

PAF procedures were performed with LASSO, Artic front cyroablation balloon and the Amigo robot (Catheter Robotics, Inc.) and weren't used in the analysis. Mean procedural time was  $107.9 \pm 35.9$  min, fluroscopy time was  $32.1 \pm 11.3$  min. Both measures were significantly shorter in the PVAC PAF group ( $p < 0.001$  for both). Mean hospital stay was  $0.84 \pm 0.6$  bed days. Mean follow-up time was  $529 \pm 187.54$  days. Subjective freedom from AF recurrence for all cases was 61%; for PAF PVAC 80% ( $p < 0.05$ ), for PAF Mesh 54% and for PersAF 59%. 76% reported some symptom improvement. 86% of patients were highly satisfied with the procedure. Major complications included: stroke in three patients (0.95%), TIA in 1 patient (0.32%), pericardial tamponade in four patients (1.27%), significant pulmonary vein stenosis in one patient (0.32%) and phrenic nerve palsy in two patients (0.64%).

**Conclusion** Our 3 year experience shows that AF ablation can be safely performed in a DGH settings with high procedural success rates and low complication rates. There was no need for acute surgical intervention in any of our cases.

### 066 ANTI-THROMBOTIC THERAPY AND ATRIAL FIBRILLATION IN SCOTLAND: RESULTS OF A NATIONAL AUDIT

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**Introduction and Methods** GP practices across Scotland were invited to participate in an audit of the management of atrial fibrillation (AF) as part of a national audit of Clinical Standards in Heart Disease by Health Improvement Scotland. A primary care database interrogation tool was developed to identify patients with AF, extract relevant data and calculate a CHADS<sub>2</sub> score for each patient.

**Results** 248 practices with a total practice population of 1376834 contributed data. 19470 patients with AF were identified (prevalence 1.4%) including 18165 patients with non-valvular AF. The majority of patients with non-valvular AF (56%) were in a high risk group for stroke (CHADS<sub>2</sub>  $\geq 2$ ) and the most prevalent risk factors overall were age  $\geq 75$  (55%) and hypertension (56%). Formal stroke risk assessment was rarely recorded in primary care (<1%). 79% of patients with AF were prescribed some form of anti-thrombotic therapy, either anti-platelet or warfarin (Abstract 066 table 1).

In the high risk group (CHADS<sub>2</sub>  $\geq 2$ ) not on warfarin, a minority of patients had recorded exclusion criteria for warfarin (10%). In patients with non-valvular AF who had a prior history of ischaemic stroke or TIA, less than half (44%) were on warfarin.

**Conclusion** In Scotland, patients with AF are not receiving anti-thrombotic therapy according to guidelines. Patients at high risk of stroke are undertreated with warfarin and those at low risk of stroke are over prescribed warfarin. Strategies to improve appropriate anti-coagulant use in this group include routine use of simple stroke risk stratification.

Abstract 066 Table 1

Stroke risk	No. of patients with AF (% of total)	No. on anti-platelet (% of group)	No. on warfarin (% of group)	No. on warfarin and anti-platelet (% of group)
CHADS <sub>2</sub> = 0	3136 (16)	1019 (32)	791 (28)	78 (3)
CHADS <sub>2</sub> = 1	5338 (28)	2039 (38)	1829 (35)	211 (4)
CHADS <sub>2</sub> $\geq 2$	9691 (56)	3778 (39)	3967 (41)	567 (6)

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### ANTICOAGULATION IN PATIENTS WITH ATRIAL FIBRILLATION AND A PERMANENT PACEMAKER REMAINS POOR AS GENERAL PRACTITIONERS ARE NOT INFORMED OF THE ARRHYTHMIA

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**Introduction** Electrocardiographic recognition of the underlying rhythm in patients with a permanent pacemaker can be very difficult. Atrial fibrillation/flutter in particular might go unreported and the paced rhythm can obscure recognition of atrial arrhythmias by the General Practitioners (GPs). Furthermore, in our region, pacing clinics are often run at the hospital independently of GPs, even if the patients are no longer followed-up in the cardiology outpatient clinic. Identification of new Atrial Fibrillation/Flutter might not be communicated adequately to GPs, therefore depriving patients from appropriate anticoagulation.

**Methods** We retrospectively reviewed records of 282 patients who attended routine outpatient pacing clinics in our institution over a 2-month period and identified patients with atrial arrhythmias suitable for anticoagulation. We considered all patients with persistent Atrial Fibrillation/Flutter or paroxysmal Atrial Fibrillation/Flutter >30 min (all 4 groups referred to as AF in the text) with a calculated CHA<sub>2</sub>DS<sub>2</sub>-Vasc  $\geq 2$  as eligible for anticoagulation. The electronic records and/or case notes were reviewed establishing whether the patients were anticoagulated and whether GPs had been informed of the diagnosis of AF.

**Results** 282 cases (men=124) were reviewed and 95 patients (33.7%) were noted to have AF (men=40, age median=83, mean CHA<sub>2</sub>DS<sub>2</sub>-Vasc=3.7). 72 patients (75.8%) had persistent AF/Flutter and 23 patients (24.2%) had paroxysmal AF/Flutter. For 24/95 (25.3%) patients, AF was first identified after pacemaker implantation at a routine pacing check and the GP (or cardiologist) had not been informed of this diagnosis. Therefore, these patients were never considered for anticoagulation. 44/95 (46.3%) were anticoagulated with warfarin and 13/95 (13.7%) were unable to take or refused warfarin due to: frequent falls (3), general fragility (1), dementia (1), gastric cancer (1), gastric bleed (1), subdural haematoma (1), hepatocellular carcinoma (1), dual antiplatelets for coronary stents (1), and due to patient refusal (3). There was no significant difference in informing GPs between paroxysmal and persistent AF/Flutter ( $\chi^2$   $p=0.16$ ), men and women ( $\chi^2$   $p=0.25$ ).

**Conclusions** We have shown that it is very common to identify AF following pacemaker implantation and the incidence of AF in patients with permanent pacemakers is much higher than historical age-matched population (33.7% vs 10.0%). Anticoagulation in this group remains sub-optimal. Up to 25.3% of the patients are found to have AF suitable for consideration of anticoagulation, however this information is not passed to the GPs for further action. A routine pacing clinic review offers an ideal opportunity for identification of AF. Liaising with the GP however, is essential to optimise anti-coagulation uptake in this population.

Abstract 067 Table 1

Total patients reviewed in pacing clinic	282	
Patients with AF	95	33.7%
Patients on warfarin	44	46.3%
Patients who were considered inappropriate/declined warfarin	13	13.7%
Patients where GP had been informed at any stage (before or after implant) of AF	14	14.7%
Patients where the GP was never informed (and never considered for anticoagulation)	24	25.3%