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| **TAVI Workup Summary and Multidisciplinary Structural Heart Team** | Royal North Shore Hospital Commercial Furniture Project | Commercial Sofa  Bed | | | | |
| **Referral Date: 28/5/25** | **Structural Physician: Bhindi** | | | | |
| Name: Sandra Clark | Referrer: F. Touma | | | | |
| DOB: 29/10/48 | Contact Details: 0419018928 | | | | |
| MRN: 1135610 | Email: sandiht57@gmail.com | | | | |
| Age: 76 | Weight: 115kg Height: 173cm | | | | |
| **Past Medical History** | **Medications** | | | | |
| * T2DM * HTN * Hypercholesterolaemia * Protein C deficiency with previous PE/DVT (warfarin) * Left sided hearing loss * OSA (does not tolerate CPAP) * Vestibular issues (balance) | * Optisulin 16u BD * Jardiance 10mg mane * Levothyroxine * Warfarin * Pravastatin * Telmisartan/amlodipine 80/5 mane | | | | |
| **Social History** | **Functional Status** | | | | |
| * Lives at home in retirement village (independent living) * x2 daughters, not close by * Independent ADLs * Mobilises 4WW outside of the home, issues with balance * Non-smoker, no ETOH * Services: domestic cleaning once a month, has level 2 HCP | * Progressively SOBOE and fatigue over last few month  ~ more difficult to do day to day task * Occasional chest tightness on exertion, one episode at rest * Has hospital bed, sleeps at 60 degrees (has been doing so for long time ?OSA * Denies oedema, syncope, PND orthopnoea | | | | |
| **TTE: RNSH 2/7/25 – Dr Choong** | | | | | |
| |  |  | | --- | --- | | LV EF: 60% | AVA: 1.0 AVAi 0.4 | | Peak Gradient: 72 | AR: Nil | | Mean Gradient: 36 | SVI: 44.6 | | Peak AV: 4.3 | MR: Mild | | Comments: Trileaflet aortic valve. Markedly calcified leaflets with severely restricted excursion on 2D (eg clip 27) and 3 D imaging (clip 29). Doppler data as listed in table above consistent with severe stenosis based on peak velocity (even after correction for proximal velocity) and valve area index | | | | | | | |
| **Angio:** | **ECG:** | | | | |
| Haemodynamically significant proximal LAD disease (70%, iFR 0.88), and severe LCx (80%) and OM2 disease (80%). | SR w/ prolonged PR interval (235). Normal QRS | | | | |
| **CT TAVI:** | | | | | |
|  | **Access:**  **Valve Choice:**  **Incidentals:** | | | | |
| **MOCA / Clinical Frailty Score** | **Bloods: Laverty 15/6/25** | | | | |
| MMSE: 30/30 (with GP) | Hb:140 | Plts: 184 | Cre: | eGFR: | Albumin: |
| **Aged Care:** | **Cardiothoracic: Dr Bassin** | | | | |
| N/A | On balance I think you should have a TAVI +/-PCI if it is technically feasible. Her comorbidities are significant risks for open surgery including Protein C deficiency with stroke, and PE/DVT, morbid obesity, immobility due to vestibular dysfunction, type 2 diabetes, and OSA. If surgery was required we discussed that this would carry a higher risk of stroke due to the Protein C deficiency and would involve a tissue aortic valve replacement, and coronary bypass to the LAD and circumflex vessels. I would be happy to see her again if a TAVI is not possible. | | | | |

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| **Multidisciplinary Structural Heart Team** | |
| **Date:** | |
| **Attendees**: DrRavinay Bhindi, Dr Peter Hansen, Dr Malcom Anastasius, Dr Chris Choong, Dr Peter Brady, Dr Michael Ward, Dr Geoff Tofler, Ingrid Bromhead, Alice Auton, Megan Inglis, Alex Baer | |
| **Essential criteria** | Confirmed severe symptomatic aortic stenosis |
| **TAVI Feasibility** | No concerning features for transfemoral access or TAVI deployment  Valve choice: |
| **Frailty / comorbidities** | Reasonable baseline cognitive function and social supports. No life limiting pathology. |
| **Lifetime planning** | N/A |
| **Special considerations** | N/A |
| **Outcome:** Approved for Transcatheter Aortic Valve Implantation (TAVI) | |