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

group than the non-PMR group (0.3% vs 52.4%; p<0.001). PMR rates did not differ significantly by THV type (Myval 25%, Sapien 19%, Evolut 7%; p=0.16).
Conclusion: At 1-year, conduction system recovery (VP≤1%) was observed in 18% of patients who underwent PPI after TAVI, with no significant differences across valve platforms. Atrial fibrillation emerged as an independent predictor of reduced PMR.

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83220 | Long-term Outcomes of Cusp Overlap Versus Three-Cusp Views in Transcatheter Aortic Valve Implantation

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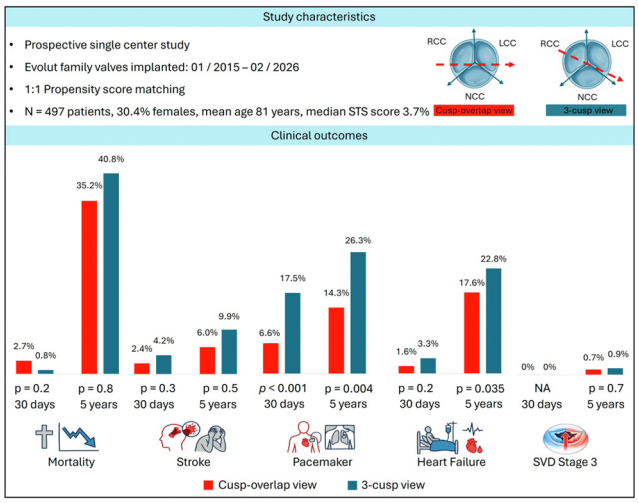
Background: Implantation in cusp-overlap (COV) view is increasingly used for transcatheter aortic valve implantation (TAVI) of self-expanding valves.
Methods: Between January 2015 and February 2026, 497 patients underwent TAVI for the treatment of native aortic stenosis with the Evolut self-expanding valve. Procedural and clinical outcomes using the COV view were compared to the 3-cusp view in the overall and in the propensity score-matched population.
Results: A total of 377 (76%) patients underwent TAVI using the COV view, the 3-cusp view was used for the remaining 120 (24%). There were no differences regarding age and sex, while STS-PROM was higher in COV patients (3.8 vs 3.4%, p=0.049). Predilatation was more frequently performed (83.6% vs 65.8%, p<0.001) and implantation depth was higher with the COV (1.8 mm vs 2.7 mm, p < 0.001). At echocardiography before discharge, mean gradients were 8 ± 4 vs 8 ± 7 mmHg, p=0.5 and ≥ mild PVL was present in 1.8% vs 0.8%, p =0.4. At 30-day follow-up, a new permanent pacemaker was required less often with the COV (6.6% vs 17.5%, p<0.001). At 5-year follow-up, a new pacemaker was required in 14.3 vs 26.3% (p=0.004), hospitalization for heart failure had occurred in 17.6% vs 22.8% (p=0.035), structural valve deterioration stage 3 had occurred in 0.7% vs 0.9% (p=0.7) and all-cause mortality was 35.0% vs 40.8% (p=0.2).
Conclusion: The use of the COV view during TAVI is associated with improved control of implantation depth, resulting in a lower rate of permanent pacemaker implantation, and hospitalization for heart failure during long-term follow-up.



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83226 | Long-term Outcomes After Transcatheter Aortic Valve Replacement: A Comparison to the Evolut Low Risk Trial

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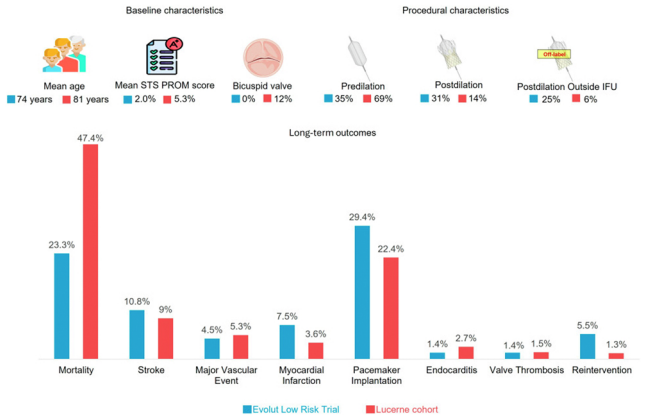
Background: A recent publication of the Evolut Low Risk trial has raised concerns about long-term durability of transcatheter aortic valve replacement (TAVR) with self-expanding Evolut and CoreValves.
Methods: Consecutive patients were included in a prospective registry and followed for up to 7 years. Outcomes were defined according to VARC-3.
Results: A total of 564 patients (mean age 81 ± 6 years, 67% male, mean STS PROM Score 5.3%) were studied. Predilation was performed in 69% of procedures, postdilation in 14% (outside instructions for use in 6%), mean implantation depth was 2.5 mm, and 66% were implanted in cusp overlap view. Technical success was achieved in 92%, 30-day device success in 86% and early safety in 76%. At 30 days, all-cause mortality was 2.1%, stroke 3.0%, hospitalization for heart failure 2.1%, and a new permanent pacemaker was required in 12.4%. At 7 years, the corresponding rates were 53.9%, 7.6%, 19.3%, and 20.3%, respectively. Structural valve deterioration stage 3 occurred in 0.4% at 5 years and 2.4% at 7 years. Reintervention (TAVR or surgical replacement) was performed in 0.2% within 5 years and in 1.5% by 7 years.
Conclusion: In this real-world cohort with a mean age of 81 years, a high rate of predilation and a very low rate of postdilation, TAVR with self-expanding Evolut or CoreValve platforms was associated with very low rates of structural valve deterioration and reintervention during long-term follow-up.



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83227 | Early Rehospitalization After Transcatheter Aortic Valve Implantation: Incidence, Predictors and Impact on Mortality

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Background: Early rehospitalization after transcatheter aortic valve implantation (TAVI) is frequently required but data regarding its prevalence, etiology, predictors and prognostic relevance are limited.
Methods: Consecutive patients undergoing TAVI between August 2012 and October 2025 were analyzed. Early rehospitalization was defined as any readmission within 30 days.