Abstracts

Regurgitation with MitraClip – Western Percutaneous Treatment of Mitral

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Percutaneous Treatment of Mitral Regurgitation with MitraClip – A Western Australian Experience

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Objectives: Severe symptomatic mitral regurgitation (MR) is associated with significant morbidity and mortality without treatment. Percutaneous edge-to-edge repair of severe MR with MitraClip has emerged as an alternative to surgical treatment for high risk or inoperable patients. This study aimed to describe our experience of MitraClip implantation in Western Australia over the past seven years.

Methods: Data of patients who underwent MitraClip implantation at Sir Charles Gairdner Hospital between January 2011 and December 2017 were retrospectively collected and analysed.

Results: Ninety-five high-risk consecutive patients with severe MR (grade 3+ or more) underwent MitraClip implantation (mean age 77.5 ± 10.1 years). Mean Society of Thoracic Surgeons (STS) mortality score was 7.98% (33.7% of patients had STS score ≥ 8%) and 96.8% of patients were in New York Heart Association (NYHA) class III or IV. Pre-procedural mean left ventricular ejection fraction was 45.1% ± 17.2%. Device implantation was successful in ninety-four patients (98.9%). There were no acute deaths or myocardial infarctions. One patient (1.1%) suffered a post-procedural stroke without permanent neurological deficits. Median post-procedural length of stay was 2 days, with 82 (86.3%) patients being discharged home. Actuarial survival was 100%, 97.9% and 88.4% at 30 days, 90 days and 1 year respectively. At 12 months, 81.1% of survivors were NYHA class II or less.

Conclusions: At our centre, MitraClip implantation was carried out with high procedural success and low complication rates. There was successful post-procedural reduction of MR severity and sustained improvements in NYHA class at 12 months.

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Pericardiocentesis for Pericardial Effusion – a Single Centre Experience

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Background: Diagnostic and therapeutic drainage of pericardial effusions can be performed percutaneously or surgically.

Methods: A retrospective audit was performed for consecutive patients who underwent pericardiocentesis at Liverpool hospital from February 2018-January 2019 using the hospital electronic medical record.

Results: 34 patients required drainage of pericardial effusions. Mean age was 60.8 ± 19.4 years (55% male). 25/34 (74%) were performed percutaneously by Cardiologist with Cardiology AT performing the majority of cases (17/25). All were echocardiographic-assisted. 47% were performed after-hours. Mean effusion-maximal diameter was 2.77 cm ± 1.02 cm. 85% had echocardiographic features of tamponade and 71% had clinical features of tamponade. 33 (37%) were malignant, 9 (25%) iatrogenic (44% post-cardiothoracic surgery) and 4 (11%) were inflammatory. 11% took aspirin,17% DAPT and 26% were anticoagulated. Most common approach was subcostal (68%). Mean total drainage output was 770.8 ± 460 ml, average dwell time 54.7 h ± 31.4 h. 4/25 had fluid re-accumulation managed with surgical pericardial window. Complications occurred in 2/25 cases [1 RV needle perforation successfully surgical repaired, 1 death from cardiac arrest from pacing wire perforation]. 9/34 (26%) had initial surgical management and were more likely to be loculated and posterior or post-surgical with suspected clot tamponade. There was 1 failed drainage and 1 death in the surgical group. Surgical management was associated with an increased ICU-stay (mean 2.7 ± 4.5 days) compared to nonsurgical (0 days).

Conclusion: Percutaneous pericardiocentesis is a successful approach to draining pericardial effusions. Complications are rare and commonly successfully surgically managed.

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