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Bilateral occlusion of the femoral veins: Does it constrain a melody implantation?**Artem Gorbatykh**

Ministry of Health, Russia

Aim: To present an experience of transcatheter valve implantation in patient with right outflow tract dysfunction without vascular approach.

Methods: A 16 year old boy, 46 kg, with repaired complex D-transposition of the great arteries (D-TGA, VSD and LVOTO) was admitted after Rastelli procedure with RVOT reconstruction using xenograft, initially modified B-T shunt was performed at the age of 1 month. After 1 year of complete repair, a conduit reimplantation had been performed due to gradually increasing gradient. 3 years later, he underwent LVOT reconstruction with expansion of the tunnel from LV to aorta using pericardial patch. Within next 4 years, he had undergone another two reconstructions of the RVOT with homografts. Following the 5-year period without hospitalization, the severely increased gradient on the homograft required reintervention and balloon dilatation had been performed through the right jugular vein due to bilateral femoral veins thrombosis. Patient was discharged with satisfactory result: RV pressure was decreased from 90% to 50% from systemic pressure. After 1 year, pressure gradient on RVOT was increased to 80 mmHg. The reoperation risk was very high and for the reason of absence of vascular access, the hybrid approach was chosen.

Results: Melody valve implantation through the parietal wall of the RV was performed. Initially obstructed area was dilated with 18×40 mm balloon. On angiography there was laminar flow through the pulmonary valve, right ventricular pressure was 46/3 mmHg. According to TEE peak pressure gradient on conduit was 27 mmHg.

Conclusion: Femoral veins thrombosis does not restrain transcatheter reconstruction of the RVOT. Using of the transventricular hybrid approach for pulmonary valve implantation is an acceptable alternative in absence of vascular access.

a.gorbatykh@mail.ru