Amiodarone and lower intake of Statins was documented. The average follow-up was 11 months and 38/303 (12.5%) pts had appropriate device intervention 23 pts (7.6%) treated with at least 1 shock and 24 pts (7.9%) with ATP. One year total mortality was 16 pts (5.7%): 10 cardiac (6 not sudden, 4 sudden but 2 not arrhythmic), 4 not cardiac, 2 not classified.

Conclusion: despite several baseline clinical differences, mortality rate in clinical practice seems to be comparable to the ICD arm of MII study, also in terms of classification.

20.3 PRIMARY PREVENTION OF SUDDEN CARDIAC DEATH WITH IMPLANTABLE CARDIOVERTER DEFIBRILLATORS: THE FRENCH EXPERIENCE

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Background: The implantation of ICDs has emerged as the dominant therapy for the secondary then the primary prevention of ventricular (V) tachycardia and V fibrillation. Numerous studies have demonstrated that prophylactic (P) implant of ICD, compared to conventional therapy, reduces not only sudden cardiac death but also total mortality.

Objective: This study was aimed to compare the clinical baseline and outcomes of patients (pts) implanted for a P or not P (NP) indication (I) with a Guaidant ICD (two resynchronization).

Methods and Results: The preliminary data of this registry, started in May 2002, concerns 602 pts implanted for a P (25.6%) versus NP (74.6%). Demographics data are represented in the table. The PI among the overall population was distributed as follows: MADIT and MUST (8.8%), MADIT II (8.5%), genetic diseases (4.5%) and others (3.8%). Furthermore, the ratio of PI increased significantly (p<0.01) from 18.2% to 25.6% during the last 14 months (m) with twice more indications for MADIT II (p<0.05). After a mean follow-up of 10 +/-7 m the percentage of first appropriate therapies (ATI) in NP and P populations was 16.2 % (73) and 5.8% (9) respectively (p = 0.001).

Conclusions: The prophylactic indications increased significantly (26%) during the last months but the rate of appropriate therapies was 3 times lower than for NP. The pts with PI seem younger but with a lower LVEF. All these results must be confirmed during the 2-year follow-up.

20.4 IMPAIRMENT OF HEART RATE TURBULENCE AFTER CORONARY ARTERY BYPASS GRAFTING

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Objectives: Coronary Artery Bypass Grafting (CABG) surgery is the method of choice for treating patients with multivessel coronary disease. Heart rate turbulence (HRT) is a new method for risk stratification based on a simple expression of ventriculophasic sinus arrhythmia, after a single ventricular premature beat (VPB). HRT also reflects baroreceptor sensitivity. The aim of this study was to evaluate the influence of CABG surgery on HRT parameters assessed 10 days after operation.

Methods: Ninety-five consecutive patients with coronary artery disease presenting with sinus rhythm were enrolled in this study (mean age 53±13, range: 39 –82). Forty patients having no VPB on holter recordings were excluded from study. In each patient, a 24 h Holter recording was obtained during a stable phase of coronary artery disease. An ELATEC Holter system was used to process the Holter recordings. All subjects had a complete history, laboratory examination and transthoracic echocardiography.

Results: All patients analyzed did not have symptoms or signs of myocardial ischemia during 24 hours holter recording period. Mean value of left ventricular ejection fraction was 52.1±5.6. HRT onset showed an increase after CABG, whereas HRT slope was found to be lower (TO: -0.66±1.77, 0.22±1.3, p=0.028; TS: -6.97±4.97, 2.81±4.47, p=0.002).

Conclusions: This study showed that HRT parameters were impaired after CABG. It may be related to the perioperative autonomic nerve damage and impairment of baroreceptor sensitivity, caused by clamping of the aorta.

20.5 LACK OF ASSOCIATION BETWEEN TACHYARRHYTHMIA AND VENTRICULAR PACING

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Recent reports stated Pacing Induced Tachycardia phenomenon in ICD recipients; others raised the suspicion that pacing itself could be arrhythmogenic. SEARCH-MI registry is a survey on the application of MADIT II results in clinical practice: 303 patients reached a mean follow-up of 11 months and 11.2% experienced an appropriate device intervention (ADI). In the analysis performed to compare patients with high and low percentage of Ventricular Pacing (VP>50% vs. VP<50%), no significant differences in ADI recurrence were observed. In order to detect the arrhythmogenic VP effects we compared its percentage intra-patient, between follow-up with and without episodes: we considered the mean percentage of pacing in at least three follow-up visits without episodes; VP percentage was derived by ICD memory.

Results: 34 patients in our registry experienced at least an ADI: 25 had follow-up with and without episodes; the mean percentage of VP in follow-ups without episodes was 11.9% and in follow-ups with episodes was 10.0 % (p=0.457).

Conclusions: in MADIT II implanted patients, an intra-patient preliminary analysis did not show a significant correlation between the VP and the incidence of ventricular tachyarrhythmias.

20.6 UTILIZATION OF IMPLANTABLE DEFIBRILLATORS IN THE OCTOGENARIAN POPULATION

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Introduction: We evaluated the use of implantable defibrillators (ICDs) in the octogenarian population to analyze the complications associated with ICD implantation; the incidence of appropriate and inappropriate discharges; as well as survival following ICD implantation.

Methods: We retrospectively evaluated the utilization of ICDs implanted and followed at our institution from 1998 to 2004 in the octogenarian population with systolic dysfunction. A control group was comprised of similar patients under the age of 80. Patients with preserved ventricular function were excluded.

Results: Two hundred twenty-six patients with systolic dysfunction were evaluated following ICD implantation. There were 51 patients over 80 years of age (mean age: 84 ± 4). A control group of 175 patients less than age 80 (mean age: 66 ± 10) was utilized for comparison. The baseline characteristics, including ejection fraction (25 ± 7%), presence of coronary disease (90%), as well as the incidence of symptomatic arrhythmias (33%) were similar in both groups. The octogenarian population did have a higher percentage of women (33% v. 18%; p=0.04). The long-term device related complication rate in the older age group was low (1.9%) and did not differ between groups. Thirty-two percent of the octogenarian group received appropriate ICD therapy over a mean follow-up period of 15 ± 16 months. The older group had fewer inappropriate discharges (6.8% v. 12.5%; p=NS) in comparison to the younger patient group. Although 78.4% of the octogenarian group survived during the follow-up period, there was a significant decrease in survival in this group as evaluated by the Kaplan Meier method (p=0.0003). In multivariate analysis, the only significant predictor of survival was age less than 80.

Conclusion: The octogenarian population can safely be treated with ICD therapy and in appropriately selected patients; they can be expected to have a high rate of therapeutic ICD utilization. Patients should be carefully selected for ICD implantation as mortality is higher in the octogenarian population and co-morbid conditions may limit the potential survival benefit offered by the ICD.

20.7 PSYCHOLOGICAL DISCOMFORT IN PATIENTS WITH ICD. BENEFICIAL EFFECT OF BIOFEEDBACK

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Background: Implantable Cardioverter Defibrillator (ICD) is an important tool in reducing mortality of patients (pts) with malignant arrhythmias, but the quality of life of these pts could be deteriorated by experience of electrical shocks.

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