each group) THVs (n=384). Win ratio analysis was performed using the Delphi method, involving 10 cardiologists. The 1-year composite endpoint included (hierarchically ranked) all-cause death, disabling stroke, non-disabling stroke, and procedure- or valve-related hospitalization. Win-ratio analysis was also conducted for an extended composite endpoint that included quality-of-life outcomes (defined as a ≥2.5-point decrease from baseline to 1-year follow-up in both the physical and mental domains of the Short-Form 12).

Results: Among 147,456 (384x384) unmatched patient pairs, the win ratio for the primary composite endpoint was 1.02 (95% CI: 0.68–1.51; p=0.94), with 17,870 (12.1%) wins for the Myval group and 17,599 (11.9%) for the contemporary group. The win difference was 0.18%, and the win odds were 1.00. For the extended composite endpoint, the win ratio was 1.13 (95% CI: 0.82–1.55; p=0.45), with 27,007 (18.3%) wins for the Myval group and 23,920 (16.2%) for the contemporary group. The win difference was 2.09%, and the win odds were 1.04. Comparisons of the primary composite endpoint between the Myval and Sapien groups, and between the Myval and Evolut groups, were also not statistically significant (Myval vs Sapien: win ratio=0.99; 95% CI: 0.61-1.60; p=0.98, Myval vs Evolut: win ratio=1.04; 95% CI: 0.64-1.68; p=0.88).

Conclusion: Win-ratio analysis demonstrated a comparable primary composite endpoint at 1-year between Myval and contemporary THVs, consistent with the primary time-to-first event analysis of the LANDMARK trial.

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83210 | Impact of Cardiac Damage on 1-Year Outcomes After TAVI in Severe Aortic Stenosis: Insights from the LANDMARK Trial Sub-Analysis

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Background: Previous studies demonstrated that the extent of cardiac damage in patients with aortic stenosis (AS) is associated with worse clinical outcomes. This study aims to report the incidence, temporal change, and clinical impact of cardiac damage in patients with severe AS who underwent transcatheter aortic valve implantation (TAVI) in the LANDMARK randomized trial (a non-inferiority trial of Myval vs. contemporary TAVI valves).

Methods: This is a post-hoc analysis. Preprocedural and 1-year transthoracic echocardiography (TTE) were evaluated by an independent core laboratory. Patients were classified into 5 stages (0-4) using modified cardiac damage classification (Genereux et al): stage 0 (no damage); stage 1 (Left ventricular damage/dysfunction: Left ventricular mass index >95 g/m^2 women, >115 g/m^2 men; Left ventricular diastolic dysfunction E/e' >14; or LV ejection fraction < 50%); stage 2 (Left atrial/mitral valve damage/dysfunction [Left atrial volume index >34 mL/m^2, atrial fibrillation, or ≥ moderate mitral regurgitation]); stage 3 (pulmonary artery vasculature/tricuspid valve damage: ≥ moderate tricuspid regurgitation and high probability of pulmonary hypertension per 2022 ESC/ERS combined criteria); stage 4 (right ventricular damage: tricuspid annular plane systolic excursion <17 mm, S' <9.5 cm/s, or right ventricular fractional area change <35%). The primary endpoint was 1-year all-cause mortality; the composite endpoint included death, stroke, and valve- or procedure-related re-hospitalisation.

Results: Among 596 patients, incidence of cardiac damage was: stage 0: 6%, stage 1: 15%, stage 2: 48%, stage 3: 14%, and stage 4: 17%; stages 0-2 and 3-4 accounted for 69% and 31%, respectively. 1-year mortality increased from stage 0 to 4: 0%, 1.1%, 4.7%, 7.2%, and 20.4% (log-rank p<0.001; AUC 0.739). Among patients with paired TTE, cardiac damage improved in 28.8%, remained unchanged in 49.8%, and worsened in 21.4%.

Conclusion: Preprocedural TTE-based cardiac damage stratified 1-year mortality post-TAVI. Stage 4 is associated with the highest mortality, highlighting the prognostic value of comprehensive echocardiographic assessment in severe AS.

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83219 | Permanent Pacemaker Recovery Post-Transcatheter Aortic Valve Implantation: Post-hoc Analysis from the LANDMARK Trial

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Background: Conduction disturbances are common after transcatheter aortic valve implantation (TAVI) and often require permanent pacemaker implantation (PPI). While some patients remain pacing-dependent, others recover conduction system over time. Data on pacemaker recovery (PMR) from randomized trials are limited. This study reports the incidence and predictors of PMR in the LANDMARK trial.

Methods: This post-hoc analysis of the LANDMARK trial (randomized [1:1 Myval vs contemporary THV series], non-inferiority trial) examined the 1-year incidence of PMR in 99 patients who received a PPI within 30 days post-TAVI (n=122 [15.9%]). Pacemaker follow-up data, including ventricular and atrial pacing rates, pacemaker mode, and lower rate setting, were collected retrospectively. Imaging data from echocardiography, 12-lead electrocardiogram (ECG), and preprocedural computed tomography (CT) were analyzed by core laboratories. Valve implantation depth was assessed by the CORRIB core lab using final procedural aortography. PMR was defined as a ventricular pacing rate of ≤1% at follow-up.

Results: Among 99 patients (mean age 80.7 ± 4.7 years), 1-year PMR occurred in 18% of patients. Patients with PMR were significantly younger than non-PMR patients (78.6 ± 3.0 vs. 81.1 ± 5.1 years, p=0.045). Baseline right bundle branch block (RBBB; 16.7% vs.27.2%, p=0.55) and left bundle branch block (LBBB, 0% vs. 8.6%, p=0.34) were numerically higher in the non-PMR group. Atrial fibrillation was significantly more prevalent in the non-PMR group (0% vs. 27.2%, p=0.01) and was identified as an independent predictor of lower odds of PMR on multivariable logistic regression (OR: 0.09, 95% CI: 0.00-0.77, p=0.02). Ventricular pacing rates were significantly lower in the PMR