Choosing the optimal lead versus the non optimal one (40%) is statistically superior than using the optimal dual left configuration versus the optimal lead only (10%) (sign test p=0.0005).

Conclusions: In patients with dilated left ventricle, adding a second LV lead ensures having the benefit of the best positioned left lead, and dual left configuration adds an additional acute benefit over standard CRT.

237

The management of preexcitation syndrome remains to be improved.

Béatrice Brembilla-Perrot [Orateur] (1), Pierre Yves Zinzius (1), Jean Marc Sellal (1), Clément Tatar (1), Jérôme Schwartz (1), Soumaya Jarrouni (1), Ibrahim Nossier (1), Radou Moisès (1), Daniel Beurrier (1), Anne Moulin-Zinsch (2), Céline Olivier Kauzner (1), Simona Malé (1)

(1) CHU Rangueil, Maladies Cardiovasculaires et Métaboliques, Rythmologie et Cardiostimulation, Toulouse, France – (2) CHU Rangueil, Maladies Cardiovasculaires et Métaboliques, Toulouse, France

Guidelines recommend the electrophysiological evaluation of preexcitation syndrome (PS) and report the indications of accessory pathway (AP) ablation and the use of antiarrhythmic drugs for the treatment of supraventricular tachycardias (SVT). PS-related adverse presentation defined as a documented life-threatening hemodynamically not tolerated arrhythmia, should disappear. The purpose of the study was to evaluate the prevalence of adverse events in patients with known PS and their cause.

Methods: Adverse presentation occurred in 65 patients between 1990 and 2010 among 735 patients aged from 5 to 85 years (34.5±17), consecutively recruited for a PS. Electrophysiological study (EPS) was systematic.

Results: The prevalence of adverse event was 8.5%. It was the first event of the disease in 36 patients who had never ECG recording nor symptoms before malignant arrhythmia (group I); 21 patients had symptoms of tachycardia but no ECG was recorded and PS was unknown (group II). PS was known but was not studied in 6 patients (group III); adverse event occurred after heavy surgery (n=3), after use of calcium inhibitors (n=4) to treat spontaneous SVT and use of salbutamol (n=1). At EPS all group I and II patients but 3, had the criteria of a malignant form of PS (maximal rate through AP>240 bpm in control state, >300 bpm after isoproterenol in AF). In group III only 5 of 8 had the electrophysiological criteria of malignancy. Malignant form at EPS was less frequent in group III than in group I and II (p<0.005).

Conclusions: EPS which should be systematic, because malignant form was generally noted in asymptomatic or symptomatic patients with a PS who presented a poorly-tolerated arrhythmia or a ventricular fibrillation. However the risk can be underestimated in patients who will have a heavy surgery. More, the management of PS remains to be improved, because some adverse events are related to classically contraindicated drugs as calcium inhibitor used to treat SVT.

238

Effect of pacing mode preserving spontaneous AV conduction on ventricular pacing burden and atrial arrhythmias

Jean-Luc Rey (1), Serge Quenum (1), Marc Hero [Orateur] (2)

(1) CHU Amiens, Hôtel Sud, Amiens, France – (2) Medtronic France, Boulogne Billancourt, France

Introduction: Transvenous ventricular pacing (VP) has been traditionally performed from the right ventricular apex (RVA) because convenience of pacing electrode positioning and long-term pacing stability. Recently, the adverse effects of pacing RVA have emerged. An increase in cumulative percentage of RVA pacing in patients treated with pacemakers results in increased risk of heart failure hospitalization, and atrial fibrillation (AF).

To decrease the adverse consequences of RVA pacing, currently two strategies are proposed: 1) substitute other VP sites, (right ventricular septum or left ventricle), 2) use dual-chamber pacemakers with new function: Manage Ventricular Pacing (MVP™) which operates in AAI/R mode with backup VP during AV block (AVB).