Eulogio García, Leire Unzué, Eduardo García, Jorge Solís, Rodrigo Teijeiro, and Belén Tarancón

Servicio de Cardiología, Hospital Universitario Madrid-Montepríncipe, Boadilla del Monte, Madrid, Spain
Servicio de Cardiología, Hospital Moncloa, Madrid, Spain

Corresponding author:
E-mail address: ejgarcia1@telefonica.net (E. García).

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REFERENCES


NEW MODELS OF PERCUTANEOUS AORTIC VALVE PROSTHESIS

Initial Experience With the DirectFlow Percutaneous Aortic Valve in Spain

Experiencia inicial en España con la prótesis aórtica percutánea DirectFlow

To the Editor,

Percutaneous implantation of an aortic prosthesis in patients with severe aortic stenosis and high surgical risk has been proven to be more effective than medical treatment and similar or superior to conventional surgery according to the experience gained with the Edwards-SAPIEN (Edwards Lifesciences; Irvine, California, United States) and Medtronic CoreValve (Medtronic; Minneapolis, Minnesota, United States) prostheses in clinical trials and clinical practice registers.

The DirectFlow prosthesis (DirectFlow Medical; Santa Rosa, California, United States) has recently been marketed; its potential advantages over existing devices are the possibility of repositioning/recapturing the device, hemodynamic stability during the procedure, and a low rate of significant aortic failure. The DirectFlow prostheses (Figure) do not have any metal components and its structure is a system of communicating vessels, which when filled with liquid, make 2 rings (fluid entry via...


![Diagram of DirectFlow prosthesis and deployment system](image)

**Figure.** A: DirectFlow prosthesis seen from the aorta. B: Lateral view of the prosthesis and deployment system (positioning cables and internal lumen holding the support guide). C: Prosthesis in position with the 2 rings full of contrast medium; in this situation, the hemodynamic functionality and patency of the coronary arteries can be evaluated. At this time, it is still possible to reposition the prosthesis and recapture it if necessary.

**Table**

Baseline Data on the Procedure and Follow-up of the 5 Patients Treated

<table>
<thead>
<tr>
<th>Sex, age, y</th>
<th>EuroSCORE</th>
<th>Comorbidities</th>
<th>Evaluation prior to the procedure</th>
<th>Procedure</th>
<th>Complications</th>
<th>Results at day 30</th>
<th>Last follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>Male, 86</td>
<td>Coronal disease, right coronary artery stent</td>
<td>Echocardiography</td>
<td>Valve size</td>
<td>Vascular surgery</td>
<td>Area, cm²</td>
<td>Follow-up time, months</td>
</tr>
<tr>
<td>Patient 2</td>
<td>Male, 66</td>
<td>Severe COPD, severe liver disease, APO requiring prior valvuloplasty</td>
<td>Mean gradient, mmHg</td>
<td>Number of positions</td>
<td>No</td>
<td>Mean gradient, mmHg</td>
<td>Alive</td>
</tr>
<tr>
<td>Patient 3</td>
<td>Female, 87</td>
<td>Severe pulmonary hypertension, atrial fibrillation</td>
<td>Aortic regurgitation</td>
<td>Positioning time, min</td>
<td>Femoral pseudoaneurysm, bleeding</td>
<td>Regurgitation</td>
<td>Alive</td>
</tr>
<tr>
<td>Patient 4</td>
<td>Male, 90</td>
<td>Atrial fibrillation</td>
<td>LVEF, %</td>
<td>Complications</td>
<td>Better</td>
<td>Functional situation</td>
<td>Better</td>
</tr>
<tr>
<td>Patient 5</td>
<td>Male, 84</td>
<td></td>
<td>CT</td>
<td></td>
<td></td>
<td></td>
<td>Alive</td>
</tr>
</tbody>
</table>

- \(\text{A:}\) Valve size: 27; Number of positions: 3; Positioning time, min: 10; Complications: Vascular surgery.
- \(\text{B:}\) Ring diameter, mm: 25.6; Distance RC/LC, mm: 13/17.
- \(\text{C:}\) LVEF, %: 61; Mean gradient, mmHg: 36; Aortic regurgitation: Mild.

**Results at day 30**

- Area, cm²: 1.7; Mean gradient, mmHg: 18; Regurgitation: Grade 1.

**Last follow-up**

- Follow-up time, months: 11; Vital situation: Alive; Functional situation: Better.
those reported with surgical biological prostheses\(^a\); in 1 patient with a functionally bicuspid valve due to fusion and calcification of the commissure between the right sinus and the noncoronary sinus, the initial postoperative gradient rose from 12 to 35 mmHg by the third day and a geometrical deformity of the polyester structure was observed via computed tomography and fluoroscopy. Despite the residual gradient (stable since then), and probably due to a reduction in the degree of aortic failure (from grade 3 to grade 1), the patient improved clinically and still has good functional status. Both prosthetic function and clinical outcome were favourable in the other patients.

The main advantages of the DirectFlow prosthesis over the Edwards-SAPIEN and Medtronic CoreValve prostheses are as follows:

- Greater flexibility
- Better hemodynamic stability during deployment (valve operative during implantation, does not require high-frequency stimulation)
- Possibility of evaluating the prosthesis prior to its deployment.
- Possibility of repositioning/recapturing the device.
- Low rate of aortic failure.

The disadvantages include:

- Less radial strength
- Slightly higher transvalvar gradient

The information available on this valve is still limited. The results presented at the 2014 EuroPCR congress seem to confirm the stability of the hemodynamic results after 1 year in the first 100 patients treated. Nonetheless, there are aspects, such as the impact of the residual gradient or the selection criteria, that require studies in larger samples and with longer follow-up periods. There are currently no data comparing the clinical results with those of the Edwards-SAPIEN and Medtronic CoreValve prostheses.

NEW MODELS OF PERCUTANEOUS AORTIC VALVE PROSTHESIS

Transcatheter Aortic Valve Replacement With Lotus\textsuperscript{TM} Valve: Initial Experience

**Implante transcatéter de la válvula aórtica Lotus\textsuperscript{TM}: serie inicial de 5 casos**

To the Editor,

Currently, transcatheter aortic valve implantation is a well-established therapeutic option for the treatment of patients with inoperable symptomatic and severe aortic stenosis or with high risk for surgery.\(^1\) Although the midterm results in this type of patient are good, moderate-severe residual paravalvular aortic regurgitation (6\%) or stroke (3\%), and their prognostic implications, have been observed in recent years.\(^2\)\(^-\)\(^3\)

Paravalvular aortic regurgitation can be caused by the implantation of a smaller-sized prosthesis, its inadequate expansion or intense calcification of the ring, which impedes correct stent apposition. The incidence of this complication has been reduced by more precise measurement of the aortic ring by using computed tomography and posterior balloon dilatation of the stent.\(^4\)

At the same time, industry has developed second-generation valves that minimize the risk of residual paravalvular aortic regurgitation. Among them is the Lotus\textsuperscript{TM} (Boston Scientific, Natick, Massachusetts, United States),\(^7\) which is a bovine pericardial tissue valve incorporated in a nitinol stent. The Lotus\textsuperscript{TM} is preloaded and designed to provide more precise release and the possibility of its repositioning or recovery after implantation. This stent also minimizes the risk of paravalvular aortic regurgitation with its new-age sealing system (urethane membrane) that adapts to the irregular surface of the ring.

This article presents 5 consecutive cases of severe degenerative aortic stenosis treated with the Lotus\textsuperscript{TM} aortic stent. Average patient age was 84 (SD, 5.63) years, and the EuroSCORE was 33% (SD, 16.7%) (Table).

The severity of the stenosis was assessed by transthoracic echocardiography and a hemodynamics study with left-right catheterization. The indication for implantation was discussed and accepted in all patients except 1, who underwent urgent implantation due to hemodynamic instability.

The procedures were done under general anesthesia with transesophageal echocardiography. Before valvuloplasty, a provisional active-fixation pacemaker for ventricular overstimulation was implanted in the septum of all patients. Right femoral access was created in all patients; the puncture was guided by fluoroscopy and, after preparing the area with 2 ProGlides\textsuperscript{TM}

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