## Abstract 0163 – Table: Table Long-term anticoagulation therapy management

<table>
<thead>
<tr>
<th></th>
<th>A GROUP (N=74)</th>
<th>B GROUP (N=63)</th>
<th>C GROUP (N=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES (N [%])</td>
<td>NO (N [%])</td>
<td>YES (N [%])</td>
</tr>
<tr>
<td>YES (N [%])</td>
<td>14 (18.9)</td>
<td>11 (14.9)</td>
<td>29 (46)</td>
</tr>
<tr>
<td>NO (N [%])</td>
<td>2 (2.7)</td>
<td>43 (58.1)</td>
<td>3 (4.8)</td>
</tr>
<tr>
<td>LTFUP (N [%])</td>
<td>4 (5.4)</td>
<td>4 (6.4)</td>
<td>2 (11.8)</td>
</tr>
</tbody>
</table>

AF: Atrial fibrillation; ACT: anticoagulant therapy; LTFUP: lost to follow up patient

**Aims**
Assessment of long-term ACT after AF-LRF according to associated atrial fibrillation (AF) and CHA2D2-VASc score.

**Methods**
From January 2012 to December 2013, patients who underwent RFA of cavotricuspid isthmus for typical atrial flutter in our centre were retrospectively included.

**Results**
Of 166 patients (137 men, mean age: 66.7±10 years), 61 (36.7%) had a history of AF. The mean CHA2D2-VASc score was 2.49. The patients were classified according to theooretical indication of LT ACT (patients with a non rhythmic ACT indication excluded – N=12; 7.2%): group A (LT ACT unclear) included patients with CHA2D2-VASc score ≥1; successful RF ablation and without AF history (N=74); group B (LT ACT indicated) included patients with CHA2D2-VASc score ≥1, AF history and/or failed AFL RFA (N=63); group C (LT ACT not included) included patient with CHA2D2-VASc score=0 (N=17). During a mean follow up of 489±244 days, 45 (68.8), 10 (15.9%) and 11 (64.7) patients stopped ACT respectively in group A, B and C differently according to AF onset (table). There were 8 (4.8%) hemorrhagic and 2 (1.2%) ischemic complications, all in patients with correct ACT management. The prevalence of AF during follow-up was 38%.

**Conclusion**
After successful AFL RF ablation, ACT was frequently stopped in the absence of associated AF. However, AF was frequent even in patients with no AF history. Ischemic and hemorrhagic complications were rare. ACT should be regularly evaluated during follow-up especially according to CHA2D2-VASc score and new onset of AF.

The author hereby declares no conflict of interest

### 0081

**Percutaneous left appendage closure: real life outcomes and mid-term results during initial experience in a dedicated electrophysiology team**

Peggy Jacon, Alix Martin, Clemence Charlon, Carole Saunier, Pascal Defaye

CHU Grenoble, La Tronche, France

*Corresponding author: pjacon@chu-grenoble.fr (Peggy Jacon)

**Purpose**
Percutaneous left atrial appendage closure (LAAC) is accepted as a valuable solution for patients (pts) with atrial fibrillation (AF) and high thromboembolic risk in case of contra-indication to oral anticoagulation (OAC). Little is known about mid-term results in the real life setting.

**Methods**
We analyzed mid-term results in a dedicated EP team (2 experienced electrophysiologists [AF ablation >200 per yr], 1 echographist, 1 anesthesiologist). All indications were discussed before the procedure in a multidisciplinary approach.

Procedures were done under general anesthesia in a dedicated EP room with in-hospital cardiac surgery facilities. All LAAC procedures were performed with Watchman devices (Boston Scientific).

**Results**
50 pts were enrolled (male 76%, 72±6 years, paroxysmal AF 44%, permanent 54%). The CHADS2 VASC average score was 4.6±1.3; ≥4: 76%, HASBLED score was 3.7±1; ≥3: 64%. All indications were definitive contra-indications for OAC due to hemorrhagic events (neurological 75%, gastrointestinal 13%, ENT 3%, other 4%). The CT-scan ruled out any thrombus before the procedure for all pts with a perioperative TEE confirmation. Success rate of implantation was 100% (time of procedure 50±10 min, scopy time 8±5mn). There were no periprocedure complications.

Postoperative therapy was: antiagregation 31%, double antiagregation 37%, anticoagulation 18%, none 3%. After 2 months, and TEE control, the initial treatment was switched to: antiagregation 50%, double antiagregation 10%, anticoagulation 10%, none 30%. Mid-term complications were: non severe haemorrhagic events 11%, recurrent non severe hemorrhagic stroke 2, TIA due to carotid stenosis N=1. There were no other adverse events during 7.4±5 months follow-up.

**Conclusion**
In a single center with large experience in EP, LAAC was performed with a very low rate of complications and excellent mid-term results regarding recurrences of thromboembolic and hemorrhagic events.

The author hereby declares no conflict of interest

### 0338

**Computed tomography evaluation of the anatomical variation of the pulmonary veins in atrial fibrillation**

Afef Ben Halima, Lobna Laroussi, Emna Bouzgarrou, Zied Belhadj, Faouzi Addad, Asma Zidi, Salem Kachbours

Hôpital Abderrahmen Mami, Ariana, Tunisie

*Corresponding author: afefnahmoud@yahoo.fr (Afef Ben Halima)

**Introduction**
The electrophysiological and anatomical properties of the pulmonary veins (PVs) have been focused on since their crucial role in triggering or generating atrial fibrillation (AF) was first revealed. The presence of four distinct pulmonary veins (two left PVs and two right PVs) has been described as the normal variant.

**Aim**
The purpose of our study was to describe the anatomy of the pulmonary veins in a cohort of patients of our country followed for AF.

**Methods and results**
Our study is a prospective study which has included 38 patients followed for AF in the cardiology’s department of our Hospital. All patients underwent a CT scan of PVs in order to characterize their anatomy. PVs’ size was represented by the largest diameter.

Our patients had a mean age of 50.5±13 years. The majority of our patients had paroxysmal AF (65.8%), 4 had persistent AF (10.5%), 9 had prolonged persistent AF (24%). AF occurred in 63.6% of cases in healthy heart and 36.4% in pathological heart, 13 patients had an anatomical variant which represent 34.2% of the population. We had 3.9 PVs in average with a minimum of 3 and a maximum of 5 PVs. The average diameter of different PV was 23.45±9.31mm for the left PVs and 19.75±7mm for the right PVs. 7 patients (18.4%) had anatomical variants which were classified as left PVs forming a core collector left in all cases. Concerning the right pulmonary veins, anatomical variations were found in 15.8% of cases, one patient (2.65%) had a single ostium forming a core right collector and 5 patients (13.5%) had 3 ostia (presence of 1 middle pulmonary veins on the right).

**Conclusion**
Cardiac CT is a non invasive procedure which can provide a detailed evaluation of the anatomy of the pulmonary veins. The presence of anatomical variations is common in patients with AF. This assessment is recommended to ensure success of the ablation procedure.

The author hereby declares no conflict of interest
Study of anatomical features of pulmonary veins assessed by computed tomography according to age

Atef Ben Halima’, Lobna Laroussi, Zied Belhadj, Emna Bouzgarrou, Faouzi Addad, Asma Zidi, Salem Kachboura
Hôpital Abderrahmen Mami, Ariana, Tunisie

Introduction Pulmonary veins (PV) play a crucial role in triggering and generating atrial fibrillation (AF). Isolation of PVs is fundamental in the AF ablation whether paroxysmal or persistent. The presence of four distinct pulmonary veins (two left PVs and two right PVs) has been described as the normal variant.

Aim The purpose of our study was to investigate whether the age of the patients had an influence on the incidence of anatomical abnormalities of PVs.

Methods Our study was a prospective study which has included 38 patients underwent a CT scan of PVs in order to characterize their anatomy. PVs’ size was represented by the largest diameter. We have divided our cohort into two groups: group 1: patients aged more than 50 years and group 2: patients aged less than 50 years.

Results Our patients had a mean age of 50.5±13 years. The majority of our patients had paroxysmal AF (65%), 4 had persistent AF (10%), 9 had prolonged persistent AF (25%).

CT Scan of PV results according to age are summarized in table.

Conclusion In our study, we found no significant relationship between age and anatomical abnormalities of the PVs. Hence, it is important to look for these anatomical anomalies whatever was the age of the patients to increase the success rate and to avoid complications during the AF ablation procedures.

The author hereby declares no conflict of interest

Reference

0362
Atrial fibrillation after radiofrequency ablation of atrial flutter: prevalence and risk factors
Mathias Guinot*, François Lesaffre, Pierre Naezyrollas, Karine Bauley, Jean-Pierre Chabert, Leïla Simone, Huu Tri Bui, Anthony Foulon, Bertrand Girodet, Julien Voyez, Damien Metz
CHU Reims, Reims, France

Introduction Obstructive sleep apnea (OSA) is associated with oxidative stress, risk factors including hypertension, and with binary presence of coronary artery disease (CAD). However, whether OSA contributes to the severity of CAD and to future adverse events in patients with CAD remains unknown.

Aim The aim of this study was to investigate the association between severe OSA and multivessel CAD.

Methods We examined the apnea hypopnea index (AHI) using polygraphy (PG) in 60 consecutive patients with ACS who underwent coronary angiography. OSA was defined by AHI≥5 events per hour and was considered severe if the AHI≥30 events per hour. The Friesinger score was calculated for each patient from the coronary angiography to evaluate the severity of CAD.

Results The average age of patients was 59.73 years±10.1 years. The sex ratio was 1.5. 61.7% of patients had an AHI≥5 and 21.7% had severe OSA with AHI≥30. The Friesinger score was significantly greater in the group with multivessel CAD (11.28±4.17 versus 5.35±3.96, p=0.0001). There were no differences between patients having multivessel CAD and those with single-vessel CAD regarding clinical characteristics.

Table summarizes these results.

Abstract 0218 – Table: Comparison of patients with multivessel CAD and with single vessel CAD.

```plaintext
<table>
<thead>
<tr>
<th></th>
<th>Multivessel CAD (n=33)</th>
<th>Single vessel CAD (n=27)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>59.2±9.1</td>
<td>60.26±11.47</td>
<td>0.72</td>
</tr>
<tr>
<td>Male</td>
<td>35%</td>
<td>25%</td>
<td>0.51</td>
</tr>
<tr>
<td>BMI</td>
<td>27.75±5.43</td>
<td>28.27±4.61</td>
<td>0.62</td>
</tr>
<tr>
<td>Smoking</td>
<td>31.7%</td>
<td>20%</td>
<td>0.31</td>
</tr>
<tr>
<td>Hypertension</td>
<td>33.3%</td>
<td>28.3%</td>
<td>0.85</td>
</tr>
<tr>
<td>Diabetes</td>
<td>35%</td>
<td>23.3%</td>
<td>0.35</td>
</tr>
<tr>
<td>Severe OSA</td>
<td>11.7%</td>
<td>10%</td>
<td>0.83</td>
</tr>
</tbody>
</table>
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Conclusion In summary, these data suggest a high occurrence of obstructive sleep apnoea in patients with CAD, which should be taken into account when considering risk factors for CAD. However, severe OSA is not more frequent in the group of multivessel CAD. Further studies are needed to evaluate the impact of the presence of severe OSA on short and long term prognosis.

The author hereby declares no conflict of interest