Pacemaker and ICD Generator Malfunctions
Analysis of Food and Drug Administration Annual Reports

William H. Maisel, MD, MPH
Megan Moynahan, MS
Bram D. Zuckerman, MD
Thomas P. Gross, MD, MPH
Oscar H. Tovar, MD
Donna-Bea Tillman, PhD, MPA
Daniel B. Schultz, MD

Pacemaker and ICD Generator Malfunctions

Context Pacemakers and implantable cardioverter-defibrillators (ICDs) are complex medical devices proven to reduce mortality in specific high-risk patient populations. It is not known if increasing device complexity is associated with decreased reliability.

Objectives To analyze postapproval annual reports submitted to the US Food and Drug Administration (FDA) by manufacturers of pacemakers and ICDs to determine the reported number and rate of pacemaker and ICD malfunctions and to assess trends in device performance.

Design and Setting Pacemaker and ICD annual reports submitted to the FDA for the years 1990-2002 were reviewed. A pacemaker or ICD generator was defined as having malfunctioned if it was explanted due to an observed malfunction, returned to the manufacturer, and confirmed by the manufacturer to be functioning inappropriately. Leads and biventricular devices were not included in the study. Deaths were attributed to device malfunction only if they were witnessed, the malfunction immediately led to the death, and the malfunction was confirmed by the manufacturer.

Main Outcome Measures Number of implanted pacemaker and ICD generators; number of reported malfunctions; and annual malfunction replacement rates. Generator malfunction replacement rates were defined as the annual number of replacements due to confirmed malfunction divided by the annual number of implants.

Results During the study period, 2.25 million pacemakers and 415,780 ICDs were implanted in the United States. Overall, 17,323 devices (8834 pacemakers and 8489 ICDs) were explanted due to confirmed malfunction. Battery/capacitor abnormalities (4085 malfunctions [23.6%]) and electrical issues (4708 malfunctions [27.1%]) accounted for half of the total device failures. The annual pacemaker malfunction replacement rate per 1000 implants decreased significantly during the study, from a peak of 9.0 in 1993 to a low of 1.4 in 2002 (P = .006 for trend). In contrast, the ICD malfunction replacement rate per 1000 implants, after decreasing from 38.6 in 1993 to 7.9 in 1996, increased markedly during the latter half of the study, peaking in 2001 at 36.4 (P = .04 for trend). More than half of the reported ICD malfunctions occurred in the last 3 years of the study. Overall, the annual ICD malfunction replacement rate was significantly higher than the pacemaker malfunction replacement rate (mean [SD], 20.7 [11.6] vs 4.6 [2.2] replacements per 1000 implants; P < .001; rate ratio, 5.9 [95% confidence interval, 2.7-9.1]). Sixty-one deaths (30 pacemaker patients, 31 ICD patients) were attributable to device malfunction.

Conclusions This study demonstrates that thousands of patients have been affected by pacemaker and ICD malfunctions, the pacemaker malfunction replacement rate has decreased, the ICD malfunction replacement rate increased during the latter half of the study, and the ICD malfunction replacement rate is significantly higher than that for pacemakers. Although pacemakers and ICDs are important life-sustaining devices that have saved many lives, careful monitoring of device performance is still required.

Author Affiliations: Cardiovascular Division, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Mass (Dr Maisel) and US Food and Drug Administration, Center for Devices and Radiologic Health, Rockville, Md (Ms Moynahan and Drs Zuckerman, Gross, Tovar, Tillman, and Schultz).

Corresponding Author: William H. Maisel, MD, MPH, Cardiovascular Division, Beth Israel Deaconess Medical Center, 185 Pilgrim Rd, Baker 4, Boston, MA 02215 (wmaisel@bidmc.harvard.edu).

See also pp 1907, 1929, 1944, and Patient Page.

©2006 American Medical Association. All rights reserved.

(Reprinted) JAMA, April 26, 2006—Vol 295, No. 16 1901
physiologic pacing. Whether these reported malfunctions and the increasing advisory rate reflect an actual change in device reliability in the setting of increasing device sophistication is not known.

The US Food and Drug Administration (FDA) is responsible for assessing both the premarket and postmarket safety and effectiveness of medical devices marketed in the United States. Additional postmarket monitoring of performance is required for selected devices. Because pacemakers and ICDs represent “life-sustaining” therapies for many patients, the FDA requires manufacturers to submit annual reports detailing the number of device implants and malfunctions that have occurred. This study analyzed pacemaker and ICD annual reports to determine the reported number, rate, and reasons for pacemaker and ICD malfunctions and to assess trends in device performance.

**METHODS**

All pacemaker and ICD generator annual reports submitted to the FDA for the years 1990-2002 were included. Each report contains the number of implanted devices by model number and information concerning device malfunctions. When a submitted report covered more or less than 1 year, the implant and malfunction data were assumed to have occurred evenly throughout the report period. Of note, there is an approximately 2-year delay in obtaining complete annual report data from manufacturers (ie, data for 2003 is submitted by manufacturers in 2004 and 2005). Biventricular pacemakers and ICDs were excluded because relatively few of these devices were implanted during the study period. Pacemaker and ICD leads were also not included because leads that malfunction are not usually returned to the manufacturer for analysis.

A pacemaker or ICD generator malfunction was defined as a situation in which a device was (1) explanted due to malfunction, (2) returned to the manufacturer, and (3) confirmed by the manufacturer to be functioning inappropriately. Devices that were not explanted, not returned to the manufacturer, or found by the manufacturer to be working normally were not counted as malfunctioning devices. Devices that had not yet been implanted were also not included. Lead malfunctions or issues unrelated to true generator malfunction (such as oversensing, undersensing, or normal battery depletion) were not included as malfunctions. Only true, verifiable, confirmed generator malfunctions were counted. Malfunction classification was based on the manufacturer-determined cause of device failure. It was assumed that malfunctioning devices that were explanted from living patients were replaced with new devices.

A death was attributed to device malfunction only if it satisfied all of the following criteria: (1) the death was witnessed, (2) the device was observed to malfunction and immediately lead to the patient’s death, (3) the device was explanted, and (4) the device was confirmed by the manufacturer to have malfunctioned. Death reports due to unconfirmed device malfunction were not considered to be due to device failure.

To calculate the annual device malfunction replacement rates, the annual number of devices explanted from living patients due to confirmed malfunction was divided by the annual number of device implants. Continuous outcomes were compared using t tests; discrete outcomes were compared using χ² and Fisher exact tests. Mantel-Haenszel χ² tests were used to assess for trends during 3 periods that were selected a priori: 1990-1996, 1996-2002, and 1990-2002.

Several potential sources of uncertainty in the device replacement rates were explored, including (1) variation in malfunction reporting rates, (2) variation in physician practice with regard to device replacement when a malfunction did occur, and (3) variation in physician reporting rate or clinical practice in the management of ICD patients compared with pacemaker patients.

Of 390 annual reports, 366 (94%) were available for review. The remaining 6% were not reviewed either because they were missing, they were not submitted, or the manufacturer was out of business. No specific year or manufacturer was more or less likely to have a missing annual report.

Statistical analyses were performed using SAS version 9.1 (SAS Institute Inc, Cary, NC). A 2-sided P value of .05 or less was interpreted as being statistically significant.

**RESULTS**

**Number of Pacemaker and ICD Implants in the United States**

From 1990 to 2002, there were 2.25 million pacemakers and 415,780 ICDs implanted in the United States. The annual number of pacemakers implanted increased almost 3-fold, from 94,755 in 1990 to 267,278 in 2002. During the same period, the annual number of ICD implants increased more than 10-fold, from fewer than 10,000 implants in 1990 to close to 100,000 in 2002 (Figure 1). Implanted cardioverter-defibrillators represented an increasingly larger proportion of implanted devices throughout the study period, increasing from 6.4% of implants in 1990 to 27.2% of implants in 2002 (P = .002 for trend).

The annual number of pacemakers implanted increased almost 3-fold and the annual number of ICD implants increased more than 10-fold during the study period. Implantable cardioverter-defibrillators represented an increasingly larger proportion of implanted devices throughout the study period, increasing from 6.4% of implants in 1990 to 27.2% of implants in 2002 (P = .002 for trend).

**Figure 1. Annual Pacemaker and Implantable Cardioverter-Defibrillator (ICD) Implants in the United States**

![Graph showing annual pacemaker and ICD implants](image-url)

- Number of pacemakers and ICDs implanted from 1990 to 2002.
- The graph illustrates the increase in the number of devices implanted, with a notable rise in the implantation rate for ICDs.

The annual number of pacemakers implanted increased almost 3-fold and the annual number of ICD implants increased more than 10-fold during the study period. Implantable cardioverter-defibrillators represented an increasingly larger proportion of implanted devices throughout the study period, increasing from 6.4% of implants in 1990 to 27.2% of implants in 2002 (P = .002 for trend).
plants (6.4%) in 1990 to 99,684 (27.2%) in 2002 (P = .002 for trend).

**Number and Replacement Rate of Device Malfunctions**

During the study period, there were 17,323 devices (8834 pacemakers and 8489 ICDs) explanted due to confirmed malfunction (Figure 2 and Table). The annual number of malfunctions ranged from 366 to 1152 for pacemakers and from 134 to 2228 for ICDs. The final year of the study demonstrated the single lowest annual number of pacemaker malfunctions. In contrast, the annual number of ICD malfunctions increased over time, with more than half of the ICD malfunctions occurring in the last 3 years of the study and close to one quarter occurring in the last year alone (Figure 2).

The annual device malfunction replacement rate ranged from 1.4 to 9.0 replacements per 1000 implants for pacemakers and 7.9 to 38.6 per 1000 implants for ICDs (Figure 3). The mean [SD] annual total device malfunction replacement rate for 1990-2002 was 6.8 [2.3] per 1000 device implants. Overall, the annual mean (SD) ICD malfunction replacement rate was significantly higher than the pacemaker malfunction replacement rate (20.7 [11.6] vs 4.6 [2.2] replacements per 1000 implants; P < .001). The ICD malfunction replacement rate was higher than the pacemaker malfunction replacement rate in all 3 preselected periods (1990-1996: rate ratio, 3.4 [95% confidence interval {CI}, 1.8-5.0]; 1996-2002: rate ratio, 7.8 [95% CI, 1.5-14.0]; and 1990-2002: rate ratio, 5.9 [95% CI, 2.7-9.1]).

The annual mean (SD) pacemaker malfunction replacement rate was lower in the second half of the study period than in the first (3.0 [1.3] vs 6.3 [1.4], P < .001). Overall, there was a significant decrease in the pacemaker malfunction replacement rate during the study (P = .006 for trend) (Figure 3). In fact, in the final year of the study, the pacemaker malfunction replacement rate was only 1.4 per 1000 devices—the lowest rate of any year in the study and far below the mean annual rate of 4.6 replacements per 1000 pacemaker implants. In contrast, the ICD replacement rate for malfunction trended down during the first half of the study (P = .09 for trend) and reached its nadir in 1994-1998 (Figure 3). The annual ICD malfunction replacement rate for 1994-1998 was less than half the overall ICD malfunction replacement rate. From 1996 to 2002, the ICD replacement rate for malfunction increased markedly (P = .04 for trend) (Figure 3). The ICD malfunction replacement rate for the final 3 years of the study, 2000-2002, was 26.8 per 1000 ICD implants, more than 10 times the pacemaker malfunction replacement rate for the same period and more than 3 times the ICD malfunction replacement rate for the mid 1990s.

**Table. Type and Frequency of Pacemaker and Implantable Cardioverter-Defibrillator (ICD) Malfunctions**

<table>
<thead>
<tr>
<th>Type of Malfunction</th>
<th>Pacemaker (N=8834)</th>
<th>ICD (N=8489)</th>
<th>Total (N=17323)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hardware</td>
<td>1392 (15.8)</td>
<td>2693 (31.7)</td>
<td>4085 (23.6)</td>
</tr>
<tr>
<td>Battery/capacitor</td>
<td>1188 (13.4)</td>
<td>790 (9.3)</td>
<td>1978 (11.4)</td>
</tr>
<tr>
<td>Charge circuit</td>
<td>6610 (74.8)</td>
<td>7217 (85.0)</td>
<td>13827 (79.8)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>352 (4.0)</td>
<td>144 (1.7)</td>
<td>496 (2.9)</td>
</tr>
<tr>
<td>Miscellaneous†</td>
<td>1337 (15.1)</td>
<td>712 (8.4)</td>
<td>2049 (11.8)</td>
</tr>
<tr>
<td>Inconclusive‡</td>
<td>1082 (12.2)</td>
<td>1 (0.01)</td>
<td>1083 (6.3)</td>
</tr>
<tr>
<td>Hardware</td>
<td>352 (4.0)</td>
<td>144 (1.7)</td>
<td>496 (2.9)</td>
</tr>
<tr>
<td>Battery/capacitor</td>
<td>1392 (15.8)</td>
<td>2693 (31.7)</td>
<td>4085 (23.6)</td>
</tr>
<tr>
<td>Charge circuit</td>
<td>1188 (13.4)</td>
<td>790 (9.3)</td>
<td>1978 (11.4)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>6610 (74.8)</td>
<td>7217 (85.0)</td>
<td>13827 (79.8)</td>
</tr>
<tr>
<td>Miscellaneous†</td>
<td>1337 (15.1)</td>
<td>712 (8.4)</td>
<td>2049 (11.8)</td>
</tr>
</tbody>
</table>

*Integral device software.
†Including physical damage, foreign material contamination, “miscellaneous” manufacturing errors, etc.
‡Manufacturer confirmed malfunction but could not determine the etiology.
Types of Device Malfunctions

Of the 17,323 total device malfunctions during the study period, hardware abnormalities were by far the most common type, affecting 13,827 devices (79.8%) (Table). Hardware abnormalities were the most common type of defect for both pacemakers and ICDs. Of these hardware problems, battery/capacitor abnormalities (4085 malfunctions [23.6%]) and electrical issues (4708 malfunctions [27.1%]) accounted for half of the total device failures. Firmware (integral device software) abnormalities and miscellaneous problems (such as physical damage, foreign material contamination, and various manufacturing errors) were much less frequent causes of device malfunctions. Only occasionally (816 malfunctions [4.7%]) could the manufacturer confirm device malfunction but not determine the cause.

Battery/capacitor abnormalities accounted for a higher percentage of device malfunctions in ICDs than in pacemakers (2693 malfunctions [31.7%] vs 1392 [15.8%], respectively; P < .001), as did charge-circuit abnormalities (1477 malfunctions [17.4%] vs 0, respectively; P < .001). Hermetic-seal abnormalities affected a much more significant percentage of pacemakers than

The annual mean (SD) ICD malfunction replacement rate was significantly higher than the pacemaker malfunction replacement rate (20.7 [11.6] vs 4.6 [2.2] replacements per 1000 implants; P < .001). The pacemaker malfunction replacement rate decreased significantly in the study (P = .006 for trend). In contrast, the ICD replacement rate for malfunction increased markedly during the latter portion of the study (P = .04 for trend).

Sensitivity Analysis

Sensitivity analysis was performed to assess the impact of potential changes in malfunction reporting frequency, physician practice regarding replacement of a malfunctioning device, and variable physician practice in the management of pacemaker vs ICD patients. The observed trends in ICD and pacemaker malfunction replacement rates were insensitive to changes in the malfunction reporting rates of even 50% during the latter half of the study. Similarly, they were insensitive to changes in physician practice (ie, ICD and pacemaker trends were still significant, even if physicians were twice as likely or half as likely to replace a device in later study years as compared with early study years). Finally, the finding that the malfunction replacement rate for ICDs was significantly higher than that for pacemakers was insensitive to even significant variable physician practice regarding management of patients receiving ICDs compared with pacemakers.
PACEMAKER AND ICD GENERATOR MALFUNCTIONS

uct performance reports, which contain information regarding device performance by model number.14-16 While these reports provide valuable information, historically they have not contained comprehensive information about the number of device malfunctions or the rate or reasons for malfunction.

Manufacturers are required to report to the FDA any medical device–related event or malfunction that caused or could have caused a serious injury or death.8 Hospitals, nursing homes, and other medical facilities are required to report serious device–related injuries to the manufacturer and device–related deaths to both the manufacturer and the FDA.9 Patients and clinicians may voluntarily report observed device malfunctions or adverse events via the FDA MedWatch program (http://www.fda.gov/medwatch). The FDA annually receives more than 100,000 device–related adverse–event reports, some of which involve pacemakers or ICDs.17 Calculation of device failure rates is hampered by the absence of data regarding the number of patients implanted with a given device.18 The FDA, therefore, requires more thorough monitoring of postmarket performance by manufacturers for selected devices, including pacemakers and ICDs.8 These pacemaker and ICD annual reports offer the unique opportunity not only to count malfunctions but also to determine trends in device reliability as reported in this investigation.

Because ICDs are substantially more sophisticated than pacemakers, it is not surprising that they have a higher device malfunction replacement rate. The specific types of malfunctions observed most often in ICDs (battery, capacitor, charge-circuit, and electrical abnormalities) are unique, critical features of the device. After an improving ICD malfunction replacement rate during the first half of the 1990s, the number and rate of ICD replacements due to device malfunction increased. During this latter period, ICDs shrank in size, maintained their high energy output, and provided more therapeutic features (such as the addition of dual-chamber pacing). The decrease in size, in particular, has necessitated modifications to battery, capacitor, and circuitry design that appear to account for some of the observed malfunctions.1 In contrast to ICDs, the pacemaker malfunction replacement rate declined during the study period. While pacemakers also have evolved and become increasingly sophisticated, they are a “mature” technology.19 As such, they did not undergo the same degree of integral component modification during the study period that ICDs underwent.

After initial marketing approval, data supporting proposed pacemaker or ICD design changes must be submitted by the manufacturer to the FDA Office of Device Evaluation prior to marketing the modified device. Applications for a battery change, for example, may be accompanied by “bench testing” describing the behavior of the battery under “rapid depletion” conditions to model anticipated battery behavior over the lifetime of the device. Firmware or software changes may be accompanied by testing that simulates conditions of clinical use. These testing scenarios have their limitations, particularly as they cannot possibly duplicate every combination of conditions that may be encountered clinically. Manufacturer bench testing may need to be improved to better identify design flaws in the premarket phase of device evaluation and to better predict actual device clinical behavior. In addition, the quality system procedures implemented by ICD manufacturers, such as purchasing controls for suppliers, production and processing controls, or corrective and preventive action procedures, may need to be strengthened.

The clinical implications of pacemaker and ICD malfunctions are substantial. The malfunctions reported in this study resulted in thousands of device explantations and replacements, although the risks of generator replacement are relatively low (small risk of bleeding, infection, etc).20 Additionally, 61 deaths were observed during the study to be directly due to device malfunction, although it is likely that additional unwitnessed deaths were also due to device failure.1 Because this study only counted actual device malfunctions, explantations due to device advisory (ie, the potential for malfunction) were not included and may account for a substantial number of additional explants.1

Routine device checks at regular intervals remain the best way for physicians to monitor ongoing device performance in individual patients.8 Technological advances that allow for remote wireless monitoring or monitoring via the Internet may become increasingly important. Despite this newly recognized increase in ICD malfunction replacement rate, ICDs effectively reduce mortality in specific high-risk populations.8,11,12 These devices have prevented innumerable sudden deaths, and they remain an important therapy for patients at high risk for sudden cardiac death.

Limitations

There are several limitations to this study. Calculation of device malfunction replacement rates assumed that living patients undergoing device removal due to malfunction would receive a new device. The duration of implant of the failed device (ie, the time to failure) was not known, although only implanted devices were counted (because devices that failed prior to implantation were not counted). The observed increase in ICD malfunction replacement rate during the latter half of the study could be due to an increased rate of reporting of ICD malfunctions, a lower threshold to replace a malfunctioning ICD, or a true increase in the ICD malfunction rate.

Device malfunction reporting to the FDA may be subject to underreporting. This investigation studied only malfunctions significant enough to warrant device replacement. Because these replacements typically occur under a manufacturer’s warranty, because the
defective device must be returned to the manufacturer to receive warranty consideration, and because the manufacturer must report these abnormalities to the FDA, ICD and pacemaker generators replaced due to malfunction may be less susceptible to underreporting. Similarly, a lower threshold to replace and/or report a defective ICD compared with that for a defective pacemaker could account for the higher observed ICD malfunction replacement rate. Sensitivity analysis, however, demonstrated that the observed trends in pacemaker and ICD performance were relatively insensitive to changes in malfunction reporting rates and changes in physician practice. Indeed, a meta-analysis of pacemaker and ICD registries (not subject to underreporting) demonstrated trends in device performance similar to those reported here.21 Finally, because fewer than 12,000 cardiac resynchronization therapy devices were implanted during this study period, reliable estimates of malfunction replacement rates for such devices could not be performed.

CONCLUSIONS

While pacemakers and ICDs are generally safe and effective devices that have saved many lives, this study demonstrates several important findings: (1) thousands of patients have been affected by pacemaker and ICD malfunctions, (2) the pacemaker malfunction replacement rate has decreased, (3) the ICD malfunction replacement rate increased during the latter half of the study period, and (4) the ICD malfunction replacement rate is significantly higher than that for pacemakers. Careful monitoring of device performance is still required. The clinical community must continue to report adverse events in a timely manner, and strategies should be developed to increase the proportion of defective devices that are returned for manufacturer analysis.

Author Contributions: Dr Maisel had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Maisel.

Acquisition of data: Maisel.

Analysis and interpretation of data: Maisel, Moynahan, Zuckenman, Gross, Tovar, Tillman, Schultz.

Drafting of the manuscript: Maisel.

Critical revision of the manuscript for important intellectual content: Maisel, Moynahan, Zuckenman, Gross, Tovar, Tillman, Schultz.

Statistical analysis: Maisel.

Obtained funding: Maisel.

Administrative, technical, or material support: Maisel, Moynahan, Zuckenman, Gross, Tovar, Tillman, Schultz.

Study supervision: Maisel.

Financial Disclosures: Dr Maisel is a paid consultant for the US Food and Drug Administration (FDA).

Funding/Support: The study was funded by the FDA.

Role of the Sponsor: FDA employees participated in the design and conduct of the study, the collection, management, analysis, and interpretation of the data, and the preparation and critical review of the manuscript.

Disclaimer: Dr Maisel is the Chair of the FDA Circulatory System Medical Devices Advisory Panel and was a special government employee while conducting the study.

REFERENCES


