Prosthesis Oversizing in Balloon-Expandable Transcatheter Aortic Valve Implantation Is Associated With Contained Rupture of the Aortic Root

Philipp Blanke, MD; Jochen Reinöhl, MD; Christian Schlensak, MD; Matthias Siepe, MD; Gregor Pache, MD; Wulf Euringer, MD; Annette Geibel-Zehender, MD; Christopher Bode, MD; Mathias Langer, MD; Friedhelm Beyersdorf, MD; Manfred Zehender, MD

Background—To retrospectively investigate the potential cause of contained rupture of the aortic root in balloon-expandable transcatheter aortic valve implantation (TAVI) by means of pre- and postinterventional multislice computed tomography.

Methods and Results—Seventy-two patients (mean age 82±7 years, mean aortic valve area 0.69±0.19 cm²) underwent balloon-expandable TAVI using the EdwardsSAPIEN Transcatheter Heart Valve (23 mm, n=19; 26 mm, n=50; 29 mm, n=3). Aortic annulus dimensions were quantified by multislice computed tomography–based cross-sectional area assessment and average diameter calculation (CAAD) before and after TAVI. Post-TAVI multislice computed tomography data sets were available in 65 patients; contained aortic root rupture was diagnosed in 3 patients. Pre-TAVI CAAD was 23.1±1.8 mm; post-TAVI CAAD was 22.9±1.3 mm. Median relative change in CAAD pre- and post-TAVI was –0.5% (interquartile range, 3.6%). Relative increase of 5% to 10% was observed in 4 patients (1 with contained rupture), relative increase >10% in 2 patients, both with contained rupture. Mean relative oversizing, calculated as the relative difference in diameter between pre-TAVI CAAD and nominal diameter of the selected prosthesis, was 9.8%±7.8%. Relative oversizing was significantly higher in patients with contained rupture compared with patients without contained rupture (24.6%±5.4% versus 9.1%±6.6%; P<0.001). Relative oversizing ≥20% occurred in 6 patients (3 with contained rupture).

Conclusions—Contained rupture of the aortic root in balloon-expandable TAVI is associated with severe prosthesis oversizing. Multislice computed tomography–based assessment of aortic annulus dimension in conjunction with adapted sizing guidelines may reduce the incidence of severe oversizing. (Circ Cardiovasc Interv. 2012;5:540-548.)

Key Words: TAVI ■ aortic valve stenosis ■ contained rupture ■ pseudoaneurysm ■ computed tomography

Transcatheter aortic valve implantation (TAVI) is increasingly used in patients with severe aortic stenosis who are denied to conventional aortic valve replacement due to severe comorbidities and a perceived high risk of perioperative mortality.1-4 Preinterventional prosthesis sizing relies on noninvasive imaging modalities such as echocardiography or multislice computed tomography (MSCT).5 Incorrect sizing may result in adverse outcomes such as paravalvular regurgitation, device embolization,6,7 or even aortic root rupture in the case of severe oversizing.8

Although there is no uniform standard for prosthesis sizing with dissenting results among different image modalities, MSCT is increasingly used because of its capability of 3-dimensional assessment of the complex aortic root anatomy.9 Recent studies suggest that MSCT might be more suitable to assess the aortic annulus size than 2-dimensional echocardiography.10-12

With the introduction of TAVI, performing physicians and surgeons may encounter incidents and complications different from those in conventional aortic valve surgery, such as annulus or aortic root rupture and pseudoaneurysm formation of the aortic root.8,13-15 These complications may be evident while performing the procedure or may be apparent at follow-up studies. However, data are limited and risk factors for these entities have not been investigated thoroughly yet.

The aim of this study was to investigate the potential cause of contained rupture of the aortic root in balloon-expandable TAVI by means of pre- and postinterventional MSCT and definition of prosthesis oversizing.

Methods

Study Population

This retrospective study was approved by the institutional review board and complies with the Declaration of Helsinki. Between June 2008 and May 2011, 107 patients with severe symptomatic aortic stenosis underwent TAVI, of whom 35 patients received a self-expandable prosthesis and 72 patients a balloon-expandable prosthesis. The study population consisted of the 72 consecutive patients with balloon-expandable TAVI, who underwent either
WHAT IS KNOWN

- Preinterventional prosthesis-sizing is critical for TAVI in order to reduce the risk of adverse outcomes, such as paravalvular regurgitation or device embolization.
- Three-dimensional imaging modalities, such as multislice computed tomography, are capable of assessing the complex 3-dimensional anatomy of the aortic root complex.

WHAT THE STUDY ADDS

- Follow-up computed tomography after balloon-expandable TAVI can establish the diagnosis of asymptomatic contained aortic root rupture.
- Contained rupture of the aortic root in balloon-expandable TAVI is associated with severe prosthesis oversizing, and was observed in patients with relative oversizing of >20% in relation to the native aortic annulus.
- Multislice computed tomography-based assessment of aortic annulus dimension in conjunction with adapted sizing-guidelines may reduce the incidence of severe oversizing.

transapical (n=59) or transfemoral (n=13) implantation of the Edwards SAPIEN Transcatheter Heart Valve (Edwards Lifesciences LLC, Irvine, CA). All patients were referred for diagnostic workup before TAVI including an electrocardiography-gated dual-source MSCT of the heart as part of their assessment. Transthoracic echocardiography and transesophageal echocardiography (TEE) were performed within a time span of 1 week, usually before MSCT.

Of the 72 patients, 19 patients received a 23-mm prosthesis, 50 received a 26-mm prosthesis, and 3 patients received a 29-mm prosthesis (available since April 2011). The technique of transapical and transfemoral implantation of the Edwards SAPIEN Transcatheter Heart Valve has been described previously. Preceding aortic balloon valvuloplasty was performed using a size 20×50 mm balloon (ZMed, NuMed) filled with 1:4 diluted contrast during a brief episode of rapid ventricular pacing. According to the manufacturer’s instructions for use, the bioprosthesis was deployed by inflating the balloon with the entire volume in the inflation device.

In the first 31 patients, selection of prosthesis size (23 mm or 26 mm) was a case-to-case decision based on pre- and intraoperative TEE: The 23-mm prosthesis was implanted for annulus sizes ≤21 mm, the 26 mm for annulus sizes between 22 and 24 mm, according to contemporary manufacturers recommendations. In the succeeding 41 patients’, prosthesis sizing was based on the calculated average annulus diameter (CAAD) derived from the cross-sectional area (CSA) assessed by means of planimetry in MSCT. For CAAD <22 mm, the 23-mm prosthesis was implanted, and for CAAD of 22 to 25 mm the 26-mm prosthesis was implanted. Starting from April 2011, the 29-mm prosthesis was implanted for CAAD ≥25 to 28 mm. Using these cutoff values, relative oversizing with regard to the nominal stent diameter ranges between 4% and 21% for CAAD of 19 to 28 mm. All patients with balloon-expandable TAVI were subject to follow-up MSCT, as routinely performed at our institution.

MSCT Protocol

All computed tomography (CT) examinations were performed using a dual-source CT scanner (Somatom Definition, Siemens Healthcare, Forchheim, Germany). For contrast-enhanced data acquisition, 90 to 110 mL of iodinated contrast agent (Imeron 350, Bracco Imaging, Germany) were injected at a flow rate of 4 to 5 mL/s via an 18-gauge needle in an antecubital vein, followed by a 50-mL saline bolus chaser administered at a flow rate of 4 mL/s. The scan was started by means of bolus tracking. Scan parameters for cardiac CT were as follows: reference tube current time product, 360 mAs/rotation; slice acquisition, 2×64×0.6 mm; pitch, 0.2 to 0.43 adapted to heart rate; gantry rotation time, 330 ms; tube voltage 120 kV; CARE Dose4D tube current modulation; scan direction, cranio-caudal. For cardiac data acquisition, scan range extended from the carina to the diaphragm as part of a comprehensive scan protocol consisting of an ECG-gated acquisition of the thorax followed by an un gated data acquisition of the abdomen. Follow-up MSCT scan was limited to the cardiac scan range with a reduced amount of contrast media (70 mL) at identical flow rate.

Contraindications for MSCT examination were severely impaired renal function (estimated glomerular filtration rate, ≤40 mL/min per 1.73 m²) or previous severe adverse reaction (anaphylactic; ie, profound hypotension, bronchospasm, severe urticaria) to an iodinated contrast agent. Patients with an estimated glomerular filtration rate between 40 and 60 mL/min per 1.73 m² underwent intravenous volume expansion with isotonic crystalloid (1.0-1.5 mL/kg per hour) for 3 to 12 hours before MSCT and for 6 to 24 hours afterward. In addition, these patients received 1200 mg of N-acetylcysteine orally twice a day before and after the procedure. Given the clinical characteristics of the study population with severe symptomatic aortic stenosis, no additional β-blockade was administered to achieve slower heart rates.

Image Reconstruction

CT data sets were reconstructed at 300 ms past the R-peak (end-systole) with a slice thickness of 0.6 mm and an increment of 0.4 mm using a medium soft tissue convolution kernel B26f and a sharp kernel B46f. All data sets were transferred to a dedicated postprocessing workstation equipped with Aquarius iNtuition (Terarecon Inc, San Mateo, CA).

Dimensions of the aortic annulus were assessed using the concept of a virtual ring joining the basal attachments of all 3 aortic valve cusps, representing the inlet from the left ventricular outflow tract into the aortic root. Using the coronal-oblique and sagittal-oblique views, the corresponding double-oblique transverse view was adjusted to transect through the most caudal attachments of all 3 native cusps, defining the orientation and position of the virtual ring. To assess the CSA, the luminal contours were tracked on the double-oblique transverse plane using automatic vessel analysis with manual correction (Figure 1). Punctiform calcifications at the most basal attachment sites of the cusps were included into the planimetric area when present. CSA and maximum and minimal diameters were noted as displayed by the segmentation software. Using the equation for the area of a circle (πr²), the average diameter of the encircled area was calculated (CAAD) as follows:

\[ CAAD = 2\sqrt{\frac{CSA}{\pi}} \]

Echocardiography

Multiplanar TEE was performed by an experienced cardiologist using a Philips iE33 echocardiography system (Philips Healthcare, Best, The Netherlands). The aortic annulus diameter was assessed on the midesophageal long-axis view (≈120°) of the ascending aorta and aortic valve at end-systole, according to the American Society of Echocardiography guidelines. Diameter was defined as the distance between the depicted hinge points of the aortic valve leaflets, using the inner edge-to-inner edge technique, including annulus calcifications.

Post-TAVI MSCT Assessment and Definition of Contained Rupture

Similar to the initial MSCT examinations, we reconstructed coronal-oblique and sagittal-oblique views through the aortic valve prosthesis, with the intersection of both views representing the axis of the unfolded stent. The position of the resulting double-oblique transverse view was adjusted to the ventricular stent ending. CSA was obtained by means of planimetry (Figure 1E–1H). Contained rupture of the aortic root was defined as discernible contrast-filled cavities, that is, pseudoaneurysms, in the immediate vicinity to the aortic root.

Oversizing

For retrospective analysis, CAAD was defined as the standard of reference. Selection oversizing was defined as selection of a 26-mm prosthesis by means of TEE in the setting of a MSCT-based CAAD <22 mm.
Relative oversizing was calculated as the relative difference in diameter between pre-TAVI CAAD and nominal diameter of the selected prosthesis. Relative change in CAAD between pre-TAVI MSCT and post-TAVI MSCT was calculated.

Statistical Analysis
Continuous variables are reported as means±1 standard deviation when normally distributed as assessed by Kolmogorov–Smirnov tests. Nonnormally distributed variables are reported as the median and interquartile range. Pearson correlation analysis and modified Bland–Altman plots,22 with the assessment of systematic bias and confidence limits for a single prediction, were used to assess agreement for anatomic measurements by TEE and MSCT. Paired t tests were used to test for significant differences between TEE and MSCT measurements. One-way ANOVA was used to test for differences of the eccentricity index (EI) between subgroups. Unpaired t test was used to compare relative oversizing between patients with and without contained rupture. All statistical analyses were performed using SPSS software (SPSS 17.0, SPSS Inc, Chicago, IL). A P value <0.05 was considered statistically significant. To quantify the degree of deviation of both, the virtual ring shape and the shape of the cross section of the unfolded stent from a perfect circle, we calculated an EI, where EI = 1−(minimal diameter/maximum diameter).23 Using this index, an EI of 0 represents a perfect circle, with higher EI indicating elliptical geometry. Noncircular was defined as EI>0.1.

Results

Study Population
Patient characteristics are listed in Table 1. Pre-TAVI MSCT data acquisitions and TEE were successfully performed in all 72 patients. Follow-up MSCT was performed at median 10 days (interquartile range, 12 days) after TAVI. One patient declined follow-up MSCT. Three patients died before follow-up MSCT. Three patients were deferred from follow-up MSCT because of renal failure. Post-TAVI MSCT data sets were thus available in 65 patients. Of them, 18 patients received a 23-mm Edwards SAPIEN valve, 45 patients received a 26-mm valve, and 2 patients received a 29-mm valve. Average heart rate and heart rate variability during data acquisition was 68.3±12.4 bpm and 4.8±6.1 bpm for pre-TAVI data acquisition and 70.5±11.7 bpm and 5.1±6.4 bpm for post-TAVI data acquisition. Average estimated radiation dose for ECG-gated CTA of the entire thorax was 15.4±4.2 mSv.

Procedural Results
Device success (defined as stable device placement and adequate function in the first attempt as assessed by angiography and intraoperative echocardiography) was 100%. Acute procedural success (defined as device success with the absence of periprocedural major cardiovascular events including death, tamponade, and coronary artery occlusion in the first 24 hours after device implantation) was 98.6% (71/72). In-hospital mortality rate was 6.9% (5/72), and 1-month mortality rate was 11.1% (8/72).

Contained Rupture
Signs of contained rupture of the aortic root were observed in 3 of 65 patients (5%). In these patients, contrast-filled cavities were found on follow-up MSCT adjacent to the stent struts with Hounsfield units equivalent to the lumen of the left ventricular outflow tract, not present on initial pre-TAVI MSCT. In all cases,
the resulting pseudoaneurysm was located adjacent to the left aortic sinus. Annulus and sizing characteristics are listed in Table 2. In all patients, the prosthesis was deployed without technical complications with no abnormal findings on postimplantation intraoperative angiography and intraoperative TEE. There was no postimplantation dilatation in any of the 3 patients.

Two of these patients, both elderly females, had received a 26-mm prosthesis. Both patients were sized by means of TEE (both 22 mm). However, retrospectively performed CAAD assessment revealed diameters of 19.9 mm and 21.2 mm with a relative increase in CAAD of 15.6% and 20.6% post-TAVI (Figure 2). Both patients were discharged on 100 mg aspirin per day. One patient underwent a second follow-up CT 6 months later, which showed the disappearance of the pseudoaneurysm. The other patient (Figure 4) did not undergo a second follow-up CT. She died after being admitted to a community hospital for a traumatic humerus fracture 844 days postimplantation. The cause of death was acute hypoxia most likely related to pulmonary embolism. Autopsy was not performed because of lacking consent by the next of kin.

The third patient, also an elderly female, was sized by means of CAAD and had received a 23-mm prosthesis, given a CAAD of 19.2 mm. Relative increase in CAAD was 9.4%. She died 15 days postimplantation because of respiratory failure after sustained retroperitoneal hematoma and prolonged intubation.

Among the 72 patients treated with balloon-expandable TAVI, there was 1 documented case of acute cardiac tamponade, which was due to insufficiency of the apical myocardial suture. There were no other unresolved cases of acute or subacute cardiac tamponade.

Aortic Annulus Dimensions

The median CSA at the level of the basal attachments of all 3 aortic valve cusps was 420.9 mm² (range, 301–564 mm²); the corresponding mean CAAD was 23.1±1.8 mm (19.6–26.8 mm). Mean minimal diameter was 20.2±2.3 mm (15.8–26.2 mm) and mean maximal diameter 26.3±1.9 mm (21.6–30.0 mm).

TEE Versus MSCT

Mean annulus diameter as assessed with TEE was 21.9±1.7 mm and significantly lower than mean CAAD (23.1±1.8 mm; P<0.001). Mean difference between CAAD measurements on MSCT and midesophageal long-axis view on TEE was 1.2±1.7 mm (range −3.1 to 4.6 mm). Limits of agreement according to Bland–Altman analysis were −2.2 mm and 4.6 mm (Figure 5).

Post-TAVI Dimensions and Relative Change in CAAD

The stent’s mean CSA was 413.6±47.7 mm² (range, 302–546 mm²); the corresponding mean CAAD 22.9±1.3 mm (range, 19.6–26.4 mm). The stent’s CSA was close to a perfect circle (EI<0.1) in 43 patients (66%) and elliptical in the other 22 (34%). Mean EI was 0.10±0.04. None of the prostheses unfolded to its nominal diameter.

Overall, median relative change in CAAD between pre-TAVI and post-TAVI was −0.5% (interquartile range, 3.6%; range −10.4% to 20.6%). Figure 6A depicts the distribution of relative change in CAAD. A relative increase of 5% to 10% was observed in 4 patients (66%) and elliptical in the other 22 (34%). Mean EI was 0.10±0.04. None of the prostheses unfolded to its nominal diameter.

Valve Selection and Oversizing

In the first 31 patients, prosthesis choice was TEE based: 11 patients had received a 23-mm prosthesis and 20 patients had received a 26-mm prosthesis. Retrospective comparison

<table>
<thead>
<tr>
<th>Sex, Age, y</th>
<th>Implanted Prosthesis, mm</th>
<th>Pre-TAVI Sizing</th>
<th>Pre-TAVI CSA/CAAD</th>
<th>Post-TAVI CSA/CAAD</th>
<th>Relative Oversizing, %</th>
<th>Relative Increase in CAAD, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>♀, 77</td>
<td>26</td>
<td>TEE 22</td>
<td>312 mm²/19.9 mm</td>
<td>452 mm²/24.0 mm</td>
<td>30.7</td>
<td>20.6</td>
</tr>
<tr>
<td>♀, 84</td>
<td>26</td>
<td>TEE 22</td>
<td>353 mm²/21.2 mm</td>
<td>472 mm²/24.5 mm</td>
<td>22.6</td>
<td>15.6</td>
</tr>
<tr>
<td>♀, 89</td>
<td>23</td>
<td>CAAD 19</td>
<td>291 mm²/19.2 mm</td>
<td>346 mm²/21.0 mm</td>
<td>20.4</td>
<td>9.4</td>
</tr>
</tbody>
</table>

CAAD indicates calculated average annulus diameter; CSA, cross-sectional area; TAVI, transcatheter aortic valve implantation; TEE, transesophageal echocardiography.

♀ indicates female sex.
of implanted prosthesis size (23 or 26 mm) with preoperative CAAD measurements revealed that selection oversizing had occurred in 5 of the 20 patients with a 26-mm prosthesis (CAAD < 22 mm). All these patients had follow-up MSCT available, and in 2 patients, contained rupture was diagnosed (relative increase in CAAD 15.6% and 20.6%). The other 3 patients with selection oversizing showed a relative increase in CAAD between 6.4% and 7.4% without the evidence of contained rupture.

Average change of CAAD in patients with contained rupture, in patients with selection oversizing but no rupture, and in patients without selection oversizing was 15.2%±5.6%, 7.0%±0.5%, and −1.6%±3.4%, respectively (P<0.001).

Distribution of relative oversizing by comparison of nominal stent diameter and CAAD is depicted in Figure 6B. Mean relative oversizing was 9.8%±7.3% (range −4.6% to 30.7%). Relative oversizing ≥10% occurred in 27 patients. Relative oversizing ≥20% occurred in 6 patients, of whom 3 showed evidence of contained rupture. Oversizing was significantly higher in patients with contained rupture compared to patients without contained rupture (24.6±5.4% versus 9.1%±6.6%; P<0.001).

**Eccentricity**

The mean calculated EI was 0.23±0.09 (range, 0.11–0.40). The annulus shape was elliptical (EI>0.1) in all patients. Average EI in patients with contained rupture, in patients with selection oversizing but no rupture, and in patients without selection oversizing was 0.24±0.10, 0.25±0.13, and 0.24±0.07 (P=0.944), respectively.

**Paravalvular Regurgitation**

Moderate, but not severe, paravalvular regurgitation was observed in 3 patients immediately after the intervention by intraoperative TEE and by TTE at time of discharge. There was no paravalvular regurgitation in the 3 patients with contained rupture and in the 3 remaining patients with selection oversizing but without contained rupture.

**Discussion**

With TAVI, the occurrence of uncontained and contained aortic annulus rupture, the latter also referred to as pseudoaneurysm formation of the left ventricular outflow tract, has been described previously. In theory, both entities may belong to the spectrum of the same pathology, namely disruption of the aortoventricular junction, caused by either the forces of the preceding valvuloplasty or the actual TAVI procedure. In the study presented, we found 3 cases of contained rupture of the aortic root by means of MSCT. Contained rupture occurred only in patients with pronounced increase in CAAD between pre-TAVI and post-TAVI MSCT data sets and relative oversizing >20%.

The balloon-expandable Edwards SAPIEN Heart Valve is available with 23 mm and 26 mm in size, and since recently with 29 mm. Current manufacturer’s recommendations for valve sizing are TEE based. Furthermore, in the majority of recent single- and multicenter studies, valve size selection is based on measurements by TEE. As described by Walther et al., patients with an aortic annulus diameter <21 mm receive a 23-mm prosthesis whereas patients with an aortic annulus...
diameter between 22 and 24 mm receive a 26-mm prosthesis. In their opinion, some oversizing of ≈10% is essential to avoid severe paravalvular leakage, but in the presence of a rigid aortic root, too much oversizing should be avoided. However, according to Webb et al, an annulus diameter of 18 to 22 mm assessed by echocardiography is considered appropriate for the 23-mm prosthesis and 21 to 25 mm for the 26-mm prosthesis, creating a twilight zone between 21 and 22 mm.

Unfortunately, the aortic annulus is not a true ring. The semilunar hinges of the aortic leaflets take the form of a 3-pronged coronet rather than a circle. Furthermore, the annulus is rather elliptical than round when viewed axially. Given this complex and ovoid geometry, different imaging modalities as well as measurement planes will yield dissenting results. We found that 2-dimensional-TEE systematically underestimated annulus dimensions by 1.2±1.7 mm when compared with CAAD. This can be partially attributed to the ovoid annulus anatomy and the midesophageal long-axis view orientation, transecting through the right and noncoronary cusps, more closely resembling the short annulus axis. Furthermore, limits of agreement were rather wide with patients having smaller but, importantly, also larger diameters in TEE than in MSCT. Larger intraindividual diameters in TEE than in MSCT may be due to the varying diameter of the aortic root, which is widest at the midpoints of the sinuses and smaller at the basal attachment of the leaflets. The leaflets’ hinges extend from the basal attachment to the sinotubular junction, following the varying root caliber. With TEE, hinge-to-hinge measurements from the basal attachment of 1 leaflet to the depicted hinge point across the lumen may take a diagonal path in relation to the aortic root’s axis, thus yielding a larger value, further augmented by the aortic root’s wider diameter toward the midpoint of the sinuses.

In contrast to the elliptical annulus anatomy, devices for balloon-expandable TAVI are circular when viewed axially.
As recently demonstrated, the Edwards SAPIEN Transcatheter Heart Valve expands to an almost circular shape in most patients, thereby altering the annulus configuration, that is, reducing eccentricity toward a more circular shape while the CSA remains constant. In the study presented, the median relative change in CAAD was \(-0.5\%\) when comparing pre- and post-TAVI data sets. An increase of \(\geq 5\%\) was observed in only 6 of 65 patients, and an increase of \(>10\%\) in only 2 patients. Although increase in CAAD was significantly higher in patients with contained rupture, contained rupture was not observed in patients with only moderate increase in CAAD.

Furthermore, relative oversizing, expressing the mismatch of CAAD and nominal prosthesis diameter, was significantly higher in patients with contained rupture. Contained rupture was only found in patients with relative oversizing \(>20\%\).

We identified 2 reasons for pronounced relative oversizing:

1. Selection oversizing by choosing a larger prosthesis because of borderline TEE measurements; and
2. Small annulus anatomy by choosing the smallest prosthesis currently available.

Given the systematic difference in annulus dimensions obtained by TEE and MSCT, TEE-based sizing guidelines cannot be simply adopted to MSCT. Considering the ovoid nature of the annulus and the circular nature of the ideally unfolded Edwards SAPIEN prosthesis, it becomes apparent that the recommended TEE-based oversizing by 10% as stated by Walther et al does not necessarily imply oversizing in terms of CAAD. Instead, the recommended oversizing by 10% compensates for the intrinsic bias of the midesophageal long-axis view on TEE, yielding smaller values than the CAAD. For the CAAD-based sizing approach, which is now routinely applied at our institution, we deliberately chose 22 mm as the cutoff value for selection between the 23-mm...
and the 26-mm prosthesis as we learned that neither of both unfolds to the nominal diameter. Since recently, the 29-mm prosthesis is chosen for CAAD of 25 to 28 mm. However, given the results of this study, it is unclear how to treat patients with a small annulus (eg, <20 mm).

Despite >30'000 TAVI procedures performed worldwide, literature on pseudoaneurysm formation and contained rupture is limited to case reports, as follow-up MSCT is not routinely performed. However, uncontained annulus rupture with cardiac tamponade and fatal outcome has been observed in larger studies. Thus, pseudoaneurysm formation might represent the lower end of the spectrum of manifestations with uncontained rupture and cardiac tamponade on the upper end. In fact, in real world single-center (eg, Pasic et al, 1 of 194 patients; Lange et al, 1 and 129 patients) or multicenter registries (Elchichonoff et al, 1 of 95 patients), the rate of uncontained aortic annulus rupture ranges between 0.5% and 1%.

As patients included into this study underwent TAVI as they did not qualify for open surgery in the first place due to a perceived high risk of perioperative mortality, the 3 patients with contained rupture underwent conservative management only. Although the clinical impact of untreated contained rupture is unknown, it appears conceivable that the occurrence of contained rupture as an assumed prestige to uncontained rupture should be avoided. Interestingly, in all 3 cases observed in the present study, as well as in the 2 cases described in literature so far, 1,3,12 contained rupture occurred adjacent to the left coronary sinus. This leads to the assumption that the tissue adjacent to the left coronary sinus represents a Locus minoris resistentiae. Furthermore, all 3 patients were elderly women, concordant with observations by others. 24

Study Limitations
This study is limited by its relatively small patient cohort and the rare incidence of pseudoaneurysm formation. However, as to our knowledge, this is the largest patient series with systematic follow-up MSCT to date. Furthermore, the time span from TAVI to follow-up varied between 3 and 66 days. Thus, smaller alterations might have been missed in some patients, as pseudoaneurysm may regress with time. Finally, because this study focused on patients with balloon-expandable TAVI, the presented concept cannot be readily applied for self-expanding devices.

Optimal sizing can be thought of being in-between excessive oversizing with subsequent rupture and undersizing with subsequent paravalvular regurgitation. Our MSCT-based sizing regimen results in relative oversizing of 4% to 21% for CAAD of 19 to 28 mm using the 3 currently available prosthesis sizes of 23, 26, and 29 mm (Europe). However, our retrospective study was not designed to investigate the optimal amount of oversizing.

Planimetry is one of the few different measurement techniques for the assessment of annulus dimensions with MSCT. Others are caliper measurements. However, planimetry followed by calculation of an average diameter has been shown to be the most reproducible measurement among different measurement techniques with MSCT. 28 Importantly, data reconstruction was deliberately chosen at 300 ms past the R-peak to ensure proper image quality, even in patients with atrial fibrillation.

Conclusion
Contained rupture of the aortic root in balloon-expandable TAVI is associated with severe prosthesis oversizing. MSCT-based assessment of aortic annulus dimension in conjunction with adapted sizing guidelines may reduce the incidence of prosthesis oversizing.

Disclosures
None.

References


17. Piazza N, de Jaegere P, Schultz C, Becker AE, Serruys PW, Anderson RH. Anatomy of the aortic valvar complex and its implications for transcathe-

operative multiplane transesophageal echocardiography examination: rec-
ommendations of the American Society of Echocardiography Council for Intraoperative Echocardiography and the Society of Cardiovascular Anes-
19. Lang RM, Bierig M, Devereux RB, Flachskampf FA, Foster E, Pellikka PA, Picard MH, Roman MJ, Seward J, Shanewise JS, Solomon SD, Spencer KT, Sutton MS, Stewart WJ; Chamber Quantification Writing Group; American Society of Echocardiography’s Guidelines and Standards Com-
mittee; European Association of Echocardiography. Recommendations for chamber quantification: a report from the American Society of Echo-
cardiography’s Guidelines and Standards Committee and the Chamber Quantification Writing Group, developed in conjunction with the Euro-
20. Bland JM, Altman DG. Statistical methods for assessing agreement be-
stration of left ventricular outflow tract eccentricity by 64-slice multi-
Prosthesis Oversizing in Balloon-Expandable Transcatheter Aortic Valve Implantation Is Associated With Contained Rupture of the Aortic Root

Philipp Blanke, Jochen Reinöhl, Christian Schlensak, Matthias Siepe, Gregor Pache, Wulf Euringer, Annette Geibel-Zehender, Christopher Bode, Mathias Langer, Friedhelm Beyersdorf and Manfred Zehender

_Circ Cardiovasc Interv._ 2012;5:540-548; originally published online August 7, 2012; doi: 10.1161/CIRCINTERVENTIONS.111.967349

_Circulation: Cardiovascular Interventions_ is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2012 American Heart Association, Inc. All rights reserved.
Print ISSN: 1941-7640. Online ISSN: 1941-7632

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circinterventions.ahajournals.org/content/5/4/540

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in _Circulation: Cardiovascular Interventions_ can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at: http://www.lww.com/reprints

Subscriptions: Information about subscribing to _Circulation: Cardiovascular Interventions_ is online at: http://circinterventions.ahajournals.org//subscriptions/