von Willebrand Factor as a Biological Sensor of Blood Flow to Monitor Percutaneous Aortic Valve Interventions

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ABSTRACT

**Rationale:** Percutaneous aortic valve procedures are a major breakthrough in the management of patients with aortic stenosis (AS). Residual gradient and residual aortic-regurgitation (AR) are major predictors of mid-term and long-term outcome after percutaneous aortic valve procedures. We hypothesized that: 1) induction/recovery of high molecular weight (HMW) multimers of von Willebrand factor (VWF) defect, could be instantaneous after acute changes in blood flow, 2) a bedside point-of-care assay (PFA-CADP), reflecting HMW-multimers changes, could be used to monitor in real-time percutaneous aortic valve procedures.

**Objective:** To investigate the time course of HMW-multimers changes in models and patients with instantaneous induction/reversal of pathological high shear and its related bedside assessment.

**Methods and Results:** We investigated the time course of the induction/recovery of HMW-multimers defects under instantaneous changes in shear stress in an AS-rabbit model and in patients undergoing implantation of a continuous-flow Left-Ventricular Assist Device (LVAD). We further investigated the recovery of HMW-multimers and monitored these changes with PFA-CADP in AS-patients undergoing transcatheter-aortic-valve implantation (TAVI) or balloon valvuloplasty (BAV).

Experiments in the AS-rabbit model and in LVAD-patients demonstrated that induction/recovery of HMW-multimers occurs within 5 minutes. TAVI-patients experienced an acute decrease in shear stress and a recovery of HMW-multimers within minutes of implantation which was sustained overtime. In patients with residual high shear or with residual-AR, no recovery of HMW-multimers was observed. PFA-CADP profiles mimicked HMW-multimers recovery both in TAVI-patients without-AR (correction) and TAVI-patients with-AR or BAV-patients (no correction).

**Conclusion:** These results demonstrate that variations in VWF multimeric pattern are highly dynamic, occurring within minutes after changes in blood flow. It also demonstrates that PFA-CADP can evaluate in “real-time” the results of transcatheter aortic valve procedures.

**Keywords:** Aortic stenosis, von Willebrand factor, blood flow, left ventricular assist device, transcatheter aortic valve interventions, bedside monitoring.

**Nonstandard Abbreviations and Acronyms:**
- TAVI: transcatheter aortic valve implantation
- BAV: balloon aortic valvuloplasty
- AS: aortic stenosis
- AR: aortic regurgitation
- VWF: von Willebrand factor
- HMW: high molecular weight
- LVAD: left ventricular assist device
- PFA-CADP: PFA-closure time ADP
- VWF:Ag: VWF antigen
- VWFpp: VWF propeptide
- VWF:CB: VWF collagen-binding activity
- NP: normal pooled plasma
- PPP: platelet poor plasma
- SDS: sodium dodecyl sulfate
INTRODUCTION

Percutaneous aortic valve procedures, including transcatheter aortic valve implantation (TAVI) and balloon aortic valvuloplasty (BAV), are recent major breakthroughs in the management of patients with aortic stenosis (AS)\(^1,\)\(^2\). In some circumstances their results can still be inadequate while their evaluation in real-time may remain difficult with current techniques\(^3\). Among examples are the cases of balloon valvuloplasty procedures and valve-in-valve TAVI procedures, where an insufficient opening of the valve and a high residual gradient can still be observed, or the cases of periprocedural aortic regurgitation (AR) observed in 10-30% of TAVI procedures with current techniques\(^1,\)\(^2\).

Acquired deficiency of von Willebrand factor (VWF), characterized by a loss of high molecular weight (HMW) multimers, is associated with cardiovascular disorders in which the entire blood volume is exposed to high shear stress\(^4-9\). It has been demonstrated that acquired VWF deficiency can be detected within days following implantation of an axial-continuous-flow-Left Ventricular Assist Device (LVAD)\(^10\). We and others\(^11,\)\(^12\) also demonstrated that the VWF deficiency present in patients with AS is corrected within days following its surgical treatment. Based on in vitro studies, it was inferred that unfolding and cleavage of the VWF A2 domain in vivo could occur within 200 seconds in response to acute changes in shear conditions\(^13\). However, the initial time course of loss/recovery of VWF HMW-multimers following acute changes in blood flow in vivo has not yet been studied.

PFA-closure time ADP (CADP) is a highly sensitive way to screen for HMW-multimers defects\(^14\) and has been shown to be prolonged in patients with “high shear-cardiovascular disorders” including those with AS\(^6,\)\(^11,\)\(^15\). As PFA-CADP can be assessed by a small whole blood analyzer (PFA-100®) it has the potential to be used as a bedside monitor of HMW-multimers changes.

We hypothesized that induction/recovery of HMW-multimers defect could occur within minutes of acute changes in blood flow induced by cardiac interventions and we further investigated the potential underlying mechanisms. We also hypothesized that HMW-multimers recovery, as assessed by PFA-CADP, could be used to monitor in real-time the results of transcatheter aortic valve procedures, including the presence of a high post-procedural aortic gradient and/or the presence of a “significant” post-procedural aortic regurgitation (AR). To evaluate these hypotheses in vivo, we investigated the time course of HMW-multimers loss/recovery in an animal model of reversible aortic stenosis specifically developed for that purpose. We further investigated the time course of HMW-multimers loss/recovery and its related bedside whole blood assessment (PFA-100 analyzer) in 38 patients included in a prospective registry and undergoing 1) implantation of an axial-continuous-flow-LVAD (HeartMate-II®, n=8) for heart failure and 2) transcatheter aortic valve procedures, either BAV (n=10) or TAVI (n=20), to treat AS.

METHODS

**Instantaneous induction and reversion of high shear stress in a rabbit model of reversible aortic stenosis.**

We developed a new rabbit model of instantaneous, reversible, calibrated supra-aortic stenosis, adapted from Assad et al\(^16\) and Godier et al\(^17\) (see supplementary methods for details). This model allowed the evaluation in the same rabbit, of the dynamic time course of loss and recovery of HMW-multimers. In each rabbit (n=17), blood was sampled, before (T0), and after the induction of aortic stenosis (5 and 30 minutes). Then the stenosis was reversed 30 minutes after its induction and blood was sampled 5 and 30 minutes after reversion (35 and 60 minutes).
Prospective patients registry.
After approval from the local ethics committee, we performed a prospective registry of patients undergoing HeartMate-II® implantation or percutaneous aortic valve intervention, including clinical data collection and blood sampling during the procedure. All patients provided informed written consent and were included in the WITAVI (Willebrand Transcatheter Aortic Valve Implantation) registry.

Induction of high shear stress in patients undergoing implantation of HeartMate-II® LVAD.

HeartMate-II® (Thoratec Corp., Pleasanton, California) is an axial-continuous-flow-LVAD. A time-course of VWF multimeric analysis was performed in vivo in 8 consecutive patients at the time of initiation of HeartMate-II® support. Samples were collected before (T0) and after initiation of HeartMate-II® support at 9000 rpm (5, 30 and 180 minutes).

Reversion of high shear stress in patients with aortic stenosis undergoing transcatheter aortic valve procedure.

A time-course of HMW-multimers analysis and its related whole blood assessment (PFA-CADP) was performed in vivo in 30 patients with severe aortic valve stenosis in stable clinical condition, with a clinical need for either TAVI (n=20) or BAV (n=10) procedures. Both procedures were performed through a percutaneous transfemoral approach according to standard practice while TAVI was performed with the Edwards-Sapien XT device. Samples were collected before (0) and after the procedure (5, 30, 180 minutes and week 4).

Evaluation of shear stress conditions, including aortic velocity and gradient and post-procedural AR, was performed by a transthoracic echocardiography performed before and 24 hours after the procedure. The presence of a “significant” post-procedural AR was defined as the presence of an AR > moderate according to the VARC2 classification.

Induction of high shear stress in vitro using a HeartMate-II® assist device model.
Using an in vitro HeartMate-II® model, we first investigated the kinetics of HMW-multimers loss and recovery in the absence of endothelium. For each experiment, human blood (either heparinized or citrated) from healthy donors was perfused in a tubing system using a circulatory flowing pump device in which the HeartMate-II® was the pump. Because the results of the experiments performed using heparinized or citrated blood were similar, they are presented together. The HeartMate-II® rotor was set to high shear (9000 rpm), as achieved in patients implanted with HeartMate-II®, or to low shear (3000 rpm). We further assessed the role of VWF proteolysis as a mechanism underlying the loss of HMW-multimers in this model (see supplementary methods).

Laboratory assessment.
VWF antigen (VWF:Ag, Staliatest, Diagnostica Stago, Inc.) and VWF propeptide (VWFpp, Life codes VWF & Propeptide Assay, Gen-probe®) levels were measured by ELISA. VWF activity was assessed by a latex immunoturbidimetric assay (Innovance® VWF Ac; Siemens Healthcare Diagnostics, Marburg, Germany). As our aim was to detect changes in HMW-multimers we chose to perform experiments by using gels with low agarose concentrations. VWF multimeric analysis was performed as previously described. The results are expressed as a ratio to normal pooled plasma (NP, standard human plasma Siemens healthcare diagnostics, Marburg, Germany). Immunoprecipitation/western blot analysis was performed to measure VWF proteolysis fragments (176 and 140kDa) (see the supplementary method section for details).
PFA-CADP was assessed by platelet-function analyzer PFA-100®, (Siemens Healthcare Diagnostics, Marburg, Germany) using ADP cartridges (PFA-CADP, normal range=68-121sec) as previously described\textsuperscript{11, 14}.

VWF:Ag and VWF multimeric analysis were newly developed for rabbits. Loading of the electrophoretic gels was normalized for VWF:Ag content. The results are expressed as relative to baseline values determined for each animal.

**Statistical analysis.**

Data were expressed as means (±SD), unless indicated otherwise. Multiple time comparisons were performed using repeated measures of 1-way ANOVA. When appropriate, time points were compared with a Wilcoxon rank test for paired or Mann Whitney for unpaired groups. P values <0.05 were considered statistically significant.

**RESULTS**

**Instantaneous induction and reversion of high shear stress in a rabbit model of reversible aortic stenosis.**

In the AS-rabbit model, a significant decrease in HMW-multimers was observed 5 minutes (0.76±0.13;p<0.01) and further 30 minutes (0.74±0.07;p<0.01) after stenosis induction when compared to baseline values (Fig 1). Conversely a significant increase in HMW-multimers was already observed 5 minutes after reversal of the stenosis (0.89±0.12;p<0.01). Thirty minutes after the reversion, a complete recovery of HMW-multimers was observed (0.98±0.10) (Fig 1).

**Rapid loss of HMW-multimers after induction of high shear stress in patients undergoing HeartMate-II® implantation.**

The kinetics of HMW-multimers loss in human blood was studied at the time of HeartMate-II® implantation in 8 consecutive patients (6 males and 2 females, aged 59±12 years). A significant time-dependent loss of HMW-multimers was observed after initiating the pump (rotor set ≈ 9,000 rpm) reaching 0.86±0.37, 0.69±0.32 and 0.48±0.18 at 5min, 30min and 180min respectively (p<0.01, Fig 2C and 2D). A significant time-dependent increase in intermediate (I) plus low (L) MW mirroring the loss of HMW-multimers was observed reaching 1.11±0.11 at 180 min compared to 1.01±0.08 at baseline (p<0.05). Consistent with the loss of HMW-multimers, a time-dependent decrease in VWF:CB/VWF:Ag ratio was also observed reaching 0.75±0.22 at 180 mm vs 0.88±0.18 at baseline (p<0.05).

These findings were further investigated in the in vitro HeartMate-II® model. In the in vitro HeartMate-II®-model, when whole human blood was submitted to high shear stress (rotor set at 9,000 rpm), a progressive and time-dependent loss of HMW-multimers was also observed. The loss of HMW-multimers was more pronounced after 5 minutes than in LVAD-patients and was complete after 180 min (p<0.0001; Fig 2A and B). The role of VWF-proteolysis was verified by: 1) a time-dependent increase in specific VWF proteolytic fragments (140 and 176kDa) in patients (Online Fig IA), and 2) an absence of time-dependent loss of HMW-multimers when spiking EDTA before pump initiation in vitro (Online Fig IB). The shear-dependency of HMW-multimers loss was also verified by setting the rotor of HeartMate-II® at 3,000 rpm (Online Fig IC).
In patients undergoing HeartMate-II® implantation, a time-dependent increase in VWFpp was observed. This VWFpp increase, already significant 5 minutes after initiating the pump (528±184UI/dL vs 259±139UI/dL at baseline, p=0.01), was still apparent after 30 minutes (538±139UI/dL) and 180 minutes (560±140UI/dL). In vitro, no change in VWFpp was observed overtime (89±27 at 180 min vs 89±32 at baseline, ns).

**HMW-multimers increase rapidly after reversion of pathological high shear stress in patients undergoing TAVI procedure**

The effect of the reversion of high shear on the VWF multimeric pattern was studied in 30 patients with AS requiring to undergo either BAV (n=10; 5 males and 5 females; aged 82±6 years, LVEF=53±10%) or TAVI (n=20; 9 males and 11 females; aged 82±6 years, LVEF=53±10%). All patients had NYHA class 3 or 4 and no patient had decompensated heart failure.

As expected, in patients with AS a HMW-multimers defect was observed at baseline (0.50±0.19 compared to NP), whereas increased levels of IMW+LMW multimers (1.07±0.04) were present.

In patients treated with TAVI, the procedure resulted in a near normalization of maximal transvalvular velocity (from 4.44±0.47 m.s⁻¹ at baseline to 2±0.56 m.s⁻¹ after valve replacement; p<0.0001) inducing a marked reduction in mean transvalvular gradient (50.6±12.5 mmHg to 9.6±5.1 mmHg; p<0.0001), while in 4 of them (20%) a post-procedural-AR≥moderate was observed. Those treated with BAV experienced a modest improvement in shear conditions (max transvalvular velocity from 4.47±0.25m.s⁻¹ at baseline to 3.88±0.65m.s⁻¹ after BAV; p<0.05) and, as a consequence, a modest decrease in mean transvalvular gradient (49.6±3.8 mmHg to 35.6±13.4 mmHg; p<0.05).

In the 20 patients undergoing TAVI, the amount of HMW-multimers dramatically increased 5 minutes after valve implantation (from 0.51±0.18 at baseline to 0.75±0.24; p=0.001). An almost complete recovery was observed after 180 min (0.91±0.15). Together with the HMW-multimers recovery, a significant time-dependent decrease of IMW+LMW multimers already significant at 5 min (1.03±0.05) and peaking at 180 min (0.99±0.04) was observed (p<0.01). A time-dependent correction of VWF:CB/VWF:Ag ratio was also observed (from 0.76±0.14 at baseline to 0.94±0.30 at 180 min, p=0.01).

BAV procedures did not increase significantly the amount of HMW-multimers (0.58±0.2, 0.66±0.25, 0.64±0.15, 0.65±0.21 at 5, 30, 180 minutes and 4 weeks after BAV respectively: p=0.59; Fig 3C and 3D). No significant time-dependent changes in IMW+LMW multimers nor in VWF:Act/VWF:Ag ratio were observed.

Of note, as part of the TAVI procedure a balloon predilatation was performed before valve implantation. This predilatation had no significant impact on HMW-multimers (0.54±0.11 at 5 minutes, p=0.61 vs baseline).

When all TAVI and BAV patients were analyzed together (n=30) a significant and inverse relation between post-procedural mean transvalvular gradient and post-procedural HMW-multimers was observed (r=−0.68, p=0.0001; Fig 4).

After TAVI, despite a consistently low residual gradient (9.6±5.1 mmHg), a relatively large standard deviation in HMW-multimer values was observed. This was mainly related to the occurrence of a significant post-procedural-AR in 4 patients in whom the HMW-multimers increased to a lesser extent and in whom HMW-multimer at 180 min was significantly lower than in the 16 TAVI-patients without post-procedural-AR (0.74±0.10 vs 1.02±0.25, p=0.04).
Acute endothelial release of VWF in patients undergoing TAVI procedures.

A potential role of the vascular endothelium in the HMW-multimers recovery was investigated by evaluating the secretion of VWF by the endothelium after reversion of high-shear in TAVI and BAV procedures. It was further investigated by studying the recovery of HMW-multimers after reversion of high-shear in a model free of endothelium (in vitro HeartMate-II®).

In TAVI procedures, VWFpp significantly increased 5 minutes after valve implantation (190±85UI/dL), and further after 30 (240±111UI/dL) and 180 minutes (394±191UI/dL) when compared to baseline (171±84UI/dL; p<0.01). In BAV procedures, VWFpp did not increase significantly overtime (275±136UI/dL at 180 min vs 199±107UI/dL at baseline, ns).

In the in vitro HeartMate-II® model, high shear was induced for 3 hours (9,000rpm), then the blood flow was submitted to low shear (by switching the speed from 9,000 rpm to 3,000 rpm) for the next 3 hours, mimicking reversal of pathological high shear. In the absence of endothelium, no recovery of HMW-multimers was observed in this model (Fig 5).

Real-time monitoring of percutaneous aortic valve procedures by PFA-CADP closure time.

As expected and mimicking the VWF multimeric profile, characterized by reduced HMW-multimers, PFA-CADP was prolonged in AS-patients (243±65sec). In TAVI-patients, a time-dependent correction of PFA-CADP was observed (195±74sec, 165±75sec, 139±73sec, 141±73sec at 5, 30, 180 min and 4 weeks respectively, p<0.0001, Fig 6). By contrast, in BAV-patients no significant change in PFA-CADP was observed overtime (212±61, 204±71, 219±76, 221±75sec at 5, 30, 180 min and 4 weeks, p=0.82; Fig 6). Mirroring the observation made with HMW-multimers, patients with a prolonged PFA-CADP value had a higher final residual gradient than patients with a normal PFA-CADP value(29.2±5.1 vs 7.85±1.12, p<0.001). Importantly all patients with a normal final PFA-CADP had final residual gradient <15mmHg.

After TAVI, and similar to the heterogeneity observed with HMW-multimer values, a relatively large standard deviation in PFA-CADP measurement was observed. This was mainly related to the occurrence of a significant post-procedural-AR in 4 patients in whom PFA-CADP measurements were significantly higher than in the 16 patients without AR (225±41 sec vs 100±23 sec, p< 0.01, Fig 7). In all patients with a residual AR the PFA-CADP at the end of the procedure was >180 sec while of those without any residual AR the final PFA-CADP was <140 sec.

Conversely, in patients undergoing implantation of a HeartMate-II® device a sudden increase in PFA-CADP was observed as soon as 5 minutes after initiation of the support (246±63 sec vs 106±40 sec, p=0.01).

DISCUSSION

The present study, performed in three clinical conditions and one animal model in which the entire blood volume is exposed to high shear stress, demonstrates that acute changes in blood flow are associated with highly dynamic consequences on the VWF multimeric profile, occurring within minutes and then remaining steady overtime. It demonstrates the key roles of HMW-multimers proteolysis and VWF multimers release by the vascular endothelium in those acute changes of VWF-multimeric profile. It further demonstrates that bedside whole blood assessment (PFA-CADP), reflecting HMW-multimers...
changes, could be used in clinical practice to monitor in real-time the quality of the results of percutaneous aortic valve procedures, in particular to detect the occurrence of post-procedural-AR. Altogether these results provide the first integrated demonstration that VWF can be considered as a biological sensor of blood flow in vivo.

**Dynamic variations in HMW-multimers in response to acute changes in blood flow.**

The present study is the first one to demonstrate that variations in VWF-multimeric profile in response to acute changes in blood flow in vivo are highly dynamic.

While it has been demonstrated that the loss of HMW-multimers could be observed the day after the initiation of LVAD support, the initial response of VWF-multimers following induction of high-shear in vivo was unknown. The dynamic onset of shear-induced proteolysis of HMW-multimers has been extensively described in vitro. Hence, when subjecting VWF to high shear forces, unfolding of large VWF multimers has been shown to occur in less than 1s in vitro and VWF cleavage was inferred to be effective within 200 seconds in vivo. The present study confirms that the loss of HMW-multimers follows a similar time frame in vivo, and occurs almost immediately after the induction of high shear stress. Indeed a significant decrease in HMW-multimers was observed 5 minutes after induction of high shear, both in rabbits submitted to an acute AS and after initiation of HeartMate-II support at high speed (9,000 rpm). Additional experiments performed in the HeartMate-II-LVAD model further confirmed the shear-dependency of HMW-multimers loss; a rapid loss of HMW-multimers was observed at high speed (9,000 rpm), while no loss was observed at low speed (3,000 rpm).

While HMW-multimers recovery has been observed within days after aortic valve surgical replacement in AS-patients, no information was available on the initial phase of correction of AS. A major finding of this study is to demonstrate a nearly immediate recovery of the HMW-multimers upon reversion of the high-shear conditions while no recovery was observed in the absence of correction. In the rabbit model and in AS-patients undergoing TAVI, HMW-multimers recovery was observed 5 minutes after correction of aortic stenosis and was sustained overtime. In AS-patients undergoing a percutaneous procedure but in whom only a weak reduction in shear forces was achieved, as those undergoing BAV or those undergoing TAVI with a significant post-procedural-AR, no consistent HMW-multimers recovery was observed.

**HMW-multimers proteolysis as a shear-dependent process.**

VWF shear-induced proteolysis is considered the main mechanism underlying the acquired HMW-multimers defect observed in “high-shear cardiovascular conditions”, such as aortic stenosis or continuous-axial-flow-LVAD support. The present study provides new experimental evidence that proteolysis links the induction of high shear to the nearly immediate loss of HMW-multimers. First, in the HeartMate-II-LVAD patients, the loss of HMW-multimers was associated with an increase in VWF proteolytic fragments. Second, the loss of HMW-multimers at initiation of high shear conditions was blunted when a protease inhibitor (EDTA) was added to the in vitro device model. Finally, the increase in IMW and LMW multimers as seen in HeartMate-II-LVAD-patients and the decrease of IMW and LMW multimers seen in TAVI-patients are also consistent with this hypothesis. Altogether these results further re-enforce that shear-induced proteolysis is the major mechanism underlying the acquired HMW-multimers loss observed in “high-shear-cardiovascular disorders.”
Vascular endothelium and recovery of HMW-multimers defect.

The inhibition of the proteolysis of HMW-multimers is not sufficient to explain alone their sudden rise in TAVI patients, unless newly secreted VWF circulate in the blood. This question was investigated by measuring VWFpp in patients undergoing TAVI. In these patients the increase of VWFpp was indicative of an acute release of VWF by the vascular endothelium. This demonstrates that in combination with the acute inhibition of HMW-multimers proteolysis, an acute release of VWF multimers by the endothelium is requested for the acute recovery of the HMW-multimers defect. The absence of recovery of the HMW-multimers in a model of acute shear-recovery but without endothelium is also consistent with this hypothesis.

Recent studies have demonstrated that an increase in the arterial luminal pressure is able to induce an acute release of VWF by the vascular endothelium. In our study, the observations of a sudden rise in VWFpp in situations where an increase of arterial luminal pressure is observed (such as TAVI- or HeartMate-II®-LVAD patients), and the lack of VWFpp increase in a model without endothelium, is consistent with this hypothesis.

Altogether this suggest that in TAVI-patients, the multimers newly provided by the endothelium in response to the increased arterial luminal pressure, are no longer submitted to local abnormal high shear and proteolysis when passing through the valve, thus resulting in an ultimate increase in the proportion of HMW-multimers (Fig 8).

PFA-CADP to monitor in real-time the result of aortic percutaneous interventions.

Peri-procedural evaluation of the result of percutaneous aortic interventions, while important because corrective measures can be undertaken at that time, remains a challenging issue. In particular, the occurrence of post-procedural-AR after TAVI is a vexing clinical problem observed in 10-30% of cases. While it has been associated with an increased long-term mortality, its detection and accurate evaluation in the catheterization laboratory remains difficult. There is therefore a critical need for a quick and reliable method of evaluation of the results of these interventions.

PFA-100®, which is a whole blood functional test of primary haemostasis, has been shown to be highly sensitive to HMW-multimers defects. A major finding is that a rapid correction in PFA-CADP, reflecting HMW-multimers recovery, was observed in patients undergoing TAVI, while no significant change was observed in those undergoing BAV. Furthermore in TAVI patients with a clinically significant AR, an incomplete correction of PFA-CADP was also observed and PFA-CAP values were able to segregate perfectly patients with (<180 sec) or without (<140 sec) residual AR. This demonstrates that PFA-100 can reflect in “real-time” acute shear modification and evaluate the quality of the results of transcatheter aortic valve procedures.

PFA-CADP could therefore be used to monitor TAVI-procedures in some critical patients such as those with a very high risk of mortality in case of AR; e.g. patients with atrial fibrillation, renal failure or pure AS without AR and/or those with conflicting results about the significance of post-procedural-AR by other investigatory means (angiography, echocardiography, …). In such circumstances, it has been shown that balloon post-dilatation could decrease the magnitude of AR but at the price of an increased risk of stroke or bioprosthesis damages. The lack of improvement of PFA-CADP measured in real-time could provide additional informations and be integrated in the decision process. Similarly, while TAVI is often performed in patients with a degenerated biological prosthesis in the so-called Valve-in-Valve procedure, the result can be hampered by the high residual transvalvular gradient due to a prosthesis/prosthesis mismatch. The development of a broader size choice and fully retrievable devices will provide the opportunity to adapt the initial choice during the procedure pending that
prosthesis/prosthesis mismatch can be accurately and quickly recognized. In this situation also, the lack of improvement of PFA-CADP could help the medical decision while the patient in still in the catheterization laboratory.

Such approach has also the potential to be helpful in tuning a ventricular assist system.

Study limitations.

The number of patients included in this study could be considered as limited. This was largely a consequence of the translational approach of our study and of our goal to provide a real-time assessment of the processes involved. We believe that such an approach favouring multiple “clinical situations” and the assessment of multiple time-points in each “clinical situation” rather than a high number of subjects in each “clinical situation” was more adapted to our research. It did not preclude the detection of significant differences, while the findings obtained in one situation allowed further validation of the findings from another.

While the rabbit model allowed us to investigate onset/offset of loss of HMW-multimers, the underlying mechanisms could not be investigated in the same model due to the lack of specific reagents for rabbits. However, these mechanisms were investigated using the HeartMate-II®-LVAD model and in patients undergoing transcatheter aortic valve procedures.

The use of multimeric analysis of VWF as a biomarker of blood flow is potentially limited by the fact that it is a time-consuming technique. This issue was offset, however, by the use of a point of care PFA-CADP assay which renders our observation clinically relevant.

Finally we have to acknowledge that the mechanistic arguments for rapid recovery of VWF-multimers, involving pressure-related endothelium-release of VWFp, while consistent with our study findings, are partly speculative. Similarly our study does not allow drawing any definite conclusion on the impact of pulsatile vs continuous blood flow on the release of VWFp. These 2 important issues will require further and dedicated investigations.

Conclusion: VWF as a biological sensor of blood flow.

Although this was previously speculated based on in vitro findings, our results provides the first integrated demonstration that circulating VWF acts as a biological mechanosensor and a dynamic marker of changes in blood flow in vivo. This observation, together with the recently described pleiotropic function of VWF suggests a key role of VWF as a biological transducer of changes in blood flow (Fig 8). In addition, the mechanosensor property of VWF, as assessed by a point of care assay, could be useful in clinical practice to monitor in real time TAVI procedures, detect key procedural complications with a deleterious impact on clinical outcome (high residual gradient, post-procedural-AR) and assist the clinical decision.
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DISCLOSURES

None.

REFERENCES


FIGURE LEGENDS

Figure 1: Dynamic loss and recovery of HMW-multimers in a rabbit “reversible” aortic stenosis model. A: Quantitative analysis of HMW-multimers (relative to baseline) after induction and reversion of aortic stenosis (repeated ANOVA, p<0.01 overall; n=17). Significant loss of HMW-multimers 5 minutes and 30 minutes after induction of stenosis (p<0.01 vs baseline) and immediate recovery 5 minutes and 30 minutes after reversion of stenosis (p<0.01 vs 30 minutes post induction) were observed. B: Representative profile of VWF multimeric patterns at the different time points after induction and reversion of stenosis in one rabbit. C: Densitometric analysis of electrophoretic gel image (black arrows indicate the front of migration, NP=normal human pooled plasma).

Figure 2: Immediate loss of HMW-multimers upon high shear stress at initiation of axial-continuous-flow HeartMate II® device. A: Quantitative analysis of HMW-multimers (relative to normal human pooled plasma) after perfusion of human whole blood under high shear conditions (9000 rpm) in the HeartMate-II® (HM II) in vitro model (repeated ANOVA, p<0.0001 overall; n=10). A significant loss of HMW-multimers occurred overtime, already significant 5 minutes after HeartMate-II® start (p<0.01 vs baseline) and complete at 180 minutes. B: Representative time course of HMW-multimers loss (with densitometric analysis) after initiating the HeartMate-II® in vitro. C: Quantitative analysis of HMW-multimers (relative to normal human pooled plasma) in patients undergoing initiation of HeartMate-II® support (repeated ANOVA, p<0.01 overall; n=8). A significant loss of HMW-multimers occurred overtime, already significant 30 minutes after initiating the HeartMate-II® support (p<0.01 vs baseline). D: Representative time course of HMW-multimers loss (with densitometric analysis) after initiating the HeartMate-II® support in vivo. (B and D: black arrows indicate the front migration, NP=normal human pooled plasma).

Figure 3: Time course of HMW-multimers recovery in patients with severe aortic stenosis undergoing transcatheter aortic valve interventions. A: Quantitative analysis of HMW-multimers in patients undergoing correction of aortic stenosis by TAVI (repeated ANOVA, p<0.0001 overall; n=20). HMW-multimers recovery was significant 5 minutes after valve implantation (p<0.05) and complete at 180 minutes (p<0.01). B: Representative time course of VWF multimeric pattern (with densitometric analysis) in a patient undergoing TAVI procedure. C: Quantitative analysis of HMW-multimers in patients undergoing BAV procedure (repeated ANOVA, p=0.21 overall; n=10). No significant changes in VWF multimeric pattern occurred after valve dilatation. D: Representative time course of VWF multimeric pattern (with densitometric analysis) in a patient undergoing BAV procedure.

Figure 4: Relation between post-procedural gradient and post-procedural HMW-multimers. The mean post-procedural gradient is plotted against the post-procedural HMW-multimers values (180 min, r=-0.68, p<0.0001).

Figure 5: Absence of HMW-multimers recovery after reversion of pathological high shear in the HeartMate-II® assist device model. Whole human blood was submitted to high shear (9,000rpm) during 3 hours and then to low shear for the next 3 hours (3,000rpm) by switching the pump. The VWF multimeric profile remained unchanged after the offset of high shear stress.

Figure 6: Real-time assessment of changes in VWF multimeric pattern with PFA-CADP in patients undergoing transcatheter aortic valve interventions. In TAVI-patients, a time-dependent correction of PFA-CADP was observed (repeated ANOVA, p<0.0001). In BAV-patients, no significant time-dependent change of PFA-CADP was observed. In TAVI-patients this correction was still present 4 weeks after the procedure and conversely PFA-CADP remained prolonged at this time point in BAV-patients.

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**Figure 7:** Impact of a significant post-procedural-AR on PFA-CADP at the end of the TAVI-procedure. In patients with a significant post-procedural-AR (n=4) the post-procedural PFA-CADP was significantly higher than in patients without AR (n=16, p<0.01) and remained as prolonged as in patients with AS.

**Figure 8:** VWF as a biomarker of transcatheter aortic valve interventions. A loss of VWF HMW-multimers is observed in severe aortic stenosis consecutive to an increase in shear-induced proteolysis of VWF through the pathological aortic valve. A recovery of VWF HMW-multimers is observed early after a TAVI-mediated new aortic valve implantation excepted in case of post-procedural aortic regurgitation whereas VWF multimeric profile remains unchanged after a BAV-mediated aortic valve dilatation associated with high residual mean transaortic gradient. We proposed that the time course of HMW-multimers recovery following TAVI procedure is mediated by two mechanisms dependent on the correction of aortic stenosis: 1) A normalization in local aortic transvalvular shear stress conditions preventing the proteolysis of circulating HMW-multimers through the implanted aortic valve. 2) An increase of HMW-multimers release by the vascular endothelium secondary to an increase in arterial luminal pressure. Finally PFA-bedside assessment reflecting HMW-multimers changes could be used clinically to monitor in real-time the results of transcatheter aortic valve interventions.
Novelty and Significance

What Is Known?

- Acquired defect of VWF has been reported in various cardiovascular disorders associated with high shear, in particular with aortic valve stenosis.
- Correction of the pathological condition has been associated with reversion of the VWF defect.
- In vitro data suggest that changes in VWF multimeric could be highly dynamic in response to changes in shear.

What New Information Does This Article Contribute?

- In response to in vivo changes in shear, the VWF multimer can change within minutes.
- VWF can be used as a biomarker of change in blood flow to evaluate percutaneous aortic valve interventions.
- Point-of-care assay could be implemented in the catheterization laboratory as part of a real time monitoring strategy of the result of percutaneous aortic valve interventions.

Based on in vitro findings, it has been previously speculated that the multimeric pattern of VWF could change dynamically in response to high shear. Our results show that circulating VWF acts as a biological mechanosensor and a dynamic marker of changes in blood flow in vivo. We describe a highly dynamic recovery of HMW-multimers along with the sudden changes in blood flow after a complete correction of aortic stenosis during percutaneous aortic valve procedures. We document that the “failure” of percutaneous aortic valve procedures, because of a high residual gradient and/or a post-procedural-AR, is detected by a point-of-care assay sensitive to HMW-multimers defect. These results provide the basis for a per-procedural evaluation of percutaneous aortic valve interventions, using VWF as a biomarker of complete aortic stenosis reversion/acute change in blood flow. We suggest that such point-of-care assay could be implemented in the catheterization laboratory as part of a real time monitoring strategy for the early detection of TAVI procedural failure.
Rabbit « reversible » aortic stenosis model

**Figure 1**

A

![Box plot showing HMW multimers](image1)

- Time (min): 0, 5, 30, 35, 60
- Stenosis induction
- Stenosis reversion
- p < 0.01

B

![Image of gel electrophoresis](image2)

C

![Electropherogram](image3)
Figure 2

A. HM II in vitro

HM multimers (relative to NP)

Start of HM II (9000 rpm)

p < 0.0001

B. HM II in vitro

NP 0 5 30 180

Start of HM II (9000 rpm)

C. HM II in vivo

HM multimers (relative to NP)

Start of HM II (~9000 rpm)

p < 0.01

D. HM II in vivo

NP 0 5 30 180

Start of HM II (~9000 rpm)
Figure 3

A

TAVI

p<0.0001

HMW multimers (relative to NP)

Time (min)

B

TAVI

C

BAV

ns

HMW multimers (relative to NP)

Time (min)

B

TAVI

D

BAV

HMW multimers (relative to NP)

Time (min)

B

TAVI

D

BAV

HMW multimers (relative to NP)

Time (min)
Figure 4

Graph showing the relationship between post-procedural transaortic gradient (mm Hg) and HMW-multimers (relative to normal pooled plasma).
Figure 5

Low shear (HM II 3000 rpm)

High shear (HM II 9000 rpm)

Low shear (HM II 3000 rpm)
Figure 6

Box plots showing the distribution of PFA-CADP (sec) over time for TAVI and BAV groups. TAVI has a statistically significant difference (p<0.0001) compared to BAV, which shows no significant difference (ns).
Severe aortic stenosis

*loss of VWF HMW-multimers*

High local transvalvular shear stress

Post-TAVI (with AR)

High shear regurgitation

No recovery of VWF HMW-multimers

Post-TAVI (no AR)

No residual local high shear

Early recovery of VWF HMW-multimers

Post-BAV

Residual local high shear

No recovery of VWF HMW-multimers

PFA-CADP

real-time bedside monitoring

Figure 8
von Willebrand Factor as a Biological Sensor of Blood Flow to Monitor Percutaneous Aortic Valve Interventions

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Supplemental methods

Rabbit model of reversible aortic stenosis

Animals

All experiments were conducted in syngeneic male New Zealand rabbits weighing 2.7–3 kg, of the same blood group. Animals were obtained from the CEGAV Breeding Colony (Les Hautes Noës, St Mars d’Egrenne, France). Rabbits were housed in individual cages under standard conditions of temperature (14–20°C) and light (12 h per day) with food and water provided ad libitum. All experiments were conducted in accordance with the European Communities Council directive (86/609/EEC) after approval was obtained from the local Ethics Review Board of Lille University, and conformed to the US National Institutes of Health guidelines for the care and use of laboratory animals. Anaesthesia, ventilation and monitoring were performed as previously described 1

Aortic stenosis and reversion

An adjustable silicone vascular clamp, consisting of a banding ring, a connecting tube and an inflation reservoir (Harvard Apparatus, Holliston, Kent, UK), was placed on the ascending aorta to induce a controlled circumferential stenosis. Non-inflated, the device was adjusted to the outside diameter of the aorta while inflation of the vascular clamp with a predefined volume allowed a reproducible stenosis. The volume was defined to obtain a reduction in cross sectional area >75% as observed in patients with severe aortic stenosis 2. Inflation and deflation using this device were performed in less than 5 seconds thus stenosis and its reversion were immediate.
**Blood sampling**

Blood samples were collected through a carotid artery catheter. Blood samples were obtained before stenosis (T0), after induction of stenosis (T5, T30) and 5 and 30 minutes after reversion of the stenosis (T35, T60). Blood loss secondary to blood sampling was compensated by continuous isotonic NaCl infusion via the carotid catheter. At the end of the experiment, once the time course was completed, rabbits were sacrificed by injection of a 2mL of T-61 (Tanax ®). VWF antigen and multimeric profile were analyzed.

**VWF antigen and VWF multimeric analysis in rabbits**

All samples were collected in 0.129 M trisodium citrate tubes (9NC BD Vacutainer, Plymouth, UK) and centrifugated at 2500 g for 15 minutes. Poor-platelet plasma (PPP) was frozen and stored at -80°C until analysis.

Rabbits PPP-samples were tested for VWF antigen (VWF:Ag) by Elisa as recommended by the manufacturer (Cedarlane® CL20403K). Results were expressed relative to baseline values observed for each animal.

Rabbits PPP-samples were subsequently tested for VWF multimeric patterns via 1.4% SDS-agarose electrophoresis as previously described for human samples, excepting the revelation step. Loading of SDS-agarose gels was normalized for VWF:Ag content. The revelation step was adapted for rabbit species using a polyclonal anti-human VWF antibody (Cedarlane® CL20403K), cross-reacting with rabbit VWF, that was conjugated to alkaline phosphatase enzyme (Lynx rapid alkaline phosphatase antibody conjugation kit, AbD serotec®). VWF multimeric pattern was detected via alkaline phosphatase-mediated NBT/BCIP (Nitroblue Tetrazolium / 5-Bromo- 4-Chloro-3-Indolyl Phosphate) hydrolysis. HMW-multimers were
determined using densitometric scanning. Results were expressed relative to baseline values
determined for each rabbit.

HeartMate-II® assist device model
Anticoagulated whole human blood (250 mL) was perfused in a circulatory perfusion system
incorporating a HeartMate-II® pump (Thoratec Corp., Pleasanton, California). Two
cylindrical tubings (1x2 x 3/32 xs; Sorin Group Implant®) were used to connect the device.
The inlet and outlet ducts of the HeartMate-II® were connected with these two tubings to
obtain a closed circuit. HeartMate-II® rotation was set to 9,000 rpm. Samples were taken 5
min before the onset of perfusion (T0) and after 5, 30 and 180 minutes.

Assessment of VWF proteolysis as underlying mechanism of HMW-multimers loss
induced by HeartMate-II® support

Spiking experiments in the presence of EDTA

Ethylenediaminetetraacetic acid (EDTA 10mM -Sigma®) was spiked in whole human blood
before the initiation of the HeartMate-II® pump. Subsequently blood was perfused under high
shear conditions (9,000 rpm). Blood was sampled before the onset of perfusion (T0) and after
5 min (T5), 30 min (T30) or 180 min (T180) for VWF multimeric analysis by SDS-agarose
gel electrophoresis.

VWF proteolysis fragments analysis by immunoprecipitation/western-blot

VWF proteolysis fragments were assessed in 3 HeartMate-II®-patients via western-blot
analysis of immuno-precipitated VWF. VWF was immuno-precipitated using rabbit
polyclonal anti-VWF antibodies (50 μg/ml beads; Dako, Glostrup, Danmark) adsorbed onto
Protein-G coated magnetic beads (Dynabeads Protein G, Invitrogen, Saint Aubin, France) for 2 h at room temperature. After extensive washing in PBS/0.1 % Tween-20, immunoprecipitated VWF was released from the beads via a 5 min incubation at 100°C in 30 μL PBS/10 μL NuPAGE-LDS 4×sample buffer (Life Technologies, Saint Aubin, France) in the presence of 2 mM dithiothreitol. Electrophoresis was performed using discontinuous 4-12% SDS-page (Invitrogen). After transfer to an Immobilon P membrane (Millipore, Molsheim, France), the presence of VWF proteolysis fragments was revealed via incubation with a pool of 10 distinct monoclonal antibodies recognizing distinct epitopes of VWF (10 μg/ml). Bound antibodies were probed using peroxidise-labeled goat anti-mouse antibodies (dilution 1:500; Santa Cruz, Heidelberg, Germany) and visualized with SuperSignal West-Pico Enhanced Chemiluminescence Substrate (Thermo-Fischer Scientific, Villebon-sur-Yvette, France). Blots were analyzed via ImageJ-1.44 software (http://rsbweb.nih.gov/ij/index.html) in order to quantify uncleaved VWF (225 kDa bands) and VWF proteolysis fragments (140 kDa and 176 kDa bands).
Supplemental references


Supplemental legends to figures

Online Figure I. Shear-induced proteolysis as underlying mechanism of VWF HMW-multimers loss after initiation of HeartMate-II® support

A: VWF proteolysis was assessed via Western blot analysis. Representative time course of immuno-precipitated VWF proteolytic bands (140 and 176 kDa bands) under high shear conditions (9,000rpm) and densitometric integration of 3 HeartMate-II®-patients. Results (mean±SD) are expressed as a ratio versus baseline. A time-dependant increase in immuno-precipitated VWF proteolytic bands was observed.

B, C: In-vitro, no loss of HMW-multimers was observed under high shear conditions (9,000 rpm) when spiking a protease inhibitor (EDTA 10mM) before pump initiation (B) nor at low shear (3,000 rpm) (C).
Online Figure I

A

B

C

225 kDa
176 kDa
140 kDa

OD (relative to baseline)

0 5 30 180

NP

0.0 0.5 1.0

OD (relative to baseline)

0 5 30 180

High shear 9000 rpm (+) EDTA

Low shear 3000 rpm