that CRT may also induce electrical remodelling but the impact on clinical outcome remains unknown.

Objective: We sought to determine 1) if chronic CRT induces a relevant shortening of the intrinsic QRS (iQRS), 2) whether changes in the native conduction system correlate with clinical or echocardiographic response to CRT and 3) to identify predictors of iQRS width shortening.

Methods: We prospectively included 85 consecutive patients with left bundle branch block who received a CRT device in 3 French centers. NYHA class, iQRS duration, LVEF and left ventricular volumes were assessed before and one year after CRT implantation. Clinical and echocardiographic were defined respectively as NYHA class improvement >1 class without heart failure hospitalization and an increase of LVEF by ≥10% and/or a decrease in LVESV by ≥15%. Electrocardiographic responders were defined as a decrease in iQRS duration by ≥20 ms.

Results: Baseline and 1-year follow-up mean iQRS durations were respectively 168.0±19.7 ms and 149.5±31.6 ms (p=0.0001). Electrocardiographic response, observed in 43/85 patients (51%), was associated with a greater rate of clinical (p=0.035) and echocardiographic (p=0.023) response. Younger age, male gender and longer baseline QRS width were independent predictors of electrocardiographic response.

Conclusion: CRT decreases iQRS duration. A reduction of at least 20 ms in iQRS duration is associated with better clinical and echocardiographic response.

179 Remote monitoring follow-up of 533 ICD/CRT-D recipients: a very low rate of inappropriate shocks
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Remote monitoring (RM) is now accepted as a safe alternative to standard follow-up (sFU) for ICD recipients (ICDr).

Methods: We analysed the long term outcomes of 533 ICD/CRT-Dr.

Patients were equipped with Boston Scientific Latitude (45%), Medtronic ICD (43%), St Jude Medical Merlin (9%) or Biotronik Home Monitoring (3%) RM systems. Automatic FU with RM was performed every 3 months, with at least one sFU/year. In emergency cases patients were invited visits.

ICD programming was done with 2 zones (VT zone=180 bpm / VF zone=220 bpm). All RM alerts and related EGMs as well as the reasons and therapies were reviewed by two physicians.

Results: We enrolled 533 pts (82% male, mean age 66±10 y.o.). 55% had ischemic cardiomyopathy, 69% were primary prevention. CRT-D (46%) and dual chamber (45%) devices were mainly represented. During a RM FU period of 15±8 months, we noted 8 automatic RM FU and 2 sFU visits/patient. 23 deaths occurred. 19 patients had major alerts (5 for ICD lead dysfunction, 1 for ERI, 9 for electrical storm). 2672 non major alerts occurred and led to multiple diagnoses: in 22 pts early detection of unknown AF, in 41 CRT-D loss of biventricular pacing. 145 ICD discharges occurred in 52 pts. Within the 66 pts with diagnosed AF by RM, 24 were managed with rhythm control strategy (11 cardioversions, 10 AA drugs introductions, 3 PAF ablations) and 10 (CRT-D) had a rate control strategy (AV node ablations in 6 and beta blocker in 4). 91 appropriate (app) ICD discharges (ICDd) occurred in 35 pts (6.5%) of which 10 were in primary prevention.

A first inappropriate ICDd occurred in 3.1% of the population (17 pts) and were mostly due to AF (76%). 74 pts had 1205 app ATP (80% successful). 5 pts with high LV impedance detected by RM had lead dislodgement and underwent reintervention.

Conclusion: In a large monocentric observational study, RM has demonstrated to be an effective mode of FU for ICDr. Early diagnoses allow rapid management of pts and are associated with a very low rate of inappropriate shocks.

180 Prevalence of ventricular tachyarrhythmias clustering in ICD treated patients with ischemic cardiomyopathy
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Objective: Ventricular tachyarrhythmias clustering (occurrence of >3 separate episodes of VT/VF within a 24 h period, each separated by >5 min) in ICD population remains a serious problem, associated with adverse prognosis. Our aim was to retrospectively assess the prevalence of VT clustering in primary and secondary SCD prevention pts and in single, dual and triple chamber ICD device.

Methods: We studied 360 consecutive pts with ischemic cariomyopathy who underwent ICD implantation for primary (20%) and secondary (80%) SCD prevention, over a mean follow-up period of 8 (5 years). Single, dual and triple chamber ICD was implanted in 29%, 61% and 10% respectively of pts. Stored endocardial electrograms were used to determine the causative rhythm disorders provoking ICD activation.

Results: VT arrhythmic clustering was recorded in 43pts (12%). Concerning primary and secondary prevention pts, the prevalence was 4% and 14% respectively (p<.001). Concerning Single, Dual and Triple chamber device, the prevalence was 12.5%, 11.9% and 12.1% respectively (p=NS).

Conclusions: Clustering of VTachyarrhythmias occurs more often in secondary than in primary prevention ICD’s pts with coronary artery disease. No differences exist between single, dual or triple chamber device.

181 Cardiac resynchronization device implantation procedure in real life. The French Electra survey
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Introduction: Cardiac resynchronization therapy (CRT) has been a major breakthrough in cardiac failure management. However, implantation procedure is not standardized.

Aim of the study: To evaluate routine implantation procedure habits in french practice.

Material and methods: A survey was e-mailed to 100 French CRT implanters in November 2011. Physicians were interviewed on their own strategy in the center. Answers had to concern the most frequent routine attitude. If appropriate, physicians could answer “no standardized attitude” or “other”

Results: Among the 62 physicians who answered, 45% practise in a university hospital, 24% in a non-university hospital and 5% in a private institution. The rate of physician implantations is <30/year, 30-50/year and >50/year in 42%, 25% and 33%, respectively. Implantations are performed by a single operator in 49%, and in 43% by two physicians, 16% of implants being done under general anaesthesia.

Default CRT-Pacemaker (CRT-P) implantations are right-sided in 18%, left-sided in 51%, unsettled in 20%, and for CRT-Defibrillator (CRT-D) 8%, 82 and 10% respectively.

The venous approach is “all cephalic” in 21%, “all subclavian” in 18% and combined in 62%.

First implanted lead is the right ventricular lead (RV) in 74%, and the coronary sinus (CS) lead in 23%. RV lead is placed in apical position in 26% and in septal position in 67%.