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Results: 9 patients in the NC group were included (78±8 y). Serum creatinine was 204±72µmol/L (clearance 34.2±17ml/min). CG included 10 patients (69,8±7 y, serum creatinine 98.7±23µmol/L). CRT implantation was successful in 8/9 patients (88.9%) without contrast injection. Patient 9 was finally implanted with CS opacification after failure of the NC technique. Mean procedure time and fluoroscopy time were similar in the two groups: 146±26 in the NC group versus 157±25 min (p = 0.34) and 24.8±15 in the NC group versus 24.5±20 min (p = 0.96) respectively. Mean CS lead implantation time was 45±21 (NC group) versus 37±12 min (p = 0.24). No major procedure-related complications were observed in both groups.

Conclusion: CRT implantation is feasible in the majority of the cases (88.9%) without contrast injection and without lengthening procedure time in patients with RI.

0107

Strategy of early detection and active management of supraventricular arrhythmia with remote monitoring: the randomized, multicenter SETAM trial

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Objective: Atrial fibrillation (AF) is a common arrhythmia associated with increased risk of thromboembolic events or other complications. The French randomized, multicenter, SETAM trial assessed the impact of the home monitoring (HM) technology on detection and treatment of supra-ventricular arrhythmia (SVA).

Methods: Patients (pts) implanted with a dual chamber pacemaker were enrolled in the study at hospital discharge if they had a sinusal rhythm at enrollment, no antiarrhythmic, anticoagulant or dual-antiplatelet therapy, and if they had a CHA2DS2-VASc score of 2 or more. The pts were randomly assigned to an active group (Act Gp), followed by Biotronik HM, or a control group (Cont Gp) without HM surveillance. The time from implantation to the first SVA-related intervention was compared between the 2 groups (primary endpoint).

Results: A total of 595 pts (mean age = 79±8 y.o, 63% male, mean CHA2DS2-VASc score = 3.7±1.2) were followed during 12.8±3.3Mo. The most prevalent co-morbidities were hypertension (82% pts), diabetes (29%) and vascular disease (24%). Implantation indications were atrio-ventricular blocks in 77% of pts, sinus node disease in 20% and others in 3%.The global SVA incidence was 25% (29% in the Act Gp vs 22% in the Cont Gp, p=ns). A therapy (drugs or ablation) was instituted for 49/291 pts (17%) in the Act Gp vs 43/304 pts (14%) in the Cont Gp (p=ns). The median time from implantation to the first therapy for SVA was 114 [44; 241] days in the Act Gp vs 224 [67; 366] days in the Cont Gp, representing a median gain of 110-days in SVA management (50% reduction, p=0.01). Over these 92 pts, 54 had AF (59%) and 38 had atrial flutter or tachyarrhythmia (41%). Anticoagulation was initiated in 80% of pts and antiarrhythmic drugs in 55%.

Conclusion: The SETAM study demonstrated that HM allows earlier detection and treatment of SVA in pacemaker pts. The next step is to report how early detection of SVA with HM can possibly improve the patients clinical outcome.

0131

Strategy of anticoagulation in pacemaker and ICD replacement procedure in real life. The French Electra survey

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Aim: to evaluate routine French implanters strategy in device replacement in patients under anticoagulation for atrial Fibrillation (AF pts).

Method: A questionnaire was e-mailed to 140 French implanters.

Results: 102 aswers were obtained. In AF patients, admission is on day of procedure D0 (10%) or D-1(80%) whether pts are on vitamine K antagonist (VKA) or New Oral AntiCoagulant (NOAC). In AF pts under VKA, only 4% bridge to Low Weight Heparine (LWH) or Unfractionated Heparine (UH) while treatment is interrupted without substitution (wos) by 61% and continued without interruption by 32%. In AF pts under NOAC, only 5% bridge to UH or LWH while treatment is interrupted on D-3 (13%), D-2(25%), D-1(44%). When interrupted, NOAC are resumed at D0 (23%), D+1(54%), D+2(10%), D+3(3%).

Conclusions: Most of implanters hospitalize AF pts at D-1 of replacement procedure. Short discontinuation (VKA, NOAC) or uninterruption (VKA) is prefered to bridging strategy.

0218

Comparison of transvenous versus surgical implantation of left ventricular lead for cardiac resynchronization therapy

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Background: Approximately 1% of the adult population have heart failure with reduced ejection fraction. Since the 1980s, therapeutic advances in this field have been significant, particularly through the development of cardiac resynchronization therapy (CRT). However, transvenous implantation of the left ventricular (LV) lead is unsuccessful in 5 – 15% of patients. For this group, surgical placement of LV lead is an alternative.

Objective: Compare the effects of transvenous versus surgical implantation of the LV lead in CRT.

Methods: We included 100 consecutive patients who had received CRT in our centre between January 2008 and July 2012 in a retrospective observational study. Twelve patients who had failed transvenous implantation of LV lead had a surgical placement.

Results: Population characteristics were a mean age of 66±11 years, 16% female, New York Heart Association class 2.9±0.5, 45% ischemic cardiomyopathy, left ventricular ejection fraction (LVEF) 24±7%, QRS width 165±23ms. There were no major difference in preoperative variables between two groups except sex category (12.5% female in transvenous group versus 42% in surgical group, p=0.022). During a mean follow-up of 508±429 days, the improvements seen in all variables showed no difference between the groups. At six months, 77% of patients had improved at least one class of their dyspnea stage, LVEF improved significantly (24±7% versus 36±10% at six months).

Conclusions: Surgical placement of LV lead offers similar benefits as compared with transvenous implantation.

0230

Repeated external electrical cardioversion after a first unsuccessful attempt in persistent atrial fibrillation

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Background: Electrical cardioversion (EC) is a major treatment of atrial fibrillation (AF). External EC in patients with persistent AF is inefficient in 10-20% of the patients already pretreated with oral amiodarone. Patients remain usually in permanent AF.

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