ever, the syncope group had a higher average score for somatization disorder (18.53 vs. 13.66, \( P = 0.002 \)). Binary logistic regression model was measured after grouping the cohort into above and below median scores. After adjusting for age, gender, and chronic illnesses, the association between syncope and somatization disorder remained significant (\( OR = 3.75, CI: 1.72, 8.15, P = 0.001 \)). Despite no statistical significance, when looking at the effect size, having an anxiety score above the median was 52% higher in cases compared to controls (\( OR = 1.52, CI: 0.74, 3.14, P = 0.255 \)). A sub-analysis of the case group was applied and showed that patients who had multiple syncopal attacks (6 or more) had higher average scores of depression, anxiety, phobia and somatization disorder compared to those who had less than 6 attacks (Table). Patients with vasovagal or US have similar incidence of depression, anxiety or phobia symptoms and higher incidence of somatization symptoms compared to control subjects. However, recurrent and more frequent attacks of syncope was predictive of more deteriorative psychological profile for all four domains. Our findings should prompt motivation to study the effectiveness of psychological intervention in patients with recurrent syncope.

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12. Physicians' knowledge and attitudes in Saudi Arabia regarding implantable cardioverter-defibrillators and cardiac resynchronization therapy

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Information is limited regarding the knowledge and attitudes of physicians in Saudi Arabia involved in the referral of patients for implantable cardioverter-defibrillator (ICD) and cardiac resynchronization and defibrillation therapy (CRT-D) devices implantation. As such knowledge is the key to provide the patient with an important treatment, we aimed for its assessment. We conducted personal interviews with physicians involved in treating patients with heart failure. We included all hospitals in Riyadh region that has no cardiac electrophysiology service. Every participant was met in person and received an oral questionnaire that aimed to assess basic knowledge about ICD and CRT. 63 physicians were met from 13 hospitals (14 consultants and 49 specialist). 41% of participants use \( \leq \text{35\%} \) as the LVEF criterion for ICD referral in patients with cardiomyopathy. 30% of participants use \( \leq \text{35\%} \) as the LVEF criterion for CRT referral. 24% of participants were not aware about CRT as a therapy for patients with heart failure. 50% of the consultants use \( \leq \text{35\%} \) for ICD and CRT referral. 70% of the participants think that ICD may improve heart failure symptoms. 45% of participants who were about CRT do not think that CRT-D may prevent sudden death due to arrhythmia. There is a lack of knowledge with current clinical guidelines regarding ICD and CRT implantation. This finding highlights the need to improve the dissemination of guidelines to practitioners involved in managing patients with heart failure in an effort to improve ICD and CRT utilization.

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13. Device therapy in secondary hospital (without a cath lab): Feasibility, logistics and outcome

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Device therapy for conduction abnormalities, heart failure, primary or secondary SCD preventions is under delivered to requiring patients. Most of these devices are implanted at tertiary care centers in major cities of most countries. This makes the availability of these guideline guided therapies to a very small percentage of needy patients. Implant of such devices at a secondary hospital (without a cardiac cath lab) with training of previously novice hospital staff and available resources as well as support of the industry is an alternative and very viable option to have such important therapy delivered to requiring patients. The usage of simple-readily available-C-arm in operating theatre (OR) or the interventional radiology suite can be utilized for this purpose. OR nursing staff and radiology technicians can be trained –with help of nursing education department– to help in such procedures over a relatively short period. Technical support utilized from the vendors representatives is an alternative to face the lack of EP technicians in local or international market. The follow up of these patients in OPD can be organized with help of the vendors on regular basis under supervision of trained cardiologist/s. This model can help establish device therapy service at a secondary hospital without huge expenditure on infrastructure or facing the lack of recruitment of specialized technical support that is difficult to find –especially for smaller cities–. We present our experience at a 250 bed secondary hospital, with a relatively small cardiac unit (3 consultants, 5 hospitalists, 10 cardiac ECG/Echo techs) and no cath lab of introduction of this service with the help of nursing education department and vendors supplying these devices as well as OR and radiology departments. Training of radiology technicians and OR nursing staff on the basic procedural support with few in-service demonstration helped prepare adequate staff helping during implant procedures. Requirement of technical support from the vendor –as a condition for purchase of devices– during the implant and follow up clinics helped overcome the lack of EP technicians. After implant of more than 100 different devices (pacemakers, AICD and BiV-AICD) the process became much...