than in men (10 vs 26%) (<0.001). The frequency of non specific VT (ventricular flutter or fibrillation) was similar in women and men (16 vs 19%). The frequency of negative EPS was higher in women than in men (73 vs 55%) (p<0.001). Syncpe was related to hypervagotonia more frequently in women than in men (15 vs 7%) (p<0.01). Other causes of syncpe were similar in women and men as supraventricular tachycardia (13 vs 14.5%) (NS), AV conduction disturbance (9 vs 8%) (NS), coronary ischemia (9 vs 8%) (NS). Non-invasive and invasive studies remained more frequently negative in women (27%) than in men (16%) (p<0.01). Implantable defibrillator (ICD) was implanted less frequently in women than in men (6 vs 14%) (<p>0.04). The frequency of sudden death (6 vs 5%) and heart failure-related death (9 vs 12%) or heart failure-related death and heart transplantation (10.5 vs 15%) were similar.

Conclusions: Women with heart disease and syncpe had less inducible monomorphic VT than men, had more hypervagotonia and unexplained syncpe than men. However, despite a similar LVEF, their prognosis was similar.

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Incidence and predictive factors of atrio-ventricular block (AVB) after aortic valve replacement (AVR) in elderly patients
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Purpose and methods: AVR by bioprosthesis was performed in 268 consecutive patients (mean age 75±8 years) not previously infected. Incidence of AVB was assessed during post-operative phase and follow-up (F.up). Multivariable analysis was performed to assess predictive factors of AVB.

Results: During post-operative phase AVB occurred in 19 pts (7.1%) and persisted in 12 patients (4.5%) requiring pacemaker (PM) implantation. During F.up (mean 29 months) AVB block requiring PM implantation occurred in 6 patients (2.3%) with a mean delay of 10 months.

In multivariable analysis predictive factors of early AVB were: previous right bundle branch block (p=0.04), and extra corporeal circulation (ECC) time (p=0.04). During F.up predictive factors were pre-operative bundle branch block (p=0.04) and regressive post-operative AVB (p=0.007). Among 7 patients with regressive early AVB, 3 patients experienced recurrent AVB: all have pre-operative bundle branch block; no recurrence was observed in the 4 other patients with sharp QRS.

Conclusions: In this series early AVB after AVR occurred in 7.1% of patients and required PM implantation in 4.5%. During F.up AVB occurred in 6 patients. Predictive factors of AVB were previous right bundle branch block and ECC time for early AVB, previous bundle branch block and regressive early AVB for late AVB. All patients with regressive early AVB and previous bundle branch block have recurrence of AVB in F.up and should be considered for early PM implantation.

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Electrophysiological characteristics in cardiac amyloidosis due to familial amyloid polyneuropathy
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Introduction: Familial amyloid polyneuropathy (FAP) is an autosomic dominant disease induced by the mis-folding of a mutated precursor of Albumin (transthyretin). Cardiopathy due to FAP include myocardial infarction and conduction disturbances.

The Val30Met mutation is the most common. The aim of our study was to compare electrophysiological characteristics of the Val30Met population to other FAP population.

Methods & Results: Data from 121 patients with genetically proven FAP were analysed. Standard ECG, echocardiography and electrophysiological study were performed. Surface ECG was abnormal in 47% (NS). Main results are shown in the following table:

<table>
<thead>
<tr>
<th></th>
<th>Val30Met</th>
<th>other mutations</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>87</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>age</td>
<td>42±13</td>
<td>54±8</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>IVS (mm)</td>
<td>11±3</td>
<td>13±3</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>AH interval (ms)</td>
<td>113±38</td>
<td>94±17</td>
<td>0.007</td>
</tr>
<tr>
<td>Wenckebach point (bpm)</td>
<td>12612±32</td>
<td>154±23</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>HV interval (ms)</td>
<td>60±12</td>
<td>68±16</td>
<td>0.004</td>
</tr>
</tbody>
</table>

HV interval was ≥70 ms in 39% of the patients. In patients carrying other mutations than Val30Met, cardiac infiltration assessed by IVS thickness was correlated with a longer HV interval (R=0.63, P<0.0005). Such association wasn’t found considering Val30Met patients.

Conclusion: Electrophysiological parameters differed significantly in cardiac amyloidosis due to FAP according to the genotype. Amongst patients carrying other mutation than Val30Met, cardiac infiltration and infra nodal block were more common and seemed to be related.

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Anatomical factors involved in difficult cardiac resynchronization therapy procedure: a non-invasive study using dual source 64-multi slice computed tomography
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In cardiac resynchronization therapy (CRT) procedure, left ventricular lead (LV) implantation is time-consuming. In this clinical study, no study has investigated the impact of right atrium anatomical parameters on both CRT implantation procedure duration and X-ray exposure. Additionally, only few studies have examined the coronary sinus (CS) using dual source 64-Multi Slice Computed Tomography (DS 64-MSCT), and its impact on CRT procedure parameters has not yet been investigated.

The aim of this prospective study was to identify local anatomical predictive factors of difficult CRT implantation procedure using DS 64-MSCT.

Between January and July 2010, 50 consecutive patients underwent primo CRT implantation. The patient population had a mean age of 70±10 years with NYHA Class 3.2±0.3 heart failure, LVEF 30±5%, and QRS width 157±30 ms. CRT implantation was attempted in 50 patients, and first LV lead implantation was obtained in 49/50 patients (98%). One implantation (2%) failed due to unsuccessful LV lead implant. Procedure parameters were as follows: median procedure time (skin to skin), 51 min (38 min); median fluoroscopy procedure time, 11.9 min (22 min); median LV fluoroscopic time, 10.3 min (22 min). In 10 patients (20%), procedures were difficult requiring an implantation lasting ≥85 min. The only predictive factor for difficult CRT implantation was the insertion level of the CS ostium (CSO), evaluated by the distance between the CSO and the bottom floor of the right atrium.

Conclusions: Today, despite improvements in the materials used problems still remain in CRT procedure. In this clinical setting, the only predictive factor for very long CRT procedures is the CSO level insertion (located high). This anatomical anomaly is responsible for 20% of difficult CRT device implantation procedures. Taking this anatomical parameter into account as evaluated by DS 64-MSCT prior to surgery may help operators reduce both operating and fluoroscopy times.