transplantation field may find useful applications in the treatment of cardiovascular disease.

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**References**

The list of references is available in the online version of this paper.

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**Late migration of balloon-expandable transcatheter aortic valve**


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A 72-year-old female patient was readmitted to hospital with recurrent heart failure NYHA III after an initially uneventful course following transcatheter aortic valve implantation (TAVI). Four month earlier she had undergone TAVI for severe aortic stenosis with a 26-mm balloon-expandable aortic valve in a transfemoral approach. Initially after the procedure she had experienced improvement of physical capacity without further symptoms of heart failure during daily life. About 6 weeks after the operation during a physical exercise she experienced a sudden onset of dyspnoea and recurrence of symptoms of heart failure symptoms, however, of lesser severity than preoperatively.

At the time of readmission, echocardiography and fluoroscopy confirmed migration of the prosthetic valve into the left ventricular outflow tract, resulting in a subannular device position just below the native aortic leaflets (Panels A–C). Owing to recurrent obstruction by the calcified native valve this was associated with moderate restenosis ($V_{max}$ 3.3 m/s, mean pressure gradient 23 mmHg) and severe paravalvular aortic regurgitation (Panel D). Therefore, re-TAVI was performed in a transapical approach to avoid the risks of retrograde wire-crossing of the native and the migrated valve with potential further dislocation. In this procedure, a 29-mm balloon-expandable valve prosthesis was positioned to secure the first valve by greater than one-third overlapping and to treat valvular dysfunction (Panel E). The patient recovered quickly after the procedure and further in-hospital course was uneventful (green dotted line = aortic sinus, asterisks = prosthetic valve; arrow = native calcified aortic leaflets).

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