Amicale des Cardiologues de la Côte d'Azur
7/01/2025

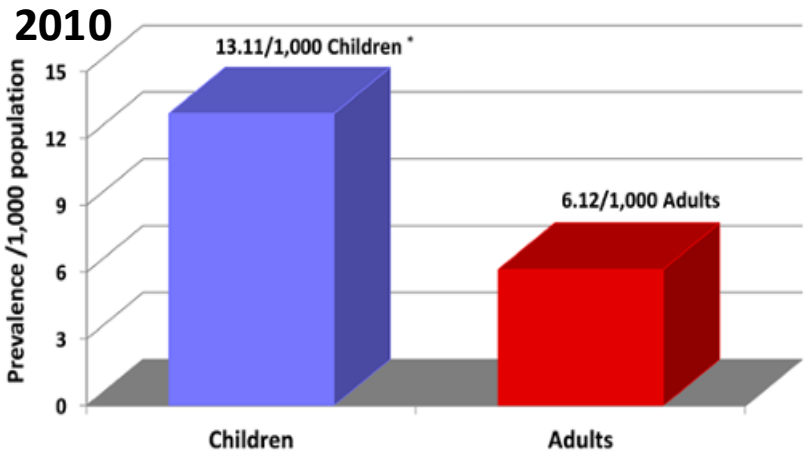
Cardiopathies Congénitales Adultes

Pr Sylvie Di Filippo

Centre Cardio-Thoracique de Monaco

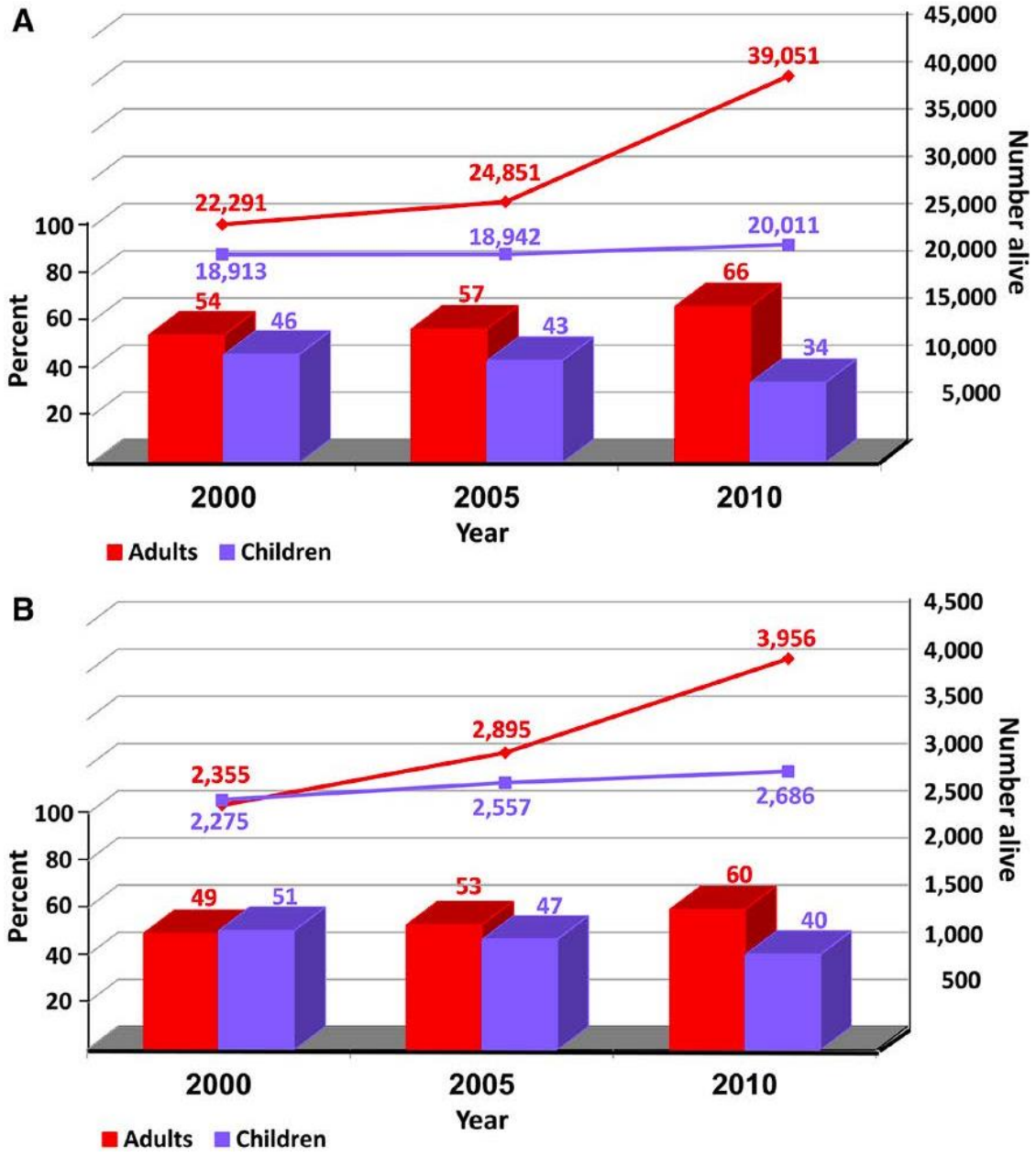
Adultes cardiopathies congénitales
Cohorte en progression

- **Cardiopathies congénitales**
  8 naissances /1000 = 775000 NN / an en France
- **Survie à 18 ans : 90%**
- **Adultes avec CC :**
  - USA = 1.5 millions
  - Europe = 1.2 millions



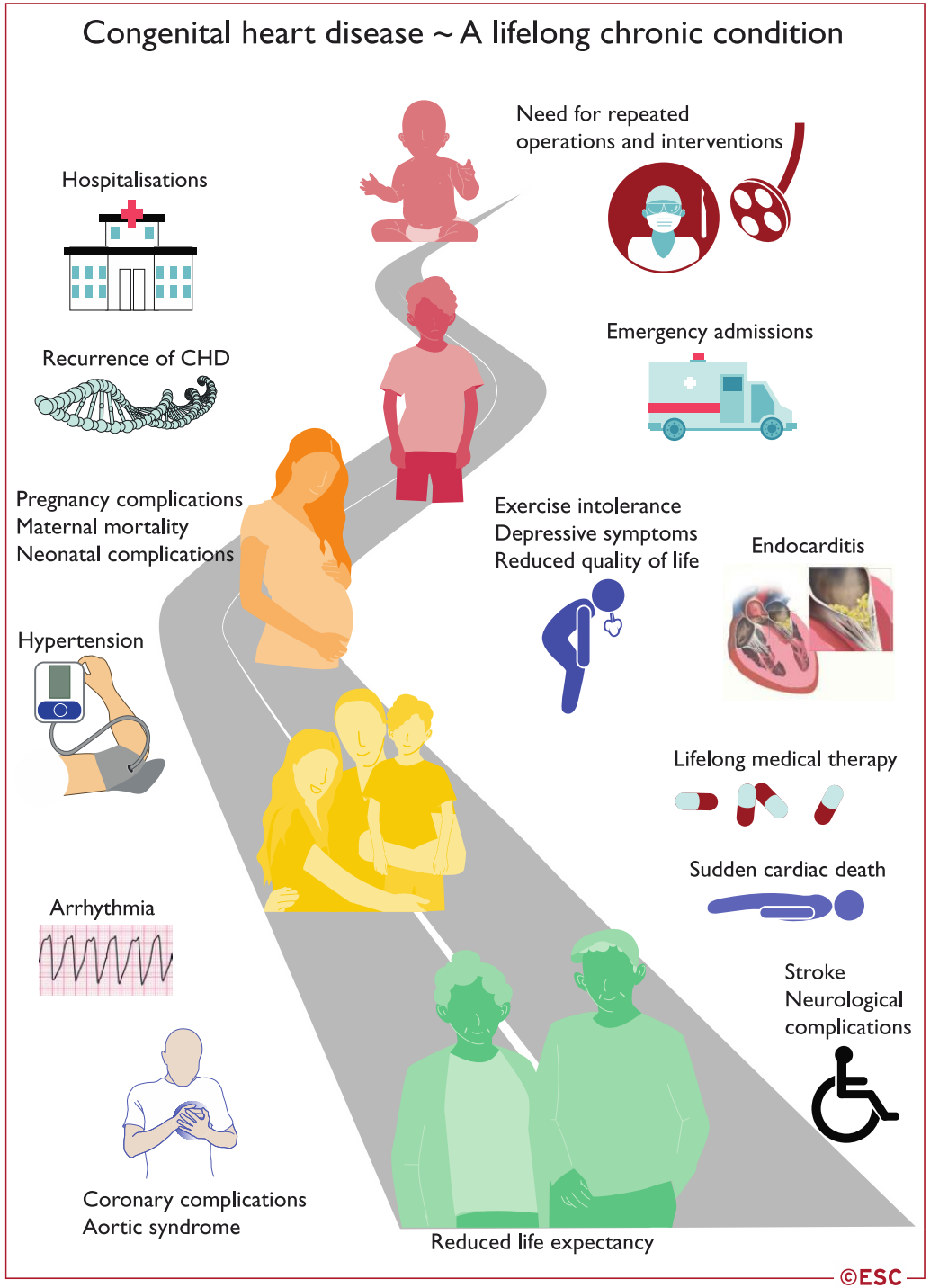
De 2000 à 2010:
augmentation de 70%
du nombre d'adultes vivant avec une CC

Circulation. 2014;130:749-756



2020 ESC Guidelines for the management of adult congenital heart disease

Eur Heart J 2021;42:563-645



Pathologie chronique

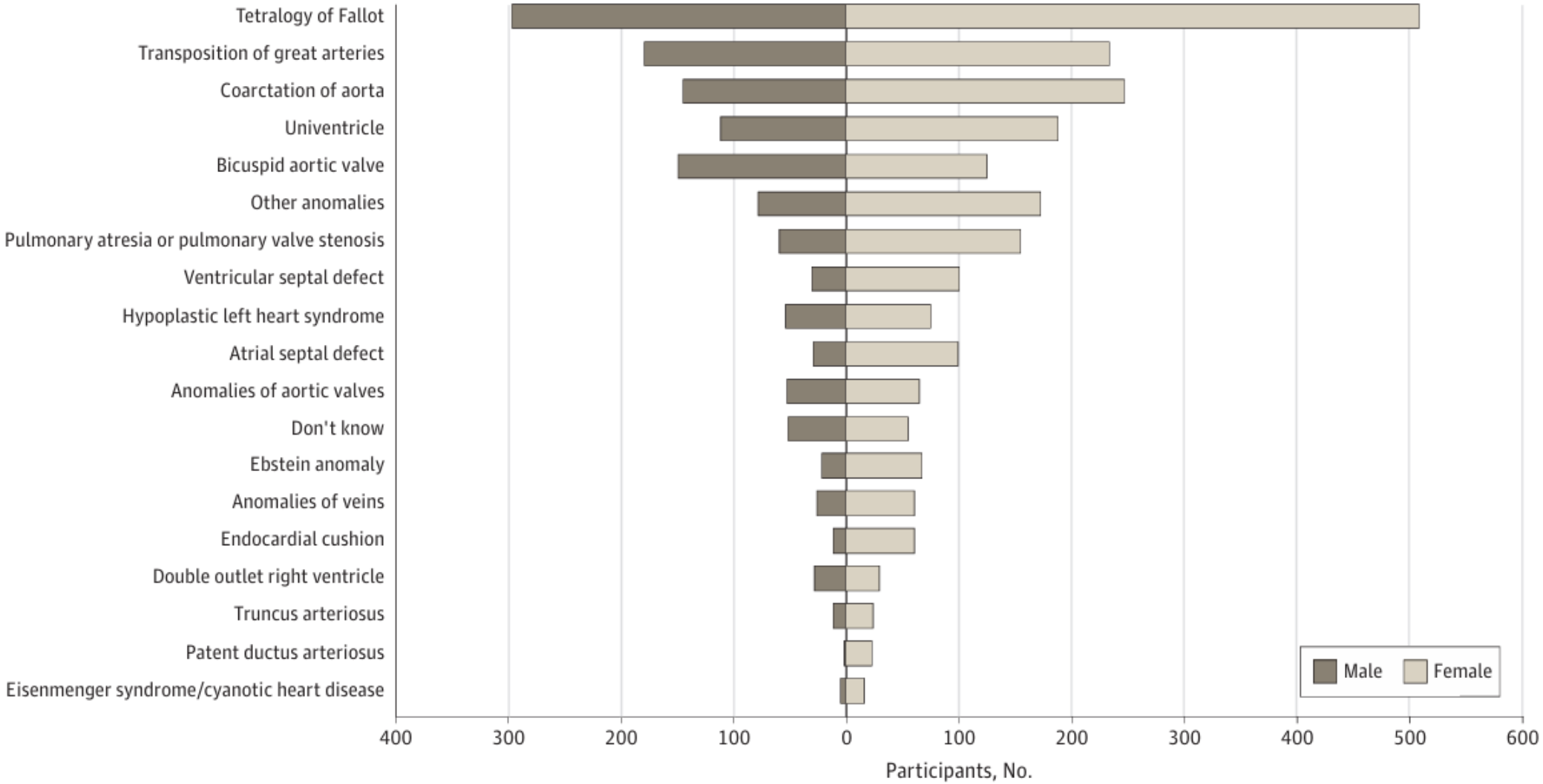
Parcours / Evènements tout au long de la vie

Classification des CC : selon la complexité

Catégorie	Type	Chirurgie	Ttt médic	Suivi	Qualité vie
CC mineure	CIV, CIA/FOP, CAP, RP, RA, PVM, BicAo RVPAPartiel	Non	Non	Espacé	Normale
CC significative « correctible »	TGV, Fallot CIV, CIA, CAP, CAVC/CAVP CoAo, IAAo RA, RP, Tronc commun VD systémique Ebstein mineur Anomalies coronaires	Oui 1 ou +	+/-	1/an ou +	Sub-normale
CC majeure « non correctible »	Ventricules uniques AT, APSI, hypoVG Ebstein majeur Eisenmenger VD systémiques complexes	+/- Palliation 1 ou +	Oui	Fréquent	Limitée

Congenital Heart Initiative (CHI) : digital, online, patient-empowered registry of patient-reported outcomes (PROs) in ACHD

4558 participants



JAMANetworkOpen.2024;7(10):e2439629

Morbidité et suivi

EVENEMENTS

- **Arythmies ++**
- **Décompensation cardiaque**
- **HTAP/ Syndrome d'Eisenmenger**
- **Coronaires / ischémie**
- **HTA / coarctation aortique**
- **Grossesse**
- **Hypoxie chronique**
- **Endocardite infectieuse**

BILANS / MOYENS

- **Explorations non invasives**
  - ETT / ETO
  - **Scanner**
  - **IRM**
- **Cathétérisme diagnostique**
  - Hémodynamique
  - Calibration
- **Marqueurs biologiques**
  - BNP/ NTproBNP
  - Troponine
- **Exploration cardiorespiratoire**
  - VO2max

THERAPEUTIQUES

- **Cathétérisme (interventionnel)**
- **Chirurgie (redux)**
- **Traitement médical**
- **Transplantation cardiaque**

Arythmies

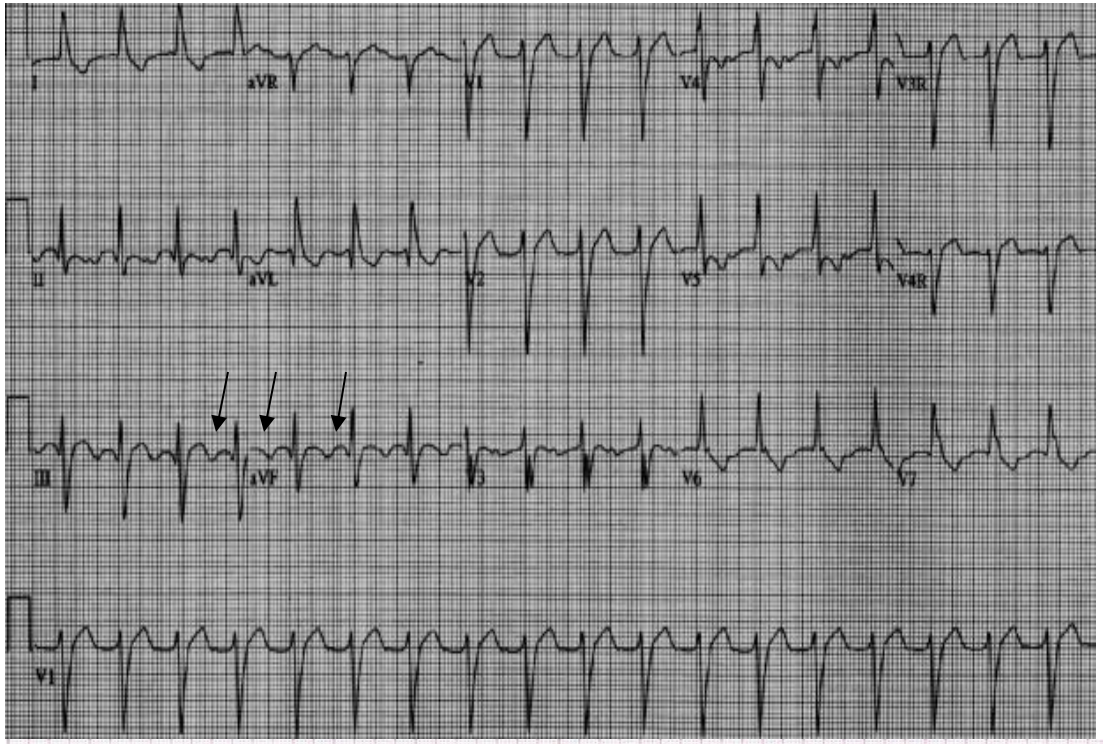
- **Fréquence des arythmies**

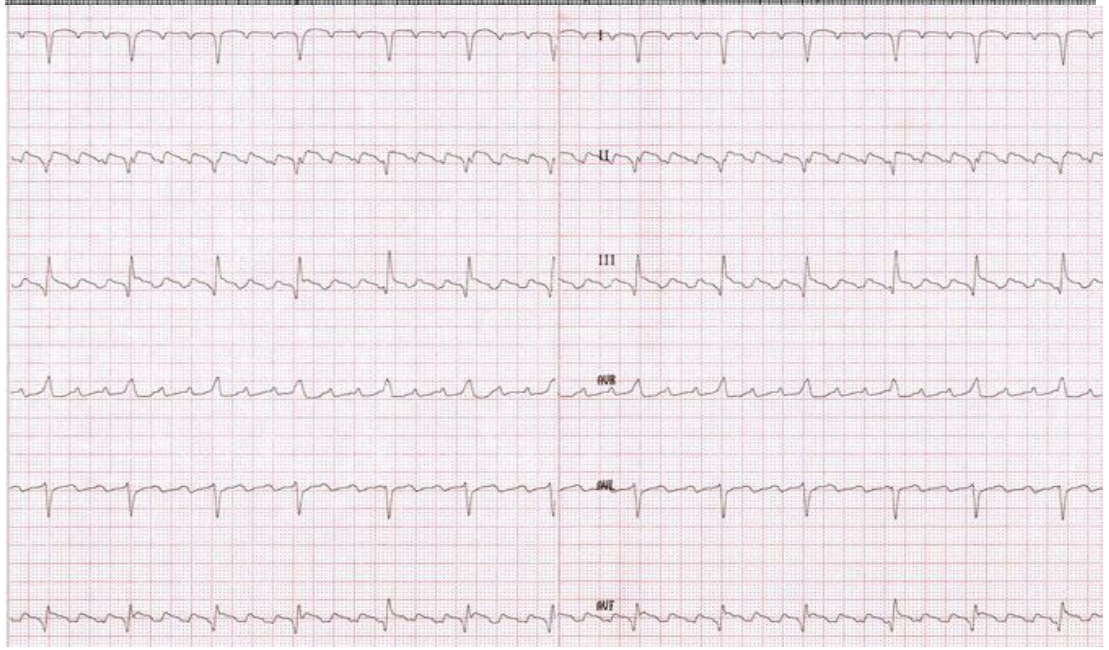
  Supraventriculaire / Ventriculaire

  FA, flutter A, TV, FV

- **Risque de**
  - **Mort subite**
  - **Décompensation cardiaque**

→ **Mauvaise tolérance hémodynamique**





Arythmies

Facteurs favorisants

- Ventriculotomie/ atriotomie
  - Circuits de réentrées
- Distension myocardique
- Dysfonction myocardique
- Fibrose myocardique
- Hypoxie chronique
- Blocs postopératoires: BAV, BDB

Cardiopathies

Fallot
TGV avec VD sous aortique (Mustard)
Ebstein
TGV corrigée (double discordance)
Ventricule unique

Eur Heart J 2021;42:563 645

	Supraventricular arrhythmias			Ventricular arrythmias and SCD		Bradycardia			
						SND		AV block	
Type of CHD	AVRT	IART/ EAT	AF	Sustained VT	SCD	Congenital	Acquired	Congenital	Acquired
Secundum ASD		++	++			(+)	+		(+)
Superior sinus venosus defect		++	+				+		
AVSD/primum ASD		++	++	(+)		(+)		(+)	++
VSD		+	(+)	+	(+)[a]				+
Ebstein anomaly	+++	++	+	(+)	++[b]		++		
TOF		++	++	++	++		+		+
TGA									
Atrial switch		+++	+	++[c]	+++[b]		+++		+
Arterial switch		+		+[c]	(+)		(+)		
ccTGA	++	+	+	(+)	++[b]			+	++
Fontan operation									
Atriopulmonary connection		+++	++		+[b]		++		
Intracardiac lateral tunnel		++	+		+[b]		++		
Extracardiac conduit		+	+		+[b]		+		
Eisenmenger physiology Incompletely palliated CHD		++	++		++[d]				

©ESC

Empty cells indicate that although not specifically indicated, arrhythmic events may occur (no symbol).

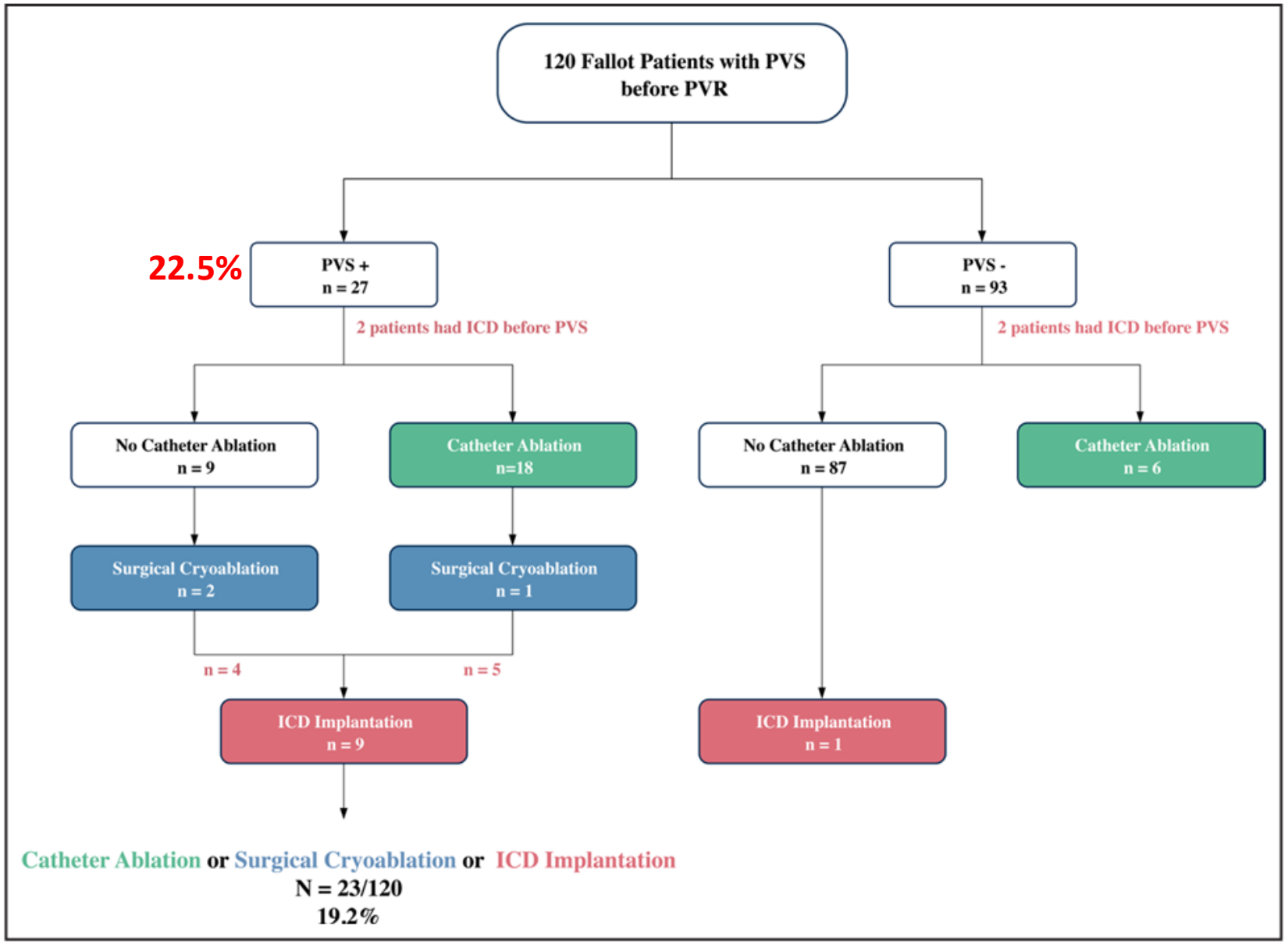
(+) = minimal risk + = mild risk ++ = moderate risk +++ = high risk

Circ Arrhythm Electrophysiol 2023;16:e011745.

FALLOT

EEP systématique avant RVP

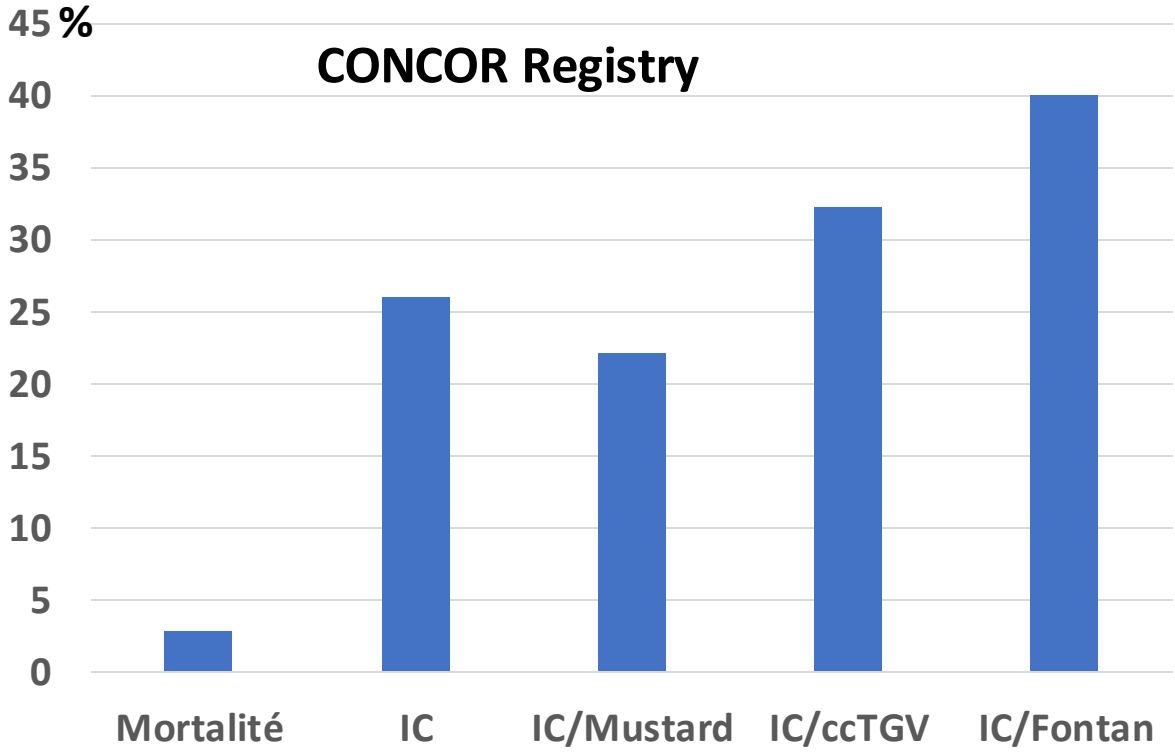
22.5% inductible



Insuffisance cardiaque

- **VG mais aussi VD ou ventricule unique**
  - VD systémique: sous aortique
  - VU de type droit
  - VG en hypoxie chronique
- **Facteurs de risque**
  - CEC itératives
  - Ventriculotomies
  - Surcharge volumétrique
  - Arythmies
  - Obstacle
  - Fuites valvulaires
  - Ischémie
- **Evaluation difficile** : VD, VU
- **Traitements classiques** : moins efficaces ?

Eur Heart J 2016;37:1419



Insuffisance cardiaque (IC)

Intern J Cardiol 2021;322:149-157

- **Risque cumulé d'IC à l'âge de 65 ans**

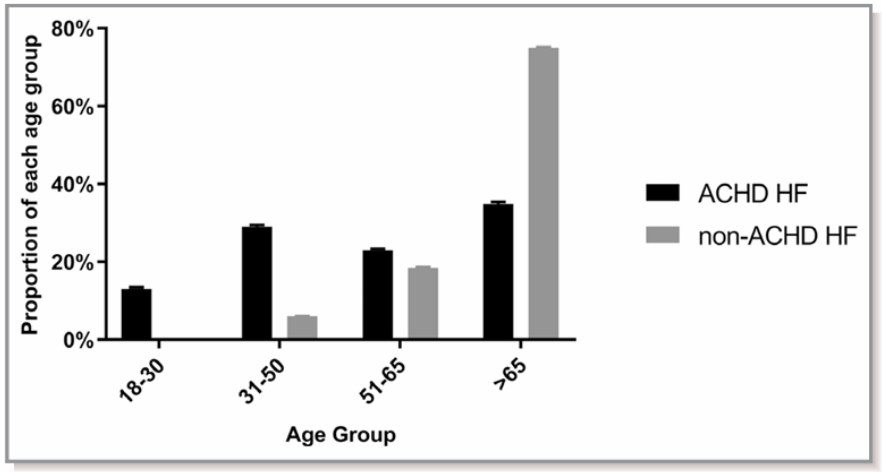
  = 12.58%

- **Facteurs de risque à 1 an**
  - Age ≥ 50 ans
  - Genre masculin
  - Sévérité de la CC
  - Accès d'IC récent (< 1 an)
  - HTAP
  - Insuffisance rénale chronique
  - Coronaropathie
  - HTA
  - Diabète

Heart 2021;107:807–813.

Patients avec IC	Groupe CC 76 557 cas	Groupe non-CC 31 137 414 cas
Age	**V.Unique : 33 ans, Bi-Ventriculaire : 62 ans**	74 ans
Admissions en urgence	78%	70%
Mortalité	V.Unique : 6.6% Bi-Ventriculaire : 6.3%	5.5%
Hospitalisation sur 10 ans	+ 46%	+ 6%

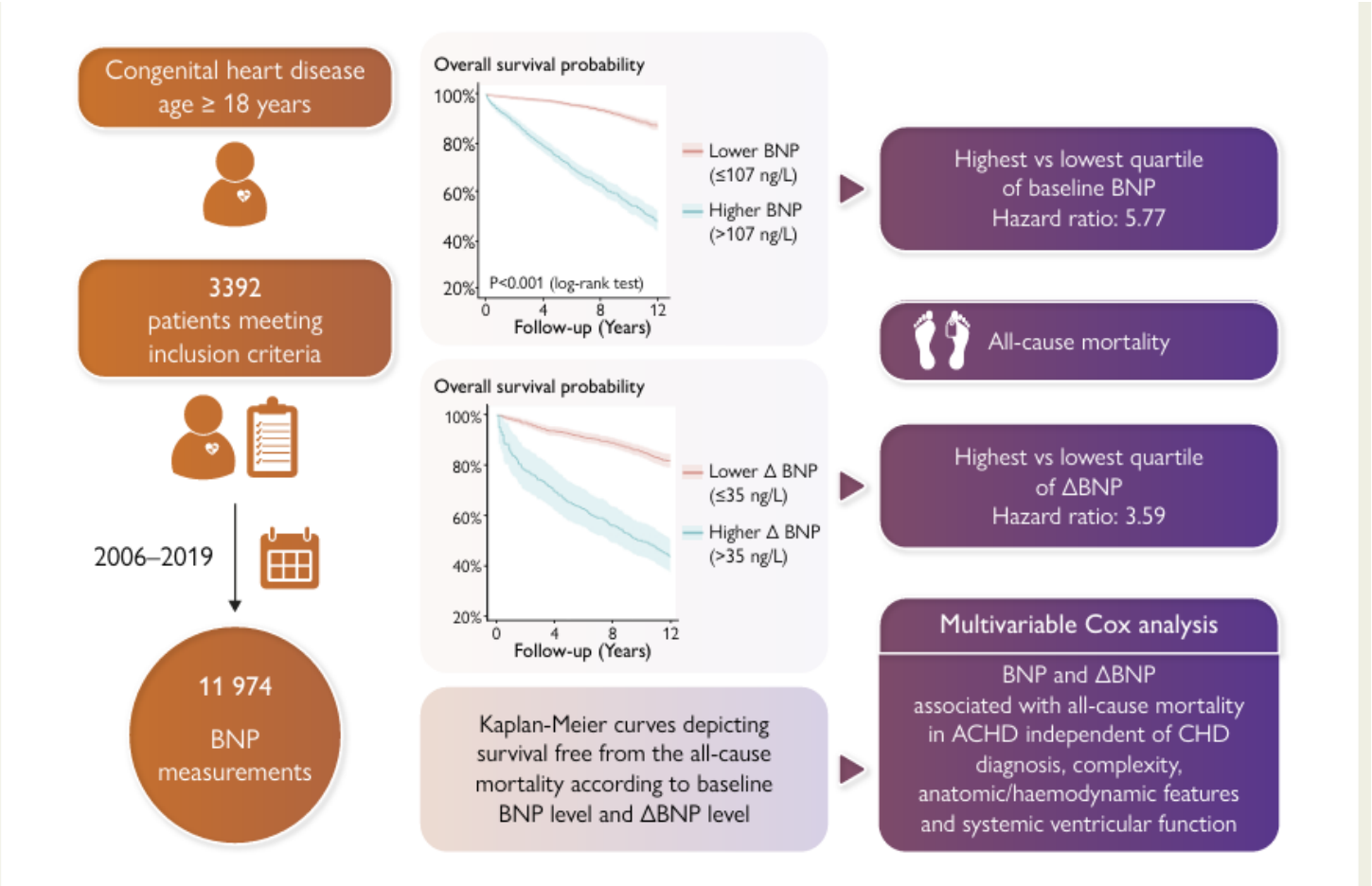
J Am Heart Assoc. 2018;7:e008775



Marqueurs biologiques : BNP

European Heart Journal 2024;45:2066–2075

- 3392 patients avec CC
- Endpoint = mortalité toutes causes
- 11 974 mesures de BNP
- BNP median basal = 47 (24–107) ng/L.
- Follow-up median = 8.6 ans
- Décès : 615 (18.1%)
- **BNP basal et modifications taux BNP : prédictifs de mortalité**
- **BNP basal >107 ng/L et augmentation BNP >35 ng/L = facteur de risque de mortalité**



ESC Guidelines 2020.
Eur Heart J 2021;42:563 645

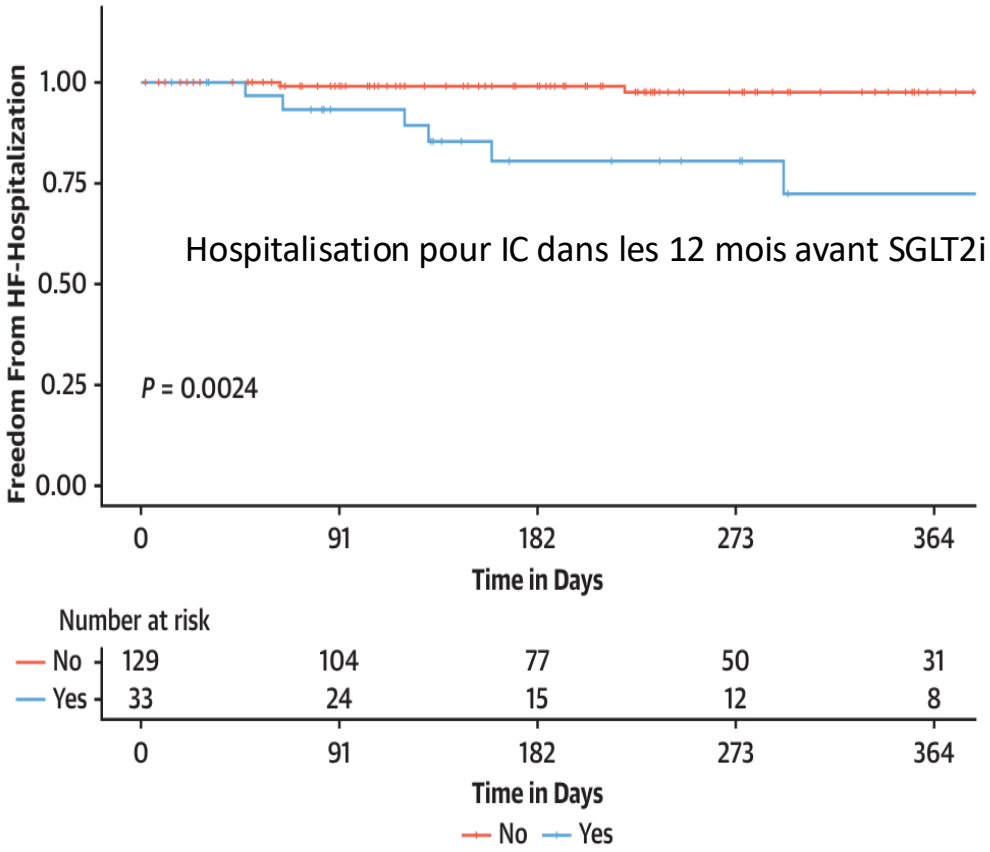
- Variabilité du taux dépendant de la cardiopathie et de la réparation
  - *Plus utile dans cardiopathie bi-ventriculaire*
  - *Moins utile dans cardiopathie uni-ventriculaire et Fontan*
- Identification des cas à risque de complications
- Taux augmenté dans CC cyanogène par sécrétion peptide due à l'hypoxie

JACC 2024;83:1403–1414

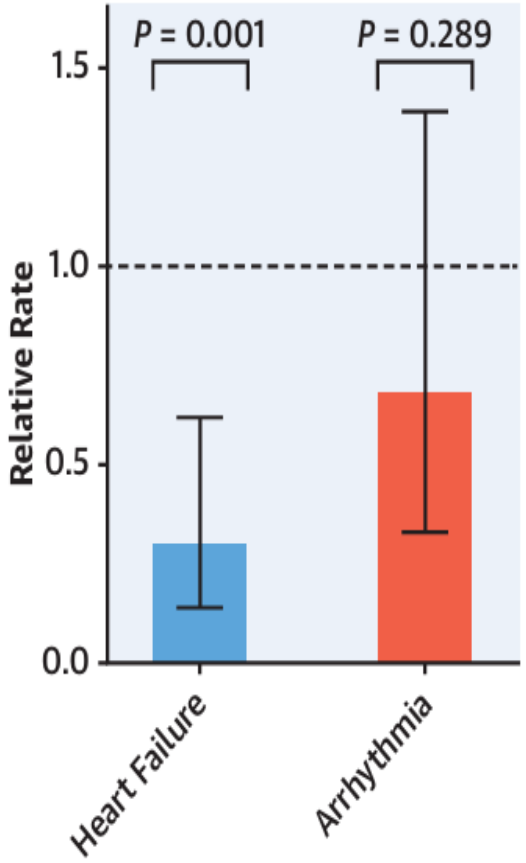
Glifozine SGLT2i et CC

Réduction au tiers des hospitalisations pour IC

3-Fold Reduction in Heart Failure Hospitalization Rate:
Relative Rate = 0.30 (95% CI: 0.14-0.62), *P* = 0.001
No Significant Reduction in Arrhythmia Admission Rate



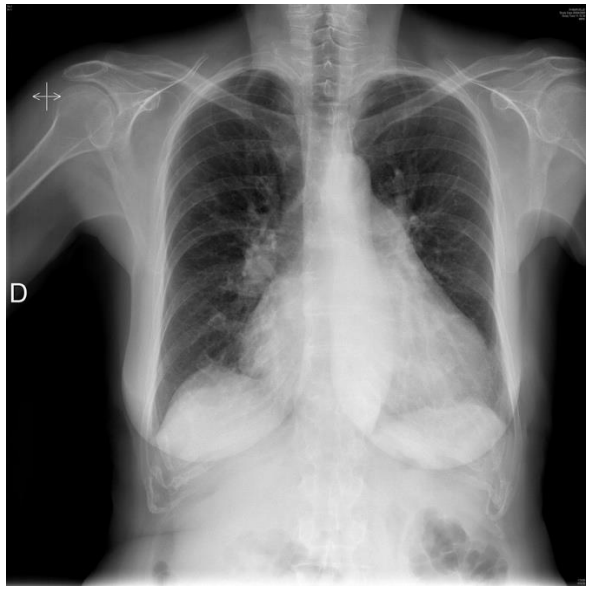
Hospitalisation pour IC dans les 12 mois avant SGLT2i

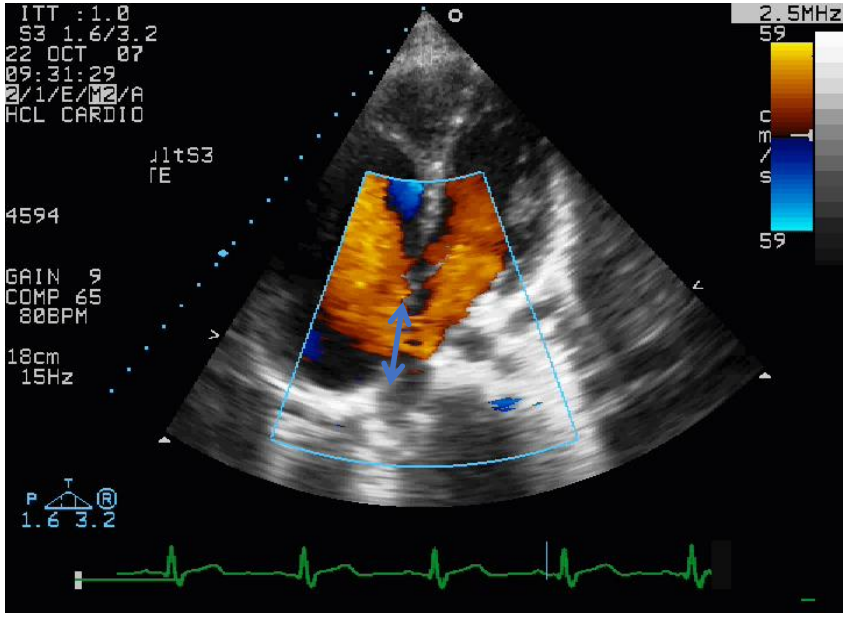


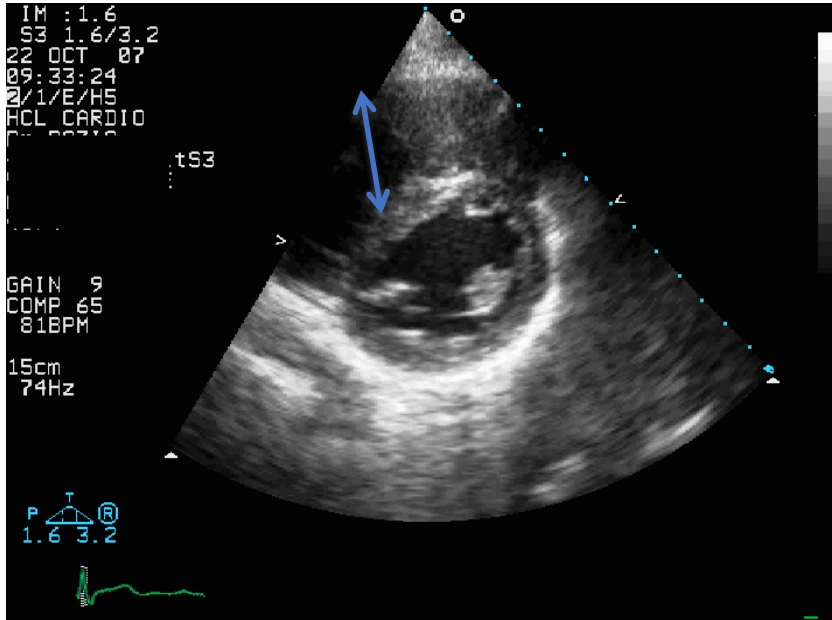
Neijenhuis RML, et al. J Am Coll Cardiol. 2024;83(15):1403-1414.

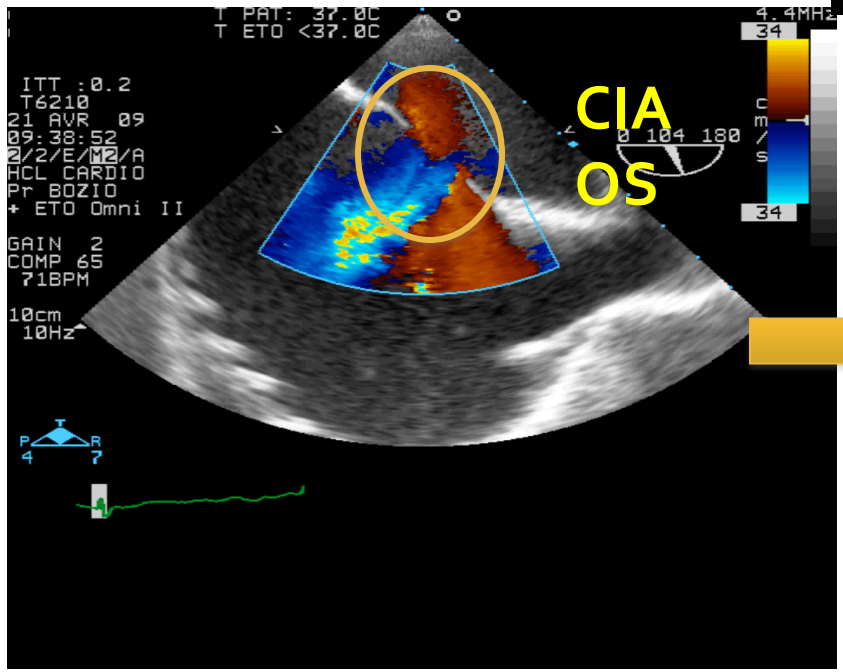
Cas clinique

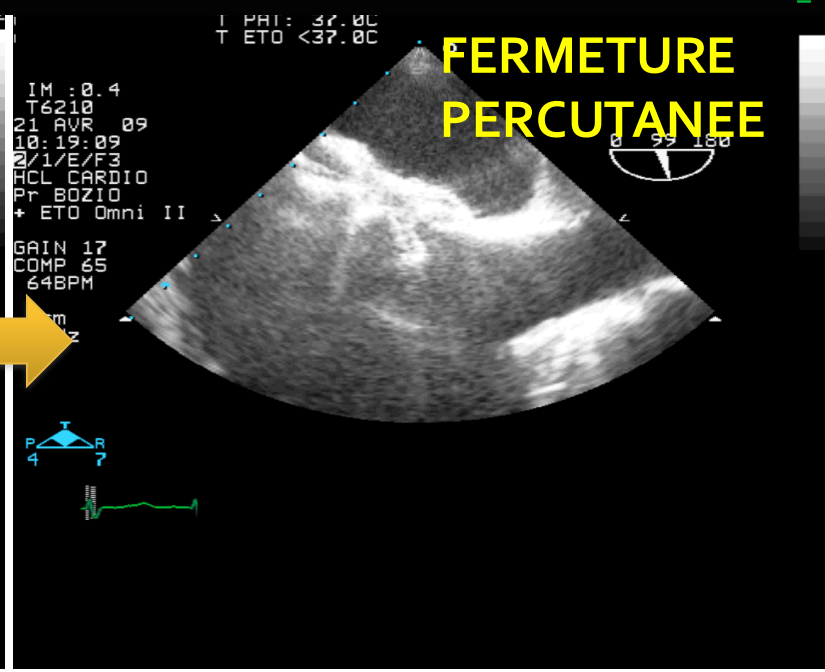
- Mme X, 58 ans
- 1 fille en BS
- Symptomatologie:
  - IC globale
  - FA rapide
  - Hospitalisation









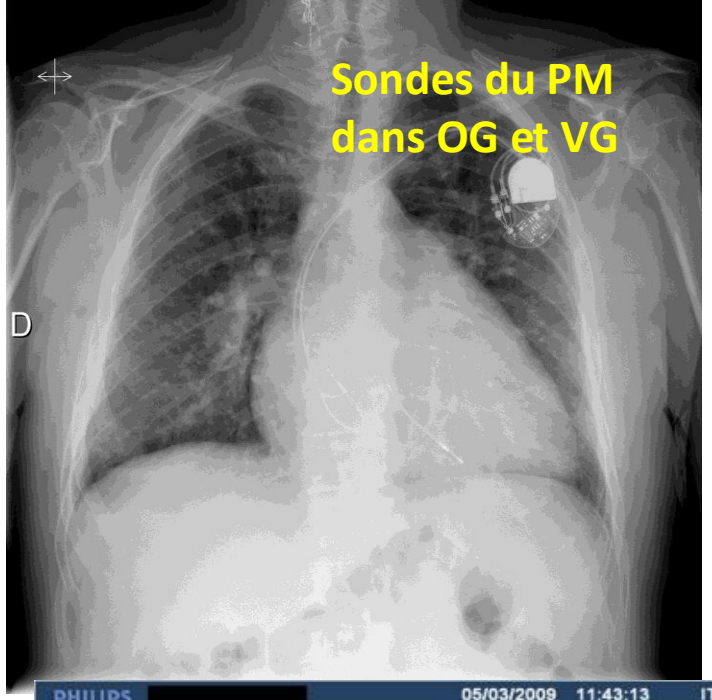


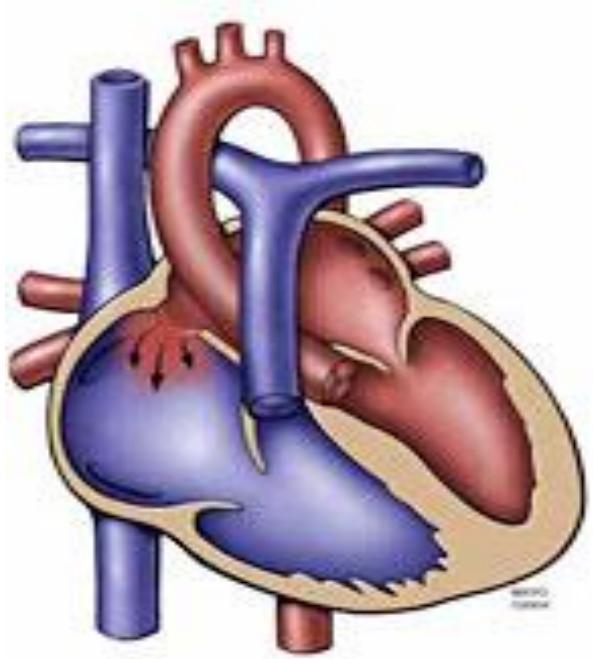
Cas clinique

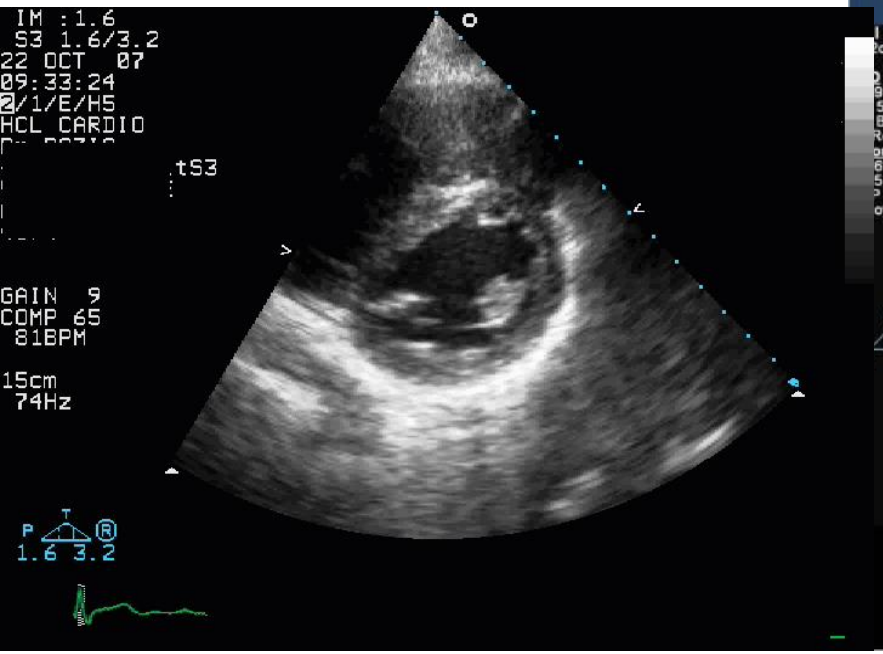
- Mr Y, 75 ans
- ATCD: Bitronculaire

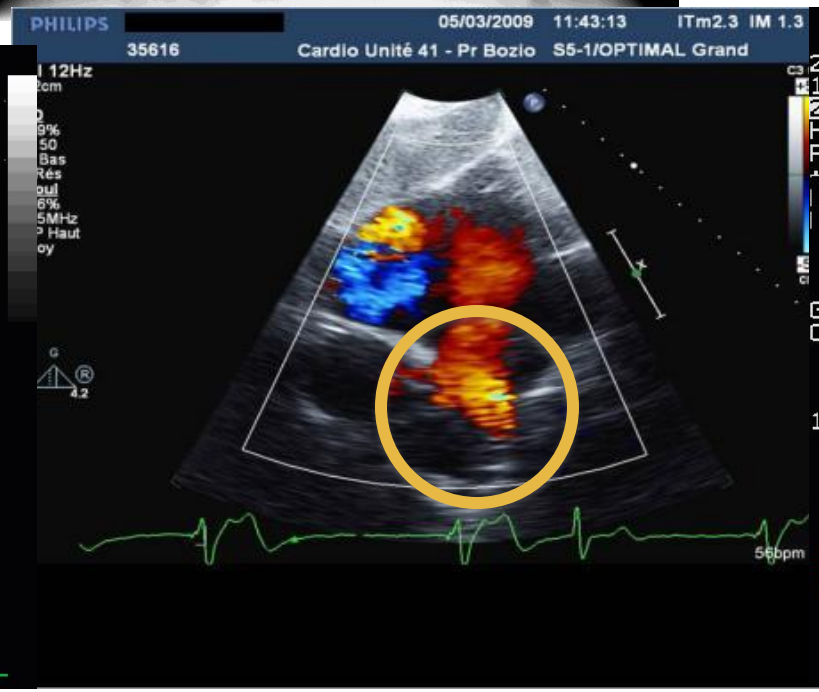
  Infarctus inférieur

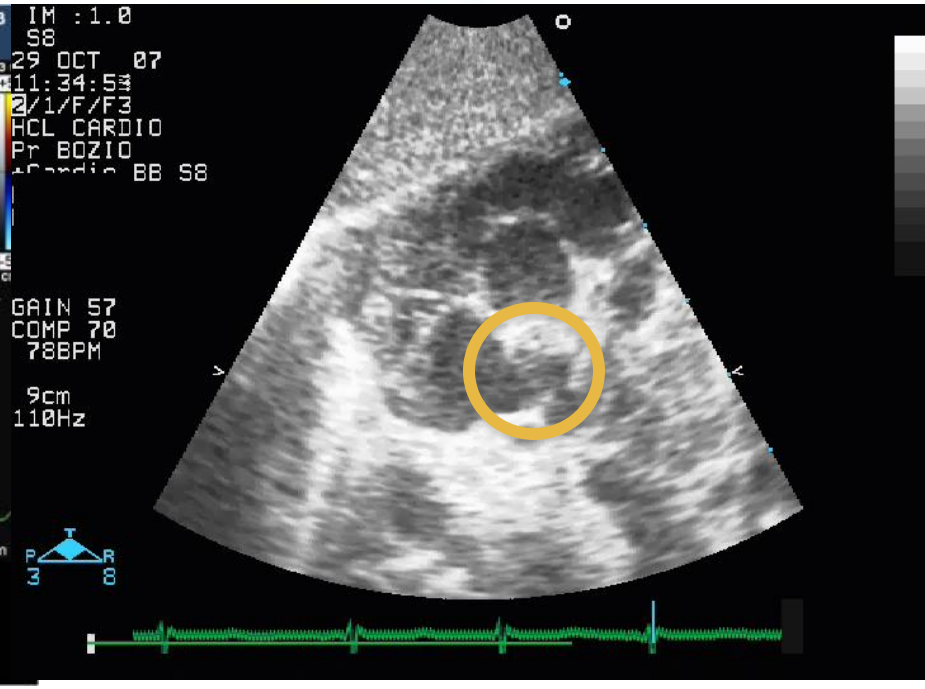
  PM double chambre
- Douleurs thoraciques





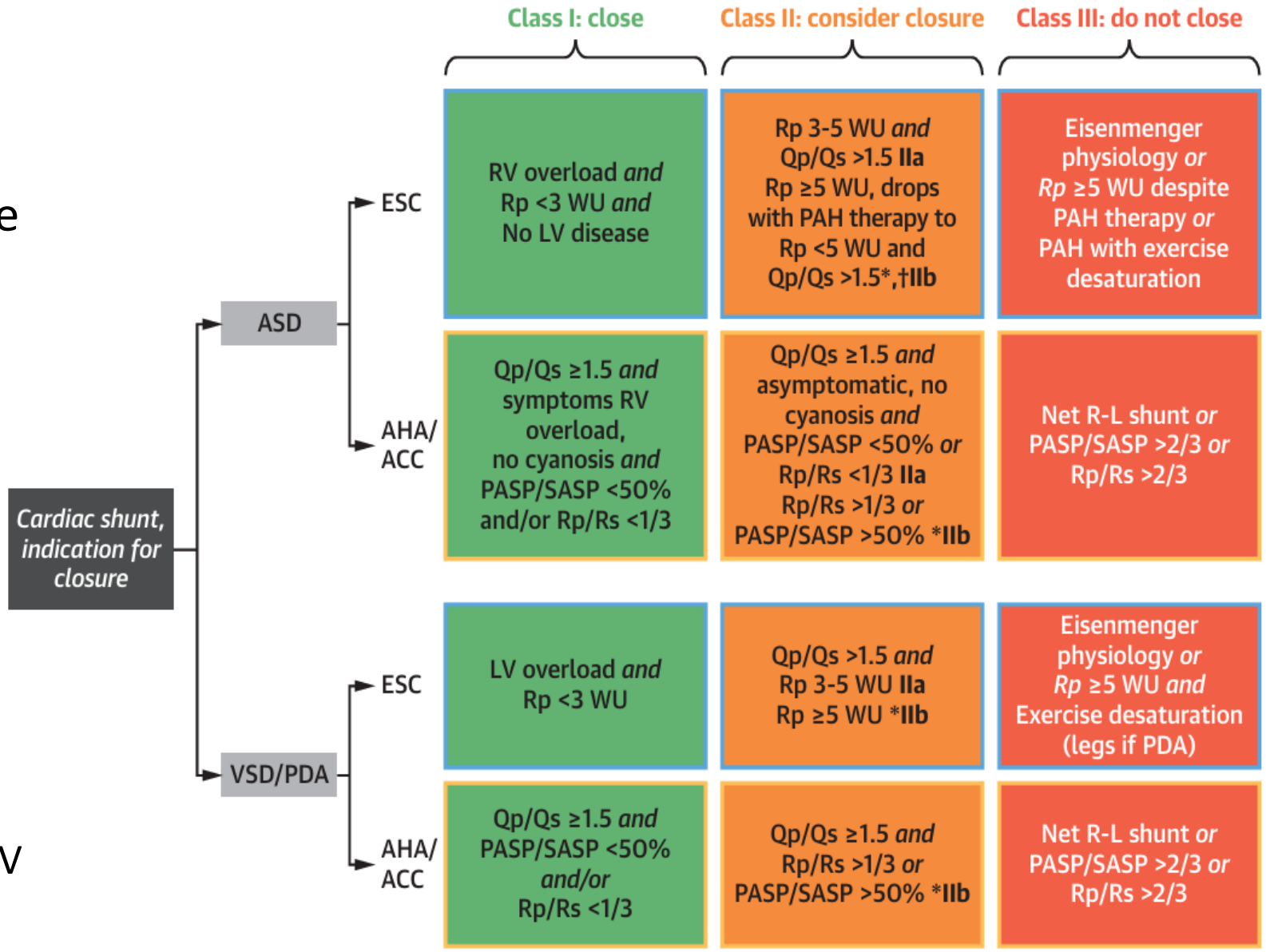






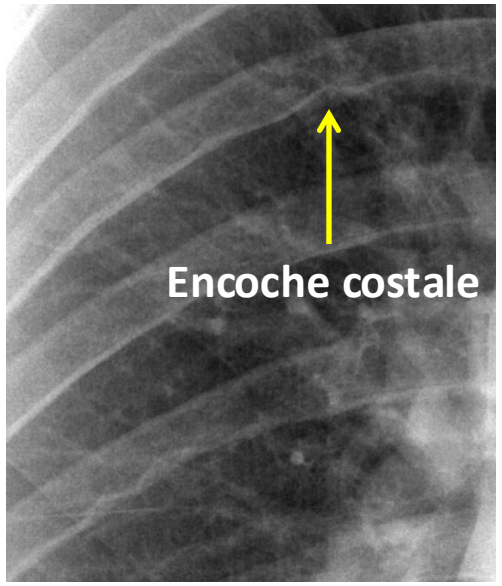
CIA de l'adulte

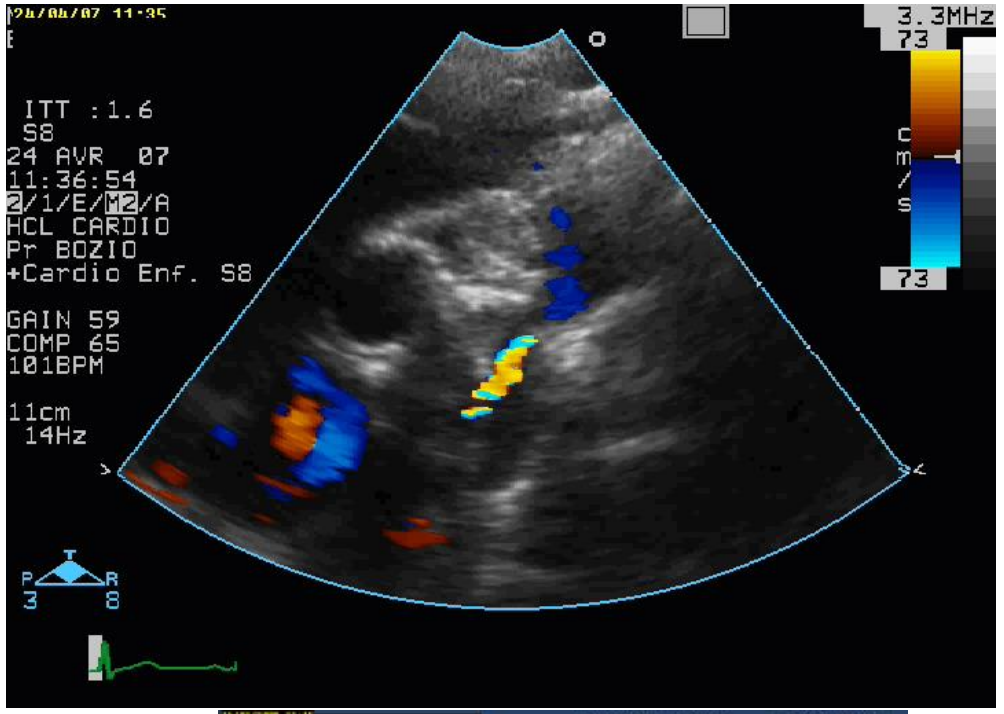
- Découverte fortuite : souffle
- Ou symptômes :
  - Arythmie
  - IC
  - thromboembolie
- Bilan d'HTAP :
  - rechercher un shunt
- Shunt GD, surcharge VD
- Localisation :
  - ne pas méconnaître la CIA/SV

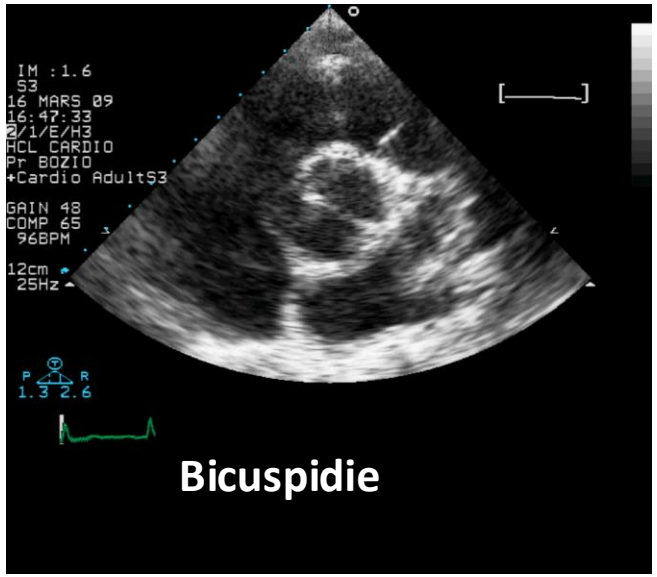


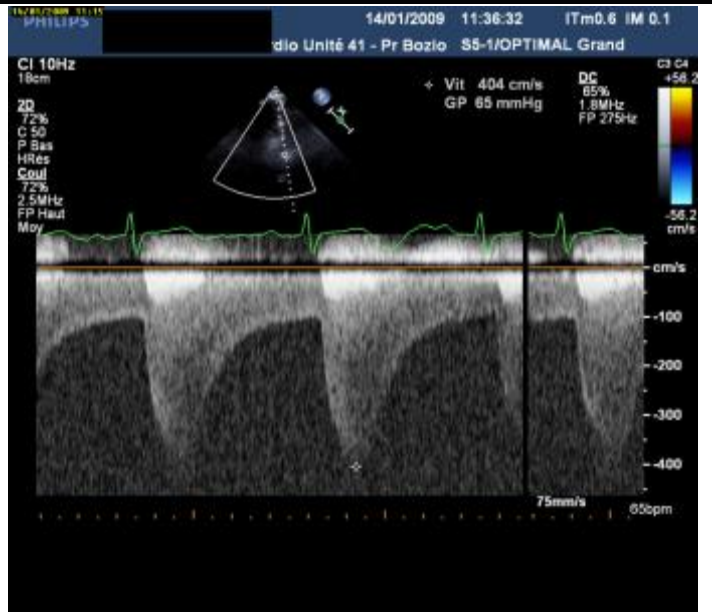
Cas clinique

- Mr B. 40 ans
- 180 cm, 80 kg
- Vie normale
- HTA traitée depuis 20 ans
- Clinique :
  - TA MSD 180/100
  - TA MID 90/40
  - Pouls fémoraux très faibles
  - Souffle dorsal continu
  - Pouls intercostaux et mammaires



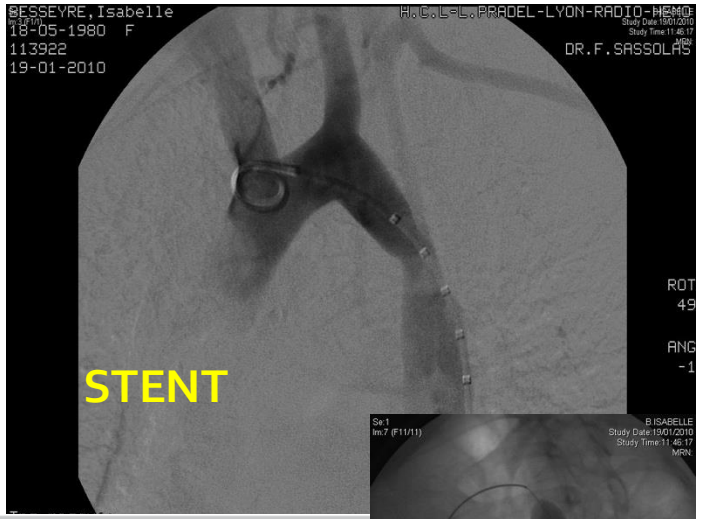


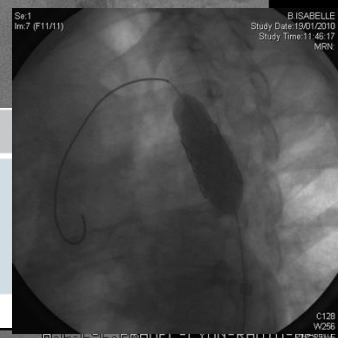




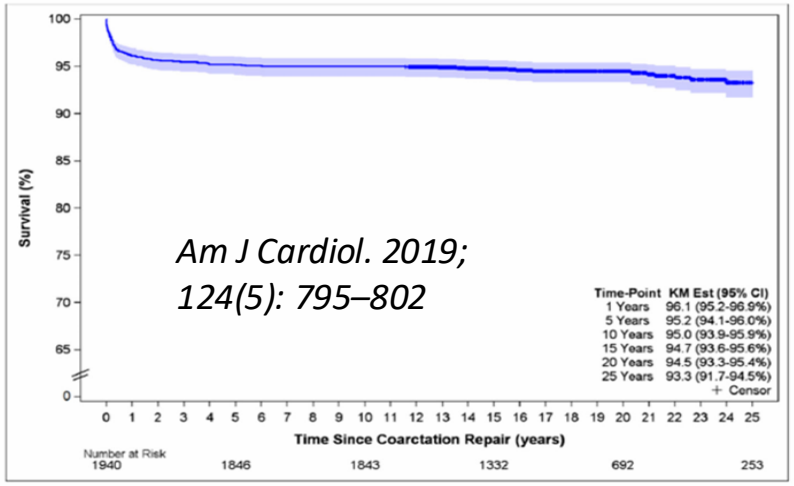
La coarctation aortique

- **HTA sujet jeune**
- **Bicuspidie aortique : 50%**
- Palper les pouls fémoraux
- Ausculter le dos
- Recherche de pouls intercostaux
- **Scanner ou IRM +++**

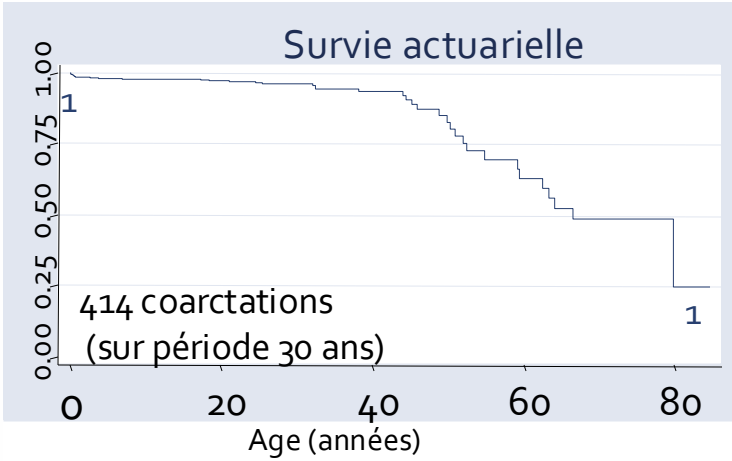


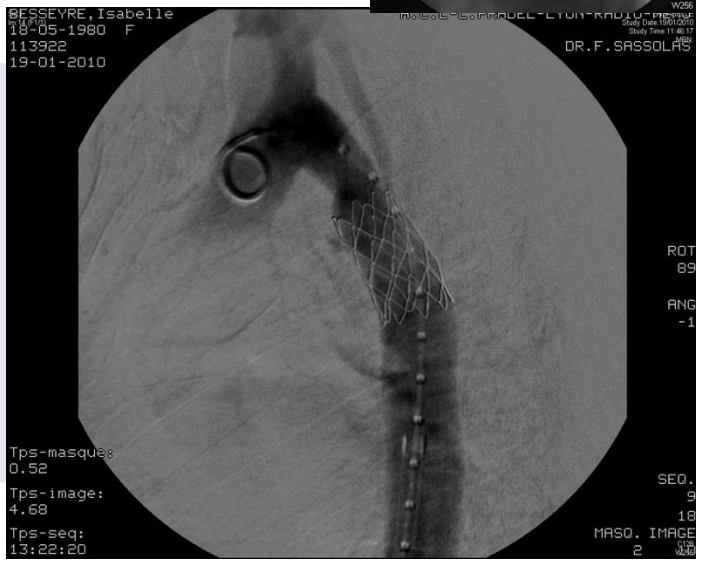


Coarctation and re-coarctation of the aorta		
Repair of coarctation or re-coarctation (surgically or catheter based) is indicated in hypertensive patients with an increased non-invasive gradient between upper and lower limbs confirmed with invasive measurement (peak-to-peak ≥20 mmHg) with preference for catheter treatment (stenting) when technically feasible.	I	C



Am J Cardiol. 2019; 124(5): 795–802



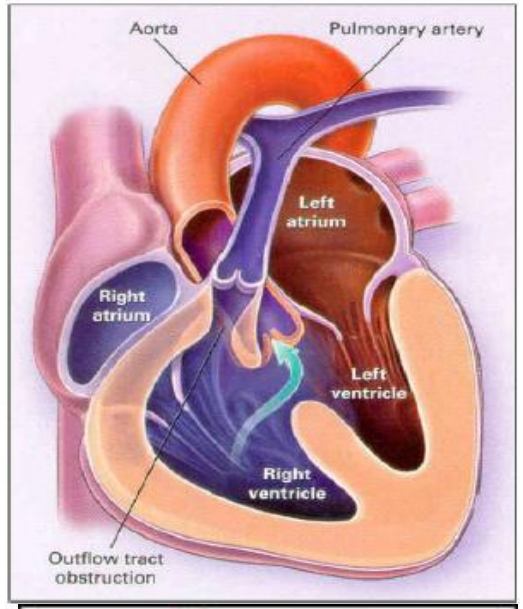


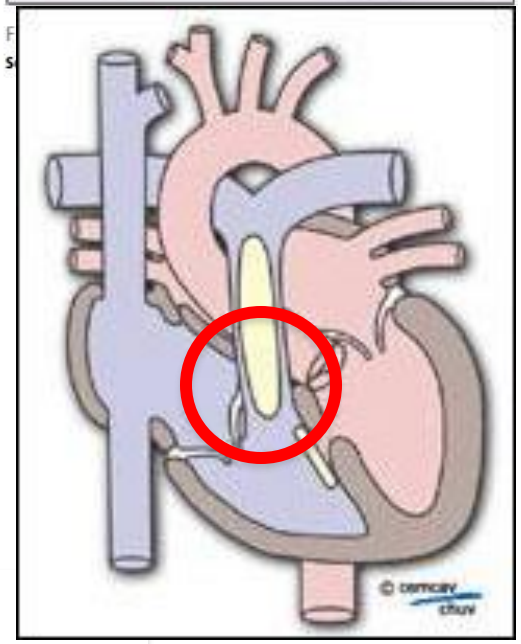
VD sous pulmonaire

Tétralogie de Fallot

- Cardiopathie cyanogène fréquente
- Hypoplasie de la voie pulmonaire (anneau, AP)
- Sténose infundibulum
- Correction complète à 6-12 mois
  - Patch CIV
  - Elargissement de la voie pulmonaire : anneau, valve, infundibulum

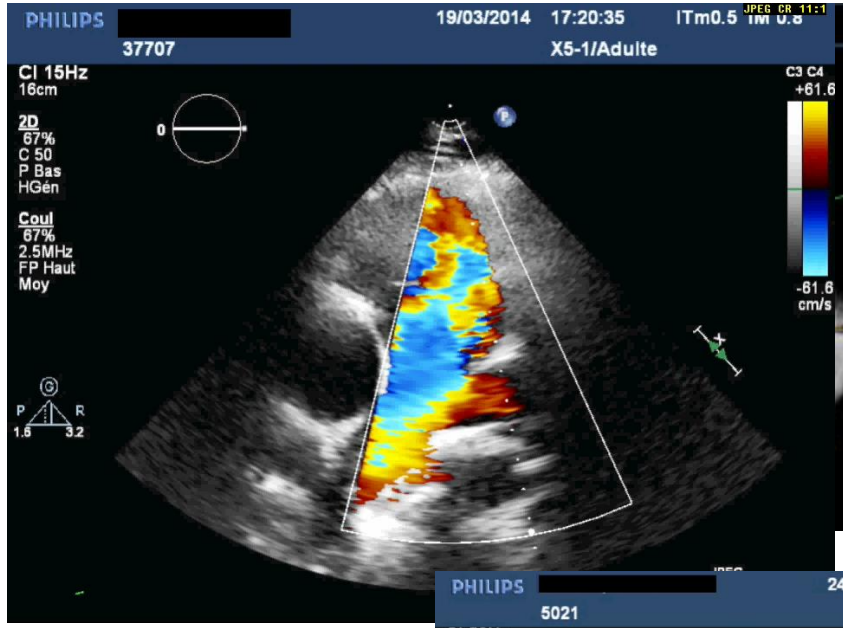
→ **FUITE PULMONAIRE**
DILATATION VD

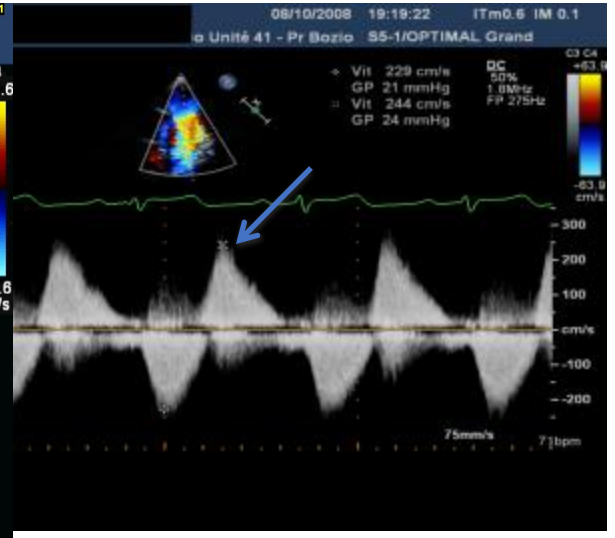


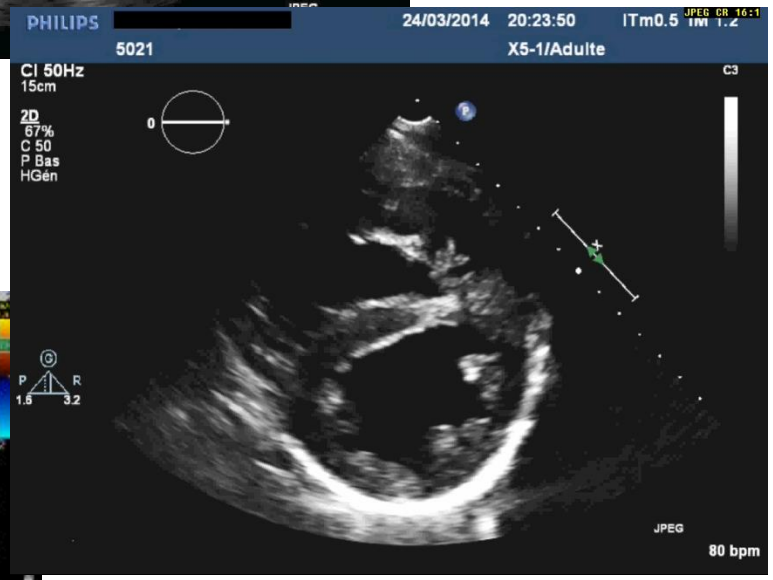


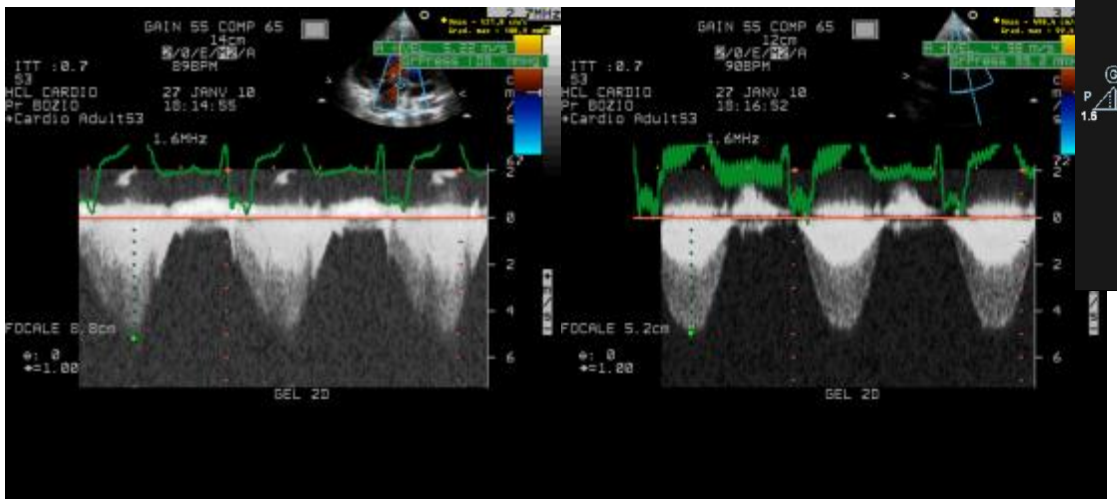
Tétralogie de Fallot adulte

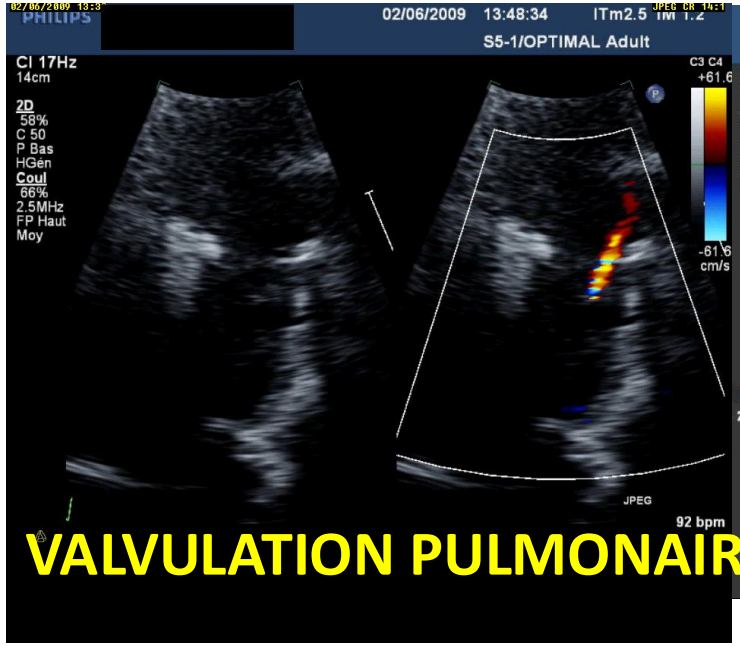
- IP massive ++
- Dilatation VD ++
- Dysfonction VD ++
- Arythmies, TV ++
- Risque de MS (effort) ++
- Parfois sténose AP et HVD

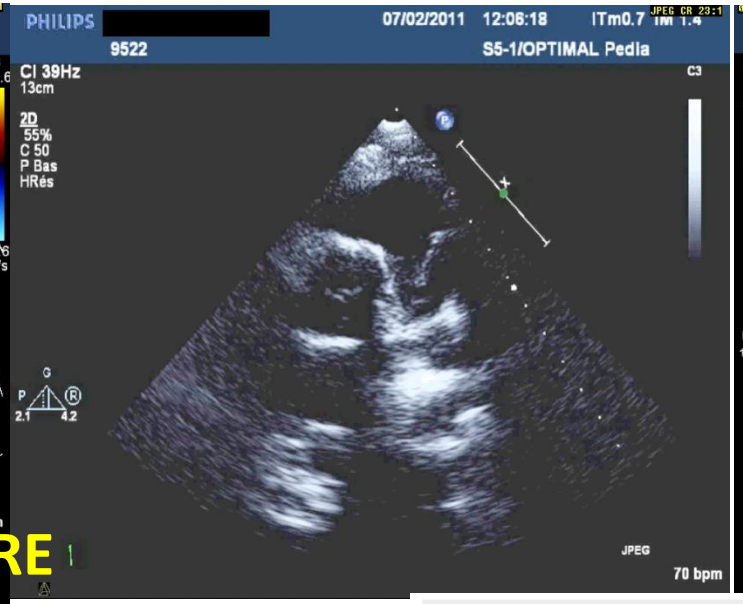


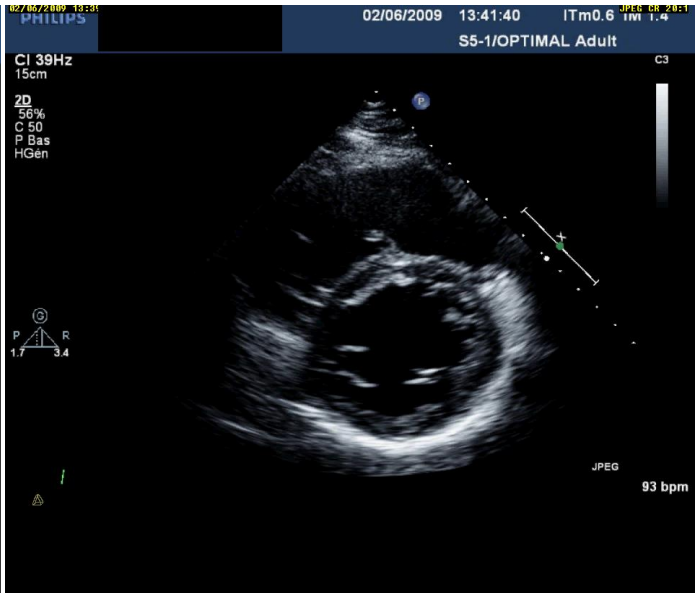












PERCUTANEE
Vs CHIRURGICALE

Timing ?
Evaluation fonction VD

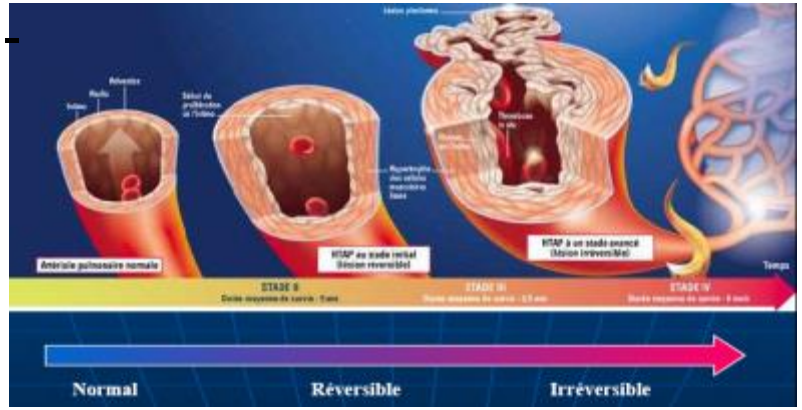
- IRM ++ (FEVD, VTDVD/m2)
- DTI, 3D

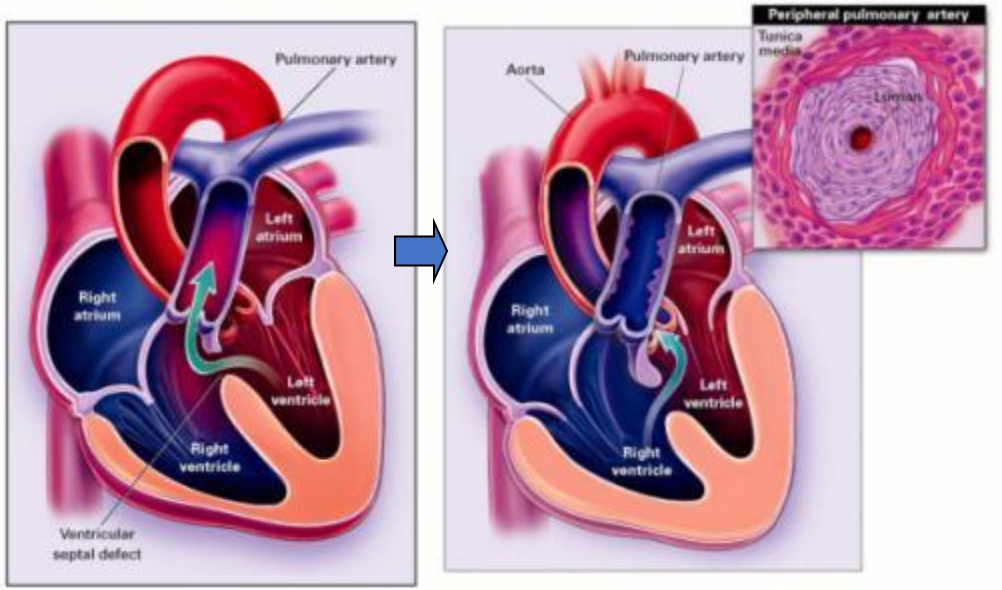
PVRep is recommended in symptomatic patients with severe PR[c] and/or at least moderate RVOTO.[d]	I	C
In patients with no native outflow tract,[e] catheter intervention (TPVI) should be preferred if anatomically feasible.	I	C
PVRep should be considered in asymptomatic patients with severe PR and/or RVOTO when one of the following criteria is present. • Decrease in objective exercise capacity. • Progressive RV dilation to RVESVi ≥80 mL/m^2, and/or RVEDVi ≥160 mL/m^2 [f], and/or progression of TR to at least moderate. • Progressive RV systolic dysfunction. • RVOTO with RVSP >80 mmHg.	IIa	C

Shunts ⇨ Eisenmenger

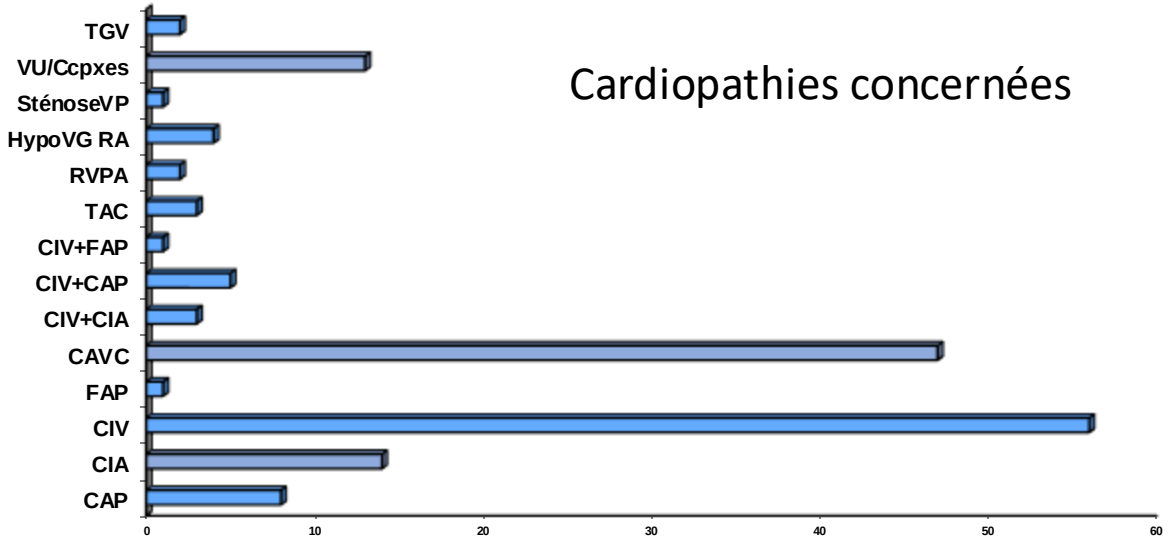
NEJM 2000; 342: 334-342

Hyperdébit: ↗ Flux + Pressions

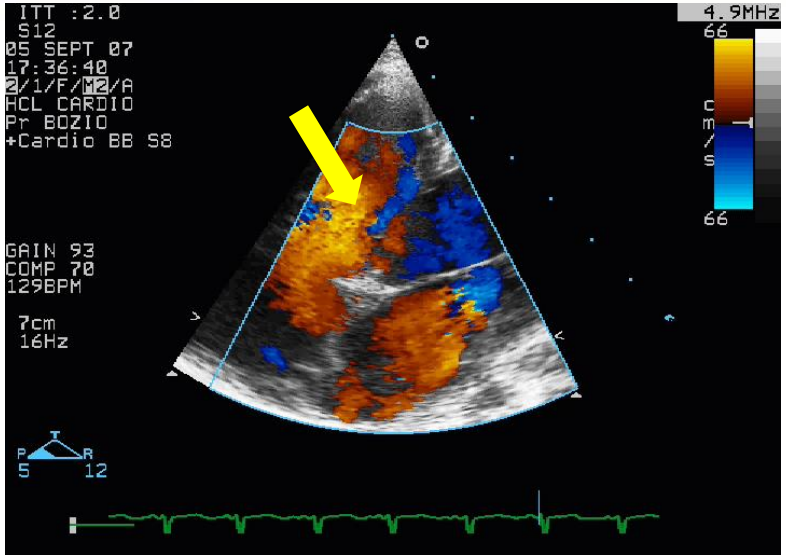




Résistances ↗ (irréversible) Évolutivité variable ++



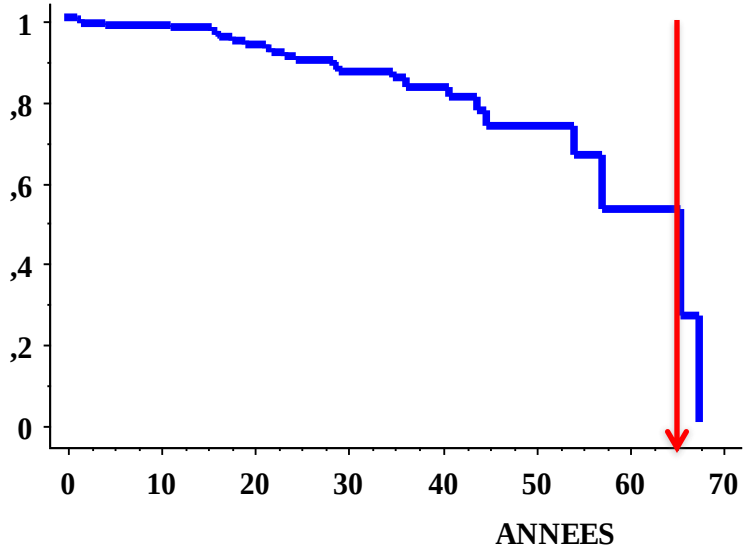
Cardiopathies concernées



Symptomatologie Complications

Circulation. 2007;115:1039-1050

- **HYPOXIE CHRONIQUE**
  - Cyanose, Hippocratisme digital, Polyglobulie
- **HYPERVISCOSITE SANGUINE**
- **DYSPNEE :** Intolérance à l'effort
- **SYNCOPES**
- **HEMOSTASE** : Thrombopénie
- **HEMORRAGIES** : Hémoptysies, cérébrales
- **THROMBOSES** : EP, AVC
- **INFECTIONS**: abcès cérébraux, EI
- **ARYTHMIES**
- **INSUFFISANCE CARDIAQUE : IVD**
- **AUTRES:** Insuffisance Rénale, Hyperuricémie, goutte, Dysfonction hépatique



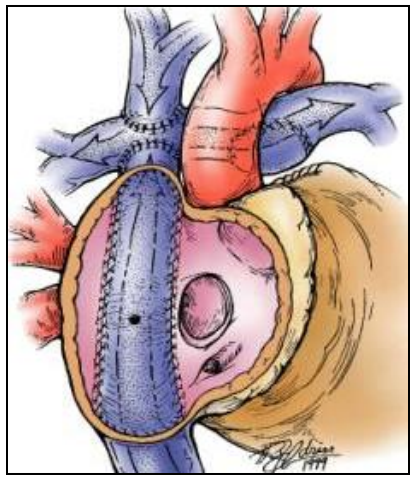
Suivi / 6 mois

- **Classe fonctionnelle**
  - Test de marche 6 minutes
  - VO^2 max
- **Biologique**
  - Hématocrite
  - Saturation cutanée (repos,effort)
  - BNP ??
- **EchoDoppler cardiaque**
  - Fonction VD
  - Mesure PAP
  - Débit cardiaque
  - Valves AV
  - Shunt
- **Hémodynamique**
  - Pressions, débits, résistances vasculaires
  - Risque ++

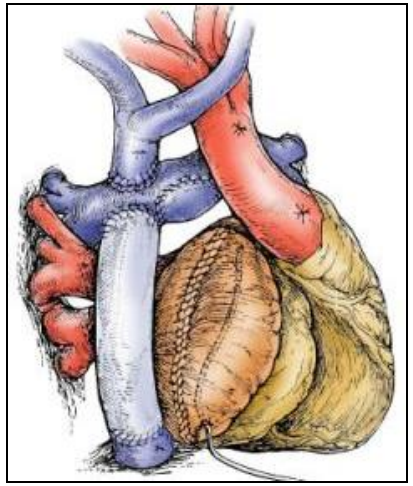
In low- and intermediate-risk patients with repaired simple lesions and pre-capillary PH, initial oral combination therapy or sequential combination therapy is recommended and high-risk patients should be treated with initial combination therapy including parenteral prostanoids.

I | A

Cœur univentriculaire : FONTAN

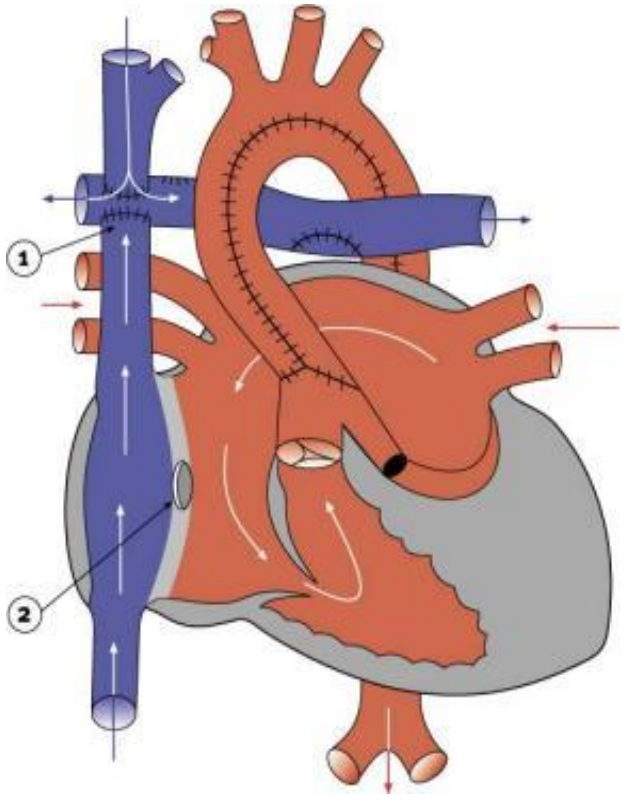


Anastomose
VCS- AP

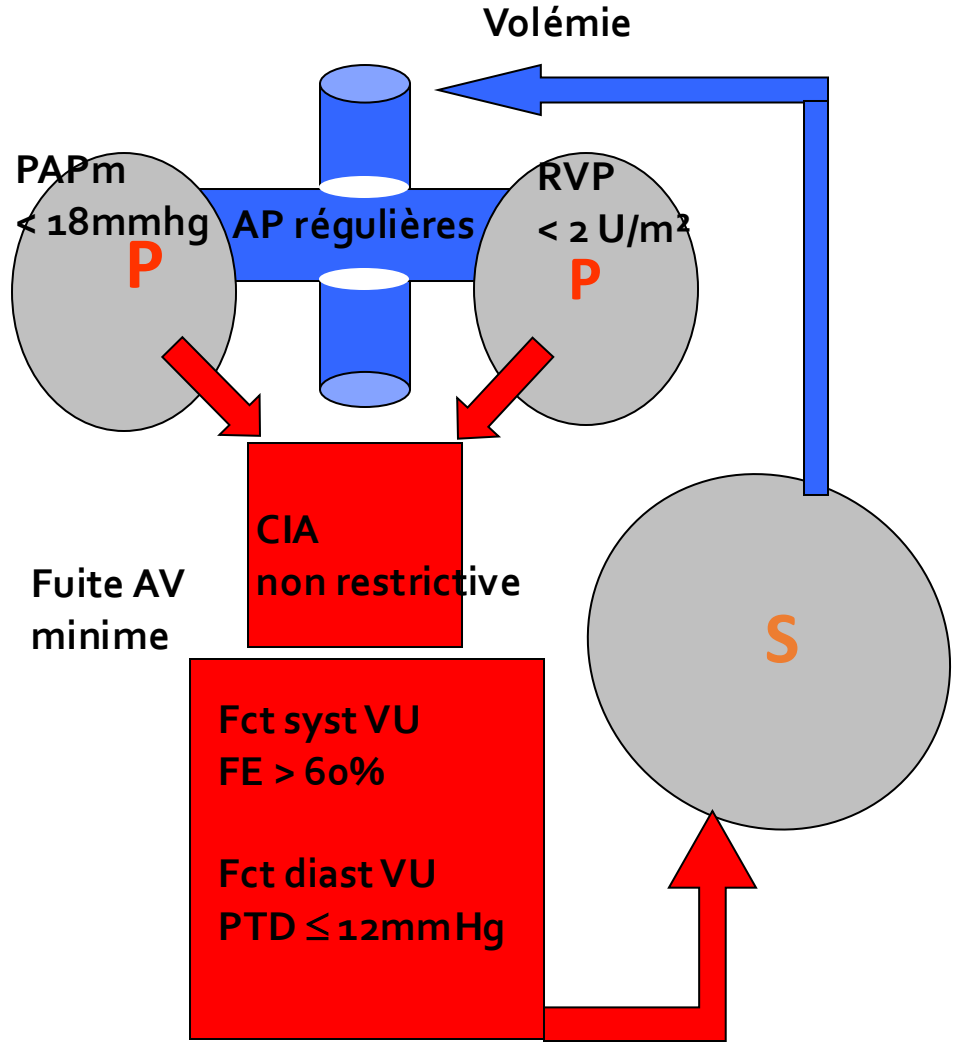


± Fenestration

Anastomose
VCI- AP

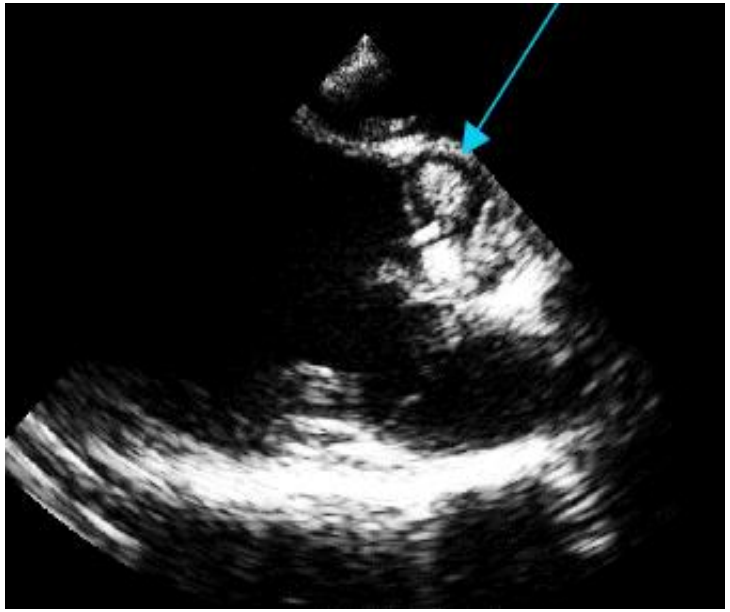


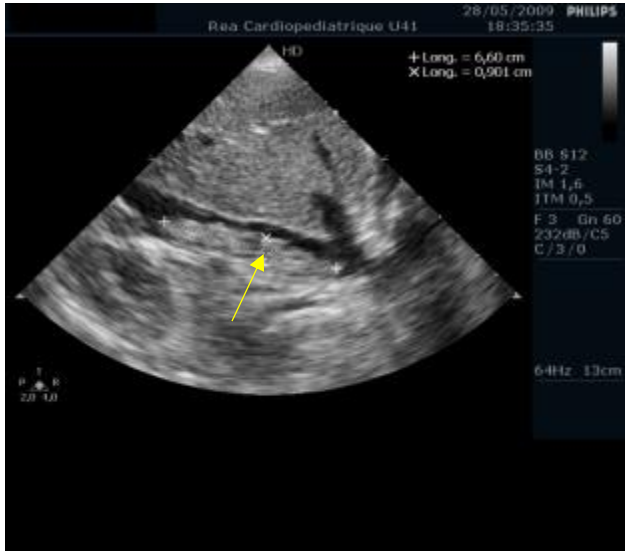
ENTRE 2 ET 3 ANS

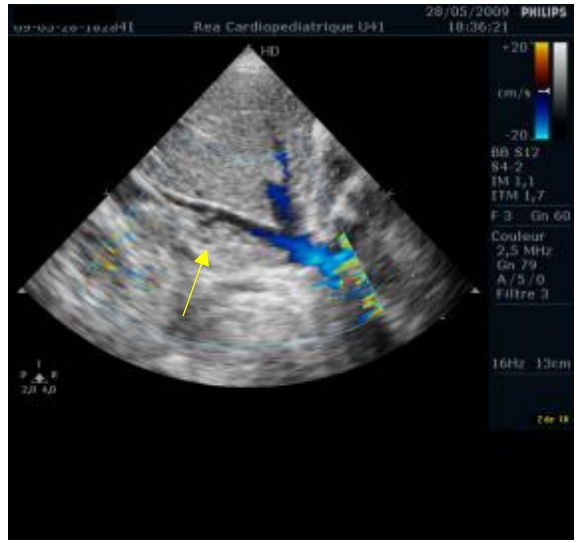


Complications

- Arythmies: SV type Flutter ou FA
  50% des cas à 20 ans
- Thrombo-embolies
- Cyanose: shunt résiduel, fistules
- Entéropathie exsudative: gravité ++
- Dysfonction myocardique
- Fuite valve auriculovetriculaire
- Obstacle voie aortique
- Dysfonction hépatique
- Epanchements récidivants
- Sténoses du circuit

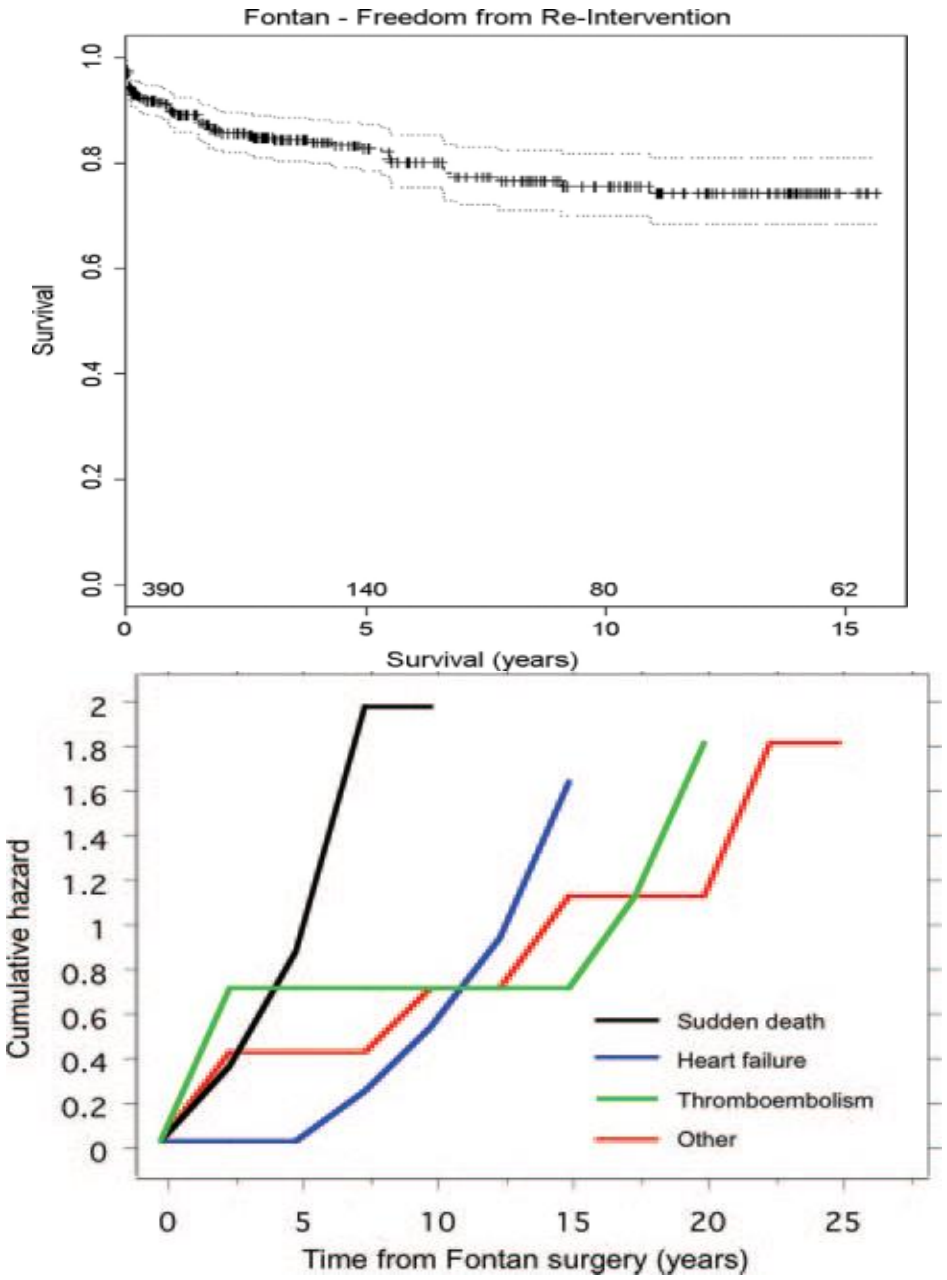






Suivi / 6 mois

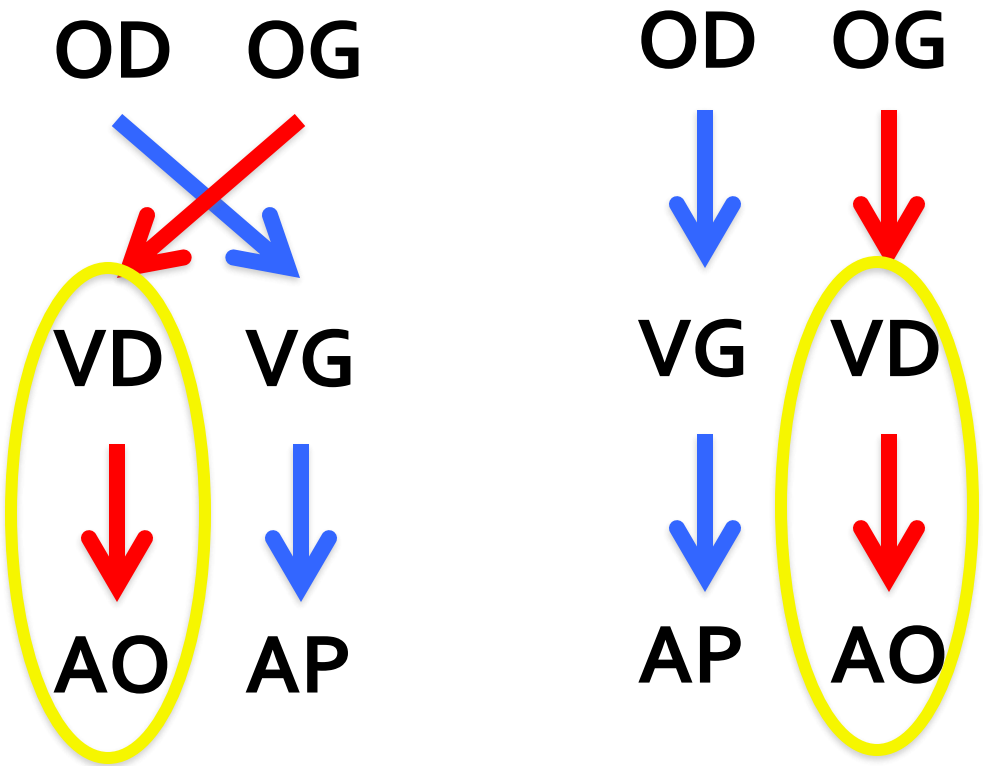
- **Echocardiographie :**
  - Fonction ventriculaire
  - Fuite sur la valve AV
  - Sténoses sur le montage
  - Thrombus intra-cavitaire
- **ECG** : étude du rythme
- **Holter ECG**
- **Test d'effort** (VO2 max)
- **Biologie**
- **IRM**
  - Anatomie précise du montage
  - Taille de l'OD
- **Cathétérisme**
  - Hémodynamique
  - Angiographie
- **Prévention de l'EI**



Le VD systémique

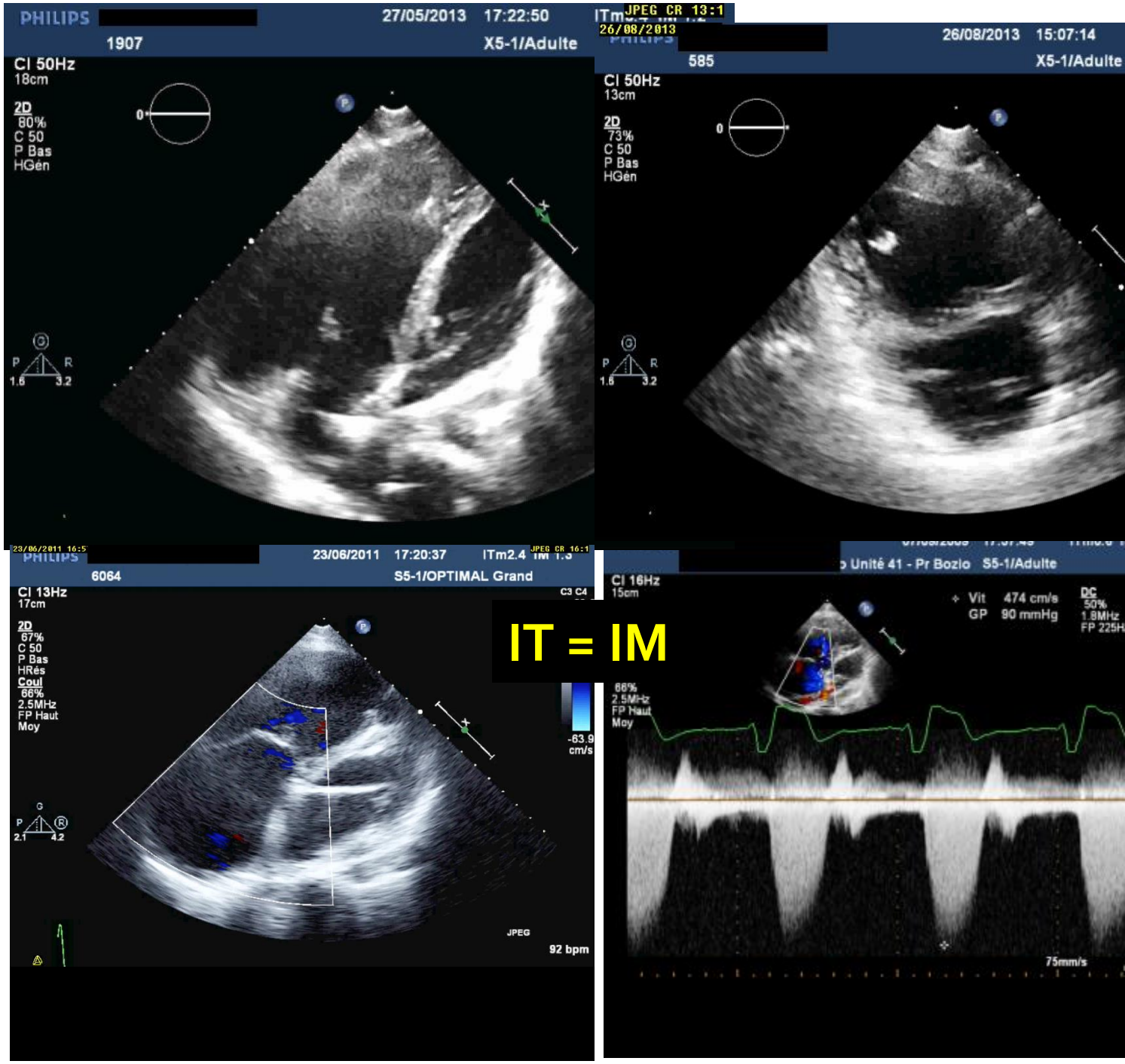
Transposition des gros vaisseaux

Mustard / Senning (atrial switch) < 1987



Double discordance

Cardiopathie native



Le VD sous aortique

Post Mustard / Senning

- Arythmies auriculaires
- Défaillance VD
- IT = IM
- Sténose chenaux caves

Double discordance

- BAV complet
- Défaillance VD
- IT = IM

Challenges

-Evaluation de la fonction VD

-Quantification de l'IT

-Evaluation du pronostic à long terme

-Efficacité des traitements de l'IC : IEC, BB ?

Congenitally corrected transposition of the great arteries		
In *symptomatic* patients with severe TR and preserved or mildly impaired systemic RV systolic function (EF >40%), TV replacement is indicated.	I	C

Transposition of the great arteries after atrial switch operation		
In *symptomatic* patients with pulmonary venous atrium obstruction, surgical repair (catheter intervention rarely possible) is recommended.	I	C
In *symptomatic* patients with baffle stenosis not amenable to catheter intervention, surgical repair is recommended.	I	C
In *symptomatic* patients with baffle leaks not amenable to catheter-based closure, surgical repair is recommended.	I	C
PA banding in adults, as LV training with subsequent arterial switch procedure, is not recommended.	III	C
In *symptomatic* patients with baffle stenosis, stenting is recommended when technically feasible.	I	C
In *symptomatic* patients with baffle leaks and cyanosis at rest or during exercise, or with strong suspicion of paradoxical emboli, stenting (covered) or device closure is recommended when technically feasible.	I	C
In patients with baffle leaks and symptoms due to L–R shunt, stenting (covered) or device closure is recommended when technically feasible.	I	C

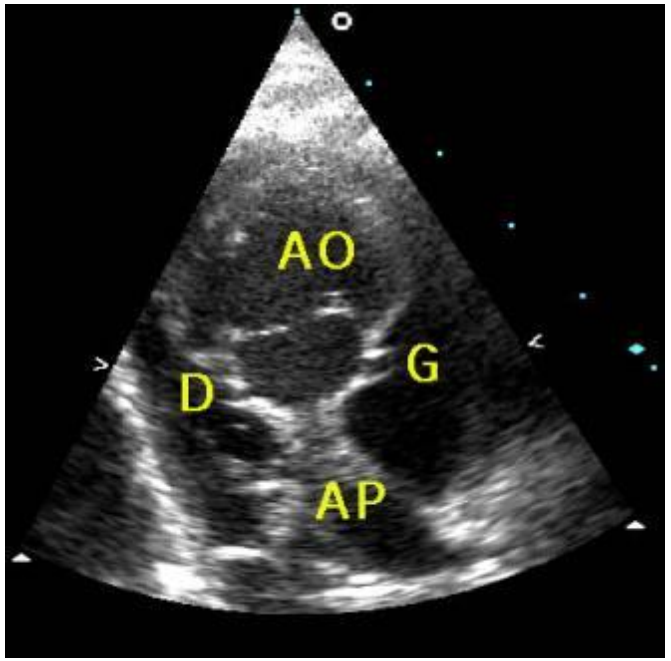
Congénital Adulte = Patient coronarien

Post opératoire

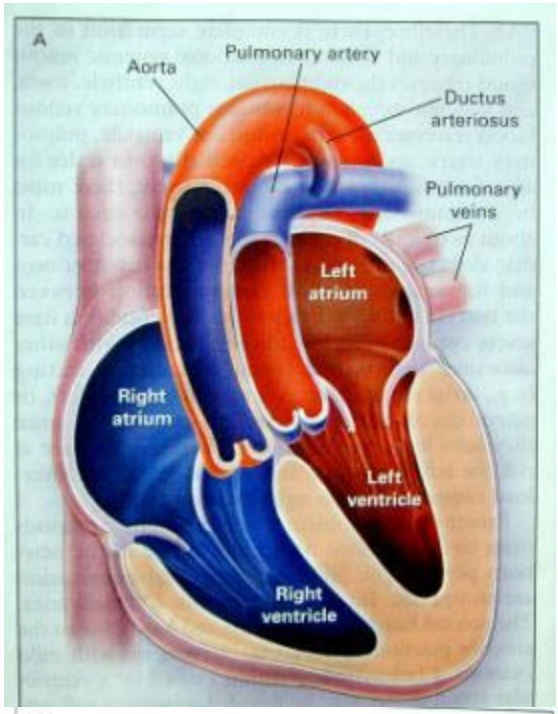
- Switch artériel pour TGV
- Intervention de Ross
- Réimplantation coronaire
- Norwood
- Transplantation cardiaque

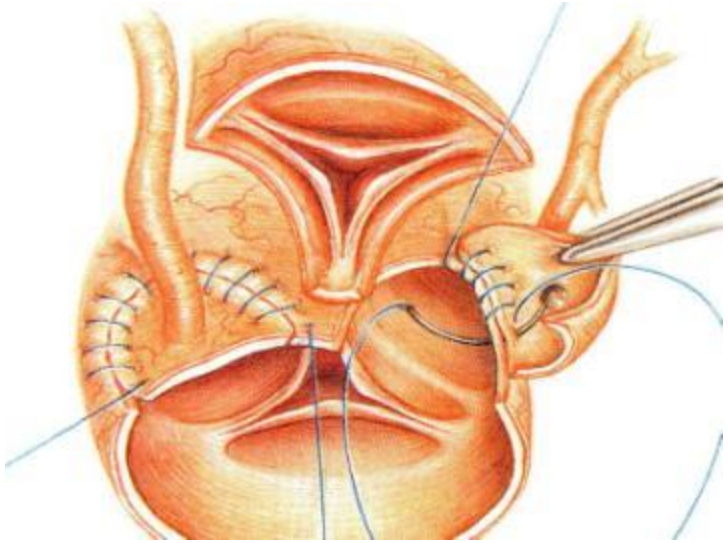
Anomalie coronaire native

- Anomalie de trajet associé aux cardiopathies
- Anomalies de trajet isolées (sinus aortique opposé)
- Anomalies de connexion (coronaire née de l'AP)



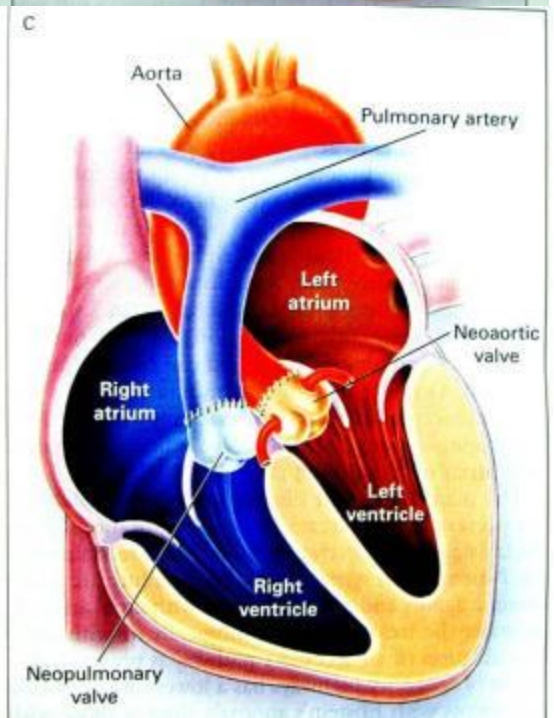
TGV

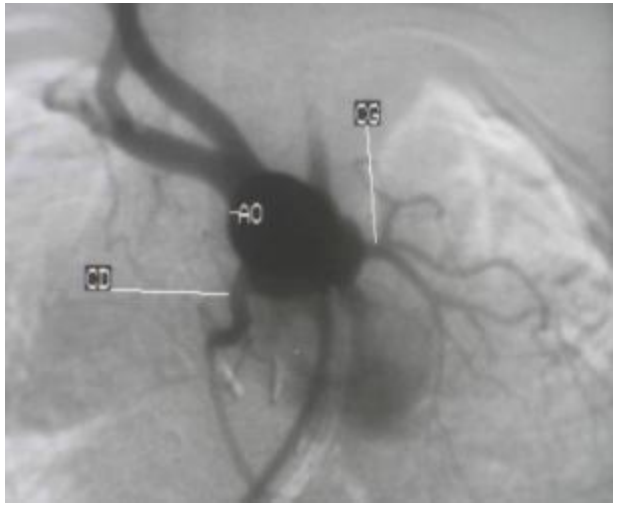


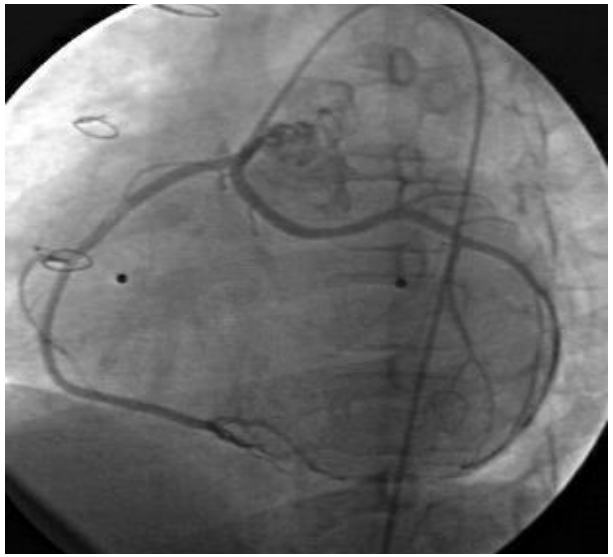


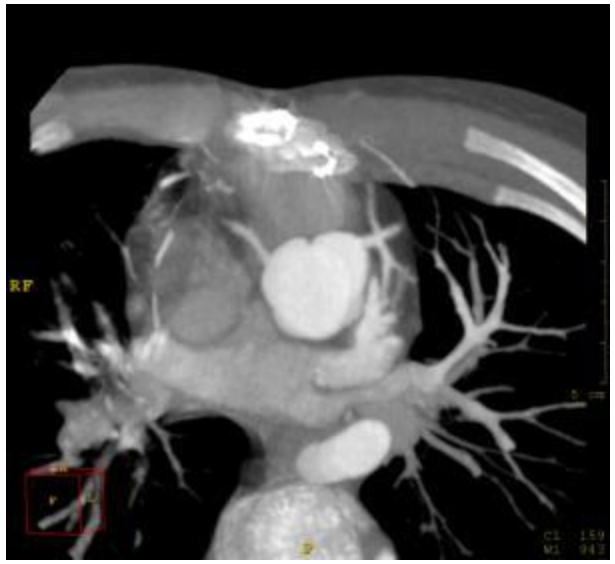
SWITCH

ARTERIEL




AO
PD

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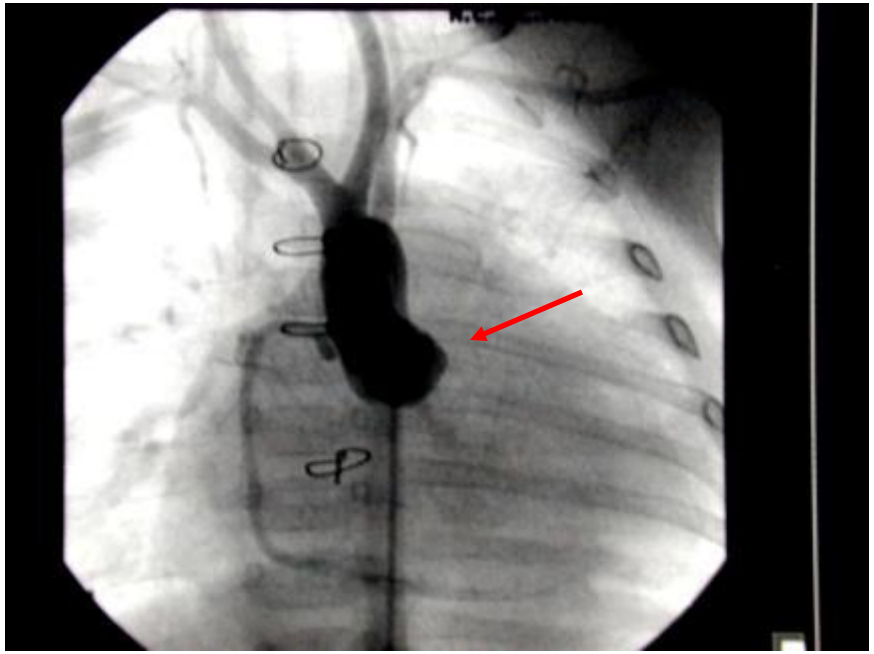
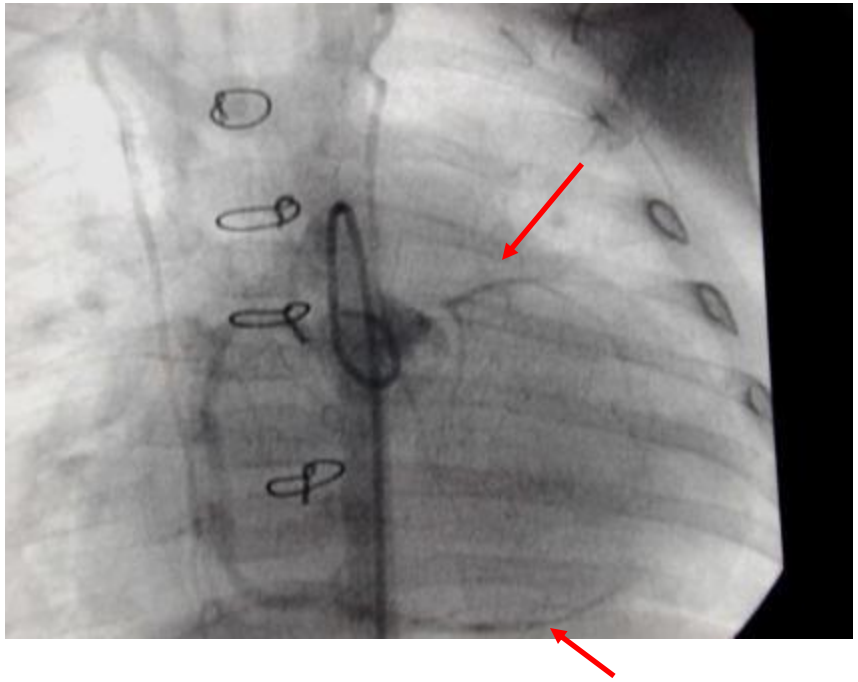
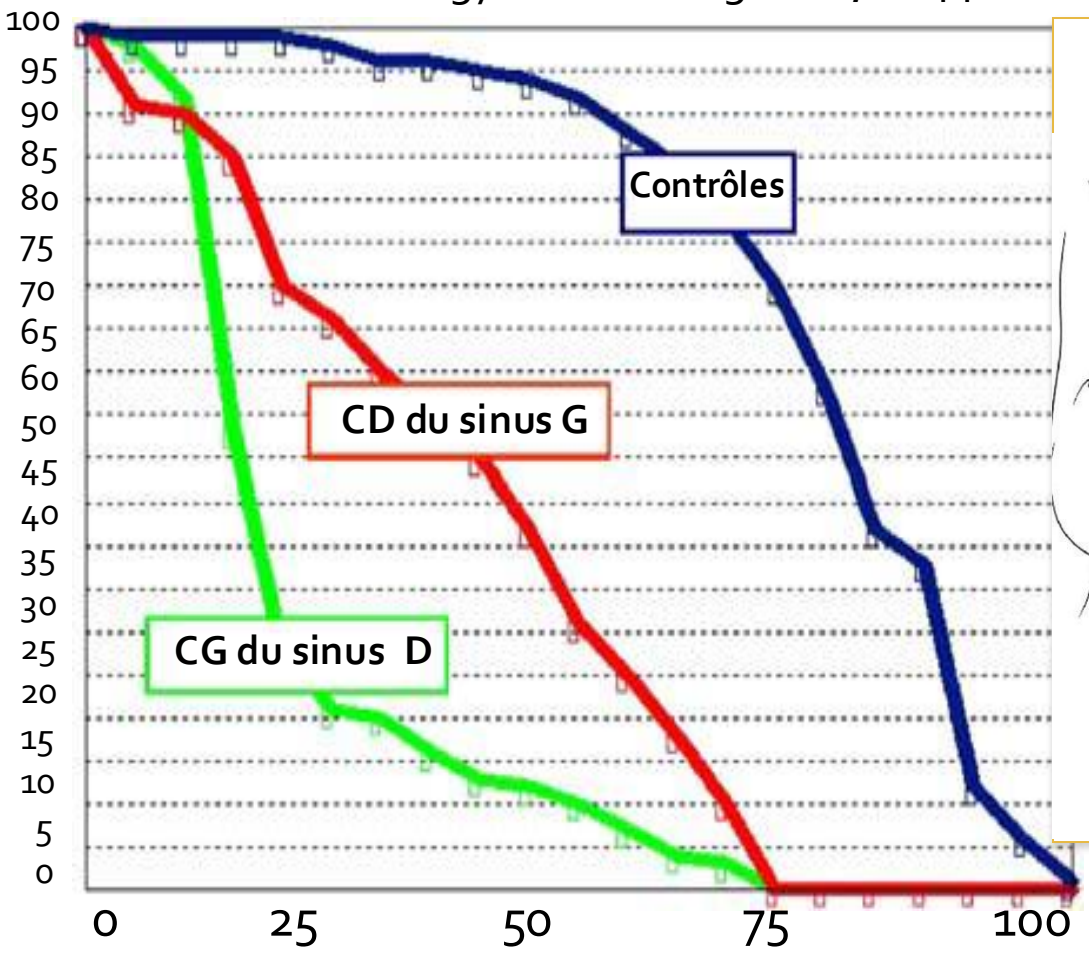


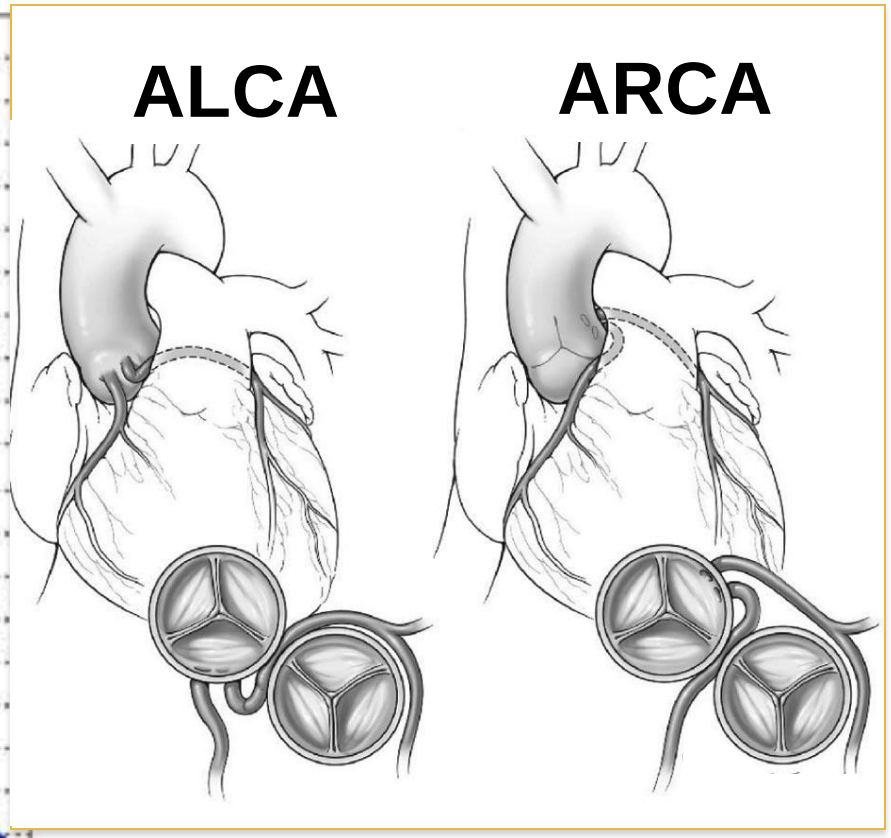


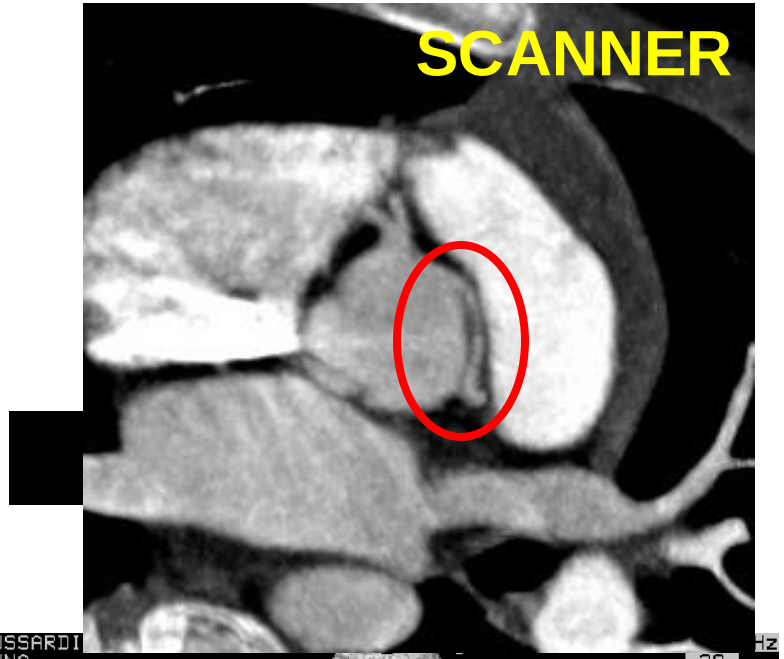
Anomalies de trajet coronaires

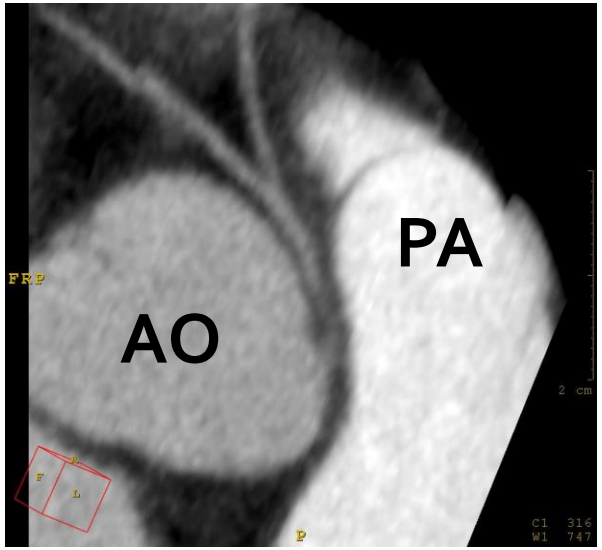
Risque : Mort subite effort / Symptômes : douleurs, malaises

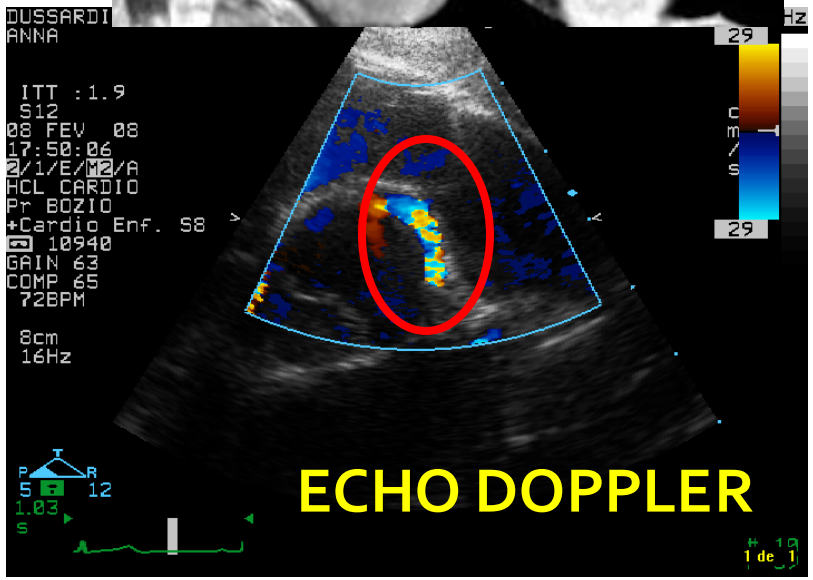
Karl TR et al. Cardiology in the Young 2010;20:44

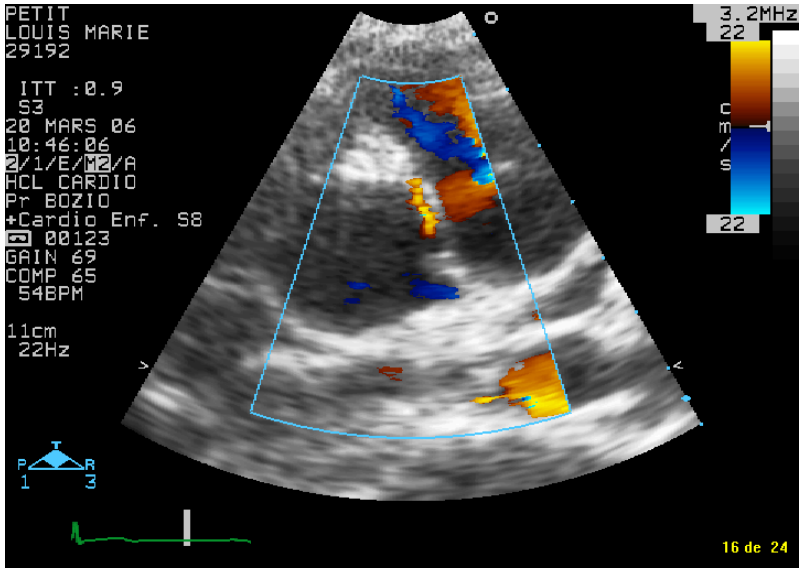












Réimplantation chirurgicale

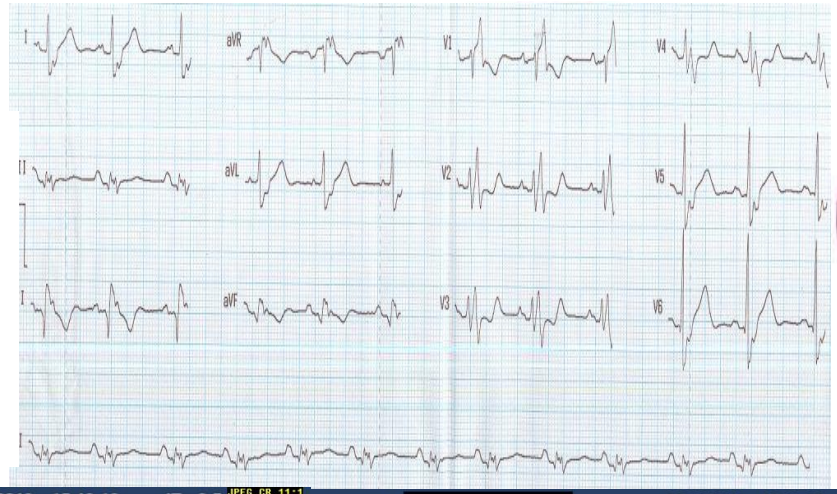
Ebstein

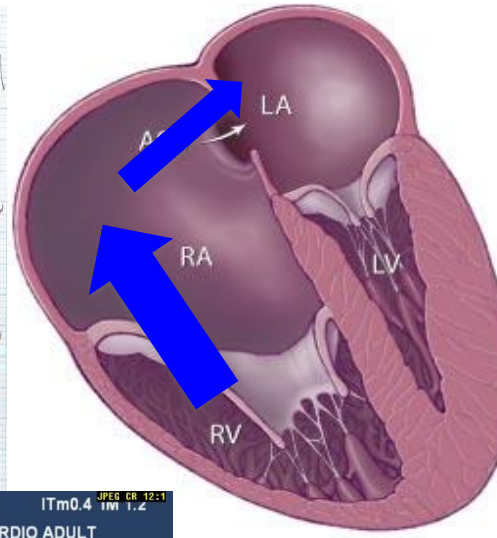
- BBDC, WPW= 26%
- Hypoxie
- ArythmieAVC
- IC, IVD

Amplatz CIA

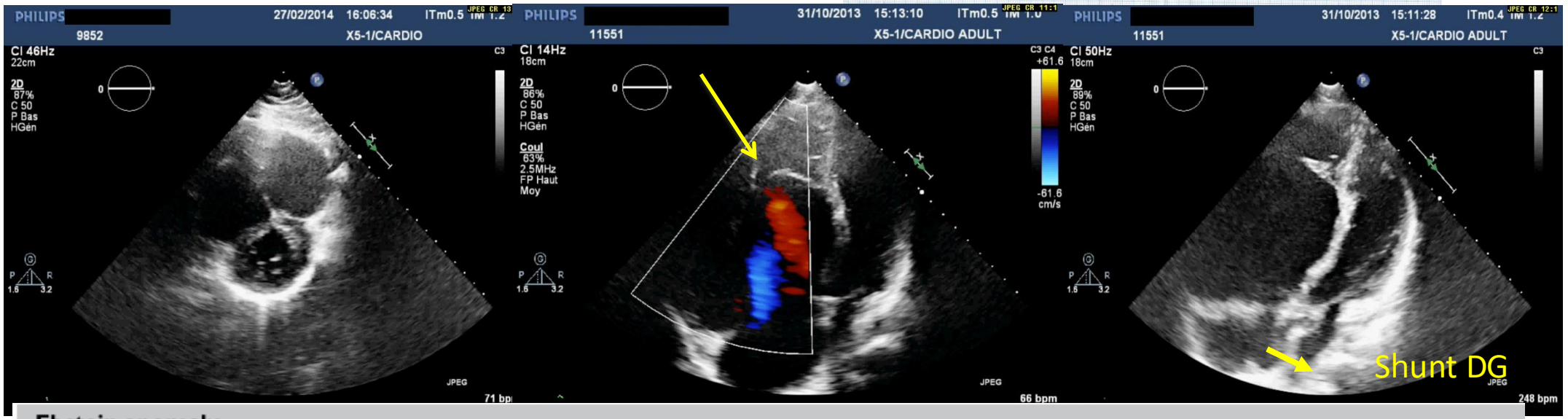
Ablation

Plastie Tricuspide



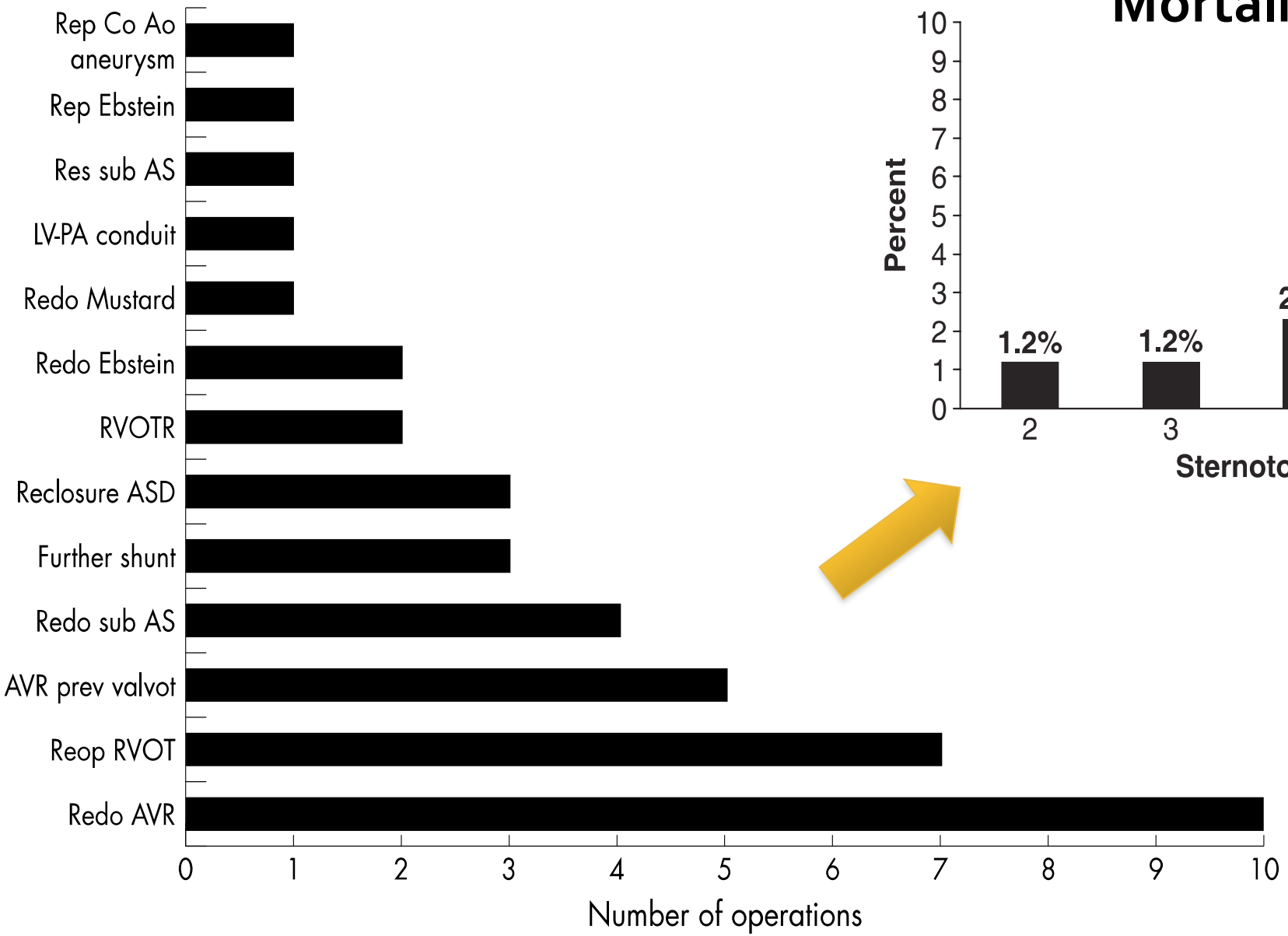


Ebstein's Anomaly



Ebstein anomaly		
Surgical repair is recommended in patients with severe TR and symptoms or objective deterioration of exercise capacity.	I	C
It is recommended that surgical repair is performed by a congenital surgeon with specific experience in Ebstein surgery.	I	C
If there is an indication for TV surgery, ASD/PFO closure is recommended at the time of valve repair if it is expected to be haemodynamically tolerated.	I	C
In patients with symptomatic arrhythmias or pre-excitation on the ECG, electrophysiologic testing followed by ablation therapy, if feasible, or surgical treatment of the arrhythmias in the case of planned heart surgery is recommended.	I	C

Chirurgie Redux



Thérapeutiques interventionnelles

- **Cathétérisme**
  - Alternative à la chirurgie
  - Complément de la chirurgie
  - Evite une CEC
- **Connaître et comprendre**
  - **La cardiopathie**
  - **Les antécédents**
  - **Les montages chirurgicaux**
  - **La situation vasculaire**

→

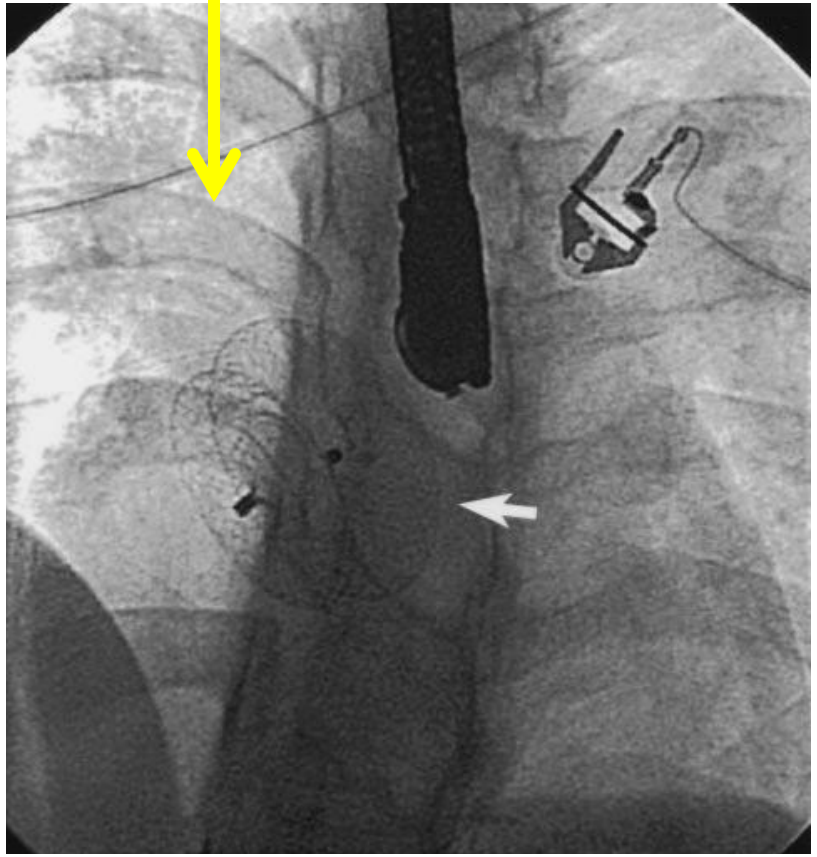
- Fermeture de shunts: CIA, CIV, CAP
- Dilatation valvulaire: RP, RA
- Prothèse valvulaire: pulmonaire
- Stent/ angioplastie: isthme Ao, AP
- Embolisation: fistule, collatérales
- Septostomie atriale

- **Rythmologie**

→

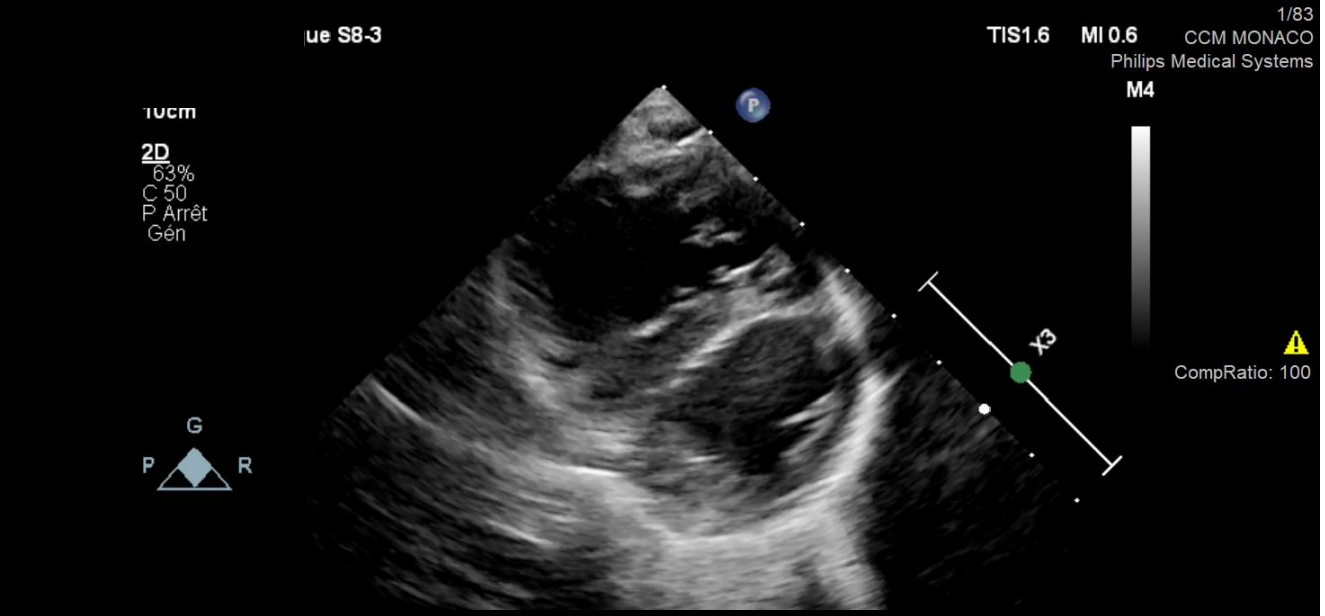
- Ablations
- Pacemakers (épicardiques…)
- Défibrillateurs, resynchronisation

Prothèse
CIA



CIA sinus venosus

Fermeture percutanée
« Optivenosus »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TIS1.6 MI 0.6
1/83
CCM MONACO
Philips Medical Systems
M4
10cm
2D
63%
C 50
P Arrêt
Gén
X3
CompRatio: 100
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P
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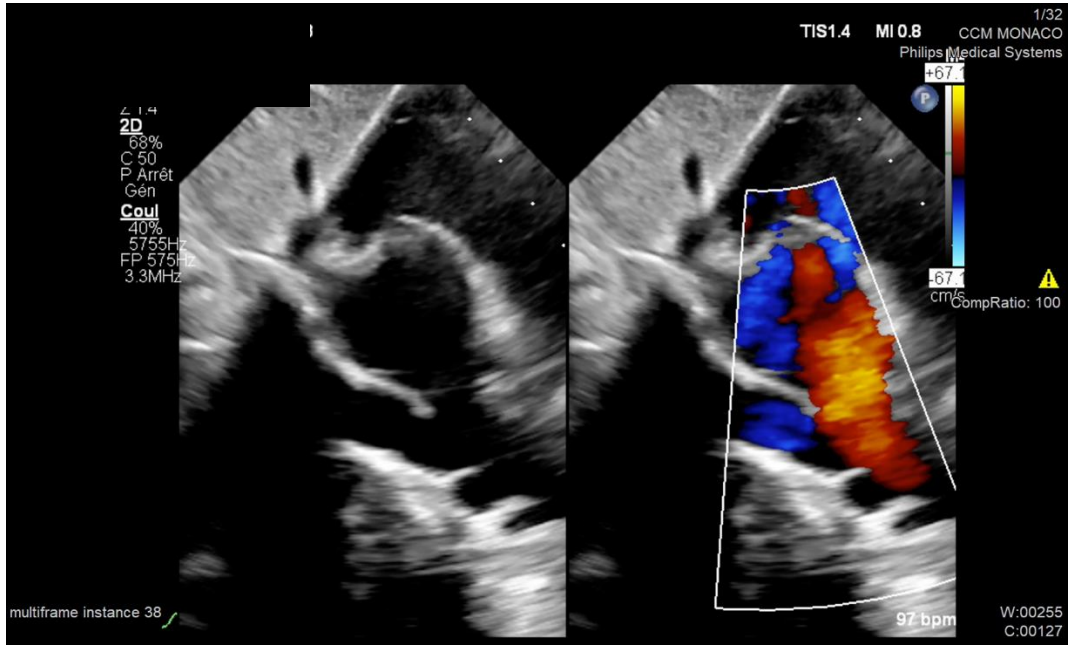
TIS1.4 MI 0.8
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CCM MONACO
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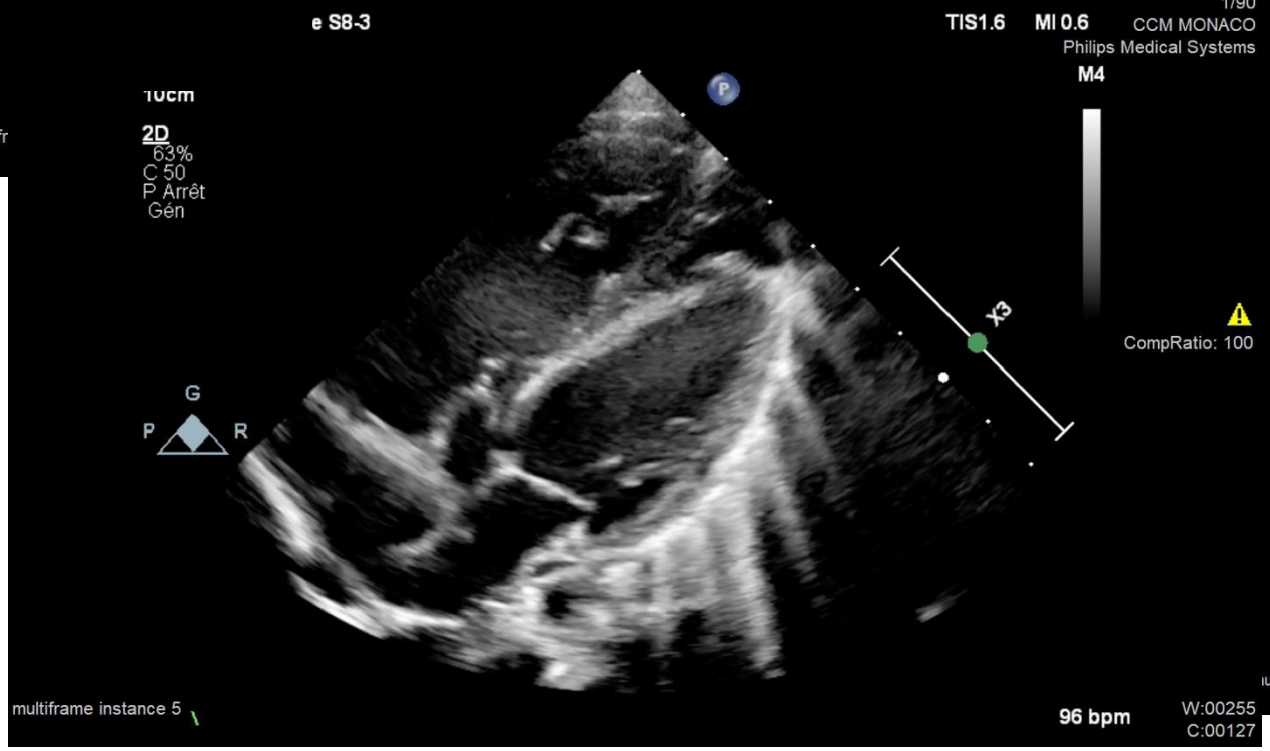
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CompRatio: 100
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96 bpm
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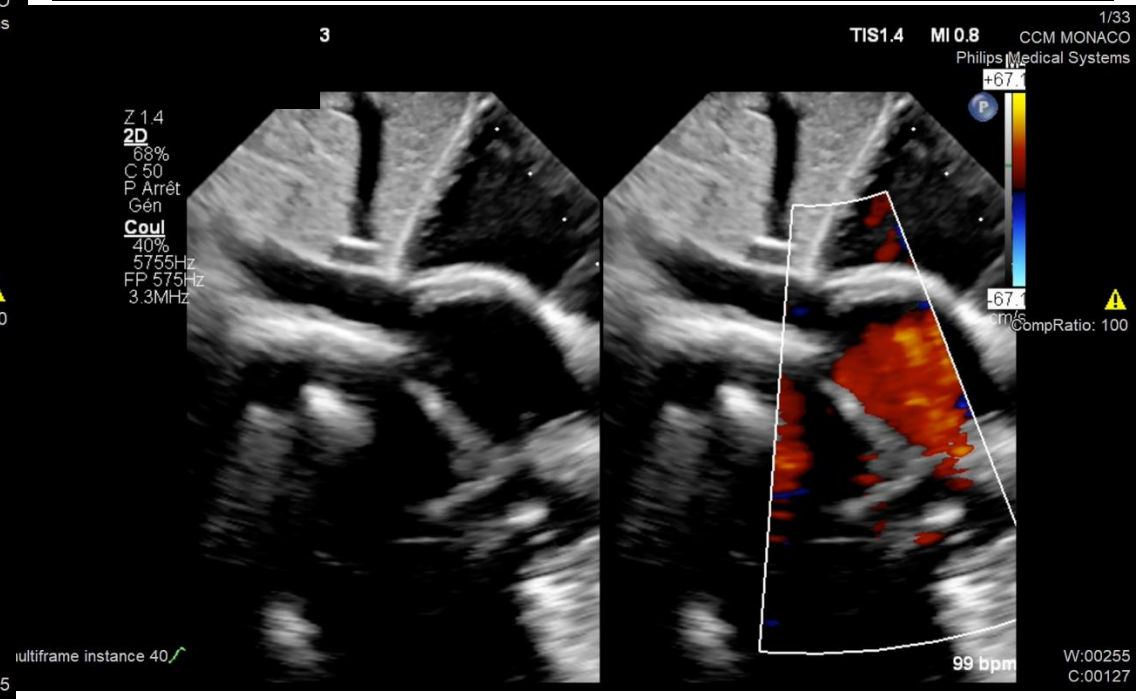
3
TIS1.4 MI 0.8
1/33
CCM MONACO
Philips Medical Systems
Z 1.4
2D
68%
C 50
P Arrêt
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5755Hz
FP 575Hz
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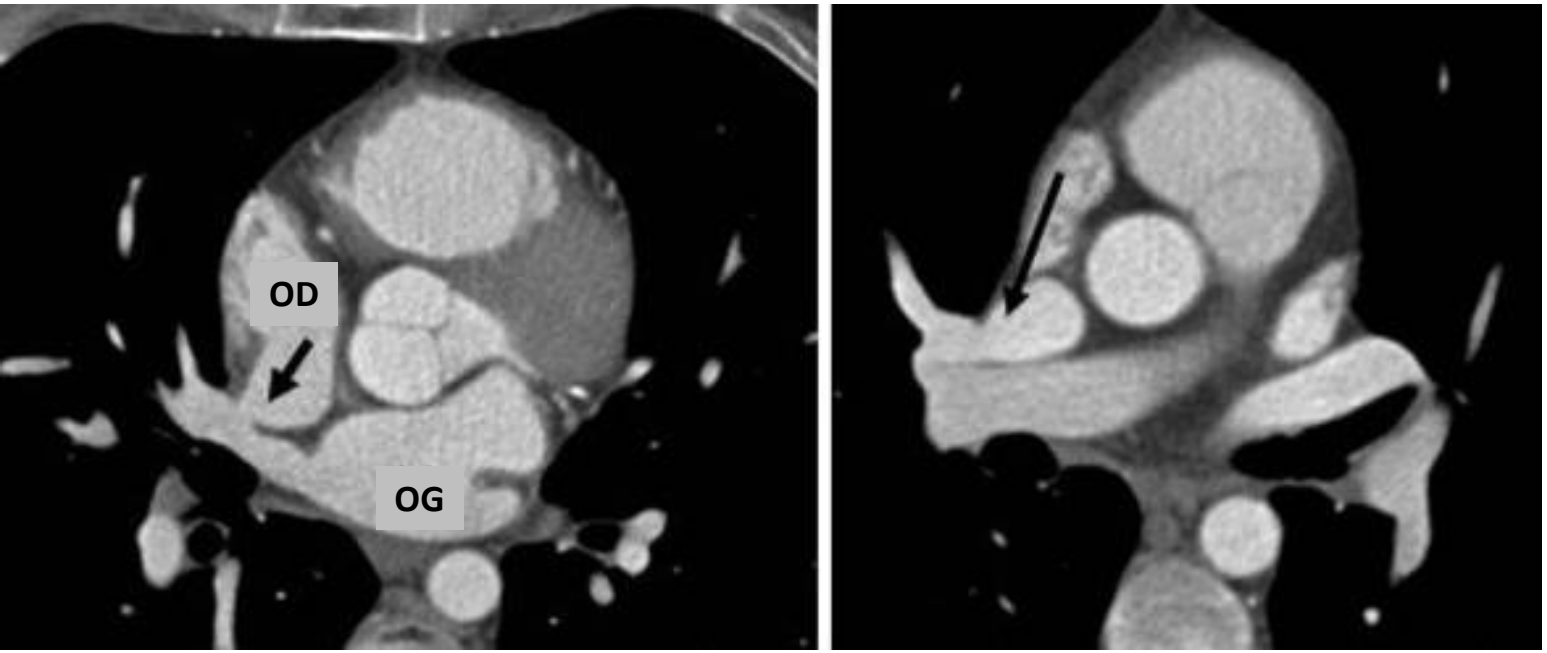
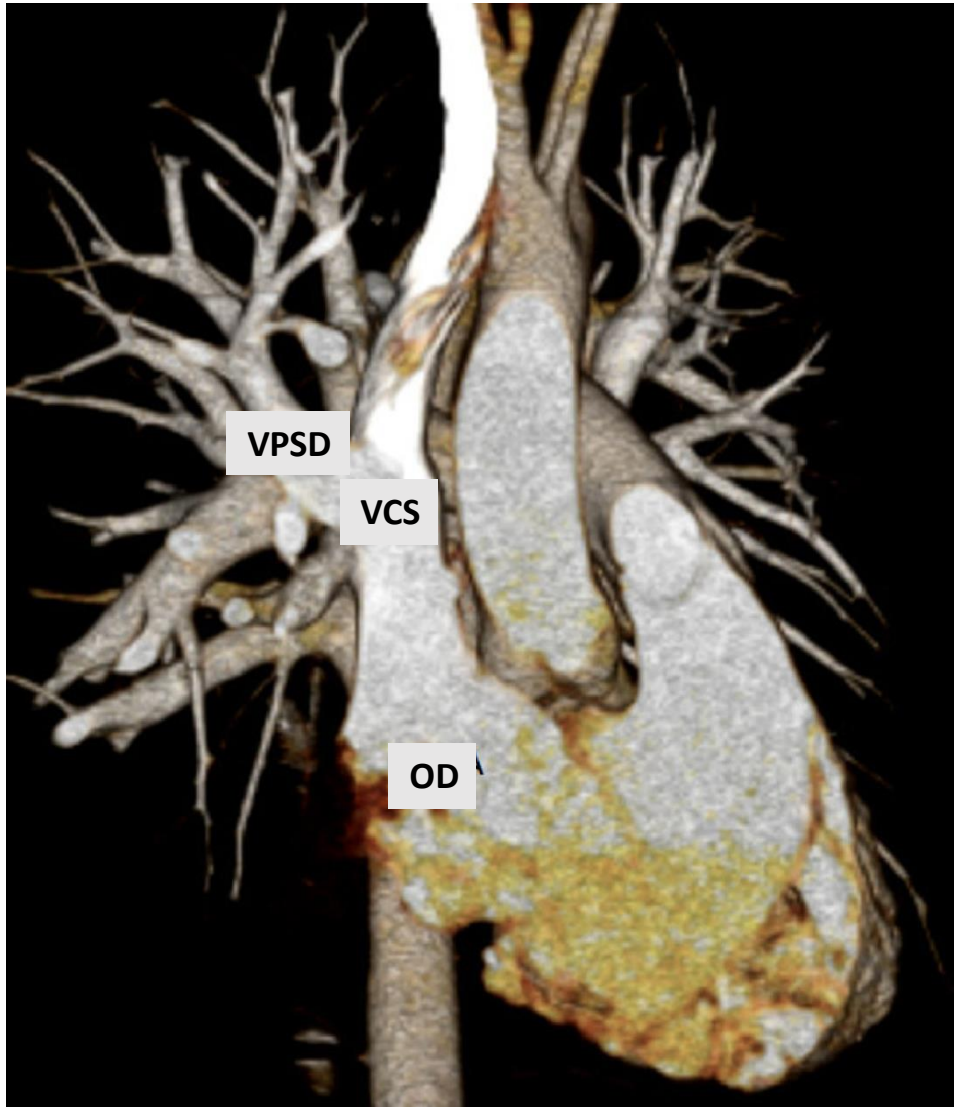
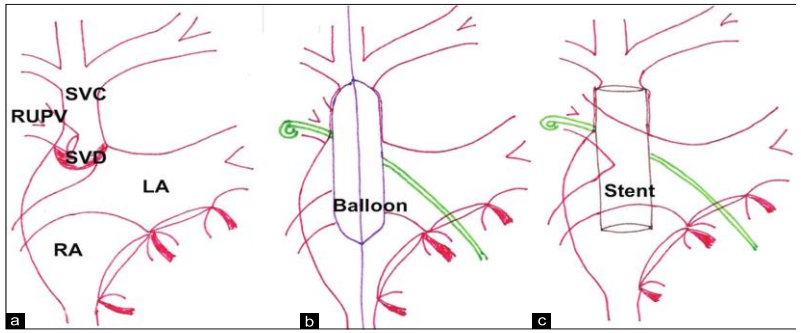
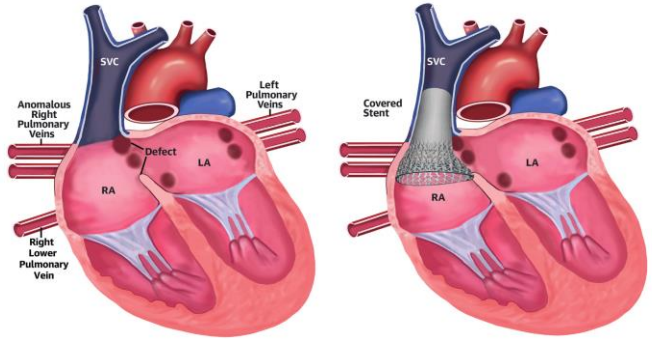
Scanner CIA sinus venosus

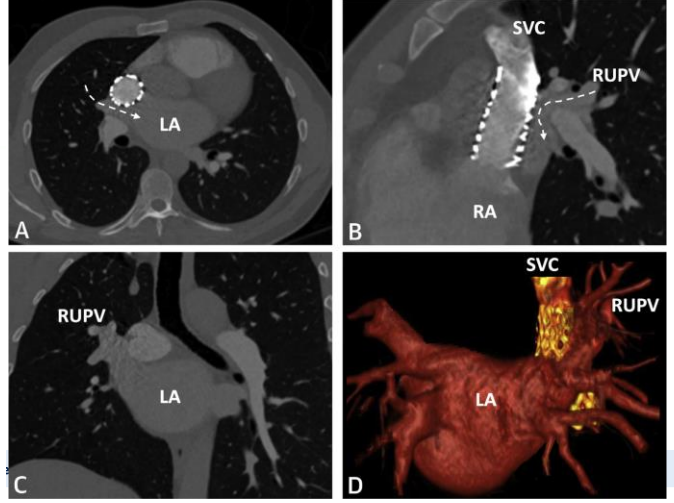


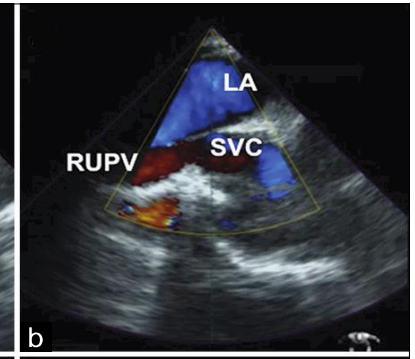


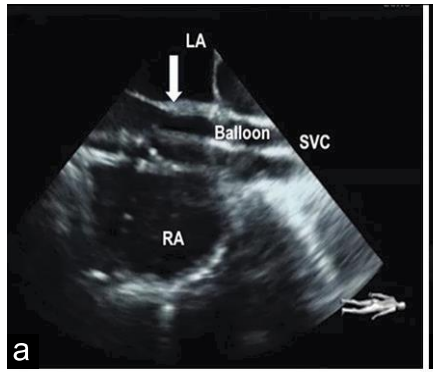
Novel technique for transcatheter closure of sinus venosus atrial septal defect. Y Hejazi et al.*Cath Card Interv 2022;100:1068*

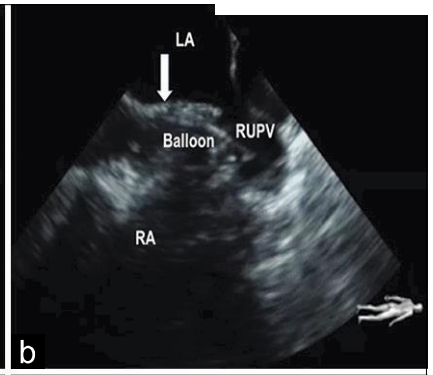


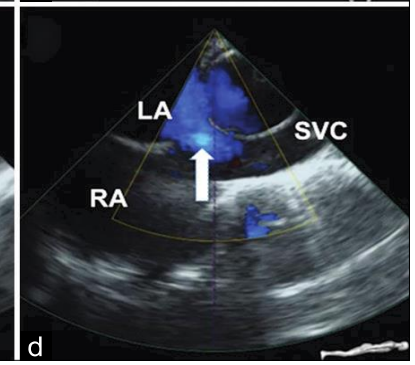


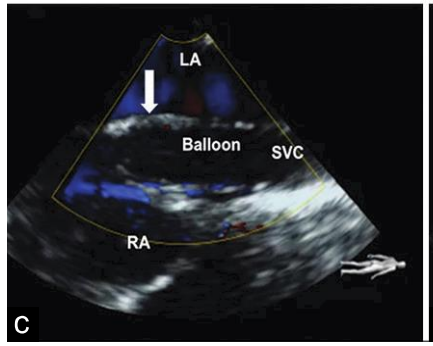


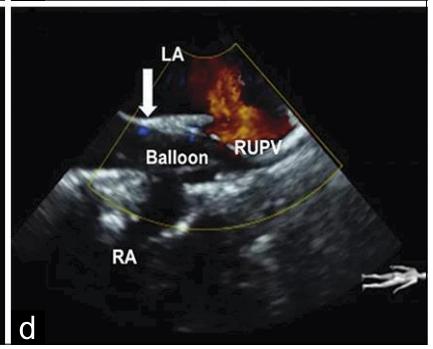


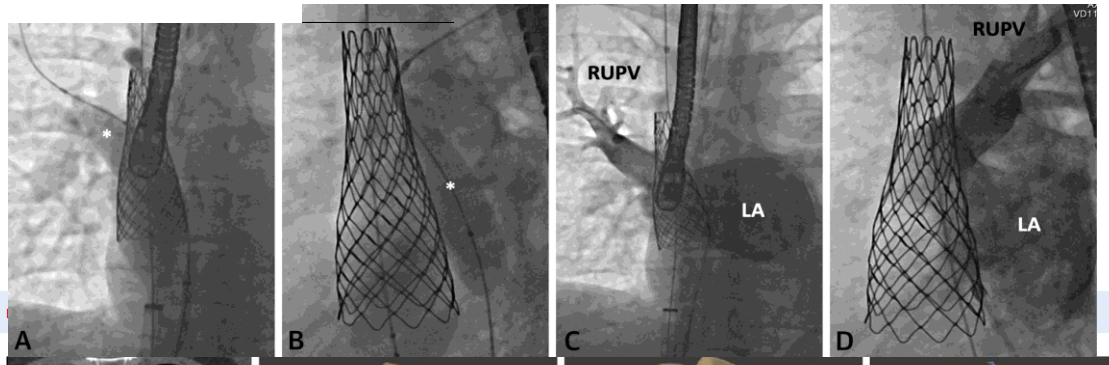


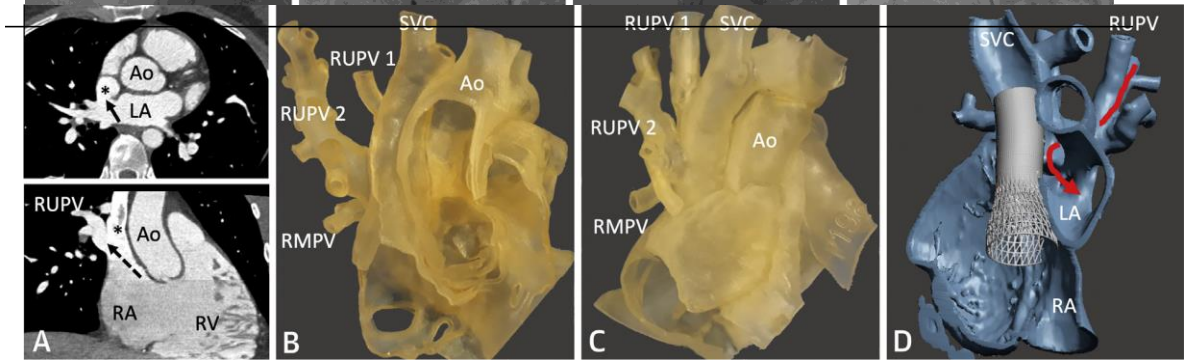


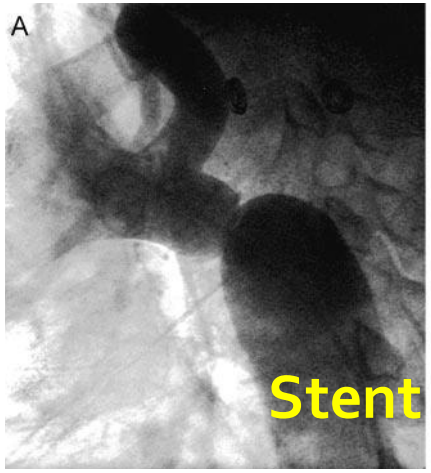


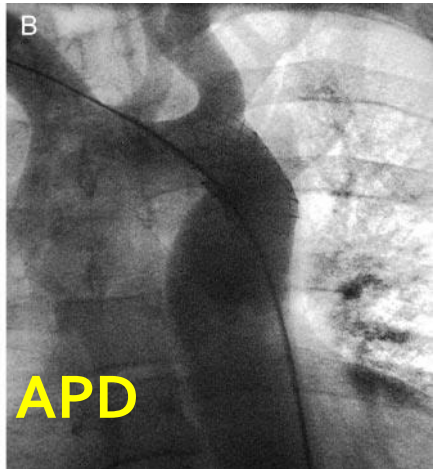












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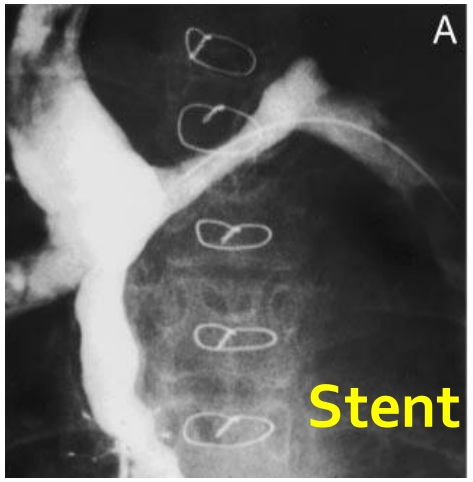
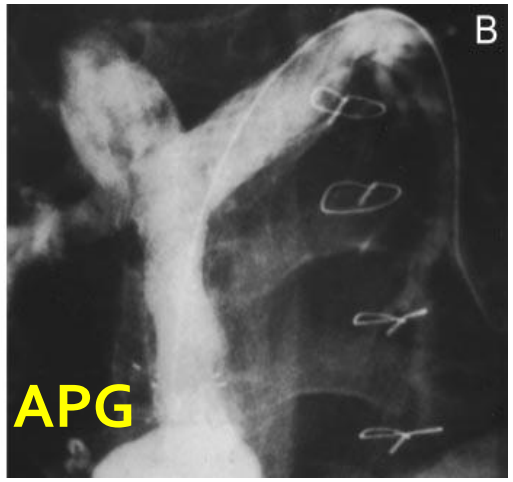
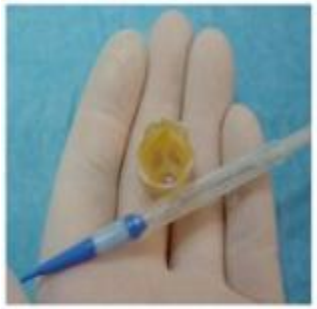
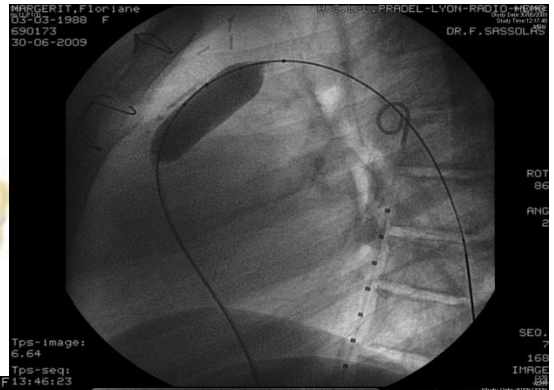


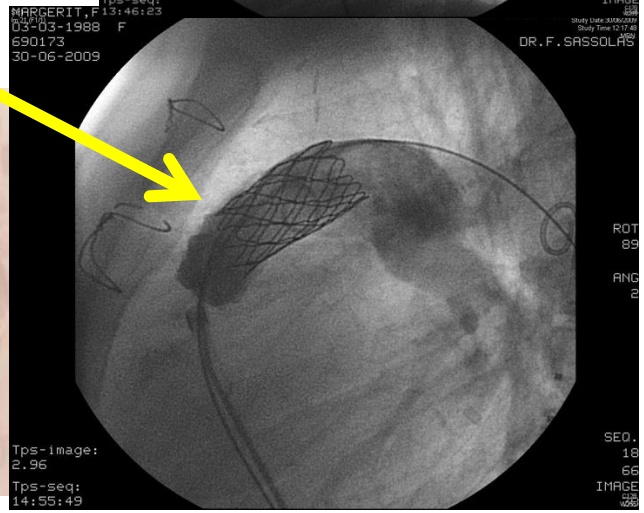


Stent APG



Valve Pulmonaire percutanée



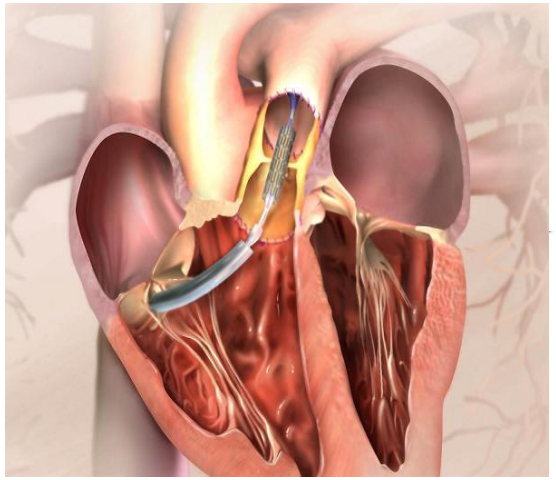


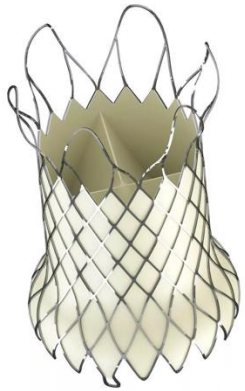
MELODY

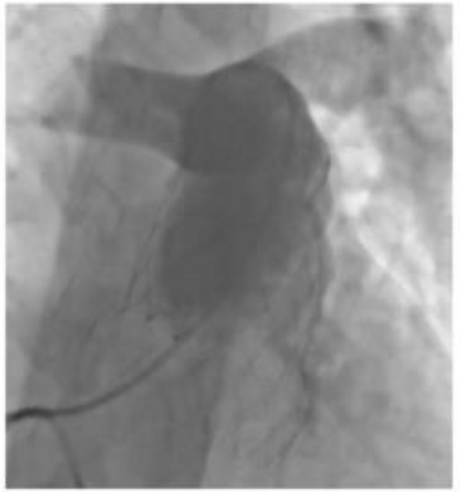
EDWARDS

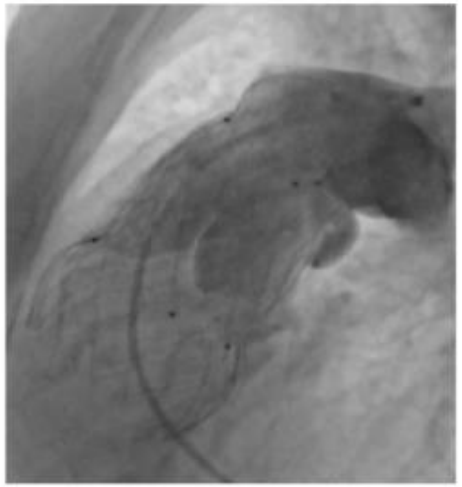
VENUS

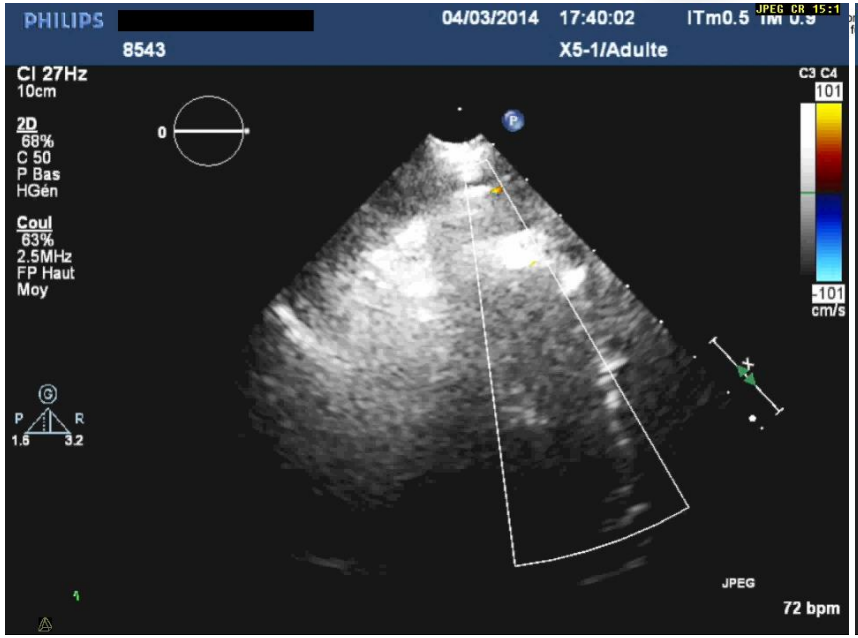
Prothèse valvulaire pulmonaire percutanée

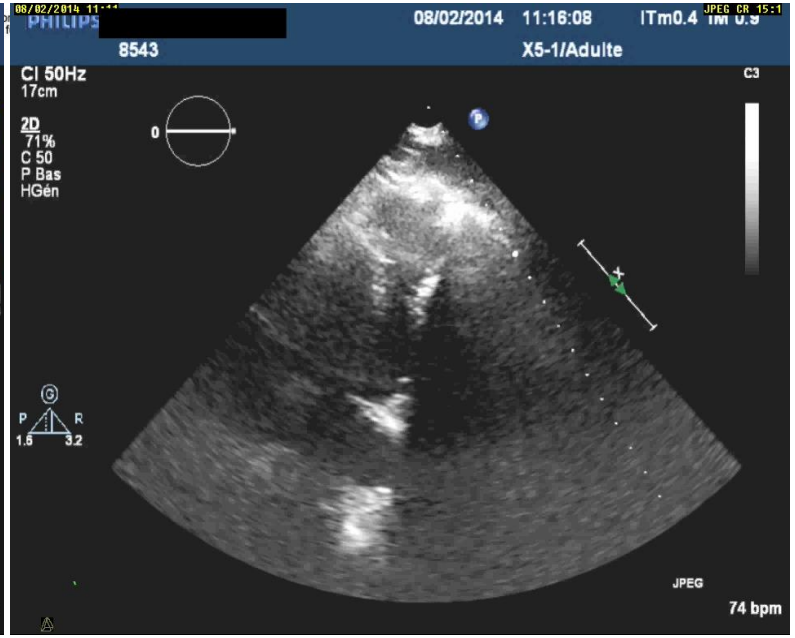


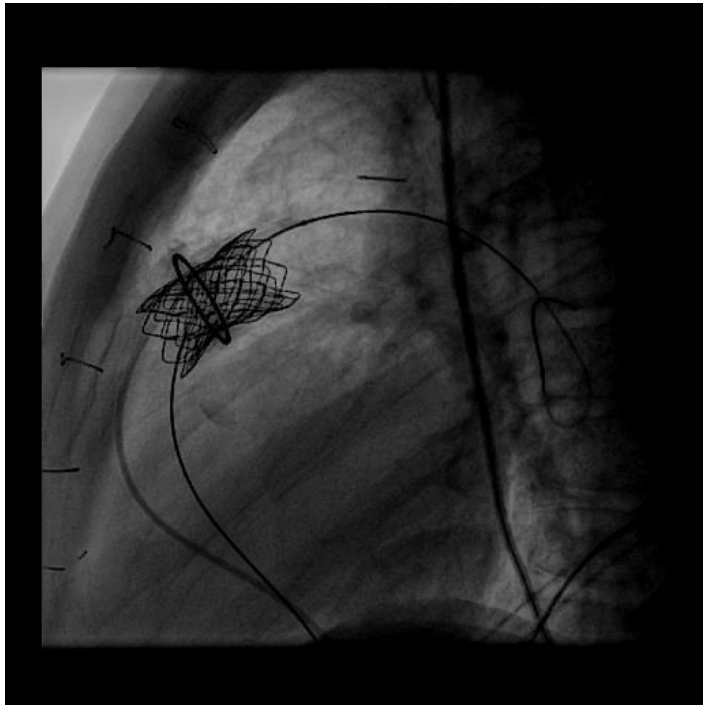




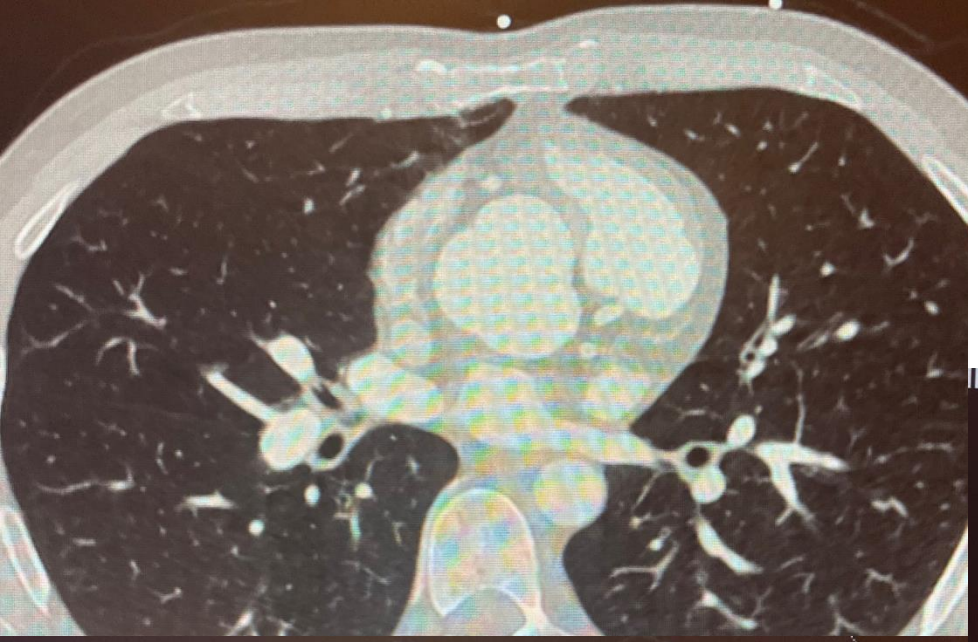


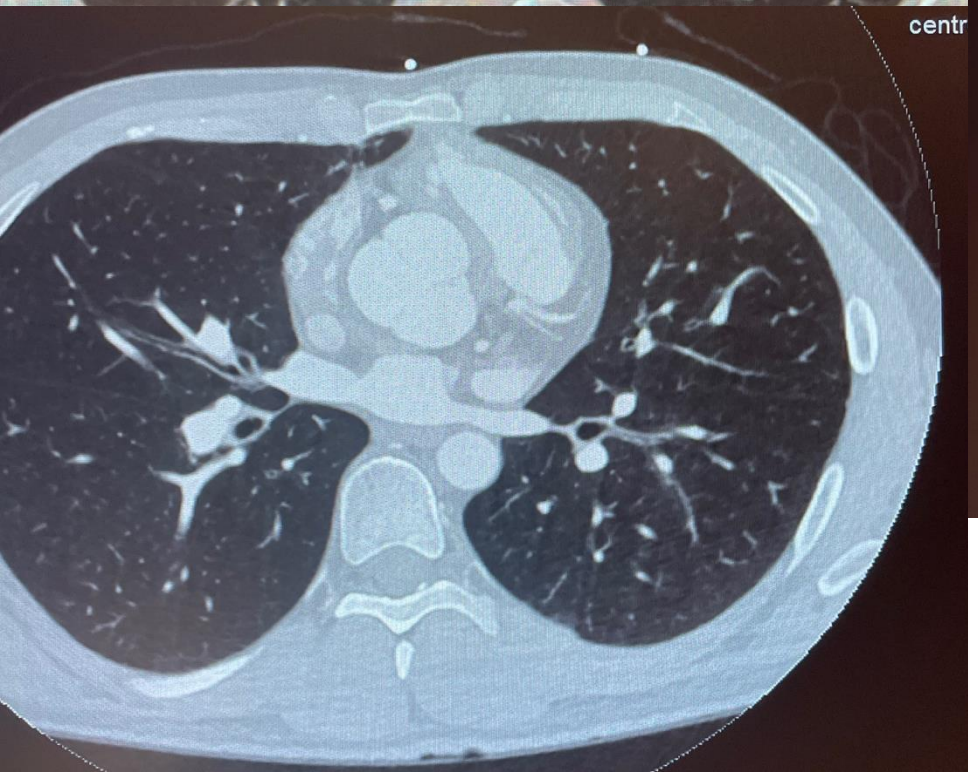


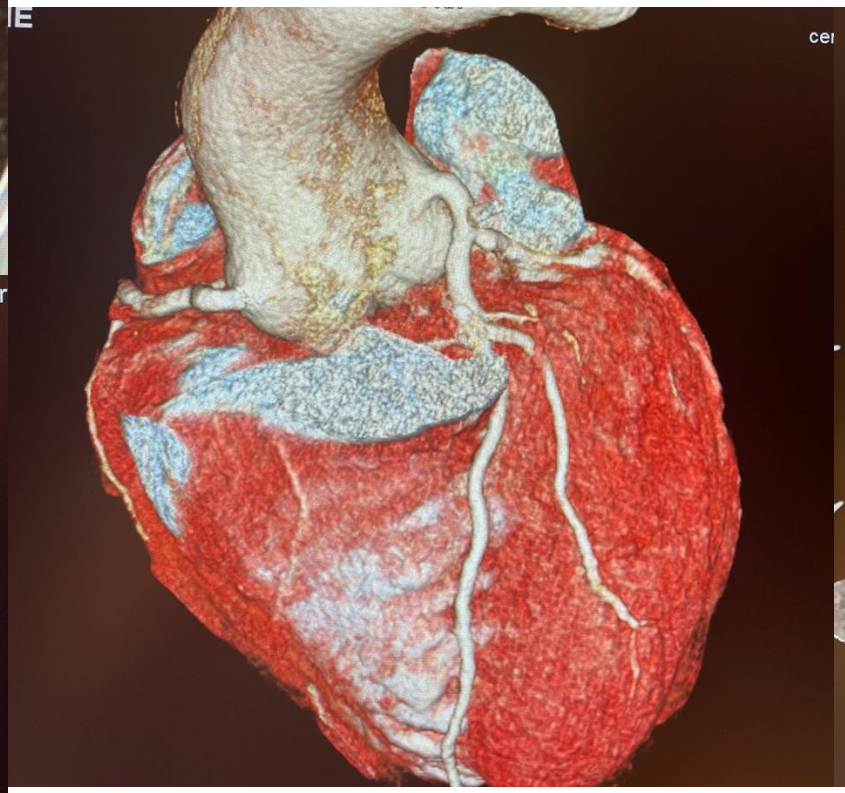


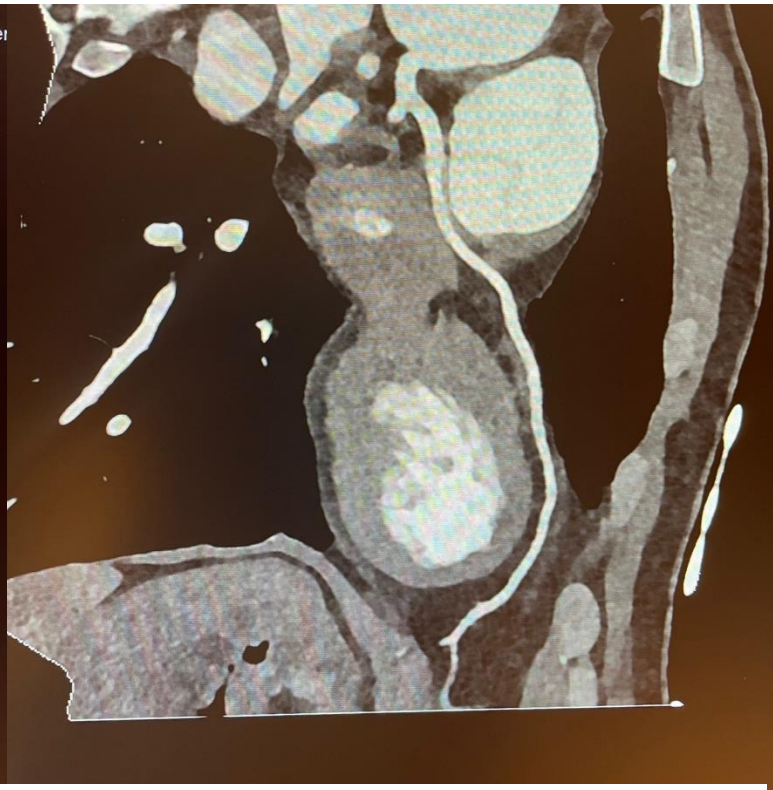


POSITION DES CORONAIRES



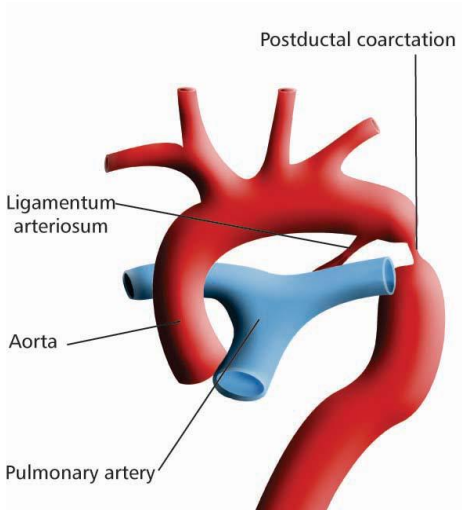


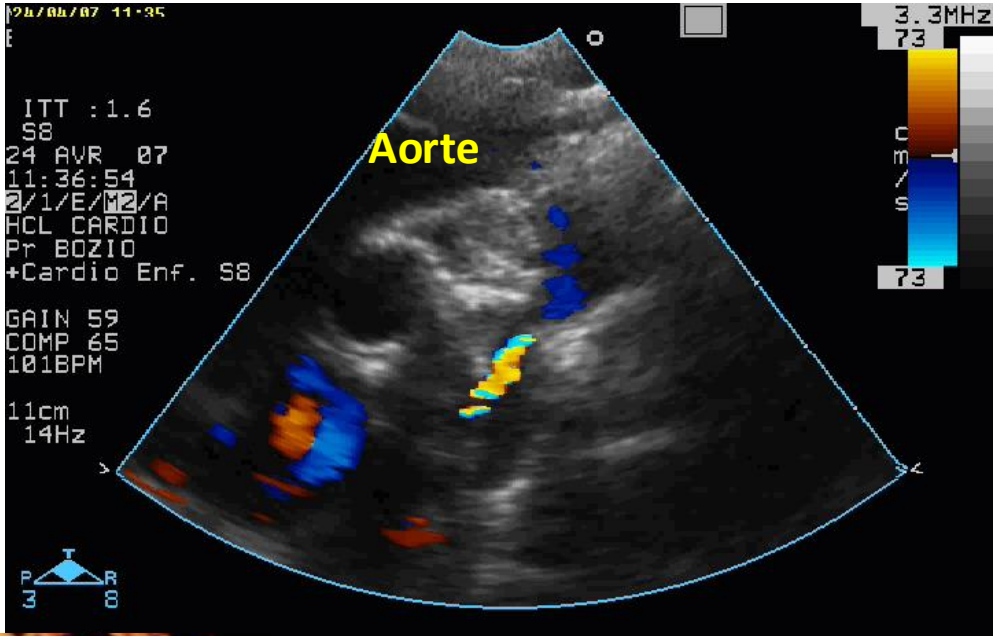


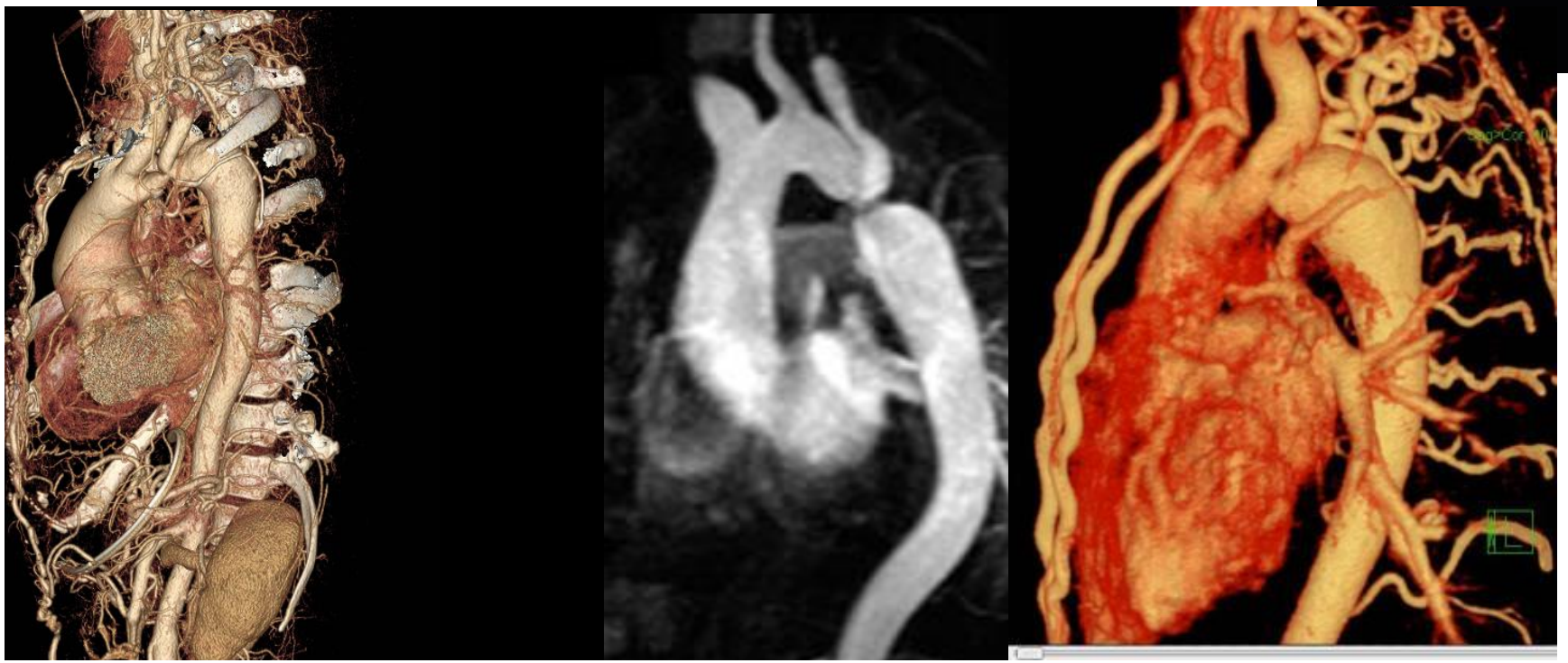


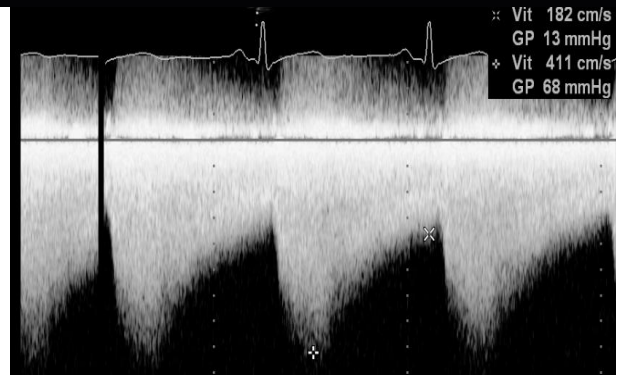
Coarctation aortique

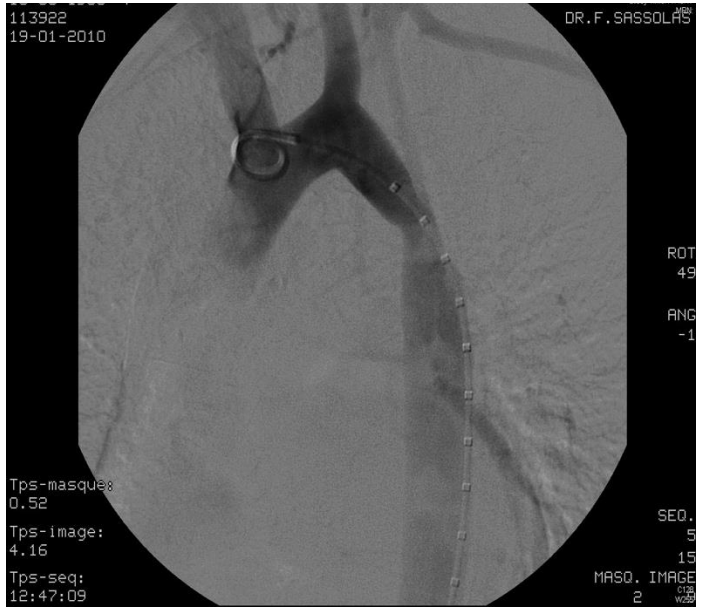
- **HTA sujet jeune**
- Bicuspidie aortique : 50%
- **Scanner ou IRM**







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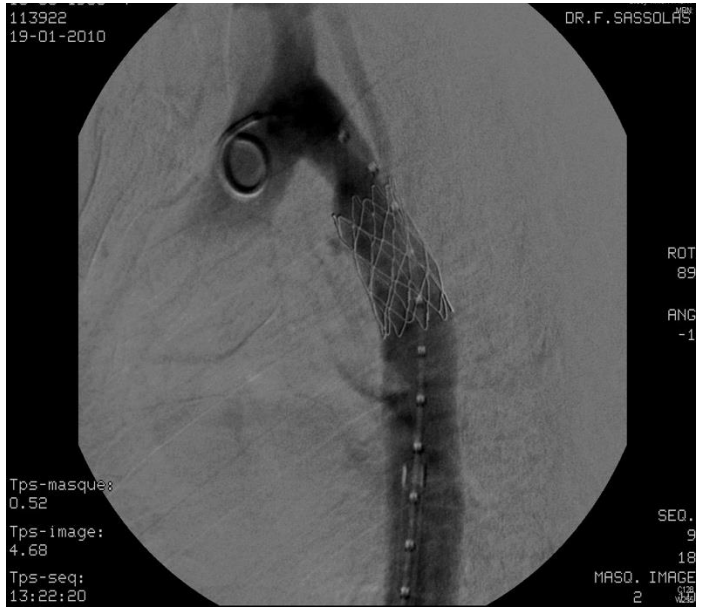
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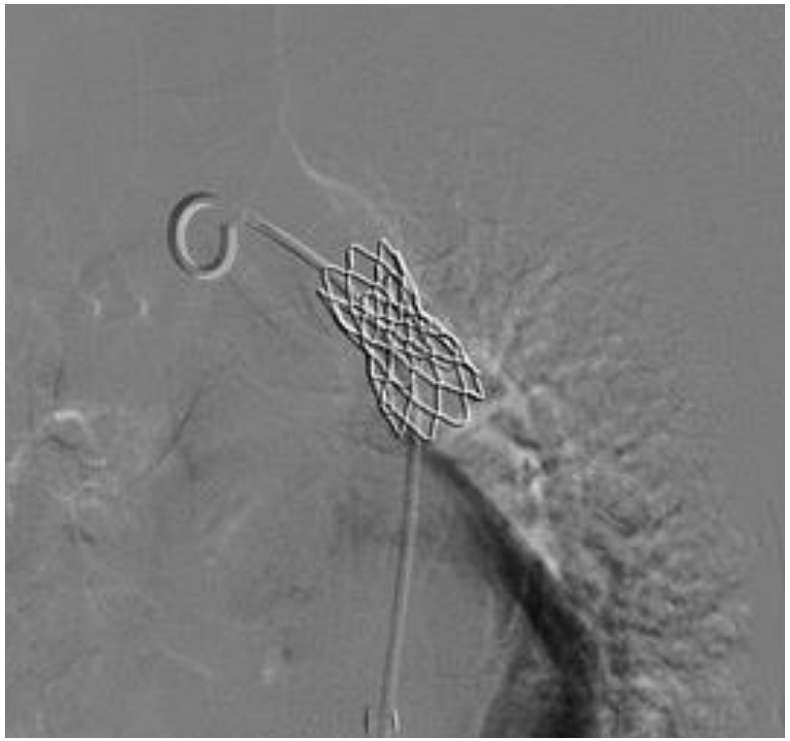
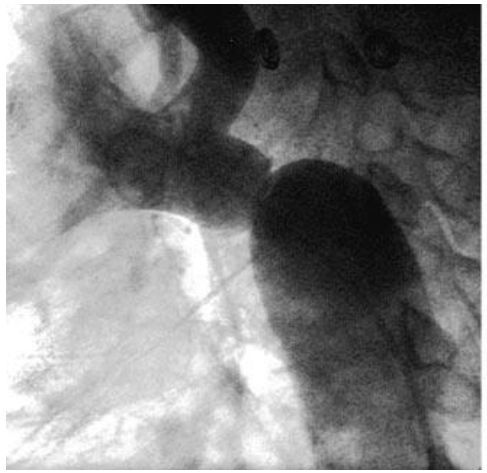
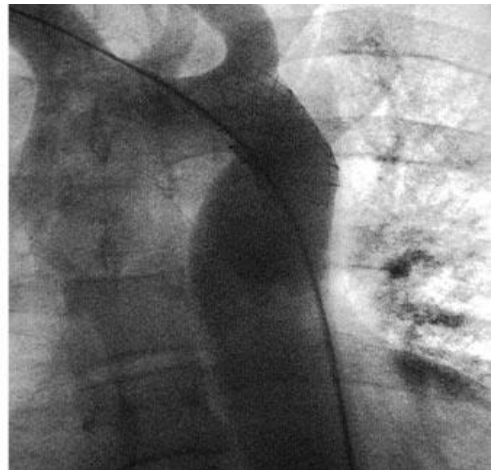


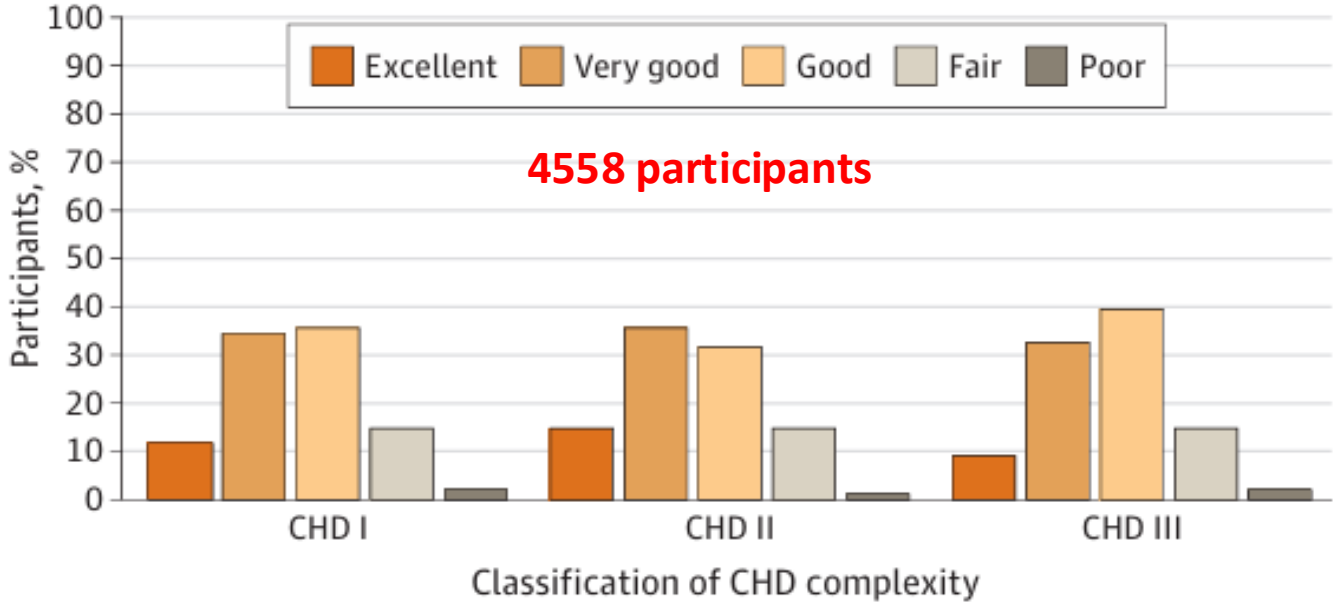




- **Qualité de vie:** satisfaisante

  Congenital Heart Initiative (CHI) :
  digital, online, patient-empowered registry
  of patient-reported outcomes (PROs) in ACHD

  JAMA Network Open 2024;7(10):e2439629



- **Sport : recommandé**
  - Intérêt de EFCR/ VO2max

JASE 2024 (24)00638-2.

- **Grossesse**
  - Le plus souvent possible
  - Récurrence de la CC

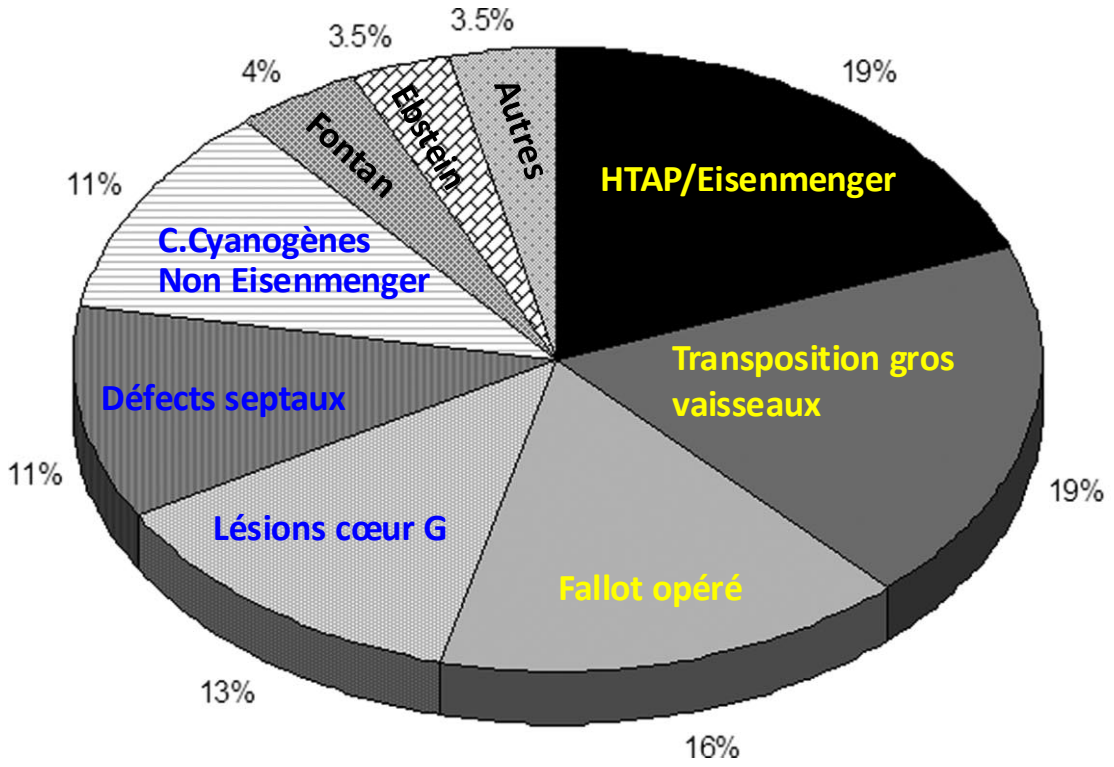
Pas de risque	Risque minime	Risque significatif	Grossesse contre indiquée
•RP, CIV,CAP petits/modérés •IM petite sur prolapsus •CIA, CIV, CAP, réparées avec succès	•CIA non opérée •Tétralogie de Fallot opérée •Dysfonction VG minime •Cardiomyopathie hypertrophique •Marfan sans dilatation de la racine de l'aorte	•Valve mécanique •VD systémique •Fontan •Cardiopathie cyanogène •Autres cardiopathies congénitales complexes	•HTAP sévère •Dysfonction VG sévère (FE<40%) •ATCD de cardiomyopathie du peripartum avec dysfonction VG •Obstruction sévère gauche •Marfan: racine aortique>40 mm

25 790 adultes avec CHD
1189 décès (5%) dont

Mort subite

213 morts subites = **19% des décès**

Circulation. 2012;126:1944-1954



Cardiopathies

- mineures: 12%
- modérées: 33%
- sévère: 55%

Variables associées à la MS

- Tachycardie supraventriculaire
  x 3,5
- Dysfonction du ventricule systémique
  x 3,4
- Dysfonction du ventricule sous pulmonaire
  x 3,4
- Élargissement QRS
  x 1,34
- Dispersion QT
  x 1,22

Stratification du risque

- **Critères**
  - Clinique: signes d'IC, malaise, syncope
  - Traitement antiarythmique
  - ECG : QRS largeur
  - Holter ECG : QT dispersion
  - ECHO : fonction myocardique
- **Evaluation spécifique à chaque cardiopathie**

Int J Cardiol 2017; 245 : 125–130
Circulation. 2012;126:1944-1954
Valente AM, *et al*. *Heart* 2014;**100**:247-

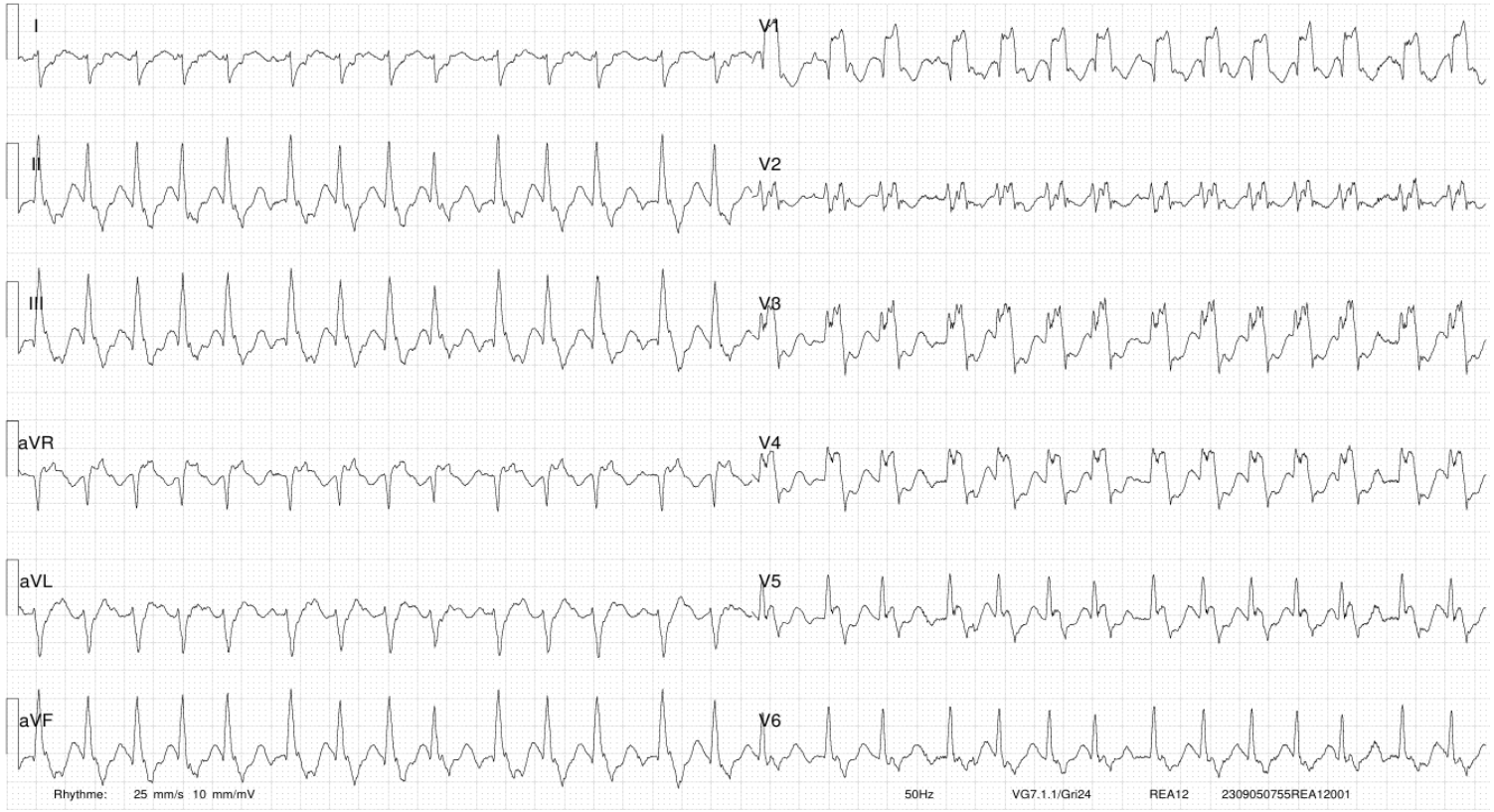
Cas clinique

- Patient de 54 ans (18/04/1969)
- **Tétralogie de Fallot**
- 22/05/1970 : anastomose AO AP gauche
- 24/07/1975 : correction complète
- Aanomalie génétique: `
  syndrome Di George
  microdélétion 22q11
- Pharyngoplastie en 2002
- Dernière consultation : 2021

Vu en urgence 4/09/2023: dyspnée depuis 4 jours, orthopnée, NYHA IV

EXAMEN: IC globale avec OAP, OMI, HMG, FC 170/mn, TA conservée, satO2 normale sous air

ECG: Flutter auriculaire



ECHODOPPLER

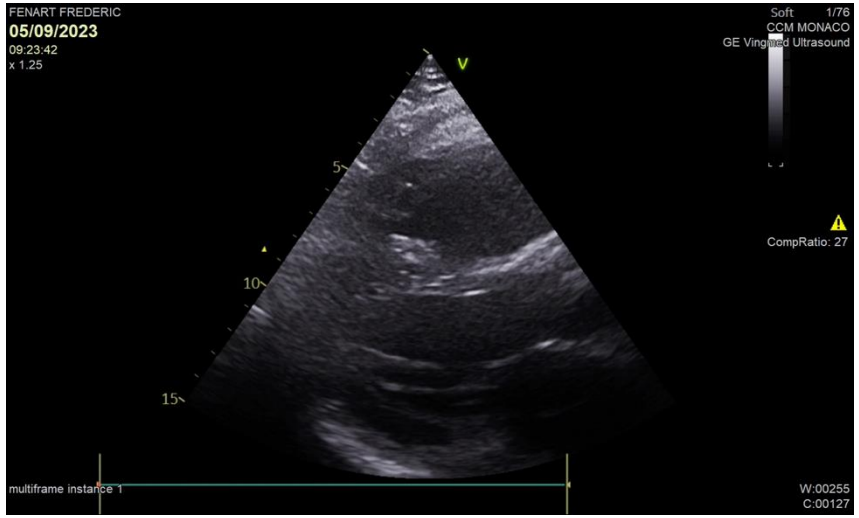
Dysfonction VD majeure

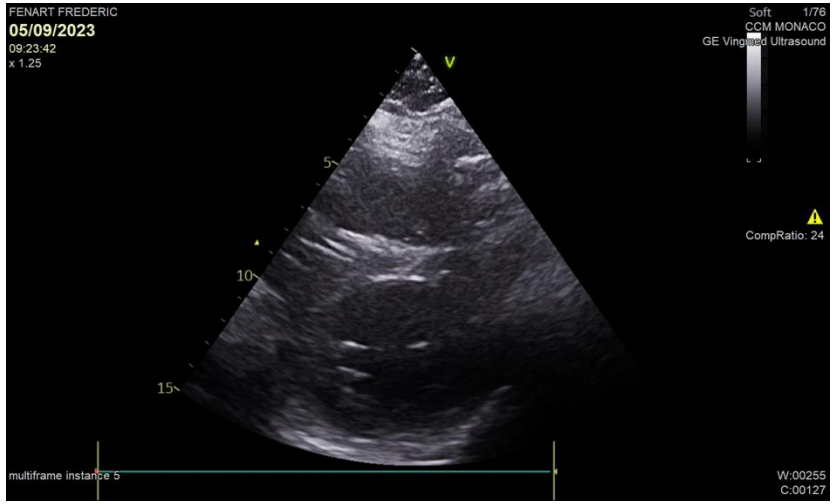
IP grade 3

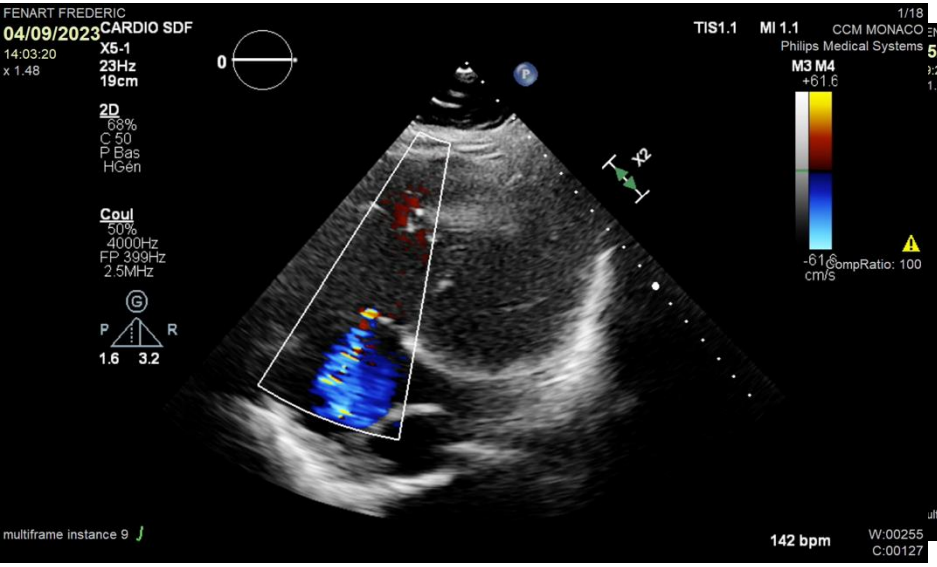
IT grade 2

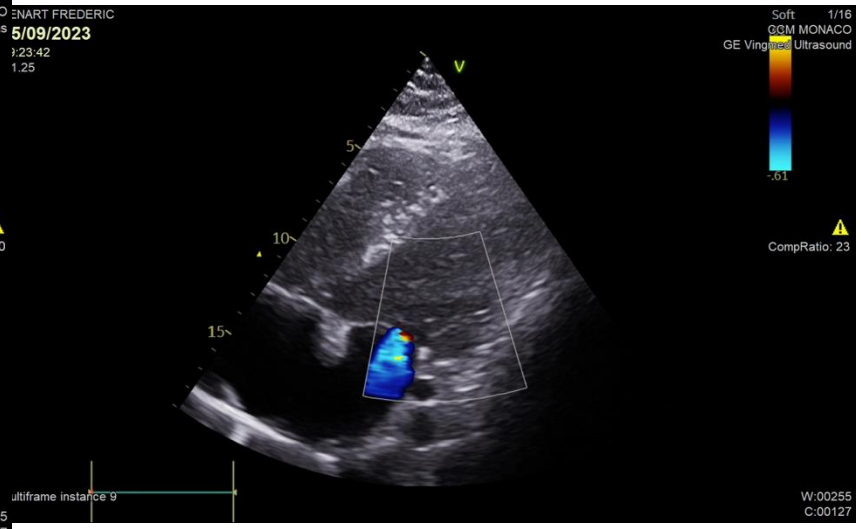
Dysfonction VG majeure

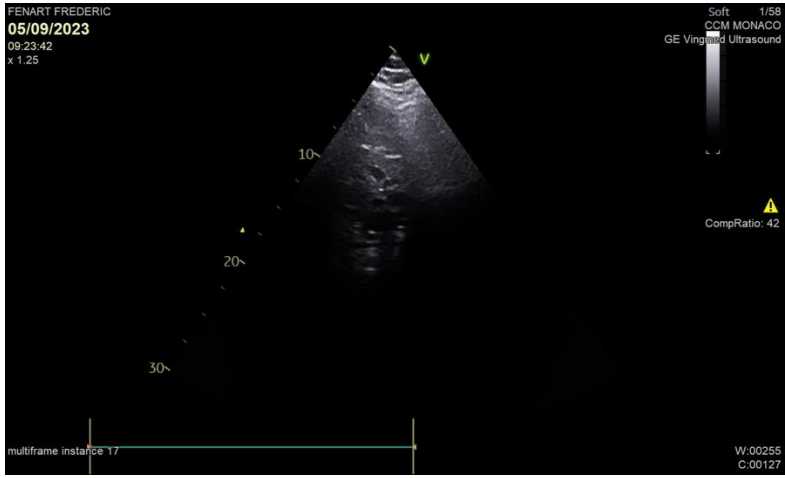
IM grade 2





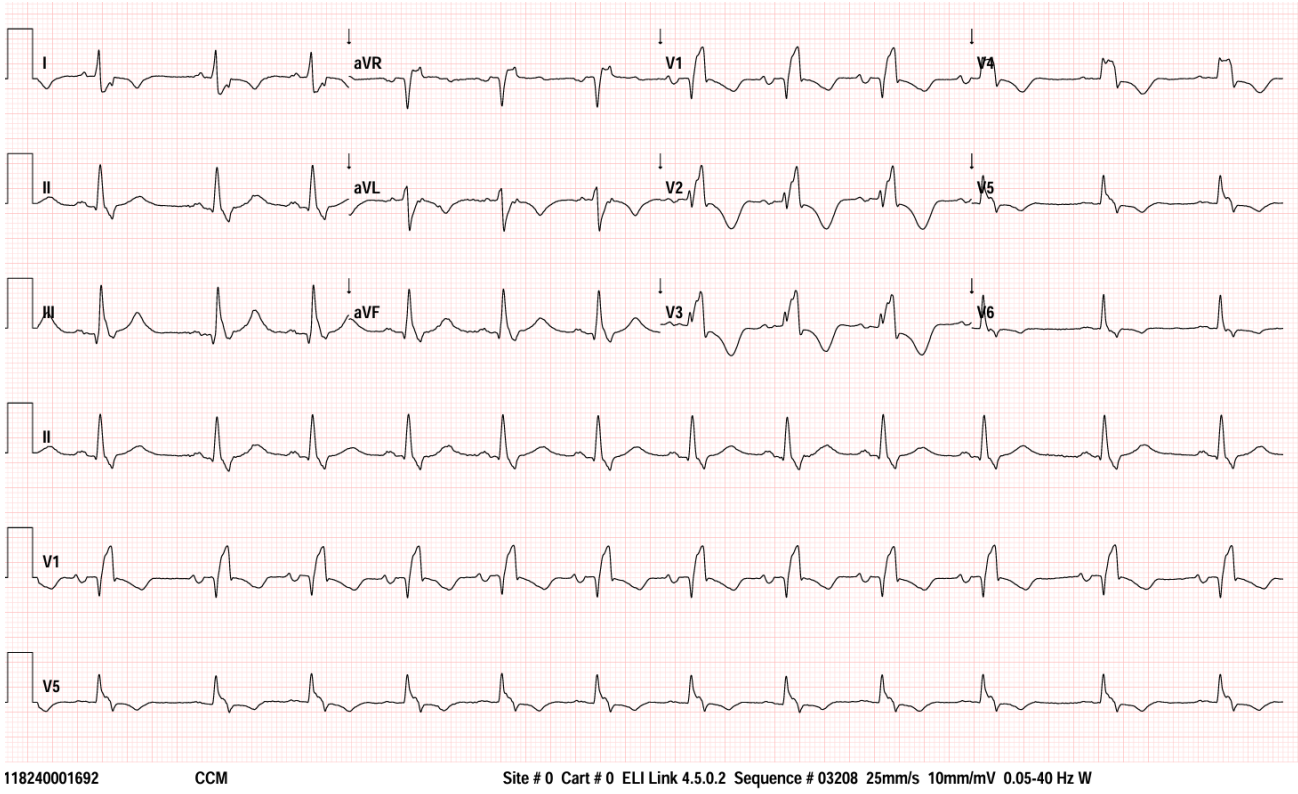






Evolution

- Prise en charge rythmologique en urgence : **ablation**
  - ➡ Retour en RS stable
- Entresto, Forxiga, Lasilix, Aldactone, bisoprolol, spironolactone, apixaban
- ECG: RS 70/mn, BBDC
- ETT: FEVG normale, pas d'IM, IT 2, VD dilaté, IP grade 3
- Scanner
- IRM



ECHODOPPLER post-ablation

Dysfonction VD modérée

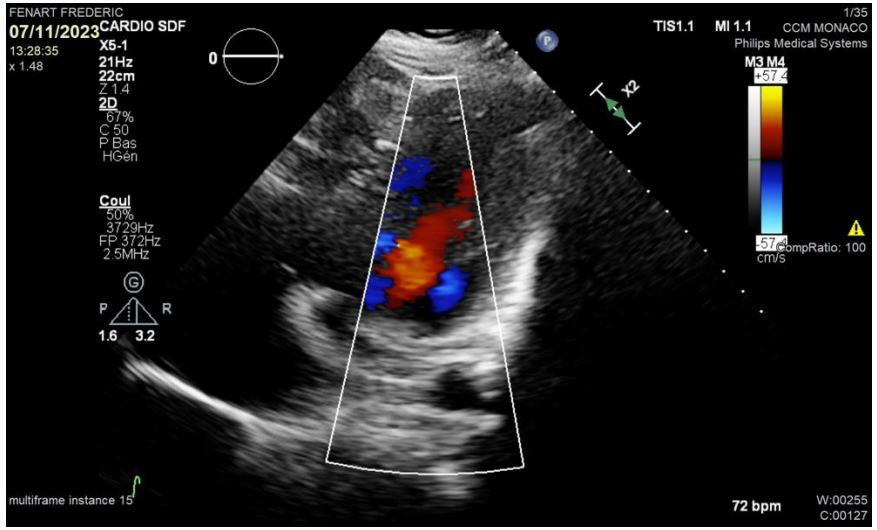
Dilatation VD

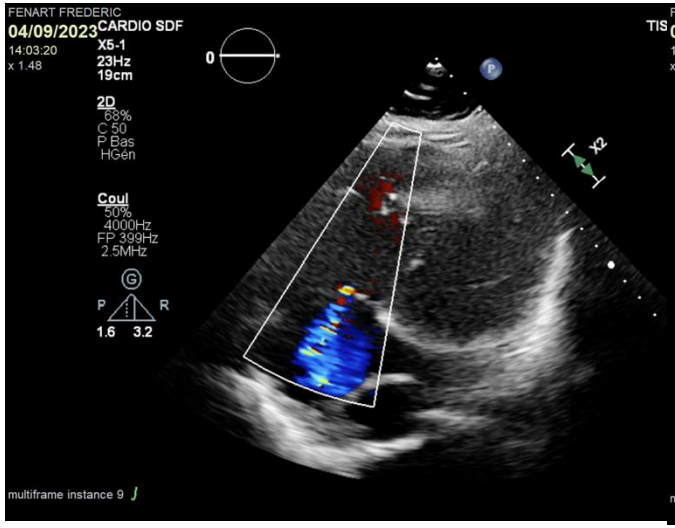
IP grade 3

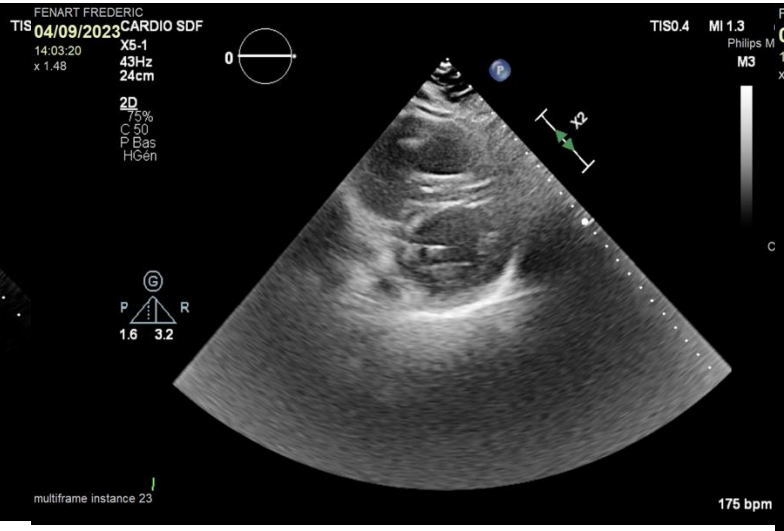
IT grade 2

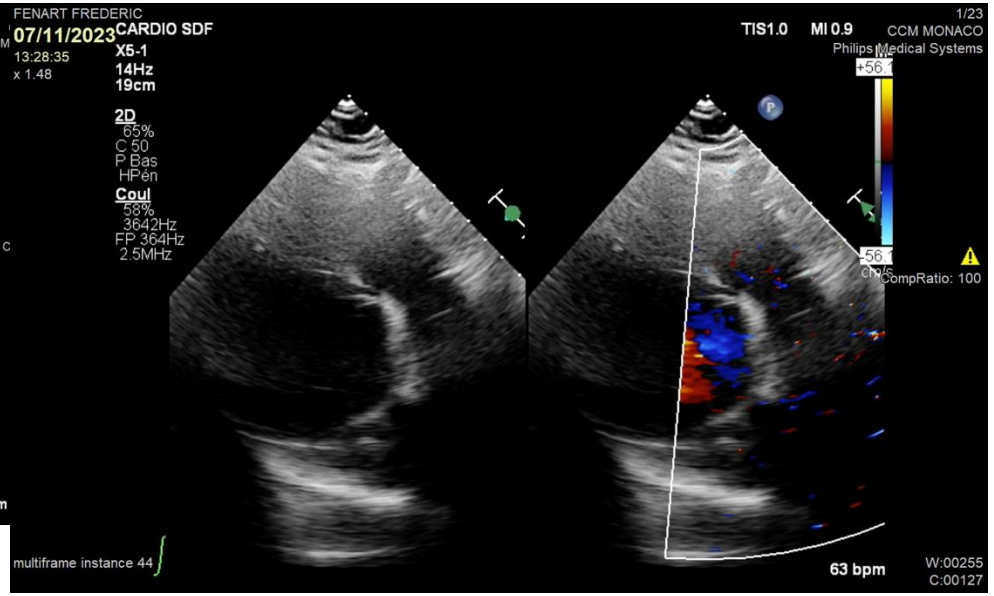
FEVG normale

Pas d'IM







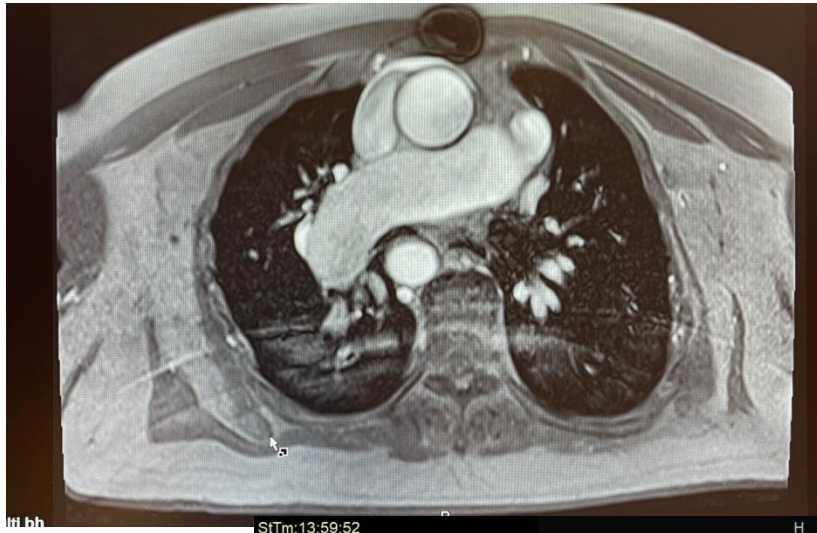


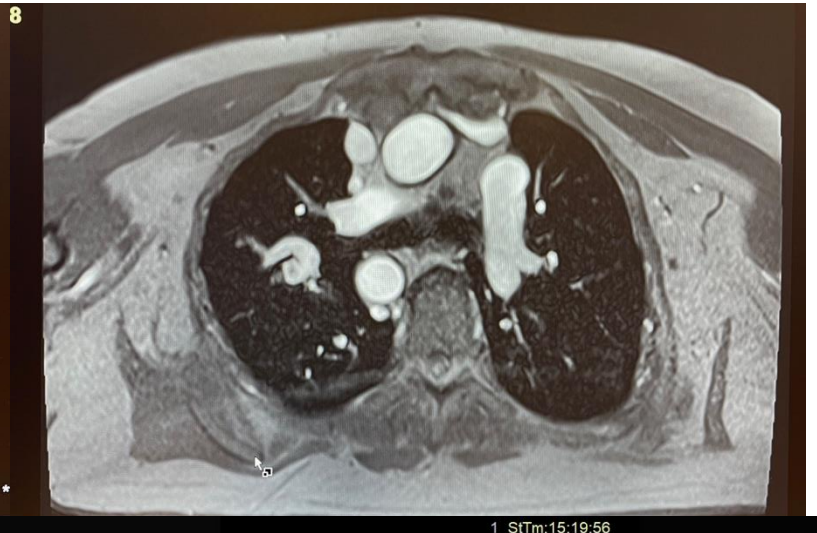
Scanner

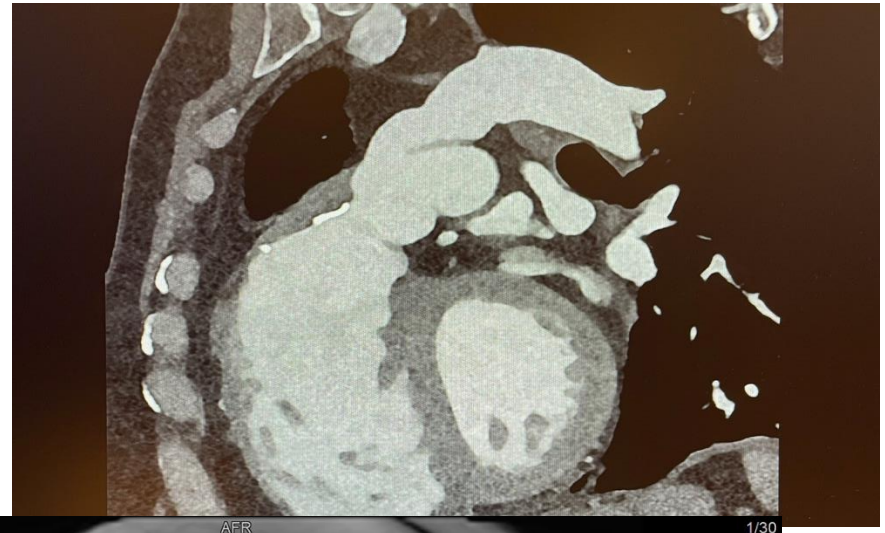
APD

APG

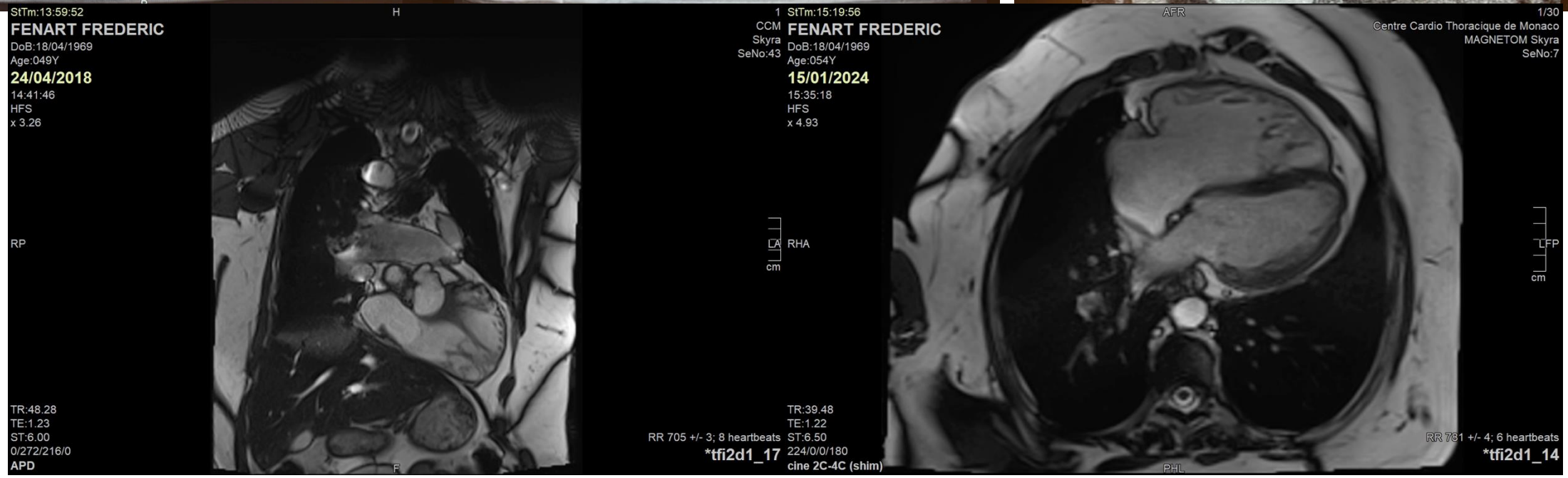
Sténose APG





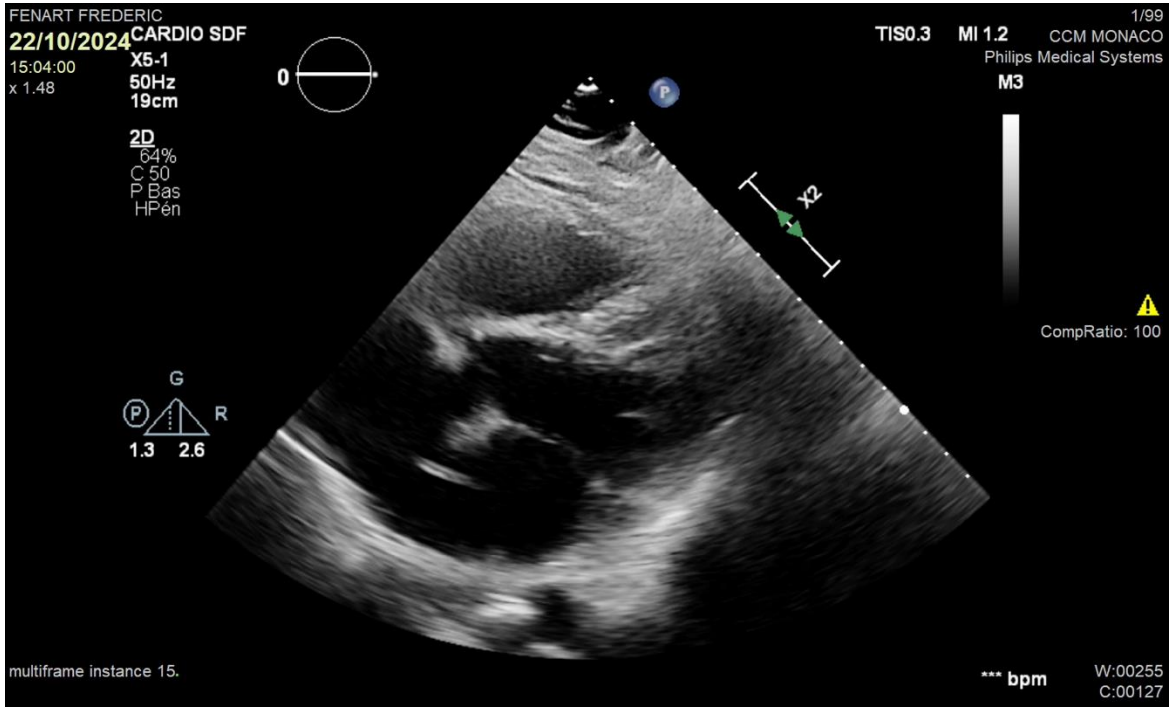


IRM



Evolution

- **Indication : RVP + plastie APG proximale**
  - 1ère intention: cathé / hémodynamique/ calibration : 04/ 07/2024
  - RVP percutané récusé
  - 2ème intention : chirurgie
- **CEC le 2/07/24 : RVP biologique + plastie APG proximale**



Conclusion

- **Cardiopathies congénitales de l'adulte**
  - Multiples plus ou moins complexes
  - Comprendre anatomie et physiopathologie
  - Connaitre l' **h**istorique médico-c**h**irugicale individuelle
  - Pronostic variable
  - Qualité de vie satisfaisante mais surestimée par le patient`
- **Prise en charge**
  - Traitement médical
  - Traitement interventionnel percutané/chirurgical
  - Importance de imagerie en coupes
  - Evaluation état fonctionnel clinique / EFCR-VO2max