Table 1. AFSS outcome scores by EHRA classification and the correlation between the AFSS outcome scores and EHRA classification

	EHRA 1	EHRA 2	EHRA 3	EHRA 4	p value	Correlation coefficient (p value)
Total AF burden (range:3-30)	7.1±5.2	14.4±5.3	17.0±4.6	22.6±3.4	< 0.001	0.7 (<0.001)
Symptom severity (range 0-35)	3.6±4.7	8.8±5.8	17.7±6.6	23.8±7.4	< 0.001	0.7 (<0.001)
Health care utilization:						
Cardioversion (0-7)*	0.2±0.6	0.3±0.84	0.4±1.2	0.7±0.8	0.5	0.1 (0.09)
Emergency room visit (0-7)*	0.2±0.4	0.7±1.1	1.7±1.8	2.8±2.0	<0.001	0.4 (<0.001)
Hospitalization (0-7)*	0.2±0.4	0.6±0.8	1.0±1.1	1.8±1.6	0.001	0.4 (<0.001)
Specialist visit (0-7)*	1.5±1.5	2.5±2.3	2.5±2.0	2.8±1.8	0.2	0.2 (0.07)

Data are presented as mean±standard deviation. *The numbers indicate the range of scores. A correlation coefficient of > 0.6 indicate strong correlation. Increasing scores indicate increasing symptoms and severity. AFSS: Atrial Fibrillation Severity Scale EHRA:European Heart Rhythm Association class

Table 2. AFSS scores by SAF classification and the correlation between AFSS outcome scores and SAF classification

	SAF 0	SAF 1	SAF 2	SAF 3	SAF 4	p value	Correlation coefficient (p value)
Total AF burden (3-30)¶	5.7±5.1	9.2±5.0	15.2±4.6	17.6±3.8	21.4±4.7	< 0.001	0.75 (<0.001)
Symptom severity (0-35)¶	3.3±4.0	4.2±5.2	9.9±4.2	15.2±5.0	23.6±.6.8	<0.001	0.79 (<0.001)
Health care utilization:							
Cardioversion*	0.4±1.0	0.2±0.5	0.2±0.5	0.5±1.4	0.5±0.7	0.80	0.08 (0.40)
Emergency room visit*	0.3±0.5	0.5±1.1	0.6±1.0	1.3±1.6	2.5±1.9	<0.001	0.4 (<0.001)
Hospitalization*	0.3±0.5	0.5±0.8	0.5±0.6	0.7±1.1	1.4±1.6	0.08	0.2 (0.05)
Specialist visit*	1.7±1.5	1.8±1.8	2.8±2.6	2.2±2.1	2.7±1.7	0.47	0.18 (0.16)

Data are presented as mean±standart deviation. A correlation coeffcient of >0.6 indicates strong correlation. ¶The numbers indicate range of scores. *The score of the items in the health care utilization subscale ranges from 0-7. Increasing scores indicate increasing symptoms. AFSS: Atrial Fibrillation Severity Scale SAF: Severity in Atrial Fibrillation class

Table 3. Internal consistency of the three domains of the AFSS

	Internal consistency (Conbach α)
Total AF burden	0.85
Symptom severity	0.90
Health care utilization	0.67

AFSS: AF severity scale AF: atrial fibrillation

ORALS

OP-148

Non-Valvular Atrial Fibrillation in the Elderly; Preliminary Results from the National AFTER (Atrial Fibrillation in Turkey: Epidemiologic Registry) Study

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Objective: This study aimed at the assessment of the clinical approach to AF in the older population and the consistency with the guidelines based on the records of the multicenter, prospective AFTER (Atrial Fibrillation in Turkey: Epidemiologic Registry) study.
Methods: 2242 consecutive patients admitted to the cardiology outpatient clinics of 17 different tertiary health care centers with at least one AF attack determined on electrocardiographic examination, were included in the study. Among the patients included in the study, 631 individuals aged 75 years and older were analyzed.
Results: The mean age of the patients was determined as 80.3±4.2 years. The most frequent type of AF in geriatric population was the persistent- permanent type with a percentage of 88%. 60% of the patients with AF were female. Hypertension was the most common co-morbidity in patients with AF (76%). While in 16% of patients a history of stroke, transient ischemic attack or systemic thromboembolism was present, a history of bleeding was present in 14% of the patients. 37% of the patients were on warfarin treatment and 60% of the patients were on aspirin treatment. In 38 % of the patients who were on oral anticoagulant treatment, INR level was in the effective range.
Conclusion: The rate of anticoagulant use in the elderly with AF was 37% and considering the reason of this situation was the medication not being prescribed by the physician, one should pay more attention particularly in the field of treatment.

OP-149

Can Superiority of Rhythm Control be Expected in Young Patients with Non-Valvular Atrial Fibrillation (AF)?

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Introduction: Since transition disease has become a reality with the aging of the population, non-valvular AF appears as a new challenge in the scope of cardiology.

There are two strategies in the treatment of atrial fibrillation. One of them is cardioversion and maintenance of sinus rhythm with antiarrhythmic drugs; the other one is respect of AF and treatment with rate control drugs.

The two strategies were widely compared in the Affirm Study Without superiority of any of them. However, with a focus on the population studied in Affirm, we notice that it concerned old population at high risk of Stroke.

The aim of our study is then to compare the two strategies from another angle by targeting a population of younger and more active patients with AF.
Methods: We randomly assigned, in a prospective open-label study, 266 eligible patients with non- valvular AF, average age 52,41±9,6 years, 174 men (65,4 %,sex ratio 1,89), to undergo a rhythm control (R=131 patients) or a rate Control (F=131 pts) strategy.

The average follow -up (FU) was 27,18 months with 4 patients lost of view.

15 pts (8 and 7) were concerned by cross over from one strategy to the other.
Results: 240 pts (90%) pts were symptomatic. AF was paroxystic in 97 pts (36%), persistent in 61pts (23%) and permanent in 108pts (41%). 203 pts had comorbidities particularly hypertension in 142 (53%) and diabetes in 34 (13%). Isolated AF was present in 63pts (24%).219 pts (82%) were at low thromboembolic risk with a CHADS2 score ≤1. The hemodynamic status was favorable with an average LVEF of 64%.

There were fewer events in the R arm than in the F one, appearing late during FU but the difference wasn't statistically significant. There was no significant difference in survival without heart failure or ischemic stroke, respectively 83.8% [CI: 68.5- 100] and 56.6% [36.4-88], p=0.43.
Discussion-Conclusion: These results can be explained by the young age of the population with a low risk in which the events are rare and late in a chronic disease that requires treatment and long term follow up. For more than 2 years FU, superiority of rhythm control over rate control wasn't demonstrated despite the patients' profile that seemed to be favorable. However, given the shape of the survival curves, we can anticipate a superiority of rhythm control in the long term.