging may be compromised. Return the device to BIOTRONIK.

#### 11.1.4 Pocket Preparation

Using standard surgical technique, create a pocket for the device either in the patient's pectoral or abdominal region dependent on patient anatomy. The device may be implanted either below the subcutaneous tissue or in the muscle tissue. The ICD/CRT-D should be implanted with the etched side facing up. The leads should be tunneled or surgically brought into the device pocket. If lead tunneling is performed, re-evaluation of the baseline lead signals, after tunneling is recommended.

### CAUTION

The ICD/CRT-D system should have detection and therapy disabled prior to performing medical procedures. In addition, the ICD/CRT-D should be checked after the procedures to assure proper programming:

**Electrocautery** - Electrosurgical cautery could induce ventricular arrhythmias and/or fibrillation, or may cause device malfunction or damage. If use of electrocautery is necessary, the current path and ground plate should be kept as far away from the pulse generator and leads as possible (at least 6 inches (15 cm)).

### 11.1.5 Lead to Device Connection

The Lumax 740 ICD/CRT-Ds have been designed and are recommended for use with a defibrillation lead systems having one IS-1 connector for ventricular sensing and pacing and up to two DF-1 connectors for delivery of shock therapy. A separate bipolar atrial lead with IS-1 connector is required for atrial sensing and pacing functions and the CS lead for biventricular pacing (LV).

[Figure 192](#) depicts the configuration of the header ports on the Lumax ICD/CRT-Ds.

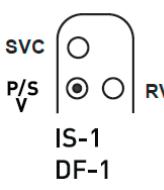
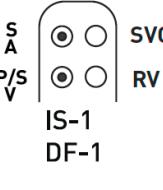
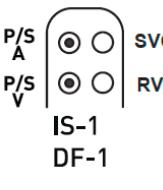
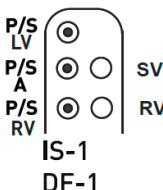
VR-T	VR-T DX	DR-T	HF-T
 IS-1 DF-1	 IS-1 DF-1	 IS-1 DF-1	 IS-1 DF-1

Figure 192: Lumax 740 ICDs and CRT-D Header Ports

### CAUTION

**Connector Compatibility** - ICD/CRT-D and lead system compatibility should be confirmed prior to the implant procedure. Consult your BIOTRONIK representative regarding lead/pulse generator compatibility prior to the implantation of an ICD/CRT-D system. For further information, please refer to [Appendix A](#).

**Setscrew Adjustment** – Back-off the setscrew(s) prior to insertion of lead connector(s) as failure to do so may result in damage to the lead(s), and/or difficulty connecting lead(s).

**Cross Threading Setscrew(s)** – To prevent cross threading the setscrew(s), do not back the setscrew(s) completely out of the threaded hole. Leave the torque wrench in the slot of the setscrew(s) while the lead is inserted.

**Tightening Setscrew(s)** – Do not over tighten the setscrew(s). Use only the BIOTRONIK supplied torque wrench.

**Sealing System** – Be sure to properly insert the torque wrench into the perforation at an angle perpendicular to the connector receptacle. Failure to do so may result in damage to the plug and its self-sealing properties.

**Far-Field Sensing** of signals from the atrium in the ventricular channel or ventricular signals in the atrial channel should be avoided by appropriate lead placement, programming of pacing/sensing parameters, and maximum sensitivity settings. If it is necessary to modify the Far Field Blanking parameter, the parameter should be lengthened only long enough to eliminate far-field sensing as evidenced on the IEGMs. Extending the parameter unnecessarily may cause undersensing of actual atrial or ventricular events.

Refer to the following steps when connecting the leads to the device.

1. Confirm that the setscrews are not protruding into the connector receptacles. To retract a setscrew, insert the enclosed torque wrench through the perforation in the self-sealing plug at an angle perpendicular to the lead connector until it is firmly placed in the setscrew. Rotate the wrench counterclockwise until the receptacle is clear of obstruction.
2. Insert the lead connector into the connector port of the ICD/CRT-D without bending the lead until the connector pin becomes visible behind the setscrew. Hold the connector in this position. If necessary, apply silicone oil only to the o-rings on the connector (not the connector pin).
3. Insert the enclosed torque wrench through the perforation in the self-sealing plug at an angle perpendicular to the lead connector until it is firmly placed in the setscrew.
4. Securely tighten the setscrew of the connector clockwise with the torque wrench until torque transmission is limited by the wrench.
5. Carefully retract the torque wrench. The perforation will self-seal.

### 11.1.6 Blind Plug Connection

The Lumax DR ICD and HF CRT-D are shipped with a blind plug (pre inserted) in an unused header port. Refer to the following steps when connecting blind plugs to the device.

1. Confirm that the setscrews are not protruding into the connector receptacles. To retract a setscrew, insert the enclosed torque wrench through the perforation in the self-sealing plug at an angle perpendicular to the lead connector until it is firmly placed in the setscrew. Rotate the wrench counterclockwise until the receptacle is clear of obstruction.
2. Insert the blind plug into the connector port of the ICD/CRT-D until the connector pin becomes visible behind the setscrew.
3. Insert the enclosed torque wrench through the perforation in the self-sealing plug at an angle perpendicular to the connector until it is firmly placed in the setscrew.
4. Securely tighten the setscrew of the connector clockwise with the torque wrench until torque transmission is limited by the wrench.
5. Carefully retract the torque wrench. The perforation will self-seal.

#### CAUTION

**Blind Plug** - A blind plug must be inserted and firmly connected into any unused header port to prevent chronic fluid influx and possible shunting of high energy therapy.

### 11.1.7 Program the ICD/CRT-D

Program the ICD/CRT-D to appropriately treat the patient's arrhythmias and other therapy needs. The information obtained during the lead system evaluation should be helpful in tailoring the various parameters of the ICD/CRT-D to treat each individual patient. The detection and therapy status of the ICD/CRT-D may be activated for testing purposes once all of the lead connectors have been securely fastened in the device header ports. The physician shall be made aware of the program that is in effect after the patient leaves the office, by viewing the parameters displayed on the programmer screen after the device has been programmed and interrogated.

## CAUTION

**Programmed Parameters** – Program the device parameters to appropriate values based on the patient's specific arrhythmias and condition.

**Programmers** - Use only BIOTRONIK's ICS 3000 or Renamic programmers to communicate with the device.

**Defibrillation Threshold** - Be aware that changes in the patient's condition, drug regimen, and other factors may change the defibrillation threshold (DFT) which may result in non-conversion of the arrhythmia post-operatively. Successful conversion of ventricular fibrillation or ventricular tachycardia during arrhythmia conversion testing is no assurance that conversion will occur post-operatively.

## WARNING

**Unwanted Shocks** – Always program ICD therapy to **OFF** prior to handling the device to prevent the delivery of shocks to the patient or the person handling the device during the implant procedure.

### 11.1.8 Implant the ICD/CRT-D

The ICD/CRT-D may be placed in the pocket at this time. Place the device into the pocket with either side facing up (it can be interrogated and programmed from either side). Carefully coil any excess lead length behind the ICD/CRT-D.

The pacing and sensing functions of the device should be evaluated. It is also recommended that at least one induction and device conversion be done prior to closing the pocket. This will ensure that the lead system has been securely connected to the device and has not changed position.

## CAUTION

**Connector Compatibility** - ICD/CRT-D and lead system compatibility should be confirmed prior to the implant procedure. Consult your BIOTRONIK representative regarding lead/pulse generator compatibility prior to the implantation of an ICD/CRT-D system. For further information, please refer to [Appendix A](#).

**Shock Impedance** – If the shock impedance is less than twenty-five ohms ( $25\ \Omega$ ), reposition the lead system to allow a greater distance between the electrodes. Never implant the device with a lead system that has a measured shock impedance of less than twenty-five ohms ( $25\Omega$ ). Damage to the device may result.

## WARNING

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

## CAUTION

**Pacing Threshold** - Testing of the pacing threshold by the ICD/CRT-D system should be performed with the pacing rate programmed to a value higher than the patient's intrinsic rate.

**Defibrillation Threshold** - Be aware that the changes in the patient's condition, drug regimen, and other factors may change the defibrillation threshold (DFT) which may result in non-conversion of the arrhythmia post-operatively. Successful conversion of ventricular fibrillation or ventricular tachycardia during arrhythmia conversion testing is no assurance that conversion will occur post-operatively.

**Electromagnetic interference (EMI)** signals present in hospital and medical environments may affect the function of any ICD/CRT-D or pacemaker. The ICD/CRT-D is designed to selectively filter out EMI noise. However, due to the variety of EMI signals, absolute protection from EMI is not possible with this or any other ICD/CRT-D.

The ICD/CRT-D system should have detection and therapy disabled prior to performing any of the following medical procedures. In addition, the ICD/CRT-D should be checked after the procedures to assure proper programming:

**Electrocautery** - Electrosurgical cautery could induce ventricular arrhythmias and/or fibrillation, or may cause device malfunction or damage. If use of electrocautery is necessary, the current path and ground plate should be kept as far away from the pulse generator and leads as possible (at least 6 inches (15 cm)).

Prior to surgically closing the pocket, the telemetry contact should be evaluated to help ensure chronic programmer communication. Close the device pocket using standard surgical technique. As the final step at device implant and each patient follow-up, the permanent program should be retransmitted to the ICD/CRT-D.

Typically, each device that you receive is in the "Shipment Mode". This mode includes factory settings that control the charge current of automatic capacitor reformations to avoid the possibility of temporary low battery readings. Shipment mode is automatically deactivated when electrophysiological tests (e.g., Impedance Measurement) are initiated by the programmer. The following can be used to verify status of the shipment mode:

- The shipment mode is ON if the device displays "Shipment Mode Active" in the event list
- The Shipment Mode is OFF if the device does not display "Shipment Mode Active" in the event list

Complete the Medical Device Registration Form provided with the ICD/CRT-D and return it to BIOTRONIK.

## 11.2 Follow-up Procedures

### 11.2.1 General Considerations

An ICD/CRT-D follow-up serves to verify appropriate function of the ICD/CRT-D system, and to optimize the programmable parameter settings.

In addition to evaluating the patient's stored therapy history and electrograms, acute testing of sensing and pacing is recommended. The physician shall be made aware of the program that is in effect after the patient leaves the office after each follow-up, by viewing the parameters displayed on the programmer screen after the device has been programmed and interrogated. As the final step at device implant and each patient follow-up, the permanent program should be retransmitted to the ICD/CRT-D. Due to longevity concerns, it is recommended the physician schedule a patient follow-up visit every 3 months.

#### **WARNING**

**Resuscitation Availability** - Do not perform induction testing unless an alternate source of patient defibrillation such as an external defibrillator is readily available. In order to implant the ICD/CRT-D system, it is necessary to induce and convert the patient's ventricular tachyarrhythmias.

#### **CAUTION**

**Programming Wand Separation Distance** – The wand (with magnet) must not be placed closer than 2 cm to the device (implanted or out of the box). Programming wand (with magnet) distance closer than 2 cm may damage the device.

Most patients require a routine follow-up exam every three months. Interim follow-ups may be necessary if there has been a change in a patient's anti-arrhythmic medication or if ATP and/or shock therapy have been delivered between routine follow-ups.

During the follow-up, all tachyarrhythmia episodes should be examined and printed. Sensing and pacing characteristics should be evaluated. Necessary changes should also be made to the programmed parameters.

### 11.2.2 Programmer Setup

Before initiating a follow-up, the surface ECG cable (i.e. PK-222) may be connected to the patient. The Lumax 740 ICD does have a far field option as well. At this time, the surface ECG display may be modified via the Preference/ECG buttons located via the More button on the lower right-hand corner of the programmer screen. Displayed below the Implant List button is the current time and date. Because the programmer time and date are transmitted to the device upon interrogation, these values should always be checked for accuracy. Changes in the time and date are made under the More/Preferences/System/Set Date (Set Time). Examples of those screens are shown below in [Figure 193](#). Changing the device time will not affect time stamps on episodes already recorded.



Figure 193: Programmer time and date setup

### 11.2.3 Follow-up Assistant

When the Lumax 740 ICD is first interrogated, the Follow-up Assistant screen is shown. It can be accessed at any time by selecting the Follow-up button at the right side of the programmer screen.

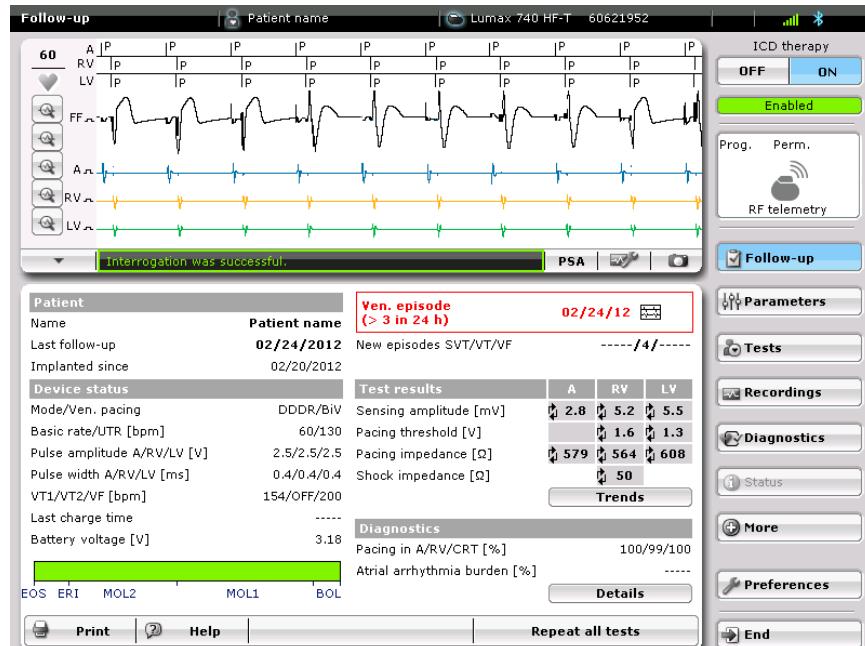


Figure 194: The Follow-Up screen after interrogation

The Follow-up page is divided into five sections; Patient, Device status, New episodes/event messages, Test results and Diagnostics.

#### 11.2.3.1 Patient

The Patient section provides information including patient name, last follow-up and implant date. The patient name and last follow-up are bolded. Selecting the patient name takes the user to the patient data page, where the user can change or update patient information. The Last follow-up link takes the user to the Follow-up History page.

History															
Date	Batt. [%]	Leads [Ω]			Sensing [mV]		Pacing threshold			Mode	BR [bpm]	Tachy detection			
		BIPL	UNIP	Pol.	Mean	Min.	Pol.	V	[ms]			VT1	VT2	VF	
02/25/2012	100	A RV LV Sh	578 564 622 51	---	BIPL BIPL BIPL	2.6 4.0 4.4	2.6 4.0 4.4	LV tip → RV ring	2.1 2.0 0.4	DDDR	60	390	OFF	300	
02/24/2012	100	A RV LV Sh	578 564 622 51	---	BIPL BIPL BIPL	2.6 4.0 4.4	2.6 4.0 4.4	LV tip → RV ring	1.6 1.3 0.4	DDDR	60	390	OFF	300	
02/23/2012	100	A RV LV Sh	578 564 622 51	---	BIPL BIPL BIPL	2.6 5.3 6.0	2.6 5.3 5.9	LV tip → RV ring	2.2 2.2 0.4	DDDR	60	OFF	OFF	OFF	
02/22/2012	100	A RV LV Sh	579 564 622 51	---	BIPL BIPL BIPL	2.8 4.5 4.8	---	LV tip → RV ring	---	DDDR	60	390	OFF	300	
02/21/2012	100	A RV LV Sh	593 564 622 51	---	BIPL BIPL BIPL	2.6 5.3 6.0	2.6 5.3 5.9	LV tip → RV ring	2.1 2.1 0.4	DDDR	60	390	OFF	300	

**Figure 195: Follow-up History page**

The History page automatically tracks the entire test data measured at implant and follow-up. The data may reveal gradual or abrupt changes that suggest further lead assessment. Follow-up data is entered into the Measurement Trend table at device interrogation and is only entered once per 24-hour period (day). The most recent data point for each day is maintained in this page. The Lumax 740 will store data from the last 11 follow-ups, as well as the implant procedure.

### 11.2.3.2 Device Status

The Device status provides information related to the current mode and pacing selection as well as information related to the basic and upper rate values, pulse amplitude and pulse width, tachycardia zone programming as well as battery information. This section shows the battery status along with the battery voltage and last charge time. A fuel gauge is also provided.

[Figure 194](#) shows the Follow-Up screen after interrogation. The device type and the serial number appear across the top of the programming screen. Next, the battery status is defined by one of five codes: 1) BOL = beginning of life; 2) MOL1 = middle of life one; 3) MOL2 = middle of life two; 4) ERI = elective replacement indication; or 5) EOS = end of service.

The five levels related to battery status:

1. Beginning of Life (BOL) = 90%-100% of battery life remaining
2. Middle of Life One (MOL1) - 40% - 90% of battery life remaining
3. Middle of Life Two (MOL2) - less than 40% of battery life remaining
4. Elective Replacement Indicator (ERI) - Pacing function and 6 maximum energy shocks remaining for DR-T and HF-T devices. For single chamber devices, no pacing and 6 maximum energy charges are assumed.
5. End of Service (EOS) - Bradycardia therapy remains but tachycardia therapy is disabled.

### 11.2.3.3 New Episodes/Event Messages

The device provides information related to new episodes which have occurred since the last follow-up. It provides the number of new episodes and the detection zone in which it was detected.

Event messages, such as the one shown in red in [Figure 194](#), are also provided in the section. Other messages would include out of range values such as shock or pacing impedances. Touching the message takes the user to the appropriate diagnostic or recordings page for more detailed information. If multiple messages are present, up/down arrows will appear on the right hand side of the messages to allow the viewer to review them.

### 11.2.3.4 Test Results

The Follow-up page displays any automatically measured data that has been recorded within the last 24 hours. The user can automatically update the values by pressing the Repeat all tests button.

The arrows next to the pacing impedance and shock impedance numbers indicate that these are measured values derived from automatic tests and will appear when the device is initially interrogated. These are measured four times daily.

#### 11.2.3.4.1 Trends

Trends provides information related to pacing thresholds, sensing measurements, pacing and shock impedances. The arrow keys on the bottom of the screen allows the user to go back and forth to view data for specific dates. The current date of the data displayed above each section is shown in an orange box at the bottom of the screen . Critical information can be quickly viewed by pressing the buttons with exclamation points on them.

An example of the Trend data is shown in [Figure 196](#).



Figure 196: Trends screen

### 11.2.3.5 Diagnostics

The section provides the percentage of pacing in each chamber since the last follow-up. The atrial burden since last follow-up is provided. Pressing the Details button takes the user to a snapshot of diagnostic data as shown in [Figure 197](#).

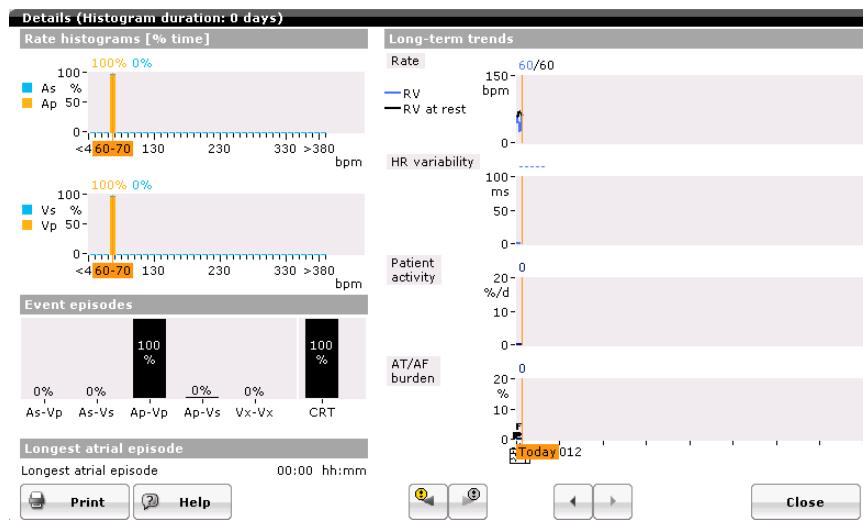


Figure 197: Diagnostics

Information provided includes Rate histogram data, Event episodes, Longest atrial episode duration, and Long-term trend information since the last follow-up. The buttons along the bottom of the page function in the same manner as discussed in the Trends section.

#### 11.2.4 Data Retrieval

Once the Follow-up Assistant is complete, all therapy data that has accumulated between follow-up exams should be printed. This includes stored IEGMs, shock data, and counter information.

Tachyarrhythmia data is retrieved via the Recordings button at the right of the screen. When Recordings is chosen, the Episode List appears. Each episode is listed with the episode number (most current on top), date and time of detection, the zone of initial detection, atrial and ventricular intervals at the time of detection, and the type of therapy delivered, atrial and ventricular intervals at termination, as well as links to the IEGM and Detail data as illustrated in [Figure 198](#).

Episodes									
No.	Time	Zone	PP [ms]	RR [ms]	Description	PP [ms]	RR [ms]	IEGM	
10	02/25/12 12:12	VF	997	236	1 Shock, induced	998	999		
9	02/25/12 12:09	VF	997	212	1 Shock, induced	998	999		
8	02/25/12 11:59	VF	997	258	induced	997	997		
7	02/25/12 11:56	VTI	997	334	1 ATP	997	997		
6	02/24/12 08:14	VTI	997	334	1 ATP	997	997		
5	02/24/12 07:59	VTI	997	334	2 ATP's	997	997		
4	02/24/12 07:56	VTI	996	337	1 ATP	997	997		
3	02/24/12 07:47	VTI	997	335	1 ATP	997	997		
2	02/24/12 07:44	VTI	996	332	1 ATP	997	997		

Display episodes  AT/AF  VT/VF  SVT  since last follow-up

Print Help

Figure 198: The Episode List chronologically displays tachyarrhythmia episodes

The IEGM records and details for each episode and can be viewed by selecting the buttons beside each episode number in the Episode List. Each IEGM record should be printed during follow-up. The selection of an IEGM for viewing will also store the IEGM in the Print manager.

The header of each category on the Episode List is a sort tab allowing the user to sort data to view in order data by groups or time.

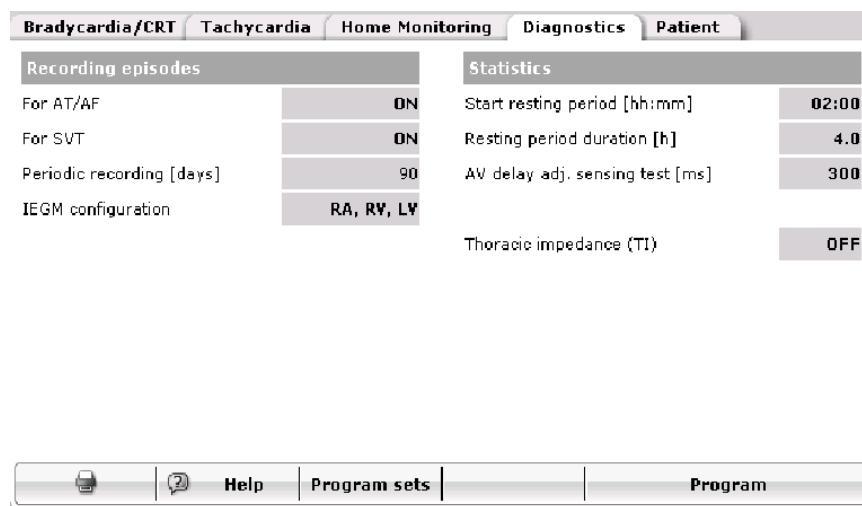
The display episodes check boxes at the bottom of the page allow the user to sort episodes by type or since last follow-up. Simply check the desired episode box(es) to view that data only.

In addition to episode data, therapy data should be printed at follow-up. The shock data can be found in the Shocks tab. This table lists shocks in chronological order, with the most current at the top. The time and date of charging, the delivered energy, charge time, and impedance values are given. A remarks field is provided to denote special conditions, such as manual shock delivery, aborted shocks and automatic capacitor reforms. Additional therapy data is located under the Counters tab. Detection counters show the total number of episodes declared in each tachyarrhythmia zone (i.e., SVT, VT-1, VT-2 and VF) since the last follow-up and over the life of the device. SVT details display the SVT episode number for each of the four SVT sub-classifications (i.e., AFlut for atrial flutter, AFib for atrial fibrillation, SinusT for sinus tachycardia, and 1:1 for atrial tachycardias). The therapy counters list the total number of successful and unsuccessful ATP and shock therapies since the last follow-up and throughout the life of the device.

## 11.2.5 IEGM Storage

By default, the memory is partitioned to provide up to 32 minutes of three-chamber IEGM data. FF IEGMs are included with single- and dual-chamber IEGM storage.

The total number of episodes is dependent on the length of recordings. The duration of each IEGM episode can be in excess of four minutes with a pre-detection length of 30 seconds without Onset criterion being met and five seconds when Onset criterion is met. AT/AF IEGMs have the option to program the pre-detection duration to greater than 60 seconds by programming Advanced ON in the Diagnostics section of the parameter page. SVT recordings may be triggered with detection and termination only if SVT EGM is turned ON ([Figure 199](#)).



**Figure 199: The Diagnostics section to set up storage of SVT and AT/Aflut EGM**

An AT/AF is determined when the device reaches a fixed criterion of 36 of 48 atrial events at the user programmed rate cut-off.

**NOTE:**

An SVT recording is triggered when the detection criteria for an SVT has been met. The detection criteria for an SVT recording is two times the VT zone detection count. For example, in the VT1 zone with a nominal default setting of 16 events, an SVT event will be triggered when 32 individual svt events are counted by the device. Termination of an SVT occurs when 5 consecutive sinus events occur.

## 11.2.6 Reprogramming

After the Follow-up Assistant is complete and all IEGM data retrieved, it may be necessary to reprogram the device to optimize the pacing, sensing, and/or detection parameters. Appropriate changes should be made and new parameters transmitted at the end of each follow-up. New parameters should be printed and a printout kept with the patient's records for future reference.

**NOTE:**

Unlike previous generations of BIOTRONIK ICDs, reprogramming the Lumax 740 device will NOT automatically enable detection and therapy.

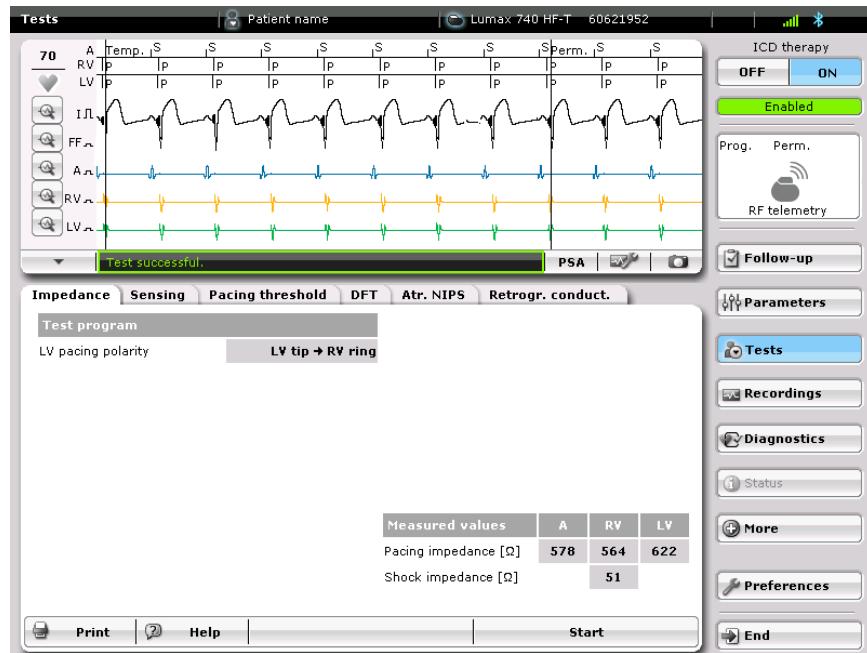
## 11.2.7 Manual Follow-Up

If desired, all tests in the Follow-up Assistant can be performed separately. Below is a brief description of each test.

### 11.2.7.1 Impedance Test

The impedance test provides information about the continuity of the lead(s), as well as shock pathway impedance information. The pacing impedances range is 200 – 3000 ohms for the device and the shock impedance is typically between 25 – 100 ohms (the device minimum reading is 25 ohms and the maximum is 150 ohms).

From the impedance screen, the painless shock impedance is performed first and then the pacing impedances. The test is performed in the programmed mode and will generally take around 5 seconds to perform. The test will use subthreshold pacing pulses. The painless shock impedance is measured between the RV coil and the SVC Coil and/or can, depending on the type of lead that is used. The painless shock impedance test is done in the same configuration as the shock pathway is programmed.

**Figure 200: Impedance Test**

One can expect a slightly higher reading with a single-coil lead, as opposed to a dual-coil lead. It is also important to note that at implant testing with a single-coil lead, the can must be in the device pocket in order to get a reading. Otherwise, an erroneous value will be displayed.

The user has the option to select only the LV pacing polarity, which may be different than the permanent choice.

### 11.2.7.2 Sensing Test

The Sensing test can be done with or without back-up pacing. When the Start button is pressed, the test will be performed in a VDI mode with VVI back-up pacing support in the ventricle. The back-up pacing rate is programmable by the user. When Intrinsic rhythm is selected, the test is performed with no back-up pacing (ODO mode). The test is only active as long as the user has the Intrinsic rhythm button pressed. See [Figure 201](#) to view the sensing screen.

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Figure 201: Sensing Test

### 11.2.7.3 Threshold Test

The Threshold test can be done with a surface ECG or by viewing the IEGM. The user can select the pacing mode and chamber to be tested. Changes can be made “on the fly” at any time while an active test is ongoing. Any value that is in bold on the screen can be changed. See [Figure 202](#) for an example of the threshold test screen.

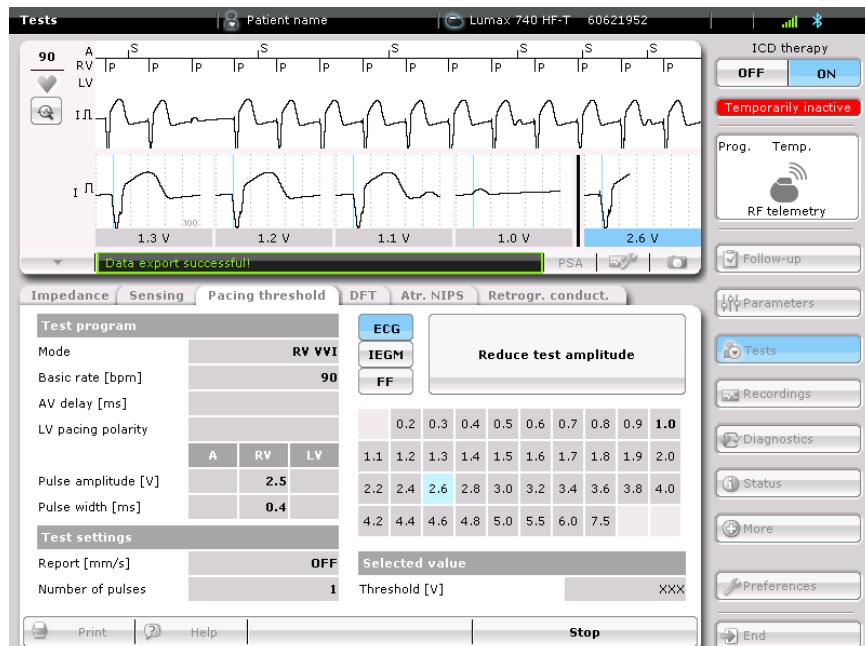


Figure 202: Threshold Test with ECG display

The Pulse amplitude and Pulse width values that are displayed will match the Mode of the Test program. For example, in [Figure 202](#), the threshold test is being performed in the RV chamber in a VVI mode. The RV amplitude and RV pulse values are displayed. If the user changes the Mode to DDD in LV, the atrial and LV outputs would be displayed. In addition, the pacing polarity will also be present for the LV lead.

As the Lumax 740 ICD family utilizes ventricular capture control, the user will have to option to use RV and LV auto threshold tests in single- and dual-chamber options. These tests will use the same algorithm as the VCC algorithm to determine pacing thresholds.

#### 11.2.7.4 Retrograde Conduction Test

The Retrograde conduction test is performed in the VDI. In the Lumax 740 HF-T, the user can select either RV or LV for pacing. If LV is selected, LV pacing polarity options are made available. The pacing rate is also programmable from 30-160 bpm.

It is recommended that the pacing rate be programmed 10-15 bpm above the intrinsic ventricular rate. As retrograde conduction may be rate dependent in some patients, consider testing at different rates if retrograde conduction is suspected.

The programmer displays the results as the maximum, minimum, and average retrograde conduction time, and the measured V-A times are displayed on the marker channel. Generally, if the min, mean and max times are within 25 ms, retrograde conduction is suspected.

[Figure 203](#) shows an example of a negative test result as there is no 1:1 correlation between ventricular pacing and an atrial response.



Figure 203: Retrograde Conduction Test

#### 11.2.8 Temporary programming

Unlike BIOTRONIK's pulse generators, there is not a temporary program button for the Lumax 740 ICD/CRT-D devices.

## 11.3 Explantation

Explanted ICDs/CRT-Ds, lead systems, and accessories may not be reused. Please complete the appropriate out of service (OOS) form and return it to BIOTRONIK with the explanted devices. All explanted devices should be sent either to the local BIOTRONIK representative or the BIOTRONIK home office for expert disposal. Contact BIOTRONIK if you need assistance with returning explanted devices. If possible, the explanted devices should be cleaned with a sodium-hyperchlorine solution of at least 1% chlorine and then washed with water prior to shipping.

The pulse generator should be explanted before the cremation of a deceased patient.

### WARNING

**Unwanted Shocks** – Always program ICD Therapy to OFF prior to handling the device to prevent the delivery of serious shocks to the patient or the person handling the device during the implant procedure.

### CAUTION

**Device Incineration** – Never incinerate the ICDs/CRT-Ds due to the potential for explosion. The ICD/CRT-D must be explanted prior to cremation.

**Explanted Devices** – Return all explanted devices to BIOTRONIK.

## 12. Longevity

The service time of an ICD/CRT-D can vary based on several factors, including the number of charge sequences, programmed parameters, number of tachyarrhythmias detected, relative amount of bradycardia pacing required, pacing lead impedance, storage time, battery properties, and circuit operating characteristics. Service time is the time from beginning of service (BOS) to the elective replacement indication (ERI). To assist the physician in determining the optimum time for ICD/CRT-D replacement, a replacement indicator is provided that notifies the user that replacement within a certain period of time is required. Upon reaching ERI, the battery has at least enough energy left to continue monitoring for three months along with the ability to deliver six high-energy shocks. After this period, all tachyarrhythmia detection and tachyarrhythmia therapy is disabled.

### CAUTION

**Charge Time** - When preparing a high energy shock the charge circuit stops charging the capacitors after 20 seconds, and delivers the stored energy as shock therapy. After the device reaches ERI the stored energy may be less than the maximum programmable energy for each shock.

The projected service times from beginning of service (BOS) to elective replacement indication (ERI) are listed in the following tables. All estimates were calculated assuming a pacing rate of 60 bpm with a pulse width of 0.4 ms and pulse amplitude of 2.5 Volts and 500 ohm pacing impedance with all shocks at maximum programmable energy at 37 °C with TI and Home Monitoring features ON. It is assumed that the shocks are equally spaced throughout the life of the ICD/CRT-D. The estimates include 1 periodic Home Monitoring message per day and 4 remote follow-ups per year with 8 event messages per year. The estimates do not include the quarterly capacitor reform process. The estimates associated with 0% pacing support assume the ICD/CRT-D is sensing an intrinsic sinus rhythm at a rate of 70 bpm. The tables represent the mean longevity estimates for the specified devices. If there are multiple available batteries for a particular device, the worst case longevity option is presented.

The longevity estimates have been determined using the 16 month Use By Date (UBD) shelf life. Each month of unused shelf life during the UBD period of 6 months - 16 months increases the longevity of the devices by 15 days.

### 12.1 Lumax 740 Devices

Table 24 provides longevity estimates for the single chamber Lumax 740 ICD. The table provides several different support scenarios. It is assumed that the shocks are equally spaced throughout the life of the ICD.

Table 24: Lumax 740 VR-T Longevity Estimates				
Pacing Support				
Shocks per year	0%	15%	50%	100%
4	10.0	9.8	9.2	8.4
8	8.1	7.9	7.5	7.0
12	6.8	6.6	6.4	6.0

Table 25 provides longevity estimates for the dual-chamber Lumax 740 ICD. The table provides several different support scenarios. It is assumed that the shocks are equally spaced throughout the life of the ICD.

Table 25: Lumax 740 DR-T Longevity Estimates				
Pacing Support				
Shocks per year	0%	15%	50%	100%
4	9.2	8.7	7.7	6.6
8	7.5	7.2	6.5	5.7
12	6.3	6.1	5.6	5.0

[Table 26](#) provides longevity estimates for the Lumax 740 VR-T DX ICDs. The table provides several different support scenarios. It is assumed that the shocks are equally spaced throughout the life of the ICD.

Table 26: Lumax 740 VR-T DX Longevity Estimates				
Pacing Support				
Shocks per year	0%	15%	50%	100%
4	9.2	8.9	8.4	7.8
8	7.5	7.3	7.0	6.5
12	6.3	6.2	6.0	5.6

[Table 27](#) provides longevity estimates for the Lumax 740 HF-T variants of ICDs. The table provides several different support scenarios. It is assumed that the shocks are equally spaced throughout the life of the CRT-D.

Table 27: Lumax 740 HF-T Longevity Estimates	
Pacing Support	
Shocks per year	100%
4	5.7
5	5.5
6	5.3
7	5.1
8	5.0
9	4.8
10	4.7
11	4.6
12	4.4

Upon reaching ERI, the battery has enough energy left to continue monitoring for three months and to deliver six high energy shocks. The estimates associated with duration of ERI assume the ICD/CRT-D is sensing an intrinsic sinus rhythm at a rate of 70 bpm. After this period the device is at EOS (End of Service) and requires explantation. Once at EOS, all tachyarrhythmia detection and therapy is disabled. The ERI and EOS voltages are listed in the [Table 28](#) and [Table 29](#).

Table 28: ERI and EOS Voltages for ICDs with the LiMnO <sub>2</sub> battery	
Operating Mode	Voltage
Elective Replacement Indicator (ERI)	2.85 Volts
End of Service (EOS)	1.75 Volts

**Table 29: ERI and EOS Voltages for ICDs with the LiSVO battery**

Operating Mode	Voltage
Elective Replacement Indicator (ERI)	2.50 Volts
End of Service (EOS)	1.75 Volts



## 13. Technical Specifications

The following are the technical specifications for the Lumax ICDs/CRT-Ds. The ranges are presented in the format:

**x...(y)...z**

where x = the lowest value, y = the increment, and z = the largest value.

**Table 30: Mechanical Properties**

	Lumax 740 VR-T	Lumax 740 VR-T DX	Lumax 740 DR-T	Lumax 740 HF-T
Dimensions	66 mm x 55 mm x 13 mm	66 mm x 55 mm x 13 mm	66 mm x 55 mm x 13 mm	66 mm x 59 mm x 13 mm
Volume	37.2 cm <sup>3</sup>	37.2 cm <sup>3</sup>	37.2 cm <sup>3</sup>	39.8 cm <sup>3</sup>
Mass	92 g	92 g	92 g	94 g
Housing	Titanium			
Header	Epoxy resin			
Seal Plug	Silicone			
VR-T Lead Ports	1 x 3.2 mm IS-1 Bipolar 2 x 3.2 mm DF-1			3 x 3.2 mm IS-1 Bipolar 2 x 3.2 mm
DR-T / DX Lead Ports	2 x 3.2 mm IS-1 Bipolar 2 x 3.2 mm DF-1			DF-1

Parameter	Range	Standard
<b>Bradycardia</b>		
<b>Atrial Sensing Parameters</b>		
Sensing	STD - standard, OFF - inactive	STD
Minimum threshold	0.2...(0.1)...2.0 mV	0.4 mV
Far-field protection after Vp	50...(25)...225 ms	75 ms
Far-field protection after Vs	Off, 25...(25)...225 ms	75 ms
Upper threshold	25, 50, 75%	50% (75% for VR-T DX)
<b>Right-ventricular Sensing Parameters</b>		
Sensing RV	STD - standard, TWS - Enhanced T-wave suppression, VFS - Enhanced VF sensitivity	STD
Minimum threshold	0.5...(0.1)...2.5 mV	0.8 mV
Blanking after atrial pacing	50...(10)...100 ms	50 ms (N/A VR-T DX)
Upper threshold	50; 75%	50 %

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Parameter	Range	Standard
Lower threshold	25; 50%	25 %
Hold of upper threshold	100...(20)...500 ms	350 ms
<b>Left-ventricular Sensing Parameters</b>		
Sensing LV	STD - standard, OFF - inactive	STD
Min. threshold	0.5...(0.1)...5.0 mV	1.6 mV
Blanking after atrial pacing	= Safety window	100 ms (N/A VR-T DX)
Upper threshold	50; 75%	50 %
Hold of upper threshold	110, 150...(50)...500 ms	350 ms
Lower threshold	50%	50 %
<b>In channel /Cross channel Blanking</b>		
In-channel blank after RV pace	100...(10)...350 ms	120 ms
In-channel blank after LV pace	100...(10)...350 ms	120 ms
LV cross-blank after RV pace	50...(10)...100 ms	80 ms
RV cross-blank after LV pace	50...(10)...100 ms	80 ms
<b>Polarity Pace / Sense</b>		
LV polarity pace	LV-tip -> LV-ring (bipolar (1)), LV-tip -> RV-ring (common ring bipolar (2)), LV-ring -> LV-tip (inverse bipolar (3)), LV-ring -> RV-ring (ring to ring bipolar (4)) LV-tip > Case (5)	LV-tip -> RV-ring
LV polarity sense	UNIP (LV-tip/housing), BIPL (LV-tip/LV-ring)	UNIP
Shock Path (Valid for all shocks including the pain-free shock impedance)	RV -> SVC + ICD (Housing) RV -> ICD RV -> SVC	RV -> SVC + ICD
<b>Pulse Amplitudes and Pulse Widths</b>		
Pulse amplitude	0.5...(0.25)...4.0...(0.5)...6.0, 7.5 V	2.5 V
Pulse width	0.4, 0.5, 0.75, 1.0, 1.25, 1.5 ms	0.4 ms
<b>RV and LV Capture Control (ATM)</b>		
RV	OFF, ATM, ON	ATM
LV (HF-T Only)	OFF, ATM, ON	ATM

Parameter	Range	Standard
<b>Mode</b>		
Modes (DR-T, HF-T)	DDD, DDDR, DDI, DDIR, VDD, VDDR, VDI, VDIR, VVI, VVIR, AAI, AAIR, DOO, VOO, OFF	DDD
Modes (VR-T DX)	VDD, VDDR, VDI, VDIR, VVI, VVIR, VOO OFF	VVI
Modes (VR-T)	VVI, VVIR, VOO OFF	VVI
<b>Basic Rate Day/Night</b>		
Basic rate	30..(5)..100..(10)..160 bpm	60 bpm
Night rate	OFF, 30..(5)..100 bpm	OFF
Night beginning	00:00..(1 min)..23:59 h:m	[22:00 h:m]
Night ending	00:00..(1 min)..23:59 h:m	[06:00 h:m]
<b>Rate Hysteresis</b>		
Rate hysteresis	OFF, -5..(-5)..-25..(-20)..-65 bpm	OFF
Repetitive	OFF; ON	[ON (10)]
Scan	OFF; ON	[ON (10)]
<b>AV Delay</b>		
AV delay	Low, Medium, High, Fixed, (individual)	Low
AV delay 1	40..(5)..350 ms	150 ms
AV rate 1	50..(10)..130 bpm	60 bpm
AV delay 2	15, 40..(5)..350 ms	120 ms
AV rate 2	60..(10)..140 bpm	130 bpm
Sense compensation	OFF; -5..(-5)..-120 ms	-40 ms (N/A VR-T DX)
AV-hysteresis mode	OFF, positive, Negative I-Opt	OFF
AV hysteresis	70, 110, 150, 200 ms	[70 ms]
AV repetitive (positive)	OFF; ON	[ON]
AV repetitive (negative)	ON (180)	ON (180)
AV scan	OFF, ON	[ON]
<b>I-Opt Lumax 740 DR-T/VR-T DX</b>		
I-Opt	OFF, ON	OFF
AV hysteresis at I-Opt	400 ms	400 ms
AV repetitive at I-Opt	ON (5)	[ON(5)]
AV scan at I-Opt	ON (5)	[ON(5)]

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Parameter	Range	Standard
<b>Post-ventricular Atrial Refractory Period (PVARP)</b>		
PVARP	175..(25)..600 ms, Auto	225 ms
Auto PVARP	OFF, ON	OFF
<b>VES Classification (VES Lock-in Protection)</b>		
VES discrimination after As	250..(50)..500 ms	350 ms
<b>Rate Adaptation (Acceleration Sensor)</b>		
Maximum sensor rate	80..(10)..160 bpm	120 bpm
Sensor gain	AUTO, Very low (1.3), Low (3), Medium (6), High (12), Very high (26)	Medium
Sensor threshold (numbers are not displayed on screen)	Very low = 0 Low = 3 Medium= 7 High = 11 Very high = 15	Medium
Rate increase	1,2,4 or 8 bpm/cycle	2 bpm/cycle
Rate drop	0.1, 0.2, 0.5 or 1.0 bpm/cycle	0.5 bpm/cycle
<b>Upper Tracking Rate (UTR)</b>		
Upper tracking rate	90..(10)..160 bpm	130 bpm
Upper tracking rate atrium	OFF, 175, 200, 240 bpm	200 bpm (N/A VR-T DX)
<b>Mode Switching</b>		
Intervention rate	OFF, 120..(10)..200 bpm	160 bpm
Activation criterion X	3..(1)..8	5
Deactivation criterion Z	3..(1)..8	5
Mode	DDI, DDIR at permanent DDD(R) VDI, VDIR at permanent VDD(R)	DDI [VDI]
Modes (VR-T DX Only)	VDI, VDIR at permanent VDD(R)	[VDI]
Change in basic rate	OFF, +5 ... (5) ...+30 bpm	+10 bpm
<b>Post-Mode Switch Response (PMSR)</b>		
Post-ModeSw rate	OFF, +5 ... (5) ...+50 bpm	+10 bpm
Post-ModeSw duration	1..(1)..30 min	1 min
<b>PMT Protection</b>		
PMT detection / termination	OFF, ON	ON
VA criterion	250..(10)..500 ms	350 ms
<b>Detection</b>		
Detection / Therapy	ON, OFF	ON

Parameter	Range	Standard
<b>Interval</b>		
Interval VT1	OFF, 270...(10)...600 ms	OFF
Interval VT2	OFF, 270...(10)...500 ms	OFF
Interval VF	OFF, 240...(10)...400 ms	300 ms
<b>Detection Counter</b>		
Detection counter VT1	10...(2)...60	[16]
Detection counter VT2	10...(2)...40	[14]
Detection counter VF	6 out of 8, 8 out of 12, 10 out of 14, 12 out of 16, 16 out of 20, 18 out of 24, 20 out of 26, 22 out of 30, 24 out of 30	8 out of 12
<b>Onset</b>		
Onset in VT1/2 with SMART	4...(4)...32 %	[20%]
Onset VT1/2 without SMART	OFF; 4...(4)...32%	20%
<b>Stability</b>		
Stability in VT1/2 with SMART	8... (4)...48 %	[12%]
Stability VT1/2 without SMART	OFF; 8...(4)...48 ms	24 ms
<b>SMART Detection</b>		
SMART detection VT1	OFF, ON	[ON]
SMART detection VT2	OFF, ON	[ON]
<b>Sustained VT (without SMART Detection and without SMART Redetection)</b>		
Sustained VT	OFF, 1,2,3,5,10, 20 or 30 min	[OFF]
<b>Forced Termination (with SMART Detection Including SMART Redetection)</b>		
Forced termination	OFF; 1...(1)...10 min	[1 min]
<b>Redetection Counter</b>		
Redetection counter VT1	10...(2)...30	[12]
Redetection counter VT2	10...(2)...30	[10]
<b>Ventricular Therapy Parameters</b>		
Energy 1st shock of VT1, VT2	OFF; 2..(2)..20..(5)..40 J	40 J
Energy 2nd shock VT1, VT2	OFF; 4..(2)..20..(5)..40 J	40 J
Number of shocks (VT1/VT2)	0, 1, 2, 6, 8	[8]
Number of shocks (VF)	6, 8	8
Confirmation (per zone)	OFF, ON	ON
Shock form (per zone)	Biphasic, Biphasic 2	Biphasic
Polarity (per zone)	Normal, Reverse, Alternating	Normal

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Parameter	Range	Standard
<b>ATP Parameters</b>		
ATP type	Burst, Ramp	[Burst]
ATP attempts	OFF, 1...(1)...10	OFF
S1 number	1...(1)...10	[5]
Add. S1	OFF, ON	[ON]
R1-S1 interval	70...(5)...95 % (adaptive)	[80 %]
S1 (RAMP) decrement	5...(5)...40 ms	[10 ms]
Scan decrement	OFF, 5...(5)...40 ms	[OFF]
Minimal ATP interval	200 ms	[200 ms]
ATP optimization	OFF, ON	OFF
ATP pulse amplitude	7.5 V	7.5 V
ATP pulse width	1.5 ms	1.5 ms
<b>ATP One-Shot Parameter (ATP in VF)</b>		
ATP type	OFF, Burst, Ramp	Burst
S1 number	1...(1)...10	[8]
R-S1 interval	70...(5)...95 % (adaptive)	[85%]
S1 decrement	5...(5)...40 ms	[10ms]
Stability	12%	12%
ATP attempts	1	[1]
ATP pulse amplitude	7.5 V	7.5 V
ATP pulse width	1.5 ms	1.5 ms
<b>Ventricular NIPS</b>		
ATP type	Burst, Ramp, Burst + PES	Ramp
Attempts	1	1
Ventricular Pacing	BiV, LV, RV	RV
S1 number	1...(1)...25	[5]
R-S1 interval	200...(10)...600 ms (absolute); 70...(5)...95 % (adaptive)	[80%]
S1 decrement	5...(5)...40 ms	[10 ms]
S1-S2 interval	200...(10)...600 ms simply alterable via [+ / -] buttons	290
S2-S3 interval	OFF, 200...(10)...600 ms simply alterable via [+ / -] buttons	OFF
S3-S4 interval	OFF, 200...(10)...600 ms simply alterable via [+ / -] buttons	OFF
Minimum ATP interval	200 ms	
<b>Atrial NIPS</b>		
Backup Stimulation (VVI-Rate)	OFF, 30 .. (10) .. 120 bpm	OFF

Parameter	Range	Standard
Report	OFF, 5, 10, 25, 50 mm/s	Preference
S1-S1 interval	80...(10)...2000 ms	600 ms
S1 cycles	0...(1)...10	7
S1-S2 interval	None, 80...(10)...1000 ms simply alterable via [+ / -] buttons	None
S2-S3 interval	None, 80...(10)...1000 ms simply alterable via [+ / -] buttons	None
S3-S4 interval	None, 80...(10)...1000 ms simply alterable via [+ / -] buttons	None
Burst rate Min.	30...(10)...250 bpm	150 bpm
Burst rate Start	30...(10)...800 bpm	250 bpm
Burst rate Max.	30...(10)...800 bpm	350 bpm
<b>Post-Shock Pacing</b>		
Mode	DDI at permanent DDD(R), DDI (R), AAI(R)  VDI at permanent VDD(R), VDI(R),  VVI at permanent VVI(R), OFF	
Modes (VR-T DX Only)	AAI  VDI at permanent  VDD(R), VDI(R),  VVI at permanent VVI(R),  OFF	
Basic rate	30 .. (5)..100..(10) .. 160 bpm	60 bpm
Rate hysteresis	OFF	OFF
AV delay	50..(10)..350 ms (fixed AV delay)	140 ms
Post-shock duration	OFF, 10 s, 30 s, 1 min, 2 min, 5 min, 10 min	10 s
<b>CRT Therapy Parameters</b>		
Initially paced chamber	LV, RV	LV
VV delay after Vp	0... (5)... 100 ms	0 ms
<b>Home Monitoring</b>		
Home Monitoring	OFF, ON	OFF
Transmission time	Time (hh:mm), Std.	Std.
IEGM for therapy episode	OFF, ON	[ON]
IEGM for monitoring episode	OFF, ON	[ON]
Periodic IEGM	OFF, Date, 30, 60, 90, 120, 180 days	[90]
Sustained atrial episode	OFF, 6, 12, 18 h	[12 h]

## Chapter 12 Technical Specifications

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Parameter	Range	Standard
<b>Diagnostics</b>		
Periodic Recordings	if Home Monitoring ON: = Cycle duration	[30]
	If Home Monitoring OFF: OFF, 30 .. (30) .. 180	[30]

**FCC Statement:** (FCC ID: QRILUMAXT50): This implant is equipped with an RF transmitter for wireless communications. This device may not interfere with stations operating in the 400.150–406.000 MHz band in the Meteorological Aids, Meteorological Satellite, and Earth Exploration Satellite Services and must accept any interference received, including interference that may cause undesired operation.

## Appendix A

### Connector Compatibility

Lumax ICDs/CRT-Ds are indicated for use only with commercially available BIOTRONIK bipolar ICD lead systems or other lead systems with which it has been tested. The separate atrial pacing/sensing lead may be any commercially available pacing lead. The Lumax family of ICDs/CRT-Ds are mechanically compatible with:

- IS-1 sensing/pacing lead connectors
- DF-1 defibrillation lead connectors.

The Lumax 740 DR-T and Lumax 740 VR-T DX ICDs have two IS-1 header ports and two DF-1 header ports while the Lumax 740 VR-T ICD has a single IS-1 header port and two DF-1 header ports. The Lumax 740 HF-T CRT-Ds have three IS-1 header ports and two DF-1 header ports.

**Appendix A**  
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## Appendix B – Known Anomalies

Anomaly	Possible Effect on Patient or Implant Procedure	Impact on Lumax 740
Lumax Application (Programmer Software)		
Event Counter Statistics may be slightly off by single counts of Vx events dependent on internal statistics state transitions. This is a rare event. ID# 410925	<p>Diagnostic Data Issue (Interrogation, Display, Printout): Display/printout of incorrect diagnostic information without risk of incorrect diagnosis.</p> <p>Behavior accepted as is due to acceptable residual risk resulting from low severity and low probability of occurrence.</p>	Product safety and performance are only marginally affected.
Inconsistent behavior for “Alert” navigation. Clicking the alert icon on the TrendView time axis and on the Information Details the expectedly the navigation leads to the corresponding trend. This is omitted if the alert icons are clicked from the Diagnostics Details. ID# 406945	<p>Functional/Usability Issue (missing, insufficient user guidance, unexpected behavior): without clinical relevance or negative therapeutical/diagnostic implication.</p> <p>Behavior accepted as is due to acceptable residual risk resulting from low severity and low probability of occurrence.</p>	Product safety and performance are only marginally affected.
Dual Chamber devices only: When programmed to DDDR mode and with sensor activity it is possible for a sudden rate drop at start of a capacitor reformation procedure. After the reformation the pacing rate again sensor indicated rate. ID# 19607	Limited effect on patient, temporary rate drop to programmed post-shock pacing rate ensures sufficient support.	N/A
An ineffective pacing program may continue during the threshold test at programming distances close to the loss of communication. Lifting the wand corrects the problem. ID# 17903	Limited potential effect on patient, non-capture is quickly recognized and removal of programming wand is typical response. This anomaly can only occur during manual threshold testing (in physician's office).	N/A



## Appendix C – Glossary

<b>A</b>	
active housing	When the housing of the ICD is used as an electrode for shock delivery.
anode	The positive pole of a circuit.
ATP (Anti-Tachycardia Pacing)	Rapid pacing therapy used to terminate tachyarrhythmias.
ASC (Auto Sensitivity Control)	The sensing algorithm used in ICDs to sense the cardiac signal over a wide range of intrinsic amplitudes.
<b>B</b>	
biphasic waveform	A waveform type with two phases, one positive and one negative.
blanking period	A period of time in which the device does not sense. A blanking period follows shock delivery or a programmable time period after a paced event.
BOL (Beginning of Life)	A term used to describe battery status.
burst	A train of pacing pulses delivered at either fixed or decreasing cycle lengths used to treat or induce tachyarrhythmias.
<b>C</b>	
capacitance	The energy stored in a capacitor is proportional to the capacitance times the square of the voltage across the capacitor.
capacitor	A circuit element consisting of two conducting surfaces separated by a nonconducting surface. A capacitor temporarily stores an electric charge for defibrillation in an ICD.
capacitor reformation	The process in which the capacitors are fully charged and discharged. In an ICD, no energy is delivered to the patient. The process may improve charge times when the charging circuit is used infrequently.
cardioversion	A shock, usually low in energy, used to terminate a tachyarrhythmia.
cathode	The negative pole of a circuit.
committed shock	A shock that is delivered without reconfirmation of an ongoing tachyarrhythmia.
confirmation type	With respect to shocks, confirmation can be programmed to YES (i.e., a uncommitted shock) or NO (i.e., a committed shock).
coupling interval	The time period between an intrinsic event and an electrical stimulus or between two consecutive programmed electrical stimuli.
current	The flow rate of a charge, measured in amperes or milliamperes.

cycle length	The time period between one event and the next in a repetitive signal (e.g., pacing pulse), measured in milliseconds.
<b>D</b>	
device-based testing	A process using the ICD and a programming system to perform DFT (induction) testing.
DFT (defibrillation threshold)	The minimum energy or voltage required to successfully terminate a tachyarrhythmia.
<b>E</b>	
EOL	A term used to describe battery status. EOL indicates End Of Life.
ERI	A term used to describe battery status. ERI indicates Elective Replacement Indicator.
<b>H</b>	
HV1	A high-voltage port on the header of an ICD. The HV1 port connects to the electrode placed in the ventricular apex.
HV2	A high-voltage port on the header of an ICD. The HV2 port connects to the electrode placed in the vena cava. HV2 is also internally connected to the housing of ICD to act as a common electrode.
<b>I</b>	
impedance	The ratio of voltage to current, measured in ohms. Also, the total opposition (i.e., resistance and reactance) to the flow of current in an electrical circuit.
<b>J</b>	
joule	A unit of work or energy. The work done in one second by current of one ampere against a resistance of one ohm.
<b>M</b>	
monomorphic VT	A ventricular tachycardia that occurs from a single focus. The ECG pattern usually shows a regular waveform.
<b>N</b>	
non-committed shock	Shocks that are delivered only after a tachyarrhythmia is verified by the device. If a tachyarrhythmia terminates during the reconfirmation period, the device does not deliver energy to the patient.
<b>O</b>	
onset	A detection enhancement used to discriminate VTs (which occur suddenly) from sinus tachyarrhythmias (whose rate increases slowly over time).
<b>P</b>	
PES (Programmed Electrical Stimulus or Premature Extra Stimulus)	A series of pacing pulses delivered at fixed or decreasing cycle lengths used to induce arrhythmias.

polarity	The condition of being positive or negative relative to a given reference. In BIOTRONIK ICDs, normal polarity refers to the configuration with the distal shock coil as the cathode and the can as the anode.
polymorphic VT	A ventricular tachycardia that may have more than one focus
post-shock pacing	Pacing, typically high in amplitude, that occurs after shock therapy.
<b>R</b>	
ramp	A burst of pacing pulses delivered in decreasing cycle lengths within a stimulation scheme.
reconfirmation	The process of verifying an ongoing tachyarrhythmia after detection, but prior to therapy delivery.
<b>S</b>	
scan	A programmable parameter that defines the amount by which an interval decreases between successive ATP attempts.
stability	Detection enhancement used to discriminate between VT and atrial fibrillation.
SVT	A fast rhythm originating from the atria.
<b>T</b>	
tilt	A measurement describing the voltage drop across phases in a shock waveform.
<b>V</b>	
ventricular fibrillation (VF)	A rapid irregular cardiac rhythm resulting from many foci resulting in death if left untreated.
ventricular tachyarrhythmia (VT)	A series of rapid beats (greater than 100 bpm) arising from the ventricles.
VT1	The lowest (i.e., slowest) programmable VT zone.
VT2	A programmable VT zone defined by a VT limit. The VT2 zone lies between VT1 and VF.
<b>X</b>	
X in Y	An algorithm requiring “X number of intervals out of a window of Y intervals” to satisfy a given criterion.













# Lumax 740 Family of ICDs and CRT-Ds

## Technical Manual

