He noted that over the preceding week, the WD had been alarm and deploy dye/gel just prior to syncope and shock. After another syncopal episode resulting in facial lacerations, the defibrillator (WD) was started on metoprolol and discharged with wearable implantable cardioverter-defibrillator (ICD) was recommended, but patient preferred to have second opinion and therefore he had provoked Brugada syndrome (BrS) Type 1 pattern. An disease. With procainamide challenge in the EP laboratory, he experienced syncope while driving. While in the ambulance, he had ventricular fibrillation requiring defibrillation. Echocardiogram and cardiac MRI were normal. Cardiac catheterization revealed non-obstructive coronary artery disease, age and BMI. The total procedural time and hospital LOS were reviewed to evaluate procedural efficiency. Results: Between Sept 2020 and Dec 2021, 6 pts underwent TAVR and leadless PPM implantation during the same procedure. All pts prior to TAVR were identified as high risk for potential need of PPM support and consented prior to the procedure. Four of the pts had preexisting RBBB, and 2 pts had preexisting left anterior fascicular block. All pts had a normal LVEF at the time of implant. One pt underwent a Micra VR device and 5/6 pts underwent Micra AV implant for CHB noted during the procedure. The average age was 83.5 yo (+/- 6.8) with a BMI of 30.6 (+/- 6.3). The average pacing percentage at discharge was 66.8% (+/- 37.2) and the average pacing percentage at 2-week f/u in 3/6 pts was 98.1% (+/- 1.3). Three pts have not had f/u testing. The average total procedural time was 157 min (+/-40) with an average leadless PPM implant time of 53 min (+/-20). The average hospital LOS was 55 hr. There were no reported 30-day complications. Conclusion: Performing TAVR and leadless PPM implantation during the same procedure may improve efficiency and reduce hospital LOS in pts requiring permanent pacing following TAVR. Further analysis of this strategy to assess pt safety, pt satisfaction and health care utilization is warranted. Collaboration between interventional cardiologists and cardiac electrophysiologists may allow for efficient care of TAVR pts with pre-existing conduction system disease.

PO-644-06

NOT EVERYTHING IS AS IT SEEMS-CONCOMITANT BRUGADA SYNDROME AND CORONARY VASOSPASM CAUSING VF ARREST

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Background: Sudden cardiac death (SCD) is the leading cause of death in the United States, and is most commonly associated with underlying coronary artery or other structural heart disease (SHD).

Objective: To describe a case of patient without overt SHD with recurrent ventricular fibrillation (VF) and 2 concomitant uncommon causes of SCD.

Methods: N/A

Results: A 49 year old healthy man with history of hypertension experienced syncope while driving. While in the ambulance, he had ventricular fibrillation requiring defibrillation. Echocardiogram and cardiac MRI were normal. Cardiac catheterization revealed non-obstructive coronary artery disease. With procainamide challenge in the EP laboratory, he had provoked Brugada syndrome (BrS) Type 1 pattern. An implantable cardioverter-defibrillator (ICD) was recommended, but patient preferred to have second opinion and therefore he was started on metoprolol and discharged with wearable defibrillator (WD). He presented to our institution ~1 week later after another syncope episode resulting in facial lacerations. The WD did alarm and deploy dye/gel just prior to syncope and shock. He noted that over the preceding week, the WD had been alarming, causing him to repeatedly push the button to avoid shocks. Review of electrograms from the WD (panel A) revealed multiple episodes of non-sustained polymorphic VT (ns-PVT) and VF. He was taken to the EP laboratory the same day for epicardial ablation for BrS. A small patch of abnormal voltage and electrograms (EGMs) noted in the epicardial right ventricular (RV) outflow tract region (panel B). The abnormal EGMs were eliminated with ablation. He was started on quinidine and restarted on metoprolol post procedure. A few days later, he had recurrent ns-PVT that was preceded by dramatic ST elevation and QRS widening consistent with coronary vasospasm (panel C). Metoprolol was discontinued and verapamil was started. ICD was implanted prior to discharge. Quinidine was later discontinued and over months of follow-up he has had no further PVT or VF.

Conclusion: We describe a case of recurrent VF caused by concomitant BrS and coronary artery vasospasm. A combination of catheter ablation targeting the epicardial substrate of BrS and coronary vasodilator therapy to prevent recurrent spasm was effective to prevent recurrent VF.

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IMPLEMENTABLE LOOP RECORDER UTILIZATION IN PATIENTS WITH BREAST AUGMENTATION

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Background: Implantable loop recorders (ILR) are subcutaneous devices that offer long-term cardiac rhythm monitoring in patients with unexplained syncope, palpitations, or cerebrovascular accident. The utilization of ILRs in numerous patient populations has been growing. Though the implant procedure is minimally invasive, patients with breast augmentation and implants provide unique challenges and safety concerns.

Objective: To identify a favorable and safe implant technique for implantable loop recorder insertions in patients with breast implants.