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Post Mitral valve repair SAM: Does it have Long term clinical implication?

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Objectives:
The risk of SAM after MV repair is caused by anterior displacement of the leaflet coaptation point, secondary to excessive height or redundant tissue of the posterior leaflet. Post repair SAM with significant MR is unacceptable, and requires immediate re-repair or valve replacement. Mild SAM immediately post repair, is handled by fluid administration, inotropes withdraw and usually the MR is mild or less, and seems to have no clinical implication. We analyzed late clinical and stress echo results of all patients, in whom tendency to have SAM was noted by TEE, immediate post degenerative mitral valve repair.

Methods:
Between 2004 and 2009, 467 patients underwent MV repair. Valve pathology was degenerative in 291 patients (62%) which were included in the study. Valve repair techniques included leaflet resection (58%), artificial chordal (44%), and edge-to-edge repair (3%), annuloplasty (98%).

Results:
There were 2 hospital deaths (1%). Mean follow up was 25±16 months. Freedoms from reoperation and from moderate or severe mitral regurgitation for all patients, were 97% and 95%, respectively.
In 10 patients we had a second pump run, from which 3 were due to significant SAM. In those patients closed ring was replaced by an open band. In 27 patients SAM was identified immediately post valve repair. Fluid administration and inotropes were withdrawn, and none of the patients had significant MR (Mild+). Late echo results demonstrated 23 patients with no or trivial MR, 2 with Mild, and 2 with Moderate MR. Those patients with early SAM, underwent stress echo, which revealed 2 patients with SAM, from which only one patient had significant gradient in the LV outflow track with SAM related moderate MR.

Conclusions:
Late post operative stress echo revealed non significant incidence of SAM in patients with immediate post repair tendency to have SAM.