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## Device-Related Thrombus After Left Atrial Appendage Occlusion With the Amulet Device

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All authors take responsibility for all aspects of the reliability and freedom from bias of the data presented and their discussed interpretation.

## **Abstract**

*Background:* Left atrial appendage occlusion (LAAO) is increasingly used for stroke prevention in patients with atrial fibrillation who are considered unsuitable for a lifelong oral anticoagulant regimen. Recently, a single-centre study reported device-related thrombus formation in 16.7% of patients treated with the second-generation Amulet device (St. Jude Medical, St. Paul, MN, USA), presenting a potential major safety concern. As “real-world” data on device-related thrombus formation following LAAO with the Amulet occluder are scarce, we aimed to evaluate this outcome in a retrospective registry.

*Methods:* Clinical and transesophageal echocardiography data after LAAO with the Amulet in consecutive patients from three centres were collated.

*Results:* Among 38 patients (mean age 75.8 years), mean (standard deviation) CHA<sub>2</sub>DS<sub>2</sub>-VASc and HAS-BLED scores were 4.4 (1.2) and 3.4 (0.9), respectively. All patients underwent successful device placement without procedure-related adverse events. The antithrombotic regimen at discharge consisted of dual antiplatelet therapy (DAPT) in 27 patients (71.1%), single antiplatelet therapy in 10 patients (26.3%), and no antithrombotic therapy in one patient (2.6%). Device-related thrombus was observed in one patient (2.6%) despite DAPT regimen. The outcome of this patient was uncomplicated after adjustment of oral anticoagulant therapy. No patients presented with a thromboembolic event following LAAO during a mean (standard deviation) follow-up of 15 (5) months.

*Conclusions:* In this retrospective study, device-related thrombus formation with the second-generation Amulet device was rare and occurred at a rate similar to that of the previous device. Importantly, no patient experienced a device-related thromboembolic event during follow-up. Larger real-life studies are required to confirm the safety profile of this increasingly used device.

## **Keywords:**

Left atrial appendage occlusion; Stroke prevention; Atrial fibrillation; Device-related thrombus formation

## **Introduction**

The concept of percutaneous left atrial appendage occlusion (LAAO) for stroke prevention in patients with atrial fibrillation (AF) was derived from several observational studies reporting that, in patients with non-valvular AF, 90% of left atrial thrombi are located in the left atrial appendage (LAA) [1]. LAAO is non-inferior to medical treatment with warfarin for the prevention of a combined outcome of stroke, systemic embolism and death in patients with non-valvular AF [2-6]. In the 2016 European Society of Cardiology guidelines for the management of AF, LAAO received a IIb level of recommendation in patients in whom long-term anticoagulant treatment was contraindicated [7]. LAAO is also recommended by some authors when electrical isolation of the LAA occurs during extensive ablation for non-paroxysmal AF [8,9]. The number of LAAO procedures is therefore increasing rapidly in such patients [10,11].

The first-generation Amplatzer Cardiac Plug (ACP) and the second-generation Amplatzer Amulet occluder (both from St. Jude Medical, St. Paul, MN, USA) are nitinol plugs widely used for LAAO [12]. However, data on the “real-world” performance of these two devices, particularly the recently released Amulet device, are scarce. The Amulet was developed to provide better occlusion of the LAA—thus presumably being more effective than the previous generation—as well as limiting device-related thrombogenesis [13]. However, in preliminary experience from Sedaghat et al. [14], there was an unexpectedly high rate of device-related thrombus (DRT) (16.7%)—despite the use of dual antiplatelet therapy (DAPT) in most patients—resulting in stroke in one patient (4.2%). If these findings are confirmed in other studies, this would raise a major concern for the safety of LAAO with the Amulet prosthesis. We therefore conducted a retrospective review of patients who underwent LAAO with the Amulet prosthesis in our three institutions, aiming to determine the rates of DRT, optimal device placement and residual periprosthetic leak.

## **Material and Methods**

### **Study Design**

This study included consecutive patients with non-valvular AF who underwent LAAO with the Amulet device due to contraindication to long-term oral anticoagulants, in three centres (Aix-Marseille

University, Nord Hospital; Aix-Marseille University, Timone Hospital; and European Hospital of Marseille) during March 2015 to December 2016. Clinical, procedural and imaging data were retrospectively examined. All operators who participated in this study had previously performed at least 15 LAAO procedures with the ACP device. M.P. and F.F. had performed 25 and 15 LAAO procedures with the ACP device respectively. S.A. is a clinical proctor for St. Jude Medical and had performed over 50 LAAO procedures with the ACP. S.A. has also a significant experience with the Watchman device with involvement in over 40 procedures.

This study complied with the Declaration of Helsinki. The research protocol was approved by the Research Ethical Committee of Aix-Marseille University. All patients gave informed consent to undergo the procedure.

#### LAAO Procedure

Preprocedural LAA imaging to evaluate LAA anatomy and dimensions was optional, performed at the discretion of the operator. The technique of LAAO device implantation has been described elsewhere [12]. The procedure was performed under general anaesthesia with transoesophageal echocardiography (TEE) and fluoroscopy guidance. Left atrial access was obtained through a transseptal puncture, at the inferior and posterior part of the fossa. After exchange from the transseptal sheath to the dedicated delivery sheath, a 100-IU/kg bolus of unfractionated heparin was administered, targeting an activated clotting time of 250–300 seconds. Two-dimensional TEE using several views from 0° to 135° and real time three-dimensional TEE views were used for both detailed LAA assessment and device positioning. Device deployment was performed under both TEE and fluoroscopy guidance. Before delivery, device stability was evaluated according to the following criteria: compression of the lobe of the device; lobe orientation in the axis of the landing zone; concave disc shape, separated from the lobe; distal position of the lobe to the circumflex coronary artery; and stability to a gentle 60-second tug test [13]. All patients underwent post-procedural transthoracic echocardiography to assess the device position and exclude pericardial effusion before hospital discharge. In line with the manufacturer's instructions, antithrombotic therapy consisted of DAPT (aspirin 75 mg plus clopidogrel 75 mg daily) for at least 6 weeks unless contraindicated.

## Definitions

According to expert consensus, technical success was defined as exclusion of the LAA without residual leak >5 mm on colour Doppler TEE without device-related complications [15]. Procedural success was defined as technical success without procedure-related complications [15]. Amulet device placement was considered optimal when the disk of the occluder covered the LAA rim [16] (Figure 1). All efforts were made to achieve optimal placement of the Amulet, including gentle counterclockwise rotation during the tug test. In all other cases, if the Amulet disk failed to “catch” the PV ridge, due to the need of a deeper placement within the LAA, a funnel-shape LAA or poor LAA orientation, the Amulet placement was considered suboptimal.

## Follow-Up

All patients underwent two dimensional (2D) and real time 3D TEE under controlled sedation with midazolam to evaluate the Amulet position and the presence of a DRT and/or peri-device leak 6–12 weeks after device placement. Full 2D screening in several views from 0° to 135° and real time 3D views were performed to detect DRT. If the TEE did not show abnormalities (thrombus or peri-device leak >5 mm), clopidogrel treatment was stopped and lifelong monotherapy with aspirin 75 mg once a day was continued thereafter.

## Statistical Methods

Owing to the small number of patients, a full statistical analysis was not undertaken. Values are presented as means (standard deviations [SDs]) or numbers (percentages).

## Results

### Patient Characteristics

Thirty-eight patients, predominantly men (76.3%), with a mean (SD) age of 75.8 (7.7) years (range 63–89 years) were included in this analysis (Table 1). Mean (SD) CHA<sub>2</sub>DS<sub>2</sub>-VASc score was 4.4 (1.2) and 14 patients (36.8%) had previous stroke, transient ischaemic attack or systemic embolism. Mean (SD) HAS-BLED score was 3.4 (0.9) (range 2–5). Atrial fibrillation was paroxysmal

in 23 patients (60.5%). Hypertension was the most frequent associated comorbidity, found in 33 patients (86.8%). Nine patients (23.7%) presented with left ventricular ejection fraction  $\leq 40\%$ .

The reason for LAAO was serious bleeding without curable cause in 33 patients (86.8%). A total of 15 patients (39.5%) presented with previous intracranial bleeding. In three patients (7.9%), LAAO was mandated due to ischaemic stroke occurring despite an adequate oral anticoagulant therapy regimen. In the remaining two patients, LAAO was performed due to the need for prolonged triple therapy following coronary artery stenting. The antithrombotic regimen at discharge consisted of DAPT in 27 patients (71.1%), single antiplatelet therapy in 10 patients (26.3%), and no antithrombotic therapy in one patient (2.6%).

#### LAAO Procedure

Technical and procedural successes were achieved in all patients. Optimal device placement according to the expert consensus was achieved in 26 patients (68.4%). No major periprocedural adverse events occurred. Groin haematoma at access site  $>6$  cm not requiring surgical intervention, representing minor bleeding according to the Munich consensus document (Bleeding Academic Research Consortium type 2), was observed in three patients (7.9%) [15].

#### TEE Follow-Up

All but one patient underwent TEE a mean (SD) of 55 (21) days after device implantation. In the remaining patient, a cardiac computed tomography scan was performed and this excluded DRT and showed optimal device placement. Device-related thrombus was found in one patient (2.6%) at TEE. The patient was 70 years old and had permanent AF. The LAAO indication was stroke occurring despite an adequate oral anticoagulant regimen (dabigatran 150 mg twice daily). The CHA<sub>2</sub>DS<sub>2</sub>-VASc score was 4 in this patient. Despite optimal device placement and DAPT, a thrombus was diagnosed during the systematic TEE 90 days after the procedure. A lifelong oral anticoagulant regimen was resumed thereafter and a TEE 4 weeks later did not reveal residual DRT. Residual leaks  $>3$  mm but  $<5$  mm were reported in five patients (13.2%). Transoesophageal echocardiography follow-up data are summarised in Table 2. No patient experienced stroke within the period from the implantation

procedure to the TEE following device placement. No procedure-related death was observed. No patients presented with a thromboembolic event following LAAO during a mean (standard deviation) follow-up of 15 (5) months.

## **Discussion**

In our three-centre study, thrombus formation following LAAO with the Amulet device was infrequent (2.6%). In addition, no patient experienced stroke during the procedure or the 15-month follow-up period.

With the first-generation ACP, the reported rate of DRT varied from 0% to 4% in most studies, with very infrequent overall periprocedural thromboembolic events related to DRT [5,13,17-19]. However, in a study from Plicht et al. [16], an unexpectedly high rate of ACP-related thrombus (17.6%) despite DAPT raised serious safety concerns with this prosthesis. Transoesophageal echocardiography highlighted the role of the central screw of the device as the origin of thrombus formation in these patients.

Left atrial appendage occlusion is increasingly being used for stroke prevention in patients with AF who are considered unsuitable for lifelong oral antithrombotic treatment; or as an alternative to oral anticoagulant treatment in the US [7]. The Amulet device is one of the most frequently used devices. The Amulet device was designed to better exclude the LAA while limiting device-related thrombogenesis. In particular, the proximal female screw on the disc has been recessed [12,13]. However, the first report regarding its clinical use, by Sedaghat et al. [14], was concerning due to a very high rate of DRT (16.7%). This value is higher than the 11.0% rate of DRT observed in a retrospective registry during LAA imaging in 101 patients after LAAO with the first- and second-generation nitinol plug [20]. In our multicentre registry, the rate of DRT following LAAO with the Amulet was very low (2.6%), while thromboembolic risk profile of the patients included in the current report was similar to those included in the Sedaghat et al. study [12]. Our results are in line with those of Gloekler et al. [21], who performed a head-to-head comparison of the two generations of Amplatzer LAA occluders. Despite DAPT, Gloekler et al. [21] reported thrombus formation in 2/50 patients (4.0%) treated with the Amulet. Similarly, in initial experience from Freixa et al. [13], among 24



patients effectively treated with the Amulet, one patient (4.2%) who was not correctly receiving DAPT presented with DRT on systematic TEE. The rate of DRT was 1.5% in the 673/1088 patients with TEE follow-up from the largest prospective registry on outcomes after LAAO with the Amulet occluder [22].

The difference in the rate of thrombosis observed between our study and that of Sedaghat et al. [14] may be related to procedural factors. In contrast to Plicht et al. [16], all thrombi observed by Sedaghat et al. [14] were located in an artificially created cul-de-sac between the ridge of the left superior pulmonary vein and the disc of the Amulet failing to cover the rim. In most of the patients, Sedaghat et al. [14] did not achieve optimal device placement, which is likely to be responsible for thrombus formation. In fact, they reported that this artificially created cul-de-sac, the so-called “neo-appendage” [14], was created in as many as 14 of the 24 patients in their study (58.3%). The rate of DRT formation reached 28.5% among the 14 patients without optimal device placement. Conversely, no patient with optimal device placement presented with DRT [14]. We therefore hypothesised that suboptimal Amulet device placement may create local conditions for device-related thrombogenesis [23]. Failure to cover the rim of the LAA with the disc of the ACP or Amulet devices is a common finding. With the ACP, such neo-appendage creation was observed in 21/34 patients (61.8%) in the study by Plicht et al. [16]. However, the rate of neo-appendage creation with the Amulet in our experience was much lower (31.6%). Optimal device choice and placement should, therefore, aim to cover the rim of the LAA and achieve complete LAA sealing. In the case of failure, careful post-procedural management including oral anticoagulant therapy—if possible—and repeated LAA imaging to enable early DRT detection may be proposed until full device endothelialisation.

According to manufacturer recommendations, DAPT is required after LAAO with the Amulet device. At discharge, DAPT seems to have both good safety and efficacy profiles for DRT prevention [15,20,24]. In our study, DAPT regimen was prescribed in 71.1% of our patients which is significantly higher than the 23.4% and 54.3% rates reported in larger studies on the Amulet device [20,22].

Finally, LAAO is associated with a steady learning curve. Our significant experience with the technique of LAAO might also explain our satisfactory outcomes.

This observational study has the limitations inherent to its retrospective design and to the small

number of patients included. However, the main limitation was that we did not conduct a direct comparison between the first- and second-generation LAA occluders. Otherwise, we did not perform late (6-12 months) LAA imaging to detect DRT occurrence after cessation of the DAPT.

## **Conclusions**

In this multicentre study, the rate of DRT after LAAO with the Amulet device was low and similar to those from the largest registries. Importantly, none of the 38 patients experienced stroke during the procedure or the 15-month follow-up period. Larger “real-world” studies are required to confirm the safety profile of this increasingly used device.

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**Conflict of Interest**

Dr. Sébastien Armero is proctor for St. Jude Medical.

## References

- [1] J.L. Blackshear, J.A. Odell, Appendage obliteration to reduce stroke in cardiac surgical patients with atrial fibrillation, *Ann. Thorac. Surg.* 1996;61:755-9.
- [2] D.R. Holmes, V.Y. Reddy, Z.G. Turi, S.K. Doshi, H. Sievert, M. Buchbinder, et al., Percutaneous closure of the left atrial appendage versus warfarin therapy for prevention of stroke in patients with atrial fibrillation: a randomised non-inferiority trial, *Lancet* 2009;374:534-42.
- [3] V.Y. Reddy, S.K. Doshi, H. Sievert, M. Buchbinder, P. Neuzil, K. Huber, et al., Percutaneous left atrial appendage closure for stroke prophylaxis in patients with atrial fibrillation: 2.3-Year Follow-up of the PROTECT AF (Watchman Left Atrial Appendage System for Embolic Protection in Patients with Atrial Fibrillation) Trial, *Circulation* 2013;127:720-9.
- [4] D.R. Holmes, Jr., S.K. Doshi, S. Kar, M.J. Price, J.M. Sanchez, H. Sievert, et al., Left Atrial Appendage Closure as an Alternative to Warfarin for Stroke Prevention in Atrial Fibrillation: A Patient-Level Meta-Analysis, *J. Am. Coll. Cardiol.* 2015;65:2614-23.
- [5] M. Urena, J. Rodes-Cabau, X. Freixa, J. Saw, J.G. Webb, M. Freeman, et al., Percutaneous left atrial appendage closure with the AMPLATZER cardiac plug device in patients with nonvalvular atrial fibrillation and contraindications to anticoagulation therapy, *J. Am. Coll. Cardiol.* 2013;62:96-102.
- [6] J. Saw, M. Lempereur, Percutaneous left atrial appendage closure: procedural techniques and outcomes, *JACC. Cardiovasc. Interv.* 2014;7:1205-20.
- [7] P. Kirchhof, S. Benussi, D. Kotecha, A. Ahlsson, D. Atar, B. Casadei, et al., 2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS, *Eur. Heart J.* 2016;37:2893-2962.
- [8] Rillig A, Tilz RR, Lin T, Fink T, Heeger CH, Arya A et al. Unexpectedly High Incidence of Stroke and Left Atrial Appendage Thrombus Formation After Electrical Isolation of the Left Atrial Appendage for the Treatment of Atrial Tachyarrhythmias. *Circ Arrhythm Electrophysiol.* 2016;9:e003461.

- [9] Tilz RR, Eitel C. Left Atrial Appendage Electric Isolation for Treatment of Atrial Fibrillation: Experimental Approach or Standard of Care? *JACC Clin Electrophysiol.* 2018;4:121-123.
- [10] T. Lewalter, R. Ibrahim, B. Albers, A.J. Camm, An update and current expert opinions on percutaneous left atrial appendage occlusion for stroke prevention in atrial fibrillation, *Europace* 2013;15:652-6.
- [11] L. Pison, T.S. Potpara, J. Chen, T.B. Larsen, M.G. Bongiorni, C. Blomstrom-Lundqvist, et al., Left atrial appendage closure-indications, techniques, and outcomes: results of the European Heart Rhythm Association Survey, *Europace* 2015;17:642-6.
- [12] A. Tzikas, S. Gafoor, D. Meerkin, X. Freixa, I. Cruz-Gonzalez, T. Lewalter, et al., Left atrial appendage occlusion with the AMPLATZER Amulet device: an expert consensus step-by-step approach, *EuroIntervention* 2016;11:1512-21.
- [13] X. Freixa, A. Abualsaud, J. Chan, M. Nosair, A. Tzikas, P. Garceau, et al., Left atrial appendage occlusion: initial experience with the Amplatzer Amulet, *Int. J. Cardiol.* 2014;174:492-6.
- [14] A. Sedaghat, J.-W. Schrickel, R. Andri , R. Schueler, G. Nickenig, C. Hammerstingl, Thrombus Formation After Left Atrial Appendage Occlusion With the Amplatzer Amulet Device, *JACC. Clin. Electrophysiol.* 2017;3:71-5.
- [15] A. Tzikas, D.R. Holmes, Jr., S. Gafoor, C.E. Ruiz, C. Blomstrom-Lundqvist, H.C. Diener, et al., Percutaneous left atrial appendage occlusion: the Munich consensus document on definitions, endpoints, and data collection requirements for clinical studies, *Europace* 2017;19:4-15.
- [16] B. Plicht, T.F. Konorza, P. Kahlert, F. Al-Rashid, H. Kaelsch, R.A. Janosi, et al., Risk factors for thrombus formation on the Amplatzer Cardiac Plug after left atrial appendage occlusion, *JACC. Cardiovasc. Interv.* 2013;6:606-13.
- [17] J. Saw, A. Tzikas, S. Shakir, S. Gafoor, H. Omran, J.E. Nielsen-Kudsk, et al., Incidence and Clinical Impact of Device-Associated Thrombus and Peri-Device Leak Following Left Atrial Appendage Closure With the Amplatzer Cardiac Plug, *JACC. Cardiovasc. Interv.* 2017;10:391-9.

- [18] A. Tzikas, S. Shakir, S. Gafoor, H. Omran, S. Berti, G. Santoro, et al., Left atrial appendage occlusion for stroke prevention in atrial fibrillation: multicentre experience with the AMPLATZER Cardiac Plug, *EuroIntervention* 2016;11:1170-9.
- [19] X. Freixa, S. Gafoor, A. Regueiro, I. Cruz-Gonzalez, S. Shakir, H. Omran, et al., Comparison of Efficacy and Safety of Left Atrial Appendage Occlusion in Patients Aged <75 to >= 75 Years, *Am J Cardiol* 2016;117:84-90.
- [20] Fauchier L, Cinaud A, Brigadeau F, Lepillier A, Pierre B, Abbey S et al. Device-Related Thrombosis After Percutaneous Left Atrial Appendage Occlusion for Atrial Fibrillation. *J Am Coll Cardiol*. 2018;71:1528-1536.
- [21] S. Gloekler, S. Shakir, J. Doblies, A.A. Khattab, F. Praz, E. Guerios, et al., Early results of first versus second generation Amplatzer occluders for left atrial appendage closure in patients with atrial fibrillation, *Clin. Res. Cardiol*. 2015;104: 656-65.
- [22] Landmesser U, Schmidt B, Nielsen-Kudsk JE, Lam SCC, Park JW, Tarantini G et al. Left atrial appendage occlusion with the AMPLATZER Amulet device: periprocedural and early clinical/echocardiographic data from a global prospective observational study. *EuroIntervention*. 2017;13:867-876.
- [23] M. Peyrol, J. Cautela, F. Thuny, L. Bonello, For Whom the Bell Tolls, *JACC. Clin. Electrophysiol*. 2017;3:84.
- [24] Reddy VY, Möbius-Winkler S, Miller MA, Neuzil P, Schuler G, Wiebe J, Sick P, Sievert H. Left atrial appendage closure with the Watchman device in patients with a contraindication for oral anticoagulation: the ASAP study (ASA Plavix Feasibility Study With Watchman Left Atrial Appendage Closure Technology). *J Am Coll Cardiol*. 2013;61:2551-6.

## Figure legend

**Figure 1.** TEE follow-up imaging after LAAO with the Amulet showing optimal device placement (a), optimal device placement with residual peri-device leak <3 mm (b), and suboptimal device placement resulting in an artificially created cul-de-sac (white arrow) between the ridge of the left superior pulmonary vein and the disc of the Amulet failing to cover the rim (c).

Abbreviations: LAAO, left atrial appendage occlusion; TEE, transesophageal echocardiography.

**Figure 2.** Distribution of patients according to CHA<sub>2</sub>DS<sub>2</sub>-VASc score. CHA<sub>2</sub>DS<sub>2</sub>-VASc, Congestive heart failure, Hypertension, Age  $\geq 75$  [doubled], Diabetes, Stroke [doubled], Vascular disease, Age 65–74, Sex category female.

Figure 1.

Figure 1a

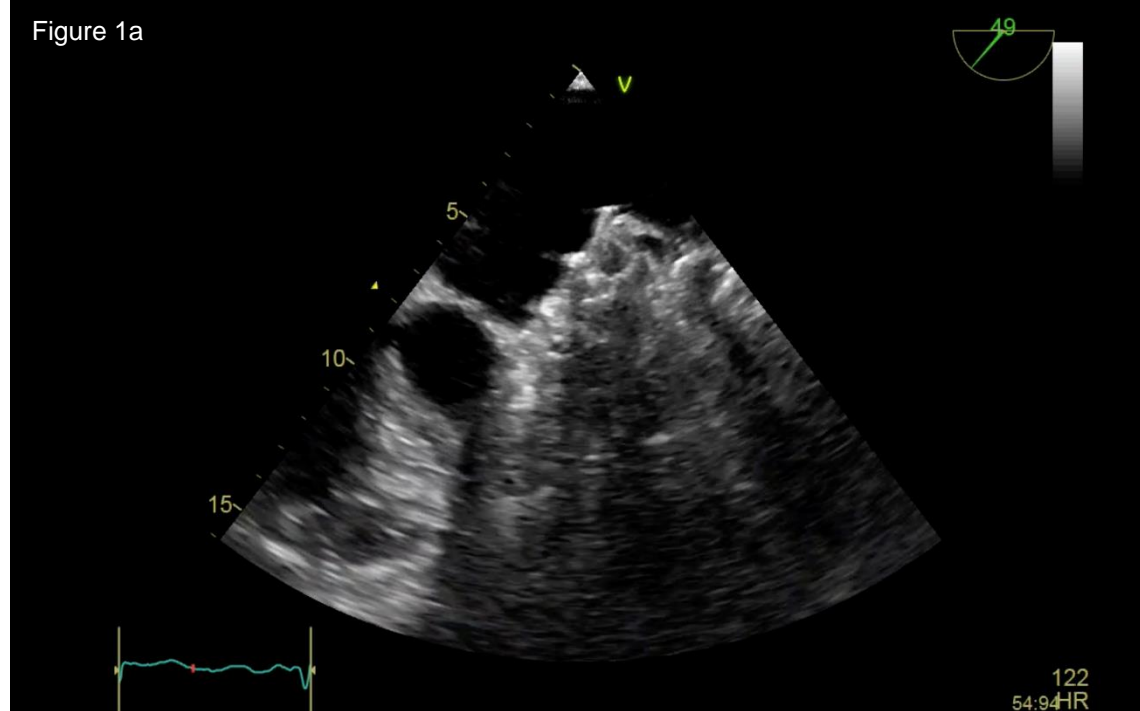


Figure 1b

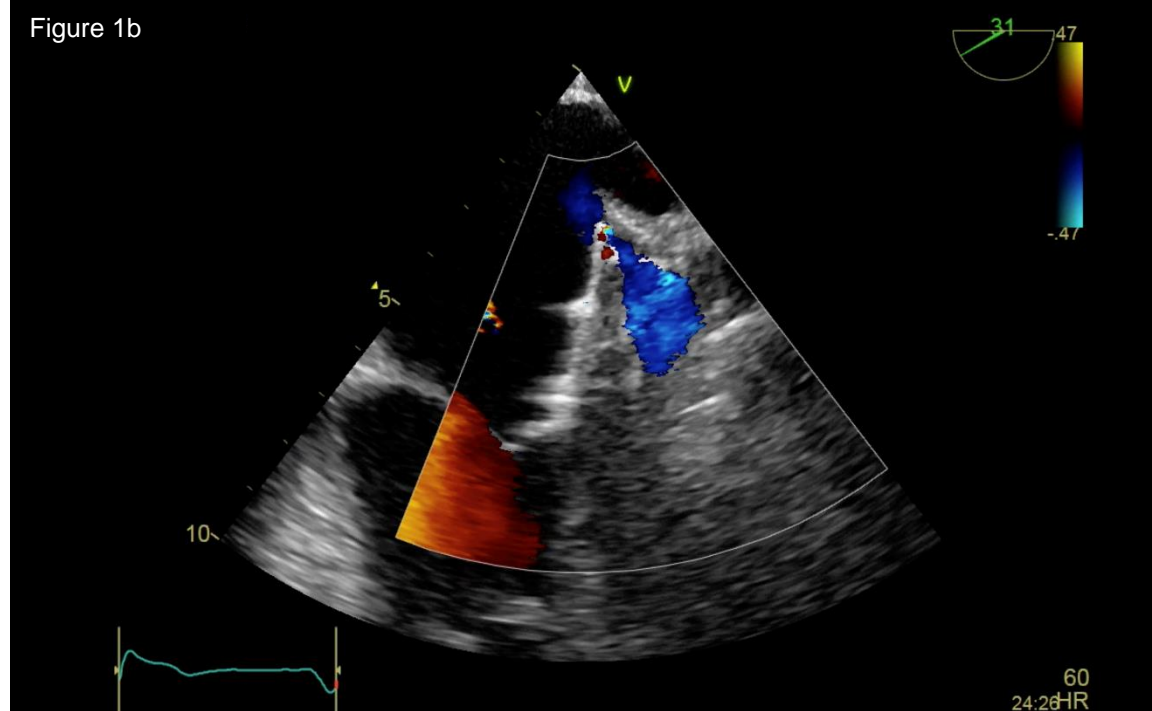
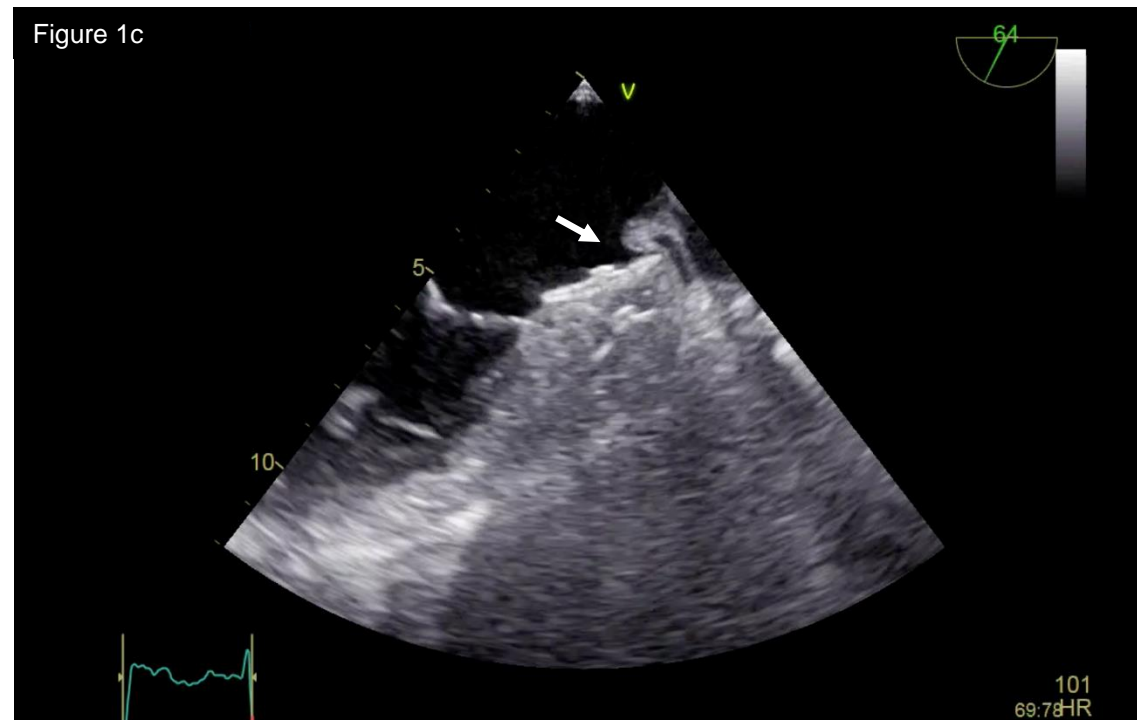


Figure 1c





**Table 1**

## Baseline patient characteristics

	All patients ( <i>n</i> = 38)
Age, years, mean (SD)	75.8 (7.7)
Men, <i>n</i> (%)	29 (76.3)
Paroxysmal AF, <i>n</i> (%)	23 (60.5)
LVEF ≤ 40%, <i>n</i> (%)	9 (23.7)
Creatinine > 200 µmol/l, <i>n</i> (%)	4 (10.5)
Prior myocardial infarction, <i>n</i> (%)	21 (55.3)
Prior severe bleeding, <i>n</i> (%)	33 (86.8)
History of LAA thrombus, <i>n</i> (%)	3 (7.9)
CHA <sub>2</sub> DS <sub>2</sub> -VASc score, mean (SD)	4.4 (1.2)
Congestive heart failure, <i>n</i> (%)	9 (23.7)
Hypertension, <i>n</i> (%)	33 (86.8)
Age ≥ 75 years, <i>n</i> (%)	20 (52.6)
Diabetes, <i>n</i> (%)	17 (44.7)
Stroke, <i>n</i> (%)	14 (36.8)
Vascular disease, <i>n</i> (%)	22 (57.9)
Age 65–74 years, <i>n</i> (%)	15 (39.5)
Sex category female, <i>n</i> (%)	9 (23.7)
HAS-BLED score on oral anticoagulant therapy, mean (SD)	3.4 (0.9)

AF: atrial fibrillation; HAS-BLED: Hypertension, Abnormal renal and liver function, Stroke, Bleeding, Labile international normalized ratios, Elderly, Drugs or alcohol; LAD: left atrial appendage; LVEF: left ventricular ejection fraction; SD: standard deviation.

**Table 2.**

Transoesophageal echocardiography follow-up

	All patients ( <i>n</i> = 37*)
Days from device implantation	55 (21)
Optimal device placement, <i>n</i> (%)	26 (68.4)
Device migration, <i>n</i> (%)	0
Device-related thrombus, <i>n</i> (%)	1 (2.6)
Peridevice leakage >3 mm, <i>n</i> (%)	5 (13.2)
Peridevice leakage >5 mm, <i>n</i> (%)	0
Pericardial effusion, <i>n</i> (%)	0

\*1 patient refused to undergo transoesophageal echocardiography follow-up.