

prompt motivation for larger and well controlled cohort studies.

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10. Effect of pacemaker/defibrillator lead extraction on pulmonary artery systolic pressure

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As the number of cardiac device implantations are on a rise, there is a parallel increase in their long-term complications including device-related infection that will require lead extraction. As the detachment of fibrosed debris reaching the pulmonary trunk can occur during the extraction, the risk of developing new-onset Pulmonary Hypertension (P. HTN) increases with every extraction. Yet, there is paucity of evidence to support such claim. Given the clinical significance of such findings, we sought to determine the risk. A chart review of 113 patients whom underwent lead extraction at Prince Sultan Cardiac Center in Saudi Arabia during the period of Jan, 2002 to Jul, 2015 was carried out. Six patients had lead extraction twice, making the total number of extractions to be 119. Of this study cohort, only 45 cases had Pulmonary Artery Systolic Pressure (PASP) measurement via Transthoracic Echocardiography (TTE) prior to and after device extraction. PASP measurements were obtained as reported whether a single measurement or a range between two readings, and an average was calculated in case of two readings. A difference of 10 mmHg or more in the PASP, whether progression or improvement, was considered clinically significant. Median follow up of TTE after lead and device extraction was 5 months. Out of 45 patients, 31 (68.9%) were males and 14 (31.1%) were females. Average age was 46.5 (SD = 17) years. Eleven patients (24.4%) experienced a significant increase of PASP after lead extraction (10 had normal pressure readings before extraction, and only one had progression to a more severe form of the disease), 9 patients (20.0%) showed improvement, and the remaining (55.6%) did not show any significant change in PASP. Average implantation-to-extraction duration of the leads was higher among those who had no pressure difference (50.6 vs. 23.3 months). When looking through potential predictors that may increase the likelihood of developing P. HTN, there was no association with a pre-existing lead-attached vegetation (2 patients only), nor the type of lead (6 high-voltage vs. 5 pacing leads across the tricuspid valve). In patients who developed P. HTN, 8 (72.7%) had their devices extracted as a result of a complicated infection (wound infections and/or infective endocarditis), as opposed to 3 (27.3%) whom underwent device extraction for other indications. Our

simple descriptive study showed that the risk of developing P. HTN following lead and device extraction is negligible. However, our findings should be interpreted in the light of the limitations such as a small sample size and lack of comparable control group. Paucity of data and evidence on the long-term complications subsequent to device and lead extractions will be a subject of further exploration given the potential connection to patient outcomes and management.

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11. Prevalence of psychiatric symptoms among patients with recurrent vasovagal and unexplained syncope

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Syncope is defined as a transient loss of consciousness and absence of postural tone followed by spontaneous recovery. Neurally mediated syncope (vasovagal) and idiopathic unexplained syncope (US) are the most common causes of syncope. Syncope is a very limiting disease that, if recurrent, affects the patients' physical and psychological health. Our objective from this study is to measure the prevalence of psychiatric symptoms among patients with US. All patients (>12 years) with vasovagal or US who were evaluated in King Khalid University Hospital were identified. Echocardiography and table tilt test reports were reviewed and patients who had cardiac syncope (due to arrhythmia or structural heart disease) were excluded ($N = 18$). Ninety-four patients were included for further psychiatric assessment. The patients were contacted to fill the Symptoms Checklist-90-Revised (SCL-90-R), which is a self-reporting questionnaire used to evaluate traits of depression, anxiety, somatization disorder and phobia. SCL-90-R scale has been translated to Arabic and validated in previous studies. Of the included cohort, 43 responded to fill the assessment scale, and 51 were excluded due to failure of communication ($N = 41$) or refusal to participate ($N = 10$). A control group was recruited with a case: control ratio of 1:3 matching for age, gender, and chronic illnesses. There were 43 patients and 129 control subjects, with predominance of females (67.4%) and an average age of 33.8 (SD = 16). There was no difference in average scores of depression (13 vs. 14.53, $P = 0.31$), anxiety (11.3 vs. 10.4, $P = 0.51$), or phobia (5.4 vs. 5.2, $P = 0.88$). How-