*Results:*

| | Lived | Died | No shock | Shock |
|---|---|---|---|---|
| Induced at RV Apex | 75% | 73% | 83% | 71% |
| Induced by S2/S2S3 | 48% | 30% | 29% | 52%* |
| Drive cycle (ms) | 460 ± 87 | 433 ± 83 | 421 ± 97 | 474 ± 82* |
| Monomorphic VT | 86% | 84% | 88% | 81% |
| RBBB morphology | 81% | 76% | 39% | 71%* |
| Superior Axis | 55% | 46% | 60% | 47% |
| SBP in VT (mmHg) | 42 ± 35 | 44 ± 33 | 38 ± 39 | 49 ± 34 |
| VT cycle length (ms) | 268 ± 49 | 264 ± 47 | 264 ± 40 | 251 ± 48 |
| Spont. termination | 9% | 11% | 10% | 13% |

(* denotes $p < 0.05$)

*Conclusions:* In this high-risk population EPS variables do not predict cardiac death; however, ease of inducibility (longer drive cycle length and 1–2 extrastimuli) of VT and a RBBB morphology of the induced VT was associated with ICD shock(s) on follow-up.

## 1073-175 Long-term Survival in the Antiarrhythmics Versus Implantable Defibrillators (AVID) Registry

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*Background:* AVID was a randomized trial comparing treatment with implantable defibrillators vs antiarrhythmic drugs in pts with life-threatening ventricular arrhythmias (VA). AVID also maintained a Registry on all pts with any sustained VA or unexplained syncope (arrhythmia types A-G) amenable to a treatment choice as well as those VA (types A-C) also eligible for the trial. The AVID Registry thus included both randomized pts and those excluded from the main trial for any reason.

*Methods:* Of 6063 pts were screened, 4623 were registered, and 1016 were randomized. To compare mortality risk among VA types, follow-up was obtained on 2953 Registry pts using the National Death Index determination of vital status as of December, 1995.

*Results:* Mortality rates by VA type, at a mean follow-up of 11.7 ± 8.6 (SD) mos, were:

| Arrhythmia Type | N | Deaths[1] |
|---|---|---|
| (A): VF cardiac arrest | 948[2] | 132 (14%) |
| (B): Syncopal VT | 399[2] | 65 (16%) |
| (C): Symptomatic VT (EF ≤ 0.40) | 586[2] | 76 (13%) |
| (D): Symptomatic VT (EFT 0.40) | 158 | 9 (6%) |
| (E): Asymptomatic VT | 373 | 50 (13%) |
| (F): VT-VF (transient/correctable) | 216 | 29 (13%) |
| (G): Unexplained syncope & inducible VT | 273 | 25 (9%) |

Global log-rank p = 0.0167; [1]crude death rates, [2]randomized and registry pts.; VT, VF = ventricular tachycardia, fibrillation; EF = ejection fraction

*Conclusion:* Mortality in pts with serious VAs is high. "Lower risk" VAs (asymptomatic VT and VT/VF with correctable cause) have a similar mortality as "higher risk", AVID eligible VAs. Only those with VT and preserved EF (group D) showed a better prognosis.

## 1073-176 Dofetilide: A New Class III Antiarrhythmic Drug Which Is Safe in Patients With Congestive Heart Failure

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*Background:* Arrhythmias are common in patients with congestive heart failure (CHF) but available antiarrhythmic drugs have severe side effects or the safety is questionable.

*Methods:* In 34 Danish coronary care units 5548 consecutive patients admitted with newly developed or worsening congestive heart failure were screened and left ventricular function was assessed using echocardiography. Left ventricular dysfunction (wall motion index ≤1.2 corresponding to a left ventricular ejection fraction ≤0.35) was found in 2552 patients, and of these 1518 gave informed consent and were randomised to receive dofetilide or placebo. Dofetilide was dosed between 0.25 mg and 1 mg daily depending on renal function and presence of atrial fibrillation. All patients were monitored with continuous telemetry for the initial 3 days of the study. The primary end point was all cause mortality and minimum follow up was 1 year.

*Results:* In the dofetilide group 311/762, 41% died and in the placebo group 317/756, 42%. The overall risk reduction on dofetilide was 0.95 (95% confidence limits 0.81–1.11, p = 0.56). At one year there was a 1.7% lower mortality on dofetilide with 95% confidence limits of ± 4%

*Conclusions:* These results demonstrate that treatment with dofetilide in CHF patients with left ventricular dysfunction was neutral with respect to all cause mortality compared to placebo.

## 1073-177 Treatment of Dysrhythmias After CABG-Surgery With the Amiodarone-derivative E 047/1

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*Background:* Dysryhthmias may jeopardize patients immediately after CABG-surgery. The therapeutic regimen, however, is under discussion and the search for an ideal drug is continuing. Experimentally, the amiodarone-derivative E047/1, with a half life of 6 hrs, reduced ventricular ectopies, markedly suppressed VF and did not influence conduction and hemodynamics. This phase II study of E047/1 investigated tolerability and efficacy in the treatment of postoperative dysrhythmias.

*Patients and Methods:* After approval by the Ethics Committee and written consent, 20 CABG-patients (mean ± SD 66 ± 5 yrs, 78 ± 11 kg) with postoperative atrial fibrillation and/or significant ventricular ectopies (PVC's > 5/min, couplets, triplets, VT), EF > 40%, plasma levels of K+ > 3.5 and Mg++ > 0.8 mmol were included in a prospective study. E047/1 was administered by bolus (1 mg/kg for 10 min) and continuous infusion (1 mg/kg/hr for 2 hrs). In addition to standard monitoring, dysrhythmias were recorded continuously (CER Patient Monitor, Hewlett Packard). Using thermodilution technique, hemodynamics and derived parameters were determined before, 10, 20, 30, 60 and 120 min. after drug initiation. ECG tracings were analyzed by a blinded investigator. Friedman's ANOVA was used for statistics. P < 0.01 was accepted as significant.

*Results:* In 17 patients with ventricular ectopies, E 047/1 induced a 55% reduction of dysrhythmias after 15 min. increasing to a 93% reduction after 60 min. Heart rate (93 ± 11 bpm), PQ- (158 ± 22 ms), QT-intervals (379 ± 33 ms) and hemodynamics did not change from baseline. Atrial fibrillation was converted to SA rhythm in 2 of 7 patients. No adverse reactions occurred.

*Conclusions:* E 047/1 appears to be a safe, effective and rapid acting drug for postoperative ventricular dysrhythmias.

## 1073-178 Is Induction of Very Rapid Sustained VT Significant in Patients With Syncope?

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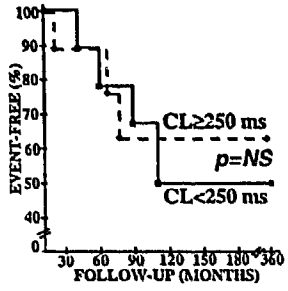
ICD implantation has become accepted therapy (Rx) for pts with syncope and inducible ventricular arrhythmias who do not have clinically documented VT. It is not known, however, whether the cycle length (CL) of induced VT at EPS is an important prognostic determinant in this population. Specifically, the prognostic significance of very rapid monomorphic VT (<250 ms), which can be considered a non-specific response to the stimulation protocol, is unknown in pts without documented VT. We evaluated 25 consecutive pts (21 M, age 67 ± 11 years, EF 29 ± 11%) who received an ICD for syncope and inducible sustained VT. Pts were followed until their first arrhythmic event requiring ICD Rx. F/u was available in 21 pts; of the 4 pts lost to f/u, 3 died of unknown cause before their first ICD interrogation. 9 pts had VT or VF requiring appropriate ICD Rx. The 30, 90, and 360 day probability of requiring ICD Rx was 22%, 42% and 54%. Pts with induced VT <250 ms (n = 10) and ≥250 ms (n = 11) had a similar likelihood of events.




*Conclusions:* Pts with ICDs for syncope have a significant incidence of arrhythmic events requiring ICD Rx. Pts are likely to have events irrespective of the cycle length of induced VT. Very rapid monomorphic VT induced during EPS should not be considered a non-specific finding; aggressive Rx is warranted in these pts with syncope.