were implanted with an ICD and eleven (32.3%) were treated with beta blocker therapy mainly because of QT prolongation > 500 ms after mental stress test or previous symptoms. After a 3.6±1.8 years of follow up, no sudden cardiac death nor syncope occurred on beta blocker therapy except for one patient implanted with an ICD after a SCA. Under beta blocker treatment the patient was asymptomatic for 5 years. After a suddenly stop of the beta blocker treatment, the patient underwent VF. For 3 years now the patient is asymptomatic under beta blocker treatment. Conclusion: In our experience, CIQTP families represent 6.5% of cases of unexplained SCD and suggest systematic screening with a mental stress test for family screening after the occurrence of a SCA. Beta blocker therapy is very efficient to reduce the risk of SCA.

PO-625-07

NOVEL STREAMLINED TECHNIQUE FOR LEFT ATRIAL APPENDAGE CLOSURE USING VERSACROSS LARGE ACCESS SYSTEM

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Background: Transseptal puncture (TSP) for left atrial (LA) access of large delivery sheaths, such as in left atrial appendage closure (LAAC), typically involves performing TSP with an 8F sheath, then “upsizing” over a wire to the device delivery sheath. This can be challenging in fibrotic or aneurysmal septa and increase the risk of air embolus.

Objective: Report early experience using the VersaCross Large Access (VLA) Solution (Baylis Medical) to streamline and optimize efficiency of LAAC procedures.

Methods: Consecutive LAAC procedures performed using the VLA system and the WATCHMAN FLX device (Boston Scientific) were retrospectively evaluated. The VLA system, consists of a 12.5F seamless sheath-dilator device, and pigtail RF wire that can be used for vascular access, TSP and WATCHMAN sheath exchange (Figure). The VersaCross pigtail RF wire (24mm) was also used to estimate the size of the left atrial appendage (LAA) and directly introduce the WATCHMAN sheath into the LAA. Contrast was injected through the WATCHMAN sheath to confirm LAA anatomy and device size. Procedural workflow efficiency was assessed in terms of the time for TSP, WATCHMAN sheath access and implant release, fluoroscopy use and procedural complications.

Results: A total of 12 patients underwent LAAC; 42% of patients had prior TSP for ablation. LAA morphology was 50% cauliflower and 33% chicken wing. TSP and procedure success was 100% without any inaprocedural complications. Time to TSP was 5.3 ± 3.1 mins from RF wire insertion, and 11.6 ± 3.3 min from femoral access. The 12.5F VLA device easily crossed the septum within 0.1 ± 0.3 min of TSP. Repeated passage of the seamless VLA device over the RF wire successfully dilated difficult septa (25% of cases) to confirm patency. Time to WATCHMAN release was 23.3 ± 3.4 min and overall procedure time was 26.5 ± 3.1 min. Fluoroscopy time and dose were 5.2 ± 2.3 min and 85.8 ± 42.6 mGy, respectively, with 60 ± 22.4 mL of contrast use.

Conclusion: The VersaCross RF system streamlined LAAC workflows, eliminating unnecessary sheath exchanges and associated risks of perforation or air embolism. The integrated 12.5F large access sheath-dilator facilitated de novo dilation of the septum for easy LA catheterization of the large bore LAAC delivery system in all patients regardless of history or septal anatomy.

PO-625-08

NEW ATRIAL FIBRILLATION DURING ACUTE COVID-19 INFECTION PREDICTS DEVELOPMENT OF FUTURE CLINICAL ATRIAL FIBRILLATION

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Background: While primarily known for its impact on the respiratory system, cardiovascular complications have been well described in Coronavirus Disease-19 (COVID-19) patients. The incidence of new onset atrial fibrillation (AF) in COVID-19 hospitalized patients is reported to be as high as 12.5%. It is not clear whether this represents a reversible acute episode or if it carries a prognostic value of future clinical AF.

Objective: To determine the risk of developing future clinical AF in COVID-19 patients that developed new AF in the acute phase of infection.

Methods: We conducted a retrospective study with the global medical research network database, TriNetX. This study examined adults at least 18 years old that had COVID-19 based on ICD codes of positive SARS-CoV-2 test without previous history of AF, that developed new onset AF within the same month of the COVID-19 diagnosis. These patients were then compared to COVID-19 patients without pervious history of AF, that did not develop new onset AF. Propensity score matching was done to account for age, gender, race, ethnicity, diabetes, dyslipidemia, obesity, cardiovascular disease, pulmonary disease, neurological disease, genitourinary disease, neoplasm, cardiac medications, and cardiac procedures. We examined the risk of developing clinical AF 6 months after COVID-19.

Results: A total cohort size of 19,877 patients with COVID-19 that developed new onset AF in COVID-19 patients that developed new AF were compared to 19,877 propensity matched COVID-19 patients that did not develop AF. Average age was 71.7 ± 12.9 years. 60% were male 72% were Caucasian. Approximately 60% in both cohorts had cardiovascular disease, 43% had genitourinary disease, 37% had neurological disease, 35% had dyslipidemia, 26% had diabetes, and 65% were on cardiovascular medications. We found that COVID-19 patients that developed new onset AF, without history of previous AF, were at increased risk of developing future clinical AF (OR 4.572, 95% CI 3.37 - 6.263, p < 0.001).