increases (Fig. 1) compared to acute. This is primarily driven by non-selective HBP measurements which have a similar SDC. Chronaxie decreases significantly in follow-up for nonselective HBP (p < 0.05), there is a trend for increase in RV chronaxie in these pts. Selective HBP SDC and chronaxie demonstrate minimal change over time (Fig. 2). Chronic rheobase increases significantly for nonselective HBP (p < 0.025), insignificantly for corresponding RV capture but not for selective HBP. Dynamic measurements in 9 pts with acute and chronic SDC confirm same observations.

**Conclusion:**
1. Chronaxie for HBP decreases in follow up.
2. Use of lower pulse widths could decrease battery current drain but is negated by increase in nonselective PT.
3. Selective HB chronaxie and PT change minimally and are low.
4. Achieving selective HBP may allow to program a lower pulse width and to save battery.

**SELECTIVE HBP AND RV SDC (ACUTE VS CHRONIC)**

**PO-619-06**

**PRIME SCORE PREDICTS NEED FOR PERMANENT PACEMAKER AFTER TRANSCATHETER AORTIC VALVE REPLACEMENT**

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**Background:** High grade atrioventricular block is a common complication of transcatheter aortic valve replacement (TAVR). Current models for predicting risk of permanent pacemaker (PPM) after TAVR are not designed to be applied clinically to assist with pre-procedural planning and risk-benefit discussions with patients.

**Objective:** To aid procedural planning and patient discussion, we sought to produce a simple predictive scoring system that can be applied pre-TAVR to stratify risk of PPM after TAVR.

**Methods:** We analyzed consecutive patients undergoing TAVR at the University of Colorado from 2013-19. Pre-procedural clinical data were recorded. Patients were split into a training cohort to develop a predictive model and a testing cohort for model validation. Stepwise and binary logistic regression were performed on the training cohort to produce a simple scoring system for predicting PPM implantation. Scores then were applied to the validation cohort and receiver operating characteristic (ROC) analysis was performed to assess predictive accuracy.

**Results:** Of 699 patients who underwent TAVR, 606 were analyzed for this study; 483 (80%) were included in the training cohort and 123 (20%) in the validation cohort. Pre-existing PPM before undergoing TAVR was the principal reason for exclusion. Pacemaker was implanted in 78/483 patients from the training cohort. The need for PPM post TAVR was associated with five pre-procedure variables: PR interval > 200 ms, Right bundle branch block (RBBB), valve In valve procedure, prior Myocardial infarction, and self-Expandable valve. The PRIME scoring system (Figure) was developed in the training cohort using these five clinical features, and was highly accurate for predicting PPM implantation both in the model training cohort (area under the curve [AUC] 0.804) and in the model validation cohort (AUC 0.830). The PRIME score offered substantial improvement over the use of RBBB alone (AUC for RBBB alone = 0.671) for the prediction of PPM after TAVR.

**Conclusion:** The PRIME score is a simple and accurate pre-procedural tool for predicting the need for PPM implantation after TAVR.

**PO-619-07**

**CHEST WALL ADIPOSE TISSUE EXCISIONAL BIOPSY DURING PACEMAKER OR DEFIBRILLATOR IMPLANTATION: FIRST REPORT OF A NEW TECHNIQUE TO DIAGNOSE AND SUBTYPE AMYLOIDOSIS**

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**Background:** Availability of disease-modifying therapies has made early diagnosis of amyloidosis crucial. Clinical criteria and S124 Heart Rhythm, Vol 19, No 5, May Supplement 2022