EDITORIAL

When the Problem Isn't the Valve: Delays in Care as Determinants of Access to Treatment in Severe Aortic Stenosis

Cuando el problema no es la válvula: las demoras asistenciales como determinantes de la atención en estenosis aórtica grave

CARLOS SZTEJFMAN[1]

The recent history of severe aortic stenosis treatment has been characterized by remarkable technological advances. The widespread adoption of transcatheter aortic valve implantation (TAVI) has profoundly transformed the management of a disease that, for decades, was limited to conventional surgery and palliative care for patients deemed inoperable. The clinical outcomes across different surgical risk categories have established TAVI as an effective, safe, and increasingly accessible therapy option.

However, as the procedure has become increasingly optimized, a less visible yet equally significant question has emerged: what happens between the moment the treatment decision is made and the day the patient finally receives the valve?

This question rarely takes center stage at congresses or in scientific literature. Discussions typically focus on procedural success rates, vascular complications, pacemaker implantation and mortality whereas administrative processes, authorizations, institutional coordination, and logistical challenges remain largely overlooked. Nevertheless, for many patients, these factors may be just as decisive as the technical aspects of the procedure itself.

The study by Chiminela et al. (1) provides a particularly valuable perspective by addressing this largely overlooked aspect of cardiovascular care. Based on the multicenter experience of three Argentine institutions, the authors systematically describe the intervals between different stages of the diagnostic-therapeutic process and the actual TAVI. Their findings show that delays may extend over several months, from the initial specialist consultation to the day of valve implantation, reflecting the administrative and organizational complexity that characterizes many healthcare systems in our region. Importantly, such delays may not be without clinical consequences.

Perhaps the most important finding of the study is not merely the magnitude of the observed delays, but the demonstration that they can be significantly reduced through relatively simple organizational interventions. The implementation of more structured care pathways—such as designating a fixed day of the week for procedures, establishing a stable and dedicated multidisciplinary team, appointing a single program coordinator, and providing individualized follow-up for each patient—was associated with a substantial reduction in waiting times.

This finding has major practical implications. In healthcare settings frequently constrained by budgetary limitations, it is tempting to assume that improvements in outcomes necessarily depend on the incorporation of new technologies or increased financial resources. However, the experience presented here demonstrates that process optimization can yield significant benefits even without substantial changes to the existing infrastructure.

This conclusion is strongly supported by international evidence. Hewitson et al. demonstrated that implementing a referral pathway with a comprehensive, on-site patient evaluation at a non-surgical center—rather than the traditional model centered on a tertiary care facility—reduced the mean time from referral to TAVI from 126 to 32 days ($p < 0.001$) and increased the acceptance rate for the procedure from 49.5% to 97.8%.(2) The key to this transformation did not lie in new technologies, but in the reorganization of the care pathway: direct triage by specialized cardiologists, standardization of diagnostic testing at the local level, and close coordination with the team at the referral center. Although the context of the British National Health Service (NHS) differs substantially

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[1] Pilar Central Hospital. Pilar, Buenos Aires

from the Argentine healthcare system, the organizational lesson remains fully transferable: the barriers that most delay access to TAVI are not technical but systemic, and addressing them is within the capacity of any institution willing to reorganize.

The issue becomes even more important when considering the natural history of severe symptomatic aortic stenosis. Several studies have shown that delays in therapeutic intervention can be associated with progressive clinical deterioration, recurrent hospitalizations, and even death prior to the procedure. The most compelling international data in this regard comes from the NHS: in 2019, 299 deaths were recorded among patients on the TAVI waiting list in the United Kingdom, which—when extrapolated to all centers—would amount to more than 500 potentially preventable deaths. (2) In this setting, waiting times cease to be a mere administrative variable and become a true indicator of the healthcare quality.

Another remarkable aspect of the study by Chiminela et al. is that it highlights a challenge shared by numerous Latin American centers. Difficulties related to authorizations, financing, device provision, and interinstitutional coordination represent daily challenges that are seldom quantified objectively. Generating local evidence is essential for understanding the magnitude of the problem and designing strategies tailored to the specific characteristics of each healthcare system.

Despite the methodological limitations inherent in its retrospective design, the limited number of participating centers, and the patient population predominantly covered by governmental funding, this study opens a new avenue for research in contemporary structural cardiology. Just as there are standardized indicators for evaluating the technical quality of procedures, the time has likely come to develop specific metrics to measure and compare the efficiency of the care pathways leading to TAVI. Their incorporation into national or regional registries could become a key health policy tool. It should be noted that, since this study was conducted, the time from authorization to valve provision has decreased considerably, representing a significant improvement in timely access to treatment.

The question that naturally arises is whether, given the impossibility of completely eliminating delays, it is at least possible to manage them more intelligently. In this regard, a recent study by Miranda et al. addresses precisely this issue.(3) Drawing on a population-based cohort of more than 13 000 patients on the TAVI waiting list in Ontario, Canada, the authors developed and validated the Canadian TAVI Triage Tool (CAN3T), a risk stratification tool that estimates the individual's probability of death, hospitalization, or urgent TAVI during the waiting period and recommends a personalized maximum waiting time for each patient. In that cohort, more than 33% of patients on the waiting list experienced at least one hospitalization, and 4.5% died before undergoing the procedure. The CAN3T is not intended to replace the reorganization of care pathways, but rather to complement it: once waiting times have been reduced through organizational measures, tools such as this allow prioritization of those who can least afford to wait. It represents the logical next step based on the insights from the work of Chiminela et al.

Ultimately, the study by our colleagues—which sheds light on an important aspect of the Argentina healthcare reality—reminds us of a fundamental lesson: in modern cardiovascular medicine, excellence depends not only on available technology or the technical expertise of operators, but also on the capacity of healthcare systems to ensure that the right patient receives the right treatment at the right time.

Sometimes, the most difficult distance to bridge is not the one between the left ventricle and the aorta, but the one between a well-established clinical indication and the actual implantation of the valve in the patient who needs it.

Conflicts of interest

None declared

(See authors conflicts of interest forms on the website).

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