In multivariate analysis, lack of palpitations (OR 9.09 [3.45-33.33]), VPB number > 20000 (OR 5.40 [1.98-14.70]), left ventricular origin (OR 4.12 [1.53-11.11]), epicardial location (OR 11.00 [1.92-62.50]), VPB right inferior axis (OR 2.51 [0.85-6.27]), baseline QRS width > 100ms (OR 3.66 [1.28-10.43]), VPB coupling interval > 500ms (OR 3.11 [1.14-8.55]) and polymorphic VPB (OR 10.40 [1.05-103.05]) were independently associated with CM compared to controls (p<0.05).

Over a mean follow-up of 22±20 months, 79% presented with a significant decrease of VPB (> 80% reduction). In these, EF increased (36±9 to 51±12%, p<0.0001) and LVEDD decreased (62±7 to 56±7mm, p<0.0001). Reversal of CM was defined by > 10% increase in EF. Only a VPB > 2mV (OR 19.2 [8.04-45.2], p<0.0001) and LVEDD decreased (62±7 to 56±7mm, p<0.0001) was independantly associated with reversal of CM in multivariate analysis.

Conclusion: Mechanisms leading to PVB-induced CM may involve lack of palpitations, a high VPB number, a left ventricular origin, an epicardial location, a VPB right inferior axis, a large baseline QRS duration, a long VPB coupling interval and polymorphic VPB. Reversal of CM after RF ablation may associate a high VPB amplitude and a shorter VPB coupling interval. This may help in selecting patients for RF ablation of suspected VPB-induced CM.

0395
Prevalence of early repolarization in congenital long QT syndrome. A combination of early and delayed repolarization
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Introduction: early repolarization (ER) in Brugada or short QT syndrome is common and has been associated with a less favourable outcome. Even if apparently paradoxical, ER can also be seen in long QT (LQT) but prevalence and correlations to other variables are unknown.

Methods: ECG of 105 LQT patients (44 men, 36±21 yo) and 269 age and gender matched controls (135 men, 36±18 yo) were reviewed. LQT was diagnosed by a positive genetic testing (n=71) or by showing abnormal T wave and long QT interval spontaneously or during epinephrin infusion in pts without discovered genetic mutation (n=34). ER was defined by > 1mm J point elevation in the inferior or lateral leads with notch or slurring pattern.

Results: QT in lead II was 433±68 msec in LQT patients and 338±41 in controls (p<0.0001) (QTc 446±52 versus 377±30 msec, p<0.0001). Heart rate wq lower in LQT patients (66±14 vs 79±19 bpm) (p<0.0001). Twenty LQT patients presented with resuscitated sudden death or torsades de pointes and 11 with syncope.

33/105 LQT patients (31%) had ER compared to 31/269 (12%) controls (p<0.0001).

ER was more frequent in LQT men (19/44, 43%) compared to women (14/61, 23%) (p=0.03) but was not correlated to age (41±20 yo with ER vs 35±21 bpm, p=0.17).

LQT patients with ER had lower heart rates (61±11 vs 69±15 bpm, p=0.02).

There was a trend toward longer QT in patients with ER (449±73 versus 428±64 msec in lead II, p=0.1) but not for corrected QT intervals (442±48 versus 448±54 msec, p=0.5).

There was more frequent ER in case of HeRG (14/26) than KCNQ1 (6/34) or KCNJ2 (2/10) mutations (p=0.008).

ER in LQT patients was not correlated to symptoms or cardiac events (5/20 patients with SD, 3/11 in patients with syncope and 25/72 asymptomatic LQT) (p=0.6).

Conclusion: ER is very common in LQT patients and is related to the gender and to the heart rate but not to age or to the corrected QT duration. ER is not correlated to cardiac events in this series but may be to HeRG mutations

0555
Arrhythmic risk stratification and prognostic value of programmed ventricular stimulation in arrhythmogenic right ventricular cardio-myopathy/dysplasia
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Background: The role of programmed ventricular stimulation (PVS) in arrhythmic risk stratification is unclear in patients with arrhythmogenic right ventricular cardiomyopathy/dysplasia (ARVC/D).

Objective: To determine clinical factors associated with inducibility of PVS and determine its prognostic value in the overall population and in three risk groups.

Methods: Between 2000 and 2010, 150 consecutive patients systematically benefited PVS at diagnosis. Predictors for PVS inducibility were studied. Risk factors for arrhythmic events were then determined by Cox regression in the entire population and in three risk groups.

Results: VT inducibility was significantly higher for males (p=0.007), symptomatic patients (p=0.001) especially those with syncope (p=0.004), patients who had spontaneous ventricular tachycardia (VT) (p<0.001) and right (p=0.001) or left (p=0.03) ventricular dysfunction.