Cardiac transplantation remains the most effective therapy for end-stage heart failure in appropriate candidates, with a median posttransplant survival of 10 years. At any given point of time there are ≈3000 candidates on the heart transplant waiting list in the United States with annual mortality on the waiting list ≈15%. The number of heart transplants performed in the United States per year has been fairly constant at ≈2500. In spite of this, many donor hearts remain unused. Bench repair of mitral valves remains rarely practiced and significant mitral valve regurgitation (MR) remains a standard contraindication to use of a donor heart.

Case 1
A 53-year-old male donor who had a cerebral infarct became available for a 61-year-old man with blood group O who received left ventricular assist device, Heartmate II (Thoratec, Pleasanton, CA), for decompensated dilated cardiomyopathy. The donor coronary angiogram was normal. Donor transesophageal echocardiogram (TTE) showed inferior wall hypokinesis, interventricular septum 1.15 cm, left ventricular ejection fraction (LVEF) 55%, and moderate MR with a posteriorly directed jet (Figure 1).

Bench analysis of the mitral valve showed a dilated annulus. Saline test revealed a central leak caused by inadequate leaflet coaptation secondary to annular dilatation and leak through prominent indentations in the posterior leaflet. (Carpentier type I dysfunction). The heart was kept in ice, and continuous retrograde cold blood cardioplegia was perfused. The indentations in the posterior leaflet were closed. On saline test now there was no leak through the indentations; however, there was persistent central leak. A 27-mm ATS annuloplasty band (Medtronic, Pleasanton, CA), for decompensated dilated cardiomyopathy. Donor transthoracic echocardiogram (TTE) showed good left ventricular function, interventricular septum 1.15 cm, left ventricular ejection fraction (LVEF) 55%, and moderate MR with a posteriorly directed jet (Figure 1).

The surgeon should review the donor echocardiogram to determine the exact nature and pathology of MR in otherwise acceptable donor hearts. If the mechanism of MR is simple, acceptable donor hearts. If the mechanism of MR is simple,
then bench repair can be performed adding only a few more minutes to warm ischemia time before transplantation.

We extended donor criteria for predicted long wait times (blood group O, high body mass index) or concerns about complications of left ventricular assist device support. A heart with a bench-repaired mitral valve may provide better odds of long-term survival compared with continued waiting on the list.

Disclosures
Dr Adams is co-inventor of the Tri-Ad Annuloplasty Ring (Medtronic Inc, Minneapolis, MN) and co-inventor of the Carpentier Edwards Physio II ring (Edwards Lifesciences, Irvin, CA). The remaining authors have no disclosures.

References

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Bench Mitral Valve Repair of Donor Hearts Before Orthotopic Heart Transplantation
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Supplemental Material

Supplemental Figure

Spectral Doppler tracing of mitral regurgitation in Case 1.

Video Legends

Movie 1. Transthoracic echo, long axis parasternal view of donor heart in Case 1.

Movie 2. Coronary angiogram of donor in Case 1; left main stem injection.

Movie 3. Coronary angiogram of donor in Case 1; right coronary artery injection.