Supplementary Materials

The following supporting figure can be downloaded at the journal website (as a separate supplementary file) and is reproduced here for review. Supplementary Figure S1 gathers the diagnostic, clinical, risk and management profile of clinically recognized perforation, a population distinct from the asymptomatic CT findings that form the core of this review.

Figure S1. Diagnostic, clinical, risk, and management profile of CIED lead perforation

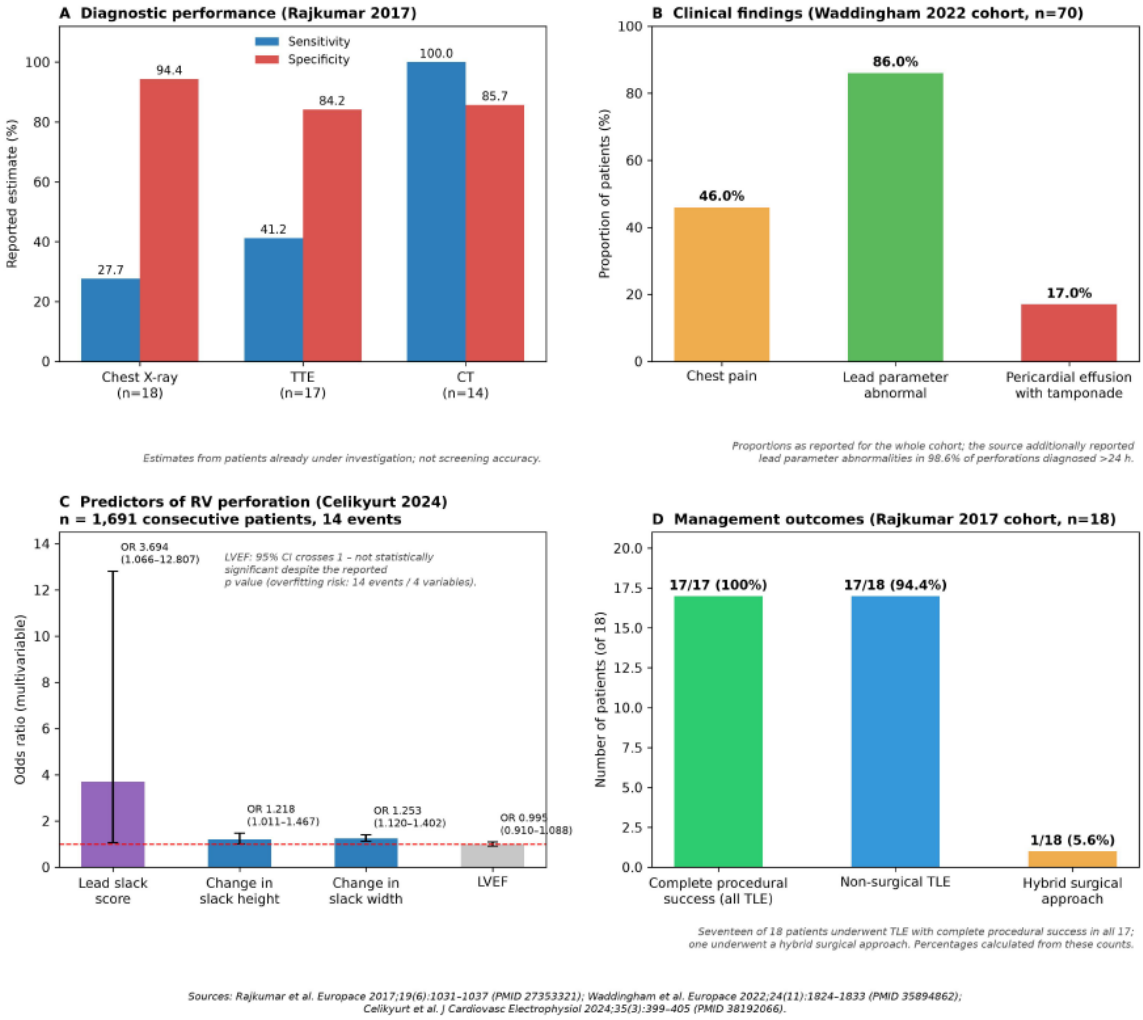


Figure S1. Diagnostic, clinical, risk and management profile of clinically recognized CIED lead perforation.b(A) Reported sensitivity and specificity of chest radiography, transthoracic echocardiography (TTE) and CT in the diagnostic evaluation of the Rajkumar cohort [24]; the patients were already under investigation for suspected perforation, so these are not accuracy estimates for screening asymptomatic recipients. (B) Clinical findings in the Waddingham cohort (n = 70) [3], reported for the cohort as a whole. (C) Independent multivariable predictors of right ventricular perforation in the Celikyurt cohort (1,691 consecutive patients, 14 events) [29]; the left ventricular ejection fraction interval crosses 1 despite the reported p value of 0.032, and the

model is prone to overfitting. (D) Management of the 18 recognized cases in the Rajkumar cohort: 17 underwent transvenous lead extraction (TLE), with complete procedural success in all 17, and one a hybrid surgical approach; percentages are calculated from these counts. Sources: Rajkumar et al., Europace 2017;19(6):1031–1037; Waddingham et al., Europace 2022;24(11):1824–1833; Celikyurt et al., J Cardiovasc. Electrophysiol 2024;35(3):399–405.