COMPLEX CHALLENGES DURING VALVE-IN-VALVE TAVI:

OVERCOMING A SERIES OF PROCEDURAL COMPLICATIONS

THE PATIENT

89-year-old male patient

Hypertension, dyslipidaemia, smoking-former

2013: AVR with Mitroflow aortic bioprosthesis no. 21

2022: Biotronik single-chamber PM implant for advanced AV block

...follow-up from 2022 for degeneration of the aortic bioprosthesis.

ECHOCARDIOGRAM (2024)

- Dilated LV with moderate parietal hypertrophy
- Mildly reduced EF
- Aortic bioprosthesis with 1) high gradients (mean grad 33 mmHgM; AVAi 0.75 cm²/m²) and 2) severe intraprosthetic insufficiency:
- LV dilatation
- ITV arch 14.6 cm
- VC 0.7 cm
- THP 236 ms



CT SCAN

- Surgical Aortic Bioprosthesis with RC cusp flail
- Prosthetic ring 280 mm²
- Ring perimeter 59 mm
- True ID 17 mm
- LMCA height: 7 mm
- LMCA VTC: 2.7 mm
- RCA height: 6 mm
- RCA VTC: 2.2 mm
- Valsalva sinuses: 25x28x28 mm

PROSTHETIC RING IN THE RANGE OF A 23 MM AORTIC PROSTHESIS FOR A TAVI VALVE-IN-VALVE

HIGH RISK OF OCCLUSION OF BOTH CORONARIES



Y

CORONAROGRAPH





Low coronary height

- LCA
 JL4 6F
 Coronary protection with wire and DES (4/24 mm)
- RCA
 JR4 6F
 Coronary protection with wire and DES (3.5/24)



VALVE-IN-VALVE TAVI 23 mm SEV

FIRST COMPLICATION: TAVI EMBOLISATION WITHOUT COMPROMISED CORONARY FLOW



HOW TO SOLVE?

IMPLANTATION OF ANOTHER 23-mm SEV (DEEPER)



UNDER-EXPANSION

BVFracturing with a 20-mm NC balloon

SECOND COMPLICATION:

INABILITY TO WITHDRAW RCA STENT TROUGH GUIDING CATHETER (Resistance caused by contact with TAVI)

How to solve?

1) Advance a second coronary wire + microcatheter: ineffective.

2) Inflate a 2.25/13 mm NC balloon to separate TAVI from STJ: effective.















CHIMNEY STENTING TECHNIQUE WITH DES 4.0/24

mm

FINAL RESULT







