

## Urgent Product Alert

### RELIANCE ePTFE (GORE) defibrillation leads

**WAND Numbers: 090701-WAND-671KJ2, 090701-WAND-671KL4, 090701-WAND-671KE1, 090701-WAND-671KD9, 091009-WAND-67N07D, 091009-WAND-67N05F, 091012-WAND-67NK5Y, 091009-WAND-67N0A5, 131118-WAND-6GKR4G, 131118-WAND-6GKR58, 131118-WAND-6GKR3U, 131118-WAND-6GKR25, 131118-WAND-6GKR4G and 131118-WAND-6GKR58**

**Medsafe Reference Number: 35563**

29 July 2025

**Subject:** Management of gradually rising daily subthreshold, low-voltage shock impedance (LVSI) pattern associated with calcification of expanded polytetrafluoroethylene (ePTFE) coated single coil (SC) and dual coil (DC) RELIANCE™ defibrillation leads manufactured by Boston Scientific Corporation (BSC) from 2002 to 2021 that are no longer available for distribution. See Appendix B for a list of affected lead models (BSC Field Action Reference: 97391810-FA).

Dear Physician or Healthcare Professional,

This letter provides important information about RELIANCE ePTFE (GORE) defibrillation leads with an increased potential to exhibit a pattern of gradual rise in LVSI which is associated with calcification of the shocking coil(s).

**Description:** The association of calcified defibrillation lead coil(s) with a pattern of gradually rising LVSI measurements has been reported to BSC and described in several publications<sup>1,2,3,4,5,6</sup>. This calcification phenomenon can biologically encapsulate and electrically insulate the defibrillation lead coil(s). BSC has completed a comprehensive investigation of ePTFE RELIANCE lead performance to identify the early signs of this phenomenon, characterize its potential effect on shock efficacy, and provide recommendations to mitigate the associated risk. Details of this investigation are described within Appendix A; key findings include:

- While fissuring of calcified ePTFE coating has been observed, calcification of the shock coil(s) does not compromise the physical or electrical integrity of the lead.
- A trend of gradually rising LVSI is correlated with shock coil calcification and is more prevalent with BSC RELIANCE ePTFE defibrillation leads compared to non-ePTFE defibrillation leads from BSC and other manufacturers; leads may be implanted for eight (8) or more years prior to manifestation of this trend.
- The shock coil encapsulant material may exhibit a polarity bias with Reversed (RV+) polarity having an elevated high voltage shock impedance (HVSI) relative to Initial (RV-) polarity<sup>7</sup>. Reversed (RV+) polarity shocks are 4.5 times more likely to initiate a high, delivered shock impedance alert (Code-1005), and defibrillation systems programmed to Reversed (RV+) polarity exhibiting a gradual rising LVSI have a lower defibrillator-determined shock success rate.
- When managing leads with calcified coil(s), delivery of commanded shocks is neither effective at permanently mitigating rising impedance risk nor predictive of future impedance as LVSI may initially decrease but typically returns to pre-shock values in less than six (6) months.

The most common harm is early lead replacement (1 in 238 at 10yrs). The most serious harm is death or need for cardiac resuscitation due to non-conversion of a sustained ventricular arrhythmia from a reduced shock energy due to high impedance (1 in 47,500 at 10yrs).

## Customer Recommendations

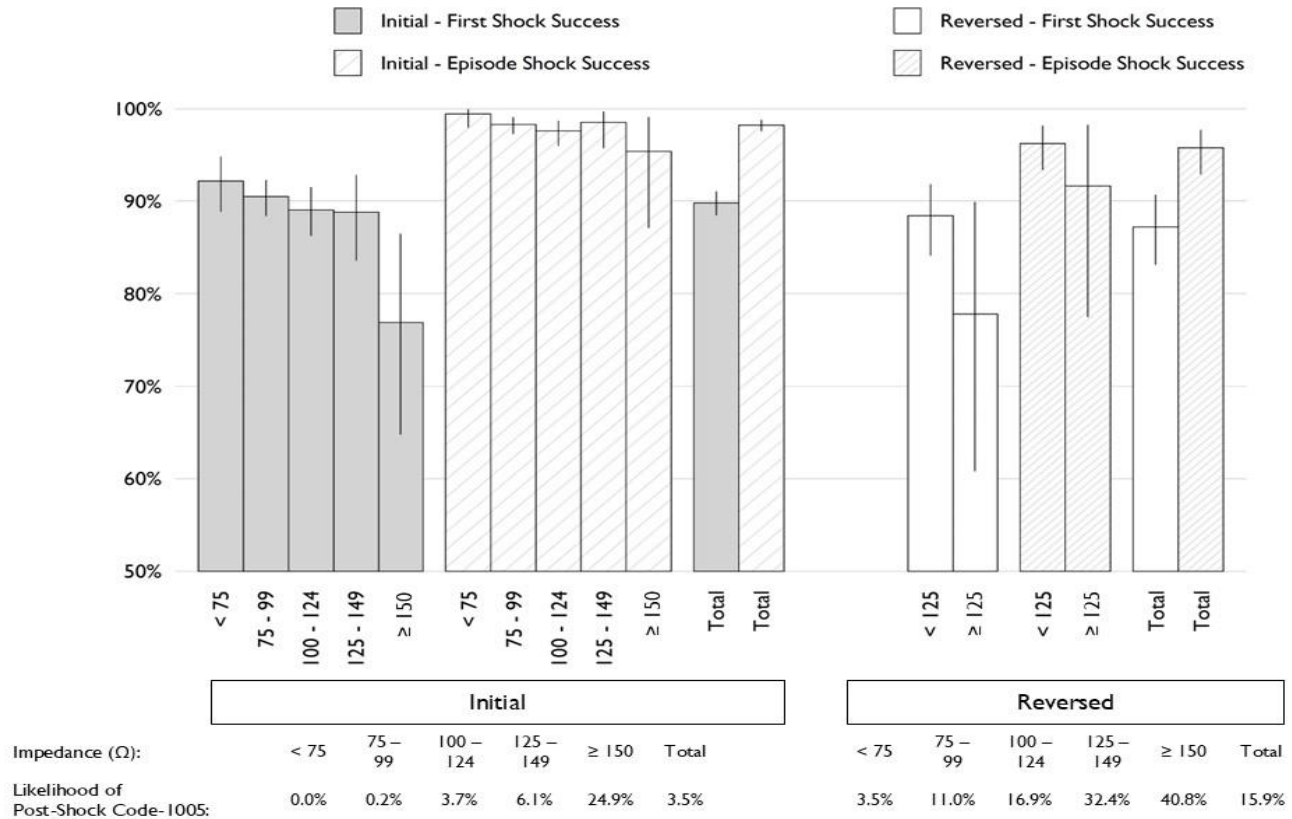
There are no changes to the scheduled follow-up interval for patients with ePTFE lead models.

1. Continue routine follow-up of defibrillation systems with ePTFE leads (Appendix B) either via in-person or remote monitoring (RM) per labeling<sup>8</sup> or medical guidelines<sup>9</sup> with consideration that RM can facilitate early detection of this pattern<sup>10</sup>.
2. During routine follow-up of affected leads, determine the most recent approximate 28-day average LVSI that has not been influenced by the delivery of a shock (see examples in Appendix C) and review HVSI for all shocks from the most recent episode since the last system check using the criteria in Table 1 and data provided in Figure 1.
3. If lead replacement is planned, carefully consider the risk/benefit of lead extraction versus abandonment. Based on implant time and likely coil calcification, these leads may pose an increased risk of extraction-related complications.
4. There may be circumstances such as routine defibrillator replacement that merit complex decision making. Contact BSC Technical Services at [aptechservice@bsci.com](mailto:aptechservice@bsci.com) / +61 2 8063 8299 for further assistance if necessary.

**Table 1** Guidance for mitigating risk by assessing 28-day average LVSI and Code-1005 alerts of defibrillation systems with ePTFE leads

Criteria	Lead Coil(s) <sup>†</sup>		Assessment and Recommended Risk Mitigations for Calcifying Defibrillation Lead Coil(s)
	SC	DC	
Most recent 28-day average LVSI not affected by delivery of a shock (see Appendix C)	>90Ω	>70Ω	<ul style="list-style-type: none"> <li>• Program Shock Polarity to Initial (RV-) and all shocks to maximum energy.</li> <li>• For patients who cannot be reprogrammed for clinical reasons to Initial (RV-) polarity, further management should be guided by the data in <a href="#">Figure 1</a>. Including consideration for lead replacement if LVSI increases.</li> </ul>
	≥150Ω		Lead replacement should be considered. <ul style="list-style-type: none"> <li>• For Initial (RV-) polarity shocks, there is a 24.9% likelihood of an associated Code-1005 and the defibrillator-determined first shock success rate decreases in absolute and relative terms versus other intervals (<a href="#">Figure 1</a>).</li> <li>• Contact BSC Technical Services for additional technical guidance to support informed lead replacement decision-making.</li> </ul>
High-Voltage Shock Impedance (HVSI), Code-1005 alert	X	X	Lead replacement should be considered. <ul style="list-style-type: none"> <li>• Contact Technical Services as directed by alert message to rule out non-invasive options.</li> <li>• The urgency for lead replacement should be commensurate with the likelihood of the patient requiring shock therapy.</li> </ul>

<sup>†</sup>If the system includes a DC lead programmed RV2CAN, treat the system as a SC system; if DC lead programmed RV2RA treat as DC; if SC lead connected to SQ array treat as DC.



**Figure 1** Defibrillator-determined shock success based on programmed polarity and post-shock Code-1005 likelihood based on polarity of individual shocks for defibrillation systems with ePTFE leads relative to preceding 28-day averaged LVSI. X-axis: LVSI Intervals and Y-axis: Defibrillator-Determined Shock Success Rate.

Please distribute this letter to all healthcare professionals (HCPs) within your organization who need to be informed, include this letter in the patient's medical record, and return the attached Customer Response form to ANZ\_Incident\_Report@bsci.com.

This action is being conducted following consultation with the Medsafe, Ministry of Health. If you have additional questions regarding this information or need assistance to report an adverse event, please contact your Boston Scientific representative or a Quality representative via email at ANZ\_Incident\_Report@bsci.com. At Boston Scientific, patient safety and customer satisfaction are our priority. We appreciate your understanding and are committed to continuing to offer products that meet the quality standards that you expect from Boston Scientific.

Sincerely,

*Seamus Gallagher*

Seamus Gallagher

Senior Quality Assurance Manager | Boston Scientific Pty Ltd Australia and New Zealand

Appendix A

**Background**

*ePTFE RELIANCE Defibrillation Leads*

The first transvenous, endocardial defibrillation lead system was introduced by Cardiac Pacemakers Incorporated (BSC) in 1993 (ENDOTAK™). Subsequent publication of the MADIT studies<sup>11</sup> prompted rapid adoption of implantable cardioverter defibrillator (ICD) therapy in the prevention of sudden cardiac death (SCD).

Anticipating potential challenges for extracting endocardial leads, a version of the RELIANCE defibrillation lead was introduced in 2002 with an ePTFE (GORE<sup>12</sup>) coating on the shock coils. This ePTFE shock coil coating is a bilaminar membrane designed with an external facing cell-exclusive layer bonded to an internal cell-permissive inner layer, which permits biological fluid permeation to support electrical conductivity while preventing cellular and vascular tissue ingrowth.

Innovations in lead extraction tools and techniques precipitated by defibrillator lead recalls in 2007<sup>13</sup> and 2011<sup>14</sup> minimized the potential benefits of ePTFE coated coil(s) in lead extraction. Additionally, because ePTFE supply constraints challenged continued production, BSC discontinued manufacturing ePTFE leads in 2021 and has continued distributing non-ePTFE leads with a medical adhesive (MA) backfilled shock coil design. Active fixation RELIANCE defibrillation leads (ePTFE and non-ePTFE; SC and DC) have a 10-year survival of 97%-99%<sup>15</sup>.

The association of calcified defibrillation lead coil(s) with a pattern of gradually rising LVSI measurements has been reported to BSC. Although fissuring of calcified ePTFE coating has been observed, calcification of the shock coil(s) does not compromise the physical or electrical integrity of the lead (e.g., shock coil(s), insulation, conductors, etc.). Within BSC's Product Performance Report<sup>16</sup>, US defibrillation leads with complaints associated with LVSI that are not in service after one or more months of implant are counted within the U.S. Chronic Lead Complication table under abnormal defibrillation impedance.

This communication focuses on managing patient safety risks of gradually rising LVSI associated with the calcification phenomenon observed in BSC ePTFE RELIANCE defibrillation lead models described in Appendix B.

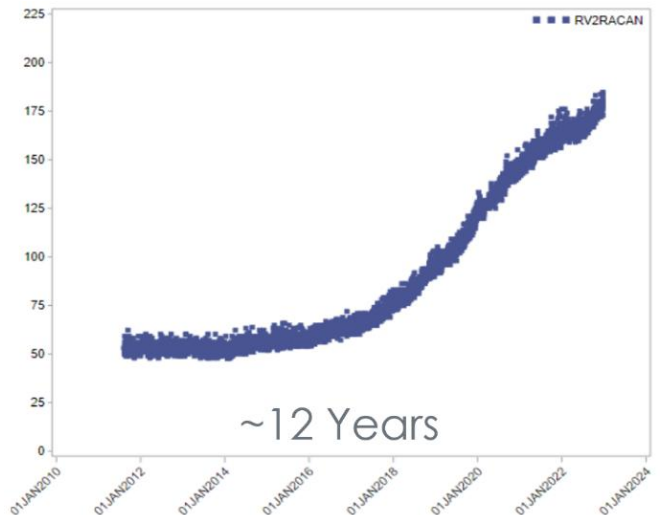
*Assessing LVSI and HVSI in BSC Defibrillators*

The importance of LVSI and HVSI for assessing lead and defibrillation system performance is documented in the system labeling and literature<sup>17,18</sup>. The nominal test pulse used for measuring LVSI daily (every 21 hours) varies by BSC product family. Previous BSC defibrillator families (COGNIS™/TELIGEN™ and INCEPTA™) deliver an 80uA LVSI test pulse, while more contemporary families

(RESONATE™ and AUTOGEN™/DYNAGEN™) deliver a 320uA test pulse. As LVSI measurements are inversely related to the test pulse amplitude, it is common to see lower LVSI values when replacing previous BSC defibrillators with smaller test pulses (80uA) as compared to contemporary defibrillators with larger test pulses (320uA). The normal high shock impedance range and alerts for LVSI and HVSI are as follows.

- BSC RELIANCE leads have a normal shock impedance range of 20-125Ω.
- BSC defibrillators include a configurable high LVSI alert nominally set at 125Ω, but programmable to 200Ω in 25Ω increments.
- BSC defibrillators include a high, delivered shock impedance alert (Code 1005) if a HVSI exceeds 145Ω.

A pattern of gradual rising LVSI over several years (Figure 2) is associated with the accumulation of a calcific encapsulant over the shock coil(s) that may reduce the electrical conductivity and increase the LVSI and HVSI impedance.



**Figure 2** Example of gradual rising LVSI from Jan 2010 to Jan 2024 in a returned ePTFE RELIANCE SC defibrillation lead with calcified encapsulant visibly surrounding the coil

Daily LVSI trends and post-shock HVSI measurements are routinely evaluated during follow-up and alerts for high out-of-range LVSI or HVSI are presented to healthcare professionals (HCPs) via the LATITUDE programmer or LATITUDE™ NXT (LATITUDE) Remote Patient Management System (BSC's RM system). Absent any lead insulation/conductor abnormalities, HVSI measurements are less than LVSI measurements because shocks deliver several orders of magnitude more energy than LVSI test pulses. High, out-of-range LVSI and/or HVSI measurements have the potential for reduced shock

## Appendix A

efficacy. If HVSI exceeds 145Ω, BSC defibrillators, by design, limit shock duration of the first shock phase to 20ms. If this occurs, the shock's bi-phasic waveform is truncated and a monophasic shock is delivered, potentially reducing shock efficacy.

A comprehensive investigation of ePTFE RELIANCE lead performance was conducted to identify the early signs of this calcification phenomenon, characterize its effect on shock efficacy, and develop recommendations to mitigate the associated risk. This investigation involved histological, mechanical, and electrical testing, along with analysis of a large de-identified, US dataset from the LATITUDE RM system. BSC is open to collaborating with other manufacturers to assist them in determining the criteria for their defibrillators connected to ePTFE RELIANCE defibrillation leads.

### Histology Assessment of ePTFE Lead Samples

Detailed histologic assessment of returned RELIANCE ePTFE defibrillation lead samples with evidence of calcification was performed. The chronic calcification process appears to originate preferentially in the bilaminar ePTFE membrane. The ePTFE membrane allows for cell debris, proteins and minerals to enter, which can initiate dystrophic calcification. These ePTFE nucleation site(s) of calcification appear then to expand and propagate outward into mature collagen layers that often form on chronically implanted blood-contacting devices<sup>19</sup>.

The combination of calcified ePTFE and collagen form the visible calcific shell seen around the shocking coils. No evidence of vascularized tissue (i.e., tissue in-growth) was observed. With sufficient encapsulation and subsequent calcification around the shock coil, this encasing shell-like reaction can be expected to function as an electrical insulator. Raman spectroscopy confirmed the calcific shell material contains hydroxyapatite, a natural component of bone. Raman and SEM analysis also occasionally found focal microscopic scale-like patches of calcification on the surface of the silicone lead body.

Examination of dissected transverse sections of calcified ePTFE samples showed evidence of microscopic fissuring of the calcified material and ePTFE coating down to the level of the shock coil. There was evidence of recalcification within these fissures, suggesting that they occurred prior to lead extraction.

### Impact on Shock Delivery

#### *Bench Test Conditions*

A bench test was designed to replicate two observed field behaviors of suspected calcified defibrillation leads by assessing shock performance of a defibrillation system with various calcified ePTFE lead samples (returned leads) and a non-calcified lead sample (control) via tank testing to

simulate *in-situ* conditions. Shocks delivered under these conditions can:

- Elicit electrolysis, which may produce faint bubbles that are the visible outgassing of molecules from solution (e.g., H<sub>2</sub>O converted into Hydrogen and Oxygen molecules); and
- Replicate HVSI measurements through a series of shocks and polarities.

These test conditions were not intended and therefore did not replicate *in-situ* conditions such as the inherent biological conditions promoting calcification or the cyclical lead stresses associated with cardiac contractions.

*Behavior #1: Successive shocks within an episode may display a noticeable reduction in HVSI and a subsequent temporary reduction in LVSI.*

A non-calcified lead (control) sample produced a homogenous distribution of faint bubbles along the shock coil after shock delivery and produced consistent HVSI throughout a series of shocks. In contrast, calcified lead samples produced heterogenous emissions of faint bubbles at various, discrete locations along the calcified coil after shock delivery. After repeated shocks from the calcified sample, the locations of faint bubbling occurred at different locations and HVSI decreased. The observations of bench testing samples in conjunction with other histopathology samples suggest that shocks may create micro fissures/fractures in the calcified encapsulant that increases electrical conductivity and reduces HVSI and LVSI measurements immediately following shock delivery.

*Behavior #2: Code-1005 occurs disproportionately during shocks with Reversed (RV+) polarity. Specifically, episodes that begin with shocks in Initial (RV-) polarity without initiating a Code-1005, but once the last shock is delivered in Reversed (RV+) polarity a Code-1005 occurs.*

- Samples with harder hydroxyapatite calcification had uniformly high HVSI for shocks delivered in either polarity.
- Samples with more flexible fibrotic encapsulant demonstrated a lower HVSI for shocks delivered in Initial (RV-) polarity and higher HVSI for Reversed (RV+) polarity, suggesting certain types of encapsulant perform with a directional electrical bias.

### Impact on Pacing

Published literature<sup>20,21</sup> has reported an association of calcification with gradually rising pacing impedances. Commercially available BSC defibrillation leads utilize the right ventricular coil as the anode for pacing (integrated bipolar). The larger surface area of the coil relative to the smaller distal electrode (pacing cathode) promotes a lower pacing impedance. For lead models with ePTFE covered shock coils, the ePTFE coating does not extend over the

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distal area of the right ventricular coil. Based on this lead design and the absence of reported harm, pacing performance is not likely to be compromised by a gradual rise in LVSI.

**Data Analysis from LATITUDE RM**

*Algorithm for Defining Gradually Rising LVSI*

An algorithm was developed to quantitatively distinguish gradually rising LVSI from other LVSI patterns. Since no standard definition exists for this pattern, events from post-market surveillance showing a gradual rise in LVSI were carefully analyzed to inform the algorithm’s development. At a minimum, the algorithm was iterated so that:

1. Detection of all Code-1005 events in a US historical, de-identified LATITUDE dataset that appeared to represent a gradual rise in LVSI was achieved.
2. Exclusion of all Code-1005 events associated with other etiologies for LVSI trends (e.g., fracture) was achieved.

The salient criteria to detect the onset of a gradual rise in LVSI included a rise over any interval after three (3) years post implant and a 20Ω rise from a post implant baseline to a minimum of 90Ω for SC leads and 70Ω for DC leads, excluding rises in excess of 30Ω per quarter. This approach eliminates normal gradual rises in LVSI during the early post-implant period and non-gradual rise patterns for other lead performance issues.

For the remainder of this document, gradually rising LVSI is defined as a lead >3yr post implant with at least a 20Ω rise to a minimum of 90Ω-SC/70Ω-DC.

*Incidence of Gradually Rising LVSI*

To identify how often a pattern of gradually rising LVSI occurs, the following de-identified US patient data<sup>22</sup> was obtained from the LATITUDE RM database.

- Approximately 250,700 patients with BSC defibrillators connected with either ePTFE leads or non-ePTFE BSC leads
- Approximately 5,700 patients with BSC defibrillators connected to non-BSC non-ePTFE leads

Table 2 shows that SC leads have a higher average baseline LVSI and shorter average onset for gradual rise of LVSI relative to DC leads. Based on the association of a gradual rise in LVSI to calcification, the average time for occurrence for any lead is eight (8) or more years. The incidence of gradually rising LVSI is described in Figure 3.

**Table 2** LVSI descriptive statistics among non-gradually rising, contemporary BSC defibrillation systems

Lead Type	LVSI Average ± Standard Deviation
Single Coil (SC)	72.0 ± 10.2Ω

**Dual Coil (DC)**

47.5 ± 6.7Ω

*Defibrillator-Determined Shock Success and Incidence of Code-1005 in Gradually Rising LVSI Leads*

An unabated, continually rising LVSI has the potential for reduced shock efficacy and to precipitate a post-shock Code-1005 alert. While the overall probability of Code-1005 in a gradually rising LVSI ePTFE lead is approximately 1 in 1,111 (0.09%) at 10 years (Figure 4), these data do not inform management decisions for a continually rising LVSI. Therefore, the defibrillator-determined first shock and episode success as well as the likelihood of Code-1005 by preceding LVSI was evaluated using the de-identified US LATITUDE RM database.

Criteria utilizing device episode data were developed to select episodes in the de-identified US LATITUDE RM database which were likely to be appropriate for delivery of shock therapy. Those criteria were adjusted to achieve a 94% positive predictive value for appropriateness in a large expert adjudicated episode dataset. Device-determined shock success (e.g., non-adjudicated) was determined for these appropriate therapy episodes and were classified by the preceding 28-day average LVSI in 25Ω intervals and programmed polarity based on the following.

- First shock success was based on the absence of a subsequent shock following the first maximum energy shock. Sub-maximum energy, first shocks that were not followed by a subsequent shock were considered successful. Multiple maximum energy shocks were considered unsuccessful.
- Episode success was based on whether the episode had fewer than the maximum number of shocks delivered within a therapy zone.

Note, BSC defibrillators allow the output of the first two shocks of each therapy zone to be programmed at sub-maximum energy with all other non-programmable shocks set to maximum energy.

Additionally, an analysis was performed to determine the likelihood of a post-shock Code-1005 in a gradually rising LVSI lead. All shocks were included independent of appropriateness, including commanded shocks and shocks during induced episodes. These shocks were classified in the same manner as shock efficacy with polarity determined for each individually delivered shock rather than the programmed polarity for the shock episode. The results of this analysis are described in Figure 1. Published literature (NORDIC, ALTITUDE, SCD-HeFT, etc.)<sup>23,24,25,26</sup> describes a first shock success range of 82.7%-93% and a shock episode success range of 98.4%-100%. It is important to note that the data in Figure 1 did not include adjudication, so comparison to published literature may not be appropriate. The analysis evaluated

Appendix A

pre-gradual device-determined episode success for both Initial (RV-) and Reversed (RV+) polarity at 98%. Device-determined shock success data is limited by sample size and resulting confidence intervals. However, the device-determined shock success trend in combination with the likelihood of Code-1005 indicates that shock success diminishes in devices programmed to Initial (RV-) polarity when a preceding 28-day average LVSI is  $\geq 150\Omega$ . Specifically,

- In devices programmed to Initial (RV-) polarity and experiencing a gradual rise in LVSI, a preceding 28-day averaged LVSI  $\geq 150\Omega$  is associated with a 24.9% likelihood for a post-shock Code-1005 and device-determined shock success decreases in absolute and relative terms compared to lower impedance intervals.
- In devices programmed to Reversed (RV+) polarity and experiencing a gradual rise in LVSI, the Code-1005 and overall device-determined success rate is less favorable when compared to Initial (RV-) polarity with the likelihood of a Code-1005 in particular 4.5 times higher.

The average time to detect calcification of an ePTFE lead through a pattern of gradual rise LVSI is up to eight (8) or more years. Less than a third of ePTFE leads that have exhibited a gradual rise in LVSI will exceed 150 $\Omega$  five (5) years later, see Figure 7.

*Post-Shock Effects on LVSI in Suspected Calcified Defibrillation Leads*

A temporary reduction in LVSI after delivery of a shock has been observed clinically. Histological analysis and shock testing of ePTFE leads suggest that shocks may fissure the calcified encapsulant temporarily lowering impedance. However, histopathologic analysis also suggests that the inherent biological healing response can re-calcify those fissures/fractures. Longitudinal data on post-shock averaged LVSI displayed in Figure 5 indicates that LVSI returns to pre-shock levels in approximately 50% of cases within six months.

**Clinical Impact**

Although physical evidence of calcified shock coil(s) was noted with returned leads exhibiting a gradual risk in LVSI, this could not be confirmed as the exclusive cause for the reported gradual rise in LVSI of leads that were not returned. The ability to establish an exclusive association of calcification and gradually rising LVSI is limited by the low number of explanted and returned leads. Although other resources, such as Computed Tomography (CT), are described as potentially useful for lead extraction planning by identifying areas of adhesion to vessel walls and/or areas of calcification<sup>27</sup>, these are not routinely performed and are not likely to be used for detection of coil calcification due to artifact from the lead components. Therefore, for the

purpose of this investigation, clinical impact was assessed based on the potential for a gradual rise in LVSI using the de-identified US LATITUDE RM dataset.

*Harms*

The most common harm is early lead replacement and was determined by analyzing de-identified US LATITUDE RM dataset of BSC defibrillators connected to gradually rising LVSI BSC ePTFE leads and BSC non-ePTFE leads (Table 3).

**Table 3** Rate of lead replacement due to gradually rising LVSI

Lead Type	Occurrence rate at 10 years
<b>BSC ePTFE Leads</b>	0.42% (1 in 238)
<b>BSC non-ePTFE Leads</b>	0.01% (1 in 10,000)

The most serious harm is death due to non-conversion of a sustained ventricular arrhythmia from a reduced shock energy due to high impedance. The potential for life-threatening harm due to arrhythmic death in ePTFE leads experiencing a gradually rising LVSI is estimated at 0.0021% (1 in 47,500 ePTFE leads at 10 years).

Other patient harms considered include death from attempted lead extraction of defibrillation leads, the remote possibility of arrhythmia induction as a result of an inappropriate shock, and additional procedures of commanded shocks and conversion testing.

*Utilizing Approximate 28-day Average LVSI in Lieu of Assessing Gradually Rising LVSI Patterns*

The LATITUDE programmer and RM display one year of LVSI data, so identification of leads exhibiting a gradual rise in shock impedance over several years requires historical data that may not be available to HCPs. Utilizing either the most recent 28-day average or preceding 28-day average prior to a recently delivered shock provides a practical approach for HCPs with an acceptable false positive or false negative rate. Determining the 28-day average from the LVSI trends is intended to be an approximation, see Appendix C for further discussion. Figure 6 provides the distribution of the highest 28-day average LVSI for defibrillation leads in the de-identified US LATITUDE dataset at 10 and 15 years of age. Note, not all leads within this dataset remain in-service.

*Discussion of Clinical Recommendations to Mitigate Risk*

If an ePTFE lead is experiencing a gradually rising LVSI that exceeds 90 $\Omega$  for a SC or 70 $\Omega$  for a DC lead, the risk of compromised shock efficacy can be mitigated by programming all shocks to maximum energy and shock polarity to Initial (RV-) in those patients whose devices are not already programmed in this manner. For ePTFE leads with a gradually rising LVSI, there is a 4.5x higher likelihood

Appendix A

of generating a FC 1005 in Reversed (RV+) polarity compared to Initial (RV-) polarity. The recommended programmed settings (i.e., Initial (RV-) polarity and maximum energy shocks correspond with nominal out-of-the box settings for BSC defibrillators. Based on review of ePTFE leads with the defibrillators active on LATITUDE RM in US, Table 4 includes the percentage of devices programmed to Initial (RV-) polarity and maximum energy shocks in all programmed shock therapy zones.

**Table 4** Percentage of defibrillators active in US LATITUDE RM database programmed to Initial (RV-) and maximum energy shocks

Parameters	% Programmed
<b>Initial (RV-) Polarity</b>	81.1%
<b>All Shocks Programmed to Maximum</b>	81.4%
<b>Initial (RV-) Polarity and All Shocks Programmed to Maximum</b>	65.3%

Based on data in Figure 1, ePTFE lead replacement should be a consideration for the following situations:

- ePTFE systems programmed to Initial (RV-) polarity and maximum energy shocks with a 28-day average LVSI that continues increasing to  $\geq 150\Omega$  are at risk of compromised shock efficacy and post-shock Code-1005.
- ePTFE systems that have presented a post-shock Code-1005.

If considering lead replacement, contacting BSC Technical Services is advised; guidance is available for ruling out other causes for impedance abnormalities and to assess if other considerations or programming options are applicable. Addition of a new defibrillation lead is a complex decision influenced by patient-specific factors (e.g., age, co-morbidities, cardiac condition, SCD risk), as well as the data/information presented herein. Lead extraction often accompanies implantation of a new defibrillation lead. These factors must be balanced against the risks of lead extraction, which increase with implant time and potential calcification. Leads affected by this phenomenon are likely to have long dwell times and possibly varying levels of calcification. Due to the heightened risk associated with extracting such leads, replacement without extraction should be considered through shared decision-making. Deaths have been reported as a result of extraction of leads exhibiting a gradual rise in LVSI.<sup>28</sup> For patients without a pacing indication, system replacement with non-transvenous defibrillation technology may be an alternative.

Conventional troubleshooting of high shock impedance prior to the findings of this investigation included commanded shocks to assess the HVSI. However, given

the median recovery of LVSI post shock was less than six months (Figure 5), delivery of commanded shocks is neither effective at permanently mitigating rising impedance risk nor predictive of future impedance. The applicability of these data and recommendations to non-ePTFE defibrillation leads is less certain due to the limited data available.

*Discussion of Non-uniform Calcification Risk of ePTFE Leads*

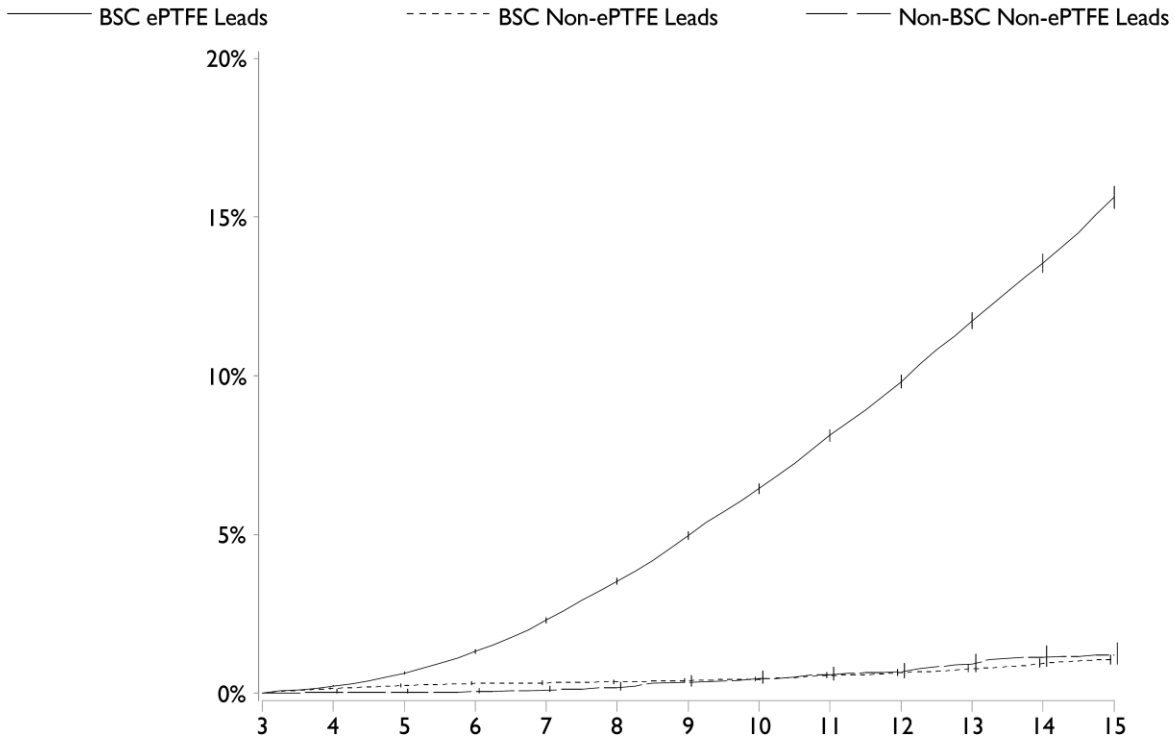
Unlike other lead-related hazardous conditions (e.g., fracture), which generally present a uniform risk, the risk associated with identification of the onset of gradually increasing LVSI is non-uniform.

- Approximately 1 in 15 (6.4%, Figure 3) 10-year-old ePTFE leads will experience a gradual rise in LVSI.
- Of the ePTFE leads experiencing a gradual rise in LVSI, less than a third of them (30%-SC and 14%-DC, Figure 7) will reach a 28-day average LVSI  $\geq 150\Omega$  in 5 years following the detection of a gradual rise and need to be considered for replacement. Based on the observed implant time at which a gradual rise occurs, exceeding a 28-day average LVSI of  $150\Omega$  is expected to occur late in the implant duration of these leads.

Thus, once the phenomenon of gradual rise in shock impedance is encountered, neither a continued gradual rise LVSI nor exceeding a  $150\Omega$  LVSI is inevitable.

Management of Potentially Calcified ePTFE Defibrillation Lead Coil(s) Using 28-Day Averaged LVSI

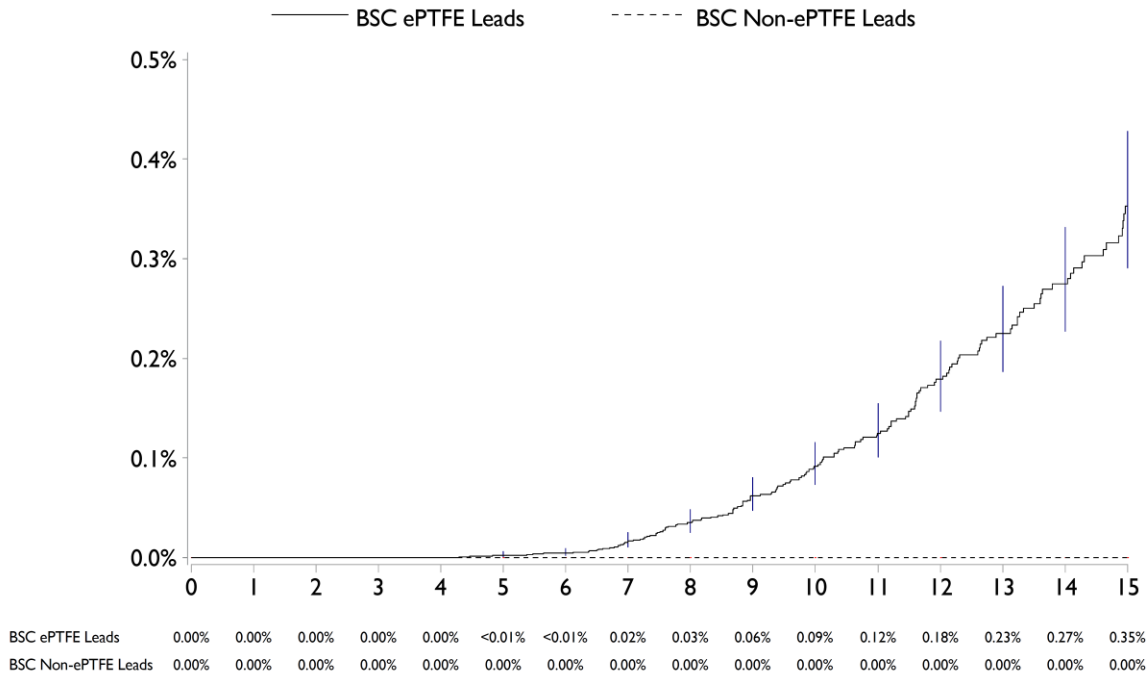
Appendix A



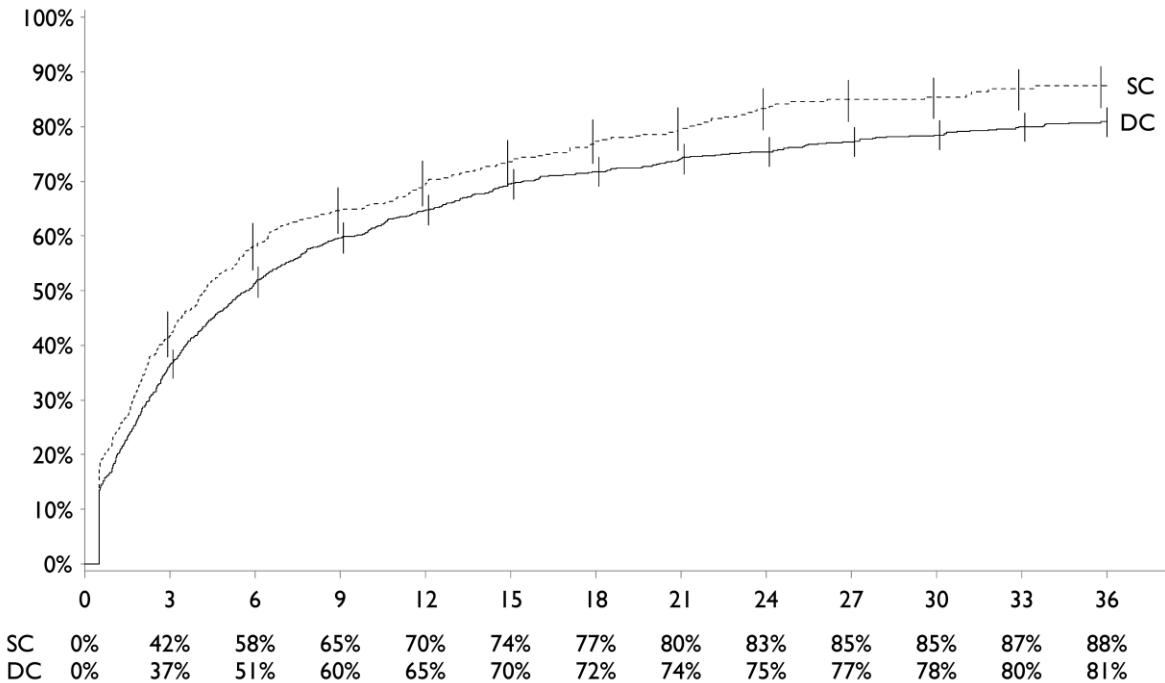
BSC ePTFE Leads	0.0%	0.2%	0.6%	1.3%	2.3%	3.5%	5.0%	6.4%	8.1%	9.8%	11.7%	13.5%	15.6%
BSC Non-ePTFE Leads	0.0%	0.2%	0.2%	0.3%	0.3%	0.4%	0.4%	0.4%	0.6%	0.7%	0.8%	0.9%	1.1%
Non-BSC Non-ePTFE Leads	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.4%	0.5%	0.6%	0.7%	0.9%	1.1%	1.2%

**Figure 3** Incidence of gradually rising LVSI in defibrillation leads based on US BSC de-identified LATITUDE and registration data. X-axis: Years Post-Implant; Y-axis: Leads with Gradual Rise (%).

Appendix A



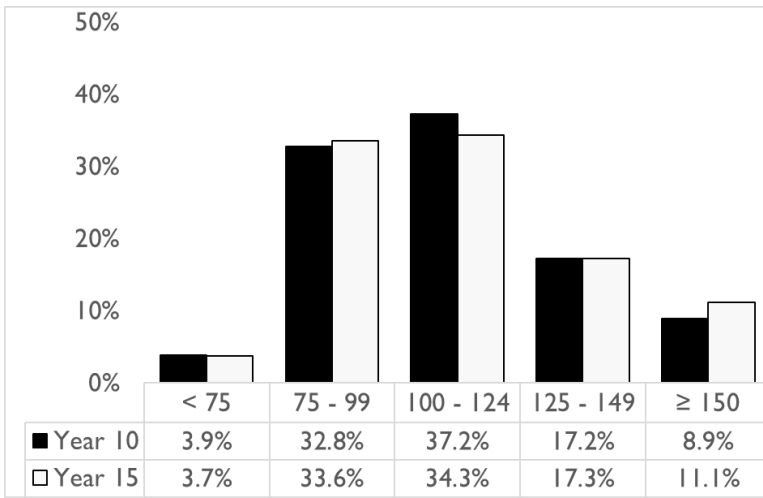
**Figure 4** Incidence of a lead having a post-shock Code-1005 after a gradual rise in LVSI. X-axis: Years Post-Implant; Y-axis: Leads with Gradual Rise and Code-1005 (%).



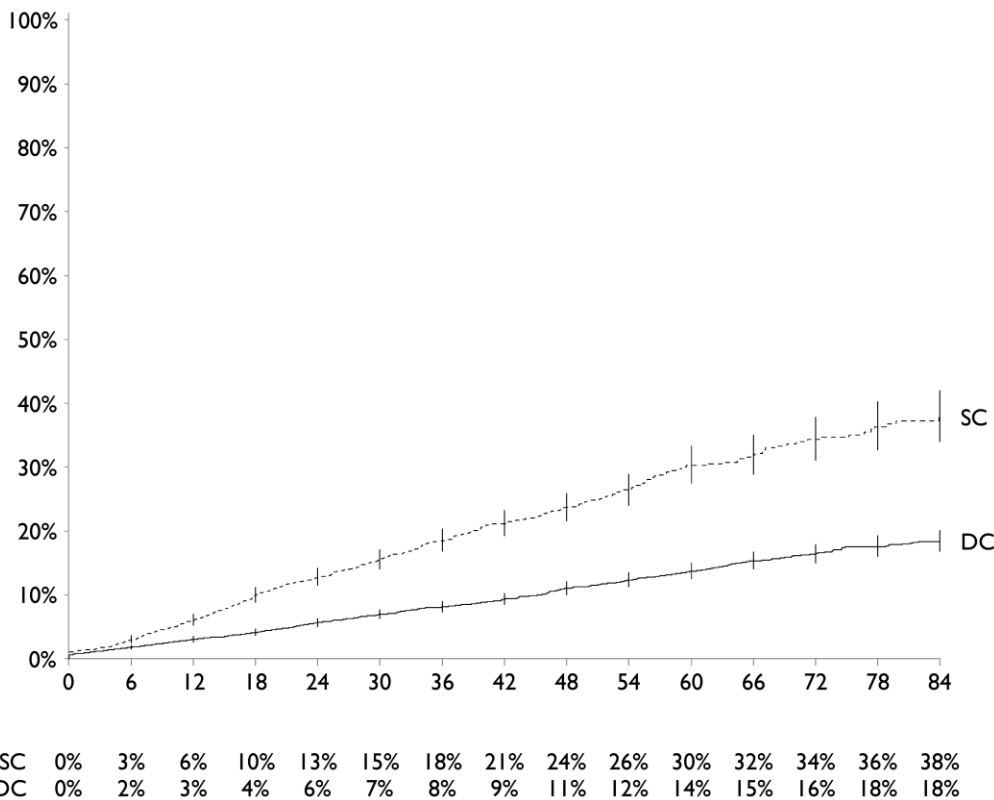
**Figure 5** Likelihood of returning to pre-shock LVSI. X-axis: Months Post-Shock; Y-axis: Leads Returned to Pre-Shock LVSI (%).

Management of Potentially Calcified ePTFE Defibrillation Lead Coil(s) Using 28-Day Averaged LVSI

Appendix A



**Figure 6** Highest 28-day average LVSI in de-identified US LATITUDE RM dataset at 10 and 15 years post-implant. X-axis: LVSI impedance intervals for 10 or 15 years; Y-axis: percent of defibrillators with LVSI. Note, not all devices from this dataset remain active.



**Figure 7** Likelihood of a lead reaching a 28-day average LVSI of at least 150Ω following a gradual rise in LVSI over time. X-axis: Months from the onset of gradual rise in LVSI; Y-axis: Leads that reach 28-day average LVSI of 150Ω (%).

Management of Potentially Calcified Defibrillation Lead Coil(s) Using 28-Day Averaged LVSI

Appendix B

The affected device population includes all BSC RELIANCE defibrillation leads with ePTFE coated coil(s) listed within the table below; note that these leads were manufactured between 2002 and 2021 and are no longer distributed. BSC estimates that approximately 354,000 remain in service globally. All serial numbers associated with the referenced lead models are included in the population. A device lookup tool is available ([www.BostonScientific.com/lookup](http://www.BostonScientific.com/lookup)) to identify affected leads. Coil(s) refers to whether a given model has dual-coil (DC) or single-coil (SC) configuration.

Product Name	Model	Coil(s)	Terminal	Product Name	Model	Coil(s)	Terminal
ENDOTAK RELIANCE	0160	SC	DF-1	ENDOTAK RELIANCE	0186	DC	DF-1
ENDOTAK RELIANCE	0161	SC	DF-1	ENDOTAK RELIANCE	0187	DC	DF-1
ENDOTAK RELIANCE	0162	SC	DF-1	RELIANCE 4-SITE	0282	SC	DF4
ENDOTAK RELIANCE	0164	DC	DF-1	RELIANCE 4-SITE	0283	SC	DF4
ENDOTAK RELIANCE	0165	DC	DF-1	RELIANCE 4-SITE	0285	DC	DF4
ENDOTAK RELIANCE	0166	DC	DF-1	RELIANCE 4-SITE	0286	DC	DF4
ENDOTAK RELIANCE	0167	DC	DF-1	RELIANCE 4-SITE	0292	SC	DF4
ENDOTAK RELIANCE	0170	SC	DF-1	RELIANCE 4-SITE	0293	SC	DF4
ENDOTAK RELIANCE	0171	SC	DF-1	RELIANCE 4-SITE	0295	DC	DF4
ENDOTAK RELIANCE	0172	SC	DF-1	RELIANCE 4-SITE	0296	DC	DF4
ENDOTAK RELIANCE	0173	SC	DF-1	RELIANCE 4-FRONT	0657	SC	DF4
ENDOTAK RELIANCE	0174	DC	DF-1	RELIANCE 4-FRONT	0658	DC	DF4
ENDOTAK RELIANCE	0175	DC	DF-1	RELIANCE 4-FRONT	0682	SC	DF4
ENDOTAK RELIANCE	0176	DC	DF-1	RELIANCE 4-FRONT	0683	SC	DF4
ENDOTAK RELIANCE	0177	DC	DF-1	RELIANCE 4-FRONT	0685	DC	DF4
ENDOTAK RELIANCE	0180	SC	DF-1	RELIANCE 4-FRONT	0686	DC	DF4
ENDOTAK RELIANCE	0181	SC	DF-1	RELIANCE 4-FRONT	0692	SC	DF4
ENDOTAK RELIANCE	0182	SC	DF-1	RELIANCE 4-FRONT	0693	SC	DF4
ENDOTAK RELIANCE	0183	SC	DF-1	RELIANCE 4-FRONT	0695	DC	DF4
ENDOTAK RELIANCE	0184	DC	DF-1	RELIANCE 4-FRONT	0696	DC	DF4
ENDOTAK RELIANCE	0185	DC	DF-1				

Management of Potentially Calcified Defibrillation Lead Coil(s) Using 28-Day Averaged LVSI

Appendix B

The affected device population includes all BSC RELIANCE defibrillation leads with ePTFE coated coil(s) listed within the tables below; note that these leads were manufactured between 2002 and 2021 and are no longer distributed. BSC estimates that approximately 354,000 remain in service globally. All serial numbers associated with the referenced lead models are included in the population. A device lookup tool is available ([www.BostonScientific.com/lookup](http://www.BostonScientific.com/lookup)) to identify affected leads. Coil(s) refers to whether a given model has dual-coil (DC) or single-coil (SC) configuration. Note, some models within the table do not have an assigned GTIN.

Product Name	Model	GTIN	Coil(s)	Terminal	Product Name	Model	GTIN	Coil(s)	Terminal	Product Name	Model	GTIN	Coil(s)	Terminal
ENDOTAK RELIANCE	0160	00802526372629	SC	DF-1	ENDOTAK RELIANCE	0170	00802526373329	SC	DF-1	ENDOTAK RELIANCE	0175	00802526550058	DC	DF-1
ENDOTAK RELIANCE	0160	00802526372643	SC	DF-1	ENDOTAK RELIANCE	0170	00802526373343	SC	DF-1	ENDOTAK RELIANCE	0175	No GTIN	DC	DF-1
ENDOTAK RELIANCE	0160	00802526372650	SC	DF-1	ENDOTAK RELIANCE	0170	00802526468377	SC	DF-1	ENDOTAK RELIANCE	0176	00802526376726	DC	DF-1
ENDOTAK RELIANCE	0160	00802526372674	SC	DF-1	ENDOTAK RELIANCE	0170	00802526482502	SC	DF-1	ENDOTAK RELIANCE	0176	00802526376733	DC	DF-1
ENDOTAK RELIANCE	0160	00802526372681	SC	DF-1	ENDOTAK RELIANCE	0170	00802526490309	SC	DF-1	ENDOTAK RELIANCE	0176	00802526376764	DC	DF-1
ENDOTAK RELIANCE	0160	00802526421303	SC	DF-1	ENDOTAK RELIANCE	0170	00802526490354	SC	DF-1	ENDOTAK RELIANCE	0176	00802526376788	DC	DF-1
ENDOTAK RELIANCE	0160	00802526421358	SC	DF-1	ENDOTAK RELIANCE	0170	00802526502163	SC	DF-1	ENDOTAK RELIANCE	0176	00802526468348	DC	DF-1
ENDOTAK RELIANCE	0160	No GTIN	SC	DF-1	ENDOTAK RELIANCE	0170	00802526502231	SC	DF-1	ENDOTAK RELIANCE	0176	00802526490705	DC	DF-1
ENDOTAK RELIANCE	0161	00802526372711	SC	DF-1	ENDOTAK RELIANCE	0170	00802526502248	SC	DF-1	ENDOTAK RELIANCE	0176	00802526490774	DC	DF-1
ENDOTAK RELIANCE	0161	00802526372735	SC	DF-1	ENDOTAK RELIANCE	0170	00802526521652	SC	DF-1	ENDOTAK RELIANCE	0176	00802526502606	DC	DF-1
ENDOTAK RELIANCE	0161	00802526372742	SC	DF-1	ENDOTAK RELIANCE	0170	No GTIN	SC	DF-1	ENDOTAK RELIANCE	0176	No GTIN	DC	DF-1
ENDOTAK RELIANCE	0161	00802526372766	SC	DF-1	ENDOTAK RELIANCE	0171	00802526373374	SC	DF-1	ENDOTAK RELIANCE	0177	00802526376818	DC	DF-1
ENDOTAK RELIANCE	0161	00802526372773	SC	DF-1	ENDOTAK RELIANCE	0171	00802526373381	SC	DF-1	ENDOTAK RELIANCE	0177	00802526376825	DC	DF-1
ENDOTAK RELIANCE	0161	00802526421396	SC	DF-1	ENDOTAK RELIANCE	0171	00802526373404	SC	DF-1	ENDOTAK RELIANCE	0177	00802526376832	DC	DF-1
ENDOTAK RELIANCE	0161	00802526421402	SC	DF-1	ENDOTAK RELIANCE	0171	00802526373411	SC	DF-1	ENDOTAK RELIANCE	0177	00802526376870	DC	DF-1
ENDOTAK RELIANCE	0161	00802526421426	SC	DF-1	ENDOTAK RELIANCE	0171	00802526373435	SC	DF-1	ENDOTAK RELIANCE	0177	00802526468445	DC	DF-1
ENDOTAK RELIANCE	0161	00802526421433	SC	DF-1	ENDOTAK RELIANCE	0171	00802526373442	SC	DF-1	ENDOTAK RELIANCE	0180	00802526411977	SC	DF-1
ENDOTAK RELIANCE	0161	00802526421457	SC	DF-1	ENDOTAK RELIANCE	0171	00802526468384	SC	DF-1	ENDOTAK RELIANCE	0180	00802526422027	SC	DF-1
ENDOTAK RELIANCE	0161	00802526421464	SC	DF-1	ENDOTAK RELIANCE	0171	00802526482519	SC	DF-1	ENDOTAK RELIANCE	0180	00802526433590	SC	DF-1
ENDOTAK RELIANCE	0161	No GTIN	SC	DF-1	ENDOTAK RELIANCE	0171	00802526490408	SC	DF-1	ENDOTAK RELIANCE	0180	00802526433597	SC	DF-1
ENDOTAK RELIANCE	0162	00802526372803	SC	DF-1	ENDOTAK RELIANCE	0171	00802526490453	SC	DF-1	ENDOTAK RELIANCE	0180	00802526433603	SC	DF-1
ENDOTAK RELIANCE	0162	00802526372827	SC	DF-1	ENDOTAK RELIANCE	0171	00802526490477	SC	DF-1	ENDOTAK RELIANCE	0180	00802526433634	SC	DF-1
ENDOTAK RELIANCE	0162	00802526372858	SC	DF-1	ENDOTAK RELIANCE	0171	00802526502279	SC	DF-1	ENDOTAK RELIANCE	0180	00802526433658	SC	DF-1
ENDOTAK RELIANCE	0162	00802526421488	SC	DF-1	ENDOTAK RELIANCE	0171	00802526502316	SC	DF-1	ENDOTAK RELIANCE	0180	00802526468292	SC	DF-1
ENDOTAK RELIANCE	0162	00802526421549	SC	DF-1	ENDOTAK RELIANCE	0171	00802526502347	SC	DF-1	ENDOTAK RELIANCE	0180	00802526470592	SC	DF-1
ENDOTAK RELIANCE	0164	00802526372888	DC	DF-1	ENDOTAK RELIANCE	0171	00802526502354	SC	DF-1	ENDOTAK RELIANCE	0180	00802526482540	SC	DF-1
ENDOTAK RELIANCE	0164	00802526373008	DC	DF-1	ENDOTAK RELIANCE	0171	00802526513473	SC	DF-1	ENDOTAK RELIANCE	0180	00802526490903	SC	DF-1
ENDOTAK RELIANCE	0164	00802526373015	DC	DF-1	ENDOTAK RELIANCE	0171	00802526521669	SC	DF-1	ENDOTAK RELIANCE	0180	00802526490910	SC	DF-1
ENDOTAK RELIANCE	0164	00802526373039	DC	DF-1	ENDOTAK RELIANCE	0171	00802526549434	SC	DF-1	ENDOTAK RELIANCE	0180	00802526490927	SC	DF-1
ENDOTAK RELIANCE	0164	00802526373046	DC	DF-1	ENDOTAK RELIANCE	0171	No GTIN	SC	DF-1	ENDOTAK RELIANCE	0180	00802526490958	SC	DF-1
ENDOTAK RELIANCE	0164	00802526421662	DC	DF-1	ENDOTAK RELIANCE	0172	00802526373466	SC	DF-1	ENDOTAK RELIANCE	0180	00802526490972	SC	DF-1
ENDOTAK RELIANCE	0164	00802526421679	DC	DF-1	ENDOTAK RELIANCE	0172	00802526373473	SC	DF-1	ENDOTAK RELIANCE	0180	00802526502804	SC	DF-1
ENDOTAK RELIANCE	0164	00802526421693	DC	DF-1	ENDOTAK RELIANCE	0172	00802526373527	SC	DF-1	ENDOTAK RELIANCE	0180	00802526502873	SC	DF-1
ENDOTAK RELIANCE	0164	00802526421709	DC	DF-1	ENDOTAK RELIANCE	0173	00802526373558	SC	DF-1	ENDOTAK RELIANCE	0180	00802526502880	SC	DF-1
ENDOTAK RELIANCE	0164	00802526421723	DC	DF-1	ENDOTAK RELIANCE	0173	00802526373565	SC	DF-1	ENDOTAK RELIANCE	0180	00802526502897	SC	DF-1
ENDOTAK RELIANCE	0164	No GTIN	DC	DF-1	ENDOTAK RELIANCE	0174	00802526373640	DC	DF-1	ENDOTAK RELIANCE	0180	00802526531149	SC	DF-1
ENDOTAK RELIANCE	0165	00802526373053	DC	DF-1	ENDOTAK RELIANCE	0174	00802526373657	DC	DF-1	ENDOTAK RELIANCE	0180	00802526540943	SC	DF-1
ENDOTAK RELIANCE	0165	00802526373077	DC	DF-1	ENDOTAK RELIANCE	0174	00802526373664	DC	DF-1	ENDOTAK RELIANCE	0180	00802526540950	SC	DF-1
ENDOTAK RELIANCE	0165	00802526373084	DC	DF-1	ENDOTAK RELIANCE	0174	00802526373688	DC	DF-1	ENDOTAK RELIANCE	0180	00802526550386	SC	DF-1
ENDOTAK RELIANCE	0165	00802526373091	DC	DF-1	ENDOTAK RELIANCE	0174	00802526373701	DC	DF-1	ENDOTAK RELIANCE	0180	00802526570001	SC	DF-1
ENDOTAK RELIANCE	0165	00802526377259	DC	DF-1	ENDOTAK RELIANCE	0174	00802526468414	DC	DF-1	ENDOTAK RELIANCE	0180	00802526591518	SC	DF-1
ENDOTAK RELIANCE	0165	00802526377266	DC	DF-1	ENDOTAK RELIANCE	0174	00802526482526	DC	DF-1	ENDOTAK RELIANCE	0180	No GTIN	SC	DF-1
ENDOTAK RELIANCE	0165	00802526377273	DC	DF-1	ENDOTAK RELIANCE	0174	00802526490507	DC	DF-1	ENDOTAK RELIANCE	0181	00802526411984	SC	DF-1
ENDOTAK RELIANCE	0165	00802526421754	DC	DF-1	ENDOTAK RELIANCE	0174	00802526490576	DC	DF-1	ENDOTAK RELIANCE	0181	00802526422034	SC	DF-1
ENDOTAK RELIANCE	0165	00802526421761	DC	DF-1	ENDOTAK RELIANCE	0174	No GTIN	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433689	SC	DF-1
ENDOTAK RELIANCE	0165	00802526421778	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373732	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433696	SC	DF-1
ENDOTAK RELIANCE	0165	00802526421785	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373749	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433702	SC	DF-1
ENDOTAK RELIANCE	0165	00802526421792	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373756	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433719	SC	DF-1
ENDOTAK RELIANCE	0165	00802526421815	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373763	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433726	SC	DF-1
ENDOTAK RELIANCE	0165	00802526421822	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373770	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433733	SC	DF-1
ENDOTAK RELIANCE	0165	No GTIN	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373787	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433757	SC	DF-1
ENDOTAK RELIANCE	0166	00802526373107	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373794	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433764	SC	DF-1
ENDOTAK RELIANCE	0166	00802526373114	DC	DF-1	ENDOTAK RELIANCE	0175	00802526373819	DC	DF-1	ENDOTAK RELIANCE	0181	00802526433771	SC	DF-1
ENDOTAK RELIANCE	0166	00802526373138	DC	DF-1	ENDOTAK RELIANCE	0175	00802526454929	DC	DF-1	ENDOTAK RELIANCE	0181	00802526468308	SC	DF-1
ENDOTAK RELIANCE	0166	00802526373145	DC	DF-1	ENDOTAK RELIANCE	0175	00802526468421	DC	DF-1	ENDOTAK RELIANCE	0181	00802526470608	SC	DF-1
ENDOTAK RELIANCE	0166	00802526373169	DC	DF-1	ENDOTAK RELIANCE	0175	00802526482533	DC	DF-1	ENDOTAK RELIANCE	0181	00802526482557	SC	DF-1
ENDOTAK RELIANCE	0166	00802526421846	DC	DF-1	ENDOTAK RELIANCE	0175	00802526490606	DC	DF-1	ENDOTAK RELIANCE	0181	00802526491009	SC	DF-1
ENDOTAK RELIANCE	0166	00802526421853	DC	DF-1	ENDOTAK RELIANCE	0175	00802526490613	DC	DF-1	ENDOTAK RELIANCE	0181	00802526491023	SC	DF-1
ENDOTAK RELIANCE	0166	00802526421884	DC	DF-1	ENDOTAK RELIANCE	0175	00802526490637	DC	DF-1	ENDOTAK RELIANCE	0181	00802526491030	SC	DF-1
ENDOTAK RELIANCE	0166	00802526421907	DC	DF-1	ENDOTAK RELIANCE	0175	00802526490668	DC	DF-1	ENDOTAK RELIANCE	0181	00802526491047	SC	DF-1
ENDOTAK RELIANCE	0166	No GTIN	DC	DF-1	ENDOTAK RELIANCE	0175	00802526490675	DC	DF-1	ENDOTAK RELIANCE	0181	00802526491054	SC	DF-1
ENDOTAK RELIANCE	0167	00802526373206	DC	DF-1	ENDOTAK RELIANCE	0175	00802526502507	DC	DF-1	ENDOTAK RELIANCE	0181	00802526491078	SC	DF-1
ENDOTAK RELIANCE	0167	00802526373220	DC	DF-1	ENDOTAK RELIANCE	0175	00802526502538	DC	DF-1	ENDOTAK RELIANCE	0181	00802526491085	SC	DF-1
ENDOTAK RELIANCE	0167	00802526373237	DC	DF-1	ENDOTAK RELIANCE	0175	00802526502569	DC	DF-1	ENDOTAK RELIANCE	0181	00802526502903	SC	DF-1
ENDOTAK RELIANCE	0167	00802526373251	DC	DF-1	ENDOTAK RELIANCE	0175	00802526502583	DC	DF-1	ENDOTAK RELIANCE	0181	00802526502941	SC	DF-1
ENDOTAK RELIANCE	0167	00802526421938	DC	DF-1	ENDOTAK RELIANCE	0175	00802526502590	DC	DF-1	ENDOTAK RELIANCE	0181	00802526502958	SC	DF-1
ENDOTAK RELIANCE	0170	00802526373282	SC	DF-1	ENDOTAK RELIANCE	0175	00802526549649	DC	DF-1	ENDOTAK RELIANCE	0181	00802526502965	SC	DF-1
ENDOTAK RELIANCE	0170	00802526373299	SC	DF-1	ENDOTAK RELIANCE	0175	00802526549687	DC	DF-1	ENDOTAK RELIANCE	0181	00802526502972	SC	DF-1



Management of Potentially Calcified Defibrillation Lead Coil(s) Using 28-Day Averaged LVSI

Appendix B

Product Name	Model	GTIN	Coil(s)	Terminal	Product Name	Model	GTIN	Coil(s)	Terminal
RELIANCE 4-SITE	0295	00802526481901	DC	DF4	RELIANCE 4-FRONT	0685	00802526533617	DC	DF4
RELIANCE 4-SITE	0295	00802526481918	DC	DF4	RELIANCE 4-FRONT	0685	00802526560972	DC	DF4
RELIANCE 4-SITE	0295	00802526481925	DC	DF4	RELIANCE 4-FRONT	0685	008025265608534	DC	DF4
RELIANCE 4-SITE	0295	00802526485800	DC	DF4	RELIANCE 4-FRONT	0685	008025265668565	DC	DF4
RELIANCE 4-SITE	0295	00802526504594	DC	DF4	RELIANCE 4-FRONT	0686	00802526533624	DC	DF4
RELIANCE 4-SITE	0295	00802526504624	DC	DF4	RELIANCE 4-FRONT	0686	00802526533655	DC	DF4
RELIANCE 4-SITE	0295	00802526504662	DC	DF4	RELIANCE 4-FRONT	0686	00802526533662	DC	DF4
RELIANCE 4-SITE	0295	00802526504686	DC	DF4	RELIANCE 4-FRONT	0686	00802526533679	DC	DF4
RELIANCE 4-SITE	0295	00802526517723	DC	DF4	RELIANCE 4-FRONT	0686	00802526533693	DC	DF4
RELIANCE 4-SITE	0295	00802526531262	DC	DF4	RELIANCE 4-FRONT	0686	00802526537721	DC	DF4
RELIANCE 4-SITE	0295	00802526541902	DC	DF4	RELIANCE 4-FRONT	0686	00802526560989	DC	DF4
RELIANCE 4-SITE	0295	00802526541926	DC	DF4	RELIANCE 4-FRONT	0686	00802526566859	DC	DF4
RELIANCE 4-SITE	0295	00802526541933	DC	DF4	RELIANCE 4-FRONT	0686	008025265668596	DC	DF4
RELIANCE 4-SITE	0295	00802526541940	DC	DF4	RELIANCE 4-FRONT	0686	008025265668602	DC	DF4
RELIANCE 4-SITE	0295	00802526541957	DC	DF4	RELIANCE 4-FRONT	0686	008025265668626	DC	DF4
RELIANCE 4-SITE	0295	00802526541964	DC	DF4	RELIANCE 4-FRONT	0686	008025265678410	DC	DF4
RELIANCE 4-SITE	0295	00802526541971	DC	DF4	RELIANCE 4-FRONT	0686	00802526609848	DC	DF4
RELIANCE 4-SITE	0295	00802526551956	DC	DF4	RELIANCE 4-FRONT	0692	00802526518843	SC	DF4
RELIANCE 4-SITE	0295	00802526554506	DC	DF4	RELIANCE 4-FRONT	0692	00802526519017	SC	DF4
RELIANCE 4-SITE	0295	00802526591594	DC	DF4	RELIANCE 4-FRONT	0692	00802526519048	SC	DF4
RELIANCE 4-SITE	0295	00802526611131	DC	DF4	RELIANCE 4-FRONT	0692	00802526519802	SC	DF4
RELIANCE 4-SITE	0296	00802526431470	DC	DF4	RELIANCE 4-FRONT	0692	00802526519819	SC	DF4
RELIANCE 4-SITE	0296	00802526474705	DC	DF4	RELIANCE 4-FRONT	0692	00802526519826	SC	DF4
RELIANCE 4-SITE	0296	00802526480164	DC	DF4	RELIANCE 4-FRONT	0692	00802526519833	SC	DF4
RELIANCE 4-SITE	0296	00802526480171	DC	DF4	RELIANCE 4-FRONT	0692	00802526519840	SC	DF4
RELIANCE 4-SITE	0296	00802526480188	DC	DF4	RELIANCE 4-FRONT	0692	00802526537745	SC	DF4
RELIANCE 4-SITE	0296	00802526481932	DC	DF4	RELIANCE 4-FRONT	0692	00802526553035	SC	DF4
RELIANCE 4-SITE	0296	00802526481949	DC	DF4	RELIANCE 4-FRONT	0692	00802526560996	SC	DF4
RELIANCE 4-SITE	0296	00802526481956	DC	DF4	RELIANCE 4-FRONT	0692	008025265668640	SC	DF4
RELIANCE 4-SITE	0296	00802526481963	DC	DF4	RELIANCE 4-FRONT	0692	008025265668657	SC	DF4
RELIANCE 4-SITE	0296	00802526481970	DC	DF4	RELIANCE 4-FRONT	0692	008025265668664	SC	DF4
RELIANCE 4-SITE	0296	00802526485824	DC	DF4	RELIANCE 4-FRONT	0692	008025265668671	SC	DF4
RELIANCE 4-SITE	0296	00802526504693	DC	DF4	RELIANCE 4-FRONT	0692	008025265668688	SC	DF4
RELIANCE 4-SITE	0296	00802526504723	DC	DF4	RELIANCE 4-FRONT	0692	008025265668695	SC	DF4
RELIANCE 4-SITE	0296	00802526504730	DC	DF4	RELIANCE 4-FRONT	0692	008025265678427	SC	DF4
RELIANCE 4-SITE	0296	00802526504761	DC	DF4	RELIANCE 4-FRONT	0692	00802526609862	SC	DF4
RELIANCE 4-SITE	0296	00802526504778	DC	DF4	RELIANCE 4-FRONT	0693	00802526518850	SC	DF4
RELIANCE 4-SITE	0296	00802526504785	DC	DF4	RELIANCE 4-FRONT	0693	00802526519055	SC	DF4
RELIANCE 4-SITE	0296	00802526531279	DC	DF4	RELIANCE 4-FRONT	0693	00802526519086	SC	DF4
RELIANCE 4-SITE	0296	00802526538209	DC	DF4	RELIANCE 4-FRONT	0693	00802526519857	SC	DF4
RELIANCE 4-SITE	0296	00802526541988	DC	DF4	RELIANCE 4-FRONT	0693	00802526519864	SC	DF4
RELIANCE 4-SITE	0296	00802526542008	DC	DF4	RELIANCE 4-FRONT	0693	00802526519871	SC	DF4
RELIANCE 4-SITE	0296	00802526542015	DC	DF4	RELIANCE 4-FRONT	0693	00802526519888	SC	DF4
RELIANCE 4-SITE	0296	00802526542039	DC	DF4	RELIANCE 4-FRONT	0693	00802526519895	SC	DF4
RELIANCE 4-SITE	0296	00802526542046	DC	DF4	RELIANCE 4-FRONT	0693	00802526537769	SC	DF4
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RELIANCE 4-SITE	0296	00802526552038	DC	DF4	RELIANCE 4-FRONT	0693	00802526561009	SC	DF4
RELIANCE 4-SITE	0296	00802526554513	DC	DF4	RELIANCE 4-FRONT	0693	008025265668701	SC	DF4
RELIANCE 4-SITE	0296	00802526591709	DC	DF4	RELIANCE 4-FRONT	0693	008025265668718	SC	DF4
RELIANCE 4-SITE	0296	00802526611124	DC	DF4	RELIANCE 4-FRONT	0693	008025265668725	SC	DF4
RELIANCE 4-FRONT	0657	00802526518706	SC	DF4	RELIANCE 4-FRONT	0693	008025265668732	SC	DF4
RELIANCE 4-FRONT	0657	00802526560934	SC	DF4	RELIANCE 4-FRONT	0693	008025265668749	SC	DF4
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RELIANCE 4-FRONT	0658	00802526519697	DC	DF4	RELIANCE 4-FRONT	0695	00802526519093	DC	DF4
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RELIANCE 4-FRONT	0682	008025265668442	SC	DF4	RELIANCE 4-FRONT	0696	00802526518874	DC	DF4
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RELIANCE 4-FRONT	0683	00802526609817	SC	DF4	RELIANCE 4-FRONT	0696	008025265668862	DC	DF4
RELIANCE 4-FRONT	0685	00802526533549	DC	DF4	RELIANCE 4-FRONT	0696	008025265668879	DC	DF4
RELIANCE 4-FRONT	0685	00802526533570	DC	DF4	RELIANCE 4-FRONT	0696	008025265678526	DC	DF4
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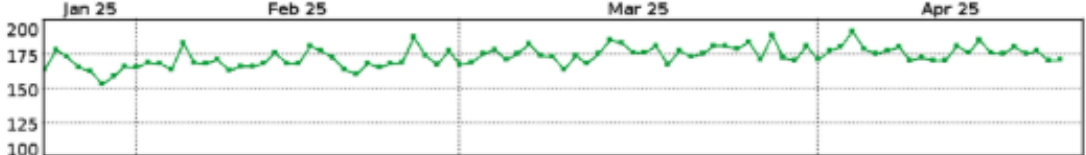
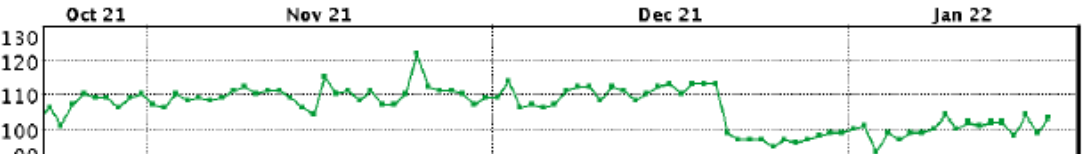
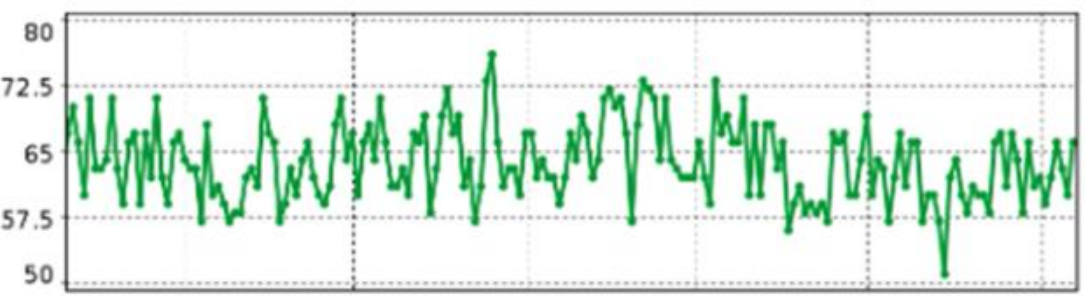
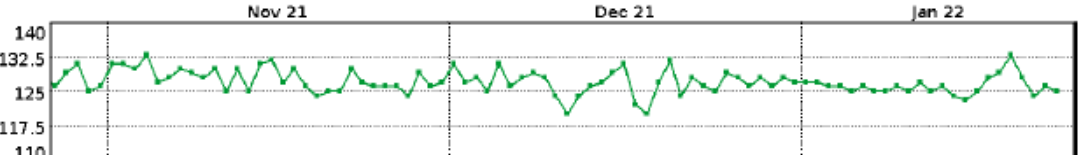
Appendix C

The recommendations state: During routine follow-up, determine the most recent 28-day average LVSI that has not been affected by the delivery of a shock.

The 28-day average LVSI used to inform the recommendations was calculated using US LATITUDE RM data. The shock impedance trends display up to one year of data through the LATITUDE programmer and RM. Review the trend and determine if there are any sudden changes in impedance that are associated with a delivered shock.

1. If there are any sudden changes in impedance, visually estimate the 28-day average LVSI prior to the impedance change.
2. If there is no sudden change in impedance, visually estimate the most recent 28-day average LVSI.

**Table 5** Examples of LVSI trends and visually estimated 28-day average impedance

Criteria	Examples
<p>No sudden change in impedance; the most recent 28-day average LVSI is about 180Ω</p>	
<p>Sudden change in impedance mid-Dec; the 28-day average LVSI before this change is about 110Ω</p>	
<p>No sudden change in impedance; the most recent 28-day average LVSI is about 60Ω</p>	
<p>No sudden change in impedance; the most recent 28-day average LVSI is about 127Ω</p>	

## Endnotes

- <sup>1</sup> Monkhouse C, Cambridge A, Chow AWC, Behar JM. High-voltage impedance rise; mechanism and management in patients with transvenous implantable cardioverter-defibrillators: a case series. *Eur Heart J Case Rep*. 2019 Dec;3(4):1-8. doi: 10.1093/ehjcr/yz220. Epub 2019 Dec 19. PMID: 31911989; PMCID: PMC6939807.
- <sup>2</sup> Swerdlow CD, Koneru JN, Gunderson B, Kroll MW, Ploux S, Ellenbogen KA. Impedance in the Diagnosis of Lead Malfunction. *Circ Arrhythm Electrophysiol*. 2020 Feb;13(2):e008092. doi: 10.1161/CIRCEP.119.008092. Epub 2020 Jan 27. PMID: 31985260.
- <sup>3</sup> Swerdlow CD, Ploux S, Poole JE, Nair SG, Himes A, Ellenbogen KA. Interpreting device diagnostics for lead failure. *Heart Rhythm*. 2022 Jan;19(1):154-164. doi: 10.1016/j.hrthm.2021.09.027. Epub 2021 Sep 28. PMID: 34597770.
- <sup>4</sup> Narayanan, Chockalingam et al. PO-05-084 Management of Gradual Elevated Shock Impedance in ENDOTAK RELIANCE ICD Leads *Heart Rhythm*, Volume 20, Issue 5, S722 - S723. <https://doi.org/10.1016/j.hrthm.2023.03.1497>.
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- <sup>7</sup> Where RV = Right Ventricle and indicates that for a given shock polarity, the RV coil is either positive(+) or negative(-) for the first phase of a biphasic waveform [e.g., Initial (RV-) or Reversed (RV+)].
- <sup>8</sup> Boston Scientific ICDs/CRT-D labeling recommends 3-month follow-ups.
- <sup>9</sup> The follow-up interval for ICDs/CRT-Ds not monitored remotely is 3-6 months and 1-3 months as the device approaches elective replacement (COR-1/LOE-C) pg e107, section 5.1; Ferrick AM Raj SR, Deneke T, et al. 2023 HRS/EHRA/APHRS/LAHRs expert consensus statement on practical management of the remote device clinic. *Heart Rhythm*, ISSN: 1547-5271, Vol: 20, Issue: 9, Page: e92-e144. <https://doi.org/10.1016/j.hrthm.2023.03.1525>.
- <sup>10</sup> In patients with CIEDs, RM is recommended as part of the standard of care (COR-1/LOE-A) pg e99. Ferrick AM Raj SR, Deneke T, et al. 2023 HRS/EHRA/APHRS/LAHRs expert consensus statement on practical management of the remote device clinic. *Heart Rhythm*, ISSN: 1547-5271, Vol: 20, Issue: 9, Page: e92-e144. <https://doi.org/10.1016/j.hrthm.2023.03.1525>.
- <sup>11</sup> Moss AJ. MADIT-I and MADIT-II. *J Cardiovasc Electrophysiol*. 2003 Sep;14(9 Suppl):S96-8. doi: 10.1046/j.1540-8167.14.s9.5.x. PMID: 12950528.
- <sup>12</sup> GORE is a trademark of W.L. Gore and associates
- <sup>13</sup> Sprint Fidelis is a trademark of Medtronic, the recall was initiated in Oct 2007, and designated a Class 1 recall by the FDA (recall ID 45403) [https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRES/res.cfm?start\\_search=1&event\\_id=45403](https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRES/res.cfm?start_search=1&event_id=45403)
- <sup>14</sup> Riata is a trademark of Abbott (St. Jude), the recall was initiated in Nov 2011, and designated a Class 1 recall by the FDA (recall ID 60571) [https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRES/res.cfm?start\\_search=1&event\\_id=60571](https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRES/res.cfm?start_search=1&event_id=60571)
- <sup>15</sup> Boston Scientific 2025 First Edition Product Performance Report for all RELIANCE active fixation leads with published 10-year cumulative survival probability data available online at [www.BostonScientific.com/ppr](http://www.BostonScientific.com/ppr).
- <sup>16</sup> Boston Scientific's Product Performance Report is available online at [www.BostonScientific.com/ppr](http://www.BostonScientific.com/ppr)
- <sup>17</sup> Swerdlow CD, et al. doi: 10.1161/CIRCEP.119.008092. Epub 2020 Jan 27. PMID: 31985260.
- <sup>18</sup> Swerdlow CD, et al. doi: 10.1016/j.hrthm.2021.09.027. Epub 2021 Sep 28. PMID: 34597770.
- <sup>19</sup> Mond HG, Helland JR, Stokes K, Bornzin GA, McVenes R. The electrode-tissue interface: the revolutionary role of steroid-elution. *Pacing Clin Electrophysiol*. 2014 Sep;37(9):1232-49. doi: 10.1111/pace.12461. Epub 2014 Jul 29. PMID: 25130977.
- <sup>20</sup> Swerdlow CD, et al. doi: 10.1161/CIRCEP.119.008092. Epub 2020 Jan 27. PMID: 31985260.
- <sup>21</sup> Swerdlow CD, et al. doi: 10.1016/j.hrthm.2021.09.027. Epub 2021 Sep 28. PMID: 34597770.
- <sup>22</sup> The US is the largest dataset with registered defibrillators and leads that include implant and out of service dates.
- <sup>23</sup> Bänsch D, Bonnemeier H, Brandt J, Bode F, Svendsen JH, Táborský M, Kuster S, Blomström-Lundqvist C, Felk A, Hauser T, Suling A, Wegscheider K; NORDIC ICD Trial Investigators. Intra-operative defibrillation testing and clinical shock efficacy in patients with implantable cardioverter-defibrillators: the NORDIC ICD randomized clinical trial. *Eur Heart J*. 2015 Oct 1;36(37):2500-7. doi: 10.1093/eurheartj/ehv292. Epub 2015 Jun 25. PMID: 26112885; PMCID: PMC4589656.
- <sup>24</sup> Cha YM, Hayes DL, Asirvatham SJ, Powell BD, Cesario DA, Cao M, Gilliam FR 3rd, Jones PW, Jiang S, Saxon LA. Impact of shock energy and ventricular rhythm on the success of first shock therapy: the ALTITUDE first shock study. *Heart Rhythm*. 2013 May;10(5):702-8. <https://doi.org/10.1016/j.hrthm.2013.01.019>
- <sup>25</sup> Blatt JA, Poole JE, Johnson GW, Callans DJ, Raitt MH, Reddy RK, Marchlinski FE, Yee R, Guarnieri T, Talajic M, Wilber DJ, Anderson J, Chung K, Wong WS, Mark DB, Lee KL, Bardy GH; SCD-HeFT Investigators. No benefit from defibrillation threshold testing in the SCD-HeFT (Sudden Cardiac Death in Heart Failure Trial). *J Am Coll Cardiol*. 2008 Aug 12;52(7):551-6. doi: 10.1016/j.jacc.2008.04.051. PMID: 18687249.
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- <sup>28</sup> Narayanan et al. <https://doi.org/10.1016/j.hrthm.2023.03.1497>.