VORBEREITUNG ZUR TRIKUSPIDALKLAPPENINTERVENTION

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TLE COMMUNITY & FRIENDS

The future belongs to those who prepare for it today!

WISSENSCHAFTLICHE LEITUNG:

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PATIENT HISTORY

- male patient, 66 years old
- NICM, NYHA III, HFrEF
- lobectomy, left lung 2012
- s.p. radiochemo 2013 lung tumor
- ICD (RA/RV, BS Charisma) 03/2020
- Persistent Afib 03/2020
- M-TEER 11/2023
- cirrhose cardiaque 01/2024
- ascites puncture 01/2024
- pneumonia 01/2024

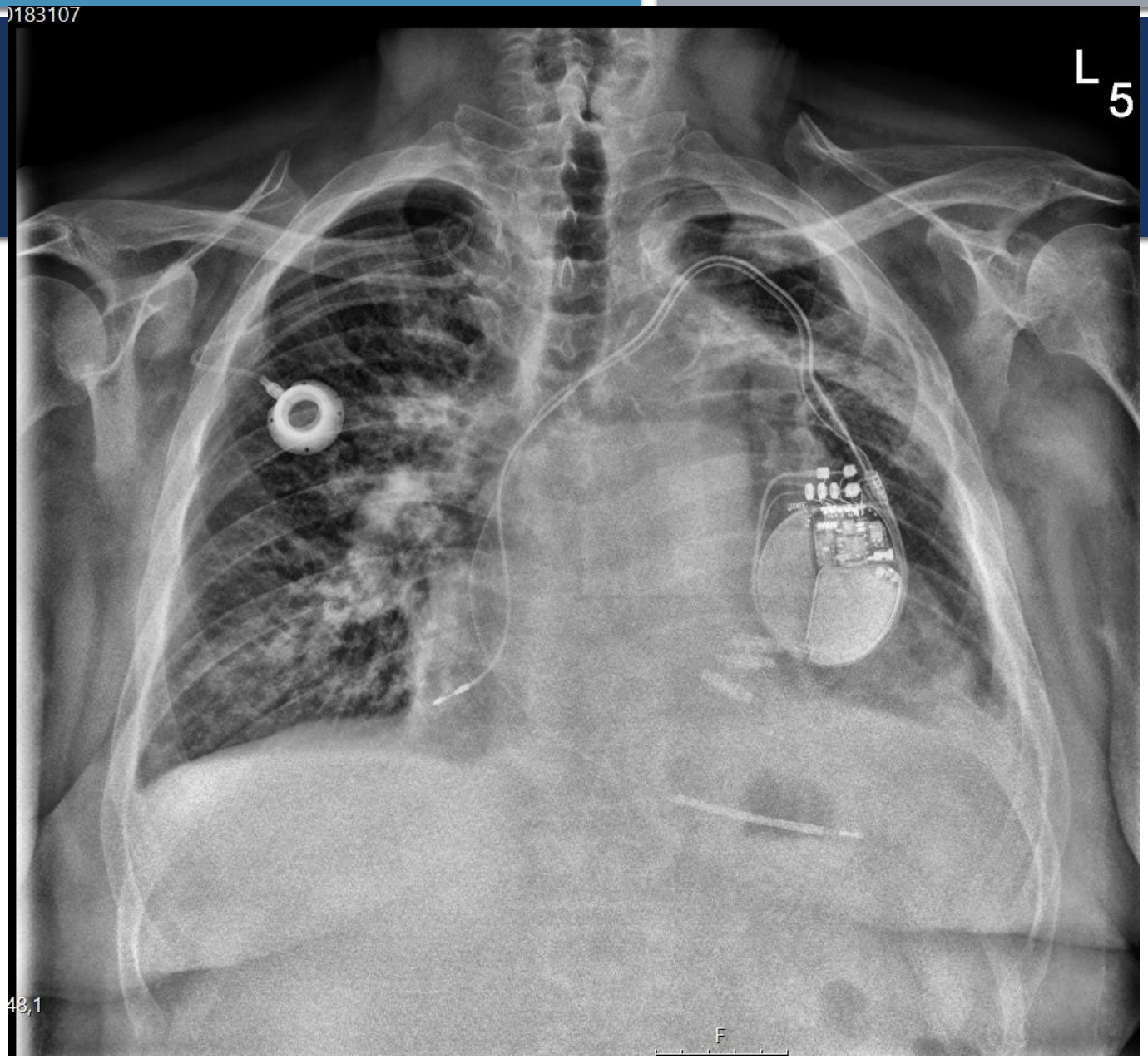
PATIENT HISTORY

- VT/VF with ICD shocks 01/2024

- Bild einfügen

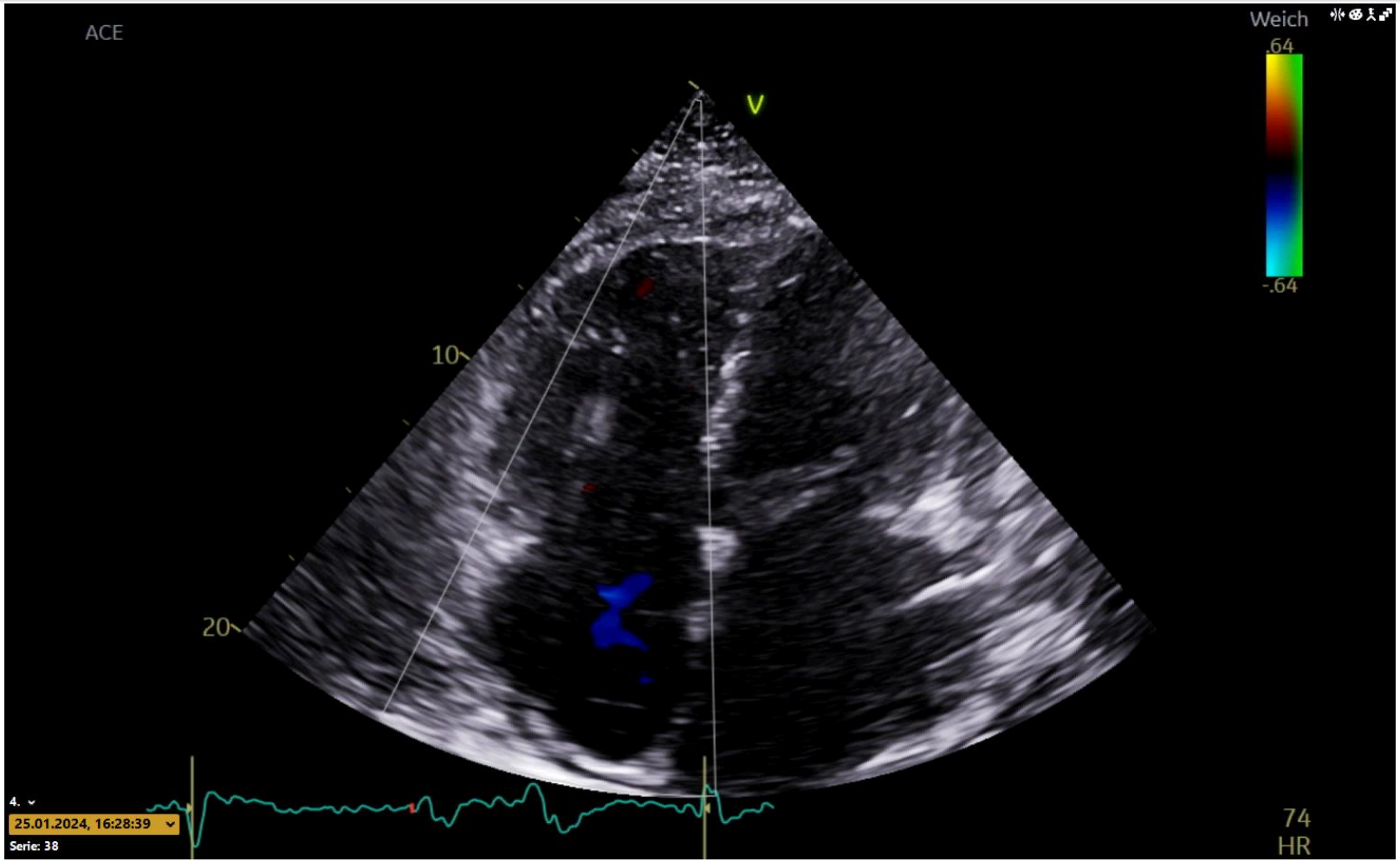
DIAGNOSTICS I

- X-ray



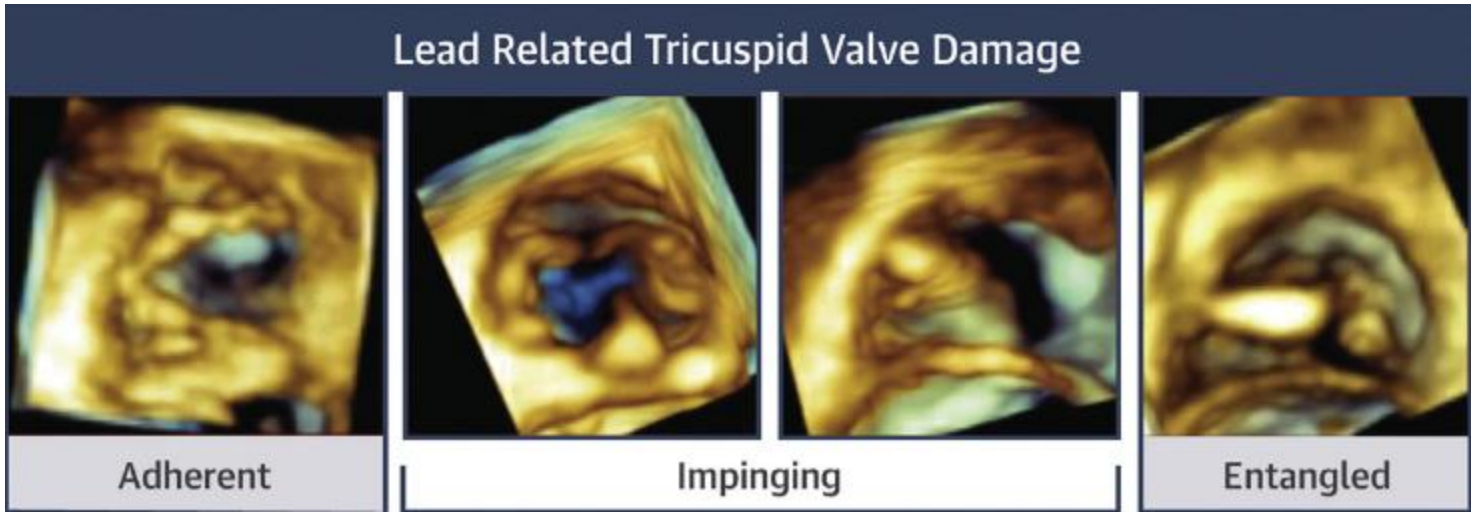
DIAGNOSTICS II

- TTE/TEE :TI III°



INDICATION

- Suspicion of lead induced TI
- Valve team: lead position correction
- - too frail for surgery
- - clipping if repositioning fails



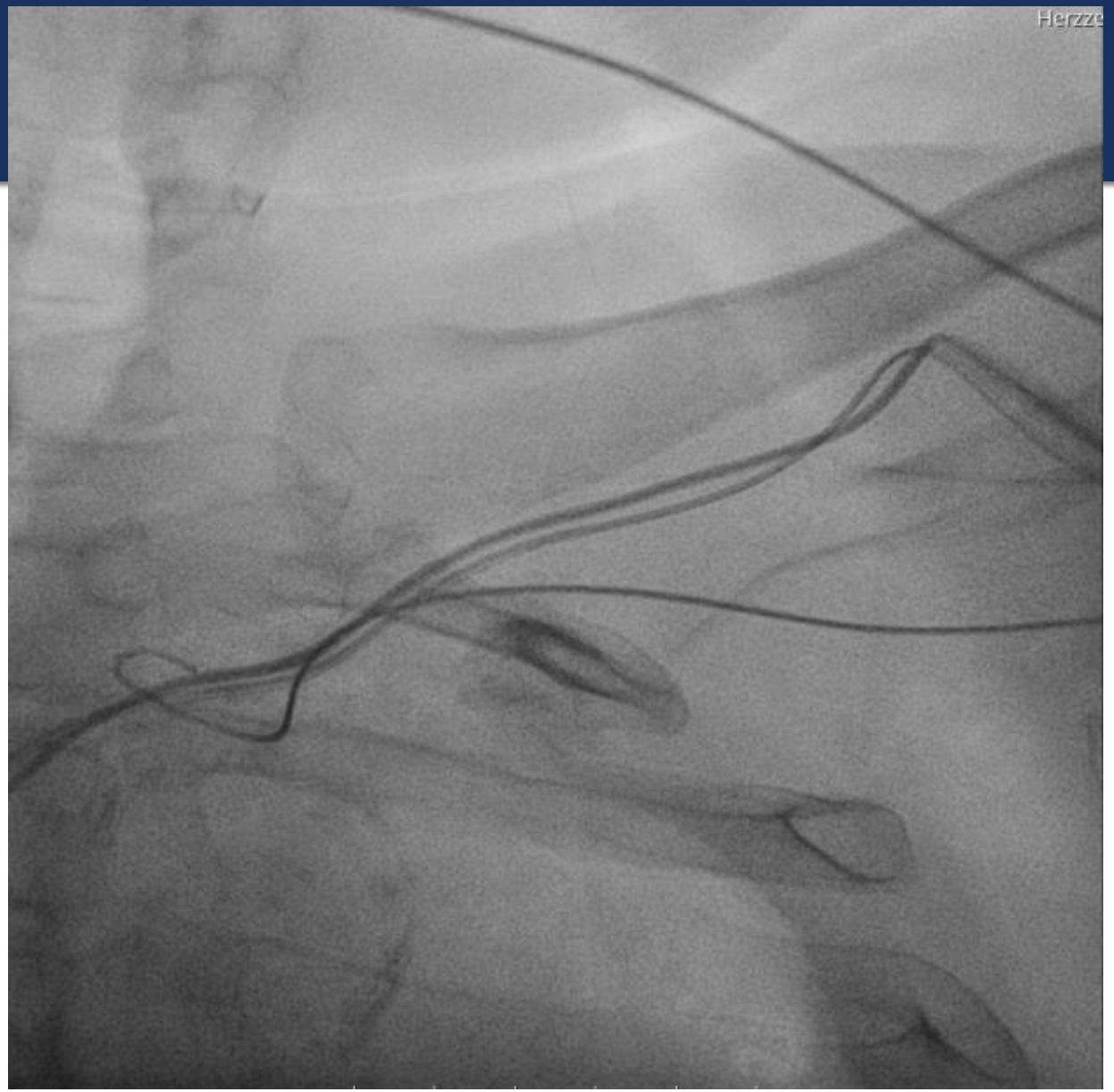
Lang et al, JACC CVI, Volume 12, Issue 4, April 2019,

PREPARATION

- deep sedation with midazolam, fentanyl, propofol
- arterial blood pressure monitoring (radial)
- 2 peripheral venous canules
- 2 6F femoral venous sheath
- need for CPAP ventilation
- cardiac surgeon in standby
- anaesthesiologist / perfusionist in standby
- 2 EP nurses, 2 TLE operators (combined experience > 1000 TLE
- 1 senior TEE operator

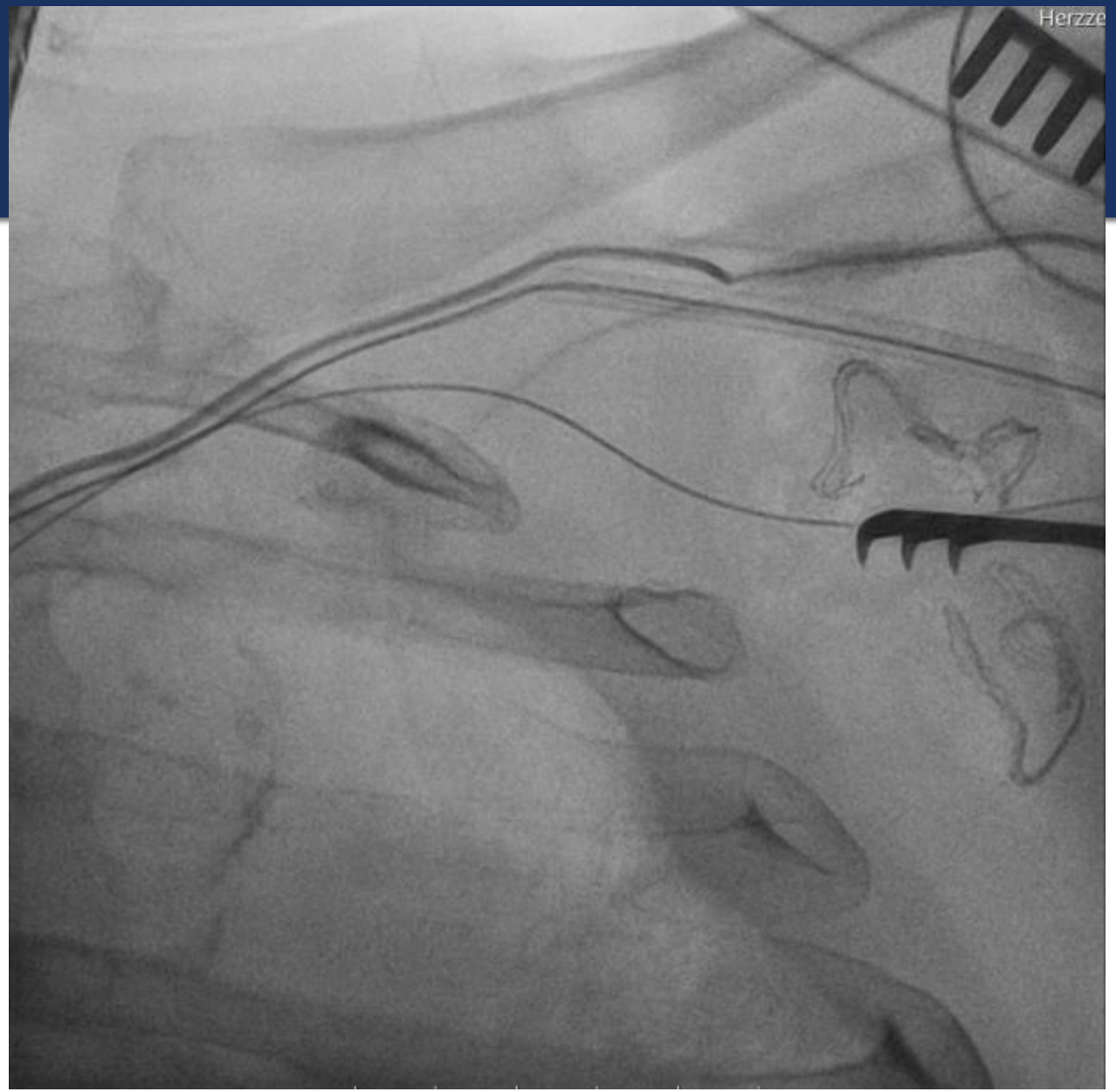
MANAGEMENT

- additional guidewire



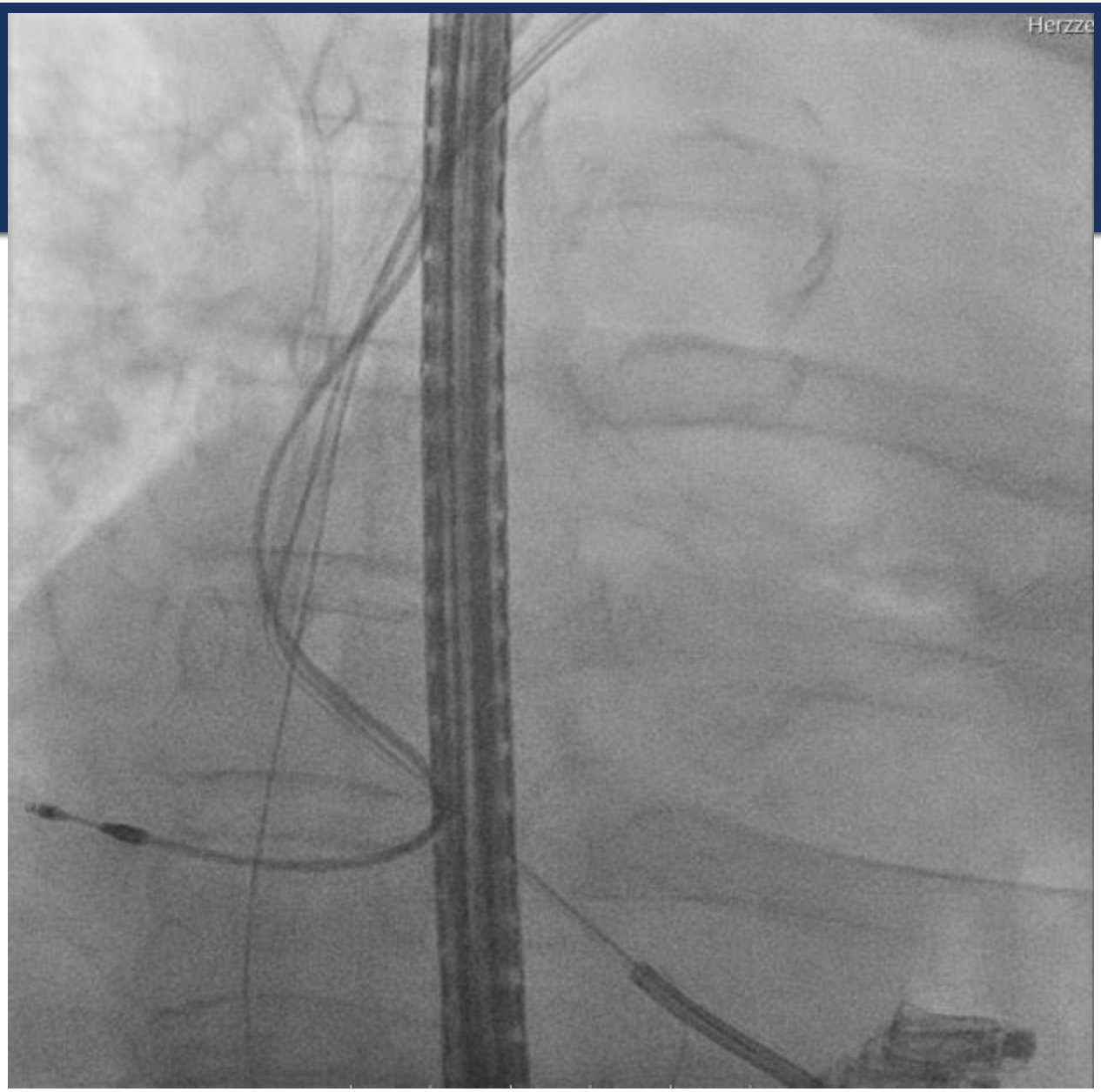
MANAGEMENT

- TLE via Byrd sheath



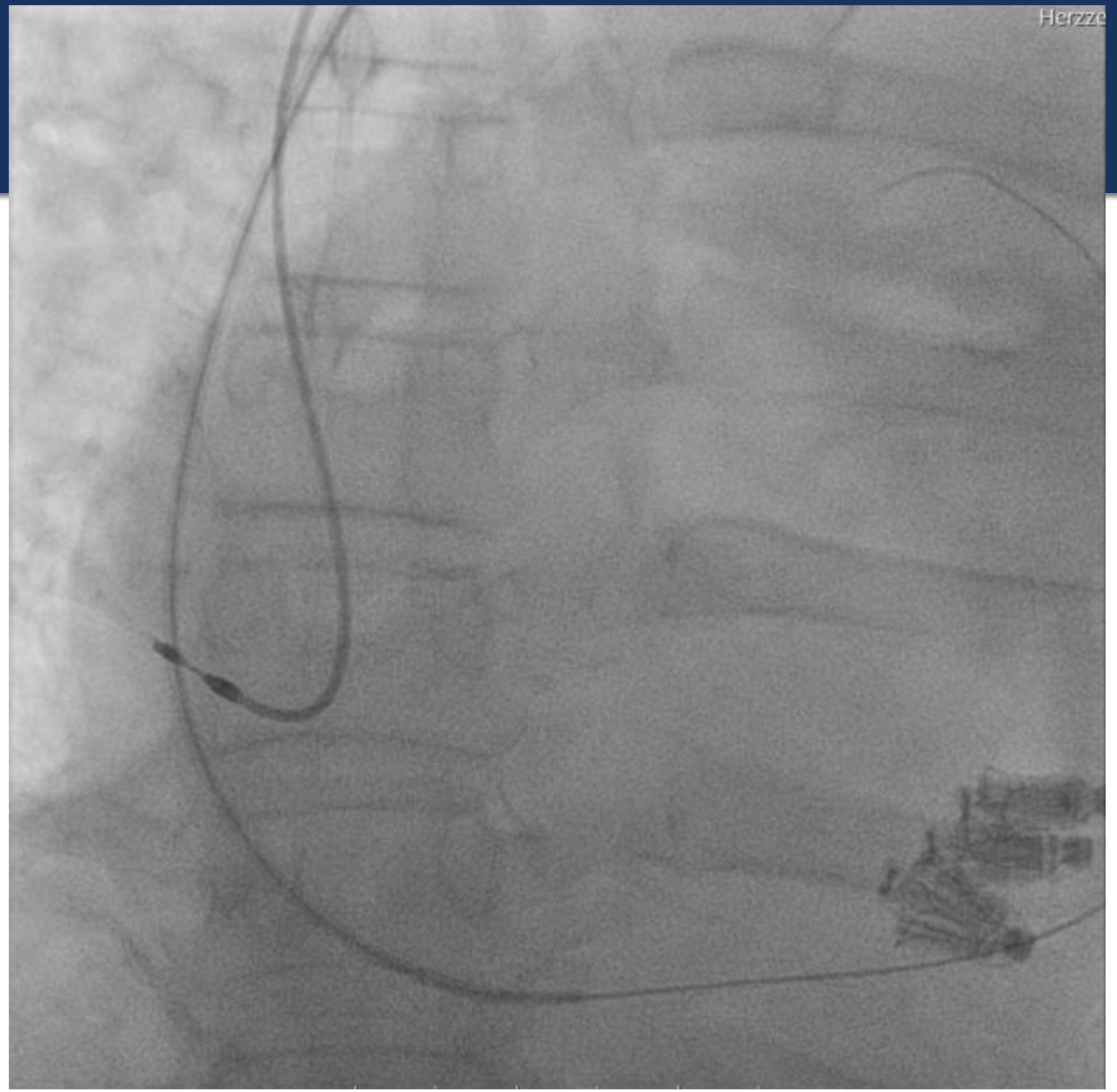
MANAGEMENT

- TEE guided TLE via Byrd sheath

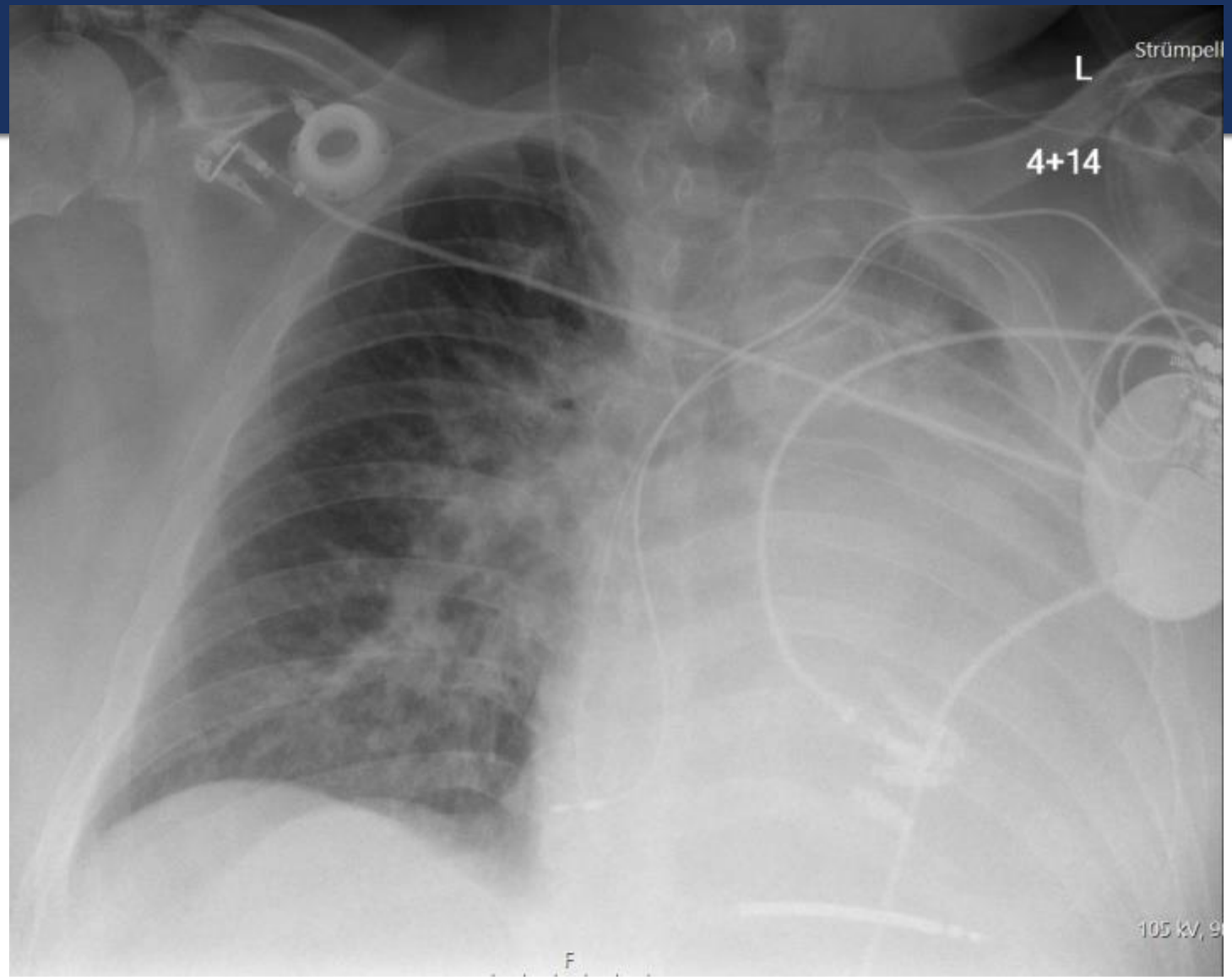


MANAGEMENT

- place stiff guidewire



OUTCOME



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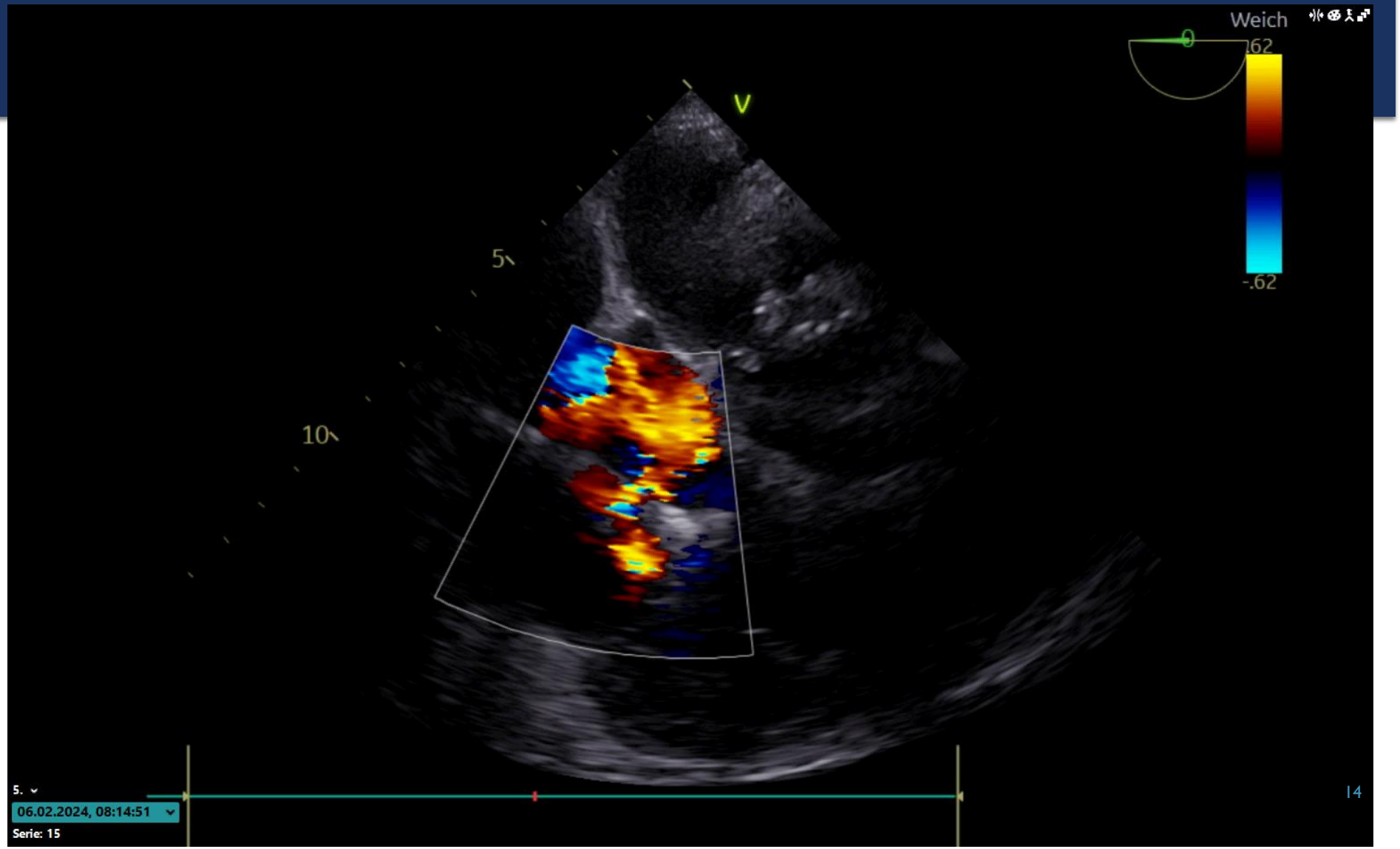

TAKE-HOME MESSAGE

- better can be the enemy of good (or not so bad)
- TI worsening occurs in 5-9% of all TLE cases (with rotational sheath)
- lack of evidence for routine TEE during and after TLE