

EDITORIAL COMMENT

Heterotopic Transcatheter Tricuspid Valve Implantation



A Useful Bailout Strategy After Failed Transcatheter Tricuspid Valve Repair?*

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In this issue of *JACC: Case Reports*, Costa et al¹ reported an interesting case of caval valve implantation (CAVI) using the TricValve system (P+F Products + Features) as a bailout strategy following unsuccessful tricuspid transcatheter edge-to-edge repair (T-TEER) because of partial detachment of a TriClip XT (Abbott).

The 71-year-old female patient had multivalvular rheumatic heart disease and underwent mitral valve replacement because of mitral stenosis. As a second step, symptomatic aortic stenosis was treated with the transfemoral implantation of a self-expanding transcatheter valve.

Following open heart surgery, worsening right ventricular (RV) dilatation and secondary tricuspid regurgitation (TR) have been observed in 31% of patients with rheumatic heart disease.² Redo surgical procedures to correct TR have been associated with excessive mortality, which is confirmed by a calculated TRI-SCORE of 7 of 12, predicting a risk of in-hospital mortality of 34% in the presented patient.³ In this context, transcatheter treatment of the tricuspid valve represents an appropriate and safe approach.

During the initial T-TEER procedure, detachment of 1 of the 3 implanted clips occurred, leading to

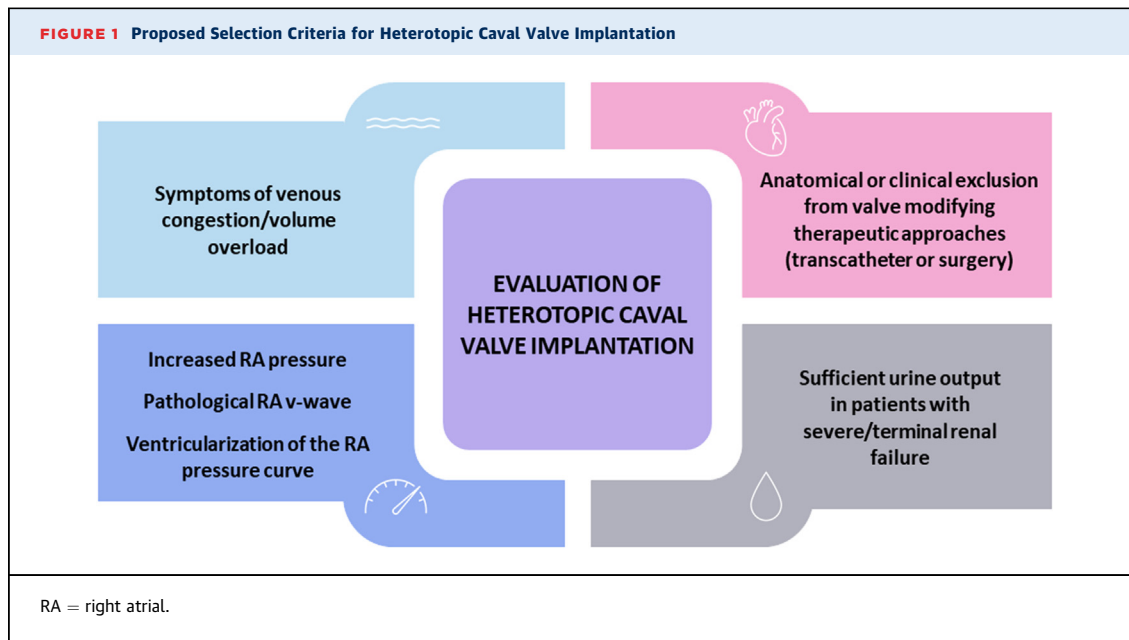
recurrent severe TR. With a prevalence ranging from 3% to 7% in published studies,^{4,5} single-leaflet device attachment is a frequent complication during or early after T-TEER, in particular in patients with suboptimal imaging because of shadowing, as sometimes observed in the presence of a mechanical mitral valve prosthesis. Previously described management strategies include stabilization using additional implants, conversion to surgery, transcatheter valve replacement, or caval valve implantation.⁶⁻⁸

The device used in this patient, the TricValve system, consists of 2 self-expanding nitinol stents with bovine pericardial leaflets, each of them specifically designed to be implanted in the superior and the inferior vena cava with the aim of alleviating congestive symptoms. The 6-month results of the European approval single-arm study, the TRICUS EURO (Safety and Efficacy of the TricValve® Transcatheter Bicaval Valves System in the Superior and Inferior Vena Cava in Patients With Severe Tricuspid Regurgitation) registry (12 centers), have been published recently and described good technical and procedural success. Furthermore, the study reported functional improvement (Kansas City Cardiomyopathy Questionnaire [KCCQ-12] score from 42.01 ± 22.3 points at baseline to 59.7 ± 23.6 at 6 months [$P = 0.004$]; patients in New York Heart Association functional class I or II from 0% at baseline to 79.4% at 6 months). Six-month all-cause mortality and heart failure hospitalization rates were 8.5% and 20%, respectively.⁹

Another dedicated caval valved stent, the Tricento system (New Valve Technology), is available in Europe and has shown comparable performance in a recently published multicenter retrospective study.¹⁰ Using cardiovascular magnetic resonance

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imaging in a subgroup of patients, evidence of RV remodeling was observed at 6 months, while fractures of the custom-made stent have been detected by systematic 4-dimensional computed tomography and triggered changes in design and patient selection criteria. Compared to the off-label use of transcatheter aortic valves, dedicated caval systems appear safer and less prone to dislocation.¹¹

Considering the technical complexity of transcatheter tricuspid valve interventions with still limited expertise and availability, as well as the high dependency on sufficient imaging conditions, CAVI may represent a simple palliative treatment alternative for patients with advanced right heart failure and no other therapeutic option. Because symptomatic response is not uniformly observed, careful patient selection, including invasive hemodynamic assessment, is required (Figure 1). Resolution of venous renal congestion (or “renal tamponade”) may represent one of the main pathophysiologic mechanisms conditioning clinical response, and therefore sufficient urine output may play a role in patients with severe or terminal renal failure.¹² Patients with failed T-TEER may be particularly suitable because the valve is generally no longer amenable to other treatment modalities due to additional still attached clips (as in the present case), interaction with the detached device,

or already increased transvalvular gradient.^{7,8} Furthermore, the heterotopic position may allow for a second intervention through the valved stent, if required.^{8,13,14}

As another interesting aspect, the presented case highlights the role of multimodality imaging during work-up but also the use of computed tomography fusion to identify the contours of the right atrium and the location of the hepatic veins, 2 key anatomic landmarks during caval valve implantation.¹⁵

Against the background of the modest clinical response and the risk of progression of RV dysfunction discussed in the present case, further studies are certainly needed to understand the exact role of CAVI in the emerging landscape of transcatheter tricuspid interventions.

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