



ACTUALIZACIÓN DE LAS GUÍAS ESC 2025 EN VALVULOPATIAS

-LA VISIÓN DEL HEART TEAM VASCO NAVARRO-

24 de septiembre. PALACIO EUSKALDUNA. BILBAO

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1. Manejo antitrombótico del paciente portador de prótesis mecánica
2. Enfermedad multivalvular
3. Paciente con estenosis aórtica severa pendiente de cirugía no cardiaca

Manejo antitrombótico en pacientes portadores de prótesis mecánicas en cirugía no cardíaca o procedimientos invasivos

Management of antithrombotic therapy in patients with mechanical heart valves undergoing elective non-cardiac surgery or invasive procedures—Section 14.3

Continuing VKA treatment is recommended in patients with an MHV for minor or minimally invasive interventions associated with no or minimal bleeding.

I

A

Interruption (3–4 days before surgery), and resumption of VKA without bridging, may be considered to reduce bleeding in patients with new-generation aortic MHV and no other thromboembolic risk factors undergoing major non-cardiac surgery or invasive procedures.

IIb

B

		Minimally invasive procedures ^a		Major NCS or invasive procedures ^a	
		Pre-procedure	Post-procedure	Pre-procedure	Post-procedure
Low thromboembolic risk					
New-generation aortic MHV and no additional risk factors ^b	OAC	No interruption of VKA	Continue VKA	Interrupt VKA at least 3–4 days prior to procedure with target INR <1.5 on the day of surgery	Resume VKA as soon as feasible, within 24 h
	Bridging	—	—	No bridging may be considered	No bridging may be considered, unless unable to administer OAC
	Supporting measures	—	Topical antifibrinolytic or haemostatic agents may be considered to improve local haemostasis	—	Mechanical and pharmacological VTE prophylaxis, if indicated
Moderate-to-high thromboembolic risk					
MHV in mitral or tricuspid position or other thromboembolic risk factors ^b	OAC	No interruption of VKA	Continue VKA	Interrupt VKA at least 4 days prior to procedure with target INR <1.5 the day of the procedure	Resume VKA within 24 h
	Bridging	—	—	Bridging with LMWH or UFH if CKD stage IV or V, starting at INR below the therapeutic range	Bridging with UFH or LMWH post-operatively within 24 h
	Supporting measures	—	Topical antifibrinolytic or haemostatic agents may be considered to improve local haemostasis	—	Appropriate mechanical and pharmacological VTE prophylaxis

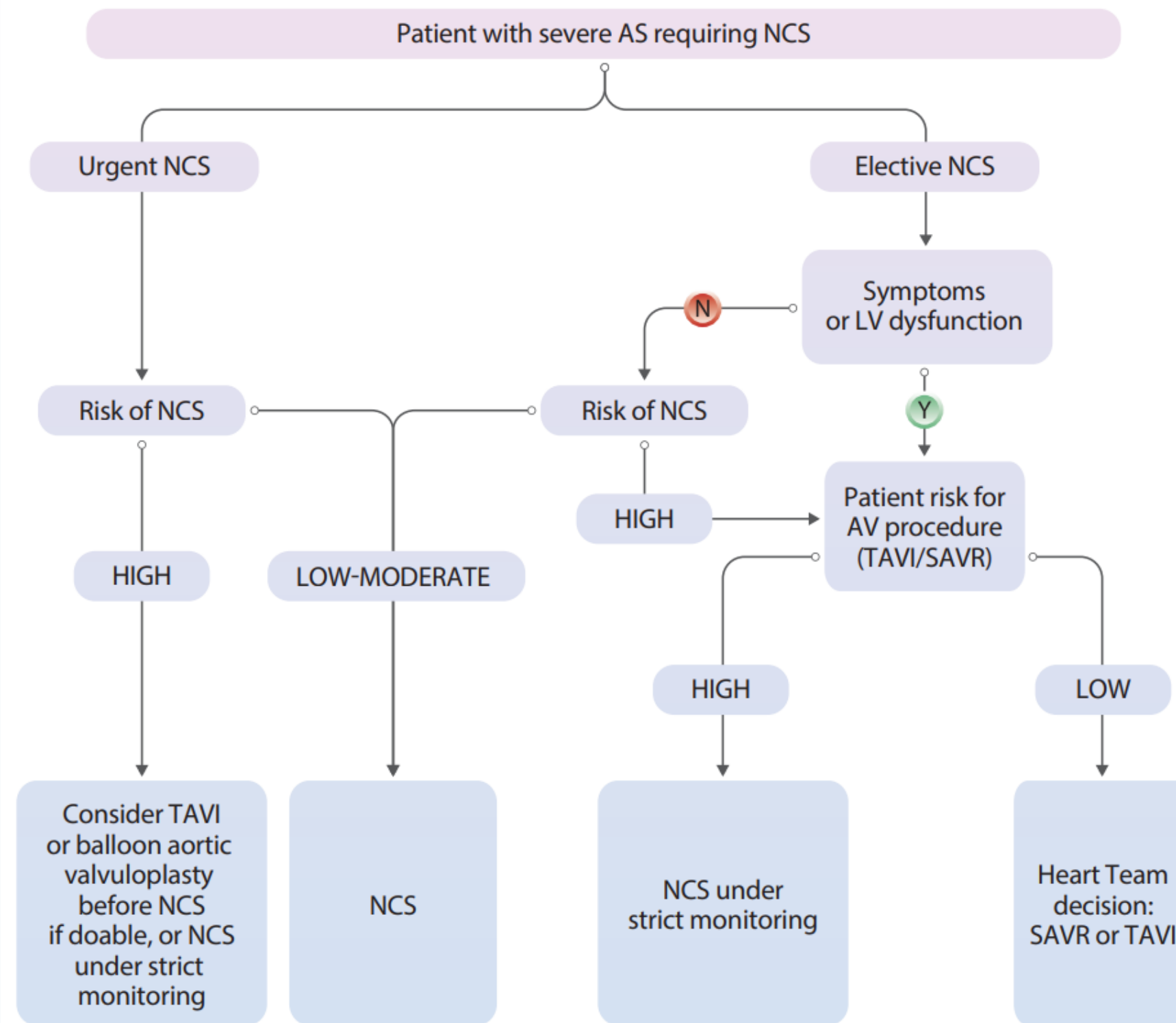
Enfermedad multivalvular

	Valve lesion to be assessed			
	AS	AR	MS	MR
Robust echo measurements	AVA (continuity equation), DVI <i>Reflection of combined burden in mixed AR and AS: V_{max} and mean gradient reflect combined burden</i>	EROA (PISA), vena contracta	Planimetry and 3D MVA (TOE) <i>Reflection of combined burden in mixed MR & MS: mean gradient reflect combined burden</i>	EROA (PISA), vena contracta
Alternative imaging modalities	CT: AV calcium scoring	CMR: regurgitant volume and fraction	—	CMR: regurgitant volume and fraction

Indications for intervention in patients with mixed moderate aortic stenosis and moderate aortic regurgitation—Section 13.3

Intervention is recommended in symptomatic patients with mixed moderate AV stenosis and moderate regurgitation, and a mean gradient ≥ 40 mmHg or $V_{max} \geq 4.0$ m/s.	I	B
Intervention is recommended in asymptomatic patients with mixed moderate AV stenosis and moderate regurgitation, with $V_{max} \geq 4.0$ m/s and LVEF <50% not attributable to other cardiac disease.	I	C

Estenosis aórtica severa con necesidad de cirugía no cardíaca





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