

AHA'S MODERATE AORTIC STENOSIS
VIRTUAL GRAND ROUNDS SERIES:
SESSION #1

**Disease Progression
and Risk in Moderate
Aortic Stenosis:
The Rationale for
Earlier Therapy**

JANUARY 29, 2026



Meeting Reminders

Please Note:

- This webinar is being recorded.
- All participants will be muted upon entry.
- Recordings of today's sessions will be enduring resources in a few weeks on www.heart.org/ModerateAS

Questions?

- We encourage an open, conversational discussion, so please engage and share your thoughts!
- Q&A is scheduled at the end of the webinar.
- Submit your questions in the chat anytime—they will be addressed during the designated Q&A.

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WELCOME & INTRODUCTIONS

Devin Marie Keating

Director of Operations, Clinical Studies
American Heart Association



Thank you to
Kardigan, Inc.
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TODAY'S SPEAKERS



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Health Policy



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TAVR Coordinator



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FACC**

Lake Charles Memorial Hospital

Valve Clinic Coordinator

STS/ACC TVT Registry Site Manager



DISCLOSURES

American Heart Association Statement

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Sreekanth Vemulapalli, MD

- Grants / Contracts: National Institutes of Health (R01 and UG3/UH3), Food and Drug Administration, Edwards Lifesciences, Abbott Vascular, American College of Cardiology, American Heart Association
- Consulting / Advisory: Edwards Lifesciences, Medtronic, Abbott Vascular, Cytokinetics, Astra Zeneca, Boehringer-Ingelheim

Jeanne Huchting, ACNP

- Speaker's Bureau, Edwards Lifesciences

Misty Theriot, BSN, RN, CPHQ, FACC

- Speaker's Bureau, Edwards Lifesciences



AGENDA:

1. **Early Disease Progression & Rationale for Earlier Intervention**
2. **Therapeutic Context: Ataciguat & KATALYST-AV**
3. **Case-Based Discussion:
Identifying the “At-Risk” Moderate AS Patient**
4. **Audience Q&A and Closing Remarks**





EARLY DISEASE PROGRESSION & RATIONALE FOR EARLIER INTERVENTION

Jeanne Huchting, ACNP

*University of California Los Angeles, Cardiovascular Center
TAVR Coordinator*

Misty Theriot, BSN, RN, CPHQ, FACC

*Lake Charles Memorial Hospital
Valve Clinic Coordinator, STS/ACC TVT Registry Site Manager*

NATURAL HISTORY & BURDEN OF MODERATE AORTIC STENOSIS: WHAT'S DRIVING DISEASE PROGRESSION

Jeanne Huchting, ACNP

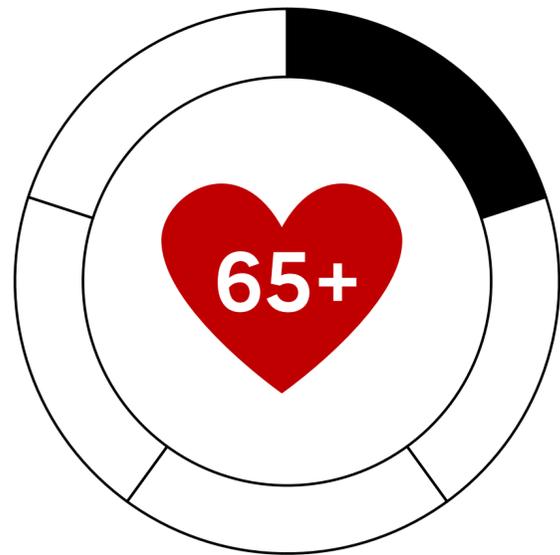
University of California Los Angeles, Cardiovascular Center

TAVR Coordinator



THE UNMET NEED IN HEART VALVE DISEASE

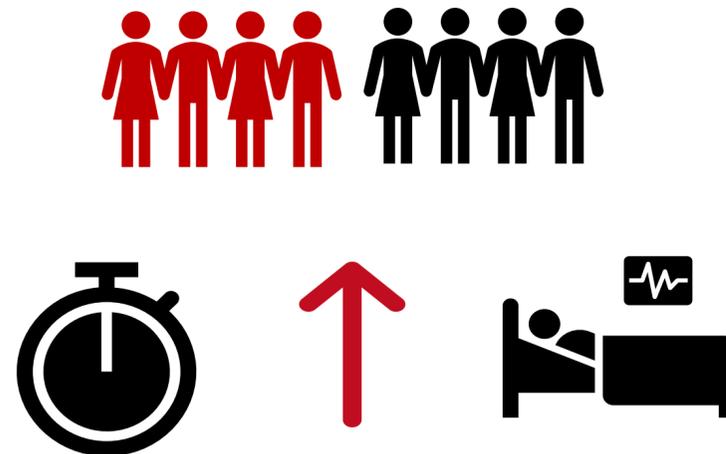
High Prevalence



Nearly 1 in 5 Americans aged 65+ have significant valvular heart disease

(PREVUE Valve Study, TCT 2025)

Under Treatment or Delayed Treatment



50% of all patients with symptomatic severe aortic stenosis remain untreated. Delayed or missed treatment increases mortality, and reduces quality of life

(Li et al., JACC, 2022)

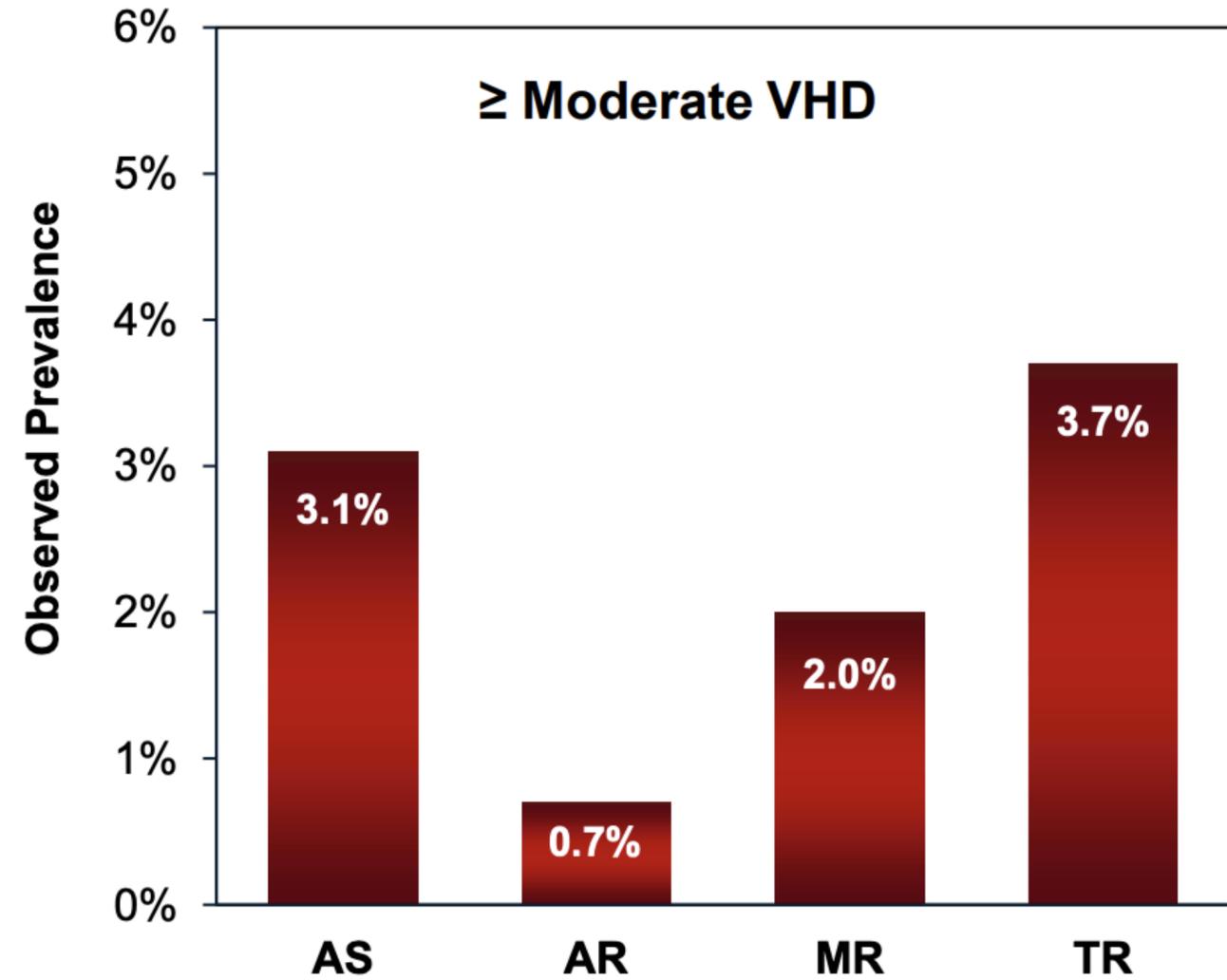
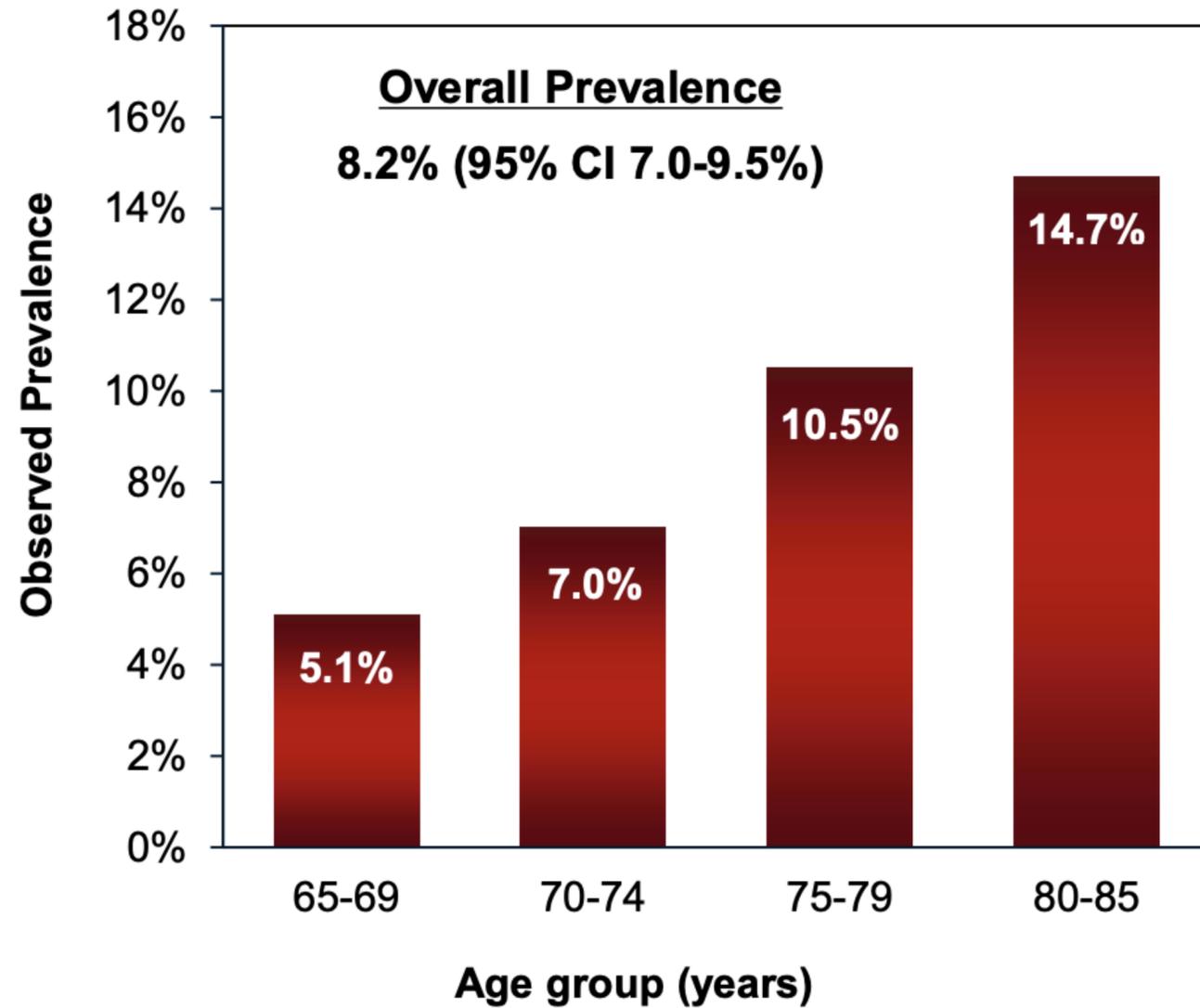
Disparities in Care



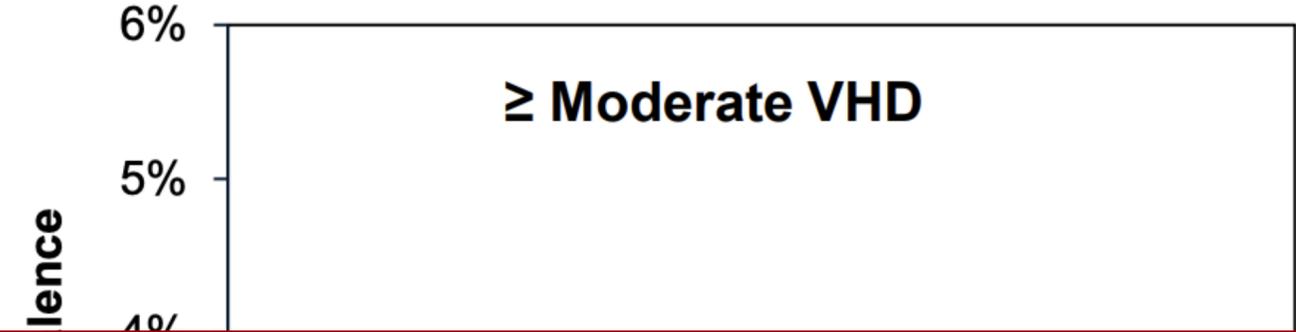
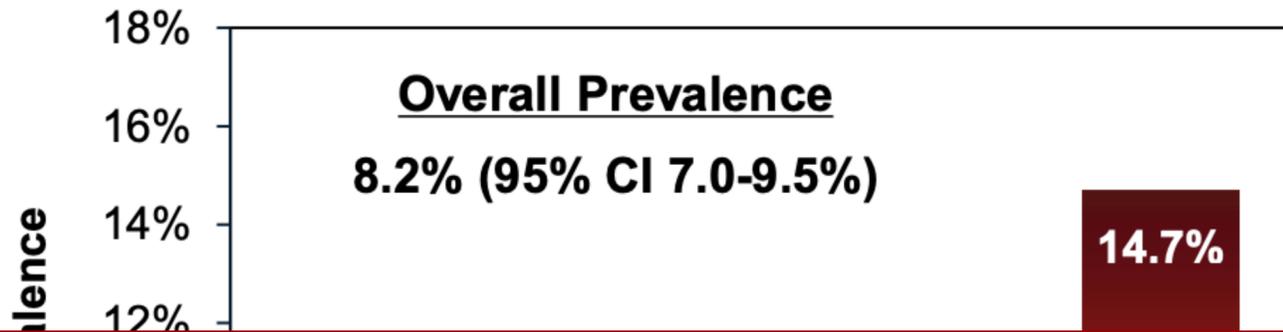
Treatment gaps disproportionately affect older adults, women, and underrepresented populations.

(Nathan, JAMA Cardiology, 2022; Tanguturi et al., Circulation, 2025)

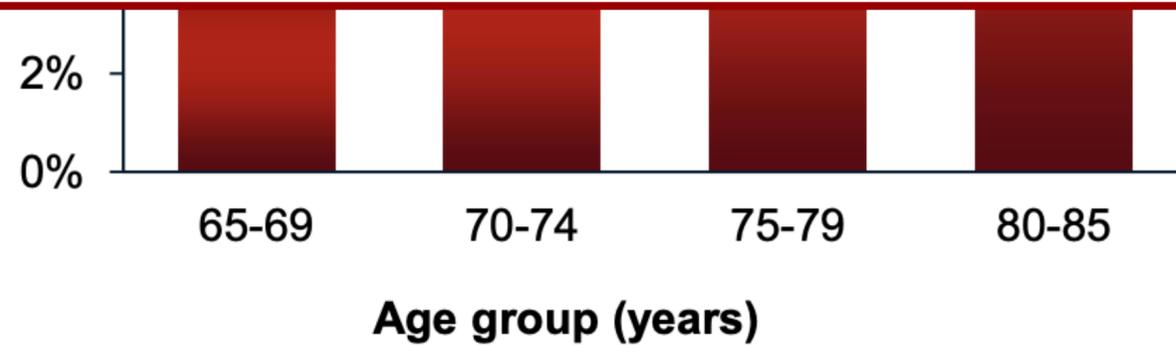
PREVUE-VALVE



PREVUE-VALVE

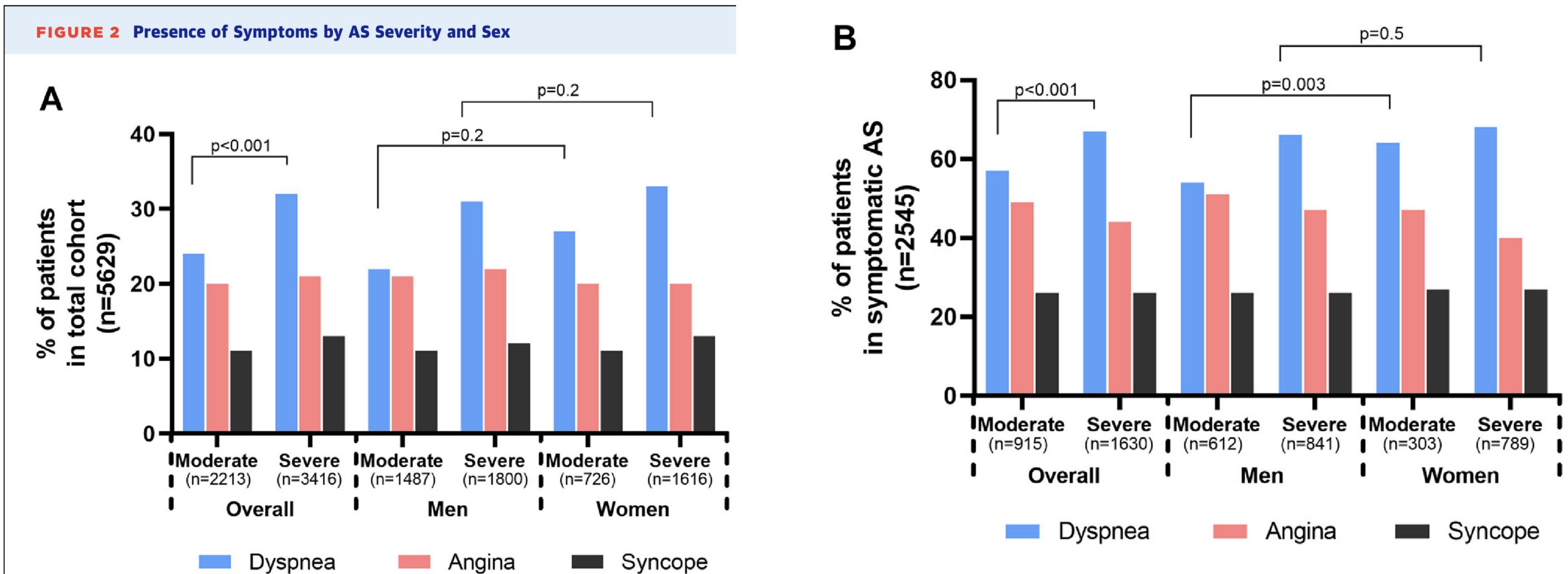


Prevalence of Moderate AS in ARIC visit 5 (2011-2013) = 0.3%

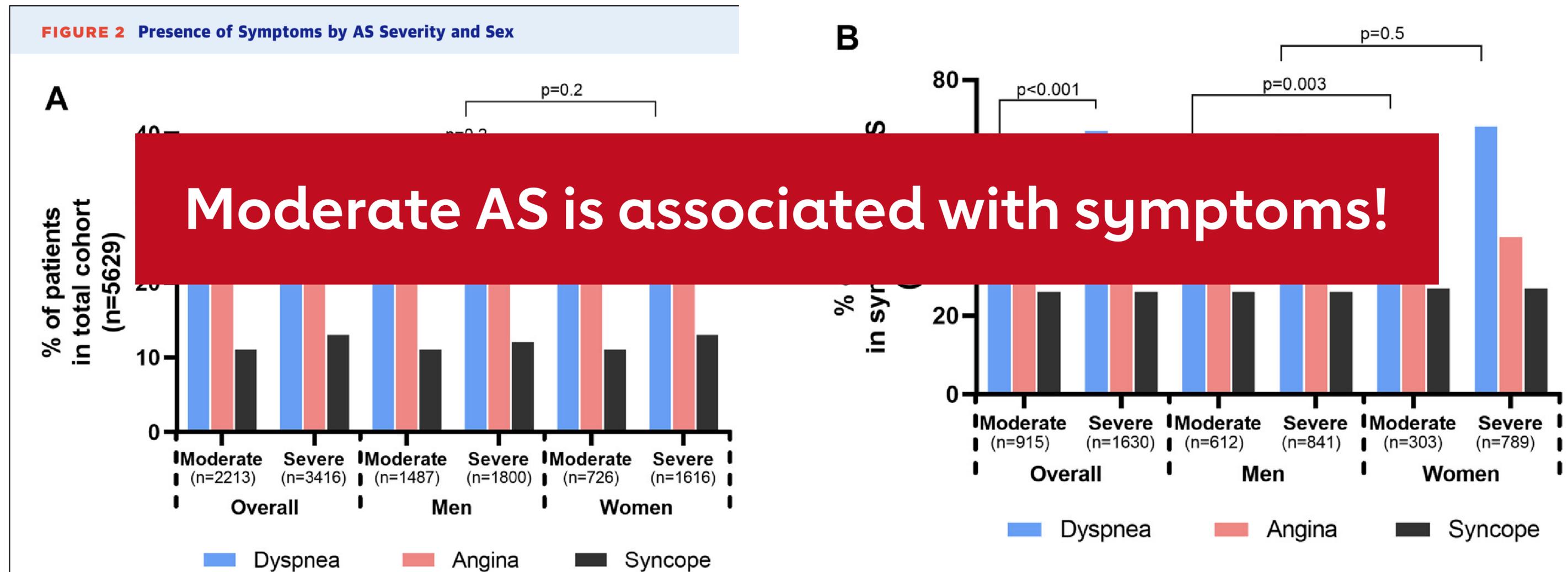


THE BURDEN OF MODERATE AORTIC STENOSIS: SYMPTOMS

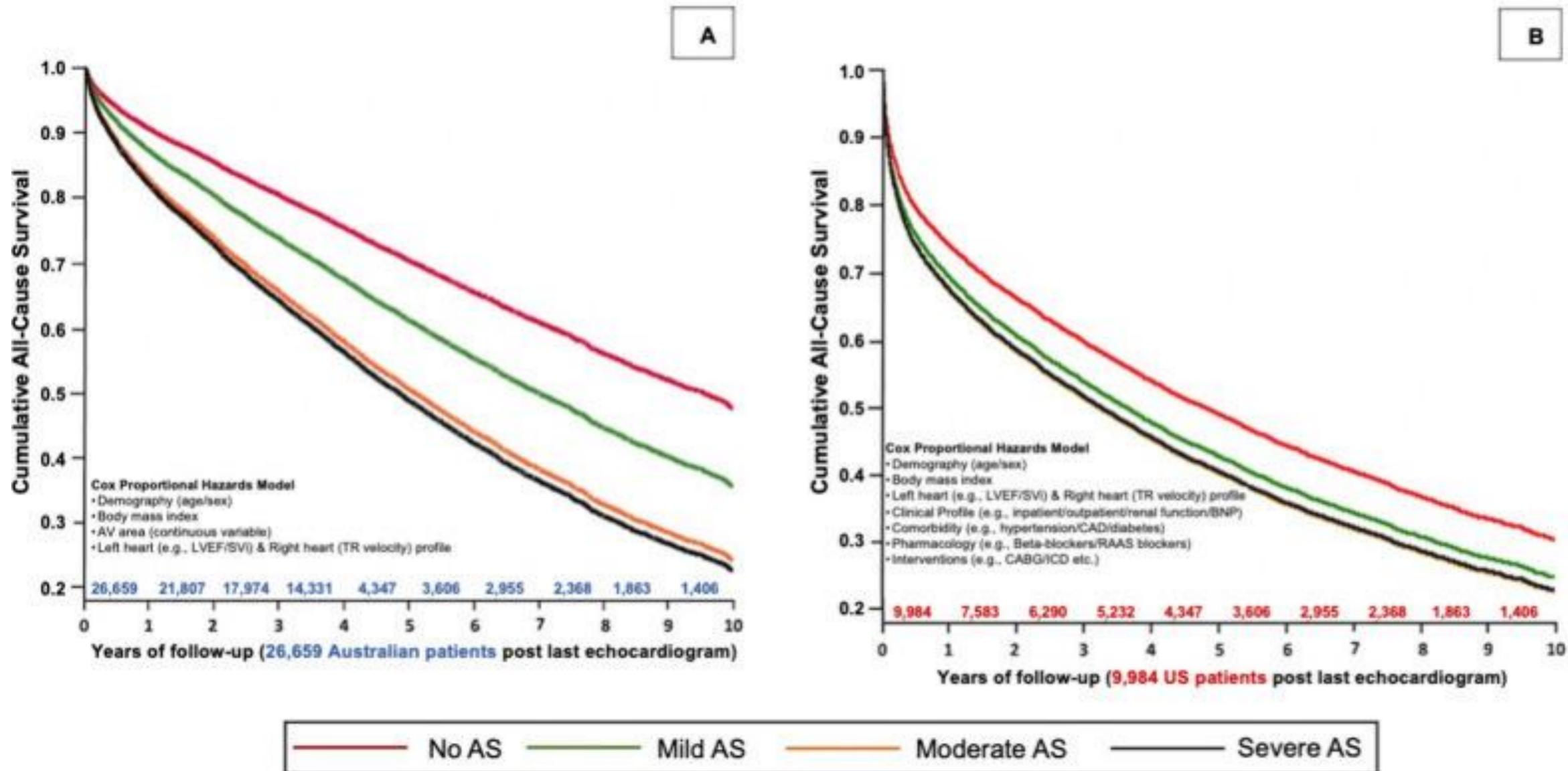
FIGURE 2 Presence of Symptoms by AS Severity and Sex



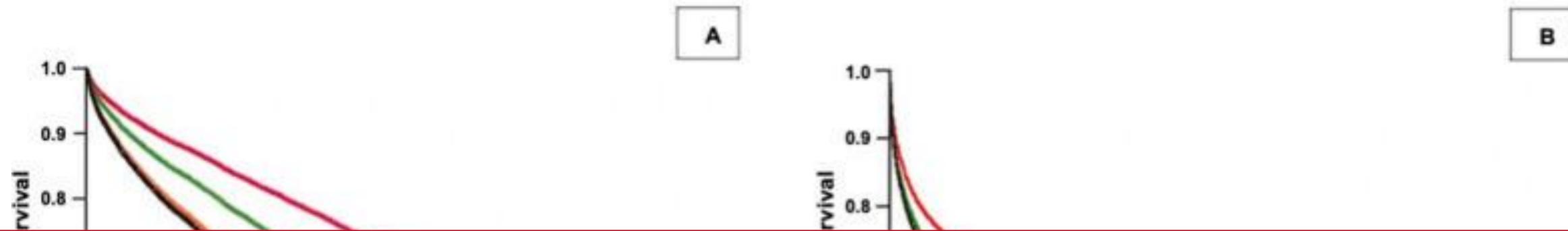
THE BURDEN OF MODERATE AORTIC STENOSIS: SYMPTOMS



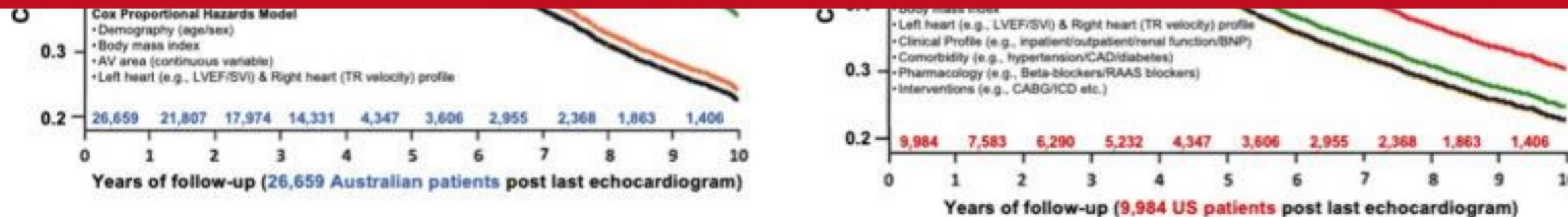
THE BURDEN OF MODERATE AORTIC STENOSIS: **OUTCOMES**



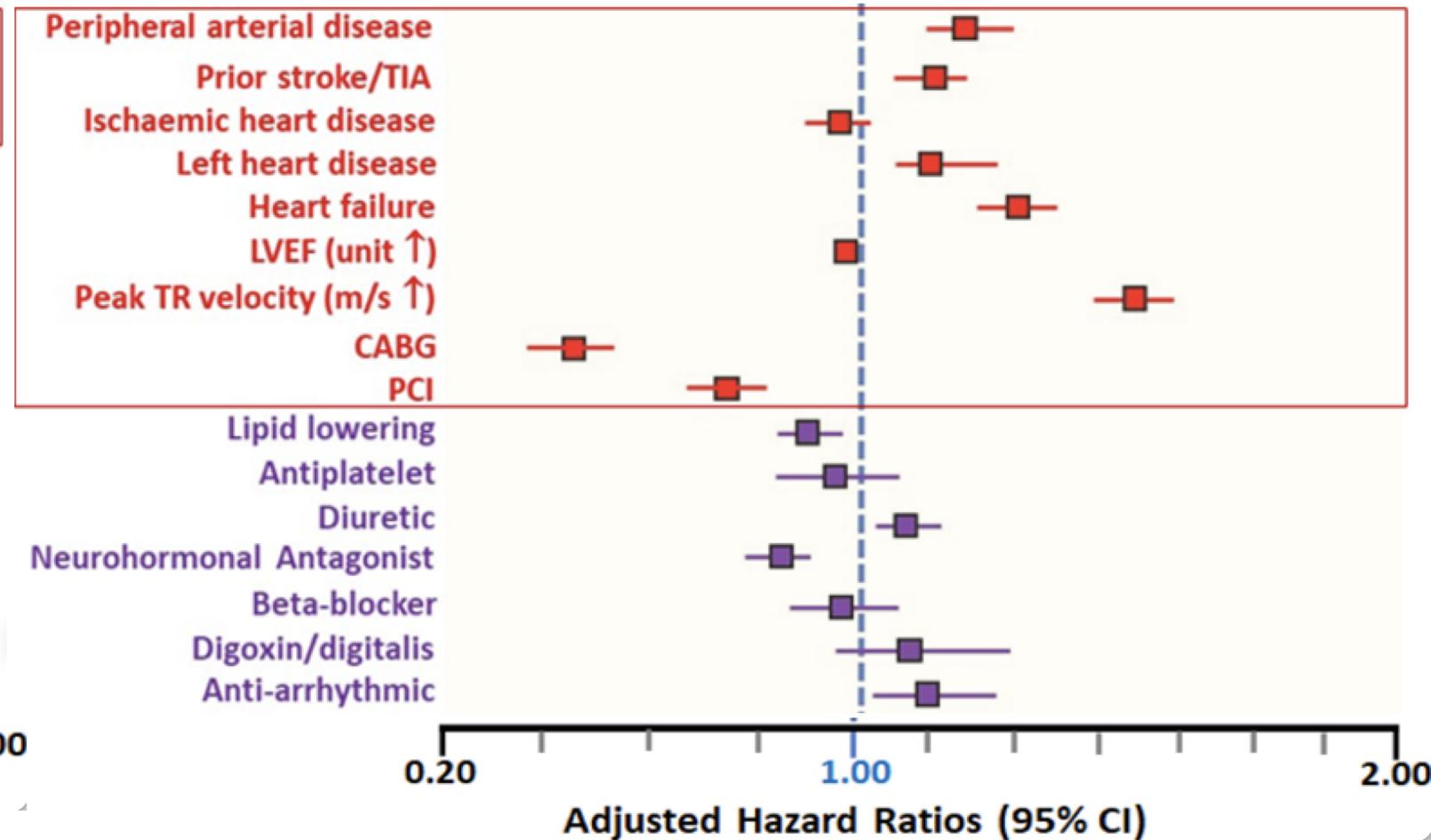
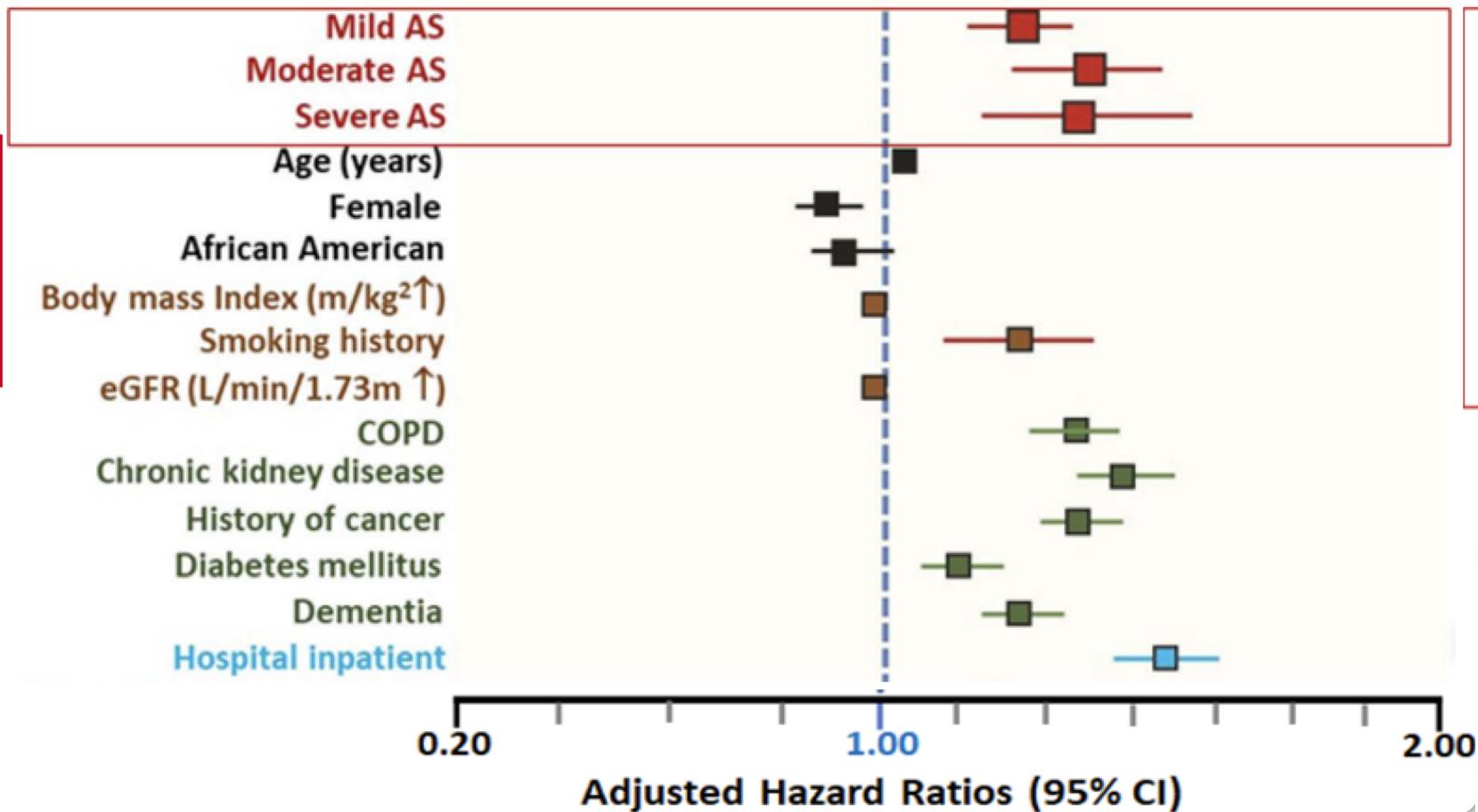
THE BURDEN OF MODERATE AORTIC STENOSIS: OUTCOMES



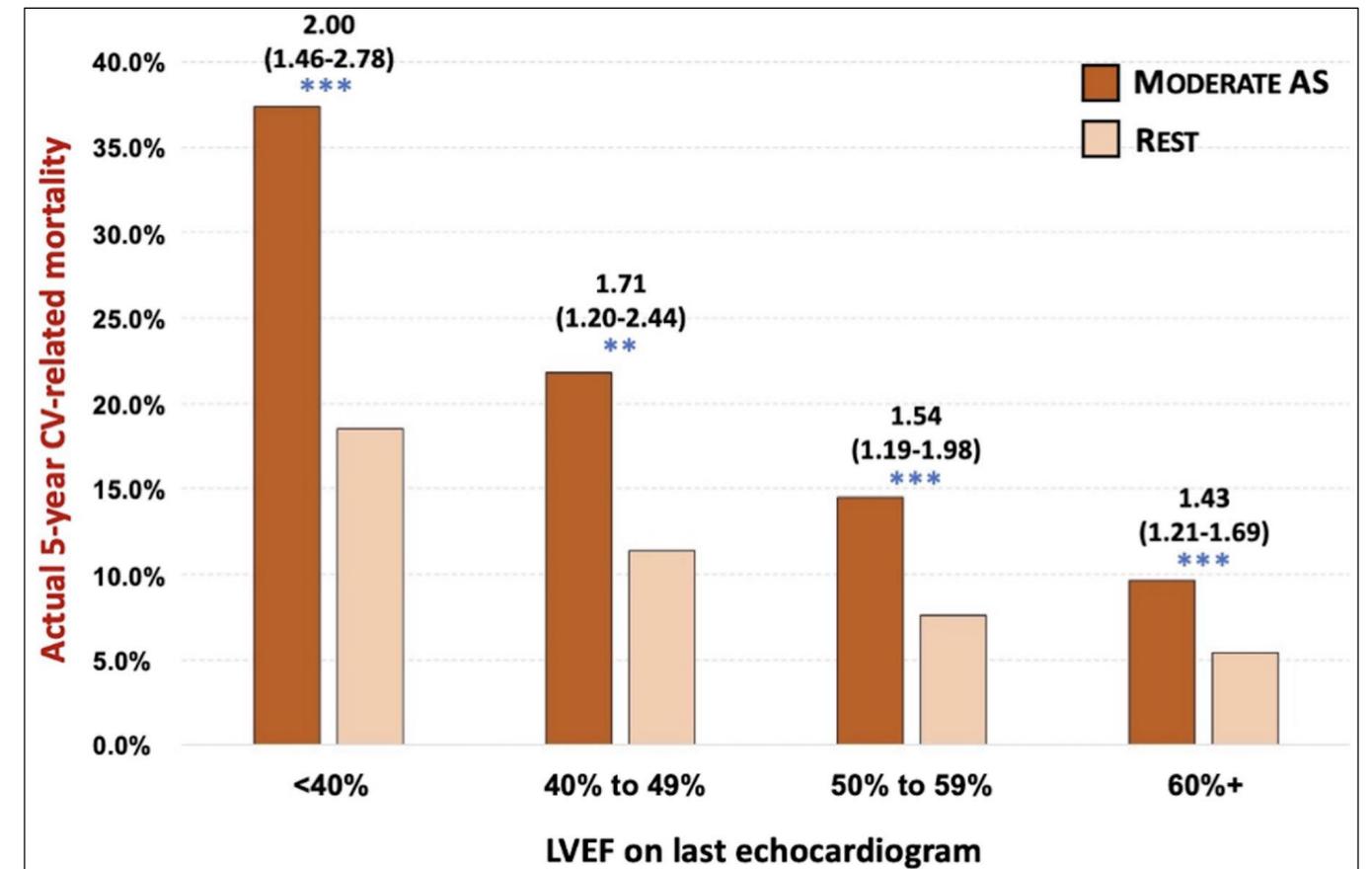
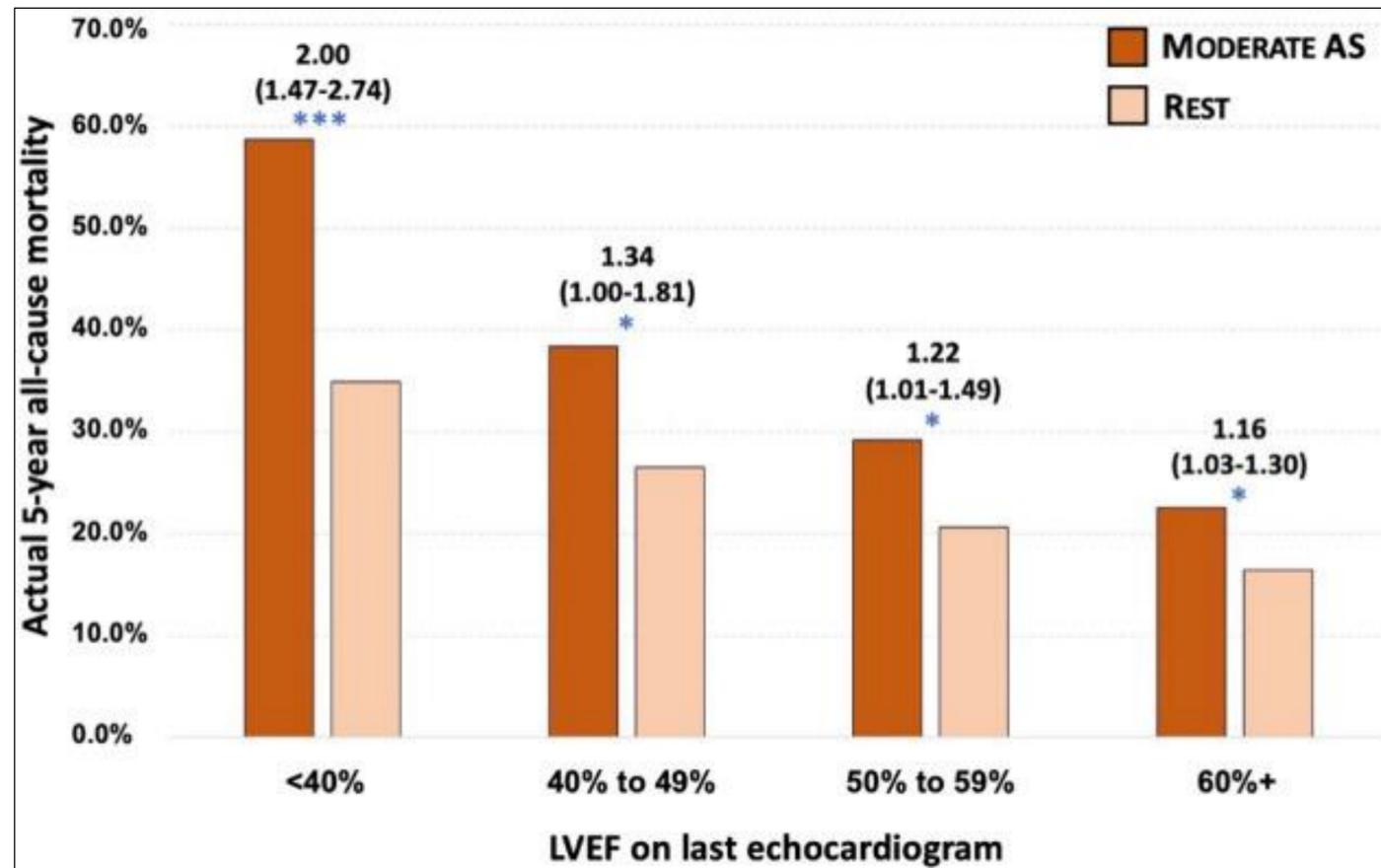
Moderate AS and Severe AS are associated with similar mortality!



THE BURDEN OF MODERATE AORTIC STENOSIS: **OUTCOMES**



ALL CAUSE AND CV MORTALITY IN MODERATE AS BY LVEF



WHY INTERVENE EARLIER? RATIONALE OF UPSTREAM THERAPY AND EARLY IDENTIFICATION IN AORTIC STENOSIS

Misty Theriot, BSN, RN, CPHQ, FACC

Lake Charles Memorial Hospital

Valve Clinic Coordinator, STS/ACC TVT Registry Site Manager

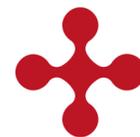


OUTLINE

Explain the rationale for **earlier identification of “at-risk”** moderate AS patients for potential trial screening

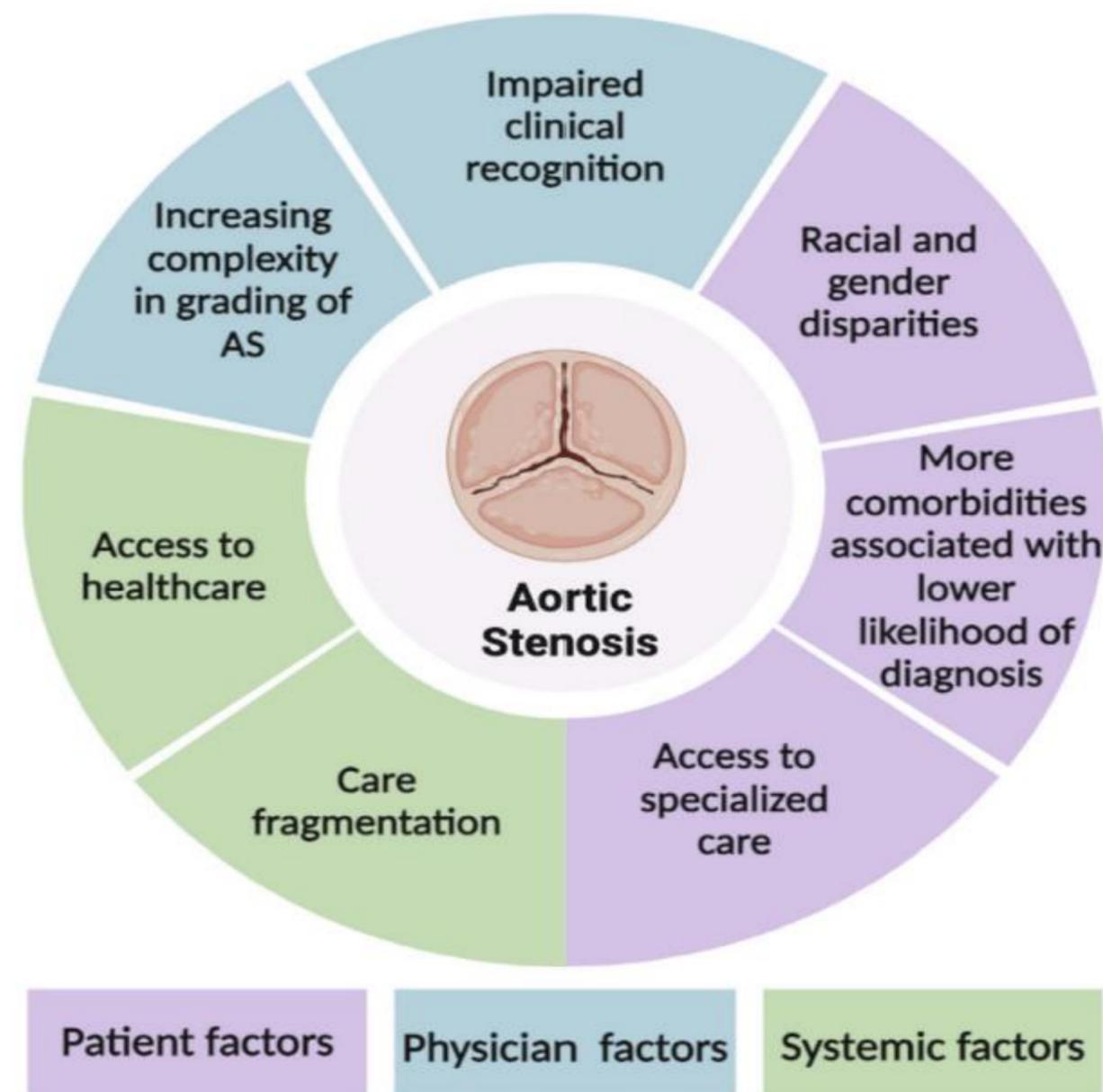
Describe **system-level approaches** to identify and monitor at-risk moderate AS earlier



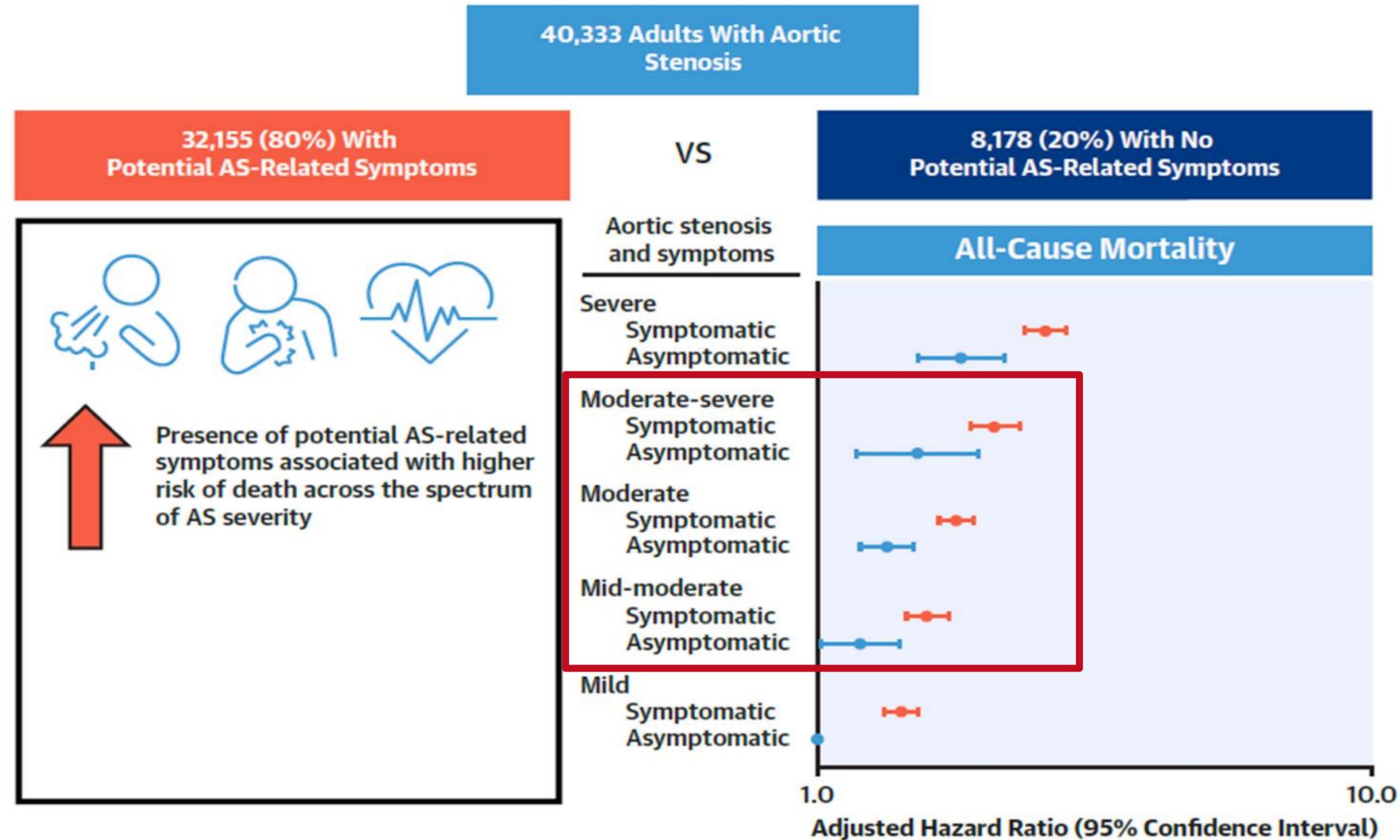


AORTIC STENOSIS: CARE AND RESEARCH CHALLENGES

- **Under-recognition** of disease
- **Poor surveillance:** No recommendations in echo report for surveillance intervals
- **Lack of “standardized systems”** for ensuring appropriate **surveillance** and **referral** of patients with valvular disease



MODERATE AS WITH SYMPTOMS CARRIES MEANINGFUL MORTALITY RISK



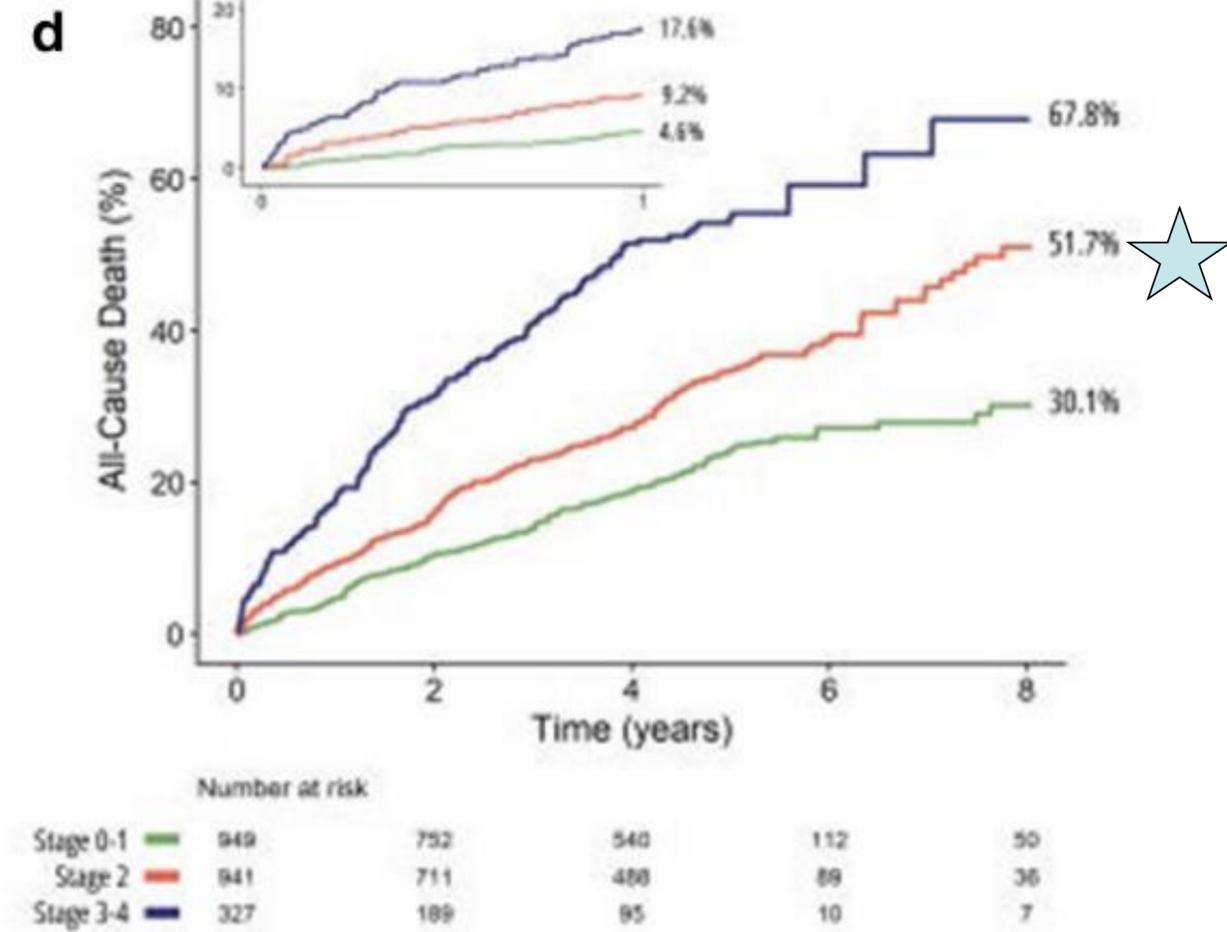
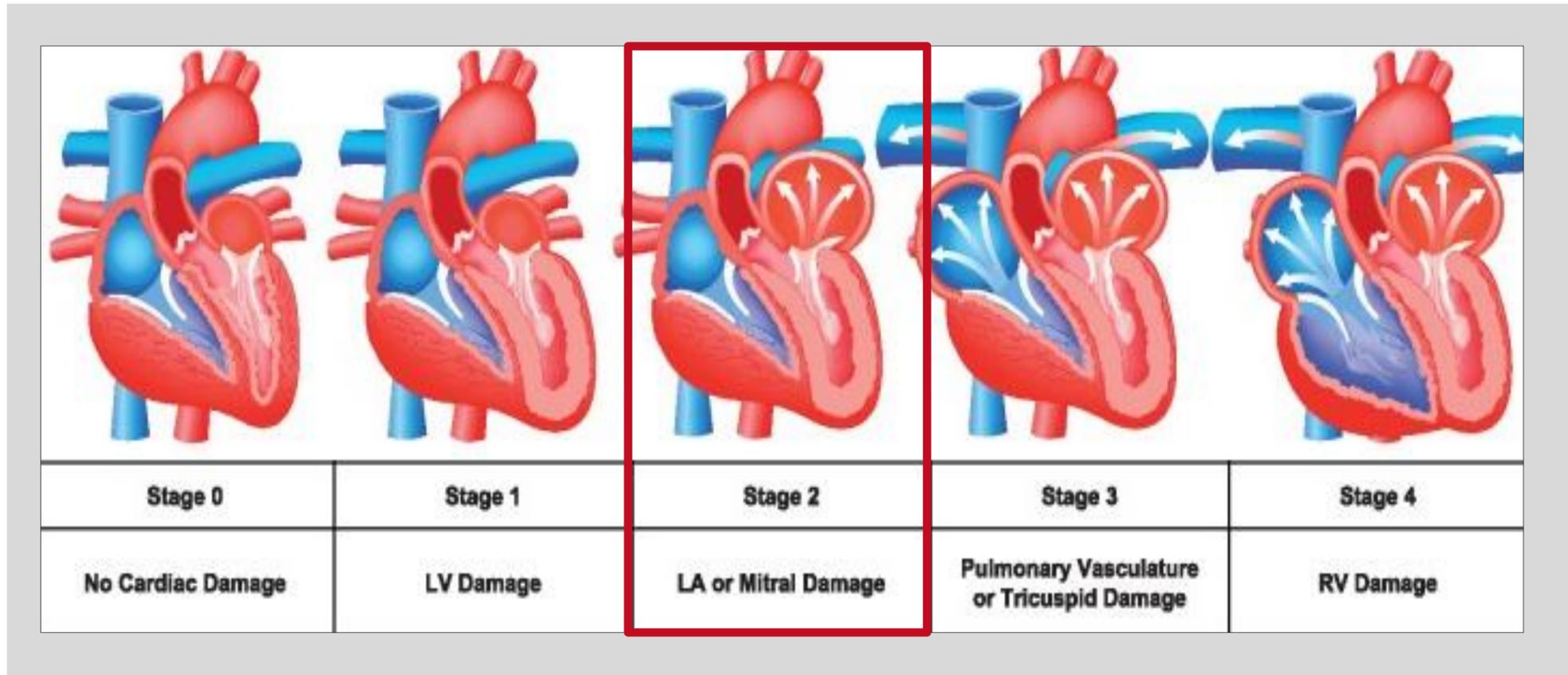
Solomon MD, et al. JACC Adv. 2025;4(8):101962.

Results stratified by potential AS-related symptom status surrounding the time of diagnosis. Patients with symptomatic moderate AS had similarly poor outcomes compared to patients with severe AS without documented symptoms. Model adjusted for competing risks using Fine-Gray estimates.



CARDIAC DAMAGE PROGRESSION

Asymptomatic
Moderate/Severe AS

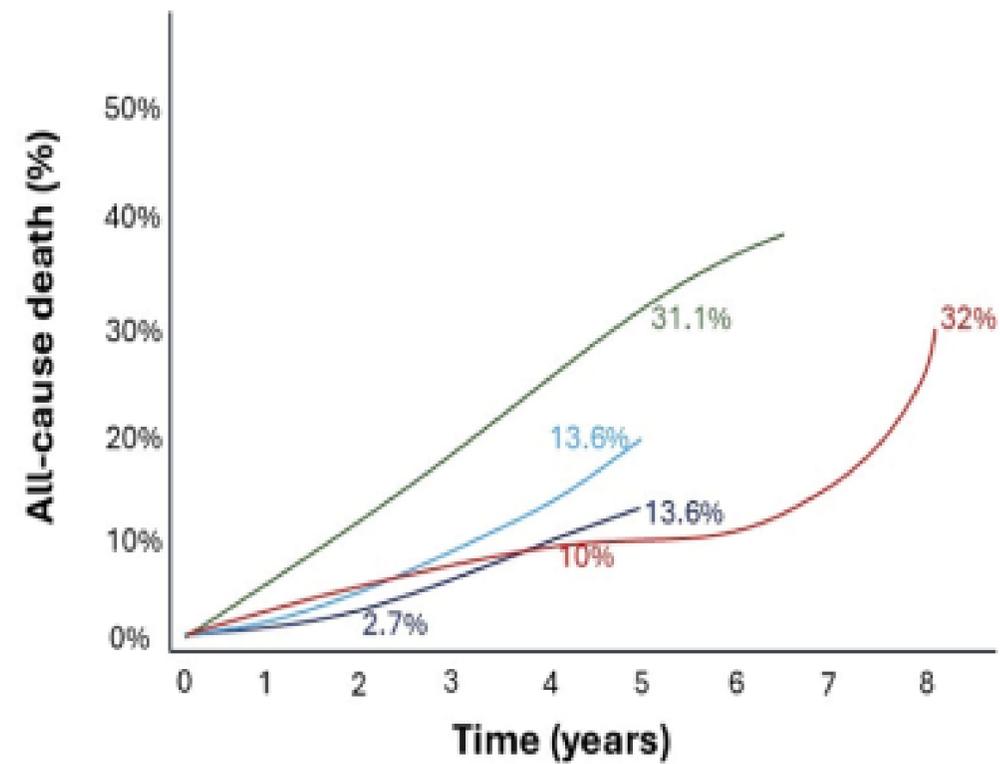


Cardiac damage often develops *during* moderate AS and is associated with worse outcomes, even before severe hemodynamic thresholds are met.

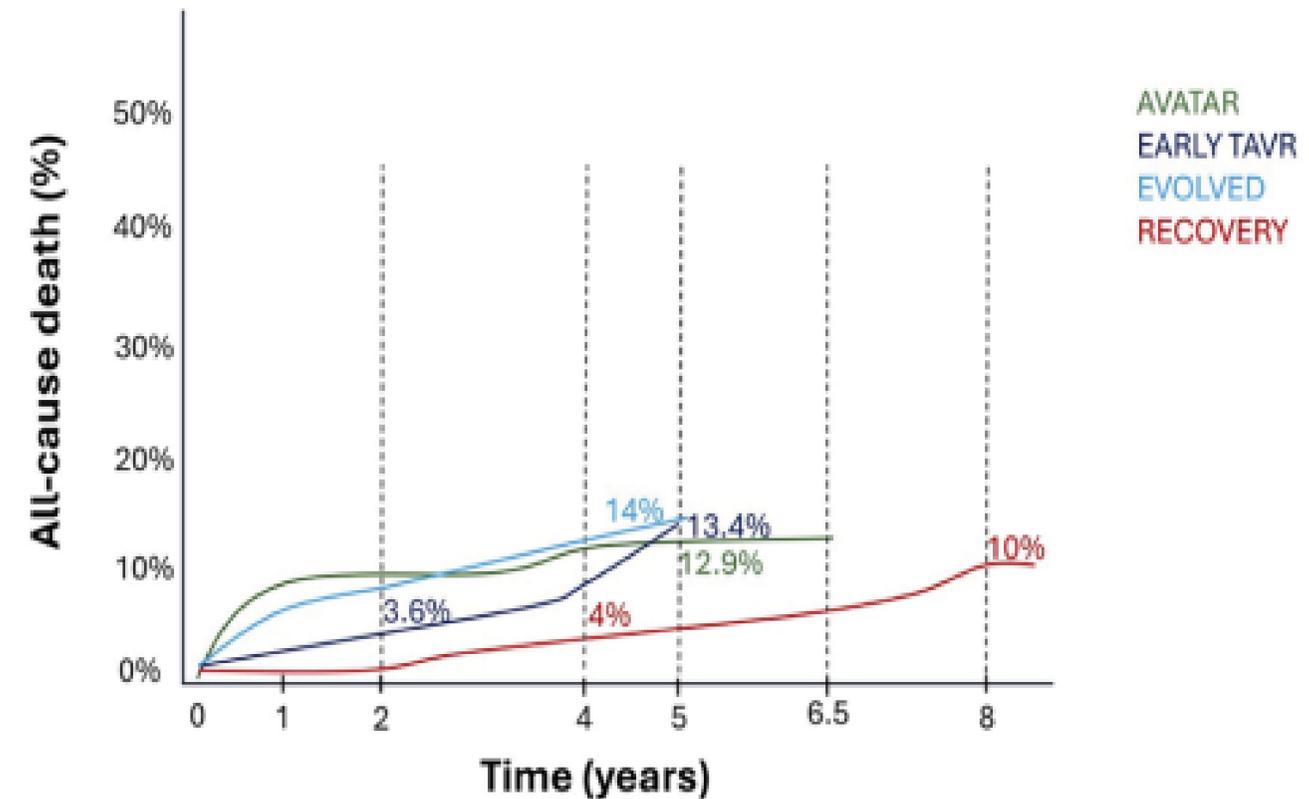


TIMING OF INTERVENTION INFLUENCES MORTALITY TRAJECTORY

A Conservative management



B Early intervention



(A) Conservative and (B) aortic valve replacement arms of the analyzed trials. Data on mortality across time were extracted from the included studies.

EVOLVED = Early Valve Replacement Guided by Biomarkers of Left Ventricular Decompensation in Asymptomatic Patients with Severe Aortic Stenosis;

AVATAR = Aortic Valve Replacement Vs Conservative Treatment in Asymptomatic Severe Aortic Stenosis; EARLY TAVR = Evaluation of TAVR Compared to Surveillance

for Patients with Asymptomatic Severe Aortic Stenosis; RECOVERY = Randomized Comparison of Early Surgery vs Conventional Treatment in Very Severe Aortic Stenosis.



TAVR FOR ASYMPTOMATIC SEVERE AS: EARLY TAVR

- **TAVR:** median time to the procedure was 14 days
- **Clinical surveillance:** median time to the procedure from symptom onset or from the decision to intervene was 32 days

“This level of vigilance may not be replicated in the real world, especially in care contexts in which aortic stenosis is undertreated.”





1 - Awareness



2 - Detection



3 - Diagnosis



4 - Referral



5 - Treatment

AHA's Target: Aortic Stenosis™¹

Goal

Assess “upstream” of treatment

Primary Quality Metric

The percentage of patients with a Class I indication for AVR treated within 90 days of diagnostic echocardiogram

Key Findings from Phase I²

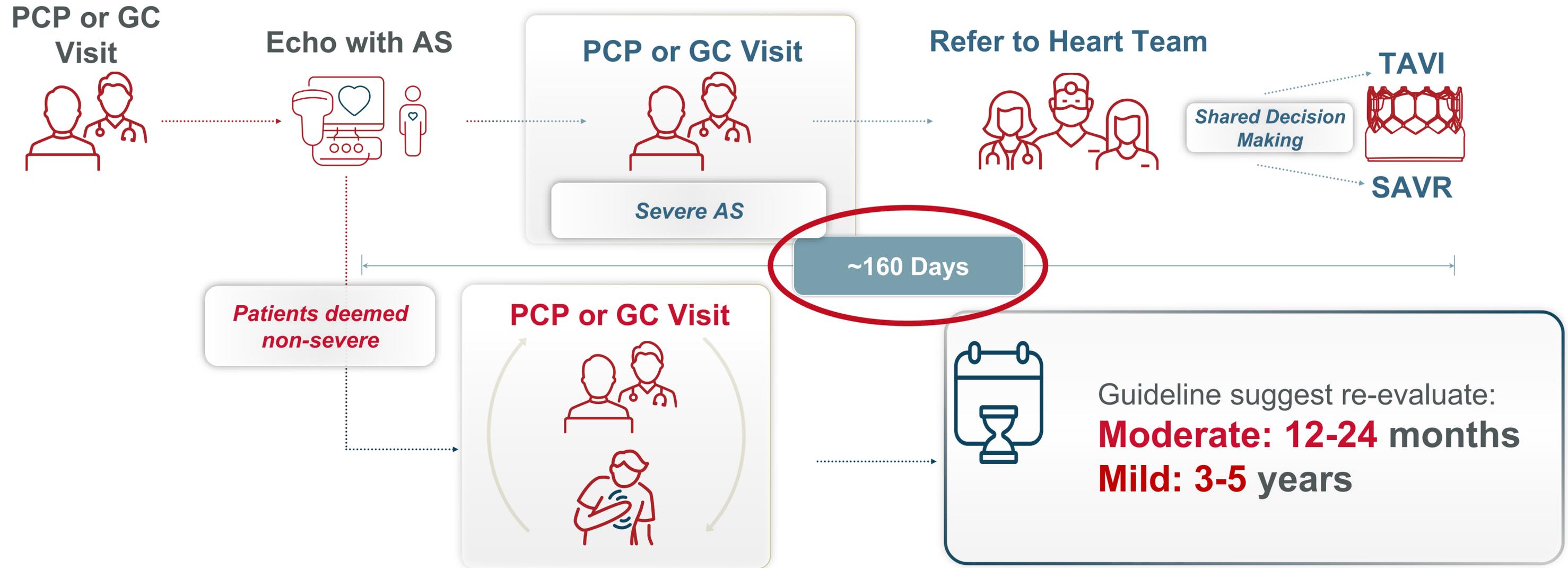
- Over **1/3** of Diagnosed sSAS Patients were **Not Treated**
- Approximately **half** of sSAS patients were **treated within 90 Days**

¹American Heart Association. Target: Aortic Stenosis. heart.org.

²Lindman B et al, Target Aortic Stenosis, Circ Cardiovasc Qual Outcomes, 2023;16(6).



SEVERE AS: TIMING MATTERS



“Delaying TAVR by 12 months increases costs by \$10,080 over 2 years.”

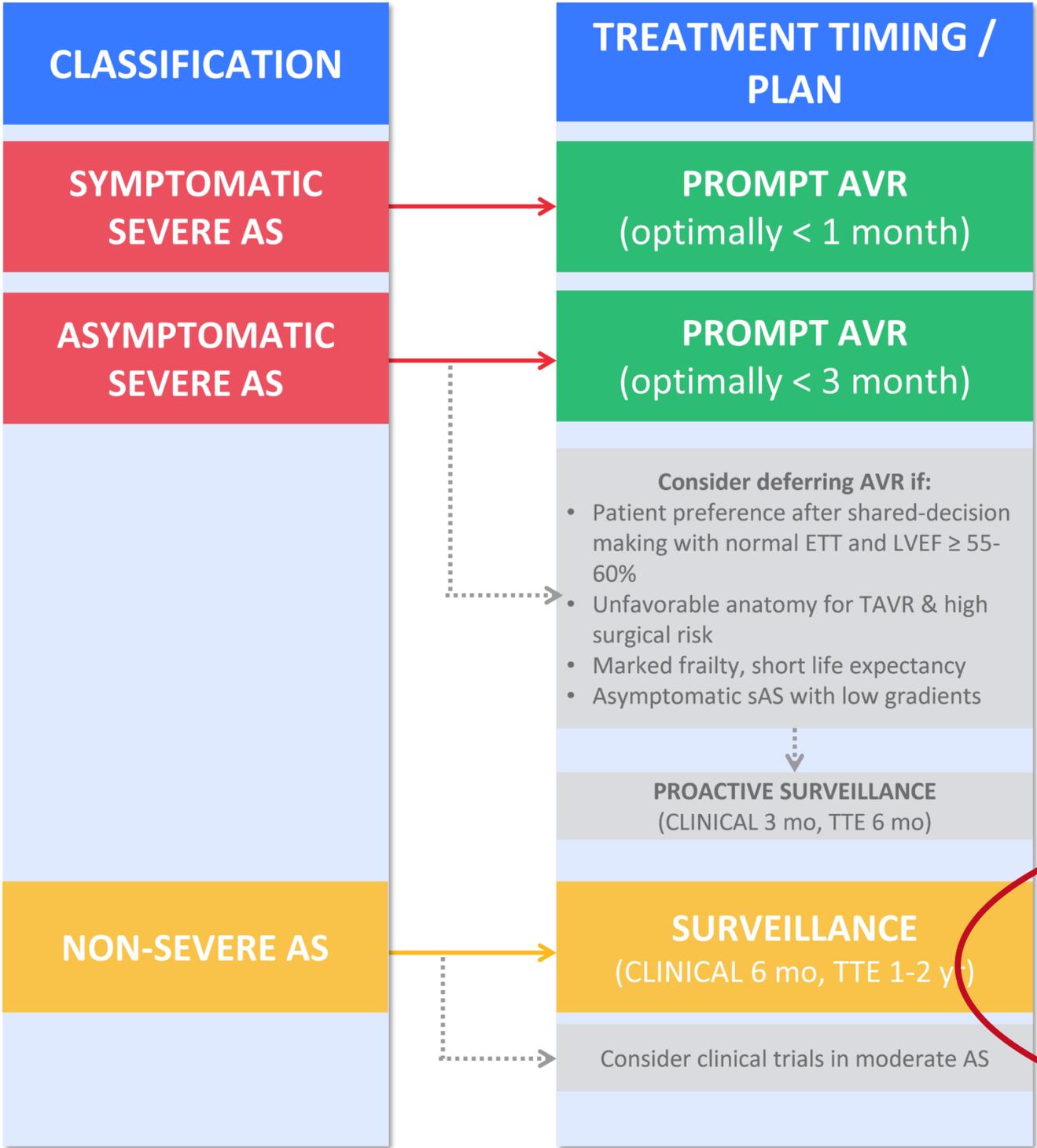


WHAT SEVERE AS HAS TAUGHT US: TIMING IS CRUCIAL

- **Delays** in intervention for severe AS are associated with **worse outcomes** and **increased healthcare costs**
- Structured **surveillance** and **timely intervention** are associated with **improved outcomes**
- Vigilance in trials **exceeds real-world practice**, revealing opportunity gaps



TREATMENT TIMING AND PLANNING



Symptomatic severe AS

- AVR within 1 month, prioritization if needed

Asymptomatic severe AS

- Shared decision making
- Favor prompt AVR, <3 months

Proactive surveillance

- Partnership between HVT and referrer
- More vigilant than every 6-12 months
- Incorporate digital tools for scale

Moderate AS

- Clinical surveillance
- Clinical trials testing AVR or medical therapy in select patients



THE ECHO LAB AND THE HEART VALVE TEAM ARE THE BACKBONE OF CARE AND RESEARCH IN VALVE DISEASE



HVT RESPONSIBILITIES¹

- Confirm/clarify AS severity
- Procedural risk assessment
- Determine treatment strategy and timing
- Proactive surveillance if no prompt AVR
- Lifetime Management

GUIDELINES AND STANDARDS

Guidelines for the Standardization of Adult Echocardiography Reporting: Recommendations From the American Society of Echocardiography

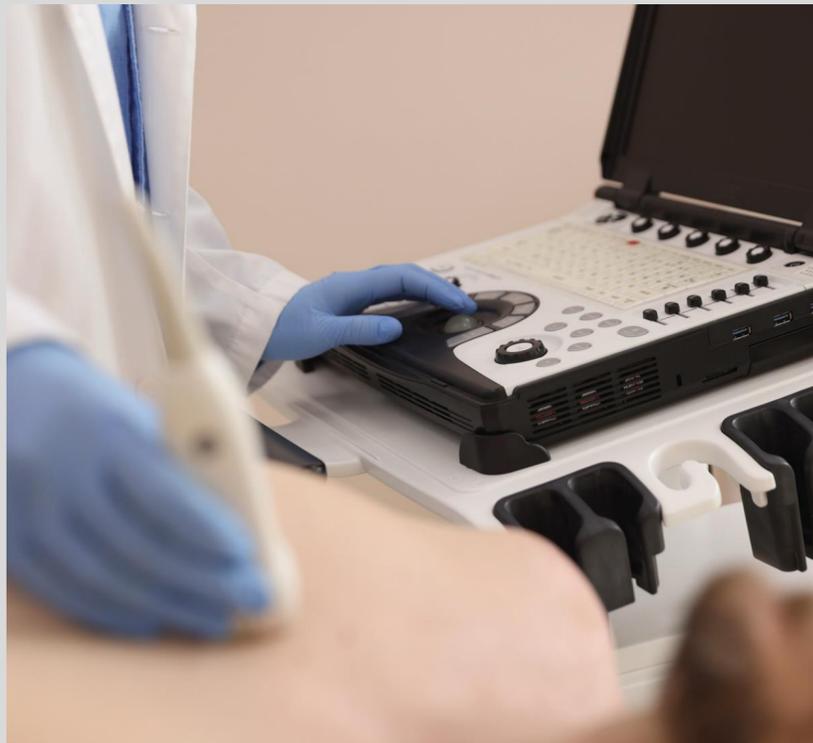
“This patient has significant aortic stenosis that, according to the current American College of Cardiology/American Heart Association/ASE valvular heart disease guidelines, may warrant treatment. As clinically appropriate, further evaluation and/or referral should be considered.²”

¹Cook C et al, Proactive Management and Treatment of Aortic Stenosis, JACC, 2025 (in press).

²Taub C et al. Guidelines for the Standardization of Adult Echocardiography Reporting, J Am Soc Echocardiogr. 2025;38(9).



OPTIMIZING PATIENT IDENTIFICATION



- **Echo Surveillance**
 - Build structured programs¹
 - Echo PACs + EMR data
- **Technology Adoption**
 - Use digital tools
 - Apply AI/NLP models
- **Workflow Integration**
 - Embed EMR-based prompts and alerts²
 - Educate on follow-up timing and referral pathway
 - Engage patients

¹Lindman B, et al. The Alarm Blares for AS Undertreatment, JACC, 2022;79(9).

²Abou-Karam R, et al, Electronic Physician Notification to Facilitate the Recognition and Management of Severe Aortic Stenosis, Am Heart J, 2024;276.



KEY TAKEAWAYS

- **Moderate AS** is an emerging frontier in valvular heart disease research and treatment
- **Earlier identification** enables structured surveillance and trial readiness
- The **echo lab and heart valve team** are positioned to serve as central hubs for clinical care and research in non-severe AS





THERAPEUTIC CONTEXT: ATACIGUAT & KATALYST-AV

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Medical Director, Duke Echo Lab and Cardiac Diagnostic Unit;
Member, Duke Clinical Research Institute;
Member, Duke-Margolis Institute for Health Policy



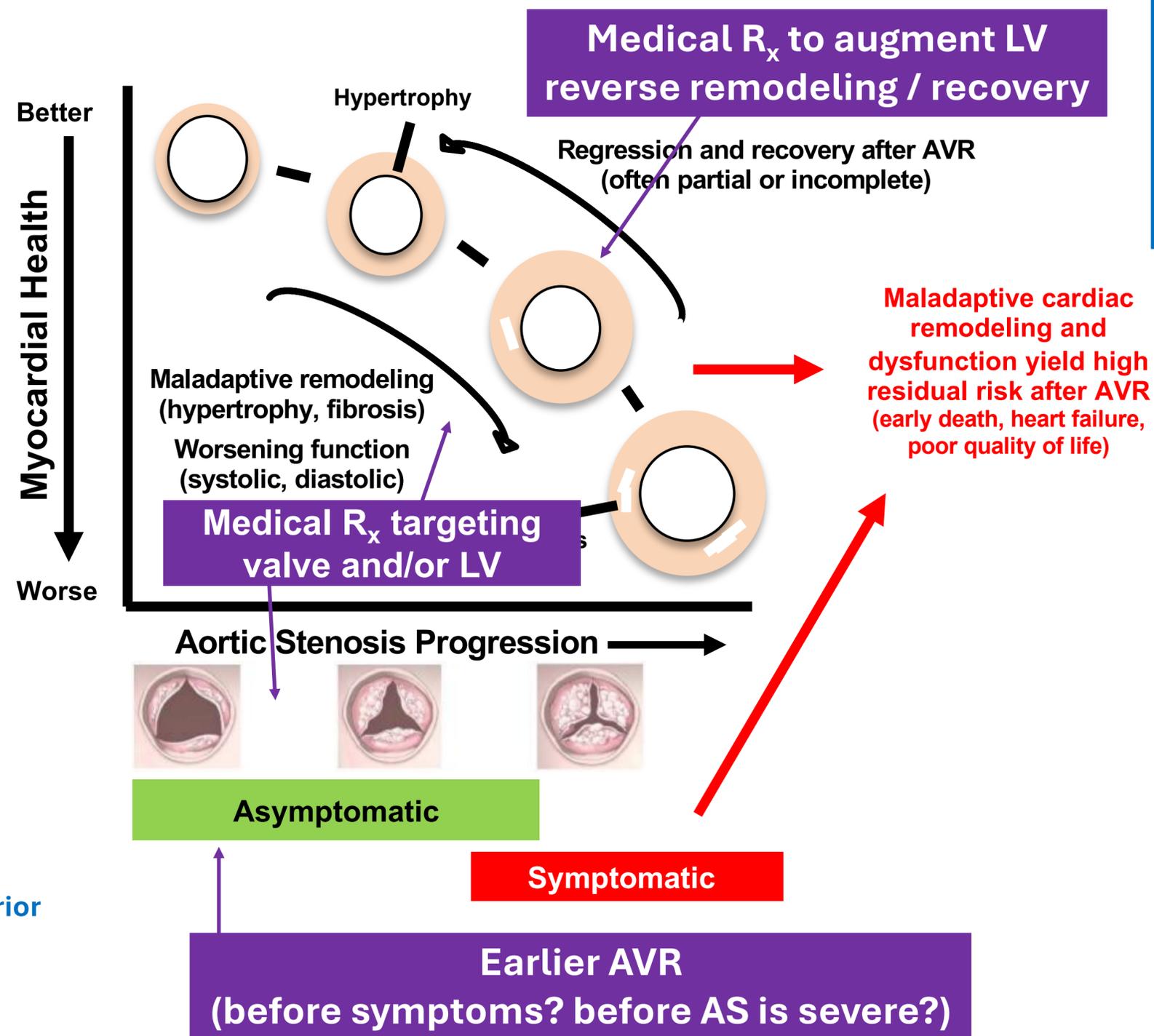
Strategies to Prevent and Mitigate Risk of Heart Failure in Calcific Aortic Stenosis

AS is a precipitant of and precursor to HF

Patients with progressive AS have stage B HF → usually transitions to stage C HF before or after AVR

Stage B HF: Structural heart disease but without signs or symptoms of HF

Stage C HF: Structural heart disease with prior or current symptoms of HF



Mitigating HF after AVR

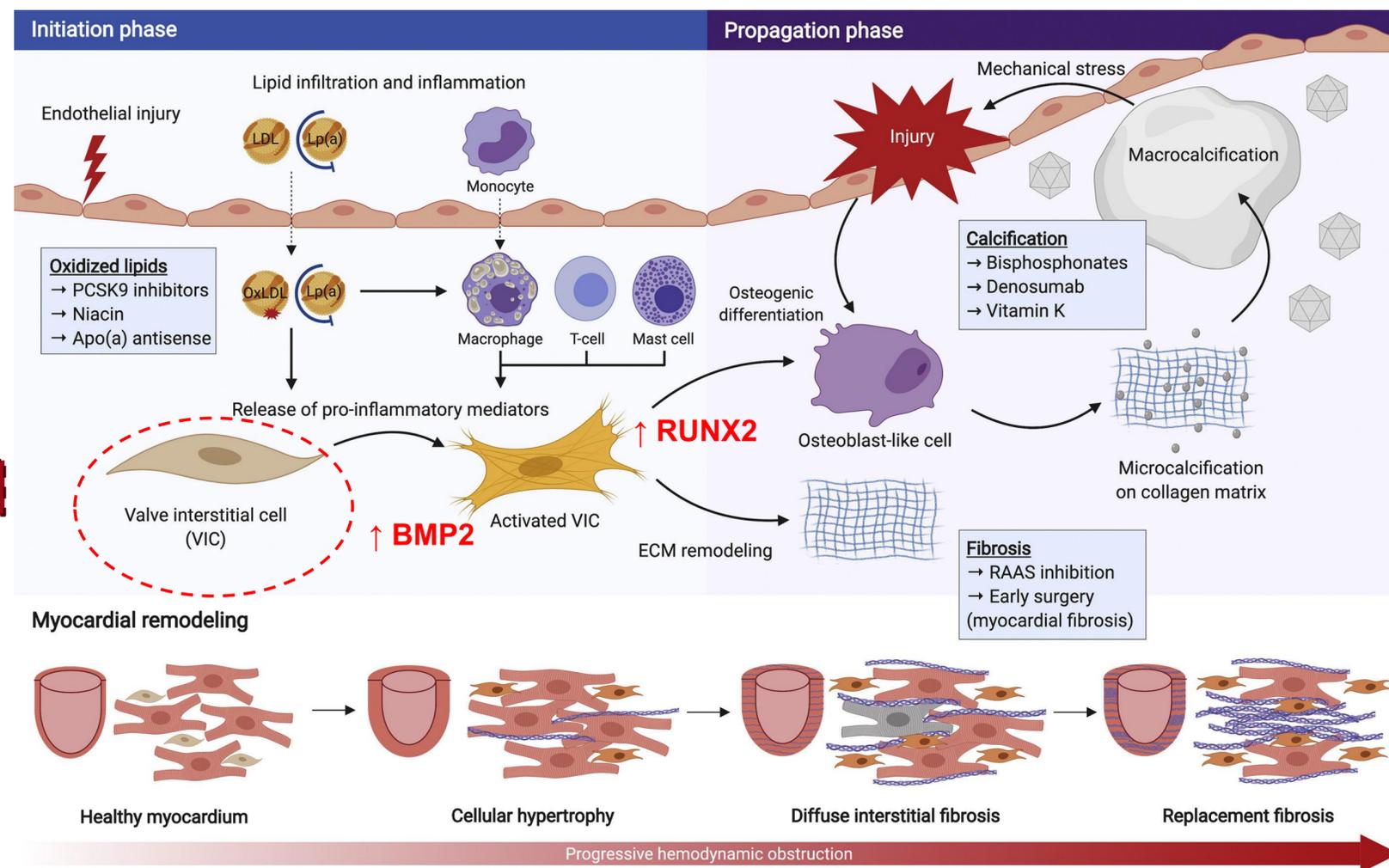
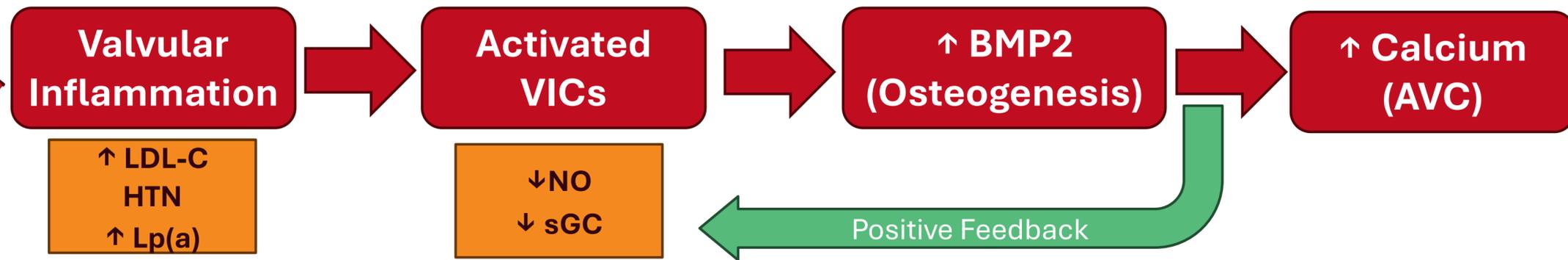
Most patients treated with AVR have stage C HF with or without persistent HF symptoms or “HF in remission”



Calcific Aortic Valve Stenosis



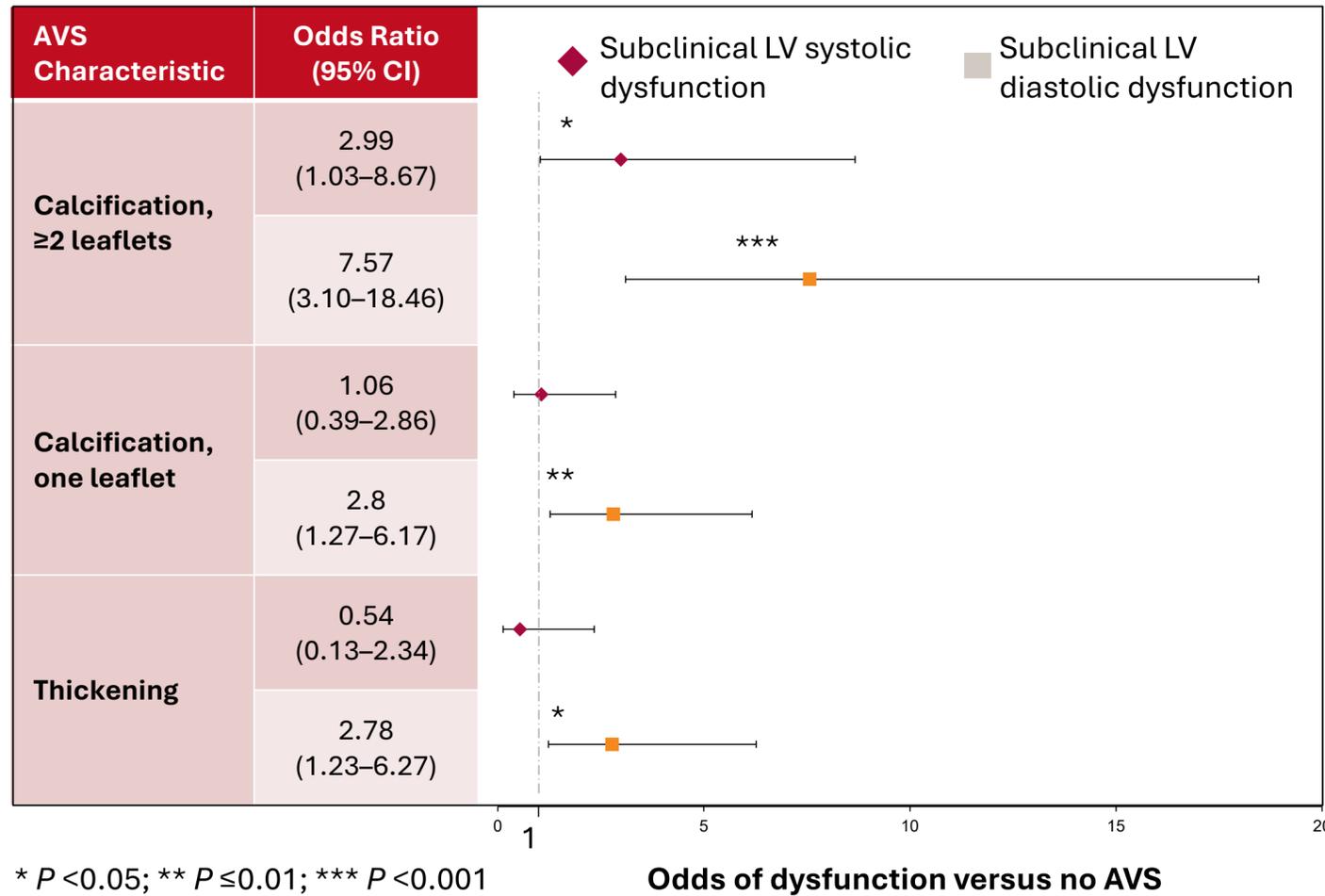
CAVS: Mechanism of Disease Activation & Propagation of Valvular Interstitial Cells (VICs) is Central to CAVS



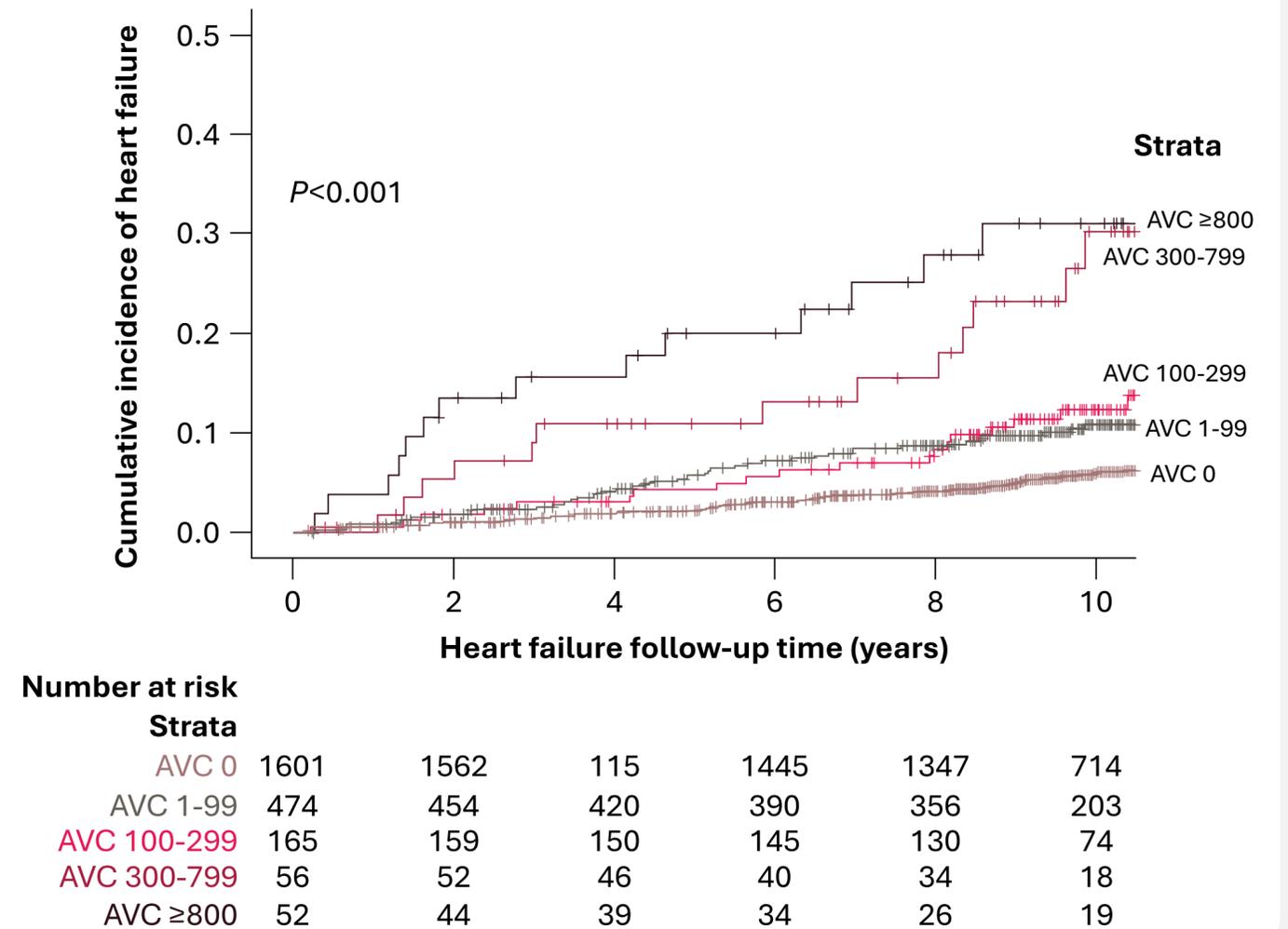
- Valvular inflammation causes oxidative stress and activates VICs
- The nitric oxide (NO) signaling pathway becomes impaired from oxidized (insensitive) soluble guanylate cyclase (sGC), causing activation of osteogenic (BMP2) pathways and an increase in aortic valve calcium (AVC) deposition

Correlation of AVC Deposition with Cardiac Function

Left ventricle functionality¹



Cumulative incidence of heart failure according to the AVC categories²



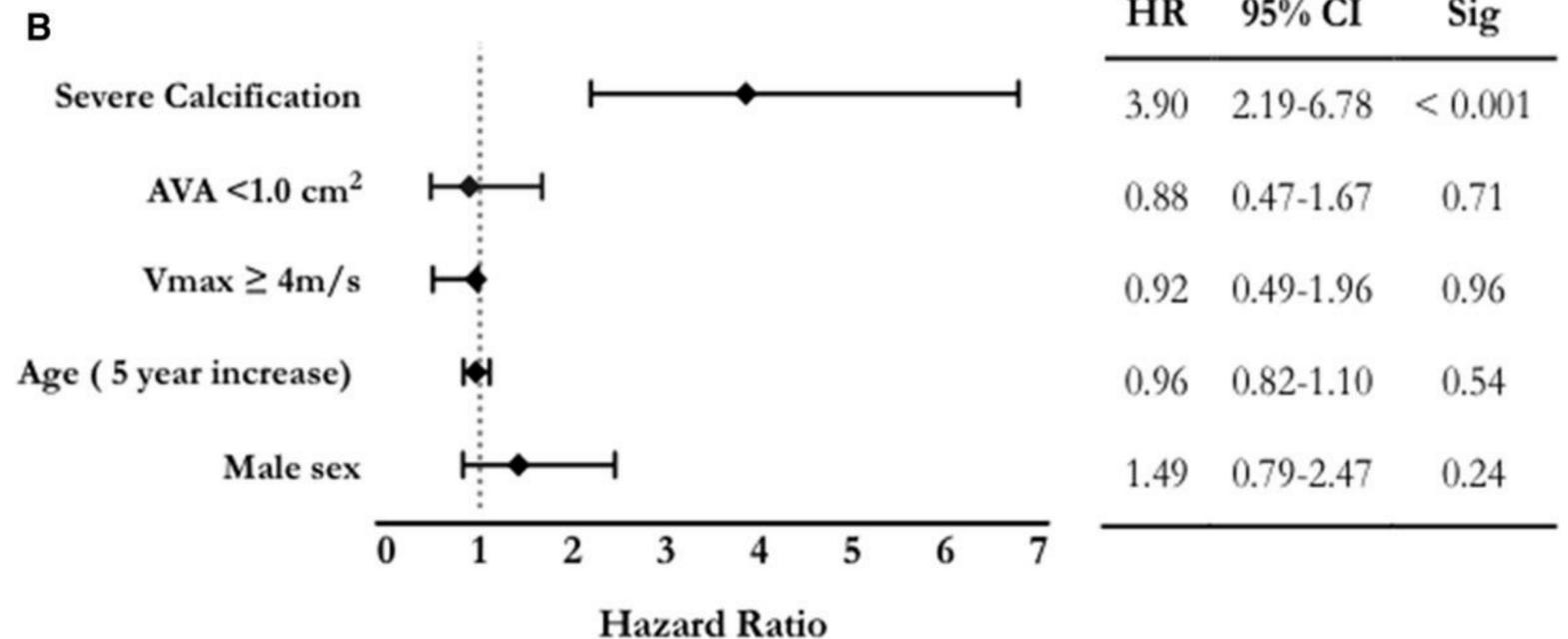
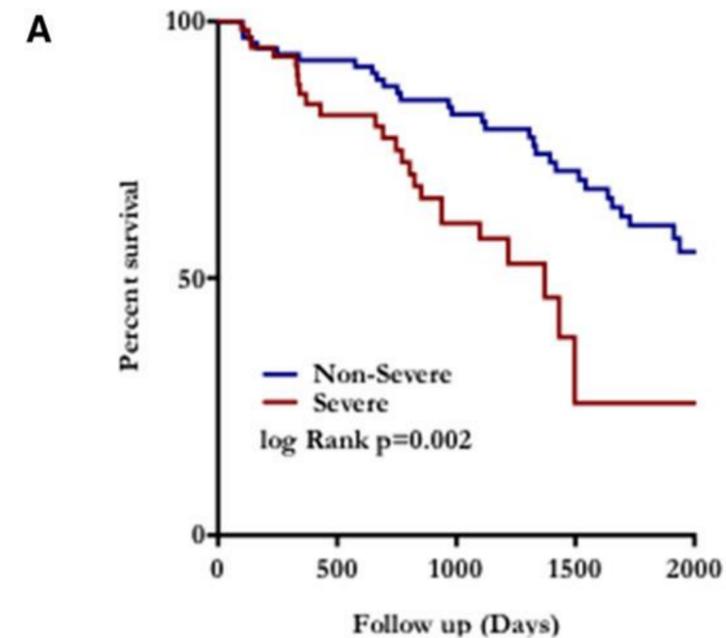
As CAVS progresses, AVC deposition correlates with impairment of cardiac structure and decline in function^{1,2}

¹Yoshida et al. *European Journal of Preventative Cardiology* (2023).

²Zhu et al. *Circulation: Cardiovascular Imaging* (2023).

Aortic Valve Calcification (AVC) is Strongest Predictor of Risk - Higher than AVA and Vmax

- Severe calcification associated with adverse prognosis
- AVC was only independent predictor of:
 - Aortic valve replacement
 - Death
- Severe AVC had 3- to 4-fold increased risk

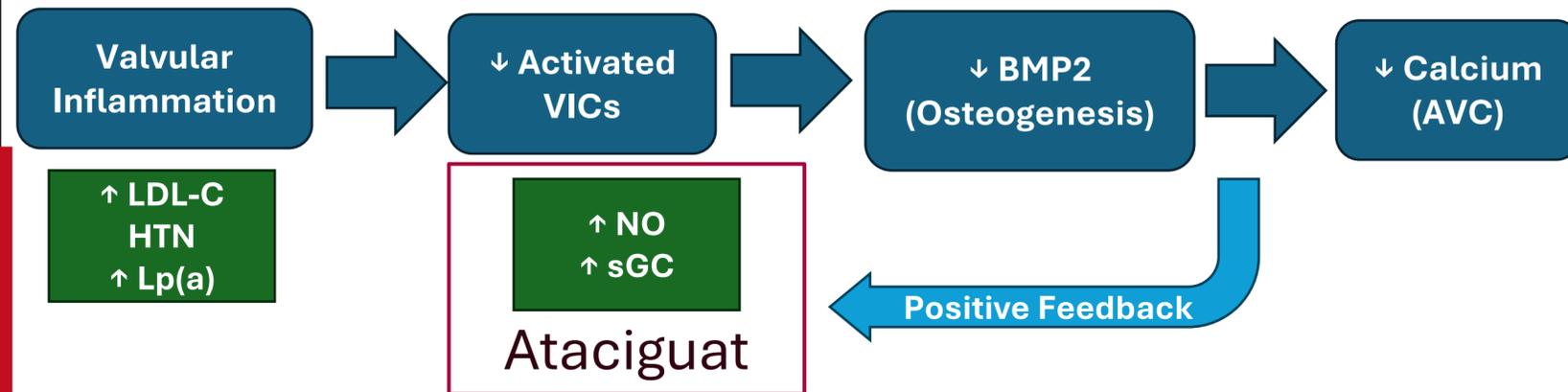


Ataciguat & CAVS

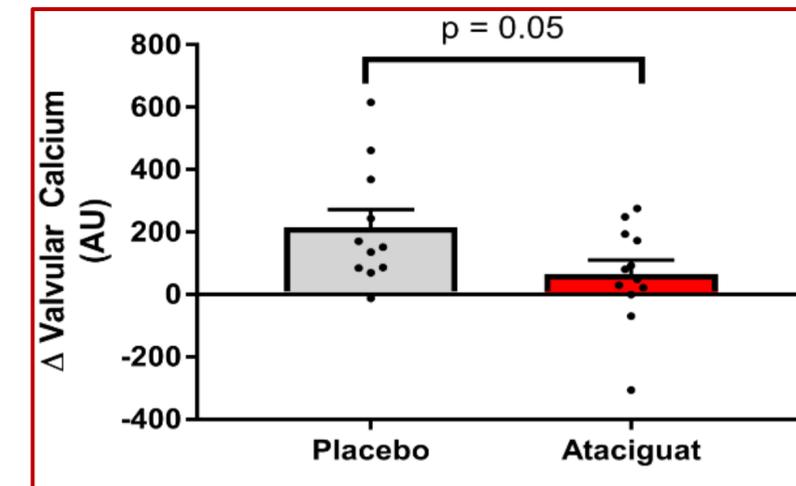
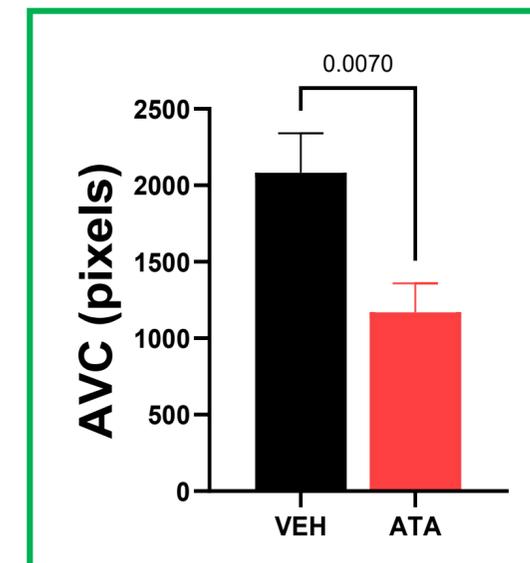


Ataciguat for CAVS: Therapeutic Hypothesis

Ataciguat Mechanism of Action



Preclinical & Clinical Evidence with Ataciguat



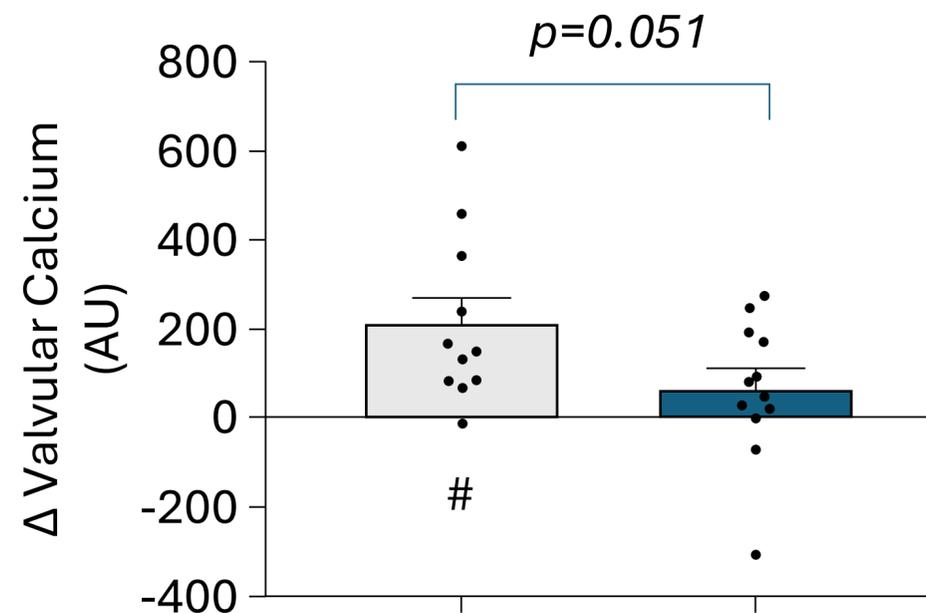
- Ataciguat is a unique sGC activator/stimulator that preferentially targets valvular oxidized sGC, unlike previously approved sGC activators, in the absence of systemic vascular effects (i.e., hypotension)
- Ataciguat reactivates the NO signaling pathway in VICs, reducing osteogenesis & aortic valve calcium

- Preclinical evidence demonstrates an ~50% reduction in aortic valve calcium (AVC) in CAVS mice
- In a phase II study of patients with moderate CAVS, treatment with Ataciguat resulted in a 50-60% reduction in AVC compared to placebo after 6 months and was associated with improvements in ventricular structure & function without observed effects on blood pressure

Key Endpoints

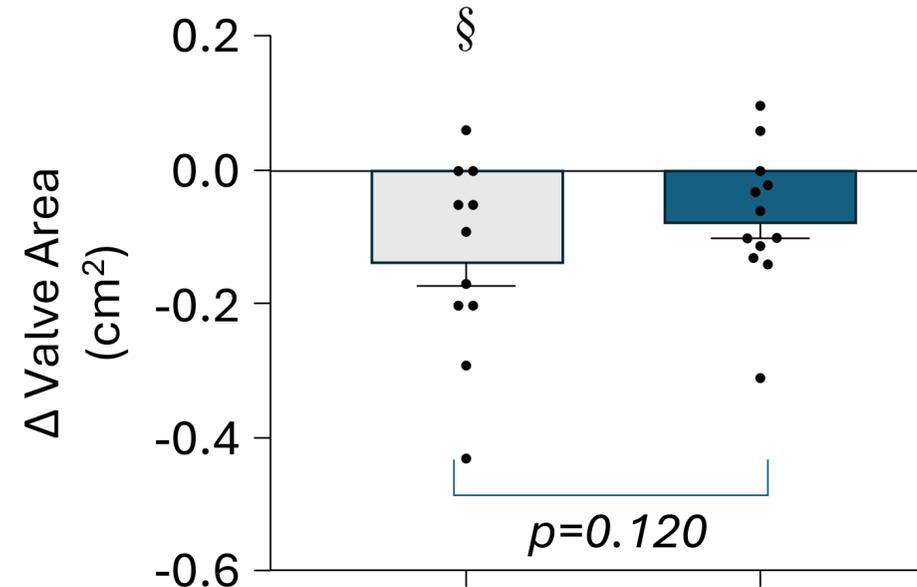
Change from baseline to 6 months

Primary endpoint: AVC



	Placebo	Ataciguat
N	11	12
Baseline values	1208	1056

AVA_{CE}



	Placebo	Ataciguat
N	11	12
Baseline values	1.33	1.36

But there was little mean change in transvalvular parameters:

	Placebo (n=11)		Ataciguat (n=12)	
	Baseline	6 mo	Baseline	6 mo
Peak gradient	26±7	28±8	26±7	29±9
Peak velocity	3.3±0.4	3.4±0.5	3.2±0.4	3.4±0.6

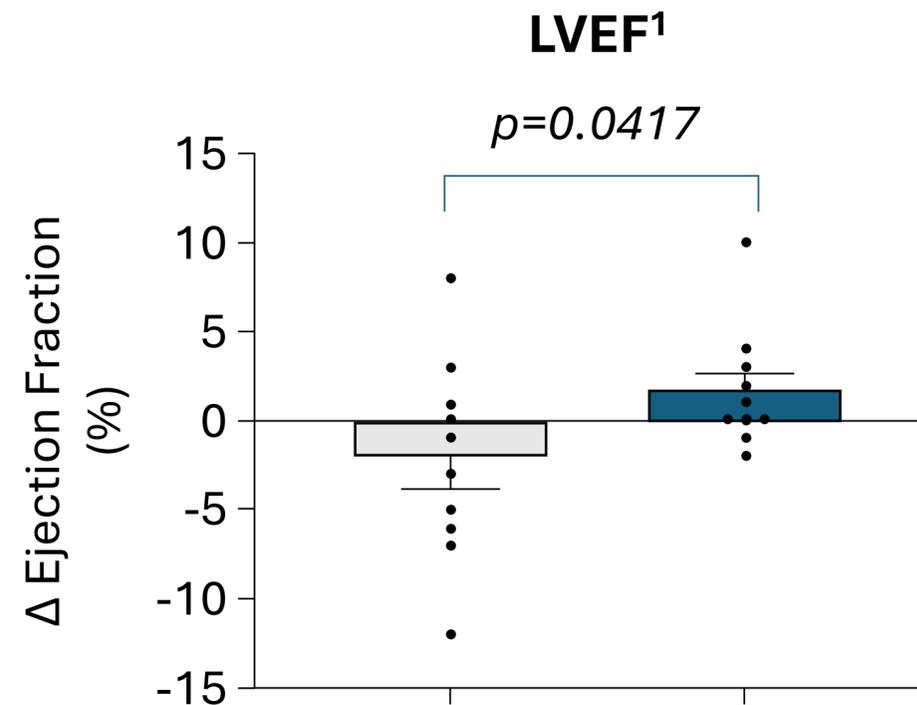
Zhang et al, *Circulation*. 2025.

#, change from baseline $P=0.004$; §, change from baseline $P=0.015$.

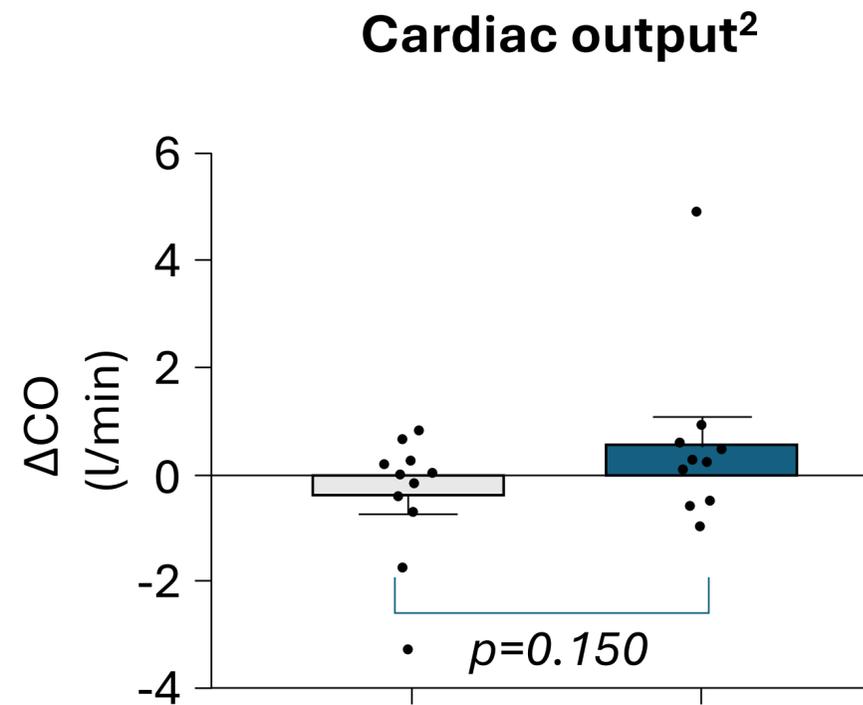
AVA_{CE}, aortic valve area by continuity equation; AVC, aortic valve calcium; mo, months.

Measures of Cardiac Function

Change from baseline to 6 months



	Placebo	Ataciguat
N	11	12
Baseline values	64%	65%



	Placebo	Ataciguat
N	11	10
Baseline values	6.3	6.3

Ataciguat treatment improved LVEF and tended towards improved CO^{1,2}

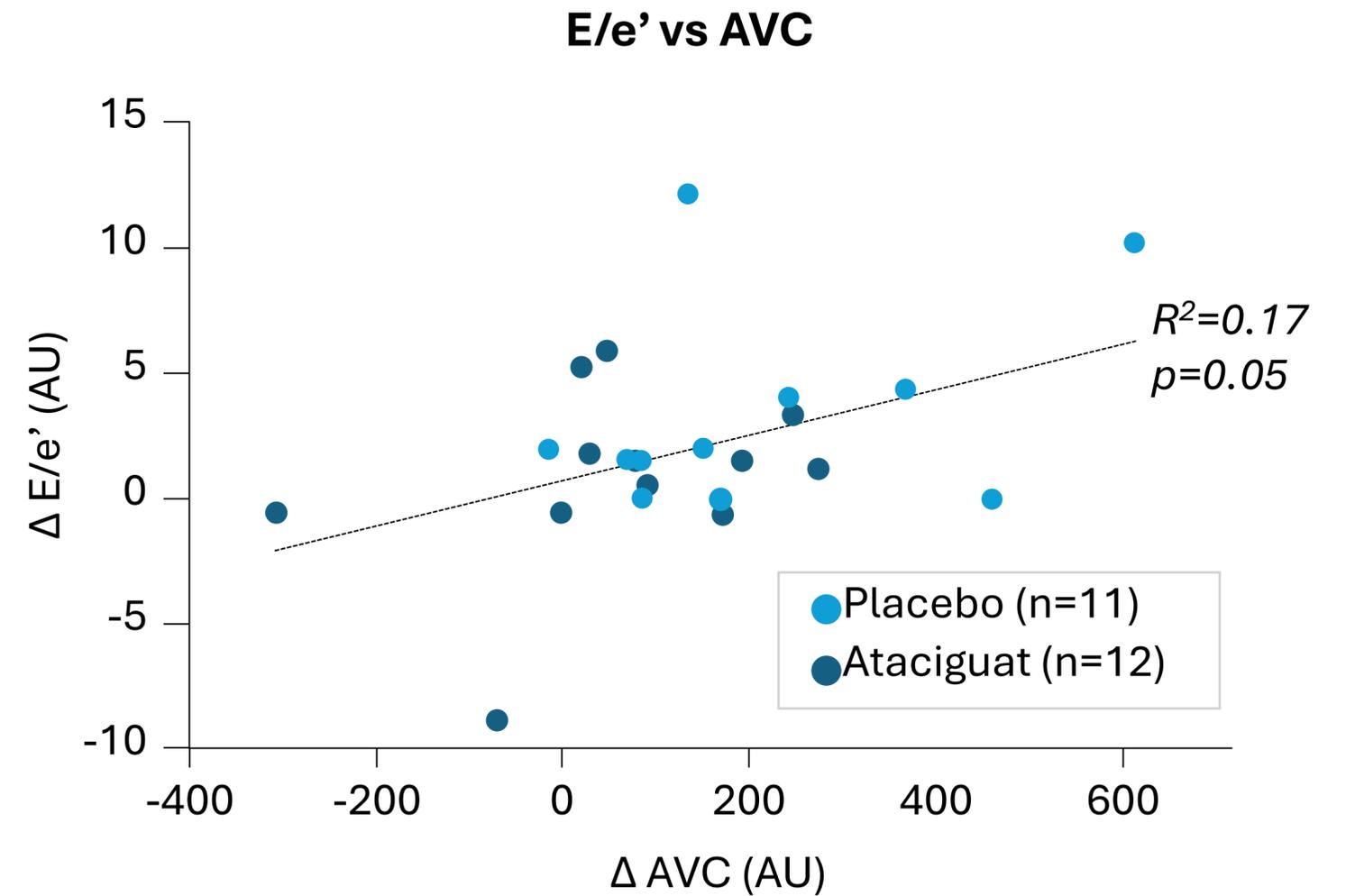
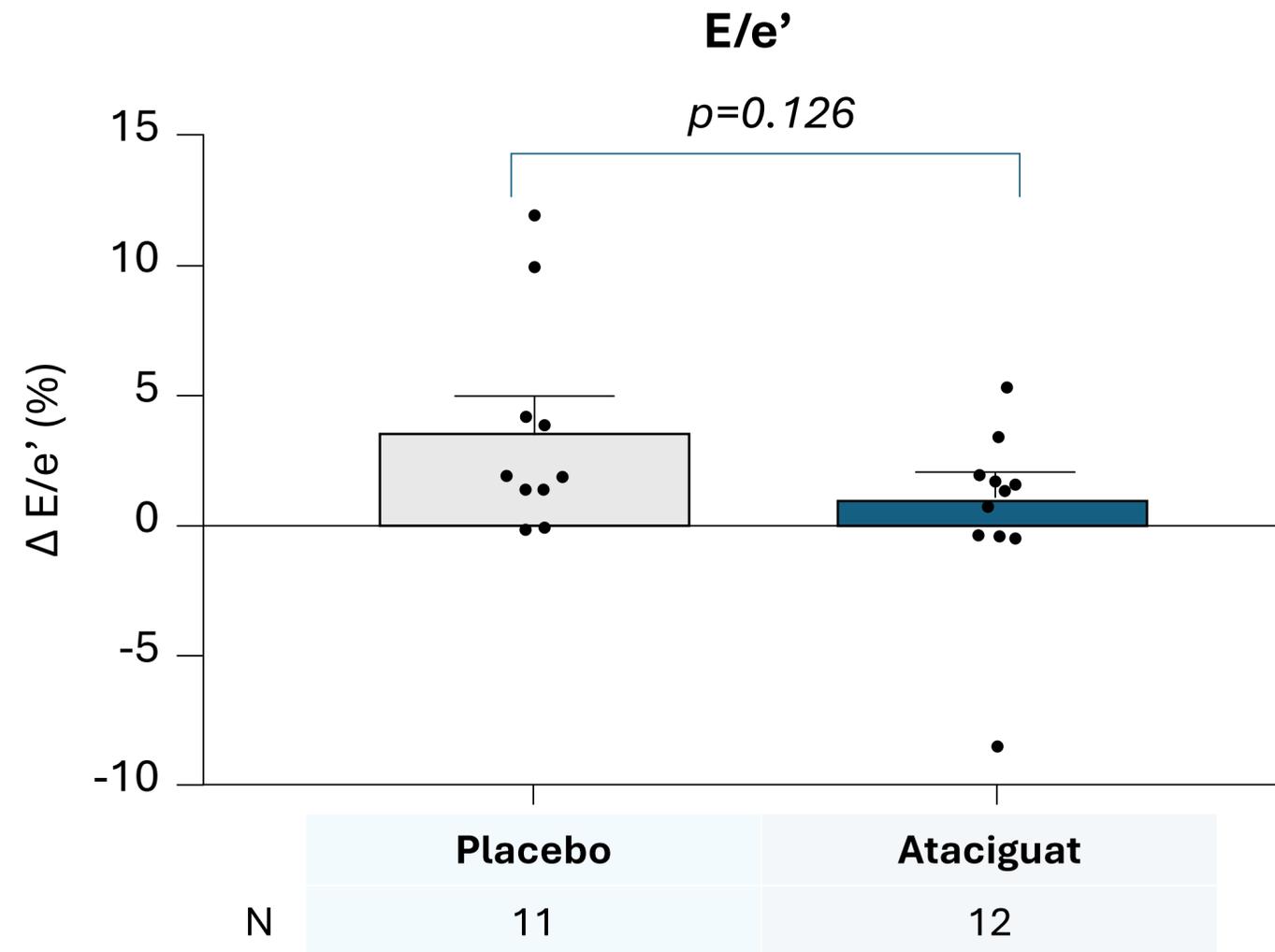
Participants with the least increase in AVC generally had the largest increase in CO, and improvements in CO were more frequent in those treated with ataciguat compared with placebo²

¹Zhang et al, *Circulation*. 2025. ²Data on file.

AVC, aortic valve calcium; CO, cardiac output; LVEF, left ventricle ejection fraction.

Changes in Diastolic Dysfunction

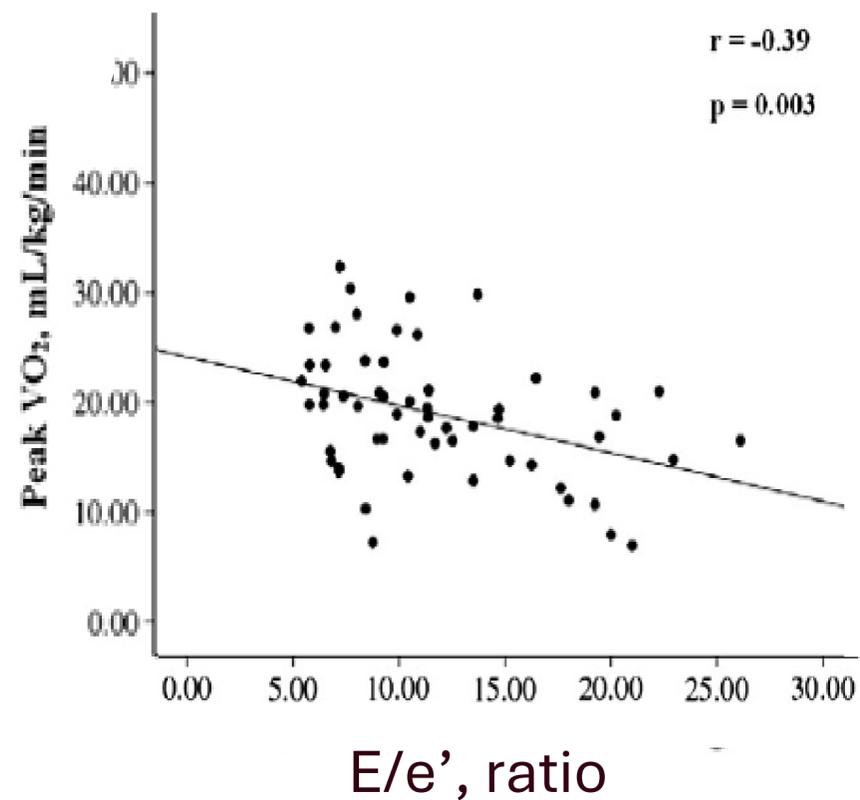
Change from baseline to 6 months



Ataciguat tended to slow worsening of E/e', and increases in AVC correlated with worsening E/e'

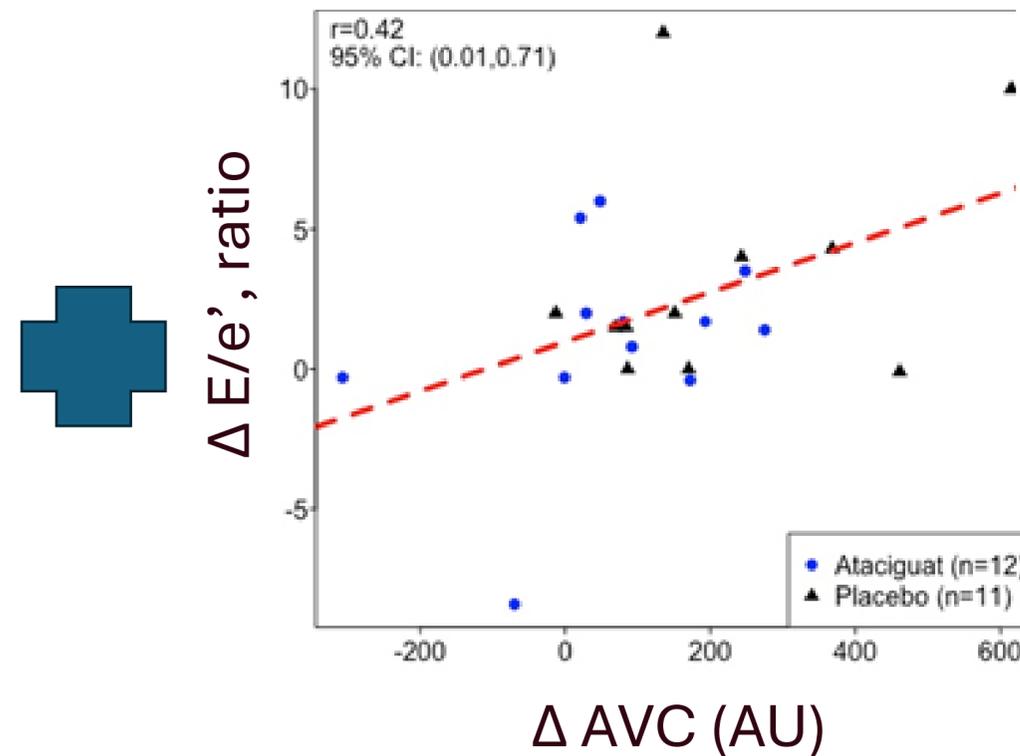
Hypothesis: Slowing AVC deposition associated with preserved pVO₂

pVO₂ Correlates w/ Diastolic Function



Dulgheru, Intl J Cardiol. 2013
DOI: 10.1016/j.ijcard.2013.01.205

AVC Progression Correlates w/ Diastolic Function



Zhang B, et al. Circulation. 2025;151(13):913–930. 2025.

Slowing AVC Progression w/ Ataciguat Projected to Preserve Cardiopulmonary Function

Addition Ataciguat Projections:

- Reduced LV mass increase
- Reduced Symptoms
- Reduced Diastolic Dysfunction
- Reduced Systolic Dysfunction
- Reduced AVA narrowing
- Prolonged time before AVR

Changes in Calcific Aortic Stenosis Associated with Changes in AV and Cardiac Measures

△ Aortic Valve Calcification



△ Aortic Valve Function
(Thickening, Compliance and Area)



△ Cardiac Structure & Function
(Systolic and Diastolic Fx, LV Mass)

Projected
Benefits

△ Symptoms
△ Cardiopulmonary Fx

Summary of Ataciguat Clinical Experience:

Safety

- Ataciguat: NO-independent soluble guanylate cyclase activator with negligible systemic vascular effects
- No inotropic effects
- Dosed orally, 200 mg, once daily
- Hepatic clearing; potential for CYP and P-gp drug-drug interaction
- **A total of 22 clinical studies (n= 999 patients)**
 - Mean SBP reduction – 1mm Hg
 - 4 indications: peripheral arterial disease (N=330), coronary artery disease (N=32), angina (N=257), neuropathic pain (N=59)
 - No unfavorable safety signals
- **Two clinical studies in AS (n= 67 patients)**
 - Phase 1b: orthostatic BP
 - No Hypotension in mild/mod AS
 - Phase 2: moderate calcific Aortic Stenosis
 - Reduced AVC progression at 6m

KATALYST-AV



A Phase 2b/3, Randomized, Double-Blinded, Placebo Controlled Study Checking the Efficacy and Safety of ATAciguat to Slow the Progression of VaLvular DYsfunction in Participants With Moderate Calcific Aortic Valve STenosis

What is the effect of ataciguat on slowing the progression of AVC?

How does the change in AVC correlate with echocardiographic measures (e.g., diastolic function)?

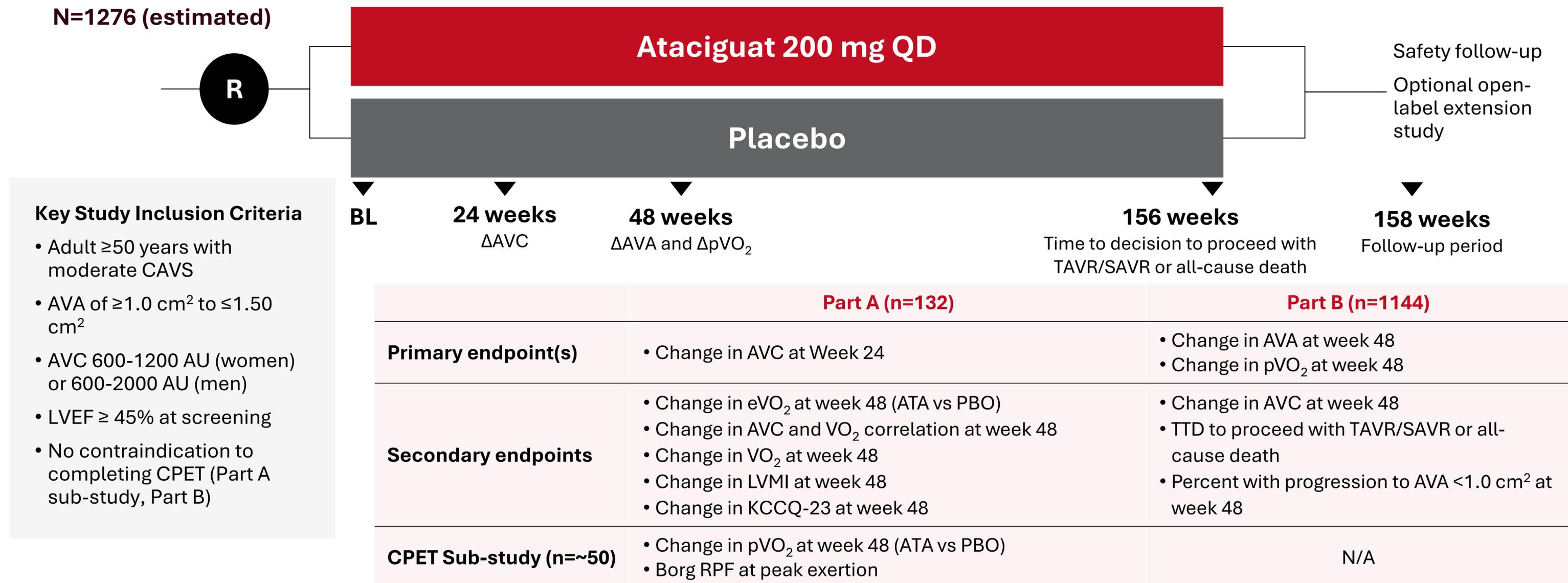
How do these changes relate to symptoms and cardiopulmonary function?

What is the direct effect of ataciguat on cardiopulmonary function?

Phase 2b/3 KATALYST-AV Clinical Trial (Currently Recruiting)¹

A Phase 2b/3, Randomized, Double-Blinded, Placebo Controlled Study Checking the Efficacy and Safety of ATAciguat to Slow the Progression of Valvular Dysfunction in Participants With Moderate Calcific Aortic Valve Stenosis (NCT07001800)

Design and Inclusion Criteria



Key Study Inclusion Criteria

- Adult ≥50 years with moderate CAVS
- AVA of ≥1.0 cm² to ≤1.50 cm²
- AVC 600-1200 AU (women) or 600-2000 AU (men)
- LVEF ≥ 45% at screening
- No contraindication to completing CPET (Part A sub-study, Part B)

*Safety, tolerability, and pharmacokinetics will also be evaluated.



CASE-BASED DISCUSSION: IDENTIFYING THE "AT-RISK" MODERATE AS PATIENT

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WHAT ABOUT THIS PATIENT:

A 76-year-old man with **hypertension, dyslipidemia, benign prostatic hyperplasia,** and **knee osteoarthritis** (*status post left total knee replacement (2022)*) was referred to the Heart Team for management of aortic stenosis.

Family History:

- Father died at 80 of MI
- Mother died at 86 of PNA

Social History:

- Married, retired DDS
- Former 0.5 pk/day smoker for 5 years, quit 45 years ago
- Socially drinks
- Denies illicit drug use

Medications:

- Atorvastatin 40mg QD
- Valsartan 40mg QD
- Multivitamin
- Alfuzosin 10mg QD

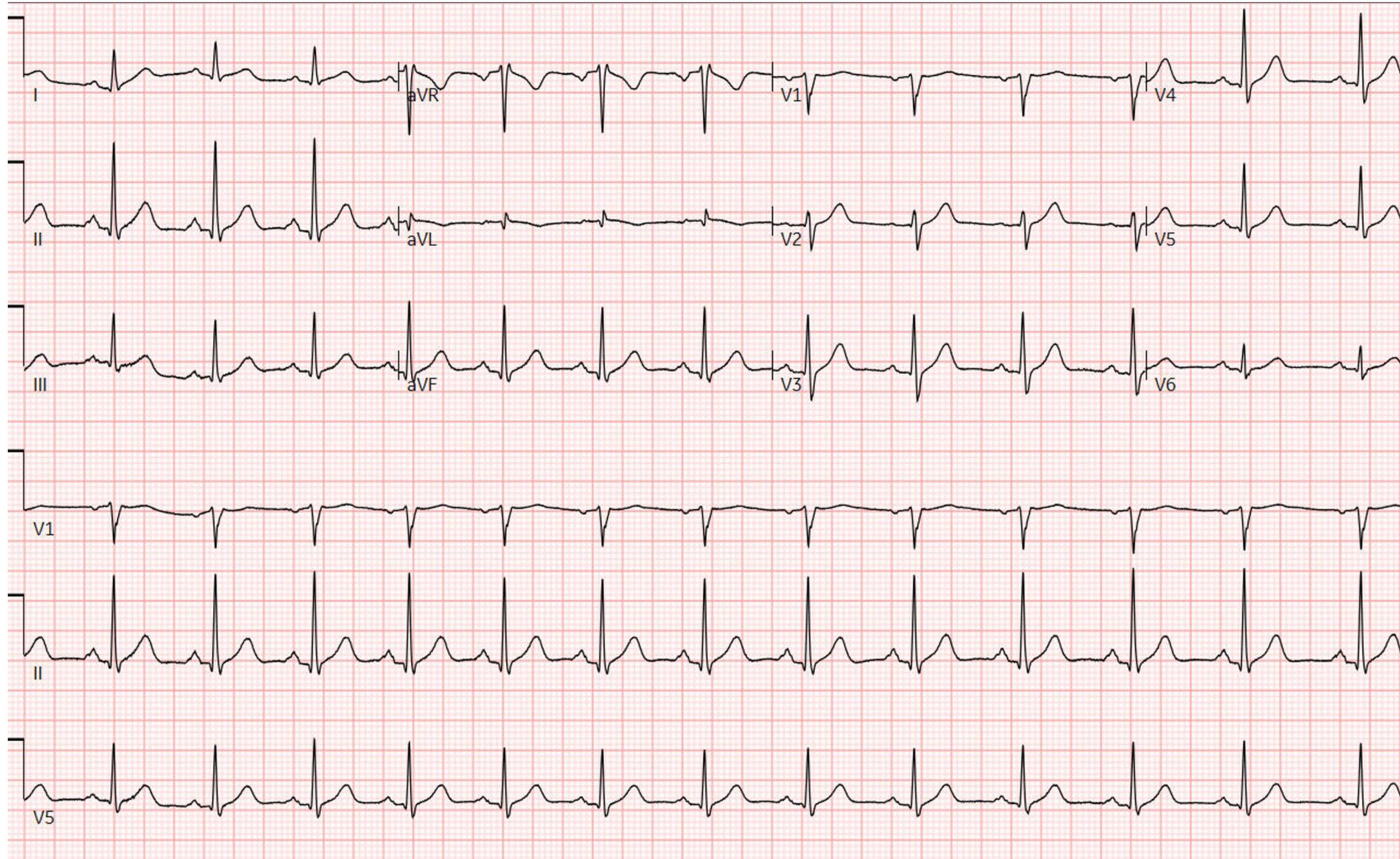


WHAT ABOUT THIS PATIENT: **VITALS**

- **Vitals:**
 - BP: 122/69 mm Hg
 - HR: 77 BPM
 - Resp: 18
 - HT: 5'3" (1.6m)
 - WT: 159 lb (72.1 kg)
 - SpO2: 92%
 - BMI: 28.17 kg/m²
- **HEENT:** EOMI, anicteric, OP clear, MMM
- **Neck:** no JVD. No LAD
- **Heart:** RRR, nl S1, S2. 2/6 SEM
- **Lungs:** CTAB, no retractions
- **Abd:** soft, NT, ND, NABS, no HSM
- **Ext:** no clubbing, cyanosis, or edema
- **Skin:** warm, dry , and well perfused
- **Neuro:** grossly non focal

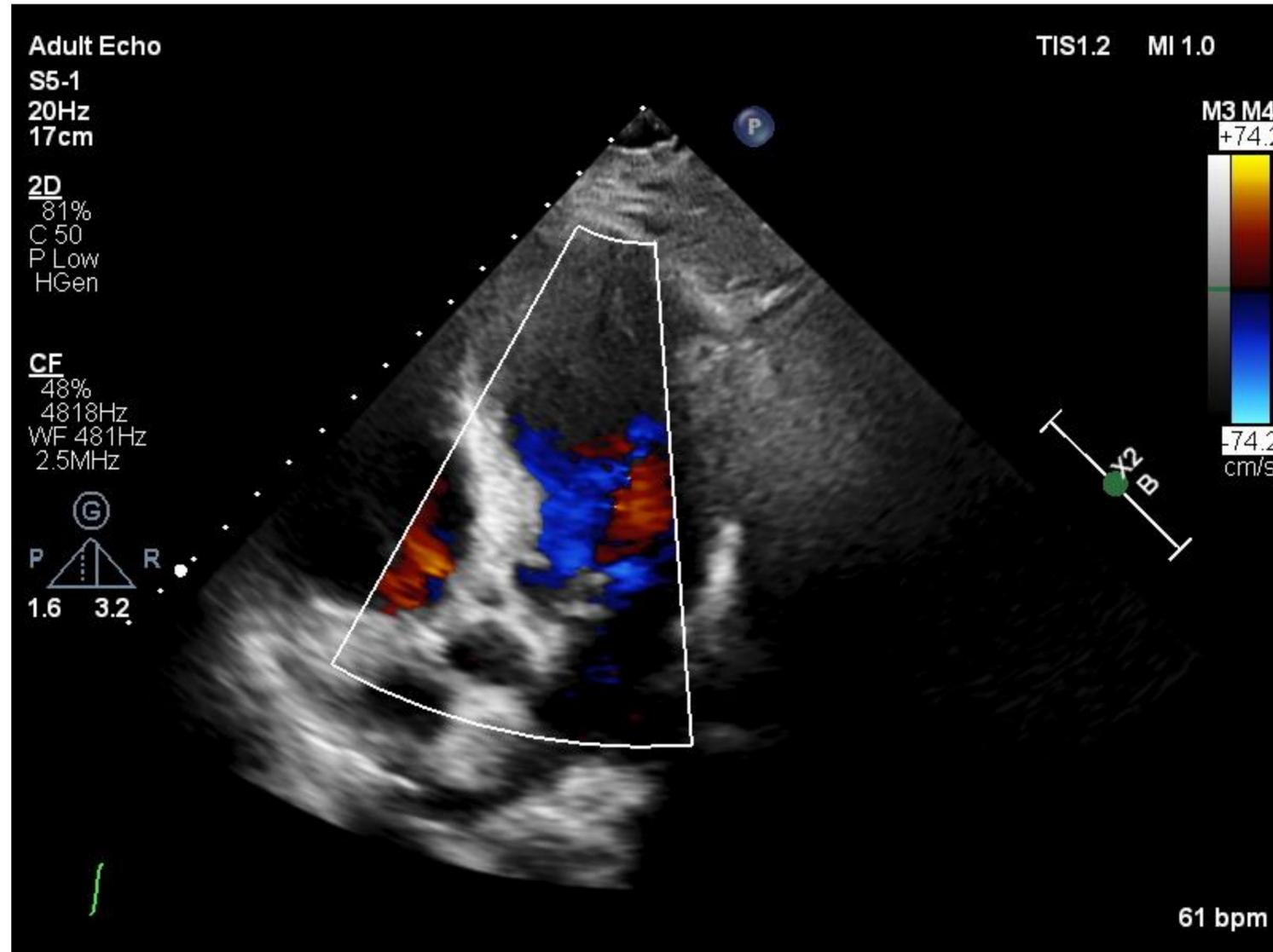


IMAGING: EKG

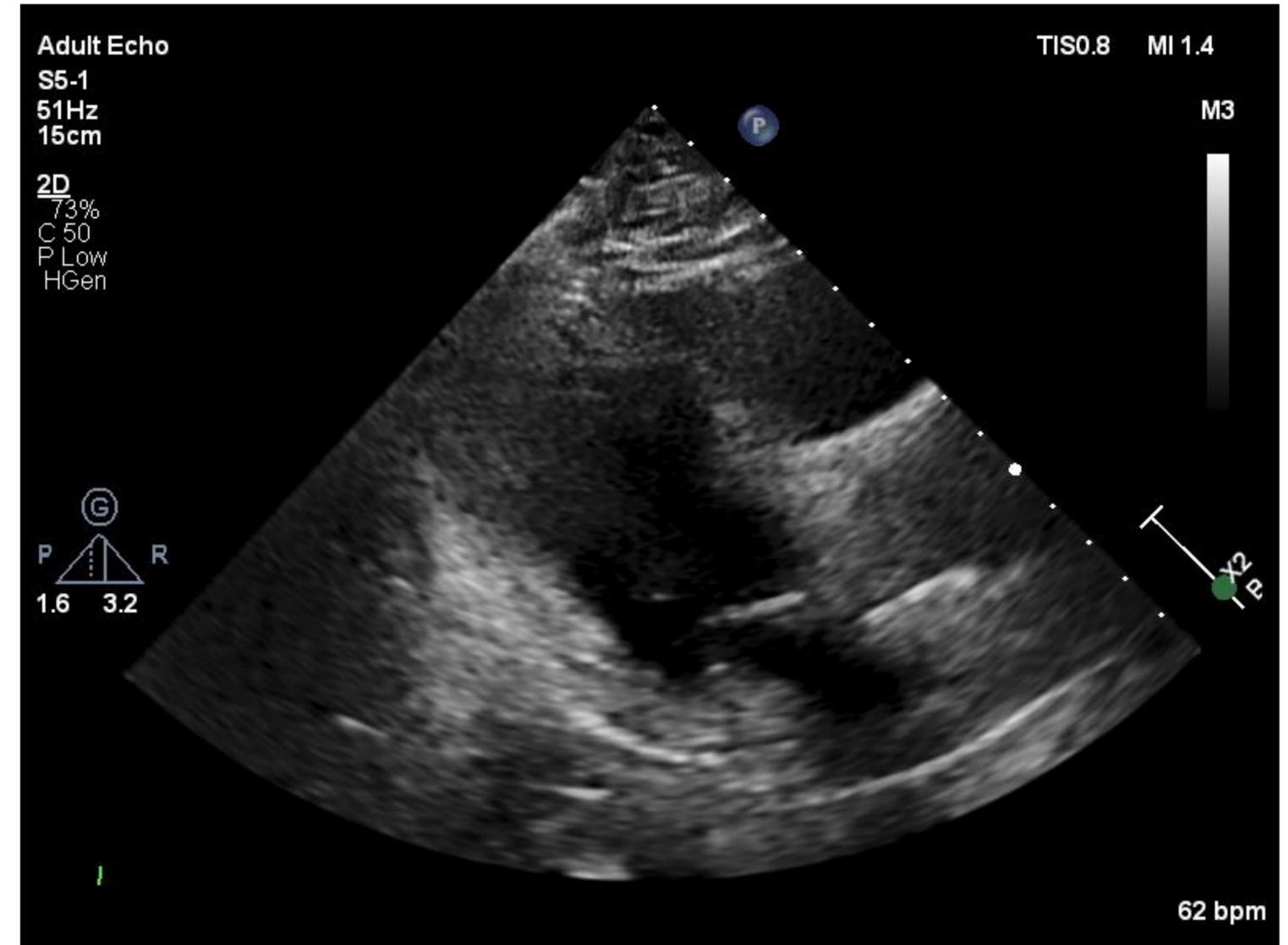


IMAGING: ECHO

Apical 5 Chamber View With Color Doppler

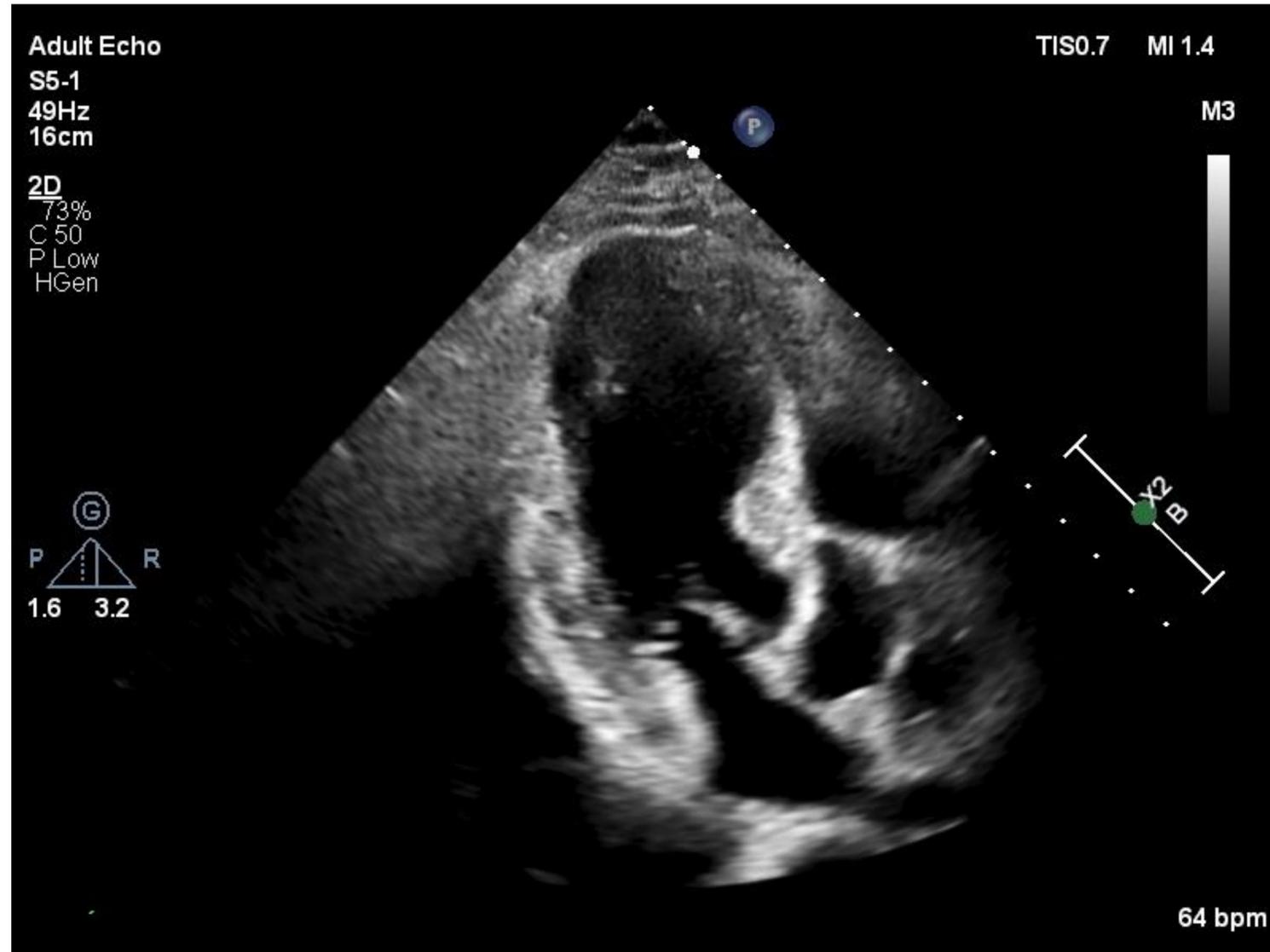


Parasternal Long Axis View

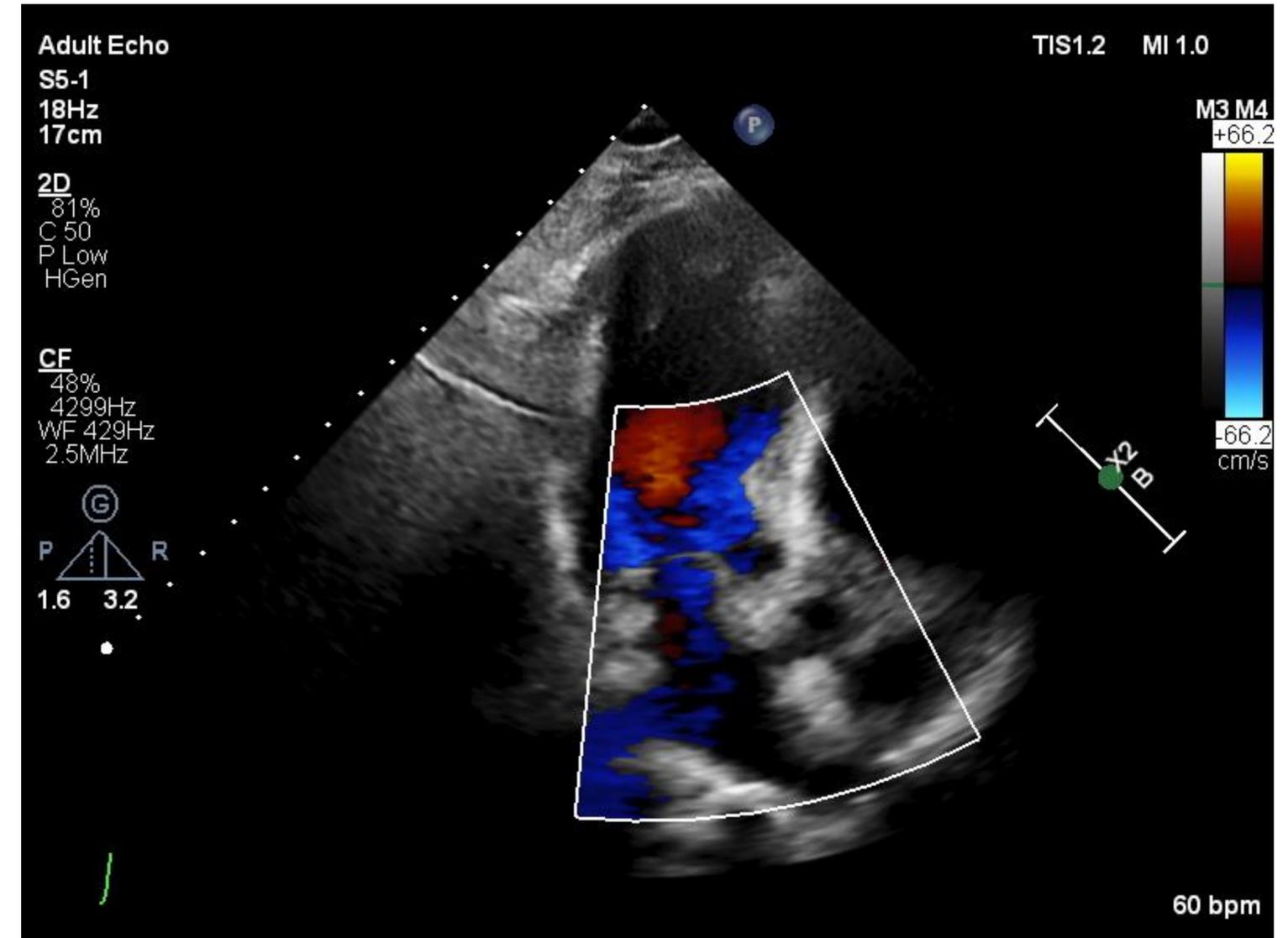


IMAGING: ECHO

Apical 3 Chamber View



Apical 3 Chamber View With Color Doppler



WHAT ABOUT THIS PATIENT:

ECHO FINDINGS

Left Ventricular:

- Normal left ventricular size.
- LV systolic function is normal.
- LV ejection fraction is approximately 60 to 65%.
- Mild basal septal left ventricular hypertrophy.
- Abnormal LV diastolic function (Grade I).
- Mildly dilated left atrium in size.

Right Ventricular:

- Normal right ventricular in size.
- Normal RV systolic function.

Aortic Valve:

- Aortic valve appears calcified and restricted.
- The calculated aortic valve area is 1.33 cm (index 0.76 cm/m) when LVOT is measured at 2.0 cm (Vmax 2.6 m/s; mean gradient 15 mm Hg).
- Normal right atrial pressure
- Mildly dilated sinus of Valsalva; sinus of Valsalva measures 41 mm (index 23 mm/m).
- Compared to prior study on 04/16/2024, aortic stenosis has progressed from mild to moderate (AVA previously 1.72 cm²)



CASE SUMMARY:

Overview:

A 76-year-old man with **hypertension, dyslipidemia, benign prostatic hyperplasia, and knee osteoarthritis** (*status post left total knee replacement (2022)*)

ECHO Findings:

- Normal LVEF
- AVA 1.33 cm²
- MG 15 mm Hg
- Vmax 2.6 m/s
- AVAi 0.76 cm/m
- Compared to echo from the previous year, the AVA has progressed from 1.70 cm²

Clinical Insights:

- Asymptomatic at high work level
- Normotensive
- Narrow complex NSR on EKG





How would you classify this patient?

- A. Mild Aortic Stenosis
- B. Moderate, asymptomatic Aortic Stenosis
- C. Severe, asymptomatic Aortic Stenosis
- D. Critical Aortic Stenosis





Would this patient trigger...?

- A. Referral to the Heart Team for education about Aortic Stenosis and what to expect in near future
- B. Close surveillance by Primary Cardiologist with Recommendation to repeat echo in 1 year
- C. Consideration for research / clinical trial
- D. No need to refer this patient since he is Asymptomatic from cardiac standpoint



Q & A



MEDICAL THERAPY VS. DEVICE TRIALS IN MODERATE AS

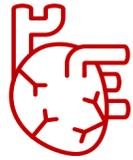
	PROGRESS	EXPAND TAVR II	KATALYST-AV
Inclusion Criteria	Age \geq 65	Age \geq 65	Age \geq 50
	Moderate AS	AVA \geq 1.0, \leq 1.5 cm ² and max velocity \geq 3.0, $<$ 4.0 or Mean gradient \geq 20, $<$ 40 mm hg	AVA \geq 1 to \leq 1.5 cm ²
	Symptoms or cardiac damage	Symptoms or Ca ⁺⁺ score or NYHA class	LVEF \geq 45%
Exclusion Criteria	Not anatomically suitable for transfemoral TAVR	Not anatomically suitable for transfemoral TAVR	CAD or expected coronary stenting
	Severe AR	Cardiac amyloidosis	Moderate, moderate to severe, or severe mitral stenosis, mitral regurgitation, and/or aortic regurgitation
	AVR or prior AV intervention	Class I indication for cardiac surgery	Long-standing permanent or persistent AFib
	LVEF $<$ 20%	LVEF $<$ 20	NYHA III or IV

KEY TAKEAWAYS

- Moderate AS is **PREVALENT**.
- Although **moderate and severe AS differ in severity**, both states are **progressive** and will advance along the disease continuum.
- Early intervention in severe AS makes a difference, **earlier intervention in moderate AS may also make a difference!**



INTERESTED IN **LEARNING MORE?**



Join our upcoming Moderate AS Virtual Grand Rounds Sessions!

COMING SOON:

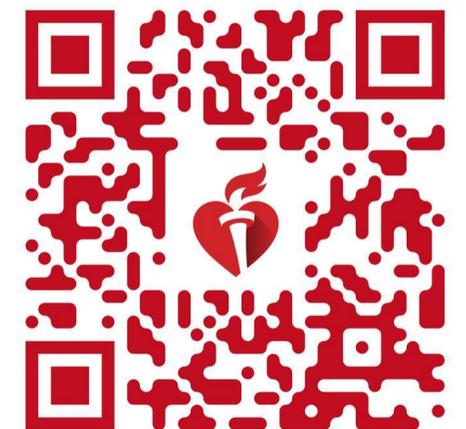
- **Session #2:** Patient Identification & Echo-Based Phenotyping – *April 2026*
- **Session #3:** Research Readiness & Trial Infrastructure in Medical Therapy Paradigm – *July 2026*
- **Session #4:** Engaging the Patient Voice & Driving Trial Participation – *October 2026*



Sessions will encourage cross-disciplinary dialogue and discuss opportunities available across the moderate AS care pathway.



Scan to visit <http://www.heart.org/ModerateAS> for a recording of today's session, additional resources, and information on future Virtual Grand Round sessions!





Thank you for joining us today!

Recordings of today's sessions will be enduring resources in a few weeks on

www.heart.org/ModerateAS



Connect with Us! Scan to email

ClinicalStudies@heart.org

