



# Management of the valvular heart disease in the light of 2017 ESC/EACTS Guidelines for the management of valvular heart disease

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**D**uring Third Congress of the 34<sup>th</sup> American College of cardiology consortium chapter of Serbia and Republic of Srpska, **PR**actical aspects and comparative analysis of **ACC/AHA** and **ESC** guidelines **In Serbia 2018 (PRACSIS 2018)** in Belgrade February 23-24 will be held.

At the turn of this century valvular heart disease is coming in the focus of cardiologist with the first catheter-based valve implantation, soon followed by the first-in-man transarterial aortic valve implantation or TAVI in man. In the period from 2012, when the previous guidelines of valvular heart disease were published, new data in diagnosing and management of valvular heart disease have accumulated requiring new guidelines. New updated Guidelines made 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) were presented in August 2017 at the ESC Congress in Barcelona.

## Key messages from these 2017 ESC/EACTS Guidelines<sup>1</sup>

**1. Heart valve centres** are needed for high-quality care of patients with valvular heart diseases. These centers include highly specialized multidisciplinary teams, comprehensive equipment, and sufficient volume of procedures.

**2. Echocardiography** is the key technique for diagnosis of valvular heart diseases. Other investigations include stress testing, CMR, CT, fluoroscopy, biomarkers and coronary angiography (in situations where non-invasive evaluation is inconclusive).

**3. In patient with aortic stenosis** the strongest indication for intervention are symptoms (spontaneous or on exercise testing).

**4. In asymptomatic patients** the presence of predictors of rapid symptom development can justify early surgery.

**5. The decision between TAVI and SAVI** (surgical aortic valve implantation) should be made by the Heart Team after careful and comprehensive individual patient evaluation weighing risk and benefit.

**6. Mitral valve repair** is the preferred method in **primary mitral regurgitation**.

**7. In secondary mitral regurgitation**, mitral surgery is recommended concomitantly in patients with an indication for coronary bypass grafting. Surgery may be considered when revascularization is not indicated but patients are symptomatic, despite optimal medical therapy.

**8. In patients at high-surgical risk percutaneous edge-to-edge repair** may be considered, avoiding futility.

**9. Wish of the informed patient** should be taken into account in deciding between **mechanical prosthesis** and a **bioprosthesis**, but the choice between a mechanical prosthesis and a bioprosthesis should not overstress the role of age of the patient.

**10. In patients with atrial fibrillation and aortic stenosis, aortic regurgitation, mitral regurgitation, or aortic bioprostheses beyond 3 months after implantation new oral anticoagulants** may be used. New oral anticoagulants are contraindicated in patients with atrial fibrillation and mitral stenosis and mechanical valves. **INR self-management** is recommended provided appropriate training and quality control are performed.

Further in the text below we present parts of this Guidelines with presentation of our cases and comments from the expert.

## References

1. Baumgartner H, Falk V, Bax JJ et al. 2017 ESC/EACTS Guidelines for the management of valvular heart disease. *Eur Heart J* 2017; 38: 2739–2786.