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 had a surgical lead placement. Short discontinuation (VKA, NOAC) or uninterruption (VKA) is possible in patients with RI.

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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Methods: Patients (pts) implanted with a dual chamber pacemaker were enrolled in the study at hospital discharge if they had a sinus rhythm at enrollment, no antiarrhythmic, anticoagulant or dual-antiplatelet therapy, and if they had been in the study at hospital discharge if they had a sinusal rhythm at enrollment. A therapy (drugs or ablation) was instituted for 49/291 pts (17%) in the Act group without HM implantation while 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.

0128
Comparison of transvenous versus surgical implantation of left ventricular lead for cardiac resynchronization therapy

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 LV lead is unsuccessful in 5 – 15% of patients. For this group, surgical placement of LV lead is an alternative.

Objective: To 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.

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 questionare was e-mailed to 140 French implanters.

Results: 102 answers 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 NOAC, only 1% 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 uninterrupted (VKA) is prefered to bridging strategy.