My best and worst Mitraclip case of the year: The single most important lesson learned

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Conflict of Interests

• Proctor for Mitraclip- Abbott
Extreme DMR case

• 62 y. old male pharmacist
• Extreme kyphoscoliosis
• Paraplegia from old polio, moving around on electric vehicle
• Pulmonary oedema 10 days before, intubated and the tracheotomy
• Known history of Mitral prolapse under ‘watchful waiting’
• On continuous Furosemide and Noradrenaline infusion
• Rejected by the Surgeons
FLAIL A3-P3 RESCUE PROCEDURE
Lessons learned- issues raised

• Mitraclip is feasible in extreme prolapses, even commissural prolapses.
• Procedure tolerated even in the most unstable frail situation
• Results can be durable (12 months- MR ¼)
• What anatomy is unsuitable for Mitraclip?
Extreme FMR case

• 79 year old male
• CABG 8 years before
• Previous Inferior MI
• LVEF 35% with known MR (functional) on medical treatment
• Mild Renal Impairment
• 3 Admissions with pulmonary oedema over the last 1 month
• ‘Crushed’ upon arrival- intubated, inotropes
EXTREME FMR- NO COAPTATION
Lessons learned

• Mitraclip is a fast rescue procedure
• Can be tolerated by the most critically ill patients
• End-stage Heart Failure may be reversible if the MR plays a crucial role and the ventricle is not-dilated and severely impaired
Healed endocarditis

- 83 year old male
- Frailty, cachexia, worsening SOB over the last 3 months (NYHA IV)
- MDS
- Renal failure
- Hep. C, mild Liver cirrhosis
- History of prolonged fever 1 year before, negative investigation
Healed endocarditis
Lessons learned

• Vegetation in the grasping area may not be an absolute contraindication for a Mitraclip
• Potentially Higher risk for embolization
• Technique may produce acceptable results by ‘trapping’ the vegetation between clips.
Combined Mitral and Tricuspid repair
2 days later
Combined Mitral and Tricuspid clipping messages

- ‘One stop shop’ for two atrioventricular valves using a single technology
- Complementary synergistic results
- Imaging of Tricuspid leaflets may be challenging- switching to transthoracic may be required
- Learning curve