Coronary artery disease and heart failure carry concurrent risk for atrial fibrillation and life-threatening ventricular arrhythmias. We review evidence indicating that at therapeutic concentrations, ranolazine has potential for dual suppression of these arrhythmias. Mechanisms and clinical implications are discussed.

**Keywords**
- Ranolazine
- T-wave alternans
- Ventricular fibrillation
- Atrial fibrillation
- Sodium current

**Introduction**

Coronary artery disease and heart failure carry a dual risk for atrial fibrillation (AF) and life-threatening ventricular arrhythmias.\(^1\)–\(^4\) Medical management of these conditions is challenging because of the complex and differing factors underlying arrhythmogenesis in the atria and ventricles. The difficulty of the problem is underscored by the fact that the main contemporary agents used for rhythm control in AF can result in ventricular proarrhythmia including torsade de pointes.\(^5\) Drugs with Class IC effects of blocking peak \(I_{\text{Na}}\) can cause myocardial depression, promote reentrant ventricular tachycardia, and increase mortality in patients with coronary disease. Anti-AF agents with the Class III action of blocking sodium current \(I_{\text{Na}}\), such as dofetilide and sotalol, can precipitate torsades de pointes. The multi-channel blocking agent amiodarone is currently widely employed, although its use can be problematic due to the potential for significant extra-cardiac toxicity, particularly in lung and thyroid tissue.\(^6\) Dronedarone, a non-iodinated benzofuran derivative of amiodarone that exhibits all four classes of antiarrhythmic action, was developed to achieve a better safety profile by eliminating the iodine moiety and substituting a methanesulfanyl group.\(^7,8\) Whereas most studies have shown that dronedarone reduces mortality and morbidity in patients with paroxysmal AF,\(^7\) it increases rates of heart failure, stroke, and death from cardiovascular causes in patients with permanent AF or moderate to severe heart failure.\(^9\) Although the exact basis for the increased risk in these patients is unclear, the potential for negative inotropy related to L-type calcium channel blockade at the currently recommended dosage has been suggested.

Ranolazine was developed as an antianginal agent and was initially thought to confer its therapeutic effects primarily through partial inhibition of fatty acid oxidation.\(^10\) These drug actions were generally observed at concentrations exceeding the plasma levels found in clinical trials (\(>10 \mu\text{M}\)).\(^11\) More recent evidence indicates that the anti-ischaemic effects of ranolazine relate to its inhibition of late \(I_{\text{Na}}\), which, through an effect on reverse sodium–calcium exchange, improves diastolic compliance, thereby increasing coronary artery blood flow.\(^12\) Subsequent experimental studies have revealed a potent antiarrhythmic effect of ranolazine against both atrial and ventricular arrhythmias.\(^12\)–\(^15\)

Clinical evidence of ranolazine’s antiarrhythmic efficacy has emerged from the MERLIN-TIMI 36 (Metabolic Efficiency with Ranolazine for Less Ischemia in Non-ST-Elevation Acute Coronary Syndrome–Thrombolysis in Myocardial Infarction 36) trial, which enrolled 6560 patients and was directed to the treatment of myocardial ischaemia in patients with non-ST elevation acute coronary syndrome.\(^16\) Ranolazine reduced the incidence of supraventricular arrhythmias with a trend towards lowering the incidence of new-onset AF across 6 days of continuous electrocardiographic recordings.\(^17\) A subsequent analysis indicated that among patients with paroxysmal AF, the overall burden tended to be lower with ranolazine than with placebo, with fewer AF-related adverse events.\(^18\) Ranolazine has also been demonstrated to be superior to amiodarone in reducing the incidence of AF following coronary artery bypass graph surgery\(^19\) and in combination therapy to improve conversion from recent onset AF over amiodarone alone.\(^20\) Murdock et al.\(^21\) recently reported in a case series that ranolazine

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can facilitate electrical cardioversion of AF in patients with cardioversion-resistant AF. Further analysis of the ambulatory electrocardiogram recordings from MERLIN TIMI-36 revealed that ranolazine can suppress not only supraventricular arrhythmias but also episodes of non-sustained ventricular tachycardia.22

The main goals of the present review are to summarize knowledge and discuss mechanisms of ranolazine’s effects on both atrial and ventricular arrhythmogenesis.

Influence of ranolazine on atrial and ventricular electrical properties in the normal, intact heart

Programmed electrical stimulation was employed in anaesthetized canine and porcine models to evaluate the effects of intravenous ranolazine on excitability, refractoriness, dromotropy, and vulnerability to AF and ventricular fibrillation (VF).23 – 27

Atrial electrical properties

Experiments in large animals demonstrated ranolazine’s potent atrial effects,24 consistent with findings in isolated tissue studies by Antzelevitch and colleagues.14,28,29 Specifically, significant effects on atrial refractoriness were found in each atrial site tested, namely high right atrium, right atrial appendage, and posterolateral left atrium (Table 1). These changes occurred in a non-frequency-dependent manner, in contrast to reports of I\(\text{Kr}\) blockade by agents such as dofetilide and d-sotalol and to results expected with peak I\(\text{Na}\) blockade and post-repolarization refractoriness. The phenomenon of non-frequency dependence may result from reverse frequency-dependent I\(\text{Kr}\) inhibition coupled with frequency-dependent peak I\(\text{Na}\) inhibition. The magnitude of the increase in atrial effective refractory period in atrial sites (>20% increase from baseline) was greater than the effect on the right ventricular endocardium (<10% increase from baseline). No significant changes were observed in atrial or ventricular diastolic thresholds. Ranolazine increased median atrial conduction time, a surrogate marker for conduction velocity, from high right atrium to posterolateral left atrium in a frequency-dependent manner in agreement with prior studies and consistent with inhibition of peak I\(\text{Na}\) in atrial tissue.

Table 1 Ranolazine’s effects on atrial and ventricular effective refractory periods

<table>
<thead>
<tr>
<th>Site</th>
<th>Median effective refractory period (milliseconds)</th>
<th>Interquartile range (milliseconds)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>High right atrium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>167</td>
<td>159–179</td>
<td>0.006</td>
</tr>
<tr>
<td>Ranolazine</td>
<td>202</td>
<td>183–231</td>
<td></td>
</tr>
<tr>
<td>Right atrial appendage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>158</td>
<td>136–164</td>
<td>0.002</td>
</tr>
<tr>
<td>Ranolazine</td>
<td>202</td>
<td>187–211</td>
<td></td>
</tr>
<tr>
<td>Posterolateral left atrium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>140</td>
<td>117–150</td>
<td>0.014</td>
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<tr>
<td>Ranolazine</td>
<td>163</td>
<td>143–193</td>
<td></td>
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<tr>
<td>Right ventricle</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>253</td>
<td>243–260</td>
<td>0.006</td>
</tr>
<tr>
<td>Ranolazine</td>
<td>275</td>
<td>271–281</td>
<td></td>
</tr>
</tbody>
</table>

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Atrial fibrillation suppression

To test whether ranolazine alters susceptibility to AF, the muscarinic transmitter acetylcholine (ACh) was administered into the pericardial space by percutaneous transatrial access.24 This approach incorporates multiple sites of action including atrial tissue, ganglionic plexi, and pulmonary veins, all of which have been implicated clinically in atrial arrhythmogenesis. A significant reduction in AF duration (Figure 1) and tendency to suppress AF re-initiation were observed following ranolazine administration. Despite the QT prolongation associated with AF-cardioversion, torsade de pointes was not observed. These results are likely indicative of the effect of ranolazine on atrial conduction velocity due to peak I\(\text{Na}\) inhibition and are similar to the actions of other potent sodium channel blockers, including flecainide and propafenone, and suggest that ranolazine affects factors that are important not only in maintaining AF but also possibly in initiating AF.

Ranolazine reduced the dominant frequency of AF,24 an index of organization of AF and the propensity for successful defibrillation,30 in both the left and right atria. Consistent with previous reports of AF in humans and in other animal models,31 the dominant frequency of AF in the left atrium was always greater than that in the right atrial appendage, indicating that the drivers for AF in
this model reside in the left atrium, where susceptibility to ACh-induced changes in rotor dynamics is enhanced. Ranolazine did not change this relationship, despite decreasing dominant frequency of AF in both atria.

The cellular and ionic mechanisms by which ranolazine reduces ACh-mediated AF are likely multifold: (i) depression of \( I_{\text{Na}} \)-dependent parameters, which reduces action potential upstroke, and increases in diastolic threshold of excitation and post-repolarization refractoriness; (ii) \( I_{\text{Kr}} \) inhibition, which counteracts ACh-induced shortening of action potential duration; (iii) late \( I_{\text{Na}} \) inhibition, which suppresses late phase 3 early after-depolarizations and reduces \( I_{\text{Kr}} \), thereby suppressing delayed after-depolarizations and triggered activity. Ranolazine at the concentrations tested has minimum effect on \( I_{\text{Ca}} \). The anti-AF capacity of ranolazine has also been shown by Lemoine et al. in terms of suppression of occurrence of early after-depolarizations and triggered activity in an animal model of LQT3 (SCN5A inactivation-impairing mutation).

### Ventricular effects

**Surface electrocardiogram analysis**

Ranolazine moderately prolonged the QTc interval in the intact porcine model, consistent with previous reports in dogs but to a larger extent than is observed in humans. The drug did not alter \( T_{\text{peak}}-T_{\text{end}} \) interval, an index of transmural dispersion of repolarization, a parameter identified in a canine wedge preparation to be attributable to differential effects on epicardial vs. M cells. These effects were at variance from d-sotalol, a selective \( I_{\text{Kr}} \) blocker, despite prolongation of action potential duration and the QT interval of the in-vitro-modelled electrocardiogram by both drugs.

**Electrophysiological testing**

Ranolazine prolonged ventricular effective refractory period in the porcine model by a mean of 40 ms over a large range of stimulation strengths. Schram et al. had previously observed a mild but non-significant increase in effective refractory period in canines at both low and high doses of ranolazine. The significant changes in effective refractory period detected by Kumar et al. may be attributable to the larger sample size.

Ranolazine caused substantial increases in the magnitude of the depolarization threshold current needed to induce the repetitive extrasystoles (RE) and VF (Figure 2). Because the intensity of the stimulus required to provoke either RE or VF is inversely proportional to the intrinsic level of cardiac electrical heterogeneity, these measures yield an index of dispersion of refractoriness. The ventricular vulnerable period width has been shown to correlate with dispersion of repolarization, lending further support to these observations and to interpretation of the electrophysiologic effects of ranolazine described. Accordingly, ranolazine’s increase in the RE and VF thresholds and reduction in vulnerable period width may indicate its potential antiarrhythmic mechanism, namely, reduction in the dispersion of repolarization and refractoriness. These changes to the underlying myocardial substrate may be complementary to ranolazine’s suppression of triggered activity due to early after-depolarizations. These findings are further supported by the report that in remodelled canine hearts with complete heart block, ranolazine suppressed drug-induced torsade de pointes, with concomitant changes in beat-to-beat variability of repolarization.

### Defibrillation threshold testing

Ranolazine did not alter the 50% probability of successful ventricular defibrillation (DFT50), likely as a consequence of the countervailing influences of \( I_{\text{Kr}} \) and \( I_{\text{Na}} \) inhibition (Figure 2). Notably, \( I_{\text{Kr}} \)
inhibition would be expected to lower DFT$_{50}$, whereas $I_{Na}$ inhibition would increase it. Ranolazine exerts minor influences on peak $I_{Na}$ at slow to moderate heart rates, but at short cycle lengths in depolarized cells, as during VF, the drug may inhibit peak $I_{Na}$ more effectively. Use dependence and increased binding at less negative, that is, at more depolarized, membrane potentials is a typical characteristic of sodium channel blockers and should also apply to ranolazine. Enhanced peak $I_{Na}$ inhibition during VF is consistent with the finding that ranolazine reduces the dominant frequency of VF, indicative of active tissue binding during VF notwithstanding the absence of an influence on DFT$_{50}$. The observation that ranolazine’s antifibrillatory effect is not associated with a significant increase in ventricular defibrillation threshold indicates that the drug appears unlikely to affect the margin of safety for defibrillation. In light of the importance of this issue, further experimentation is warranted including testing defibrillation threshold during acute myocardial ischaemia.

**Antifibrillatory effects of ranolazine in the ischaemic heart**

**Ventricular effects during severe coronary artery stenosis**

Because ischaemic heart disease is associated with increased risk for ventricular arrhythmias, the effects of ranolazine during severe left anterior descending coronary artery (LAD) stenosis were assessed in the intact porcine model. Electrode catheters allowed assessment of the effects of severe LAD stenosis on the levels of VF threshold and T-wave alternans (TWA), a beat-to-beat fluctuation in the ST-segment and T-wave, which has been shown to reflect susceptibility to malignant ventricular arrhythmias.

Ranolazine significantly increased VF threshold not only in the normal heart but more importantly during myocardial ischaemia, when the effects occurred independently of changes in LAD coronary blood flow, which was controlled with a hydraulic occluder. During normal coronary artery flow, blockade of $I_{Kr}$ and consequent prolongation of action potential duration contributed to increases in VF threshold induced by both ranolazine and the $I_{Kr}$ blocker E-4031. However, during severe myocardial ischaemia, E-4031 was profibrillatory, as it decreased VF threshold from control stenosis, whereas ranolazine increased it. Importantly, TWA tracked the ranolazine- and E-4031-induced changes in VF threshold during myocardial ischaemia, that is, ranolazine decreased but E-4031 did not alter TWA levels from the control stenosis (Figures 3 and 4). Studies involving assessment of lactate production by sampling coronary venous effluent or other methods involving wall motion abnormalities and measurement of regional myocardial blood flow with microspheres are required to establish an effect of ranolazine on metabolism during myocardial ischaemia.

Ranolazine’s effects on VF threshold and TWA levels indicate significant blunting of ischaemia-induced dispersion of repolarization and refractoriness. TWA reflects spatiotemporal heterogeneity of repolarization between neighbouring myocardial regions, as has been shown in investigations in intact large animals and in patients with cardiomyopathy. The effects of ranolazine and
E-4031 on VF threshold and TWA reflect their direct influences on
the electrophysiological properties of the ventricular myocardium
and are not attributable to changes in coronary artery blood flow
as stenoses were maintained at the same level before and after
drug administration. These results are consistent with findings
reported by Kloner et al., who showed in rats subjected to prox-
imal left coronary artery occlusion followed by reperfusion that
ranolazine at a dose consistent with inhibition of late \( I_{Na} \) exerts
a potent antiarrhythmic effect and is superior to sotalol or
lidocaine.

**Ischaemia-induced atrial fibrillation**

Ischaemic heart disease is associated not only with increased risk
for malignant ventricular arrhythmias but also for AF. In patients
with acute coronary syndromes, the incidence of AF has been
reported to be 6–22% and is associated with increased short-
and long-term morbidity and mortality. Nattel and coworkers,
provided experimental evidence indicating that atrial ischaemia
can create a substrate for maintenance of AF by increasing local
conduction slowing, leading to unidirectional block and reentry.
They found that the L-type calcium channel blocker diltiazem and
the beta-adrenergic receptor blocker nadolol were protective
but that peak \( I_{Na} \) and \( I_{Kr} \) inhibition with flecainide and dofetilide,
respectively, were not effective.

Recently, we induced concurrent atrial and ventricular ischae-
mia to evaluate simultaneously the effects of antiarrhythmic
agents on vulnerability to AF and ventricular tachyarrhythmias.
Stenosis at the origin of the left circumflex coronary artery,
which supplies all three major branches to the left atrium, namely, the proximal, intermediate, and distal arteries, induces
significant left atrial ischaemia (Figure 5). In a preliminary
report, we found that ranolazine at a plasma concentration in
the clinical dose range completely suppressed the ischaemia-
induced reduction in AF threshold. This protective effect against
ischaemia-induced AF appears to be due to direct effects on
atrial electrical properties independent of coronary flow, as this
variable was controlled.

We also demonstrated that ranolazine and dronedarone at low
dosages exhibit a synergistic, antiarrhythmic effect on vulnerability
to AF and ventricular tachyarrhythmias during concurrent atrial
and ventricular ischaemia. Specifically, when low doses of
either agent were given alone, there was no protective effect,
but the drug combination prevented the ischaemia-induced fall in
AF threshold, reduced AF inducibility, and shortened AF duration
while decreasing T-wave heterogeneity, a clinically relevant
measure of susceptibility to life-threatening ventricular arrhyth-
mias. Overall, these findings are consistent with the discovery by
Burashnikov et al. that ranolazine and dronedarone afford syner-
gistic antiarrhythmic actions with respect to AF susceptibility.
The clinical relevance of synergistic antiarrhythmic protection by
the combination of low doses of ranolazine and dronedarone is
under investigation in ‘A Study to Evaluate the Effect of Ranolazine
and Dronedarone When Given Alone and in Combination
in Patients with Paroxysmal AF’ (HARMONY) trial (NCT
01522651). The effect of the drugs on AF burden will be studied

![Figure 5](link)
in patients with implanted dual chamber programmable pacemakers with AF detection capabilities.

### Ionic basis for ranolazine’s antiarrhythmic effects

The three most likely ion channel currents responsible for the electrophysiological effects of ranolazine in the normal or ischaemic atrial and ventricular myocardium are late $I_{Na}$, peak $I_{Na}$, and $I_{Kr}$. Analysis of excised atrial appendages from patients with AF have implicated late $I_{Na}$ inhibition, while experimental studies in canine isolated perfused atrial tissue have provided evidence that ranolazine’s antifibrillatory effect in the atria is attributable primarily to inhibition of peak $I_{Na}$. At therapeutic concentrations, ranolazine also inhibits the delayed rectifier potassium current ($I_{Kr}$) which has been extensively investigated as a target to suppress AF. Investigations in a canine heart failure model demonstrated that ranolazine reversibly blocked diastolic intracellular Ca$^{2+}$ accumulation and spontaneous Ca$^{2+}$ release by late $I_{Na}$ inhibition. In terms of improvement in myocardial mechanical function, love-lock et al. demonstrated in a murine model that diastolic dysfunction can be reversed by ranolazine, most likely resulting from a direct influence on myofilaments.

It is unlikely that ranolazine’s antifibrillatory effects in both atrial and ventricular tissue during myocardial ischaemia without overt proarrhythmia are solely due to inhibition of peak $I_{Na}$ and $I_{Kr}$ as flecainide and E-4031, potent inhibitors of peak $I_{Na}$ and $I_{Kr}$, respectively, were not protective during ischaemia, while ranolazine was antiarrhythmic. Inhibition of late $I_{Na}$ with consequent reductions in the arrhythmogenic effects of intracellular calcium overload and...
improvement in repolarization reserve, is a plausible mechanism of the antiarrhythmic effects of ranolazine and freedom from proarrhythmia.

Conclusions and future directions
Collectively, these experimental studies in intact large animal models indicate that at therapeutic concentrations, ranolazine exerts significant beneficial effects on electrophysiological properties of both the atria and ventricles, with greater effects on the former structure. Ranolazine’s potent cardioprotective effects offer distinct advantages over other contemporary agents, as proarrhythmia was found not to be a factor in the MERLIN-TIMI-36 clinical trial and in these large, intact animal models. Rather, the agent provides safe, dual protection against ischaemia-induced atrial and ventricular arrhythmias. Ranolazine also reduces ischaemia-induced TWA and T-wave heterogeneity, electrocardiographic phenomena indicating risk for ventricular arrhythmogenesis. As TWA can be assessed during routine exercise testing or ambulatory electrocardiogram monitoring, it can be employed to gauge clinical relevance of the experimental findings.

Notwithstanding this progress, there remains a need to explore further the underlying mechanisms responsible for ranolazine’s antiarrhythmic action, in particular, to understand better the potential involvement of metabolic and antiischaemic influences in ranolazine’s action. Also, it is important to study the effects of the agents in models in which chronic disease is simulated by infarction and electrical and structural remodelling.

Several clinical trials are underway that address these issues in populations with diverse indications, as referenced at www.clinicaltrials.gov. Collectively, the information reviewed and heightened interest in this compound with its unique mode of action are likely to contribute to important inroads in the management of supraventricular and ventricular arrhythmias.

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