according to AGLA, at intermediate risk after reclassification, and could become true low risk through intensified intervention.

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Determinants and trajectory of phobic anxiety in patients living with an implantable Cardioverter defibrillator
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Background: The implantable cardioverter defibrillator (ICD) is the gold standard therapy to prevent life-threatening arrhythmias. Phobic anxiety predicted ventricular arrhythmia in coronary heart disease patients, but little is known about phobic anxiety in ICD patients. Therefore, we aimed to identify determinants and the course of phobic anxiety in ICD patients.

Methods: Study participants were 140 patients living with an ICD (mean age 56+/−14 years, 66% men). They completed the phobic anxiety subscale of the Symptom Checklist-90-Revised at a mean of 27+/−21 months (range 3-109) post-ICD placement (baseline) and after an average follow-up of 41+/−18 months (range 10-82). Multivariate linear regression models considered sociodemographic factors, clinical variables, and psychological scales as potential determinants of phobic anxiety scores.

Results: Higher age (p=0.003), previous shock experience (p=0.007), depressed mood (p<0.001) and hypochondriasis (p=0.005) were associated with higher phobic anxiety scores at baseline. An elevated number of non-cardiac diseases (p=0.030) and higher baseline phobic anxiety scores (p<0.001) determined greater phobic anxiety scores at follow-up. Younger age (p=0.029) and an elevated number of non-cardiac diseases (p=0.019) were both associated with an increase in phobic anxiety scores from baseline to follow-up. Moreover, slightly more patients had a high phobic anxiety level (score > 4) at follow-up compared to baseline (31% vs. 24%, p=0.048).

Conclusions: Even at high levels, phobic anxiety scores are considerably persistent over time in ICD patients. Modifiable determinants of phobic anxiety were identified which may inform tailored interventions to improve ICD patients’ distress and perhaps prognosis.

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A near fatal interaction - torsade de pointes associated with an acquired long QT under sotalol and moxifloxacin
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Case: A 78 year old female was brought to the emergency department after having suffered multiple syncopal attacks, at least one of which was followed by a generalised seizure (observed by her son). She was on Sotalol (160mg-0-80mg) as regular medication for a paroxysmal atrial fibrillation as well as lisinopril, torasemid and aspirin cardio. Antibiotic treatment with moxifloxacin for a suspected pulmonary infection had been established four days prior to hospital admission.

The initial ECG showed a QTc of 630ms. Whilst being questioned about her symptoms, she experienced several episodes of recurrent self-limiting sensations of dizziness and tightness in the chest for several seconds without losing consciousness. The electrocardiographic recording showed ventricular tachyarrhythmias in the form of torsades de pointes. Laboratory tests revealed hypokalaemia, hypocalcaemia and elevated inflammatory markers.

Initially 2 grams magnesiumsulfat were given intravenously twice; a continuous infusion of magnesium and potassium was started. Sotalol was discontinued, as was moxifloxacin. Following these actions her heart rhythm stabilised. Four days later her rhythm switched to tachycardic atrial fibrillation, which then was rate controlled by metoprolol.

Discussion: Torsade de pointes is associated with an acquired or congenital prolongation of the QT-interval. Typically terminating spontaneously, it recurs frequently and can lead to ventricular fibrillation and hence sudden cardiac death. It is caused by decreased repolarising currents which can lead to afterdepolarisations. These can trigger the tachyarrhythmia if they occur in the vulnerable phase of repolarisation (R on T). Various drugs, such as sotalol and fluorchinolone, prolong the QT-interval by directly inhibiting the influx of potassium responsible for repolarisation.

In our case the patient has been treated for paroxysmal atrial fibrillation with sotalol and already had a prolonged QT-interval (500ms) noted seven years ago. Adding moxifloxacin to her regular medication, lead to the consequences described above. In addition, she had several further risk factors: age, female gender, hypokalaemia, structural heart disease (diastolic dysfunction).