Percutaneous Mitral Valve Repair of Mitral Valve Prolapse using MitraClip

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Abstract

Background: Chronic mitral regurgitation can be divided into primary and secondary. The most common cause of chronic primary mitral regurgitation in developed countries is mitral valve prolapse. Many patients remain asymptomatic for quite some time, although its presence has an impact on the prognosis that is why it is mandatory to be address appropriately. In patients with chronic symptomatic, severe mitral regurgitation from degenerative cause, surgical mitral valve repair remains the gold standard. However, percutaneous mitral valve repair has been in progress in different countries and it has shown propitious result. Mitraclip restores leaflet coaptation by approximating the edges of the regurgitant mitral valve leaflets under transesophageal echocardiography and fluoroscopic guidance.

Case: This is a case of a 61-year-old male, hypertensive, who came in for routine checkup prior to endoscopy which showed severe mitral regurgitation from posterior mitral valve prolapse three years ago. He was given the option to undergo surgical versus transcutaneous repair of the mitral regurgitation but opted to be treated medically. Four months prior to consult patient underwent emergency ventriculo-peritoneal shunting and coil embolization secondary to left posterior cerebral artery aneurysm. He was discharged improved with no residual deficit. Afterwards, the patient reconsidered the choice of mitraclip.

Diagnostics and therapeutic: Work-up done to the patient revealed moderate coronary artery disease of the ramus intermedius and severe mitral regurgitation secondary to posterior mitral valve prolapse for which he underwent percutaneous mitral clip.

Conclusion: The successful performance of mitraclip in our institution offers our future patients an alternative to surgical repair or replacement. It is comparable to surgery in terms of reducing the left ventricular volume, dimension and mitral gradient.

Background

Mitrval regurgitation or insufficiency is a common heart valve problem and treatment will depend on the severity and the presence of symptoms. Mild to moderate mitral regurgitation usually does not require treatment whereas the gold standard for chronic, severe MR is surgical replacement or repair of valve [1,2]. Chronic mitral regurgitation can be divided into primary and secondary. The most common cause of chronic primary mitral regurgitation in developed countries is mitral valve prolapse [3]. Many patients remain asymptomatic, but despite this, the severity of mitral regurgitation has an impact on the prognosis of mitral valve prolapse. It usually has frequent and serious complications, including mitral regurgitation requiring surgery, stroke, atrial fibrillation, and heart failure [1-3]. Continued follow-up is needed and it is mandatory that symptoms and changes on the valve defect be addressed accordingly and appropriately. In patients with chronic symptomatic, severe mitral regurgitation from degenerative cause, surgical mitral valve repair remains the treatment of choice [4]. Search for a safer solution for high-risk individuals in whom surgery poses a great threat drove the use of the MitraClip procedure [5]. MitraClip produced lower rates of hospital mortality and adverse events according to ACCESS-EU study [6] Mitraclip approximates the edges of the regurgitant mitral valve restoring leaflet coaptation. This is being done under transesophageal echocardiography and fluoroscopic guidance [7]. Worldwide, there is increasing use of the said procedure. Several clinical registries in the USA and Europe established its high procedural success rates, safety and durability [8,9]. In the Philippines, there were only two previous attempts for MitraClip Procedure and only one was successful. This paper aims to present the 3rd attempt for Mitra Clip Procedure here in the Philippines and to discuss the techniques done which possibly contributed to a successful outcome.

Case report

A 61-year-old male came in our institution for routine checkup. Patient claimed to be asymptomatic, physically active without limitations of his daily activities. He consulted with a private physician and requested to have endoscopy. On physical examination, there was a presence of murmur hence 2d-echocardiogram was requested and revealed severe mitral regurgitation secondary to a posterior mitral valve prolapse. He was referred to a cardiologist for further management. He was advised to undergo repair via surgery or percutaneous procedure but opted medical therapy initially. On the interim, patient developed...
severe headache, and was rushed to a nearby hospital. Blood pressure was elevated at 178/104 with progressive decrease in sensorium. Cranial CT scan revealed aneurysm of the posterior cerebral artery with increase in intracerebral pressure. He underwent emergency ventriculostomy and was transferred to our institution for coiling of the left posterior cerebral artery aneurysm. He was discharged well and after one month was noted to be ambulatory with no neurologic deficit.

He had close follow up at outpatient for monitoring. The option of undergoing trans-catheter repair of the mitral regurgitation was contemplated. After four months of follow up, he was admitted for the MitraClip procedure. On physical examination, he was conscious, coherent and ambulatory, with a BMI of 21.5 kg/m². He had stable vital signs of 100/60, 75, 18 with a JVP of 5 cmH₂O. He had dynamic precordium, AB at the 6th LICS, MCL (+) LV heave, (+) thrill, normal S1 and S2, (+) 4/6 holoystolic murmur area best heard on apical area accentuated by standing, palpable P2, with no Carvallo’s sign. Rest of the physical and neurologic examination was normal. His maintenance medications were Perindopril, Amlodipine, Atorvastatin and Clopidogrel.

Diagnoses

Prior to the procedure, diagnostic examinations were requested. His 12-L ECG was sinus rhythm with normal axis, left atrial enlargement and left ventricular hypertrophy (Figure 1). In Figure 2, his chest radiogram showed an enlarged heart with left ventricular (LV)

Table 1. Anatomical Selection Criteria for the MitraClip device adapted from Maisano et al. [10].

<table>
<thead>
<tr>
<th>Anatomical Selection Criteria for the MitraClip Device</th>
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<tbody>
<tr>
<td><strong>Recommended anatomical criteria (from the EVEREST trial)</strong></td>
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<tr>
<td>MR originates from the A2-P2 area</td>
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<tr>
<td>Coaptation length &gt; 2 mm</td>
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<tr>
<td>Coaptation depth &lt; 11 mm</td>
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<tr>
<td>Flail gap &lt; 10 mm</td>
</tr>
<tr>
<td>Flail width &lt; 15 mm</td>
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<tr>
<td>Mitral valve orifice area &gt; 4 cm²</td>
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<tr>
<td><strong>Additional Criteria for Caution</strong></td>
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<tr>
<td>Short posterior leaflet (&lt; 8 mm)</td>
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<tr>
<td>Restricted posterior leaflet prolapse/flail width &gt; 15 mm</td>
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<tr>
<td>Calcification in the grasping area</td>
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<tr>
<td>Cleft or subcommissures in the area of the jet</td>
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</tbody>
</table>

Diagnostics

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Percutaneous MVR procedure

The two-part system of MitraClip consists of the Clip delivery system and the Steerable guide catheter. The device is usually made of a polyester fabric and a metal alloy. The way it function is like doing an Alfieri repair technique wherein it grasps the mitral leaflets causing an end-to-end approximation. The patient was sedated and intubated under general anesthesia. Transvenous access through right femoral was done. Atrial transeptal puncture was performed via transesophageal guidance. Thereafter, the MitraClip was fed through the catheter and directed towards the mitral valve where it is aligned with the maximum jet originating from the regurgitant lesion. The clip

Figure 1. 12-L-ECG showed sinus rhythm, normal axis, left atrial enlargement and left ventricular hypertrophy.
was adjusted and positioned several times to allow for the device to have a better grasp of the leaflets. After adequate reduction of regurgitation using multiple echo views, the first clip was deployed approximating the A2P2 segments. Persistent moderate regurgitation necessitated a second clip to be deployed. The second clip was inserted and positioned near the first deployed clip. The thorough views of TEE provided the best position to deploy the second clip reducing the regurgitation remarkably to trivial.

The previously mentioned selection criteria for valves with the best morphology that warrants mitraclip are again the following: mitral valve opening area >4 cm², mobile length of the posterior leaflet ≥10 mm and coaptation depth <11 mm, normal leaflet strength and mobility, flail width <15 mm and flail gap <10 mm, central pathology in segment 2 with no calcification [12]. In our patient, he had a central
pathology with no calcification, flail gap of 4.7 mm and flail width of 4.1 mm. The two mitraclips were placed on the A2P2 segments where it gave a good grip of the leaflets approximating thru the entire cardiac cycle. Here in the Philippines, this is the third attempt for MitraClip procedure and 2nd successful one. This percutaneous repair thru mitraclip was the first case in Cardinal Santos Medical Center. Patient tolerated the procedure with uneventful hospital stay. He was discharged after 3 days. He is currently maintained on clopidogrel, aspirin, atorvastatin, perindopril, amlodipine, carvedilol, mucosta and pantoprazole. Currently, patient is still asymptomatic with no murmur noted and a trivial mitral regurgitation on echocardiogram. According to EVEREST trial, percutaneous repair of the mitral valve has no difference to surgery in the future occurrence of MR or mitral valve intervention between 1 year and 4 year follow up. This translates to be an alternative strategy to mitral surgery.

Incidence of failure and reasons

Patients treated with MitraClip who failed to satisfy the EVEREST Trial Anatomical Selection Criteria was associated with more procedural failure and shorter durability.

Conclusion

The successful performance of this percutaneous approach in our institution offers our future patients an option for a safe, advantageous and effective treatment modality for patients who needs mitral valve repair but at the same time is high risk for surgical procedure because of co-morbidities.

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References


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