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PARTNER 2A Study: Late Outcomes of TAVR

Transcatheter aortic valve replacements are routinely done at many institutions in patients not deemed candidates for open-heart surgery. Over the years, many short term studies have been published on the outcomes of TAVR. Findings from the PARTNER 2 study were published in 2016 and now, PARTNER 2A presents the late outcomes of TAVR. These findings have been published in the New England Journal of Medicine.

After 5 years, the PARTNER 2A trial has shown similar rates of death, primary endpoint or disabling stroke in older patients with severe symptomatic aortic stenosis who were at intermediate surgical risk and underwent either surgical aortic valve replacement or TAVR.

In previous reports, the same investigators had shown comparable primary outcomes at 24 months in patients who underwent open-heart surgery or TAVR. Despite the use of the first generation transcatheter aortic valves, the results appear to have held for 5 years showing comparable clinical outcomes of stroke, death, valve haemodynamics and quality of life measurements between surgery and TAVR. The risk of the primary endpoint for patients who underwent TAVR with transfemoral access was not increased compared to the open heart surgery patient. However, the risk was slightly increased in TAVR patients who had transthoracic access.

The PARTER 2A results are reassuring that in elderly patients with severe aortic stenosis, the outcomes of TAVR are comparable to open-heart surgery.

As the technology of percutaneous valve implantation improves, TAVR is now often used to manage patients with aortic stenosis who are at low surgical risk as shown by EVOLU and PARTNER 3 trials. Similarly, the SURTAVI trial showed that TAVR can also be used to manage intermediate-risk patients and have the same outcomes as surgical aortic valve replacement.

However, it is important to know that the valves used in the trials have been different and overall, the TAVR has been associated with a slightly higher rate of reintervention when compared to open-heart surgery. When reintervention was required after TAVR it did not affect morbidity or mortality, but if an intervention was required in patients with open-heart surgery, then the mortality was much higher compared to the TAVR group.

With TAVR, reintervention is most often due to the paravalvular leak and does affect survival if it is not treated. It is hoped that the next generation of aortic valves will have a better fit in the aortic annulus and be associated with a lesser incidence of paravalvular leak.

Source: NEJM
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