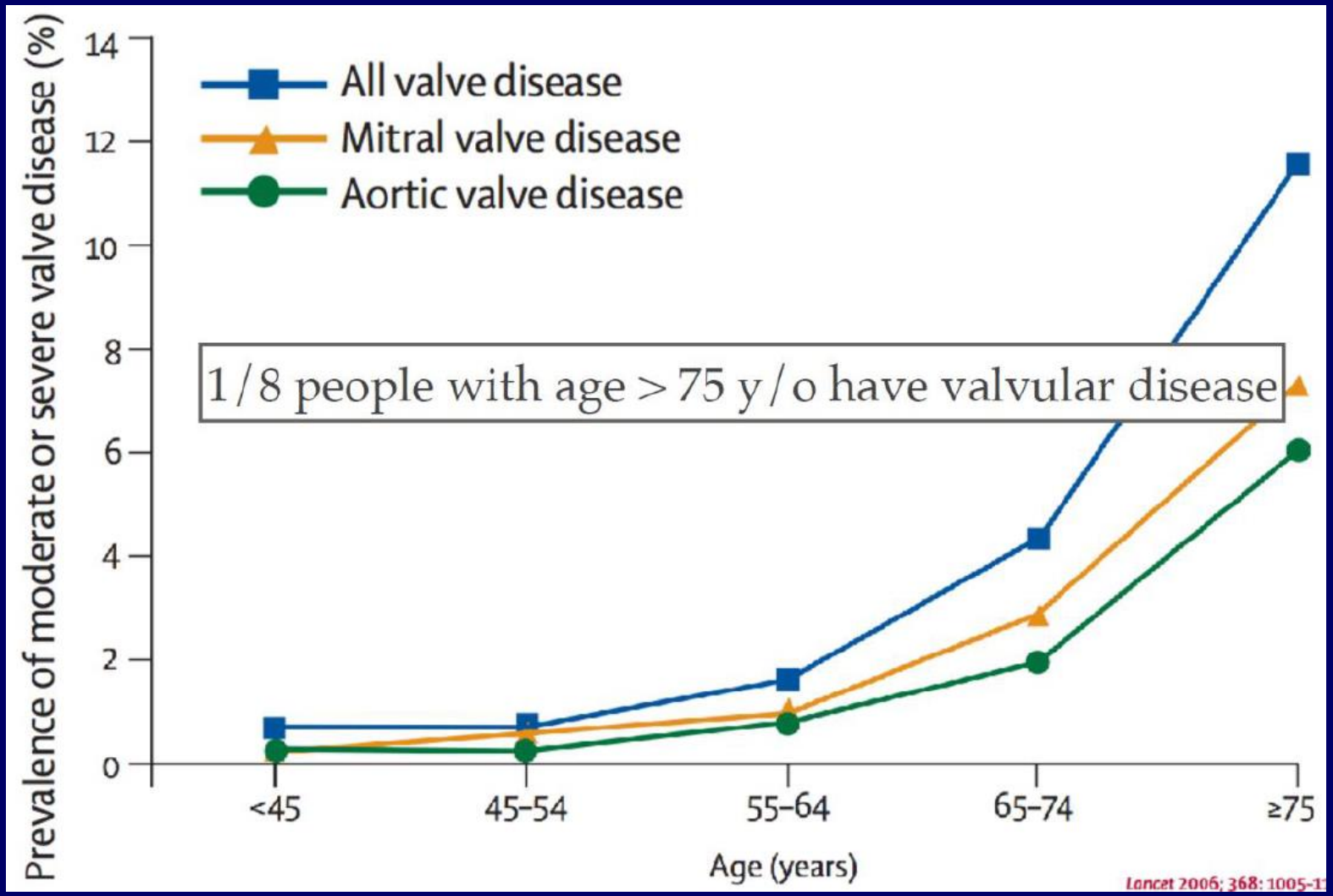
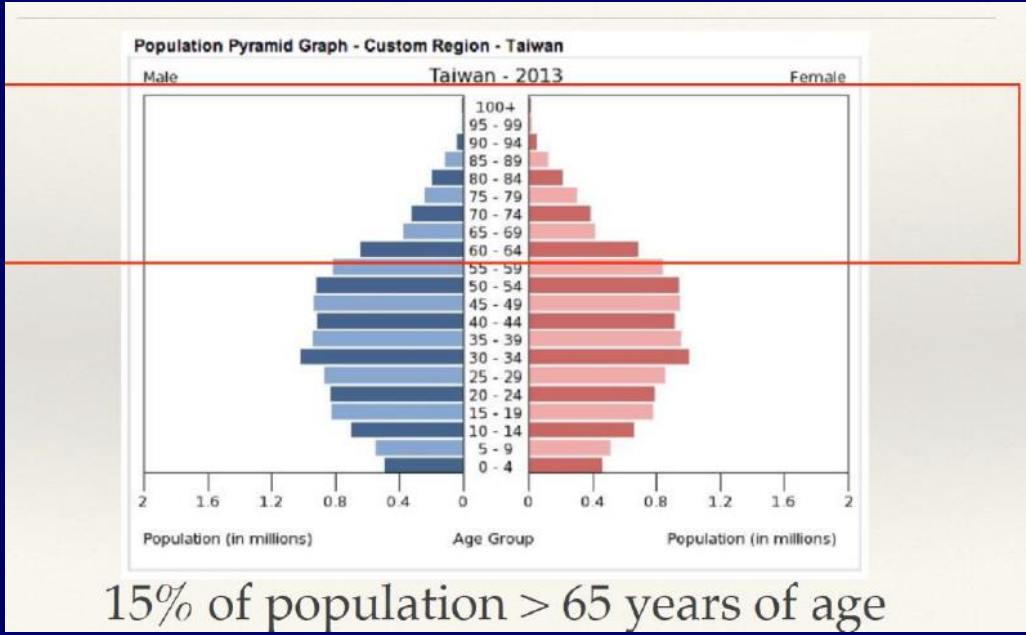
Should my patient with severe aortic stenosis undergo TAVI?

Michael KY Lee 李耿淵
Queen Elizabeth Hospital
Founding President, HKSTENT

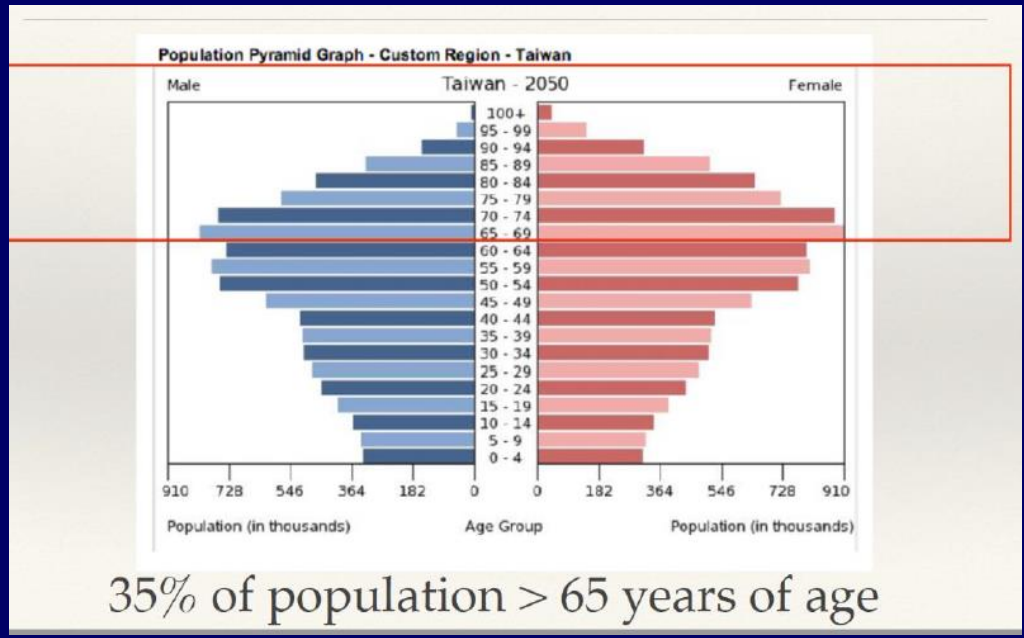
HK College of Cardiology Annual Scientific Congress 2019


Prevalence of moderate or severe valve disease (%)
14
12
10
8
6
4
2
0
All valve disease
Mitral valve disease
Aortic valve disease
1/8 people with age > 75 y/o have valvular disease
<45
45–54
55–64
65–74
≥75
Age (years)
Lancet 2006; 368: 1005-11

Change of Population Pyramid in Taiwan



15% of population > 65 years of age



35% of population > 65 years of age

Introduction

- Aortic Stenosis - common valvular heart disease in the elderly
- 4.6% in adults $\geqq$75 years of age
- Once symptomatic, average survival 2-3 years with high risk of sudden death
- TAVI (Transcatheter Aortic Valve Implantation) or TAVR (Transcatheter AV Replacement) has emerged as a viable alternative in inoperable or high risk elderly patients with symptomatic AS
- ~5% immediate complications
- 30-day mortality of <5%
- Reduces all-cause mortality by 27% at 3 years

Aortic stenosis severity

Indicator	Mild	Moderate	Severe
Jet Velocity *(m/s)*	< 3.0	3.0 – 4.0	> 4.0
Mean Gradient *(mmHg)*	< 25	25 – 40	> 40
Valve Area *(cm^2)*	> 1.5	1.0 – 1.5	< 1.0
Valve Area Index *(cm^2/m^2)*	–	–	< 0.6

Bonow RO. ACC/AHA 2006 Guidelines for the Management of Patients with Valvular Heart Disease: A Report of the American College of Cardiology/American Heart Association on Practice Guidelines. *Circulation* 2006;114:e84-e231.

CoreValve® Transcatheter Procedure

Balloon catheter threaded through sheath and into heart

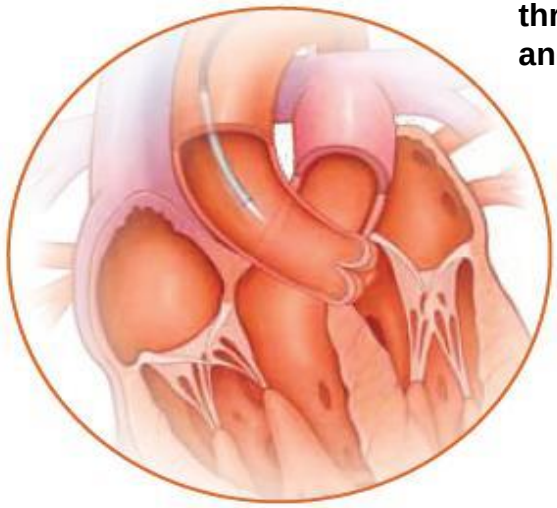


Figure 1

CoreValve placed into position over the diseased aortic valve

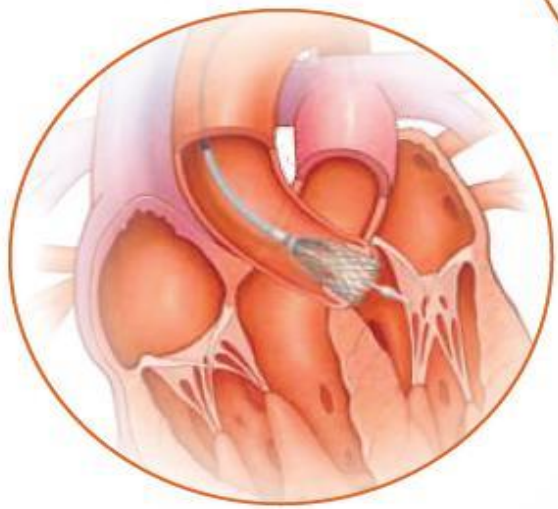


Figure 2

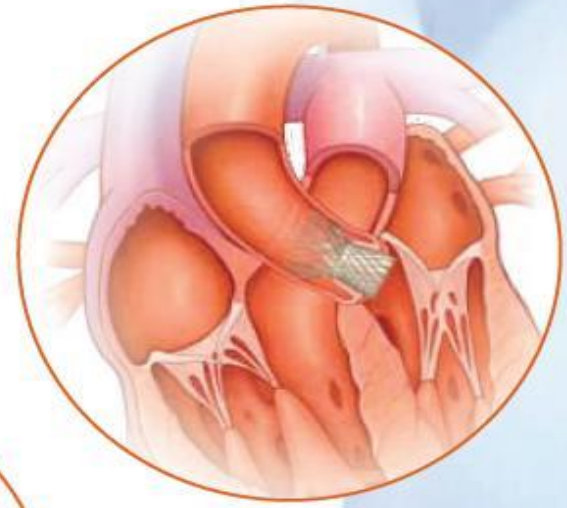


Figure 3

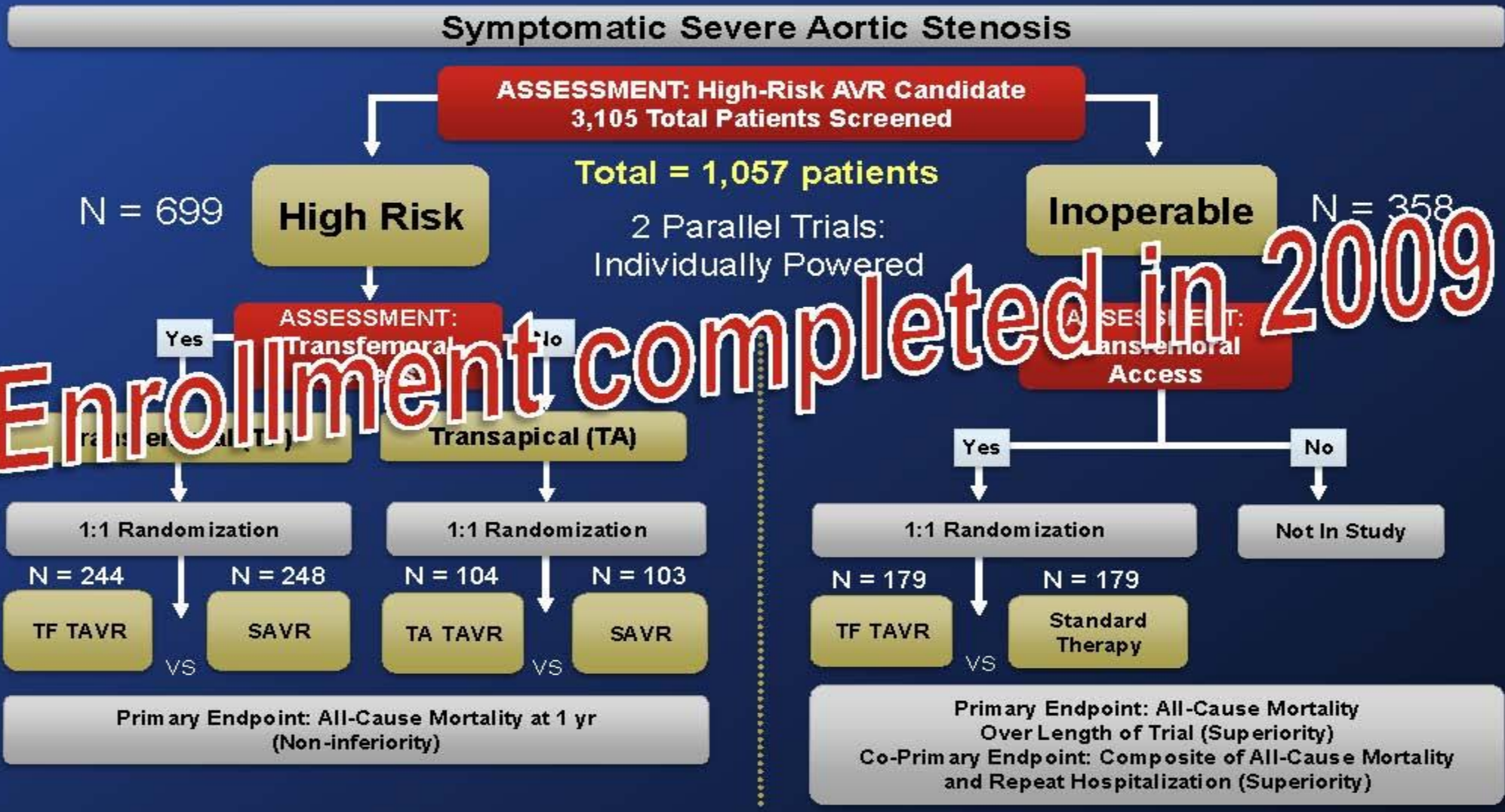
CoreValve in place, procedure completed

Experimental Device in the United States and Limited by Federal Law to Investigational Use.

What does the evidence show?

Inoperable & High-risk
STS >8%

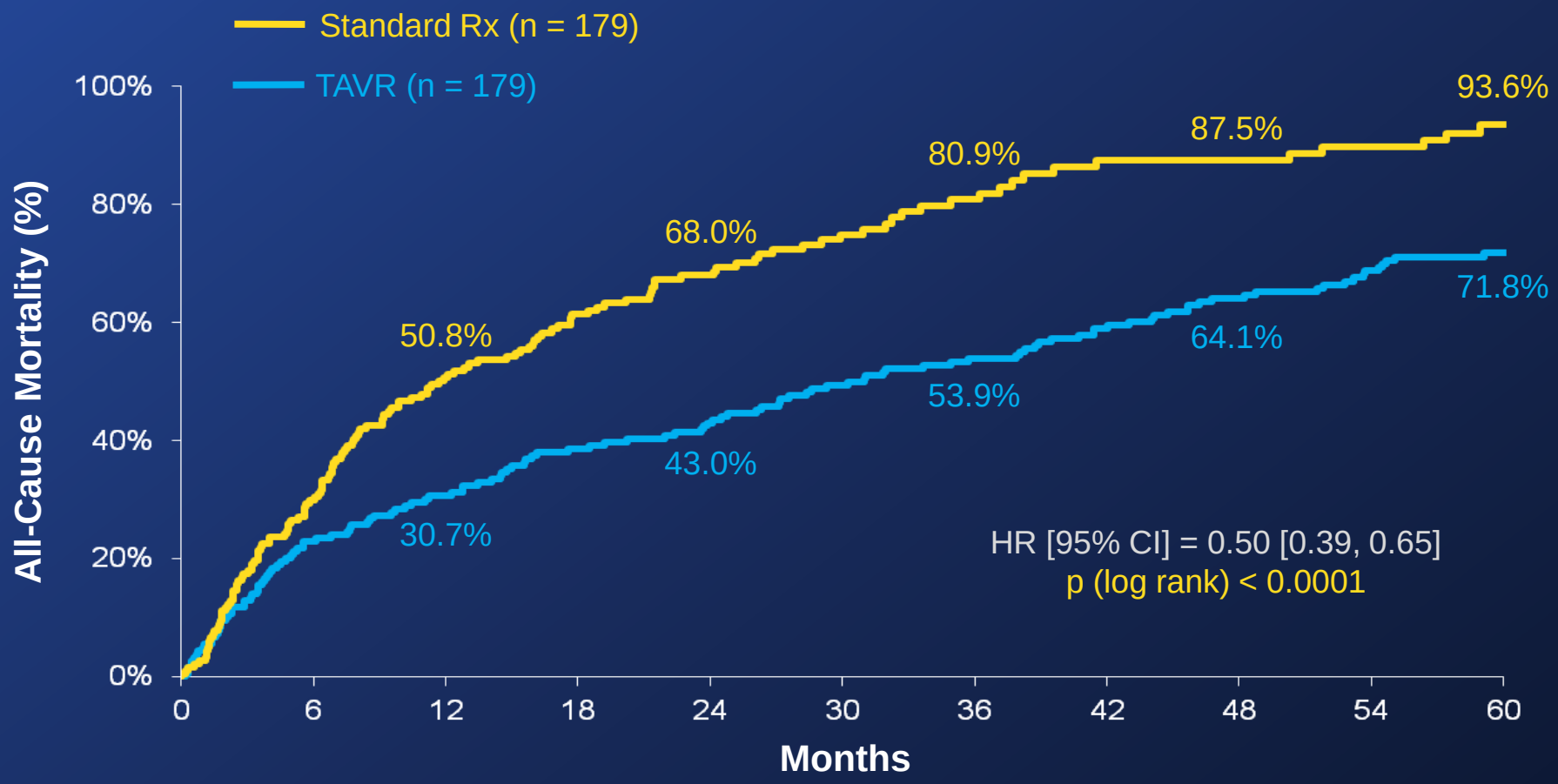
PARTNER Study Design



Enrollment completed in 2009

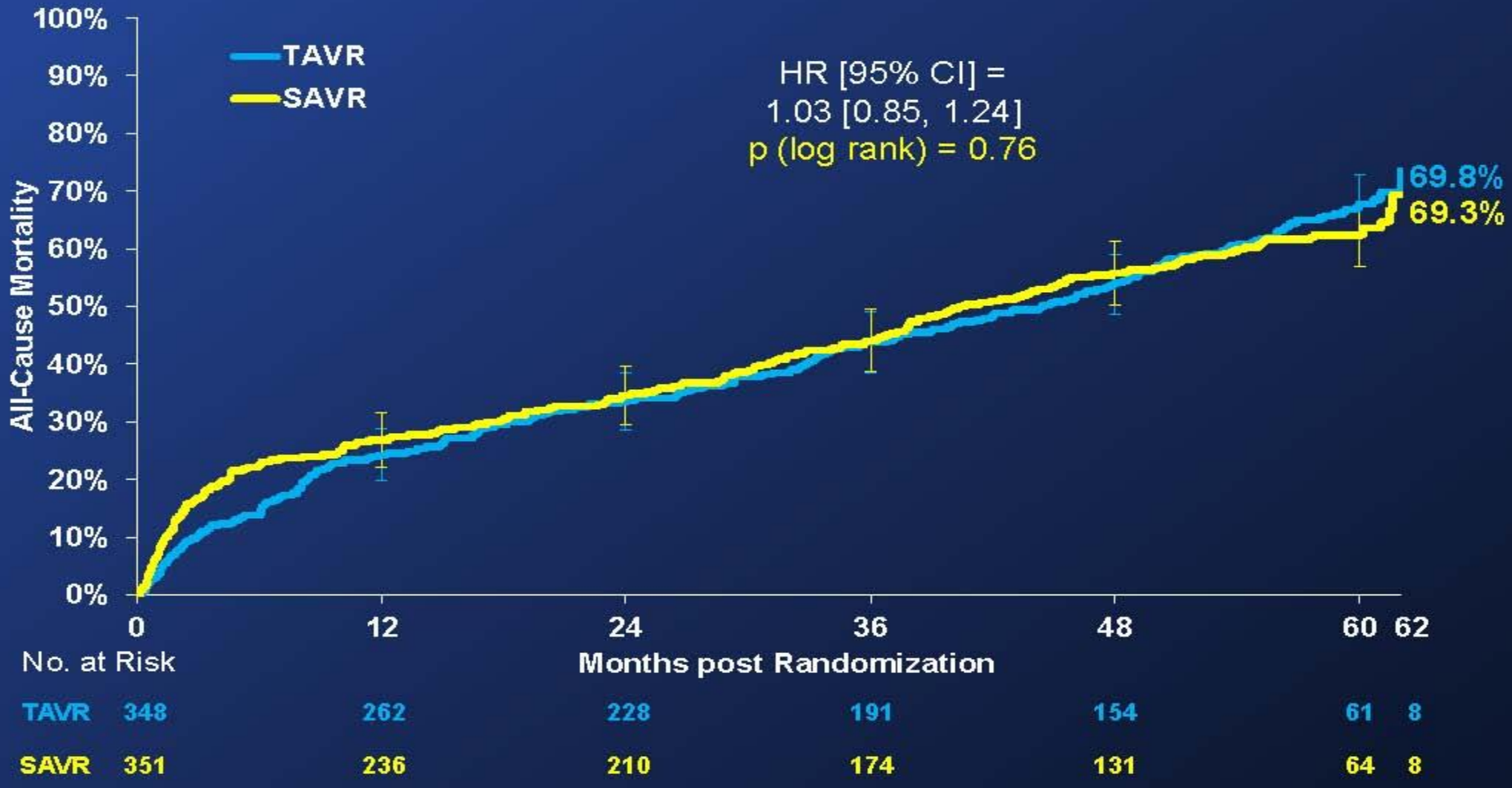
All-Cause Mortality (ITT)

Crossover Patients Censored at Crossover



** In an age and gender matched US population without comorbidities, the mortality at 5 years is 40.5%.*

All-Cause Mortality (ITT)
Pooled Approaches



Pivotal Trial Design

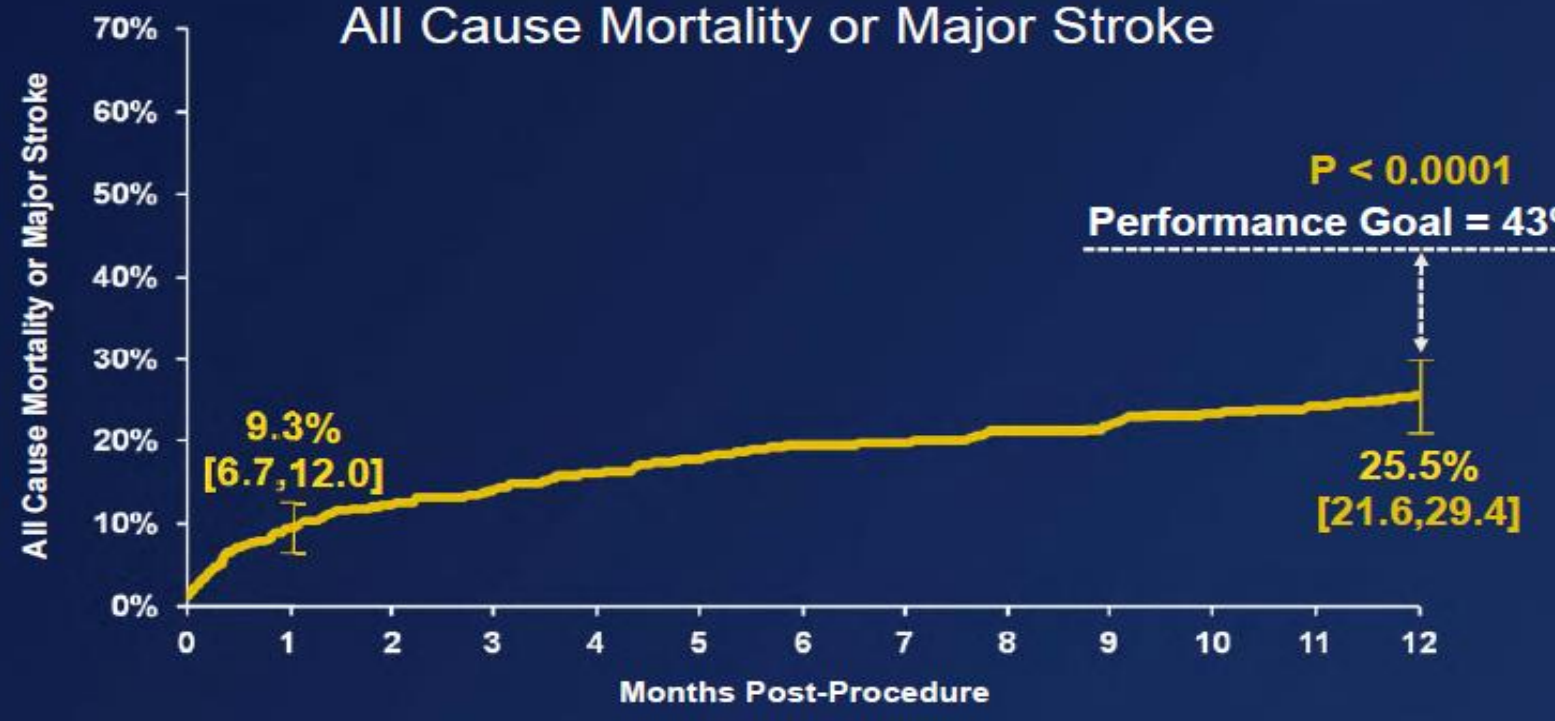
Enrollment completed in 2012

* Randomization stratified by intended access site

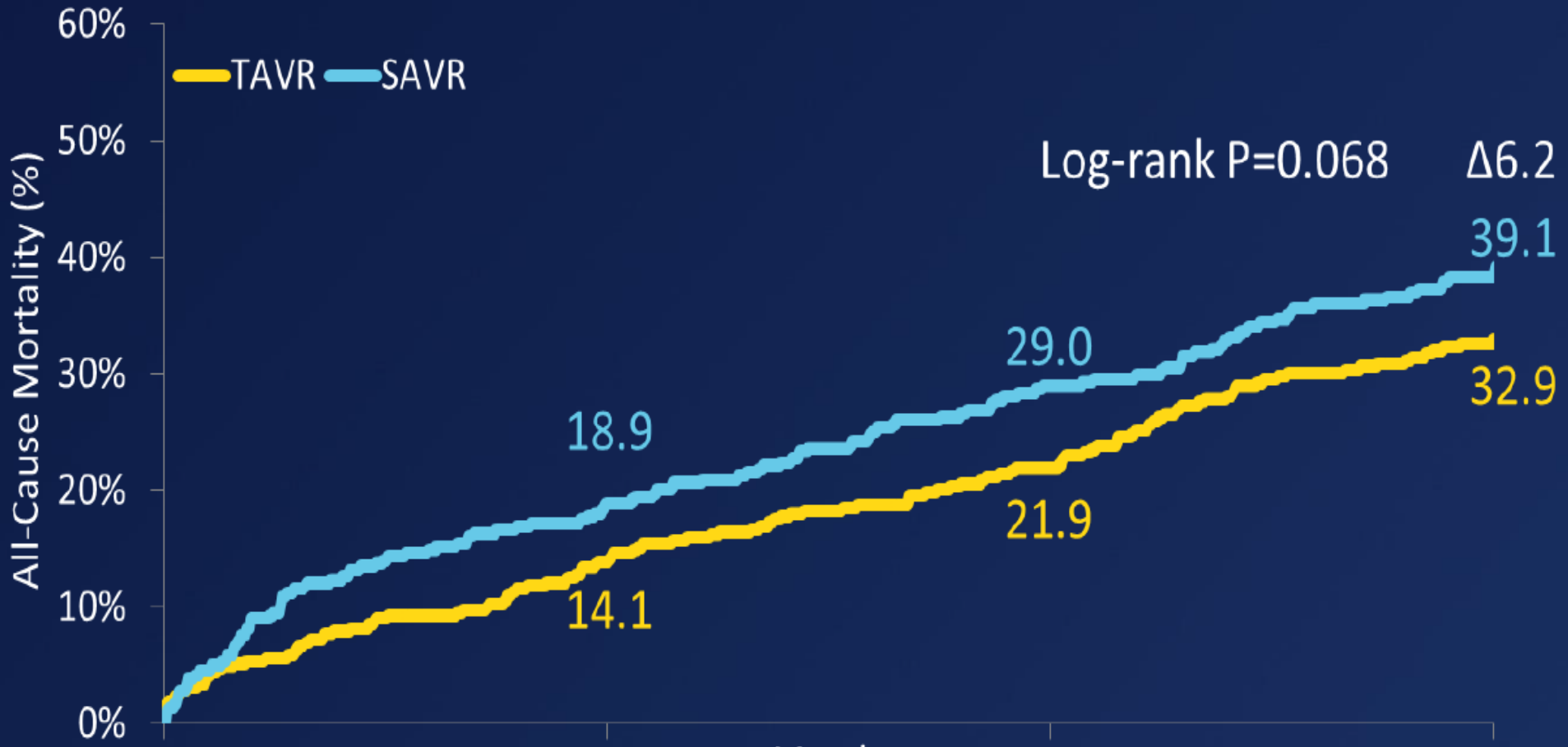
1-Year All-cause Mortality
CoreValve US Pivotal Trial

Primary Endpoint

CoreValve US Clinical Trials



All-Cause Mortality



Intermediate Risk
STS 4-8%

Transcatheter or Surgical Aortic Valve Replacement in Intermediate Risk Patients with Aortic Stenosis:

Final Results from the PARTNER 2A Trial

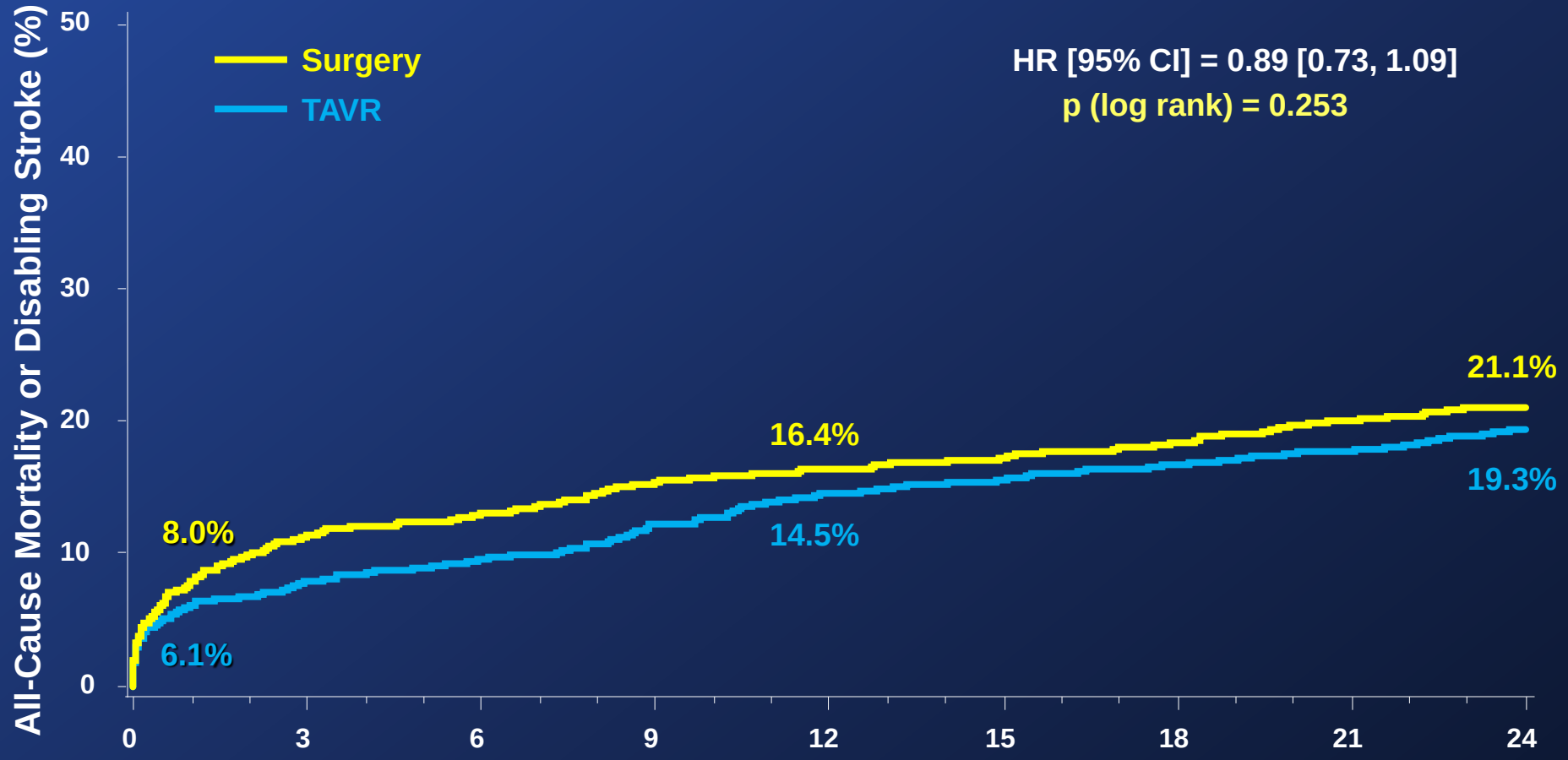
Craig R. Smith, MD
on behalf of the PARTNER Trial Investigators

ACC 2016 | Chicago | April 2, 2016

THE PARTNER II TRIAL

Primary Endpoint (ITT)
All-Cause Mortality or Disabling Stroke

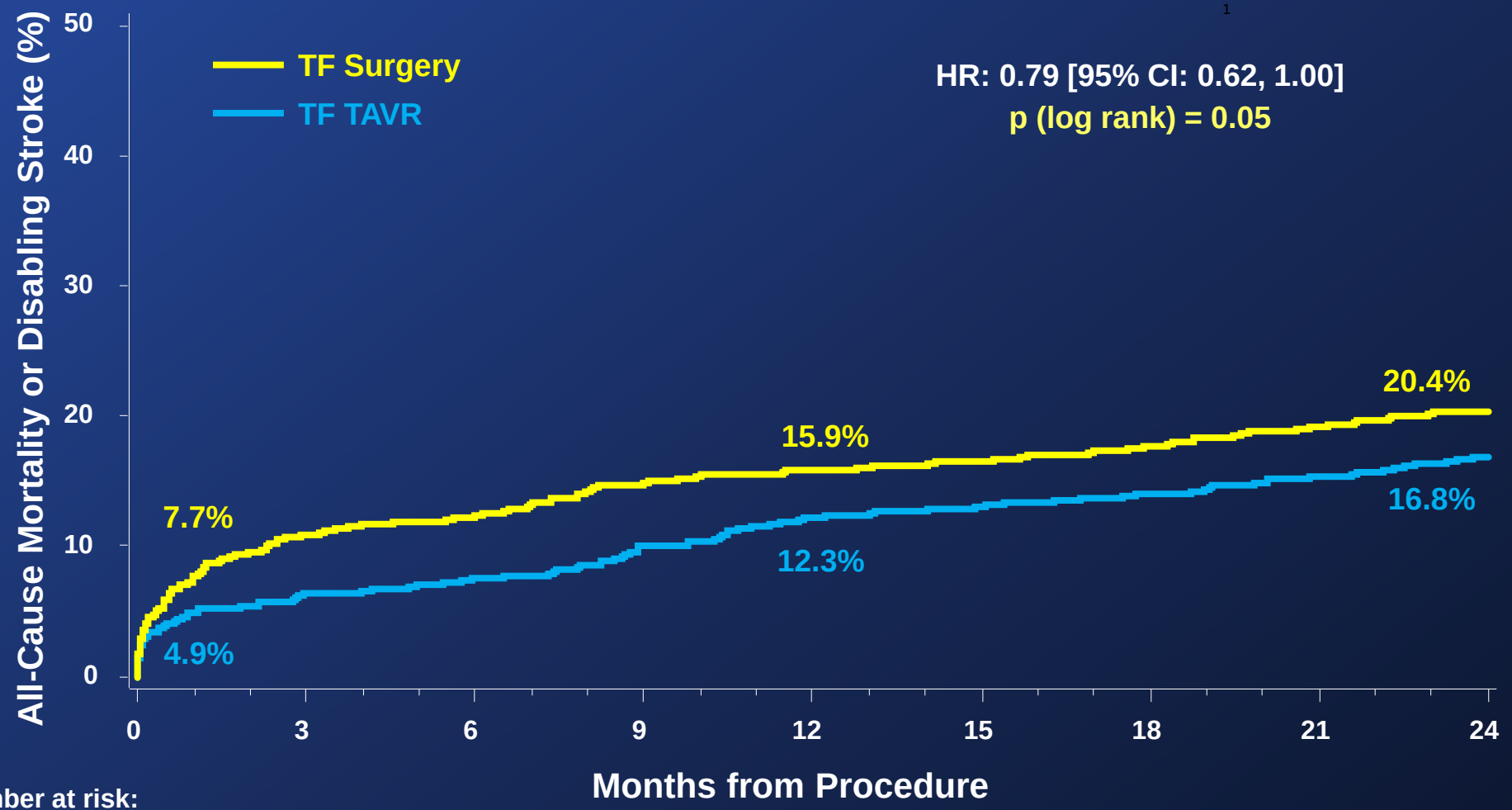
THE PARTNER II TRIAL



Number at risk:									
Surgery	1021	838	812	783	770	747	735	717	695
TAVR	1011	918	901	870	842	825	811	801	774

TF Primary Endpoint (ITT)
All-cause Mortality or Disabling Stroke

THE PARTNER II TRIAL



Number at risk:									
TF Surgery	775	643	628	604	595	577	569	557	538
TF TAVR	775	718	709	685	663	652	644	634	612

Low Risk
STS <4%

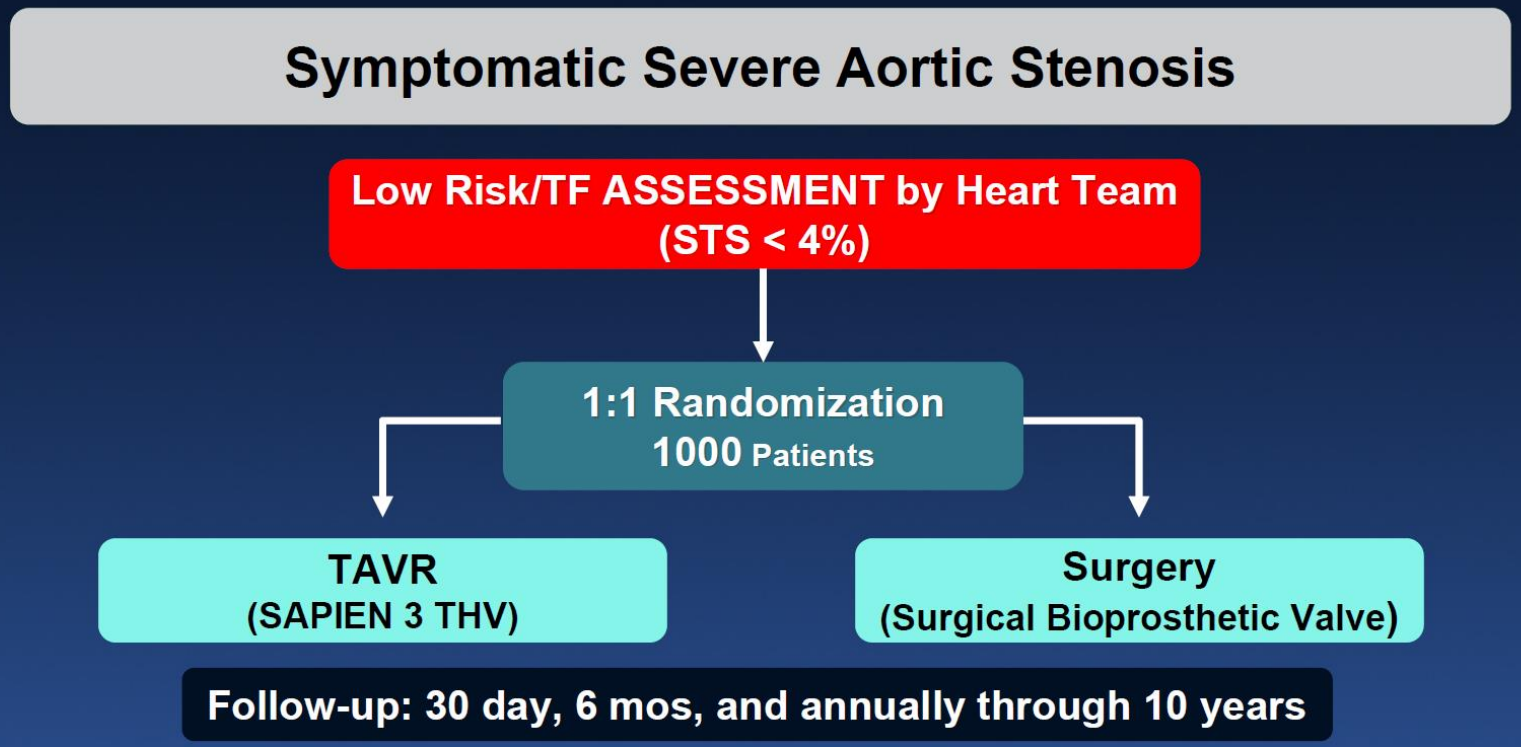
THE PARTNER 3 TRIAL

PARTNER 3

Transcatheter or Surgical Aortic Valve Replacement in Low Risk Patients with Aortic Stenosis

Martin B. Leon, MD &
Michael J. Mack, MD
on behalf of the PARTNER 3 Trial Investigators

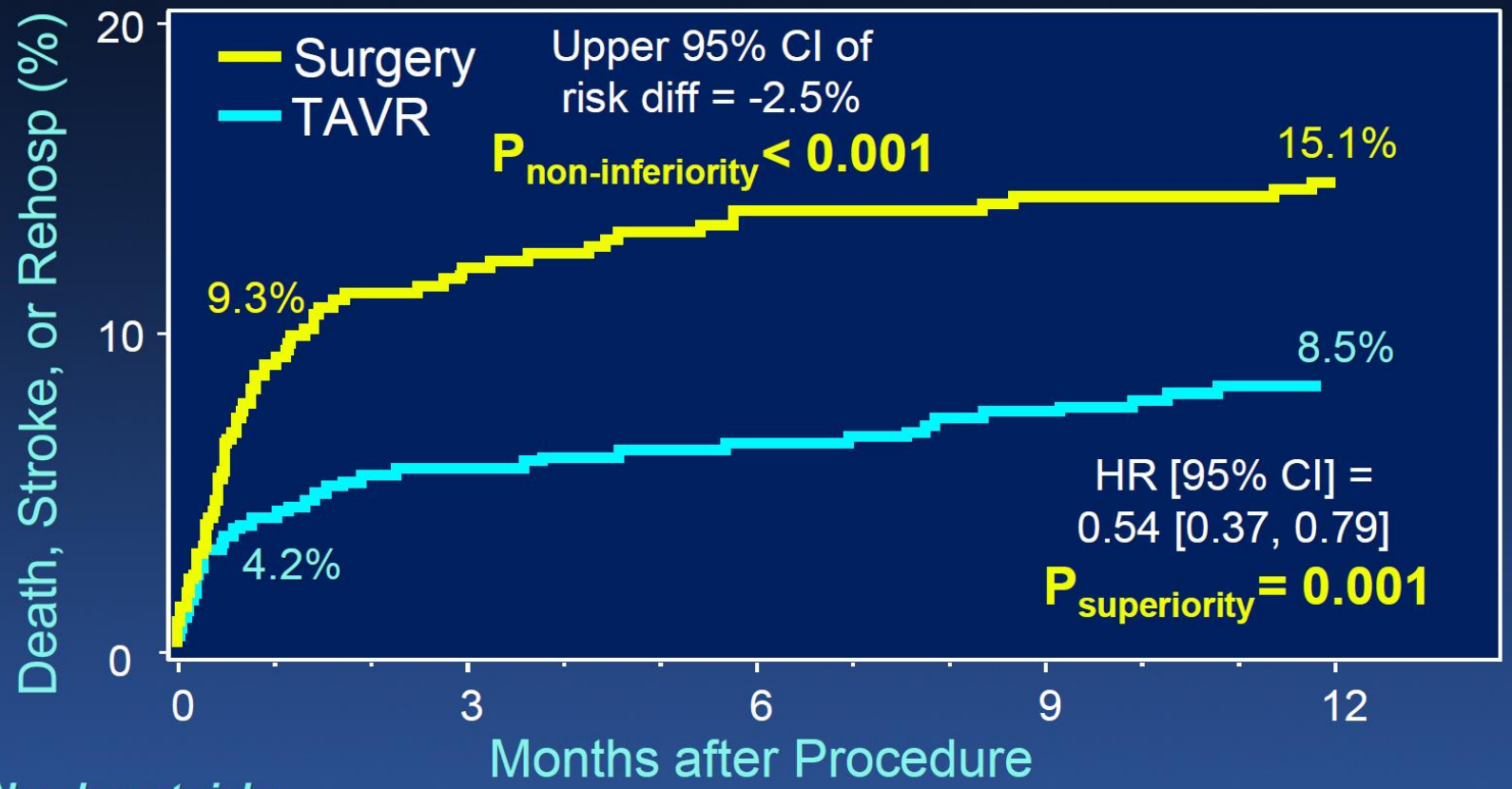
PARTNER 3 Study Design



PRIMARY ENDPOINT:
Composite of all-cause mortality, stroke, or CV re-hospitalization
at 1 year post-procedure

THE PARTNER 3 TRIAL

Primary Endpoint

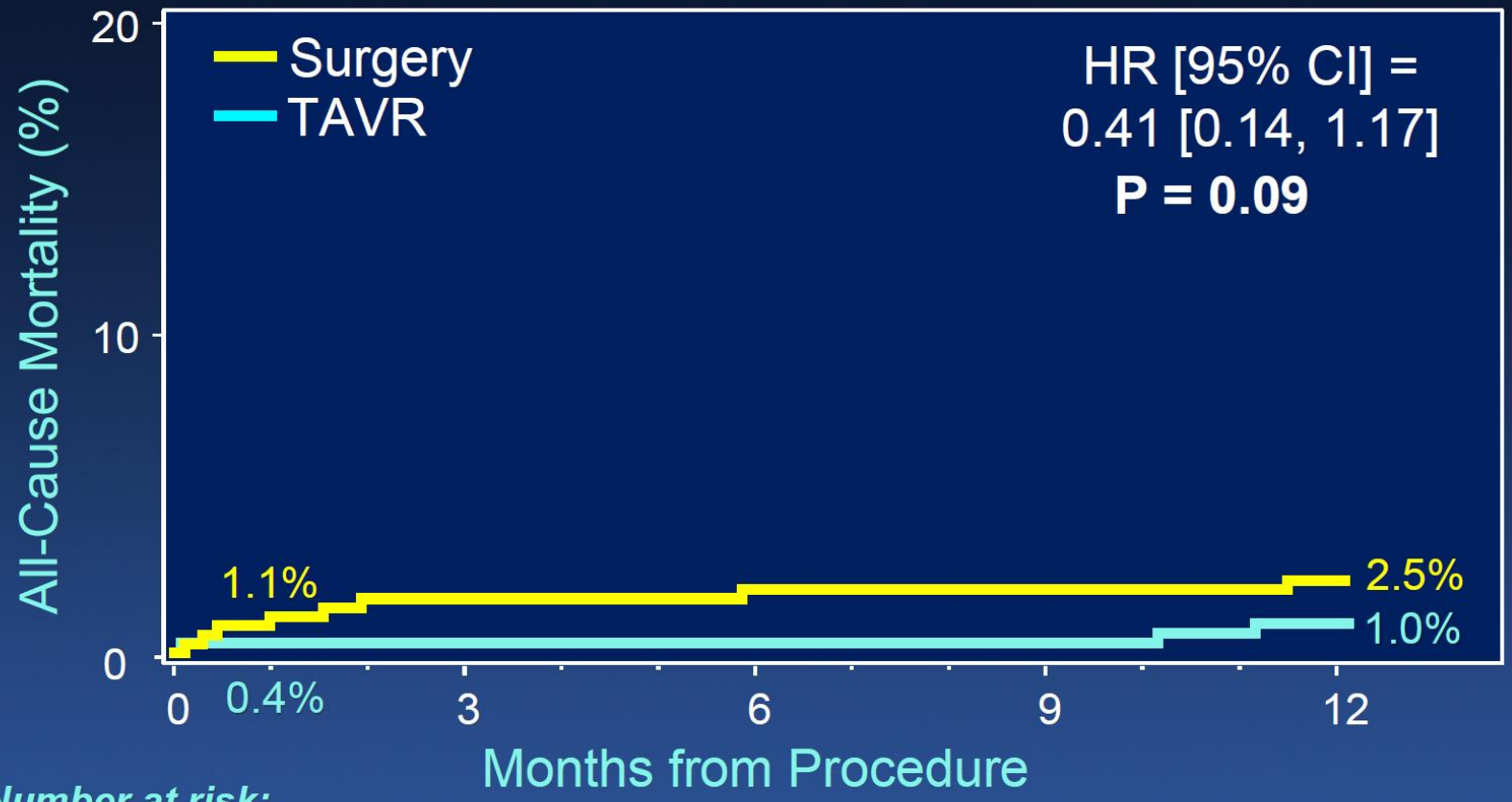


Number at risk:

Surgery	**454**	**408**	**390**	**381**	**377**	**374**
TAVR	**496**	**475**	**467**	**462**	**456**	**451**

THE PARTNER 3 TRIAL

All-Cause Mortality



Number at risk:

Surgery	**454**	**445**	**438**	**433**	**431**	**427**
TAVR	**496**	**494**	**494**	**493**	**492**	**488**

Evolut™ Low Risk Trial

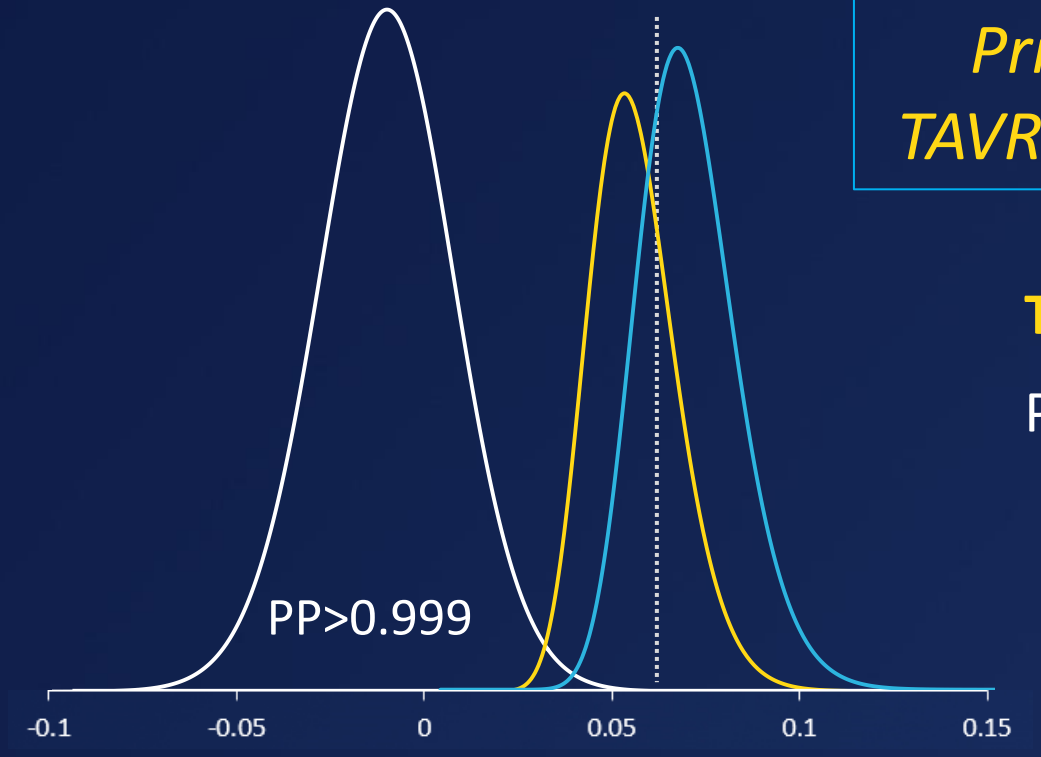
Primary Results From the Evolut Low Risk Trial

Michael J. Reardon, MD, FACC
Houston Methodist DeBakey Heart & Vascular Institute, Houston, TX
For the Evolut Low Risk Trial Investigators

Primary Endpoint

All-Cause Mortality or Disabling Stroke at 2 Years

Evolut™ Low Risk Trial



Primary Endpoint Met
TAVR is noninferior to SAVR

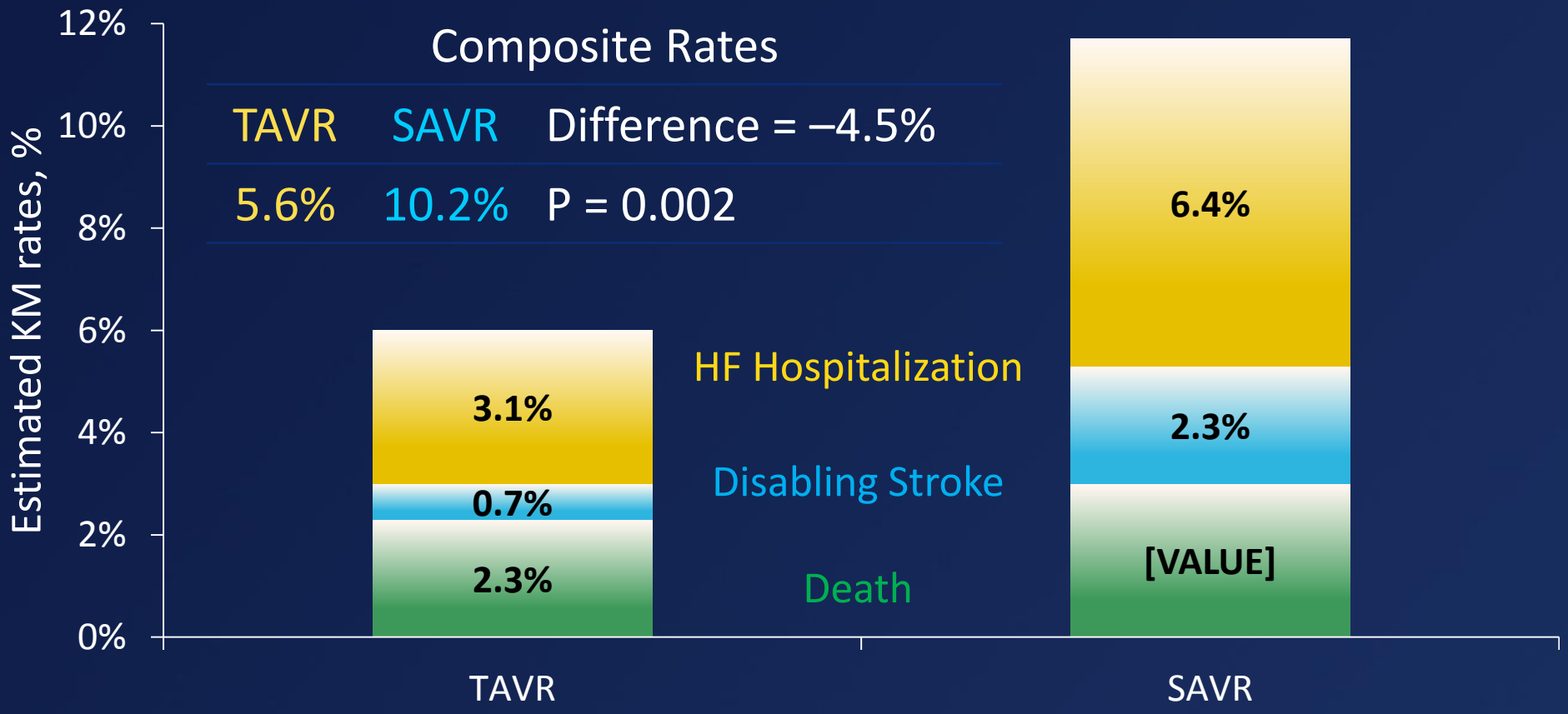
TAVR 5.3% **SAVR 6.7%**

Posterior probability of noninferiority > 0.999

TAVR –SAVR difference = -1.4% (95% BCI; -4.9, 2.1)

Clinical Implications

Death, Disabling Stroke and Heart Failure Hospitalizations to 1 Year



Current Guideline for TAVI

Class I:

- Heart Team Required
- On-Site Cardiac Surgery
- Patients Not Suitable for AVR (PARTNER B / CoreValve US Extreme Risk)

Class IIa:

- High-Risk Operable as an Alternative to Surgery
- Determined by Heart Team and Case-Based Discussion (PARTNER A / CoreValve US High-Risk)

Acute Complications of TAVI

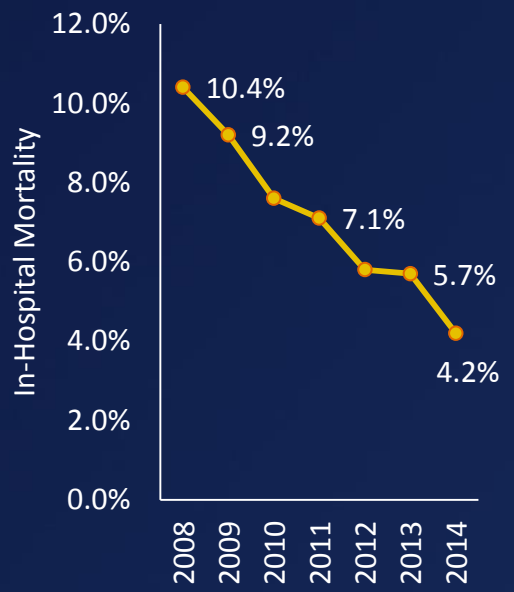
- Early Mortality
- Annular rupture / LV perforation
- Vascular complication
- Para-valvular leakage
- Pacemaker
- Stroke

Early Mortality

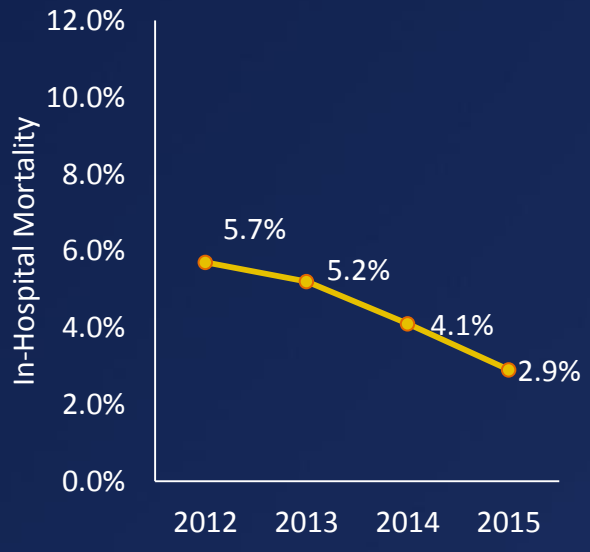
Established TAVR Markets

- Within these established markets, rates of early mortality have steadily decreased with time. 30-day mortality is under 5% in contemporary practice.
- Each geography has also shown declining rates of complications which are known to impact mortality, such as aortic regurgitation, vascular injury, and severe acute complications such as annular rupture.

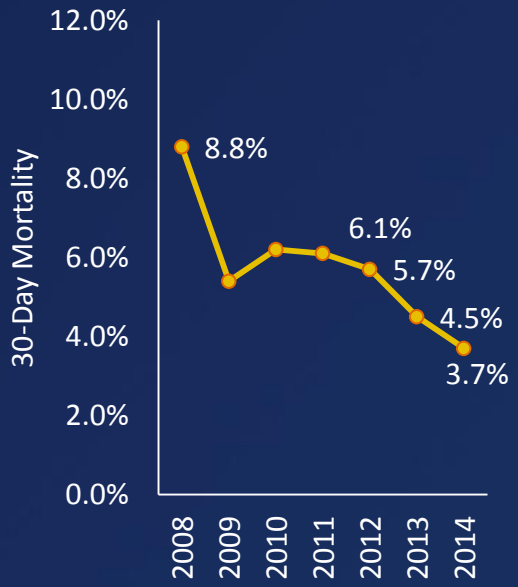
Germany



STS / ACC TVT Registry



UK TAVI Registry

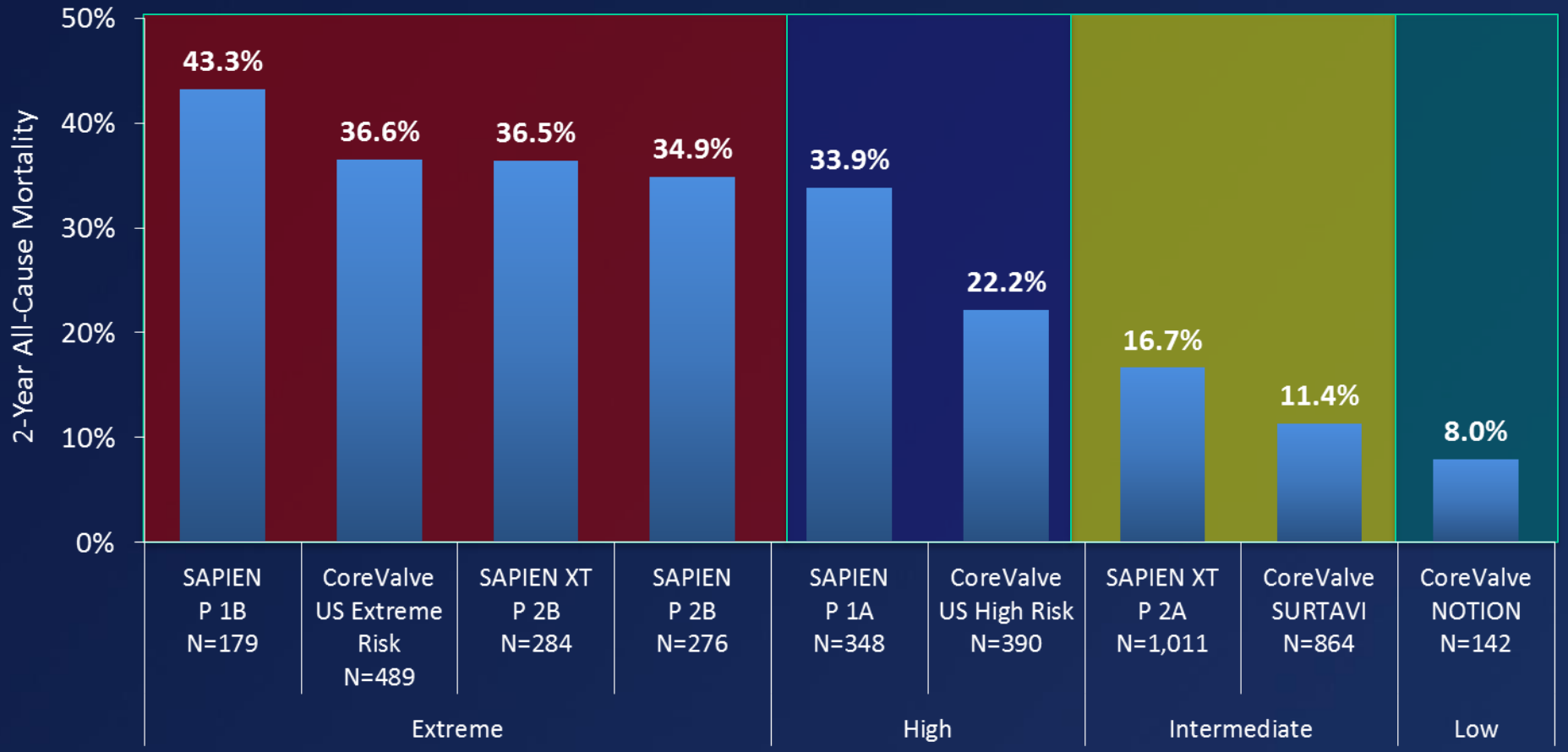


[1]Grover, et al., *J Am Coll Cardiol* 2016; epub; [2]Moat, et al., presented at TCT 2016

2-Year All-Cause Mortality with TAVR

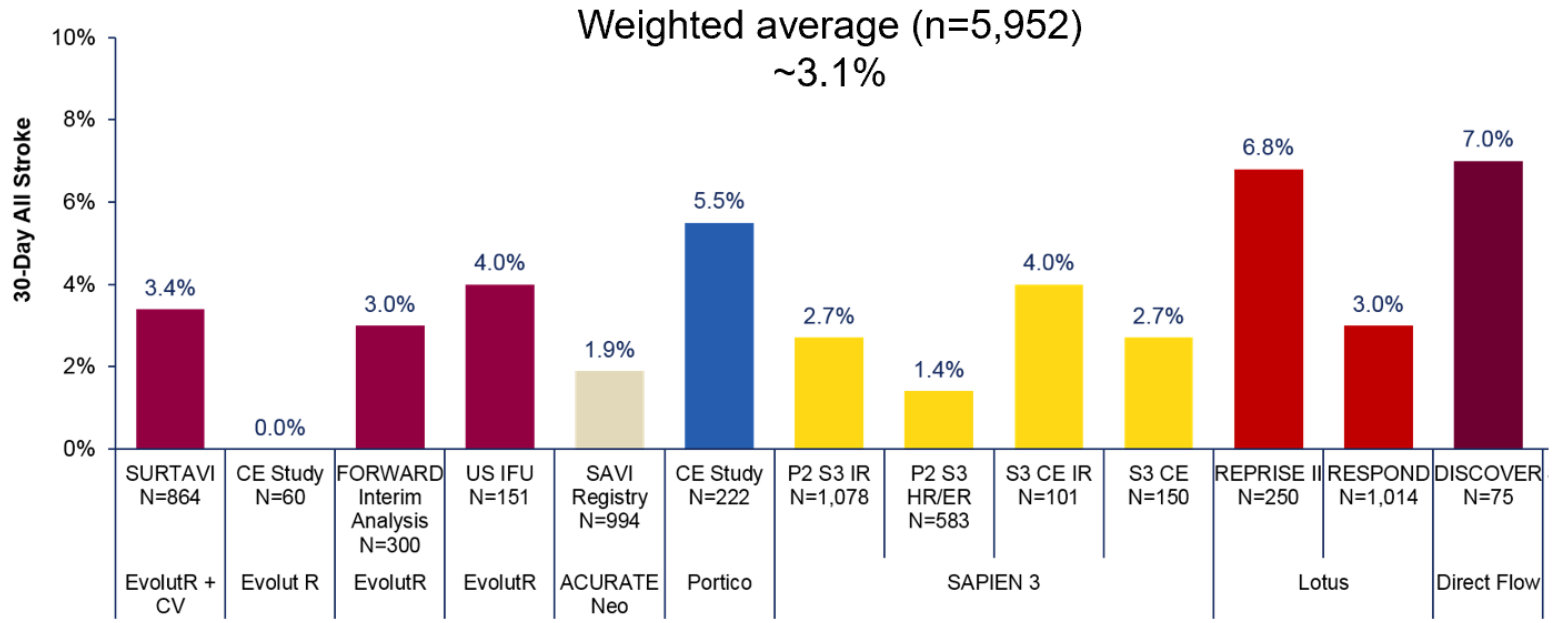
Importance of Patient Clinical Profile

Long-term TAVR outcomes follow the spectrum risk, with better outcomes in patients with better clinical profile at baseline



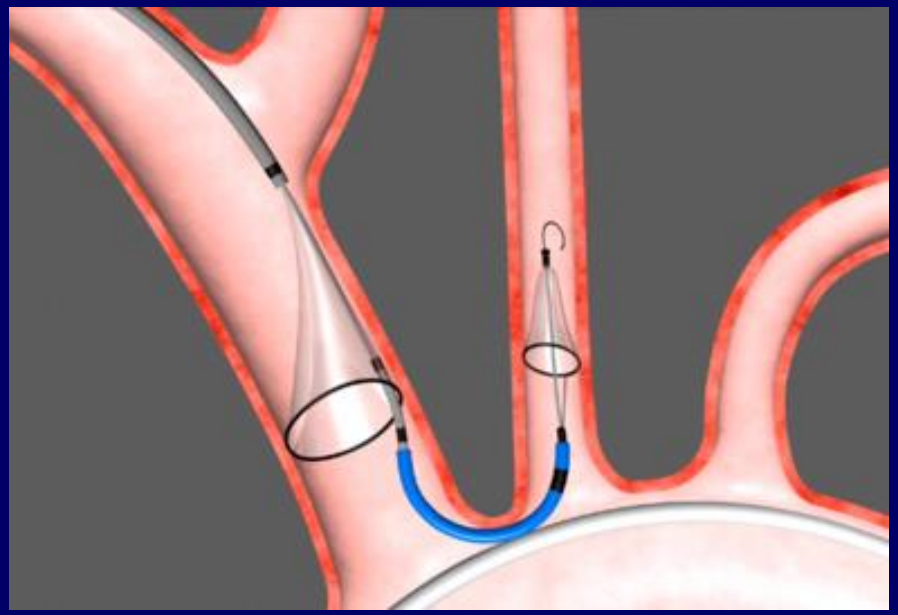
[1]Leon, et al., *N Engl J Med* 2010;363:1597-1607; [2]Popma, et al., *J Am Coll Cardiol* 2014;63:1972-81; [3]Webb, et al., *J Am Coll Cardiol Intv* 2015;8:1797-806; [4]Smith, et al., *N Engl J Med* 2011;364:2187-98; [5]Adams, et al., *N Engl J Med* 2014;370:1790-8; [6]Leon, et al., *N Engl J Med* 2016;374:1609-20; [7]Reardon, et al. *N Engl J Med* 2017; 376:1321-31; [8]Thyregod, et al., *J Am Coll Cardiol* 2015;65:2184-94

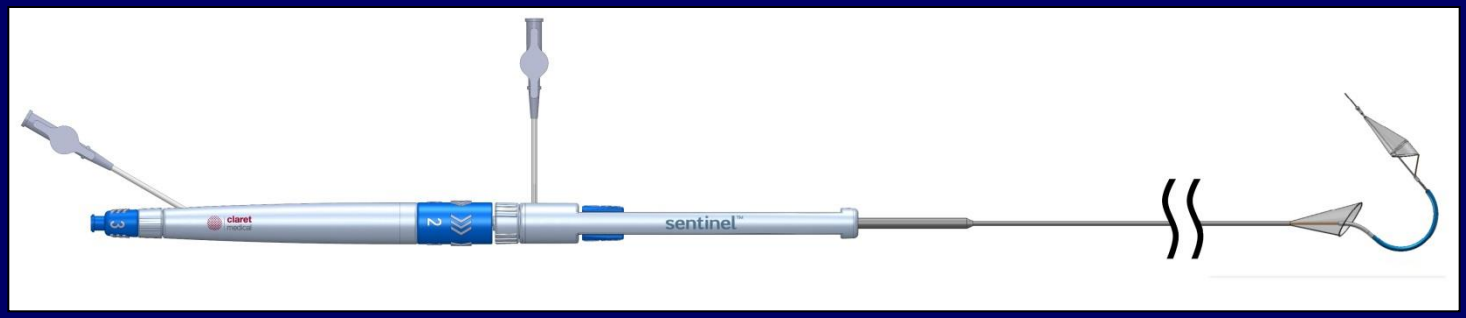
TAVI Stroke Rates with Contemporary Devices



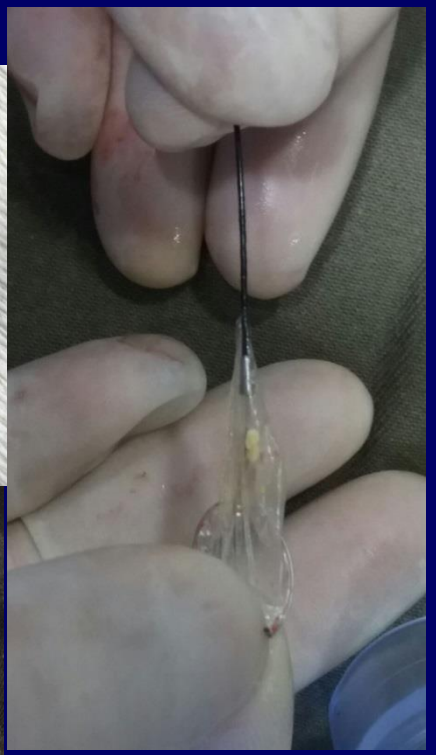
[1]Manoharan, et al., *J Am Coll Cardiol Intv* 2015; 8: 1359-67; [2]Moellman, et al., presented at PCR London Valves 2015; [3]Linke, et al., presented at PCR London Valves 2015; [4]Kodali, et al., *Eur Heart J* 2016; doi:10.1093/eurheartj/ehw112; [5]Vahanian, et al., presented at EuroPCR 2015; [6]Webb, et. al. *J Am Coll Cardiol Intv* 2015; 8: 1797-806; [7]DeMarco, et al, presented at TCT 2015; [8]Meredith, et al., presented at PCR London Valves 2015; [10]Falk, et al., presented at EuroPCR 2016; [11]Kodali, presented at TCT 2016; Reardon, M Published in NEJM March 2017

Claret Sentinel Cerebral Protection Device
First use of the device in Asia Pacific (27.9.2016)



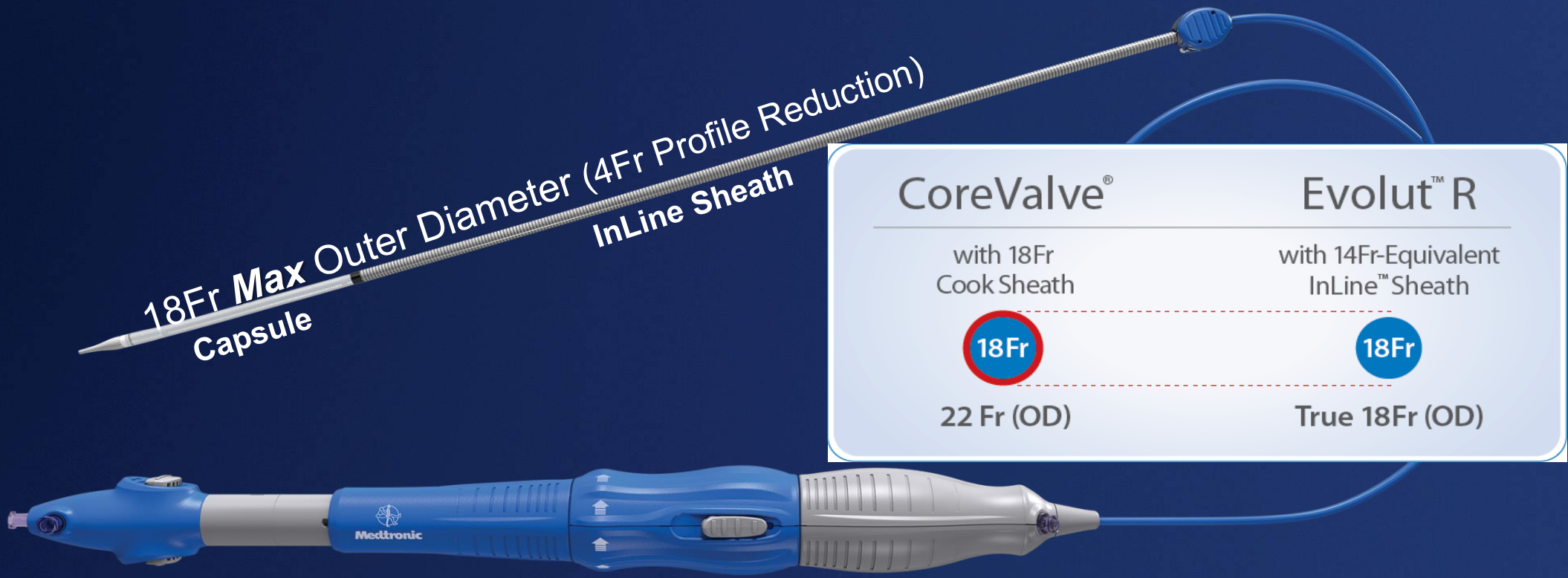


Claret Sentinel Cerebral Protection Device
First use of the device in Asia Pacific (27.9.2016)



EnVeo™ R Delivery System

14Fr Equivalent System with EnVeo InLineTM Sheath



CoreValve®	Evolut™ R
with 18Fr Cook Sheath	with 14Fr-Equivalent InLine™ Sheath
18Fr	18Fr
22 Fr (OD)	True 18Fr (OD)

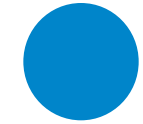
EVOLUT PRO DELIVERY CATHETER SYSTEM
DELIVERY PROFILE COMPARISON

Lowest delivery profile across **all valve sizes** with InLine Sheath

Evolut R 23/26/29 mm TAV		Evolut PRO /Evolut R 34 mm TAV
≥ 5.0 mm	Treatable Access Vessel Diameter	≥ 5.5 mm

18 Fr OD

14 Fr Equivalent



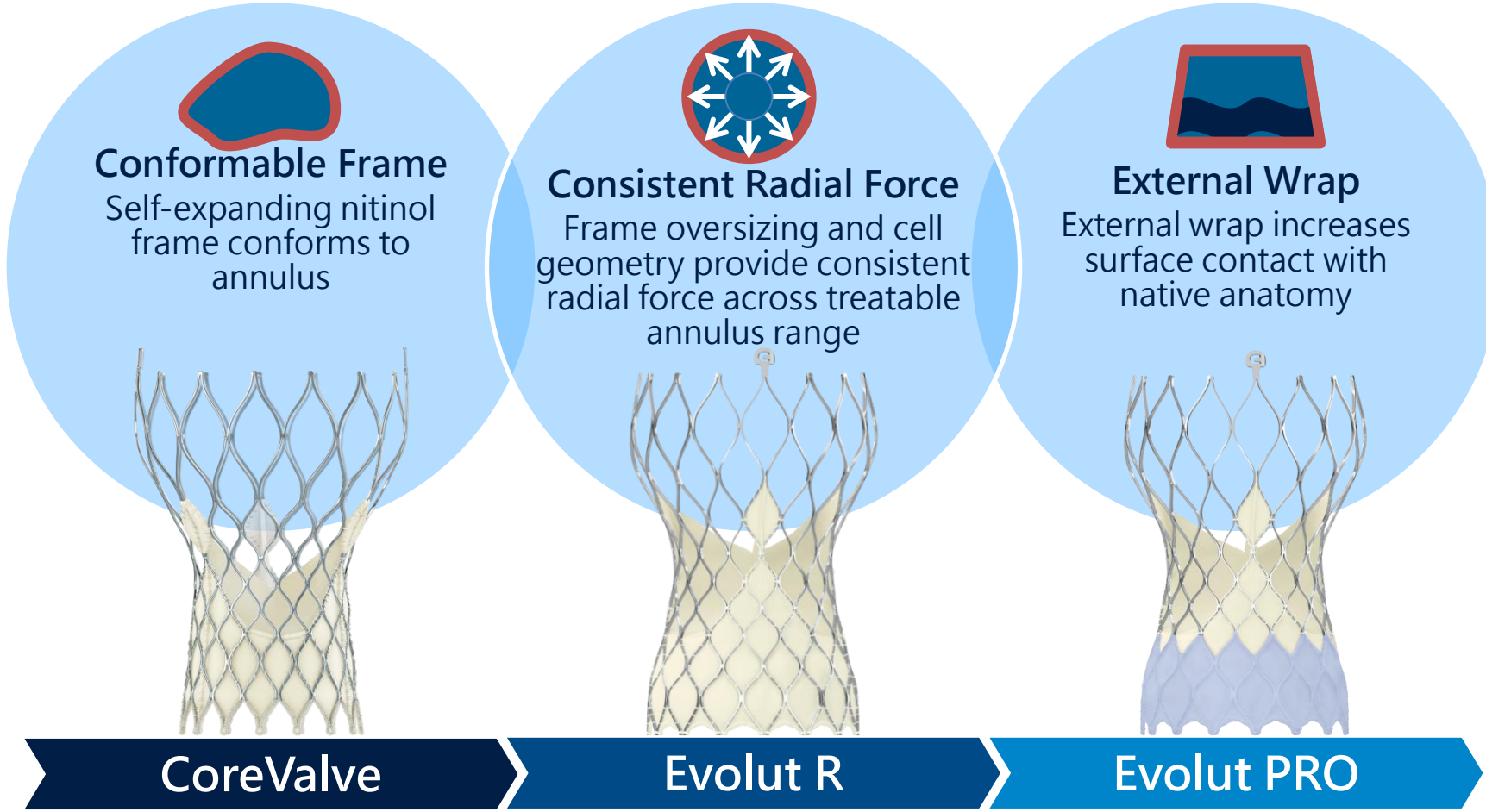
20 Fr OD

16 Fr Equivalent

The Evolut System retains its outer diameter as it enters the vessel and remains at this diameter as it is advanced to the annulus.

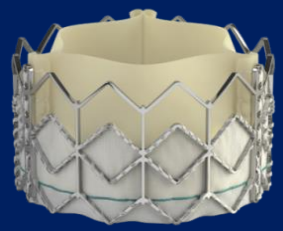
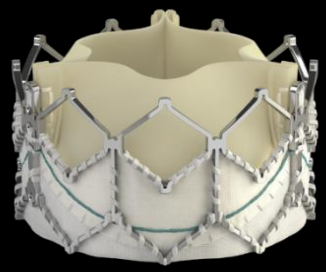
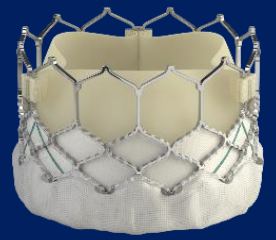
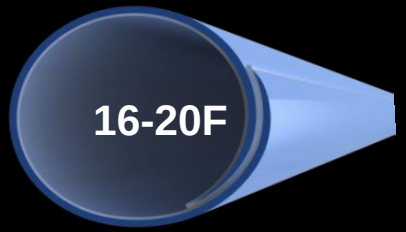
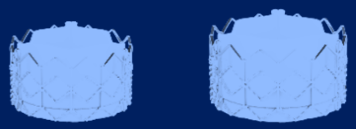
EVOLUT PRO TRANSCATHETER VALVE
ADVANCED SEALING

Building on Proven Design for Advanced Sealing



PARTNER SAPIEN Platforms
Device Evolution

THE PARTNER II TRIAL

	SAPIEN	SAPIEN XT	SAPIEN 3
Valve Technology			
Sheath Compatibility			
Available Valve Sizes	 23 mm 26 mm	 23mm 26mm 29mm*	 20 mm 23 mm 26 mm 29 mm

*First Implant Oct 30, 2012

Long-term Concerns of TAVI

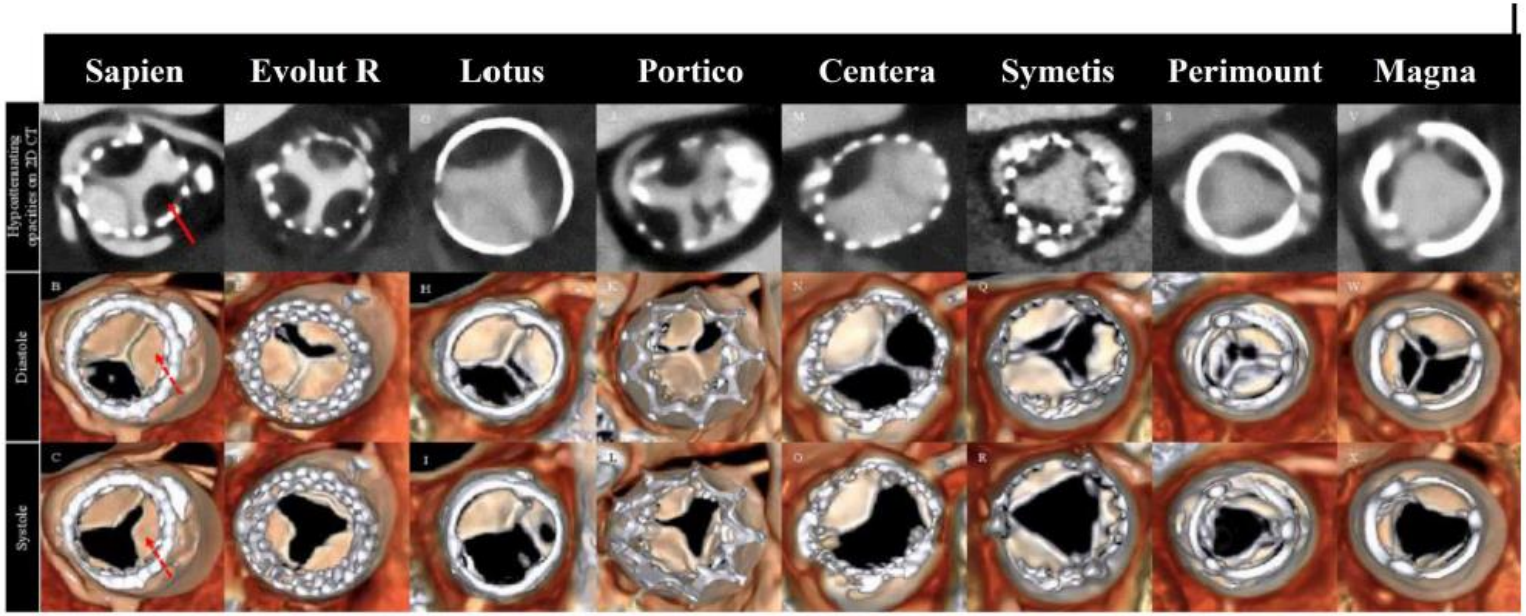
- Early Mortality
- Annular rupture / LV Perforation
- Vascular complication
- Para-valvular leakage
- Pacemaker
- Stroke

- Access to future coronary intervention
- Valve Thrombosis
- Durability
- Bicuspid AV

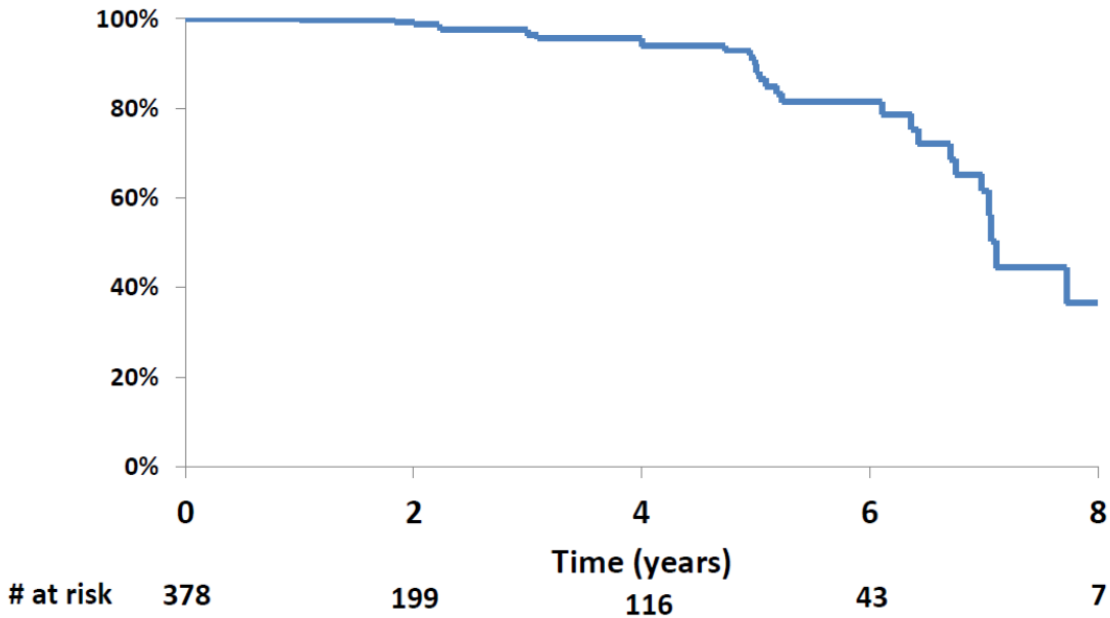
Subclinical Leaflet Thrombosis in Bioprosthetic Valves

Chakravarty et al. Lancet 2017

- *890 patients with interpretable CT scans were included (RESOLVE registry, n=626; SAVOR Registry, n=264)*
- *Incidence: 12%: 4% after SAVR and 13% after TAVR (p<0.001)*



TAVR bioprotheses long-term follow-up: Based on THV Degeneration



THV degeneration was defined as at least moderate regurgitation AND/OR mean gradient ≥ 20mmHg, which did not appear within 30 days of the procedure and is not related to endocarditis.
KM estimate of THV degeneration included censoring of patients at their date of last known THV functioning well without evidence for degeneration per study definition.

D. Dvir, EuroPCR 2016

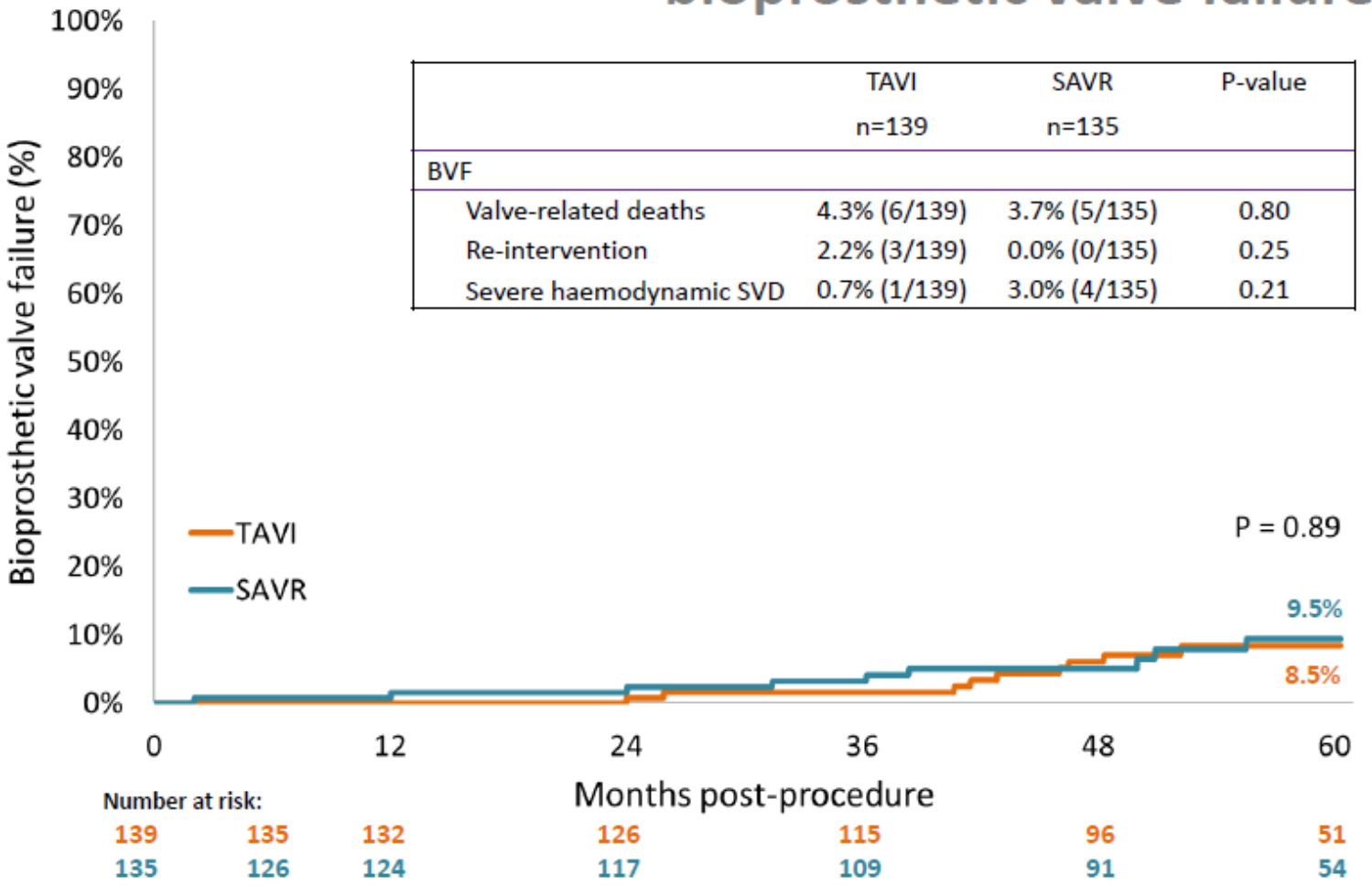
Definition of THV Degeneration:

- Moderate aortic regurgitation
  And/or
- Mean Gradient ≥ 20mmHg
- Not related to endocarditis

The NOTION Trial

bioprosthetic valve failure

	TAVI n=139	SAVR n=135	P-value
BVF			
Valve-related deaths	4.3% (6/139)	3.7% (5/135)	0.80
Re-intervention	2.2% (3/139)	0.0% (0/135)	0.25
Severe haemodynamic SVD	0.7% (1/139)	3.0% (4/135)	0.21



Hong Kong Experience

Dec 2010
Queen Elizabeth Hospital

Nov 2011
Prince of Wales Hospital

June 2013
Union Hospital

2010 2011 2012 2013

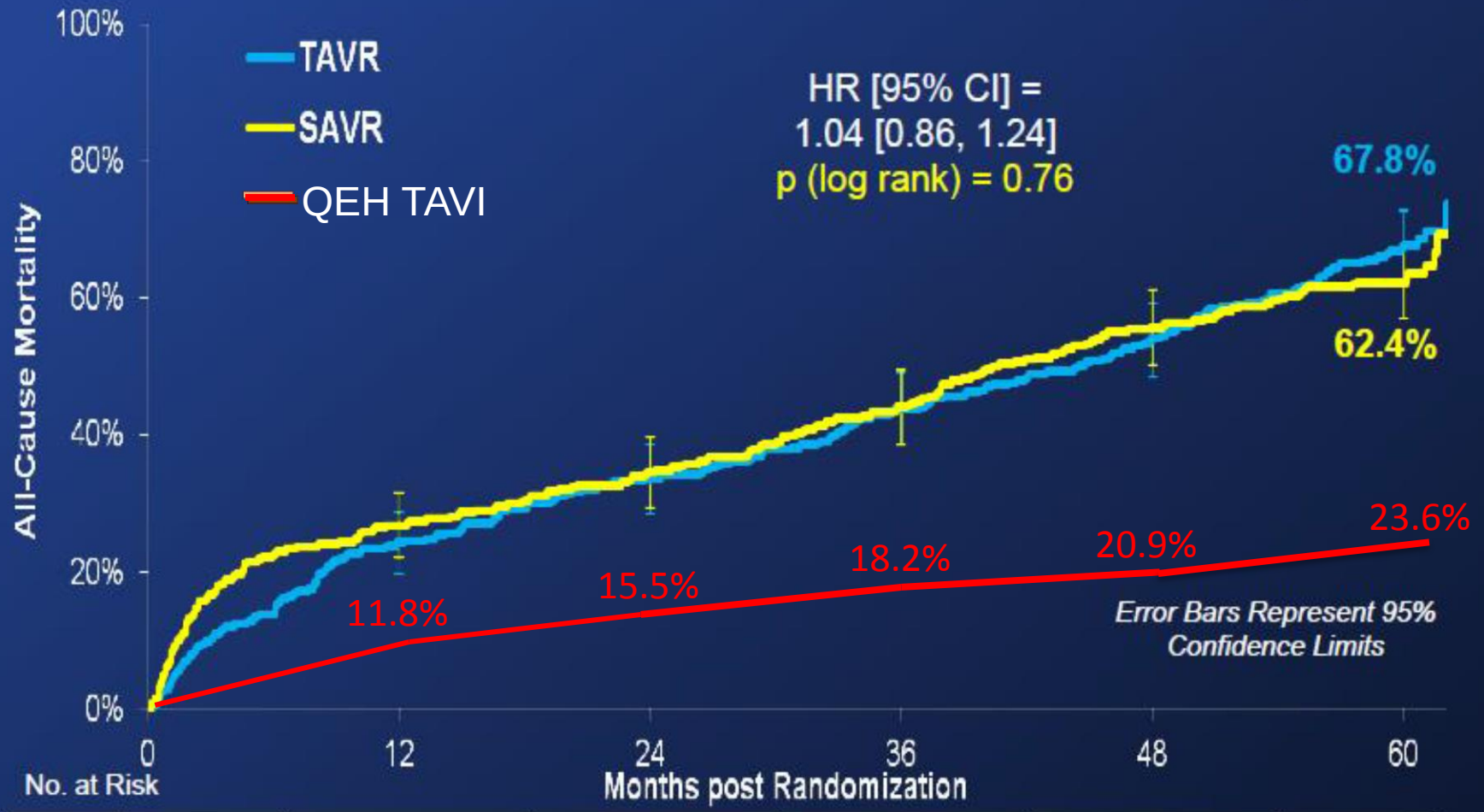
May 2011
HK Adventist Hospital

Dec 2012
Queen Mary Hospital

All-Cause Mortality (ITT)

All Patients

THE PARTNER TRIAL

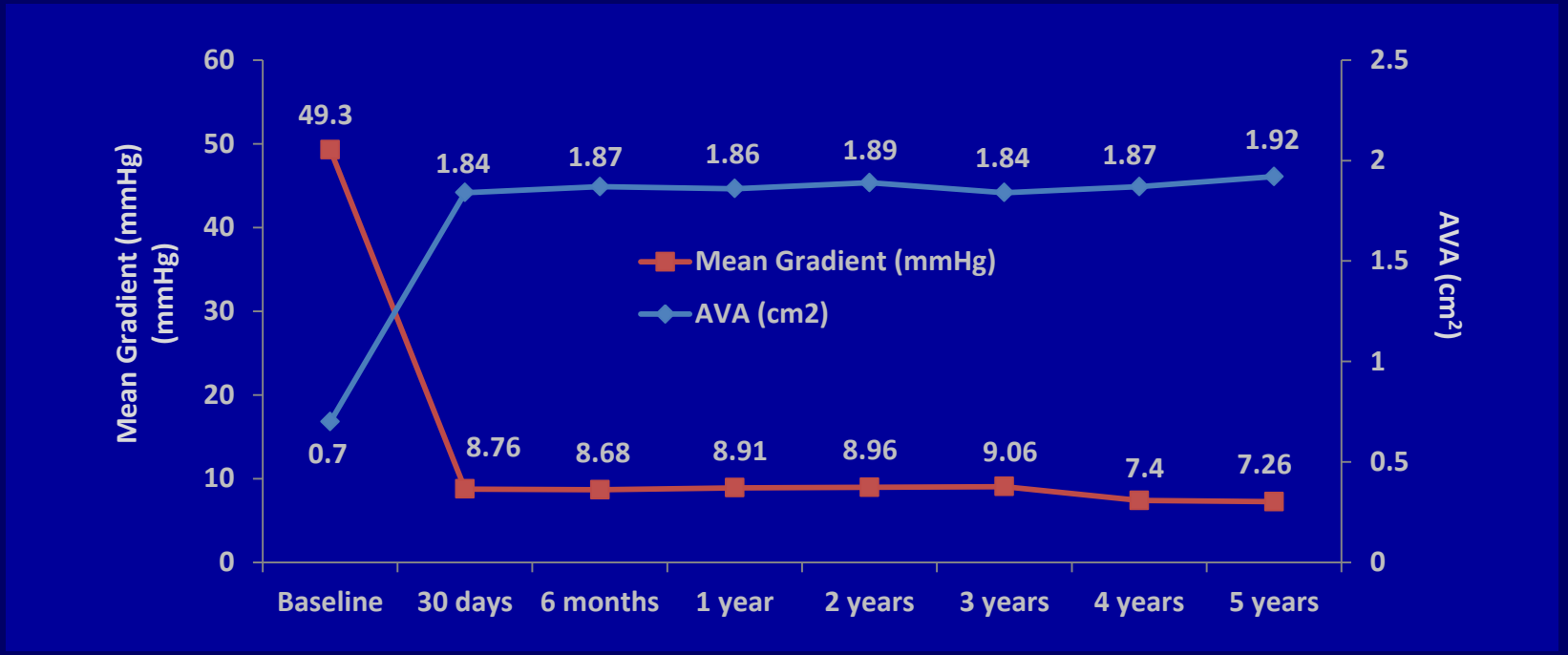


No. at Risk

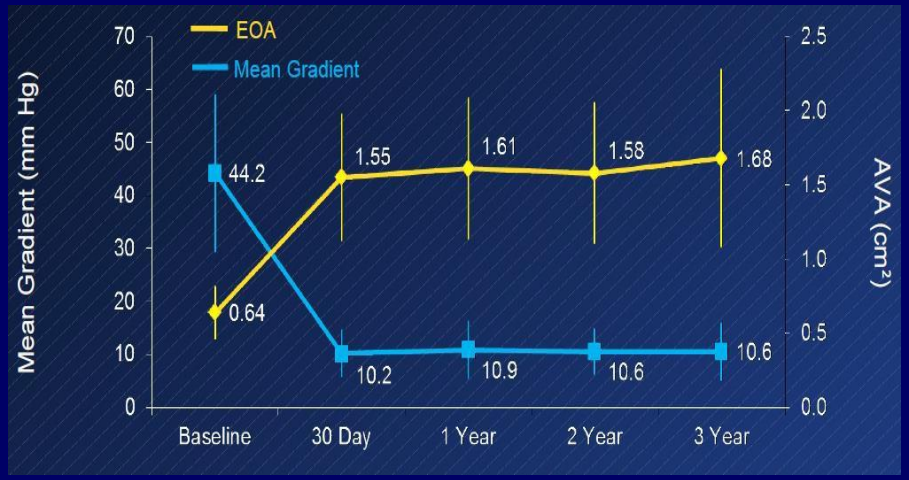
TAVR	348	262	228	191	154	61
SAVR	351	236	210	174	131	64

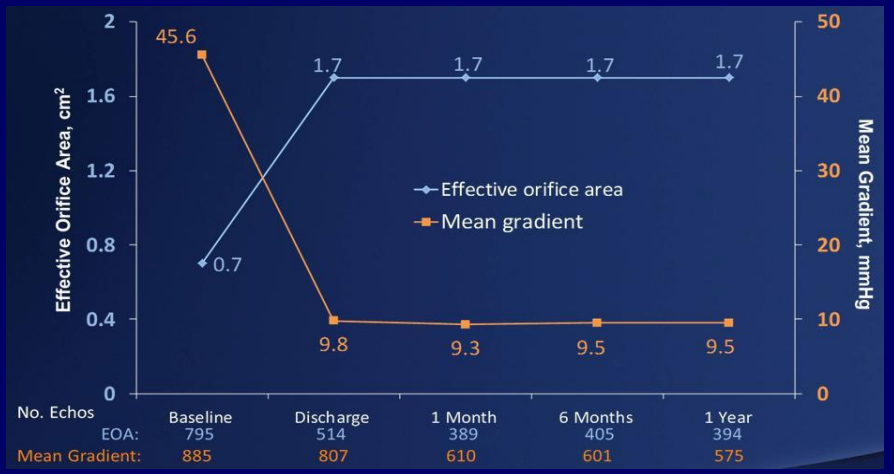
Mean Gradient & Valve Area

QEH Registry



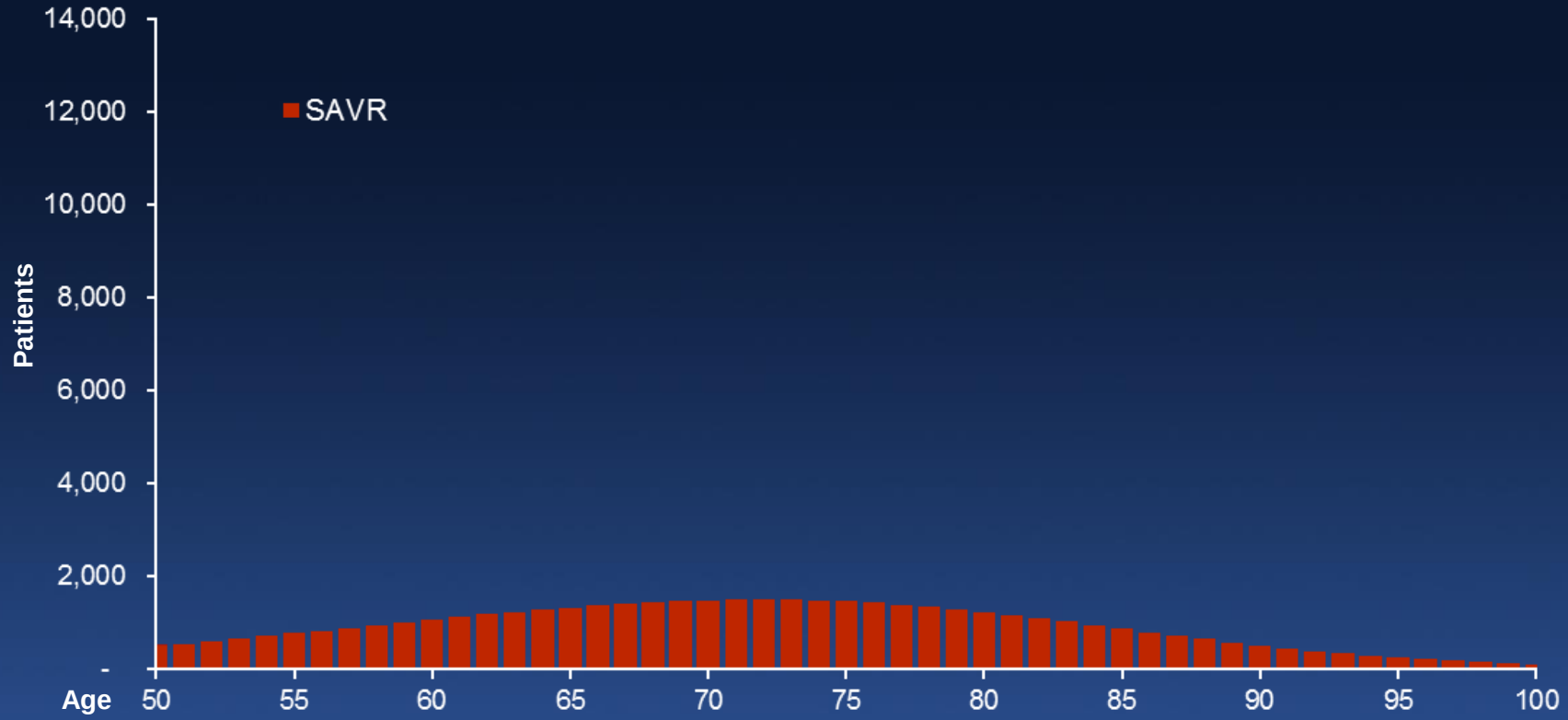
The PARTNER Trial CoreValve ADVANCE Study





Historically, Our Understanding of Aortic Stenosis was Based on Surgical Experience

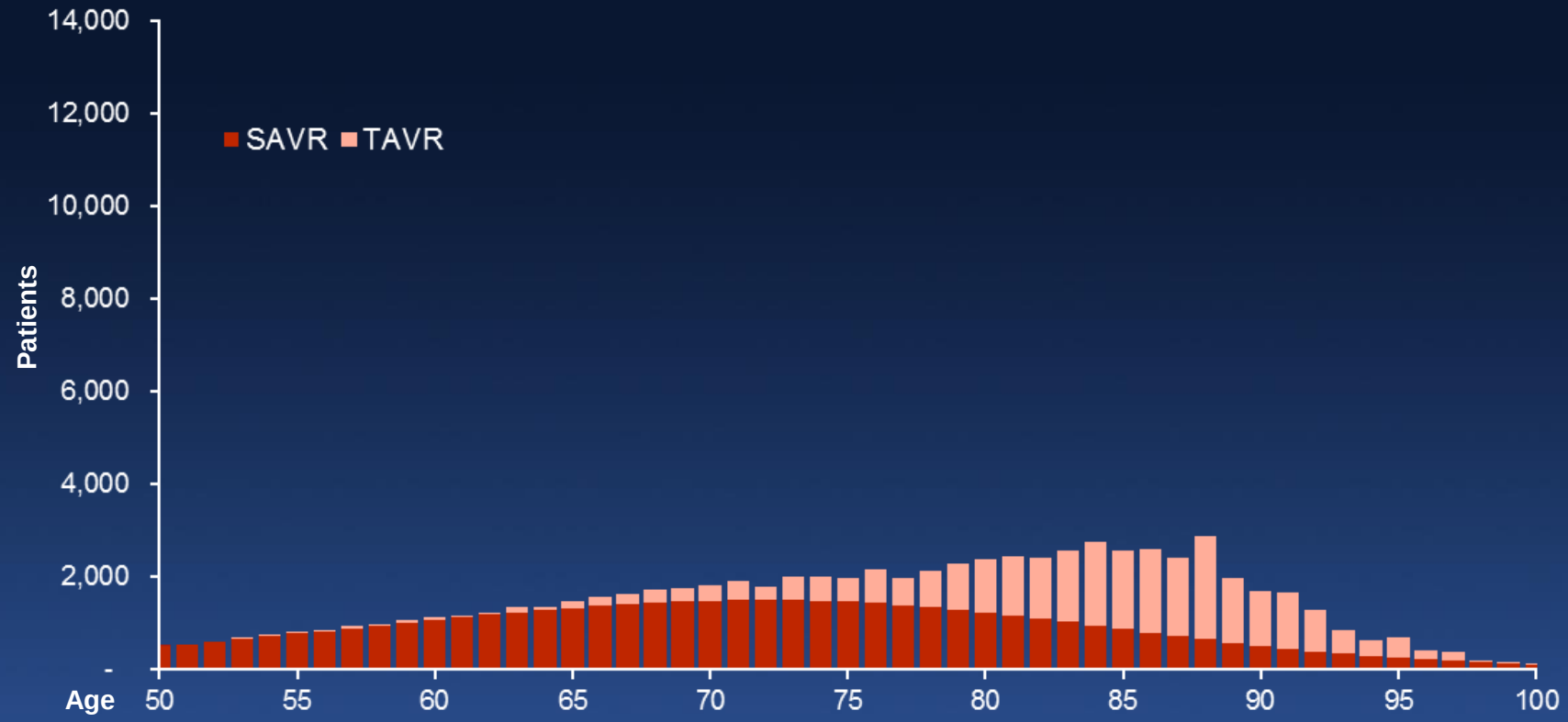
2015 Severe Symptomatic AS Patients in the U.S.[1]



(1) Nkomo 2006, Iivanainen 1996, Aronow 1991, Bach 2007, Freed 2010, Iung 2007, Pellikka 2005, Brown 2008, Thourani 2015,

The TAVR Experience Has Changed Our Understanding of Aortic Stenosis

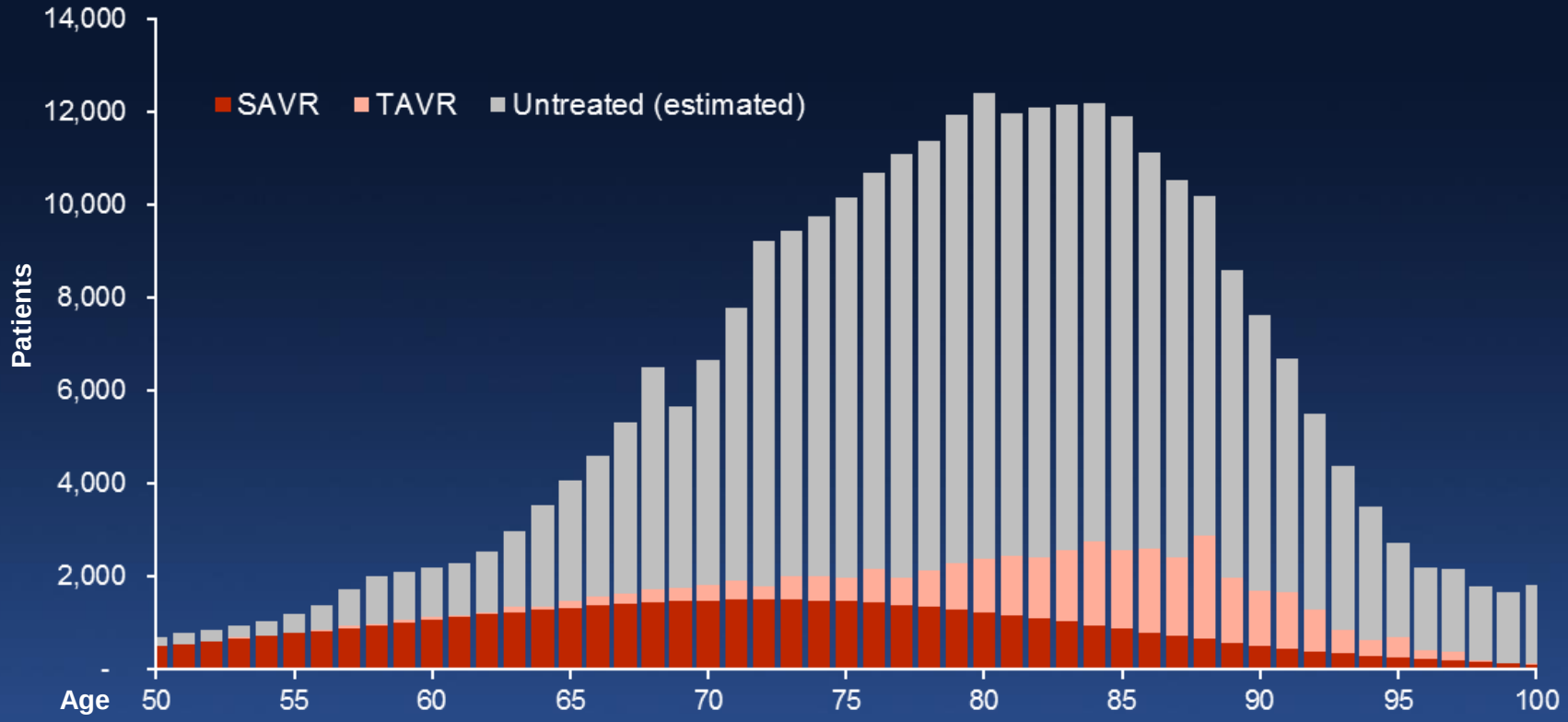
2015 Severe Symptomatic AS Patients in the U.S.[1]



(1) Nkomo 2006, Iivanainen 1996, Aronow 1991, Bach 2007, Freed 2010, Iung 2007, Pellikka 2005, Brown 2008, Thourani 2015,

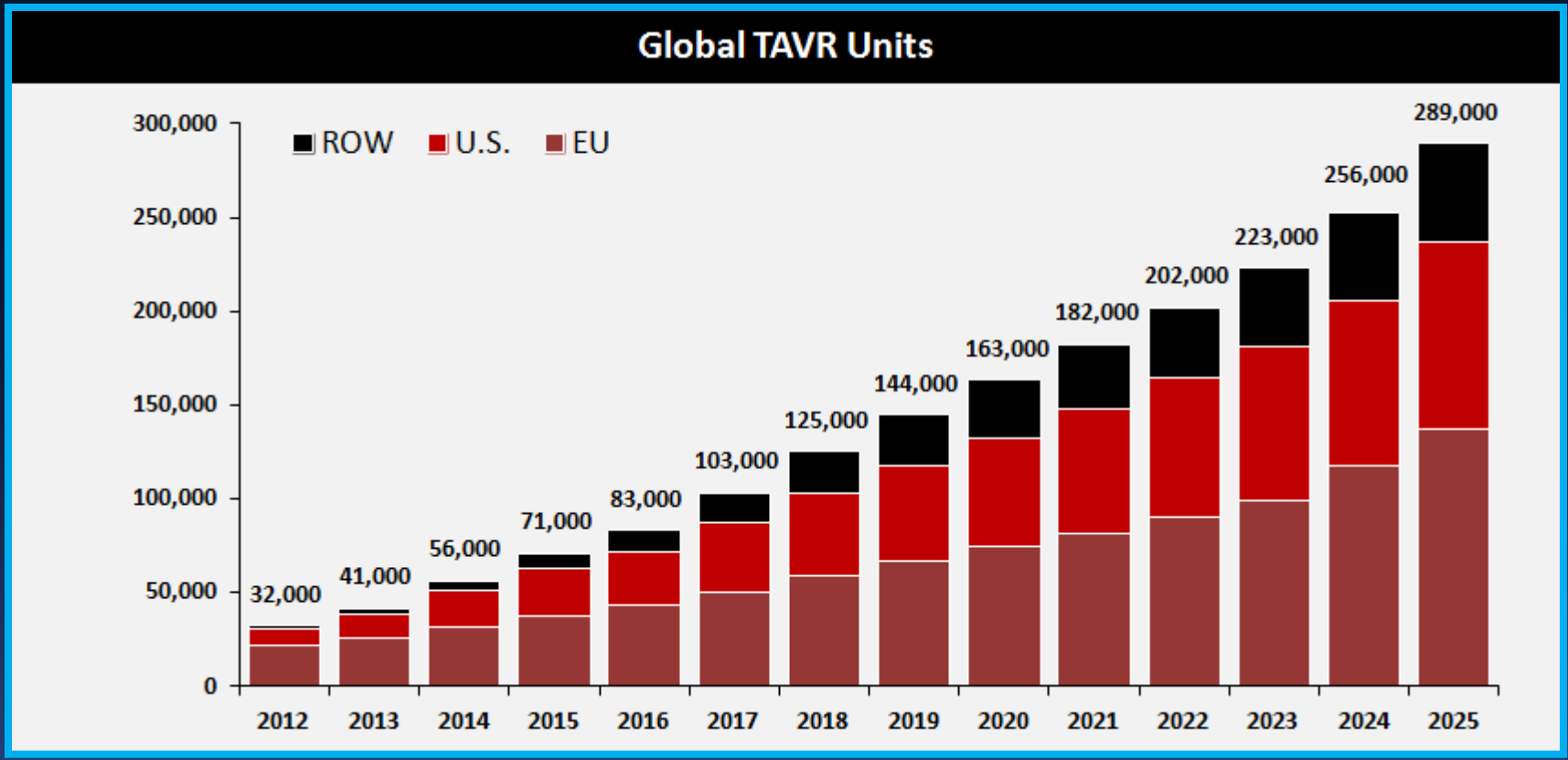
A Large Population of Severe Symptomatic AS Patients Remain Undiagnosed and Untreated

2015 Severe Symptomatic AS Patients in the U.S.[1]



(1) Nkomo 2006, Iivanainen 1996, Aronow 1991, Bach 2007, Freed 2010, Iung 2007, Pellikka 2005, Brown 2008, Thourani 2015,

Estimated Global TAVR Growth



SOURCE: Credit Suisse TAVI Comment –January 8, 2015. ASP assumption for 2024 and 2025 based on analyst model. Revenue split assumption in 2025 is 45% U.S., 35% EU, 10% Japan, 10% ROW

In the next 10 years, TAVR growth will increase X4!

TAVR UNLOAD Trial

Study Design

(600 patients, 1:1 Randomized)

TAVR UNLOAD Trial

International Multicenter Randomized

Heart Failure
LVEF < 50%
NYHA ≥ 2
Optimal HF therapy (OHFT)
Moderate AS

R

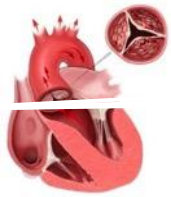
TAVR + OHFT

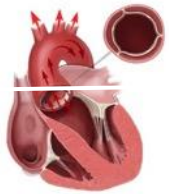
OHFT Alone

Follow-up:
1 month
6 months
1 year

Clinical endpoints
Symptoms
Echo
QoL

Primary Endpoint
Hierarchical occurrence of:
- **All-cause death**
- **Disabling stroke**
- **Hospitalizations for HF, aortic valve disease**
- **Change in KCCQ**



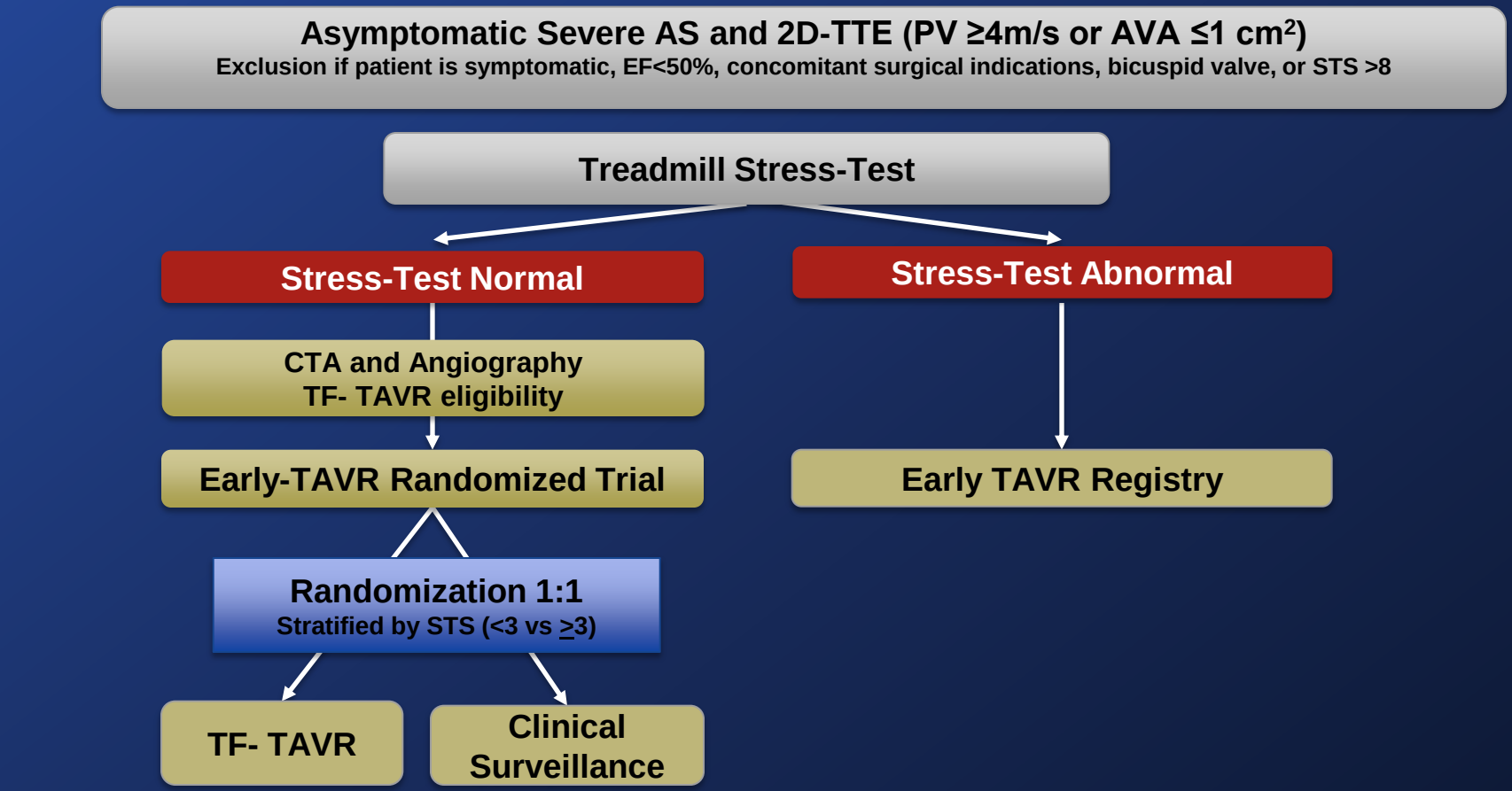


Reduced AFTERLOAD
Improved LV systolic and diastolic function

Columbia University Medical Center
NewYork-Presbyterian

EARLY TAVR Trial
Study Flow

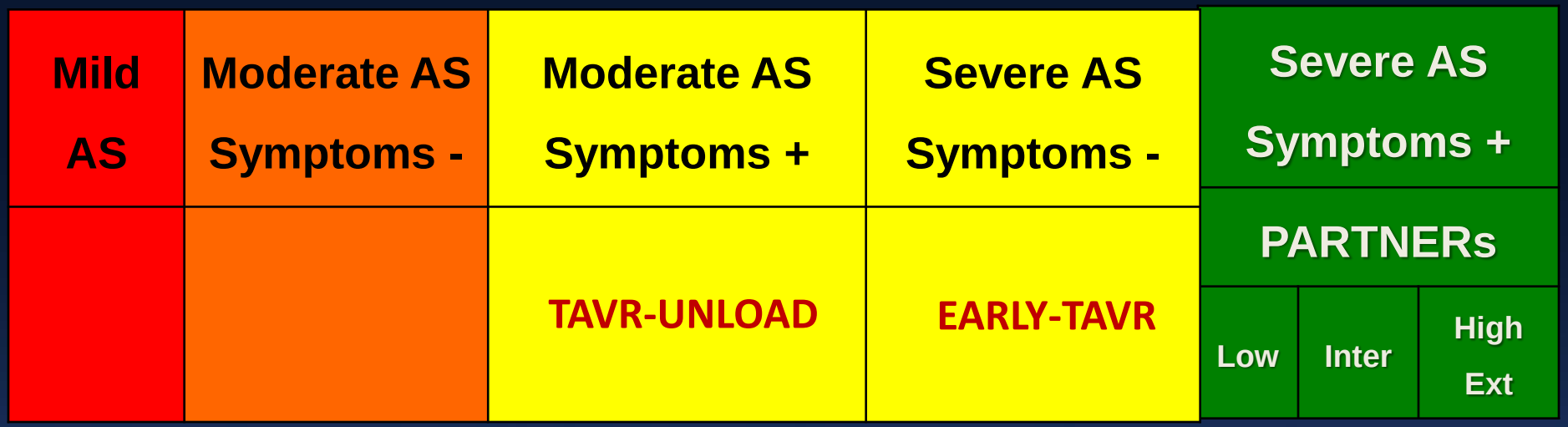
THE PARTNER 3 TRIAL



Primary Endpoint (superiority): 2-year composite of all-cause mortality, all strokes, and repeat hospitalizations (CV)

Aortic Stenosis Redefined:

Functional Classification



≈2020

2012

Courtesy of P. Généreux TVT 2016

Minimalist TAVI

- Heart Team
- LA/Conscious Sedation
- No TEE, TTE if needed
- No central line
- No temporary pacing wire
- LV pacing through the stiff GW
- R femoral for 14F sheath, L femoral for 5F pigtail
- R radial for Sentinel cerebral embolic protection
- Early ambulation
- Discharge 48-72 hours

From This……. To This *(since 2012)*

Comparison of Transfemoral Transcatheter Aortic Valve Replacement Performed in the Catheterization Laboratory (Minimalist Approach) Versus Hybrid Operating Room (Standard Approach)

CME

Should my patient with severe AS undergo TAVI?

- Once symptoms develop for severe AS, early intervention is indicated regardless of age
- Severe AS in cardiogenic shock or for high-risk PCI, perform BAV first and consider the use of Impella
- Minimalist TAVI under LA, stay in hospital for 2-3 days
- Immediate complications ~5%
- 30-day mortality <5%

Should my patient with severe AS undergo TAVI?

- >75 y/o severe AS → go for TAVI irrespective of risk score
- 70-75 y/o severe AS → go for TAVI if there is any of the high risk features, consider other factors as well, e.g. frailty score, cirrhosis, COPD, ESRF
- 55-70 y/o severe AS → go for SAVR with bioprosthesis unless inoperable (porcelain aorta)
- <55 y/o → SAVR with mechanical heart valve unless otherwise indicated


asia
AiCT PCR
The Official Course of APSIC
A new Course is born!
Don't miss the first edition of the new learning platform for Asia Pacific
Join us!
4-6 July 2019
Singapore
www.aict-asiapcr.com
PCR Your Daily Practice Companion

HKSTENT - CICF 2020

Cardiovascular Intervention Complication Forum 2020

13 - 15 March 2020
Hong Kong

A Complication Case Based Meeting & the First Dedicated Complication Forum in Asia

Mark Your Calendar!

For updates, please visit

►►► www.hkstent.org ◄◄◄

Organized by:

Hong Kong Society of Transcatheter ENdo-cardiovascular Therapeutics (HKSTENT)


Thank you !