Brief report

Early Development of Leaks in the CoreValve Percutaneous Aortic Valve Prosthesis: Echocardiographic Assessment

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ABSTRACT

The study investigated echocardiographic findings after 1 month in 22 patients who received a CoreValve prostheses to treat aortic valve stenosis. Particular attention was paid to the evaluation of valvular leaks and the left ventricular wall thickness. Echocardiograms were obtained prior to implantation, at discharge and 1 month later. The patients’ mean age was 77 ± 4 years. At discharge, 16 patients (75%) had aortic regurgitation: 8 grade I and 8 grade II. At 1 month, only 13 (62%) presented with the condition: 10 grade I and 3 grade II, with 8 patients (38%) demonstrating a reduction of at least one grade (P < .005). The septal thickness decreased (from 14.2 ± 2 mm at baseline to 11.2 ± 1 mm at 1 month; P < .001), as did the posterior wall thickness (from 10.9 ± 2.4 mm at baseline to 8.3 ± 1.2 mm at 1 month; P < .001). In our patient series, the frequency and grade of residual aortic regurgitation after implantation of the CoreValve prosthesis decreased within 1 month, and favorable left ventricular remodeling was also observed.
with symptomatic severe aortic stenosis. All of the patients gave their informed consent and a CvPr implantation committee supervised their progress.

**Inclusion Criteria**

All the patients who had undergone implantation of a CvPr and had a follow-up of at least one month's duration were included in the study.

**Transsthoracic Echocardiography (TTE) Measurements**

All the studies were performed with the same echocardiographic unit (Philips iE33). The Teicholz method was used to assess ventricular function. The degree of prosthetic regurgitation was determined by quantifying the depth and width of the jet, according to the recommendations of other authors and the echocardiographic guidelines, and the location (paravalvular, transvalvular) and number of jets were also recorded. We measured the peak and mean aortic gradients and the aortic area by means of the continuity equation. The measurements of the ventricular diameters, septal thickness, and left ventricle posterior wall were made using M mode in diastole. The average of three cardiac cycles was taken in the presence of sinus rhythm; five cycles were averaged in the case of atrial fibrillation.

**Follow-up**

All of the patients who survived the procedures underwent TTE at the time of their discharge from the hospital and one month after implantation to assess the same parameters that were evaluated prior to the procedure.

**Statistical Analysis**

Quantitative data are presented as the mean plus or minus the standard deviation. Qualitative data are expressed as percentages. For the quantitative variables, fitness to normal distribution was studied using the Kolmogorov–Smirnov test. To compare changes in the quantitative variables during follow-up, Student’s t test for paired data or the Wilcoxon test was utilized, depending on whether or not the data fit the normal distribution. For the qualitative variables, the Wilcoxon rank test was employed.

A result was considered to be statistically significant when the P value was less than .05.

**RESULTS**

The mean age of the patients was 77 years (range: 69–82 years) and 50% of them were men. Table 1 summarizes the most relevant baseline characteristics of the study population.

Following implantation, one of the 22 patients died as a consequence of pericardial tamponade secondary to left ventricular rupture. In the remainder, the procedure was successful, although complete atrioventricular block occurred in seven patients: transient in four (19%) and persistent in three (14%), who required permanent pacemakers.

At discharge, 16 of the 21 patients had paravalvular leaks (76% of the population who underwent the follow-up study) (Fig. 1). Of these, eight patients (50%) had a grade I leak and the other eight (50%) a grade II leak. In five of the 16 cases (31%), the regurgitation involved two jets at different sites and in the remaining 11 patients there was a single jet. Thus, in all, there were 21 jets at the time of discharge. After one month of follow-up, paravalvular leakage was observed in only 13 patients (62%): grade I in 10 patients (77%) and grade II in three (23%). With respect to the number of regurgitant jets, two different jets remained in only three of the 13 patients (23%) and there was a single jet in the remaining 10, for a total of 16 regurgitation jets after one month of follow-up. There was a significant reduction in the regurgitation, amounting to at least one grade, in eight patients (38%) (P < .005) (Figs. 1 and 2), as well as a decrease in the absolute number of jets from 21 to 16. Regurgitation did not exceed grade II in any patient and no transvalvular regurgitation was detected.

At one month, there was a significant reduction in left ventricle thicknesses and the septum measurement decreased from 14.2 ± 2.4 mm to 11 ± 2.4 mm and the posterior wall from 10.9 ± 2.4 mm to 8.3 ± 1.2 mm (P < .001) (Table 2; Fig. 3).

**DISCUSSION**

Valve regurgitation is a possible technical complication of percutaneous prosthesis implantation. In our study, in contrast to other series, we had no cases of moderate to severe paravalvular regurgitation (higher than grade II) following implantation. Moreover, we observed an early reduction in the paravalvular regurgitation grade after CvPr implantation, which was evident after one month of follow-up and probably related to the high adaptability and self-expandability of the nitinol prosthesis.
We should also point out the reduction during follow-up in the absolute number of jets, which implies that some of them disappeared completely despite these being the first cases treated by our group, which would include those corresponding to the initial learning curve.

In previous studies, the majority involving Edwards prostheses, mild or moderate paravalvular leaks have been observed after the procedure, with few changes in the degree of severity throughout follow-up. For example, in the series of Webb et al.\textsuperscript{3} and Cribier et al.,\textsuperscript{2} with Edwards prostheses, the grade of total prosthetic...
regurgitation showed no significant changes after one and two years of follow-up, respectively. Likewise, in a series involving the CoreValve prosthesis, Grube et al. observed no differences in the prosthetic regurgitation grade over a short-term follow-up. In contrast, Moss et al. found that there did appear to be a reduction in the grade of the leaks during the early follow-up period, and the trend persisted for 12 months. However, this reduction proved to be significant only for the transvalvular regurgitations, and is not comparable with our results.

Nevertheless, none of the studies published to date have assessed the course of left ventricular hypertrophy. It can be deduced from our analysis that the hypertrophy, as a mechanism to compensate for the obstruction of left ventricular outflow, is reversible over the short term, a fact that indicates the excellent hemodynamic profile of the prosthesis. In other series, an improvement in left ventricular systolic function has been observed, more marked in patients with baseline dysfunction; this was not the case in our study, probably because it did not include patients with ventricular dysfunction.

One limitation to our study is the assessment of the leaks in prosthetic valves, since we have followed the recommendations made by Kapur et al. Another limitation is the case series design of the study, with a reduced number of patients and short follow-up period. Studies with the proper design, a larger number of patients and a longer follow-up will establish the definitive role of this therapeutic alternative.

We can conclude that the paravalvular leaks in our series of patients with CoreValve percutaneous aortic prostheses were not severe in any case and that there was an early and significant reduction in their grade and number.

One month after implantation, favorable left ventricle remodelling was already observed, and there was a reduction in ventricular hypertrophy, quite plausibly due to the excellent hemodynamic profile of the prosthesis.

**CONFLICTS OF INTEREST**

The authors state that they have no conflicts of interest.

**REFERENCES**