

TRICUSPID STENOSIS

Epidemiology and Aetiology

Tricuspid stenosis (TS) is a very rare condition in developed countries. It is mainly due to rheumatic disease, but only 3% to 5% with rheumatic mitral valve disease have concurrent TS. Other causes are congenital TS, carcinoid, endomyocardial fibrosis, and right atrial tumors.^{1, 2}

Physical Findings and Diagnosis

Because patients with rheumatic TS invariably have

Due to the usual coexistence of mitral valve disease, it is difficult to separate symptoms and signs specific to TS:

SOBOE and **peripheral edema**

Elevated JVP with a prominent a wave and slow y descent.

Opening snap, followed by a **diastolic rumbling murmur** at the right sternal border that varies with respiration.

As with TR, physical findings may be subtle and the murmur often inaudible.

Diagnosis is made by echocardiography. TS is considered severe when the valve area is $<1.0 \text{ cm}^2$ (Table 1), but the accuracy of echocardiography is less than with MS. TTE is essential in patients with TS to assess the anatomy of the valve complex, evaluate severity of stenosis, and characterize any associated regurgitation and/or left-sided valve disease. Invasive hemodynamic assessment may be considered in symptomatic patients when clinical and noninvasive data are discordant.

Therapy

Valve replacement is usually the only treatment (Table 1). The choice of prosthesis should be individualized. Tricuspid balloon valvotomy might also be considered, but it may result in severe TR. Management in pregnancy is described in General Principles.

References

1. Chan KM, et al. Tricuspid valve disease: pathophysiology and optimal management. *Prog Cardiovasc Dis.* 2009;51:482-6.
2. Praz F, et al. 2025 ESC/EACTS Guidelines for the management of valvular heart disease. *Eur Heart J.* 2025.