

**CRT-700.07**

**Predictors of 1-Year Mortality After TAVR**



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**BACKGROUND** Transcatheter aortic valve replacement (TAVR) is approved as an alternative to surgical aortic valve replacement (SAVR) in patients with prohibitive, high and intermediate risk. STS score and frailty score are widely used to risk stratify patients before TAVR. The goal of this study is to assess predictors of 1-year mortality after 1 TAVR.

**METHODS** We identified all severe aortic stenosis (AS) patients who underwent TAVR between 01/2012 to 6/2016. The baseline characteristics, clinical, procedural and follow-up data of all patients that underwent TAVR were obtained and followed for up at least one year post-procedure. Hierarchical logistic regression was used to assess predictors of 1-year mortality after 1 TAVR.

**RESULTS** A total of 400 TAVR Patients were included in the analysis. The overall mortality rate was 2.5% at 30 days and 10.5% at 1 year. Predictors of mortality at 1 year were STS > 6 (RR= 2.24; CI = 1.03 to 4.89, P= 0.04), Severe COPD (RR= 1.98; CI = 1.01 to 3.89, P= 0.04); home oxygen use (RR= 2.72; CI = 1.17 to 6.38, P= 0.02); prior peripheral vascular disease PAD (RR=2.07; CI 1.02 to 4.18; P=0.04) and EF < 35% (RR=2.19; CI 1.05 to 4.54; P=0.03). Other factors in regards of gender, sex, presence of coronary artery disease, hyperlipidemia, hypertension, diabetes, transaortic valve gradient, flow or velocity were not predictive of 1-year outcomes.

**CONCLUSION** In addition to STS score, the presence of COPD, PAD, Home oxygen use and low EF are predictive of mortality at 1 year.

**CRT-700.08**

**The Impact of Beta Blockers on Transcatheter Aortic Valve Replacement Outcomes**



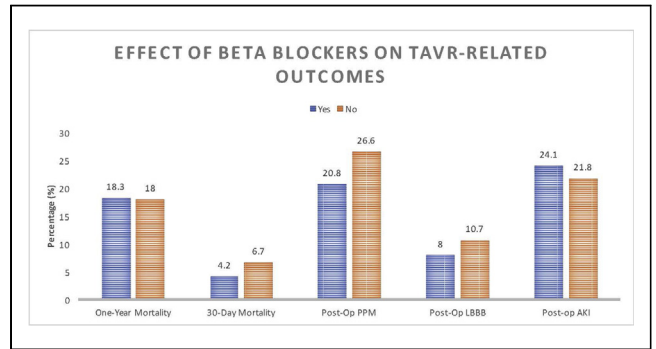
Abdulah Alrifai, Swethika Sundaravel, Edwin Grajeda, Mohamad Kabach, Jesus Pino, Pradeep Dayanand, Eduardo Venegas, Lawrence Lovitz, Mark Rothenberg, Roberto Cubeddu, George Daniels, Eric Heller, Cristiano Faber, Robert Chait, Marcos Nores  
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**BACKGROUND** Trans-catheter Aortic Valve Replacement (TAVR) is a novel procedure that has revolutionized the treatment for severe aortic stenosis (AS). There is limited data on the pre-operative beta-blocker (BB) impact on TAVR outcomes.

**METHODS** A Retrospective analysis of 373 patients with severe AS who underwent TAVR between March 2013 and March 2016. The primary outcomes were 30-day and 1-year mortality. 2-sample independent t-tests and logistic regression were used.

**RESULTS** There were 284 (76.2%) patients in the BB group and 89 (23.8%) patients in the control group. After propensity matching analysis, both groups were found to have similar outcomes. There was no significant difference in 30 day (4.2% vs 6.7%, p=0.495) or 1-year mortality (18.3% vs 18%, p=1), post-op atrial fibrillation (8.2% vs 6.4%, p= 0.789), complete heart block (15.6% vs 16.7%, p= 0.955) or pacemaker implantation (20.8% vs 26.6%, p=0.358).

**CONCLUSIONS** The use of pre-operative BB did not improve the overall outcomes of TAVR including 30-day and 1-year mortality or post-op complications.



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**Of Tight Valves and Bleeding Bowels—Gastrointestinal Bleeding in Patients After Transcatheter Aortic Valve Replacement (TAVR)**



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**BACKGROUND** Extra-cardiac complications of transcatheter aortic valve replacement (TAVR) are important to recognize as TAVR becomes more accessible to moderate surgical risk patients with severe aortic stenosis. Patients undergoing TAVR frequently have clinical and demographic characteristics that place them at significant risk of post-procedural gastrointestinal bleeding (GIB). Our study aimed to evaluate incidence, predictors, endoscopic findings and outcomes of GIB in the post-procedural period following TAVR.

**METHODS** A retrospective analysis was performed on all adult patients undergoing TAVR from September 2013 to December 2016 (n=193) at a single urban tertiary care academic medical center.

**RESULTS** The overall incidence of GIB following TAVR was 7% (n=14/193) with median time to GIB of 28 days (range 4-850 days). Compared to the non-GIB group, the GIB group had higher prevalence of active smoking (21% vs. 3%; p=0.02) and history of atrial fibrillation/flutter (57% vs. 29%; p=0.037). At baseline, more non-GIB group patients were on gastric protection with proton pump inhibitors (PPI) compared to GIB group (71% vs. 29%; p=0.002). Post-procedurally, more GIB patients were on combination of anti-platelet and anticoagulant therapies compared to non-GIB patients (71% vs. 41%; p<0.01). Independent of GIB status, patients on the combination therapy had a higher all-cause mortality compared to patients receiving only antiplatelet, only anticoagulant therapy, or none (p<0.01).

**CONCLUSIONS** Patients on combination antiplatelet and anticoagulant therapy are not only at a higher risk of developing GIB but also at an increased risk of all-cause mortality. The use of GI prophylaxis (i.e., PPI) could potentially limit the occurrence of GIB.