Impact of operator experience on peri-procedural outcomes with Watchman FLX: Insights from the FLX-SPA registry

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Abbreviations: ICE, intracardiac echocardiography; LAA, left atrial appendage; LAAO, left atrial appendage occlusion; OAC, oral anticoagulation; TEE, transesophageal echocardiography.
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1. Introduction

Left atrial appendage occlusion (LAAO) is an established non-pharmacological alternative to oral anticoagulation (OAC) for stroke prevention in patients with non-valvular atrial fibrillation (AF) at high bleeding risk [1]. Since conception of this technique, several LAAO dedicated devices with differential design features have been developed [1, 2]. Amongst them, the Watchman 2.5 device (Boston Scientific, Marlborough, Massachusetts, US) gathers the greatest body of evidence supporting its safety and efficacy, both in the form of randomized clinical trials and multicenter registries [3–4]. Notwithstanding, LAAO with the Watchman 2.5 device can be challenging in certain left atrial appendage (LAA) anatomies such as broad and shallow LAA, those with a complex internal architecture as well as chicken-wing-shaped LAA with a short proximal segment and an acute bend [1, 5].

The Watchman FLX is a device upgrade of the previous Watchman 2.5 that incorporates substantial design changes aimed to simplify the LAAO procedure in a broader range of LAA anatomies. Since its approval by CE mark authorities in 2019, several registries have reported promising peri-procedural outcomes with the Watchman FLX, including lower need for device recapture and repositioning, reduced number of devices used per procedure and a high degree of complete LAA sealing [6–7]. More recently, the PINNACLE FLX trial confirmed consistent favorable results at 1-year follow-up [8]. Notwithstanding, these studies were performed in centers with a high volume of LAAO procedures, by operators with prior experience with the Watchman 2.5 device, which could have exerted a positive bias on the results. In order for new centers to incorporate the Watchman FLX device into their therapeutic arsenal, it remains relevant to assess if operators without prior experience with the Watchman 2.5 device, as well as those with a shorter experience with the Watchman FLX, may achieve similarly favorable peri-procedural outcomes [9].

The aim of the multicenter FLX-SPA registry is to report and compare peri-procedural outcomes with the Watchman FLX device in centers with and without prior experience with the Watchman 2.5 device, as well as in centers with varying degrees of procedural volume with the Watchman FLX.

1. Both Authors have contributed to this work in the same amount and should both be considered as first authors.
clinical and imaging features, procedural details and peri-procedural results of both groups were compared.

2.3. Watchman FLX device

Specific design features of the Watchman FLX device have been previously described [6–8]. Main refinements in the design of the Watchman FLX in comparison to the Watchman 2.5 include a 10–20% length reduction and a closed end configuration that facilitate device implantation in shallow LAA (minimum depth required is 50% of device size). Additionally, device advancement within the LAA can be performed while partially deployed in the “ball” configuration, thanks to its atraumatic distal end with a fluoroscopic marker that reduces the risk of distal perforations. Furthermore, polyester fabric coverage has been extended to reduce peri-device leaks, the delivery cable screw recessed to reduce device related thrombus (DRT) and fixation mechanisms enhanced, with the addition of an extra row of 18 J-shaped anchors.

2.4. Pre-procedural imaging

Pre-procedural evaluation of the LAA was performed with TEE in all cases and its morphology and dimensions registered. The landing zone (LZ) was measured from the inferior part of the ostial plane at the level of the circumflex coronary artery, to a point 1–2 cm distal to the left upper pulmonary vein ridge. Patients with LAA thrombus, prior LAA surgical ligation as well as those with a LAA anatomy unsuitable for Watchman FLX implantation as per manufacturer’s instructions of use (LZ diameters <17 mm or >31 mm and LAAs shorter than the diameter of the required occlusion device) were excluded. No other morphological exclusion criteria for Watchman FLX implantation existed. Device sizing was selected according to the maximal LZ diameter, with oversizing aimed to attain final device compression between 10 and 30%.

2.5. Procedural details and outcomes

LAAO was performed under general anesthesia or conscious sedation, employing transesophageal echocardiography (TEE), micro-TEE or intracardiac echocardiography (ICE) according to local practice. Technical success was defined as complete LAA exclusion with no peri-device leak >5 mm on color-Doppler TEE and no device-related complications. Peri-procedural outcomes were recorded during the first 7 days after LAAO. Major peri-procedural adverse events were registered according to the definitions in the Munich Consensus Document on LAAO [10] and included, but were not limited to, device embolization and thrombosis, cardiac perforation, tamponade and pericardial effusion requiring intervention, major bleeding defined as type ≥3 of Bleeding Academic
Supplementary Tables 1 and 2.

3.1. Peri-procedural details

Imaging and procedural characteristics according to centers experience and procedural volume are summarized in Tables 2 and 3.

Mean maximal and minimal LZ diameters were 20.9 ± 3.8 mm and 18.1 (SD 3.5) mm, respectively, range 12 to 34 mm, and mean LAA depth was 25.1 (SD 6.1) mm. In 54 (15.1%) of patients, the LAA depth was shorter than the maximal LZ diameter, a factor that would have precluded LAOO with the Watchman 2.5 device. In addition, the LZ diameter exceeded 31 mm in 2 (0.6%) patients and was ≤ 17 mm in 44 (12.3%) of cases. Overall, 78 (21.7%) of patients undergoing LAOO with the Watchman FLX in our sample would have been unsuitable candidates for LAOO with the Watchman 2.5, according to the instructions for use.

LAOO was performed under general anaesthesia in 201 (56%) patients. The majority of procedures were guided by TEE (68.5%), while micro-TEE and ICE were used in 27.6% and 3.4% of patients, respectively. Centers that had performed ≤ 10 Watchman FLX implants employed general anesthesia more frequently (83.7% versus 46.4% p = 0.001), while use of micro-TEE was more common in centers that had performed > 10 Watchman FLX implants (36% versus 3.3%, p = 0.001) as well as in those with prior experience with the Watchman 2.5 device (30.3% versus 5.1, p = 0.001). Overall, 7 (1.9%) patients underwent combined procedures with LAAO (1 transcatheter aortic valve implantation, 2 percutaneous edge-to-edge mitral valve repair and 4 pulmonary vein ablation), without differences according to the hospitals characteristics.

The most frequently implanted device size was Watchman FLX 27 mm, in 38.2% of patients. Technical success was achieved in 354 (98.6%) cases, without differences between centers, Fig. 1. Successful LAOO with the first selected device size was achieved in 343 (95.5%) cases and the device was implanted at first attempt in 282 (78.6%) patients. Device recapture and repositioning was significantly more frequent in centers that had performed > 10 Watchman FLX implants, whilst “Watchman 2.5 naïve centers” employed a greater volume of contrast than centers with prior experience.

3.2. Peri-procedural and in-hospital outcomes

Major peri-procedural and in-hospital complications recorded during the first 7-days post-procedure occurred in 9 (2.5%) patients, as depicted in Tables 4 and 5, Fig. 2. No patient died within index hospitalization. BARC ≥ 3 bleedings were the most frequent complication in 4 (1.1%) patients and there was just 1 (0.3%) pericardial tamponade requiring pericardiocentesis. Acute device-related complications included 1 (0.3%) early DRT that was successfully managed with low-molecular weight heparin for 4 weeks. There were no cases of device embolisation. Complete LAA sealing post-procedure was confirmed by TEE in 344 (97.2%) patients and there were no severe (>5mm) peri-device leaks. No differences in peri-procedural complications between centers existed.

Mean length of hospital stay was 1.8 (SD 1.8) days. At discharge, 164 (45.7%) were managed with dual antiplatelet therapy, 73 (20.3%) with single antiplatelet therapy, 86 (23.9%) with anticoagulation alone and 27 (7.5%) with an antiplatelet agent on top of anticoagulation, Table 4 and 5.

4. Discussion

Our study provides further evidence on procedural safety and efficacy of LAOO with the Watchman FLX device in real-world practice with similarly favorable results regardless of the centers degree of expertise.

Its main findings can be summarized as follows: first, technical success rates with the Watchman FLX were remarkably high at 98.6%, regardless of LAA anatomy and there were no cases of severe (>5 mm)
peri-device leaks on post-procedural TEE. Second, LAAO with the Watchman FLX was safe, with a low incidence of major peri-procedural adverse events during the first 7 days after LAAO (2.5%) and no cases of device embolization or death. Third, operators with no experience with the previous device iteration, the Watchman 2.5, as well as those that had performed ≤10 Watchman FLX implants, attained similar technical success and peri-procedural complication rates than more experienced operators. The Watchman FLX has recently emerged as a valuable option for LAAO that enables a simpler implantation procedure in a wider span of LAA anatomies than its previous device iteration, thanks to several design enhancements [6–7]. These finding were recently confirmed in the PINNACLE FLX randomized trial [8].

Our registry provides similarly high technical success rates as previous studies in a large sample of real-world patients with unsselected LAA anatomies, including 21.7% of cases that would have been perceived as technically challenging or unsuitable for LAAO with the Watchman 2.5. Of note, complete LAA sealing was achieved with the first selected device size in 95.5% of cases, with a low number of device recaptures per patient at 0.9 (SD 1.1). This value is lower than previously described for the Watchman 2.5 [11–12], despite a substantial proportion of cases being performed at centers with limited experience with the device. Altogether, these results support that LAAO procedure can be simplified with the Watchman FLX, as compared to its prior device iteration.

Moreover, there were no severe peri-device leaks and mild-to-moderate leaks occurred in only 2.8% of patients. Although our study does not provide follow-up TEE data, lack of progression from mild to severe leaks described in prior reports along with minor variations in the prevalence of peri-device leaks during follow-up after Watchman FLX implantation are comforting and suggest that post-procedural outcomes observed in the current study are likely to maintain over time [6,8].

Regarding peri-procedural safety, we observed 9 (2.5%) major procedural and in-hospital complications, an outcome largely determined by post-procedural bleeding events, which occurred in 4 (1.1%) patients. Our safety results are similar to those reported in previous registries with the Watchman FLX but substantially higher than those described in the PINNACLE FLX study [8]. However, the latter did not include bleeding events into the primary safety endpoint and targeted patients with a substantially lower bleeding risk, as predicted by HAS-BLED Score [3.8 (SD 0.9) in the SPA-FLX registry versus 2.0 (SD 1.0) in the PINNACLE FLX trial], two factors likely to have influenced these findings. Of importance, there was only one pericardial effusion in our study which was successfully managed with percutaneous drainage and no cases of death or device embolization, a complication that led to study withdrawal in the PINNACLE FLX trial] [8].

Table 2

| Peri-procedural characteristics according to centers experience with Watchman 2.5 device. |
|---------------------------------------------------------------|
| No prior experience Watchman 2.5 (n = 39) | Prior experience Watchman 2.5 (n = 320) | Total sample (n = 359) | Difference of the means (95% CI) | p-value |
|---------------------------------------------------------------|
| LAA morphology(n,%)* |
| Chicken-wing | 9(37.5) | 67(27.3) | 76(28.4) | 0.030 |
| Windsock | 9(37.5) | 116(47.3) | 124(46.3) |  |
| Cauliflower | 1(4.2) | 45(18.4) | 46(17.2) |  |
| Cactus | 5(20.8) | 17(6.9) | 22(8.2) |  |
| LAA landing zone(mm) | 20.6 ± 4.5 | 20.9 ± 3.8 | 20.9 ± 3.8 | -0.26 (-1.9, +1.3) | 0.946 |
| Maximal diameter | 17.2 ± 3.8 | 18.2 ± 3.5 | 18.1 ± 3.5 | -0.98 (-2.3, +0.4) | 0.215 |
| Minimal diameter | 27.3 ± 8.5 | 24.9 ± 5.7 | 25.1 ± 5.7 | 0.689 |
| LAA length(mm) | 9(32.1) | 69(21.6) | 78 (21.7) | 0.829 |
| Unsuitability for Watchman 2.5 device (n,%) | 14(35.9) | 144(45) | 158(44) | 0.182 |
| Procedural anaesthesia(n,%) | 25(64.1) | 176(55) | 201(56) | 0.001 |
| Procedural imaging guidance(n,%) | 1(2.6) | 6(1.9) | 7(1.9) | 0.556 |
| Technical success(n,%) | 17(4.8) | 59(16.4) | 76(28.4) | 0.689 |
| Device recaptures/patient(n,%) | 7(17.9) | 35(10.9) | 42(11.7) | 0.689 |
| Device recapture(n,%) | 13(33.3) | 124(38.8) | 137(38.2) | 0.561 |
| Device per patient | 2(5.1) | 13(4.1) | 13(4.1) | 0.754 |
| Devices per patient | 1.0 ± 0.2 | 1.1 ± 0.2 | 1.0 ± 0.2 | 0.007(-0.06, +0.08) | 0.903 |
| Device recapture/patient(n,%) | 7(17.9) | 70(21.9) | 77(21.4) | 0.08) 0.903 |
| Device recapture/patient(n,%) | 0.8 ± 1.3 | 1.0 ± 1.1 | 0.9 ± 1.1 | -0.2 (-0.8, +0.3) | 0.182 |
| Device compression(n,%) | 23(61.5) | 27(8.2) | 26(8.2) | -0.9 (-2.3, +1.0) | 0.118 |
| Fluoroscopy time(minutes) | 15(4.1) | 13(4.1) | 13(4.1) | 0.142 |
| Contrast media volume(ml) | 7.5(48.8-105) | 80(52-107) | 34.9 (7.1,62.7) | <0.001 |

Values: mean ± SD, median (interquartile range) or n(%). *N = 269.

CI: Confidence Interval. ICE: intracardiac echocardiography; LAA: left atrial appendage; TEE: transesophageal echocardiography.
which has not been reported in studies with the newer generation of the device [6–8].

Our study provides an important contribution to existing evidence as it supports the adoption of the Watchman FLX by less experienced centers, with similar procedural safety and efficacy outcomes than more expert institutions. This finding is relevant given the continuous raise in LAAO procedures along with LAAO operators and implanting centers that is taking place across the world in the last few years [9].

The association between operator’s experience and LAAO procedural results has been previously described. Indeed, several real-life studies have reported that increasing operators experience and hospital procedural volume are linked with a lower rate of peri-procedural adverse events, while the association with procedural success is more limited [12–15]. Similarly, the latest registries with the Watchman 2.5 have reported growing technical success rates along with a declining incidence in peri-procedural complications, as compared to studies reporting on the initial experience with this device [3–4,9].

Thus, our findings suggest a lower learning curve for LAAO with the Watchman FLX than that previously reported for the Watchman 2.5 device, with high procedural success rates achievable not only by more expert operators, but also by those performing a lower volume of procedures and no prior experience with the Watchman 2.5 device. These outcomes can be justified by several novel features of the Watchman FLX device that facilitate optimal device alignment and positioning, including its ability to be totally recaptured and repositioned both proximally as well as distally in the “ball” configuration and the possibility to perform rotational adjustments during deployment, without the need to completely retrieve or change the device.

In summary, the results of the present study reaffirm the outstanding device performance of the Watchman FLX in unselected, real-world patients. In addition, the Watchman FLX emerges as an attractive option for institutions that are initiating a LAAO program, given its reproducible safety and efficacy results in centers unfamiliar with its prior device iteration and with lower procedural volume. However, studies assessing longer-term outcomes following LAAO with the Watchman FLX are warranted, in order to establish firm conclusions regarding the safety and efficacy of this device.

### Table 3

| Procedure Characteristic | Centers with ≤ 10 Watchman FLX implants (n = 92) | Centers with > 10 Watchman FLX implants (n = 267) | Total sample (n = 359) | Difference of the means (95% CI) | p-value |
|--------------------------|-------------------------------------------------|-------------------------------------------------|-----------------------|---------------------------------|---------|
| LAA morphology (n,%)<sup>a</sup> | Chicken-wing: 23(31.9) | 53(26.9) | 76(28.4) | 0.039 |
| Windsock: 28(38.9) | 97(49.2) | 124(46.3) |
| Cauliflower: 10(13.9) | 36(18.3) | 46(17.2) |
| Cactus: 11(15.3) | 11(5.6) | 22(8.2) |
| LAA landing zone (mm) | Maximal diameter: 20.6 ± 3.9 | 21 ± 3.8 | 20.9 ± 3.8 | -0.4 (-1.5, +1.60) | 0.401 |
| Minimal diameter: 17.9 ± 3.3 | 18.2 ± 3.6 | 18.1 ± 3.5 | -0.3 (-1.2, +0.60) | 0.500 |
| LAA length (mm): 26.4 ± 6.2 | 24.5 ± 5.9 | 25.1 ± 6.1 | 0.021 |
| Unsuitability for Watchman 2.5 device (n,%) | Technical success: 90(97.8) | 264(98.9) | 354(98.6) | 0.606 |
| Procedural anaesthesia (n,%) | 15(16.3) | 124(46.4) | 139(43.1) | <0.001 |
| General anaesthesia: 77(83.7) | 143(52.6) | 158(44) |
| Procedural imaging guidance (n,%) | Micro-TEE: 87(94.6) | 159(59.6) | 246(68.5) | 0.074 |
| ICE: 3(3.3) | 96(36) | 99(27.6) |
| Combined procedure: 2(2.2) | 12(4.5) | 14(4.3) |
| Size of implanted device | FLX-20mm: 12(13.5) | 30(11.2) | 42(11.7) |
| FLX-24mm: 36(39.4) | 101(37.8) | 137(38.2) |
| FLX-27mm: 29(31.5) | 72(27) | 101(28.1) |
| FLX-31mm: 13(14.1) | 49(18.4) | 59(16.4) |
| FLX-35mm: 2(2.2) | 15(5.6) | 17(4.8) |
| Technical success (n,%) | 90(97.8) | 264(98.9) | 354(98.6) | 0.606 |
| -1 device per patient (n,%) | 5(5.4) | 10(3.7) | 15(4.2) | 0.485 |
| Devices per patient | 1.1 ± 0.2 | 1.0 ± 0.2 | 1.0 ± 0.2 | 0.01 (-0.04, +0.06) | 0.351 |
| Device recapture (n,%) | 34(37) | 43(16.1) | 77(21.4) | <0.001 |
| Device recapture patient | 1 ± 1.2 | 0.9 ± 1.0 | 0.9 ± 1.1 | 0.07 (-0.3, +0.45) | 0.718 |
| Device compression (%) | 25.7 ± 12.7 | 27.3 ± 12.5 | 26.8 ± 12.4 | -1.6 (-4.9, +1.7) | 0.354 |
| Fluoroscopy time (minutes) | 168(24) | 149(19) | 149(20) | 0.281 |
| Contrast media volume (ml) | 80(50–100) | 80(52.8–119) | 80(52–107) | -143 (-27.7, -0.83) | 0.087 |

Values: mean ± SD, median (interquartile range) or n(%).<sup>a</sup>N = 269.

CI: Confidence Interval. ICE:intra-cardiac echocardiography; LAA:left atrial appendage; TEE:transesophageal echocardiography.
The Watchman FLX device.

and are reproducible by operators at their initial experience with the Watchman FLX device and are reproducible by operators at their initial experience with the Watchman FLX device.

6. Conclusions

The Watchman FLX attains high procedural success rates with complete acute LAA sealing in a wide range of LAA anatomies, along with a very low rate of peri-procedural complications. Favorable peri-procedural outcomes following LAAO with the Watchman FLX are not influenced by operators prior experience with the Watchman 2.5 device and are reproducible by operators at their initial experience with the Watchman FLX device.

| Table 4 | Procedural and 7-day outcomes according to centers experience with Watchman 2.5 device. |
|---------------------------------|---------------------------------------------------------------|
|                               | No prior experience Watchman 2.5 (n = 39) | Prior experience Watchman 2.5 (n = 320) | Total sample (n = 359) | p-value |
| Peri-procedural complications(n,%) | 0 | 9(2.8) | 9(2.5) | 0.605 |
| Death(n,%) | 0 | 0 | 0 | |
| Ischemic stroke/ transient ischemic attack / Systemic embolism(n,%) | 0 | 1(0.3) | 1(0.3) | 0.891 |
| Hemorrhagic stroke(n, %) | 0 | 0 | 0 | |
| Major bleeding (BARC ≥ 3(n,%) | 0 | 4(1.3) | 4(1.1) | 0.630 |
| Pericardial effusion requiring intervention(n,%) | 0 | 1(0.3) | 1(0.3) | 0.891 |
| Major vascular complication(n,%) | 0 | 1(0.3) | 1(0.3) | 0.891 |
| Ventricular arrhythmia (n,%) | 0 | 1(0.3) | 1(0.3) | 0.891 |
| Device-related complications(n,%) | 0 | 0 | 0 | 0.891 |
| Device embolization | 0 | 1(0.3) | 1(0.3) | |
| LAA leak post-procedure(n,%) | 3(0.7%) | 9(2.9) | 10(2.8) | 0.697 |
| Mild(1–3 mm) | 2(0.4) | 6(1.9) | 7(2.0) | |
| Moderate(3–5 mm) | 0 | 3(1) | 3(0.8) | |
| Significant(>5mm) | 0 | 0 | 0 | |
| Antithrombotic therapy at discharge(n,%) | 6(1.5) | 23(7.2) | 29(8.1) | 0.004 |
| None | 1(0.2) | 2(0.6) | 3(0.8) | |
| Any antiplatelet therapy | 34(87.2) | 203(62.4) | 237 | (56.1) |
| Any anticoagulation | 4(10.3) | 109(34.1) | 113 | (34.1) |

Values:mean ± SD or n(%).

BRAC: Bleeding Academic Research Consortium; ICE: intra-cardiac echocardiography; LAA: left atrial appendage.

 procedural phase and follow-up results including long-term device-related outcomes were not evaluated. Notwithstanding, prior studies with the Watchman FLX have reported low incidence of DRT and only small variations in the incidence of peri-device leaks, as compared to acute results assessed at the end of the procedure. Finally, the non-randomized design of the study and lack of a control group constitute a further limitation, and the possibility of patient selection bias cannot be discarded.

6. Conclusions

The Watchman FLX attains high procedural success rates with complete acute LAA sealing in a wide range of LAA anatomies, along with a very low rate of peri-procedural complications. Favorable peri-procedural outcomes following LAAO with the Watchman FLX are not influenced by operators prior experience with the Watchman 2.5 device and are reproducible by operators at their initial experience with the Watchman FLX device.

| Table 5 | Procedural and 7-day outcomes according to the centers procedural volume. |
|---------------------------------|---------------------------------------------------------------|
|                               | Centers with ≤ 10 Watchman FLX implants (n = 92) | Centers with > 10 Watchman FLX implants (n = 207) | Total sample (n = 359) | p-value |
| Peri-procedural complications(n,%) | 1(1.1) | 8(3.0) | 9(2.5) | 0.457 |
| Death(n,%) | 0 | 0 | 0 | |
| Ischemic stroke/ transient ischemic attack / Systemic embolism(n,%) | 1(1.1) | 0 | 1(0.3) | 0.256 |
| Hemorrhagic stroke (n, %) | 0 | 0 | 0 | |
| Major bleeding (BARC ≥ 3) (n,%) | 0 | 4(1.5) | 4(1.1) | 0.576 |
| Pericardial effusion requiring intervention(n,%) | 0 | 1(0.4) | 1(0.3) | 0.744 |
| Major vascular complication(n,%) | 0 | 1(0.4) | 1(0.3) | 0.744 |
| Significant procedural arrhythmia(n,%) | 0 | 1(0.4) | 1(0.3) | 0.744 |
| Device-related complications(n,%) | 0 | 0 | 0 | 0.744 |
| Device embolization | 0 | 1(0.4) | 1(0.3) | |
| LAA leak post-procedure(n,%) | 3(3.3) | 7(2.6) | 10(2.8) | 0.488 |
| Mild(1–3 mm) | 2(2.2) | 5(1.9) | 7(2.0) | |
| Moderate(3–5 mm) | 11(1.1) | 20(0.8) | 30(0.8) | |
| Significant(>5mm) | 0 | 0 | 0 | |
| Antithrombotic therapy at discharge(n,%) | 6(6.5) | 20(7) | 29(8.1) | 0.21 |
| None | 57(61.9) | 181(67.8) | 238 | (66.3) |
| Any antiplatelet therapy | 29(31.5) | 84(31.5) | 113 | (31.5) |

Values: mean ± SD or n(%).

BRAC: Bleeding Academic Research Consortium; DOAC: direct oral anticoagulants; LAA: left atrial appendage; LMWH: low-molecular weight heparin; VKA: vitamin K antagonists.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.
Fig. 2. Peri-procedural complications. Peri-procedural major adverse events following LAAO with the Watchman FLX. P-value > 0.05 for all comparisons.

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Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijcha.2021.100941.

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