Expanding Role of TAVI to

Asymptomatic Severe Aortic Stenosis

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Disclosure of Relevant Financial Relationships

Antegrade Medical: Equity, consultant; Abbott Vascular: Consultant, advisor, speaker Fees, PI Eclipse Trial; CARANX Medical: Consultant; Edwards LifeSciences: Consultant, advisor, speaker fees, proctor, research grant, PI EARLY-TAVR trial, PI PROGRESS trial; ECHOIQ: Equity, consultant; egnite inc.: Consultant, advisor; Haemonetics: Consultant, advisor, speaker Fees; Medtronic: Consultant, advisor, speaker fees; Pi-Cardia: Equity, consultant; Puzzle Medical: Equity, consultant; Spiralis: Equity, consultant; Teleflex: Consultant; 4C Medical: Consultant, PI Feasibility study

The Evidences for Treating Asymptomatic Severe AS

4 RCTs, 1 Meta-analysis

The NEW ENGLAND JOURNAL of MEDICINE

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Early Surgery or Conservative Care for Asymptomatic Aortic Stenosis

Duk-Hyun Kang, M.D., Ph.D., Sung-Ji Park, M.D., Ph.D., Seung-Ah Lee, M.D., Sahmin Lee, M.D., Ph.D., Dae-Hee Kim, M.D., Ph.D., Hyung-Kwan Kim, M.D., Ph.D., Sung-Cheol Yu[illegible], Jong-Min Song, M.D., Ph.D., Cheol-Hyun Chung, M.D., Ph.D., Ja[illegible], Jae-Won Lee, M.D., Ph.D., and Seung-Woo Park,

META-ANALYSIS

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Transcatheter Aortic-Valve Replacement for Asymptomatic Severe Aortic Stenosis

P. Généreux, A. Schwartz, J.B. Oldemeyer, P. Pibarot, D.J. Cohen, P. Blanke, B.R. Lindman, V. Babaliaros, W.F. Fearon, D.V. Daniels, A.K. Chhatriwalla, [illegible]nsky, H. Gada, P. Shah, M. Szerlip, T. Dahle, K. Goel, W. O'Neill, T. Sheth, [illegible]vidson, R.R. Makkar, H. Prince, Y. Zhao, R.T. Hahn, J. Leipsic, B. Redfors, [illegible]ocock, M. Mack, and M.B. Leon, for the EARLY TAVR Trial Investigators*

ESC European Society of Cardiology

European Heart Journal (2024) 45, 4526–4535 https://doi.org/10.1093/eurheartj/ehae585

Aortic Valve Replacement vs Clinical Surveillance in Asymptomatic Severe Aortic Stenosis

A Systematic Review and Meta-Analysis

Philippe Généreux, MD,[a] Marko Banovic, MD, PhD,[b,c] Duk-Hyun Kang, MD, PhD,[d] Gennaro Giustino, MD,[a] Bernard D. Prendergast, MD,[e,f] Brian R. Lindman, MD,[g] David E. Newby, MD, PhD,[h] Philippe Pibarot, DVM, PhD,[i] Björn Redfors, MD, PhD,[j,k,l] Neil J. Craig, MD,[m] Jozef Bartunek, MD, PhD,[n] Allan Schwartz, MD,[o] Roxanna Seyedin, PhD, MPH,[p] David J. Cohen, MD, MSc,[q,r] Bernard Iung, MD,[s] Martin B. Leon, MD,[q,r] Marc R. Dweck, MD, PhD[h]

Aortic valve replacement vs. c[illegible] treatment in asymptomatic se[illegible] stenosis: long-term follow-up of the AVATAR trial

Marko Banovic [1,2]*, Svetozar Putnik[1,3], Bruno R. Da Costa[4], Martin Penicka[5], Marek A. Deja[6], Martin Kotrc[7], Radka Kockova[8], Sigita Glaveckaite [9], Hrvoje Gasparovic [10], Nikola Pavlovic [11], Lazar Velicki[12,13], Stefano Salizzoni [14], Wojtek Wojakowski[15], Guy Van Camp [4], Sinisa Gradinac[16], Michael Laufer[17], Sara Tomovic[1], Ivan Busic[1], Milica Bojanic[18], Arsen Ristic [1,2], Andrea Klasnja[19], Milos Matkovic[1,3], Nikola Boskovic[2], Katarina Zivic[2], Miodrag Jovanovic[20], Serge D. Nikolic[21], Bernard Iung[22], and Jozef Bartunek[4]*

JAMA The Journal of the American Medical Association

Early Intervention in Patients With Asymptomatic Severe Aortic Stenosis and Myocardial Fibrosis

The EVOLVED Randomized Clinical Trial

Krithika Loganath, MD[1]; Neil J. Craig, MD[1,2]; Russell J. Everett, PhD[2]; et al

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

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Atlantic Health System

Généreux et al. N Engl J Med. 2025 Jan 16;392(3):217-227

THE EARLY TAVR TRIAL

Study Design

Prospective, multicenter RCT evaluating patients with asymptomatic, severe AS aged ≥ 65 years w/ an STS score ≤ 10% and LVEF ≥ 50%

Asymptomatic Status
Confirmed by negative treadmill stress test*

Randomization 1:1

Transfemoral-TAVR
(SAPIEN 3 or SAPIEN 3 Ultra THV)

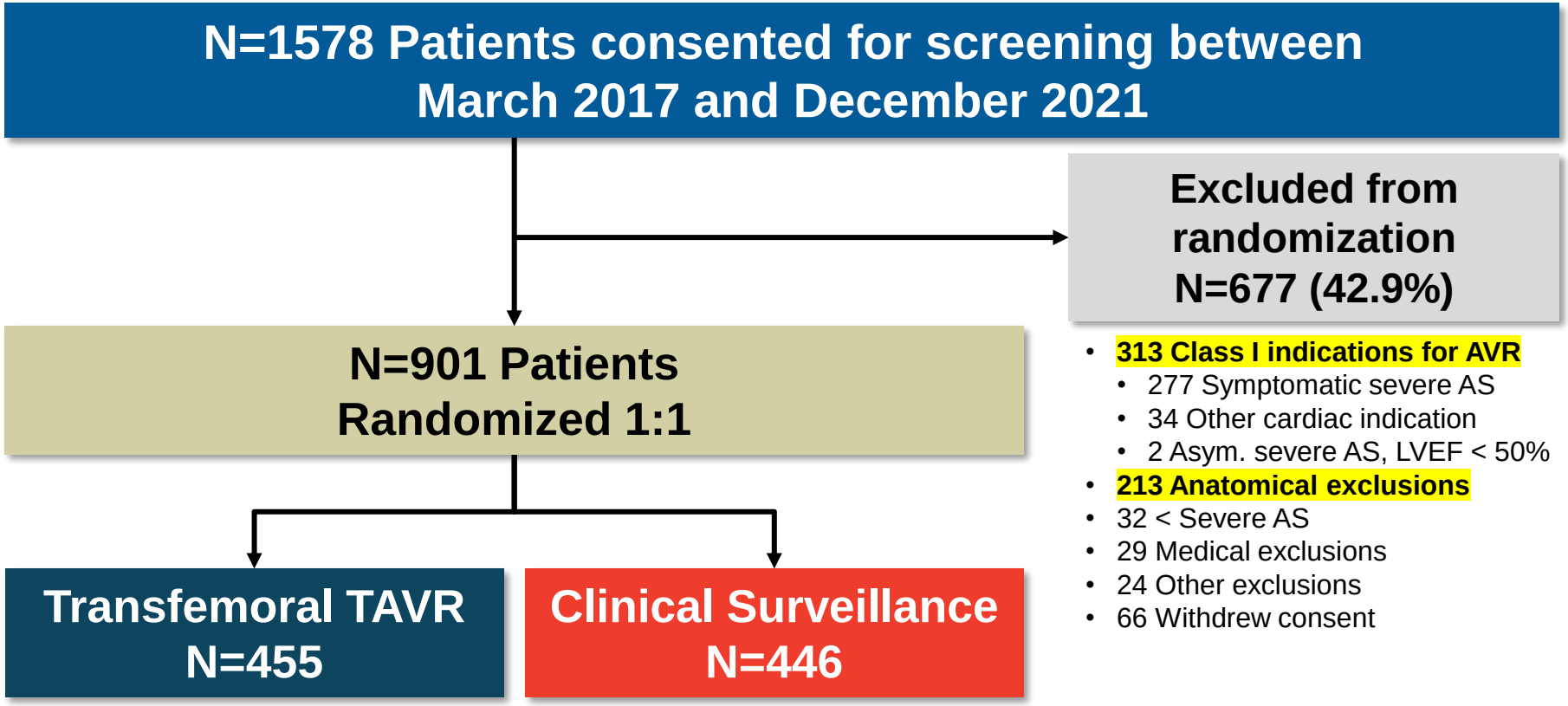
Clinical Surveillance

PRIMARY ENDPOINT (Superiority)
Non-hierarchical composite of all-cause death, any stroke, or unplanned CV hospitalization at a minimum follow-up of 2 years

*Confirmed by detailed clinical history alone if patient was unable to perform stress test

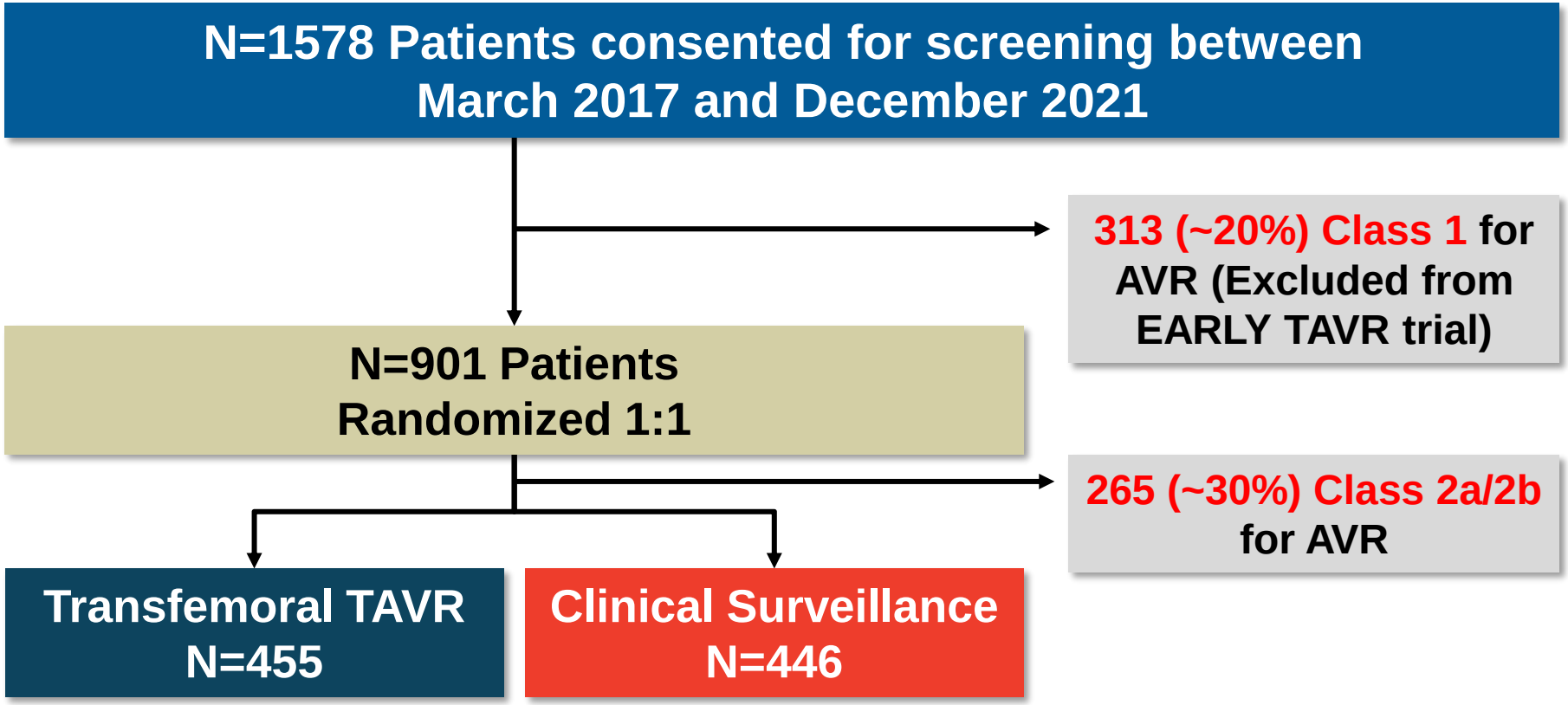
THE EARLY TAVR TRIAL

Patient Flow



THE EARLY TAVR TRIAL

Patient Flow



THE EARLY TAVR TRIAL

Baseline Characteristics

Characteristic	TAVR (N=455)	CS (N=446)	Characteristic	TAVR (N=455)	CS (N=446)
Age, y	76.0 ± 6.0	75.6 ± 6.0	Bicuspid valve	8.1%	8.8%
Female sex	28.8%	33.0%	Hx of afib	15.6%	13.2%
BMI, kg/m^2	28.4 ± 4.6	28.6 ± 4.8	Pacemaker†	4.6%	2.0%
STS score, %	1.8 ± 1.0	1.7 ± 1.0	Prior MI	5.1%	4.0%
Low-risk per Heart team	83.5%	83.9%	Prior stroke	4.2%	4.5%
Asymptomatic Criteria			CAD	29.2%	25.3%
Treadmill stress test	90.3%	90.8%	PVD	7.3%	4.7%
Clinical history only*	9.7%	9.2%	HTN	81.1%	81.8%
KCCQ Score	92.7 ± 8.7	92.7 ± 9.4	Diabetes	26.2%	25.6%
NT-proBNP, pg/mL	276 (139, 599)	297 (148, 608)	eGFR <45 mL/min/ 1.73 m^2	6.8%	4.5%

Values presented as %, mean ± SD, or median (IQR)

*Unable to take the stress test for orthopedic and/or neurologic reasons

†P<0.05 at baseline

THE EARLY TAVR TRIAL

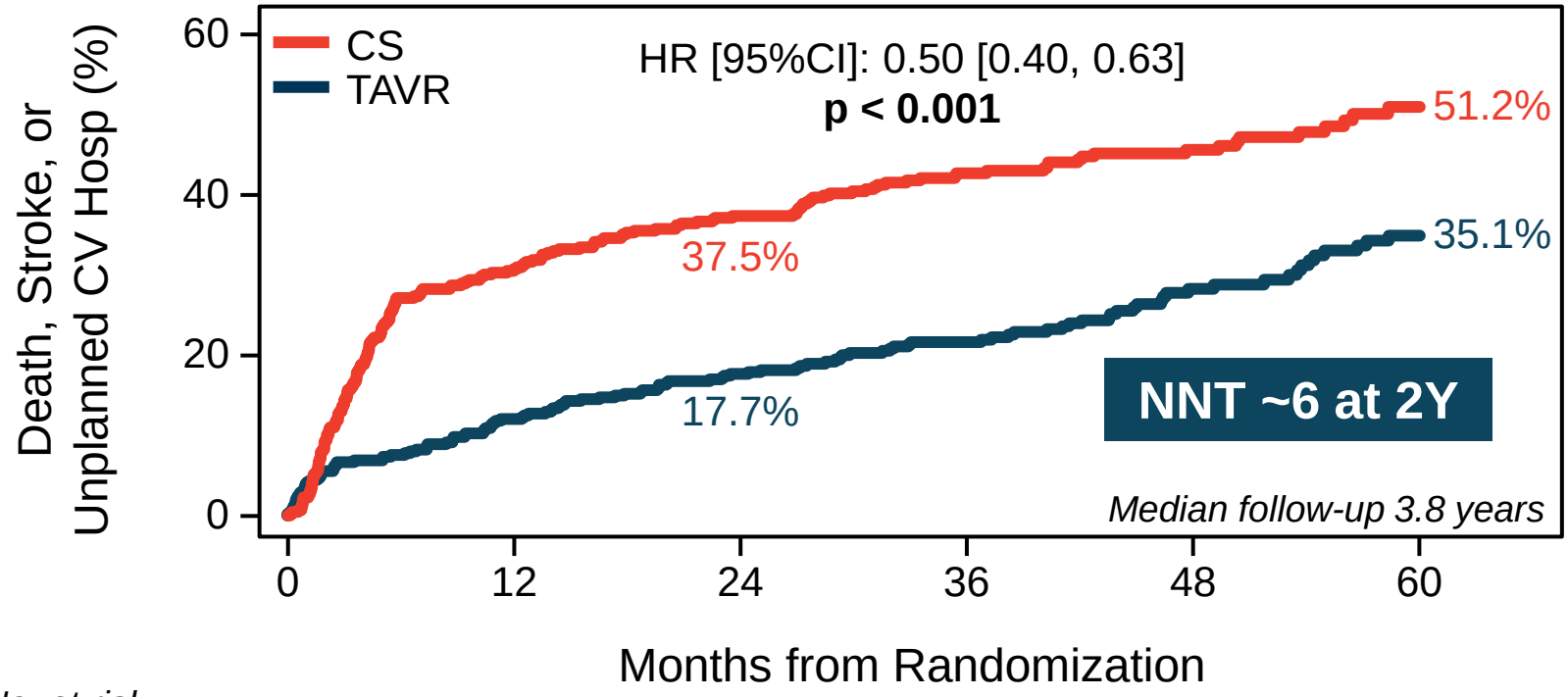
Baseline Echo Characteristics

Characteristic	TAVR (N=455)	CS (N=446)
AVA, cm^2	0.9 ± 0.2	0.8 ± 0.2
Peak velocity, m/s	4.3 ± 0.5	4.4 ± 0.4
Mean gradient, mmHg	46.5 ± 10.1	47.3 ± 10.6
LVEF, %	67.4 ± 6.5	67.4 ± 6.7
LV diastolic dysfunction ≥ Grade II	42.7%	37.3%

Values presented as % or mean ± SD

THE EARLY TAVR TRIAL

Primary Endpoint



No. at risk:

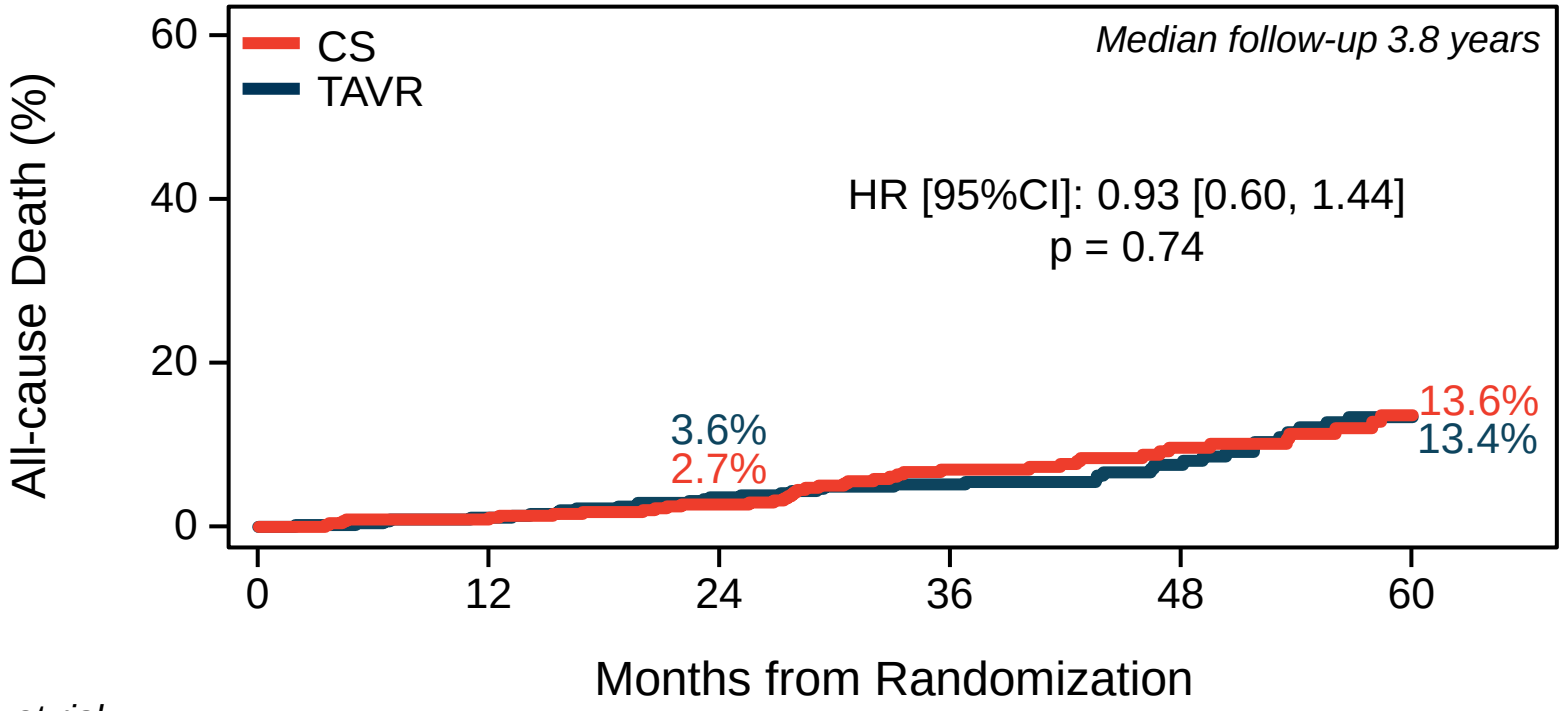
TAVR	455	390	363	285	142	103
CS	446	305	266	187	117	46

Event rates are Kaplan-Meier estimates

Patients had a minimum follow-up of 2 years

THE EARLY TAVR TRIAL

All-cause Death



No. at risk:

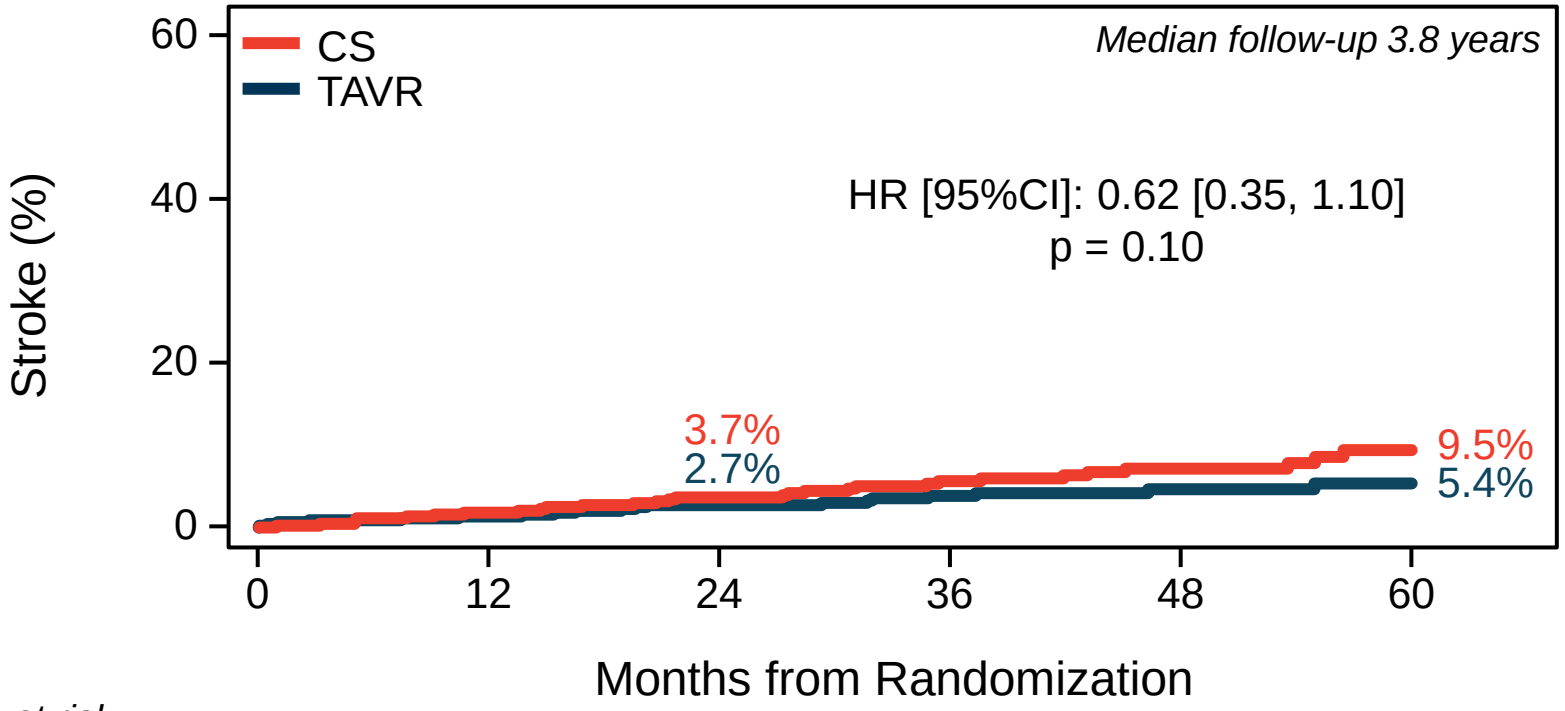
TAVR	455	439	425	346	187	136
CS	446	436	418	310	199	95

Event rates are Kaplan-Meier estimates

Patients had a minimum follow-up of 2 years

THE EARLY TAVR TRIAL

Stroke



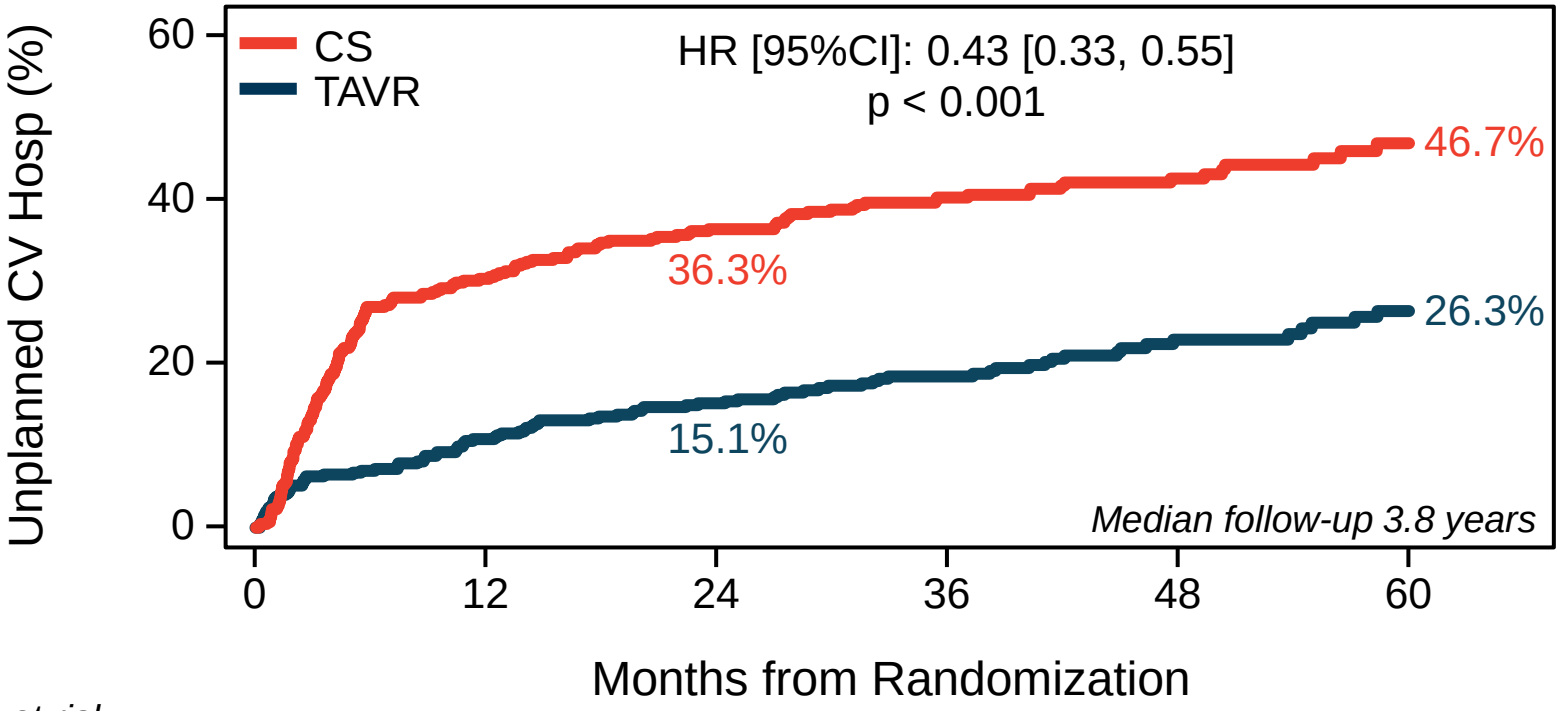
No. at risk:

TAVR	455	433	415	335	180	130
CS	446	429	406	295	185	87

Event rates are Kaplan-Meier estimates

Patients had a minimum follow-up of 2 years

Unplanned CV Hospitalization



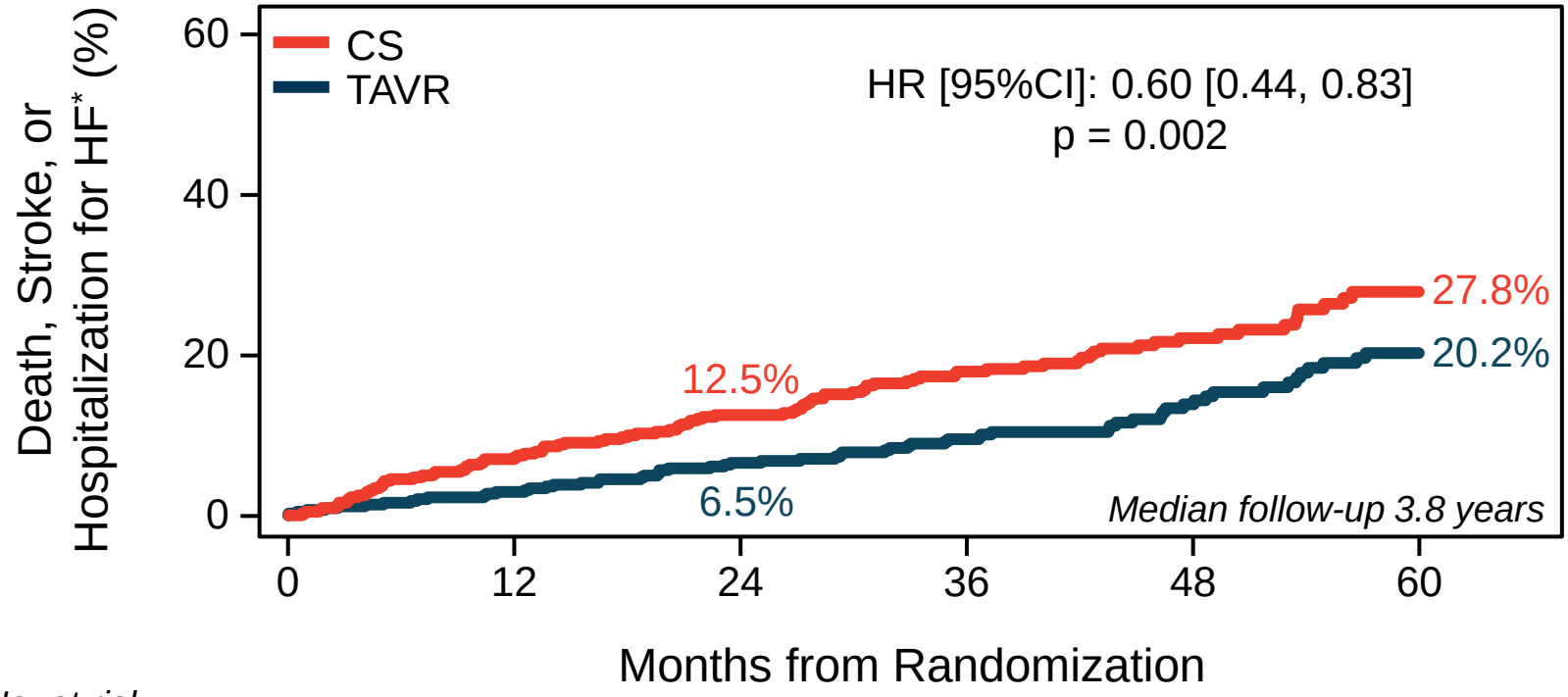
No. at risk:

TAVR	455	392	365	287	142	103
CS	446	306	267	189	118	46

Event rates are Kaplan-Meier estimates

Patients had a minimum follow-up of 2 years

Death, Stroke, or Hosp. for HF*



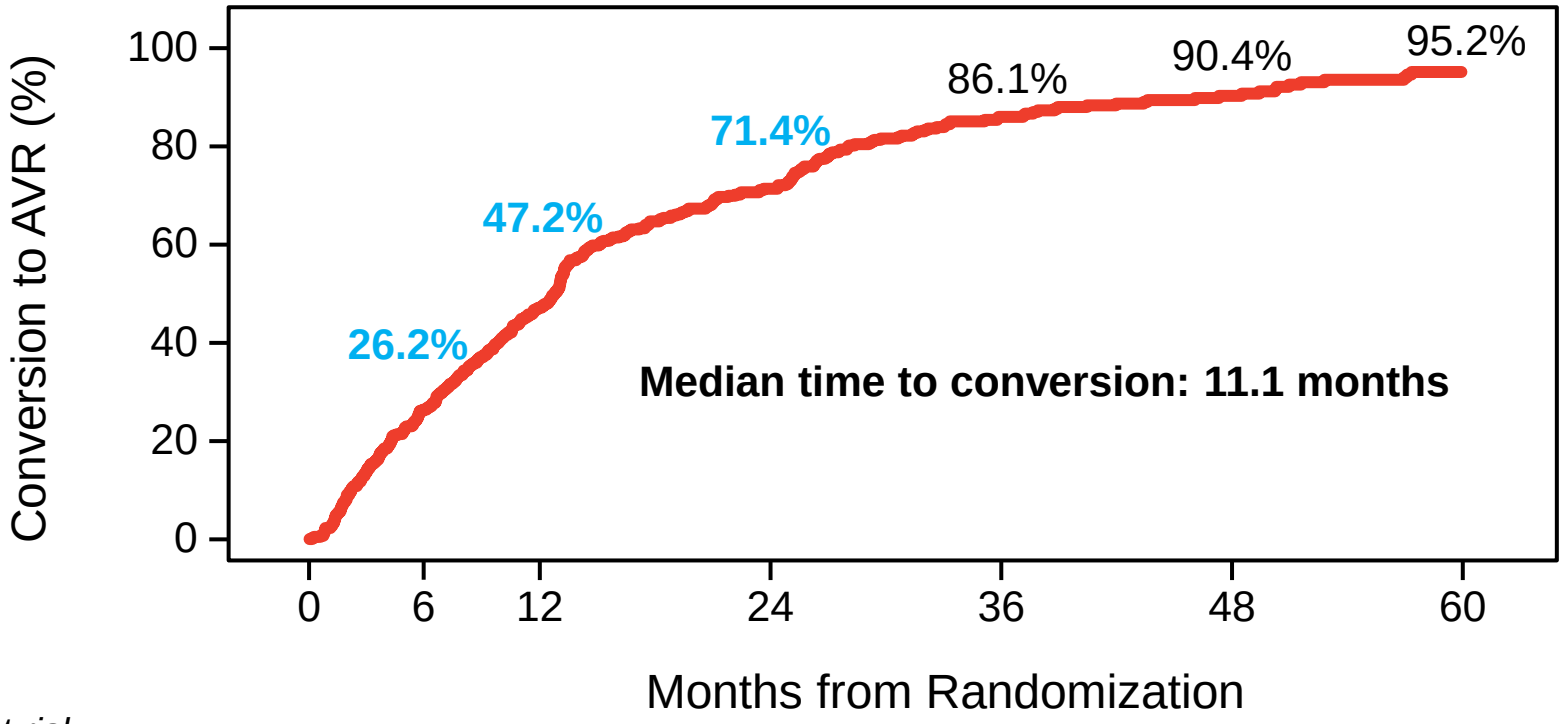
No. at risk:

TAVR	455	431	412	331	175	128
CS	446	410	376	268	163	77

*Hosp for symptomatic CHF treated with IV diuresis, inotropic therapy, IABP, ventilation for pulmonary edema, or hemodialysis for vol. overload

THE EARLY TAVR TRIAL

Conversion to AVR in CS



No. at risk:

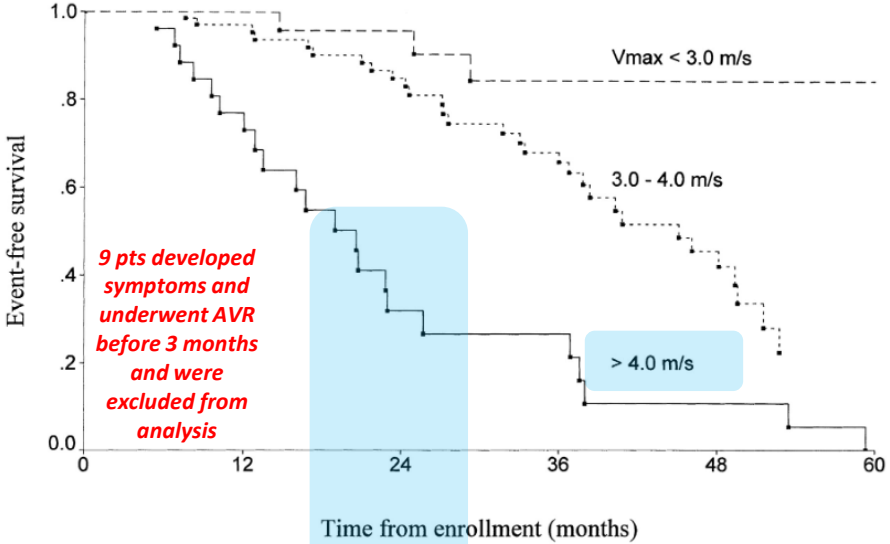
Clinical Surveillance	446	326	231	119	45	22	9

Median follow-up 3.8 years; At the time of analysis, 30 patients were still on study but hadn't converted to AVR

Circulation

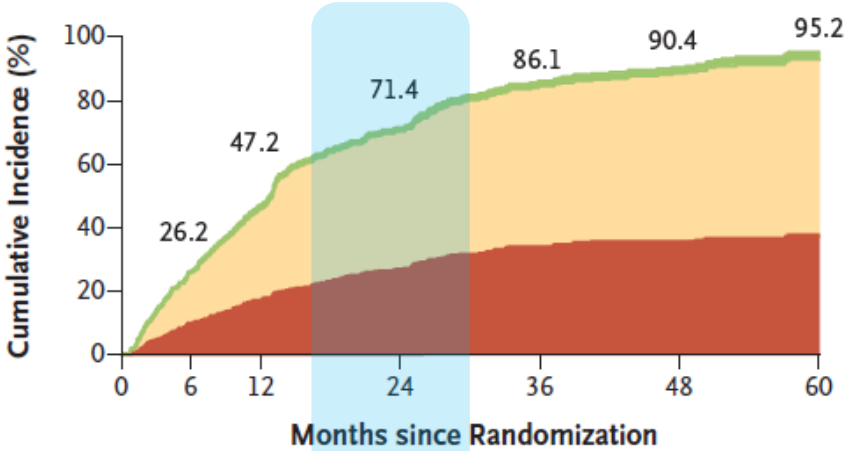
The NEW ENGLAND JOURNAL of MEDICINE

1997; Otto et al.
Prospective Study of Asymptomatic Valvular AS
N=123 pts
AVR or Death



Asymptomatic Severe AS	1 year	2 years	3 years	4 years	5 years
	~30%	~70%	75%	90%	95%

2025; Généreux et al.
TAVR for Asymptomatic Severe AS
N=901 pts
Conversion to AVR



Asymptomatic Severe AS	1 year	2 years	3 years	4 years	5 years
	47.2%	71.4%	86.1%	90.4%	95.2%

Natural History of Asymptomatic Severe AS: Otto et al. 1997 almost identical to Généreux et al. 2025 EARLY TAVR

Conversion to AVR due to Anxiety?

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THE EARLY TAVR TRIAL

Symptoms at Time of Conversion to AVR

CS Patients who Converted to AVR with Symptoms	Total (N=377)
Most Common Symptoms*	
Dyspnea	**83.0%**
Angina	24.9%
Dizziness	24.7%
Fatigue	22.0%
Syncope	7.2%
Multiple Symptoms	
Experienced 2 symptoms	34.5%
Experienced ≥ 3 symptoms	13.3%
Symptom/HF Severity	
NYHA II	70.0%
NYHA III/IV	**30.0%**
Accompanying Signs of Worsening AS*	
Peak velocity > 5 m/s	22.3%
LVEF drops to < 50%	4.8%
≥ 3-fold increase in NT-proBNP	6.7%

*Categories are not mutually exclusive

Circulation

ON MY MIND

New Classification to Describe Clinical Presentation in Aortic Stenosis: Stable, Progressive, and Acute Valve Syndrome

Philippe Généreux, MD; Brian R. Lindman, MD, MSc; Philippe Pibarot, DVM, PhD

Atlantic Health System

Généreux et al. Circulation. 2025;151:1627–1629

Clinical Presentation at Time of AVR Conversion

Patients classified based on acuity and severity of signs/symptoms

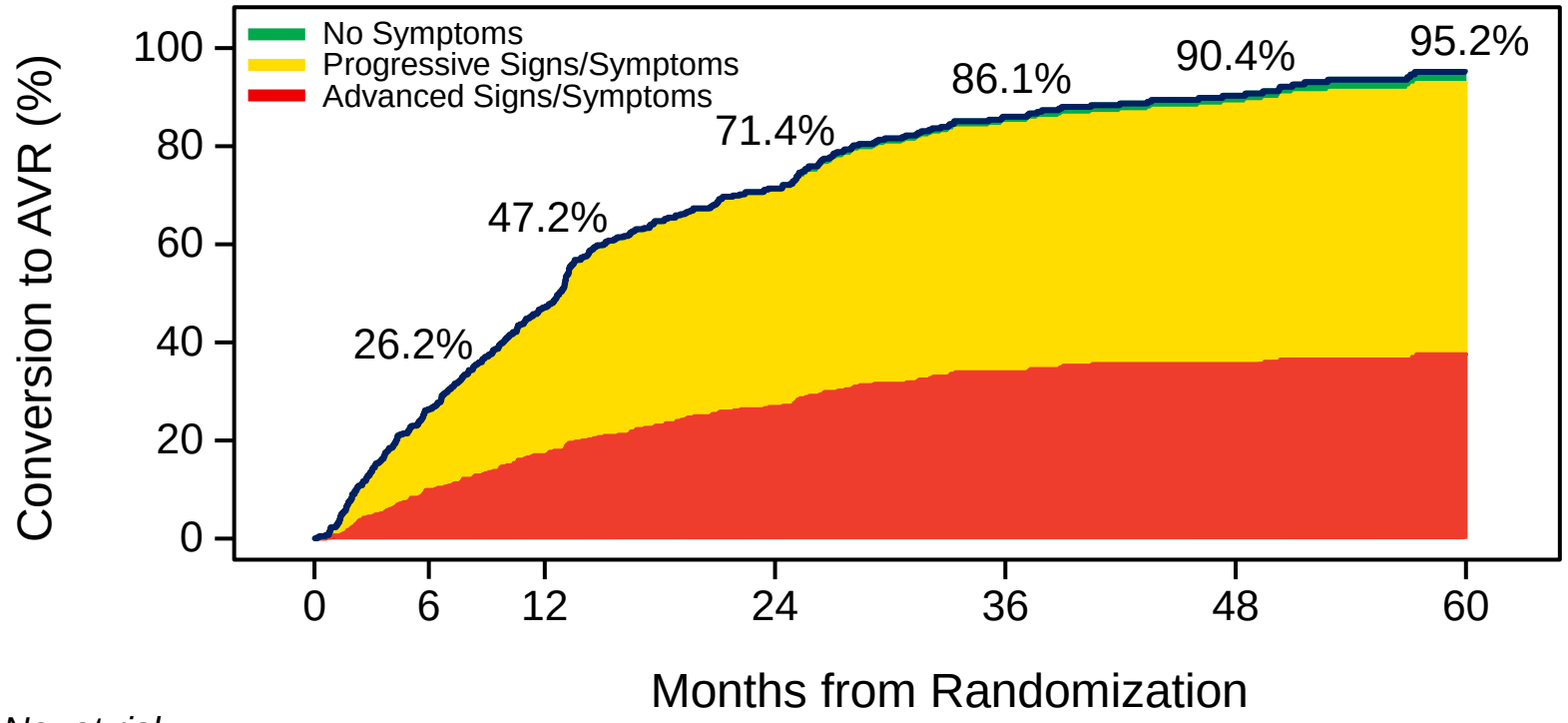
Asymptomatic
Includes pts who may have converted to AVR b/c they required additional medical procedures

Progressive Signs or Symptoms
NYHA II
Increase in HF rx from baseline
≥1.5- to < 3-fold increase in NT-proBNP from baseline and age-specific threshold*

Advanced Signs or Symptoms / Acute Decompensation
NYHA III/IV
Syncope
Atrial fibrillation
Ventricular arrhythmia
Resuscitated sudden death/cardiac arrest
Hospitalization for HF and/or pulmonary edema
LVEF drops to < 50%
≥ 3-fold increase in NT-proBNP from baseline and age-specific threshold*

*125 pg/mL for patients ≤ 75 years and 450 pg/mL for > 75 years

Signs & Symptoms at Time of Conversion to AVR



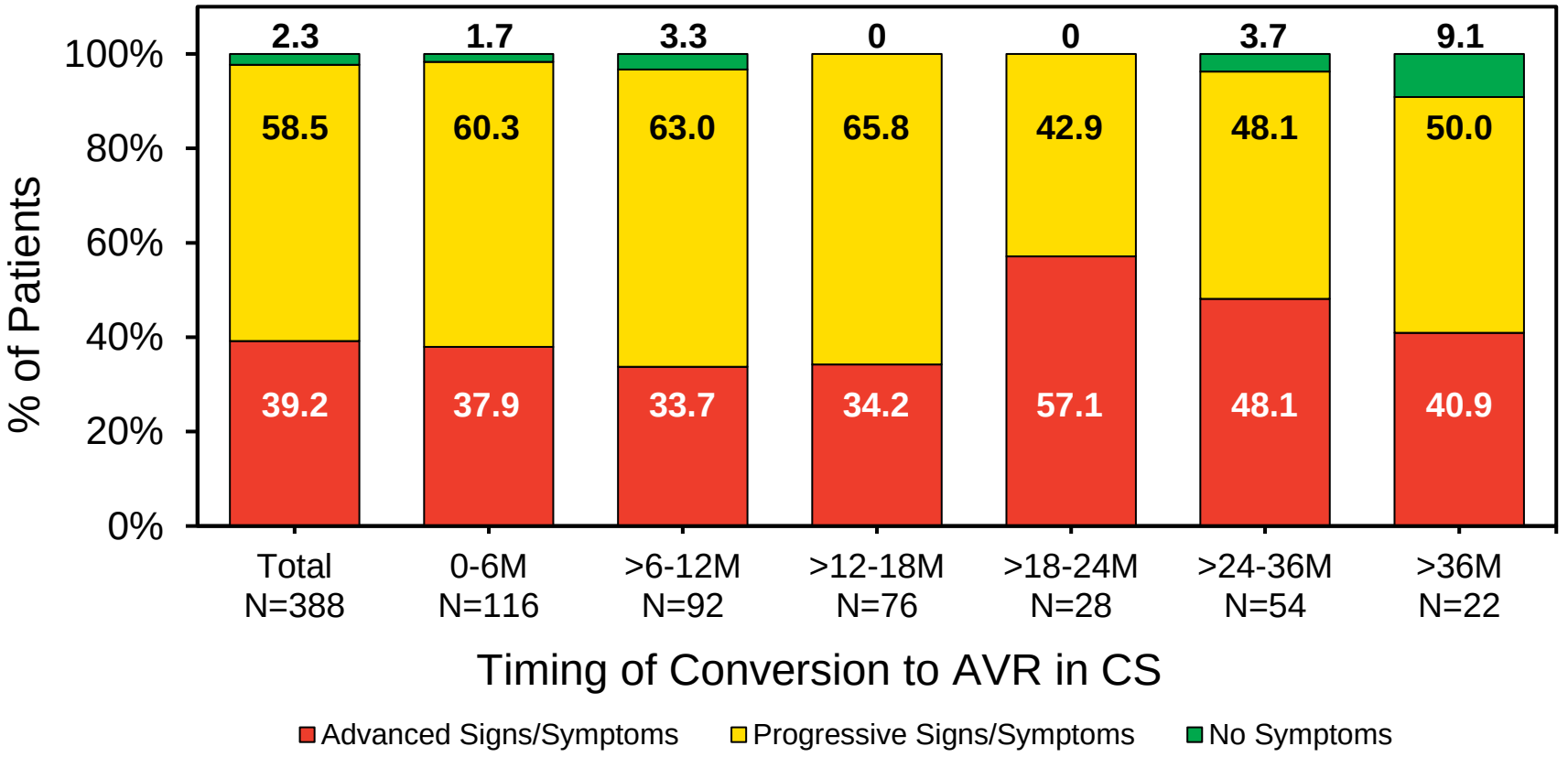
No. at risk:

CS	446	326	231	119	45	22	9

Median follow-up 3.8 years; At the time of analysis, 30 patients were still on study but hadn't converted to AVR

THE EARLY TAVR TRIAL

Proportion of Patients Presenting with Advanced Signs/Symptoms was Consistent Through Time

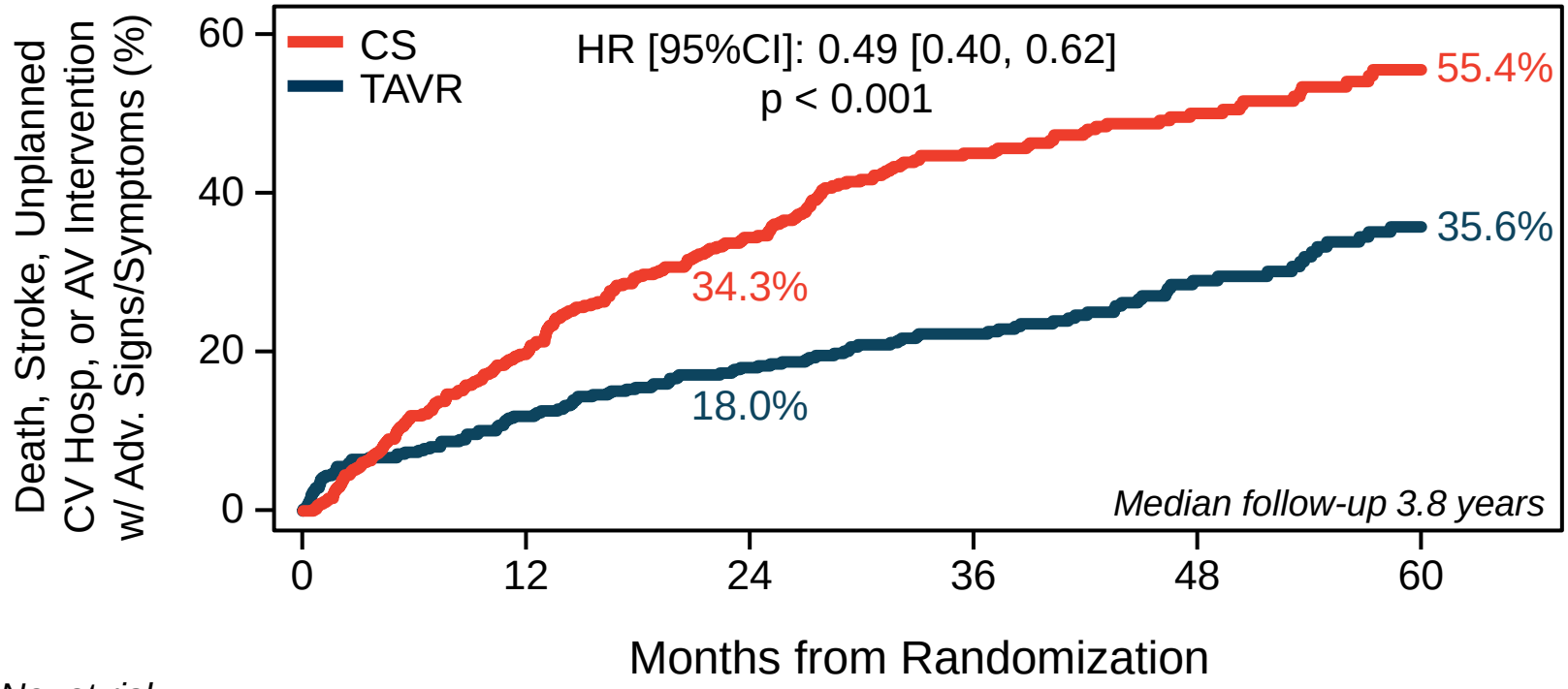


At the time of analysis, 30 patients were still on study but hadn't converted to AVR

THE EARLY TAVR TRIAL

THE EARLY TAVR TRIAL

Exploratory Analysis of the PE



No. at risk:

TAVR	455	391	362	284	140	101
CS	446	354	281	186	108	52

Patients had a minimum follow-up of 2 years

THE EARLY TAVR TRIAL

Promptness of Treatment

Median (IQR) timing from:	Early TAVR (N=444)	CS with AVR (N=388)
Randomization to early TAVR	14 (9, 24) days	-
AVR indication to conversion*	-	32 (18, 58) days

*N=381 (98.2%) underwent TAVR; N=7 (1.8%) underwent SAVR

87.9% of clinical surveillance patients who converted to AVR were treated within 3 months of indication for AVR

THE EARLY TAVR TRIAL

Periprocedural* Outcomes

Outcome – Kaplan-Meier Estimates	TAVR (N=444)	CS with AVR (N=388)
All-cause death	0.2%	0%
CV death	0%	0%
Non-CV death	0.2%	0%
Stroke	0.9%	1.8%
Disabling stroke	0%	1.0%
Non-disabling stroke	0.9%	0.8%
New onset atrial fibrillation	4.5%	3.1%
New permanent pacemaker	5.7%	8.4%
Life-threatening/disabling or major bleeding	2.5%	3.6%
Acute kidney injury (site-reported)	2.5%	3.4%
Major vascular complications	1.4%	1.0%
Myocardial infarction	0.5%	0.5%
Coronary obstruction requiring intervention	0%	0%

*Periprocedural defined as ≤ 30 days from index procedure in the TAVR arm or date of conversion to AVR in the CS arm

JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY

Aortic Valve Replacement vs Clinical Surveillance in Asymptomatic Severe Aortic Stenosis

A Systematic Review and Meta-Analysis

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EARLY TAVR, EVOLVED, AVATAR, RECOVERY

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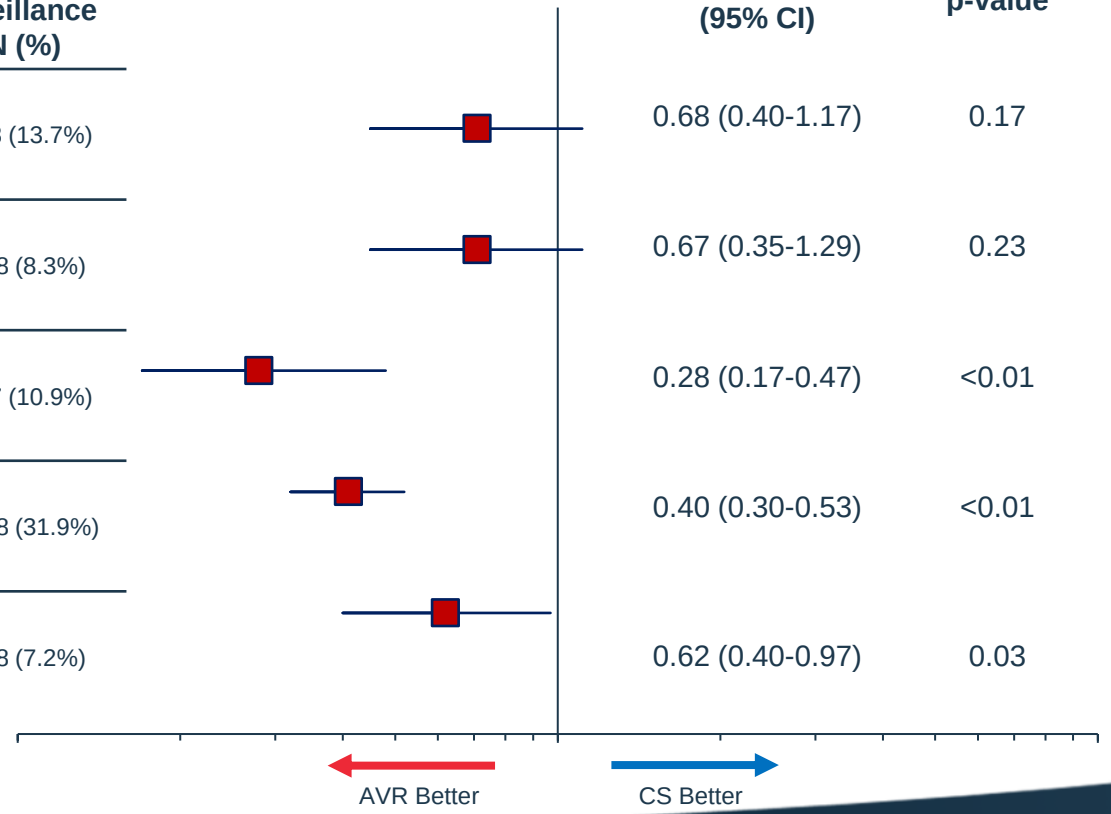
Meta-Analysis 4 RCTs Asymptomatic Severe AS

	Early AVR n/N (%)	Clinical Surveillance n/N (%)	Pooled Hazard Ratio* (95% CI)	p-value
All-Cause Mortality	70/719 (9.7%)	97/708 (13.7%)	0.68 (0.40-1.17)	0.17
Cardiovascular Mortality	37/719 (5.1%)	59/708 (8.3%)	0.67 (0.35-1.29)	0.23
Heart Failure Hospitalization	18/606 (3.0%)	65/597 (10.9%)	0.28 (0.17-0.47)	<0.01
Unplanned CV or HF Hospitalization	105/719 (14.6%)	226/708 (31.9%)	0.40 (0.30-0.53)	<0.01
Stroke	32/719 (4.5%)	51/708 (7.2%)	0.62 (0.40-0.97)	0.03



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Genereux et al. JACC 2025

ESC European Society of Cardiology
European Heart Journal (2025) **00**, 1–102
https://doi.org/10.1093/eurheartj/ehaf194

ESC GUIDELINES

2025 ESC/EACTS Guidelines for the management of valvular heart disease

Developed 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)

Authors/Task Force Members: Fabien Praz *†, (ESC Chairperson) (Switzerland), Michael A. Borger *†, (EACTS Chairperson) (Germany), Jonas Lanz ‡, (ESC Task Force Co-ordinator) (Switzerland), Mateo Marin-Cuartas ‡, (EACTS Task Force Co-ordinator) (Germany), Ana Abreu (Portugal), Marianna Adamo (Italy), Nina Ajmone Marsan (Netherlands), Fabio Barili (Italy), Nikolaos Bonaros (Austria), Bernard Cosyns (Belgium), Ruggero De Paulis (Italy), Habib Gamra (Tunisia), Marjan Jahangiri (United Kingdom), Anders Jeppsson (Sweden), Robert J.M. Klautz (Netherlands), Benoit Mores (Belgium), Esther Pérez-David (Spain), Janine Pöss (Germany), Bernard D. Prendergast (United Kingdom), Bianca Rocca (Italy), Xavier Rossello (Spain), Mikio Suzuki (Serbia), Holger Thiele (Germany), Christophe Michel Tribouilloy (France), Wojtek Wojakowski (Poland), and ESC/EACTS Scientific Document Group

ESC European Society of Cardiology
European Heart Journal (2025) **00**, 1–102
https://doi.org/10.1093/eurheartj/ehaf194

Asymptomatic patients with severe aortic stenosis		
Intervention is recommended in asymptomatic patients with severe AS and LVEF <50% without another cause.[14,354–359]	I	B
Intervention should be considered in asymptomatic patients (confirmed by a normal exercise test, if feasible) with severe, high-gradient AS and LVEF ≥50% as an alternative to close active surveillance, if the procedural risk is low.[360–363,367,368]	IIa	A
Intervention should be considered in asymptomatic patients with severe AS and LVEF ≥50% if the procedural risk is low and one of the following parameters is present: • Very severe AS (mean gradient ≥60 mmHg or V_{max} >5.0 m/s).[14,362,363,482–484] • Severe valve calcification (ideally assessed by CCT) and V_{max} progression ≥0.3 m/s/year.[303,353,364] • Markedly elevated BNP/NT-proBNP levels (more than three times age- and sex-corrected normal range, confirmed on repeated measurement without other explanation).[97,365] • LVEF <55% without another cause.[14,354,356–359]	IIa	B
Intervention should be considered in asymptomatic patients with severe AS and a sustained fall in BP (>20 mmHg) during exercise testing.	IIa	C

360. Généreux P, Schwartz A, Oldemeyer JB, Pibarot P, Cohen DJ, Blanke P, *et al.* Transcatheter aortic-valve replacement for asymptomatic severe aortic stenosis. *N Engl J Med* 2024;**392**:217–27. https://doi.org/10.1056/NEJMoa2405880

368. Généreux P, Banovic M, Kang DH, Giustino G, Prendergast BD, Lindman BR, *et al.* Aortic valve replacement vs clinical surveillance in asymptomatic severe aortic stenosis: a systematic review and meta-analysis. *J Am Coll Cardiol* 2024;**85**:912–22. https://doi.org/10.1016/j.jacc.2024.11.006

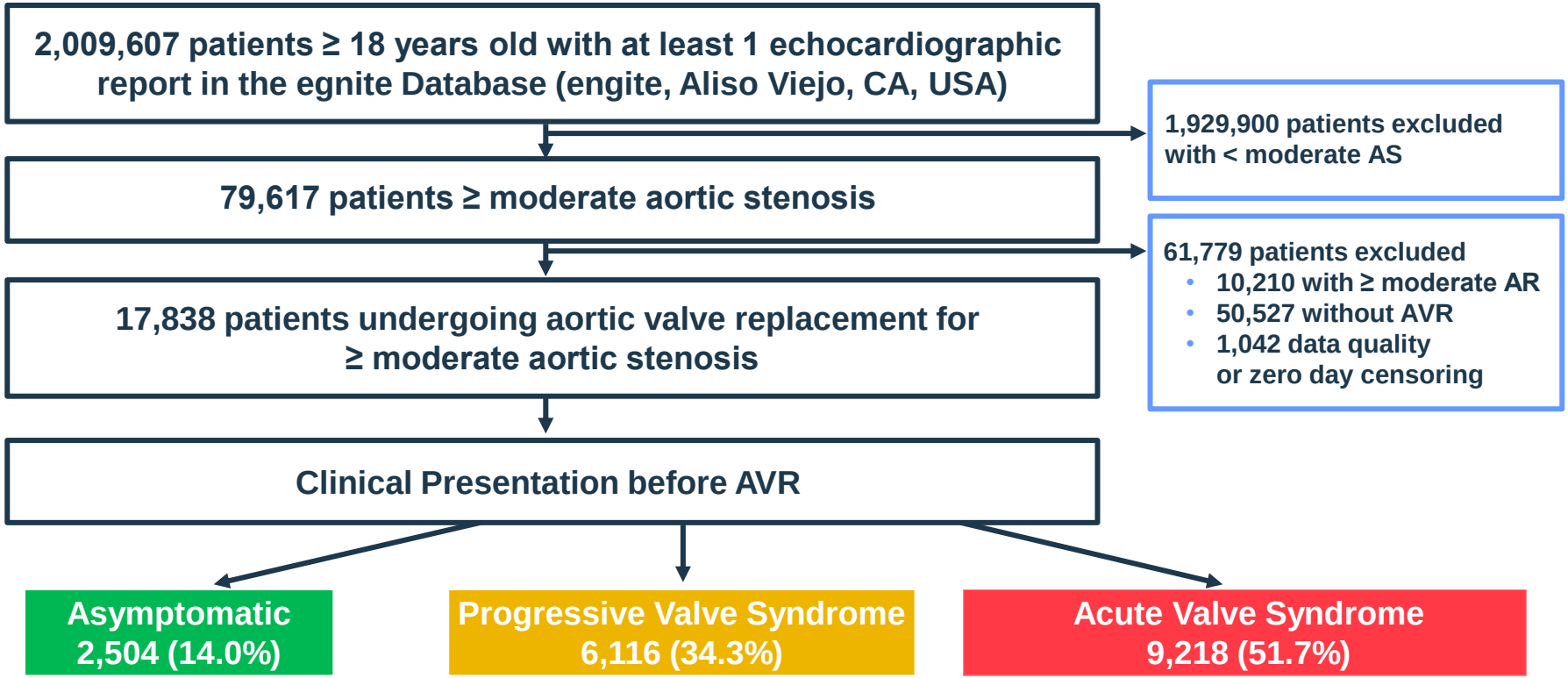
Just Published on-line

Acute Valve Syndrome in Aortic Stenosis

Philippe Généreux, MD Patricia A. Pellikka, MD, Brian R. Lindman, MD, MSCI, Philippe Pibarot, DVM, PhD, Santiago Garcia, MD, Konstantinos P. Koulogiannis, MD, Evelio Rodriguez, MD, Vinod H. Thourani, MD, Michael Dobbles, MS, Gennaro Giustino, MD, Rahul P. Sharma, MBBS, David J. Cohen, MD, MSc, Allan Schwartz, MD, Martin B. Leon, MD, Linda D. Gillam, MD, MPH

Atlantic Health System

Study Flow Chart



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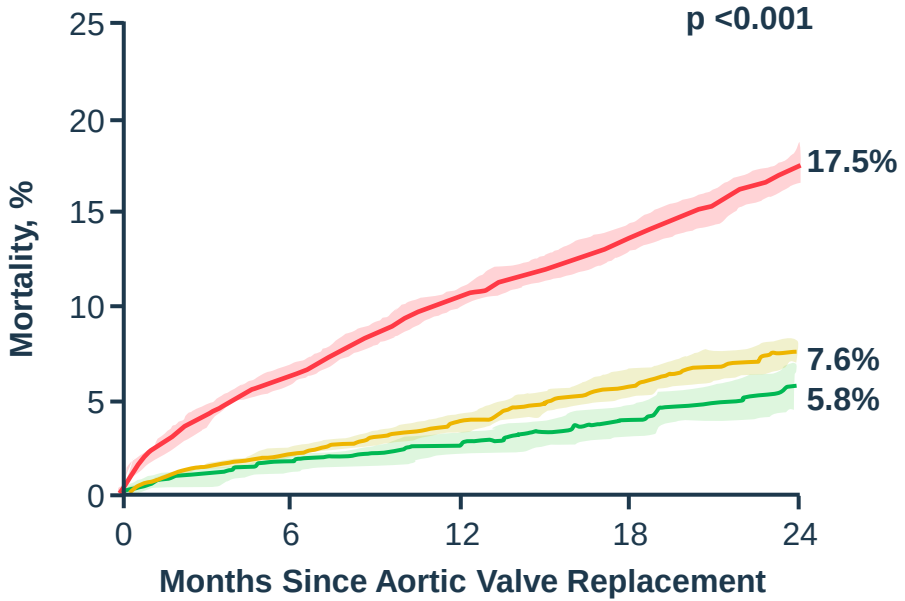
TAVR: 78.6%, SAVR: 21.4%
Mean age: 76.5±9.7 years, 40.2% were female

2-Year Mortality After AVR Per Clinical Presentation

ASx vs. Progressive vs. Acute Valve Syndrome



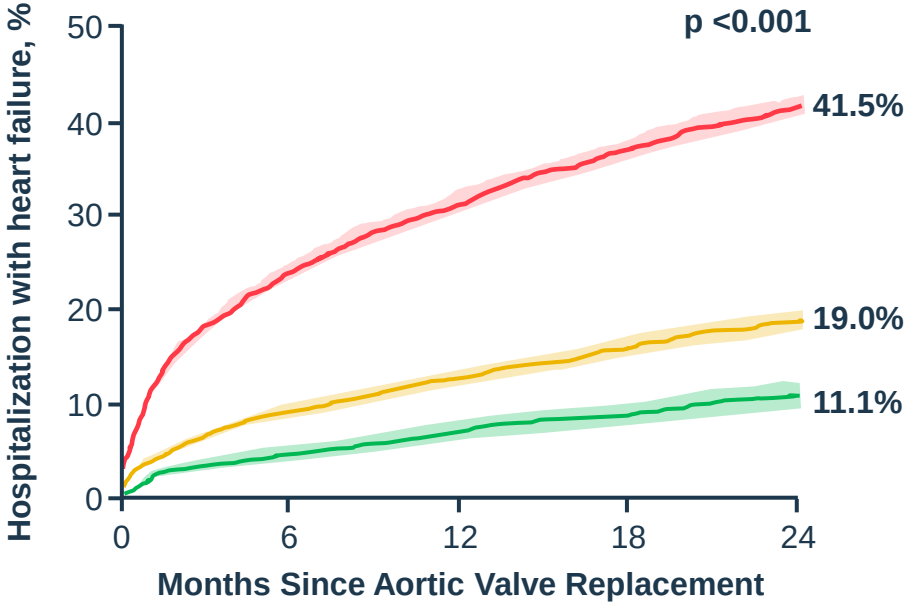
No. at Risk					
Asymptomatic	2504	1859	1540	1176	934
Progressive	6116	4710	3867	2871	2147
Acute	9218	6667	5243	3702	2700

Atlantic Health System

Genereux et al. Structural Heart In Press 2025

2-Year HF Hospitalization After AVR Per Clinical Presentation

ASx vs. Progressive vs. Acute Valve Syndrome



No. at Risk					
Asymptomatic	2504	1774	1449	1094	855
Progressive	6116	4311	3426	2471	1792
Acute	9218	5210	3801	2514	1750

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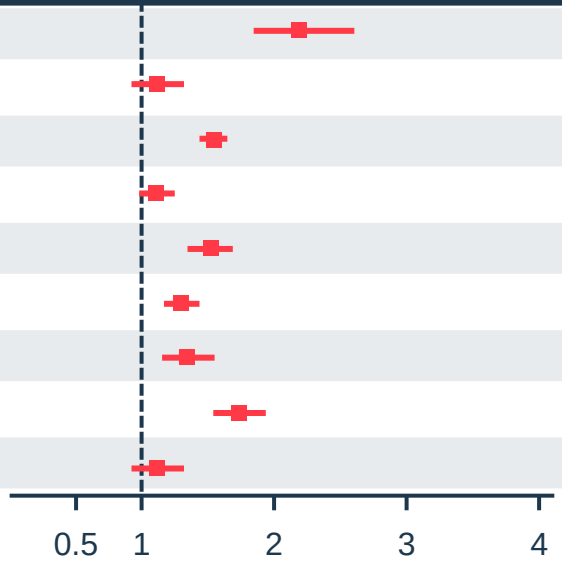
Predictor of 2-Year Mortality after AVR

Covariate	HR (95% CI)
Acute Valve Syndrome	2.2 (1.8 to 2.6)
Progressive Valve Syndrome	1.1 (0.9 to 1.4)
Age (Decade)	1.6 (1.5 to 1.6)
Male	1.1 (1.0 to 1.2)
COPD	1.5 (1.4 to 1.7)
Diabetes	1.3 (1.2 to 1.4)
Myocardial Infarction	1.4 (1.2 to 1.5)
Renal Disease	1.7 (1.6 to 1.9)
Stroke	1.1 (0.9 to 1.3)



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2-Year Hospitalization with Heart Failure after AVR

Covariate	HR (95% CI)
Acute Valve Syndrome	3.3 (2.9 to 3.8)
Progressive Valve Syndrome	1.5 (1.3 to 1.8)
Age (Decade)	1.3 (1.2 to 1.3)
Male	0.9 (0.8 to 1.0)
COPD	1.6 (1.5 to 1.7)
Diabetes	1.3 (1.2 to 1.4)
Myocardial Infarction	1.4 (1.2 to 1.5)
Renal Disease	1.7 (1.5 to 1.9)
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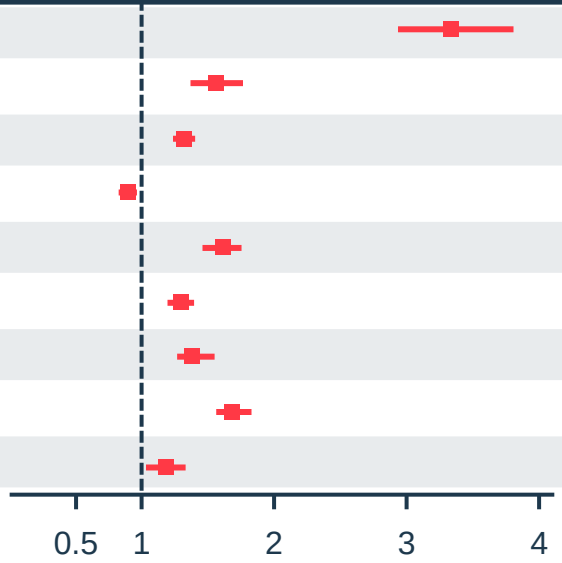

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Journal of the American Heart Association

ORIGINAL RESEARCH

Acute Valve Syndrome Before Aortic Valve Replacement: Impact on Clinical Outcomes, Health Care Costs, and Resource Use

Philippe Généreux, MD; Gennaro Giustino, MD; Brian R. Lindman, MD; Philippe Pibarot, DVM, PhD; Suzanne J. Baron, MD, MSc; Chantal Asselin, MD; Alissa Dratch, MPH; Shannon M. E. Murphy, MA; Soumya Chikermane, PhD; Vinod H. Thourani, MD; Kostantinos P. Koulogiannis, MD; Allan Schwartz, MD; Martin B. Leon, MD; Patricia P. Pellikka, MD; Linda D. Gillam, MD, MPH

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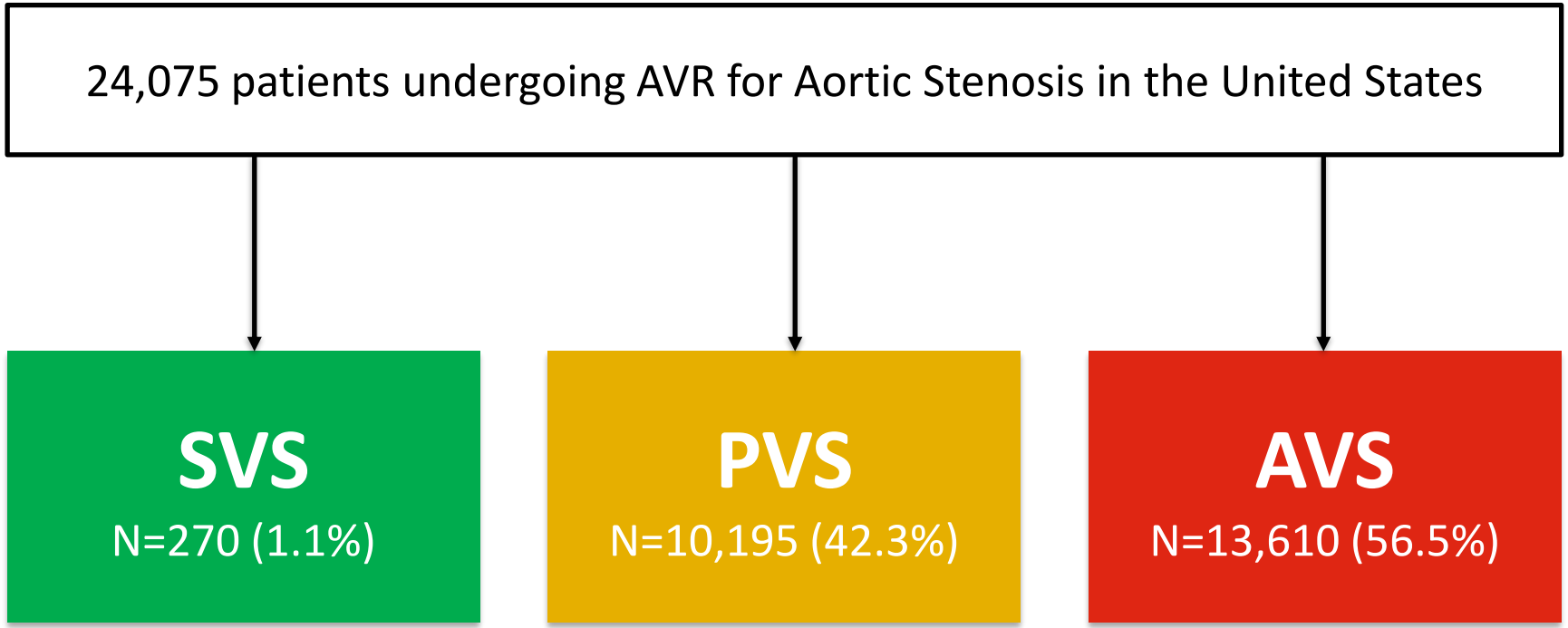
Study Cohort: Clinical Presentation Before AVR



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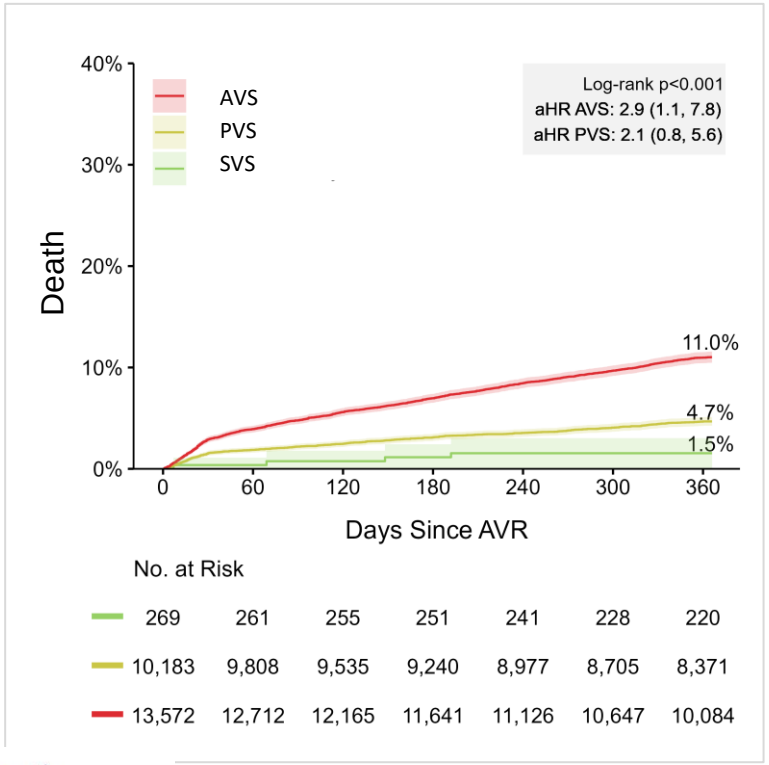
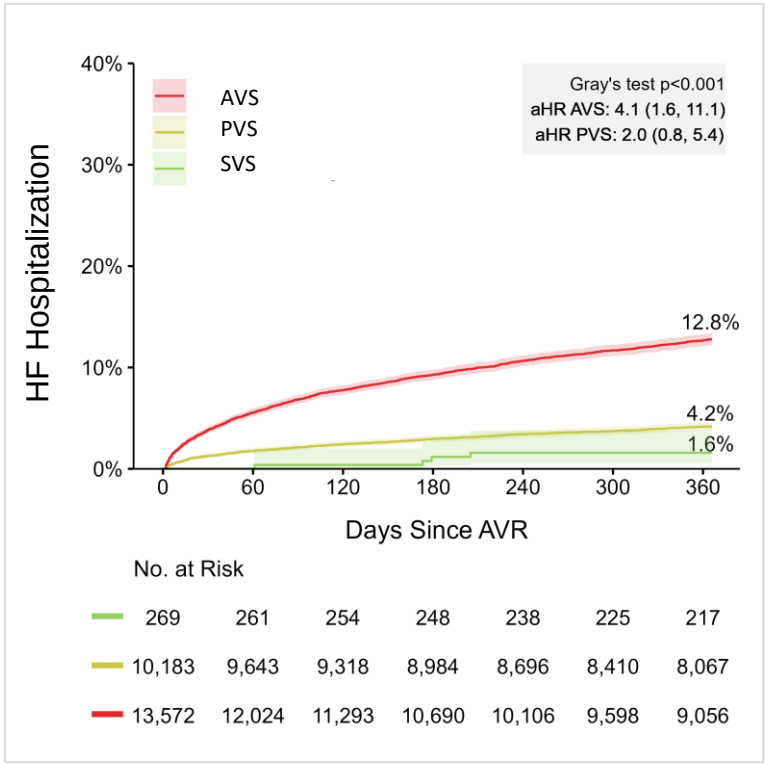
Acute Valve Syndrome is Associated with Increased Risk of Death and HF Hospitalization Post-AVR





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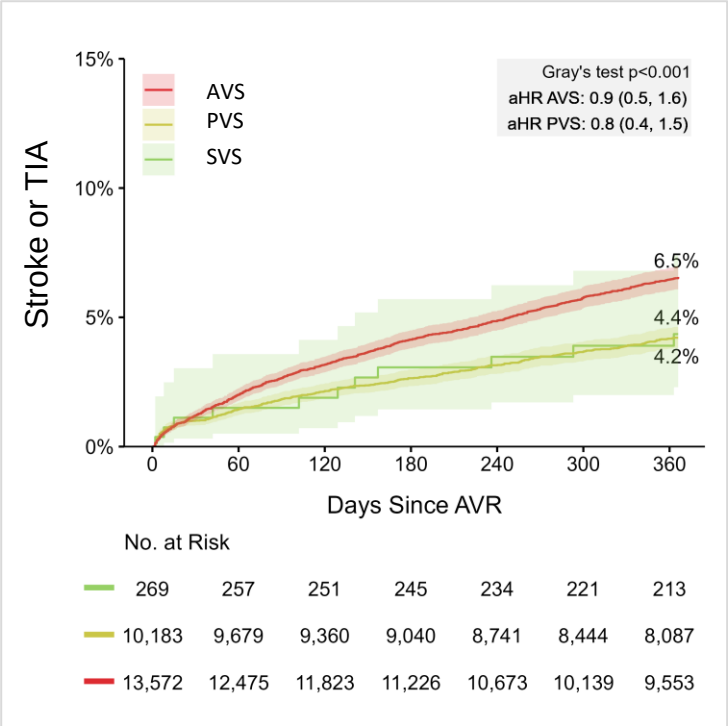
Acute Valve Syndrome is Associated with Increased Risk of Stroke Post-AVR



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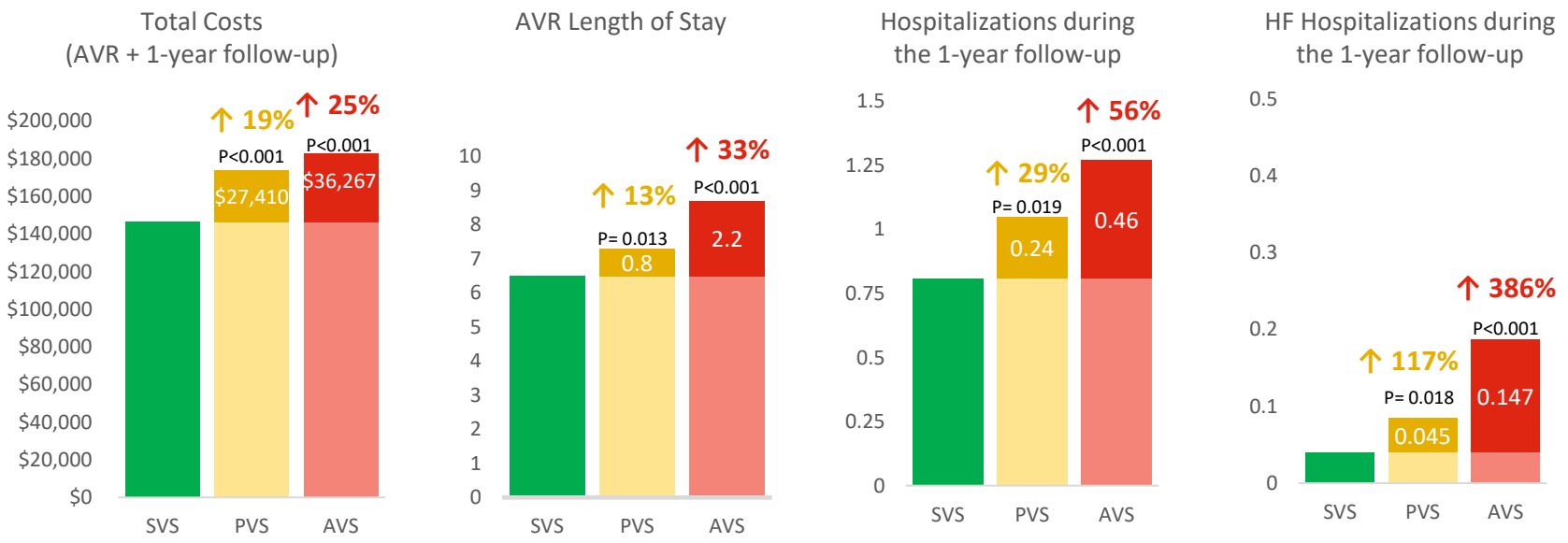
Healthcare Cost and Utilization by Clinical Presentation before AVR



AVS and PVS before AVR are associated with higher total costs, increased LOS, higher all-cause and HF hospitalizations post AVR.

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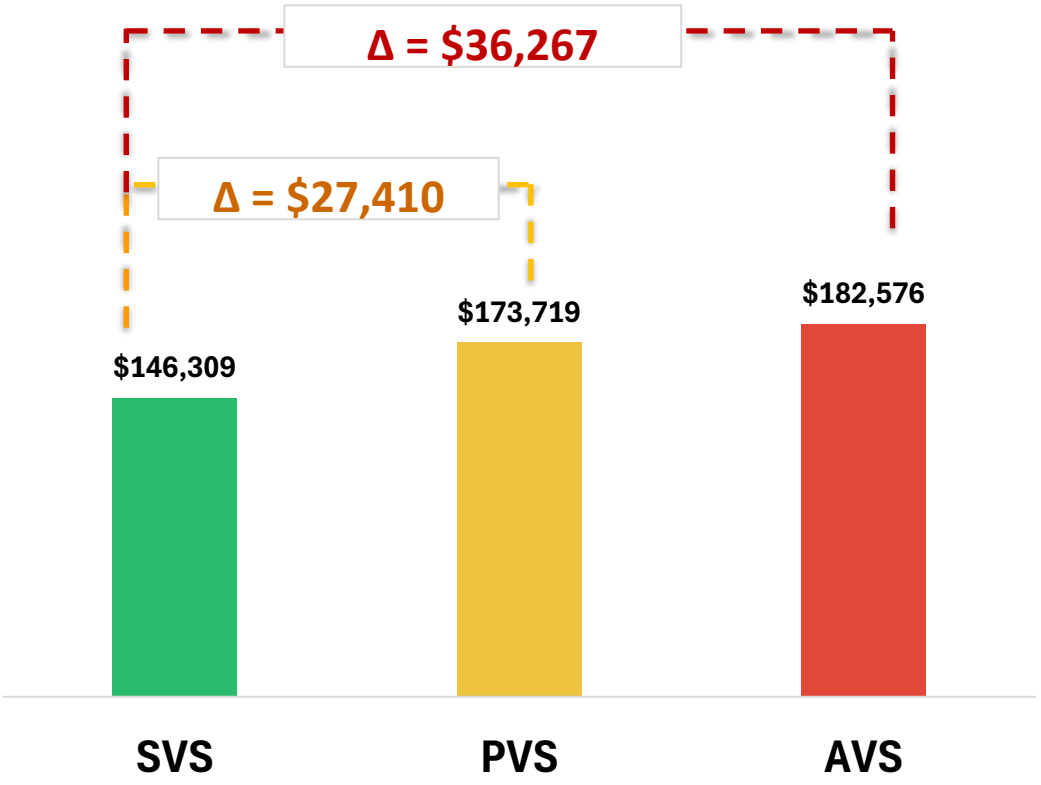
Total Healthcare Cost Up to 1 year after AVR Across Clinical Presentation



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Post EARLY TAVR:

What do I say to My Patients? To Referring Physicians?

- **Refer early** (Severe AS no symptoms or Moderate AS)
- **Complete workup for AS treatment**
  - CT-Scan for procedural planning
  - Dental work
  - Plan your AVR date ahead of time **to avoid AVS**
  - If you wait for symptoms, ***treat within 3 months of symptoms onset*** to mitigate mortality risk of longer waiting period
- **There was no penalty to early intervention**
  - Prompt Treatment will save heart failure hospitalization, stroke, and AVS
  - Prompt Treatment will save cardiac damage and $$$ to the Health Care System

The Future of TAVR?

Prevention of Cardiac Damage

THE EARLY TAVR TRIAL

Asymptomatic Severe, Calcific AS

Screening
Not eligible if <65, has Class 1 indication for AVR, bicuspid valve, not suitable for TF access or STS > 10

Asymptomatic N=901 pts
Negative stress test OR confirmation via med history*

Randomization 1:1
Stratified by ability to perform stress test

TF- TAVR | **Clinical Surveillance**

Clinical and Echo Follow-up:
30 days (TAVR only), 1, 2, 3 and 5 years

Symptomatic
Positive stress test

Registry

Commercial AVR (TAVR or SAVR), Clinical Trial (P3), etc.

Telephone Follow-up:
1, 2, 3 and 5 years

Primary Endpoint (superiority):
2-year composite of all-cause death, all stroke, and unplanned cardiovascular hospitalization

Principal Investigator: Philippe Généreux, MD
Co-PI: Allan Schwartz, MD
Chair: Martin B. Leon, MD

THE PROGRESS TRIAL

Local Heart Team, Case Review Board & Core Lab Assessments

Moderate aortic stenosis **with symptoms or cardiac damage / dysfunction**
Anatomy appropriate for transfemoral access

1:1 Randomization
(750 patients)

TAVR
(SAPIEN 3 Platform)

vs.

CS
(Delayed aortic valve replacement is allowed for patients that develop severe AS)

Primary endpoint
2-Year
All-cause mortality and unplanned cardiovascular hospitalization

Follow-up
Annually Through 10 years

Conclusion

Future of Aortic Stenosis Management

- Screening will become key to detect significant (moderate, severe) AS
- Early Referral to ensure adequate and preemptive procedural planning
- Timely and prompt AVR is key; don’t wait for symptoms >3 months
- Lifetime management is important while planning the first intervention