therapy as a stroke prevention strategy. In MOST trial, AHRE were seen in almost 50% of patients treated for sinus node dysfunction and were associated with an increased risk of stroke (1.69% per year if CHADS score≥2) in ASSERT study. Nevertheless currently there are no antithrombotic recommendations for these patients. We tried to describe the different therapeutic alternatives in usual practice.

Materials and methods: We started a prospective registry of patients with silent AF detected in DDD or CRT PMK/ICD of all constructors. Inclusion criteria were: age > 18 y, AHRE diagnosed by device algorithms and > 6 minutes confirmation, by atrial endocavitary electrogram. We excluded patients with a previous history of “clinical AF” or valvular AF. The antithrombotic strategy was decided by the referent physician.

Results: From November 2013 to May 2014, 43 patients were included. The median age was 77 years old. 26 patients (60%) had a DDD PMK (10 for sinus node dysfunction (23%), 15 for AF block (35%), 1 for obstructive CMP), 10 patients (23%) a DDD ICD (6 (14%) for primary prevention and 4 (9%) for secondary prevention) and 7 patients a CRT-D (16%). The median CHADS2 score was 2, the median CHADS2VASC score was 4. The median age was 77 years old. 26 patients (60%) had a DDD PMK (10 for sinus node dysfunction (23%), 15 for AV block (35%), 1 for obstructive CMP), 10 patients (23%) a DDD ICD (6 (14%) for primary prevention and 4 (9%) for secondary prevention) and 7 patients a CRT-D (16%). The median CHADS2 score was 2, the median CHADS2VASC score was 4 (mean respectively 2.36 and 3.56): 5 patients had a history of embolic event (11%). Only 5 patients the association aspirin/clopidogrel (11%). 2 patients did not receive any antithrombotic treatment. There were no difference in CHADS and CHADSVASC scores between patients treated or not with anticoagulants (respectively p=0.21 and p =0.57).

Conclusion: Most of patients in this study received an anticoagulation therapy as a stroke prevention strategy.