The Society of Thoracic Surgeons

Adult Cardiac Surgery Database

Monthly Webinar

December 3, 2025

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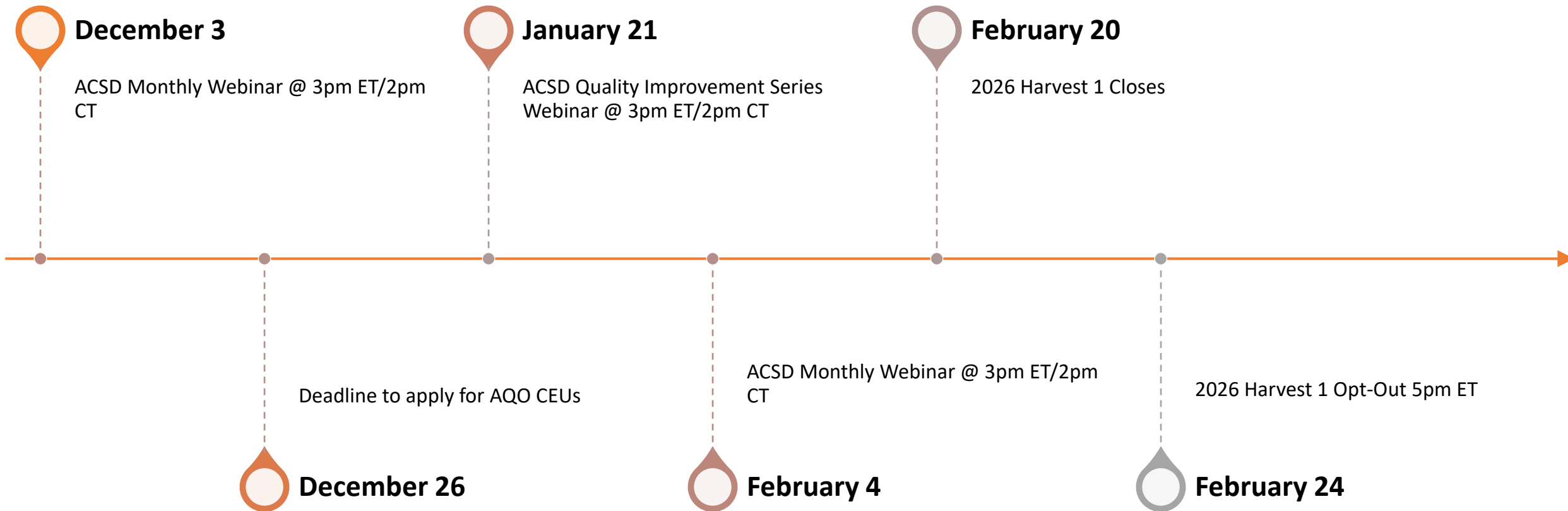
Important Dates-Timeline

December 3

ACSD Monthly Webinar @ 3pm ET/2pm CT

January 21

ACSD Quality Improvement Series Webinar @ 3pm ET/2pm CT

February 20

2026 Harvest 1 Closes

Deadline to apply for AQO CEUs

ACSD Monthly Webinar @ 3pm ET/2pm CT

2026 Harvest 1 Opt-Out 5pm ET

December 26

February 4

February 24

CE/CEU Evaluations

[AQO Meeting Platform](#)
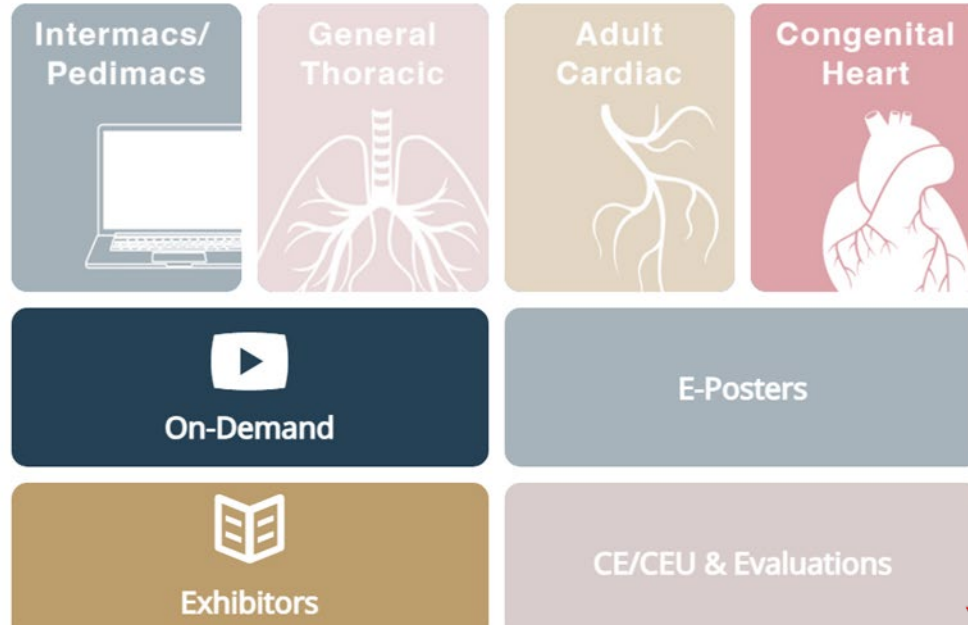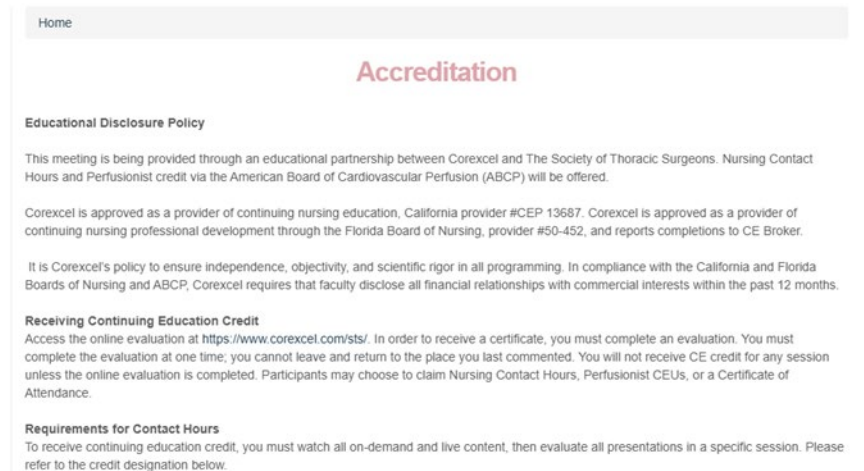
- Don't forget to view all on-demand content and live content prior to completing your evaluations.

- You must complete the evaluation at one time; you cannot leave and return to the place you last commented.

- **Deadline to claim credit is Friday, December 26, 2025.**

Important Dates-2026 Harvest

2026 Harvest

| Term	Harvest Submission Window Close	Opt-Out Date	Includes Procedures Performed Through:	Report Posting	Comments
Harvest 1	February 20	February 24	December 31, 2025	Spring 2026	Star Rating
Harvest 2	May 29	June 2	March 31, 2026	Summer 2026	
Harvest 3	August 28	September 1	June 30, 2026	Fall 2026	Star Rating
Harvest 4	November 20	November 24	September 30, 2026	Winter 2026/2027	

Analysis for each harvest is based on a 36-month window.

Data Submission Open is continuous for all harvest terms. Submission Close occurs at 11:59 p.m. Eastern on the date listed.

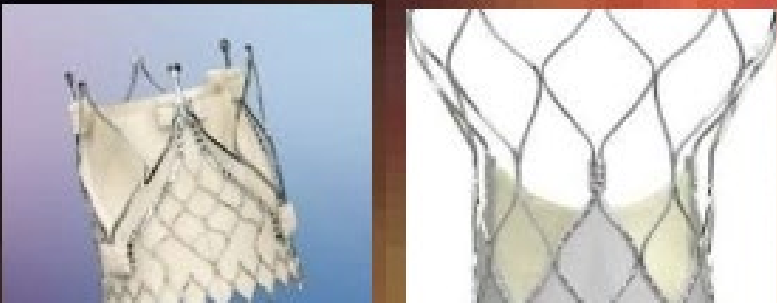Harvest Opt-Out closes at 5:00 p.m. Eastern on the date listed.

Aortic
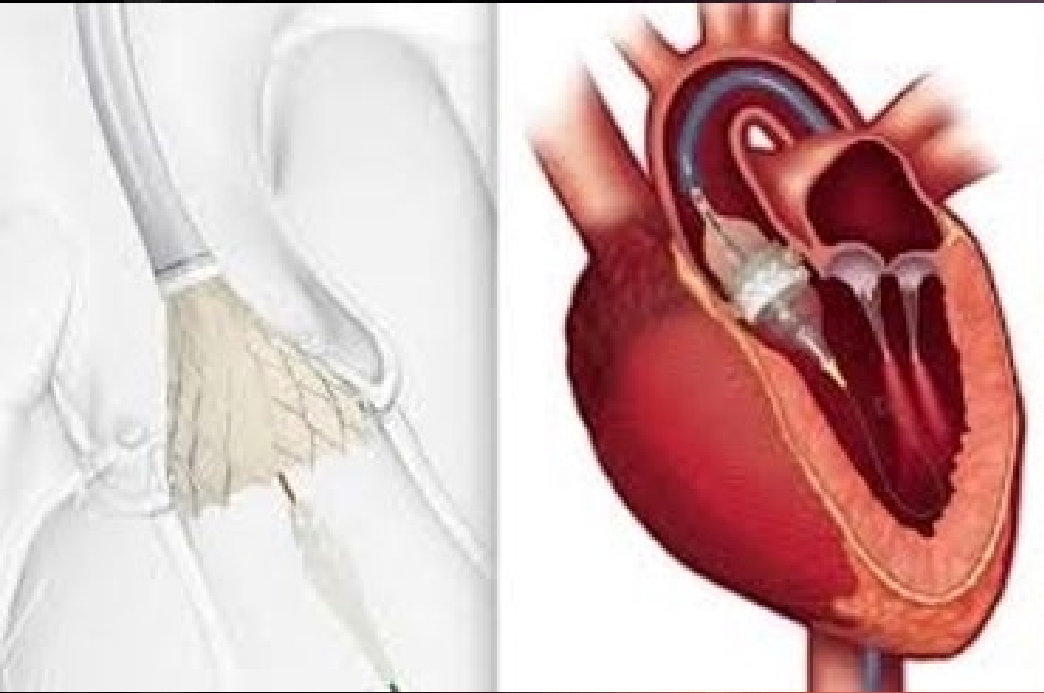
AVR After TAVR

Melinda Offer, RN, MSN

Contemporary Incidence and Procedural Volume of Transcatheter Aortic Valve Reintervention

Maxwell C. Braasch, MD, MPH[1]; Sophia R. Pyeatte, MD[1]; June He, MS, MBBS[1];

Mehran Rahimi, MD[1]; Alexander A. Brescia, MD, MSc[1]; Puja Kachroo, MD[1]; Harold G. Roberts Jr, MD[1];

Nathan Frogge, MD, MBA[2]; Nishath Quader, MD[2]; Marc A. Sintek, MD[2]; Alan Zajarias, MD[2];

Nicholas Kouchoukos, MD[1]; Tsuyoshi Kaneko, MD[1]
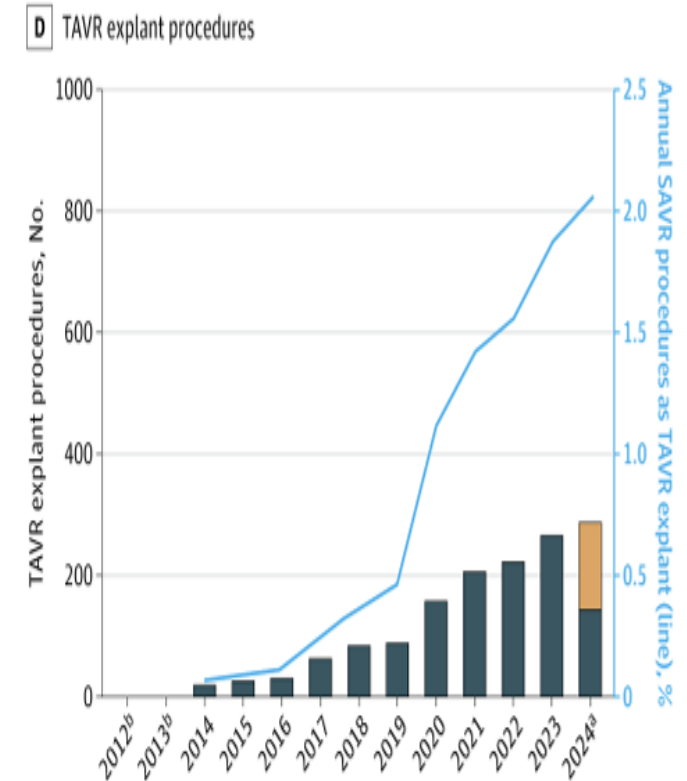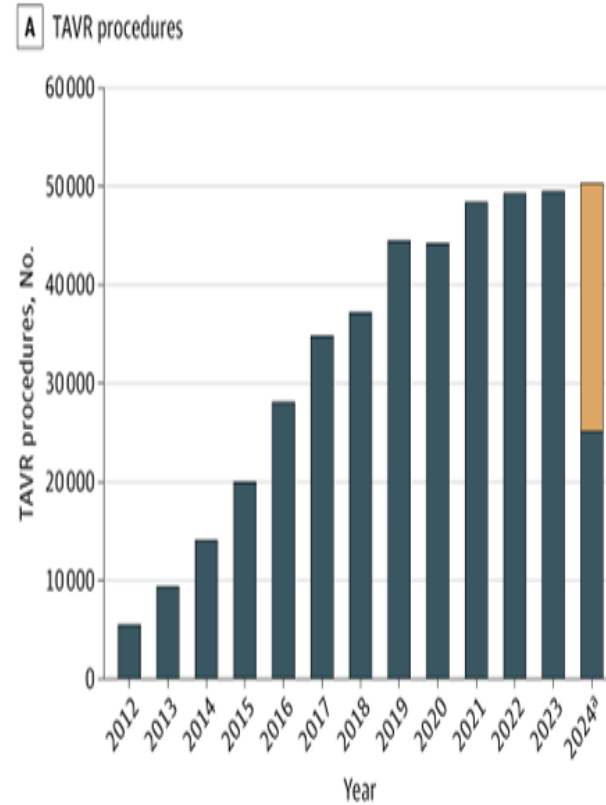
- **There has been an increasing amount of TAVR interventions**
- **This increase has implications for surgical procedures after these interventions**
- **TAVR explant procedures are increasing**

Reasons for Surgical Intervention

Emergent/Acute	Early	Late
*Coronary Obstruction (TAVR)	*Early Valve Dysfunction from Degeneration	*Late Valve Dysfunction from Degeneration
*Valve Embolization	Early Valve Dysfunction from Prosthesis-Patient Mismatch	Late Valve Dysfunction from Prosthesis-Patient Mismatch
Aortic Root Rupture (TAVR)	Prosthetic valve infection	Prosthetic valve infection
Aortic Dissection (TAVR)	*Paravalvular Leak	*Paravalvular Leak

*if untreatable by transcatheter means

Today we are going to focus on Early and Late surgical intervention

Surgical Complexity in TAVR Explant

- **Duration of implant**
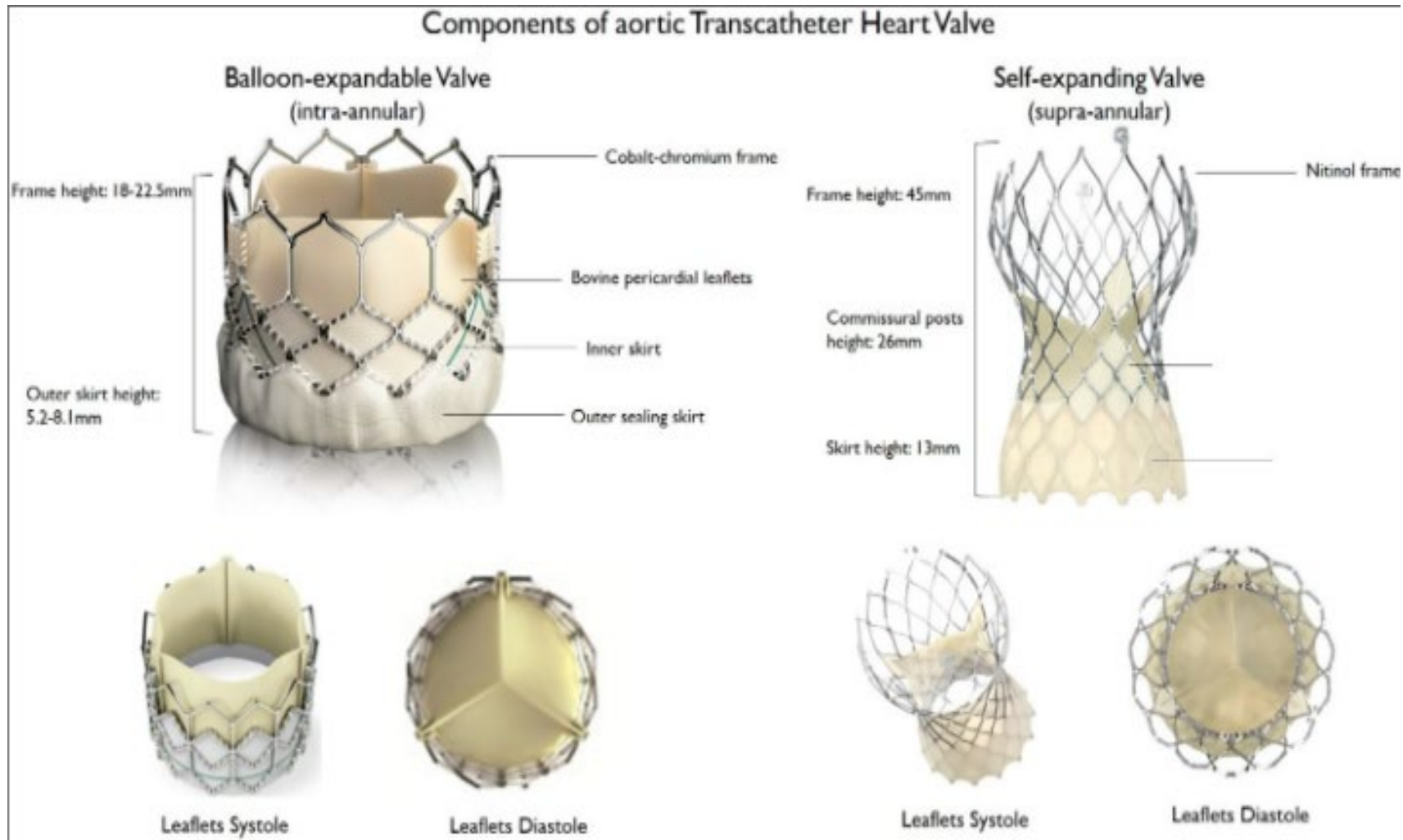
- **Type of TAVR valve balloon expandable vs Self-expanding**

- **Native TAVR vs TAVR in SAVR vs TAVR in TAVR**

TAV-in-TAV   TAV-in-SAV

Components of aortic Transcatheter Heart Valve

Balloon-expandable Valve (intra-annular)

Self-expanding Valve (supra-annular)

Cobalt-chromium frame
Bovine pericardial leaflets
Inner skirt
Outer sealing skirt
Frame height: 18-22.5mm
Outer skirt height: 5.2-8.1mm

Nitinol frame
Frame height: 45mm
Commissural posts height: 26mm
Skirt height: 13mm

Leaflets Systole
Leaflets Diastole
Leaflets Systole
Leaflets Diastole

- **Balloon-Expandable Valves are deployed using a balloon catheter that inflates to position the valve precisely.**

- **Self-Expanding Valves are made of a flexible material that expands automatically once released.**

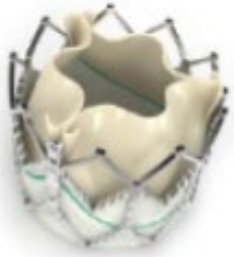El-Mawardy M et al. . Expert Review of Cardiovascular Therapy 2014; 12.
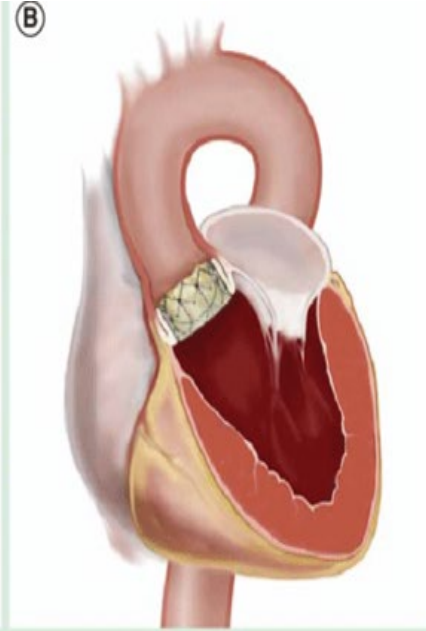
Balloon-Expandable - often preferred for patients with less calcification, as they provide precise placement.
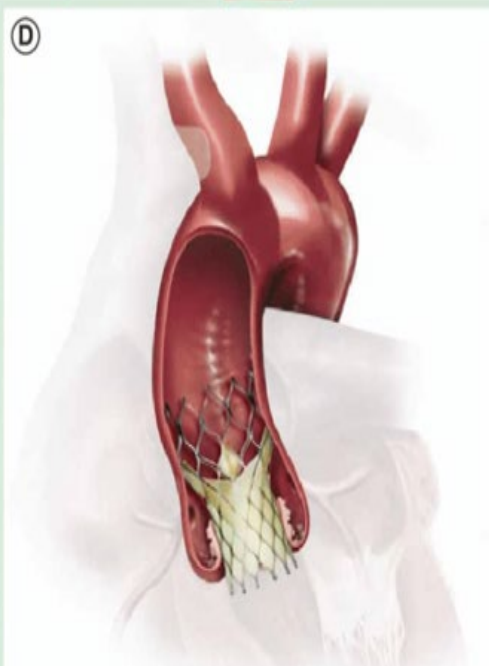
Self-Expanding Valve are more flexible and can adapt to irregular or heavily calcified anatomies they are often preferred for patients with smaller or more complex anatomy.

Balloon-expandable devices	
Sapien XT	**Sapien 3**

Self-expanding devices			
Evolut R	**Acurate Neo**	**Portico**	**Allegra**

- Knowledge of the type of valve is important when considering explant

- Challenges of explant are based on the distinctive designs and implantation techniques.

Explant of Short Stent Frame Valves (Balloon Expandable Valves)

Tsuyoshi Kaneko, MD [a] ✉ · Vinayak N. Bapat, MD [b] · Ali M. Alakhtar, MD [a] · … · Martin B. Leon, MD [c] · Gilbert H.L. Tang, MD [P] · Shinichi Fukuhara, MD [q] … Show more

Double Kocher technique

The fundamental technique for balloon expandable valve (BEV) explant is inwardly deforming the stent frame of the valve (Video 4). The first step is separating the aortic wall from the distal stent frame (Figure 3, A). Typically, endarterectomy spatulas are used, but in cases with significant adhesions a No. 15 scalpel can facilitate safe dissection (Figure 3, B) Once this is achieved circumferentially down to the halfway point of the frame, the stent is grasped with 2 long Kocher clamps (Figure 3, C). Perpendicular clamp application mobilizes the sharp edge of the BEV and serves as a handle for the valve explantation maneuver. As more frame is liberated, the clamps are repositioned deeper toward the base of the valve. The edges of the BEV valve may injure the aorta if not handled carefully. It is critical to enter the plane between the native valve leaflets and the TAVR cuff. Contrary to redo SAVR, native aortic valve leaflet still exist in TAVR-explant, making this dissection easier if the correct plane is entered. Care must be taken for the mitral valve, left ventricular outflow tract, and membranous septum in cases with deep device implantation during the index TAVR.

Roll technique

Another technique for BEV explant is the roll technique (Video 5). First, grasp the valve at the top of the commissures with a Tonsil or long clamp (Figure 4, A). Then, use a freer elevator and bluntly dissect the plane between the native valve and TAVR until reaching the cuff. The explant will be easier if more of the sealing cuff is freed from the aorta/aortic valve. Then, place 2 clamps 180° apart, with 1 jaw on the inside of BEV, ideally to the bottom of the cuff, and the other in the plane between the native valve and BEV (Figure 4, B). Roll both clamps inward simultaneously, with a complete 360° turn on both (Figure 4, C). This collapses the valve to the smallest diameter, allowing easy prosthesis removal. The roll technique offers several advantages: Due to the metal properties, rolling it radially requires less force than trying to fold it along its diameter so the resulting profile is much smaller along the entire length of the valve, such that when you extract it from the native valve it is less likely to damage the root or the aorta. The benefit of the roll technique is to minimize the dissection around the annulus and ascending aorta, hence decreasing the risk of injury.

Explant of Tall Stent Frame Valves (Self-Expanding Valves)

Tsuyoshi Kaneko, MD ⊠ a · Vinayak N. Bapat, MD b · Ali M. Alakhtar, MD o · ... · Martin B. Leon, MD o · Gilbert H.L. Tang, MD p · Shinichi Fukuhara, MD q ... Show more

Tourniquet technique

As seen in Video 6, most self-expanding valves (SEVs) are made of nitinol and have a tall supra-annular hourglass shape, which makes dissection around the frame difficult. The tourniquet technique can make this process safer and faster. Following the aortotomy just above the frame, a freer elevator is carefully used to lift the neointima and frame from the aortic wall (Figure 5, A). Silk ties are passed through the top cells of the frame at opposite ends (Figure 5, B). Next, snare the silk ties through a three-eighths inch pump tubing piece (Figure 5, C). The tubing is advanced to create a tourniquet and recapture the valve, making the hourglass-shaped valve a smaller profile, allowing easier removal of the TAV and avoiding injury to the aorta from the top of the frame.

Handlebar and mustache

Radial infolding of SEVs has also been described, the so-called handlebar mustache technique, wherein the valve is divided in half transversely to remove the crown, and then cut longitudinally. The valve is then grasped at the cut edges and infolded. Although the concerns regarding the sharp edges of the metal frame are present, it is an alternative to the tourniquet technique.

Surgery After TAVR Considerations for Coding the Case

Previous Valve Intervention(s) - *Aortic valve replacement, TAVR?*

Current Valve Disease – *what is the AV disease etiology?*

Surgery Incidence – *Re-op or not?*

Valve Explant – *what is the etiology?*

Current Procedure – *what procedures performed?*

Capturing the AV Disease Etiology

History: TAVR valve placed in 2020. The patient recently experienced syncope after exertion. The valve was stenotic with a mean gradient of 50 mmHg. CT scans indicated HALT, and the patient completed a course of coumadin. During the procedure, leaflet thrombus and prosthetic thickening were noted.

What is Aortic Valve Disease etiology?
   A. Degenerative- Calcified
   B. Reoperation-Failure of previous AV repair or replacement
   C. Supravalvular Aortic Stenosis
   D. Mixed Etiology

Answer Capturing the AV Disease Etiology

<u>History</u>: TAVR valve placed in 2020. The patient recently experienced syncope after exertion. The valve was stenotic with a mean gradient of 50 mmHg. CT scans indicated HALT, and the patient completed a course of coumadin. During the procedure, leaflet thrombus and prosthetic thickening were noted.

What is Aortic Valve Disease etiology?

    A.   Degenerative- Calcified

    B.   Reoperation - Failure of previous AV repair or replacement

    C.   Supravalvular Aortic Stenosis

    D. Mixed Etiology

Rationale: *Failure of previous AVR due to HALT seems to be the primary etiology for the current AVR.*

HALT stands for hypoattenuated leaflet thickening. HALT typically represents subclinical leaflet thrombosis in asymptomatic patients, and as a result it often is detected incidentally. However, HALT also may worsen in severity, resulting in leaflet immobility and/or valve deterioration.

Capturing the AV Disease Etiology

History: TAVR valve placed 19 months ago, now with severe symptomatic stenosis. The TAVR valve was inspected and appeared under-deployed, with incomplete expansion of the leaflets, resulting in restricted leaflet motion in all three cusps.

What is Aortic Valve Disease etiology?
   A. Degenerative- Calcified
   B. Reoperation-Failure of previous AV repair or replacement
   C. Supravalvular Aortic Stenosis
   D. Mixed Etiology

Answer Capturing the AV Disease Etiology

History: TAVR valve placed 19 months ago, now with severe symptomatic stenosis. The TAVR valve was inspected and appeared under-deployed, with incomplete expansion of the leaflets, resulting in restricted leaflet motion in all three cusps.

What is Aortic Valve Disease etiology?

A. Degenerative- Calcified

B. **Reoperation-Failure of previous AV repair or replacement**

C. Supravalvular Aortic Stenosis

D. Mixed Etiology

Rationale: Failure of previous AVR due to incomplete expansion of the leaflets seems to be the primary etiology for the current AVR.

Coding the Surgical Incidence

<u>History</u>: Previous TAVR in 2019, now with severe TAVR valve stenosis.

<u>Planned Procedure</u>: TAVR explant and AVR.

How would incidence be coded for this scenario?
   A. First cardiovascular surgery
   B. First re-op cardiovascular surgery
   C. Second re-op cardiovascular surgery

Answer Coding the Surgical Incidence

History: Previous TAVR in 2019, now with severe TAVR valve stenosis.

Planned Procedure: TAVR explant and AVR

How would incidence be coded for this scenario?

A. First cardiovascular surgery

B. First re-op cardiovascular surgery

C. Second re-op cardiovascular surgery

Rationale: Incidence Coding - Prior TAVR case that needs a redo-AVR should be coded as the first reoperation.

- *In this situation, the previously placed TAVR valve will affect the incidence since you are replacing the AV.*
- *The reason that it affects incidence has to do with the difficulty of removing the TAVR valve, which is embedded in the valve structures.*

Coding the Surgical Incidence

<u>History</u>: Previous TAVR, now with severe mitral valve regurgitation.
<u>Planned Procedure</u>: MVR

How would incidence be coded for this scenario?
   A. First cardiovascular surgery
   B. First re-op cardiovascular surgery
   C. Second re-op cardiovascular surgery

Answer Coding the Surgical Incidence

History: Previous TAVR, now with severe mitral valve regurgitation.

Planned Procedure: MVR

How would incidence be coded for this scenario?

A. **First cardiovascular surgery**

B. First re-op cardiovascular surgery

C. Second re-op cardiovascular surgery

Rationale: *Incidence Coding - Prior TAVR case that needs another cardiac procedure, such as a CAB or MVR – incidence should be coded as first CV surgery.*

*   *In this situation, the previously placed TAVR valve will not affect the incidence since we are replacing the mitral valve.*

Capturing the Explant Etiology

History: TAVR valve placed in 2020. The patient recently experienced syncope after exertion. The valve was stenotic with a mean gradient of 50 mmHg. CT scans indicated HALT, and the patient completed a course of coumadin. During the procedure, leaflet thrombus and prosthetic thickening were noted.

What is the TAVR Explant etiology?
   A. Failed Repair
   B. Prosthetic Deterioration
   C. Stenosis
   D. Thrombus

Answer Capturing the Explant Etiology

History: TAVR valve placed in 2020. The patient recently experienced syncope after exertion. The valve was stenotic with a mean gradient of 50 mmHg. CT scans indicated HALT, and the patient completed a course of coumadin. During the procedure, leaflet thrombus and prosthetic thickening were noted.

What is the TAVR Explant etiology?
A. Failed Repair
B. Prosthetic Deterioration
C. Stenosis
D. **Thrombus**

Rationale: The valve thrombosis (HALT) seems to be the primary reason for the explant.

- *HALT stands for hypoattenuated leaflet thickening. HALT typically represents subclinical leaflet thrombosis in asymptomatic patients, and as a result it often is detected incidentally. However, HALT also may worsen in severity, resulting in leaflet immobility and/or valve deterioration.*

Capturing the Explant Etiology

History: TAVR valve placed 19 months ago, now with severe symptomatic stenosis. The TAVR valve was inspected and appeared under-deployed, with incomplete expansion of the leaflets, resulting in restricted leaflet motion in all three cusps.

What is the TAVR Explant etiology?
   A. Failed Repair
   B. Sizing/Positioning Issue
   C. Stenosis

Answer Capturing the Explant

History: TAVR valve placed 19 months ago, now with severe symptomatic stenosis. The TAVR valve was inspected and appeared under-deployed, with incomplete expansion of the leaflets, resulting in restricted leaflet motion in all three cusps.

What is the TAVR Explant etiology?
   A. Failed Repair
   B. **Sizing/Positioning Issue**
   C. Stenosis

Rationale: Based on the documentation in the OP note, the sizing/positioning of the TAVR valve is the primary reason for the explant.

Coding the Procedure

<u>Procedure</u>: TAVR Explant and AVR with a 23 mm prosthesis.

<u>OP NOTE</u>: The valve was separated from the aortic wall using an endarterectomy spatula. Two clamps were used to grasp the stent frame to fold the frame edges inward as we dissected the valve free from the native leaflets. Once the valve was explanted, the native aortic valve leaflets were resected, and the annulus was debrided of calcium. The aortic root was intact from the TAVR explant with little injury to the aortic wall. The annulus was sized, and a 23 mm prosthesis was selected and placed using everting sutures.

Which procedures should be coded?
  A. Explant TAVR, AVR, Other Cardiac Other
  B. Explant TAVR, AVR

Coding the Procedure

<u>Procedure</u>: TAVR Explant and AVR with a 23 mm prosthesis.

<u>OP NOTE</u>: The valve was separated from the aortic wall using an endarterectomy spatula. Two clamps were used to grasp the stent frame to fold the frame edges inward as we dissected the valve free from the native leaflets. Once the valve was explanted, the native aortic valve leaflets were resected, and the annulus was debrided of calcium. The aortic root was intact from the TAVR explant with little injury to the aortic wall. The annulus was sized, and a 23 mm prosthesis was selected and placed using everting sutures.

Which procedures should be coded?

A. Explant TAVR, AVR, Other Cardiac Other

B. Explant TAVR, AVR

Rationale: The procedures performed were an AVR and explant of the TAVR. Nothing additional was performed.

Coding the Procedure

Procedure: TAVR Explant, AVR with a 25 mm bioprosthetic tissue valve, and aortic root reconstruction with repair of 2 separate tears - right coronary sinus and noncoronary sinus.

OP NOTE: I did an ascending aortotomy and exposed the Sapien transcatheter valve. Sapien valve struts were stuck in 2 main regions of the aortic root, one in the noncoronary sinus and one in the right coronary sinus, right underneath the right coronary artery takeoff. I cut the valve frames and explanted it, but it was stuck to the right coronary sinus and the noncoronary sinus that to get the metal off, I had to peel it off the aortic wall. Then, I cut out the native aortic valve. Next, I proceeded to repair the aortic root. I dissected the aortic root on the outside and placed pledgeted sutures to repair the 2 portions of the aortic root. I then proceeded to do an AVR. I placed aortic valve sutures along the annulus, brought a 25 mm bioprosthetic tissue valve and put the valve sutures through the cuff and tied down the valve in place.

Which procedures should be coded?

A. Explant TAVR, AVR

B. Explant TAVR, AVR, Other Cardiac Other

C. Explant TAVR, AVR, Major root reconstruction/debridement without coronary ostial reimplantation

Answer Coding the Procedure

Procedure: TAVR Explant, AVR with a 25 mm bioprosthetic tissue valve, and aortic root reconstruction with repair of 2 separate tears - right coronary sinus and noncoronary sinus.

OP NOTE: I did an ascending aortotomy and exposed the Sapien transcatheter valve. Sapien valve struts were stuck in 2 main regions of the aortic root, one in the noncoronary sinus and one in the right coronary sinus, right underneath the right coronary artery takeoff. I cut the valve frames and explanted it, but it was stuck to the right coronary sinus and the noncoronary sinus that to get the metal off, I had to peel it off the aortic wall. Then, I cut out the native aortic valve. Next, I proceeded to repair the aortic root. I dissected the aortic root on the outside and placed pledgeted sutures to repair the 2 portions of the aortic root. I then proceeded to do an AVR. I placed aortic valve sutures along the annulus, brought a 25 mm bioprosthetic tissue valve and put the valve sutures through the cuff and tied down the valve in place.

Which procedures should be coded?

A. **Explant TAVR, AVR**

B. Explant TAVR, AVR, Other Cardiac Other

C. Explant TAVR, AVR, Major root reconstruction/debridement without coronary ostial reimplantation

Rationale: The repair of the two tears were part of the procedure to explant the TAVR valve. Nothing additional to code.

Coding the Procedure

Procedure: TAVR Explant, AVR with a 25 mm bioprosthetic tissue valve, and aortic root repair of left coronary sinus.

OP NOTE: The TAVR prosthetic was palpated in the aortic root. The aorta was transected approximately 2 cm above the STJ. The double Kocher technique was utilized to grasp the valve frame and deform it. The plane between the TAVR and native leaflets was accessed with a freer and separated until the valve was explanted. There was extensive aortic annular calcification which was debrided. The native leaflets were also excised. The annulus was then sized and a 25 mm bioprosthetic valve was placed. There was an area of intima damaged from the TAVR stent frame at the top of the left coronary cusp. This was repaired primarily with two sutures from inside-out.

Which procedures should be coded?

A. Explant TAVR, AVR, Other Cardiac Other

B. Explant TAVR, AVR

C. Explant TAVR, AVR, Major root reconstruction/debridement without coronary ostial reimplantation

Coding the Procedure

Procedure: TAVR Explant, AVR with a 25 mm bioprosthetic tissue valve, and aortic root repair of left coronary sinus.

OP NOTE: The TAVR prosthetic was palpated in the aortic root. The aorta was transected approximately 2 cm above the STJ. The double Kocher technique was utilized to grasp the valve frame and deform it. The plane between the TAVR and native leaflets was accessed with a freer and separated until the valve was explanted. There was extensive aortic annular calcification which was debrided. The native leaflets were also excised. The annulus was then sized and a 25 mm bioprosthetic valve was placed. There was an area of intima damaged from the TAVR stent frame at the top of the left coronary cusp. This was repaired primarily with two sutures from inside-out.

Which procedures should be coded?

    A.   Explant TAVR, AVR, Other Cardiac Other

    B.   Explant TAVR, AVR

    C.   Explant TAVR, AVR, Major root reconstruction/debridement without coronary ostial reimplantation

Rationale: The repair of the left coronary sinus was part of the procedure to explant the TAVR valve.
Nothing additional to code.

Case Scenario

History: TAVR in 2020 with Evolut Pro Plus #23, severe AS.

Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

OP NOTE: The pericardium was opened. The Evolut valve was palpated. The aorta was opened distal to the Evolut valve through a transverse aortotomy. We used a 5-mm scope to visualize the Evolut valve. The leaflets were heavily calcified and were excised. The C-arm was brought into the field and positioned for optimal visualization of the Evolut valve, minimizing displacement and allowing for identification of the nodes. The Edwards 23 Ultra (9750TFX) valve was brought to the field. It was positioned into the annulus and deployed with a very slow inflation, using real-time fluoroscopy to guide positioning.

Is this a TAVR or Open Surgical AVR?
  A. TAVR
  B. Open Surgical AVR

Answer Case Scenario

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Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

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Is this a TAVR or Open Surgical AVR?

    A.   TAVR

    B.   Open Surgical AVR

Rationale: For STS / TVT, if the TAVR/TMVR valve is placed using <u>direct aortic or mitral valve visualization</u>, that is considered an SAVR, not a TAVR or a SMVR not a TMVR

- *If during the procedure, the operator could visually see the native valve, the procedure would be required entry in ASCD and not be included in TVT.*

- *If during the procedure, the operator punctured a great vessel and could not visually see the native valve, the procedure would be included in TVT and is optional for entry into ACSD.*

Coding the Surgical AVR Device Type

History: TAVR in 2020 with Evolut Pro Plus #23, severe AS.

Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

OP NOTE: The pericardium was opened. The Evolut valve was palpated. The aorta was opened distal to the Evolut valve through a transverse aortotomy. We used a 5-mm scope to visualize the Evolut valve. The leaflets were heavily calcified and were excised. The C-arm was brought into the field and positioned for optimal visualization of the Evolut valve, minimizing displacement and allowing for identification of the nodes. The Edwards 23 Ultra (9750TFX) valve was brought to the field. It was positioned into the annulus and deployed with a very slow inflation, using real-time fluoroscopy to guide positioning.

What is the Surgical AVR Device Type?
A. Mechanical
B. Bioprosthetic
C. Surgeon fashioned pericardium (Ozaki)
D. Other

Answer Coding the Surgical AVR Device Type

History: TAVR in 2020 with Evolut Pro Plus #23, severe AS.

Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

OP NOTE: The pericardium was opened. The Evolut valve was palpated. The aorta was opened distal to the Evolut valve through a transverse aortotomy. We used a 5-mm scope to visualize the Evolut valve. The leaflets were heavily calcified and were excised. The C-arm was brought into the field and positioned for optimal visualization of the Evolut valve, minimizing displacement and allowing for identification of the nodes. The Edwards 23 Ultra (9750TFX) valve was brought to the field. It was positioned into the annulus and deployed with a very slow inflation, using real-time fluoroscopy to guide positioning.

    What is the Surgical AVR Device Type?
        A. Mechanical
        B. Bioprosthetic
        C. Surgeon fashioned pericardium (Ozaki)
        D. Other

Rationale: In this situation, the best choice is other since we do not have a selection for TAVR valve

Case Scenario

History: TAVR in 2020 with Evolut Pro Plus #23, severe AS.

Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

OP NOTE: The pericardium was opened. The Evolut valve was palpated. The aorta was opened distal to the Evolut valve through a transverse aortotomy. We used a 5-mm scope to visualize the Evolut valve. The leaflets were heavily calcified and were excised. The C-arm was brought into the field and positioned for optimal visualization of the Evolut valve, minimizing displacement and allowing for identification of the nodes. The Edwards 23 Ultra (9750TFX) valve was brought to the field. It was positioned into the annulus and deployed with a very slow inflation, using real-time fluoroscopy to guide positioning.

Do we code valve explant in this situation?

A. Yes

B. No

Case Scenario

History: TAVR in 2020 with Evolut Pro Plus #23, severe AS.

Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

OP NOTE: The pericardium was opened. The Evolut valve was palpated. The aorta was opened distal to the Evolut valve through a transverse aortotomy. We used a 5-mm scope to visualize the Evolut valve. The leaflets were heavily calcified and were excised. The C-arm was brought into the field and positioned for optimal visualization of the Evolut valve, minimizing displacement and allowing for identification of the nodes. The Edwards 23 Ultra (9750TFX) valve was brought to the field. It was positioned into the annulus and deployed with a very slow inflation, using real-time fluoroscopy to guide positioning.

Do we code valve explant in this situation?
- A. Yes
- B. No

Rationale:

We need to capture the "explant" on the explant form, even though it was not really explanted – it was crushed with the new TAVR valve being deployed over it. You should still code as an explant so you can track the transcatheter valve.

Coding the Explant

History: TAVR in 2020 with Evolut Pro Plus #23, severe AS.

Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

OP NOTE: The pericardium was opened. The Evolut valve was palpated. The aorta was opened distal to the Evolut valve through a transverse aortotomy. We used a 5-mm scope to visualize the Evolut valve. The leaflets were heavily calcified and were excised. The C-arm was brought into the field and positioned for optimal visualization of the Evolut valve, minimizing displacement and allowing for identification of the nodes. The Edwards 23 Ultra (9750TFX) valve was brought to the field. It was positioned into the annulus and deployed with a very slow inflation, using real-time fluoroscopy to guide positioning.

K. Valve Surgery Explant
(If Valve Explanted (ValExp) is Yes ↓)

First Valve Prosthesis Explant:

Explant Position: ☒ Aortic ☐ Mitral ☐ Tricuspid ☐ Pulmonic
ValExpPos (3315)

Explant Type:
ValExpTyp (3320)
☐ Mechanical Valve ☐ Bioprosthetic Valve ☐ Homograft ☐ Autograft
☐ Annuloplasty Device ☐ Leaflet Clip ☐ Other ☐ Unknown
☒ Transcatheter Valve ☐ Transcatheter Valve in Valve with prosthetic valve

Explant Etiology:
ValExpEt (3325)
☐ Endocarditis ☐ Incompetence ☐ Prosthetic Deterioration ☐ Thrombus
☒ Failed Repair ☐ Pannus ☐ Sizing/Positioning issue ☐ Other
☐ Hemolysis ☐ Paravalvular leak ☐ Stenosis ☐ Unknown

Explant Device known: ☒ Yes ☐ No (If Yes→)   **Explant model#:** TAVXX Medtronic Evolut Pro Plus
ValExpDevKnown (3330)   ValExpDev (3335)

Unique Device Identifier (UDI): __UTD from OP note__
ValExpUDI (3340)

Year of Implant Known: ☒ Yes ☐ No (If Yes→) **Year:** ___2020___
ValExpYrKn (3341)   ValExpYr (3342)

Coding the Implant

History: TAVR in 2020 with Evolut Pro Plus #23, severe AS.

Procedure: Hybrid procedure with surgical leaflet excision and open TAVR deployment.

OP NOTE: The pericardium was opened. The Evolut valve was palpated. The aorta was opened distal to the Evolut valve through a transverse aortotomy. We used a 5-mm scope to visualize the Evolut valve. The leaflets were heavily calcified and were excised. The C-arm was brought into the field and positioned for optimal visualization of the Evolut valve, minimizing displacement and allowing for identification of the nodes. The Edwards 23 Ultra (9750TFX) valve was brought to the field. It was positioned into the annulus and deployed with a very slow inflation, using real-time fluoroscopy to guide positioning.

Aortic Valve or Valve Repair Device Implant: ☒ Yes ☐ No (If Yes ↓) AorticImplant (3472)		
	Implant Model Number: 9750TFXX Edwards Spapient 3 Transcatheter Heart Valve VSAoIm (3480)	Implant Size: 23 VSAoImSz (3485)
	Unique Device identifier (UDI): UTD from OP note VSAoImUDI (3490)	
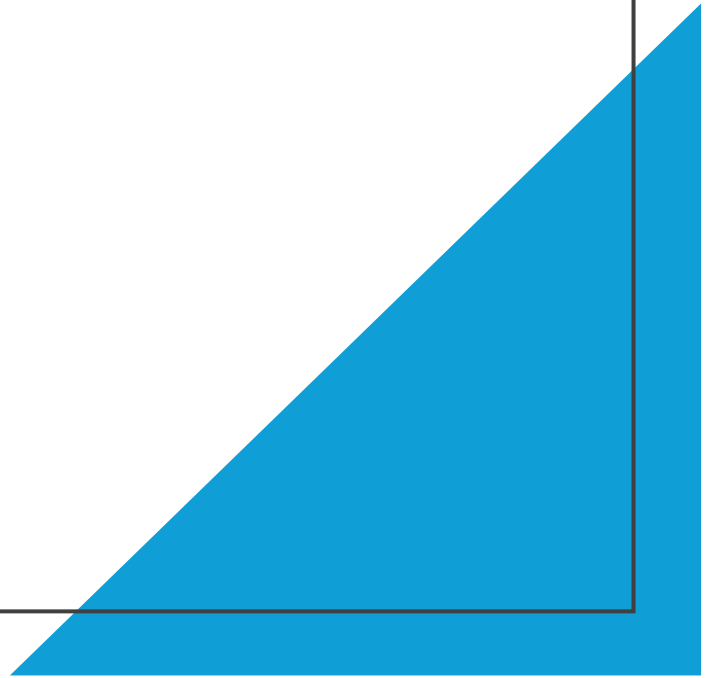
Open Discussion

Please use the Q&A function.

Please use the raise-hand function.

We will answer as many questions as possible.

We encourage your feedback and want to hear from you!

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- STSDB_Helpdesk@sts.org
  - IQVIA/Database Platform Questions (Uploader, DQR, Missing Variable, Dashboard, Password and Login)

- STSDB-FAQ@sts.org
  - Clinical Questions

Thank You for Joining!

Wishing everyone a safe and happy holiday season!