SOCIEDAD
VASCO NAVARRA
DE CARDIOLOGÍA

ACTUALIZACIÓN DE LAS GUÍAS ESC 2025 EN VALVULOPATIAS

-LA VISIÓN DEL HEART TEAM VASCO NAVARRO-

INSUFIENCIA MITRAL

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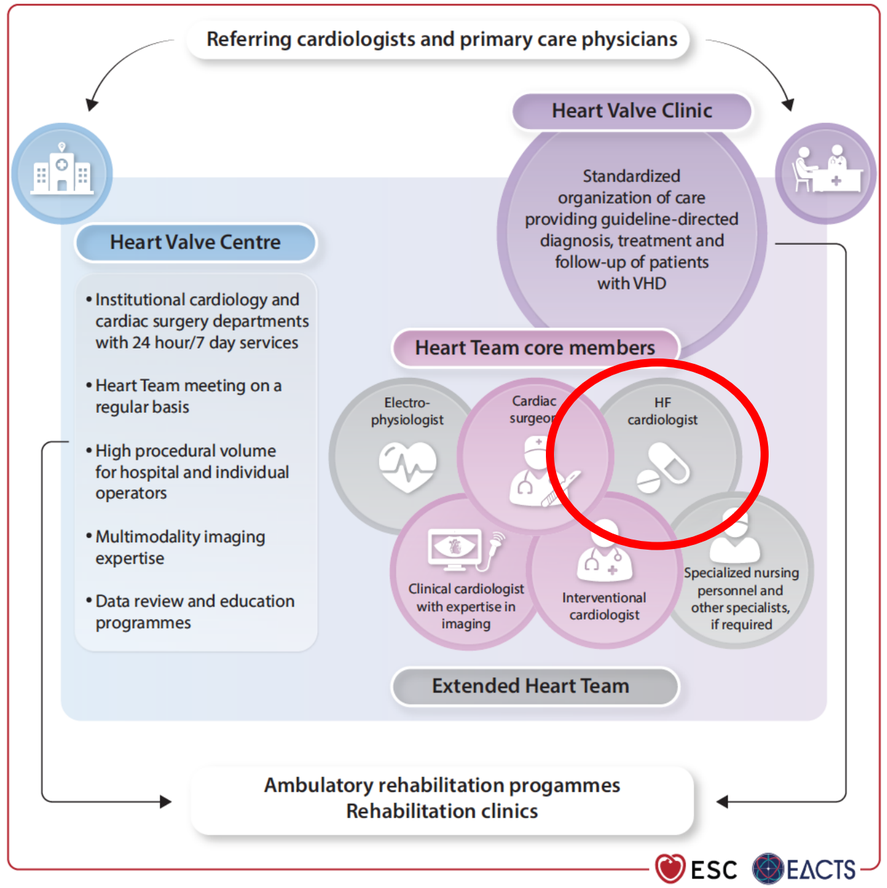
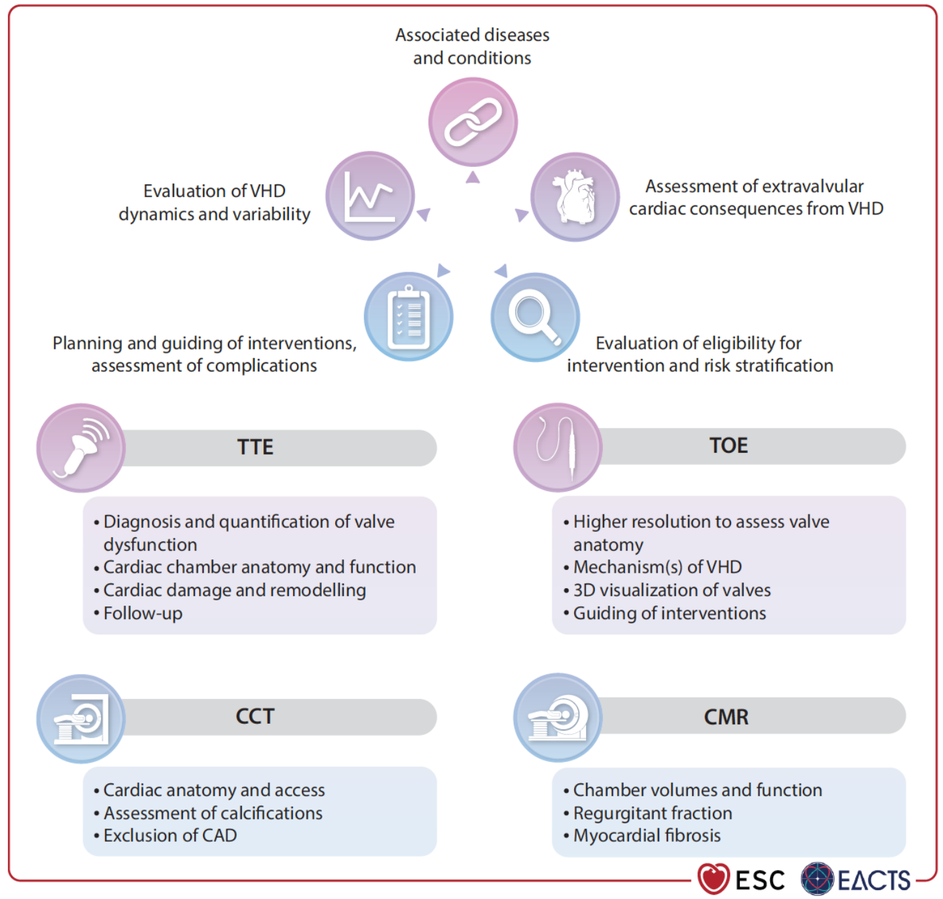
INSUFICIENCIA MITRAL





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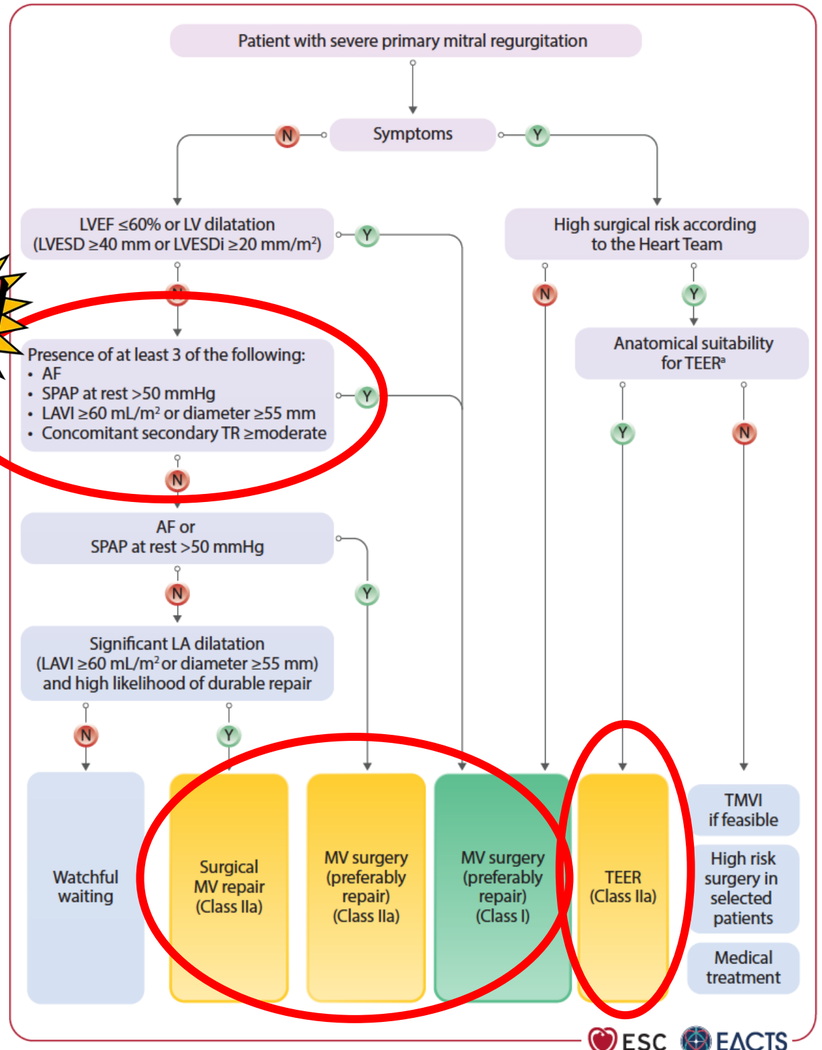
INSUFICIENCIA MITRAL **PRIMARIA**



Recommendations in 2021 version	Class[a]	Level[b]	Recommendations in 2025 version	Class[a]	Level[b]
TEER may be considered in symptomatic patients who fulfil the echocardiographic criteria of eligibility, are judged inoperable or at high surgical risk by the Heart Team, and for whom the procedure is not considered futile.	IIb	B	TEER should be considered in symptomatic patients with severe PMR who are anatomically suitable and at high surgical risk according to the Heart Team.	IIa	B

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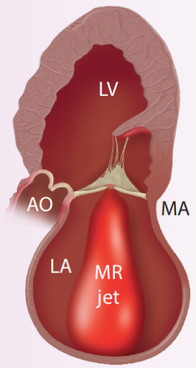
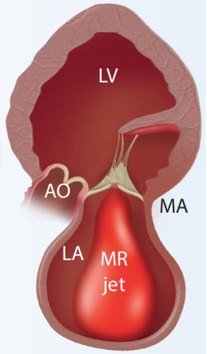
INSUFICIENCIA MITRAL **SECUNDARIA**

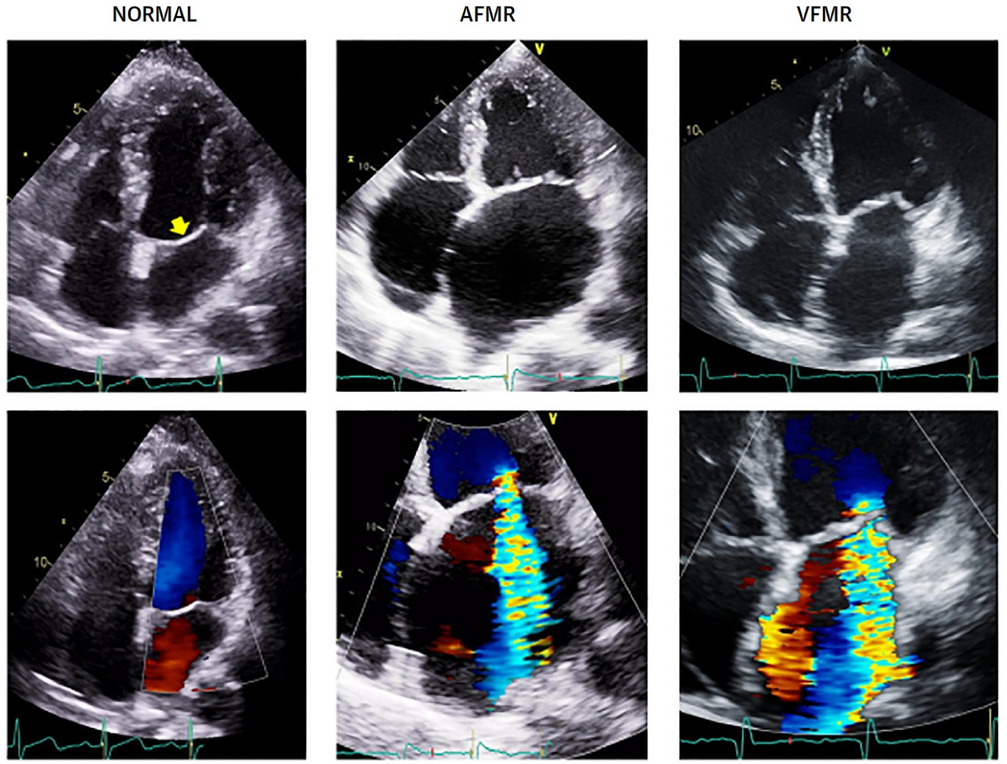
NEW

	Atrial SMR	Ventricular SMR
Key criteria		
	LVEF ≥50% without regional wall motion abnormalities	LVEF <50% with or without regional wall abnormalities
	No or mildly dilated LV cavity[a] without leaflet tethering	Restrictive leaflet motion with tethering
	Mitral annulus dilatation (AP >35 mm)	Normal leaflet morphology
	Enlarged LA (LAVI >34 mL/m^2)	Central or eccentric jet
Additional echocardiographic criteria[b]		
	Normal leaflet motion	Dilated LV
	Normal leaflet morphology	Dilated LA
	Usually central jet	Dilated MV annulus
Additional clinical criteria		
	Atrial fibrillation	Ischaemic heart disease
	HFpEF	Dilated cardiomyopathy





ESC EACTS



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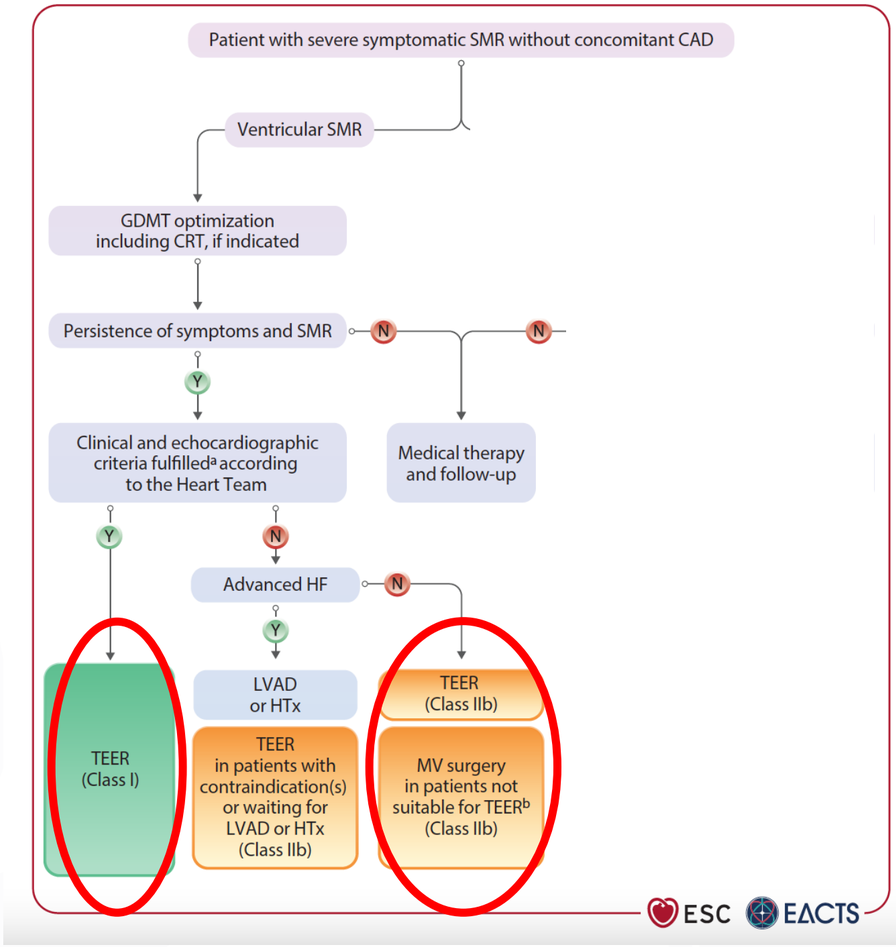
INSUFICIENCIA MITRAL SECUNDARIA **VENTRICULAR**



Recommendations in 2021 version	Class[a]	Level[b]	Recommendations in 2025 version	Class[a]	Level[b]
TEER should be considered in selected symptomatic patients not eligible for surgery and fulfilling criteria suggesting an increased chance of responding to the treatment.	IIa	B	TEER is recommended to reduce HF hospitalizations and improve quality of life in haemodynamically stable, symptomatic patients with impaired LVEF (<50%) and persistent severe ventricular SMR, despite optimized GDMT and CRT (if indicated), fulfilling specific clinical and echocardiographic criteria.	I	A

TEER may be considered for symptom improvement in selected symptomatic patients with severe ventricular SMR not fulfilling the specific clinical and echocardiographic criteria,[c] after careful evaluation of LVAD or HTx.[203,608–610]	IIb	B
MV surgery may be considered in symptomatic patients with severe ventricular SMR without advanced HF who are not suitable for TEER.[617]	IIb	C

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INSUFICIENCIA MITRAL SECUNDARIA **VENTRICULAR**

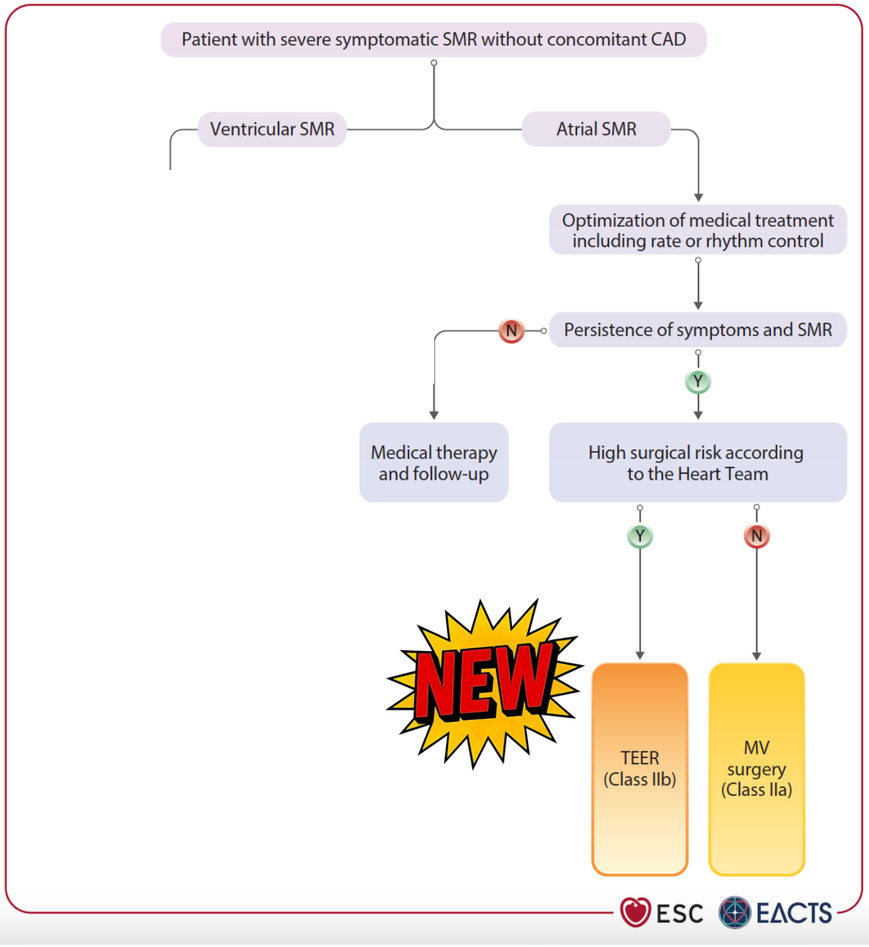
Table S2 **Anatomical criteria for mitral valve transcatheter edge-to-edge repair suitability based on complexity of valve morphology and centre experience**

Non-complex Ideal for mitral TEER	Complex Suitable for mitral TEER	Very complex Challenging for mitral TEER	Mitral TEER very difficult or impossible
TEER	**TEER in experienced centre**	**TEER in experienced centre**	**TMVI or surgery**
• Central pathology • No calcification • MVA >4.0 cm^2 • Posterior leaflet >10 mm • Tenting height <10 mm • Flail gap <10 mm • Flail width <15 mm	• Isolated commissural lesion (A1/P1 or A3/P3) • MAC without leaflet involvement • MVA 3.5–4.0 cm^2 • Posterior leaflet length 7–10 mm • Tenting height >10 mm • Asymmetric tethering • Coaptation reserve <3 mm • Leaflet-to-anulus index <1.2 • Flail width >15 mm • Flail gap >10 mm • Two jets from leaflet indentations	• Commissural lesion with multiple jets • MAC with leaflet involvement • Fibrotic leaflets • Wide jet involving the whole coaptation • MVA 3.0–3.5 cm^2 • Posterior leaflet length 5–7 mm • Barlow's disease • Cleft • Failed surgical annuloplasty	• Concentric MAC with stenosis • MVA <3.0 cm^2 • Relevant MS (mean gradient >5 mmHg) • Posterior leaflet <5 mm • Calcification in the grasping zone • Deep regurgitant cleft • Leaflet perforation • Multiple/wide jets • Rheumatic MS

Table 7 **Clinical and echocardiographic criteria predicting outcome improvement in patients with severe ventricular secondary mitral regurgitation undergoing mitral transcatheter edge-to-edge repair**

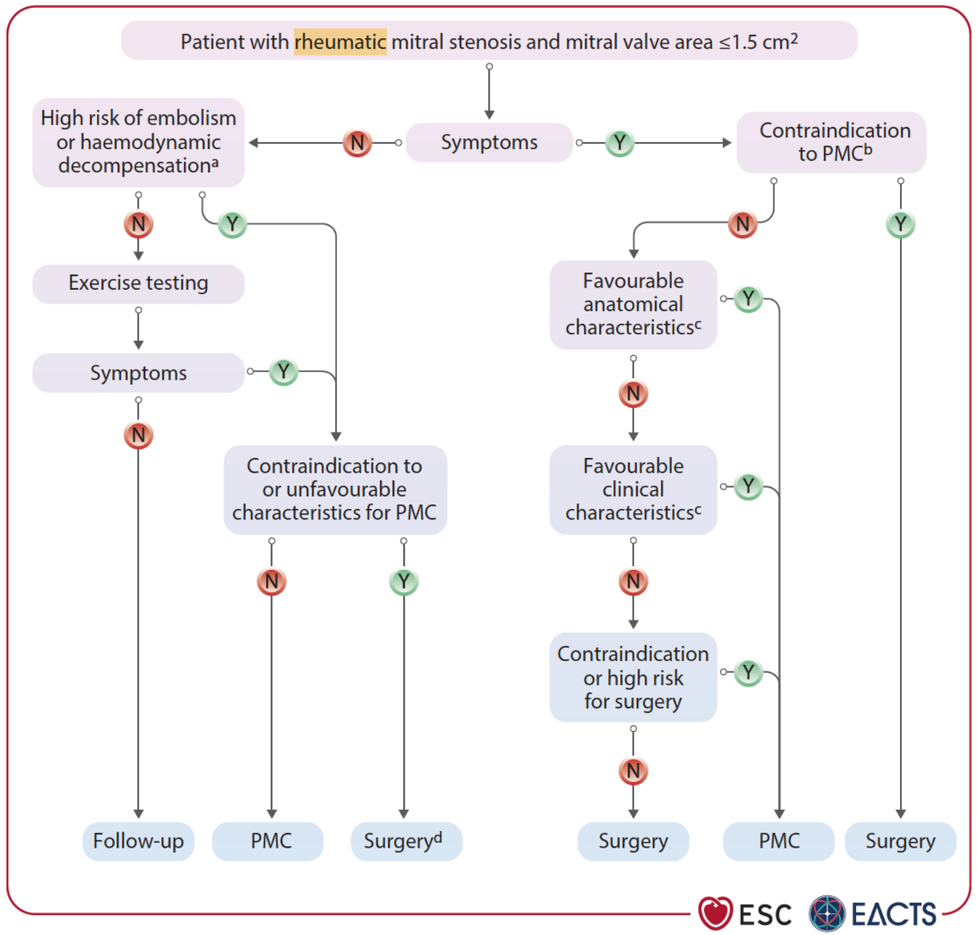
Anatomy deemed suitable for M-TEER
NYHA class ≥II
LVEF 20%–50%
LVESD ≤70 mm
At least one HF hospitalization within the previous year or increased natriuretic peptide levels (BNP ≥300 pg/mL or NT-proBNP ≥1000 pg/mL)
SPAP ≤70 mmHg
No severe RV dysfunction
No Stage D or advanced HF
No CAD requiring revascularization
No severe AV and/or TV disease
No hypertrophic, restrictive, or infiltrative cardiomyopathies

INSUFICIENCIA MITRAL SECUNDARIA **AURICULAR**



MV surgery, surgical AF ablation, if indicated, and LAAO should be considered in symptomatic patients with severe atrial SMR under optimal medical therapy.[627–630,636,637]	**IIa**	**B**
TEER may be considered in symptomatic patients with severe atrial SMR not eligible for surgery after optimization of medical therapy including rhythm control, when appropriate.[588,590,638,639]	**IIb**	**B**

ESTENOSIS MITRAL **REUMÁTICA**



Recommendations	Class[a]	Level[b]
PMC is recommended in symptomatic patients in the absence of unfavourable characteristics for PMC.[c] 651–653,662,665	I	B
PMC is recommended in any symptomatic patients with a contraindication or at high risk for surgery.	I	C
MV surgery is recommended in symptomatic patients who are not suitable for PMC.	I	C
PMC should be considered as initial treatment in symptomatic patients with suboptimal anatomy but no unfavourable clinical characteristics for PMC.[c]	IIa	C
PMC should be considered in asymptomatic patients without unfavourable clinical and anatomical characteristics for PMC, and: • High thromboembolic risk (history of systemic embolism, dense spontaneous contrast in the LA, new-onset or paroxysmal AF), and/or • High risk of haemodynamic decompensation (SPAP >50 mmHg at rest, need for major NCS, pregnant or desire for pregnancy).	IIa	C

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ESTENOSIS MITRAL **DEGENERATIVA**

TMVI may be considered in symptomatic patients with extensive MAC and severe MV dysfunction at experienced Heart Valve Centres with expertise in complex MV surgery and transcatheter interventions.[542,680,681]	IIb	C

CONCLUSIONES

IMAGEN

HEART TEAM

INTERVENCIONISMO ESTRUCTURAL

REPARACIÓN MITRAL

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¡GRACIAS!

Abbott

Edwards

MERCÉ V. ELECTROMEDICINA

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