5% (n = 2) on non-ibrutinib TKIs. 8% (n = 6) of patients on ibrutinib required antiarrhythmic drugs vs 5% (n = 2) on non-ibrutinib TKIs. Patients with NSVT on event monitor were more likely to be seen by cardiology and EP specialists (p = 0.002 and p = 0.018).

**Conclusion:** In this large dataset of ambulatory cardiac monitors receiving ibrutinib vs non-ibrutinib TKIs, with a high incidence of treatment interruption due to arrhythmia burden. More research is required to optimize strategies to diagnose, monitor, and manage TKI related arrhythmias.

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**THE PERI-INFART “GRAY ZONE” OF MYOCARDIAL FIBROSIS IS A BETTER PREDICTOR OF VENTRICULAR ARRYTHMIAS THAN DENSE CORE FIBROSIS IN PATIENTS WITH PREVIOUS MYOCARDIAL INFARCTION**

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**Background:** Current sudden cardiac death (SCD) risk stratification relies heavily on left ventricular ejection fraction (LVEF), but markers to refine risk assessment are needed. Dense core fibrosis (DCF) and peri-infarct “gray zone” of myocardial fibrosis (GZF) on late gadolinium enhancement (LGE) cardiac magnetic resonance (CMR) have been proposed as arrhythmogenic substrates.

**Objective:** We aimed to determine whether DCF and GZF could predict the occurrence of ventricular arrhythmias in patients with previous myocardial infarction.

**Methods:** We performed a single centre retrospective study enrolling consecutive patients with previous myocardial infarction undergoing CMR before implantable cardioverter-defibrillator (ICD) implantation. Areas of LGE were subdivided into “core DCF” and “peri-infarct” GZF zones based on signal intensity (>5 SD, and 2-5 SD above the mean of reference myocardium, respectively). The primary endpoint was a composite of sudden arrhythmic death, appropriate ICD shock, ventricular fibrillation (VF), or sustained ventricular tachycardia (VT) as detected by the device.

**Results:** A total of 88 patients (median age 61 years [IQR 54-73], 84% male, median LVEF 30% [IQR 23-36%]) were included.