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ECMO VS LVAD IN LATAM

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The Society of Thoracic Surgeons

EACTS
European Association For Cardio-Thoracic Surgery

Relevant Financial Relationship Disclosure Statement

The following relevant financial relationships exist related to my role in this session: Speaker St Jude Medical now Abbott

ECMO as circulatory support is completely different than respiratory support

- FCV 2017 ELSO registry report

	ADULTS		
	Cannulated	Decannulation	Discharge
Respiratory	22	19(86%)	17(77%)
Cardiac	45	26(57.8%)	18(40%)

ECMO as MCS some facts

- high-risk, complex, and resource-intensive
- has grown rapidly
- Save some patients
- Outcomes are suboptimal in cardiac surgery

Poscardiotomy Adults

Survival to discharge

Brasil a* 4/24(16%)

Brasil b* 1/9 (16%).

Colombia FCV 3/15 (20%)

- Vasoplegia + poscardiotomy 0/6 (0%)
- Poscardiotomy arrested 0/2 (0%)

Primary Graft Dysfunction

Survival to discharge
Brasil b* 8/11 (72%)
Colombia FCV 4/7 (57%)
Proactive 4/5 (80%)
Reactive 0/2 (0%)

ECMO as MCS in cath lab

Survival to discharge
Colombia FCV 13/21 (61%)
Proactive 8/8 (100%)

ECMO as a Bridge to Transplant

Survival to discharge

Brasil 3/9 (33%) -Caneo et al, Arq Bras Cardiol. 2014-

Colombia 5/9 (55%) –Salazar et al, Acta Colomb Cuid Intensivo 2015;15:178-86-

ECMO in a complex cardiac surgery + prolonged CBP + difficult CBP weaning + refractory high dose multiple inotropes/vasoconstrictors = BAD OUTCOME

ECMO as proactive support in primary graft dysfunction and complex cath lab patients has good outcomes

ECMO is not the best MCS for bridging to transplant. Switching to temporary or long term VAD or using them from the beginning would be a better option