



A case of TAV in SAV with Evolut FX

A nightmare case?

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86 years old, female

severe SVD, post SAVR (CEP 19mm in 2009)

CKD

<PE> HT 145.9 cm, BW 42.2 kg, BSA 1.306 m², STS score 7.403 %
eGFR 22, Hb 11.7, Plt 12.2万

<ECG> AF, block- <Spirometer> FEV1.0 1.07L

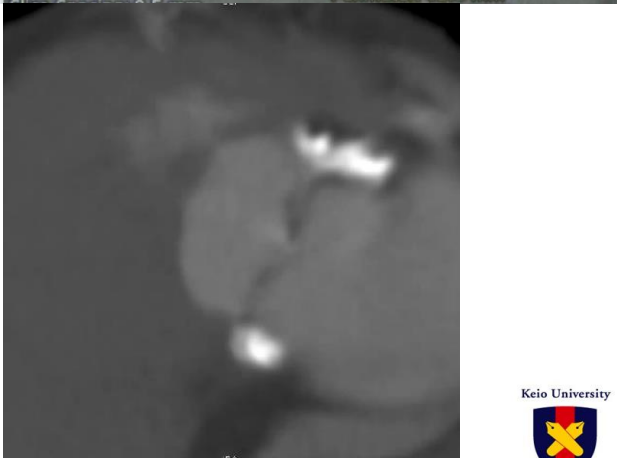
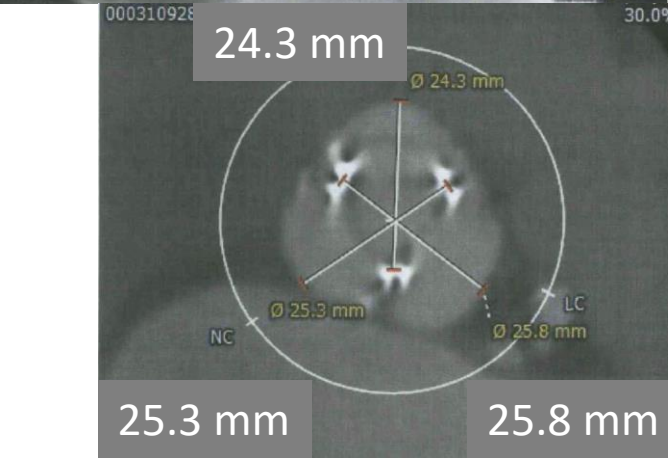
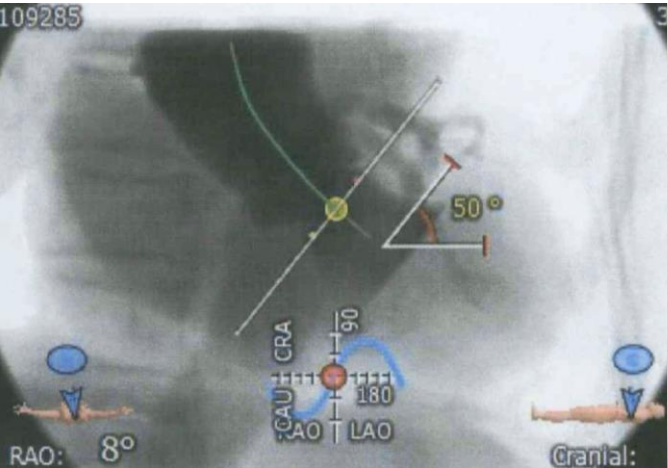
<CT> no sig stenosis

<TTE> mild AR, moderate MR, trivial TR

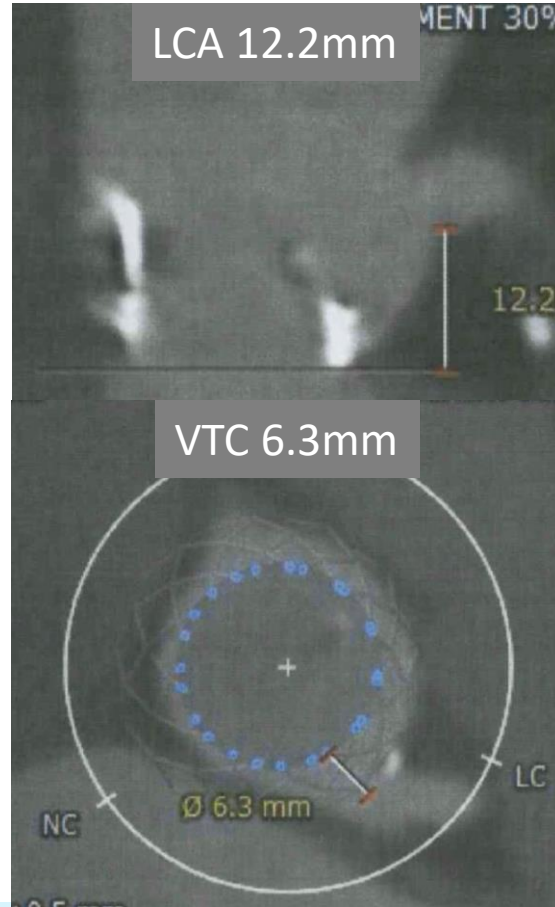
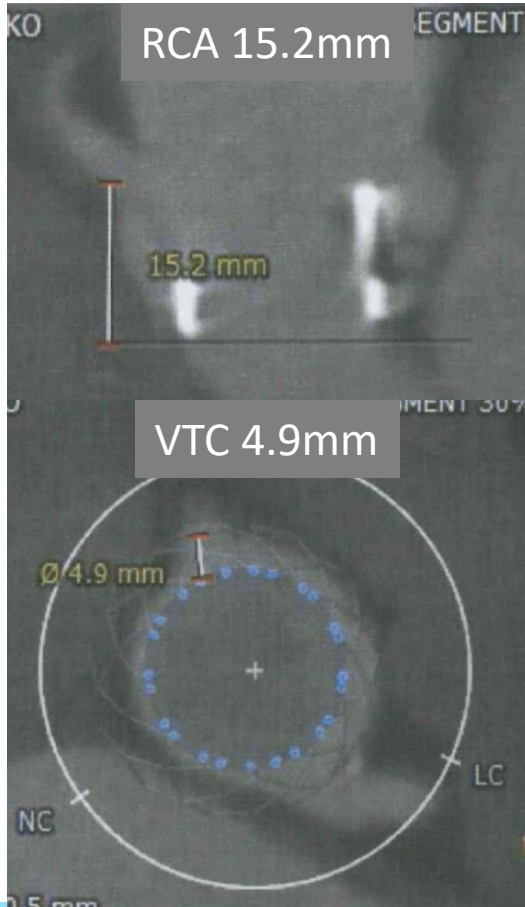
EF 68.9%, LVDd/Ds 46/26 mm, SVi 43.5ml/ m²

p/m PG 61/28 , pVel 3.9m/s, AVA 0.66 cm², iAVA 0.50 cm² /m²

CT images

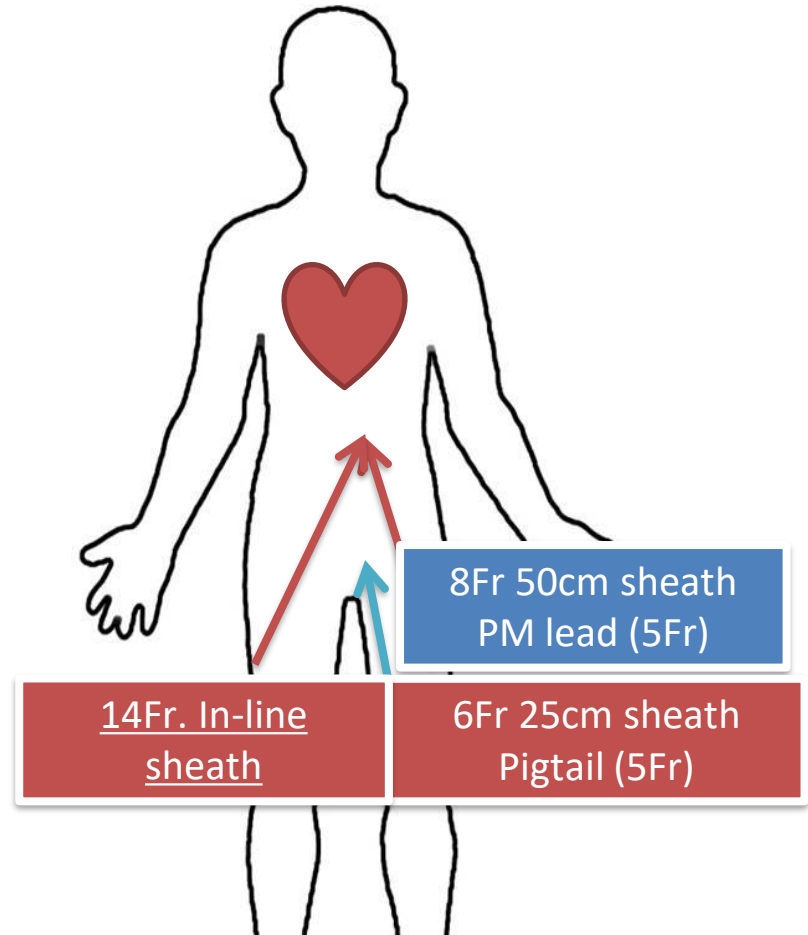


Ilio-femoral access



Procedural planning

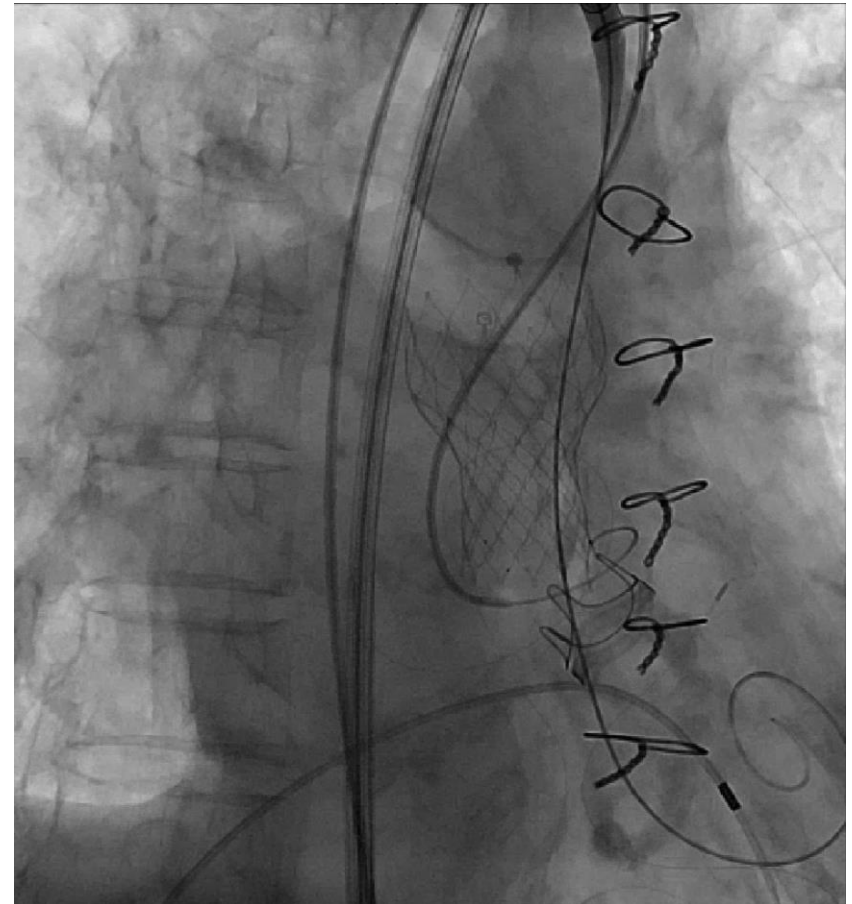
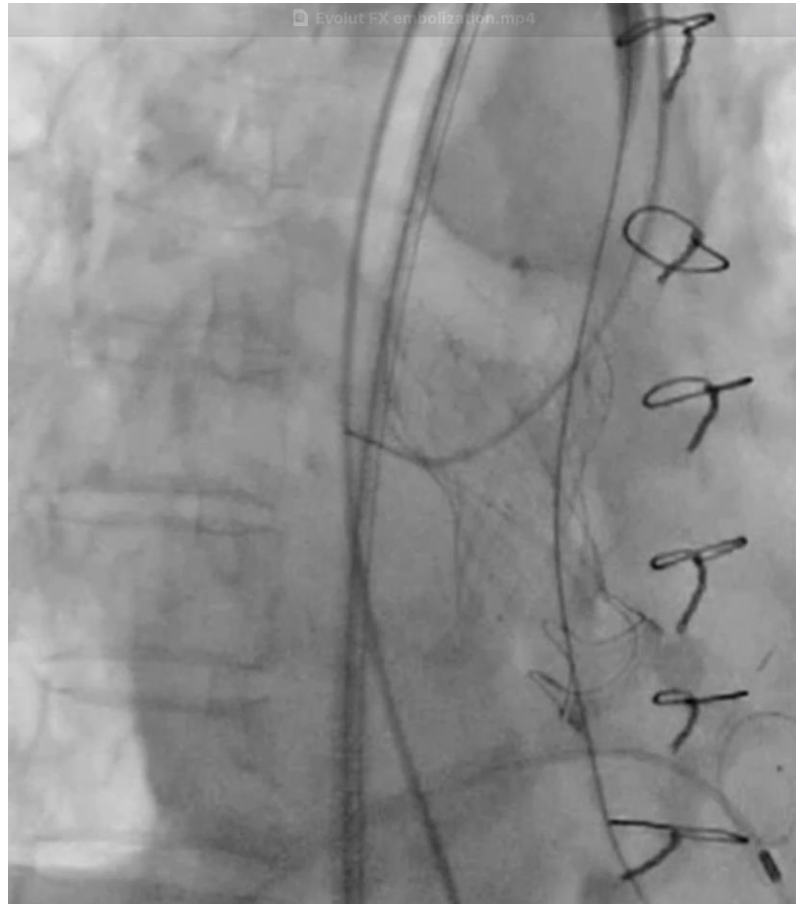
- TF-TAV in SAV
- Evolut FX 23mm
- Direct implantation
- Post-dilatation if needed



Was it too high?



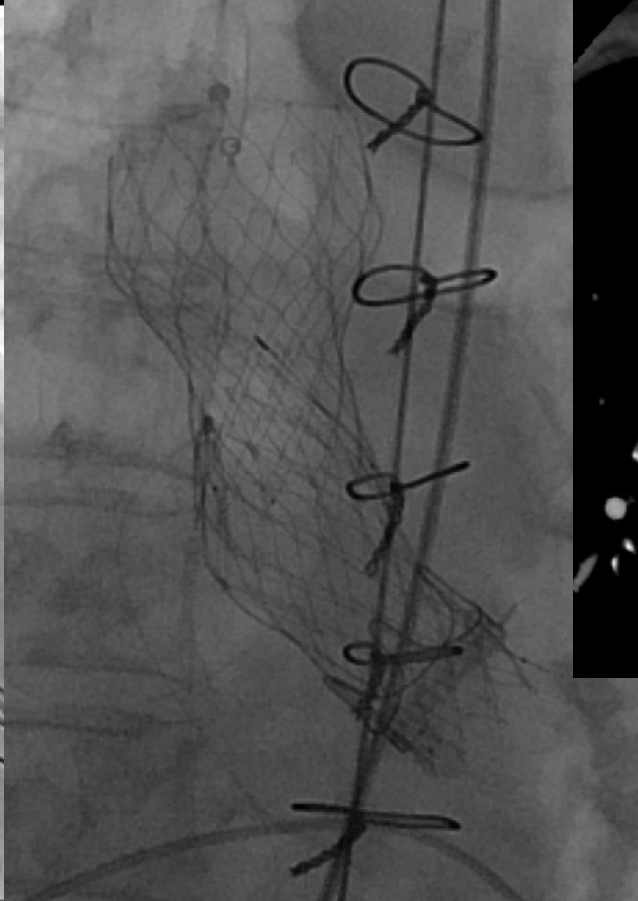
Crossing the cell at the outer curvature



Controlling the migrated valve with balloon anchoring (10mm)

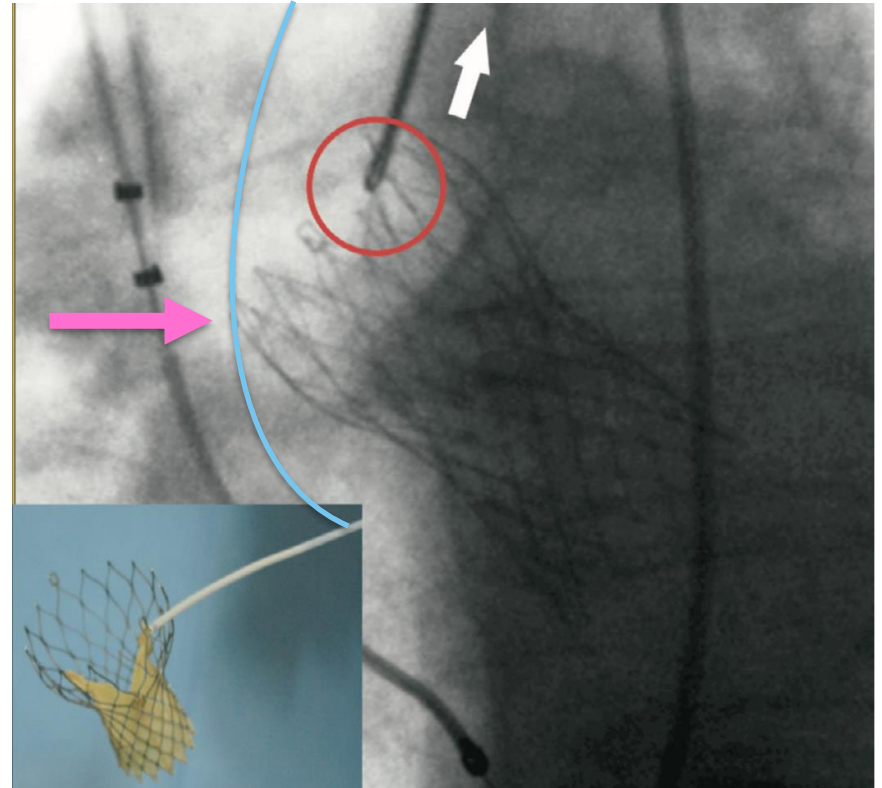


Post-dilatation



Challenges in snaring of a migrated valve

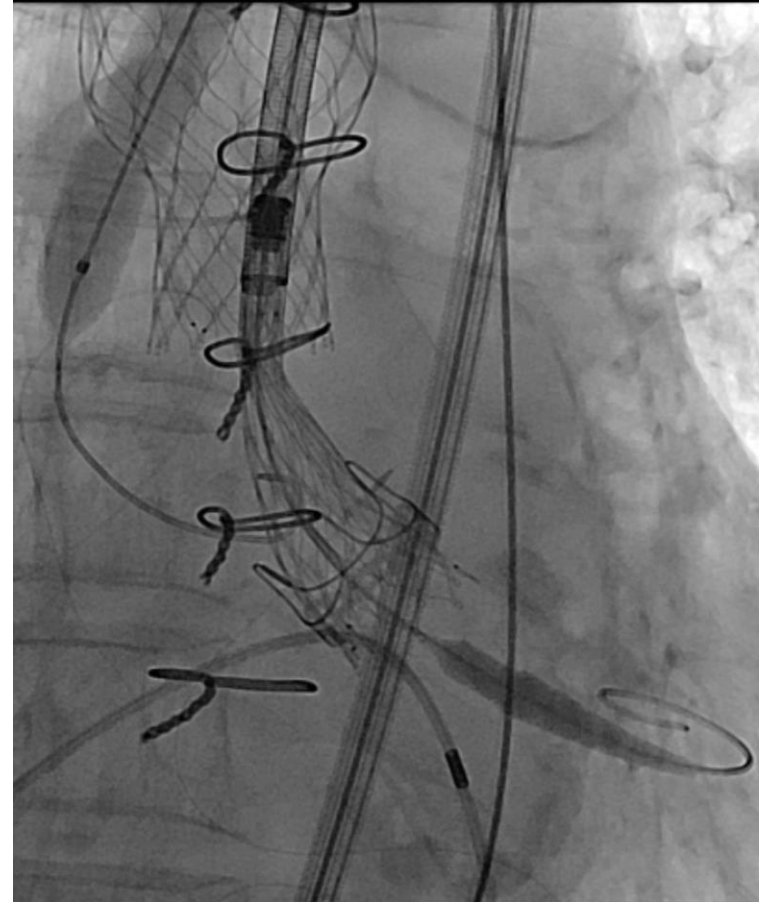
- Snaring a migrated valve is sometimes challenging
- Snaring the inner tab may cause injury of the ascending Ao by the outer tab



Ussia et al. EuroIntervention 2012, modified

Advantage of balloon anchoring

- Balloon anchoring of outer side provides easier control and less chance of injury
- This technique also provides upward and downward control of the valve



Conclusions

- Positioning of Evolut for TAV in SAV should be conservative
- Balloon anchoring of the outer side of the migrated Evolut worked well
- Avoidance of the consecutive complication is important



Thank you!!