Abstract 0463 – Figure: Characteristics of the population

<table>
<thead>
<tr>
<th></th>
<th>1st CB(n=106) N (%)</th>
<th>2nd GB(n=106) N (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>58±11</td>
<td>57±9</td>
<td>0.46</td>
</tr>
<tr>
<td>Gender (male)</td>
<td>64 (60%)</td>
<td>79 (75%)</td>
<td>0.03</td>
</tr>
<tr>
<td>AF history (years)</td>
<td>4.2±3</td>
<td>3.8±3</td>
<td>0.34</td>
</tr>
<tr>
<td>Enlarged LA</td>
<td>50 (47%)</td>
<td>54 (52%)</td>
<td>0.45</td>
</tr>
<tr>
<td>Complete PVI during the first procedure</td>
<td>97 (92%)</td>
<td>106 (100%)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Phrenic nerve palsy</td>
<td>4 (4%)</td>
<td>5 (5%)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Asymptomatic patients at 1year</td>
<td>53 (50%)</td>
<td>81 (76%)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Documented AF recurrence</td>
<td>47 (43%)</td>
<td>10 (9%)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Redo procedure</td>
<td>41 (37%)</td>
<td>10 (9.4%)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

0029

Redo-ablations of atrial fibrillation: procedural characteristics depending on the choice of cryoenergy or radiofrequency ablation as the first line therapy

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Introduction Pulmonary vein (PV) isolation has become a cornerstone therapy for symptomatic paroxysmal AF refractory to anti-arrhythmic drugs. Nowadays, the most common energies used to achieve PV isolation are cryoenergy and radiofrequency (RF). However, approximately one third of the patients have recurrences, mainly due to PV reconnections.

Little is known about the characteristics of the redo procedure, depending on the choice of the initial energy.

Methods Patients referred to our center for a RF redo ablation procedure of symptomatic paroxysmal AF refractory to anti-arrhythmic drugs, were collected. Number and location of PV gaps, and redo characteristics were reviewed.

Results 74 patients scheduled for a redo ablation of AF were included, 38 and 36 using RF or cryoablation for the first procedure, respectively. For the initial ablation, procedural and fluoroscopy times were significantly shorter when using cryoenergy (147.8±52.6 vs. 226.6±64.3 min, p<0.001, and 954.1±796.7 vs. 1476.7±1269.6, p=NS), respectively.

Conclusions During redo procedures, gaps location pattern is different for patients first ablated with cryo or RF energy, and RSPV reconnections occur more frequently after RF ablation, probably due to poor contact in this region. Procedural characteristics of the redo ablation are similar.

Keywords atrial fibrillation; ablation; cryoablation; radiofrequency; redo

The author hereby declares no conflict of interest

0299

De novo atrial fibrillation in the acute coronary syndrome

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Introduction De novo atrial fibrillation (AF) is common in the acute coronary syndrome (ACS), but most patients (P) are discharged in sinus rhythm (SR). The recurrence of arrhythmia in follow-up (FU) remains unknown and its undervaluation may have prognostic impact.

Aim To characterize a population with ACS and de novo AF and determine its prognostic impact.

To evaluate the recurrence of AF and the incidence of ischemic stroke/systemic embolism in FU.

Methods We analyzed 2383 P consecutively admitted with ACS and with a minimum of 180 days FU.

De novo AF has been defined as AF first detected on admission or during hospitalization.

Results It has been observed de novo AF in 199 P (8.4%), the majority being male (70.4%). These patients were significantly older (p<0.001) and had higher HTA prevalence (p<0.001).

The echocardiographic evaluation showed a higher prevalence of mitral insufficiency (p<0.001) and left ventricular ejection fraction <40% (p<0.001). These P developed more frequently heart failure (p<0.001) and stroke (p<0.001) during hospitalization.
The in-hospital mortality (9.5% vs 3.3%, p<0.001) and at 6 months (15.6% vs 6.6%, p<0.001) were also higher, however, the presence of de novo AF was not an independent predictor of these events. Most P were discharged in SR (n=134) and without anticoagulant therapy (n=117).

Conclusion The presence of de novo AF was associated with increased risk of adverse events, although it may constitute only a marker of severity. We observed recurrence of AF in a considerable sample, which denotes the need for appropriate evaluation of thromboembolic risk of these P.

The author hereby declares no conflict of interest

January 16th, Saturday 2016

0523

Right ventricular dysfunction and epsilon wave: new predicting factors of recurrence of VT after radiofrequency catheter ablation in arrhythmogenic right ventricular dysplasia/cardiomyopathy

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Background Radiofrequency catheter ablation (RFCA) is increasingly used in the management of ventricular tachycardia (VT) in arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVC/D) but it is associated with a high level of recurrences.

Objective To determine predictors associated with VT recurrence after RFCA in ARVC/D.

Methods This study included 85 consecutive patients referred to the Pitié Salpêtrière Hospital (Paris, France) who underwent a total of 149 RFCA procedures between 2000 and 2010. Predictors of recurrence of VT following RFCA were assessed by Cox regression.

Results The mean age of the cohort was 36±13 years, 74 (87.1%) were men and 80 (95.2%) were proband. 70 (83.3%) experienced spontaneous VT before diagnosis. 30 (58.8%) patients required ≥2 procedures. In 13 (10.7%) patients, RFCA was performed through epicardial access. Over a mean follow-up of 11±4.60 months, the overall freedom from VT of the 149 procedures was 79%, and 56%, at 1 and 5 years, respectively. The presence of an epsilon wave and of right ventricular (RV) dysfunction (defined by RV angiography ejection fraction <40% or right area fractional change <35% by TTE) were associated with higher level of recurrences on multivariate analysis. The cumulative freedom from VT (Figure) in patients without RV dysfunction nor epsilon wave was 86% at 1 and 5 years, which was significantly longer than those without (76% and 47% respectively, P=0.003).

Conclusion Absence of RV dysfunction or of an epsilon wave are strongly associated with higher success after VT RFA in ARVC/D. Patients without those risk factors should therefore be considered as good candidates for VT ablation.

The author hereby declares no conflict of interest

0376

Early and late atrial arrhythmias after lung transplantation: incidence, predictive factors and impact on mortality

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Background Atrial arrhythmias (AA) are observed frequently early after lung transplant and also late after the surgery. Several predictive factors of post-operative AA after lung transplant have been already identified whereas those of late AA are still not known. Whether AA after lung transplant impacts mortality and the optimal strategy of rhythm management are still debated.

The Purpose of the study was to assess in a large cohort of lung transplanted patients the incidence of AA early and late after surgery, their predictive factors and their impact on mortality.

Methods and results We included 271 consecutive patients single or double lung-transplanted over a 9-years period in a large French center. We collected baseline clinical, surgery and post-operative data. The follow-up was 2.9±2.4 years. 33% patients developed post-operative AA. Age (HR=2.35; CI [1.31-4.24]) and chronic obstructive pulmonary disease (HR=1.028; CI [1.12-4.03]) were independent predictive factors of post-operative AA. Late AA occurred 2.2±2.7 years after transplant in 8.8% of the patients. Systolic pulmonary arterial pressure was the only independent predictive factor of late AA (HR=1.028; CI [1.001; 1.056]). Double lung transplant was associated with long term freedom from AF compared with single transplant (p=0.05) whereas the Kaplan-Meier curve for the development of late atrial flutter was similar in single and double lung transplant. Early and late AA after surgery showed no impact on mortality. Bilateral lung transplant was associated with a better survival.

Conclusion Post-operative AA after lung transplantation are common with good outcome and contrast with the low occurrence of late organized AA. Early and late AA after transplantation have been already identified whereas those of late AA are still not known. Whether AA after lung transplant impacts mortality and the optimal strategy of rhythm management are still debated.

The author hereby declares no conflict of interest