

Cas clinique ACCA

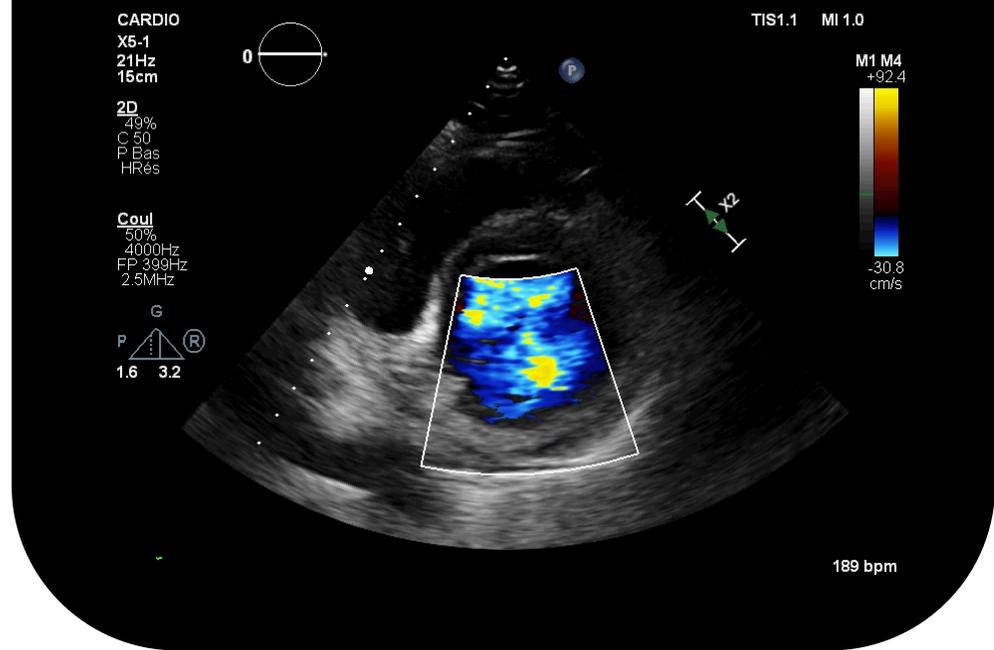
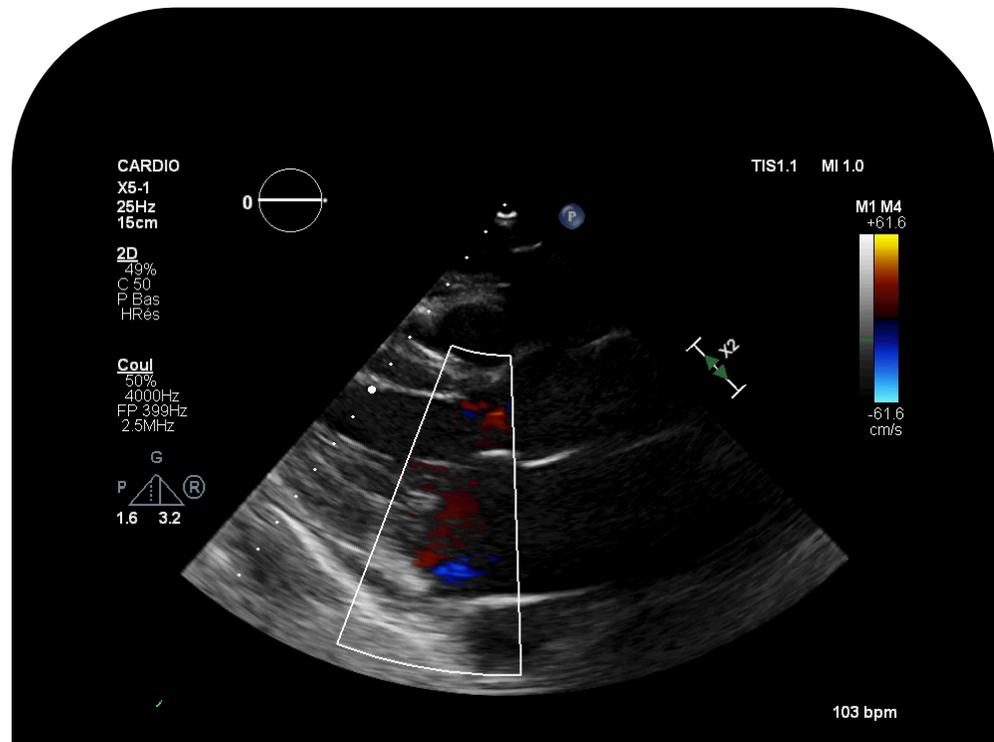
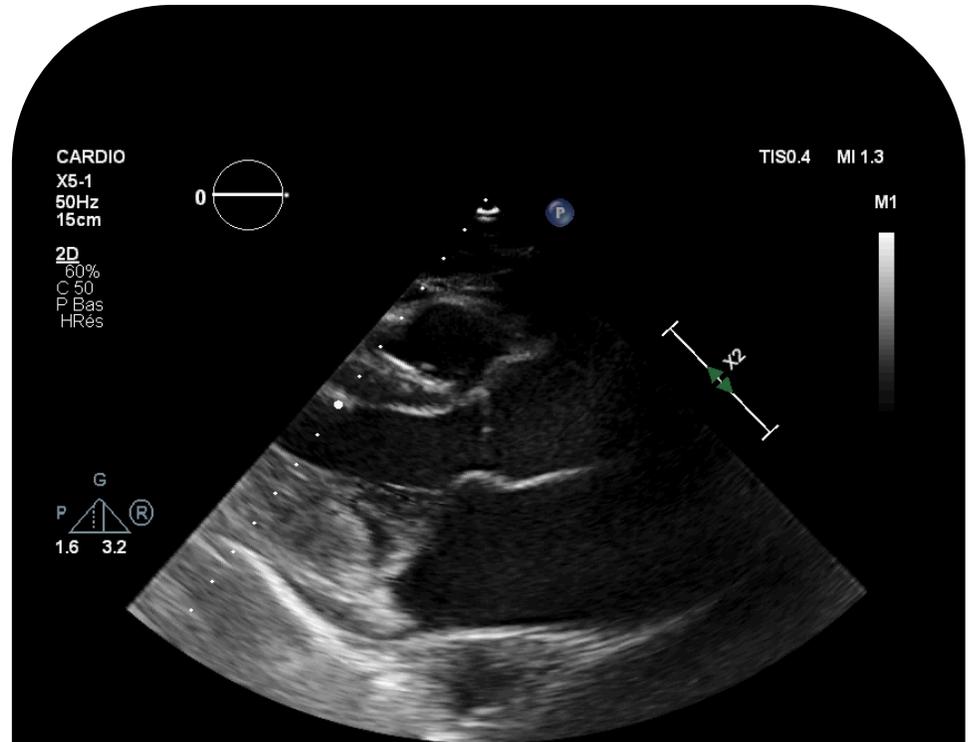
F Wautot
F Levy

4 février 2020



Cas clinique

- Patiente de 62 ans, dyspnée d'effort
- Souffle systolique 4/6 à renforcement mésotélé
- VG et OG dilatées
- Réparabilité?



CARDIO

X8-2t
18Hz
12cm

2D

62%
C 46
P Arrêt
Gén

Coul

48%
5999Hz
FP 539Hz
3.3MHz



PAT T: 37.0C
TEE T: 38.5C

TISO.4 MI 0.7

M4

69.3

cm/s

*** bpm

CARDIO

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2D

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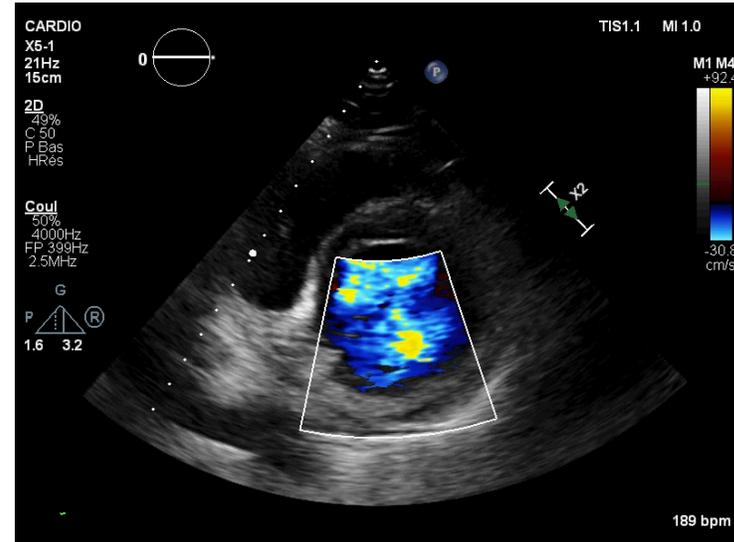
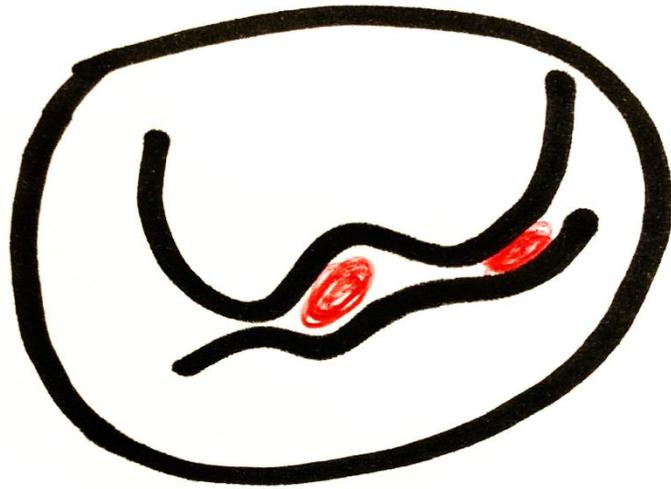
TISO.6 MI 0.4

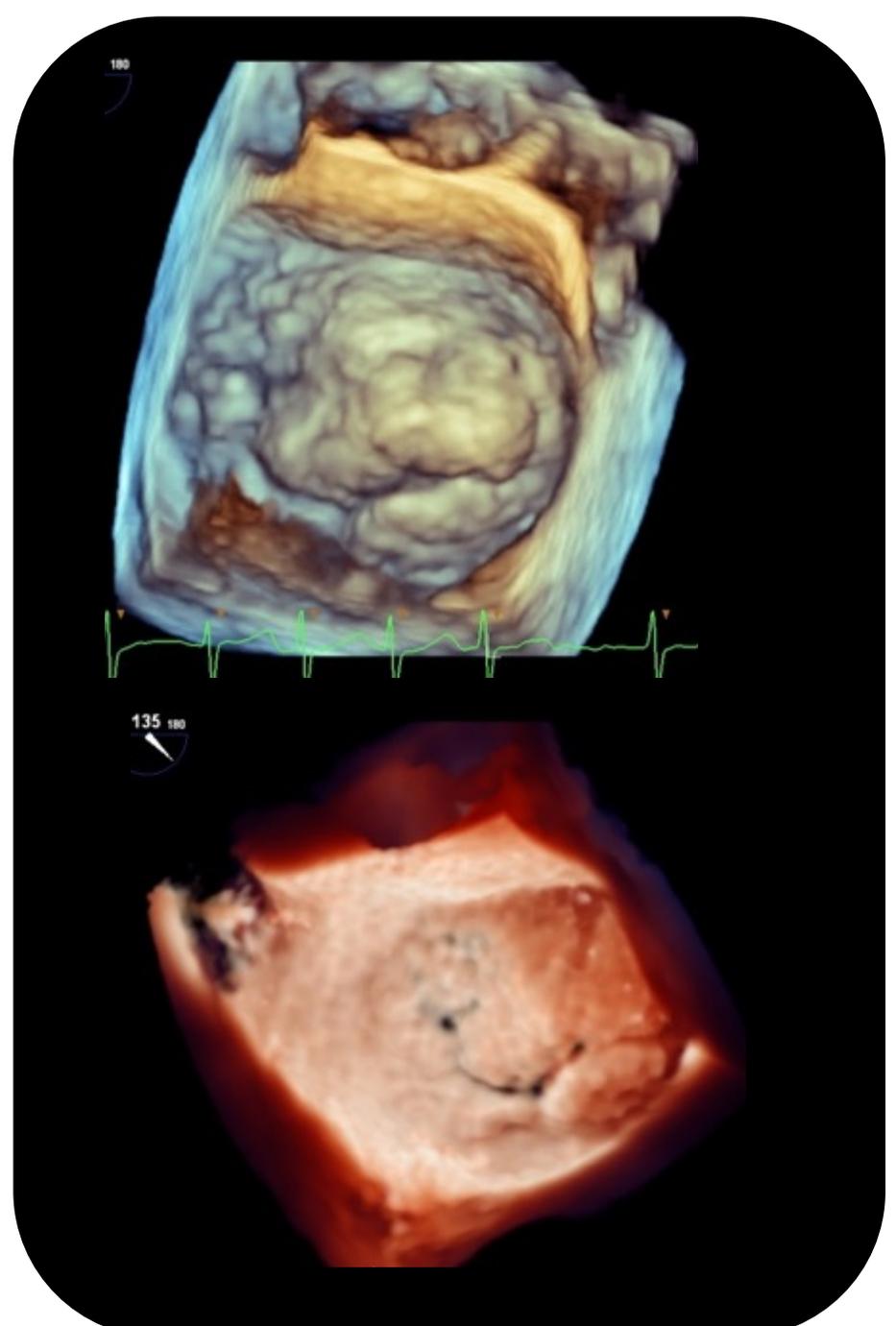
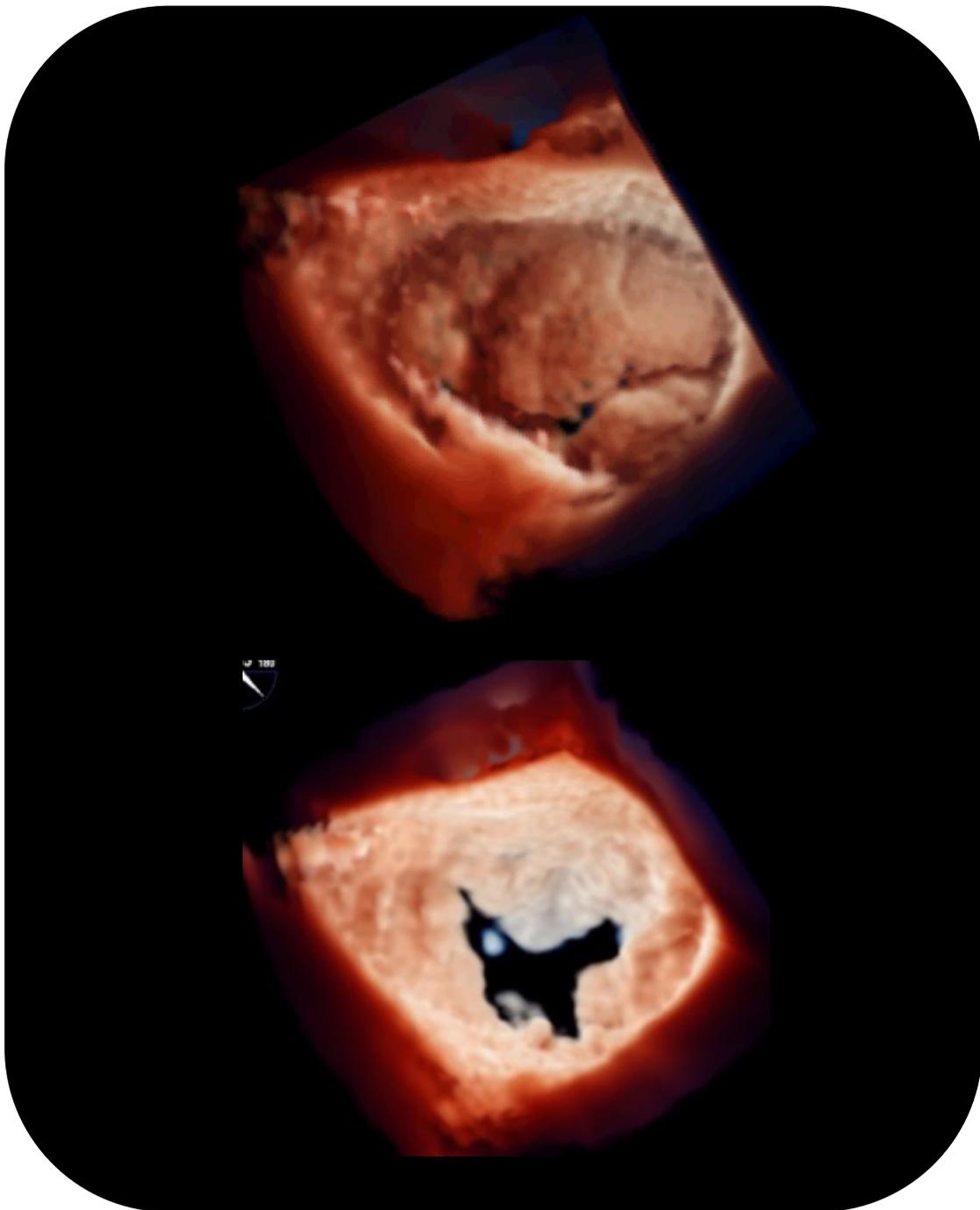
M4

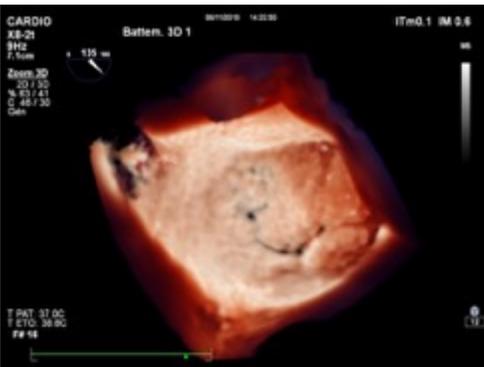
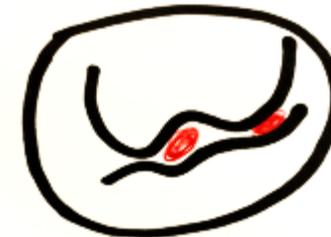
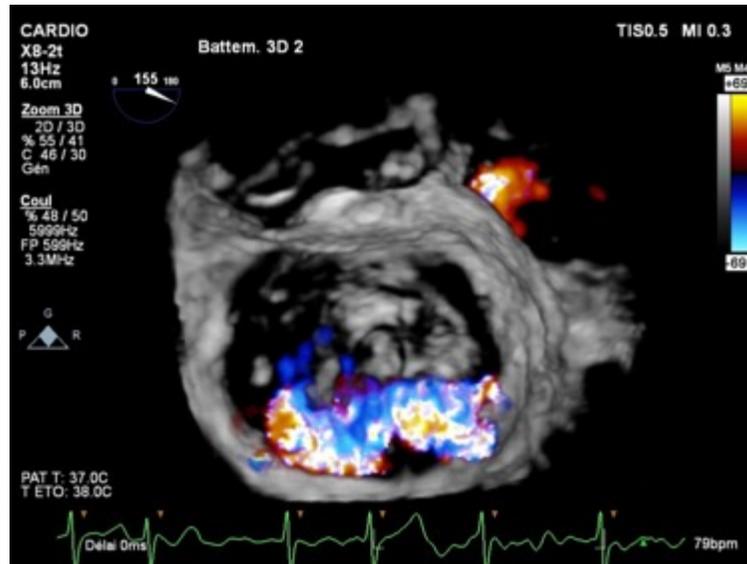
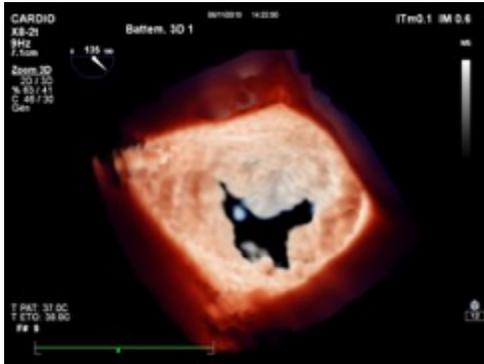
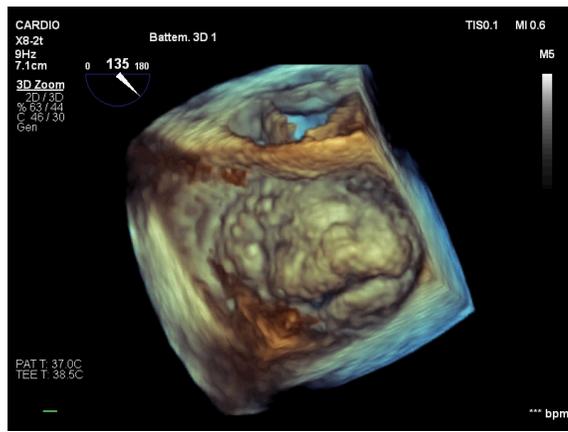
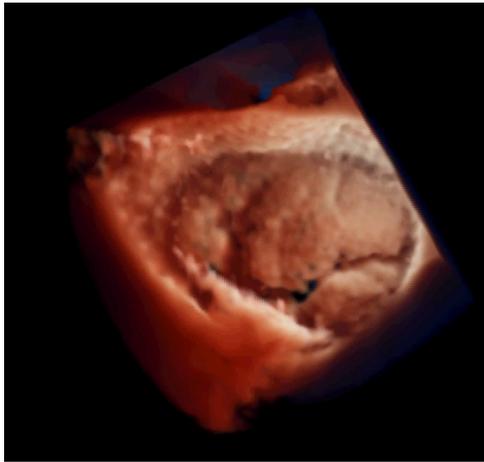
69.3

cm/s

87 bpm







Que pensez vous de la réparabilité de cette mitrale?

- A. Pas de problème, j'en ai réparé deux pareilles la semaine dernière...
- B. HUUUU....Elle n'est pas réparabe c'te mitrala
- C. Elle est réparabe mais méfi...
- D. M'en bati, je pensais que c'était rythmosud ce soir...



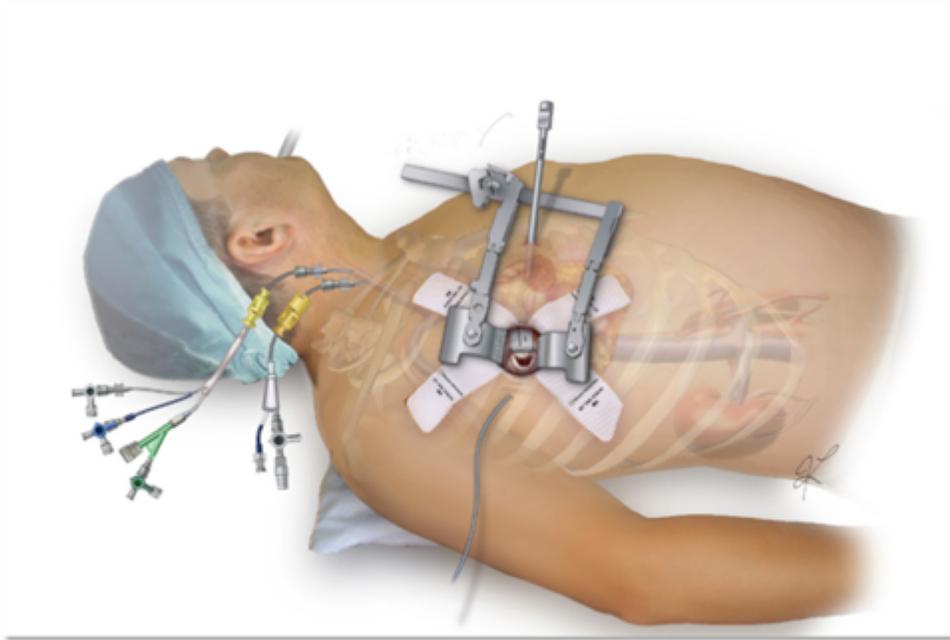
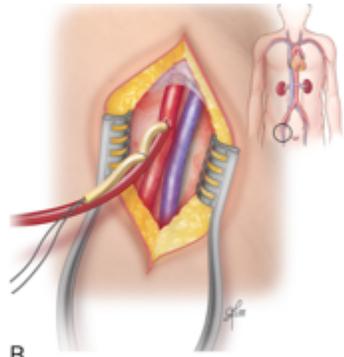
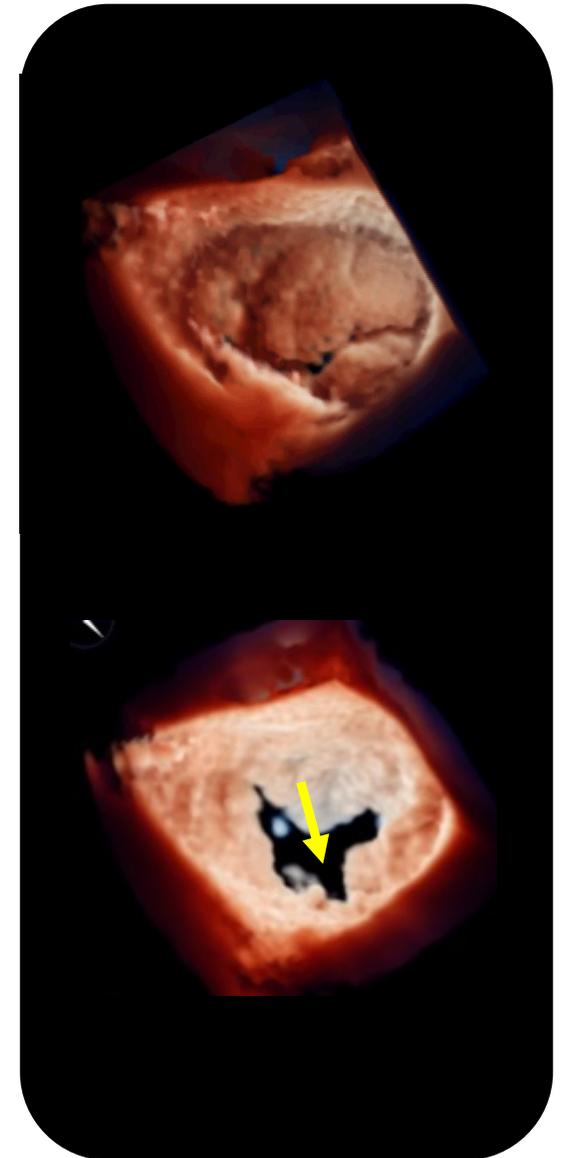
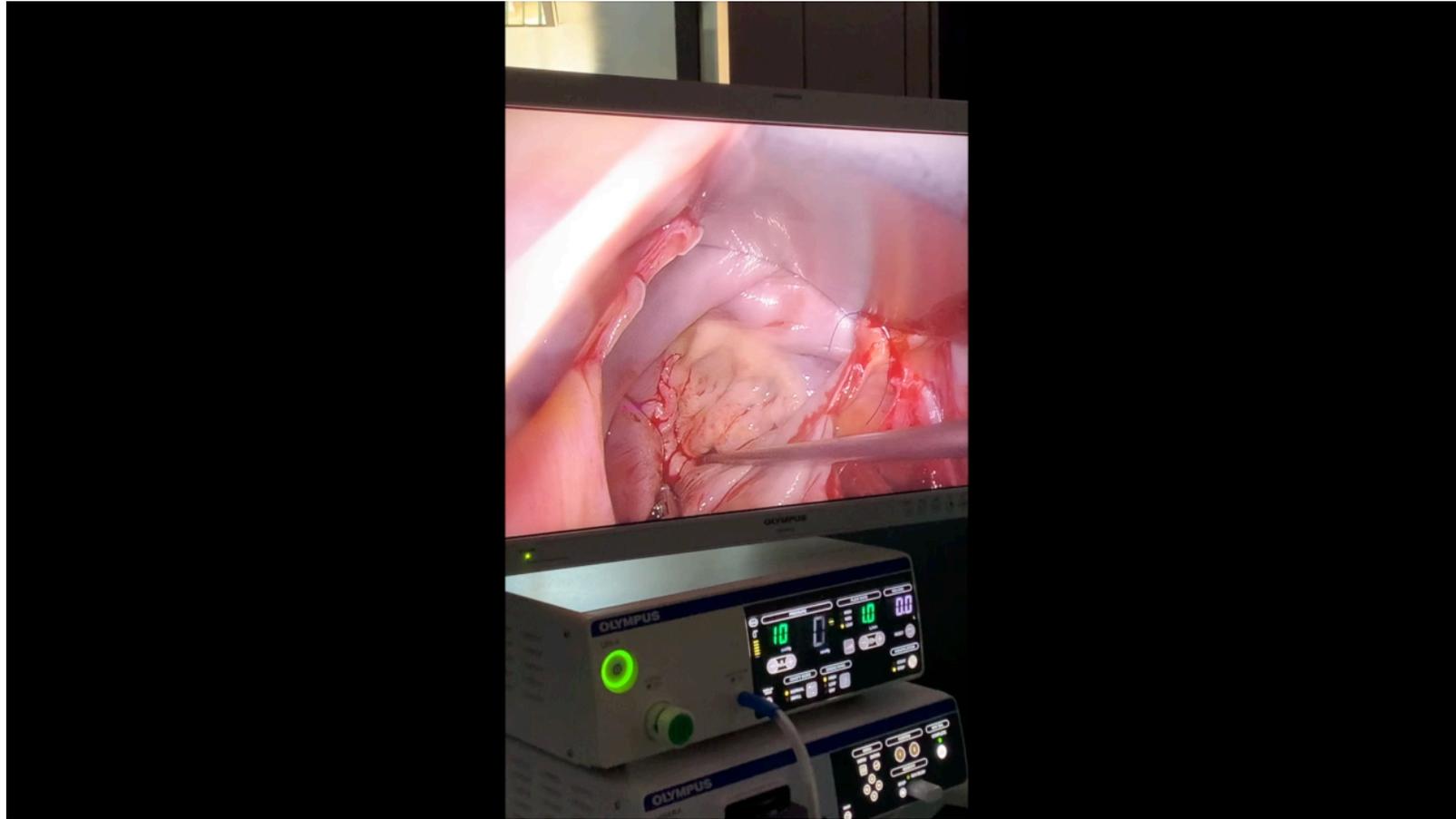
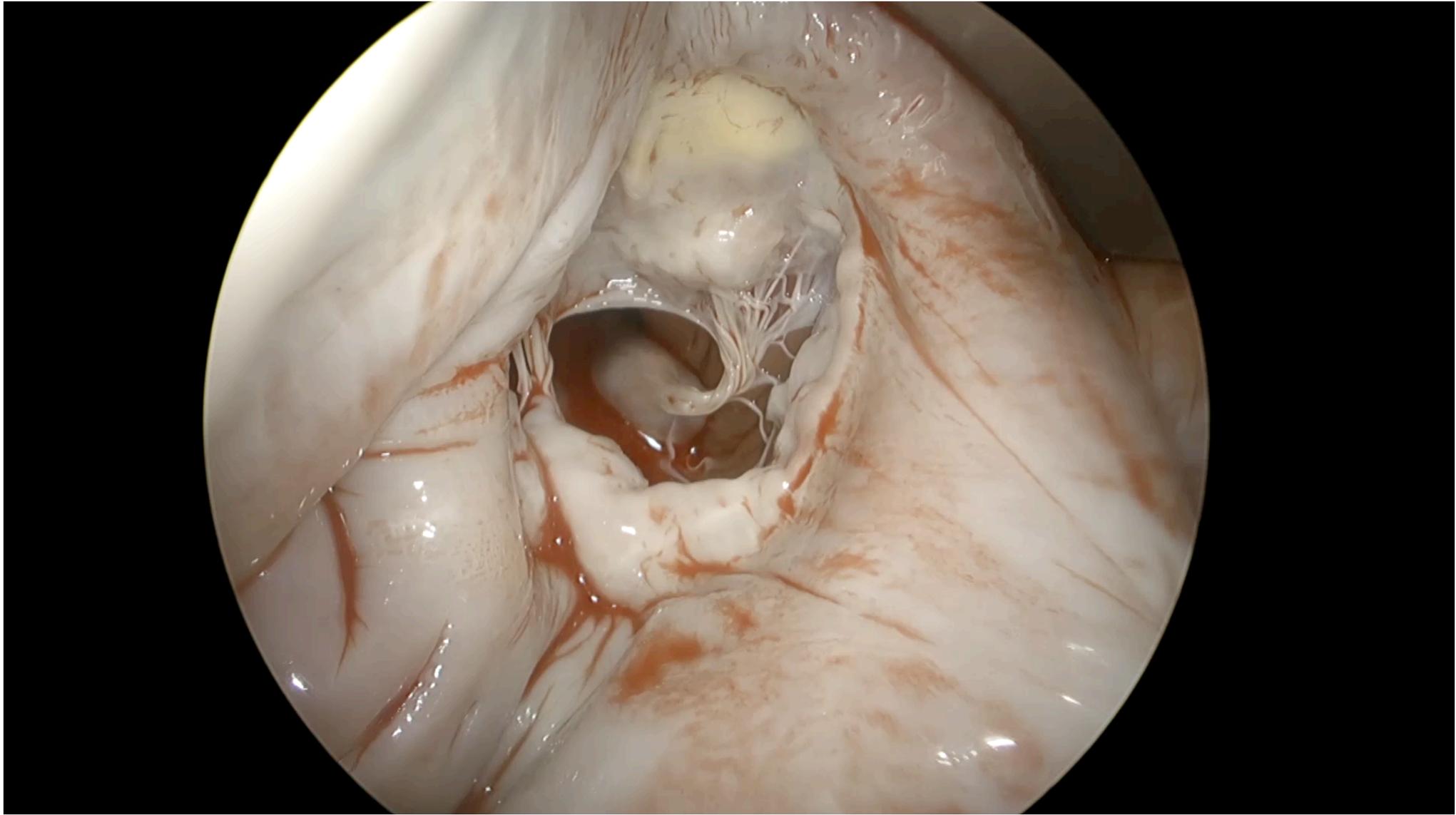


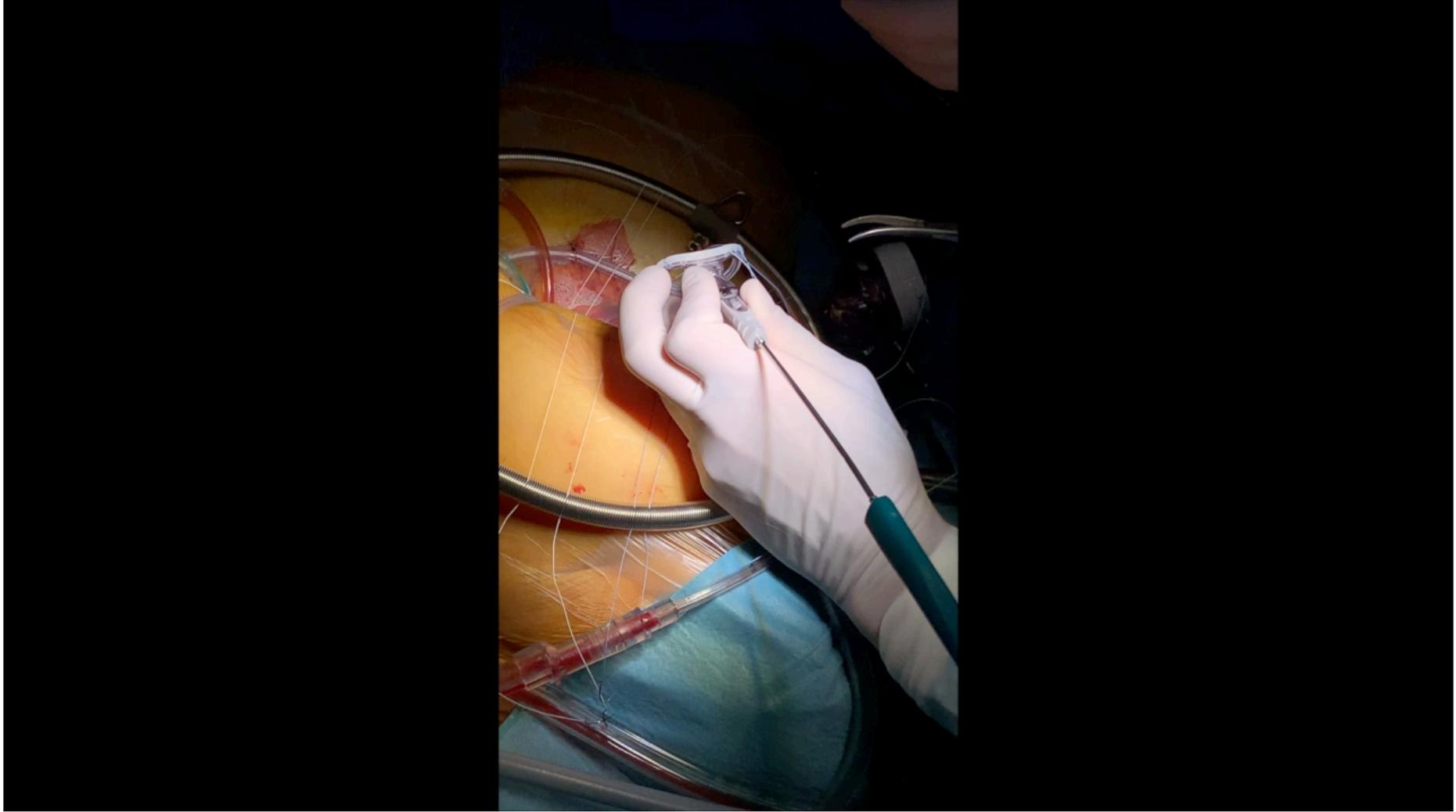
Figure 4 Mini-thoracotomy working port.



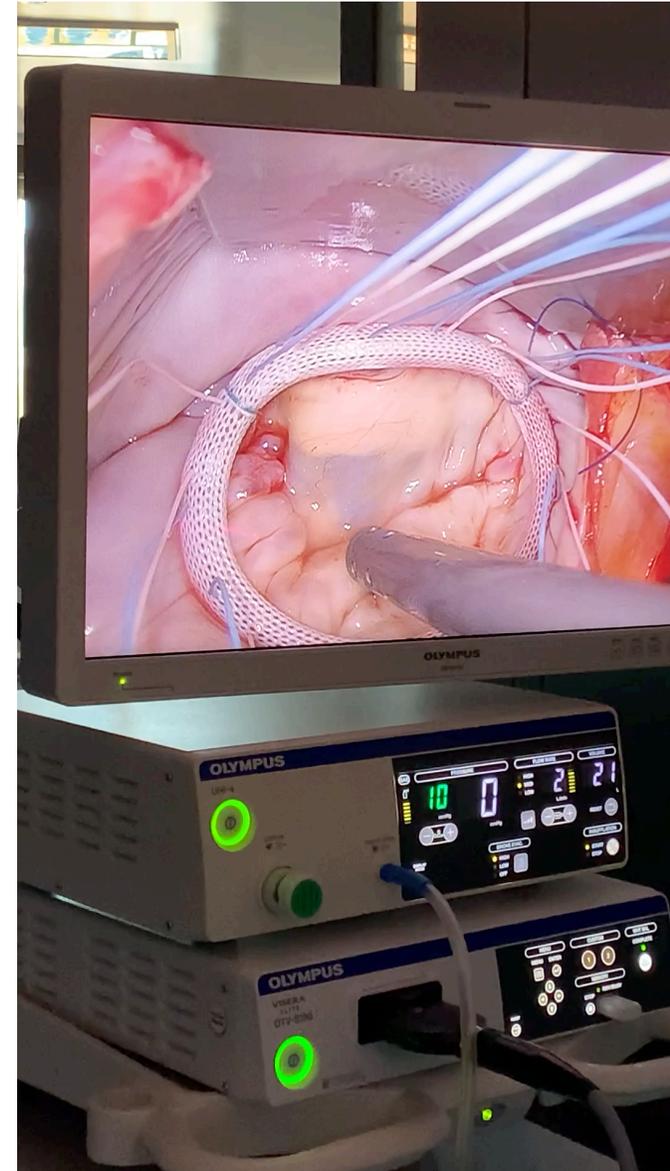
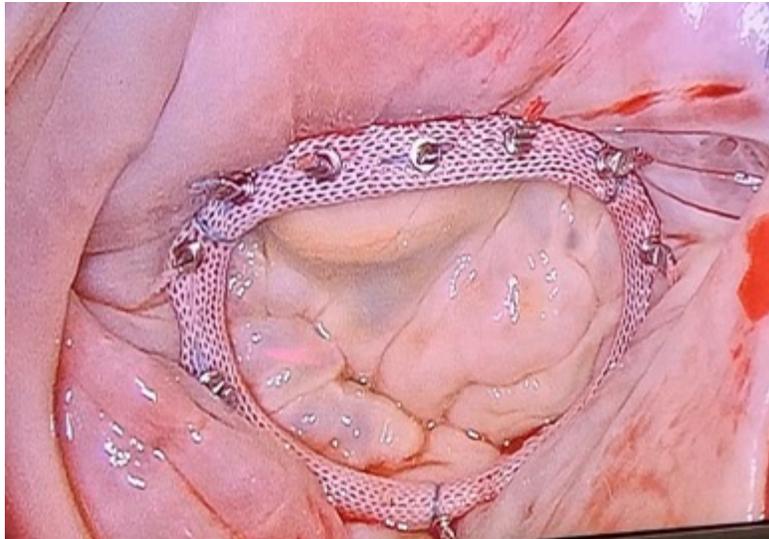
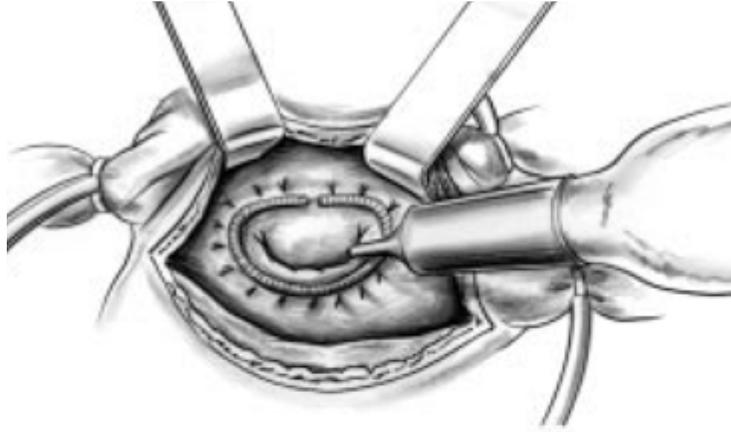
analyse: pas de rupture de cordage

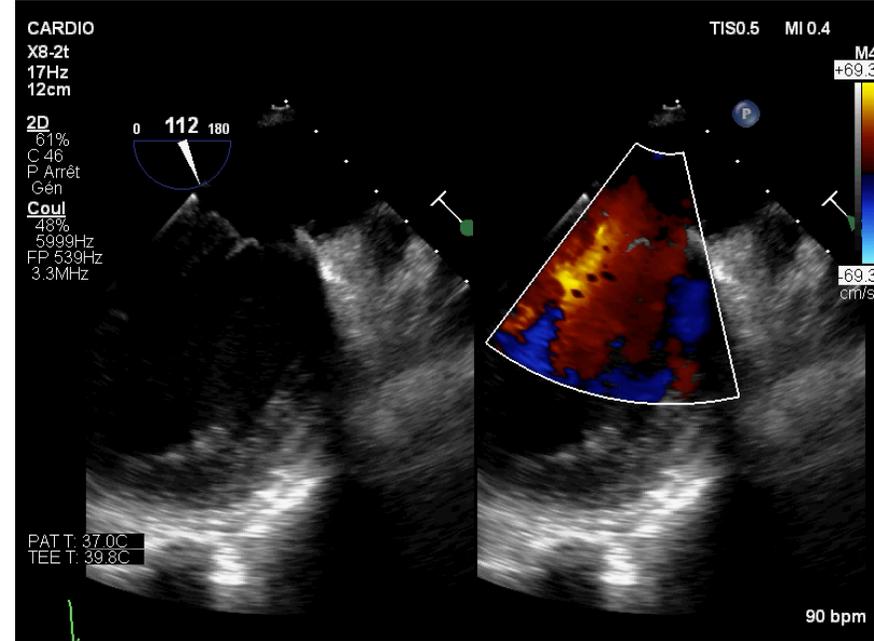
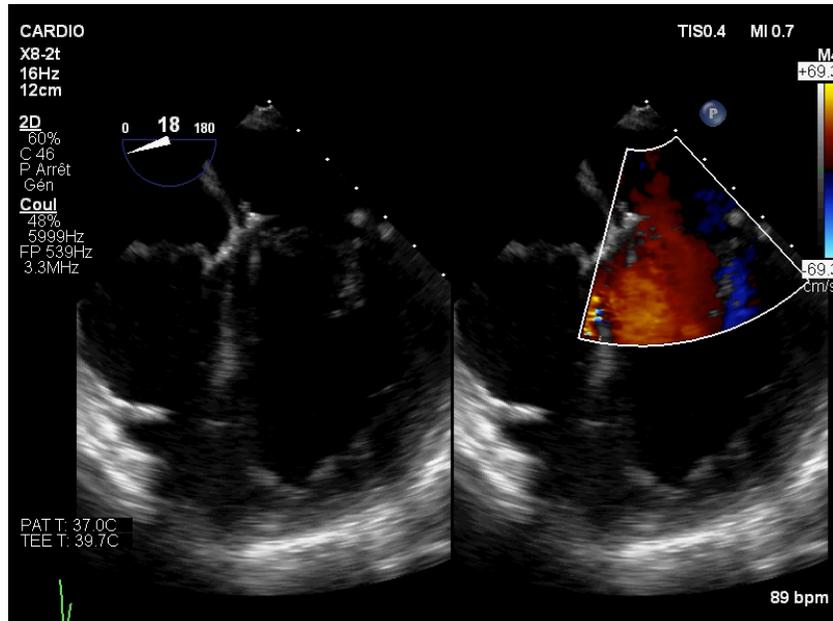
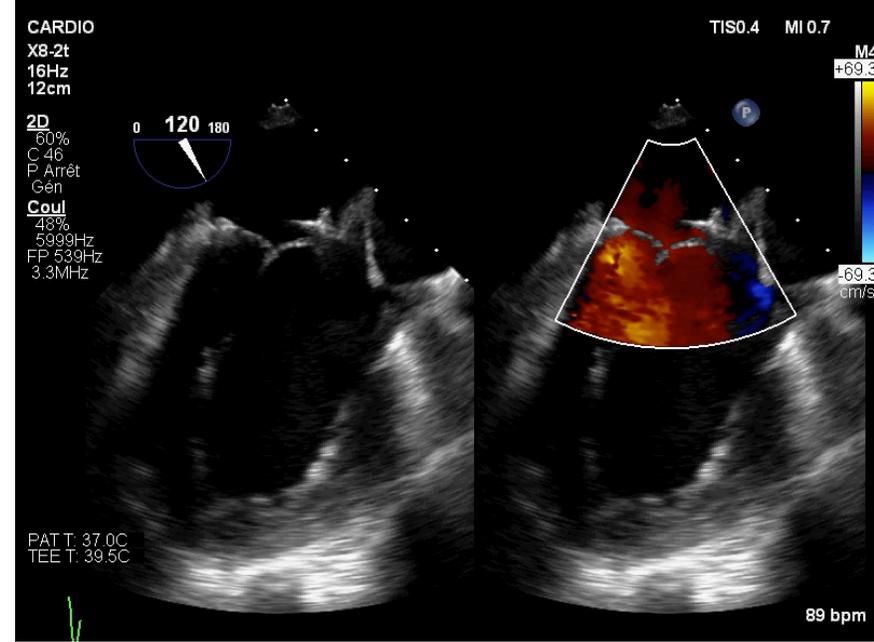
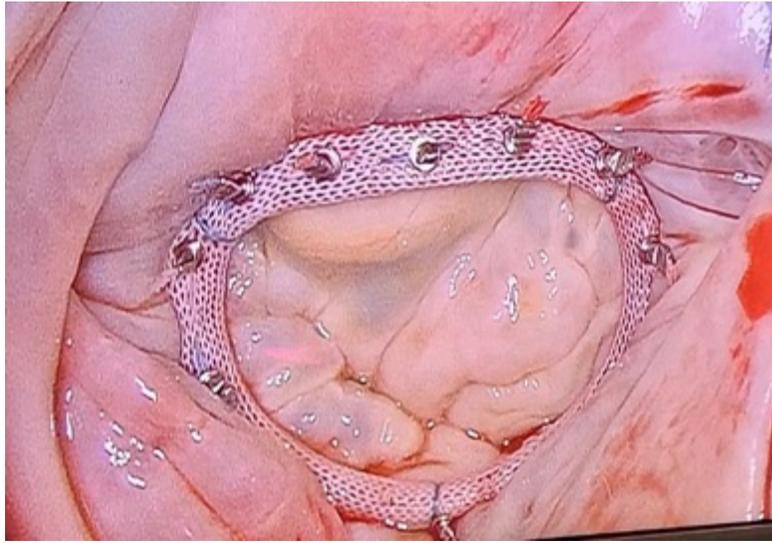






Test à l'eau





CARDIO

X8-2t
20Hz
12cm

2D

68%
C 46
P Arrêt
Gén

Coul

48%
5999Hz
FP 539Hz
3.3MHz

0 135 180

PAT T: 37.0C
TEE T: 38.5C

TIS0.6 MI 0.4

M4

+69.3

-69.3

cm/s

87 bpm

CARDIO

X8-2t
16Hz
12cm

2D

60%
C 46
P Arrêt
Gén

Coul

48%
5999Hz
FP 539Hz
3.3MHz

0 120 180

PAT T: 37.0C
TEE T: 39.5C

TIS0.4 MI 0.7

89 bpm

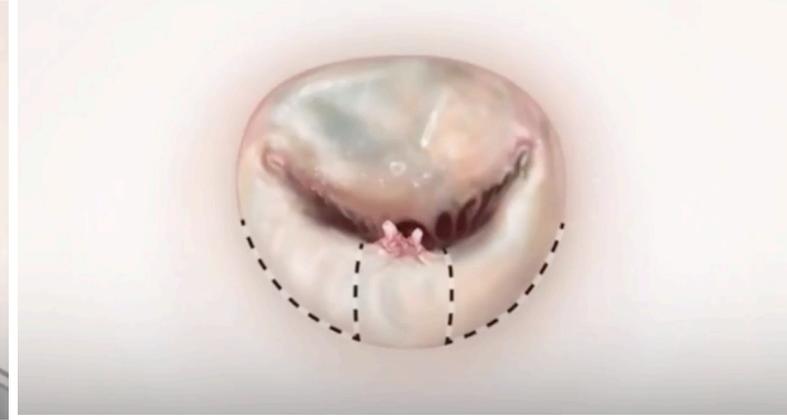
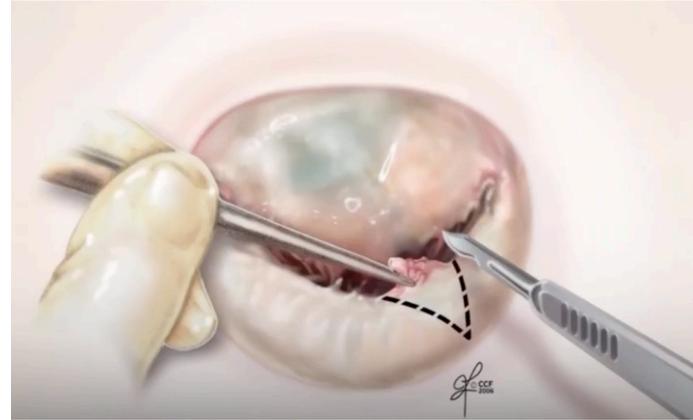


Mitral valve reconstruction in Barlow disease: Long-term echocardiographic results and implications for surgical management

Jérôme Jouan, MD,^{a,b} Alain Berrebi, MD,^{a,b} Sylvain Chauvaud, MD,^{a,b} Philippe Menasché, MD, PhD,^{a,b,c} Alain Carpentier, MD, PhD,^{a,b} and Jean-Noël Fabiani, MD, PhD^{a,b}

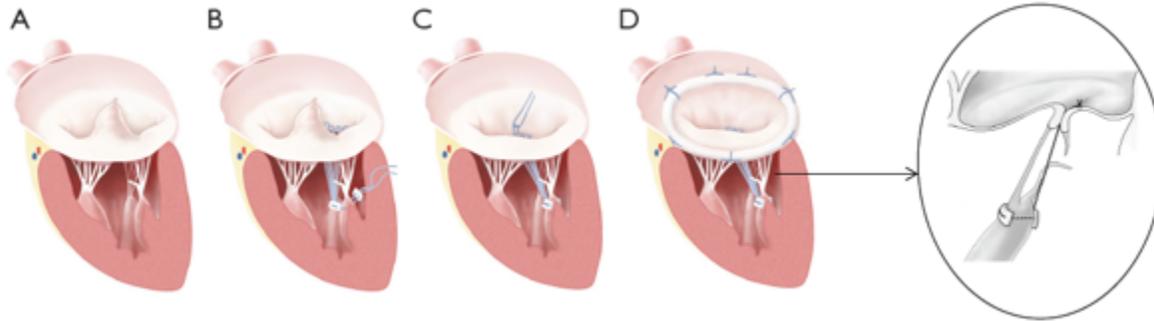
CONCLUSIONS

Barlow disease is a specific degenerative process leading to extensive lesions of the MV. **Despite its complexity, MV reconstruction is most often possible** and should be preferred in this young population. The long-term results are good, provided that surgeons use reproducible techniques and do not accept more than mild MR on the postoperative control echocardiogram. However, owing to the possible progression of this degenerative process, close follow-up has to be achieved after surgery.



Résection triangulaire

Sliding

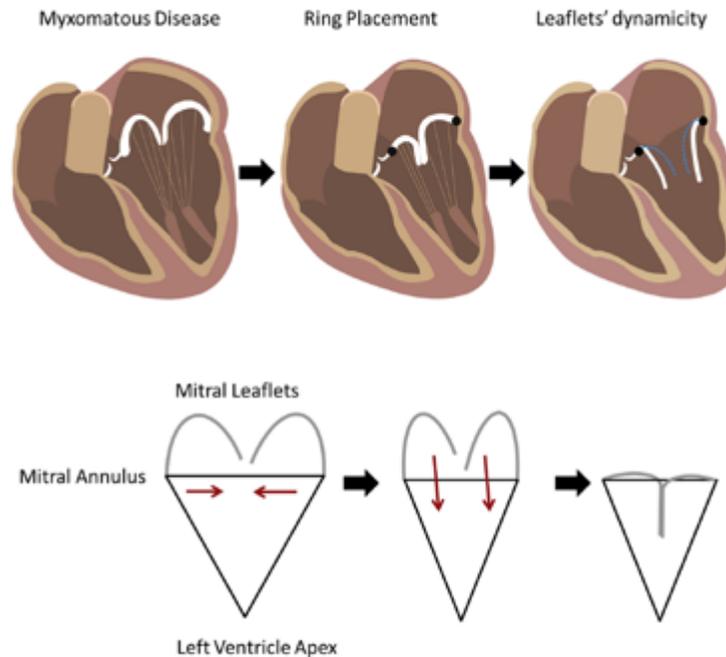


Level	Type	Value (%)	No. of patients
Annulus	Ring annuloplasty	100	182
	Decalcification	8.8	16
Posterior leaflet	Resection	29.7	54
	Sliding plasty	69.8	127
Anterior leaflet	Chordal transfer	7.7	14
	Resection	3.8	7
	Chordal transfer	25.3	46
Commissure	Neochordae	4.4	8
	Edge-to-edge	5.5	10
	Chordal transfer	25.3	46
Papillary muscle	PM shortening	25.3	46
	PM sliding plasty	10.4	19
	Chordal shortening	4.4	8

ACQUIRED CARDIOVASCULAR DISEASE: MITRAL VALVE

Simple repair approach for mitral regurgitation in Barlow disease

Sagit Ben Zekry, MD,^{a,c} Dan Spiegelstein, MD,^{b,c} Leonid Sternik, MD,^{b,c} Innon Lev, MD,^{b,c}
Alexander Kogan, MD,^{b,c} Rafael Kuperstein, MD,^{a,c} and Ehud Raanani, MD^{b,c}

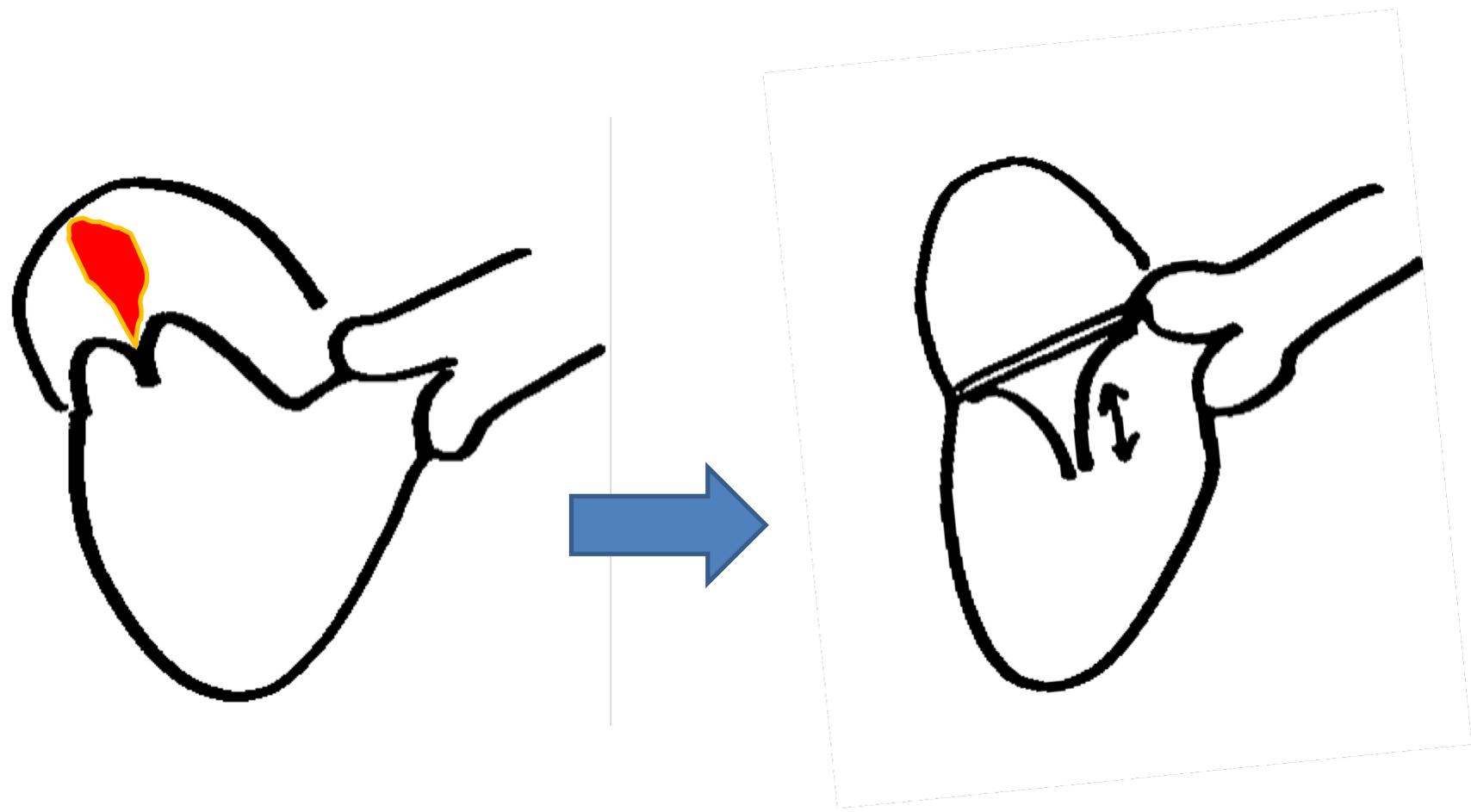


Central Message

A simple valve repair technique limited to mitral annuloplasty for patients with Barlow disease and multisegment involvement.

Perspective Statement

Mitral valve repair for myxomatous Barlow disease is a challenging procedure. We present a simple valve repair technique limited to mitral annuloplasty. This technique was applied on 24 patients with Barlow disease and multisegment involvement causing mainly central jet. The technique was found to be reproducible with excellent late outcomes.





1924-2008

Refusé dans *Circulation*

Le click n'est pas extracardiaque
(adhérences pleuropericardiques selon Gallavardin)

Fibrose d'un cordage mitral postérieur à l'autopsie d'un patient

Angio vg: le click est lié au reflux telesystolique

J.B. Barlow, W.A. Pocock, P. Marchand, D.M. Denny **The significance of late systolic murmurs**
Am Heart J, 66 (1963), pp. 443-452

The significance of late systolic murmurs

J. B. Barlow, M.R.C.P.*
W. A. Pocock, M.B.B.Ch.**
P. Marchand, M.D., Ch.M., F.R.C.S.***
M. Denny, D.M.R.****
Johannesburg, South Africa

Although it is generally agreed that an apical pansystolic murmur with late systolic accentuation is due to mitral incompetence, the late systolic murmur which has no early systolic vibrations demonstrable on a phonocardiogram has been regarded as innocent¹⁻³ and probably extracardiac⁴⁻⁸ in origin. Late systolic murmurs are not rare and their "innocent" significance has been supported by the usual absence of electrocardiographic or radiologic evidence of cardiac abnormality. These murmurs are often accompanied by a mid or late systolic click which has also been regarded as extracardiac in origin.^{4,5,9-11} Leatham¹² has recently claimed that the murmur which is confined to late systole is likely to be entirely innocent "for this curious timing does not fit our present knowledge of hemodynamics." McKusick³ has observed that late systolic murmurs sometimes extend beyond the aortic component of the second heart sound, and he believes that this, together with the mid-late systolic clicks which are often associated, provide evidence that late systolic murmurs are of pericardial origin.

A pansystolic murmur with late systolic accentuation implies that there is an increased amount of regurgitation in late systole in spite of a decreasing pressure gradient between the ventricle and the atrium at that time. This must result from some anatomic deformity of the mitral valve which makes it more incompetent during this period. It seems logical, therefore, that, in the presence of mild mitral valve disease, regurgitation could occur only in late systole and that in such instances a phonocardiogram would show only a late systolic murmur without early systolic vibrations.

It is the purpose of this paper to show that apical late systolic murmurs, whether they be pansystolic with late accentuation or entirely confined to late systole, denote mild mitral regurgitation. The possible cause and significance of the commonly associated systolic clicks are briefly discussed.

Material and methods

Seven patients with apical late systolic murmurs on clinical auscultation were selected for investigation (Cases 1-7, Table

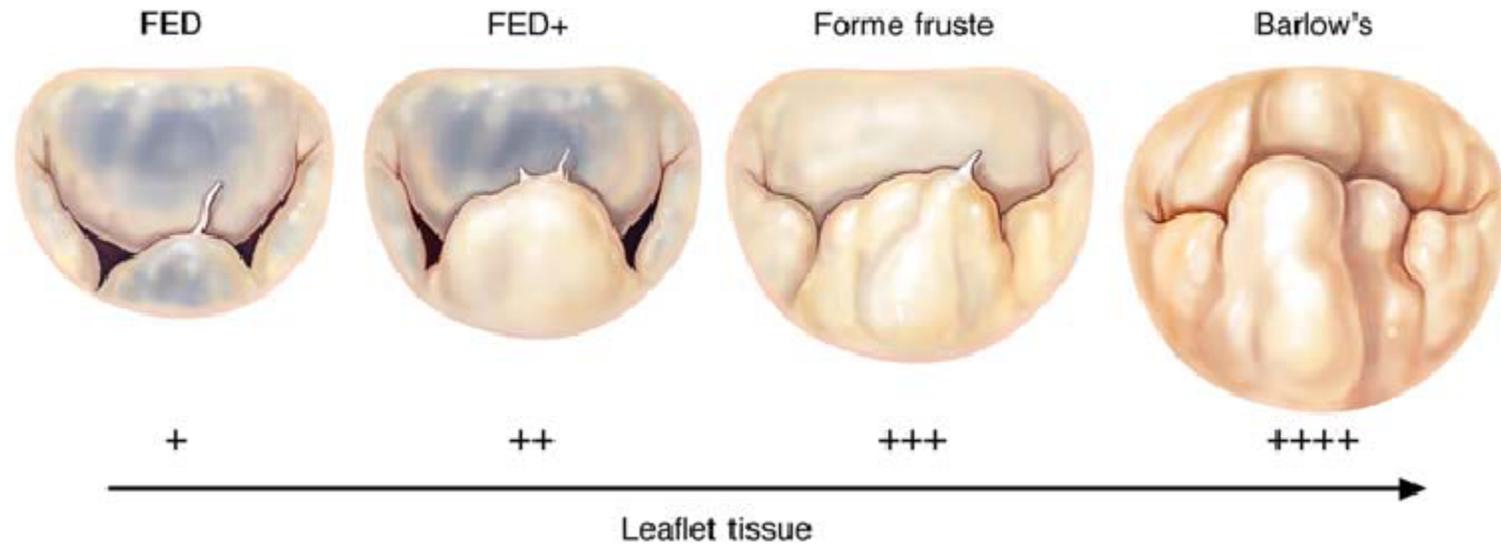
From the Cardiac Clinic, Johannesburg General Hospital, and C.S.I.R. Cardiopulmonary Research Unit, Departments of Medicine and Thoracic Surgery, University of the Witwatersrand, and the Radiological Department, Brompton Clinic, Johannesburg, South Africa.

Received for publication Dec. 17, 1962.

*Internal Medicine, Department of Medicine, University of the Witwatersrand, and Johannesburg General Hospital.

**C.S.I.R. Senior Research Bureau attached to Cardiopulmonary Research Unit, Department of Medicine, University

Epaisseur tissulaire



Rupture de
cordage

Dilatation de
l'anneau

indentation

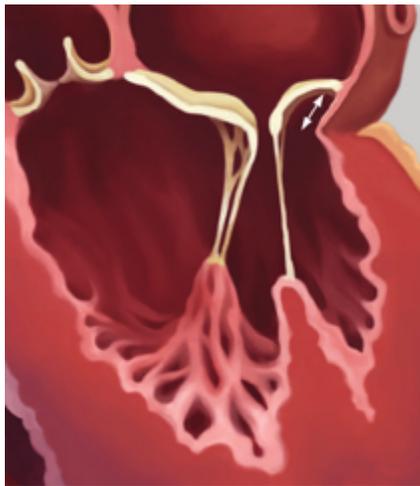
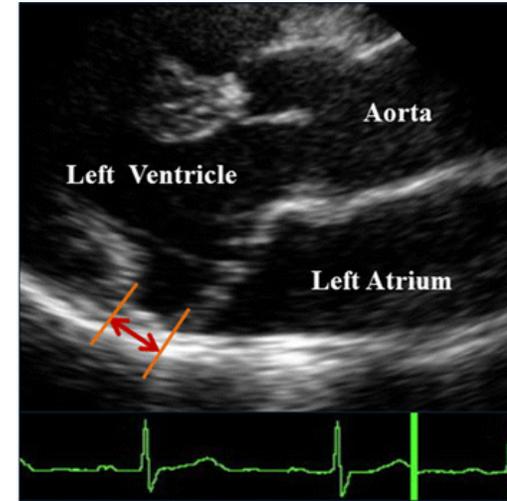
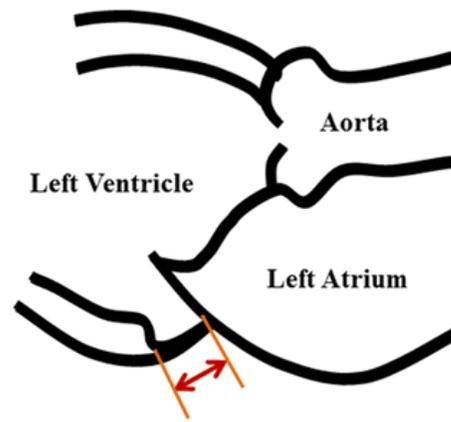
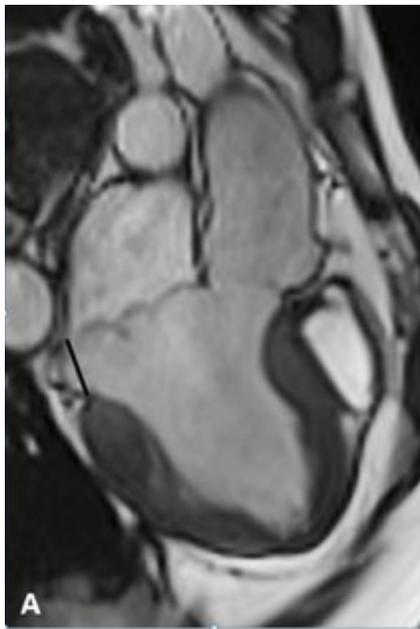
Calcification



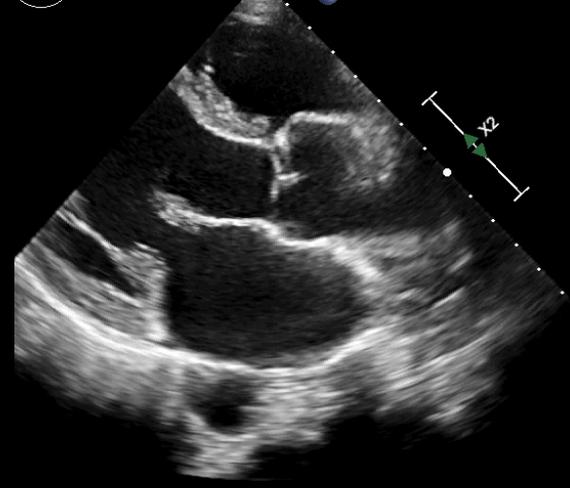
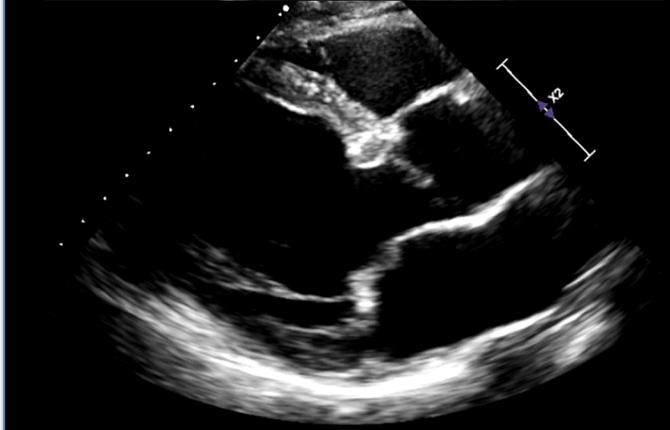
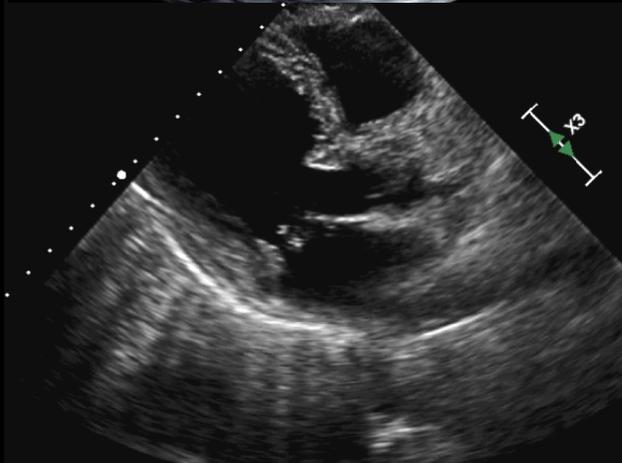
Excès
tissulaire

MAD

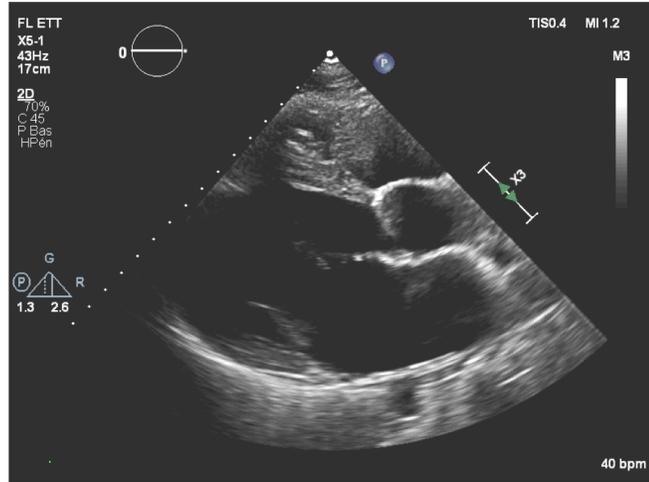
Mitral annular disjunction



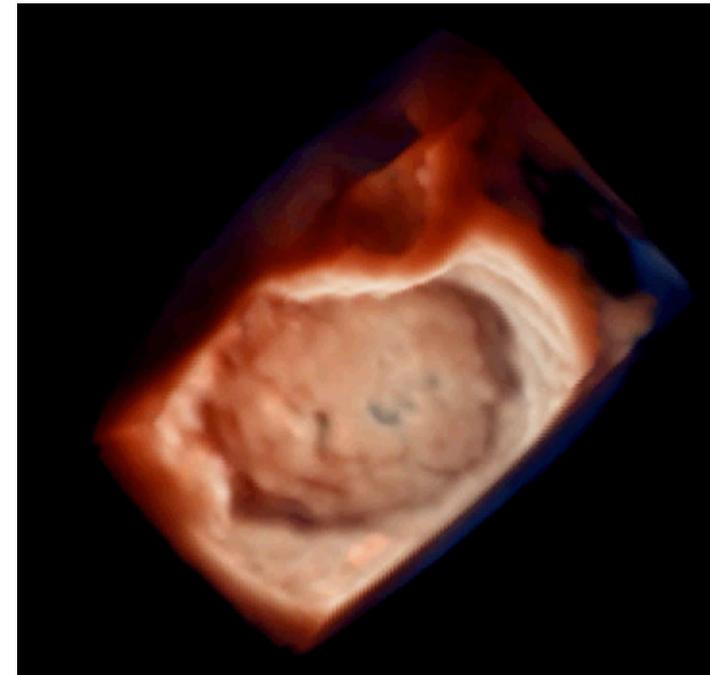
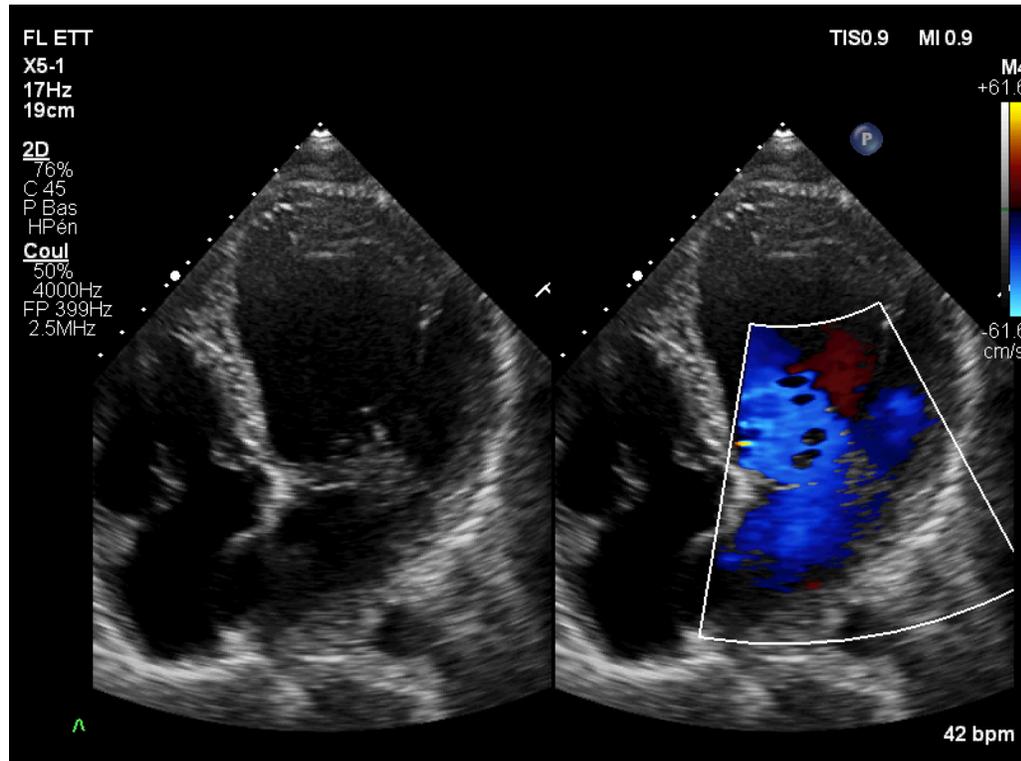
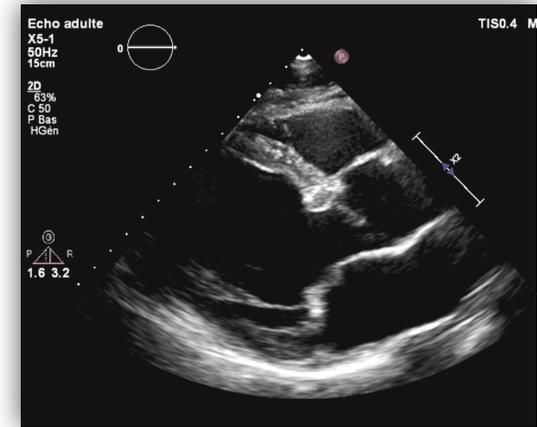
Forme fruste



rupture de cordage



Pas de rupture de cordage



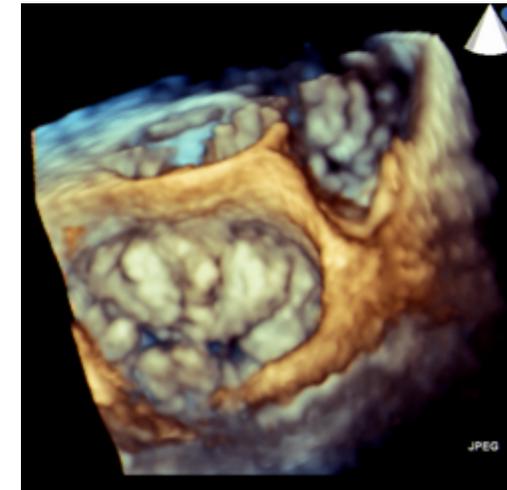
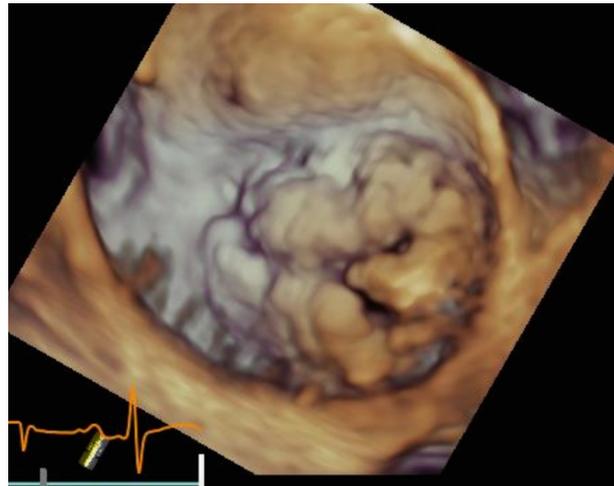
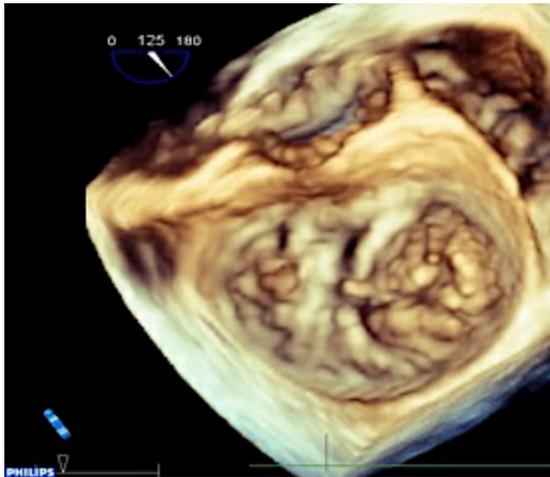
Mechanism of MR

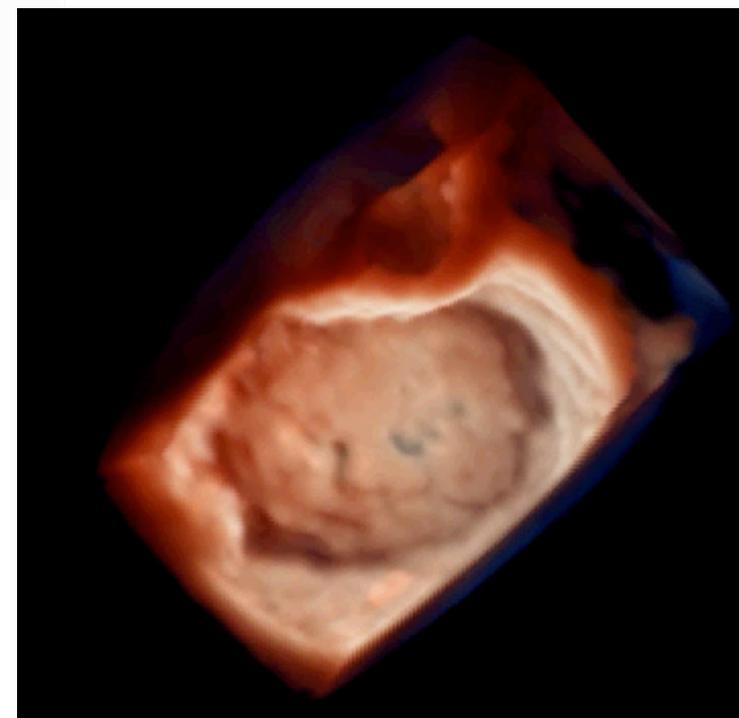
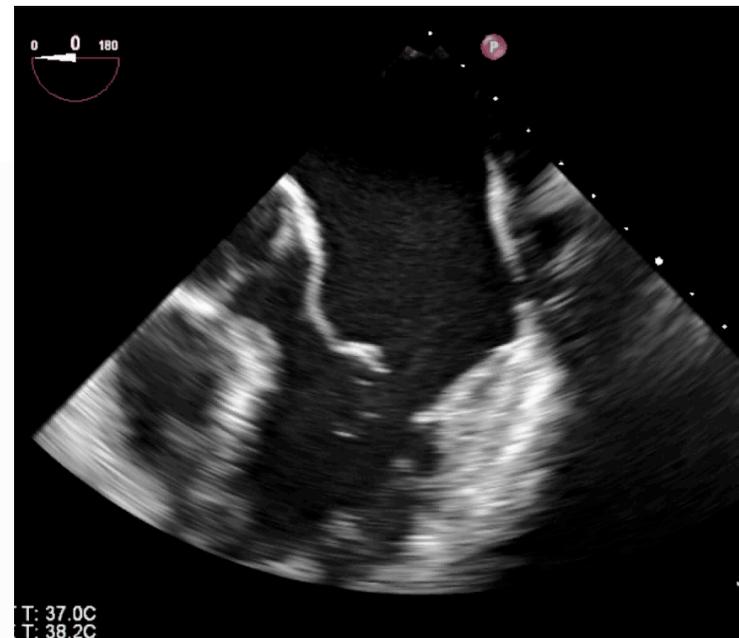
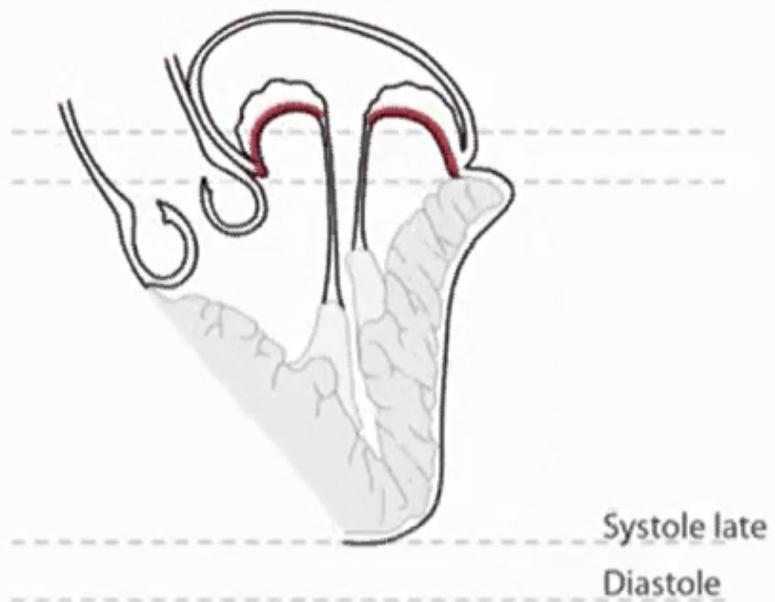
Barlow's disease

Chordal rupture

Cleft

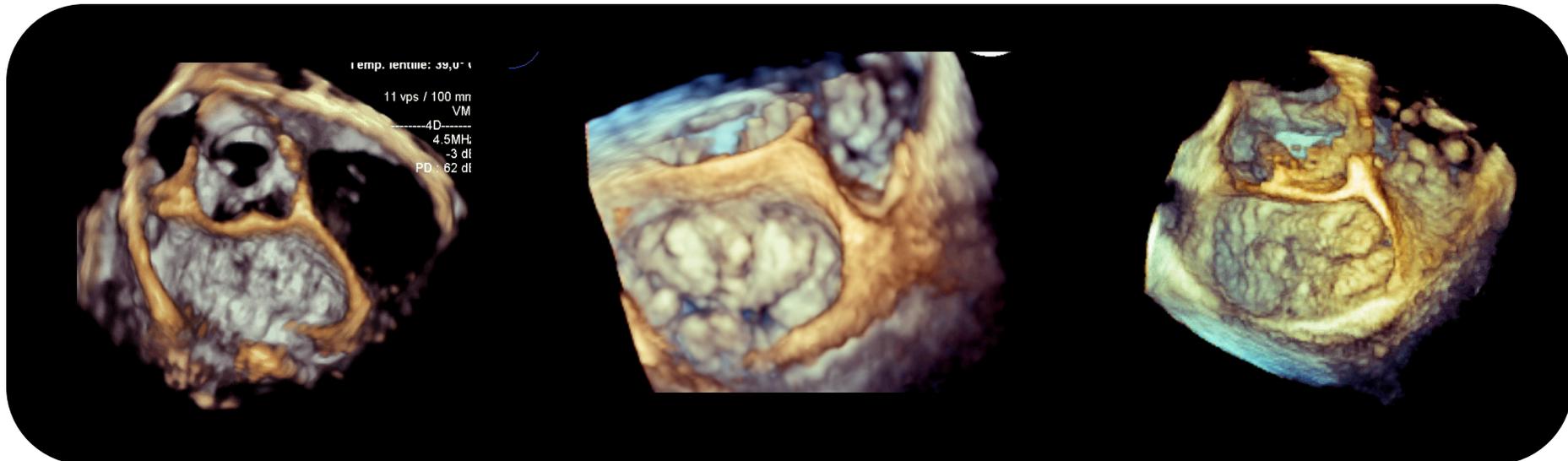
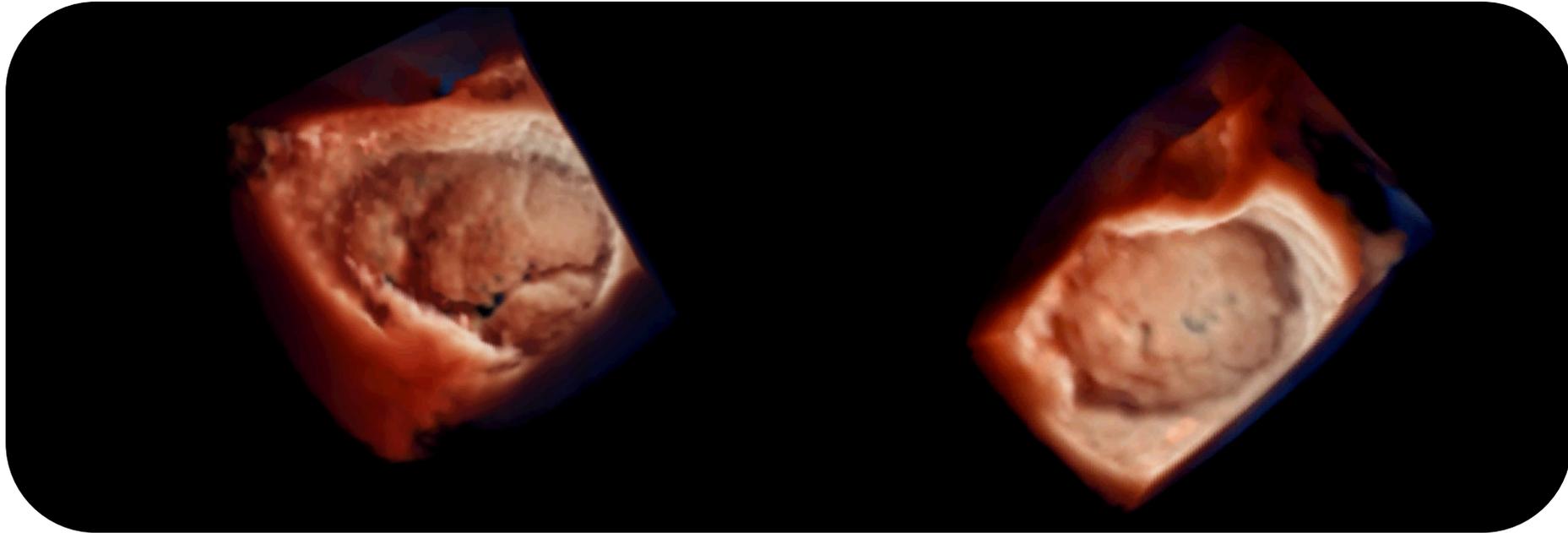
Dynamic





Klautz R, Tomsic A, Palmén M, van Brakel TJ, Perier P.
Optimal surgical mitral valve repair in Barlow's disease: the concept of
functional prolapse.
Multimed Man Cardiothorac Surg 2016;2017, doi:

Formes réparables avec un anneau





merci! la baieta !
