Clinical History

- 83 yrs old male.
- Diabetic on insulin (20 years).
- He was known as a significant aortic stenosis 3 years ago.
- He was admitted in the ICU with cardiogenic shock (December 2016), severe chest infection and intubated for more than 2 weeks.
- Renal impairment (creatinine was 3.8mg/dl, urea 118mg/dl)
- On inotropic support (adrenaline, nor adrenaline and dopamine).
Clinical History

- He was poorly mobile due to his musculoskeletal problems.
- He is semi-conscious.
- On renal dialysis (6 sessions/3 weeks).

Risk scores
HEART TEAM DISCUSSION

• SAVR?
• TAVR?
• The patient is a very high risk for SAVR and TAVR.
• The life expectancy and the decision to do aortic balloon valvuloplasty to differentiate between if this pt is very sick because of AS or he is very sick with concomitant AS.

POST BALLOON

• The patient improved after 5 days and he extubated.
• The renal function was improved and the dialysis sessions was stopped.
• The inotropic support was reduced to noradrenaline only(150 mic/kg/h).
CT was done

The mean annulus diameter was 24.6mm²
EVOLUTE R 29 was planned

The follow up

- The patient improved and discharged from the hospital after 15 days.
- No conduction abnormality.
- No more renal dialysis session.
- His echocardiography showed mild to moderate aortic paravalvular leakage immediately post TAVI.
- One month later the echocardiography showed mild paravalvular leakage and normal LV function.
TAKE HOME MESSAGE

Decision making in elderly individuals with multiple comorbidities is both a science and an art.
Procedural success critically depends on proper selection, meticulous preplanning, experienced teams (interventional and surgical) and well equipped units. A good TAVI operator is simply not enough.

Differentiation between those who are very sick because of AS and those who are very sick with concomitant AS is very important.

In fact we had a lot of lessons from such of those cases.

Thank you