The first mechanical heart valve prosthesis, designed by Dr Charles Hufnagel, was implanted to the descending aorta of a 30-year-old woman with severe aortic regurgitation in 1952.1 Eight years after the initial successful prosthetic aorta of a 30-year-old woman with severe aortic regurgitation, clinical impact of such a trend.5

With these improvements, the age cutoff to use bioprosthetic valves was gradually lowered to avoid lifelong anticoagulation. However, this series provides some benchmarks when transcatheter VIV therapy is considered for bioprosthetic valve failure. The 30-day rates of mortality (8.4%) and stroke (2%) are not much different from what was observed in the early experience of TAVR for inoperable patients. On the other hand, 3 issues were more frequent and consequential than TAVR for native AS, including high transvalvular gradients, coronary occlusions, and valve malpositioning.

High Transvalvular Gradients
Overall, 28% of patients had a mean transvalvular gradient of >20 mm Hg after TAVR. In patients with small surgical prosthesis (internal diameter <20 mm), this rate was doubled. High gradients were also more common when the Edwards valve was used. These findings represent less than ideal hemodynamic results.

The bioprosthesis, unlike the native aortic annulus, provides a rigid boundary for the new valve that is placed inside it. Accordingly, the size of the surgically placed valve has a paramount importance in the planning and outcome of the VIV procedure. Determining the true internal diameter of a given valve is not an easy task. The sizes that are given by the manufacturers frequently correspond to the sewing ring diameter but do not represent the actual internal diameters. The magnitude of discrepancy between the manufacturer’s size and the actual measurements vary among the different valves.12–14 In the Global VIV Registry reported by Dvir and colleagues, >75% of the bioprostheses were <23 mm. There is a large variation in internal diameter of bioprosthetic valves, ranging from 17 mm to 20 mm for a 21-mm and 15 mm to 19 mm for a 19-mm valve, based on intraoperative measurements. The measurements not only depend on the valve type, but also on whether the bioprosthetic valve is
placed supra- or intra-annularly and whether valve pledgets are placed above or below the annulus. Understanding the complexity of the dimensions and knowing the true internal diameter of the prosthetic valve are critical in the planning of VIV procedure.

The opening that will accommodate the new prosthesis is also determined, albeit to a lesser extent, by presence and severity of pannus formation, bulky nature of the degenerated and calcified prosthetic valve leaflets, and the severity of stenosis. The issue of internal diameter size of the diseased valve is more important for the Edwards Sapien valve because of its intra-annular positioning, than for the CoreValve which has functioning leaflets above the minimum internal diameter.

Creating a relatively small effective orifice area and consequently high transvalvular gradients will frequently lead to patient–prosthesis mismatch. Whether this less than optimal orifice translates into higher long-term mortality or functional impairment remains to be seen. Available data in the surgical literature suggest that there may be a price to pay for larger residual gradients. With that said, for patients with no surgical option as a result of multiple comorbidities, expectations may be different. For the time being, VIV for a no-option patient with severely dysfunctional 19-mm or 21-mm prosthesis may not be a perfect solution, but it may offer an acceptable result with improvement in symptoms, particularly with a supra-annular valve.15

**Coronary Occlusion**

The data in the registry highlight another critical procedural problem and point to the importance of careful patient selection and procedure planning. Coronary artery occlusion with attendant 57% mortality occurred more frequently in the stentless valves and valves with leaflet mounted on the outside of the frames (Figure). It is not clear whether or not there is an interaction between the diseased prosthesis and the type of TAVR used, although there was no difference in the frequency of the coronary occlusion between the 2 types of transcatheter valve. To prevent this frequently lethal complication, we need to examine the relationships between the coronary artery ostia, the bioprosthetic valve sewing ring, the leaflets, the sinotubular junction, and Sinuses of Valsalva. For the time being we should either avoid or use extreme caution in using the VIV technique in the particular prosthesis mentioned above that leaves little space between the prosthetic leaflets and coronary ostia.

**Malpositioned Valve**

The malpositioning rate of 15.3% and the need for a second TAVR valve in 8.4% of patients are surprisingly high. The valve that moves cranially during deployment up the aorta can often be managed via catheter techniques, but if it moves in toward the left ventricle open-heart surgery may be necessary. These complications can potentially be prevented by clear understanding of the anatomy of different valves, preprocedural planning with CT scan, and use of guiding intraprocedural radioscopic software for positioning.13

**Long-Term Outcome**

There appears to be no loss of improved valve function in a small number of patients who had 1-year echocardiograms. Follow-up is too short and very limited to draw comfort for durability of the VIV technique. The longer term follow-up from larger TAVR cohorts cannot be readily used for VIV procedures. For the time being, the impact of the frequently constrained conditions of the functioning VIV, interaction between 2 different prosthetic surfaces on the durability of the transcatheter valve, is not clear.

**Bioprosthesis Now, TAVR Later?**

The question at hand is as follows: does TAVR offer a reasonable solution to the difficult problem of the severely
symptomatic patient with malfunctioning aortic prosthesis who is not a surgical candidate or at very high risk for surgical mortality and morbidity? The answer is a qualified yes; not all surgical prostheses are suitable, and much improvement in technology and procedural technique is needed.

The question for the future is as follows: Should we take the option of VIV-TAVR technique into consideration when deciding the surgical valve type for aortic valve disease patients of all ages? The answer is a cautious maybe. In the future, availability of new versions of TAVR devices specifically for VIV will make this approach more feasible as long as the durability issue is addressed. But the size of the surgically implanted valve will continue to be the most important determinant of the success of the VIV procedure. Accordingly, surgeons who envision a prospective TAVR procedure if a valve bioprosthesis fails should make sure a large valve is implanted during the first surgery. This may require wider use of the root enlargement procedures.

Valve in valve is another milestone in the advance of transcatheter valve therapies. Dvir et al should be congratulated for reporting the initial global experience. They show us the promise and the pitfalls of the new technique and point to the hard work ahead to overcome the challenges.

Disclosures

Dr Tuzcu is an unpaid member of the executive committee and investigator of the Placement of Aortic Transcatheter Valve (PARTNER) trial. Dr Kapadia is an unpaid member of the steering committee and investigator of the PARTNER trial. Dr Svensson is an unpaid member of the executive committee and investigator of the PARTNER trial. The other authors report no conflicts.

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