Complex Cases: Mitral Regurgitation and HF

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Disclosures

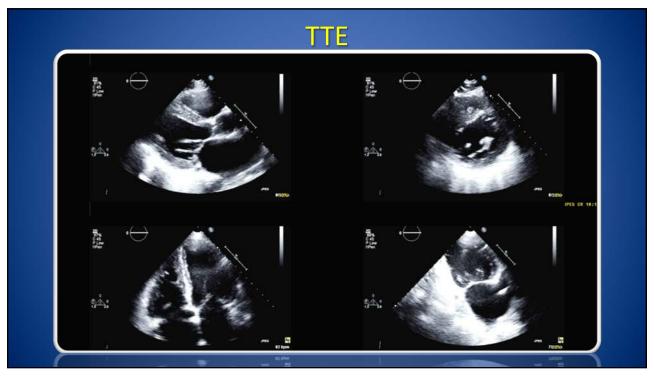
- Academic Echo Core Lab
 - Abbott / St Jude Medical
 - Edwards
 - Medtronic
 - Boston Scientific
 - Caisson Livanova
 - NeoVasc
 - GDS Ancora

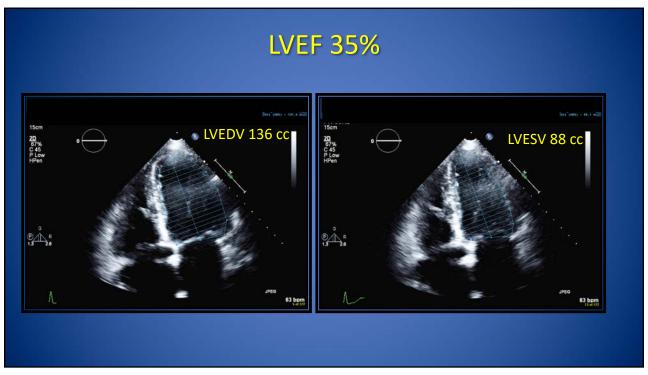


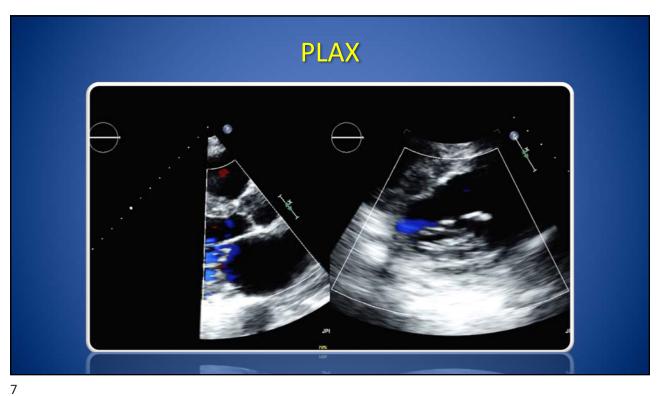
- 80 M
- HTN, HLP, Chronic A fib on anticoag
- CKD, stage 3 w Cr: 1.8-2.4
- AMI 1993, Inf and IL walls
- CABG x 4, 2003
- Known MR for 10 years
- Chronic HF, Worsening DOE for 1 year,
- Recent admissions for HF.
- Loop diuretics, BB

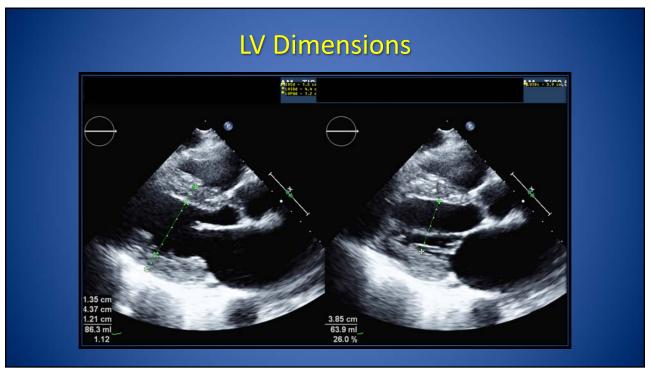
Will get an echo... What information are we seeking for?

- MR?
- Severity?
- Etiology?

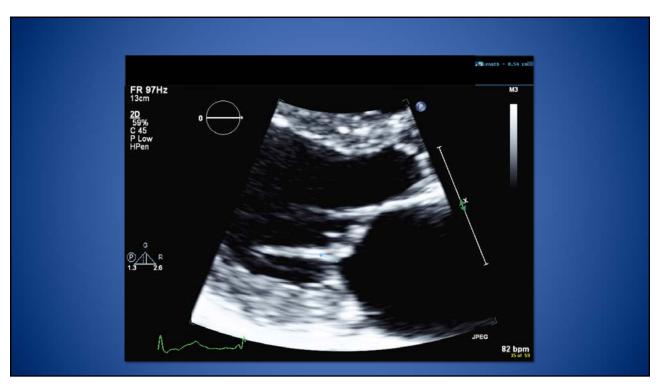


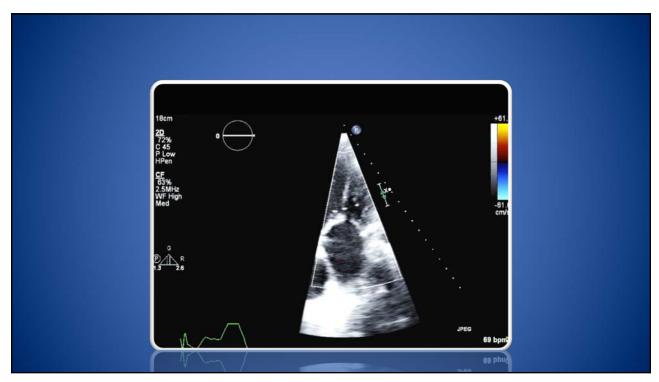


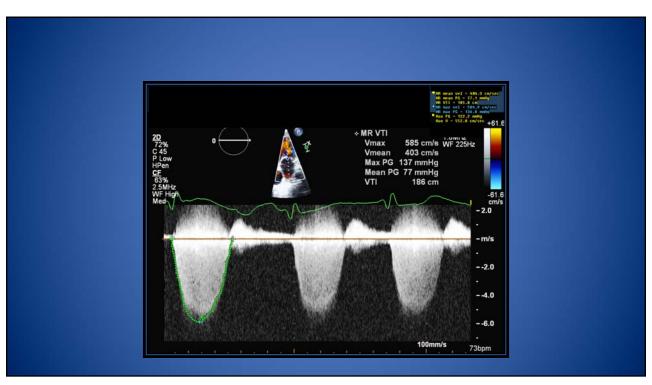




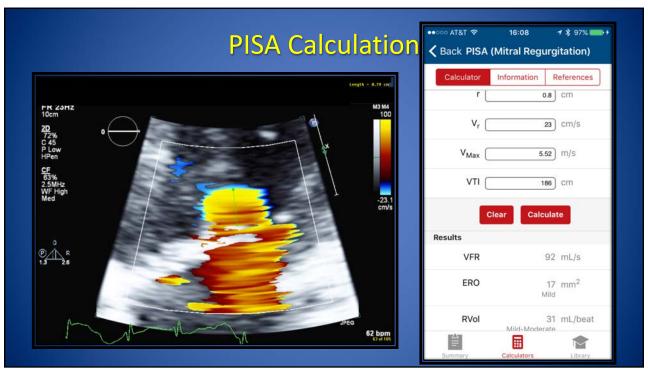












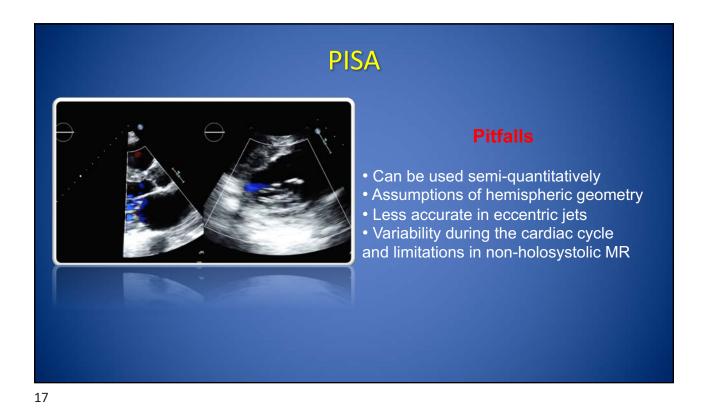
What is the most likely MR etiology?

- 1. Primary (degenerative –DMR-), rheumatic
- 2. Primary (degenerative –DMR-), prolapse
- 3. Secondary (functional), LV remodeling
- 4. Secondary (functional), LA remodeling
- 5. Mixed / Cannot determine yet

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How would you grade the SMR severity?

- 1. Mild
- 2. Moderate
- 3. Moderate to Severe
- 4. Severe
- 5. Need more info, Cannot determine yet

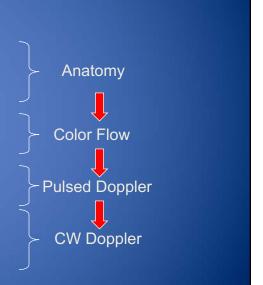


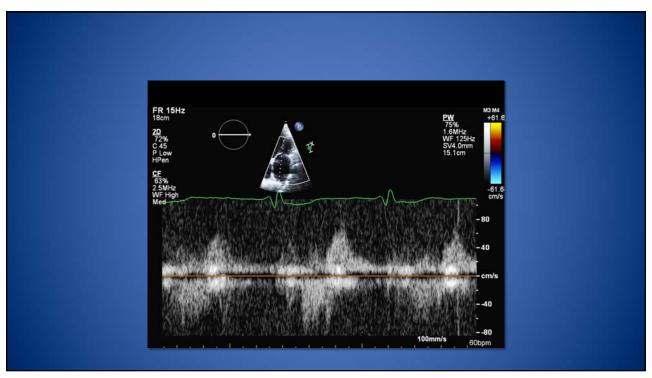
Mitral Regurgitation

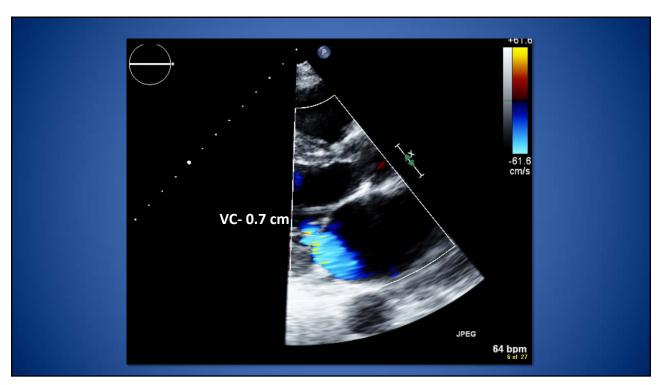
- Mitral valve pathology
- LV/ LA size
- Color Doppler:
 Vena contracta, Jet Area, Flow convergence

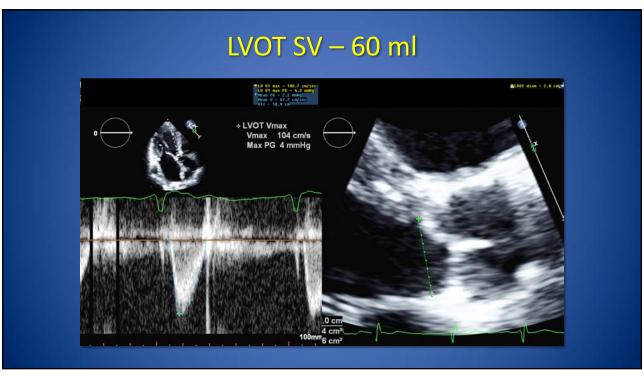
Indicators of Severity

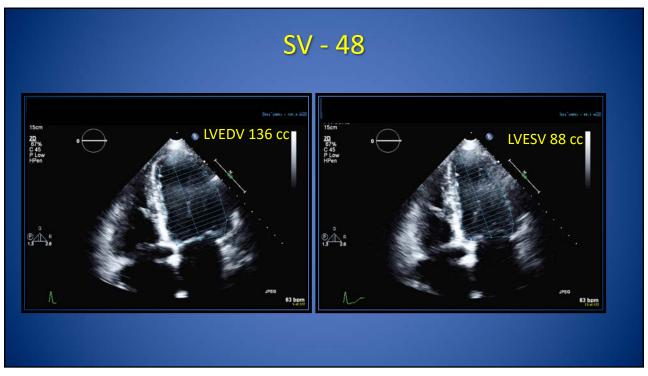
- Mitral E; Pulmonary vein pattern
- Regurgitant flow/fraction
- CW density and contour











Regurgitant Volume & Fraction

Advantages

- Quantitative, valid in multiple jets and eccentric jets
- Provides both lesion severity and volume overload

Limitations

- Needs training; Cumbersome; wide (20%) confidence limits
- Measurement of flow at MV annulus is less reliable in calcific MV and/or annulus
- 2D LV volumes underestimate, cannot combine with Doppler or 3D values for calculations.

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IVC 2.8 cm, non collapsing Vel 330 cm/s PG 44 mmHg 75mm

TTE Summary

- Low EF (35%)
- Discordant values for MR severity:
 - Large jet by color Doppler
 - VC = 0.7
 - PISA
 - EROA: 0.17
 - RV 31 ml
 - PV systolic flow reversal
 - Dense CW
- Pulmonary Hypertension

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Discussion

- Is this MR significant? ...
- Is etiology relevant?

ASE GUIDELINES AND STANDARDS

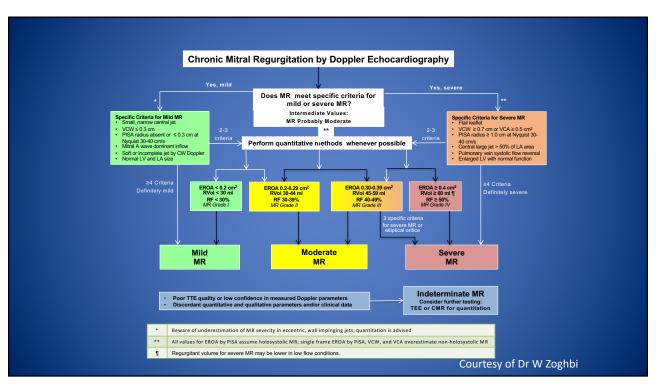
Recommendations for Noninvasive Evaluation of Native Valvular Regurgitation

A Report from the American Society of Echocardiography Developed in Collaboration with the Society for Cardiovascular Magnetic Resonance

William A. Zoghbi, MD, FASE (Chair), David Adams, RCS, RDCS, FASE, Robert O. Bonow, MD, Maurice Enriquez-Sarano, MD, Elyse Foster, MD, FASE, Paul A. Grayburn, MD, FASE, Rebecca T. Hahn, MD, FASE, Yuchi Han, MD, MMSc,* Judy Hung, MD, FASE, Roberto M. Lang, MD, FASE, Stephen H. Little, MD, FASE, Dipan J. Shah, MD, MMSc,* Stanton Shernan, MD, FASE, Paaladinesh Thavendiranthan, MD, MSc, FASE,* James D. Thomas, MD, FASE, and Neil J. Weissman, MD, FASE, Houston and Dallas, Texas; Durham, North Carolina; Chicago, Illinois, Rochester, Minnesota; San Francisco, California; New York, New York; Philadelphia, Pennsylvania; Boston Massachusetts; Toronto, Ontario, Canada; and Washington, DC

J Am Soc Echocardiogr. 2017 Apr;30(4):303-371

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Discussion

- Should MR be treated?
- What else do we need to decide on best mitral valve treatment?

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Cath 5/22/17

- RA 18
- PA 80/40
- PCWP 35 (large V wave)
- CI 1.6
- PA sats 50%
- Grafts are patent (SVG to LAD/Dg, OM, PDA)

- Given inability to diurese and compensate, IABP was placed awaiting therapeutic decisions to be made:
- Medical Therapy ?
- Surgical MVR/R?
- TMVR?
- Mitral Clip or other percutaneous interventions?





