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| **Mitral Patient Summary** |  |
| **Structural Physician:** Dr Hansen | |
| **Name:** Mr Donald Low  **Contact:** 0415522577  GP: Dr Kharwadkar Neutral Bay | **Referrer:** Dr Shubhada Kharwadkar  Neutral Bay Medical Centre  116 Military Road  NEUTRAL BAY NSW 2089 |
| **DOB**: 26/11/1944  Height 170 cm  Weight 78 kg | **Allergies:** |
| **ME number:** ME00195919  **RNSH:** 070-93-28 | **Antiplatelets/anticoagulation**: warfarin |
| **Age:** 80 | **Current Symptoms:**  SOBOE  Peripheral oedema |
| **Past Medical History** | **Social History** |
| IHD  - AF  - CRTD  - CABG 2016 - Dr John Brereton  CKD - Dr Patrick Lan,  HTN  Prostate ca  - Radiotherapy 5 years ago | Lives with wife  Independent |
| **Current Medical Heart Failure Therapy** | |
| |  |  |  | | --- | --- | --- | | **Drug Type** | **Drug Name** | **Dosage** | | Beta Blocker | bisoprolol 5mg bd |  | | ACE/ARB/ARNI | Entresto | 24//26mg bd | | MRA |  |  | | SGLT2 |  |  | | Diuretics | fruse 80 bd |  | |  |  |  | | |
| **Baseline blood**s | |
| Date: 5/6/25 Hb: 131 Plat: 83 INR: 2.2 Creat: 322 eGFR: 15 | |
| **ECG** | |
| Rhythm: Ventricular Paced rhythm BiV | |
| **Coronary angiography: 20/06/2025** | |
| RA: V=27 (19)mmHG  PA: 39/24 (31) mmHg  PCW: V=26 (24) mmHG  TPG: 7mmHG  C.O: 3.54L/min  PVR: 1.98 Wood Units   |  |  | | --- | --- | | RHC: RIJ, US-G, MPT, uncomplicated.  Coronary angio: Patent native LCX. Patent LIMA to LAD. Prehydration for renal protection. | | |  |  | | |
| **Renal** | |
| Discussed many potential scenarios.  If EF remains low may not be able to tolerate dialysis  If cardiac intervention can improve EF, renal function should improve but also may deterioriate.  Long term dialysis may be required.  Mr Low feels his QOL is majorly impacted + if cardiac intervention can improve that then he wants it despite egfr. | |
| **CTx** | |
| **Dr Brereton:** Whereas there a number of factors making the repair of both valves percutaneously quite difficult, the concept of double valve surgery in someone of 82 years of age, with a creatinine well over 300, and a seriously impaired ventricle, is a little hard to hold.  Surgery would require planning for post-operative dialysis, initially CVVHD, and quite possibly ECMO for a  number of days. This would require keen commitment from the hospital and staff. On the other hand, I cannot look Mr Low in the eye and say that there is nothing more that can be done when he is cognitively not limited and 1 year ago was walking pretty well when the BiV device was functioning.  Let us hope that the mitral valve can be addressed percutaneously even if it is necessary to leave the tricuspid valve alone. This would be the best option. I would not say however that is not suitable for salvage, I cannot say that. Should the mitral valve percutaneous treatment not being successful with time over the first 6 months, then open surgery will need to be considered again, but I would certainly get a second opinion from another surgeon as well as from an experienced and committed intensivist.  [02 9439 9699](tel:02%209439%209699) | |
| **TOE/TTE** | |
| |  |  | | --- | --- | | LV EF: 20% | **MR Grade:**  **Mechanism of MR:**  Primary  Secondary | |  |  | |  |  | |  |  | | Severe secondary mitral valve regurgitation, predominant ventricular mechanism with posterior leaflet restriction; broad MR jet arising from the medial aspect of A2/P2 and extending to A1/P1 segments; challenging mitraClip/TEER given medial indentations; however, can consider x2/3 Clips, medial aspect of A2/P2, and then A2/P2 and A1/P1.  Severe secondary tricuspid valve regurgitation (PISA radius 1.1cm, aliasing velocity 0.34m/s, peak TR velocity 1.4m/s, VTI 35cm, EROA 1.8cm2; type IIIb tricuspid valve, broad TR origin, arising between the anterior/septal, posterior/septal and anterior/posterior tricuspid valve leaflets. GLIDE score 3; tricuspid TEER/Clip not feasible at present given large coaptation gap and star-shaped en face TR morphology. | | | |
| **Procedure Plan – discussed at feasibility 15/07/2025** | |
| TEER  Atrial functional MR  MRat A3 & P3  Broad jet  Restricted posterior  Also has TR – to treat MR first then reassess TR.  Procedure Rating: Urgent  Plan:   * 2 central clips, clip medial. Use p5 pascal. * Will require MRI post procedure when assessing TR, if device MRI compatible. * Admit days prior for dobutamine * Consider may need ASD closure * Liaise with renal. * APPROVED AT FEASIBILITY.  |  |  |  | | --- | --- | --- | | **Clip Number** | **Clip Type** | **Leaflet attachment location** | | **1st** |  |  | | **2nd** |  |  |     Clipping Strategy  En Face View of the Mitral Valve: Definition and Acquisition | Semantic  Scholar  Pre-operative optimisation plan: | |

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| **Structural Heart Multidisciplinary Team Meeting** | |
| **Date:** | |
| **Attendees**: | |
| **Essential criteria** |  |
| **Feasibility** |  |
| **Frailty / comorbidities** | . |
| **Lifetime planning** |  |
| **Special considerations** |  |
| **Outcome:** | |

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| 12/06/25 | Bloods done yday, to see ph in rooms tmrw with bloods before angio. |
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