OP-173
Carotid Artery Back Pressure and Cerebral Intolerance During the Occlusion in Carotid Stenting with the MoMa Proximal Embolic Protection Device

Mehmet Bilige1, Recai Alemader2, Sina Ali3, Ayse Saatci Yasar2, Ozgur Kirbas2, Ahmet Aksel2, Ozge Karsmus2, Turgay Asli2, Cemal Koseoglu2, Bilge Karahanum Duran2, Mehmet Erdogm2, Serkan Sivri2, Halin Soygun2
1Yildirim Beyazit University, Faculty of Medicine, Division of Cardiology, Ankara, 2Ataturk Education and Research Hospital, Division of Cardiology, Ankara

Introduction: The MoMa proximal embolic protection system provide neurologists not to change significantly at the end of occlusion (immediately before the deflation of carotid balloon). As expected, the carotid back pressure was under 30 mmHg in the patients developing symptoms during the occlusion. However, 4 asymptomatic patients had also a distal back pressure under 30 mmHg during the occlusion.

Conclusion: One of the most important concerns with the use of MoMa proximal embolic protection device is possible cerebral intolerance. This usually consists to transient neurological symptoms which may occur during the proximal occlusion. In the patients undergoing CAS with the Mo.Ma system, a commonly held notion is that back pressure of <30 mm Hg cause symptoms of cerebral intolerance during the occlusion. However, our study showed that a low carotid back pressure of <30 mm Hg may not always result in symptoms of intolerance during occlusion.

OP-174
Efficacy and Safety of Percutaneous Suture-Mediated Closure Devices in Intervventional Cardiology: Outcomes of the Largest Series of Percutaneous Vascular Closure in Turkey

Mehmet Bilige1, Recai Alemader2, Sina Ali3, Ayse Saatci Yasar2, Ozgur Kirbas2, Turgay Asli2, Bilge Karahanum Duran2, Cemal Koseoglu2, Ozge Karsmus2, Mehmet Erdogm2, Mustafa Duran2, Serkan Sivri2, Filiz Ozcengil2
1Yildirim Beyazit University, Faculty of Medicine, Division of Cardiology, Ankara, 2Ataturk Education and Research Hospital, Division of Cardiology, Ankara

Introduction: Closure devices are well established as an alternate to mechanical compression or surgical closure after some percutaneous intervention. The single ProGlide, the Prostar device and the double ProGlide devices can be used for 5F to 8F, 8.5F-24F and 9F-21F access sites, respectively. We evaluated the incidence and types of access-related major adverse events included perforation, bleeding, lower leg hemorrhage in the event of device failure. We evaluated the incidence and types of access-related major adverse events included perforation, bleeding, lower leg hemorrhage in the event of device failure. We evaluated the incidence and types of access-related major adverse events included perforation, bleeding, lower leg hemorrhage in the event of device failure. We evaluated the incidence and types of access-related major adverse events included perforation, bleeding, lower leg hemorrhage in the event of device failure. We evaluated the incidence and types of access-related major adverse events included perforation, bleeding, lower leg hemorrhage in the event of device failure.

Methods: In this single center retrospective study, our medical records were reviewed for the patients having access site closures with the single Perclose ProGlide, double ProGlide and Prostar devices performed in conjunction with some percutaneous interventions (TAJV, balloon aortic valvuloplasty, carotid stenting, renal stenting, renal denervation, and coronary interventions). Procedure success was defined as hemostasis with the preclosure technique without the need for any ancillary procedure. Access-related major adverse events included perforation, bleeding, lower leg ischemia, pseudoaneurysm, arteriovenous fistula, hematoma, embolization, laceration, femoral artery thrombosis, nerve injury, infection, or death owing to an access site injury.

Results: We identified 251 consecutive patients, between June 2011 and June 2013 in whom single ProGlide, double ProGlide and Prostar closure devices were used during 98 peripheral vascular interventions (renal, carotid), 53 coronary interventions, 46 TAVI procedure and 7 aortic balloon valvuloplasty procedures. In the single ProGlide, double Proglide and Prostar closure devices, procedure success were achieved in 167 (98.8%) of 169 patients, in 49 (94.2%) of 52 patients and in 1 (66.6%) of 30 femoral sites, respectively. In the single Proglide group (n=169), there were only 2 device failures managed with manual compression. Minor complications included two groin hematomas and two cases of persistent pain at the arteriotomy site. In the double Proglides group, there were three device failures treated with surgical closure or Prostar (n=1). Minor complications included two groin hematomas and two cases of persistent pain at the arteriotomy site. In the Prostar group, there were one device failure treated with surgical closure and, two minor complications included two cases of persistent pain at the puncture site.

Conclusion: In our study, vascular complications were considerably low in the three groups. We have also found the double ProGlide technique to be easy to use, safe and feasible for access sites ≥9F.

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OP-175
A Novel Indicator for Assessment of Mitral Regurgitation Severity: Proadrenomedullin

Yasin Turker1, Yusuf Aksan1, Yasemin Turker1, Taner Ugcan2, Mehmet Akkan2, Melih Engin Erkan1
1Department of Cardiology, Duzce University Faculty of Medicine, Duzce, 2Family Medicine Center, Duzce, 3Department of Biochemistry and Clinical Biochemistry, Duzce University Faculty of Medicine, Duzce, 4Department of Cardiology, Beyzaklem University Hospital, Istanbul, 5Department of Nuclear Medicine, Duzce University Faculty of Medicine, Duzce

Background: In some patients, including elderly, physically inactive or obese patients, it is difficult to assess the symptoms because of inactivity in patients with chronic mitral regurgitation. A noninvasive marker that shows early changes in the cardiovascular system would therefore be helpful in evaluating patients with MR. The aim of this study was to evaluate the association between plasma pro-adrenomedullin levels and MR and its prognostic value as indicator of cardiovascular prognosis in patients with moderate/severe MR.

Methods: A total of 221 consecutive patients (129 women [58.4%]; mean age 61.6±12.5 years) with isolated and organic moderate MR, moderate to severe MR or severe MR were included in the study. Patients were categorized according to the NYHA functional class. We assessed and graded the severity of MR using a multiparametric approach. Pro-adrenomedullin was measured with ELISA method. Patients were followed-up by outpatient assessments and telephone contact.

Results: Baseline demographic and clinical characteristics of the study population are listed in Table 1. Echocardiographic and laboratory parameters of patients with mitral regurgitation and comparison between asymptomatic and symptomatic patients are listed Table 2. Pro-adrenomedullin was significantly higher among symptomatic MR patients when compared with asymptomatic patients (p<0.001). Median pro-adrenomedullin levels increased significantly with NYHA class (p<0.001, Figure 1) and with higher degrees of MR (p<0.001, Figure 2). Increased levels of serum creatinine, pro-adrenomedullin level, male gender, reduced LVEF, and higher NYHA functional classes were significantly associated with an increased risk of death during follow-up. In multivariate analysis, LVEF and NYHA class were the only independent predictors of death (Table 3).

Conclusion: Pro-adrenomedullin levels can help to identify patients with asymptomatic moderate/severe mitral regurgitation from the symptomatic ones. This may be useful in the optimal timing of mitral valve surgery in certain subset of patients.