Traitement du RA par implantation de valve trans- artérielle TAVI

Dr Olivier Bouchot
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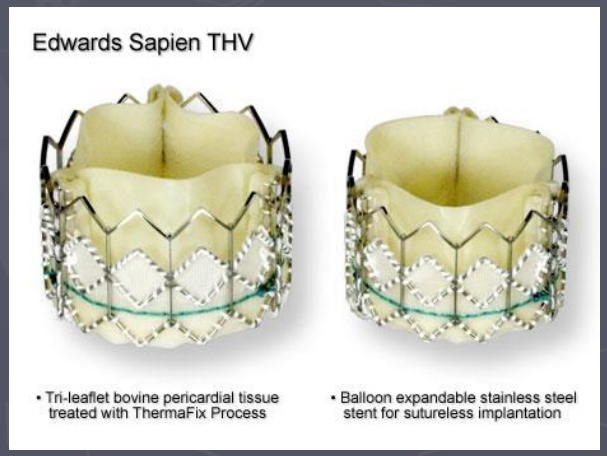
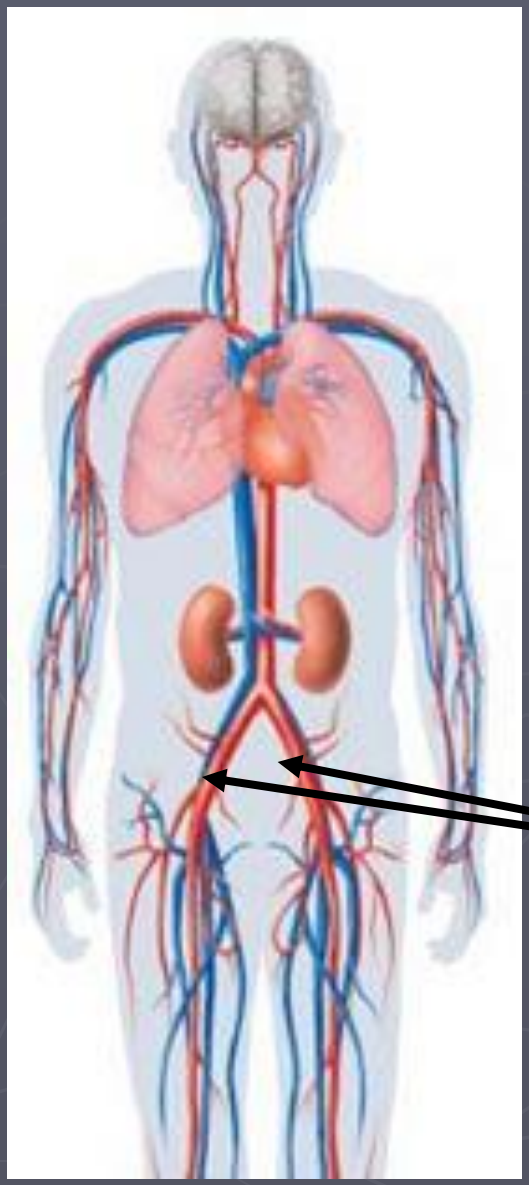
CHU DIJON
www.chircardiaque-dijon.fr

Solutions


Edwards Sapien THV
• Tri-leaflet bovine pericardial tissue treated with ThermaFix Process
• Balloon expandable stainless steel stent for sutureless implantation

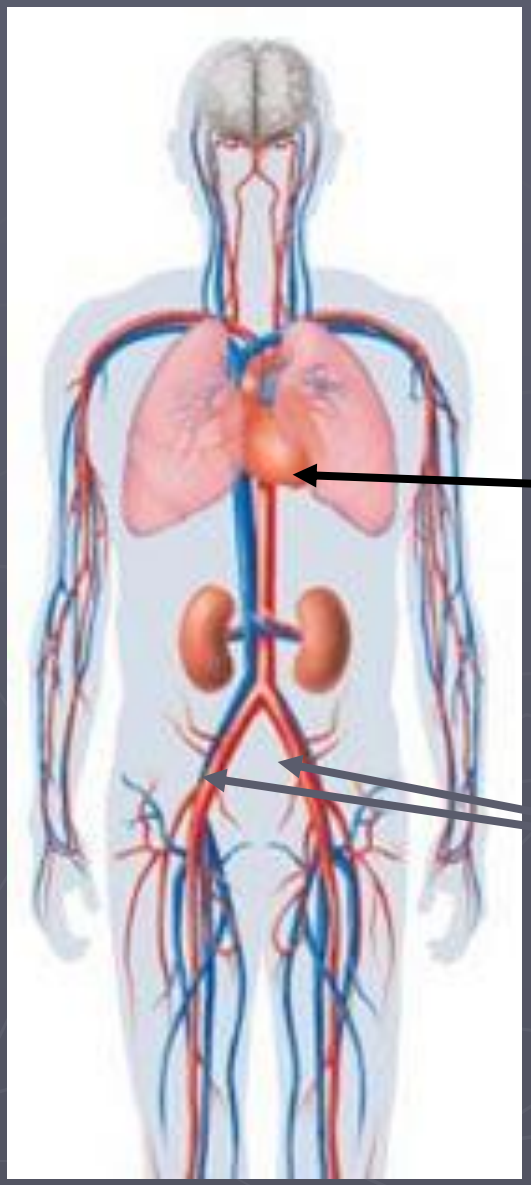
Voies d'abords



Artères fémorales

70%

Voies d'abords

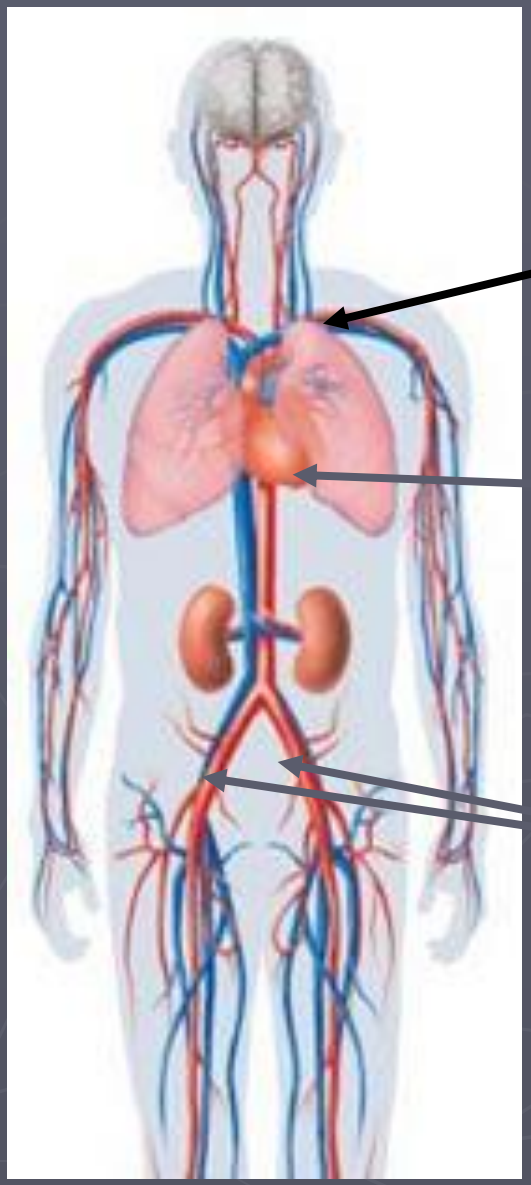


Voie apicale

20 % (⇓)

Artères fémorales

Voies d'abords



Voie sous Clavière

5 %

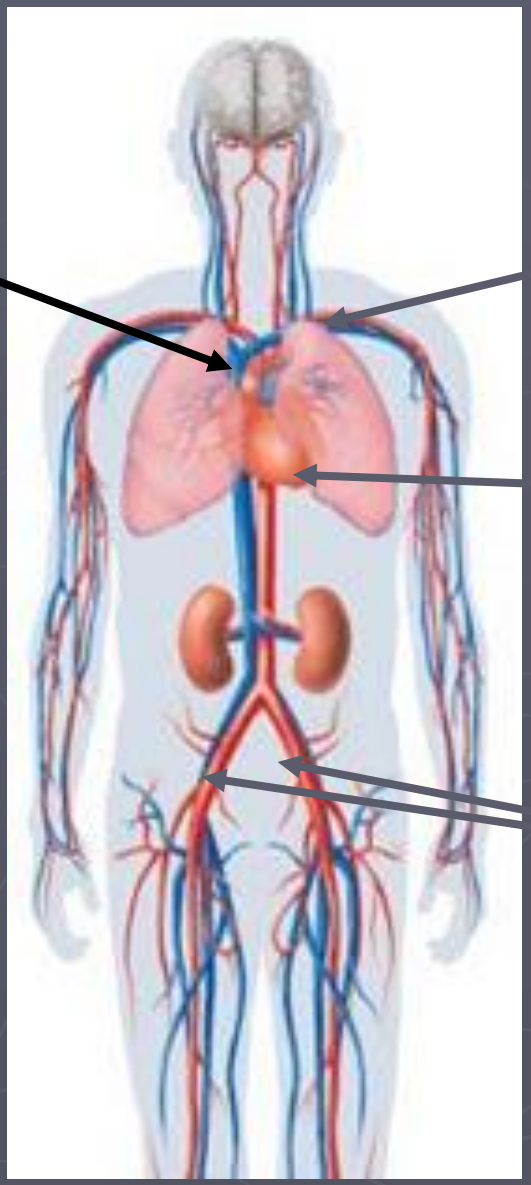
Voie apicale

Artères fémorales

Voies d'abords

Voie trans-aortique

5 % (⇑)



Voie sous Clavière

Voie apicale

Artères fémorales

Voie fémorale

- **Avantages**
  - Facile d'accès
  - Percutané
  - Anesthésie locale
- **Inconvénients**
  - Voie rétrograde (crosse aortique)
  - AOMI (7 mm)
  - Tortuosité, calcification
  - AAA

Voie apicale

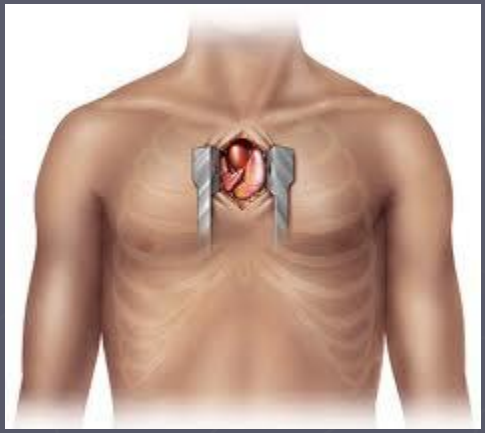
- **Avantages**
  - Voie antérograde
  - Proche de la valve aortique
  - Aorte porcelaine
- **Inconvénients**
  - Thoracotomie droite
  - Fragilité apex VG

Voie sous Clavière gauche

- **Avantages**
  - Alternative à la voie fémorale
  - Rarement athéromateuse
  - Proche du cœur
- **Inconvénients**
  - Rétrograde
  - Fragile
  - Accès parfois difficile

Voie trans aortique

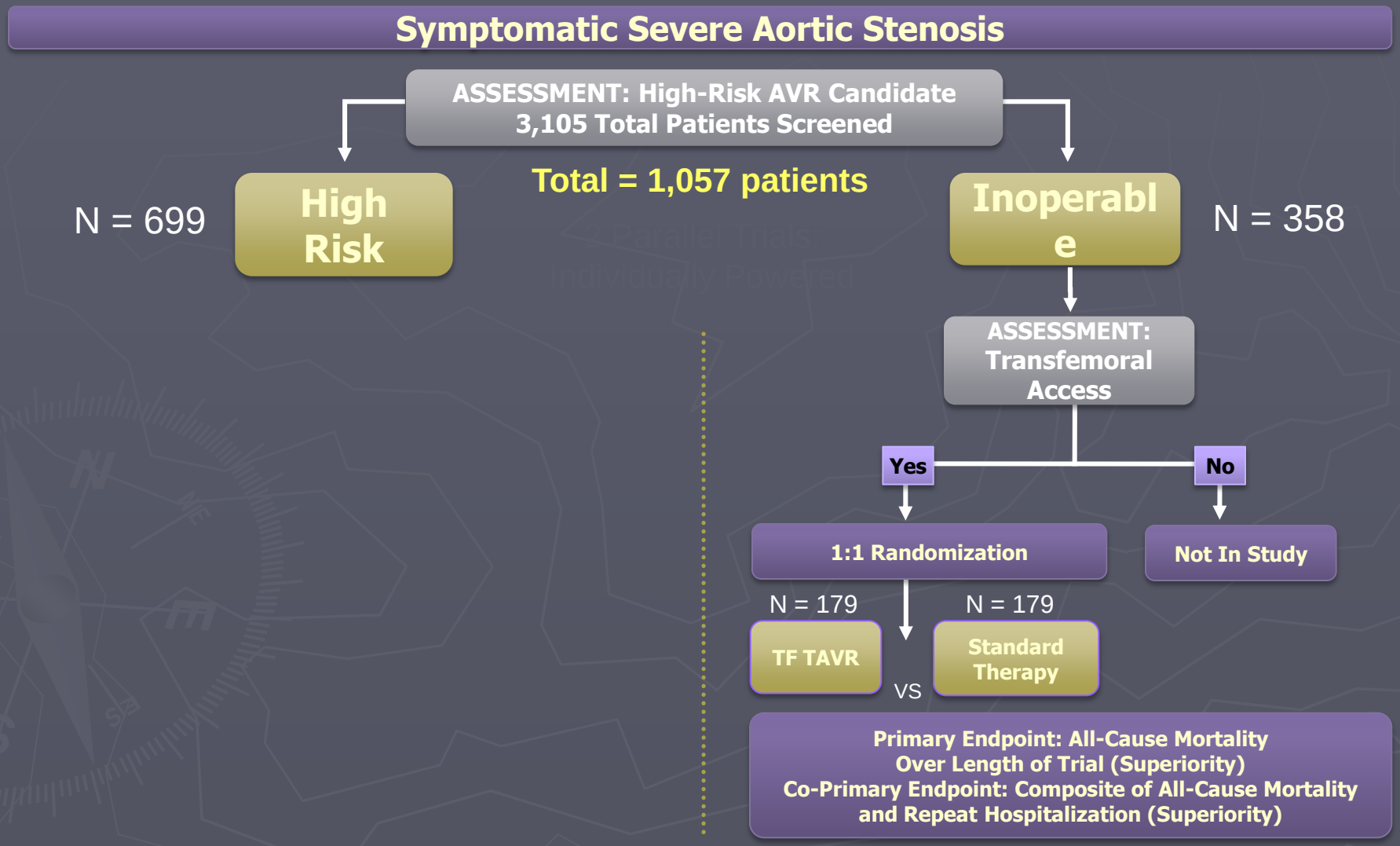
- **Avantages**
  - Proche du cœur
- **Inconvénients**
  - Manubriotomie



Résultats : France 2

- 1688 patients au 1er mars 2011
- Age moyen 82 ans
- Mortalité
  - 1 mois : 10%
  - 6 mois : 20%
- Pace maker : 12%
- Cmp vasculaire: 10%
- Cmp Neuro: 3%

Résultats : PARTNER B



Résultats : PARTNER B

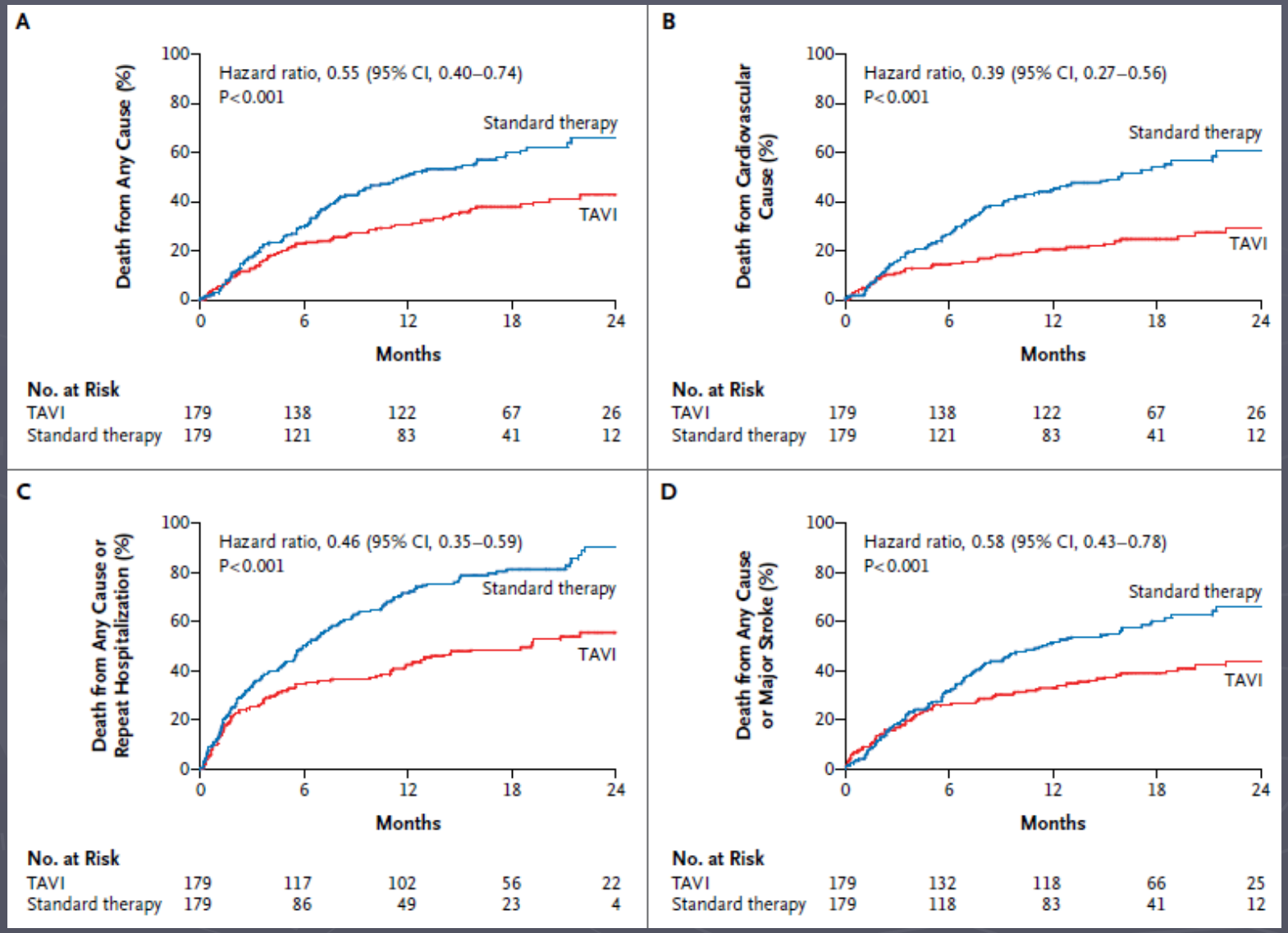
The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 OCTOBER 21, 2010 VOL. 363 NO. 17

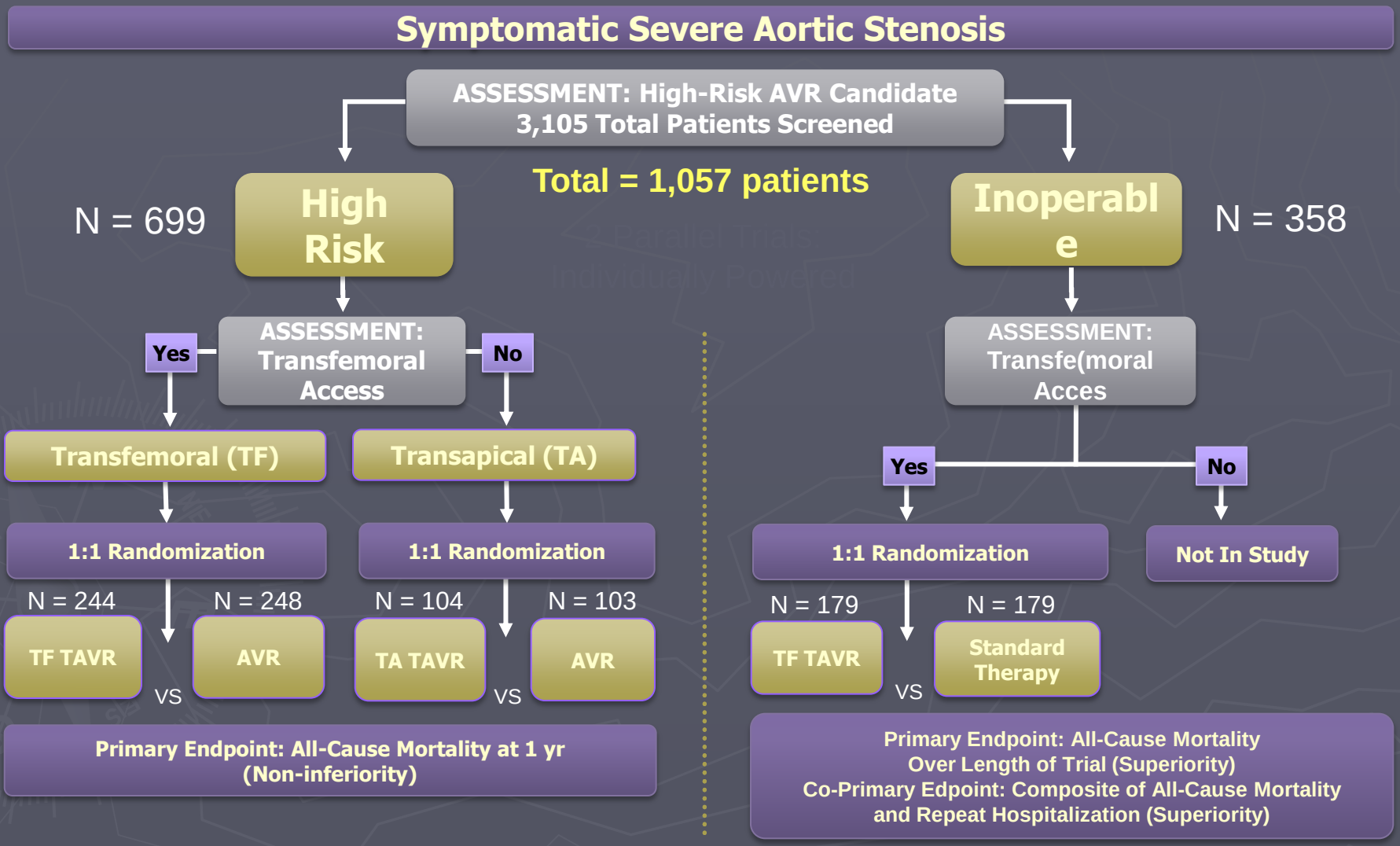
Transcatheter Aortic-Valve Implantation for Aortic Stenosis in Patients Who Cannot Undergo Surgery

Martin B. Leon, M.D., Craig R. Smith, M.D., Michael Mack, M.D., D. Craig Miller, M.D., Jeffrey W. Moses, M.D., Lars G. Svensson, M.D., Ph.D., E. Murat Tuzcu, M.D., John G. Webb, M.D., Gregory P. Fontana, M.D., Raj R. Makkar, M.D., David L. Brown, M.D., Peter C. Block, M.D., Robert A. Guyton, M.D., Augusto D. Pichard, M.D., Joseph E. Bavaria, M.D., Howard C. Herrmann, M.D., Pamela S. Douglas, M.D., John L. Petersen, M.D., Jodi J. Akin, M.S., William N. Anderson, Ph.D., Duolao Wang, Ph.D., and Stuart Pocock, Ph.D., for the PARTNER Trial Investigators*

Résultats : PARTNER B



Résultats : PARTNER A



Résultats : PARTNER A

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JUNE 9, 2011 VOL. 364 NO. 23

Transcatheter versus Surgical Aortic-Valve Replacement in High-Risk Patients

Craig R. Smith, M.D., Martin B. Leon, M.D., Michael J. Mack, M.D., D. Craig Miller, M.D., Jeffrey W. Moses, M.D., Lars G. Svensson, M.D., Ph.D., E. Murat Tuzcu, M.D., John G. Webb, M.D., Gregory P. Fontana, M.D., Raj R. Makkar, M.D., Mathew Williams, M.D., Todd Dewey, M.D., Samir Kapadia, M.D., Vasilis Babaliaros, M.D., Vinod H. Thourani, M.D., Paul Corso, M.D., Augusto D. Pichard, M.D., Joseph E. Bavaria, M.D., Howard C. Herrmann, M.D., Jodi J. Akin, M.S., William N. Anderson, Ph.D., Duolao Wang, Ph.D., and Stuart J. Pocock, Ph.D., for the PARTNER Trial Investigators*

Résultats : PARTNER A

Table 2. Clinical Outcomes at 30 Days and 1 Year in the Intention-to-Treat Population.*

Outcome	30 Days			1 Year		
	Transcatheter Replacement (N=348)	Surgical Replacement (N=351)	P Value	Transcatheter Replacement (N=348)	Surgical Replacement (N=351)	P Value
	no. of patients (%)			*no. of patients (%)*		
Death						
From any cause	12 (3.4)	22 (6.5)	0.07	84 (24.2)	89 (26.8)	0.44
From cardiac causes	11 (3.2)	10 (3.0)	0.90	47 (14.3)	40 (13.0)	0.63
Repeat hospitalization	15 (4.4)	12 (3.7)	0.64	58 (18.2)	45 (15.5)	0.38
Death or repeat hospitalization	25 (7.2)	33 (9.7)	0.24	120 (34.6)	119 (35.9)	0.73
Stroke or transient ischemic attack						
Either	19 (5.5)	8 (2.4)	0.04	27 (8.3)	13 (4.3)	0.04
Transient ischemic attack	3 (0.9)	1 (0.3)	0.33	7 (2.3)	4 (1.5)	0.47
Stroke						
Minor	3 (0.9)	1 (0.3)	0.34	3 (0.9)	2 (0.7)	0.84
Major	13 (3.8)	7 (2.1)	0.20	17 (5.1)	8 (2.4)	0.07
Death from any cause or major stroke	24 (6.9)	28 (8.2)	0.52	92 (26.5)	93 (28.0)	0.68
Myocardial infarction	0	2 (0.6)	0.16	1 (0.4)	2 (0.6)	0.69
Vascular complication						
Any	59 (17.0)	13 (3.8)	<0.001	62 (18.0)	16 (4.8)	<0.001
Major	38 (11.0)	11 (3.2)	<0.001	39 (11.3)	12 (3.5)	<0.001
Acute kidney injury						
Creatinine >3 mg/dl (265 μmol/liter)	4 (1.2)	4 (1.2)	0.95	12 (3.9)	8 (2.7)	0.41
Renal-replacement therapy	10 (2.9)	10 (3.0)	0.95	18 (5.4)	20 (6.5)	0.56
Major bleeding	32 (9.3)	67 (19.5)	<0.001	49 (14.7)	85 (25.7)	<0.001
Endocarditis	0	1 (0.3)	0.32	2 (0.6)	3 (1.0)	0.63
New-onset atrial fibrillation†	30 (8.6)	56 (16.0)	0.006	42 (12.1)	60 (17.1)	0.07
New pacemaker	13 (3.8)	12 (3.6)	0.89	19 (5.7)	16 (5.0)	0.68

Résultats : PARTNER A

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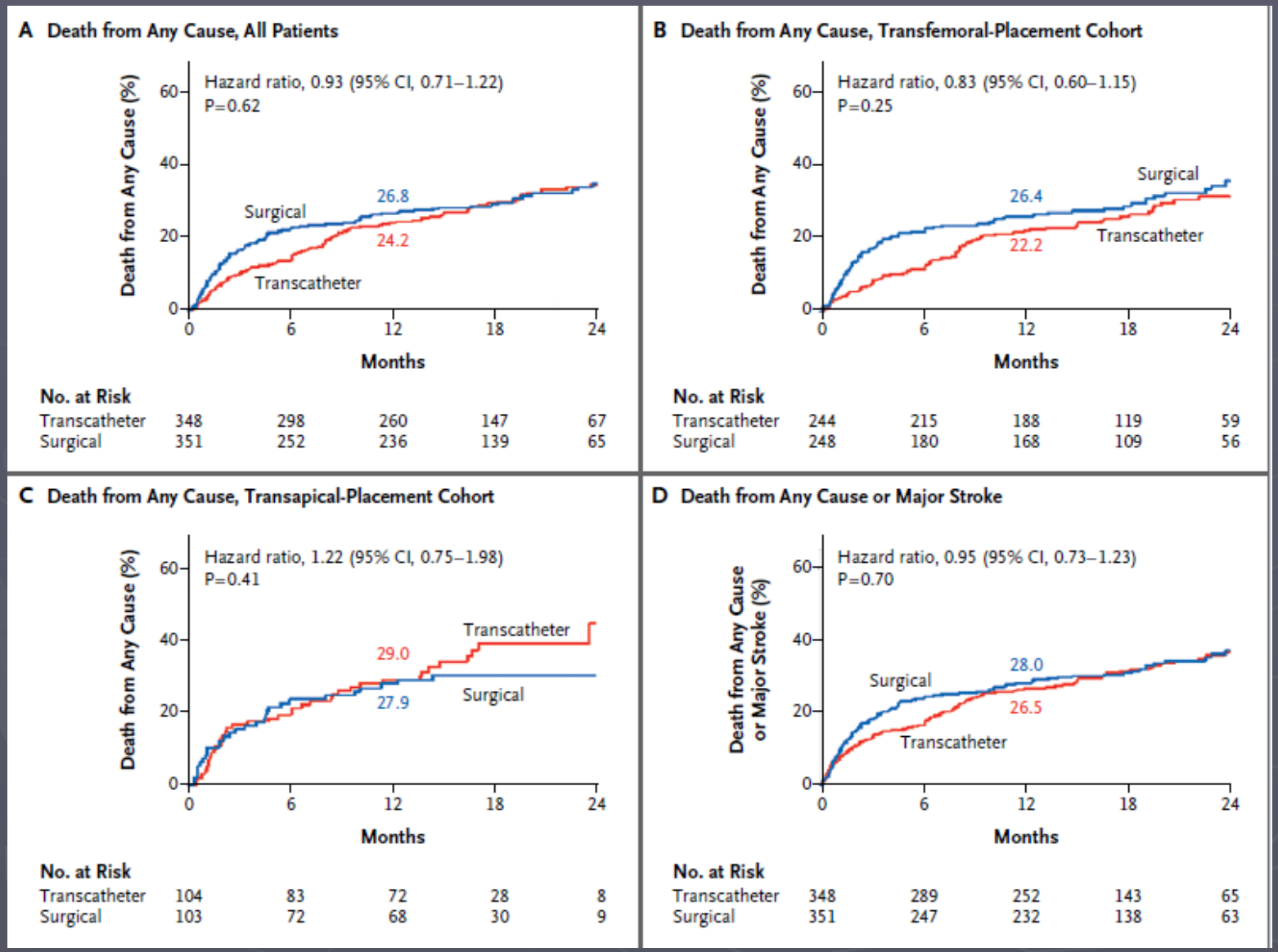
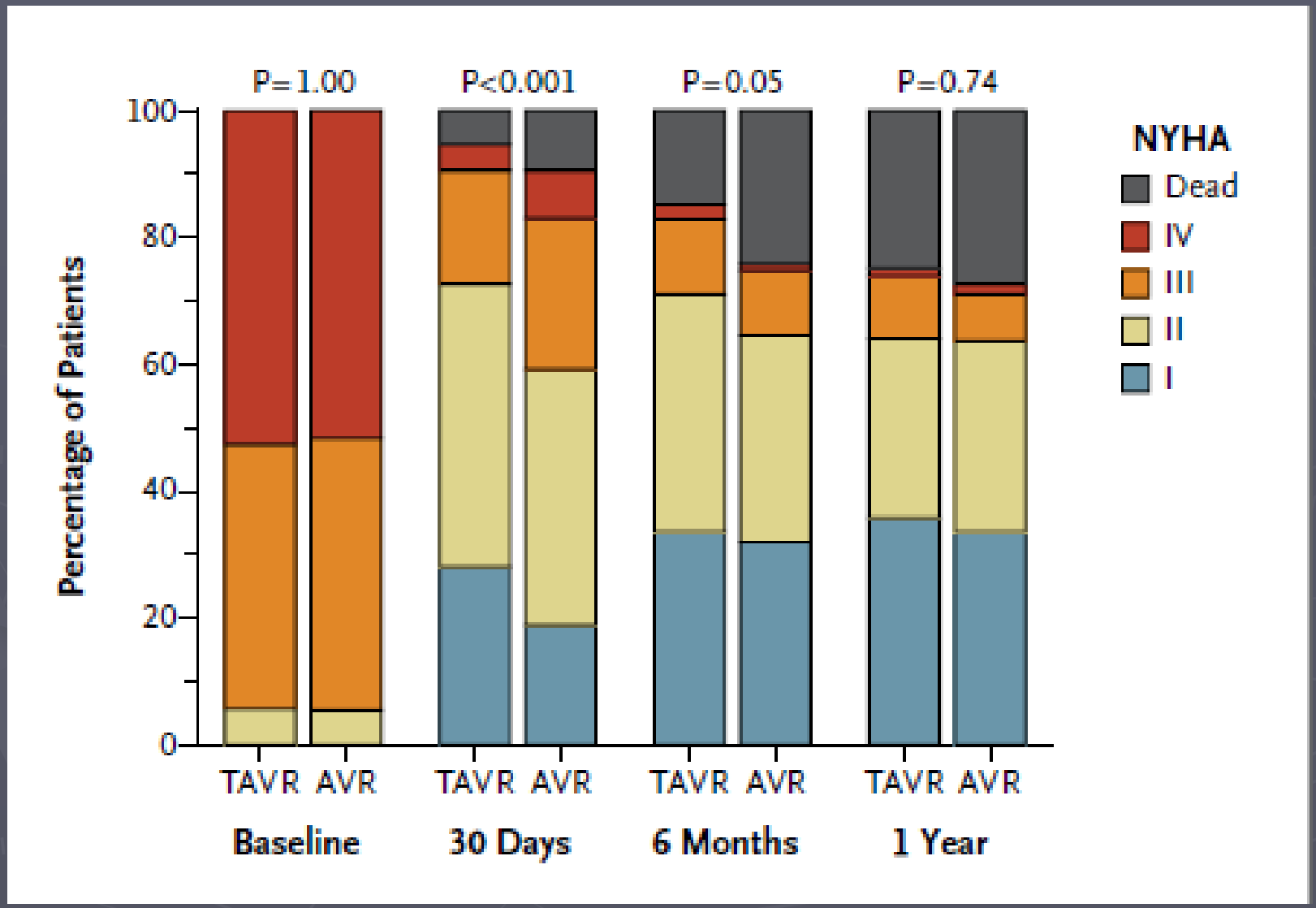
Résultats : PARTNER A



Résultats : PARTNER A



Conclusions

- Le traitement de référence du RA reste le RVAO chirurgical

- Mais pour les patients contre-indiqués (euroscore élevé, âge, antécédents de pontages coronariens, Aorte calcifiée…)

⇒TAVI

Conclusions

- **Prise en charge multidisciplinaire**
  - Cardiologues
  - Chirurgiens cardiaques
  - Anesthésistes
  - Gériatres

- **Bilan et sélection des patients**
- **Voie d'abord**
- **Implantation:**
  - **cardiologues (2)**
  - **chirurgien (1 ou 2)**
  - **anesthésiste**