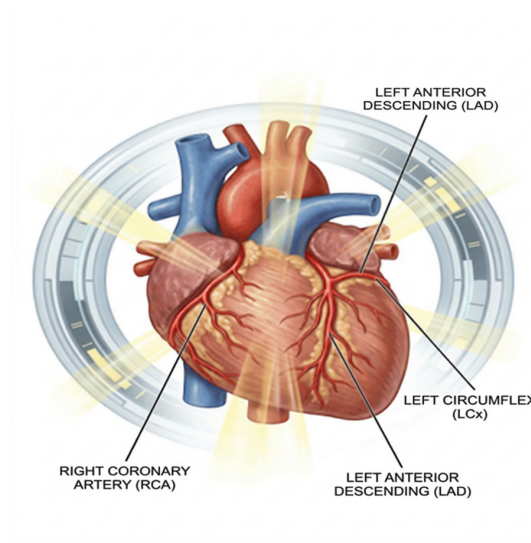


Understanding TAVR

Transcatheter Aortic Valve Replacement

Less Invasive. Same Goal: A Better-Working Valve.



Online: <https://go.riasalimd.com/tavr-guide>

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Names & Terms You Will Hear

Term	Meaning
TAVR	Transcatheter Aortic Valve Replacement (US term we use)
TAVI	Transcatheter Aortic Valve Implantation (European / global term)
Percutaneous valve replacement	less common term, same procedure
Catheter-based aortic valve replacement	long-form description
BAV-then-TAVR	balloon valvuloplasty as a bridge before TAVR
SAVR	Surgical Aortic Valve Replacement — the open-heart alternative
Heart team	the group of cardiologists and surgeons who decide TAVR vs SAVR for you
Aortic stenosis (AS)	the underlying condition TAVR treats — a narrowed aortic valve



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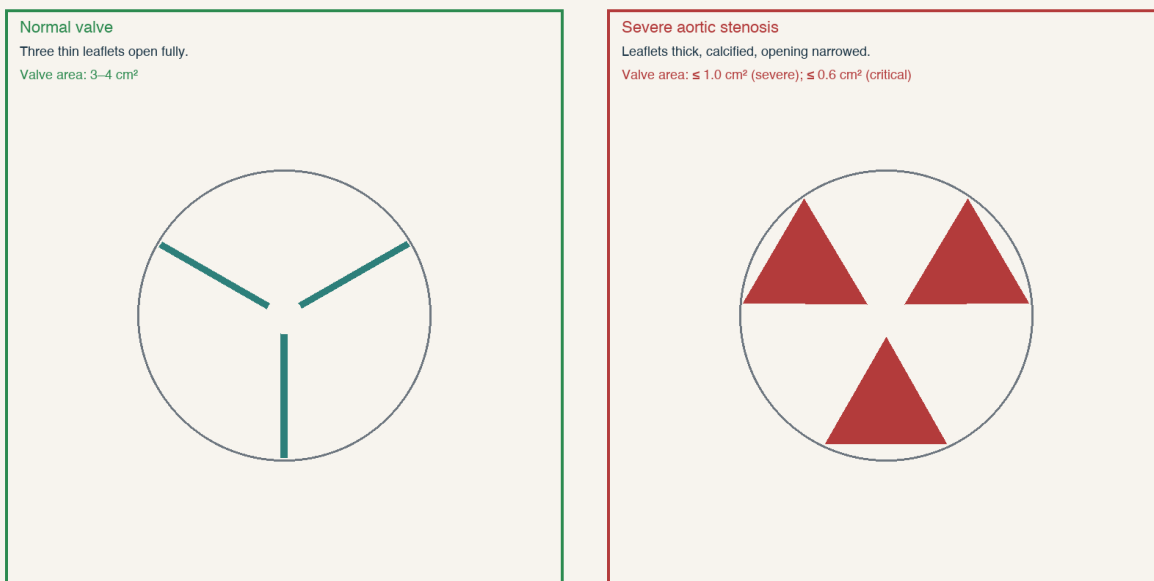
Quick Background — Aortic Stenosis

Aortic stenosis (AS) is a narrowing of the heart's main outlet valve. It is one of the most common valve problems in older adults. **Severe AS** is defined by a mean pressure across the valve of 40 mm Hg or more, peak valve flow speed of 4 m/s or more, or a valve area of 1 cm² or less. **Critical AS** is even tighter — a valve area at or below 0.6 cm² or severe AS with symptoms despite a trial of medicines. Once AS becomes severe and causes symptoms (shortness of breath, chest pain, fainting), untreated mortality is high — about half of patients die within 2 years.

Treatment for severe symptomatic AS is valve replacement. The two ways are TAVR (this guide) and SAVR (open surgery). For low- and intermediate-risk patients, the PARTNER 3 and Evolut Low Risk trials showed TAVR was non-inferior to SAVR for the combined endpoint of death or stroke at 1 and 2 years. For higher-risk and inoperable patients, TAVR has been the standard of care for over a decade. Medical therapy alone does not fix AS — it is a mechanical problem that needs a mechanical solution.

For full background on aortic stenosis — what it is, how we diagnose it, when to act, and how to live with mild or moderate AS — see Dr. Ali's full [Aortic Stenosis Patient Education Guide](#). This guide focuses on TAVR specifically: how it works, what to expect, and how to recover.

Normal vs Stenotic Aortic Valve



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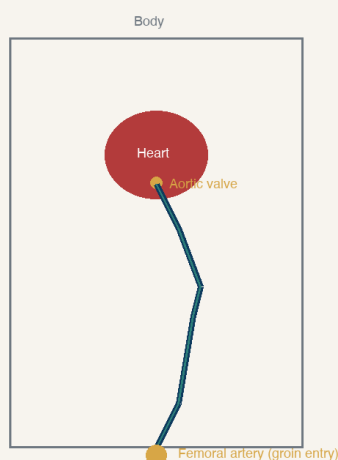
What Is TAVR?

- TAVR places a new aortic valve through a small artery — usually in the groin — without opening your chest.
- The new valve is mounted on a wire frame (called a stent). It is delivered folded inside a thin tube (a catheter).
- Once positioned inside your old, narrowed valve, the new valve is expanded and takes over.
- The whole procedure usually takes 60–90 minutes. Most patients go home in 1–2 days.
- TAVR is done under conscious sedation or general anesthesia — your heart team decides what fits.

TAVR — How It Reaches the Heart

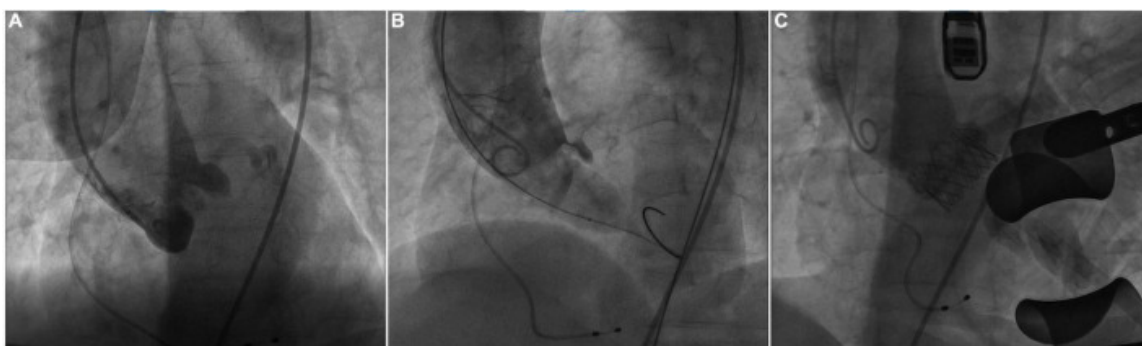
Steps

1. Tiny needle in the femoral artery (groin)
2. Guide wire threaded up to the heart
3. Catheter delivers folded valve to old valve
4. Valve expanded inside old valve
5. Catheter removed; artery closed



Quick facts

Procedure time: 60–90 minutes
Hospital stay: 1–2 nights
Most patients walk within 6 hours
No chest opening for >95% of cases
Conscious sedation common; GA available



Real fluoroscopy (live X-ray) images from an actual TAVR procedure. The doctor watches this screen in real time to guide the new valve into place and confirm the coronary arteries stay open before, during, and after deployment. Image: Dai et al., *Frontiers in Cardiovascular Medicine* 2022 (CC BY 4.0).



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Who Is a Candidate?

- You have severe symptomatic AS confirmed by echocardiogram (and often a CT scan).
- Your heart team has reviewed your case. The team is required by national policy.
- Your anatomy is suitable — coronary heights, annulus size, peripheral artery diameter.
- Your overall health and other organ function support a procedure.
- Lower-risk patients now have TAVR as a guideline-supported option (2020 ACC/AHA VHD; PARTNER 3; Evolut Low Risk).
- Patients with bicuspid valves are increasingly treated with TAVR in experienced centers.



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How We Reach the Valve — Access Routes

Route	When Used	Notes
Transfemoral (groin)	First choice for over 95% of patients	Smallest incision; quickest recovery.
Subclavian / axillary (under collarbone)	Femoral arteries too small or diseased	Slightly more recovery; same valve types.
Transcaval (through inferior vena cava to aorta)	Femoral and subclavian both unusable	Specialized centers; specific anatomy needed.
Transapical (through chest wall into apex of heart)	Rarely used today	More invasive; reserved for unusual cases.



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Valve Types

Two main families of TAVR valves are in use today. Your heart team picks one based on your anatomy.

Type	Brand Examples	How It Deploys	Notes
Balloon-expandable	Edwards SAPIEN 3 / SAPIEN 3 Ultra	A balloon expands the stent in one step.	Predictable size; lower pacemaker risk than older self-expanding.
Self-expanding	Medtronic Evolut PRO+ / FX	Stent springs open as it leaves the catheter.	Better for small annulus or high coronaries; slightly higher pacemaker rate.
Mechanically expandable	Boston Scientific LOTUS (legacy) / future devices	Expanded by a mechanical mechanism rather than balloon.	Ongoing research; not currently first-line.



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What to Expect on Procedure Day

- You arrive early in the morning — nothing to eat or drink after midnight.
- An IV is placed; you meet the heart team again. You sign final consent.
- In the cath lab, sticky electrodes go on your chest; sterile drape covers most of your body.
- Most patients receive conscious sedation (sleepy but breathing on your own). Some need general anesthesia.
- The cardiologist accesses the femoral artery with a needle, then a wire and small tube.
- The catheter carrying your new valve is advanced up to your aortic valve under X-ray guidance.
- The valve is positioned and deployed (expanded). The team checks it works with imaging.
- Catheters are removed. The artery is closed (suture, plug, or pressure).
- You wake up in recovery. Most patients walk within 6 hours.



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Recovery After TAVR

- Hospital stay — usually 1 to 2 nights for transfemoral TAVR.
- Activity — you can walk and do light activity right away. No heavy lifting (more than 10 lb) for 1 week.
- Driving — most patients can drive in 3–5 days if not on narcotic pain medicine.
- Showering — yes, the next day. Pat the access site dry; do not soak in a tub for 1 week.
- Anticoagulation — most TAVR patients take a single antiplatelet (aspirin) for life. Some need a DOAC if AFib is present.
- Cardiac rehab — supervised exercise program over 6–12 weeks. Improves recovery and lowers future events.
- Follow-up echo — within 30 days, then yearly. Watches for valve function and any leak.
- Return to work — most desk jobs in 3–7 days. Physical jobs in 2–4 weeks.



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TAVR vs SAVR — Side by Side

TAVR vs SAVR — Side by Side

Feature	TAVR	SAVR (Open Surgery)
Approach	Catheter through artery	Open chest, sternotomy
Anesthesia	Conscious sedation common	General anesthesia
Heart-lung machine	Not used	Used
Hospital stay	1–2 nights	5–7 nights
Recovery	1–2 weeks	6–8 weeks
Stroke risk	1–3%	Similar (2–4%)
Pacemaker	5–15%	1–4%
Durability data	10+ years (still maturing)	Decades
Best for	Most patients (low/intermediate/high risk)	Patients needing concomitant cardiac surgery
Anticoagulation	Single antiplatelet (often aspirin)	Single antiplatelet for tissue valve; warfarin for mechanical



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Risks, Benefits, and Alternatives

The choice between TAVR, SAVR, and conservative care is shared between you and your heart team. Use this table to start the conversation.

Option	Risks	Benefits	Alternatives
TAVR	Stroke (1–3%), pacemaker (5–15%, depends on valve), paravalvular leak, vascular complications, very rare valve embolization or coronary obstruction. Lifelong valve surveillance required.	No chest opening. Quicker recovery (1–2 days vs 5–7 days). Comparable mortality to SAVR at low risk through 5 years (PARTNER 3, Evolut Low Risk). Symptom relief usually within days.	SAVR (gold-standard durable repair, longer recovery), balloon valvuloplasty (palliative bridge only), conservative care if patient is not a candidate (poor prognosis).
SAVR (Open Surgery)	Stroke (similar overall to TAVR), bleeding requiring transfusion, atrial fibrillation post-op (~30%), longer hospital stay, sternal wound issues.	Direct visualization. Long-track-record durability data (decades). Allows concomitant CABG or other valve work in one operation.	TAVR (less invasive), staged procedures.
Balloon Aortic Valvuloplasty (BAV)	Restenosis within 6–12 months. Stroke. Vascular access complications.	Bridge to TAVR or SAVR in unstable patients. Sometimes used to test if symptoms will improve with valve work.	Direct TAVR if anatomy and stability allow.
Conservative care (no procedure)	Severe symptomatic AS without valve replacement carries about 50% mortality at 2 years.	Avoids procedure risk in the very few patients in whom procedure risk truly outweighs benefit.	TAVR or SAVR — almost always preferred when feasible.



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Complications — What Can Happen

Modern TAVR is safe for the right patient — but every procedure has risks. We talk through these honestly before signing consent.

Complication	What It Is	How Often	What We Do
Stroke	Brain blood-vessel blockage during or shortly after the procedure.	About 1–3% in low-risk PARTNER 3; lower with newer techniques and embolic protection in some centers.	Cerebral embolic protection device (Sentinel) when offered; aggressive BP and AFib management.
Pacemaker (LBBB or complete heart block)	The valve sits next to the heart's electrical wires; injury can trigger a slow rhythm needing a pacemaker.	5–15%, varies by valve type and depth of implant.	ECG monitoring 1–3 days post-procedure; pacemaker if persistent block.
Paravalvular regurgitation (PVR)	Blood leaks around the new valve where it meets your old valve ring.	Mild PVR is common; moderate or severe is uncommon (< 5%) with modern valves.	Post-deployment ballooning, oversized valve, or rare valve-in-valve.
Vascular access complications	Bleeding, hematoma, or rare artery injury at the groin entry site.	Major: about 1–2%. Minor bruising: common.	Closure devices, ultrasound-guided puncture, surgical repair if needed.
Acute kidney injury	Drop in kidney function from contrast dye and procedural stress.	About 5%; usually transient.	Pre-hydration, contrast minimization, close labs after.
Valve thrombosis	Tiny clots can form on the new valve leaflets, sometimes silent.	Subclinical thrombosis: 5–15% on imaging at 1 year.	Surveillance echo; sometimes short-course anticoagulation.
Endocarditis	Infection of the new valve.	Less than 1% per year — same risk as SAVR.	Antibiotics before dental work; promptly evaluate fever after the procedure.
Structural valve degeneration	Wear and tear of valve leaflets over years.	5- to 10-year durability data is favorable. Long-term (15+ years) data still maturing.	Annual echo; valve-in-valve TAVR if valve fails.



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Common Misconceptions

Myth	Reality
TAVR is just a quick procedure with no real risks.	TAVR is safer than open surgery for most patients but still carries stroke, pacemaker, and bleeding risks. The decision still belongs to a heart team.
Once I have TAVR I'm done — no follow-up.	TAVR requires lifelong follow-up. Annual echo, watch for new symptoms, and a single-pill antiplatelet (most often aspirin) is typical.
TAVR is only for very old or very sick patients.	TAVR is now an option across the risk spectrum. PARTNER 3 and Evolut Low Risk extended approval to low-risk patients in 2019.
Pacemaker after TAVR means TAVR failed.	A pacemaker is a known complication of TAVR — not a sign that TAVR did not work. The valve can function normally even with a pacemaker.
If I am asymptomatic, I do not need anything.	Some patients with very tight AS benefit from earlier valve replacement (RECOVERY trial). Talk with your cardiologist about timing.
Mechanical valves last forever, so TAVR must be worse.	TAVR uses tissue (bioprosthetic) valves. Tissue valves can wear out over years, but modern data show good durability and valve-in-valve TAVR is feasible.
I can stop my heart medicines after TAVR.	Blood pressure, cholesterol, and rhythm medicines usually continue. The valve is fixed; the rest of the cardiovascular system still needs care.
All TAVR valves are the same.	Two main families (balloon-expandable and self-expanding) have different strengths. Your heart team picks based on your anatomy.



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Points to Know

Carry these eight points with you.

- TAVR replaces the aortic valve through a small artery — no chest opening for most patients.
- TAVR is approved across all risk levels (low, intermediate, high). Heart team decides the best route.
- PARTNER 3 and Evolut Low Risk showed TAVR was non-inferior to surgery for low-risk patients at 2 years.
- Most patients go home in 1–2 days and return to normal activity in 1–2 weeks.
- Pacemaker is the most common 'expected' complication (5–15%); stroke is the most feared (1–3%).
- Lifelong follow-up matters: annual echo, single antiplatelet (often aspirin), report new symptoms early.
- Cardiac rehab improves recovery and outcomes — say yes if it is offered.
- If your dentist or another doctor schedules a procedure, tell them you have a prosthetic aortic valve.



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When to Call Us — and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- Stroke symptoms (face droop, arm weakness, speech change) — call 911.
- New chest pain, severe shortness of breath, or fainting — call 911.
- Bleeding from the groin access site that does not stop with 10 minutes of pressure — call 911.
- Fever above 100.4°F more than 48 hours after the procedure — call us same day (rule out endocarditis).
- New irregular heartbeat, pounding, or skipped beats — call us within 24 hours.
- Leg pain, coolness, or color change in the access leg — call us within 24 hours.
- Pacemaker site swelling, redness, or pain — call us within 24 hours.
- Sudden weight gain (more than 3 lb overnight) or new ankle swelling — call us within 24 hours.

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Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- [AHA — Heart Valve Problems and Disease](#) — Plain-language overview of valve disease and treatments.
- [Mayo Clinic — TAVR / TAVI](#) — Comprehensive overview of TAVR with FAQs.
- [Cleveland Clinic — TAVR](#) — Procedure details and recovery information.
- [STS Public Reporting \(US TAVR Registry\)](#) — Hospital-level outcomes for TAVR programs in the US.
- [Dr. Ali — Aortic Stenosis Patient Guide](#) — The companion guide for full background on AS itself.



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Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- [2020 ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease \(Otto et al., JACC 2021\) \[Guideline\]](#)
Primary reference for the guide's aortic stenosis severity grading, intervention timing thresholds, and shared decision-making framework for TAVR vs. SAVR.
Short link: <https://doi.org/10.1016/j.jacc.2020.11.018>
- [PARTNER 3 — TAVR vs SAVR in Low-Risk Patients \(Mack et al., NEJM 2019; PMID 30883058\) \[Clinical Trial\]](#)
Foundational evidence cited in the guide's section explaining why TAVR is now a guideline-endorsed option for low-surgical-risk patients.
Short link: <https://doi.org/10.1056/NEJMoa1814052>
- [Evolut Low Risk — Self-Expanding TAVR vs SAVR in Low-Risk Patients \(Popma et al., NEJM 2019; PMID 30883053\) \[Clinical Trial\]](#)
Supports the guide's explanation that self-expanding TAVR platforms are non-inferior to surgery in low-risk patients, reinforcing the PARTNER 3 finding.
Short link: <https://doi.org/10.1056/NEJMoa1816885>
- [PARTNER 2A — TAVR vs SAVR in Intermediate-Risk Patients \(Leon et al., NEJM 2016; PMID 27040324\) \[Clinical Trial\]](#)
Evidence for the guide's historical timeline section showing TAVR expanded from high-risk to intermediate-risk patients based on non-inferiority data.
Short link: <https://doi.org/10.1056/NEJMoa1514616>
- [PARTNER 1A — TAVR vs SAVR in High-Risk Patients \(Smith et al., NEJM 2011; PMID 21639811\) \[Clinical Trial\]](#)
Cited in the guide's origin story of TAVR as the first RCT to show TAVR was non-inferior to surgery in high-surgical-risk patients with severe AS.
Short link: <https://doi.org/10.1056/NEJMoa1103510>
- [PARTNER 1B — TAVR vs Standard Care in Inoperable Patients \(Leon et al., NEJM 2010; PMID 20961243\) \[Clinical Trial\]](#)
Basis for the guide's section on patients who cannot have surgery, where TAVR reduced all-cause mortality by 46% compared with medical therapy.
Short link: <https://doi.org/10.1056/NEJMoa1008232>
- [2021 ESC/EACTS Guidelines for the Management of Valvular Heart Disease \(Vahanian et al., Eur Heart J 2022\) \[Guideline\]](#)
Provides the European perspective on TAVR indications and the Heart Team decision model referenced in the guide's 'Who Decides?' section.
Short link: <https://doi.org/10.1093/eurheartj/ehab395>
- [RECOVERY — Early Surgery vs Conservative Care in Asymptomatic Severe AS \(Kang et al., NEJM 2020 \[published online Nov 2019\]; PMID 31733181\) \[Clinical Trial\]](#)
Supports the guide's discussion of why watchful waiting in truly asymptomatic but very severe AS carries risk, and why early intervention may be considered.
Short link: <https://doi.org/10.1056/NEJMoa1912846>



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- [AHA — Heart Valve Problems and Disease \(heart.org\)](https://www.heart.org/en/health-topics/heart-valve-problems-and-disease) [Patient Education]
Recommended take-home reading for patients wanting a plain-language overview of how heart valves work and what happens when they become diseased.
Short link: <https://www.heart.org/en/health-topics/heart-valve-problems-and-disease>
- [AHA — Aortic Stenosis: What You Need to Know \(heart.org\)](https://www.heart.org/en/health-topics/heart-valve-problems-and-disease/heart-valve-problems-and-causes/aortic-stenosis) [Patient Education]
Cited in the guide's 'Understanding Your Diagnosis' section for patients wanting condition-specific information on aortic stenosis symptoms and treatment options.
Short link: <https://www.heart.org/en/health-topics/heart-valve-problems-and-disease/heart-valve-problems-and-causes/aortic-stenosis>



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About This Guide

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Version: 2026-08-16

Reviewer note: Reviewed against AHA Heart Valve Problems page, Mayo Clinic TAVR page, and Cleveland Clinic TAVR page. Ours adds: explicit AS-context bridge with severe vs critical stratification, RBA framework, complications nomenclature (LBBB, paravalvular regurgitation, structural valve degeneration), expanded misconceptions, and lifelong follow-up cadence.

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.



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