Percutaneous Pulmonary Valve Implantation
Edwards-Sapien Valve

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Disclosure: None Related to this

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Pulmonary Regurgitation

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Significant PR results in:

Progressive RV dilation & development of ventricular arrhythmias.

RV dysfunction & sudden death.

Pulmonary valve replacement at an appropriate age may restore RV function and improve the symptoms.

Early clinical exprience with transcatheter pulmonary valve replacement is safe and very encouraging.

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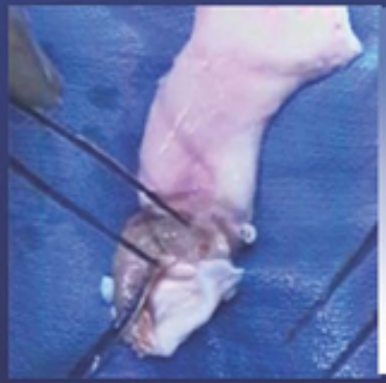
Conduit Types

Homograft

Cloth tube conduit – porcine valve mounted into polyester tube

Medtronic Contegra – bovine jugular vein

- **Conduit/valve stenosis is primary failure mode**



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Unmet Clinical Need

Conduit durability is often limited by resulting stenosis, thrombosis and calcification of the valve causing clinical deterioration and requiring reoperation.

- **Mean time to reoperation*:**
  - **10.3 years for xenografts**
  - **16 years for homografts**
- **Reoperations associated with increasing mortality**:**
  - **4% mortality rate on initial procedure**
  - **7% mortality rate on first re-operation**
  - **11% mortality rate on second re-operation**
  - **13% mortality rate on additional operations**

*Tweddell et al. Factors affecting longevity of homograft valves used in RVOT reconstruction for CHDCirc 2000;102:(Suppl):III-130-III-135 and Homann M, et al. Reconstruction of the RVOT with valved biological conduits: 25 years experience with allografts and xenografts. EurJCardioThorac Surg 2000; 17:624-30

**Dore A et al. Cardiac Surgery for Grown-Up Congenital heart patients: Survey of 307 Consecutive Operations from 1991-1994 Am J Cardiol 1997; 80:906-13 and Somerville J. Grown-up congenital heart disease - medical demands look back, forward 2000. Thorac Cardiovasc Surg 2001; 49(1): 21-6

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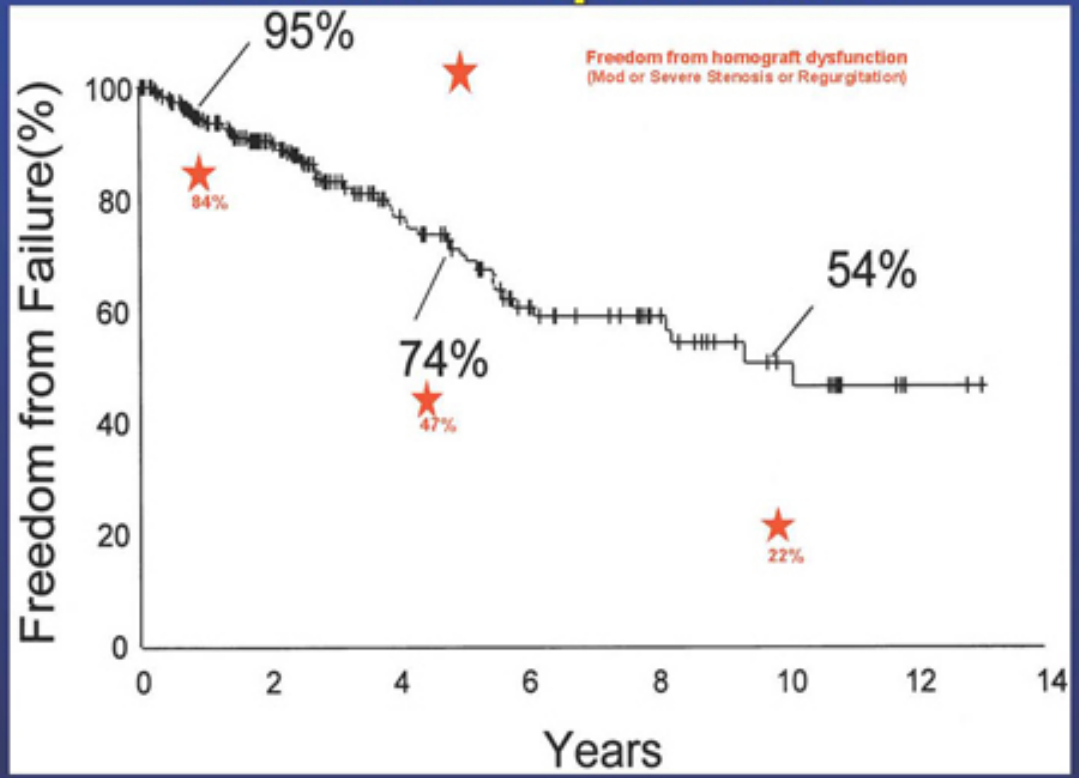

Tweddell et al. Factors affecting longevity of homograft valves used in RVOT reconstruction for CHD Circ 2000;102:(Suppl):III-130-III-135.

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ACC/AHA 2006 Guidelines for the Management of Patients With Valvular Heart Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Revise the 1998 Guidelines for the Management of Patients With Valvular Heart Disease) Developed in Collaboration With the Society of Cardiovascular Anesthesiologists Endorsed by the Society for Cardiovascular Angiography and Interventions and the Society of Thoracic Surgeons

Robert O. Bonow, Blase A. Carabello, Kanu Chatterjee, Antonio C. de Leon, Jr, David P. Faxon, Michael D. Freed, William H. Gaasch, Bruce Whitney Lytle, Rick A. Nishimura, Patrick T. O'Gara, Robert A. O'Rourke, Catherine M. Otto, Pravin M. Shah, Jack S. Shanewise, Sidney C. Smith, Jr, Alice K. Jacobs, Cynthia D. Adams, Jeffrey L. Anderson, Elliott M. Antman, David P. Faxon, Valentin Fuster, Jonathan L. Halperin, Loren F. Hiratzka, Sharon A. Hunt, Bruce W. Lytle, Rick Nishimura, Richard L. Page, and Barbara Riegel

J. Am. Coll. Cardiol. 2006;48;e1-e148
doi:10.1016/j.jacc.2006.05.021

PRACTICE GUIDELINE: FULL TEXT

ACC/AHA 2008 Guidelines for the Management of Adults With Congenital Heart Disease

A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Develop Guidelines on the Management of Adults With Congenital Heart Disease)

Developed in Collaboration With the American Society of Echocardiography, Heart Rhythm Society, International Society for Adult Congenital Heart Disease, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons

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Percutaneous Pulmonary Valve Implantation

AHA Scientific Statement

Indications for Cardiac Catheterization and Intervention in Pediatric Cardiac Disease

A Scientific Statement From the American Heart Association

Endorsed by the American Academy of Pediatrics and Society for Cardiovascular Angiography and Intervention

Timothy F. Feltes, MD, FAHA, Chair; Emile Bacha, MD; Robert H. Beekman III, MD, FAHA; John P. Cheatham, MD; Jeffrey A. Feinstein, MD, MPH; Antoinette S. Gomes, MD, FAHA; Ziyad M. Hijazi, MD, MPH, FAHA; Frank F. Ing, MD; Michael de Moor, MBBCh; W. Robert Morrow, MD; Charles E. Mullins, MD, FAHA; Kathryn A. Taubert, PhD, FAHA; Evan M. Zahn, MD; on behalf of the American Heart Association Congenital Cardiac Defects Committee of the Council on Cardiovascular Disease in the Young, Council on Clinical Cardiology, and Council on Cardiovascular Radiology and Intervention

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Indications to Replace PV

- Symptomatic patients with severe PR-NYHA Class II-III
- Asymptomatic patients: Regurgitant fraction >40%; RVEDV>150 ml/m2; RF EF<40%; QRS>180 msec

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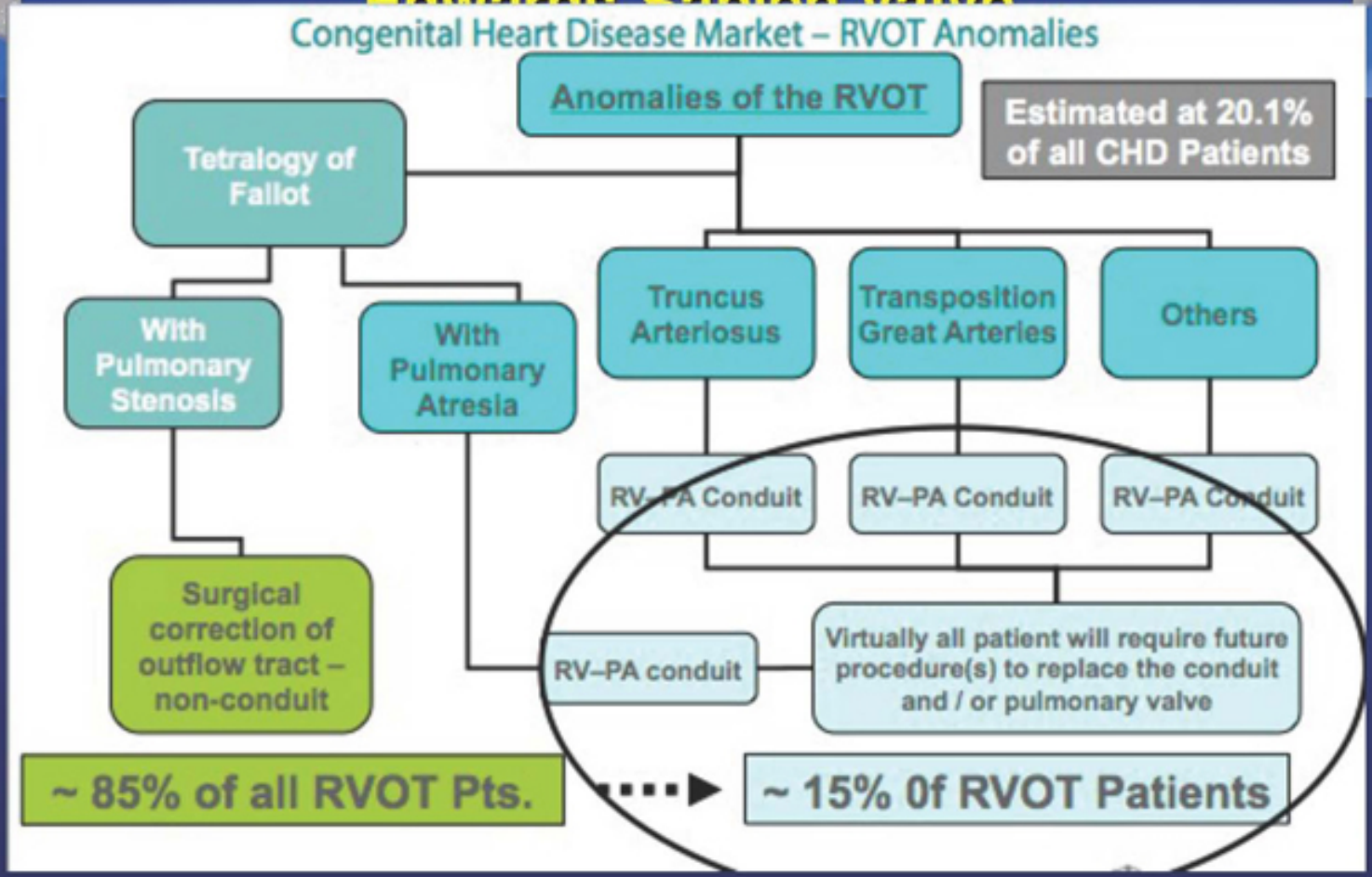

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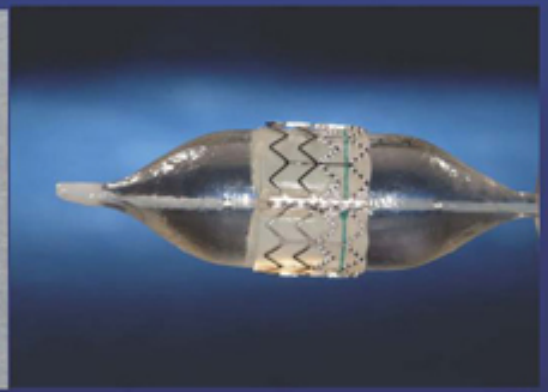
The Edwards Sapien THV™

- Made of three Bovine pericardial leaflets
- Stent: stainless steel, 14 mm long, maximal diameter is 23-26mm.
- Requires 22-24 Fr sheath for delivery



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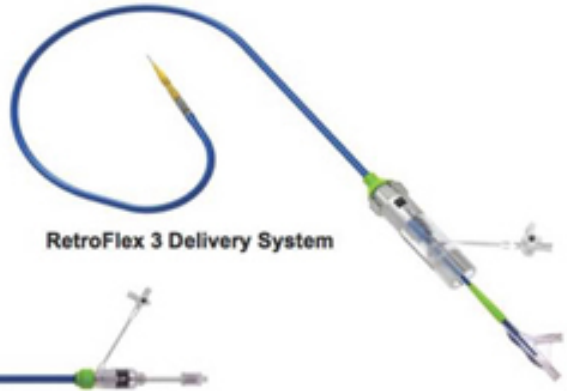
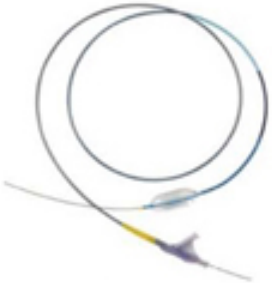
Edwards SAPIEN THV



RetroFlex 3 Delivery System



RetroFlex Balloon Catheter

RetroFlex 3 introducer Sheath Set

Atrion
Inflation Device

Crimper

RetroFlex Dilator Kit

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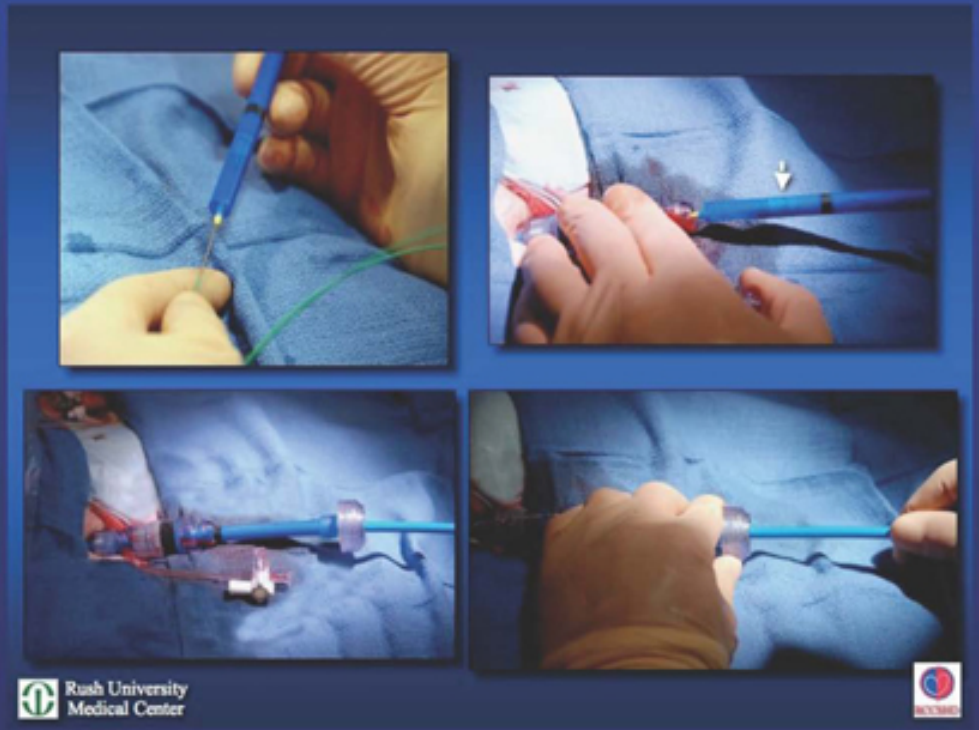

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The COMPASSION Study

COngenital **M**ulticenter trial of **P**ulmonic v**A**lve regurgitation
Studying the **S**APIEN™ Interventi**ON**al THV
Inclusion Criteria

- 1. Weight>35 kg
- 2. Conduit >16mm & <24mm
- 3. Severe PR >3+ or >40% regurgitant fraction and or severe PS
- 4. Subject is symptomatic as evidenced by CP exercise testing
- 5. Must comply with F/U
- 6. Subject agrees to come back for F/U
- 7. Catheterization is feasible

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Exclusion Criteria

- 1. Active Infection
- 2. Previously enrolled in this study
- 3. Subject has prosthetic heart valve
- 4. Severe Chest wall deformity
- 5. Leukopenia (<3000)
- 6. Acute or chronic anemia (<9 gm%)
- 7. Platelet count <100,000
- 8. Echo evidence of intracardiac mass/ thrombus
- 9. History of or active endocarditis
- 10. Hypersensitivity to aspirin or heparin
- 11. Life expectancy <1 year

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Exclusion Criteria

- 12. Obstruction of the central veins
- 13. Positive pregnancy test
- 14. RVOT aneurysm
- 15. Ileofemoral vessel that would preclude 22-24F
- 16. Contraindication to MRI
- 17. Need for concomitant interventional procedure (ASD/ VSD)

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24 y/o Female, Wt: 46 Kg

Dx: Subaortic obstruction. Age 2yr: resection.
Age 5 yr: Modified Kono, resulted in CHB & AR.
Age 7 yr: Ross Operation, 21 mm Homograft.
NYHA-II

Age 24: cath: RV:DAO 62:97.

Post P3110 stent on 20mm BiB: RV:DAO 42:97.

Post 23mm Sapien RV:DAO 25:117

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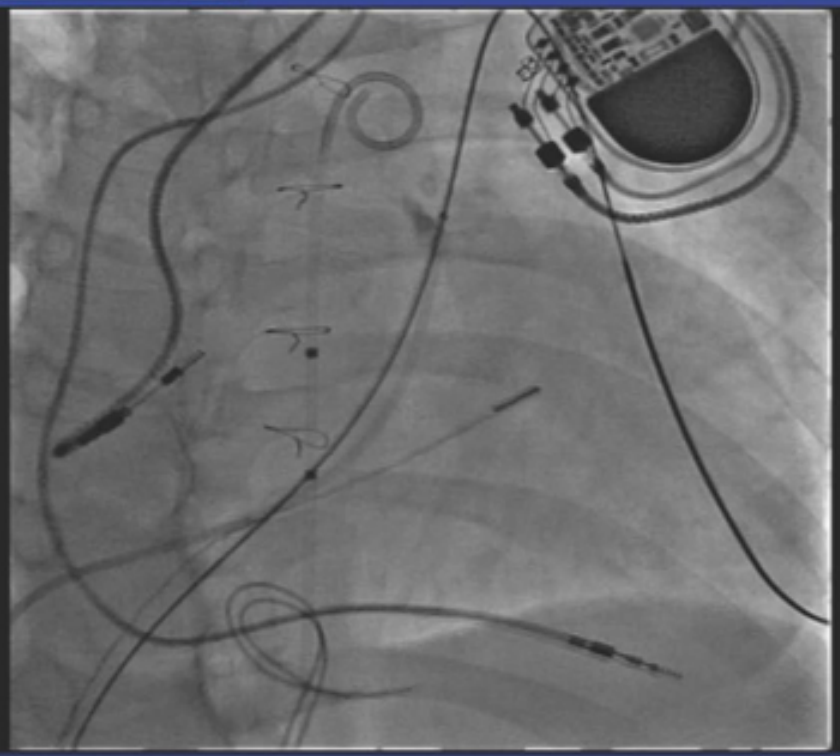

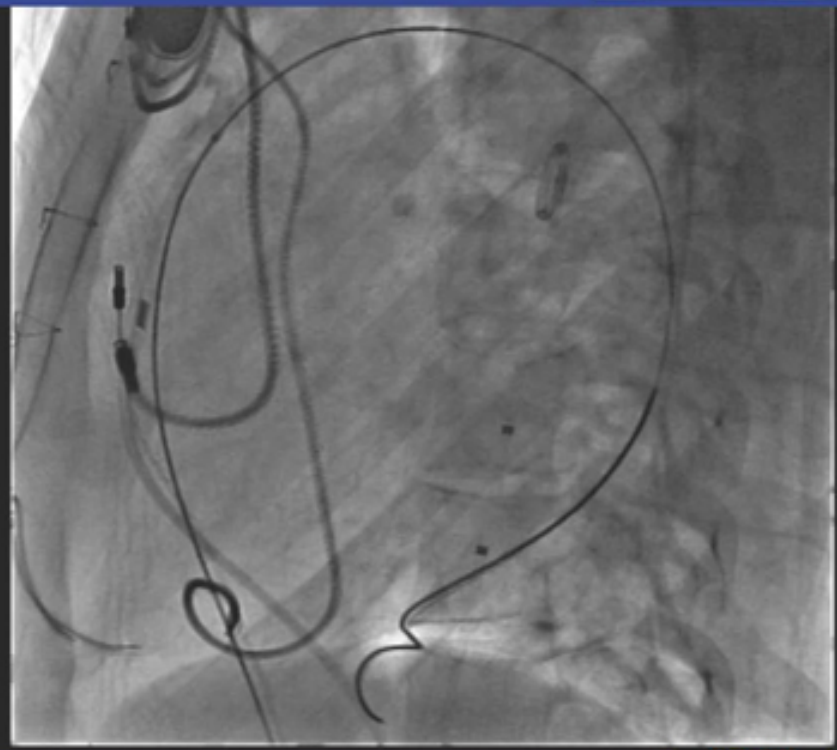

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Take Home Messages

- 1. tPVR is available option for patients with dysfunctional conduits
- 2. Pre-stenting of conduits
- 3. Very high pressure balloons are needed
- 4. Evaluation of coronary artery proximity to the conduit

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Interim Analysis

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Methods - Criteria

- Dysfunctional RV-PA conduit:
  - ≥3+ PR by TTE or PRF ≥40% by cardiac MRI ± stenosis
  - body weight was ≥35kgs
  - *In situ* conduit diameter was ≥ 16mm and ≤ 24mm
- Schedule of Events:* *includes NYHA*

	Baseline	D/c	30/7	6/12	12/12	Annual
Physical*	☆	☆	☆	☆	☆	☆
AEA		☆	☆	☆	☆	☆
CXR/TTE	☆	☆	☆	☆	☆	☆
CPET	☆			☆	☆	☆
MRI	☆			☆		
CTA	☆			☆	☆	☆

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Outcomes

- **Primary Outcome:**
  - *Freedom from device failure or procedure related death and/or reoperation at 1 year*
- **Secondary Outcomes:**
  - *Freedom from major adverse cardiac and cerebral events at 6 months*
  - *evidence of functional improvement assessed by improvement in:*
    - –degree of pulmonary regurgitation and stenosis on TTE
    - –pulmonary regurgitation on MRI

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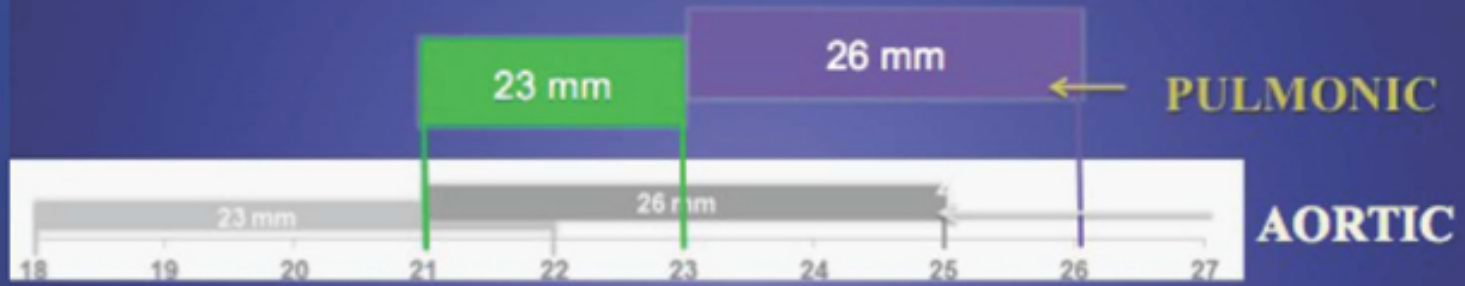
Edwards SAPIEN THV Sizing



	SAPIEN Valve Size
Dilated Conduit Diameter 21- 23mm	23mm
Dilated Conduit Diameter 23- 26mm	26mm

*For non-stenotic conduits, 10-15% oversizing is recommended

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PICS-AICS
Pediatric and Adult Interventional Cardiac Symposium

COMPASSION Patient Summary

• Patients (AT)	n = 50
• Age	28.7 ± 15.0 years (10 – 72)
• Sex	31M:19F
• Weight	72.8 ± 24.5kgs
• Diagnosis	
ToF	40%
Ross Procedure	36%
• Open Heart Surgeries	2.1 (1-4)
• RVOT Conduit Type	96% homograft
• Original RVOT Conduit Size	24 ± 3mm (18 – 29mm)
• Indication	
• Mixed	64%
• Regurgitation	18%
•RVOT Pre-stenting	100%

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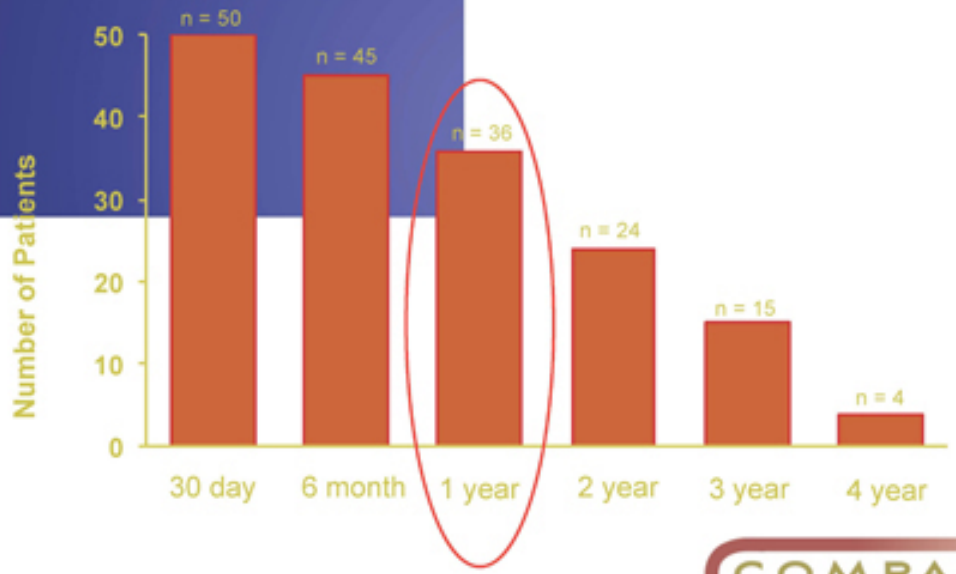
Patient Follow-up

- 50 implants, 5 centers (26mm valve, n=15)
- 87.9 total patient years, mean = 1.76 ± 1.2 year



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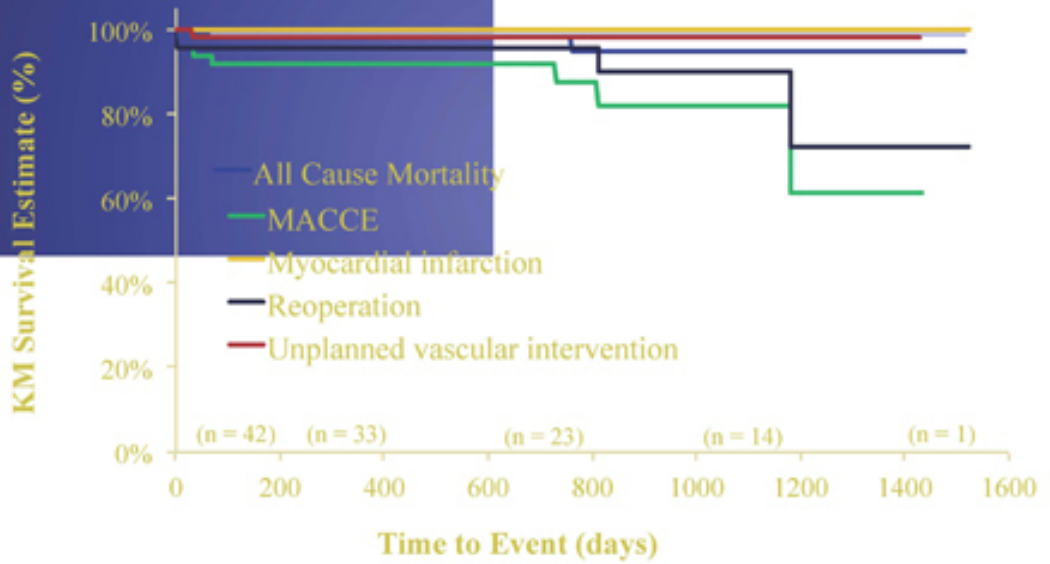
- 96% Freedom from death or reoperation at 1 year
- 94% Freedom from MACCE at 6 months and 1 year



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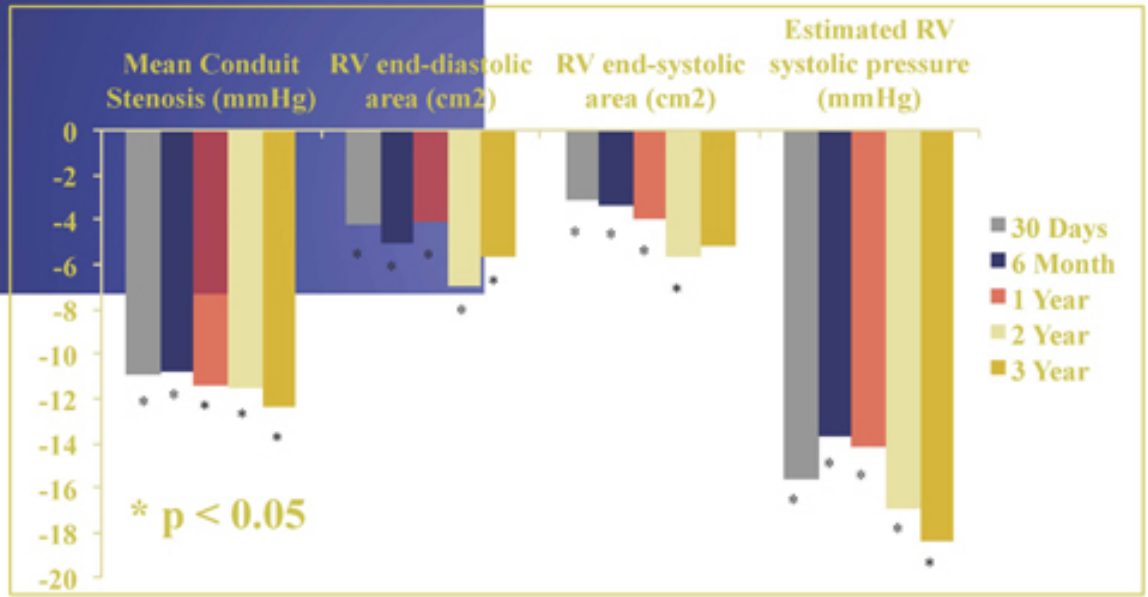
Echocardiographic Changes from Baseline



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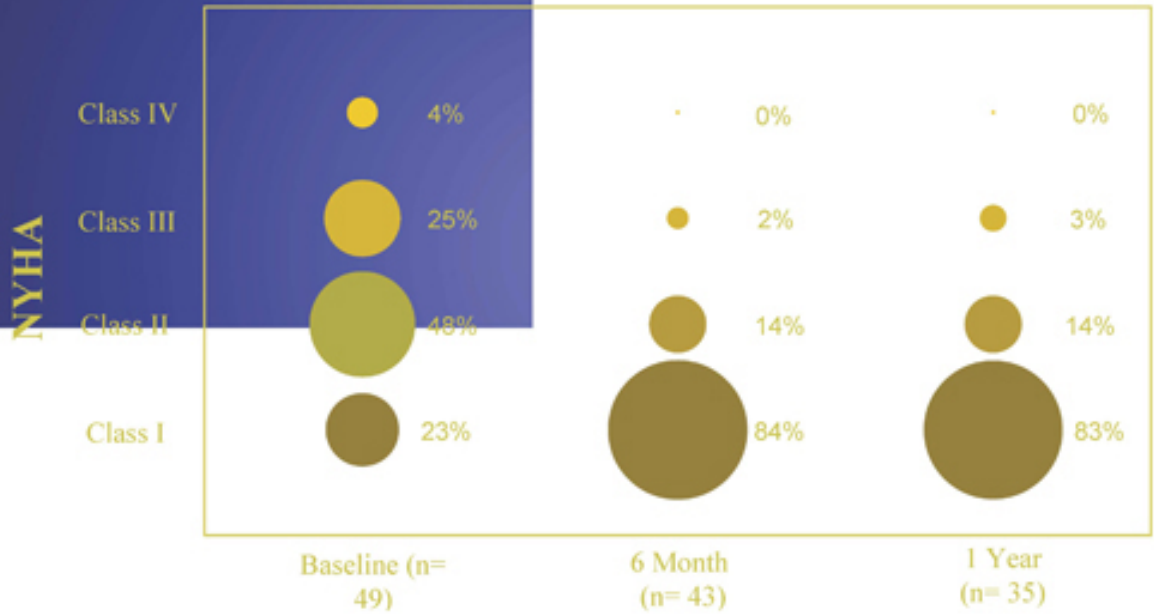
- 77% improvement in NYHA of at least 1 class at 1 year *



* Overall improvement for patients with NYHA ≥ Class II

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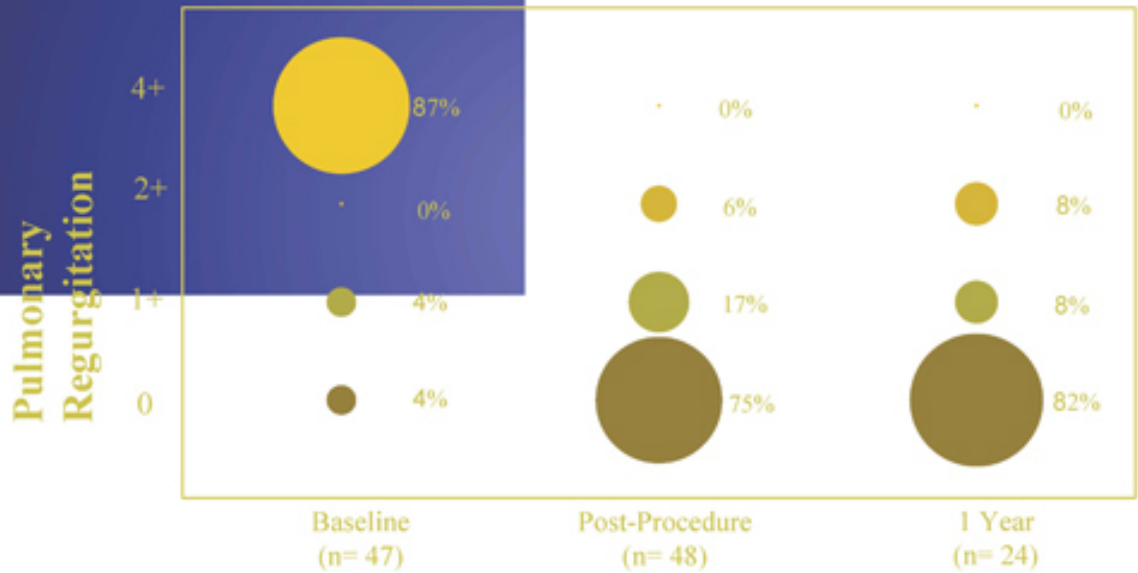
- 100% Improvement (≥ 1 grade) in PR at 1 year



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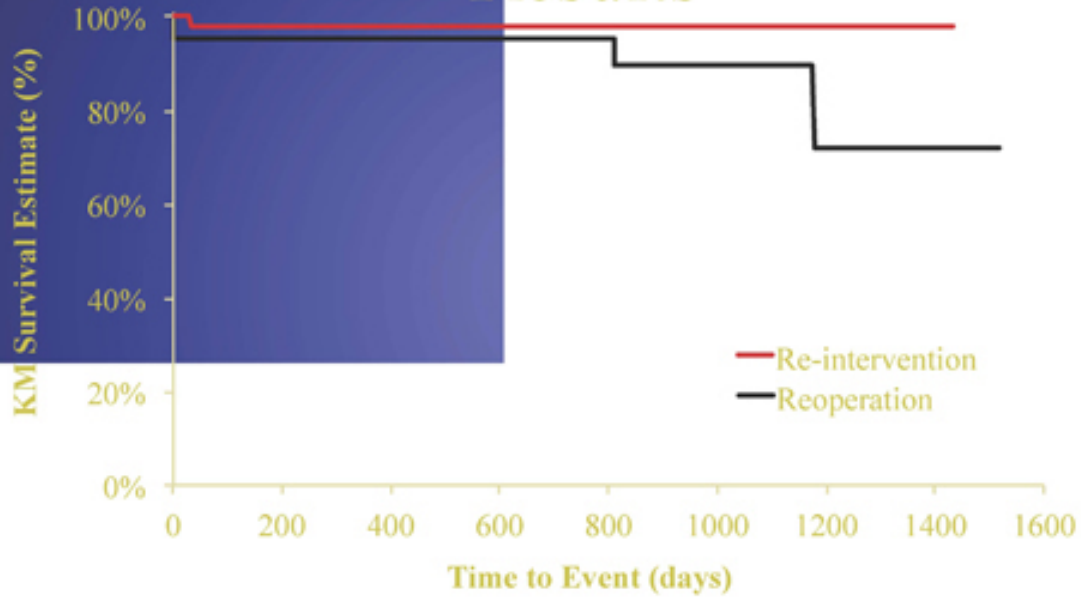
Results



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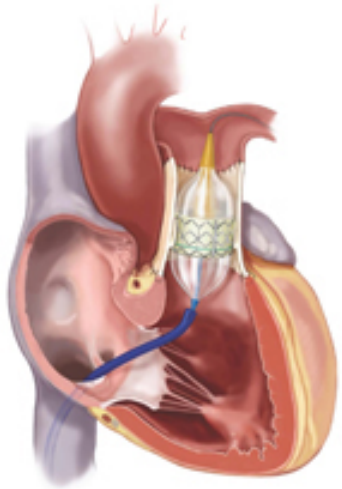
Summary

- COMPASSION enrollment and extended follow-up ongoing
- 50 patients, 5 centers
  - 36 patients with 1 year follow-up
  - 87.9 total patient years, mean = 1.76 ± 1.2 year
- Outcomes, latest data extract:
  - 96% Freedom from death or reoperation at 1 year
  - 94% Freedom from MACCE at 6 months and 1 year
  - 77% Improvement (≥ 1 class) in NYHA at 1 year *
  - 100% Improvement (≥ 1 grade) in PR at 1 year
  - *Other functional improvements currently under analysis*
  - No SAPIEN fractures
  - No endocarditis in implanted population



* Overall improvement for patients with NYHA ≥ Class II

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CONCLUSIONS

Transcatheter Pulmonary valve replacement (tPVR) therapy is safe and effective in patients with a dysfunctional conduit between the RV-PA.

The COMPASSION trial has been expanded to include 10 US sites.

tPVR is a game changer!

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