Methods 961 patients referred for PS were referred for PS and electrophysiological study (EPS). Clinical history, echocardiography and treatment were collected. Patients were followed from 3 months up to 10 years (5.3±5 years).

Results There were 72 patients ≥60y (mean 68.5±6), 889 patients <60y (mean 30.5±14). Electrophysiological data and recurrence to accessory pathway (AP) ablation (43% vs. 48.5%, p=0.375) did not significantly differ between the two groups. Older patients more often had symptomatic forms (81% vs. 63%, p=0.003) and more often had history of spontaneous atrial fibrillation (AF)(8% vs. 3%, p=0.01) or poorly-tolerated arrhythmias (18% vs. 7%, p=0.0009). In multivariable analysis, patients ≥60 had a significantly higher risk of history of AF (OR=4.2, 2.1-8.3, p=0.001) and poorly-tolerated arrhythmias (OR=3.8, 1.8-8.1, p=0.001). In patients who underwent AP ablation, age ≥60 was associated with an increased risk of major complication (9.6% vs. 1.9%, p=0.006). During follow-up, occurrence of AF (13.9% vs. 3.6%, p=0.001) and poorly-tolerated tachycardia (4.2% vs. 0.6%, p=0.001) were more frequent in patients ≥60 although frequency of major complication (9.6% vs. 1.9%, p=0.006). During follow-up, occurrence of AF (13.9% vs. 3.6%, p=0.001) and poorly-tolerated tachycardia (4.2% vs. 0.6%, p=0.001) were more frequent in patients ≥60 although frequency of major complication was similar (20% vs. 15.5%, p=0.52). In multivariable analysis, patients ≥60 had a significantly higher risk of AF (OR=2.9, 1.2-6.8, p=0.01).

Conclusions Referring of older patients was infrequent in our clinical practice (7.5% of patients with a PS). Patients ≥60 have a higher risk of AF and poorly-tolerated tachycardia both at admission and during follow-up but also have a higher risk of procedure complications. Nevertheless, given a risk of important complications below 10%, the risk/benefit balance appears to favor AP ablation in the elderly.

The author hereby declares no conflict of interest

0428
Cardiac arrhythmia after initiation of sofosbuvir-including regimen in patients with chronic hepatitis C virus infection
François Bagate*, Arnaud Lazarus, Hélène Fontaine, Caroline Perciaux, Philippe Sogni, Stanislas Pol, Denis Duboc
APHP-Hôpital Cochin, Paris, France
*Corresponding author: francois2801@hotmail.com (François Bagate)

Introduction Treatment of chronic hepatitis C virus (HCV) infection has dramatically improved since the advent of direct anti-viral agents, including Sofosbuvir. Sustained virological response may be achieved in more than 90% of patients without interferon, ensuring broad use of these regimens. To date, several thousands of patients have been treated with Sofosbuvir-based regimens worldwide. Since their approval in France, combination therapy is given to patients with complications, including cirrhosis and life-threatening extrahepatic manifestations.

Methods We analyzed retrospectively the incidence of arrhythmias and conduction disorders in a cohort of patients treated by Sofosbuvir (new anti-viral HCV) in our hospital from January 2, 2014 to December 31, 2014.

Results We observed five cases (1.2%) of severe arrhythmia, including three cardiac conduction defects, within the first days of Sofosbuvir-based therapy among 415 patients who had been treated in our center. There were two females and three males. The median age was 58 (50-75) years. Two patients were coinfected with HIV. Arrhythmia relapsed when Sofosbuvir was reintroduced in one patient. Among the 3 conduction disorders, one patient was under beta-blocker and amiodarone another. A pacemaker was implanted in all 3 patients with conduction disorders. The three patients who underwent a pacemaker implantation were not pacemaker-dependent, on the controls after stopping antiviral treatments (figure 1).

Conclusion Sofosbuvir seems to have cardiac toxicity. The mechanism underlying Sofosbuvir cardiotoxicity has to be determined. A particular attention should be given to patients with a medical history of rhythm or conduction anomalies, including careful monitoring (e.g., Holter ECG recordings) of cardiac rhythm during the first days of Sofosbuvir therapy.

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0272
Why accessory pathway refractory period can be shorter at esophageal electrophysiological study than at intracardiac study?
Julie Vincent (1), Nicolas Girerd (2), Béatrice Brembilla-Perrot* (2)
(1) CHU Nancy, Brabois, Vandoeuvre Les Nancy, France – (2) Université de Lorraine, INSERM, Centre d’Investigations Cliniques 9501, Vandoeuvre Les Nancy, France
*Corresponding author: b.brembilla-perrot@chu-nancy.fr (Béatrice Brembilla-Perrot)

Background Preexcitation syndrome (PS) is a potential cause of sudden cardiac death, its prognostic assessment is a major issue. The aim was to assess the contribution of esophageal electrophysiological study (EPS) compared to intracardiac EPS for the prognostic evaluation in patients with PS.

Methods We conducted a prospective single-centre study between November 1st, 2008 and December 1st, 2014, in patients who underwent both esophageal and intracardiac EPS for a PS. Accessory pathway effective refractory period (APERP) and induction of sustained supraventricular tachyarrhythmias (SVT) were noted for both methods.

Results 69 patients were included. 45 (65%) were males and mean age was 36±16 years. There were no significant differences in the induction of SVT between both methods. APERPs were significantly shorter at esophageal EPS compared to intracardiac EPS in control state (≥40 ms) in 51% of patients, but APERPs did not decrease significantly after isoproterenol: in these patients with shorter APERP at esophageal EPS, age and gender was similar to other patients; APERPs in basal state were shorter than in patients with similar APERPs at both studies (226±33 vs 231±45)(0.55); the shortening of APERP after infusion of isoproterenol was significantly less than in patients with similar APERPs at esophageal and intracardiac EPS (30±31ms vs 49±45 ms)(p<0.05). The sensitivity of esophageal EPS in prognostic assessment was 88% in control state, 100% during isoproterenol infusion. The area under ROC curve of transesophageal EPS in prognostic assessment based on APERP measurement was 0.74.

Conclusion Esophageal EPS was a reliable and sensitive method of prognostic assessment in patients with PS. APERP was shorter in 51% of patients but did not decrease significantly after isoproterenol at esophageal EPS compared to intracardiac EPS, indicating esophageal EPS-related stress.

The author hereby declares no conflict of interest