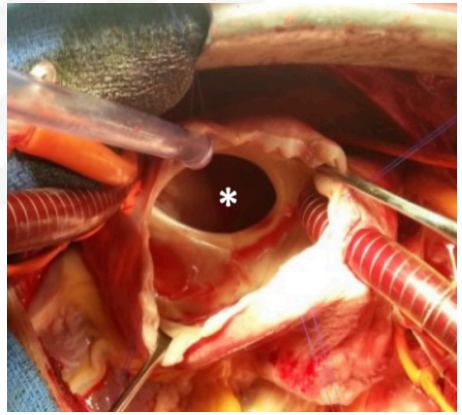
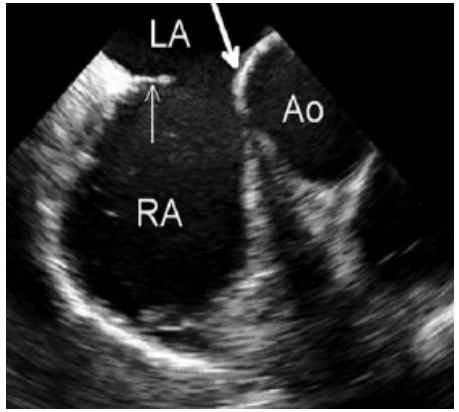
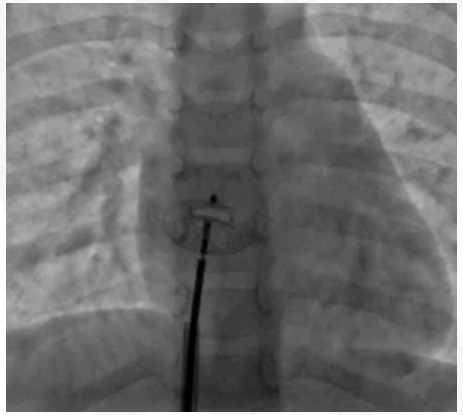
L'INSTITUT DE RYTHMOLOGIE ET MODÉLISATION CARDIAQUE
BORDEAUX

CIA - CAV partiel - RVPA partiel







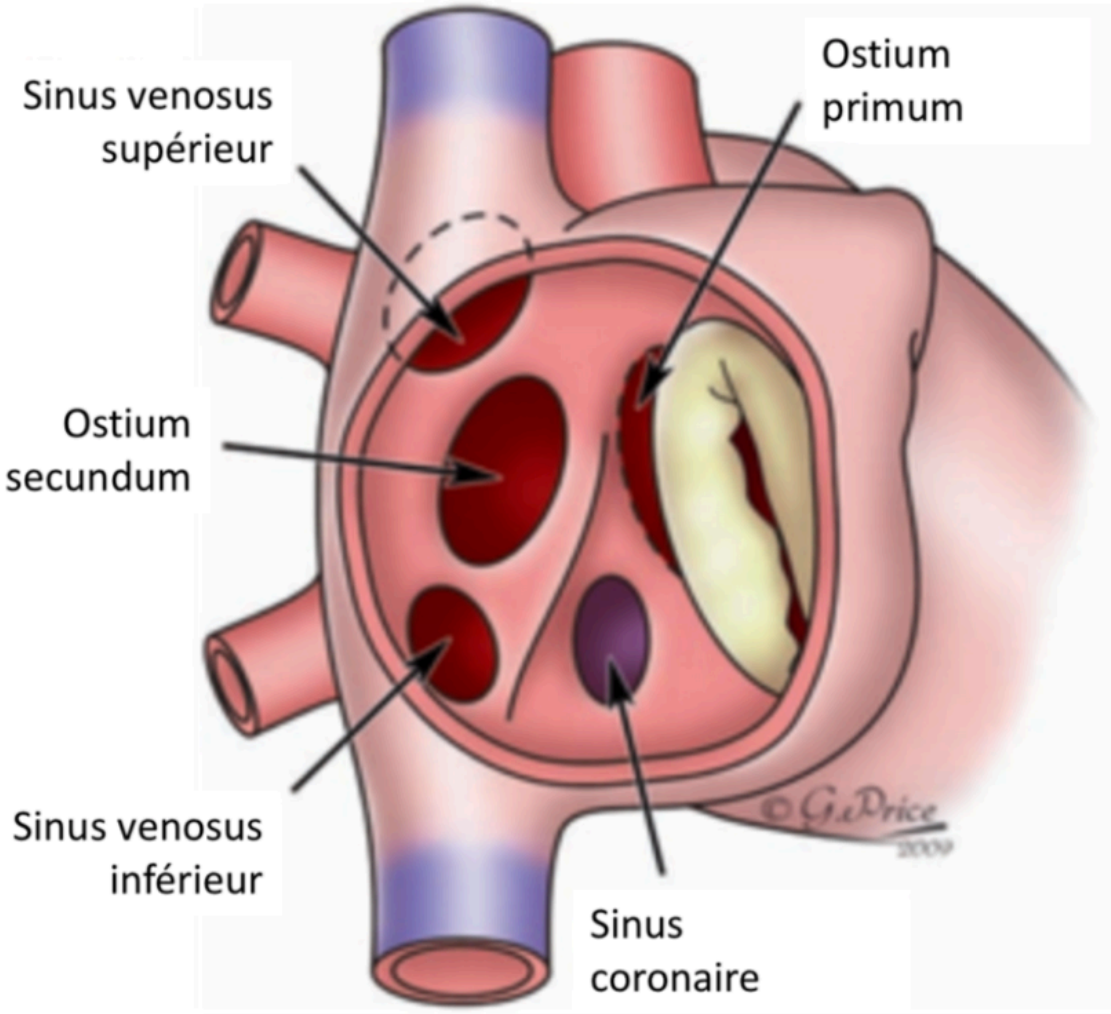
Zakaria Jalal – MD, PhD

Service des cardiopathies congénitales de l'enfant et de l'adulte

Hôpital cardiologique Haut Lévêque- Bordeaux

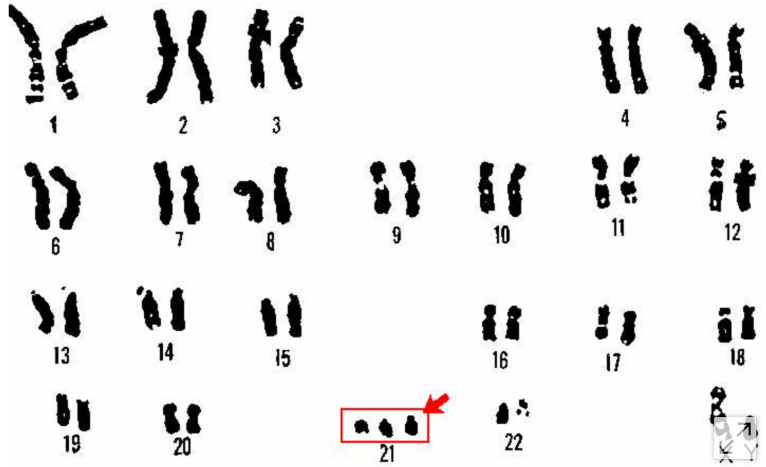
INTRODUCTION

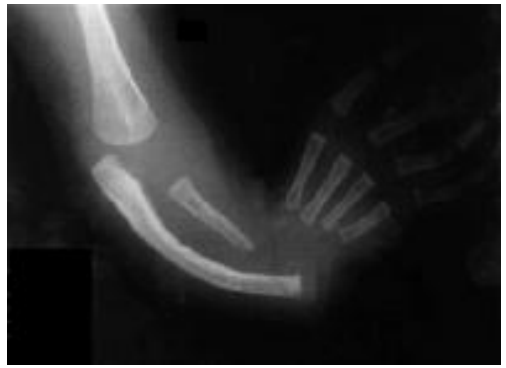
- 1/1500 naissances (10% des MCC)
- Associée à environ 50% des autres CC
- Diagnostic fréquent à l'âge adulte
- Types anatomiques:
  - CIA ostium primum (15%) => CAV
  - CIA ostium secondum (80%)
  - CIA sinus venosus (5%) => RVPAp
  - CIA sinus coronaire (rare)



GENETIQUE

- CIA ostium primum : T21
- CIA ostium secundum:
  - Holt Oram (TBX5, malformation MS)
  - NKX2.5 (CIA + BAV)
  - Elis Van Creveld (EVC1/EVC2, polydactylie, côtes courtes)





CANAL ATRIO-VENTRICULAIRE PARTIEL

ANOMALIE DES BOURGEONS ENDOCARDIQUES ET DE LA SEPTATION

- Non fermeture de l'ostium primum

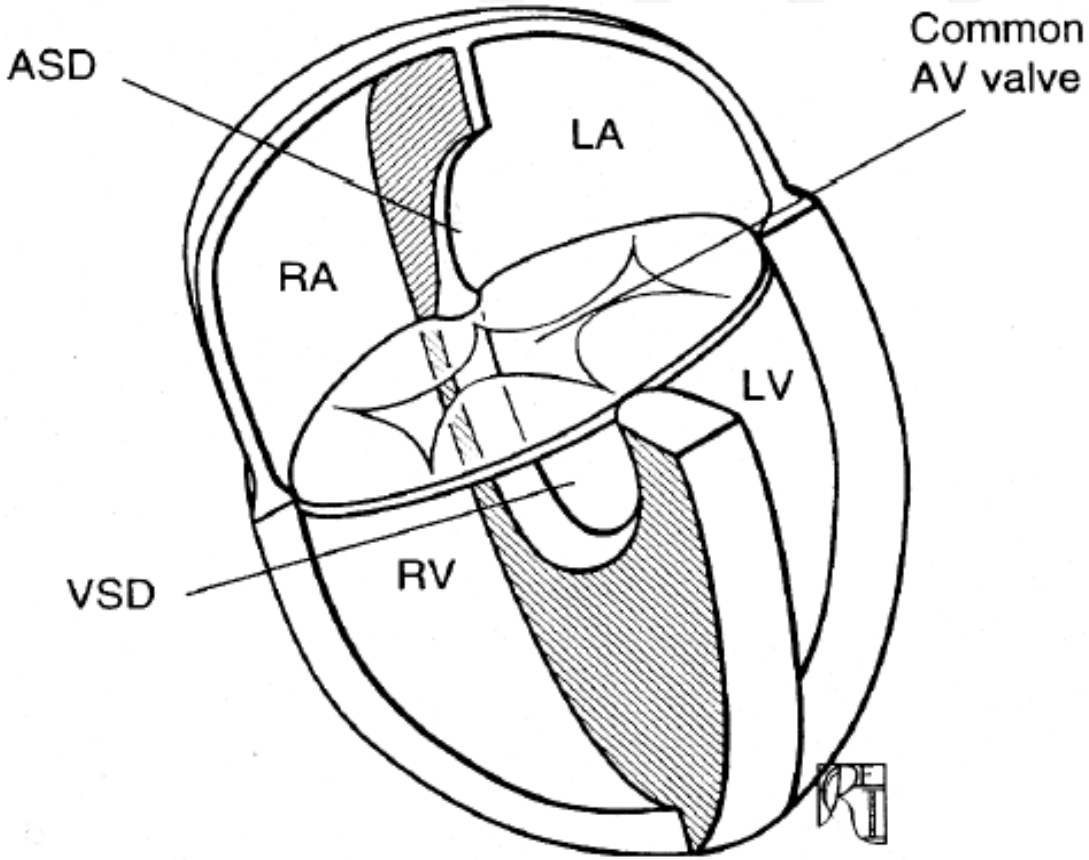
  ⇨ CIA

- Persistance d'une jonction auriculoventriculaire commune

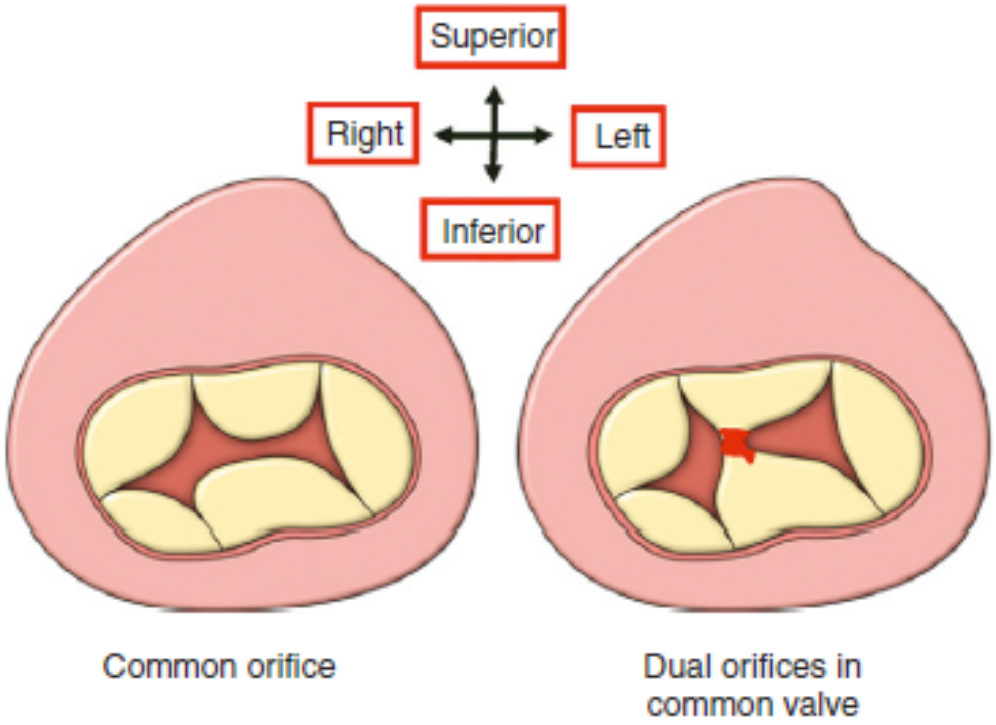
  ⇨ un seul anneau valvulaire

- Développement anormal du septum d'admission

  ⇨ CIV



CANAL ATRIO-VENTRICULAIRE PARTIEL



1 anneau auriculoventriculaire

1 orifice valvulaire (CIV)

2 orifices valvulaires (CIV fermée)

CAV complet

A

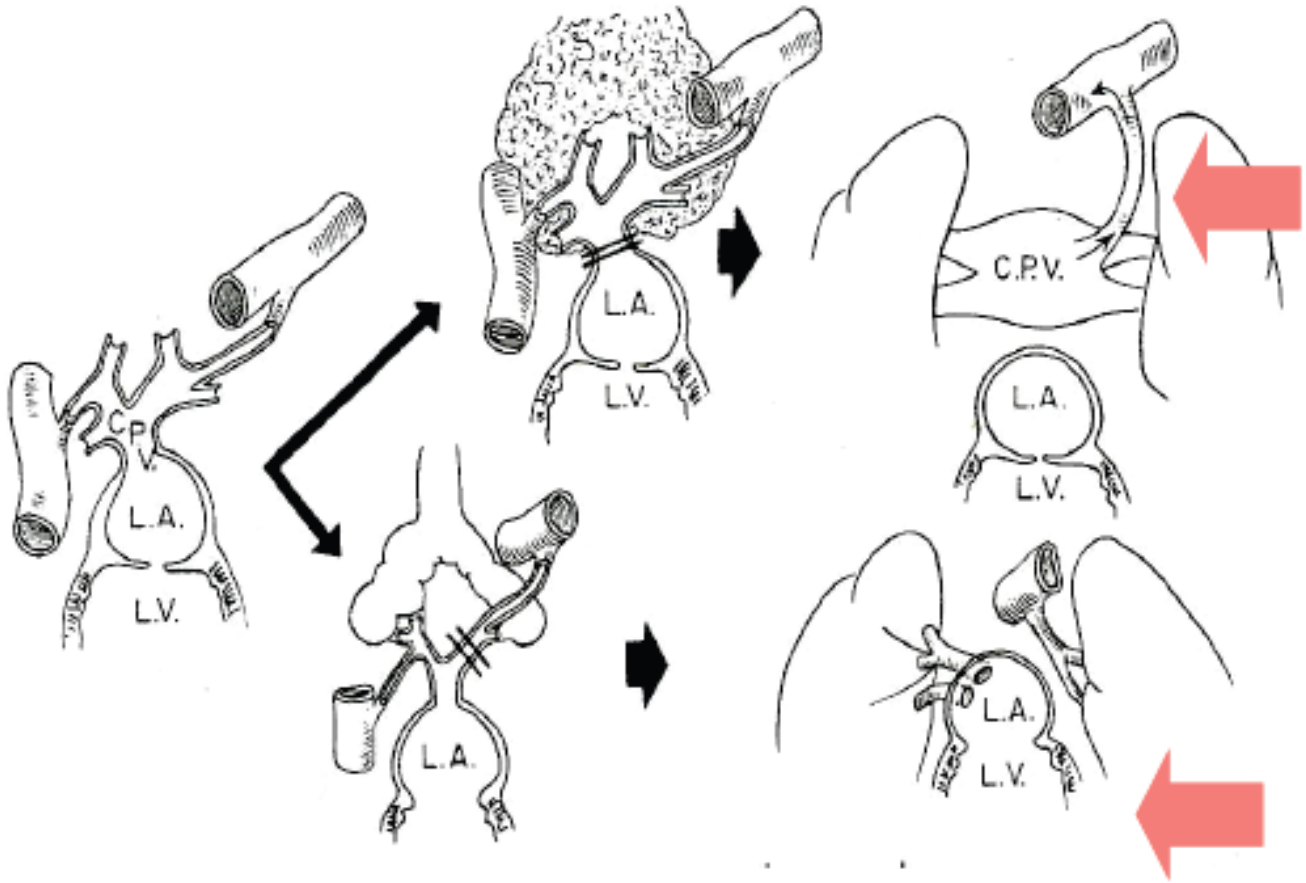
B

C

CAV intermédiaire (CIV restrictive)

CAV partiel

RVPAP



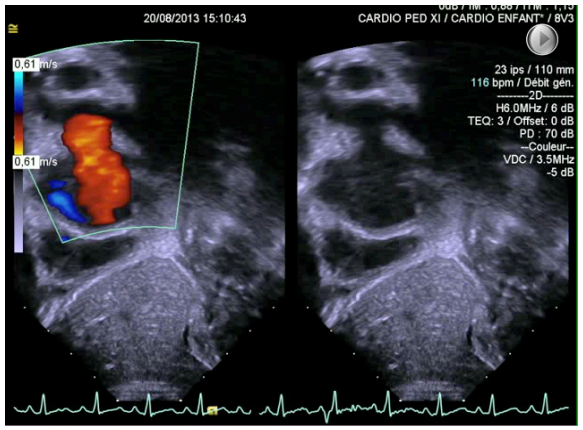
Atrésie de la veine pulmonaire commune : RVPA total avec persistance d ' une connexion (v. verticale)

Atrésie d' une branche de la VP commune : RVPA partiel

RVPAP

VP DROITES

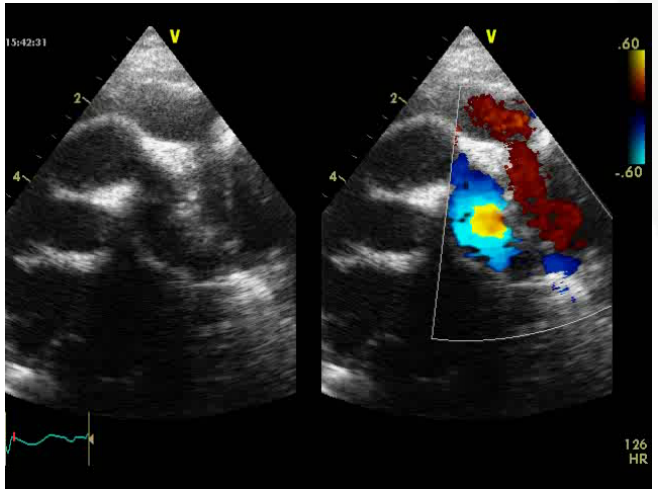
VCS

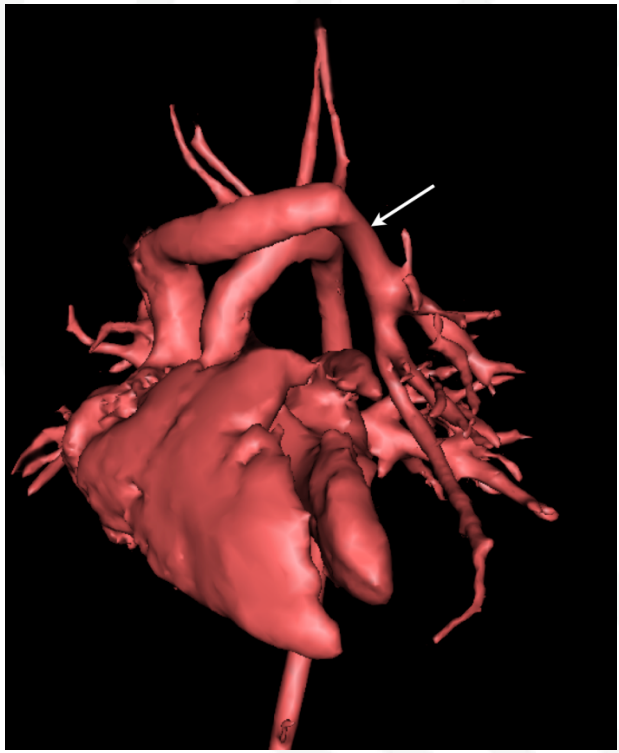


VCI

VP GAUCHES

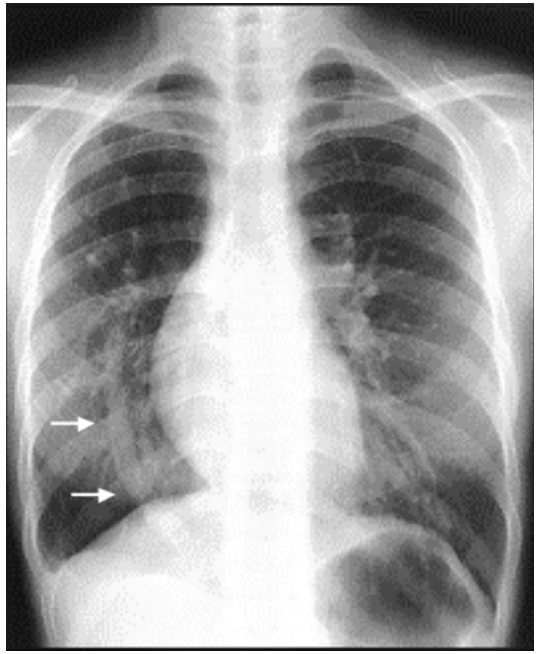
TVI

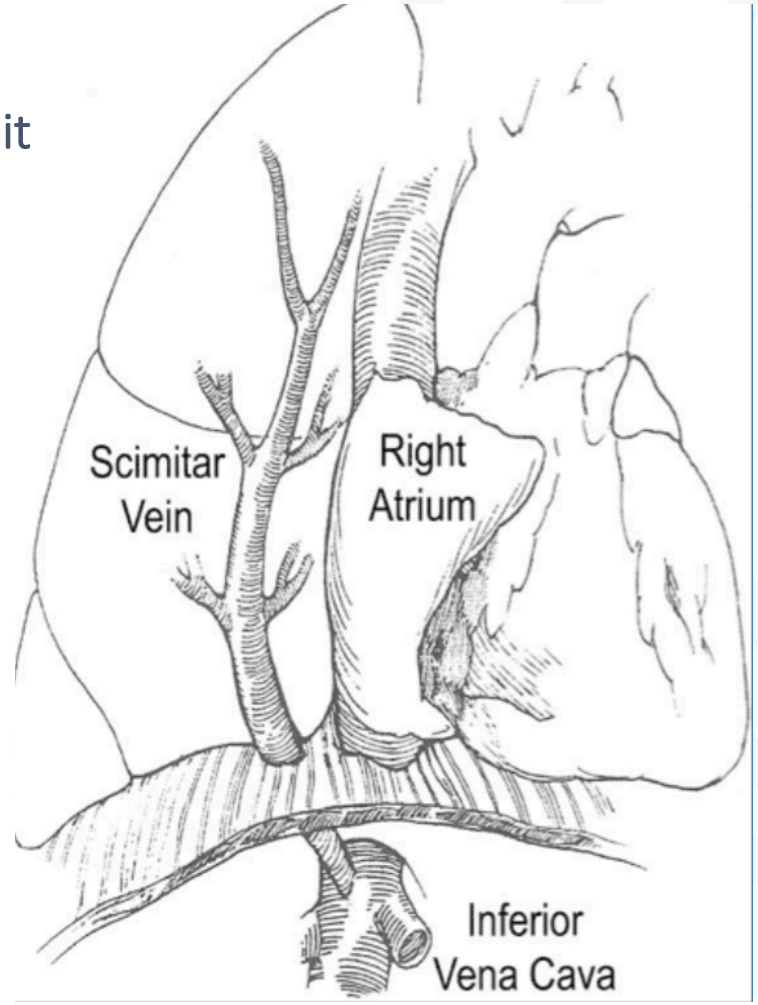




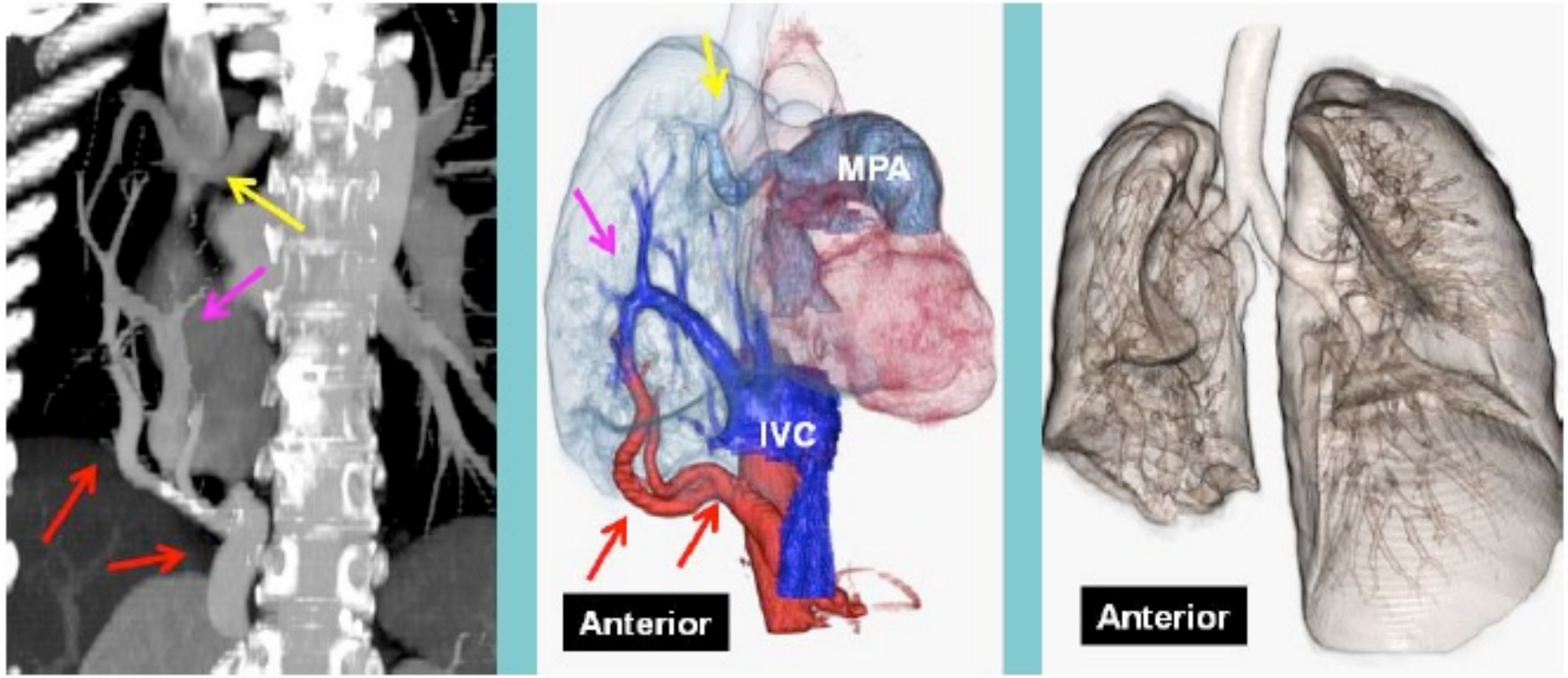
SYNDROME DE CIMETERRE

- RVPAP poumon D => VCI
- Hypoplasie pulmonaire droite
- Artère sequestrante poumon droit
- HTAP



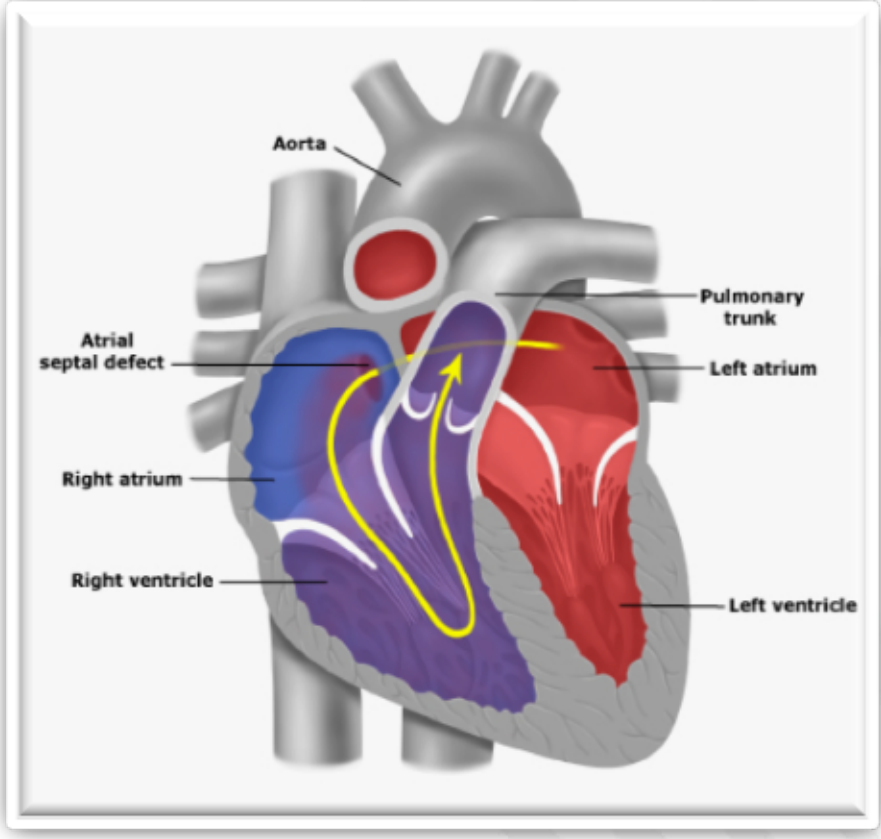


SYNDROME DE CIMETERRE



PHYSIOPATHOLOGIE

- Shunt dépendant des **compliances ventriculaires**
- Classiquement VD>VG => **Shunt G-D pré-tricuspide**
- **Surcharge volumique** cavités droites
- **Hyper débit** pulmonaire
- **Arythmies atriales**
- Syndrome **d'Eisenmenger**
- **Shunt D-G** d'emblée si SVP, anomalie tricuspide, HTAP

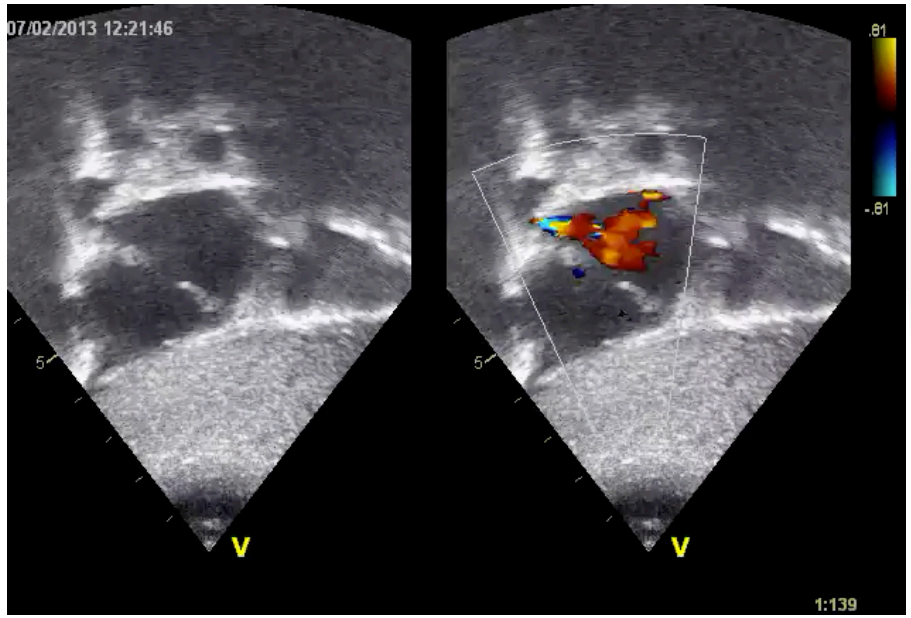


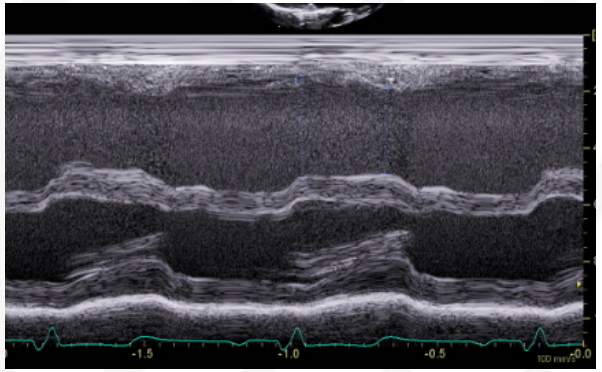
CLINIQUE

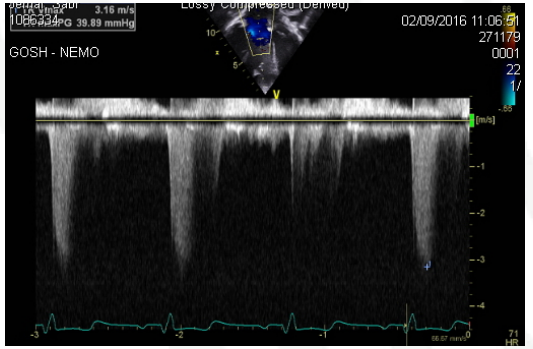
- Souvent **asymptomatique** (découverte fortuite adulte)
- **Hyperdébit pulmonaire** => Dyspnée, retard croissance, infections respiratoires
- **Arythmies** => Palpitations révélant une FA/Flutter/TA
- **Embolie paradoxale**
- **Insuffisance cardiaque droite**
- **Cyanose**

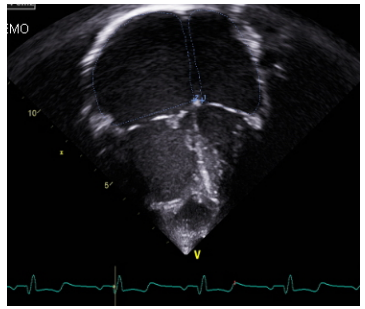
ECHOCARDIOGRAPHIE

- Diagnostic anatomique
- Retentissement:
  - Dilatation cavités droites
  - PAP
  - Qp/Qs
- Lésions associées (Valves AV, voie sous aortique, etc.)
- Possibilité de fermeture percutanée



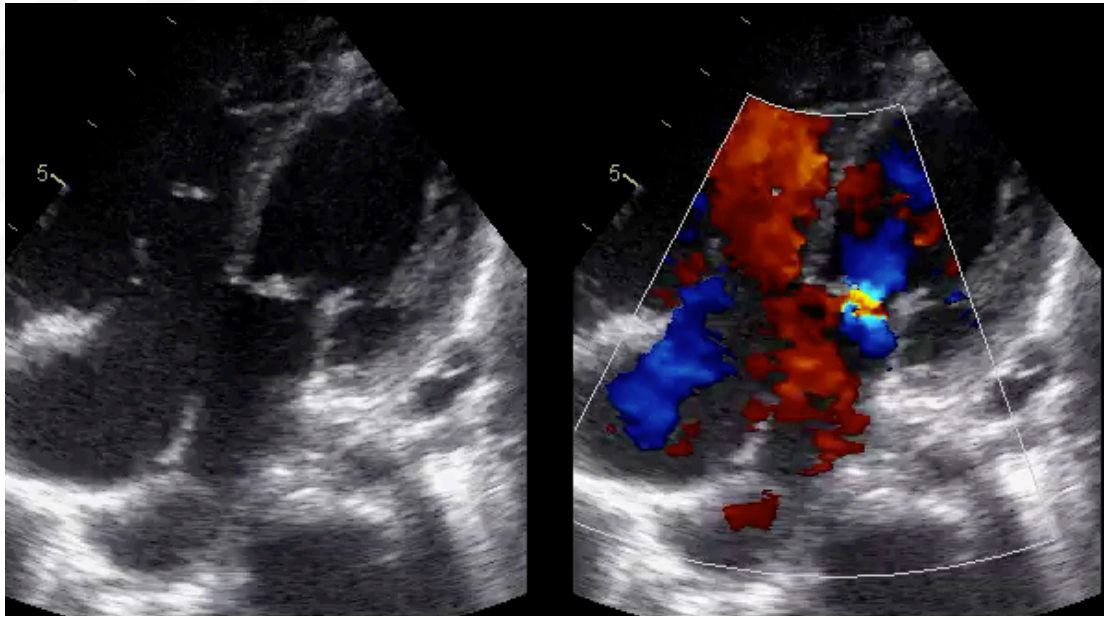


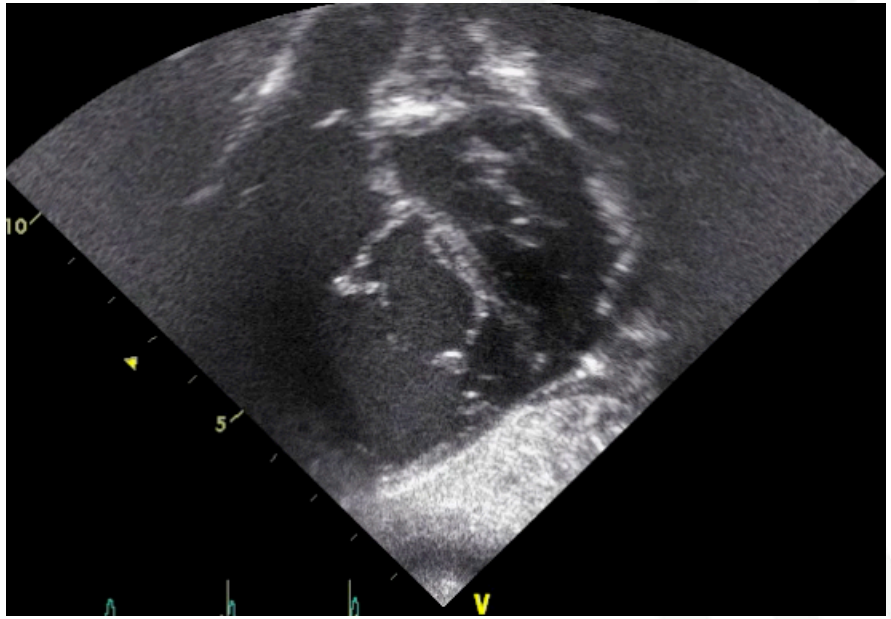




ECHOCARDIOGRAPHIE

CANAL ATRIO-VENTRICULAIRE PARTIEL

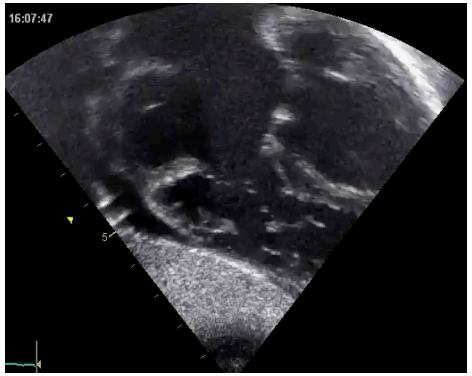




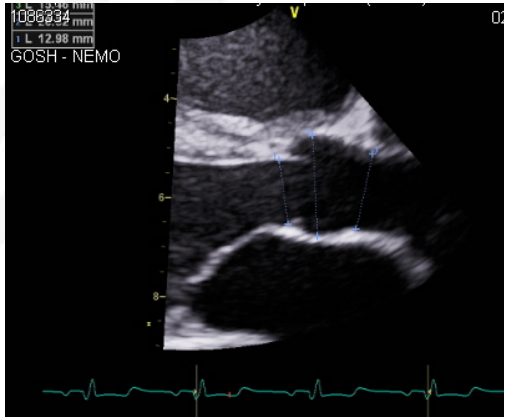
Un seul anneau valvulaire

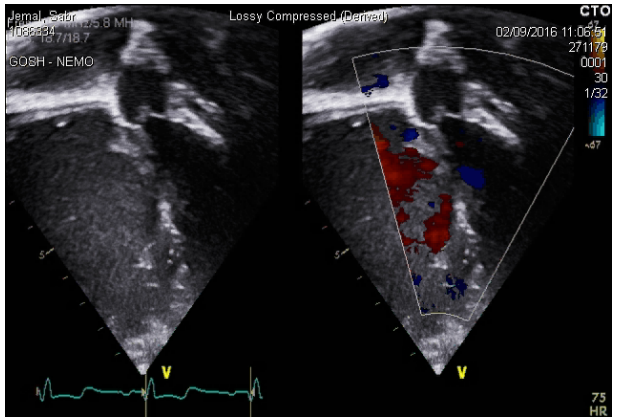
CIA Ostium Primum

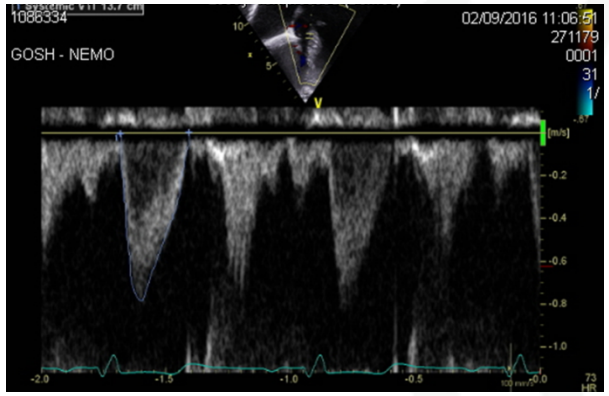
Fente VAV gauche

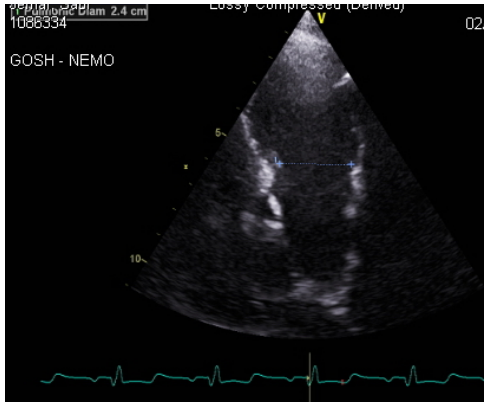


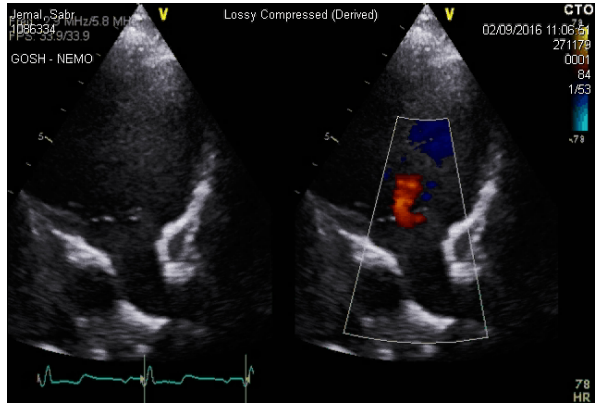
ECHOCARDIOGRAPHIE

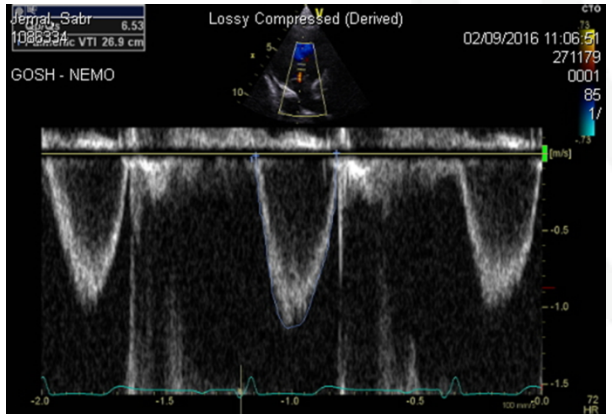












$$Qp/Qs = \frac{CSA\ (RVOT) \times VTI\ (RVOT)}{CSA\ (LVOT) \times VTI\ (LVOT)}$$

AUTRES EXAMENS COMPLEMENTAIRES

TDM/IRM

Anomalies du retour veineux pulmonaire

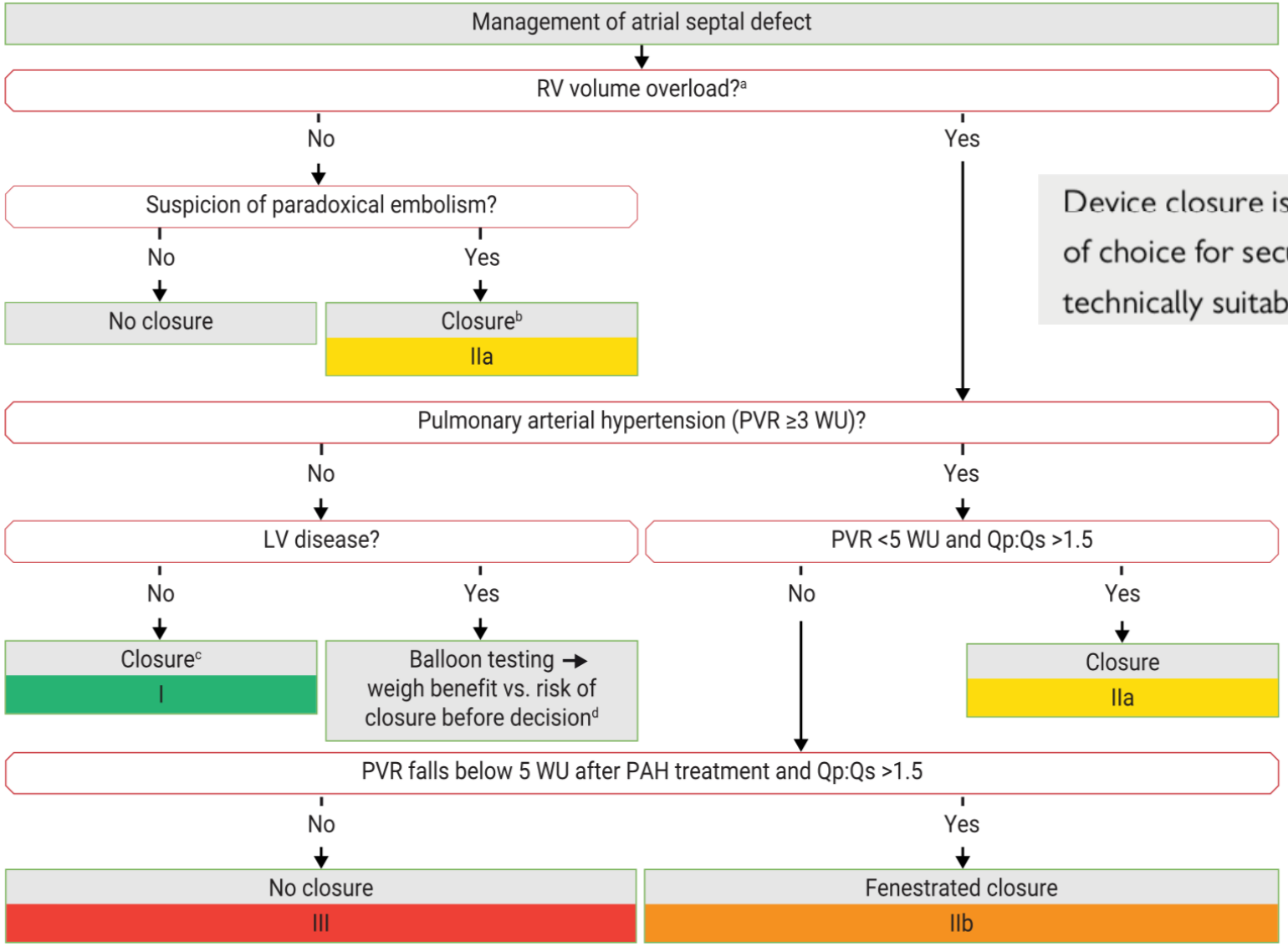
KT

Si HTAP en ETT

Mesure Pressions; Qp/Qs

Résistances pulmonaires+++

TRAITEMENT



Device closure is recommended as the method of choice for secundum ASD closure when technically suitable.	I	C

Baumgartner et al. Eur Heart Jour 2020

TRAITEMENT

CANAL ATRIO-VENTRICULAIRE PARTIEL

Partial AVSD (primum ASD)		
Surgical closure is recommended in patients with significant RV volume overload and should only be performed by a congenital cardiac surgeon.	I	C
For further details see recommendations for intervention in ASD (*section 4.1*).		
AV valve regurgitation		
Valve surgery, preferably AV valve repair, is recommended in symptomatic patients with moderate to severe AV valve regurgitation and should be performed by a congenital cardiac surgeon.	I	C
In asymptomatic patients with severe left-sided AV valve regurgitation, valve surgery is recommended when LVESD ≥45 mm[d] and/or LVEF ≤60% provided other causes of LV dysfunction are excluded.	I	C

RVPAP

4.1.5 Specific aspects of isolated anomalous pulmonary venous connections

Indications for surgery follow the principals of recommendation for ASD closure, but technical suitability for repair and operative risk must be weighed against the potential benefit of intervention. It is unusual for a single anomalous pulmonary venous connection of only one pulmonary lobe to result in a sufficient volume load to justify surgical repair.

Baumgartner et al. Eur Heart Jour 2020

FERMETURE PERCUTANÉE – LES PIONNIERS

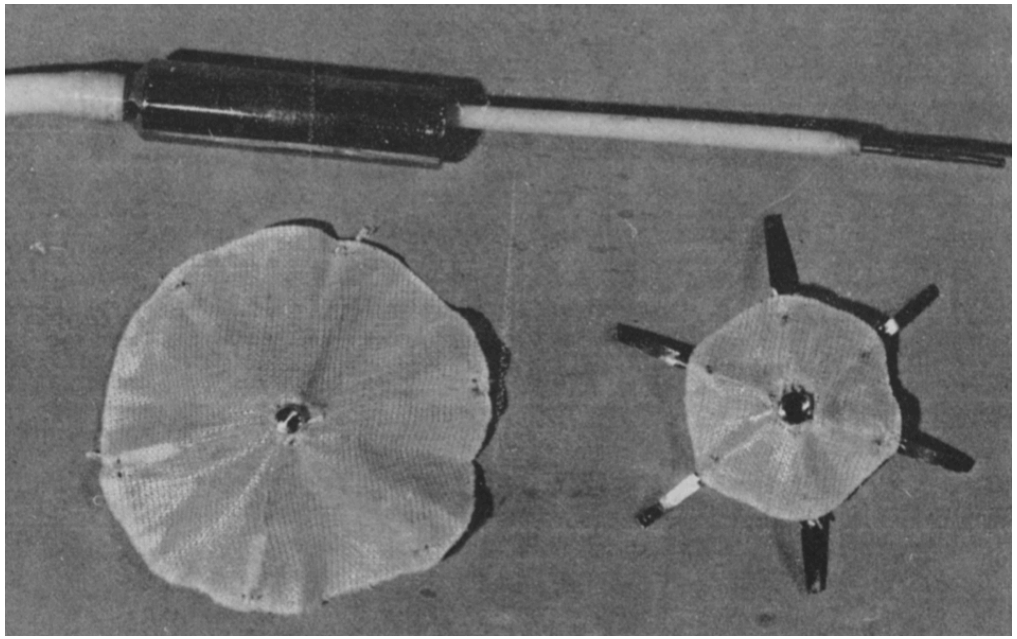
Secundum Atrial Septal Defect

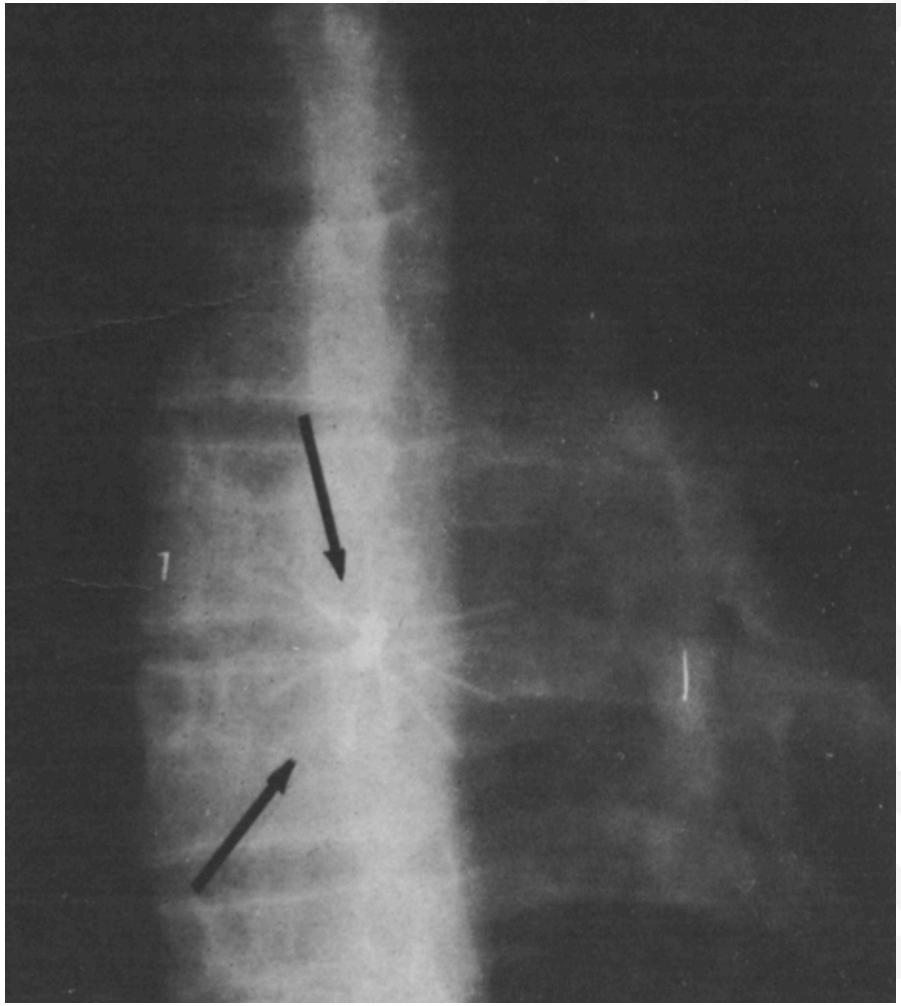
Nonoperative Closure During Cardiac Catheterization

Terry D. King, MD; Sandra L. Thompson, RN; Charles Steiner, MD; Noel L. Mills, MD

• A 17-year-old girl had clinical and cardiac catheterization findings compatible with a secundum atrial septal defect. During cardiac catheterization, the atrial septal defect was sized and closed using a transvenous umbrella technique.

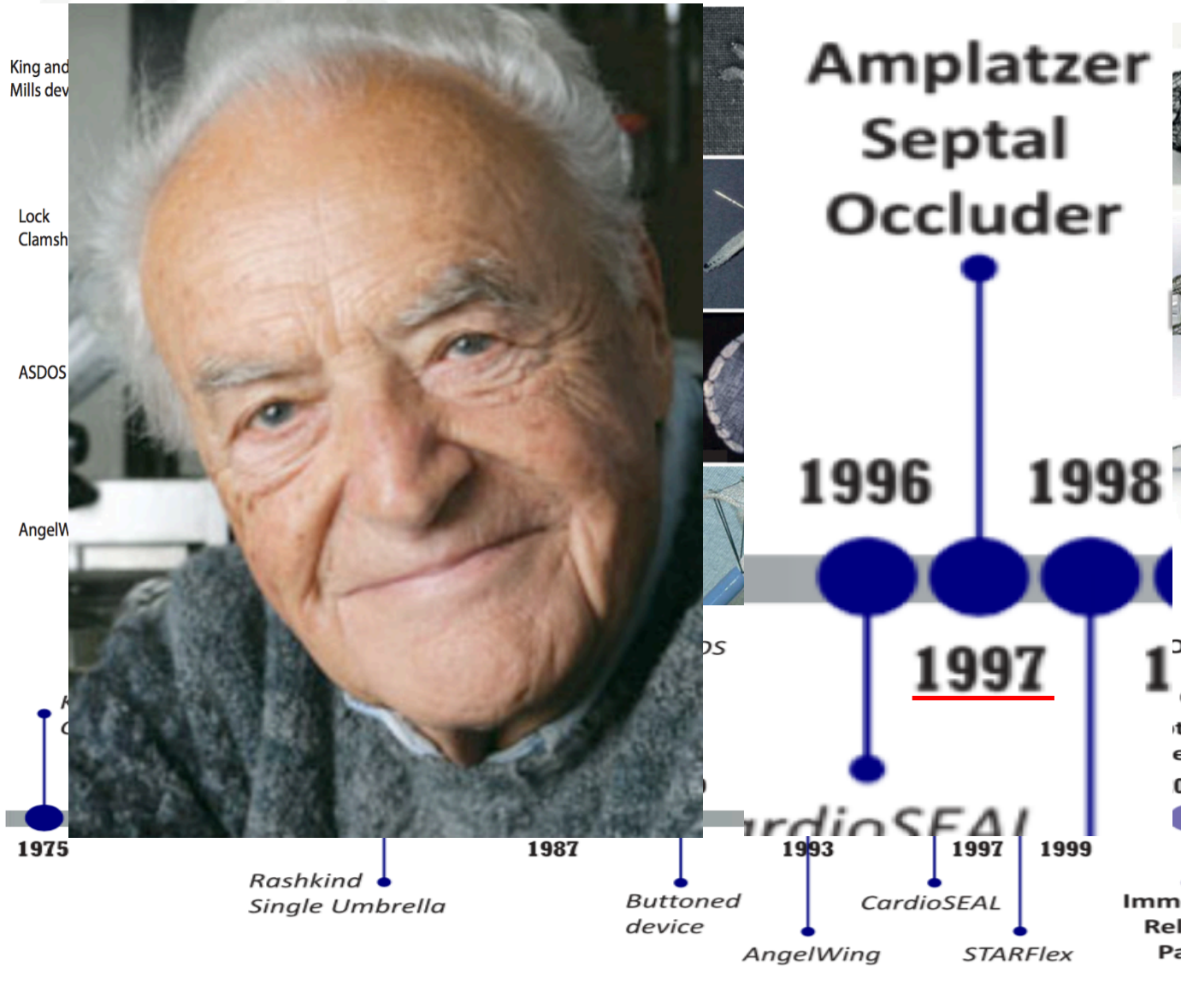
(*JAMA* 235:2506-2509, 1976)

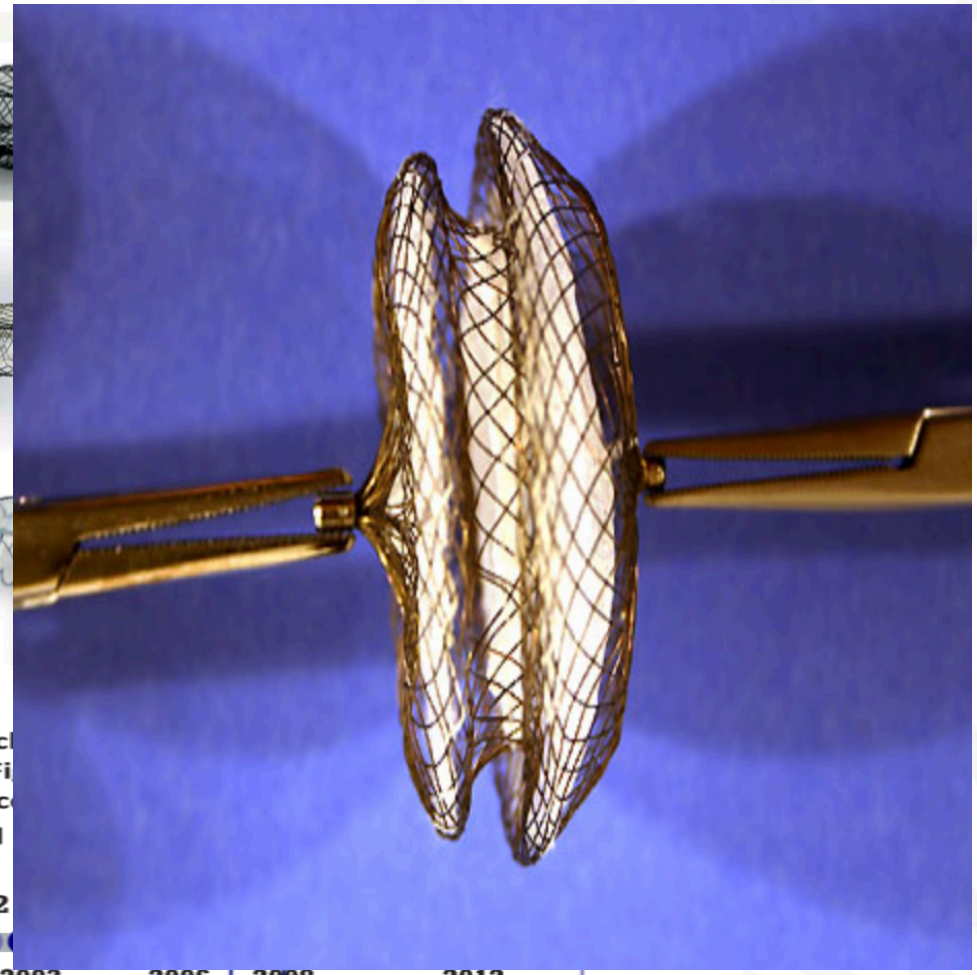




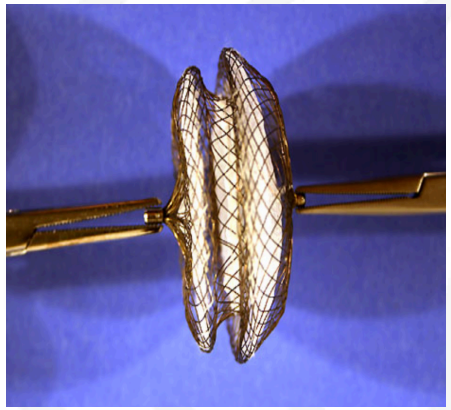
King et al. JAMA 1976

FERMETURE PERCUTANÉE – LA RUPTURE





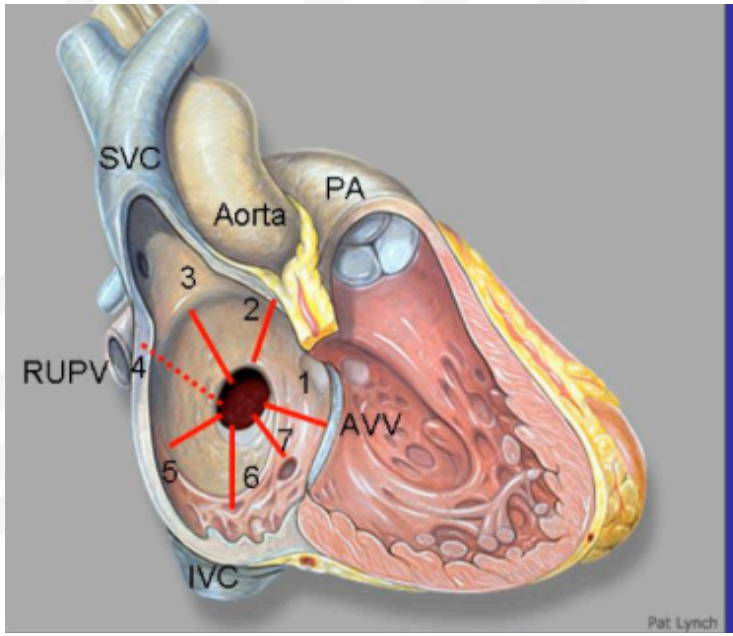
AMPLATZER SEPTAL OCCLUDER



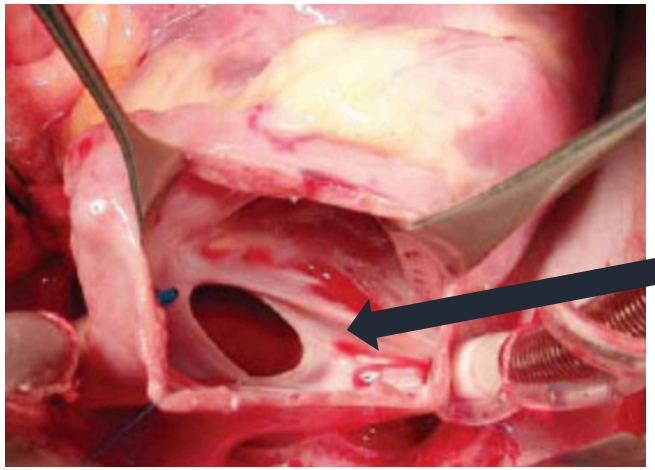
Nitinol (55% Ni + 45 % Ti)
+
Polyéthylène téréphtalate

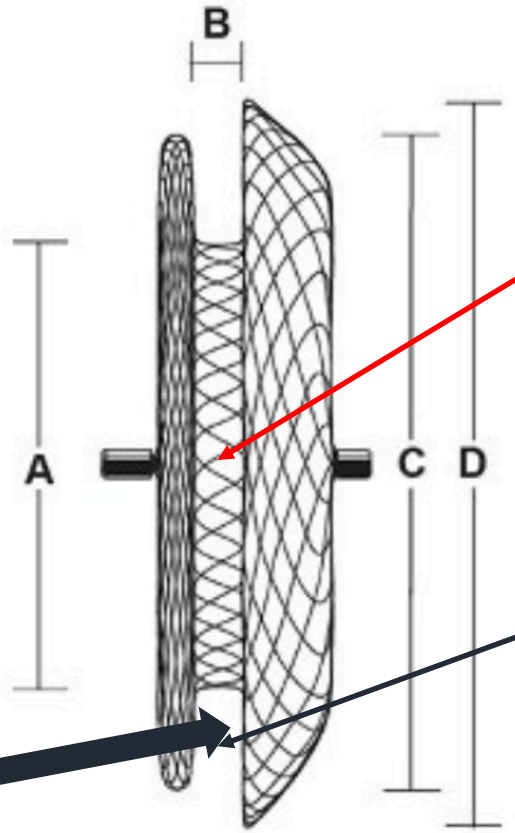
Mémoire de forme
Recapturable
Biocompatibilité
Profil

EVALUTATION ETT



1. AV valve rim
2. Aortic rim
3. SVC rim
4. RUPV rim
5. Posterior rim
6. IVC rim
7. ? CS rim





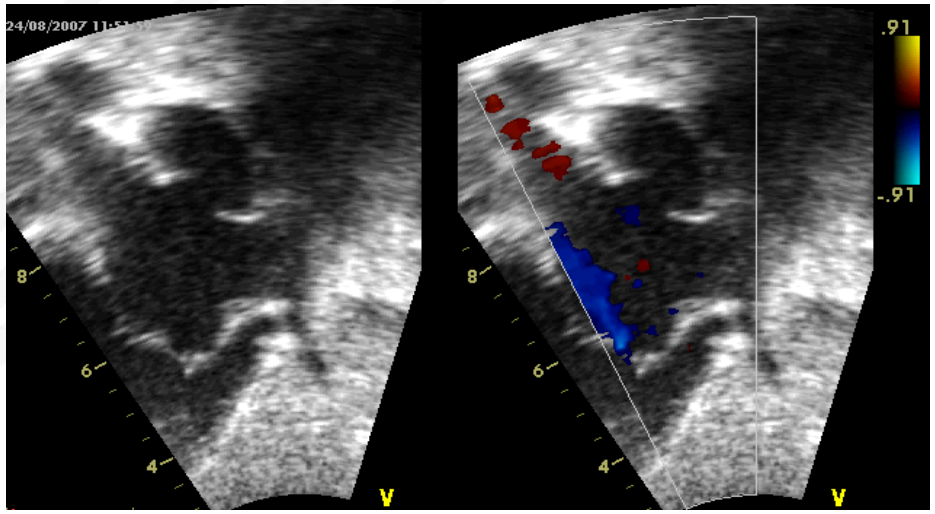
Size (central waist)	4-40 mm (every 1 mm up to 20 mm, > 20 mm, every 2 mm)
Central waist length	3-4 mm
Difference between disc and central waist	8/12 mm (ASO 4-10), 10/14 mm (ASO > 11), 10/16 mm (ASO > 34)
Release sheath size	6-12 Fr

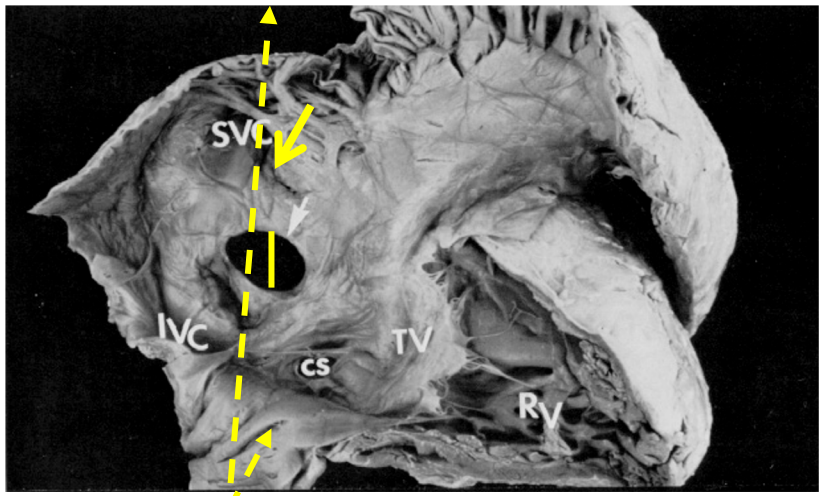
BERGES > 5-mm

EVALUTATION ETT

Vue sous costale

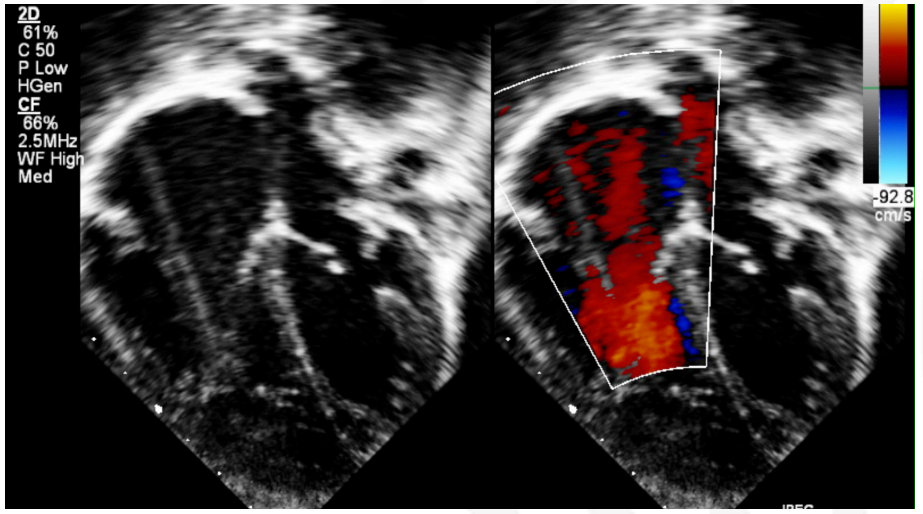
BERGES CAVES

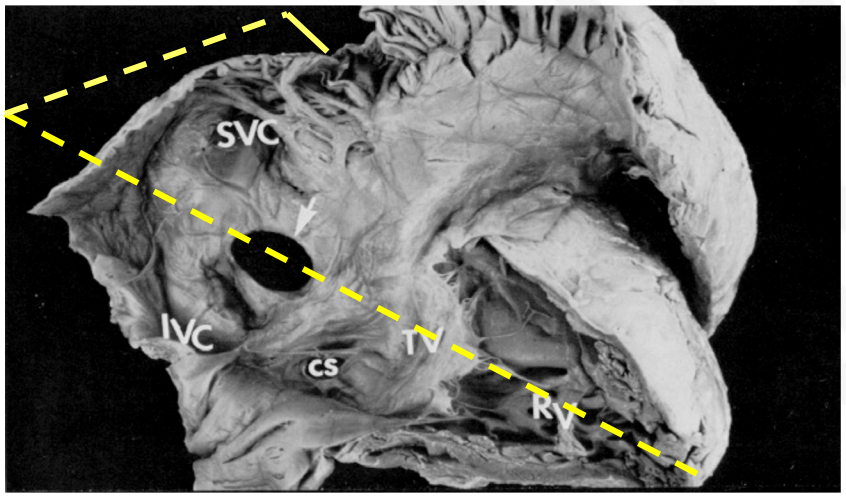




AC4 -> A5C

BERGES POST et ANT

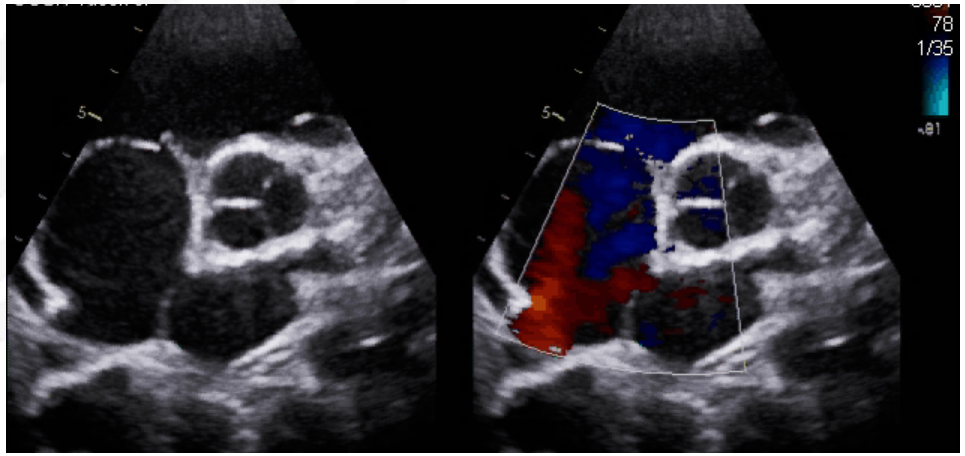


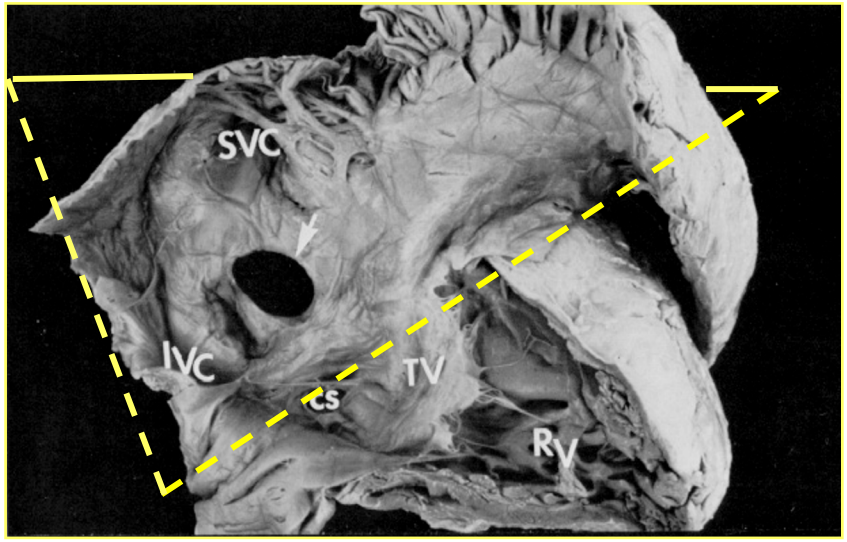


Courtesy X. Iriart

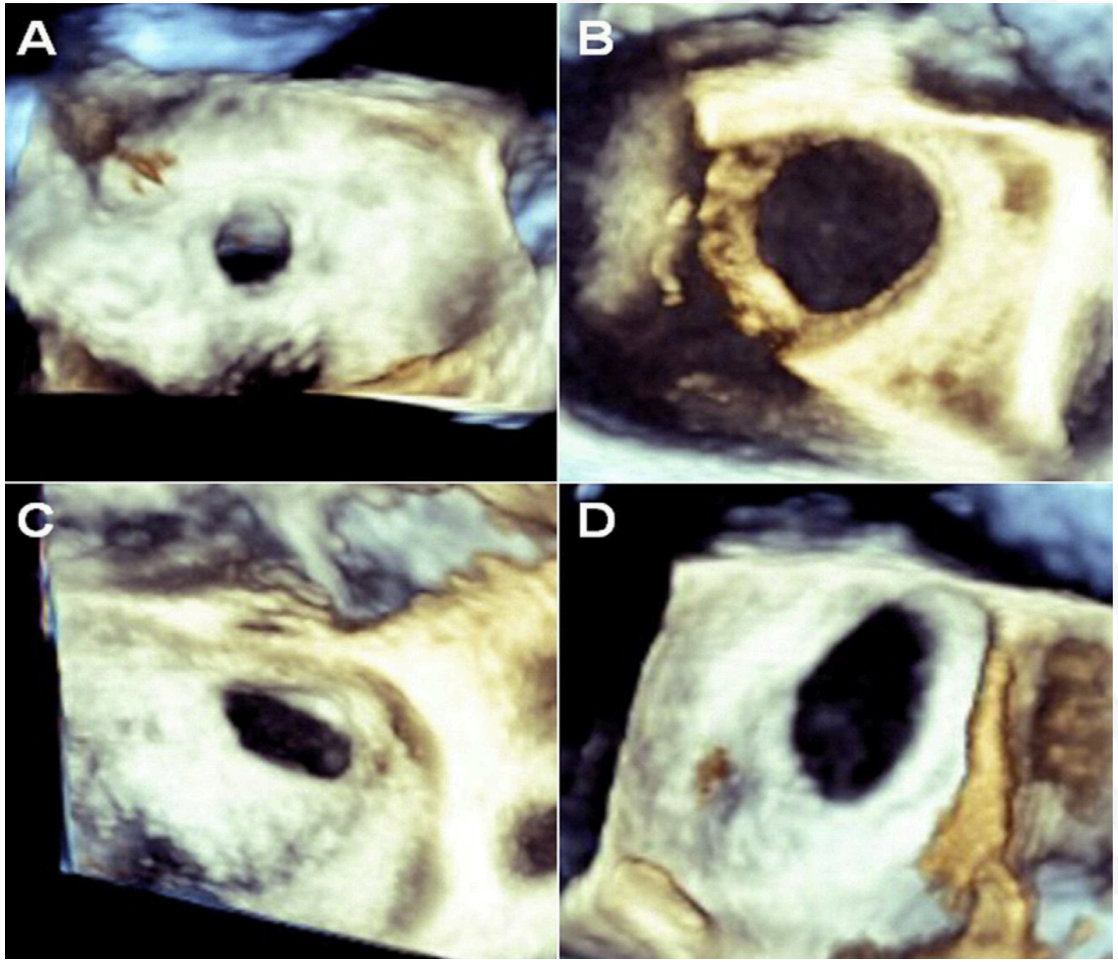
EVALUTATION ETT

PSPA
BERGES RETRO-Ao



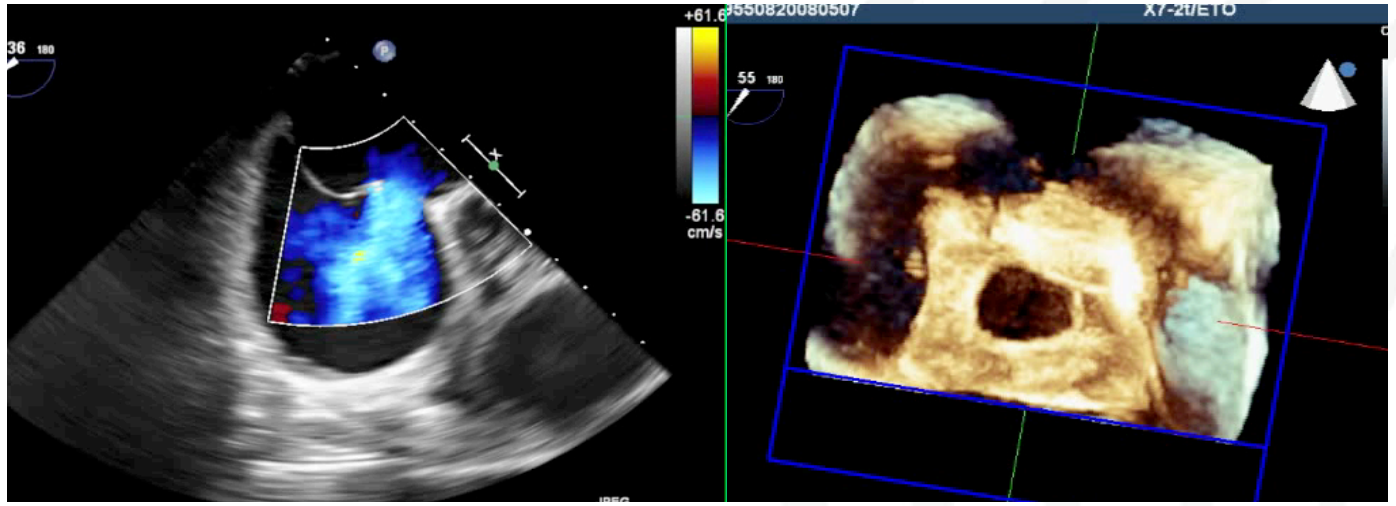


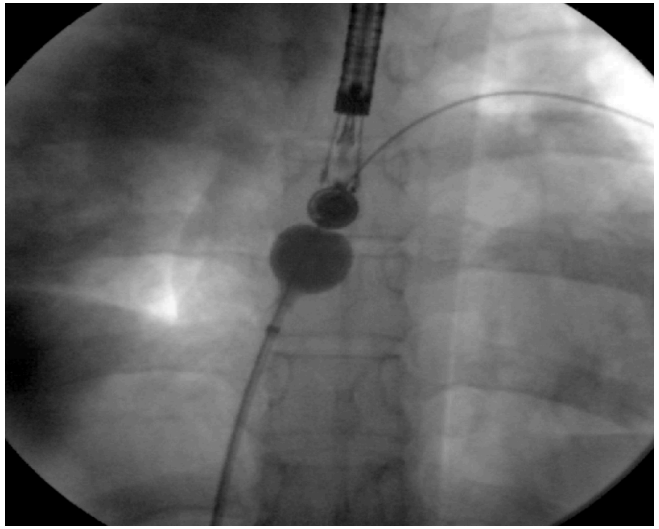
TAILLE ET MORPHOLOGIE DU SHUNT

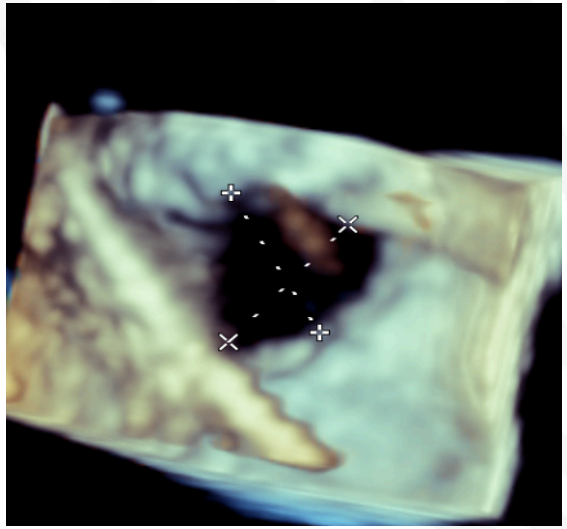


FERMETURE PERCUTANÉE - PROCÉDURE

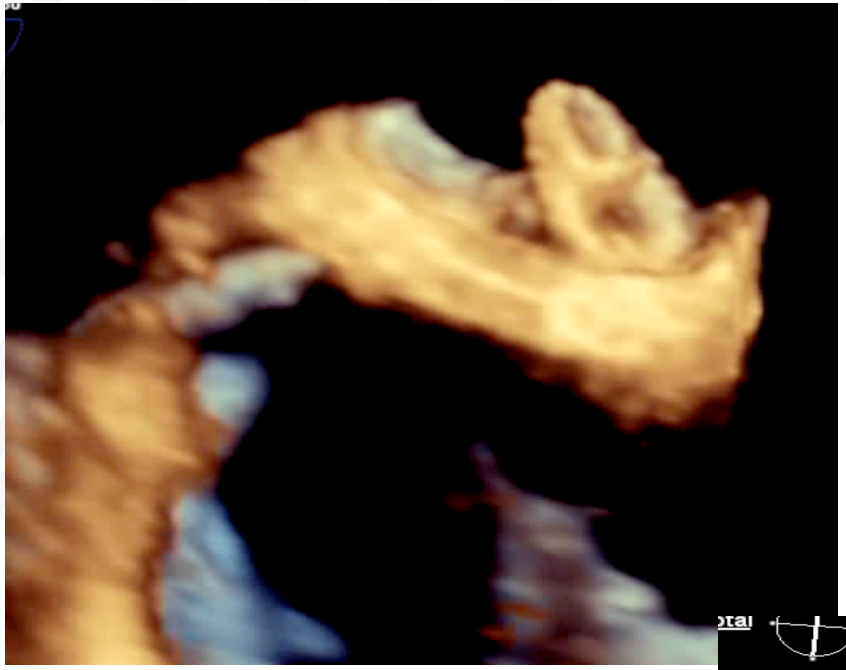
- Sous AG/AL
- Contrôle ETO (ETT, ICE)
- Accès veine fémorale
- Traitement anti-thrombotique (HNF, AAP)
- Trajet: VFD-OD-CIA-OG-VP => guide VP
- Calibration au ballon et/ou échographique
- Taille prothèse = taille défect + 2-4mm
- Déploiement
- Test stabilité prothèse

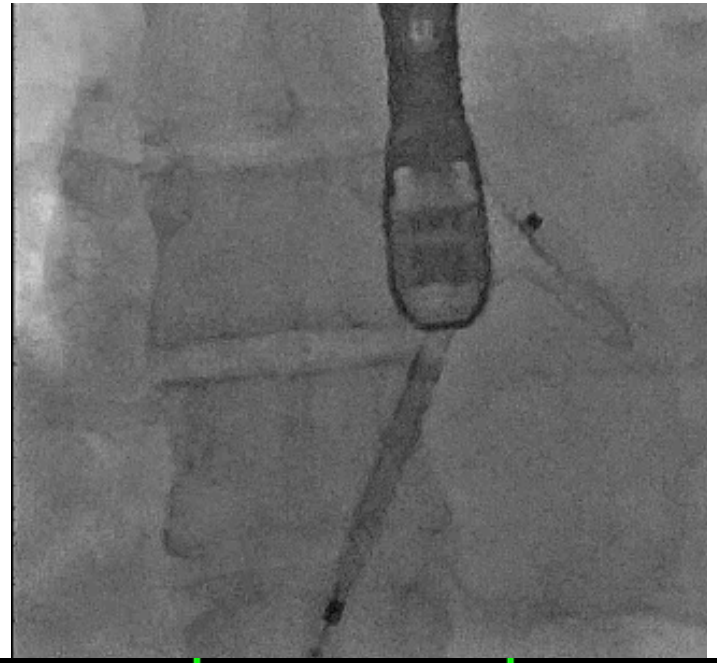


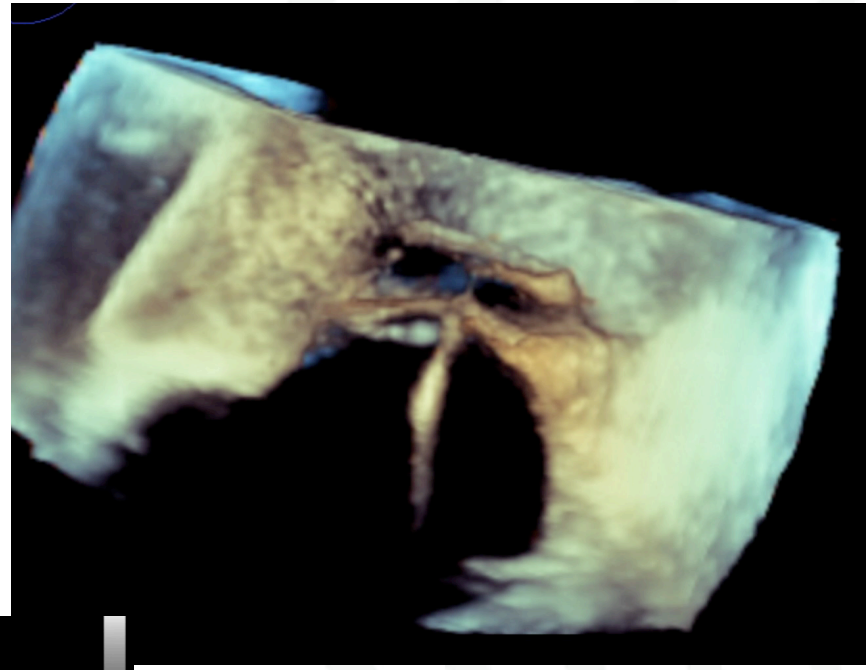


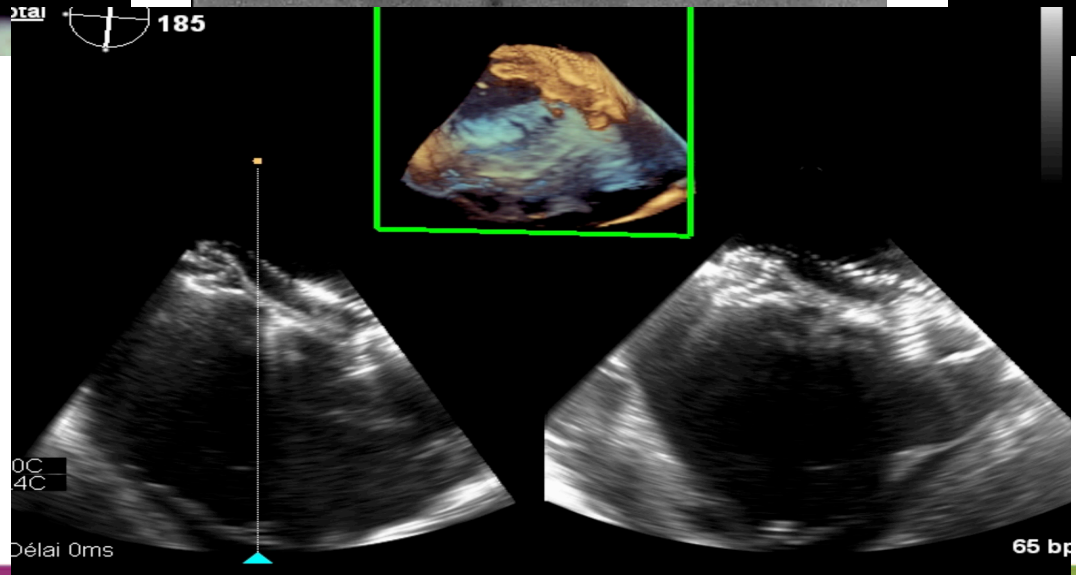


FERMETURE PERCUTANÉE - PROCÉDURE





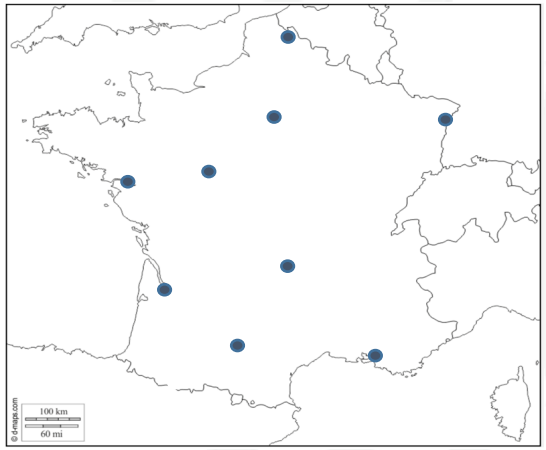


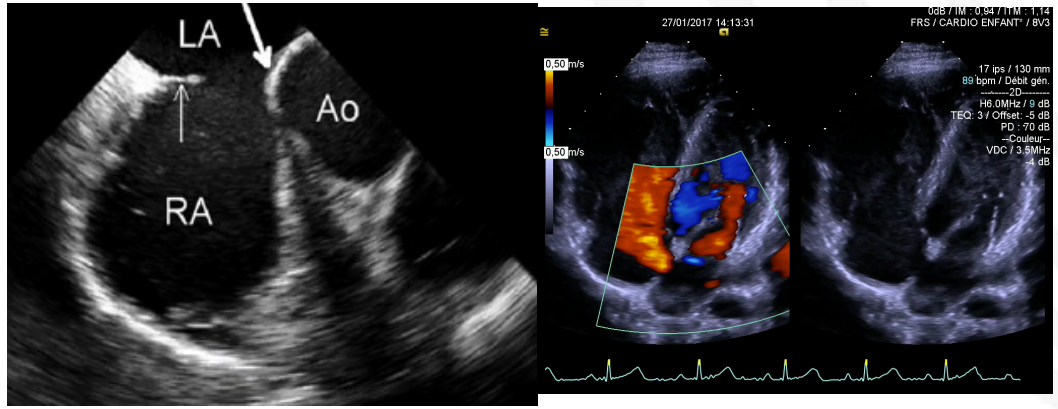


FERMETURE PERCUTANÉE - RÉSULTATS

ÉTUDE RÉTROSPECTIVE MULTICENTRIQUE NATIONALE , 9 CENTRES, (1998-2016)

- Inclusion: enfants < 18 ans, tentative de fermeture de CIA par ASO
- Caractéristiques démographiques
- Evaluation Anatomique du shunt (taille, berges)
- Procédure (guidance, succès, complications)
- Suivi à long terme (Statut fonctionnel, Complications)

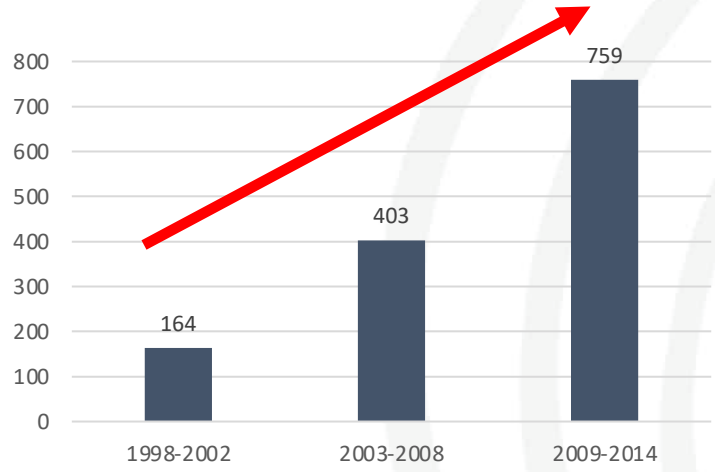




FERMETURE PERCUTANÉE - RÉSULTATS

RÉSULTATS

- 1326 patients (exclusion de 69 patients)
- Age: 9 ans (0.7-18);
- Poids: 28 kg (3.6 – 92)
- ≤ 15 kg: 95 (7%)
- Lésions cardiaques associées: 137 (10.3%)
- Pathologies extracardiaques: 62 (4.6%)



ASO implantés entre 1998 et 2016

TABLE 3 ASD Characteristics and Procedural Data

Preprocedural ASD assessment	
ASD echographic diameter, mm	15 (3-41)
Indexed diameter (ASD/body surface area, mm/m^2)	14.8 (3.5-48.6)
Large ASD (≥20 mm/m^2)	254 (19.1)
Deficient rims (n = 1,133)	
Aortic	321 (28.3)

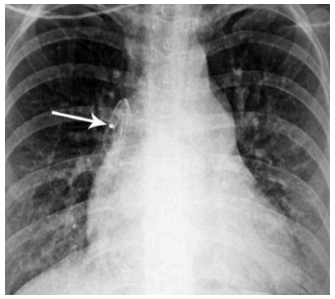
Jalal et al. J Am Coll Cardiol Intv - 2018

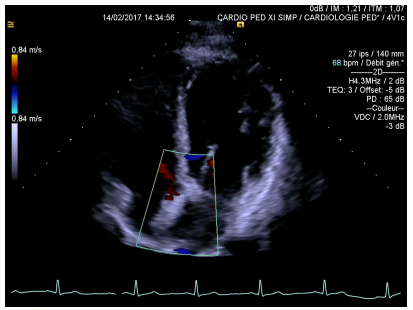
FERMETURE PERCUTANÉE - RÉSULTATS

RÉSULTATS

Succès 95.3% (95%CI: 93.9%–96.3%)

Successful implantation	1,264 (95.1)
ASO device size, mm	18 (4-40; IQR: 15-24)
Reason for occlusion failure	62 (4.7)
Defect was considered too large to be closed with the ASO	47
ASO embolization	7
Unstable device	5
Atrioventricular valve damage	2
Atrioventricular block	1

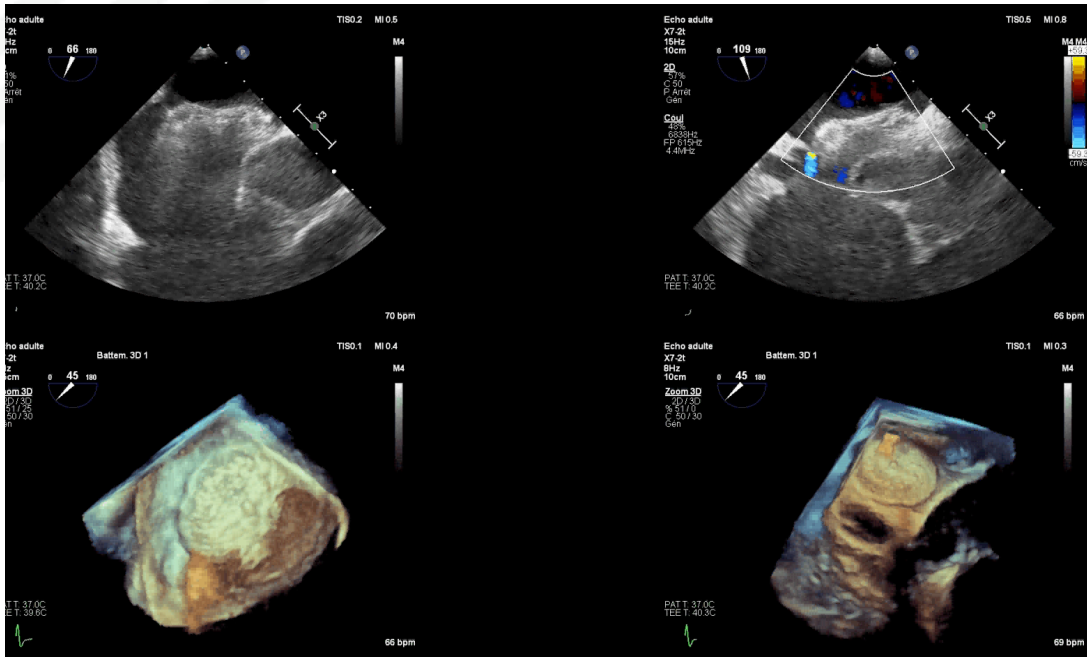


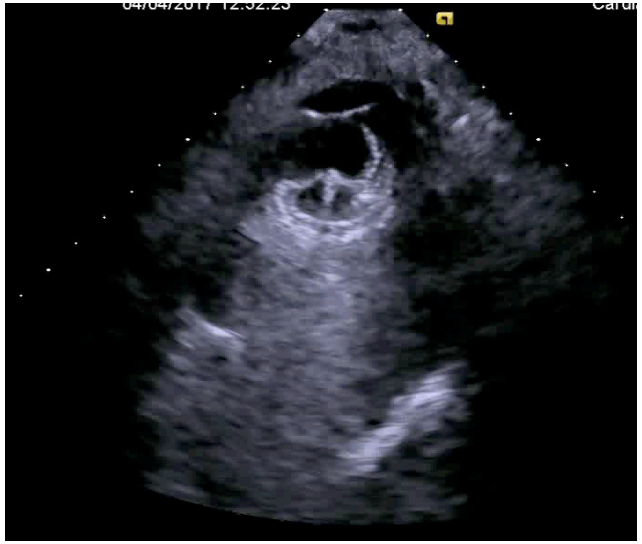


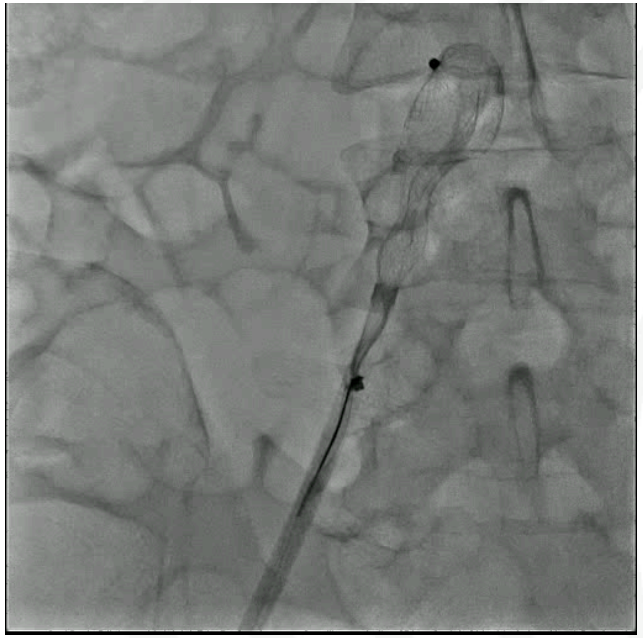
Complications	24pts (1.8 %)
Embolisation dispositif	10 (0.8%)
Régurgitation mitrale	1 (0.07 %)
Régurgitation aortique	0 (0)
Hémolyse	1 (0.07 %)
Erosion	0 (0)
Épanchement péricardique	6 (0.5%)
OAP	0 (0)
Embolie gazeuse	1 (0.07 %)
AVC	0 (0)
Bloc auriculo-ventriculaire	5 (0.4%)
Arythmies supra-ventriculaires	0 (0)
Arythmies ventriculaires	0 (0)
Endocardite Infectieuse	0 (0)
Hypertension pulmonaire	0 (0)

FERMETURE PERCUTANÉE - RÉSULTATS

CIA OS de 20-mm
FERMETURE par ASO 24mm







EMBOLISATION AIGÜE (ETT À H2)
PROTHÈSE DANS L'AORTE
RECAPTURÉE VIA ABORD ARTÉRIEL

FERMETURE PERCUTANÉE - RÉSULTATS

RÉSULTATS

Patients n = 1158 (91.6%) Suivi Médian : 3.5 ans (0.5 – 18; IQR: 1 – 7; 13% > 10 ans)	
Vivants (n, %)	1158 (100)
Asymptomatique (n, %)	1118 (96)
Érosion cardiaque	0 (0)
Arythmies	8 (0.69)
AVC	2 (0.17)
Bloc atrio-ventriculaire	0 (0)
Insuffisance cardiaque	0 (0)
Endocardite infectieuse	0 (0)
Hypertension pulmonaire	2 (0.17)

COMPLICATIONS À LONG TERME

(n=12; **1.04%**; 95% CI: 0.5% - 1.6%)

GROSSESSE

- **69 femmes** (8.5%) => 78 **grossesses**
- **Délai Médian 10 ans** (2 – 15)
- **Pas de complications** péri-partum

COMPLICATIONS AU LONG COURS

Review

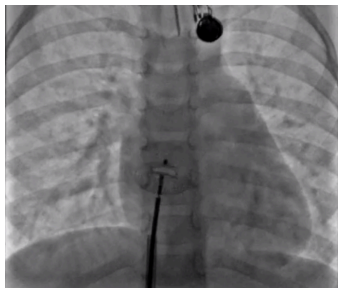
Long-term Complications After Transcatheter Atrial Septal Defect Closure: A Review of the Medical Literature

Zakaria Jalal, MD,[a,b,c] Sebastien Hascoet, MD,[a,d] Alban-Elouen Baruteau, MD, PhD,[a,e] Xavier Iriart, MD,[b] Bernard Kreitmann, MD, PhD,[b] Younes Boudjemline, MD, PhD,[a,f,g] and Jean-Benoit Thambo, MD, PhD[a,b,c]

ÉROSION CARDIAQUE

VALVULOPATHIES

TROUBLES CONDUCTIFS



THROMBOSES

ARYTHMIES ATRIALES

AVC

ENDOCARDITE

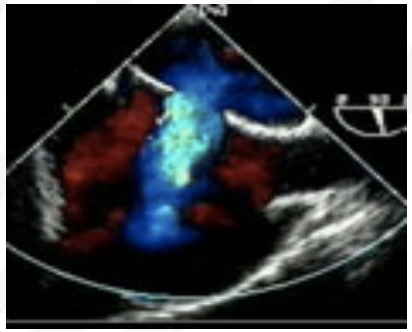
ALLERGIE AU NICKEL

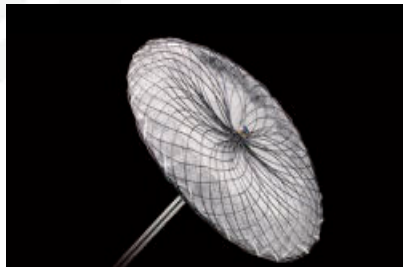
Table 1. Summary of the main long-term complications after percutaneous ASD

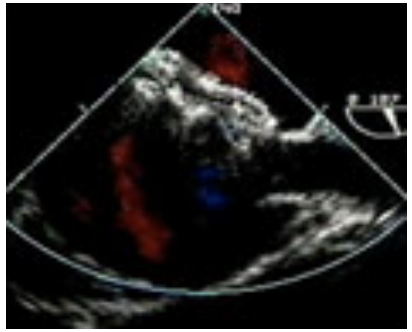
Complication	Incidence	Delay from closure	Complications
Cardiac erosion	0.04%-0.28%	Up to 9 y	Death (0.05%) Stroke
Device thrombosis	0.8%-1.2%	Up to 2 y	Stroke (10%-15%)
Atrial arrhythmias	11% 10 years after closure	—	Stroke
Complete AV block	5 published cases	Up to 4 y	—
Infective endocarditis	6 published cases	Up to 4 y	—

Jalal et al. Can Jour Cardiol 2016

PROBLÉMATIQUE

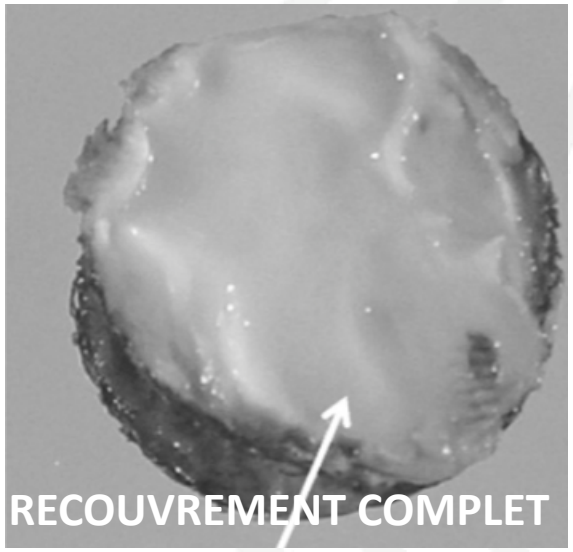


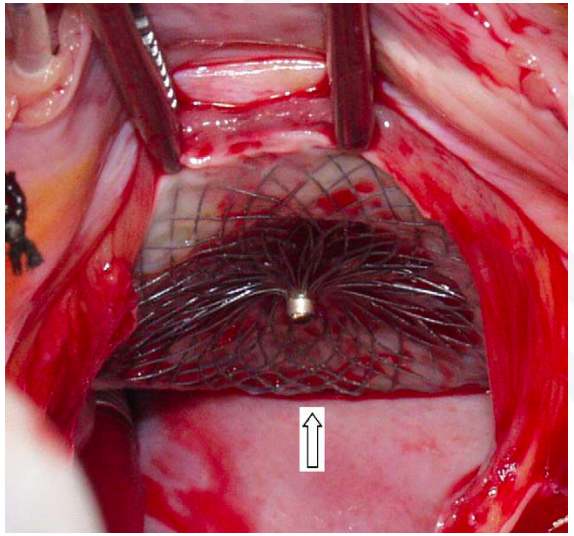




Aspirine
+
Prophylaxie EI

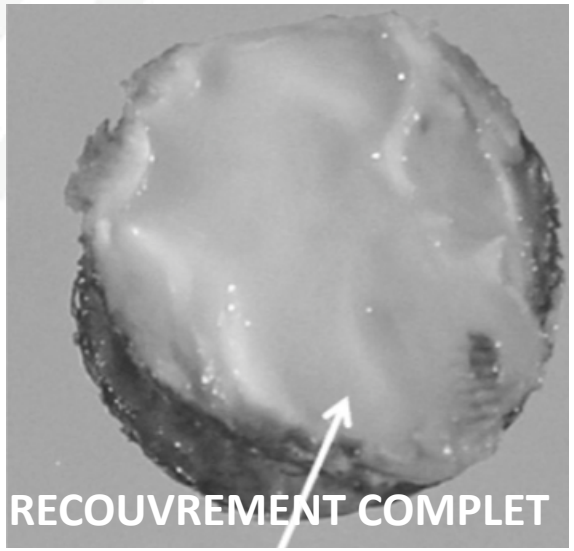
6 MOIS

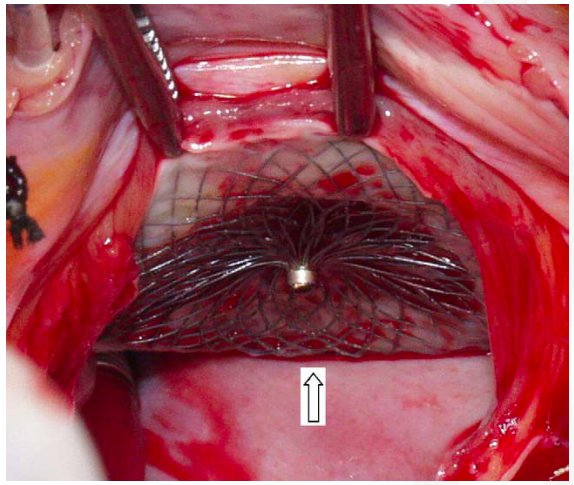




RECOUVREMENT INCOMPLET

QUESTIONS SANS RÉPONSES





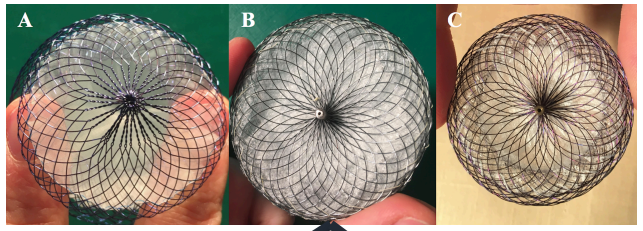
RECOUVREMENT INCOMPLET

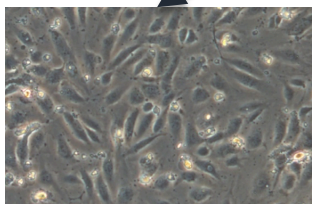
- Peut-on étudier le recouvrement prothétique en utilisant des cellules humaines?
- Le phénomène de recouvrement diffère-t-il entre différents dispositifs commercialisés?
- Pourrait-on réaliser une évaluation individuelle du recouvrement par méthodes non invasives?

PROJETS DE RECHERCHE EN COURS

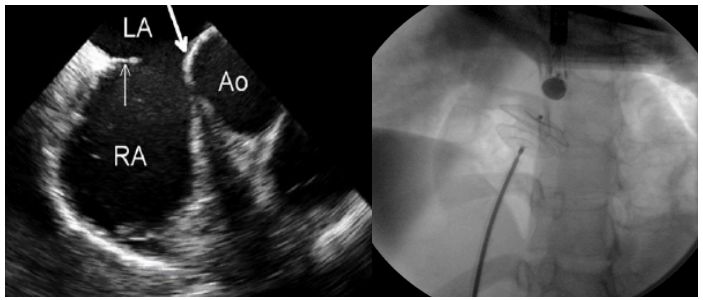
ÉVALUATION MULTIMODALE DU RECOUVREMENT DES PROTHÈSES

Travaux Fondamentaux

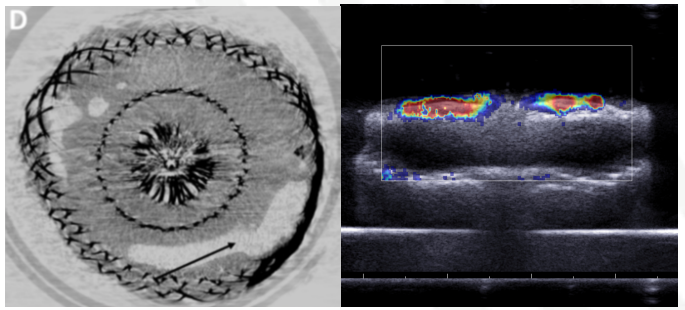




Travaux Clinique



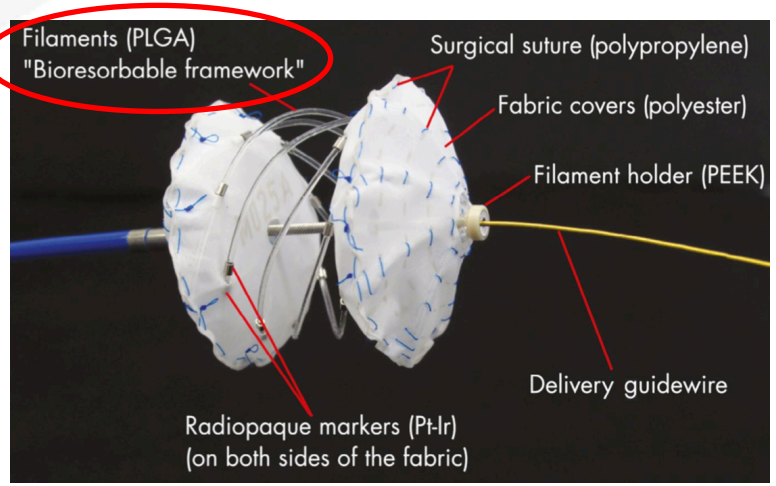
Imagerie du recouvrement

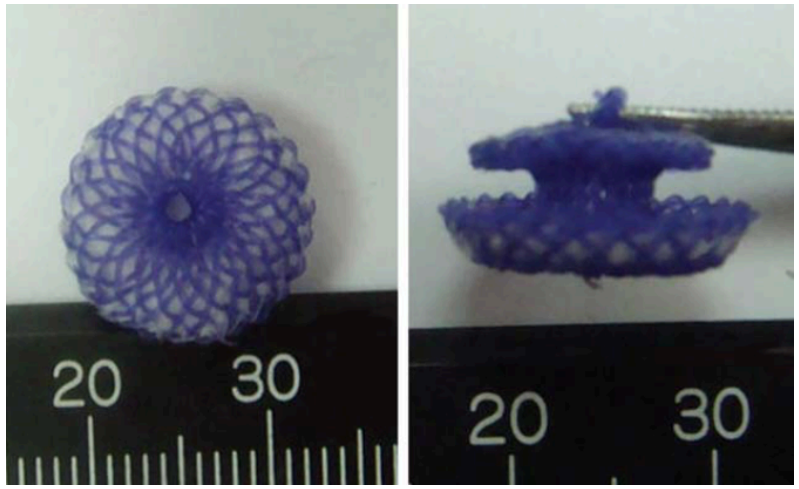


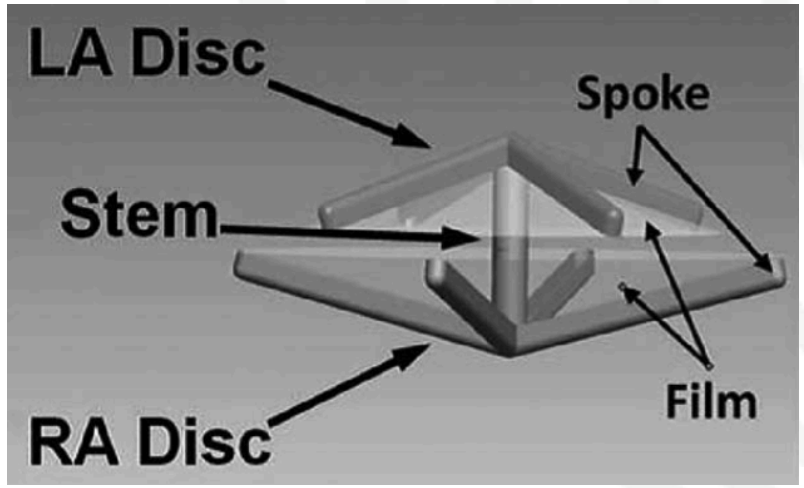
PERSPECTIVES

DISPOSITIF IDÉAL

- Si les tissus du patient prennent la place et la fonction du dispositif => indispensable?
- DISPOSITIFS BIORÉSORBABLE
- Résorption partielle ou totale



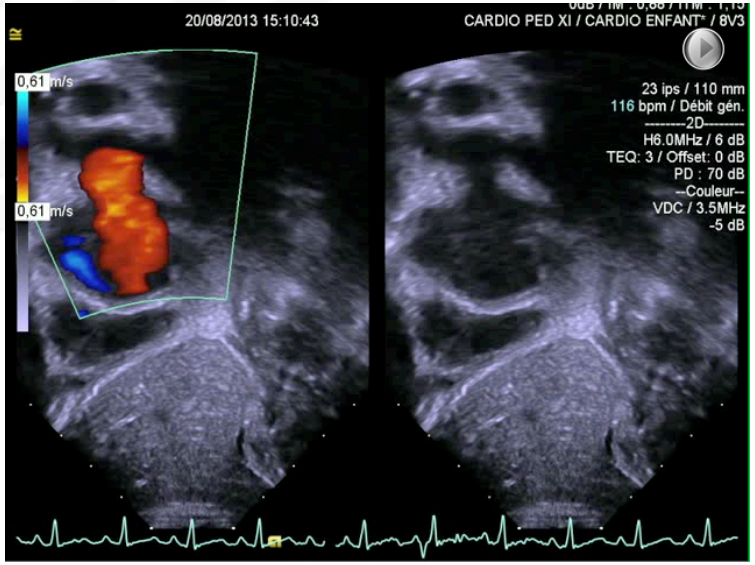


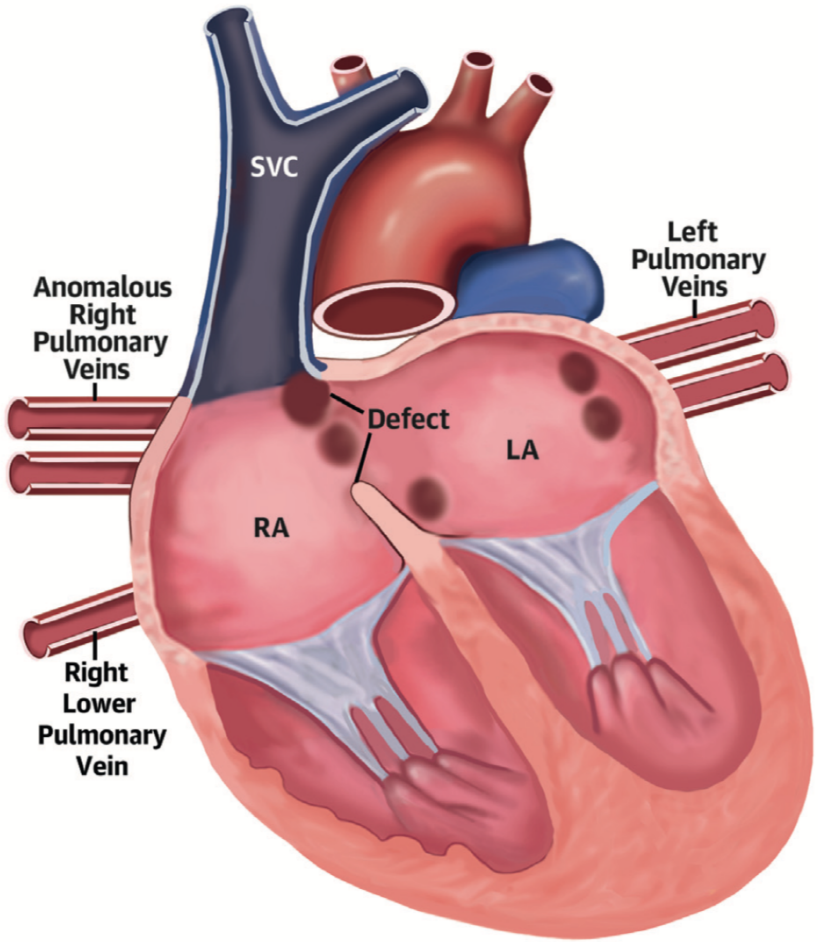


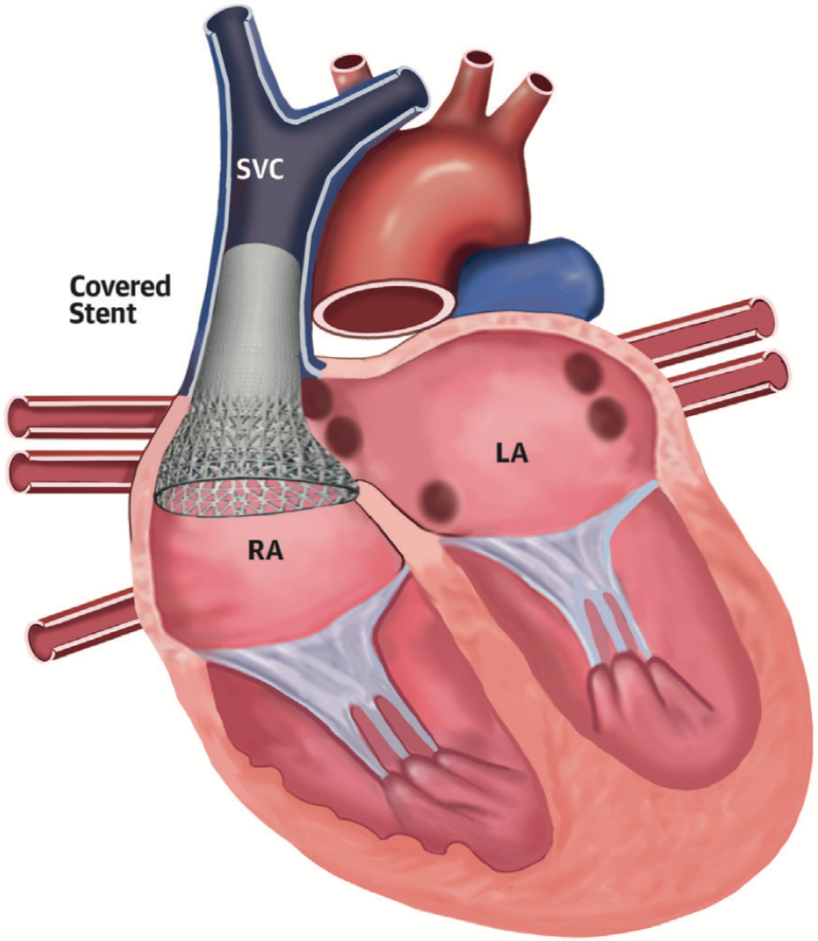
Sigler et al. EuroIntervention 2018
Duong-Hong et al. CCI 2010
Zhu et al. J Biomed Biotechnol. 2012

CIA SINUS VENOSUS – APPROCHE PERCUTANEE

STENT COUVERT JONCTION SVC - OD

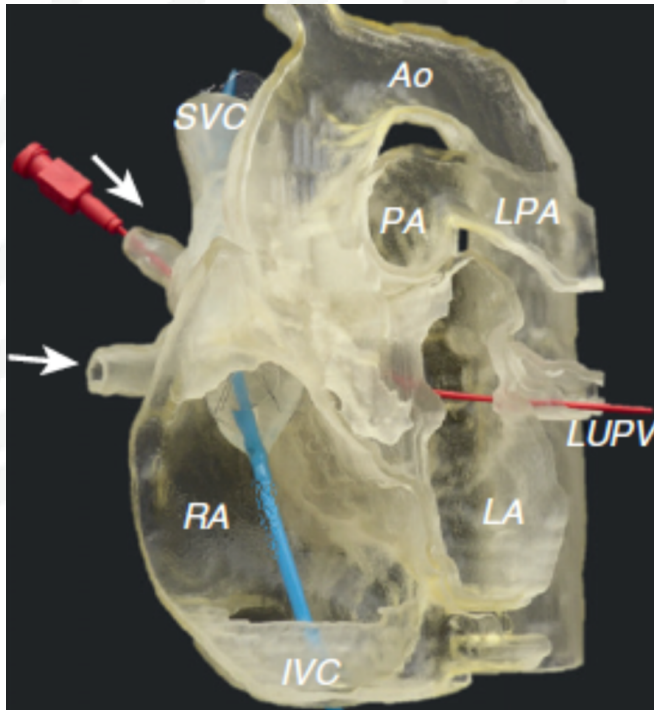


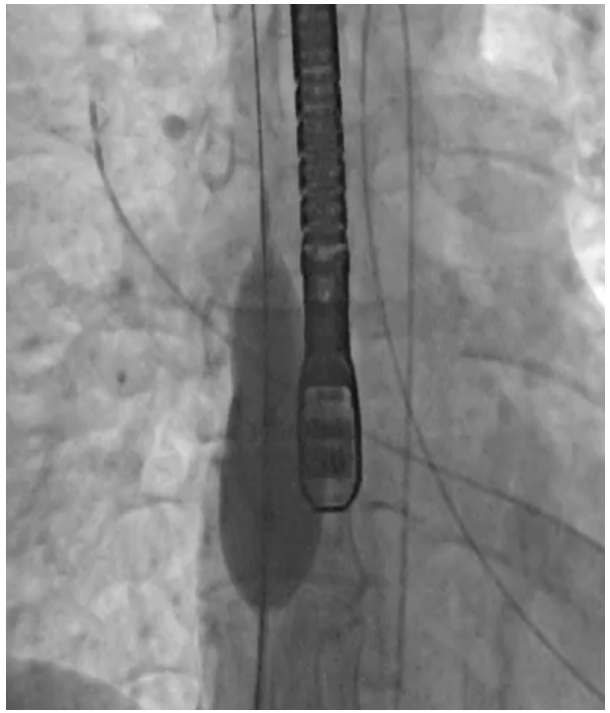


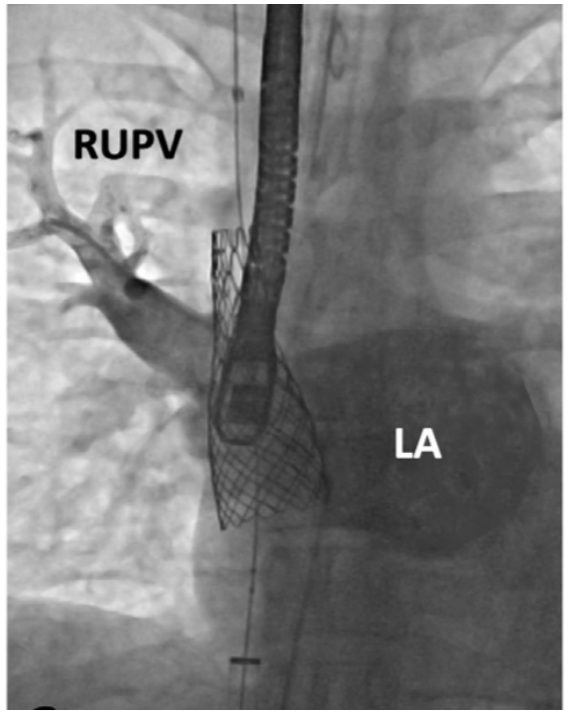


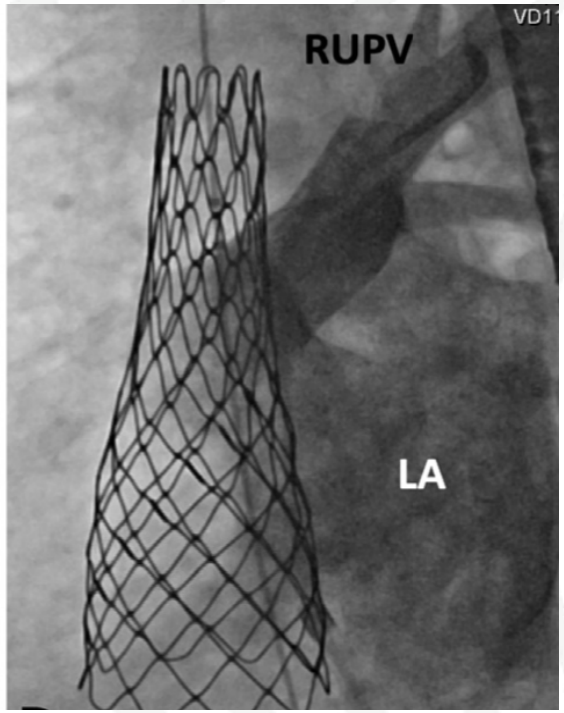
Hansen et al. JACC 2020

CIA SINUS VENOSUS – APPROCHE PERCUTANEE









3D-PRINTED MODEL

IN-VIVO ASSESSEMENT

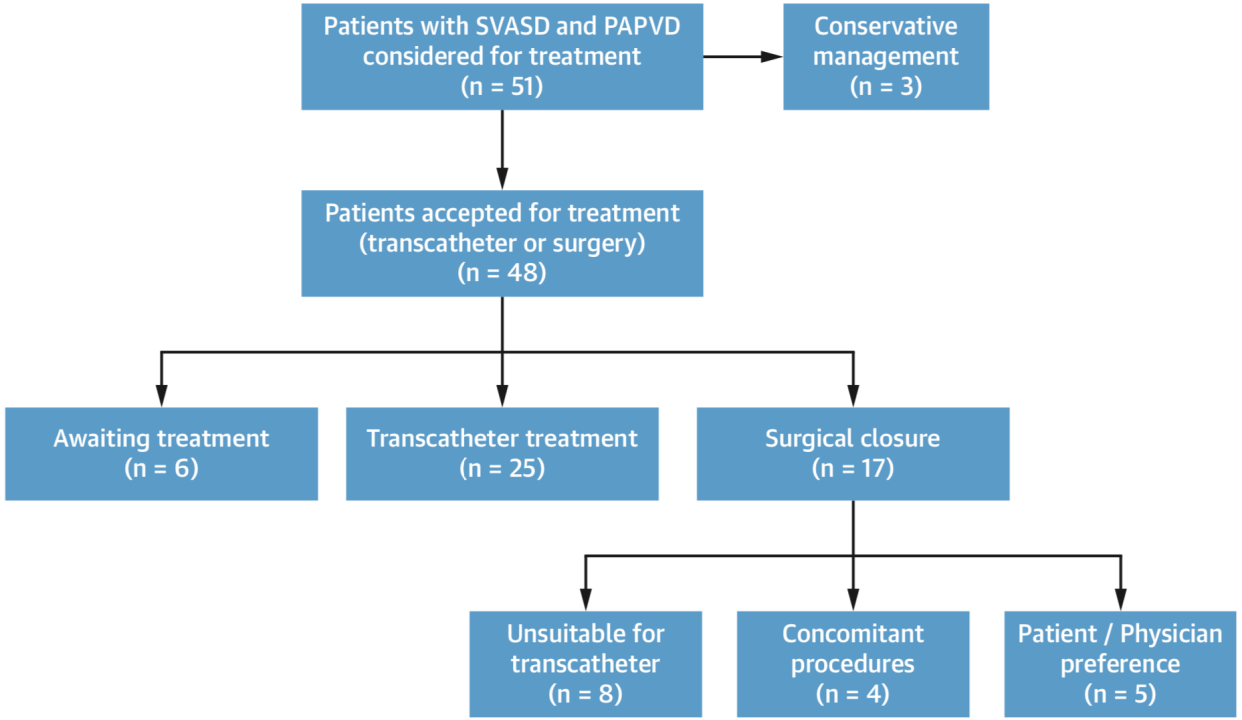
SHUNT CLOSURE RUPV PATENCY

Courtesy A. Baruteau

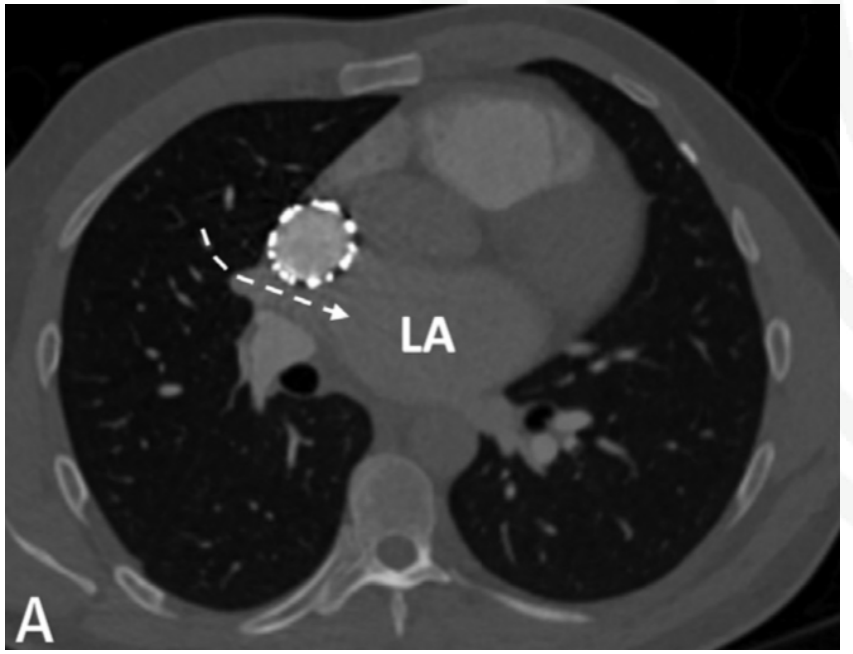
Hansen et al. JACC 2020

CIA SINUS VENOSUS – APPROCHE PERCUTANEE

25 patients , 45 ans (33–54)

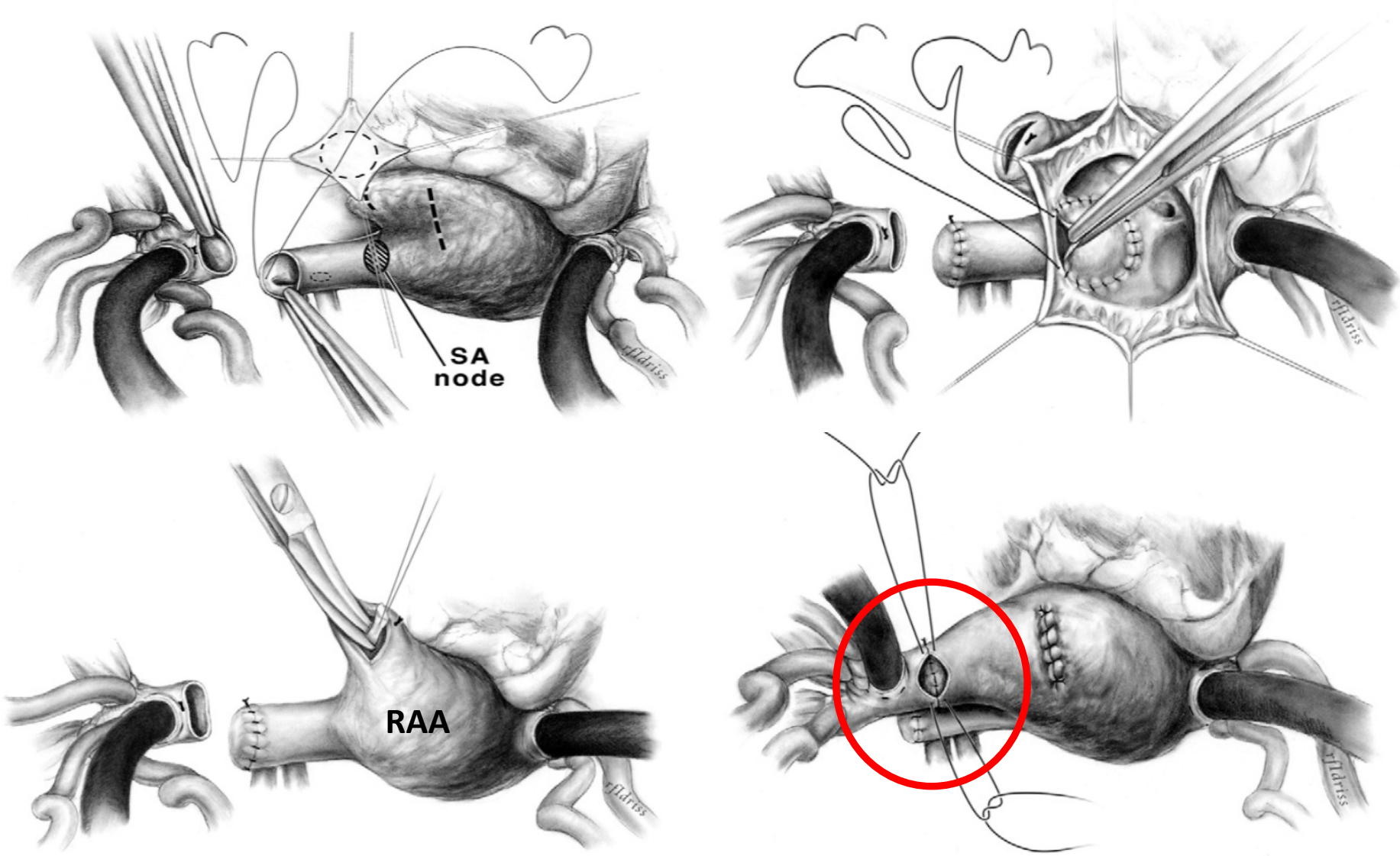


- Succès: 100%
- 1 hémopericarde, 1 embolisation précoce de stent
- Aspirine-Clopidogrel 2 mois puis Aspirine 4 mois
- Suivi: 1.4 ans: pas de shunt résiduel, 0 complications
- 100% VPSD perméable



Hansen et al. JACC 2020

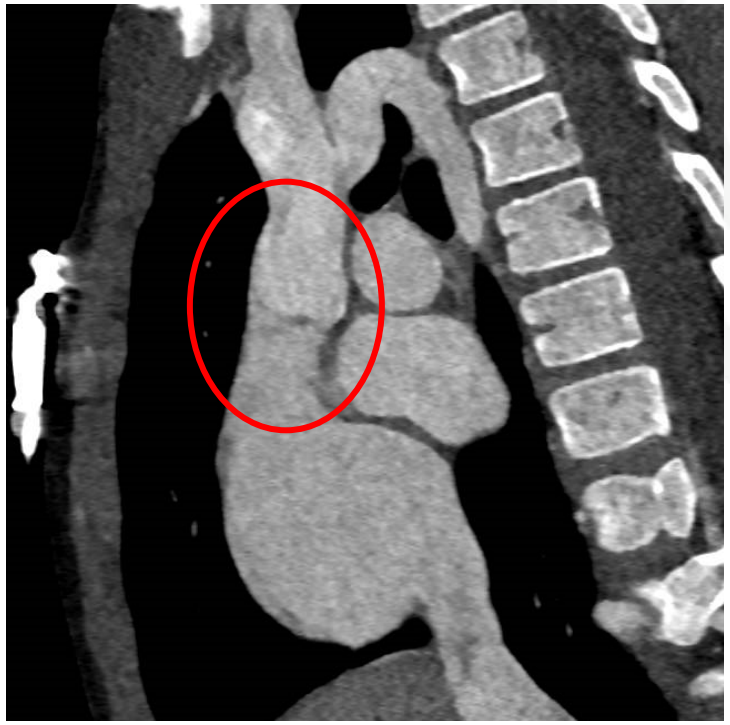
REPARATION CHIRURGICALE - WARDEN



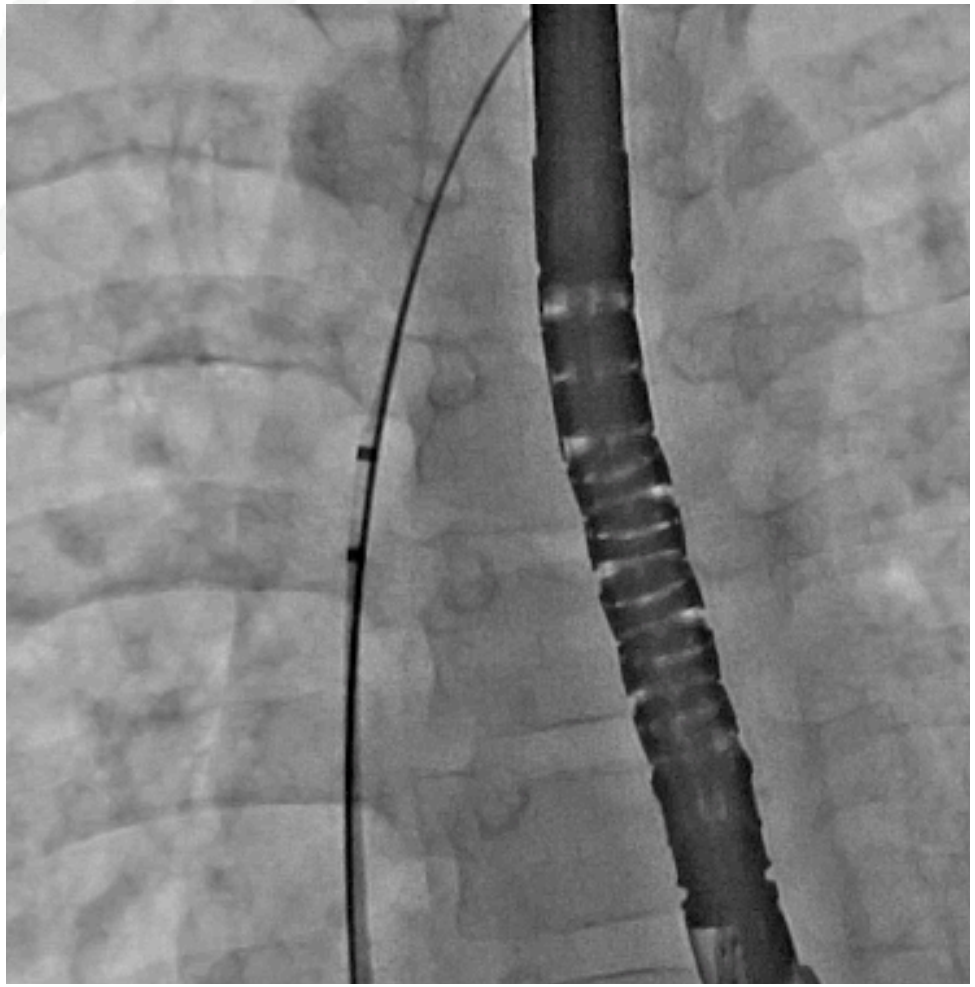
Stewart et al. Ann Thorac Surg 2007

COMPLICATION POST-OPERATOIRE

- Garçon de 7 ans
- 2017: Cure chirurgicale CIA-SV (Warden)
- 2019: Œdème facial, circulation veineuse collatérale
- TDM: Sténose suture VCS-OD

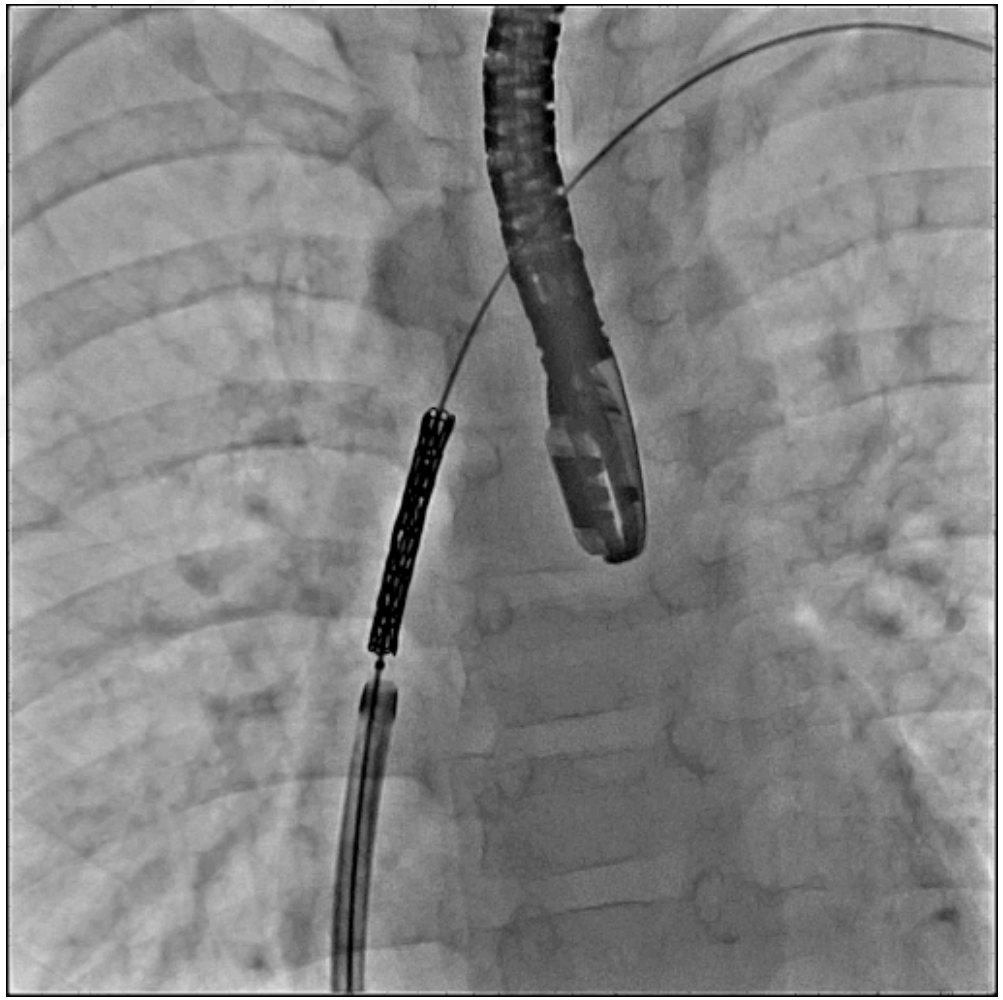


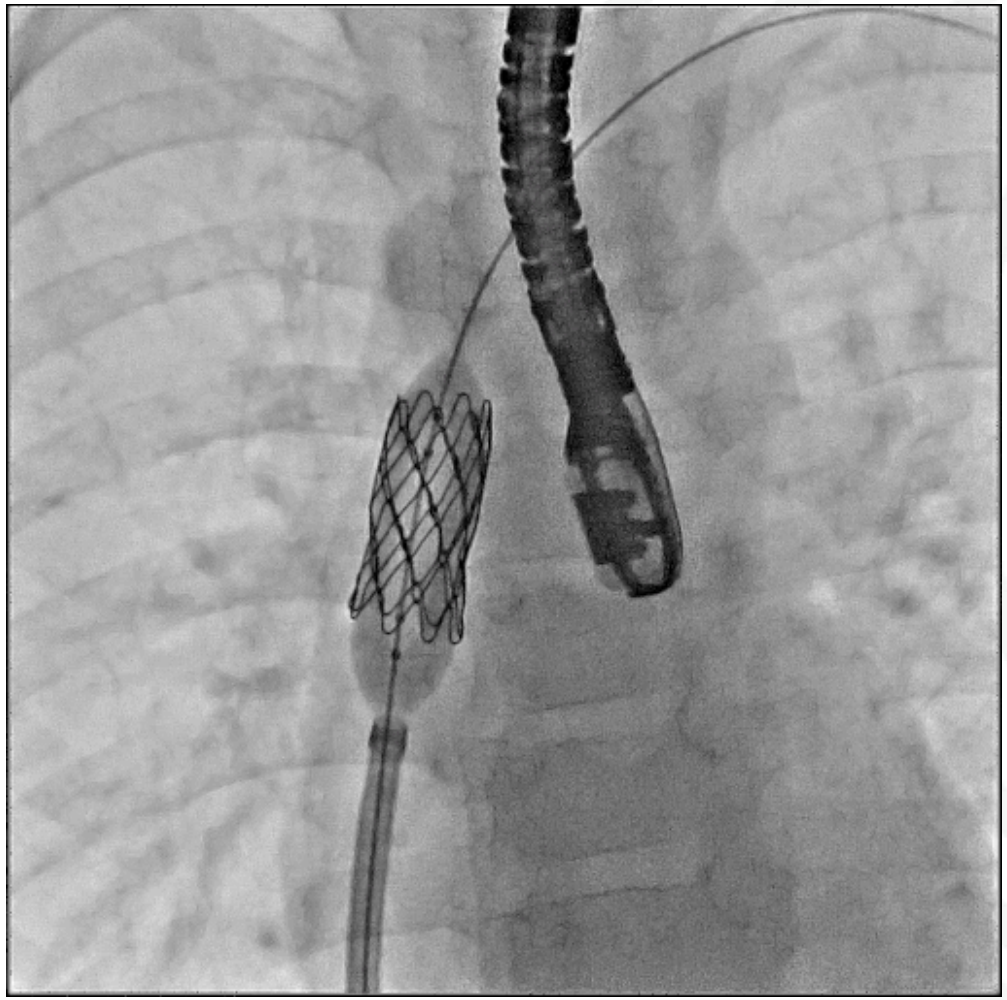
COMPLICATION POST-OPERATOIRE



Pressions: VCS = 28-mmHg; OD= 10-mmHg

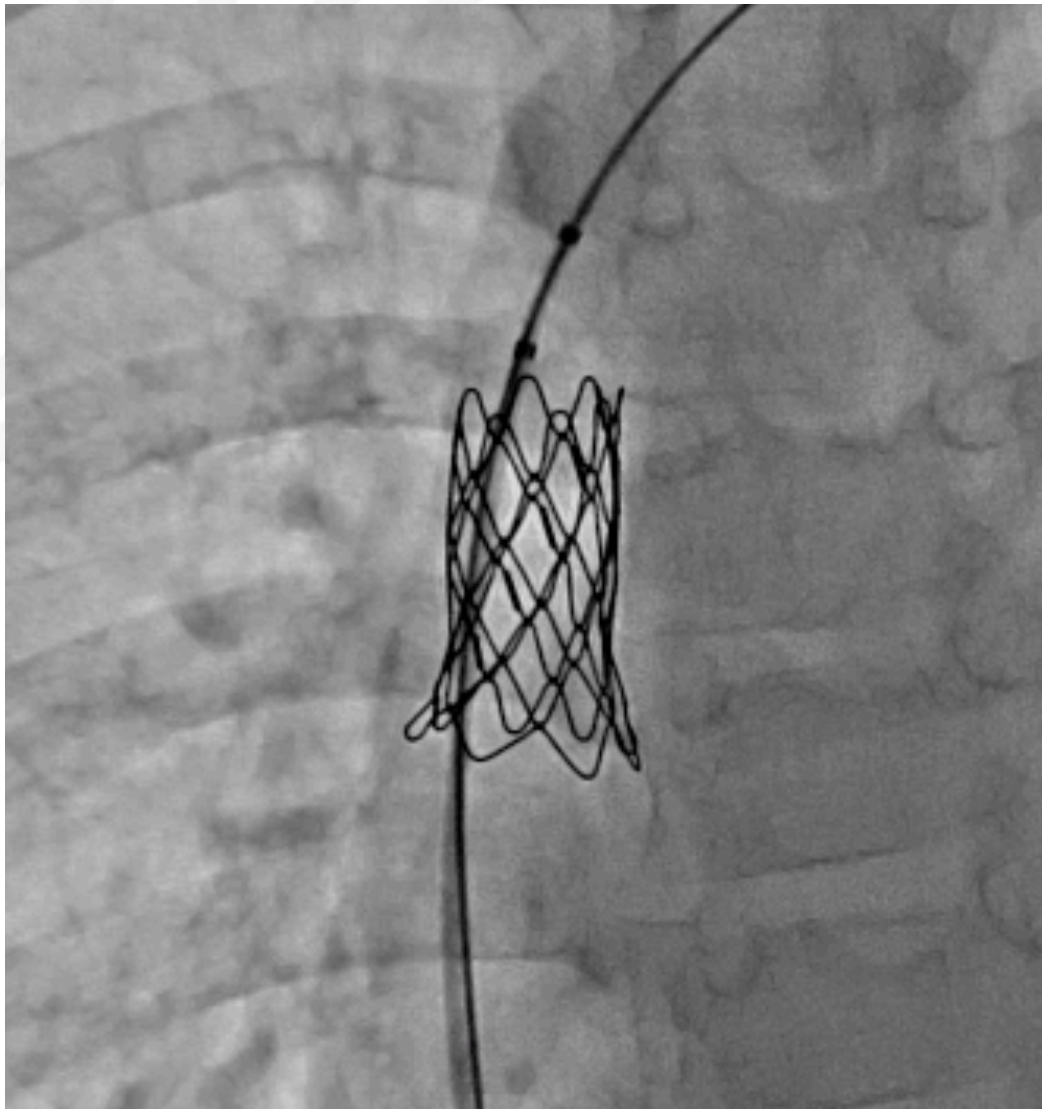
COMPLICATION POST-OPERATOIRE





34mm Coverer CP-Stent – 15x40mm Balloon

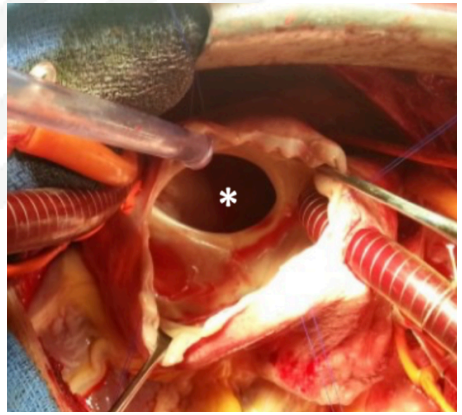
COMPLICATION POST-OPERATOIRE

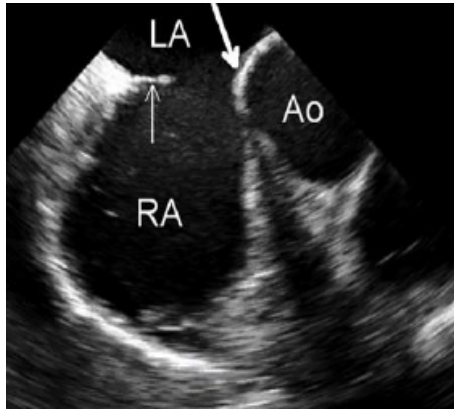


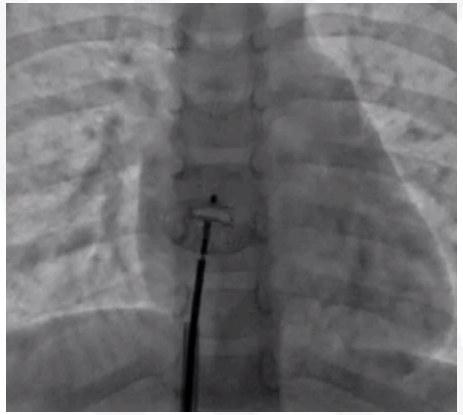
- Sortie J2 sous Aspirine
- 3 mois: disparition symptômes
- Croissance => post-dilatation stent

L'INSTITUT DE RYTHMOLOGIE ET MODÉLISATION CARDIAQUE
BORDEAUX

MERCI POUR VOTRE ATTENTION







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