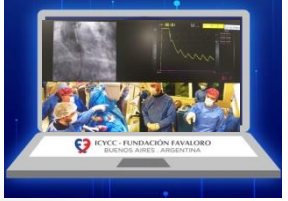

New Strategy for TAVI Implantation

- **Oscar A. Mendiz.MD.FACC.FSCAI**
- **Director Cardiology & Cardiovascular Institute (ICyCC)**
- **Chief Interventional Cardiology Department**

Conflictos de Interés

O Mendiz MD.

Medtronic: Proctor CoreValve, Speaker
BSCI; Proctor Acurate Neo
Edwards: Proctor
Philips: Speaker
Cannon; Speaker

The beginning of our journey

Sept 2099

First Cases Enthusiasm

Operator & Proctors

SILENT audience

Valve preparation behind operators

First Contribution

- Direct TAVI Implantation without Predilatation
  - Rationale: Less maneuvers >>>> ⬇ periprocedural stroke rate

JACC: CARDIOVASCULAR INTERVENTIONS
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DOI: 10.1016/j.jcin.2011.03.015

CVN Interview

Feasibility of Transcatheter Aortic Valve Implantation Without Balloon Pre-Dilation

A Pilot Study

Eberhard Grube, MD,* Christoph Naber, MD,† Alexandre Abizaid, MD,‡ Eduardo Sousa, MD,‡ Oscar Mendiz, MD,§ Pedro Lemos, MD,‖ Roberto Kalil Filho, MD,‖ Jose Mangione, MD,¶ Lutz Buellesfeld, MD#

Bonn and Essen, Germany; Sao Paulo, Brazil; Buenos Aires, Argentina; and Bern, Switzerland

Objectives The purpose of this pilot study was to evaluate the feasibility and safety of transcatheter aortic valve implantation (TAVI) without balloon pre-dilation.

Background Balloon pre-dilation of the stenosed aortic valve is currently believed to be a necessary step for valve preparation before device placement in patients undergoing TAVI and, therefore, is considered an obligatory part of the procedure. However, clear evidence supporting this policy is lacking. In contrast, pre-dilation might be responsible in part for distal embolizations as well as atrioventricular conduction disturbances seen during TAVI procedures.

Methods A total of 60 consecutive patients (mean age 80.1 ± 6.4 years, 53% female, mean logistic EuroScore 23.3 ± 15.2%) undergoing TAVI using the self-expanding Medtronic CoreValve prosthesis (Medtronic, Minneapolis, Minnesota) have been prospectively enrolled at 13 international centers.

Results Pre-procedural mean transaortic valve gradient was 47.8 ± 15.5 mm Hg, mean effective orifice area was 0.67 ± 0.15 cm^2. Technical success rate was 96.7% (58 of 60) of patients. Post-dilation was performed in 16.7% (10 of 60) of patients. Post-procedural mean valve gradient was 4.4 ± 2.0 mm Hg. Circular and noncircular valve configuration was present in 41 and 19 cases (68.3% vs. 31.7%), respectively, with similar effective orifice areas (1.74 ± 0.10 cm^2 vs. 1.71 ± 0.22 cm^2, p = NS). In-hospital mortality, myocardial infarction, stroke, and major vascular complications occurred in 6.7% (4 of 60), 0%, 5%, and 10% of patients. There was no valve embolization. New permanent pacing was needed in 11.7% (7 of 60) of patients.

Conclusions Transcatheter aortic valve implantation without balloon pre-dilation is feasible and safe, resulting in similar acute safety and efficacy as the current standard approach of TAVI with pre-dilation. (J Am Coll Cardiol Intv 2011;4:751–7) © 2011 by the American College of Cardiology Foundation

It is feasible and safe

Grube E, et al. J Am Coll Cardiol Intv 2011;4:751–7)

Catheterization and Cardiovascular Interventions 82:292–297 (2013)

Transcatheter Aortic Valve Implantation Without Balloon Predilation: A Single-Center Pilot Experience

Oscar A. Mendiz,* MD, Hugo Fraguas, MD, Gustavo A. Lev, MD, Leon R. Valdivieso, MD, and Roberto R. Favaloro, MD

Aim: To assess the results of transcatheter aortic valve implantation (TAVI) using the Medtronic CoreValve prosthesis (Medtronic, Minneapolis, MN), without balloon predilation, in high-risk patients with degenerated severe aortic stenosis. **Methods and Results:** Fifty-one consecutive patients who underwent direct TAVI, 98% through a transfemoral approach. Patients were 79 ± 8 years of age, 74% in New York Heart Association classes III or IV and at high risk for surgical valve replacement (mean logistic EuroScore 20 ± 15). Mean aortic valve area was 0.7 ± 0.2 cm^2. Procedural success rate was 94.2%. In-hospital, there were 2 deaths, 1 minor stroke with minimal sequelae, and 14 (28%) pacemaker implantation. At 30 days, there was one additional stroke and no new deaths. The mean postprocedural transprosthetic gradient was 15 ± 5 mm Hg; periprosthetic severe regurgitation was absent and moderate in one case. After a median follow-up of 7 months, there were five additional deaths (two cardiac), while 84% of survivors were in New York Heart Association classes I or II. **Conclusions:** These results suggest that direct CoreValve implantation in patients with severe aortic stenosis is feasible and may lead to hemodynamic and clinical improvement in patients who are poor candidates for aortic valve surgery, pending confirmation in larger series with longer follow-up. © 2013 Wiley Periodicals, Inc.

Key words: aortic stenosis; direct transcatheter aortic valve implantation; device underexpansion

INTRODUCTION

Transcatheter aortic valve implantation (TAVI) is emerging as a true alternative to surgical valve replacement in high-risk patients affected with symptomatic selected by our multidisciplinary team had severe aortic stenosis, and deemed high surgical risk (age ≥80 years or logistic EuroScore ≥15, or 1 to 2 high-risk comorbidities such as cirrhosis of the liver, pulmonary insufficiency, previous cardiac surgery, systolic pulmo-

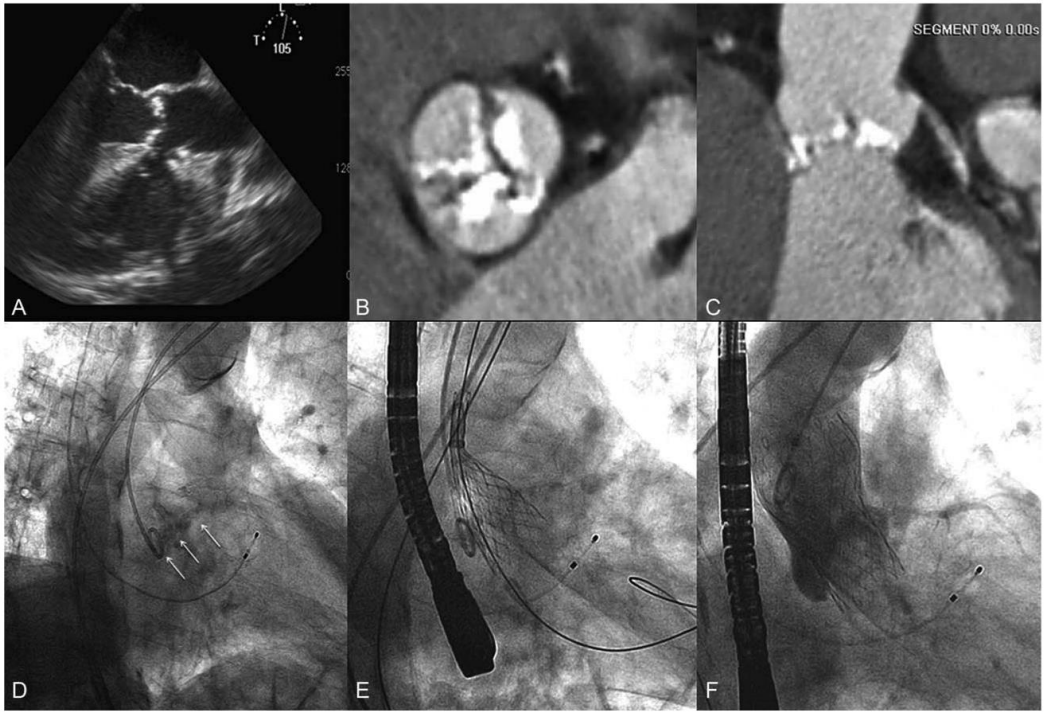


Fig. 1. TEE sagittal image (A), coronal and transverse (B and C) cross-sectional CT images showing severe aortic valve calcification. Left oblique angiographic images: at baseline (D) showing severe calcification at the level of the aortic cusps (arrows), during (E) and after (F) direct CoreValve deployment. Note device placed at correct height without aortic regurgitation.

TABLE I. Baseline Characteristics

TABLE II. Baseline Echocardiographic Variables

Final Conclusion:

- Stroke rate is similar with or without predilatation
- Final conclusion:
  - Predilatation should be used at operators' discretion

What We Have Learned from TAVI Evidence?:

What do we know?

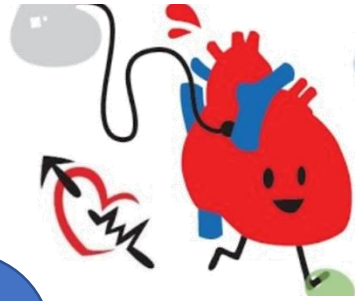
- There is not a one single trial showing that SAVR is superior to TAVR, according to periprocedural and middle-term follow-up outcomes.

TAVR EVIDENCE:

- **Extreme Risk**: (5y F-Up)
  - PARTNER IB
  - CoreValve Extreme Risk (registry)
- **High Risk: (5y Fup)**
  - CoreValve Pivotal Trial
  - PARTNER IA
- **Intermediate Risk;**
  - SURTAVI
  - NOTION **(7y F-Up)**
  - PARTNER IIA
  - UK TAVI
- **Low Risk: (2y F-Up)**
  - PARTNER III
  - Low Risk CorValve Trial

Potential Limitations Nº1: Durability

- we don’t want an early pit stop (new intervention) because an early device deterioration



Potential Limitation Nº 2: Conduction Disturbances (PPMI)

Conduction disturbances after TAVR: All Cause Mortality

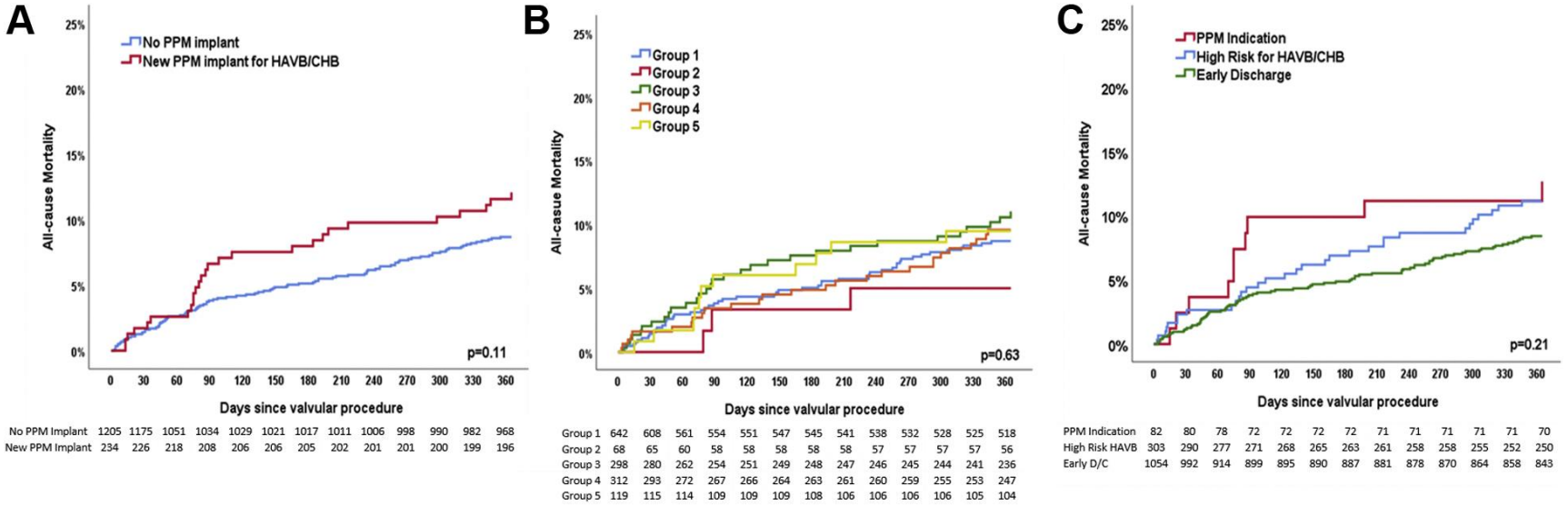
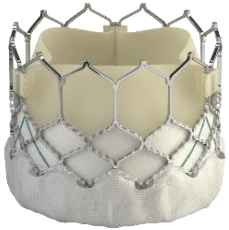


Figure 4: All-Cause Mortality After TAVR

All-cause mortality after TAVR in Kaplan-Meier analysis is shown according to need for PPM implantation for HAVB or CHB within the first 30 days (A), the recommendation of the algorithm (B), and the initial group assignment (C). Differences in all-cause mortality were assessed using the log-rank test. D/C = discharge; other abbreviations as in Figures 1 and 3.

Daniel Malebranche et al. *J Am Coll Cardiol Intv* 2021; 14:981-991.

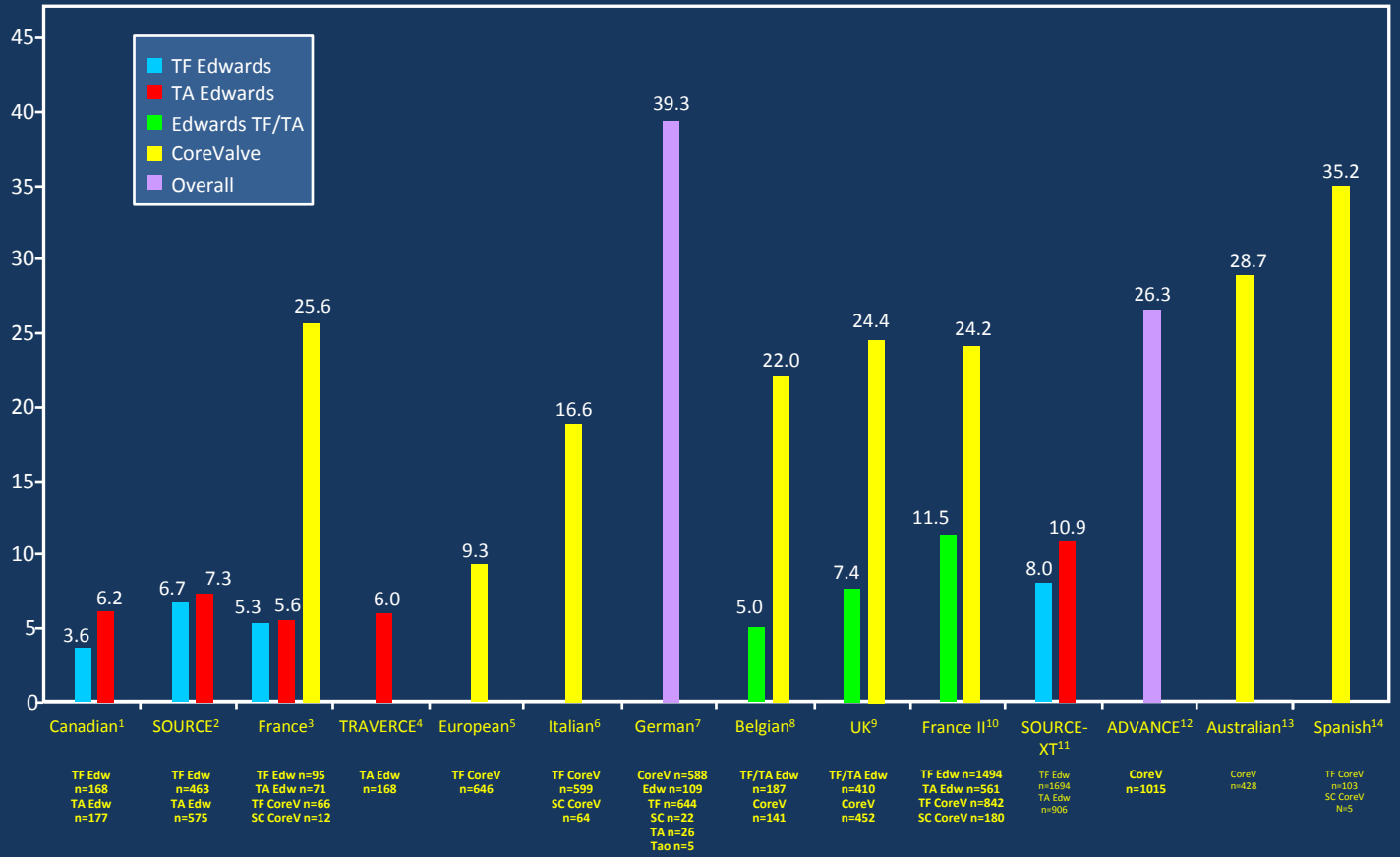
Conduction Disturbances with BEV



30-day PPMI rate after TAVI

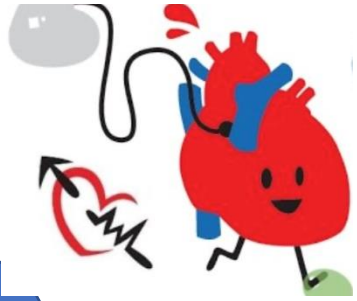
PARTNER I	6.4%
PARTNER II	3.8%
PARTNER III	6.5%

Need for Pacemaker Implantation Following TAVI



1-Rodes-Cabau et al, JACC 2010
2-Thomas et al, Circulation 2010
3-Eltchaninoff et al, Eur Heart J, 2010
4-Walther et al, Eur J Cardiothorac Surg, 2010
5-Piazza et al, EuroInterv 2008
6-Tamburino et al, Circulation, 2011
7-Zahn et al, Eur Heart J, 2010
8- Bosmans et al, Inter Cardiovasc and Thor Surg, 2011
9-Moat et al, JACC 2011
10-Gilard et al, NEJM 2012
11-Wendler et al, EuroPCR 2012
12-Linke at al, TVT 2012
13-Meredith et al, TVT 2012
14-Ayanzas et al, Rev Esp. Cardiol 2010

Edw:Edwards
CoreV: Corevalve
TF: transfemoral
TA: transapical
Tao: transaortic



Potential Lin… …AVI: Conducti… …ces (PPMI)

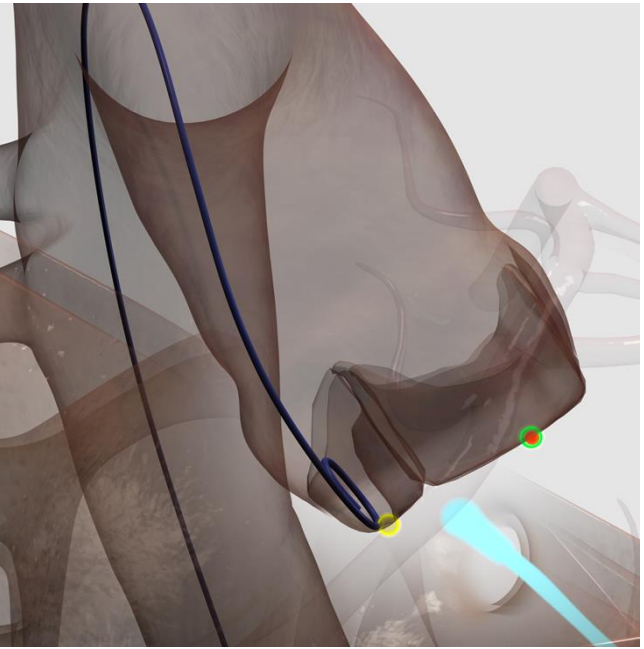
Let's Try to Reduce PPMI rate by Using COVL view for Implantation

Conduction Disturbances (PPMI)

PRECISION !!

We need a **Reliable View** for an

Accurate Assessment of Depth

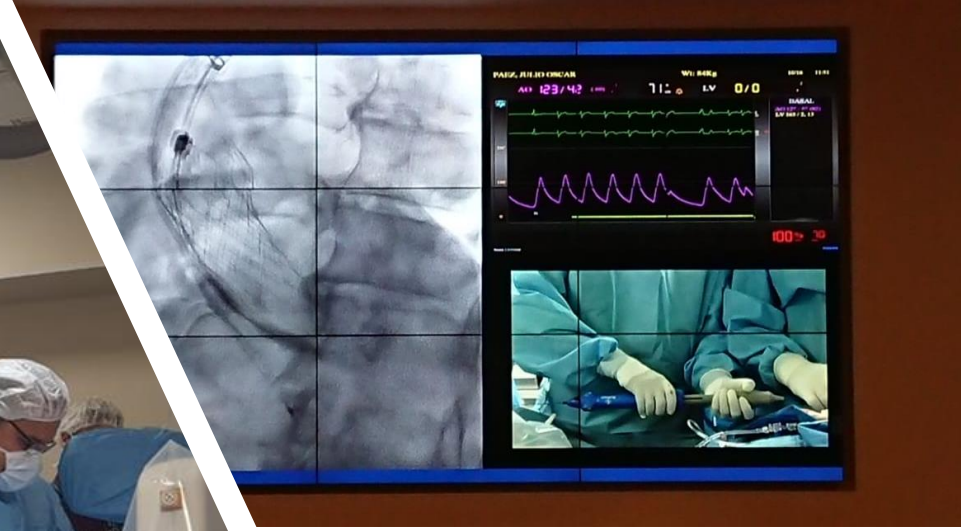


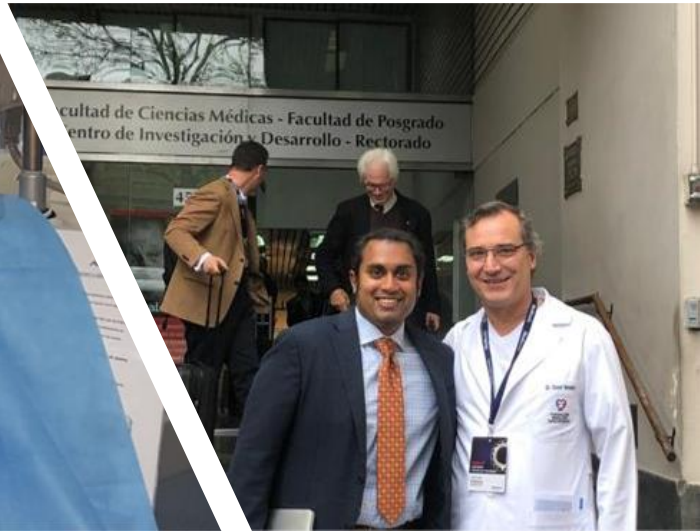
Courtesy Dr Hemal Gada

The cusp overlap view isolates the NCC to provide accurate assessment of deployment depth and:

- Maintains basal plane alignment of the coronary cusps
- Elongates the view of the LVOT
- Reduces or removes parallax in the marker band
- Provides an accurate view of the root regardless of angulation

The Beginning of COVCL Experience at Favaloro Foundation

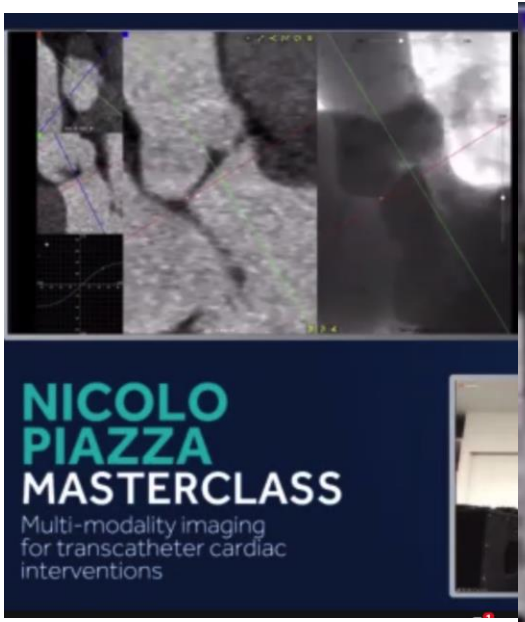


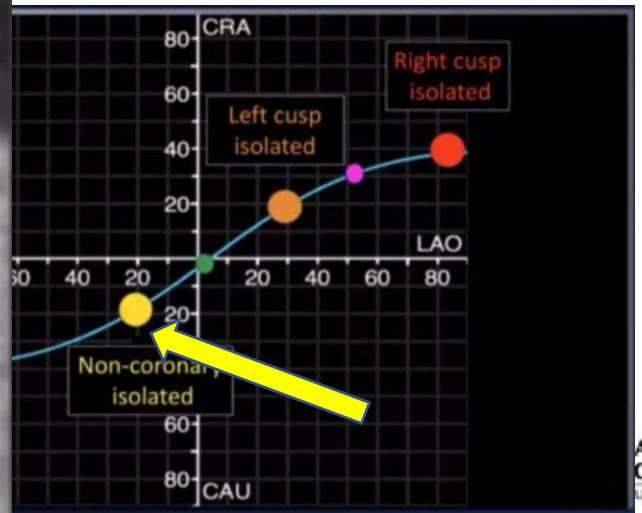


Oct 18, 2019

Tips & Tricks for COVL:

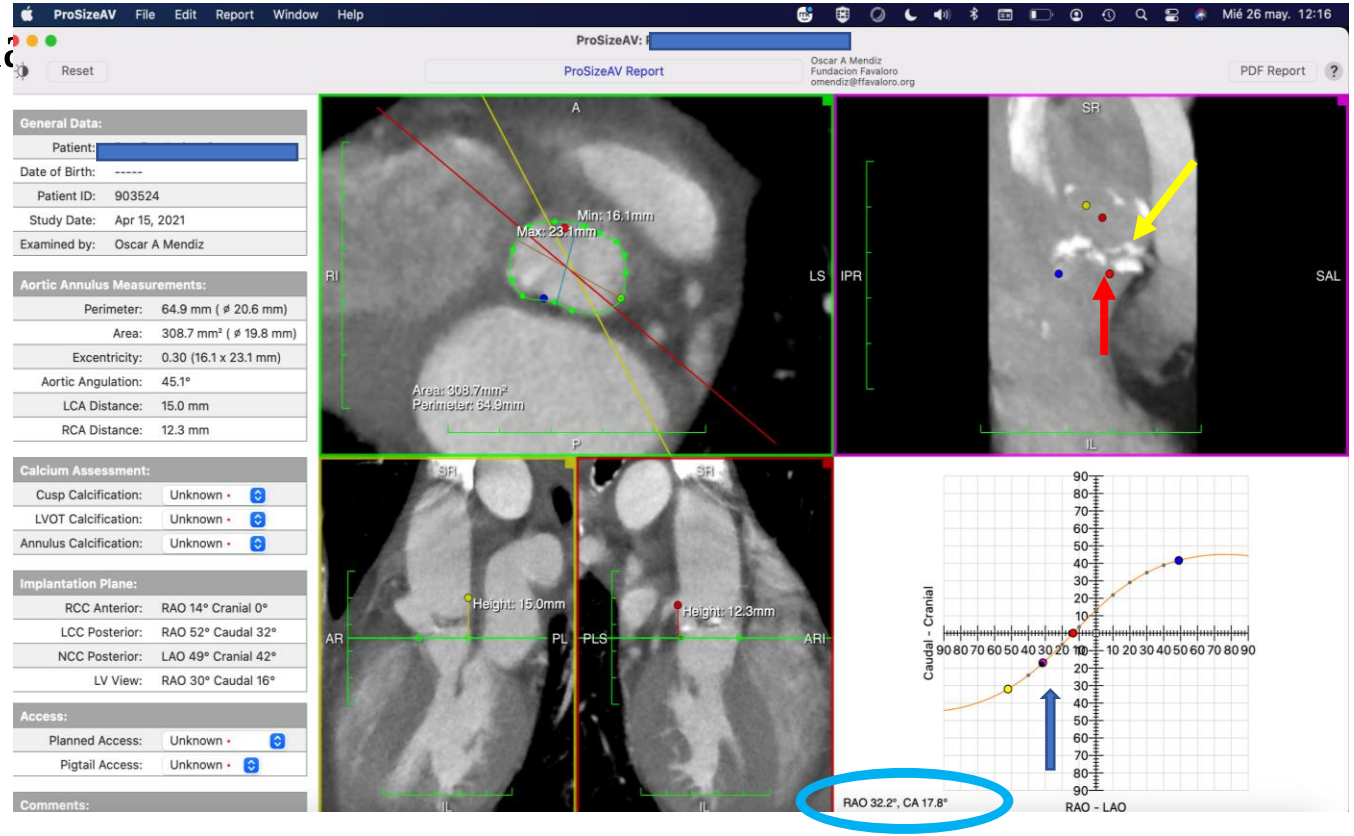
- To understand why this view would be useful





Tips & Tricks for COVL: 3

- CT Pla



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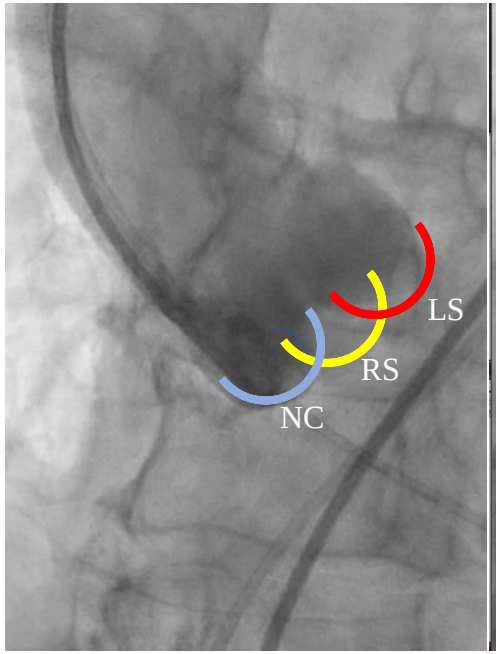
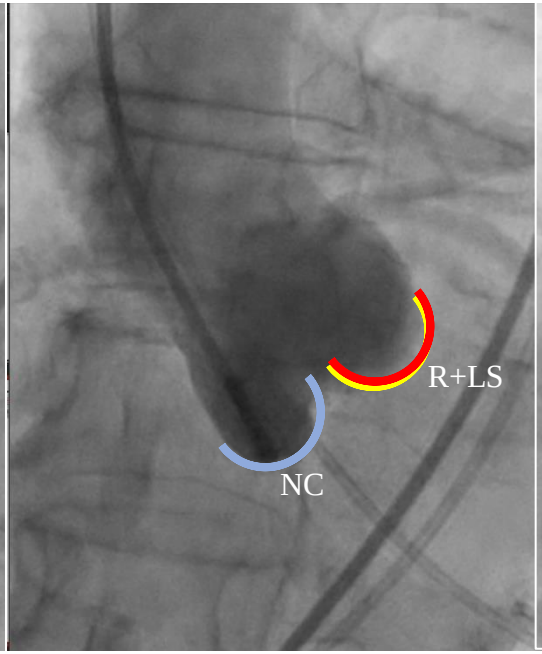
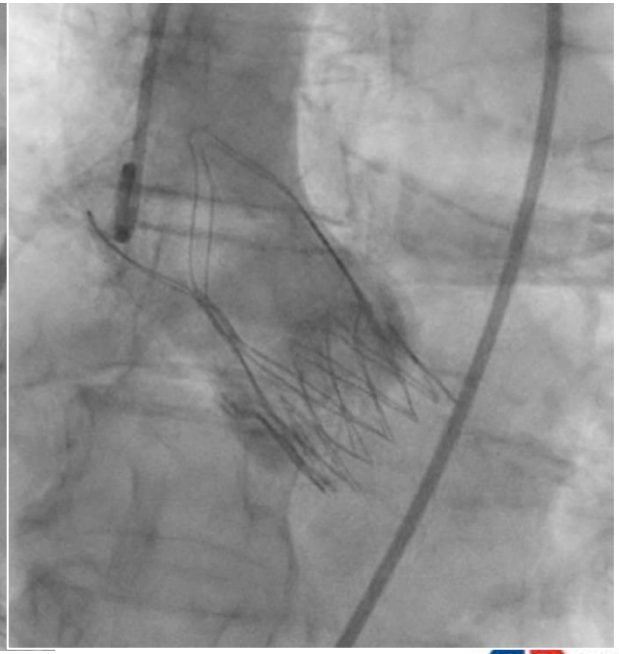
Overlapping Technique: (Acurate Neo)

Previous Implantation Position



OVERLAPPING Implantation Position





Hindawi
Journal of Interventional Cardiology
Volume 2021, Article ID 9991528, 7 pages
https://doi.org/10.1155/2021/9991528

Research Article

Impact of Cusp-Overlap View for TAVR with Self-Expandable Valves on 30-Day Conduction Disturbances

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[5]*UPMC Heart and Vascular Institute, Pinnacle Health, Harrisburg, PA, USA*
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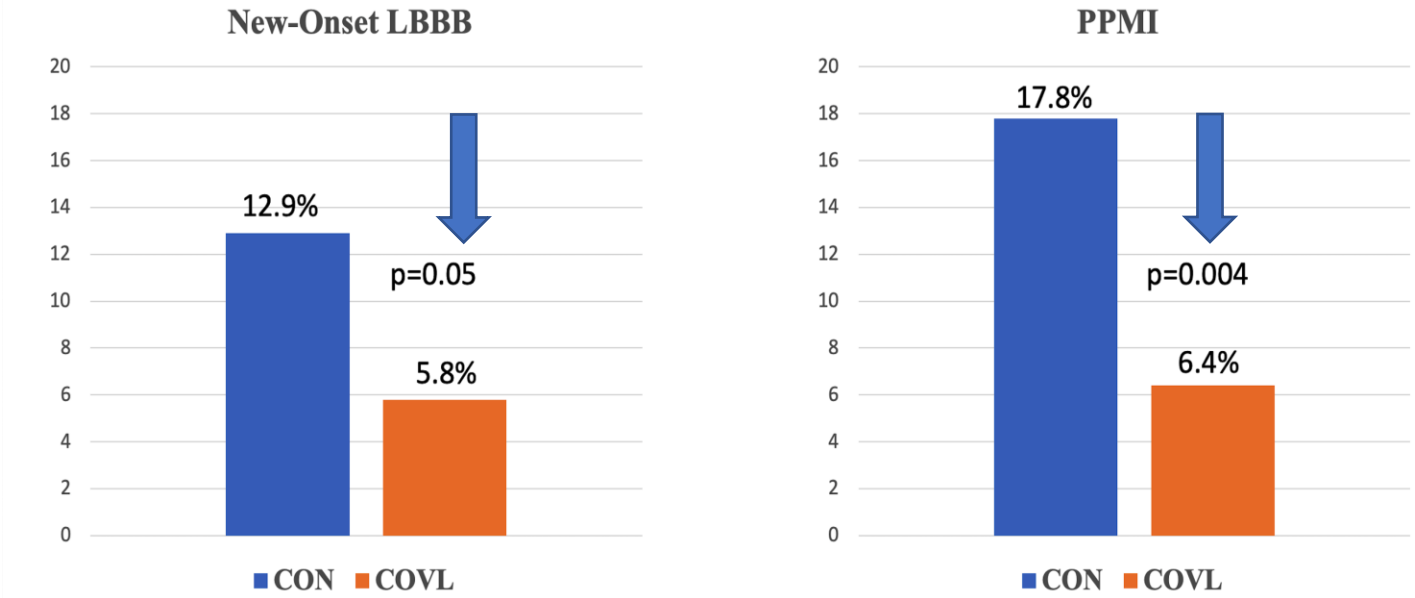
Academic Editor: Viktor Kočka

Background and Aim. Conduction disturbances leading to permanent pacemaker implantation (PPMI) remains a common complication for TAVR procedures, particularly when self-expanding valves are used. We compared the 30-day incidence of new-onset left bundle branch block (LBBB) and permanent pacemaker implantation (PPMI) rate between two consecutive groups using either conventional 3-cusp coplanar view (CON) and right/left cusp-overlap view (COVL) for implantation. *Methods and Results.* We retrospectively compared 257 consecutive patients undergoing TAVR with self-expandable valves using either CON

Impact of Cusp-Overlap View for TAVR with Self-Expandable Valves on 30-day Conduction Disturbances



CON=101 Ptes
COVL=156 Ptes
Centers: Fundación Favaloro & Sro Finochietto from Argenitna, Medicor (Slovenia), Hospital Clinica Biblica (Costa Rica)

Mendiz OA, et al. J Interv Cardiol. 2021 Apr 28;2021:9991528. doi: 10.1155/2021/9991528. eCollection 2021

Evolute Low Risk Trial:

Clinical Outcomes at 30 Days

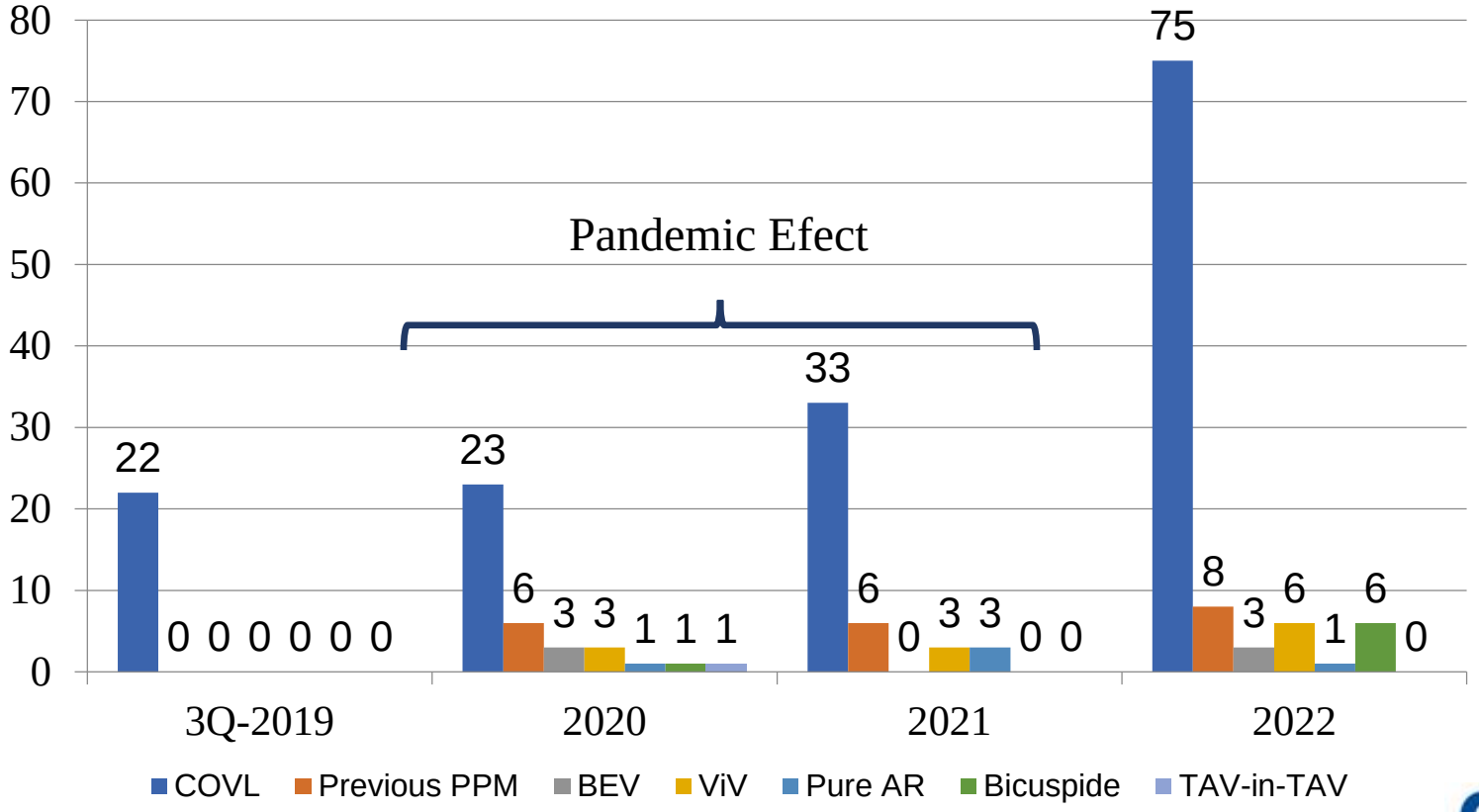
Bayesian rates as %	TAVR (N=725)	SAVR (N=678)	(95% BCI for Difference)
30-Day composite safety endpoint*	5.3	10.7	(-8.3, -2.6)
All-cause mortality	0.5	1.3	(-1.9, 0.2)
Disabling stroke*	0.5	1.7	(-2.4, -0.2)
Life-threatening or disabling bleeding*	2.4	7.5	(-7.5, -2.9)
Acute kidney injury, stage 2-3*	0.9	2.8	(-3.4, -0.5)
Major vascular complication	3.8	3.2	(-1.4, 2.5)
Atrial fibrillation*	7.7	35.4	(-31.8, -23.6)
Permanent pacemaker implant*	17.4	6.1	(8.0, 14.7)
All-cause mortality or disabling stroke*	0.8	2.6	(-3.2, -0.5)
All stroke	3.4	3.4	(-1.9, 1.9)
Ao[illegible]	0.4	0.4	(-0.8, 0.7)

* Significantly favors TAVR; * Significantly favors SAVR

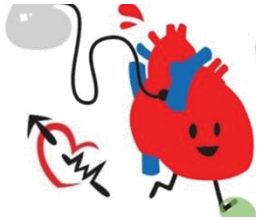
Our PPMI rate using COVL is similar to SAVR in arm of this trial

Michael J. Reardon. ACC 2019

TAVI Using COVL View: ICyCC Experience



TAVI Using COVL View: ICyCC Experience
Ptes Characteristics



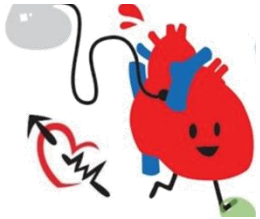
	n (%)
N (Oct 2019- Nov 2022)	153
Age	81,5±6,1
≥80 años	112 (73,2)
Male	82 (53,6)
Previous PCI	66 (43,1)
PCI Pre TAVI (within 3 months)	48 (31,4)
Previous CABG	19 (12,4)
STS Score	7,3±4,1
LVEF (%)	55,7±9,9 %
LVEF ≤40%	18 (11,8)

Excluding BEV, Previous PPM, ViV, Bicuspide, Pure AR, TAV-in-TAV.

TAVI Using COVL View: ICyCC Experience
Procedural Characteristics

	n (%)
Conscious sedation	153 (100%)
Percutaneous Vasc. Closure	150 (98)
Femoral Access	149 (97,4)
Subclavian	3 (2)
Percutaneous TransAxilary	1 (0,7)
Predilatation	134 (87,6)
Post-dilatation	57 (37,2)
Pop Up	-

TAVI Using COVL View: ICyCC Experience
Ptes Characteristics

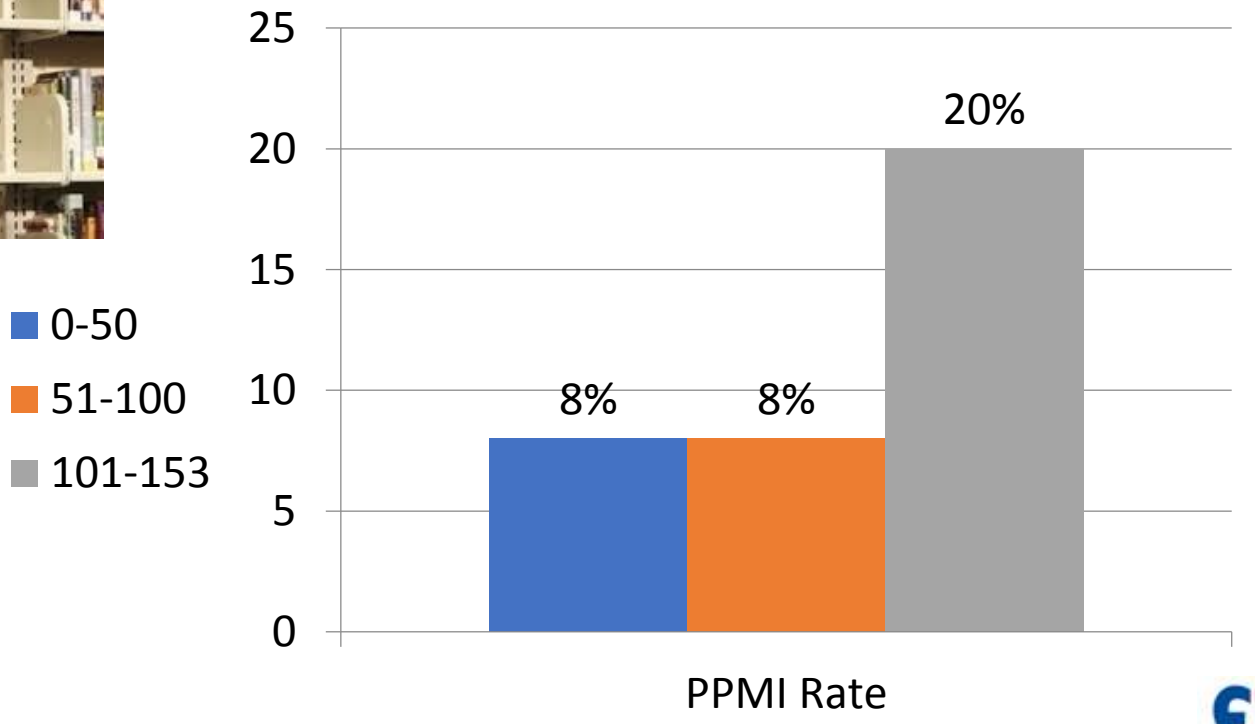


	n (%)
Pte with Normal Sinus Rhythm	**78 (51%)**
Atrial Fibrillation	33 (21,6)
Any previous conduction Disturbances	**57 (37%)**
Trifasicular Block	4 (2,6)
RBBB	24 (15,7)
Complete LBBB	16 (10,4)
Uncomplete LBBB	6 (3,9)
LAFB	7 (4,6)

TAVI Using COVL View: ICyCC Experience
30-day Outcomes

	n (%)
Mortality	4 (2,6)
AMI	1 (0,6)
Any Stroke	1 (0,6)
Major Bleeding	1 (0,6)
Vascular Compl. (all solved with stent graft)	6 (3,9)
PPMI	**17 (11,1)**
New LBBB	10 (6,5)

TAVI Using COVL View: ICyCC Experience
30-day Outcomes: PPMI rate according to the experience



TAVI Using COVL View: ICyCC Experience
Preprocedural EKG Findings

	0-50 n (%)	51-100 n (%)	101-153 n (%)
Normal RS	25 (50)	27 (54)	23 (**43,4**)
1º AV Block	-	6 (12)	8 (15,1)
Trifasicular Block	-	1 (2)	3 (5,7)
RBBB	6 (12)	5 (10)	13 (24,5)
LBBB	3 (6)	7 (14)	6 (11,3)
Incomplete LBBB	1 (2)	2 (4)	3 (5,7)
LAHB	-	3 (6)	4 (7,5)
A Fib.	15 (30)	7 (14)	11 (20,7)

TAVI Using COVL View: ICyCC Experience
30-day Outcomes

Previous Conduction Distrubances and PPMI rte

N=153 Ptes	PPMI 18 (%)	No PPMI 135 (%)	p
Normal SR	**3 (16,7)**	**75 (55,5)**	**0,002**
1º AV Block	**4 (22,2)**	**10 (7,4)**	**0,05**
Trifasicular Block	**2 (11,1)**	**2 (1,5)**	**0,04**
RBBB	**9 (50)**	**15 (11,1)**	**<0,001**
Complete LBBB	1 (5,5)	15 (11,1)	0,77
Incomplete LBBB	-	6 (4,4)	1
LAHB	1 (5,5)	6 (4,4)	0,47
A Fib.	4 (22,2)	33 (24,4)	0,83

TAVI Using COVL View: ICyCC Experience
Preprocedural EKG Findings and PPMI Rate

	Previous Cond. Disturbances	No Cond. Distrubances
PPMI (18 Ptes)	**15 (83,3%)**	3 (16,7%)
No PPMI (135 Ptes)	41 (30,4%)	94 (69,6%)

p=<0,001

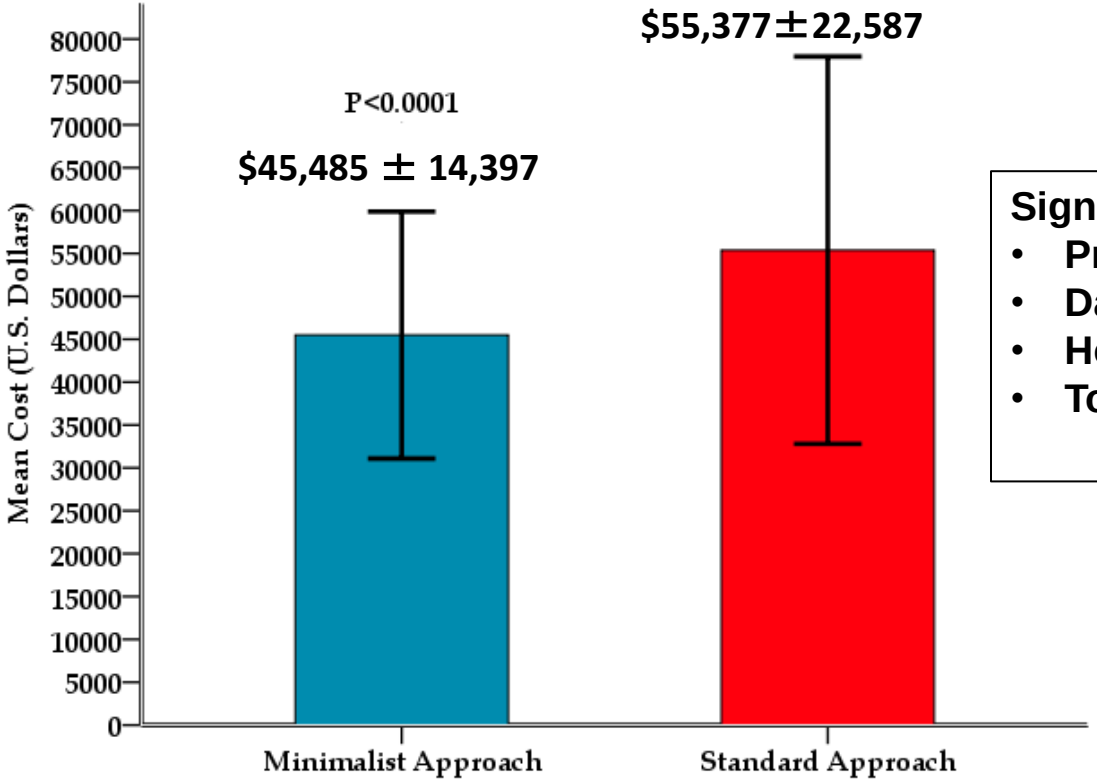
Mendiz OA, et al. Unpublished data

TAVR Minimalist Approach:

Minimally Invasive TAVR

- **Selection:**
  - No high risk (clinical or anatomic)
- **Minimalist Approach**
  - Conscious Sedation
  - Transthoracic Echo
  - No neck line or Swan Ganz
  - Percutaneous Vascular Access
  - No Foley catheter
  - ICU ???

Cost Saving with Minimalist Approach



Significantly Reduced:

- **Procedure time**
- **Days in ICU**
- **Hospital days**
- **Total hospital costs ($45K vs $55K)**

Bavaliaros V, et al. JACC Cardiovasc Interv. **2014** Aug;7(8):898-904

Conscious Sedation vs. General Anesthesia for TAVR: Insights from the NCDR® STS/ACC TVT Registry

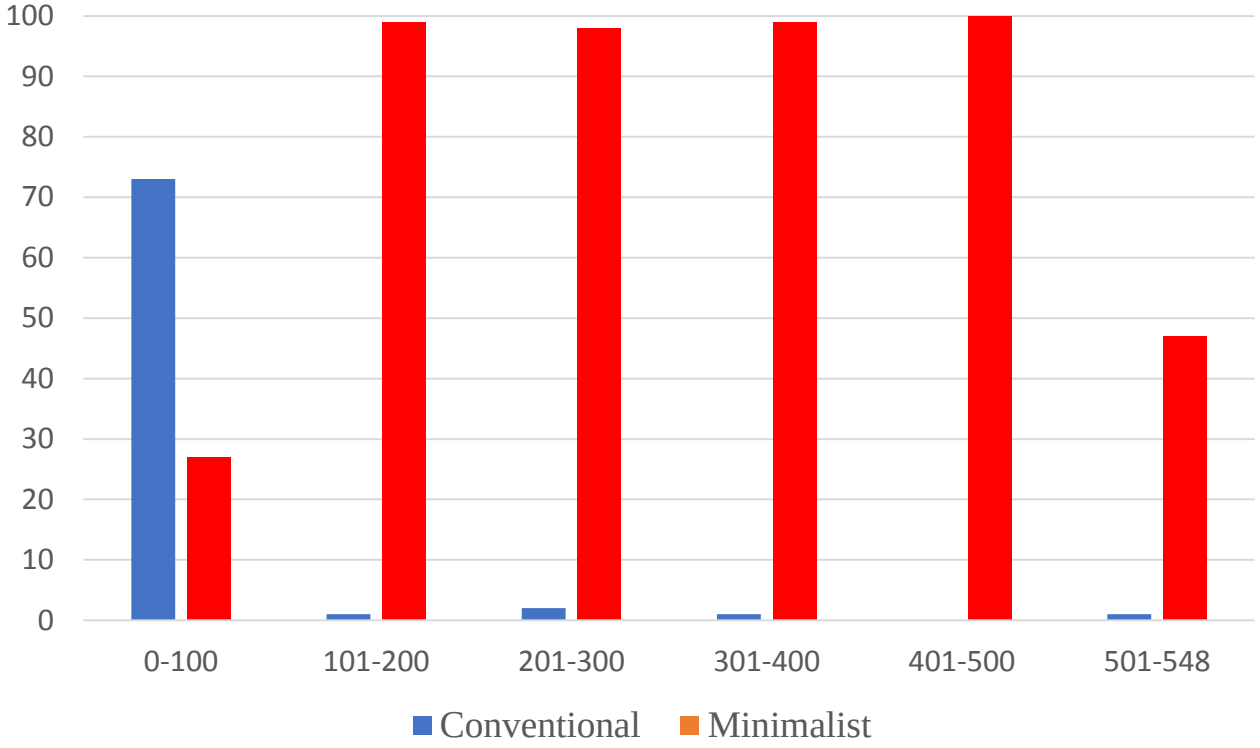
Conscious sedation was used in 1,737/10,997 (15.8%) cases with a significant trend of increasing usage over the time

Outcome	Unadjusted General Anesthesia	Unadjusted Conscious Sedation	P Value	Odds Ratio*	95% CI	Adjusted General Anesthesia	Adjusted Conscious Sedation	P Value
In Hospital Outcomes								
Mortality (%)	2.5%	1.6%	0.03	0.65	(0.44, 0.96)	2.4%	1.5%	0.01
Mortality/Stroke (%)	4.2%	3.1%	0.03	0.72	(0.54, 0.96)	4.1%	3.1%	<0.001
Procedural Success (%)	98.5%	98.2%	0.31	0.82	(0.56, 1.21)	98.6%	97.9%	<0.001
Intraprocedural Inotrope Use (%)	43.9%	36.8%	<0.0001	0.74	(0.67, 0.83)	43.7%	29.3%	<0.001
Procedural Duration (hours)	2.1 ± 3.4	1.9 ± 2.9	0.0003	0.95	(0.92, 0.99)	1.7 ± 1.6	1.9 ± 1.5	0.14
Hospital Length of Stay (days)	6.7 ± 9.6	6.0 ± 10.7	<0.0001	0.99	(0.98, 1.0)	6.5 ± 5.5	6.0 ± 7.1	<0.001
Discharge Home (%)	74.8%	80.7%	<0.001	1.41	(1.24, 1.61)	74.4%	77.1%	<0.001
30-day Outcomes								
Mortality (%)	4.1%	2.9%	0.03	0.70	(0.50, 0.97)	4.0%	2.3%	<0.001
Mortality/Stroke (%)	6.4%	4.8%	0.02	0.74	(0.57, 0.95)	6.4%	4.8%	<0.001

Conclusions: In U.S. practice, conscious sedation is associated with briefer length of stay and lower in-hospital and 30-day mortality compared to TAVR with general anesthesia.

Hyman et al. Circulation. 2017 Nov 28;136(22):2132-2140

More Experience, Less Invasive



Transcatheter Laceration of Aortic Leaflets to Prevent Coronary Obstruction During TAVI:

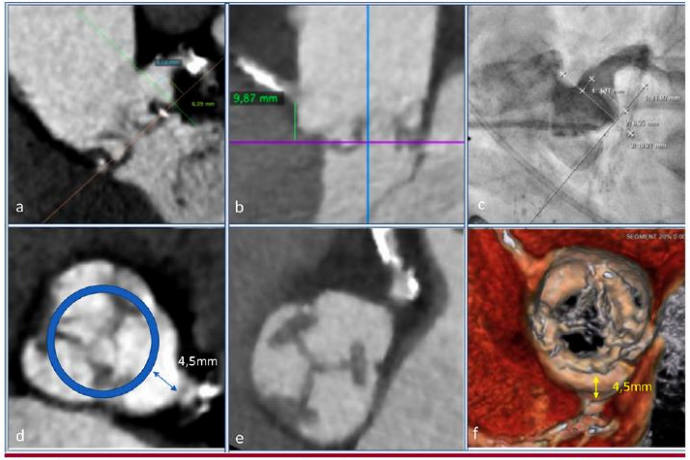


Fig. 1.– a- y **c-** Mediciones de altura y distancia desde la válvula previa al ostium de la Coronaria Izquierda (CI), **B-** altura del ostium de la Coronaria Derecha, **d-** distancia virtual al ostium de CI, **e-** relación del ostium de CI con los postes de la válvula previa, **f-**distancia ostium de CI.

defectos (DID). Tipo **B**: defecto grande junto a otro moderado y acompañado con otros defectos pequeños con diferentes DID. Tipo **C**: septum interauricular cribiforme con 5 o más defectos. Tipo **D**: defectos pequeños y moderados con DID igual o mayor a 7 mm. Los defectos más oscuros son los que deberían elegirse para implantar el dispositivo. Defecto grande (15 mm), moderado (5-14 mm) y pequeño (<5 mm). Seno coronario (SC). Adaptado de Farhaj Z y col (3).

Pacientes con cortocircuitos residuales después del cierre de FOP p de eventos recur fugas residuales implantar un se cortocircuitos re

Este caso repr a la necesidad de CIA después de FOP con disposit de evitar cortoci prevención secu

Declaración de co
Los autores declar (Véase formula en la web / Materi

Consideraciones é
No aplican

Alejandr María Lau
[1]Servicio de Hem Hospital Privado Instituto Universi
[2]Servicio de Neurol Instituto Modelo d

second closure device in patients with residual shunt after percutaneous closure of patent foramen ovale. Catheter Cardiovasc Interv 2004;63:490-5.https://doi.org/10.1002/ccd.20221

Laceración intencional de la valva de una bioprótesis valvular aórtica para prevenir oclusión coronaria durante el TAVI

Una complicación poco frecuente, pero con severas consecuencias durante el implante de una válvula

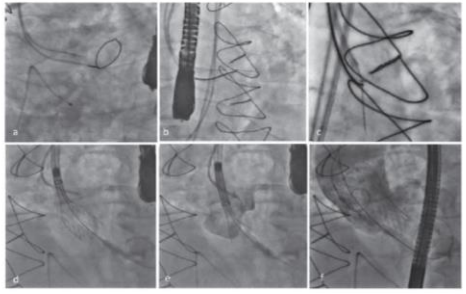


Fig. 2. a- Perforación de la valva protésica, **b-** enlazado de la guía en la cavidad ventricular, **c-** corte de la valva mediante electrobisturí conectado al alambre guía, **d-e** posicionamiento de la válvula aórtica auto-expandible por cateterismo (TAVI), **f-** resultado final que muestra la permeabilidad del ostium izquierdo y el correcto implante de la TAVI.

Consideraciones éticas
No aplican

Carlos M. Fava[1], Oscar A. Mendiz[1], Miguel Cerda[2]
[1]Departamento de Cardiología Intervencionista. Hospital Universitario Fundación Favaloro. Instituto de Cardiología y Cirugía Cardiovascular
[2]División de Ecocacardiografía. Hospital Universitario Fundación Favaloro. Instituto de Cardiología y Cirugía Cardiovascular
E-mail: omendiz@ffavaloro.org y cfava@ffavaloro.org

BIBLIOGRAFÍA

1. Ribeiro HB, Webb JG, Makkar RR, Cohen MG, Kapadia SR, Kodali S, et al. Predictive factors, management, and clinical outcomes of coronary obstruction following transcatheter aortic valve implantation: insights f stry. J Am Coll Cardiol 2013;62:1552-62. https://doi.org/10.1016/j.jacc.2013.07.040.

mailto:omendiz@ffavaloro.org

FUNDACIÓN FAVALORO
HOSPITAL UNIVERSITARIO

TAVI in Calcified Iliac Artery

Clinical Case:

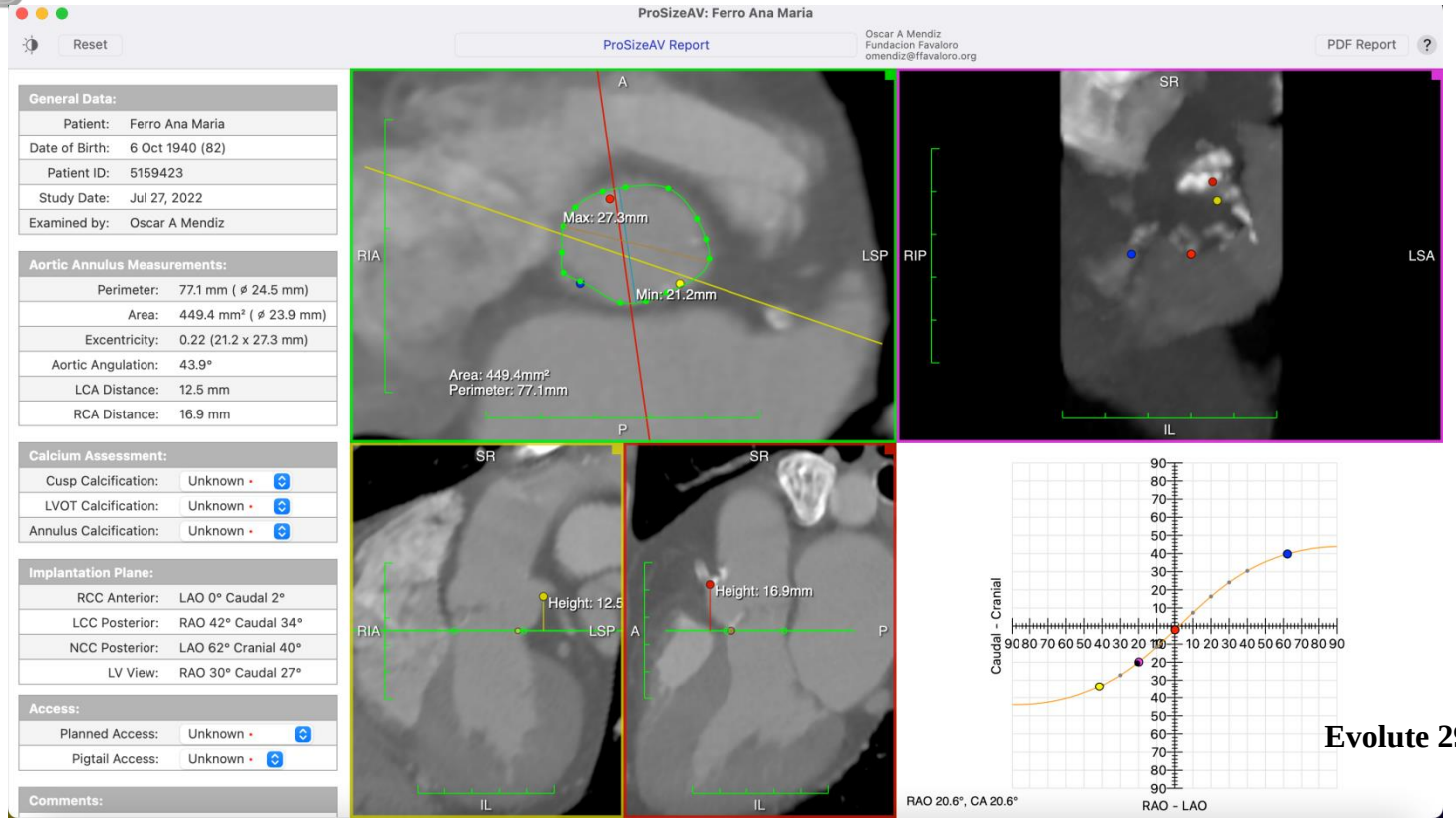
- Female 84y/o
- Presentation:
  - Dyspnea
- Clinical History:

  RF: HTA - DSP -

  Fragile

  Echo: Severe AS (Gradients: 55/30mmHg, area 0.7cm2), LVEF 60%

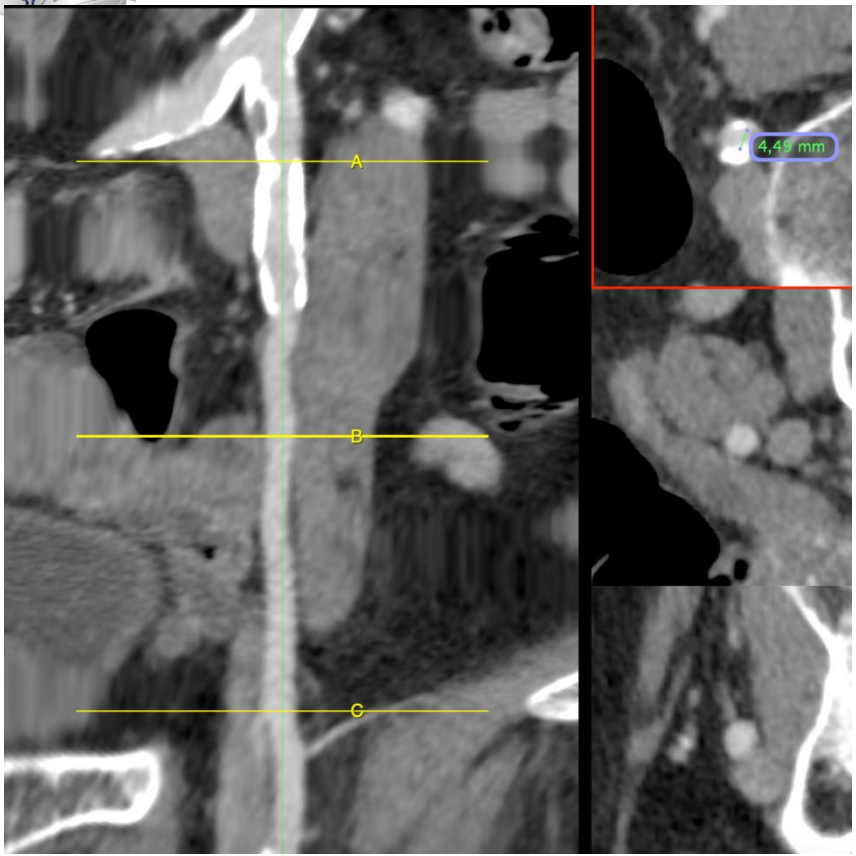
Clinical Case:

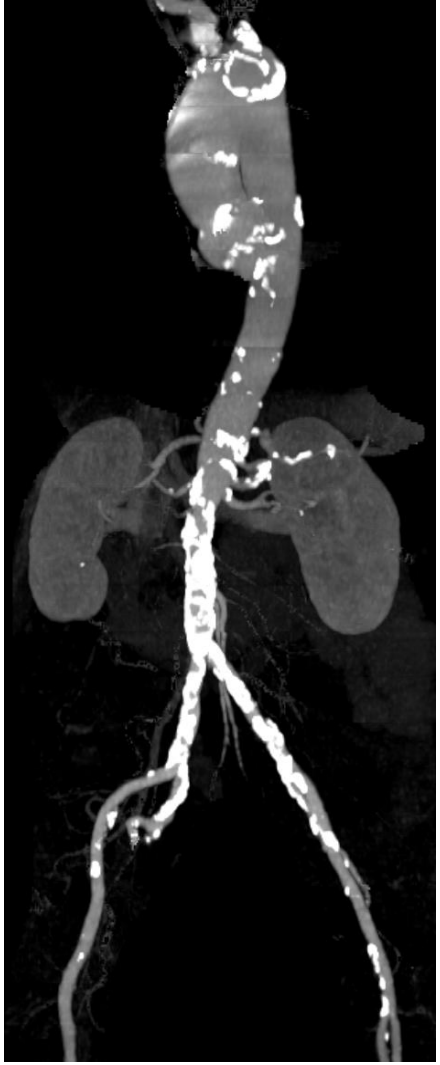


Evolute 29

HCl

AngioCT:





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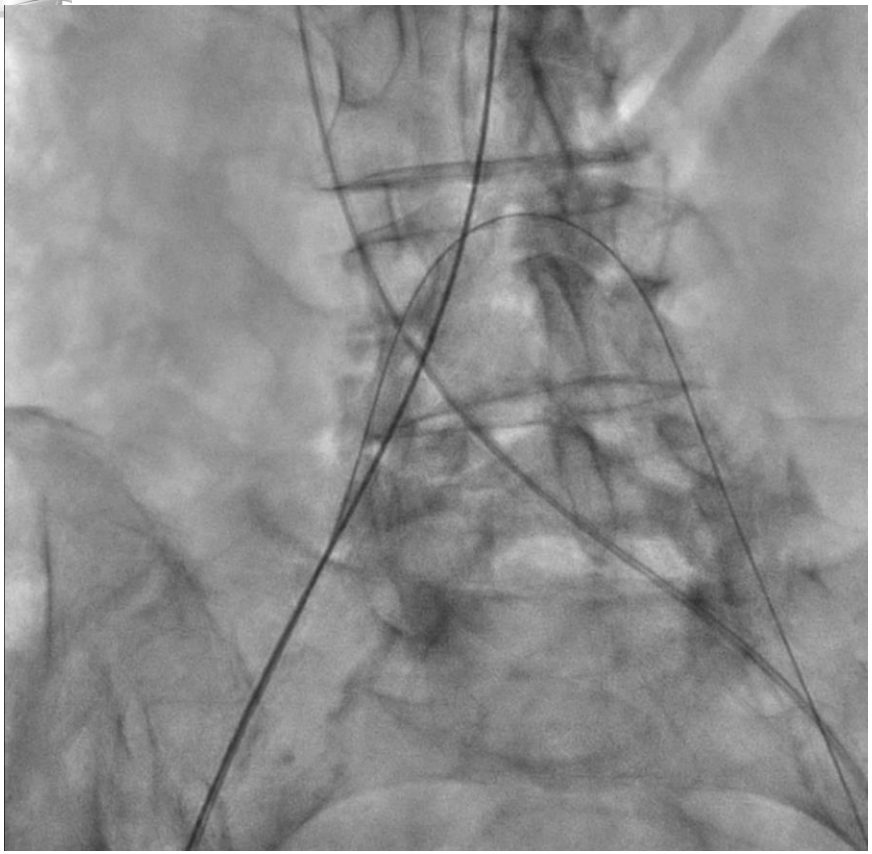

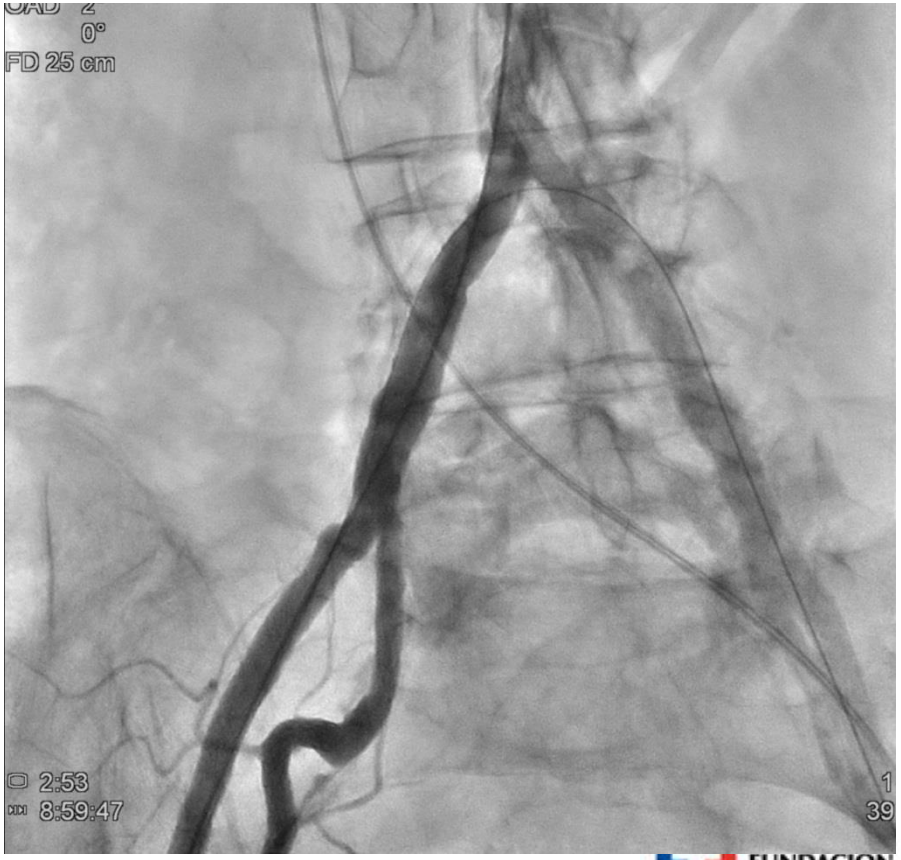

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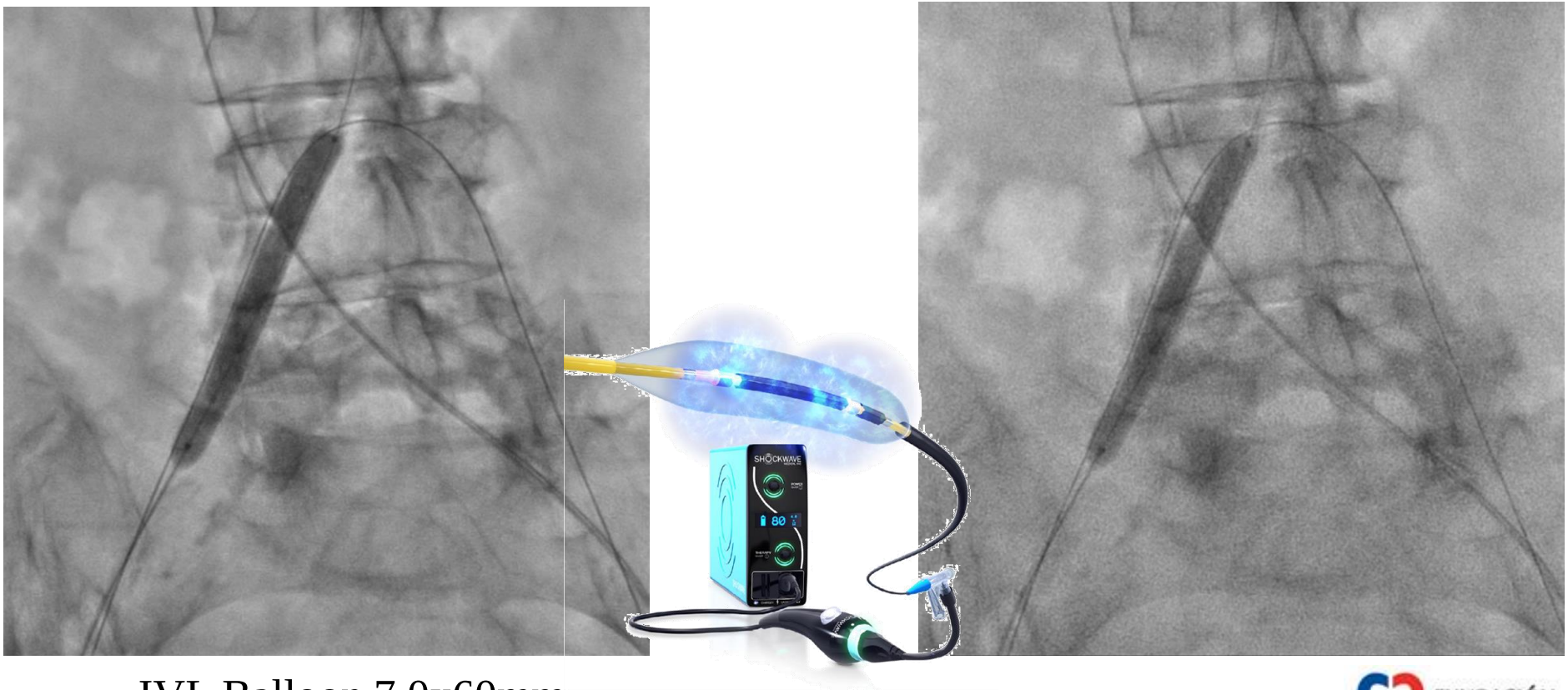
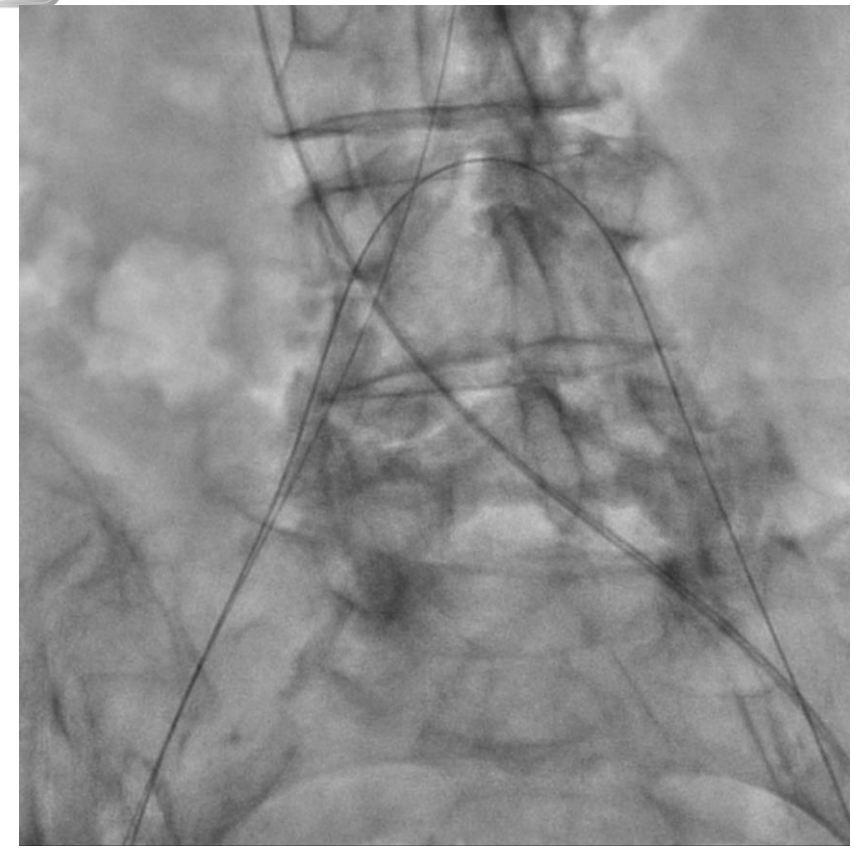


IVL Balloon 7.0x60mm

Vascular Access:



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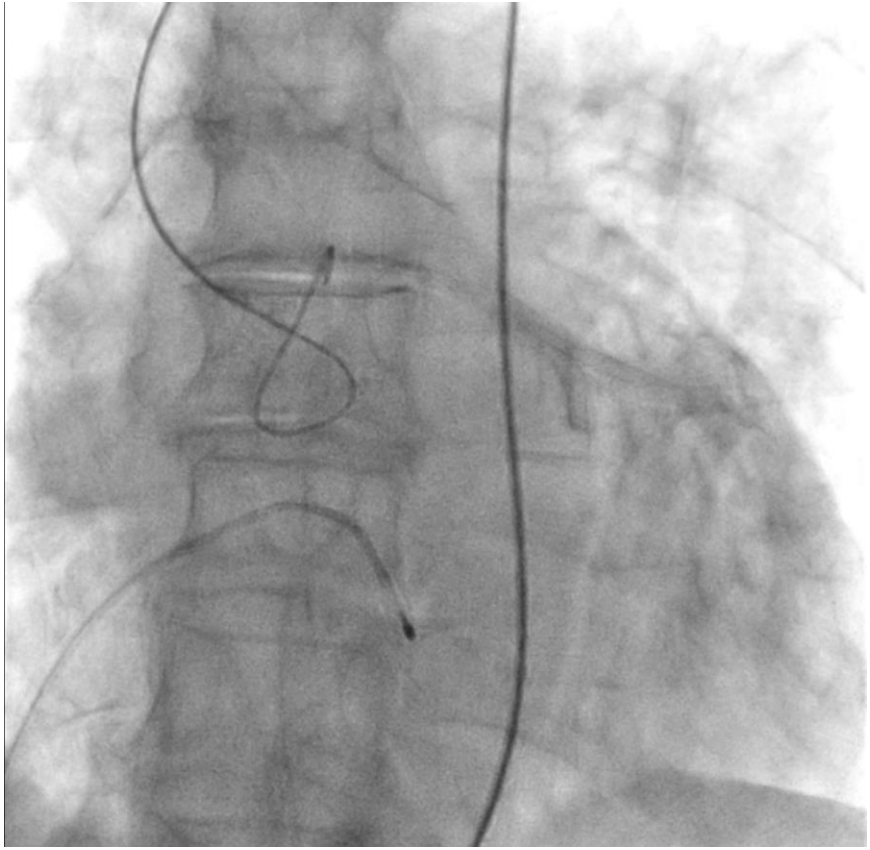

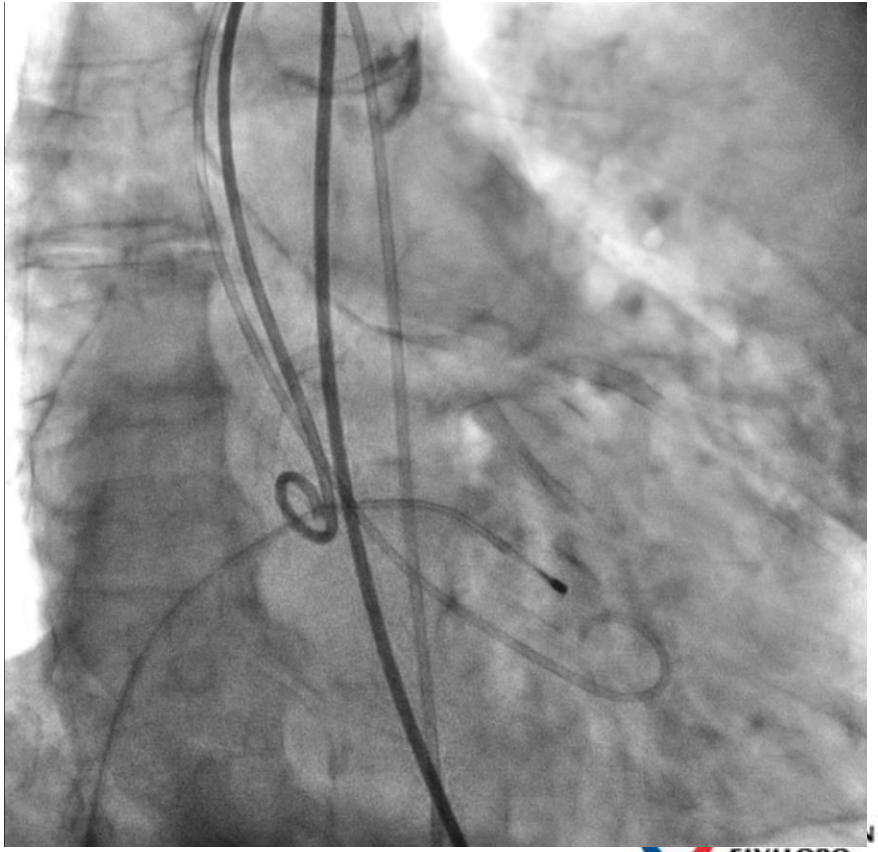

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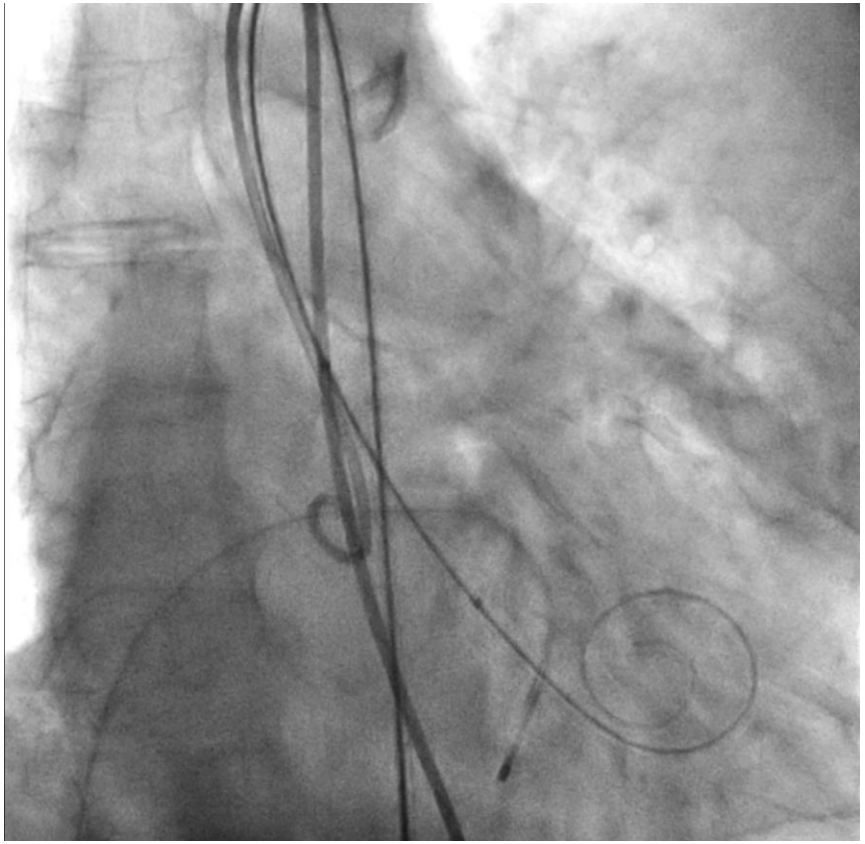

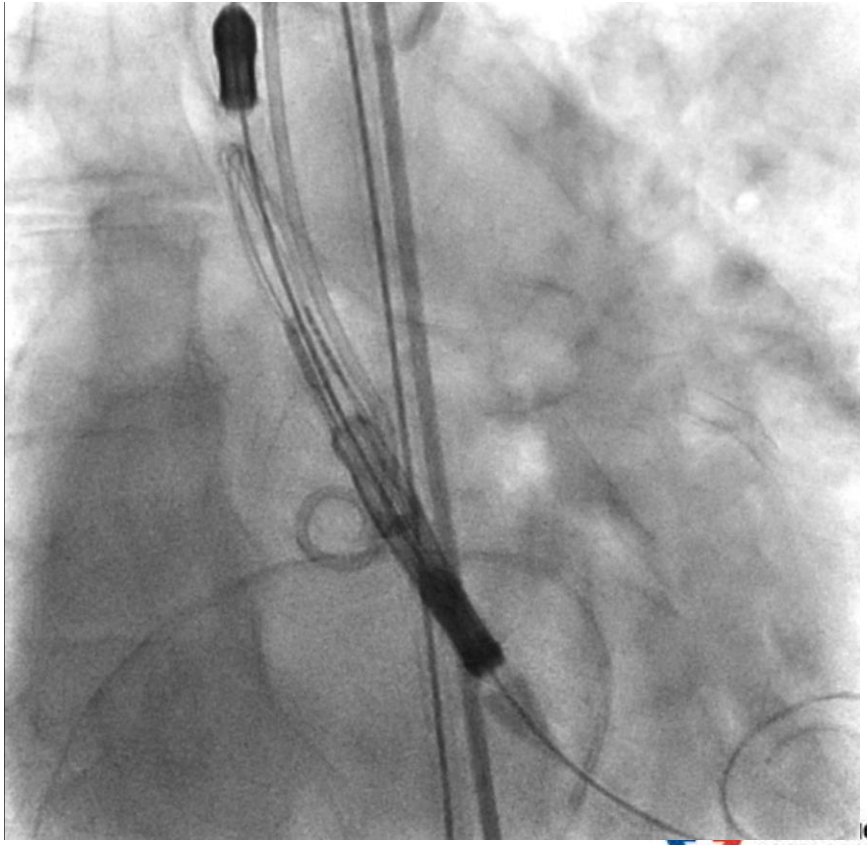

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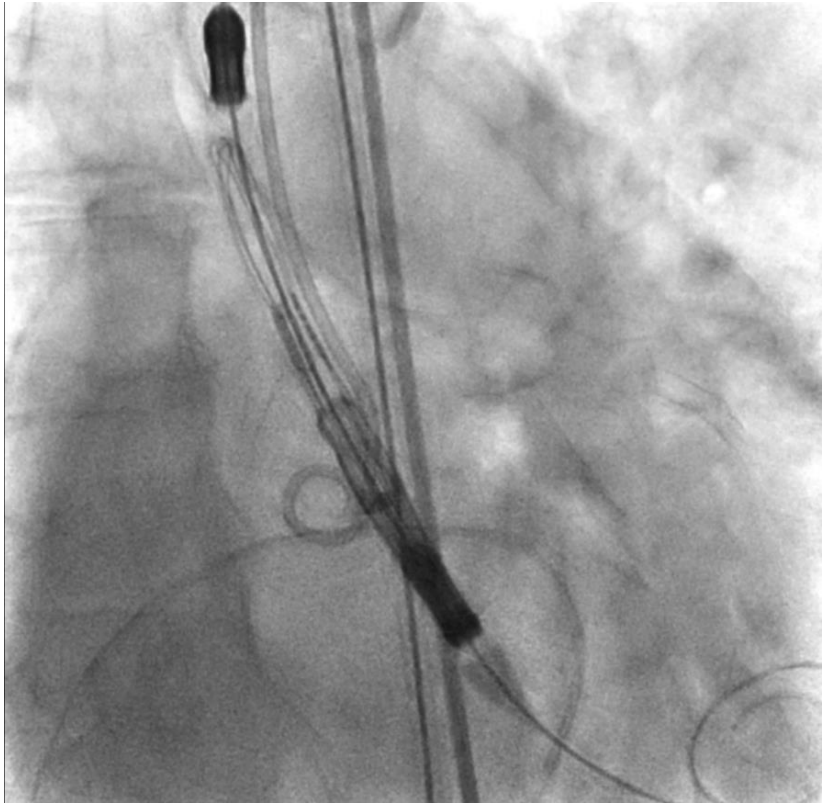

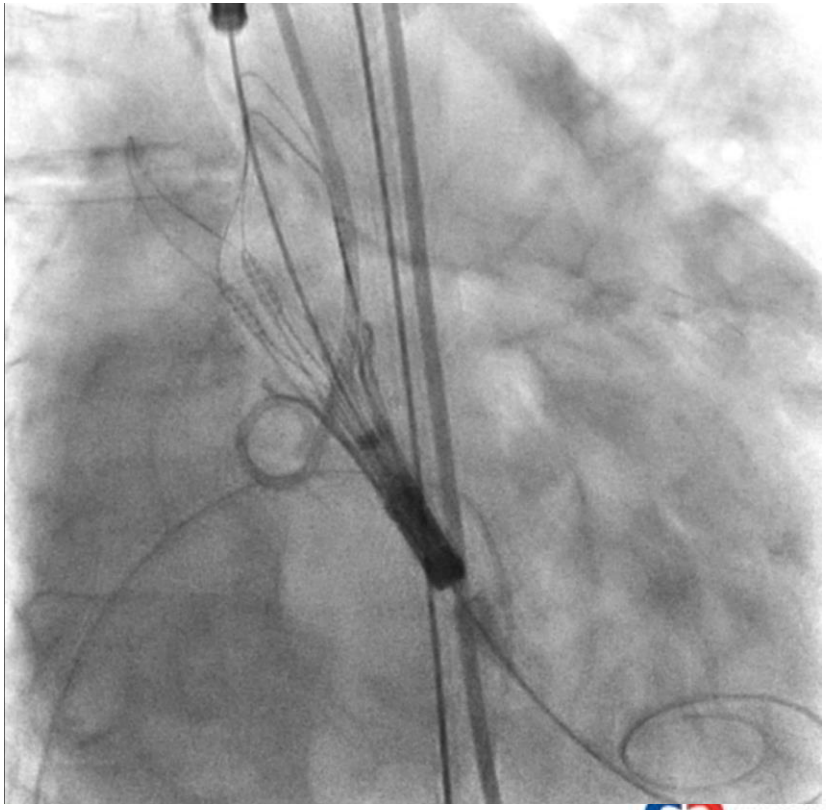

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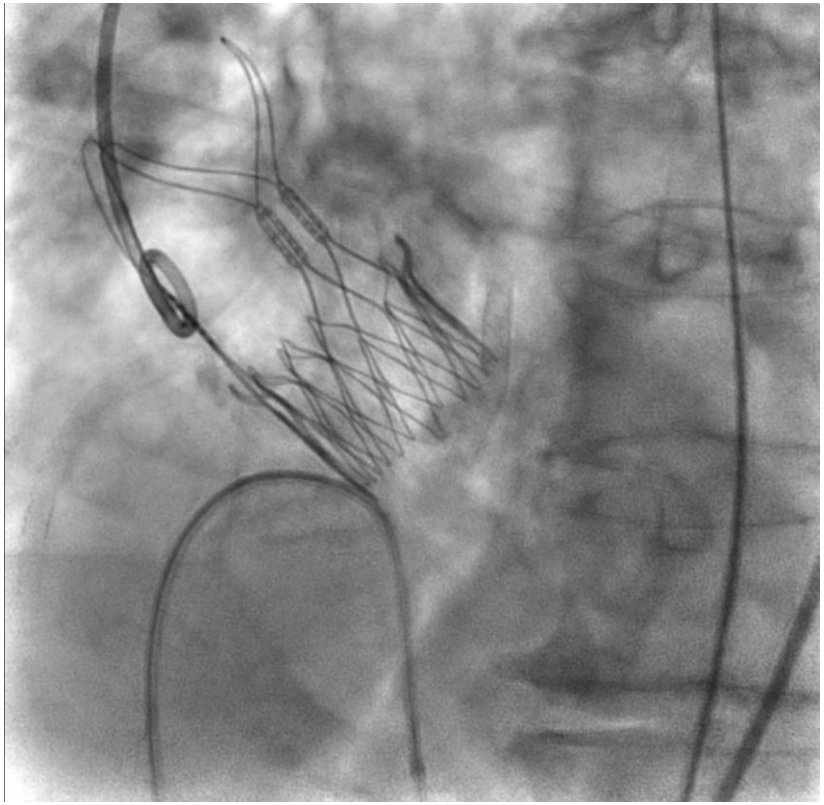

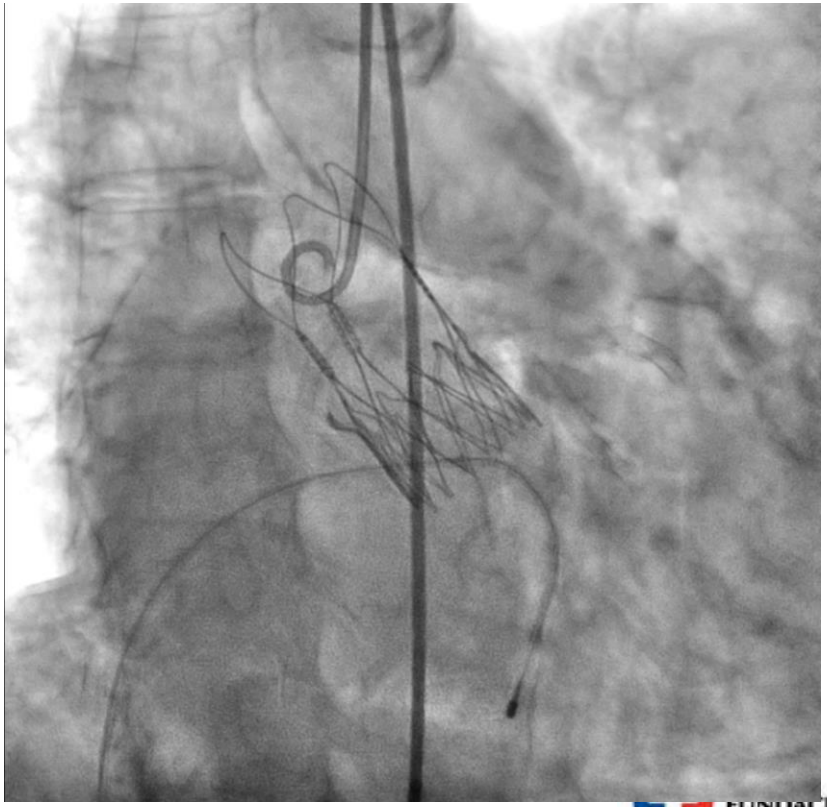

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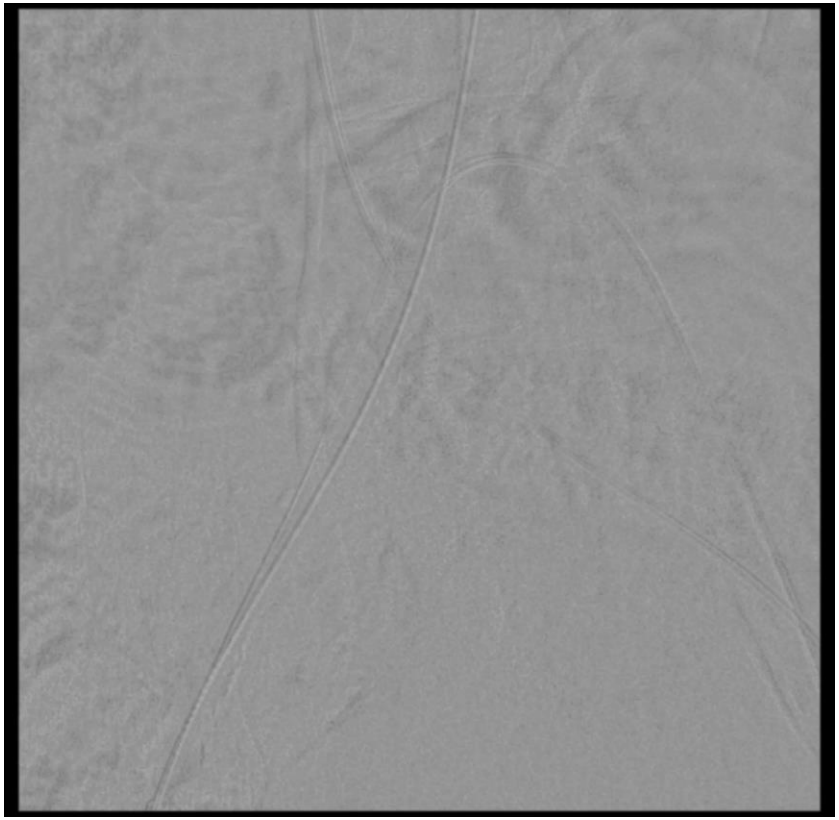
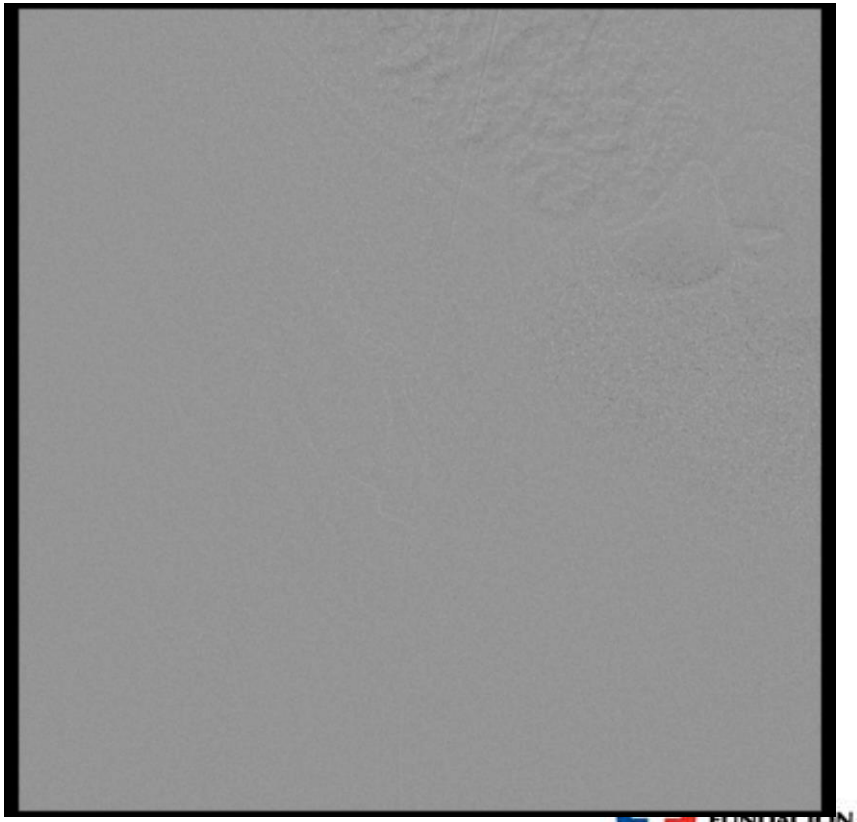




TAVR ViV
Calcified Iliac Artery

Clinical Case:

- Female 84y/o
- Presentation:
  - Dyspnea
- Clinical History:

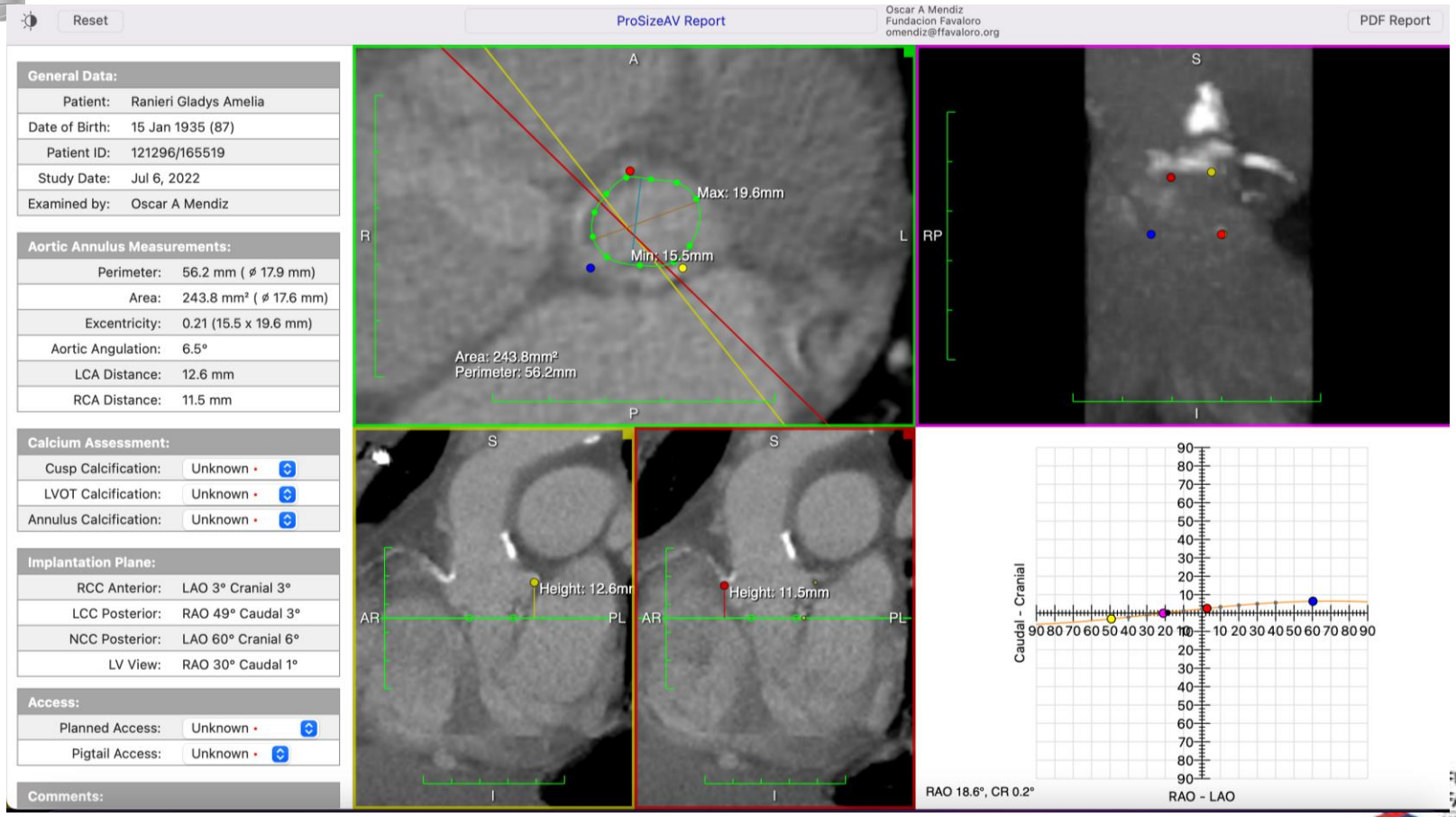
  RF: HTA - DSP - DBT II

  Fragile

  AVR St Jude Nº 21 (13 years ago)

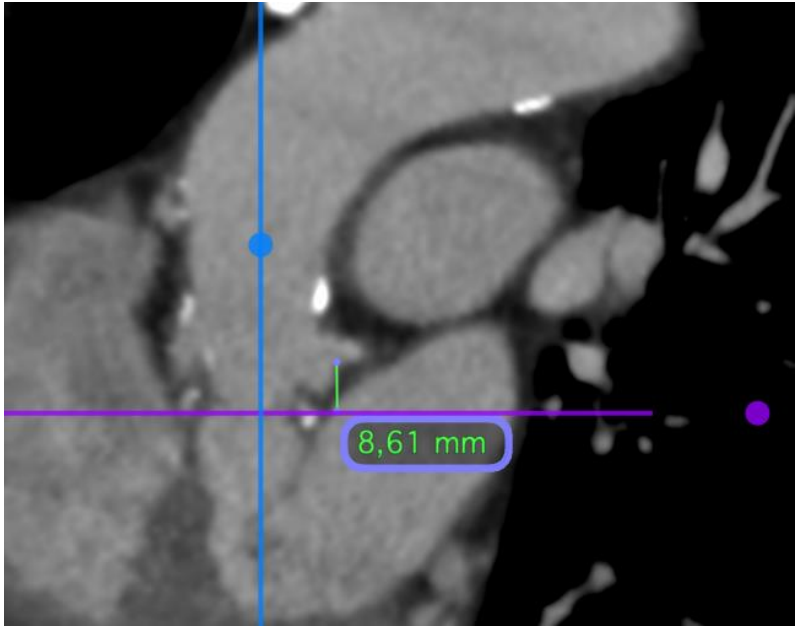
  AV dysfunction (Gradients: 68/41mmHg)

AngioCT:

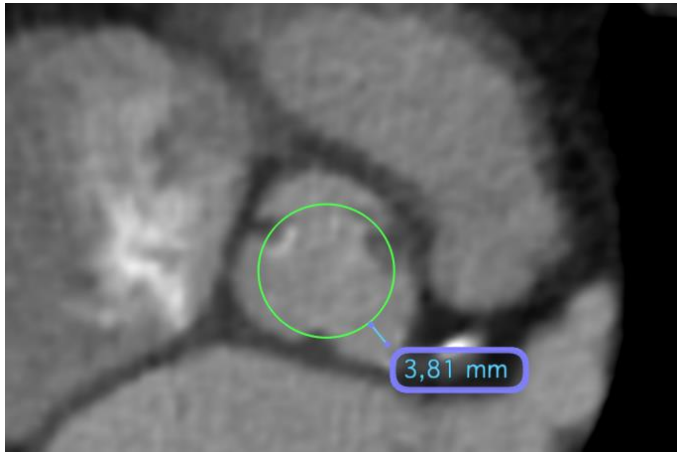

Reset
ProSizeAV Report
Oscar A Mendiz
Fundacion Favaloro
omendiz@ffavaloro.org
PDF Report
General Data:
Patient: Ranieri Gladys Amelia
Date of Birth: 15 Jan 1935 (87)
Patient ID: 121296/165519
Study Date: Jul 6, 2022
Examined by: Oscar A Mendiz
Aortic Annulus Measurements:
Perimeter: 56.2 mm (ø 17.9 mm)
Area: 243.8 mm² (ø 17.6 mm)
Excentricity: 0.21 (15.5 x 19.6 mm)
Aortic Angulation: 6.5°
LCA Distance: 12.6 mm
RCA Distance: 11.5 mm
Calcium Assessment:
Cusp Calcification: Unknown
LVOT Calcification: Unknown
Annulus Calcification: Unknown
Implantation Plane:
RCC Anterior: LAO 3° Cranial 3°
LCC Posterior: RAO 49° Caudal 3°
NCC Posterior: LAO 60° Cranial 6°
LV View: RAO 30° Caudal 1°
Access:
Planned Access: Unknown
Pigtail Access: Unknown
Comments:
A
R
L
P
Max: 19.6mm
Min: 15.5mm
Area: 243.8mm²
Perimeter: 56.2mm
S
RP
I
Height: 12.6mm
Height: 11.5mm
AR
PL
Caudal - Cranial
RAO 18.6°, CR 0.2°
RAO - LAO

AngioCT:

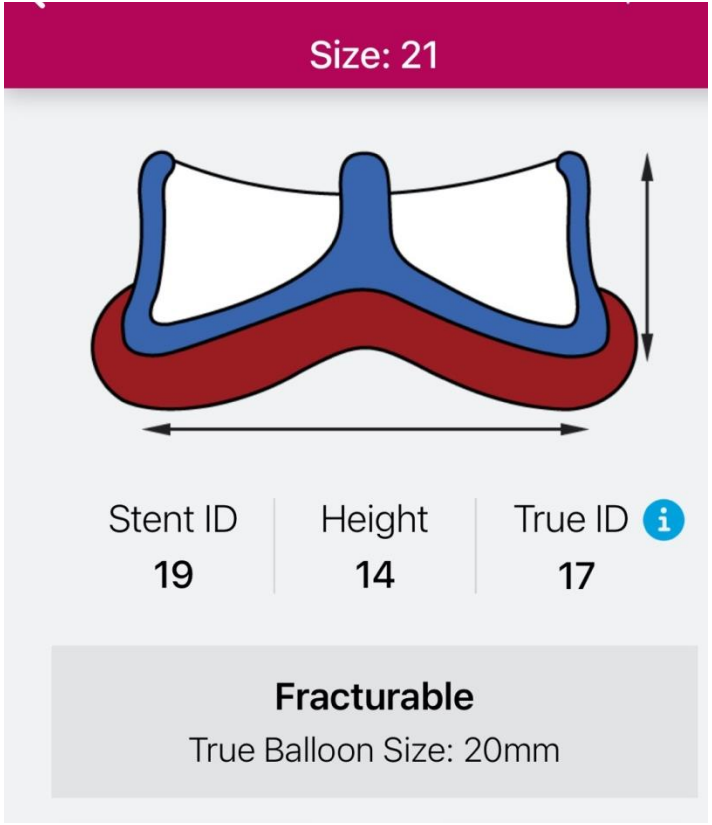
LM Ostium Height



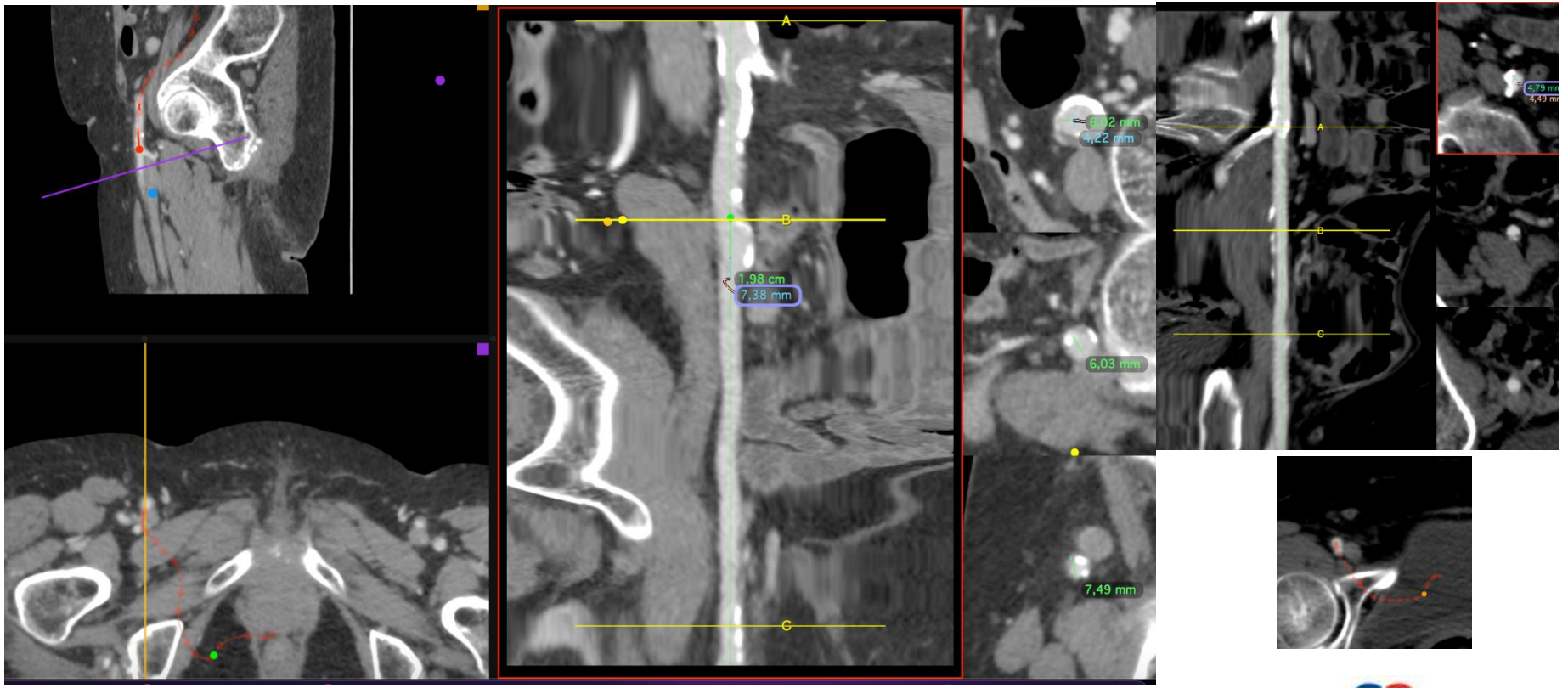
THV Distance



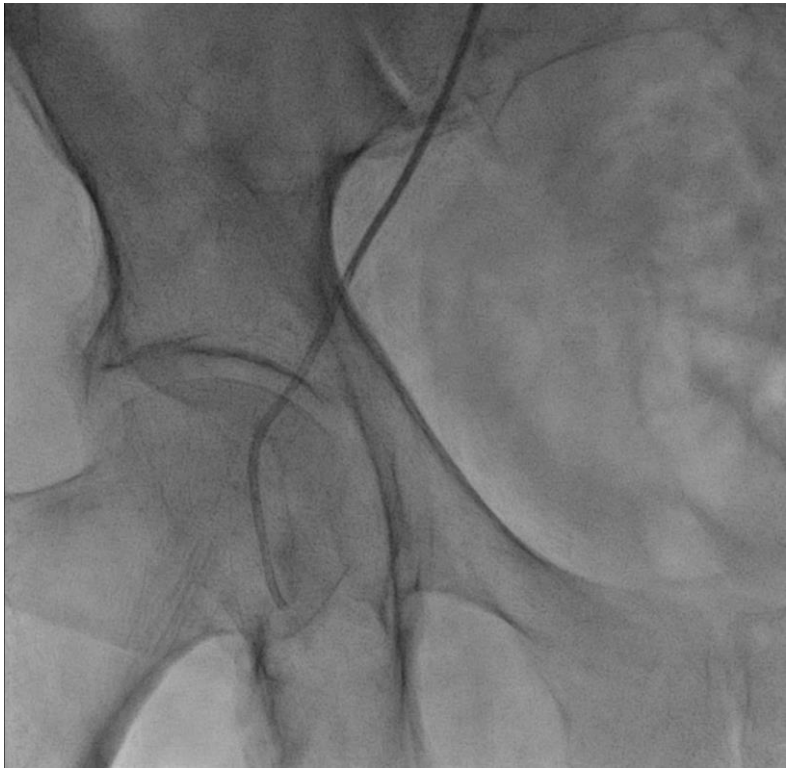
Surgical Aortic Valve: Biocor Nº 21



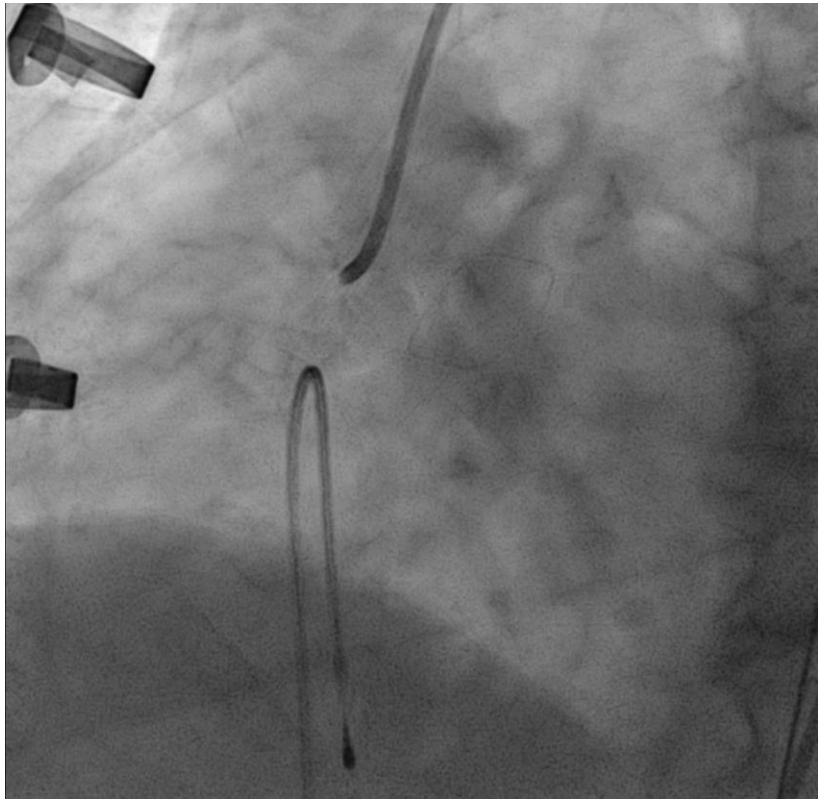
AngioTAC: Vascular Access

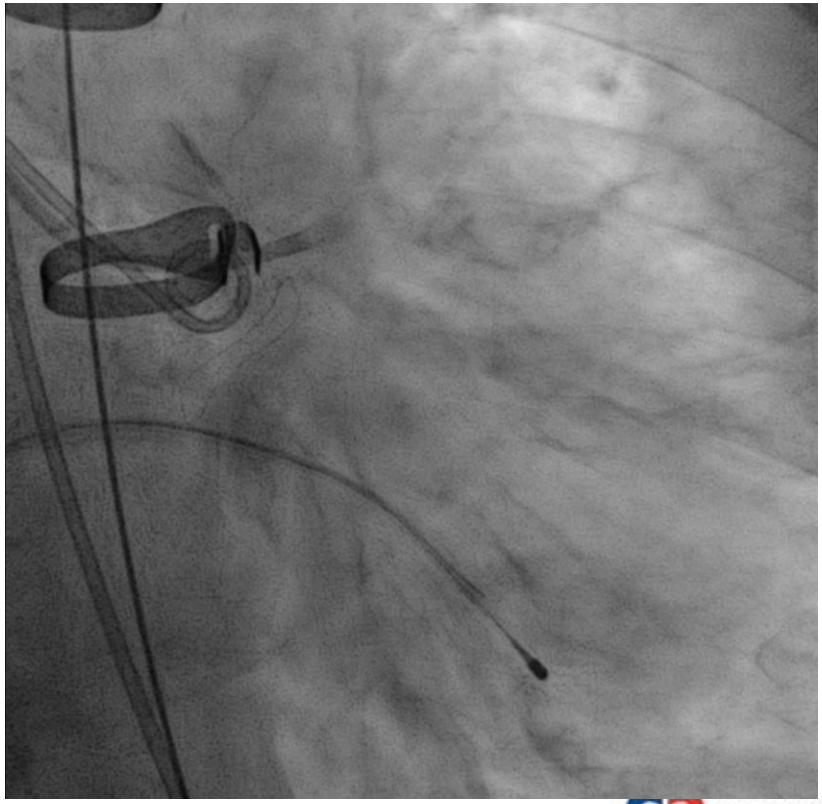


Angio Guided Vascular Access

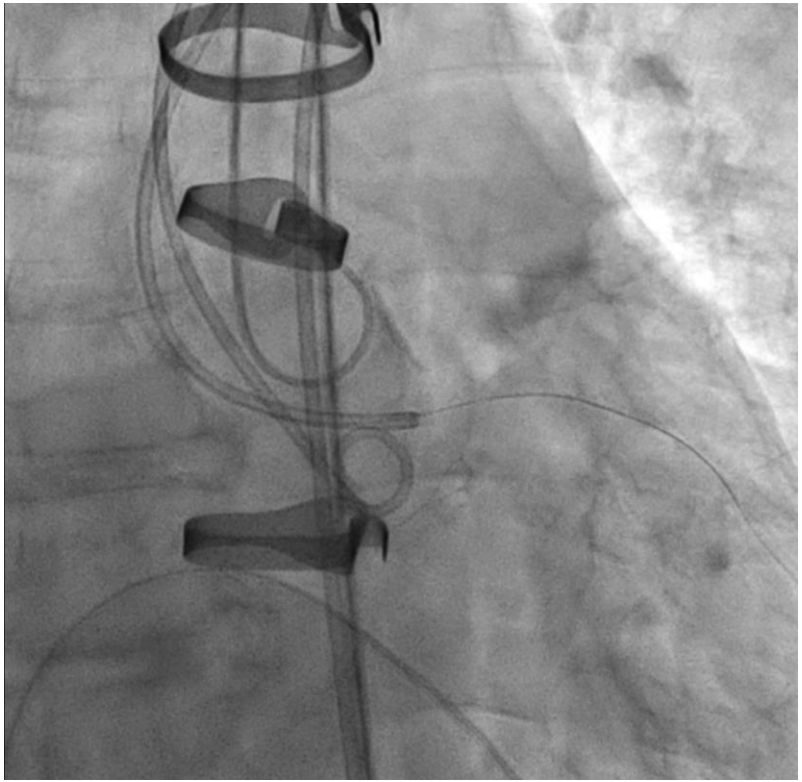


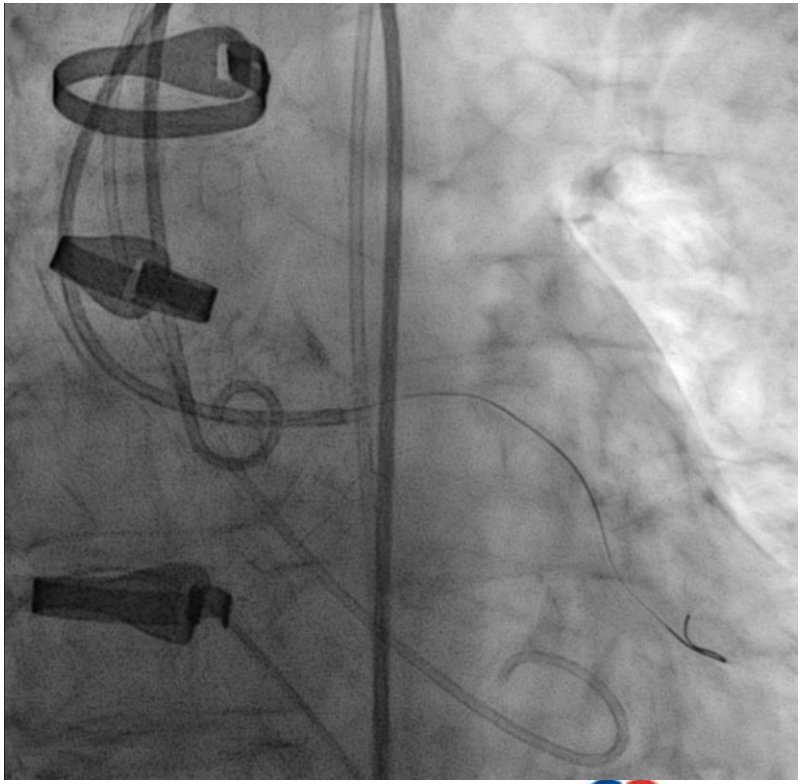
Coronary Angio





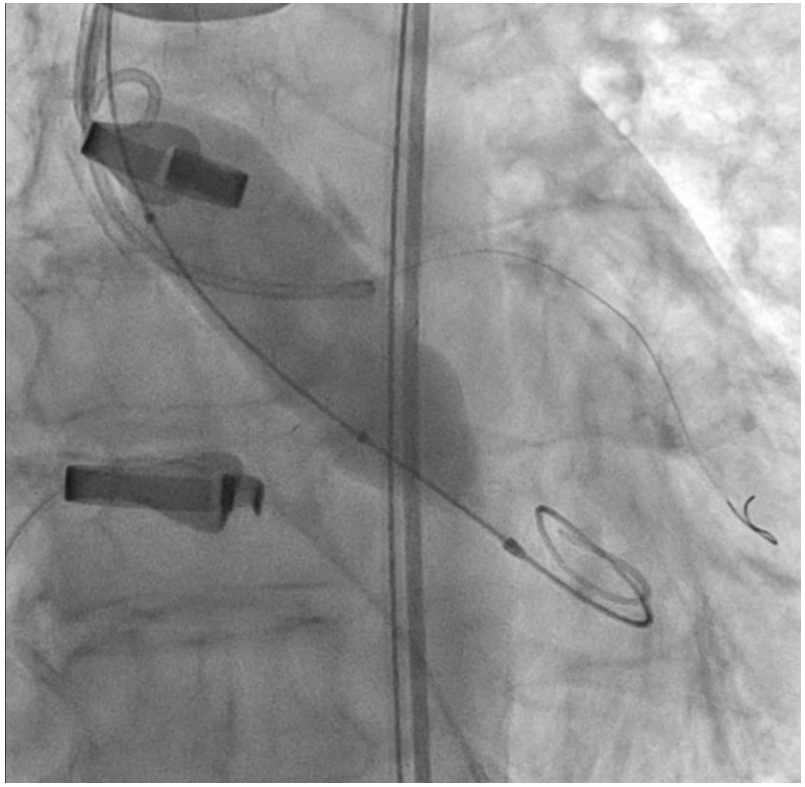
LM Protection





902492

Pre TAVI Surgical Valve Cracking



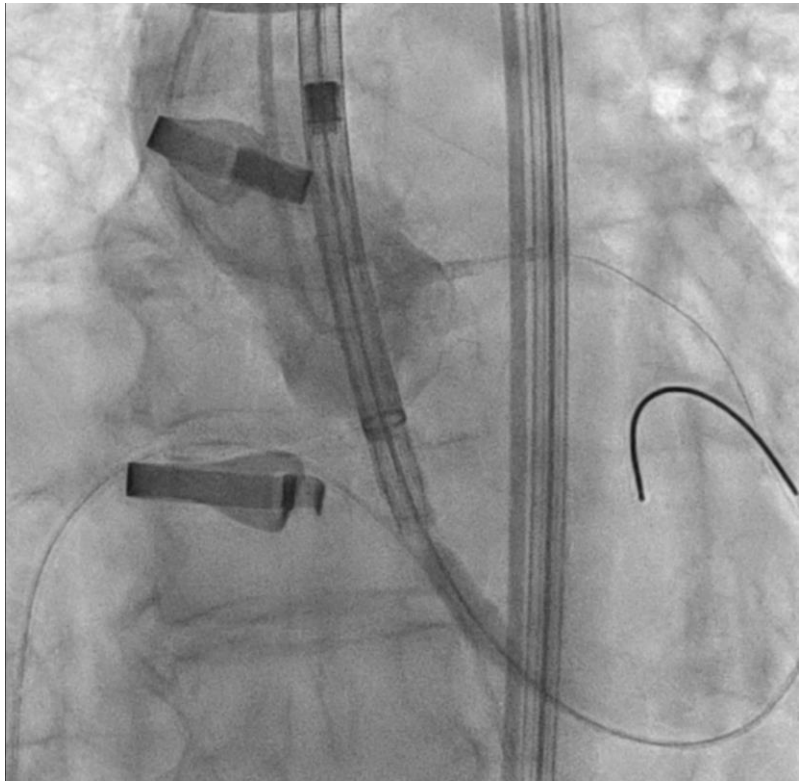
Pte Crushed
CPR was initiated

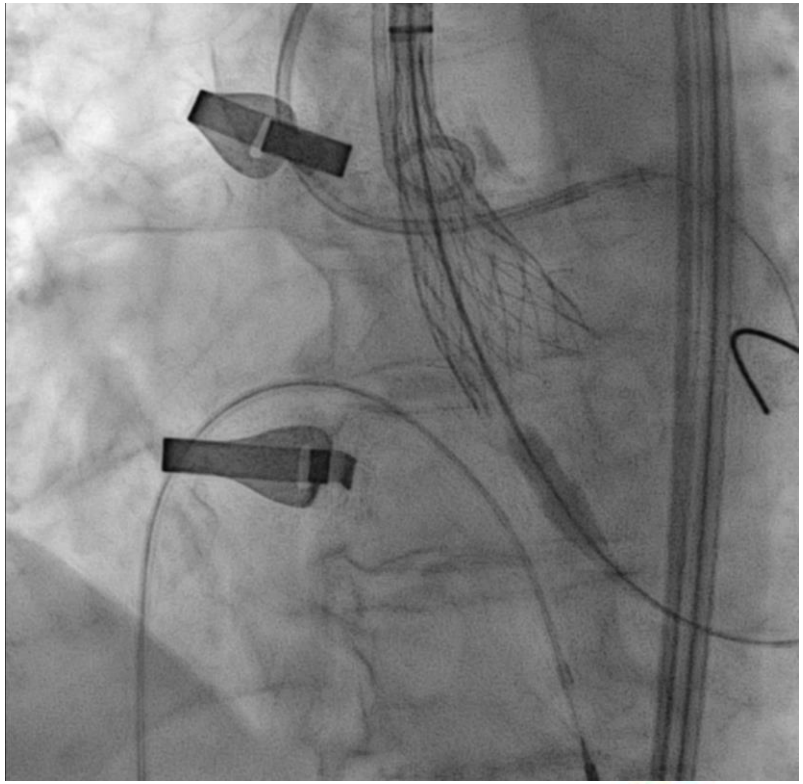
Echo did not show pericardial effusion

902492

Atlas Gold™☐ 20mm

TAVI in a Pte under CPR

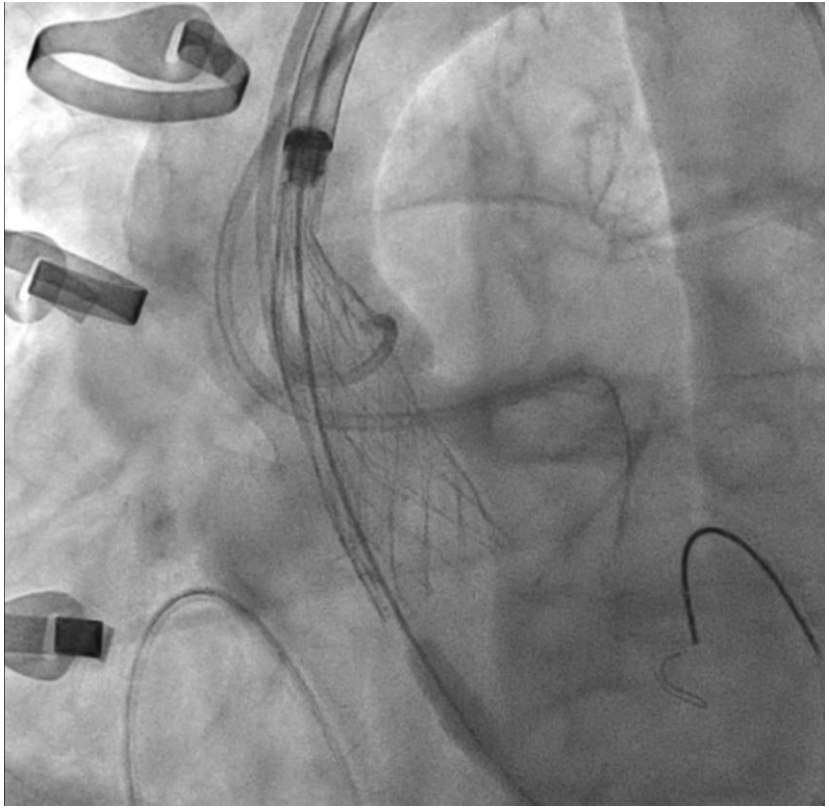


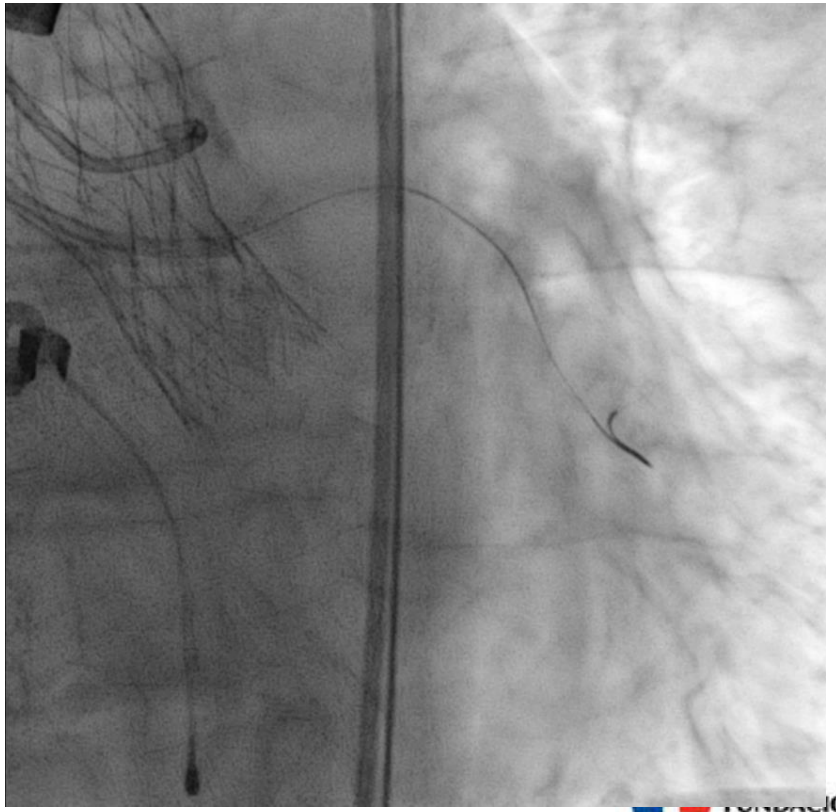


Evolute 23

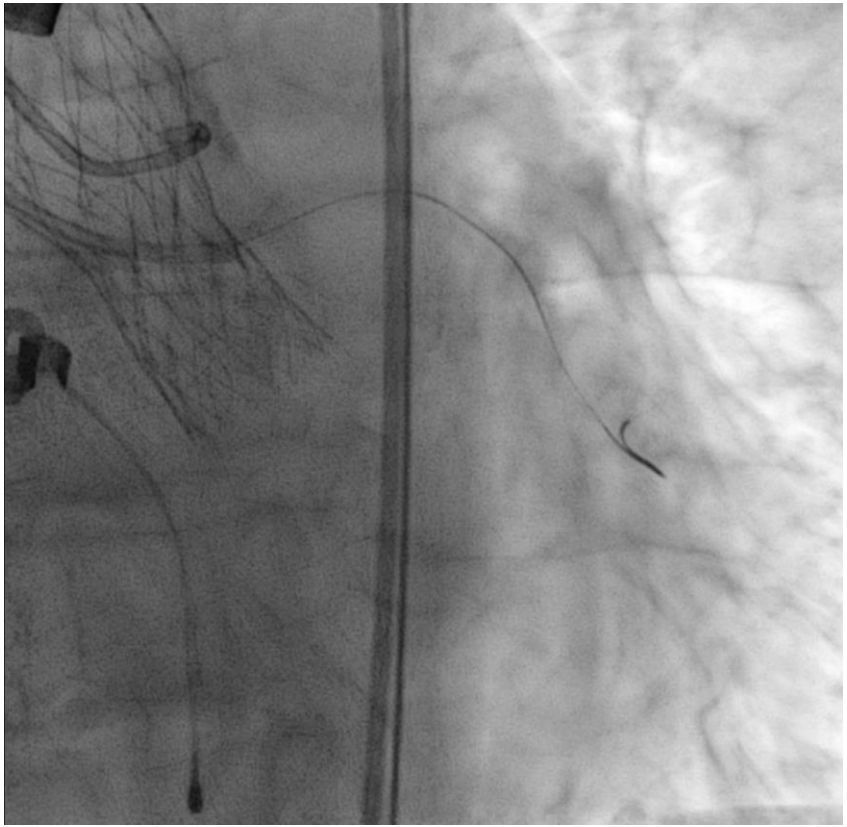
902492

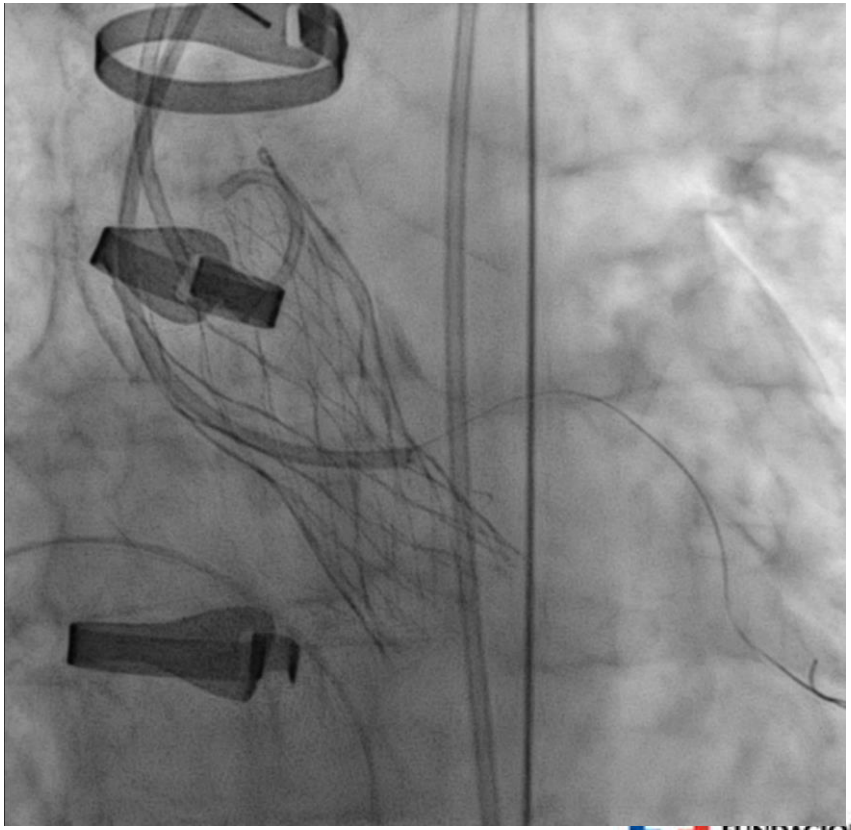
TAVI: final Delivery





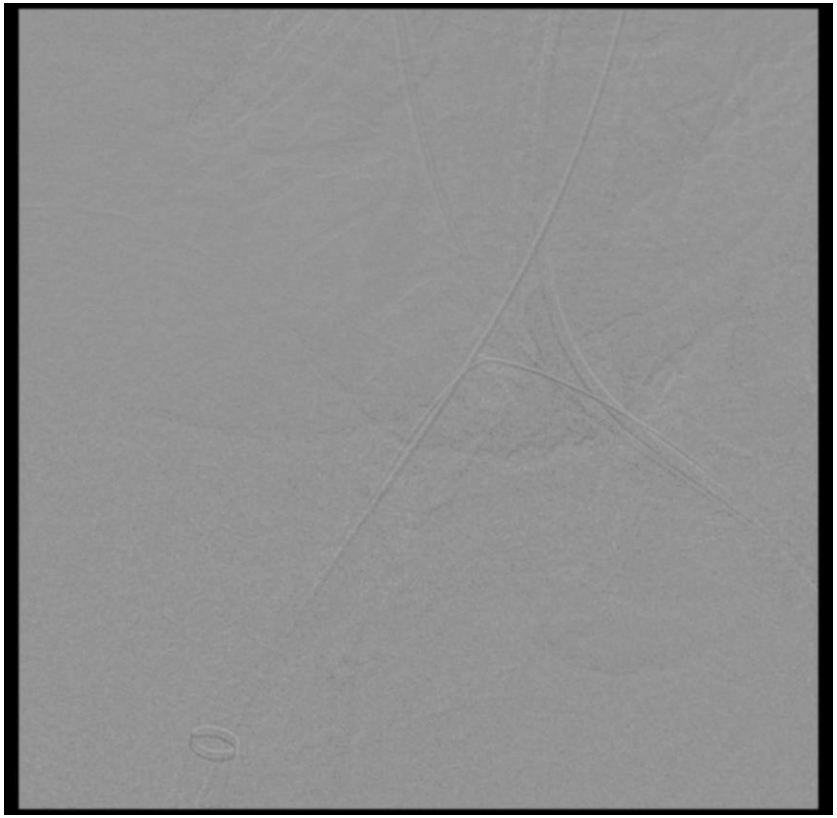
TAVI: LM Patency

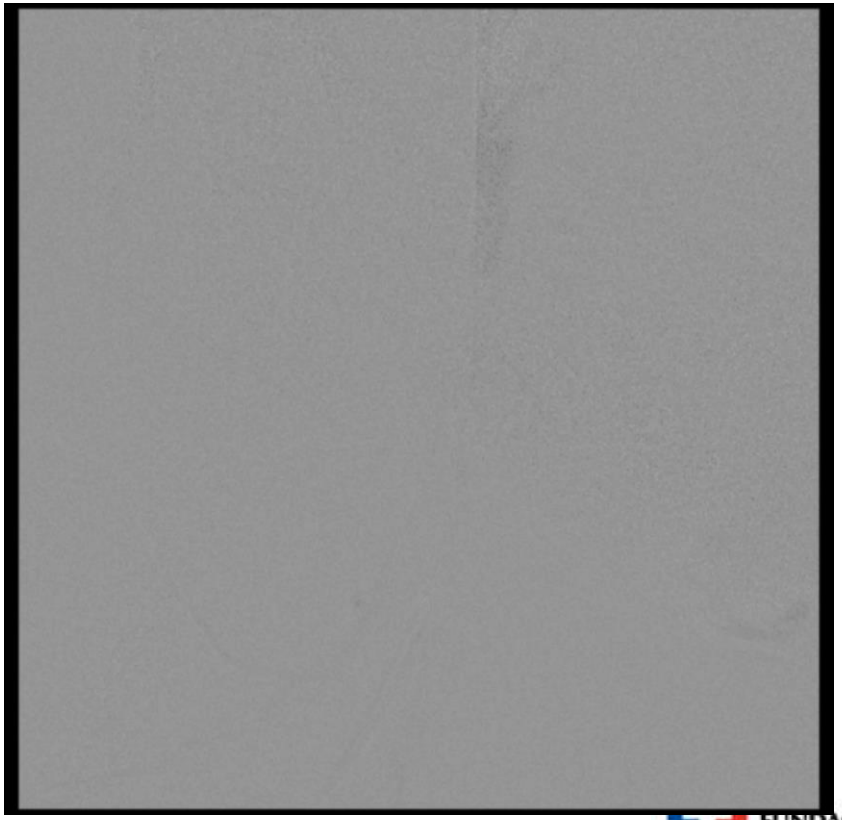




902492

TAVI: Vascular Access Control





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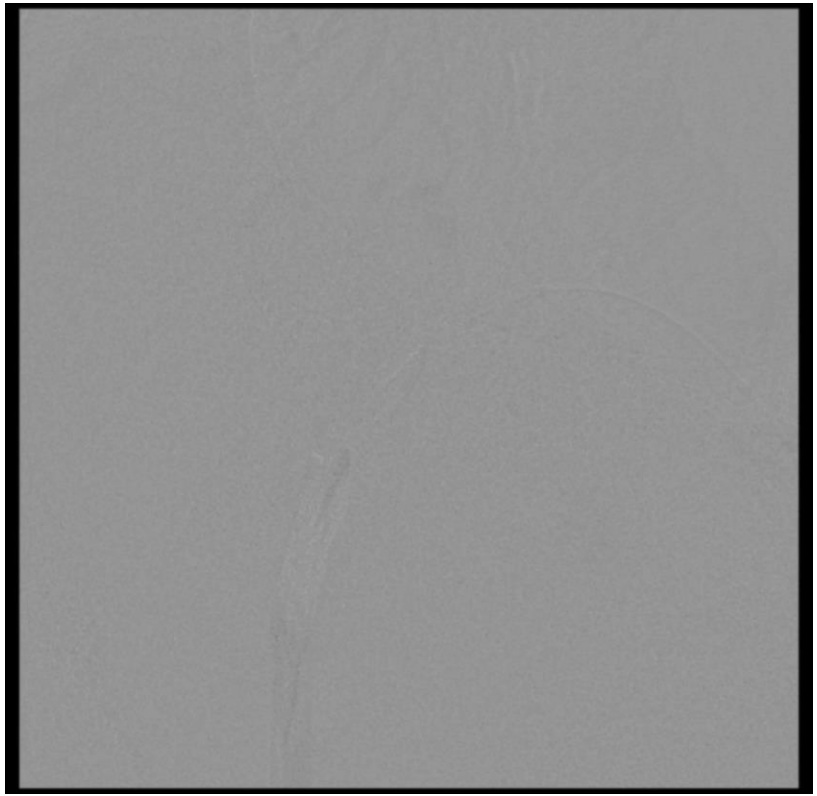
TAVI: Iliac Dissection



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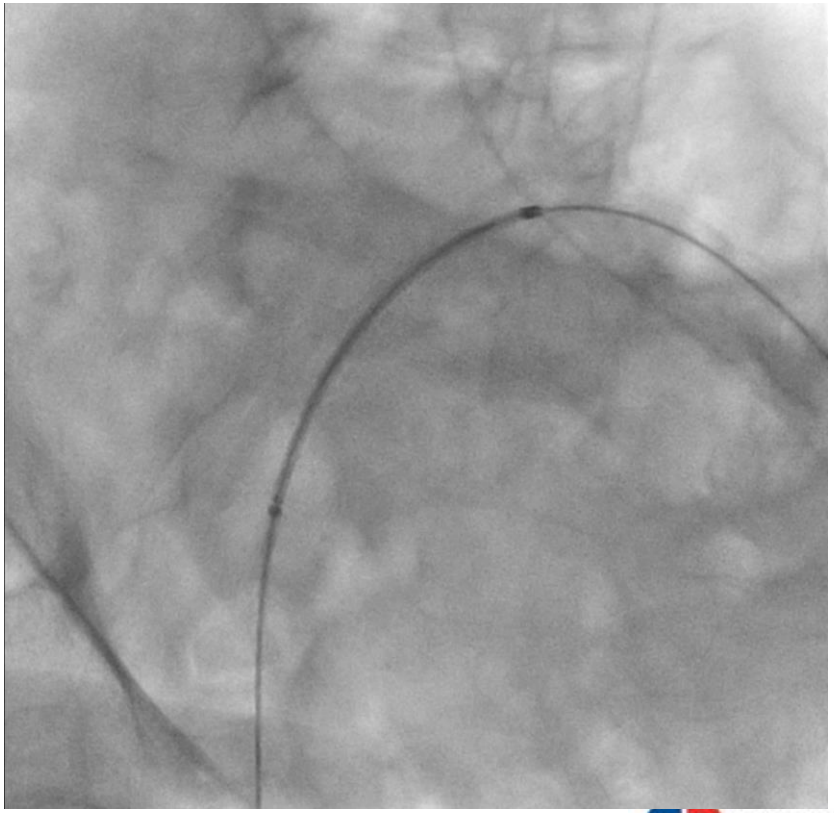
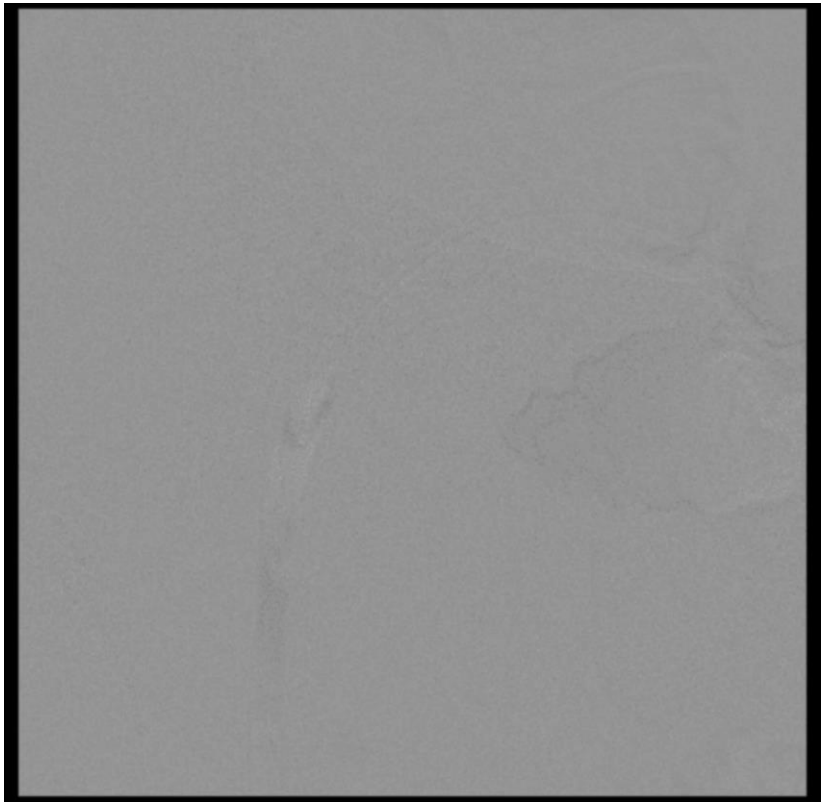
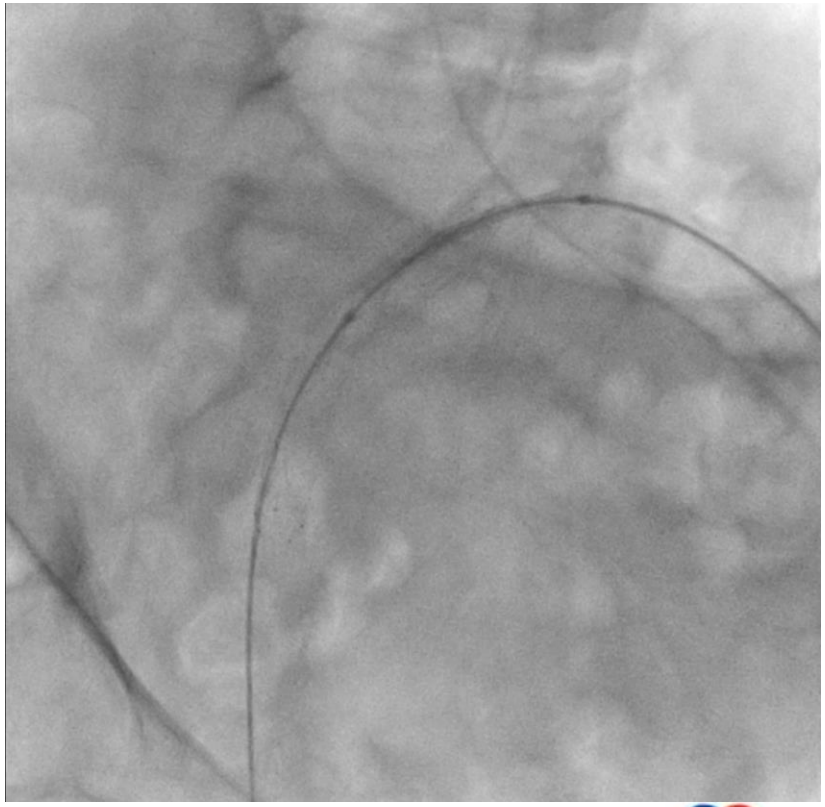


9.0x60mm Self-Expandable Stent

TAVI: Iliac Dissection

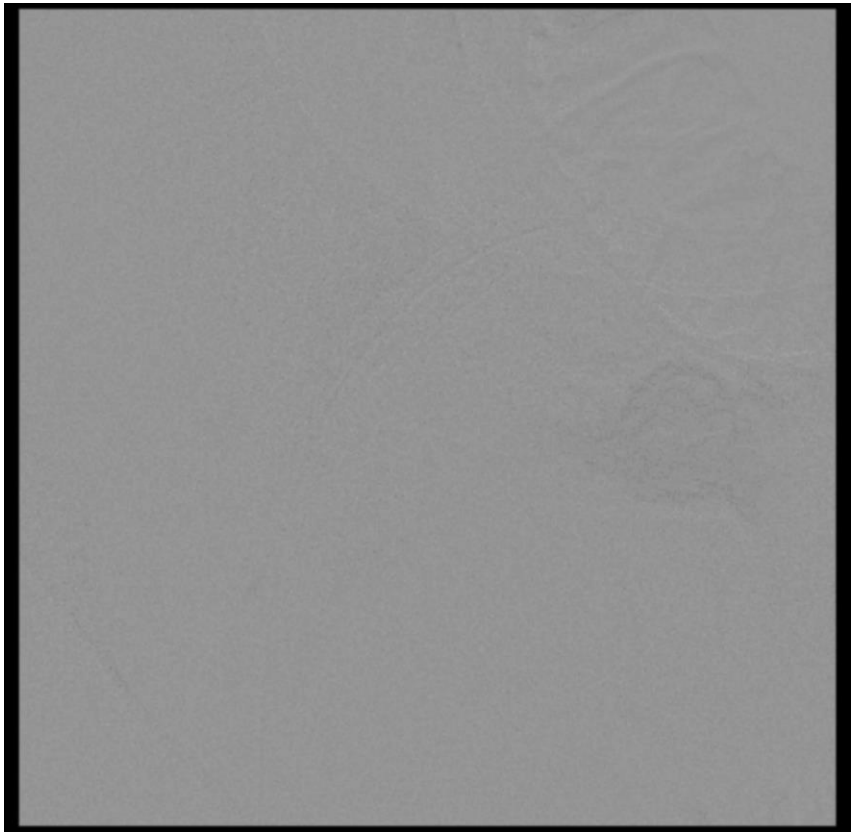




902492

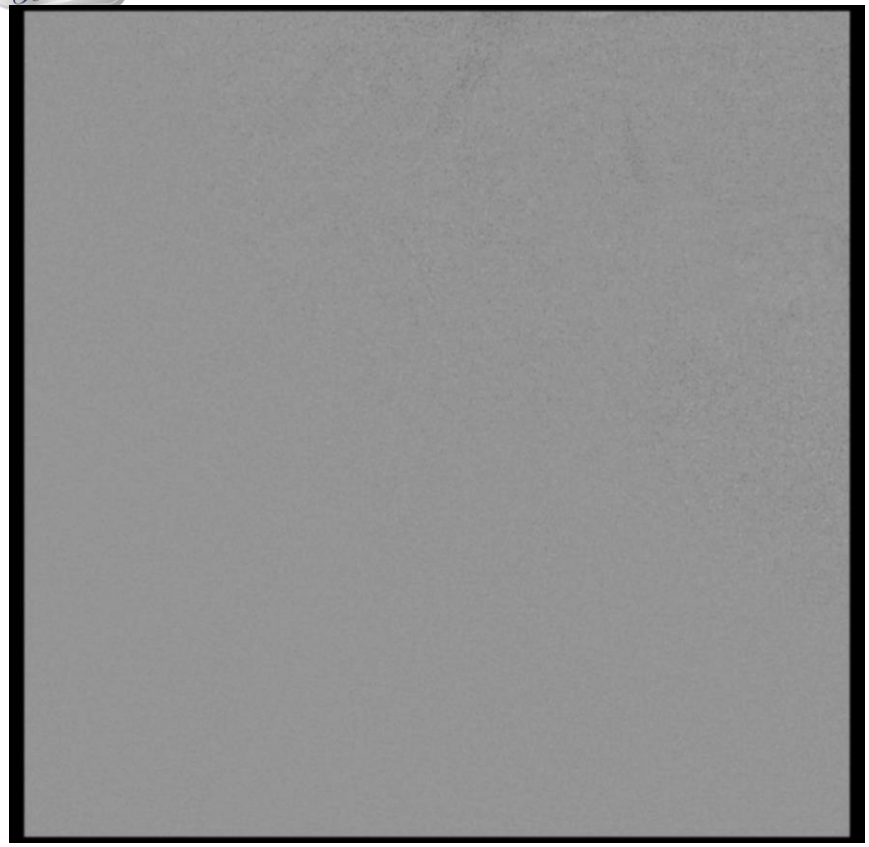
9.0x27mm Balloon-Expandable Stent

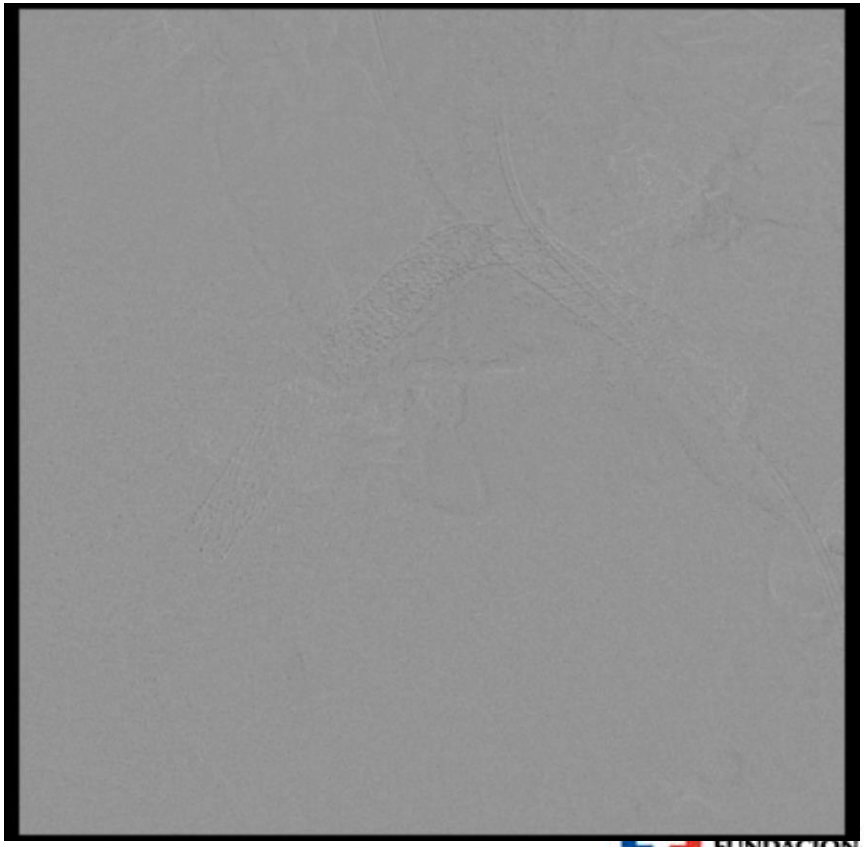
TAVI: Iliac Dissection



902492

TAVI: Iliac Dissection





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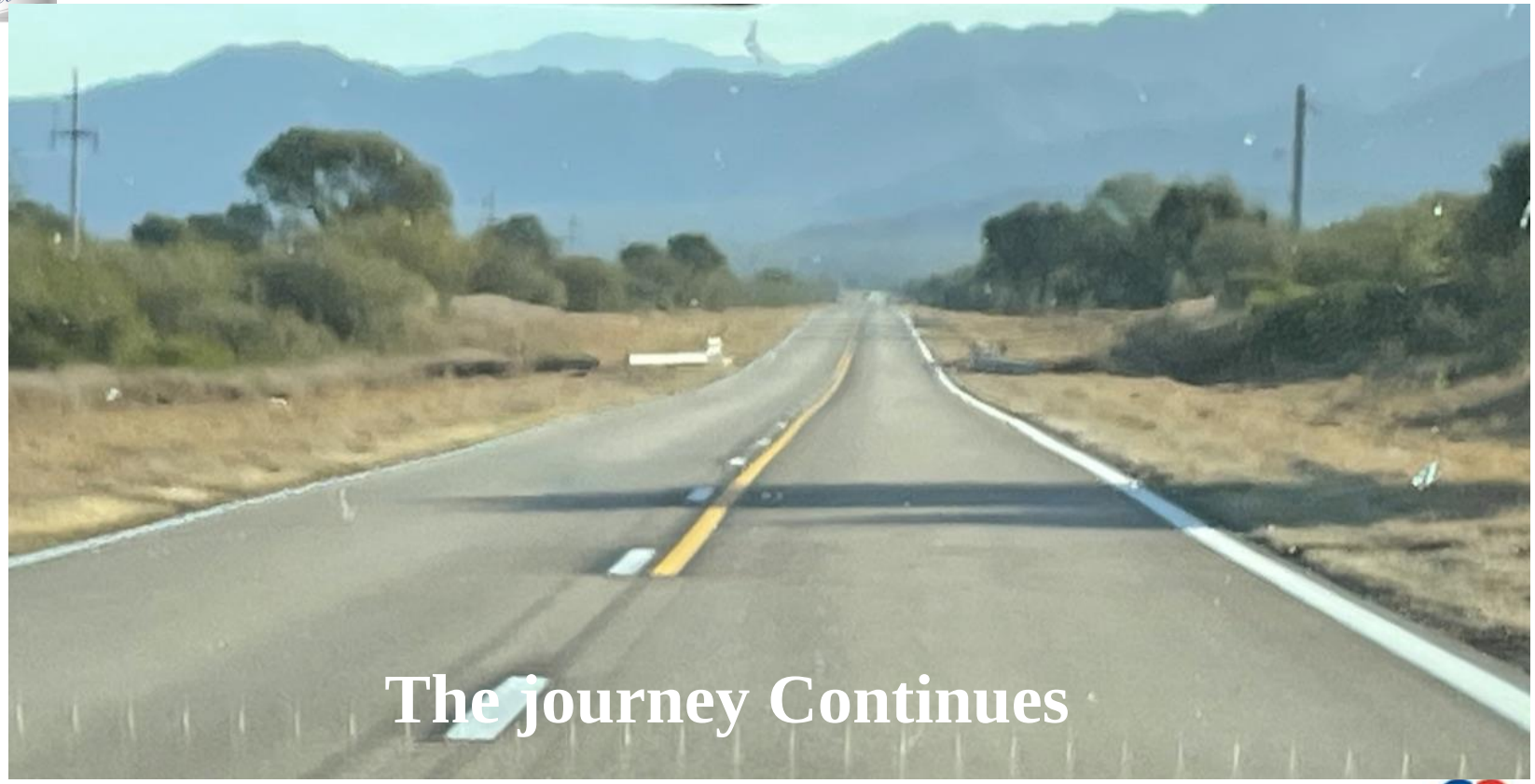
The journey Continues


AFA
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