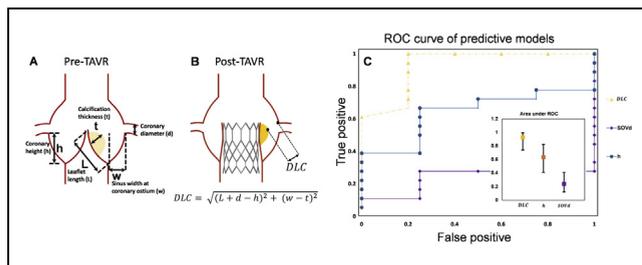


patients (Figure 1A), and the predicted Distance between the Leaflet tip and Coronary ostium after TAV deployment was calculated (Figure 1B).

RESULTS CO had an incidence of 21.7% (5/23) in high-risk population equivalent to 0.83% (5/600) in total, mostly occurring in left coronary artery. The left h and SOVD were 10.7mm +/- [3.9] and 30.9mm +/- [4.2] respectively. The novel CO predictive parameter *DLC* was 0.97mm +/- [0.5]. SOVD and *h* resulted in area under ROC curves [95% CI] = 0.24 [0.12-0.41] and 0.63 [0.41-0.82] respectively, while *DLC* significantly increased the area under ROC curve to 0.92 [0.74-0.99] (Figure 1C).

CONCLUSION With this study a novel criterion was successfully developed to screen for CO during TAVR and assist cardiologists in the pre-TAVR decision-making process. Additional measurements of aortic root variables are recommended for patient at high risk of CO.

REFERENCES: 1. Ribeiro HB, et al. J Am Coll Cardiol 2013;62:1552-62. 2. Yamamoto M, et al. Int J Cardiol 2016;217:58-63.



ASD/PFO OCCLUDERS

CRT-700.38

Patent Foramen Ovale is Not Associated with Neurologic Events in Patients Undergoing Liver Transplantation



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BACKGROUND Patent foramen ovale (PFO) is present in approximately 20% of individuals and may result in transient intra-cardiac shunting, a causative factor for those with cryptogenic cerebrovascular accident (CVA). During liver transplantation (LT), intra-operative transesophageal echocardiography can observe transient intra-cardiac shunting of atheromatous debris via a PFO. Closure of PFOs prior to LT has thus been suggested as a potential treatment to reduce perioperative CVAs. The objective of this study was to assess if the presence of a PFO is associated with CVAs in patients undergoing LT.

METHODS Three hundred fifty-eight patients undergoing LT at a single academic institution were included. All patients underwent standardized cardiac evaluation including a detailed cardiovascular history and physical examination, electrocardiogram and trans-thoracic echocardiogram (TTE). Five patients were excluded because of poor TTE image quality, and 3 patients were excluded because of PFO closure prior to LT, yielding a study population of 350. In-hospital events including major adverse cardiovascular events (MACE), death, myocardial infarction and CVA were collected.

RESULTS Mean age was 53.4±10.2 years; 61% male and 5% of patients had a prior history of CVA. Alcohol and hepatitis C were the most common etiologies for liver disease. MELD score at the time of LT was 28.7±11.3. Forty-six patients (13.1%) were diagnosed with a PFO. In-hospital CVA occurred in 6 patients (1.7%). The prevalence of a CVA was not significantly higher in patients with a PFO compared to patients without a PFO, 2.2% vs 1.6%, p=0.57. In-hospital mortality was similar in patients with a PFO compared to patients without a PFO, 4.4% and 5.3%, p=1.0.

CONCLUSIONS The presence of a PFO in patients undergoing LT is not associated with peri-operative neurologic events. Prophylactic

closure of PFOs, in the absence of other accepted indications, does not appear to be warranted in patients undergoing LT.

CLOSURE OF VALVE LEAKS

CRT-700.39

Elective Percutaneous Paravalvular Leak Closure Under Monitored Anesthesia Care, Procedural and Clinical Outcomes. First Reported Experience in the United States



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BACKGROUND Paravalvular leaks (PVL) are a well-recognized complication of prosthetic valve replacement. Most are asymptomatic and benign, but some may cause symptoms due to a large regurgitant volume or hemolysis. Surgical repair of paravalvular leak carries significant morbidity and mortality. The percutaneous approach of paravalvular leak is emerging as an alternative treatment for high-risk surgical candidates.

METHODS We investigated a cohort of patients admitted electively for catheter-based treatment of symptomatic prosthetic paravalvular regurgitation from Jan 2013 to June 2017. Both mitral and aortic valve PVLs were studied. Patients demographics, risk factors, procedural indications and outcomes, In-hospital and thirty-day mortality were all reported.

RESULTS A total of 22 patients were included (55% aortic & 45% mitral). Average hospital stay was 1-2 days (1.5 days overall cohort, less than 24 hours for the aortic subgroup). All cases were performed under moderate sedation. Technical success of the procedure was 100%. Procedural success as defined by any significant residual shunt was 77%. No procedural death reported. Short-term mortality during the first 30 days was less than 1%.

CONCLUSION Elective catheter-based repair of symptomatic prosthetic paravalvular regurgitation appears to be safe and effective. The use of moderate sedation with monitored anesthesia care resulted in short hospital stay.

LEFT ATRIAL APPENDAGE

CRT-700.40

Patients Undergoing Left Atrial Appendage Closure Aged Over 80 Years Present More Bleeding Events Than Predicted by HAS-BLED Score. Results of the Iberian Registry



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BACKGROUND The elderly is a sub-group of patients with an increased risk of bleeding events. We explored whether age affects the risk of gastrointestinal (GI) and major bleeding in non-valvular atrial fibrillation patients undergoing left atrial appendage closure (LAAC).

METHODS AND RESULTS The Iberian Registry compared two populations with non-valvular atrial fibrillation aged < or ≥80 years (465 vs 133 patients). Mean age was 71 vs 83 (p<0.001). CHA₂DS₂-VASc scores were 4.2±1.5 vs 5.1±1.4 (p<0.001) and HAS-BLED scores were 3.3±1.2 vs 3.5±1.1 (p=0.248). Events are presented as follow-up adjusted rate deaths: 5.7% vs 13.7% (p<0.001), stroke: 1.8% vs 2.5% (p=0.56), ICH: 0.7% vs 0.5% (p=0.64), GI bleeding: 2.8% vs 9.1% (p<0.001), and major bleeding: 4.3% vs 13.3% (p<0.001) patient-years. A significant decrease in GI bleeding events appears after 1 year with patients aged <80 years (0.5% vs 2.9% patient-years).