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COLEGIO ARGENTINO DE CARDIOANGIÓLOGOS INTERVENCIONISTAS

SAC.25
y el 21° Congreso Argentino de Cardiología Pediátrica

Aplicabilidad de las guías ESC de tratamiento en enfermedad valvular aortica 2025 en Argentina

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ESC Congress 2025 Madrid
TOGETHER WITH
World Congress of Cardiology
29 August to 1 September

2025 ESC/EACTS Guidelines for the management of valvular heart disease

Developed by the task force for the management of valvular heart disease of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS)

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HIPOTESIS:

Los cambios de las **guías ESC 2025** en **pacientes** con **estenosis aortica severa** son **aplicables** a nuestra realidad sanitaria **en Argentina en 2025**

ESC Guidelines for the management of valvular heart disease (European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194

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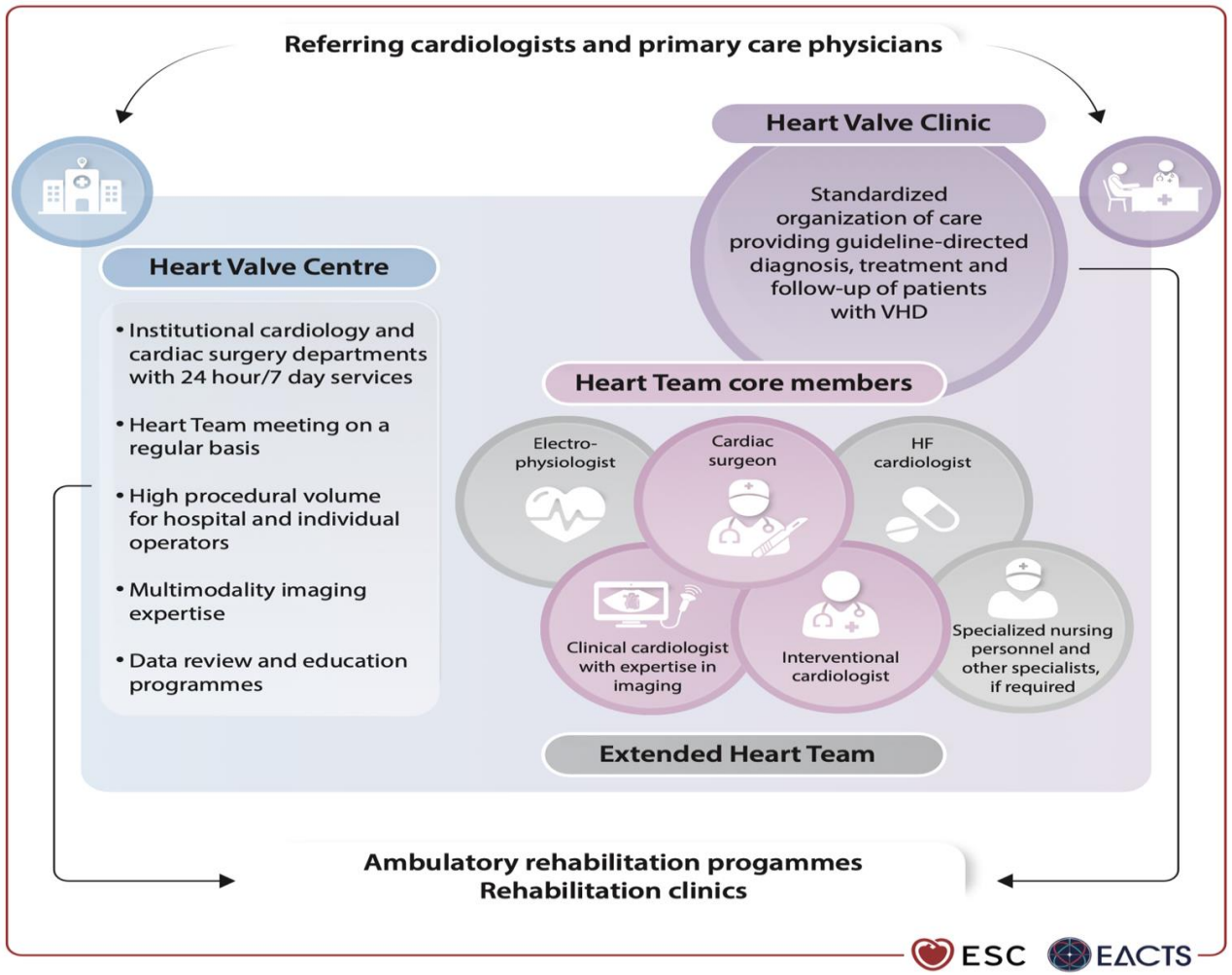
01

HEART TEAM

Equipo multidisciplinario que interviene en la decisión



ESC Guidelines for the management of valvular heart disease (European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194

Actualización 2024 del Consenso sobre Implante Valvular Aórtico Percutáneo del Colegio Argentino de Cardioangiólogos Intervencionistas

En pacientes de entre 70 y 80 años con una evaluación geriátrica con riesgo aumentado, el TAVI es	I	A
una alternativa razonable a la RVAo siempre que	I	A
el acceso femoral sea factible. Clase I. Nivel de evidencia A.	II	C
Se recomienda discutir en el Heart Team en casos de riesgo intermedio y anatomía de riesgo para TAVI como raíz aórtica adversa, ostium coronario bajo y válvula bicúspide.		

RACI 2025;(1):0194-0210

Requirements for a Heart Valve Centre

Requirements
Centre performing heart valve procedures with on-site interventional cardiology and cardiac surgery departments providing 24 h/7 day services. **Heart Team core members:** Cardiologist with imaging expertise, interventional cardiologist, cardiac surgeon. **Additional specialists, if required (Extended Heart Team):** Specialized nursing personnel, HF specialist, electrophysiologist, cardiovascular anaesthetist, geriatrician, and other specialists (e.g. intensive care, vascular surgery, infectious diseases, neurology, radiology). The Heart Team must meet on a regular basis and work according to locally defined standard operating procedures and clinical governance arrangements. A hybrid cardiac catheterization laboratory is desirable. High volume for hospital and individual operators.
Multimodality imaging (including advanced echocardiography, CCT, CMR, and nuclear techniques) and expertise in peri-procedural imaging guidance of surgical and transcatheter procedures.
Heart Valve Clinic for outpatient assessment and follow-up.
Data review: continuous monitoring, evaluation, and reporting of procedural volumes and quality indicators, including clinical outcomes, as well as PROMs complemented by local/external audits. Education programmes targeting primary care and referring physicians, operators, and diagnostic and interventional imaging specialists.

ESC Guidelines for the management of valvular heart disease
(European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194)

Complex procedures ideally performed in the most experienced Heart Valve Centres

ESC EACTS

Transcatheter interventions	Surgical interventions

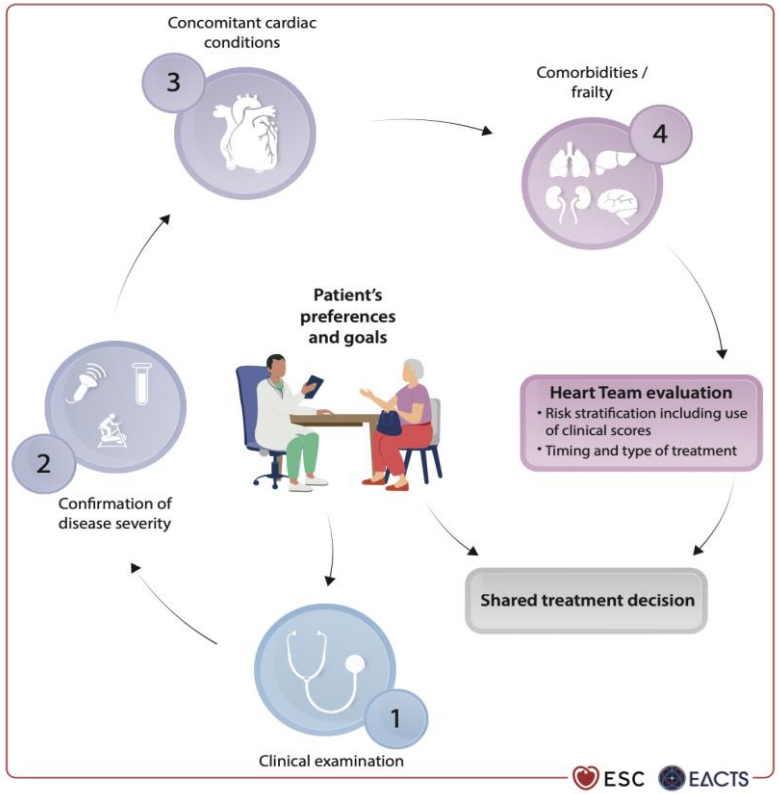
• Transfemoral TAVI in patients with high-risk features:
  ○ Low coronary ostia
  ○ Difficult femoral anatomy
  ○ Bicuspid valve
  ○ Severe calcification protruding into the LVOT
  ○ Severe LV and/or RV impairment
  ○ Pure AV regurgitation
  ○ Multiple valve disease
  ○ Complex coronary artery disease
  ○ Severe extracardiac disease (e.g. renal failure, PH)
• Non-transfemoral TAVI
• Valve-in-valve (including TAV-in-TAV)
• All leaflet modification procedures (BASILICA, LAMPOON etc.)
• PVL closure
• Complex M-TEER
• Redo M-TEER procedures
• Tricuspid or mitral valve-in-ring or valve-in-valve, valve-in-MAC
• TMVI
• All tricuspid procedures
	• High-risk procedures (especially in patients with LV and/or RV impairment)
	• Redo procedures
	• Minimally invasive and robotic valve surgery
	• Complex MV repair
	  ○ Barlow disease
	  ○ Anterior or bileaflet prolapse
	  ○ High risk of SAM
	  ○ Severe MAC
	• AV repair
	• Ross procedure
	• Valve surgery combined with complex surgery of the aorta
	• Endocarditis surgery

ESC Guidelines for the management of valvular heart disease (European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194

02

Preferencias del paciente

Patient-centred evaluation for treatment of valvular heart disease



TAVI is recommended in patients ≥70 years of age with tricuspid AV stenosis, if the anatomy is suitable.[d] 1–4,389–397,465,485,486	I	A
SAVR is recommended in patients <70 years of age, if the surgical risk is low.[e] 413,429,487	I	B
SAVR or TAVI are recommended for all remaining candidates for an aortic BHV according to Heart Team assessment. 2,4,396,397,429,488–490	I	B

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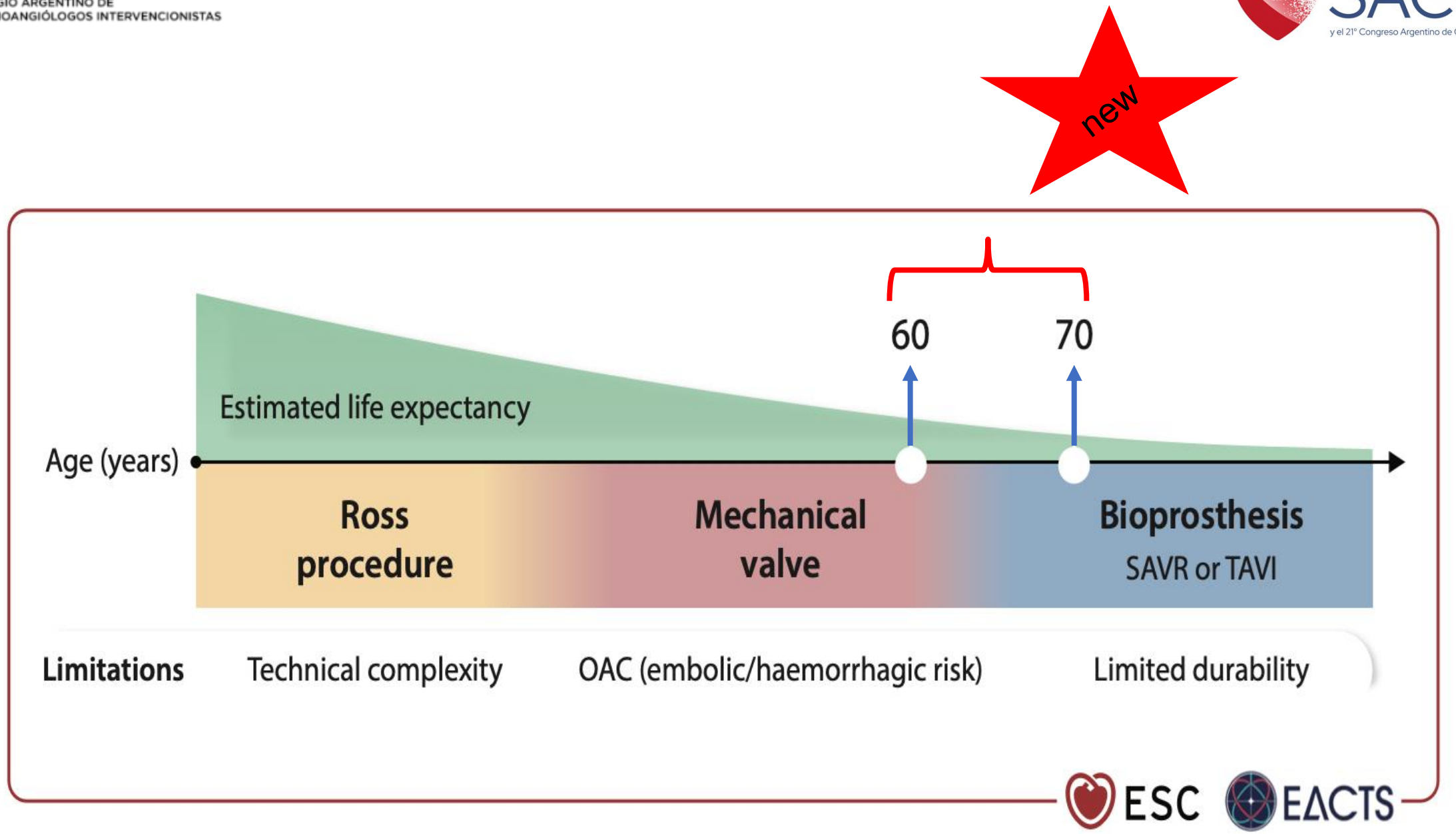
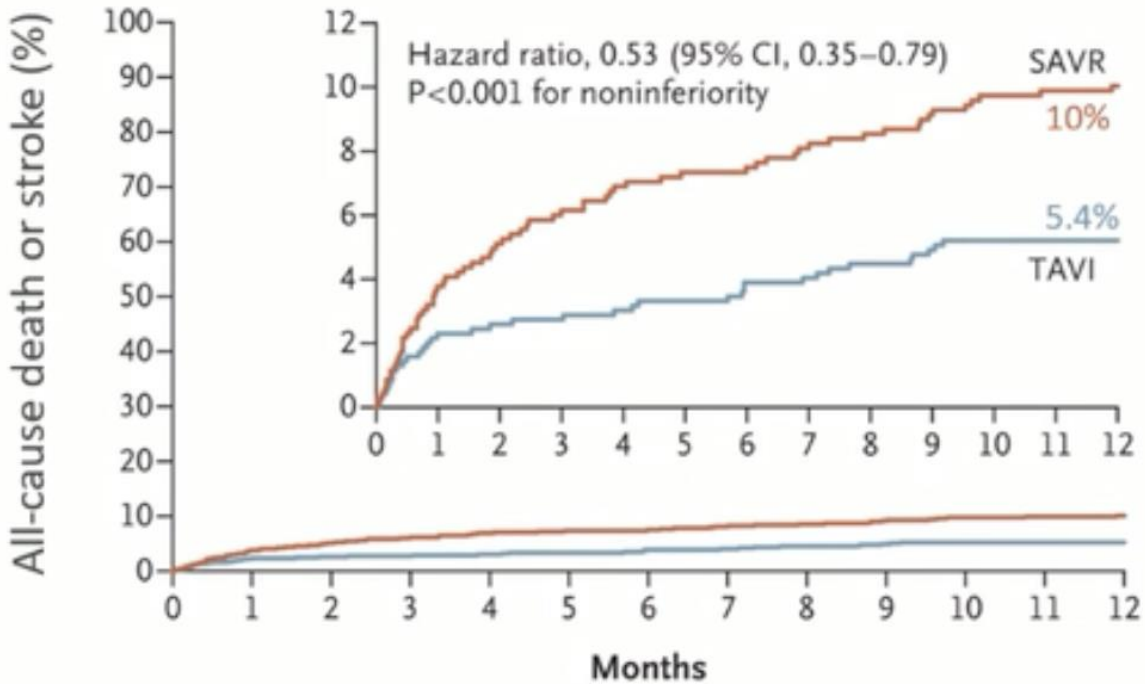

new
60
70
Estimated life expectancy
Age (years)
Ross procedure
Mechanical valve
Bioprosthesis
SAVR or TAVI
Limitations
Technical complexity
OAC (embolic/haemorrhagic risk)
Limited durability
ESC
EACTS

DEDICATE

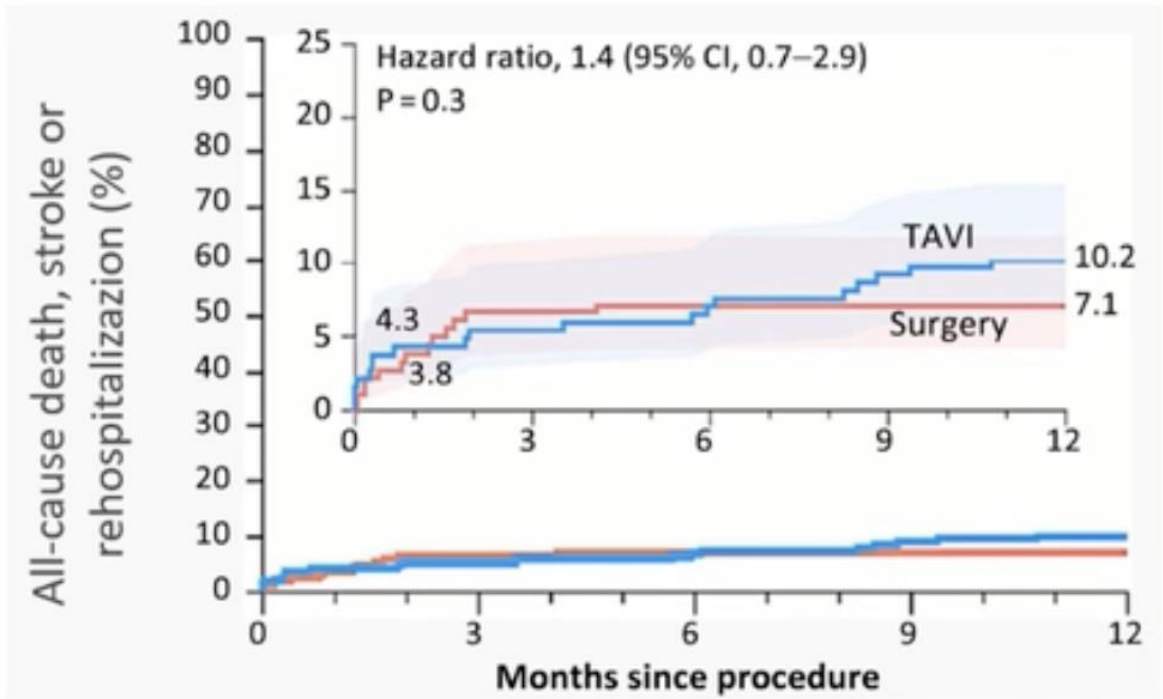
1414 patients, mean age 74 years (50% < 75 yrs)



Blankenberg et al. N Engl J Med 2024;390:1572-83

NOTION 2

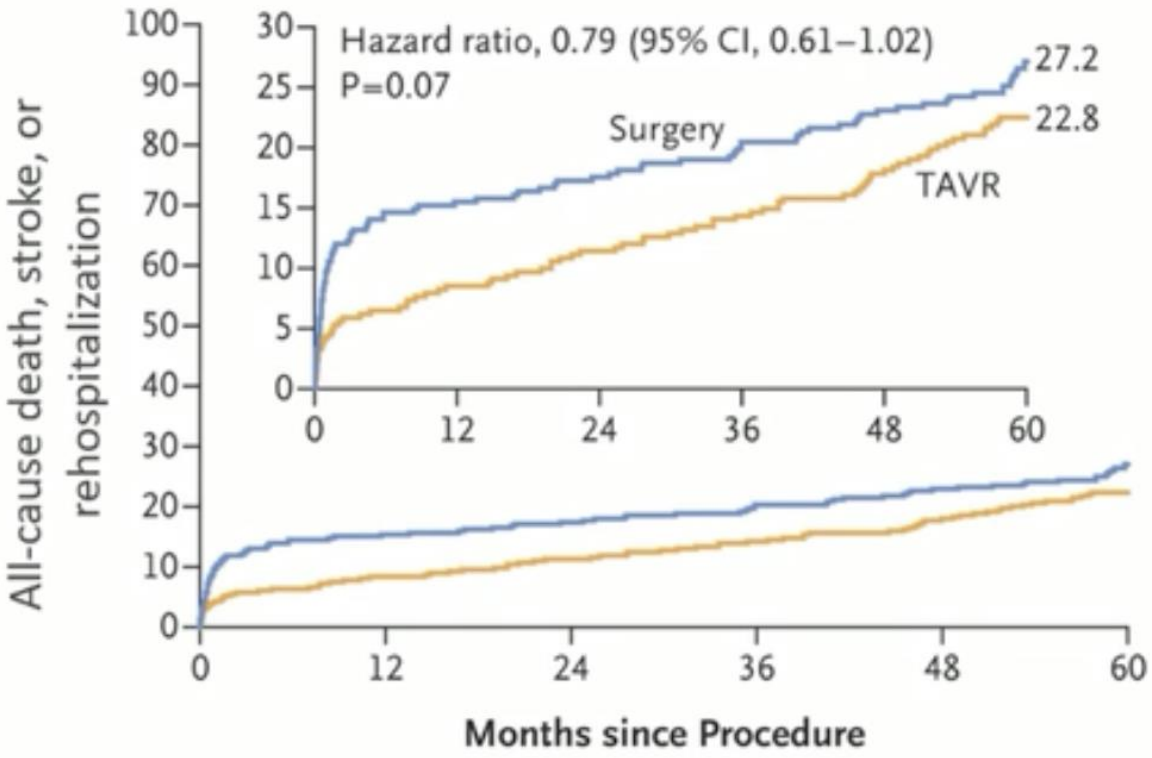
370 patients, mean age 71.1 years (all < 75 yrs)



100 patients with BAV: 14.3% vs. 3.9% HR 3.8; 95% CI, 0.8 - 18.5

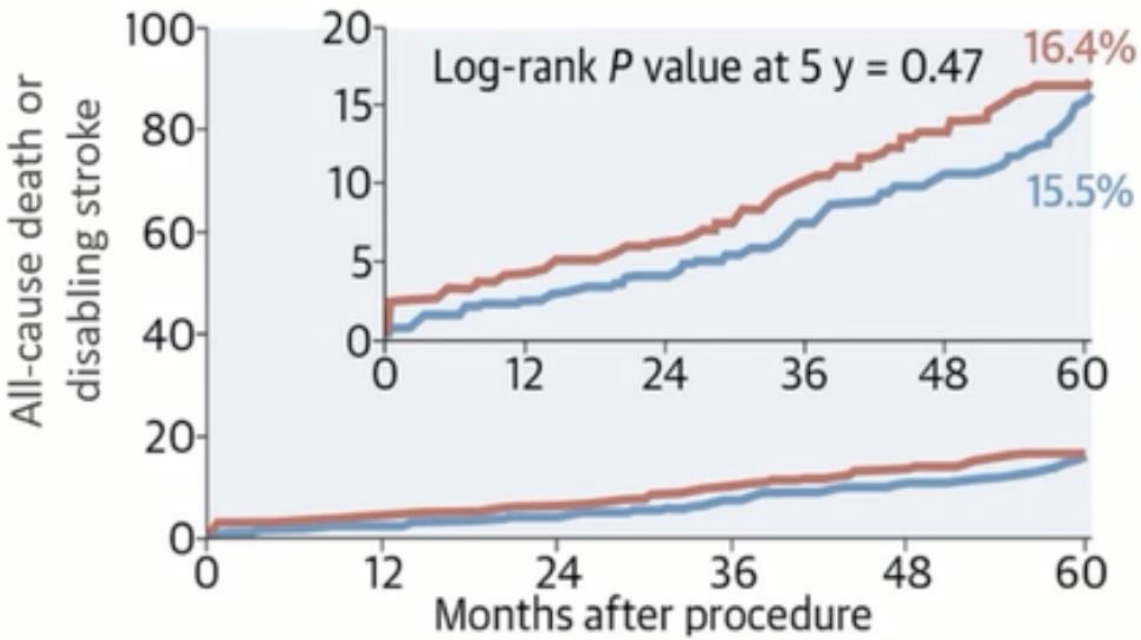
Jørgensen TH et al. Eur Heart J. 2024 Oct 5;45(37):3804-3814

PARTNER III (5 years)
1000 patients, mean age 73 years (56% < 75 yrs)

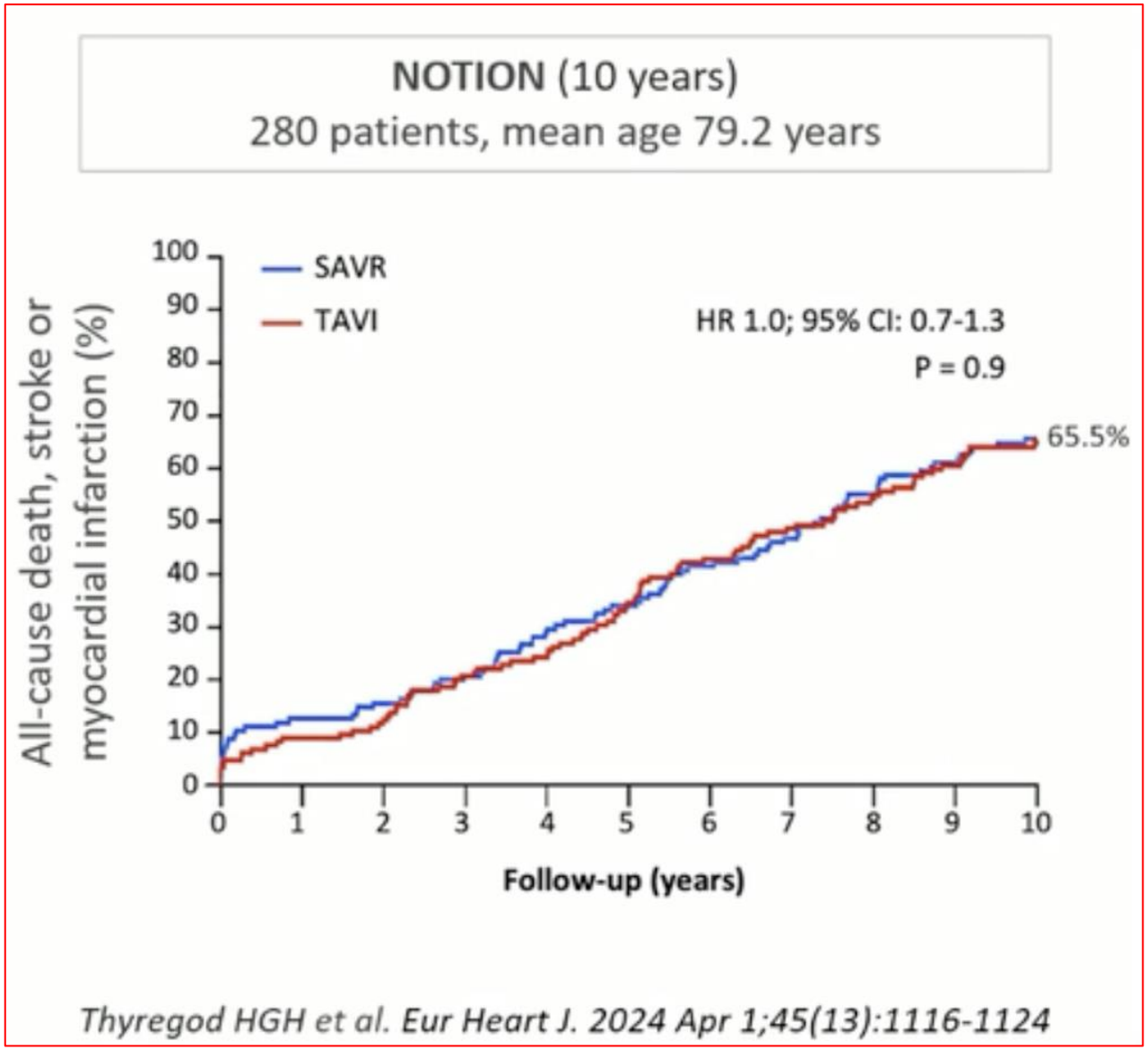


Mack M et al. N Engl J Med 2023;389:1949-1960

Evolut Low Risk (5 years)
1414 patients, mean age 74 (50% < 75 yrs)



Forrest JK et al. JACC 2025; 85:1523-1532.



Thyregod HGH et al. Eur Heart J. 2024 Apr 1;45(13):1116-1124

03

EAO sintomática

Cambios en guías ESC 2025

Recomendación para intervención en EA sintomática

Symptomatic patients with severe aortic stenosis		
Intervention is recommended in symptomatic patients with severe, high-gradient AS [mean gradient ≥40 mmHg, V_{max} ≥4.0 m/s, AVA ≤1.0 cm^2 (or ≤0.6 cm^2/m^2 BSA)].[388,471–474]	I	B
Intervention is recommended in symptomatic patients with low-flow (SVi ≤35 mL/m^2), low-gradient (<40 mmHg) AS with reduced LVEF (<50%) after careful confirmation that AS is severe.[342,345,346,348,475]	I	B

Irrespective of evidence of Flow (contractile) reserve

Recommendations in 2021 version	Class	Level	Recommendations in 2025 version	Class	Level
Indications for intervention in symptomatic severe aortic stenosis					
Intervention is recommended in symptomatic patients with severe low-flow (SVi ≤35 mL/m^2), low-gradient (<40 mmHg) AS with reduced LVEF (<50%), and evidence of flow (contractile) reserve.	I	B	Intervention is recommended in symptomatic patients with severe low-flow (SVi ≤35 mL/m^2), low-gradient (<40 mmHg) AS with reduced LVEF (<50%) after careful confirmation that AS is severe.	I	B
Intervention should be considered in symptomatic patients with low-flow, low-gradient (<40 mmHg) AS with normal LVEF after careful confirmation that the AS is severe	IIa	C	Intervention should be considered in symptomatic patients with low-flow (SVi ≤35 mL/m^2), low-gradient (<40 mmHg) AS with normal LVEF (≥50%) after careful confirmation that the AS is severe.	IIa	B

ESC Guidelines for the management of valvular heart disease (European Heart Journal: 2025 – doi: 10.1093/eurheartj/ehaf194

Estenosis Aortica severa y Enfermedad coronaria

new

recommendations (1)

ESC EACTS

Recommendations	Class	Level
Diagnosis of coronary artery disease		
Omission of invasive coronary angiography should be considered in TAVI candidates, if procedural planning CCTA is of sufficient quality to rule out significant CAD.	IIa	B
PCI should be considered in patients with a primary indication to undergo TAVI and ≥90% coronary artery stenosis in segments with a reference diameter ≥2.5 mm.	IIa	B
Indications for intervention in severe aortic regurgitation		
TAVI may be considered for the treatment of severe AR in symptomatic patients ineligible for surgery according to the Heart Team, if the anatomy is suitable.	IIb	B
Indications for intervention in symptomatic and asymptomatic severe aortic stenosis, and recommended mode of intervention		
Intervention should be considered in asymptomatic patients (confirmed by a normal exercise test, if feasible) with severe, high-gradient AS and LVEF ≥50%, as an alternative to close active surveillance, if the procedural risk is low.	IIa	A
TAVI may be considered for the treatment of severe BAV stenosis in patients at increased surgical risk, if the anatomy is suitable.	IIb	B

ESC Guidelines for the management of valvular heart disease (European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194

new

TAVI mas DAPT no es recomendable

Recommendations	Class	Level
Management of antithrombotic therapy in patients with a biological heart valve or valve repair		
Surgical biological heart valve without indication for oral anticoagulation		
Lifelong low-dose ASA (75–100 mg/day) may be considered 3 months after surgical implantation of an aortic or mitral BHV in patients without clear indication for OAC.	IIb	C
Transcatheter aortic valve implantation without indication for oral anticoagulation		
DAPT is not recommended to prevent thrombosis after TAVI, unless there is a clear indication.	III	B
Surgical repair without indication for oral anticoagulation		
Low-dose ASA (75–100 mg/day) may be considered after surgical MV or TV repair in preference to OAC in patients without clear indication for OAC and at high bleeding risk.	IIb	C
Surgical biological heart valve with indication for oral anticoagulation		
OAC continuation is recommended in patients with a clear indication for OAC undergoing surgical BHV implantation.	I	B
DOAC continuation may be considered after surgical BHV implantation in patients with an indication for DOAC.	IIb	B

ESC Guidelines for the management of valvular heart disease (European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194

04

EAO asintomática/bicúspide

Cambios en guías ESC 2025

new

Recomendación para intervención en EA ASINTOMÁTICA

Asymptomatic patients with severe aortic stenosis		
Intervention is recommended in asymptomatic patients with severe AS and LVEF <50% without another cause.[14,354–359]	I	B
Intervention should be considered in asymptomatic patients (confirmed by a normal exercise test, if feasible) with severe, high-gradient AS and LVEF ≥50% as an alternative to close active surveillance, if the procedural risk is low.[360–363,367,368]	IIa	A
Intervention should be considered in asymptomatic patients with severe AS and LVEF ≥50% if the procedural risk is low and one of the following parameters is present: • Very severe AS (mean gradient ≥60 mmHg or V_{max} >5.0 m/s).[14,362,363,482–484] • Severe valve calcification (ideally assessed by CCT) and V_{max} progression ≥0.3 m/s/year.[303,353,364] • Markedly elevated BNP/NT-proBNP levels (more than three times age- and sex-corrected normal range, confirmed on repeated measurement without other explanation).[97,365] • LVEF <55% without another cause.[14,354,356–359]	IIa	B
Intervention should be considered in asymptomatic patients with severe AS and a sustained fall in BP (>20 mmHg) during exercise testing.	IIa	C

new

ESC Guidelines for the management of valvular heart disease (European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194

new

Estenosis aortica bicúspide

Recommendations	Class	Level
TAVI may be considered for the treatment of severe BAV stenosis in patients at increased surgical risk, if the anatomy is suitable.	IIb	B

New

Recommendations	Class	Level
Non-transfemoral TAVI should be considered in patients who are unsuitable for surgery and transfemoral access.	IIa	B

Revised

ESC Guidelines for the management of valvular heart disease (European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194

Mensaje Final

ANATOMI
ANILLO
ANATOMIA
ACCESOS
NO FUTILI
DECISION HEART TEAM
COBERTURA MEDICA

ACCESIBILIDAD LIMITADA AUN EN CONDICIONES FAVORABLES

Muchas gracias por su atención