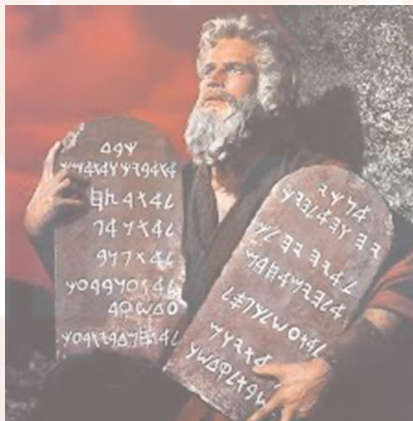


CARDIOPATIE VALVOLARI ED ENDOCARDITI: UPDATE 2026

Linee guida ESC nelle cardiopatie valvolari 2025: i 10 comandamenti



Dott.ssa Claudia Altieri



- Invecchiamento della popolazione
- Nuove evidenze cliniche
- Espansione di TAVI e TEER
- Nuovo concetto di Heart Valve Centre

2025 ESC/EACTS GUIDELINES

TEN COMMANDMENTS FOR THE MANAGEMENT OF VALVULAR HEART DISEASE

PATIENT-CENTERED • EVIDENCE-BASED • MULTIDISCIPLINARY

Key updates summarizing the major principles and advances introduced in the 2025 ESC/EACTS Guidelines for the management of valvular heart disease. These 10 commandments reflect a new era of precision, personalization, and collaborative care.

- HEART TEAM AND HEART VALVE CENTRES**
Multidisciplinary Heart Teams should manage VHD patients within a Heart Valve Network. Complex cases and high-risk interventions must be performed in expert Heart Valve Centres with on-site cardiac surgery and interventional cardiology to optimize outcomes.
- PATIENT-CENTERED CARE AND SHARED DECISION-MAKING**
Patient preferences, goals, and values are central to treatment decisions. The Heart Team provides information and recommendations, but the final decision is made together with the informed patient, considering clinical benefit and quality of life.
- ADVANCED CARDIAC IMAGING**
Echocardiography remains the first-line tool for diagnosis and grading. Cardiac CT and CMR play an expanding role in assessing severity, etiology, cardiac remodeling, and in pre-procedural planning for both surgical and transcatheter interventions.
- VHD-ASSOCIATED CONDITIONS**
Updated recommendations for coronary artery disease assessment emphasize the role of coronary CT angiography. Indications for concomitant surgical atrial fibrillation ablation and left atrial appendage closure have been strengthened for eligible patients undergoing cardiac surgery.
- EARLIER INTERVENTION IN THE DISEASE PROCESS**
New LV indexed thresholds guide surgery in asymptomatic AR and primary MR. Early intervention is now Class I or LCE. A1 in asymptomatic aortic high gradient AS with LVF $\geq 50\%$ as an alternative to close surveillance. Treat TR before significant right ventricular dysfunction develops.
- NEW INSIGHTS IN TAVI**
The age threshold for recommending TAVI in bicuspid AS is lowered to 70 years, regardless of risk. Non-transfemoral access may be used in high surgical risk patients with unsuitable femoral access. TAVI is an option in AR and bicuspid AS patients who are ineligible for surgery.
- NEW INDICATIONS FOR PRIMARY MITRAL REGURGITATION**
Surgery remains the standard of care. New Class I (LOE B) triggers for surgery are defined in asymptomatic patients. Transcatheter edge-to-edge repair (TEER) is a validated alternative for high-risk patients with suitable anatomy.
- ATRIAL AND VENTRICULAR SECONDARY MR**
For the first time, distinct diagnostic criteria and treatment pathways are provided. TEER in selected HVEF patients (LVEF $< 50\%$) with severe ventricular secondary MR is upgraded to Class I (LOE A) based on RCTs and meta-analyses.
- REFINEMENTS IN TR TREATMENT PATHWAYS**
TR surgery is recommended for patients undergoing left-sided valve surgery when TR is moderate or more; repair may be considered in selected mild TR with annular dilatation. Transcatheter intervention is recommended in high-risk patients with severe symptomatic TR despite medical therapy.
- CLINICIAN-FRIENDLY SECTION ON ANTICOAGULATION IN VHD**
New practical recommendations for oral anticoagulation after mechanical or bioprosthetic valve implantation, after transcatheter interventions, and in the presence of atrial fibrillation or other thromboembolic risk factors.

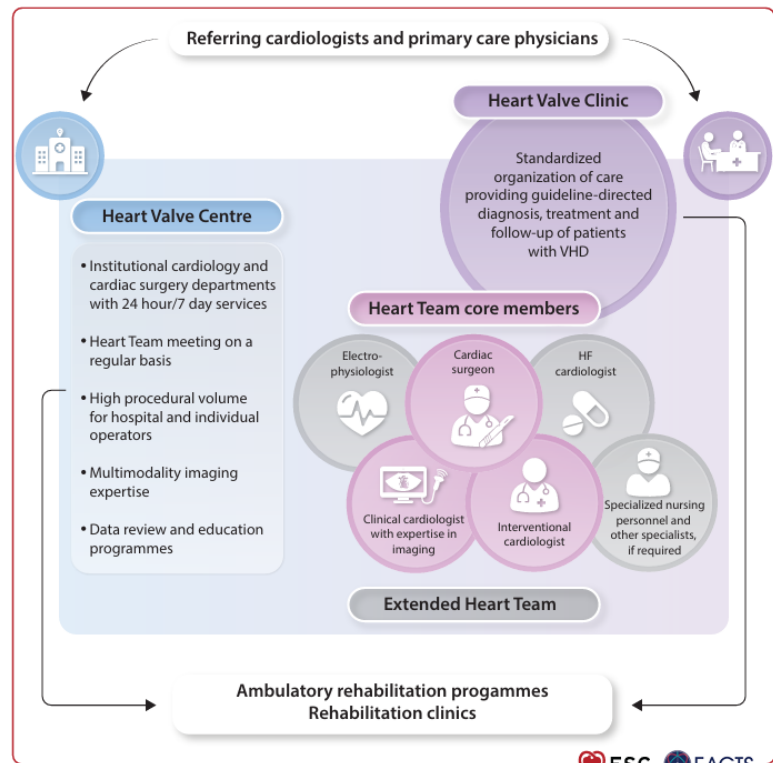
A NEW STANDARD OF CARE

- Heart Team collaboration in expert centers
- Patient values and shared decision-making
- Precision diagnosis with multimodality imaging
- Timely intervention before irreversible cardiac damage
- Expanded role of transcatheter therapies
- Better outcomes, quality of life and remodeling
- Clear guidance for anticoagulation management

REFERENCE
Borger MA, Phas F, on behalf of the ESC/EACTS Task Force for the management of valvular heart disease. The 'Ten Commandments' for the 2025 ESC/EACTS Guidelines for the Management of Valvular Heart Disease. European Heart Journal. 2026;47:2724-2726. doi:10.1093/eurheartj/ehg096

HEART TEAM E HEART VALVE CENTRES

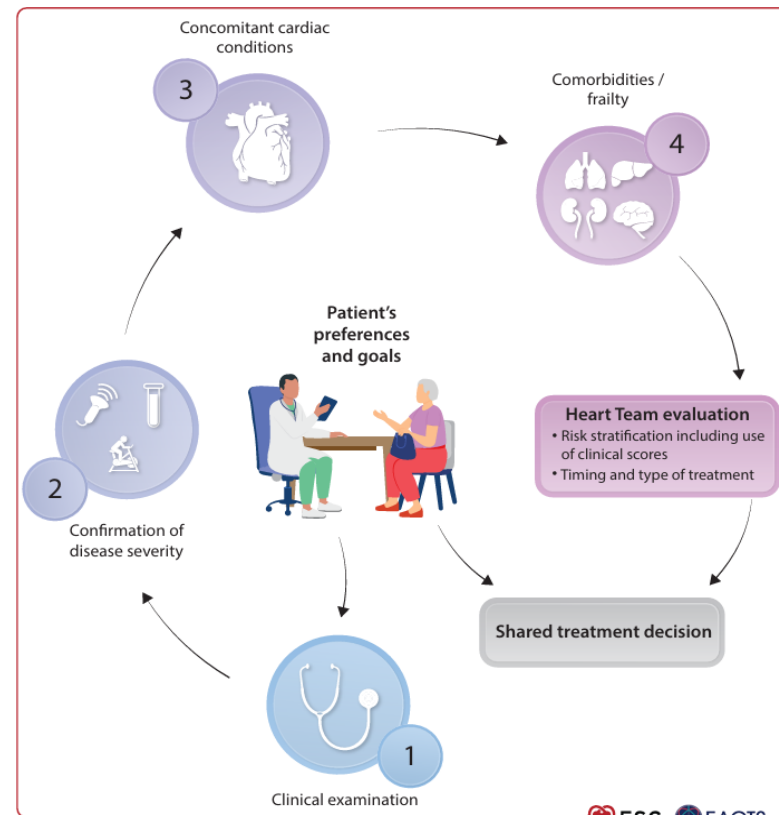
- Il team multidisciplinare che si occupa dei pazienti con VHD dovrebbe operare all'interno di una rete regionale **di Heart Valve**.
- I pazienti che richiedono procedure complesse dovrebbero essere gestiti in centri esperti con cardiologia interventistica e cardiocirurgia in sede, per ottenere risultati ottimali.



CURE CENTRATE SUL PAZIENTE E DECISIONE CONDIVISA

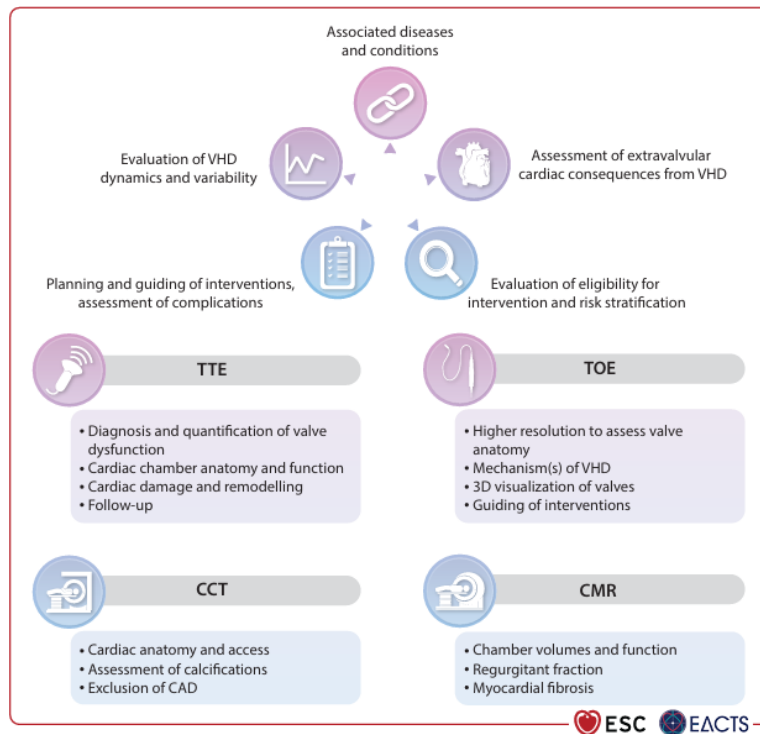
Le raccomandazioni terapeutiche si basano su informazioni mediche sintetizzate dal team, la decisione finale viene presa insieme al paziente informato, considerando obiettivi e preferenze:

Qualità di vita, fragilità e preferenze



IMAGING CARDIACO AVANZATO

L'ecocardiografia rimane il metodo principale per lo screening e la valutazione della gravità della VHD, ma viene sottolineato il ruolo crescente della tomografia computerizzata cardiaca e della risonanza magnetica cardiaca. La determinazione accurata della severità e dell'eziologia delle valvulopatie, così come la valutazione del danno cardiaco associato e la pianificazione pre-procedurale, richiede una combinazione di queste tecniche.



CONDIZIONI ASSOCIATE ALLA VHD

Diagnosis of coronary artery disease		
CCTA is recommended before valve intervention in patients with moderate or lower ($\leq 50\%$) pre-test likelihood of obstructive CAD. ^{122–124}	I	B
Invasive coronary angiography is recommended before valve intervention in patients with high and very high ($> 50\%$) pre-test likelihood of obstructive CAD.	I	C
Invasive coronary angiography is recommended in the evaluation of CAD in patients with severe ventricular SMR.	I	C
Omission of invasive coronary angiography should be considered in TAVI candidates, if procedural planning CT angiography is of sufficient quality to rule out significant CAD. ^{125–129}	IIa	B

Surgical interventions		
Concomitant surgical ablation is recommended in patients undergoing MV surgery with AF suitable for a rhythm control strategy to prevent symptoms and recurrence of AF, according to an experienced team of electrophysiologists and arrhythmia surgeons. ^{166–173}	I	A
Surgical closure of the LA appendage is recommended as an adjunct to OAC in patients with AF undergoing valve surgery to prevent cardioembolic stroke and systemic thromboembolism. ^{160–162}	I	B
Concomitant surgical ablation should be considered in patients undergoing non-MV surgery with AF suitable for a rhythm control strategy to prevent symptoms and recurrence of AF, according to an experienced team of electrophysiologists and arrhythmia surgeons. ^{167,169,174,175}	IIa	B

Indications for myocardial revascularization		
CABG is recommended in patients with a primary indication for valve surgery and coronary artery stenosis $\geq 70\%$. ^c	I	C
CABG should be considered in patients with a primary indication for valve surgery and coronary artery stenosis $\geq 50\%$ – 70% .	IIa	C
PCI should be considered in patients with a primary indication to undergo TAVI and $\geq 90\%$ coronary artery stenosis in segments with a reference diameter ≥ 2.5 mm. ¹³⁴	IIa	B
PCI may be considered in patients with a primary indication to undergo transcatheter valve interventions and coronary artery stenosis $\geq 70\%$ in proximal segments of main vessels. ^{135–137}	IIb	B

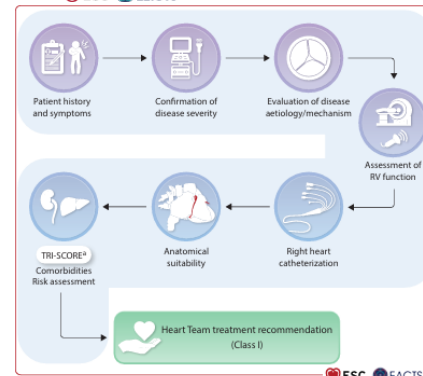
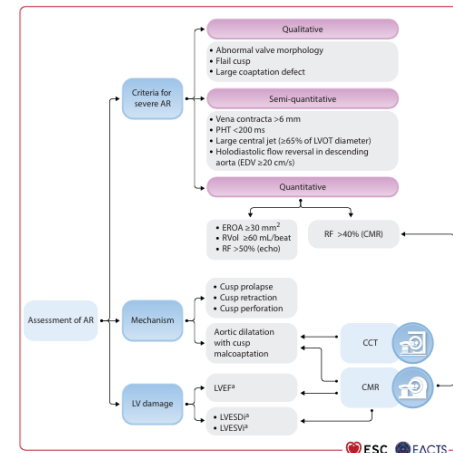
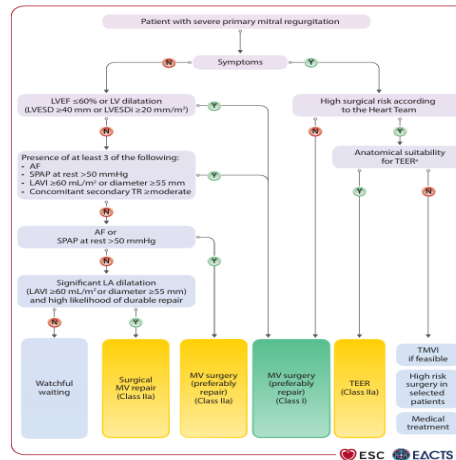
Le raccomandazioni riguardanti diagnosi e trattamento della malattia coronarica associata sono state modificate, con un ruolo crescente della TC coronarica

Le raccomandazioni per l'ablazione chirurgica concomitante della fibrillazione atriale e la chiusura dell'auricola sinistra sono state rafforzate nei pazienti sottoposti a chirurgia.



INTERVENTO PIÙ PRECOCE NEL DECORSO DELLA MALATTIA

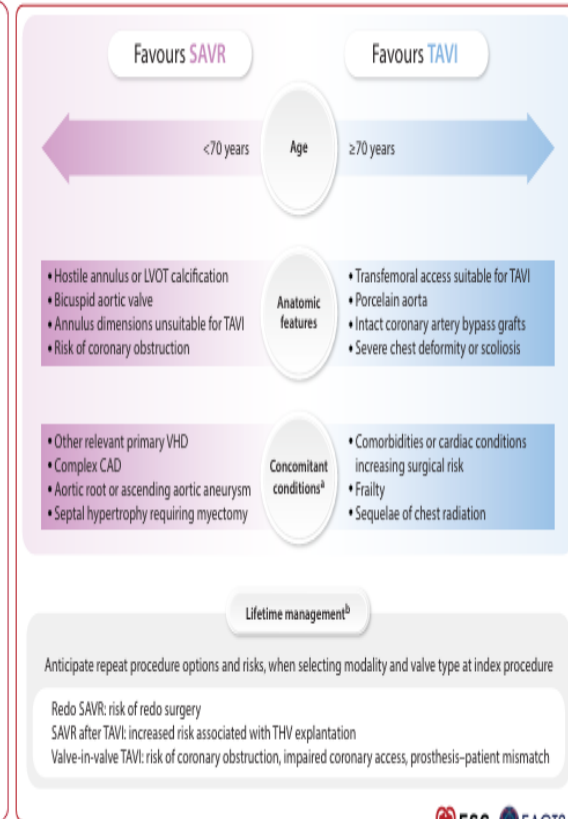
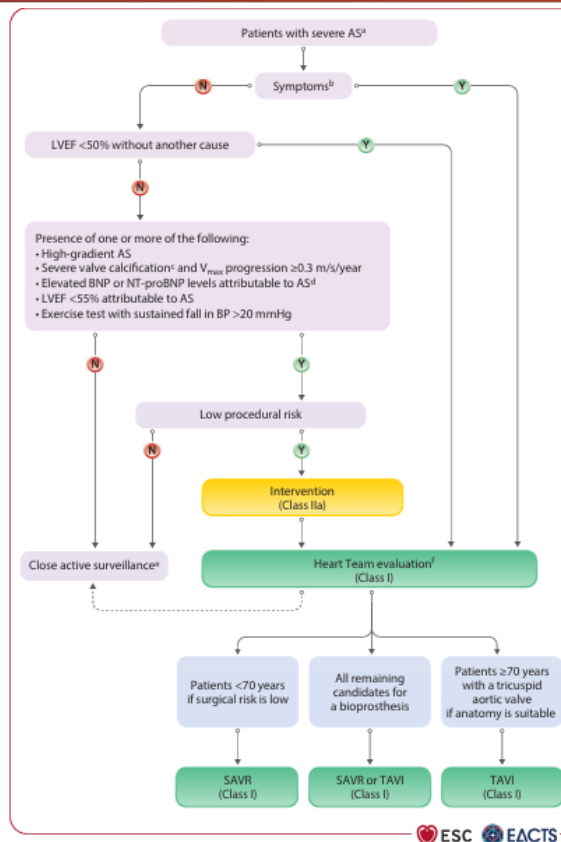
1. Nuove soglie indicizzate del ventricolo sinistro per raccomandare la chirurgia nei pazienti con insufficienza aortica (AR) asintomatica ed insufficienza mitralica primaria (MR).
2. I pazienti con stenosi aortica severa ad alto gradiente asintomatica e FE $\geq 50\%$ hanno una nuova raccomandazione Classe II, livello di evidenza A, per intervento precoce
3. L'intervento per insufficienza tricuspidale (TR) dovrebbe essere eseguito prima dell'insorgenza di una significativa disfunzione del ventricolo destro



NUOVE EVIDENZE SULLA TAVI

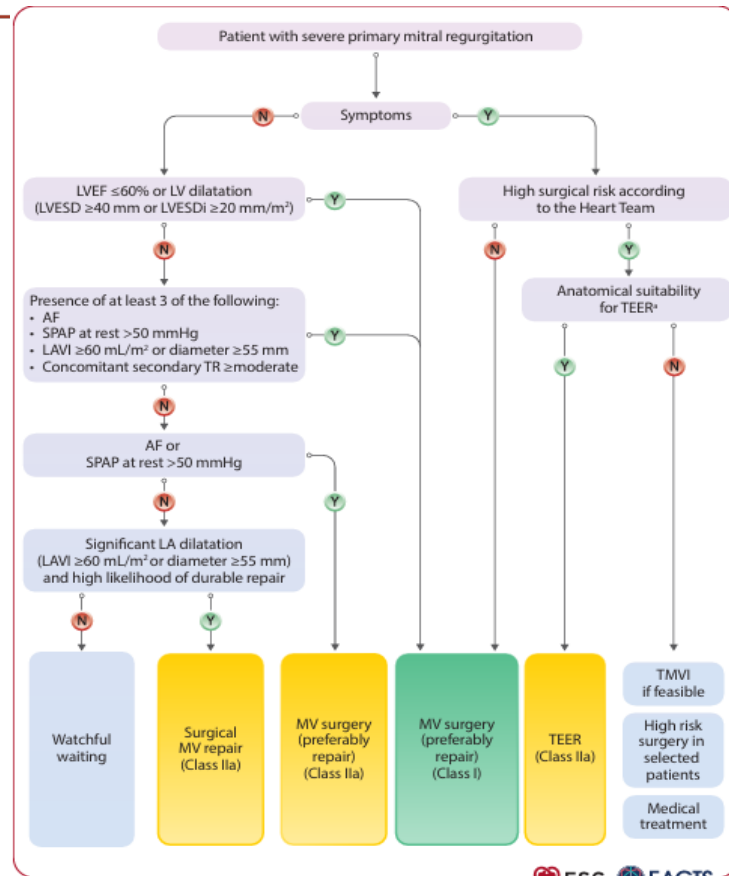
- L'età dei pazienti da sottoporre a TAVI affetti da stenosi aortica tricuspid è stata ridotta a 70 anni
- La TAVI rappresenta un'alternativa per pazienti con AR e stenosi aortica bicuspid non candidabili alla chirurgia.

PARTNER 3 TRIAL

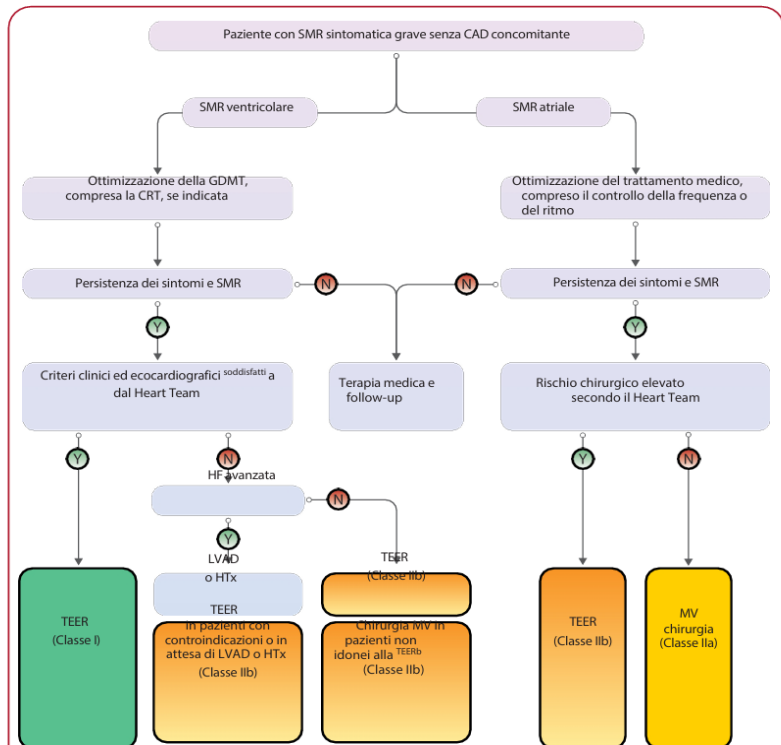


NUOVE INDICAZIONI PER MR PRIMARIA

1. La chirurgia rimane il trattamento di scelta per i pazienti con severo MR primario.
2. Sono stati identificati nuovi trigger clinici per raccomandare la chirurgia nei pazienti asintomatici con severo MR, con una nuova raccomandazione Classe I, livello di evidenza B
3. La riparazione transcateretere edge-to-edge (TEER) è un'alternativa sempre più utilizzata nei pazienti ad alto rischio con anatomia favorevole.



NUOVE INDICAZIONI PER MR SECONDARIO



Adapted from: <https://academic.oup.com/eurheartj/advance-article/doi/10.1093/eurheartj/ehad048/6411313>, 13 settembre 2023

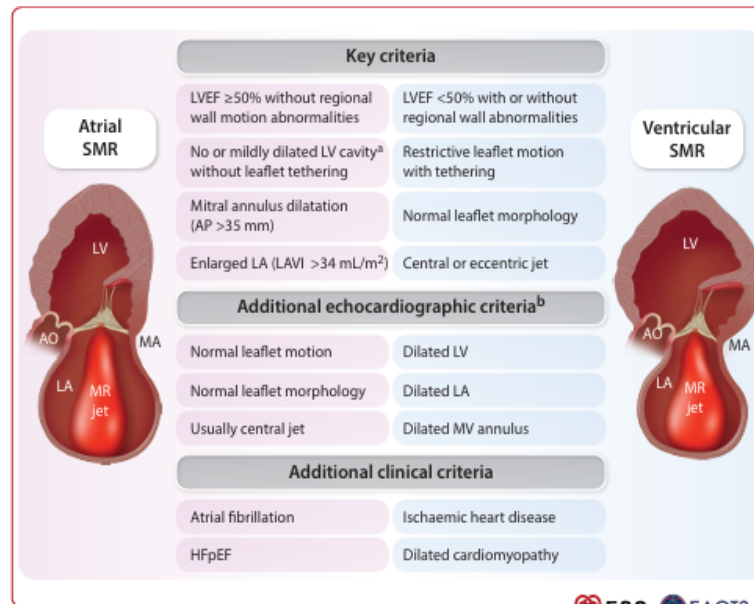


Figura 13 Trattamento dell'insufficienza mitralica secondaria grave senza concomitante malattia coronarica. CAD, malattia coronarica; CRT, terapia di risincronizzazione cardiaca; GDMT, terapia medica guidata dalle linee guida; HF, insufficienza cardiaca; HTx, trapianto cardiaco; LVAD, dispositivo di assistenza ventricolare sinistra; MV, valvola mitrale; MR, insufficienza mitralica; SMR, sindrome mitralica; TEER, procedura di chiusura percatetere della valvola mitrale.



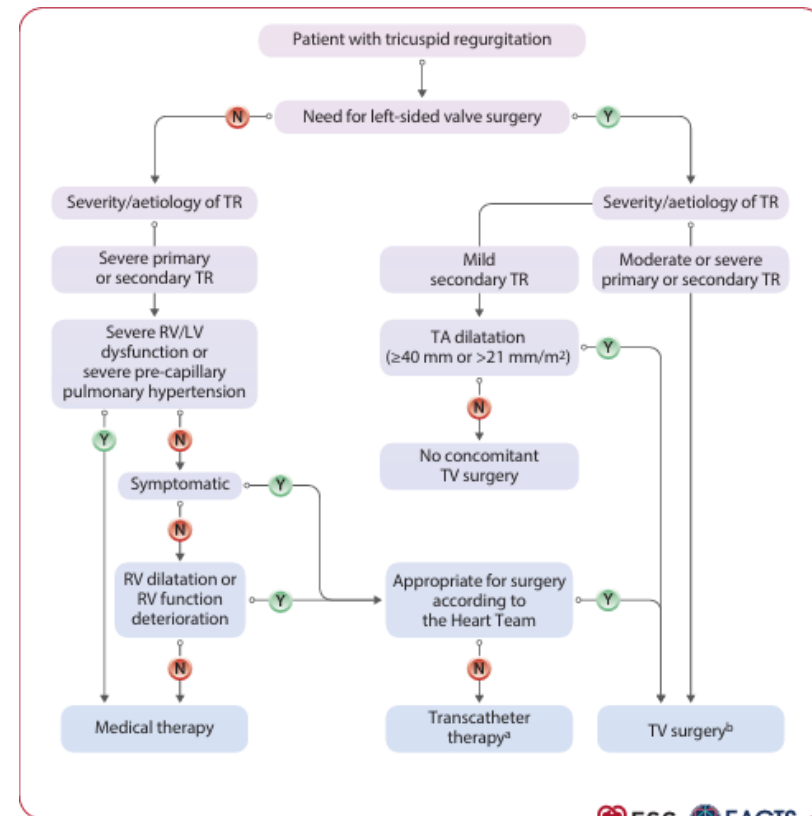
PERCORSI TERAPEUTICI DELLA TR

- Le nuove linee hanno confermato e in parte anticipato la necessità di un **trattamento precoce e proattivo** della valvola tricuspidale durante la chirurgia sinistra (mitralica o aortica)

TR Severa: Classe I (Livello di Evidenza C)

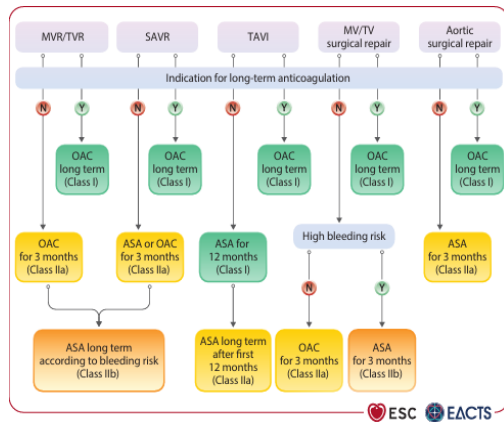
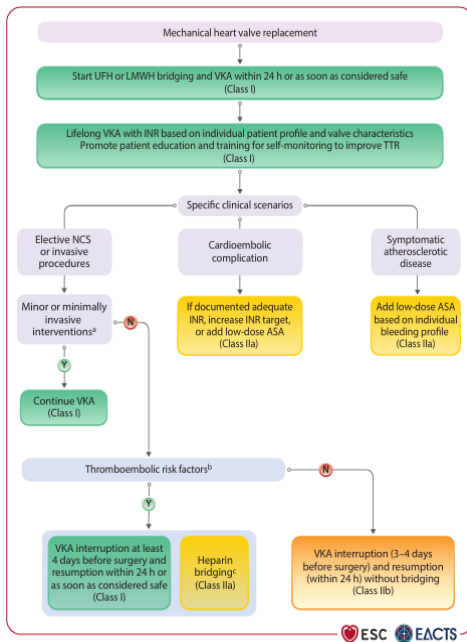
TR da Lieve a Moderata con Dilatazione dell'Anulus Classe II (Livello di Evidenza B)

- la novità principale risiede nell'introduzione di criteri di imaging multiparametrici ancora più rigorosi per definire la dilatazione e la disfunzione del ventricolo destro, riducendo il rischio di interventi tardivi.
- L'intervento transcateretere dovrebbe essere considerato nei pazienti ad alto rischio con TR severa sintomatica nonostante terapia medica ottimale **Classe II Livello di Evidenza A**

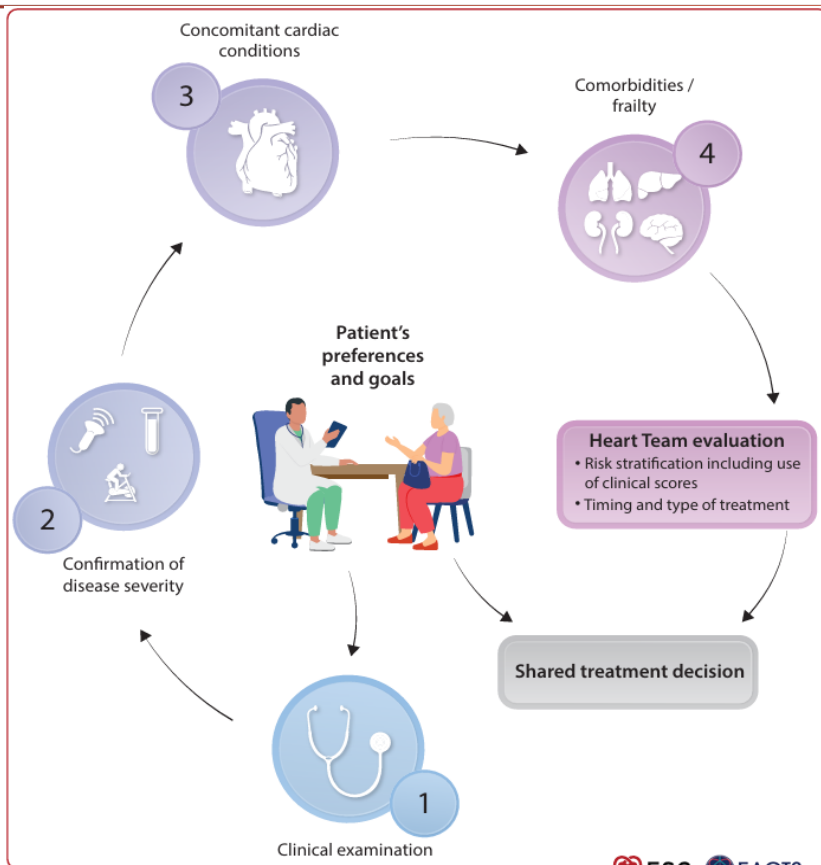


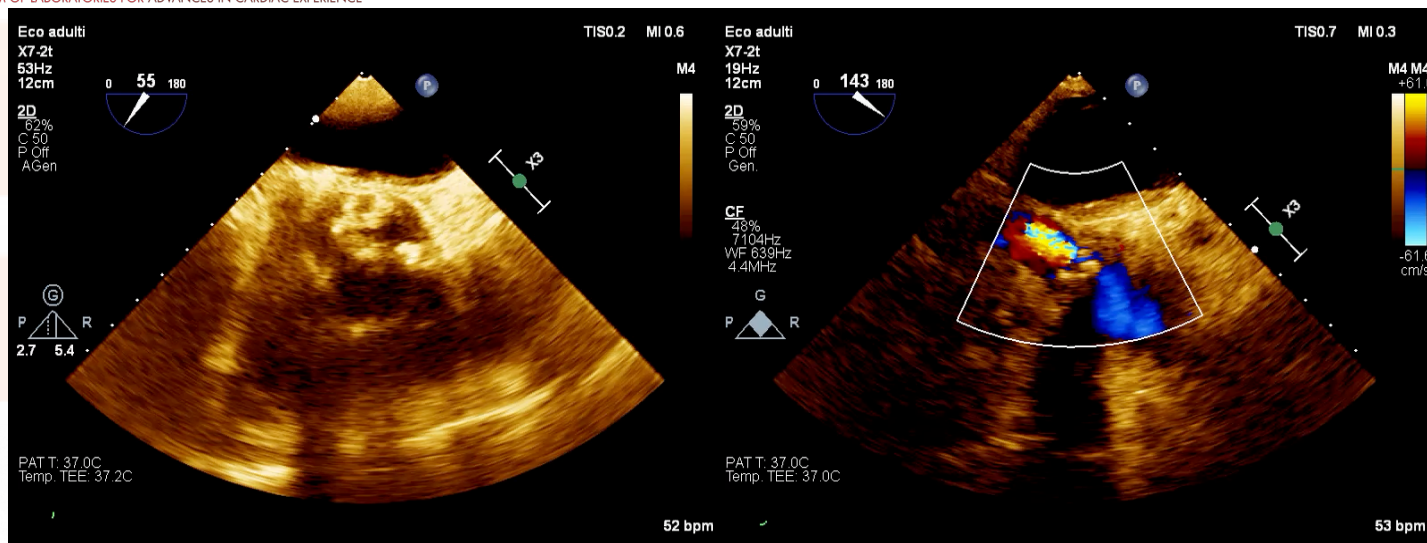
ANTICOAGULAZIONE NELLA VHD

- a. Sono state aggiunte nuove raccomandazioni per la gestione della terapia anticoagulante orale (OAC) dopo impianto di valvola meccanica, inclusi il bridging prima e dopo chirurgia non cardiaca e il ruolo dell'educazione del paziente.
- b. È inoltre evidenziato il crescente ruolo degli anticoagulanti orali diretti nei pazienti con protesi biologica e indicazione preesistente all'OAC. Algoritmi pratici mostrano chiaramente la gestione antitrombotica raccomandata dopo tutti i tipi di intervento per VHD.



- **HEART TEAM**
- **IMAGING MULTIMODALE**
- **INTERVENTO PRECOCE**
- **LIFETIME MANAGEMENT**
- **PATIENT-CENTRED CARE**





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