TAVR/I more prominently featured in latest guidelines

Key updates from the 2020 ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease related to severe symptomatic aortic stenosis (sSAS) and transcatheter aortic valve replacement/implantation (TAVR/I)

- TAVR/I is now a recommended approach to aortic valve replacement in adults aged 65 to 80 (pg 4)
- Multiple randomized trials (eg, PARTNER) have led to expanded TAVR/I indications (pg 4)
- TAVR/I is associated with shorter hospital stays, and lower risk of AF and major bleed/pain (pg 5)
- Guideline's focus has shifted from risk-focused to age-focused, emphasizing a multidisciplinary decision-making process (pgs 3-5)

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Overview

When intervention is considered, patients should be evaluated by a Heart Team (Class 1C-EO)

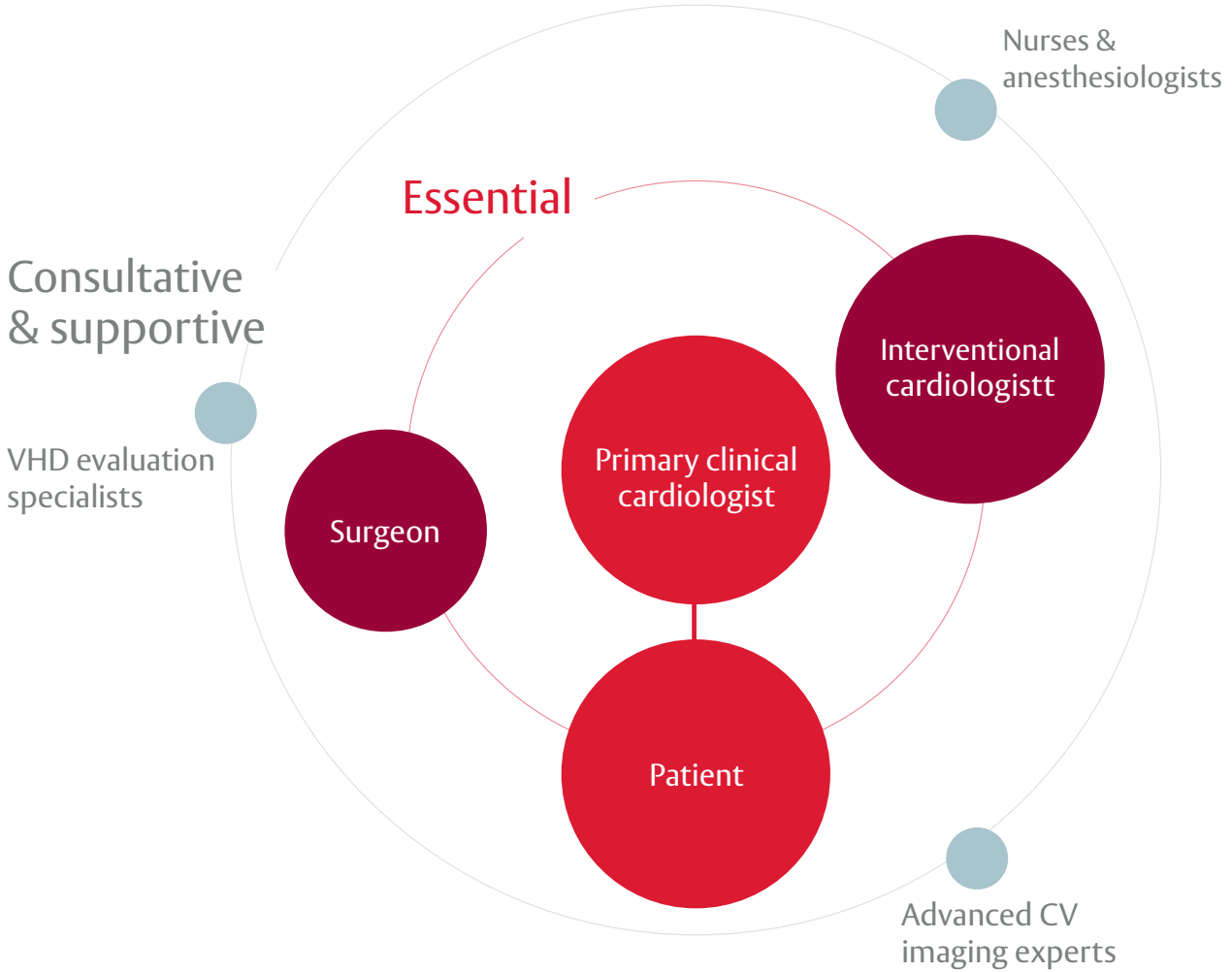
Engagement between the Heart Team and the primary clinical cardiologist is of critical importance

Recommendations for intervention now focus on age and shared decision-making

For sSAS patients 65 to 80 years old, TAVR/I should be considered, based on shared decision-making

All patients with severe valvular heart disease being considered for valve intervention **should be evaluated by a multidisciplinary team...”**

2020 ACC/AHA Guideline, Top 10 Take-Home Messages



Intervention and the Heart Team

Evaluations should be multidisciplinary and multi-institutional with essential roles working together to leverage consultative and supportive roles when needed.

TAVR/I is a recommended approach to aortic valve replacement in adults 65 to 80 years of age

2020 AHA/ACC guidelines on intervention recommendations by age

>80 years or life expectancy <10 years

65 to 80 years

For symptomatic patients with severe AS and no anatomic contraindication to transfemoral TAVR/I

Indications for TAVR/I are expanding as a result of multiple randomized trials, including the latest PARTNER trials, which are reflected in these recommendations.

Recommendations shift their focus

2014	2020
• Recommendations for choice of intervention were based primarily on level of surgical risk • Prohibitive, high, intermediate, and low	• Only use risk score to eliminate SAVR as an option for high or prohibitive risk patients • Utilize age as the key factor • Emphasizes a shared decision-making process that accounts for the patient's values and preferences

Guidelines recognize the benefits associated with TAVR/I,* independent of surgical risk

Shorter hospital length of stay

More rapid return to normal activities

Lower risk of transient or permanent AF

Lower risk of major bleed and pain

*When compared to SAVR. SAVR is associated with a lower risk of paravalvular leak, less need for valve reintervention, and permanent pacemaker.

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