in that it has a skirt designed to prevent paravalvular leak, improved coaxial alignment, and more accurate positioning.

**Aims** To evaluate paravalvular aortic regurgitations after 30-day after TAVI using the Edwards SAPIEN 3 prosthesis.

**Methods** Prospective monocentric study including 66 high-risk or non-operable patients with severe aortic stenosis undergoing TAVI using Edwards SAPIEN 3 prosthesis via transfemoral access, between September 2014 and March 2015.

**Results** Mean age of patient was 84±7.1 years (70% female). The MDCT estimated an aortic annular diameter 25.07±2mm. Mean logistic EuroSCORE was 15.8±10.8. In our study, the device success rate was 98.5%. The pros thesis has been deployed correctly in all cases and no failure of valve or embolization had occurred. Post TAVR, mean transaortic gradient decreased from 46.0±12.33mmHg to 8.2±3.77mmHg (p<0.001). No patient had moderate or severe PAR. At 30 days follow up, transthoracic echocardiography (TTE) showed that the PAR was absent or trivial in 66% of patients and mild in the remainder. Possible reasons for this low PAR rate include: 1) the outer polyethylene terephthalate sealing cuff, which enhances paravalvular sealing; 2) more accurate positioning; and 3) improved sizing with adjunctive MDCT.

**Conclusion** In our study, TAVI with Edwards SAPIEN 3 demonstrated lower paravalvular aortic leak rates than earlier generation devices in patients at high risk for surgery.

The author hereby declares no conflict of interest

**0298**

**Prosthetic valve endocarditis. A 15-years cohort study**

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**Introduction** Prosthetic valve endocarditis (PVE) is an uncommon complication after valve replacement surgery, but potentially fatal. The scarcity of clinical trials makes harder the diagnostic and therapeutic approach of this entity.

**Aim** To define the clinical characteristics and in-hospital evolution of a population with PVE.

**Methods** Retrospective study based on a sample of 173 patients (P) with the diagnosis of infective endocarditis (IE), according to the modified Duke criteria, admitted from 1998 to 2013. We analyzed demographic and clinical features, complications, and in-hospital mortality of P with PVE.

**Results** We found 34 P (20%) with PVE, mean age 60.2±17.6 years with a female predominance (53%). The most common form was the community-acquired IE, registering 11 P (32%) with health care-associated IE. There was a preferential engagement of the mitral valve (56%) and 26% had early PVE. The cardinal complaints at presentation were constitutional symptoms (97%); fever (74%); 50% of P showed signs of acute heart failure (HF). The most common analytical abnormalities were elevated inflammatory biomarkers (CRP 94% and leukocytosis 41%), anemia (88%) and increased creatinine (60%). The microbial agent was isolated in 24 P (71%), being Staphylococcus spp (26%) and Streptococcus spp (21%) the most common.

The prosthesis dehiscence (60%), severe regurgitation (29%) and paravalvular abscesses (21%) were the most frequent complications seen at initial echocardiographic evaluation.

The most common adverse events were acute kidney injury (74%), persistence of HF (56%), septic shock (15%) and stroke (12%). There was need for urgent referral to surgery in 38% of P. The in-hospital mortality was higher than other P with IE (21% vs 13%).

**Conclusion** The PVE is associated with a poor prognosis at short term. Its adverse developments should lead to the early identification of riskier P and timely consideration of the possible benefit of surgery.

The author hereby declares no conflict of interest

**0369**

**Surgical valvular reoperations: indications and reoperations time – A series of 45 cases**

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**Objectives** Valvular heart disease still common despite improved health conditions that have reduced the incidence of rheumatic fever. Surgical and interventional indications have expanded and today we operate at early stages, sometimes even an asymptomatic stage. Valvular reoperation is required in about 15% of cases during the evolution of an operated valve disease. We report in this study the results of surgical valvular reoperations to identify the indications for these reoperations.

**Methods** This is a retrospective study of 45 patients aged between 18 and 70 years, admitted to the cardiology department from January 2011 to July 2013, and having a valve disease already operated and requiring reoperation.

**Results** Our series consisted of 45 patients; the average age is 41 years. 73% of patients are women and 27% of men (sex ratio of 3). The mitral valve reoperations are motivated in most cases by a restenosis after a surgical commissurotomy (84%) and in 7% of cases by a prosthetic dysfunction, while aortic valve reoperations are represented primarily by the dysfunction of prosthesis (44%) and aortic regurgitation neglected (56%). Finally, the reoperation on the tricuspid valve is dominated essentially by regurgitation neglected during the first intervention (62%). The average time between the two interventions, any kind focused, is 21 years, but this “timing” is variable if we take into consideration the repair technique.

**Conclusion** Cardiac reoperations may occur during the evolution of a valvulopathy. The patient should be warned of this and the possibility of reoperation should be considered at the first cardiac surgery. Good initial cardiac evaluation is needed to overcome the risk of reoperation for valve disease neglected.

**Keywords** reoperation, prosthesis dysfunction, degeneration, bioprostheses, valvuloplasty, commissurotomy.

The author hereby declares no conflict of interest