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بهداشتی درمانی تهران

مرکز قلب تهران

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**12<sup>th</sup>**

**Annual Tehran Heart  
Center Congress**

**7th CRITICAL CARDIOVASCULAR CARE**

**دوازدهمین کنگره سالیانه مرکز قلب تهران**

**2025**

۲۵ و ۲۶ بهمن ماه ۱۴۰۳

**13 & 14 February  
Tehran Heart Center  
Tehran, Iran**

# Advanced heart failure in a patient with good LVEF

**Nasim Naderi MD, FESC**

**Professor of cardiology-Heart failure specialist**

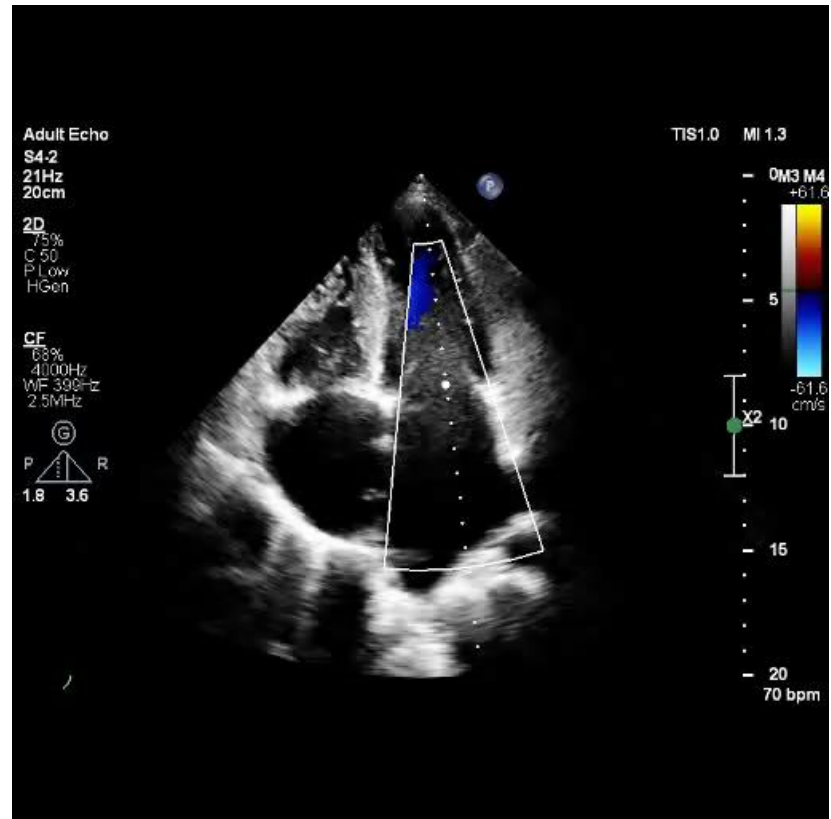
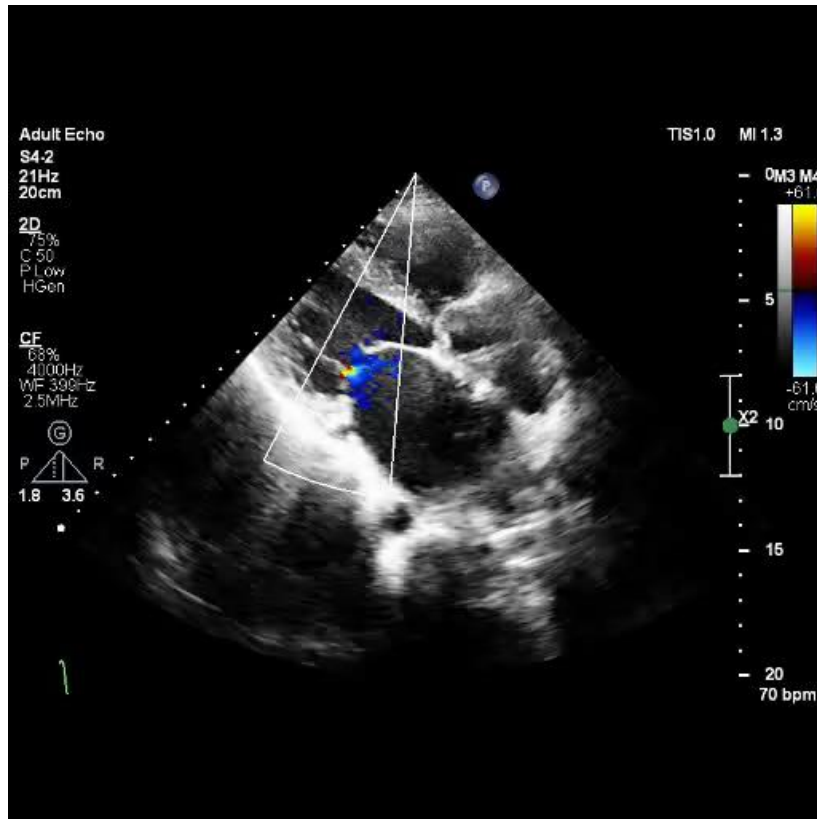
**Rajaie Cardiovascular institute**

# Case Presentation

- 32 years old lady
- History of hypertrophic heart syndrome and CHB since childhood
- No FHx
- PPM → ICD
- AF/pace rhythm

- Her symptoms were increased as frequent congestive symptoms at 32 years
- Easily controlled by increasing doses of diuretics
- Her congestive symptoms were increased more and more following several episodes of COVID-19

# ECHO





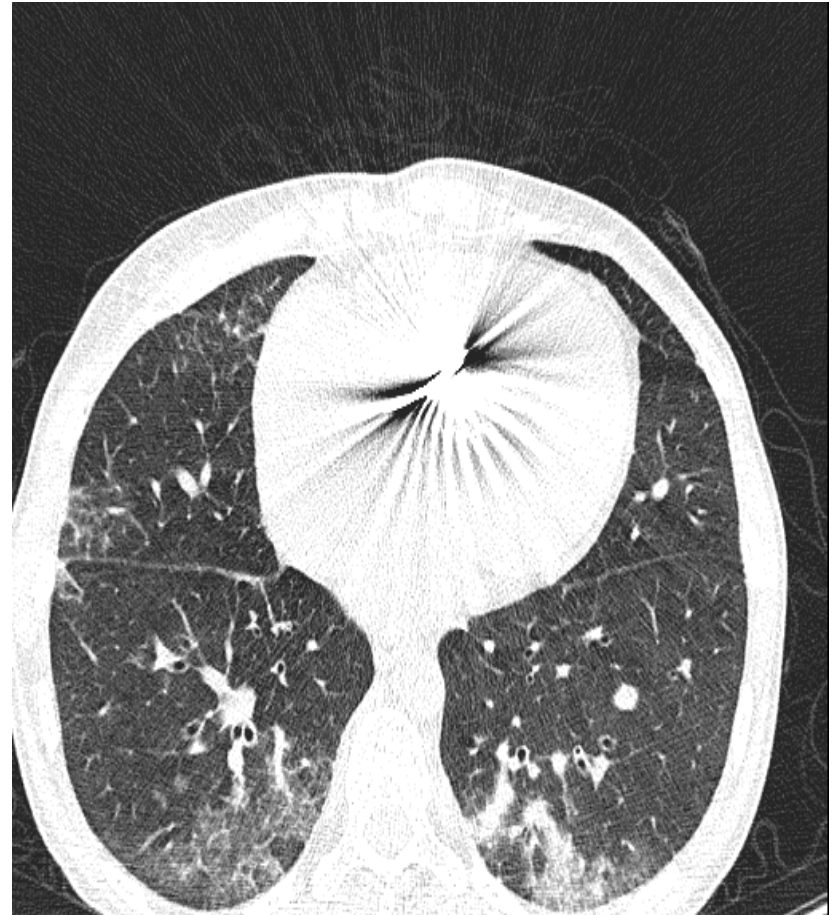
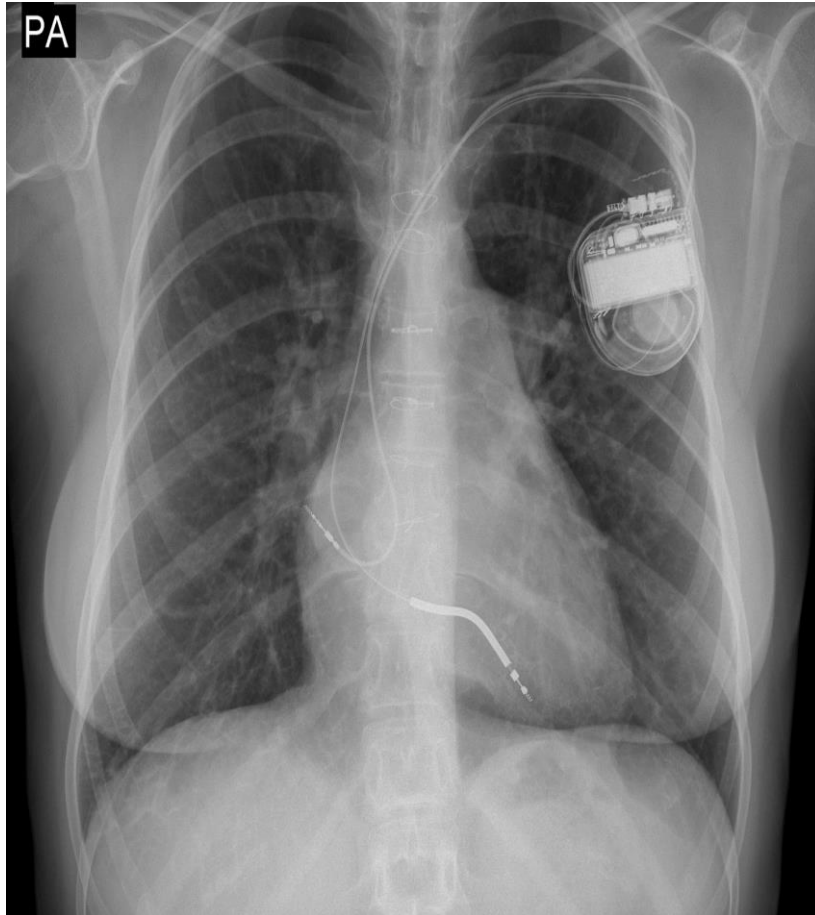
- The patient got listed
- Liver and Kidney were normal
- Surgery consult for HTX ??
- Pulmonologist consult ??

# RHC

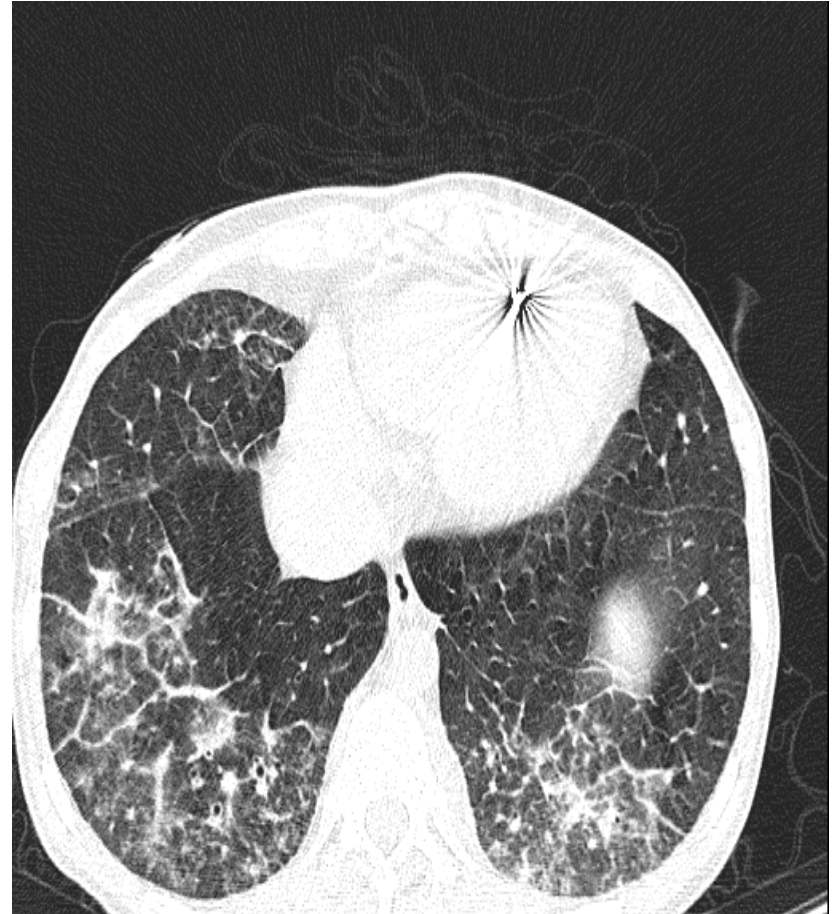
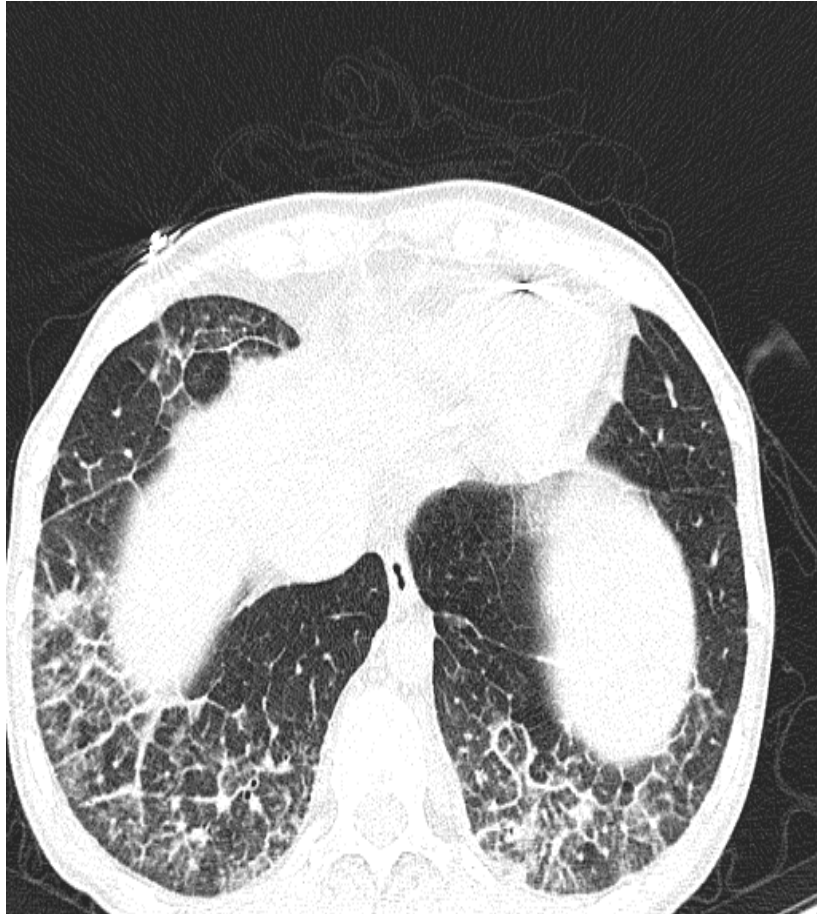
- CO:2.66 lit/min
- CI=1.65 Lit/min/BSA
- CVP=20 mmHg
- PAP=50/25(32)
- PCWP=19
- Systemic O2 Sat=95%
- Mixed venous O2 sat=49%
- **PVR=4.88**
- SVR=25.9
- BP=113/77(89)
- HR=70 (pace rhythm)

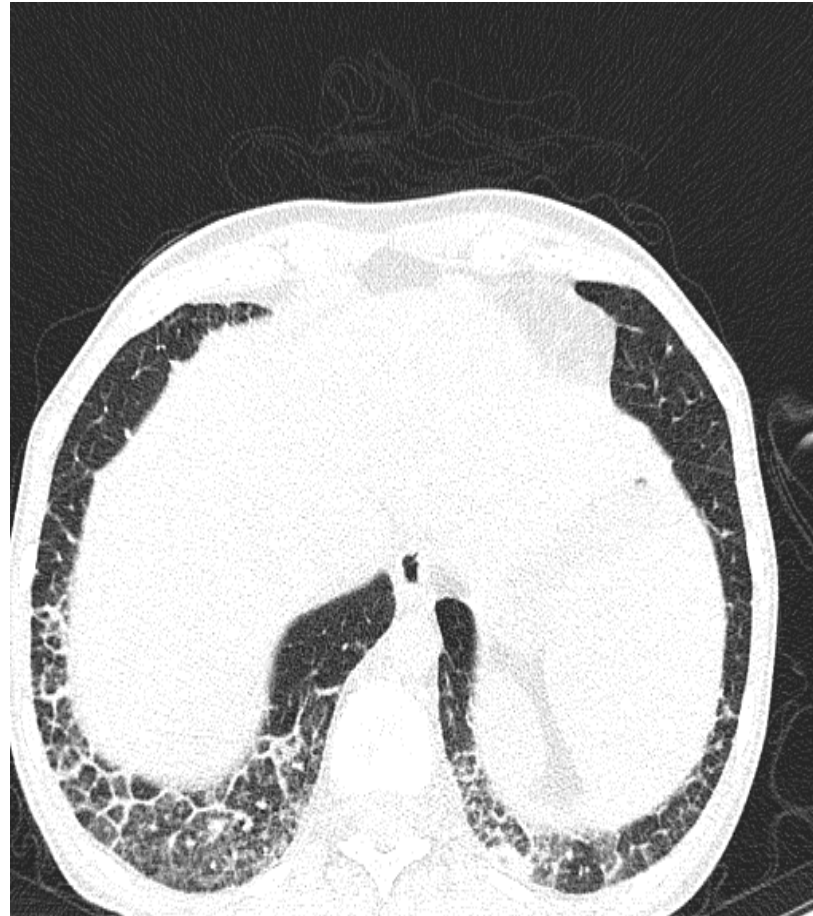


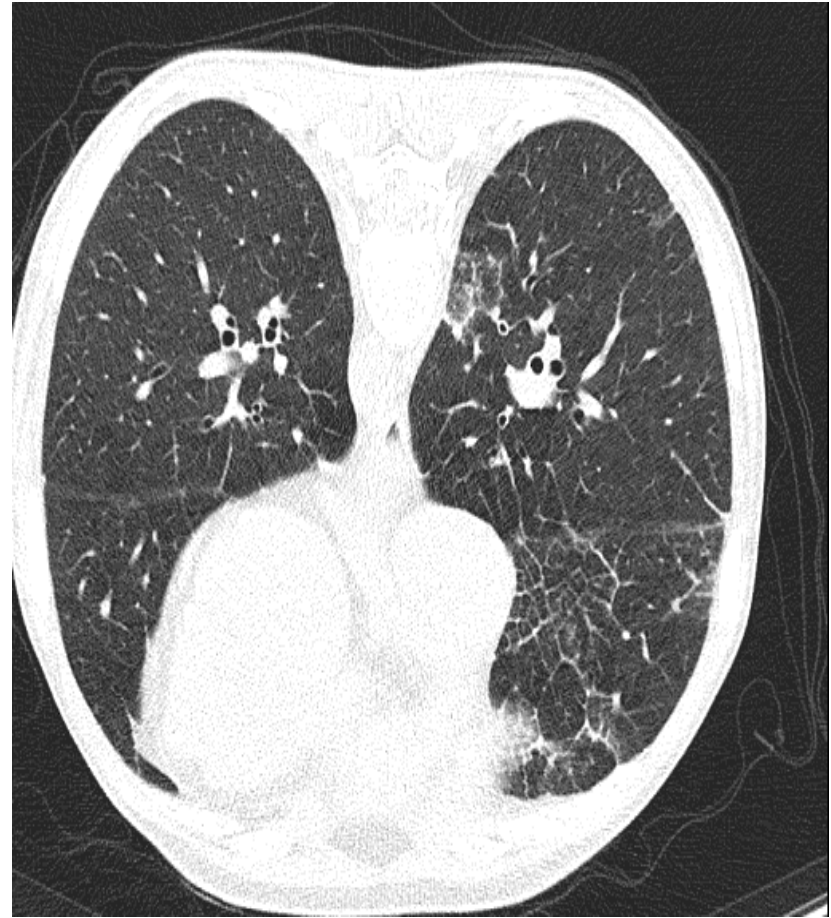
# Chest CT

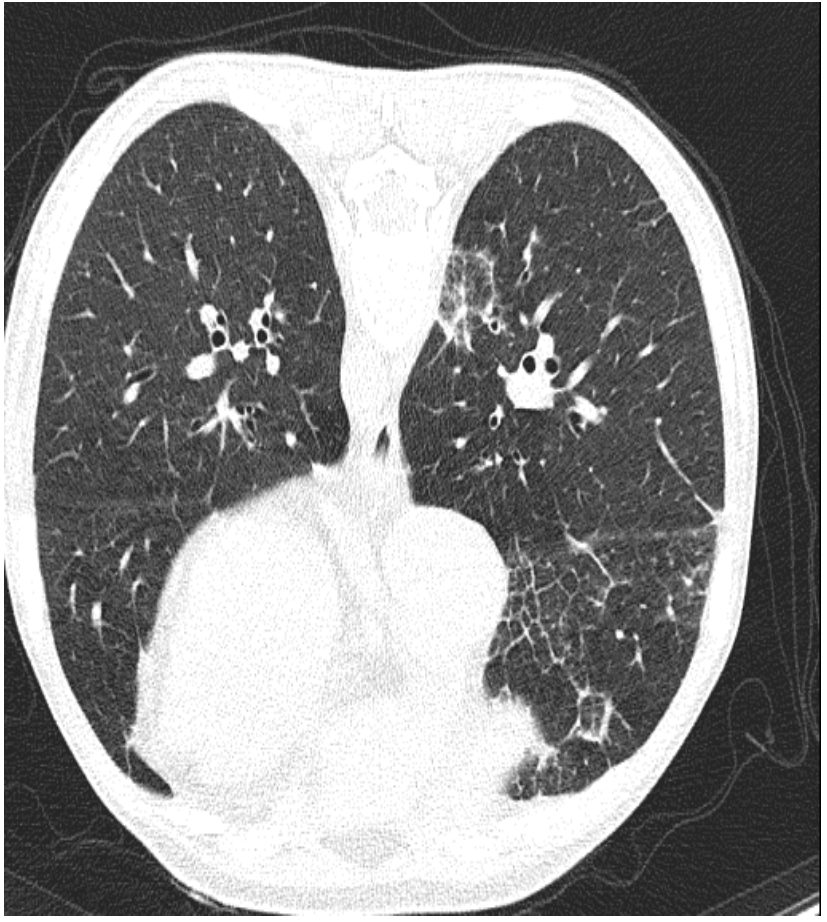
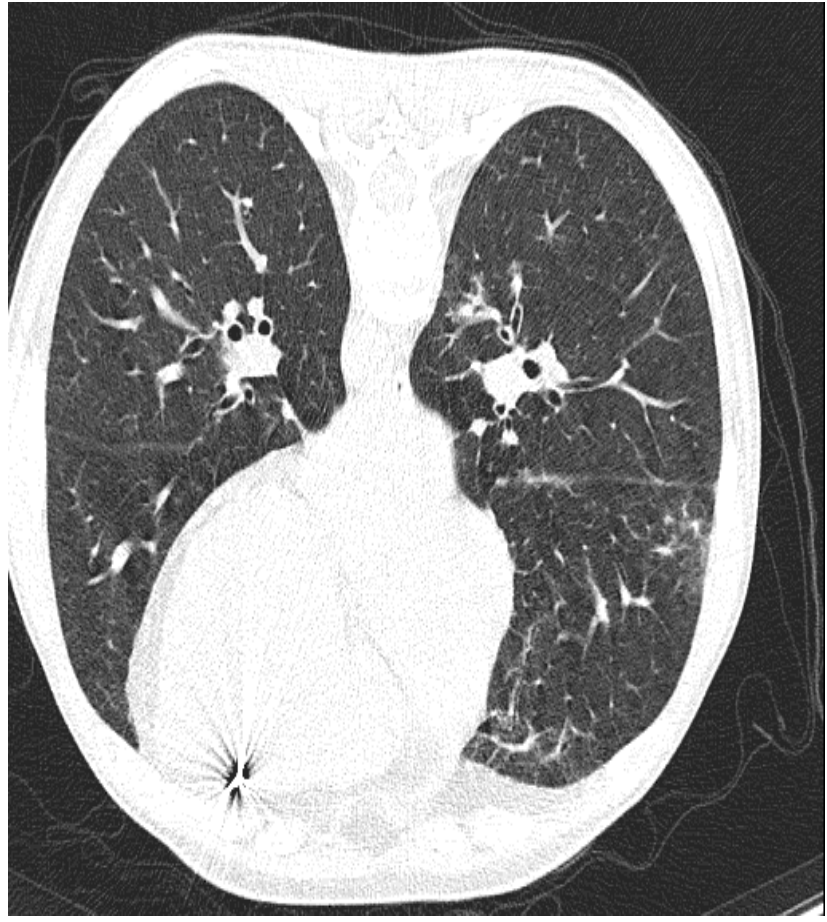




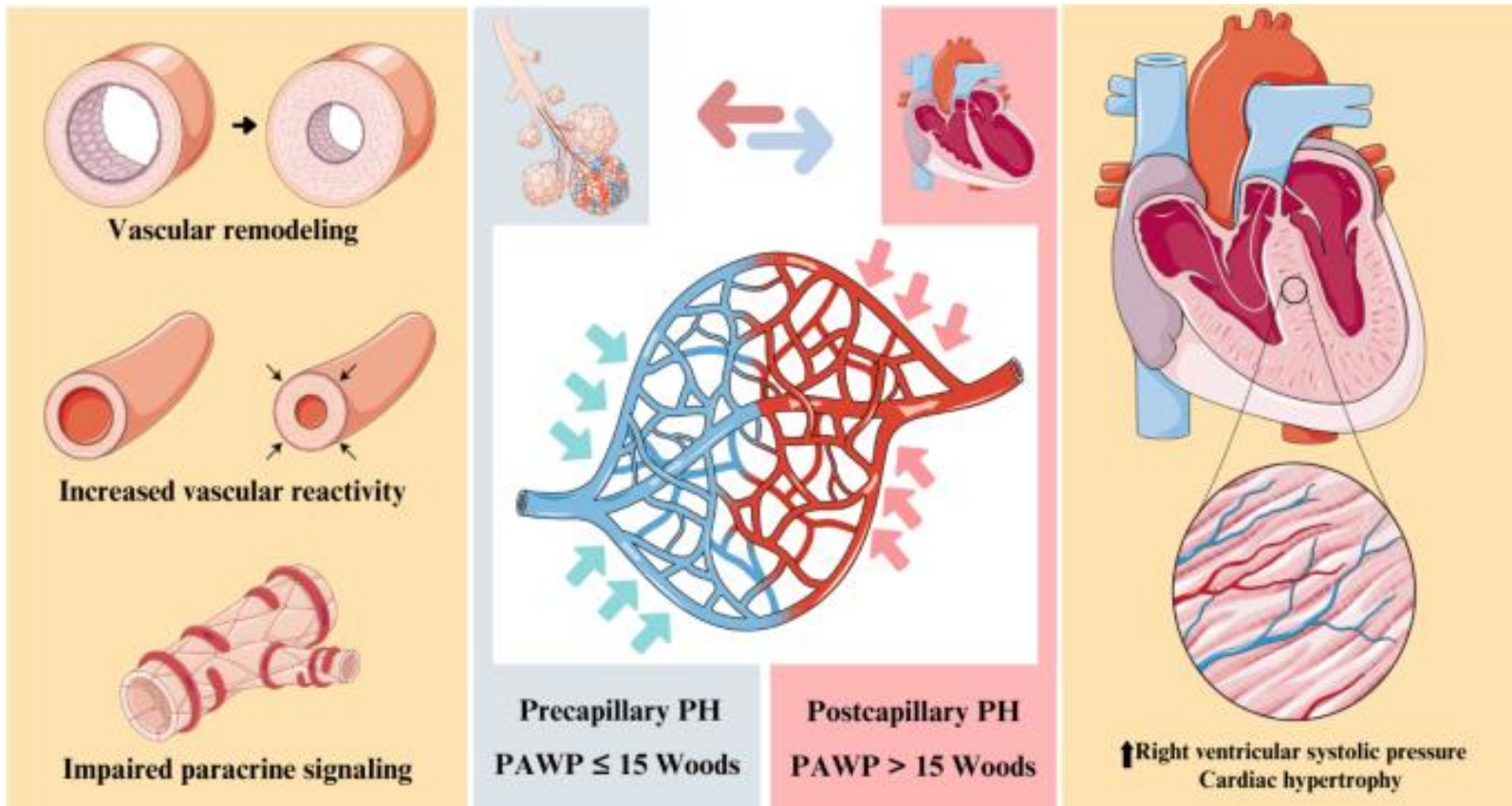




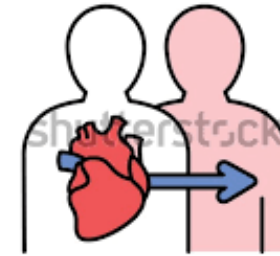




# What about High PVR???



# The patient Got Transplanted



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- Early post op. Coarse



JACC: HEART FAILURE  
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## STATE-OF-THE-ART REVIEW

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# Advanced Heart Failure Therapies for Hypertrophic Cardiomyopathy

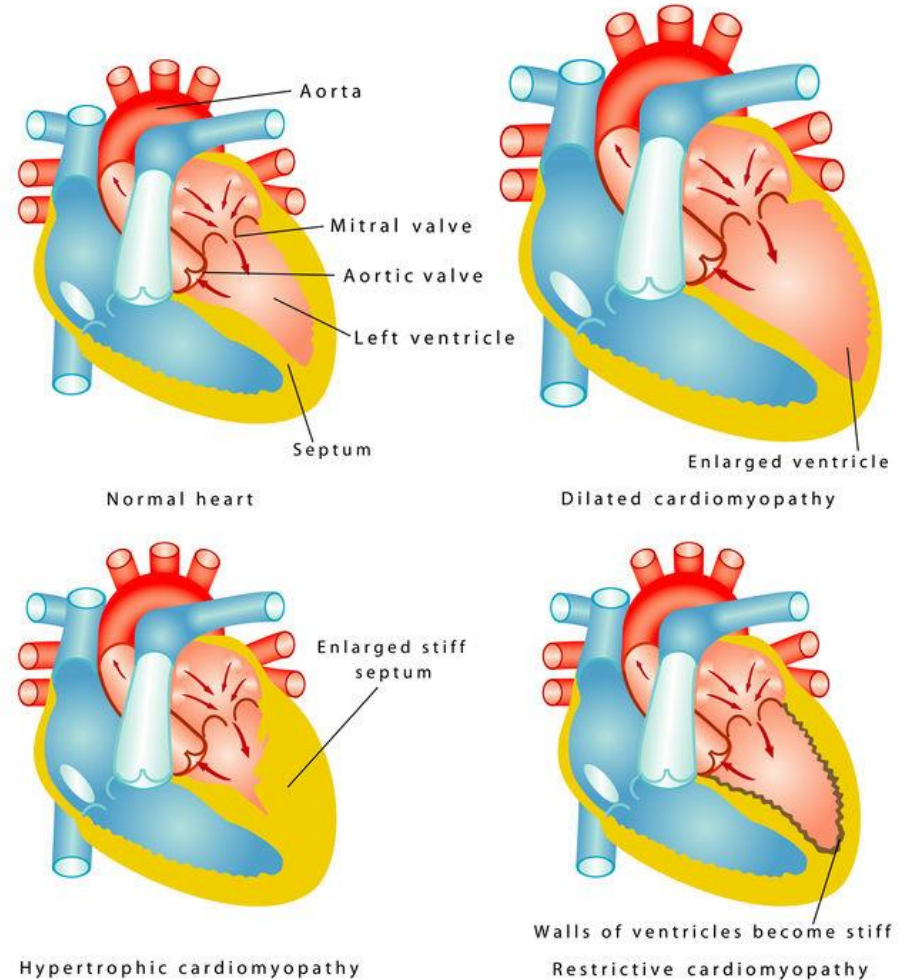
## State-of-the-Art Review and an Updated Analysis From UNOS



Lusha W. Liang, MD, MSc,\* Heidi S. Lumish, MD,\* Lorenzo R. Sewanan, MD, PhD, Yuichi J. Shimada, MD, MPH,  
Mathew S. Maurer, MD, Shepard D. Weiner, MD, Gabriel Sayer, MD, Nir Uriel, MD, MSc, Kevin J. Clerkin, MD, MSc

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- Advanced heart failure among patients with HCM is underappreciated
- 1 in 15 patients with HCM will progress to advanced heart failure.



TYPES OF CARDIOMYOPATHY



**TABLE 1** OPTN/UNOS Review Board Guidance for Hypertrophic/Restrictive Cardiomyopathy Exception Requests

Status 2 Exception Criteria	Status 3 Exception Criteria
<ol style="list-style-type: none"> <li>1. Continuous hemodynamic monitoring with a pulmonary artery catheter</li> <li>2. The candidate is on maximally tolerated inotropic dosages</li> <li>3. Two markers of hemodynamic instability or 1 marker of hemodynamic instability and 1 marker of end-organ dysfunction</li> </ol> <p>Hemodynamic instability:</p> <ul style="list-style-type: none"> <li>• Systolic BP &lt;90 mm Hg</li> <li>• LVEDP, RVEDP, or PCWP &gt;20 mm Hg</li> <li>• Cardiac index <math>\leq 2.2</math> L/min/m<sup>2</sup></li> <li>• Mixed venous saturation &lt;50%</li> <li>• Transpulmonary gradient <math>\geq 15</math> mm Hg</li> <li>• Pulmonary vascular resistance <math>\geq 2.5</math> WUs</li> </ul> <p>End-organ dysfunction:</p> <ul style="list-style-type: none"> <li>• Arterial lactate &gt;2.5 mmol/L</li> <li>• Increase in serum creatinine &gt;50% above baseline</li> <li>• Increase in total bilirubin &gt;50% above baseline</li> <li>• AST or ALT &gt;2 times upper limit of normal</li> </ul>	<ol style="list-style-type: none"> <li>1. Has either: <ul style="list-style-type: none"> <li>• Invasive pulmonary artery catheter</li> <li>• Daily hemodynamic monitoring to measure cardiac output and left ventricular filling pressures</li> </ul> </li> <li>2. Is supported by continuous inotropic infusion to improve end-organ perfusion/function</li> <li>3. Prior to initiation of inotropes, demonstrated evidence of decompensated heart failure, as evidenced by <i>at least 2</i> of the following: <ul style="list-style-type: none"> <li>• Systolic blood pressure &lt;90 mm Hg</li> <li>• Left or right atrial pressure, left or right ventricular end-diastolic pressure, or pulmonary capillary wedge pressure &gt;20 mm Hg</li> <li>• TPG <math>\geq 15</math> mm Hg</li> <li>• PVR <math>\geq 2.5</math> WUs</li> <li>• Cardiac index &lt;1.8 L/min</li> </ul> </li> </ol>

ALT = alanine aminotransferase; AST = aspartate aminotransferase; BP = blood pressure; LVEDP = left ventricular end-diastolic pressure; OPTN = Organ Procurement and Transplantation Network; PCWP = pulmonary capillary wedge pressure; PVR = pulmonary vascular resistance; RVEDP = right ventricular end-diastolic pressure; TPG = transpulmonary gradient; UNOS = United Network for Organ Sharing.

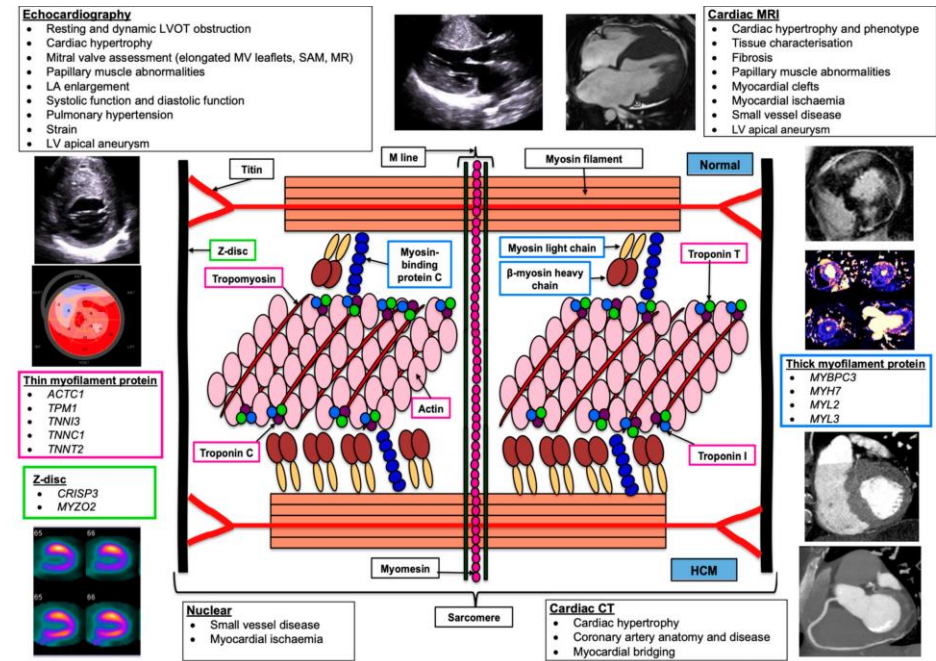
**TABLE 2 Hemodynamics of Candidates at the Time of Listing for Heart Transplantation Since Adoption of the 2018 Heart Allocation System in the United States**

	HCM	All Others	P Value
PA systolic, mm Hg	40 (32-50)	40 (30-51)	0.41
PA diastolic, mm Hg	20 (14-25)	20 (14-26)	0.94
PCWP, mm Hg	19 (13-24)	18 (12-25)	0.11
PVR, WU	2.25 (1.54-3.33)	2.16 (1.43-3.14)	0.009
Cardiac index, L/min/m <sup>2</sup>	1.97 (1.68-2.34)	2.08 (1.73-2.49)	<0.001

Values are median (IQR).

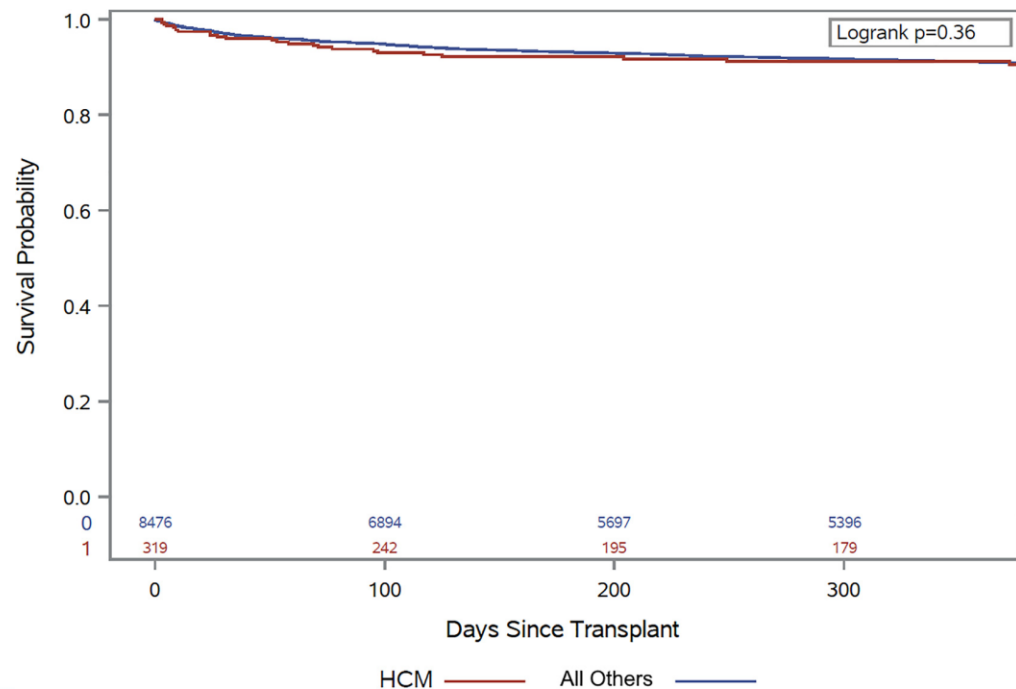
HCM = hypertrophic cardiomyopathy; PA = pulmonary artery; other abbreviations as in [Table 1](#).

- The diagnosis of advanced heart failure among patients with HCM requires the integration of multiple diagnostic tests
- echocardiography,
- cardiac magnetic resonance,
- right heart catheterization,
- CPET



- LVADs ???
- patients with smaller left ventricles (LVEDD <5 cm) have poor outcomes.

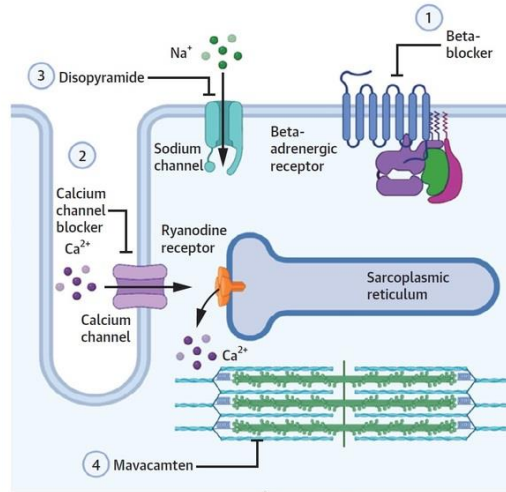
- Heart transplantation is the best heart replacement therapy for patients with hypertrophic heart syndrome
- Post transplantation outcomes are excellent.



- Latent precapillary PH places patients at an increased risk post-transplantation right ventricular dysfunction.
- Following transplantation, the donor heart is exposed to the pretransplantation medications that remain in the recipient's system.



**Medical Management or Septal Reduction Therapy**



**Progression to Advanced Heart Failure**



LVAD



Heart Transplant

**Potential Challenges**

- Arrhythmia from suction events
- Device thrombosis
- Low flow from cannula obstruction



**Potential Challenges**

- Post-transplant right ventricular dysfunction due to elevated PVR
- Post-transplant graft dysfunction due to pretransplant negative inotropic medications





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