Interim ICD shocks between visits A and B correlated with reduced QOL and increased CAQ.

**Conclusion:** Psychosocial symptoms stably improved after inclusion of a psychologist in a multidisciplinary VA clinic, supporting routine psychology counseling at least for patients with high baseline symptom burden.

### CE-540-04

**PROGNOSTIC VALUE OF PROGRAMMED STIMULATION AND NOT TESTING AFTER SCAR-RELATED VTABLATION: AN IVTCC STUDY**

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**Background:** Programmed stimulation (PS) is an established acute endpoint for ablation of scar-related VT. The characteristics and outcomes of patients rendered noninducible, inducible for non-clinical VTs, and those without PS have not been examined compared to those with acute failure in the multicenter IVTCC.

**Objective:** Evaluate characteristics and prognostic value of PS for freedom from VT recurrence, transplant, and death.

**Methods:** Data from scar-related VT ablations (both ischemic and non-ischemic) performed at 12 international referral centers were analyzed. Four categories of acute outcome based on PS were: 1) Non-inducible (NI), 2) Inducible for non-clinical VT (Partial), 3) not tested (NT), and 4) Inducible for clinical VT (Failure) and evaluated for VT and transplant-free survival.

**Results:** Data for 1,903 pts with VT ablation (12.8% women, 65 (55-72) years old) were analyzed. Eighty-five patients (4.5%) did not undergo PS after ablation. Compared with NI, Partial, and Failure patients, those NT had lower baseline EF (35%, 30%, 30% vs 25%, p<0.001), more frequent Class IV heart failure (4.9%, 3.3%, 63% vs 14.5%; p=0.002), and electrical storm (32.1%, 39.6%, 33.3% vs 51.3%, p=0.003). Procedurally, compared with NI, Partial, and Failure patients, those NT were more likely to have only unmappable VT (34.6%, 44.1%, 47.5% vs 64.6%, p<0.001), required more ablation (31 min, 36 min, 22 min vs 48 min, p<0.001), longer procedural time (240 min, 270 min, 270 min vs 293 min, p<0.001), and had more procedural complications (4.3%, 10.4%, 11.4% vs 14.1%, p<0.001). Patients rendered NI had highest freedom from VT, transplant, and death compared to Partial, NT, and acute Failure, respectively (74.1% vs 65.0%, 50.6%, 43.2%; p<0.001). Kaplan Meier estimates showed no significant differences between those with Failure and NT, which were both significantly worse than those that achieved NI and Partial acute endpoints.

**Conclusion:** Acute procedural success defined by complete or partial noninducibility is predictive of higher freedom from VT recurrence, transplant, and death. Failure to test after ablation is associated with poor heart failure status, longer ablation and procedural duration, and higher rates of complications, with adverse outcomes comparable to those with acute procedural failure.

### ABSTRACT CE-539:

(Under-)Utilization of Anticoagulation for AF

Saturday, April 30, 2022
9:15 AM - 10:15 AM

**CE-539-01**

**RACIAL AND ETHNIC INEQUITIES IN ORAL ANTICOAGULATION AND ASSOCIATED OUTCOMES FOR PATIENTS WITH ATRIAL FIBRILLATION - THE GET WITH THE GUIDELINES ATRIAL FIBRILLATION REGISTRY**

Utibe R. Essien MD, MPH; Lisa Kaltenbach MS; Tracy Wang MD, MHS, MSc; Gregg C. Fonarow MD; Kevin Thomas MD, FHRS; Mintu P. Turakhia MD, MS, FHRS; Emelia J. Benjamin MD, MS; Fatima Rodriguez MD, MPH; Margaret Fang MD, MPH; Jared Magnani MD, MSc and Jonathan P. Piccini MD, MHS, FHRS

**Background:** Oral anticoagulation (OAC) is under-prescribed in racial/ethnic minority patients with atrial fibrillation (AF). Little is known of how OAC rates differ in hospitalized patients with AF and how differential prescribing relates to inequities in AF outcomes.

**Objective:** We compared OAC initiation and AF-related outcomes by race/ethnicity in Get With The Guidelines Atrial Fibrillation (GWTG-AFib), a national quality improvement initiative for hospitalized AF patients.

**Methods:** Our primary outcome was the presence of OAC at discharge by race/ethnicity. We used Medicare linkage data to assess our secondary outcome of ischemic stroke, bleeding, or all-cause mortality at 1-year post-discharge by race/ethnicity.