Abstract 0163 – Table: Table Long-term anticoagulation therapy management

<table>
<thead>
<tr>
<th></th>
<th>A GROUP (N=74)</th>
<th>B GROUP (N=63)</th>
<th>C GROUP (N=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES (N [%])</td>
<td>NO (N [%])</td>
<td>YES (N [%])</td>
</tr>
<tr>
<td>TAC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES (N [%])</td>
<td>14 (18.9)</td>
<td>11 (14.9)</td>
<td>29 (46)</td>
</tr>
<tr>
<td>NO (N [%])</td>
<td>2 (2.7)</td>
<td>43 (58.1)</td>
<td>3 (4.8)</td>
</tr>
<tr>
<td>LTFUP (N [%])</td>
<td>4 (5.4)</td>
<td>4 (6.4)</td>
<td>2 (11.8)</td>
</tr>
</tbody>
</table>

AF: Atrial fibrillation; ACT: anticoagulant therapy; LTFUP: lost to follow up patient

Aims Assessment of long-term ACT after AFL RFA according to associated atrial fibrillation (AF) and CHA2DS2VASC score.

Methods From January 2012 to December 2013, patients who underwent RFA of cavitricuspid isthmus for typical atrial flutter in our centre were retrospectively included.

Results Of 166 patients (137 men, mean age: 66.7±10 years), 61 (36.7%) had a history of AF. The mean CHA2DS2VASC score was 2.49. The patients were classified according to theoretical indication of LT ACT (patients with a non-rhythmic ACT indication excluded – N=12; 7.2%): group A (LT ACT unclear) included patients with CHA2DS2VASC score ≥ 1, successful RF ablation and without ACT history (N=74); group B (LT ACT indicated) included patients with CHA2DS2VASC score ≥ 1, AF history and/or failed AFL RFA (N=63); group C (LT ACT not indicated/included patient with CHA2DS2VASC score=0 (N=17)). During a mean follow up of 489±244 days, 45 (60.8), 10 (15.9%) and 11 (64.7) patients stopped ACT respectively in group A, B and C differently according to AF onset (table). There were 8 (4.8%) hemorrhagic and 2 (1.2%) ischemic complications, all in patients with correct ACT management. The prevalence of AF during follow-up was 38%.

Conclusion After successful AFL RF ablation, ACT was frequently stopped in the absence of associated AF. However, AF was frequent even in patients with no AF history. Ischemic and hemorrhagic complications were rare. ACT should be regularly evaluated during follow-up especially according to CHA2DS2VASC score and new onset of AF.

The author hereby declares no conflict of interest

0081

Percutaneous left appendage closure: real life outcomes and mid-term results during initial experience in a dedicated electrophysiology team

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Purpose Percutaneous left atrial appendage closure (LAAC) is accepted as a valuable solution for patients (pts) with atrial fibrillation (AF) and high thromboembolic risk in case of contra-indication to oral anticoagulation (OAC). Little is known about mid-term results in the real life setting.

Methods We analyzed mid-term results in a dedicated EP team (2 experienced electrophysiologists [AF ablation ≥200 per yr], 1 echographist, 1 anesthesiologist). All indications were discussed before the procedure in a multidisciplinary approach.

Procedures were done under general anesthesia in a dedicated EP room with in-hospital cardiac surgery facilities. All LAAC procedures were performed with Watchman devices (Boston Scientific).

Results 50 pts were enrolled (male 76%, 77±6 years, paroxysmal AF 44%, permanent 54%). The CHADS2 VASC average score was 4.6±1.3; ≥4: 76%, HASBLED score was 3.7±1; ≥4: 64%. All indications were definitive contra-indications for OAC due to hemorrhagic events (neurological 75%, gastrointestinal 13%, ENT 3%, other 4%). The CT-scan ruled out any thrombus before the procedure for all pts with a perioperative TEE confirmation. Success rate of implantation was 100% (time of procedure 50±10 min, scopy time 8±3 min).

There were no perioperative complications.

Postoperative therapy was: antiagregation 31%, double antiagregation 37%, anticoagulation 18%, none 3%. After 2 months, and TEE control, the initial treatment was switched to: antiagregation 50%, double antiagregation 10%, anticoagulation 10%, none 30%. Mid-term complications were: no severe hemorrhagic events; non severe hemorrhagic stroke N=1, TIA due to carotid stenosis N=1. There were no other adverse events during 7.4±5 months follow-up.

Conclusion In a single center with large experience in EP, LAAC was performed with a very low rate of complications and excellent mid-term results regarding recurrences of thromboembolic and hemorrhagic events.

The author hereby declares no conflict of interest

0338

Computed tomography evaluation of the anatomical variation of the pulmonary veins in atrial fibrillation

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Introduction The electrophysiological and anatomical properties of the pulmonary veins (PVs) have been focused on since their crucial role in triggering or generating atrial fibrillation (AF) was first revealed. The presence of four distinct pulmonary veins (two left PVs and two right PVs) has been described as the normal variant.

Aim The purpose of our study was to describe the anatomy of the pulmonary veins in a cohort of patients of our country followed for AF.

Methods and results Our study is a prospective study which has included 38 patients followed for AF in the cardiology’s department of our Hospital. All patients underwent a CT scan of PVs in order to characterize their anatomy. PVs’ size was represented by the largest diameter.

Our patients had a mean age of 50.5±13 years. The majority of our patients had paroxysmal AF (65.8%), 4 had persistent AF (10.5%), 9 had prolonged persistent AF (24%). AF occurred in 63.6% of cases in healthy heart and 36.4% in pathological heart, 13 patients had an anatomical variant which represent 34.2% of the population. We had 3.9 PVs in average with a minimum of 3 and a maximum of 5 PVs. The average diameter of different PV was 23.4±9.31mm for the left PVs and 19.75±7mm for the right PVs. 7 patients (18.4%) had anatomical variants, 17 patients had single ostium forming a core collector left in all cases.

Concerning the right pulmonary veins, anatomical variations were found in 15.8% of cases, one patient (2.65%) had a single ostium forming a core right collector and 5 patients (13.5%) had 3 ostia (presence of 1 middle pulmonary veins on the right).

Conclusion Cardiac CT is a non invasive procedure which can provide a detailed evaluation of the anatomy of the pulmonary veins. The presence of anatomical variations is common in patients with AF. This assessment is recommended to ensure success of the ablation procedure.

The author hereby declares no conflict of interest