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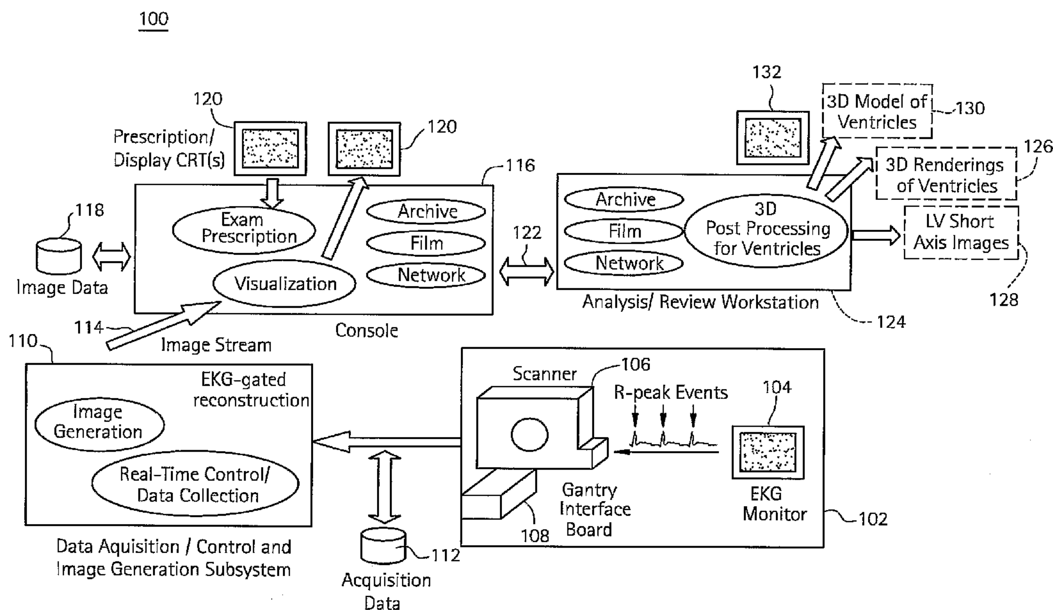
(54) **Title:** CARDIAC IMAGING SYSTEM AND METHOD FOR PLANNING SURGERY



(57) **Abstract:** A method (200) for planning minimally invasive direct coronary artery bypass (MIDCAB) for a patient includes obtaining acquisition data from a medical imaging system, and generating a 3D model (130) of the coronary arteries and one or more cardiac chambers of interest. One or more anatomical landmarks are identified on the 3D model (130), and saved views of the 3D model (130) are registered on an interventional system. One or more of the registered saved views are visualized with the interventional system.

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CARDIAC IMAGING SYSTEM AND METHOD FOR PLANNING SUGERY

CROSS REFERENCE TO RELATED APPLICATIONS

This application claims the benefit of United States provisional application No. 60/484,012, filed July 1, 2003, the contents of which are incorporated by reference herein in their entirety.

BACKGROUND OF THE INVENTION

The present disclosure relates generally to cardiac surgical bypass systems and, more particularly, to a cardiac imaging system and method for planning minimally invasive direct coronary artery bypass surgery (MIDCAB).

According to American Heart Association statistics, over 500,000 coronary artery bypass grafts (CABGs) are performed every year in the United States alone. In coronary artery disease, the arteries that bring blood to the heart muscle (i.e., the coronary arteries) become clogged by plaque, which is a buildup of fat. During CABG surgery, the blood is rerouted around the clogged arteries in order to improve blood flow and oxygen to the heart. A healthy blood vessel, such as the left internal mammary, is detached from the chest wall and is thereafter used to circumvent the blocked area. Alternatively, a segment of vein from the leg can also be used for the CABG. One end of the vessel/vein is sewn onto the aorta (the large artery leaving the heart), while the other end is attached or "grafted" to the coronary artery beyond (or past or distal to) the blocked area. Patients may undergo multiple bypasses at the same time.

Cardiopulmonary bypass using a heart-lung machine is typically used to stop the movement of the heart at the time of the CABG procedure. Although CABG is the treatment of choice in many cases (and is one of the most common surgical procedures performed today), there are several potential complications from this surgery, as well as from the cardiopulmonary bypass technique required during the CABG procedure. In a recent study published in the New England Journal of

Medicine, 53 percent of patients had diminished mental acuity at the time of discharge from the hospital after a CABG procedure. In addition to the prolonged hospital stay and the possible need for transfusions, sternal wound infection at the site of the incision can occur in 1 to 4 percent of patients and carries a mortality (death) rate of about 25 percent. Furthermore, as many as 8 percent of patients may develop kidney dysfunction as a result of the CABG procedure.

As a result of the above described problems associated with CABG, minimally invasive direct coronary artery bypass (MIDCAB) surgery has been used as an alternative in some patients, wherein the MIDCAB procedure does not require reliance on the heart-lung machine. In MIDCAB surgery, a 10-12 cm access incision is made in the patient's chest, after which several different instruments are used to stabilize the heart at the time of surgery. The surgeon then connects a graft to the diseased coronary arteries while the heart is beating without artificial support. Due to the nature of the operation, grafting (the attaching of the vessels) must be done under the surgeon's direct vision and the coronary artery that is to be bypassed must lie directly beneath the incision (surgical opening). Consequently, this procedure is currently used in only a limited number of patients, and only if it is known that just one or two of the arteries require a bypass.

Although it is estimated that over 30 percent of patients who need CABG may be suitable candidates for MIDCAB surgery, presently the procedure is performed in only 10 percent of patients because of this unknown factor. There is, therefore, a distinct need for an improved system and method to make this procedure more effective and easier to perform.

BRIEF DESCRIPTION OF THE INVENTION

The above discussed and other drawbacks and deficiencies of the prior art are overcome or alleviated by a method for planning minimally invasive direct coronary artery bypass surgery (MIDCAB) for a patient. In an exemplary embodiment, the method includes obtaining acquisition data from a medical imaging system, and generating a 3D model of the coronary arteries and one or more cardiac chambers of

interest. One or more anatomical landmarks are identified on the 3D model, and saved views of the 3D model are registered on an interventional system. One or more of the registered saved views are visualized with the interventional system.

In another embodiment, a method for planning minimally invasive direct coronary artery bypass surgery (MIDCAB) for a patient includes obtaining acquisition data from a medical imaging system using a protocol directed toward the coronary arteries and left ventricle. The acquisition data is segmented using a 3D protocol so as to visualize the coronary arteries and the left ventricle. A 3D model of the coronary arteries and the left ventricle of the patient is generated, and one or more anatomical landmarks on the 3D model are identified. Saved views of the 3D model are registered on an interventional system, and one or more of the registered saved views are visualized the interventional system. The orientation and any anomalies associated with the coronary arteries and the left ventricle are identified from the 3D model.

In still another embodiment, a method for planning minimally invasive direct coronary artery bypass surgery (MIDCAB) for a patient includes obtaining acquisition data from a cardiac computed tomography (CT) imaging system using a protocol directed toward the coronary arteries and left ventricle. The acquisition data is segmented using a 3D protocol so as to visualize the coronary arteries and left ventricle, including interior views of the coronary arteries. A 3D model of the coronary arteries and left ventricle of the patient is generated, and one or anatomical landmarks on the 3D model are identified. Saved views of the 3D model are registered on a fluoroscopy system, and one or more of the registered saved views are visualized with the fluoroscopy system. The orientation and any anomalies associated with the coronary arteries and the left ventricle are identified from the 3D model.

In still another embodiment, a system for planning minimally invasive direct coronary artery bypass surgery (MIDCAB) for a patient includes a medical imaging system for generating acquisition data, and an image generation subsystem for receiving the acquisition data and generating one or more images of the coronary arteries and the left ventricle of the patient. An operator console is configured for identifying one or

more anatomical landmarks on one or more of the generated images, and a workstation includes post processing software for registering saved views of the 3D model on an interventional system. The interventional system is configured for visualizing one or more of the registered saved views therewith, quantifying distance and location information for a cardiac point of interest, and identifying an incision location and path for MIDCAB based on the quantified distance and location information for the cardiac point of interest.

BRIEF DESCRIPTION OF THE DRAWINGS

Referring to the exemplary drawings wherein like elements are numbered alike in the several Figures:

Figure 1 is a schematic diagram of a medical imaging system, such as a computed tomography (CT) system, suitable for planning minimally invasive direct coronary artery bypass (MIDCAB), in accordance with an embodiment of the invention;

Figure 2 is a flow diagram of a method for planning minimally invasive direct coronary artery bypass (MIDCAB), in accordance with a further embodiment of the invention;

Figure 3 is an exemplary CT image of the chest and heart, on which distance and angles may be measured for MIDCAB planning; and

Figure 4 is a cardiac CT image showing necrosed LV due to myocardial infarction.

DETAILED DESCRIPTION OF THE INVENTION

Disclosed herein is a cardiac imaging system and method for planning minimally invasive direct coronary artery bypass surgery (MIDCAB), so as to enable a practitioner (e.g., electrophysiologist, cardiologist, surgeon) to plan in advance the approach to take for the procedure. With more detailed 3D and navigator (interior) views, a geometric representation of the coronary arteries and the left ventricle (LV) is obtained with an imaging modality such as CT, magnetic resonance imaging or ultrasound. The practitioner can then identify the orientation, size, anomalies, and

extent of blockage in the coronary arteries to be targeted for MIDCAB. Using this information, a more exact approach can be taken for the MIDCAB, with incisions made at the most appropriate sites, allowing for more areas to be targeted and, at the same time, allowing for smaller incisions.

Although the exemplary embodiments illustrated hereinafter are described in the context of a computed tomography (CT) imaging system, it will be appreciated that other imaging systems known in the art (e.g., magnetic resonance, ultrasound, 3D fluoroscopy) are also contemplated with regard to planning MIDCAB.

Referring now to Figure 1, there is shown an overview of an exemplary cardiac computed tomography (CT) system 100 with support for cardiac imaging. Again, it should be understood that the cardiac CT system 100 is presented by way of example only, since other imaging systems known in the art (e.g., magnetic resonance, ultrasound, 3D fluoroscopy) may also be used in an embodiment of the present invention. A scanner portion 102 of the system 100 includes an EKG monitor 104 that outputs R-peak events into a scanner 106 through a scanner interface board 108. A suitable example of scanner interface board 108 is a Gantry interface board, and can be used to couple an EKG system to the scanner. The cardiac CT subsystem defined by scanner portion 102 utilizes EKG-gated acquisition or image reconstruction capabilities to image the heart (and more specifically the coronary arteries and left ventricle) free of motion in its diastolic phase, as well as in multiple phases of systole and early diastole.

Data are outputted from the scanner portion 102 into a subsystem 110 that includes software for performing data acquisition, data control and image generation. In addition, data that is outputted from the scanner 106, including R-peak time stamps, is stored in an acquisition database 112. Acquisition is performed according to one or more acquisition protocols that are optimized for imaging the heart and specifically the coronaries and LV in diastole and multiple phases in systole and early diastole. Image generation is performed using one or more optimized 3D protocols for automated image segmentation of the CT image dataset for identifying the orientation, size and any anomalies of the coronary arteries. The 3D protocols are further

optimized to generate navigator (interior) views of the coronaries to assess the size and extent of the lesions therein.

The image data stream 114 is sent to an operator console 116. The data used by software at the operator console 116 for exam prescription and visualization is stored in an image database 118, along with the data from the image data stream 114. Display screens 120 are provided to the operator of the exam prescription and visualization processes. The image data may be archived, put on film or sent over a network 122 to a workstation 124 for analysis and review, including 3D post processing. The post processing software depicted in the workstation 124 includes one or more optimized 3D protocols and short axis protocols from an automated image segmentation of the CT image dataset for the LV anatomy, movement of LV walls during systole (i.e., LV contractility), epicardial fat location, location of viable tissue, blood vessels and their branches and orientation.

The 3D protocols and short axis protocols of the post processing software enable the software to provide views of the LV, including blood vessels, branches and slow motion cine of the LV, particularly the posterolateral wall or other areas of the LV. These special views and video (cine) clips may be saved into a 3D rendering of ventricle files 126 and LV short axis images 128 for use by the practitioner for interventional planning and procedure. The post processing software also provides for the export of detailed 3D models 130 of the thoracic wall and ventricle surfaces. The 3D models 130 (which may be implemented through color coding, contouring, movie views, etc.) may be viewed on display screen 132 associated with workstation 124 and are configured to include geometric markers inserted into the volume at landmarks of interest such that the thoracic wall and the LV are visualized in a translucent fashion with the opaque geometric landmarks.

In addition, the 3D models 130 may be in exported in any of several formats, including but not limited to: a wire mesh geometric model, a set of contours, a segmented volume of binary images, and a DICOM (Digital Imaging and Communications in Medicine) object using the radiation therapy (RT) DICOM object

standard or similar object. Other formats known in the art can also be used to store and export the 3D models 130.

Referring now to Figure 2, there is shown a flow diagram 200 illustrating a method for MIDCAB planning, in accordance with a further embodiment of the invention. Beginning at block 202, a volume of data is initially acquired on the cardiac CT system, using a protocol that is preferably optimized for the coronaries and LV regions of the heart. A continuous sequence of consecutive images is collected from a volume of a patient's data, in which a shorter scanning time using faster scanners and synchronization of the CT scanning with the QRS (peak) on the ECG (Electrocardiogram) signal will reduce motion artifacts (e.g. blurring, shadowing, streaking) in a beating organ like the heart. The ability to collect a volume of data with a short acquisition time allows reconstruction of images that have more precise depictions of anatomical landmarks, making them easier to understand.

At block 204, the image dataset is segmented with post-processing software using a 3D protocol and short axis protocols optimized for MIDCAB. Automated or semi-automated procedures may be employed, where appropriate, with or without queues from the operator. This operation can be performed on short axis reformatted cardiac images for each phase and slice location to obtain the displacement profile, or on multiphase, long axis reformatted cardiac images.

Then, as shown in block 206, the coronary arteries and LV are visualized using 3D surface and/or volume rendering to create 3D models thereof that provide certain quantitative features of the coronaries and the ventricles such as contour, position, orientation, dimensions of the coronaries and the ventricles and, additionally, the function and the areas of scarred tissue of the ventricles. As shown in block 208, the orientation, size and extent of the lesions in the coronary arteries targeted for MIDCAB are identified. In this manner, the size and contour of the vessels as well as the size and extent of the lesions are measured and determined, as shown in block 210.

For example, Figure 3 illustrates an exemplary CT image of the chest and heart and their spatial relationship therebetween. Exact distances and angles may be measured in 3D for planning MIDCAB and, in addition, such information may also be used to generate thickness graphs or plots, as well as 3D geometric visualization for quick analysis. This information can contribute significantly to identification and isolation of the optimal path through the chest wall.

Referring again to Figure 2, method 200 proceeds to block 212 for identification of anatomical landmarks over the thoracic wall, coronary arteries and ventricles. At block 214, explicit geometric markers are then inserted into the volume at landmarks of interest, wherein the markers may be visualized in a translucent fashion using 3D surface and/or volume rendering so as not to obscure the image. An example of such a visualization is presented in Figure 4, which illustrates a cardiac CT image showing a necrosed LV due to myocardial infarction. The specific images (e.g., Dicom images, video clips, films, etc.) are saved as desired for subsequent reference during the MIDCAB. As shown in block 216 of Figure 2, the saved views are then exported and registered with the computer workstation of the interventional system. After the registered images are imported, they may be visualized over the interventional system by the practitioner, as seen in block 218.

In addition to the registering markers, the workstation of the interventional system may also configured to register the instruments used for the specific MIDCAB procedure, as shown in block 220. Finally, the actual MIDCAB surgery is performed at block 222.

It will be appreciated that automatic techniques may be employed to perform any of the above steps by using one or more of the several computer-assisted detection, localization and visualization methods available. Such steps may include, for example, quantitative analysis of defects, localized contractility profile (LV wall movement), and identification of blood vessels using the continuity of same intensity levels. Moreover, these methods could be either completely automatic when the procedure and the organ of interest is specified or partly interactive with input from the user.

It will further be appreciated that through the use of the above described method and system embodiments, the planning of MIDCAB is improved in that the imaging information generated and registered allows for an appropriately tailored approach to the interventional procedure. In choosing the appropriate approach, the duration of the procedure itself is reduced and any unnecessary procedures are also eliminated. More particularly, a detailed 3D geometric and axial representation of the coronary arteries and LV increases the precision of the MIDCAB procedure. The identification of necrosed myocardium, if any, enables the practitioner to avoid such areas and determine an exact location of the incision is determined in advance before the surgery is performed.

The above described planning process thus reduces the amount of time required to perform the MIDCAB. Moreover, the identification of appropriate locations increases the efficacy of treatment and can reduce the risk of complications. After the procedure is completed, the data can be archived, read and processed in the form of CD-ROMs, floppy diskettes, hard drives or any other mediums used for this purpose as in the acquisition and transportation stages. Thus, the computer and the medium also become an apparatus for the purposes of the present invention.

While the invention has been described with reference to a preferred embodiment, it will be understood by those skilled in the art that various changes may be made and equivalents may be substituted for elements thereof without departing from the scope of the invention. In addition, many modifications may be made to adapt a particular situation or material to the teachings of the invention without departing from the essential scope thereof. Therefore, it is intended that the invention not be limited to the particular embodiment disclosed as the best mode contemplated for carrying out this invention, but that the invention will include all embodiments falling within the scope of the appended claims.

WHAT IS CLAIMED IS:

1. A method (200) for planning minimally invasive direct coronary artery bypass (MIDCAB) for a patient, the method (200) comprising:

obtaining acquisition data from a medical imaging system (202);

generating a 3D model (130) of the coronary arteries and one or more cardiac chambers of interest of the patient (206);

identifying one or more anatomical landmarks on said 3D model (130) (208);

registering saved views of said 3D model (130) on an interventional system (220); and

visualizing one or more of said registered saved views with said interventional system (222).

2. The method (200) of claim 1, further comprising identifying, from said 3D model (130), orientation, size and dimensions of the coronaries and ventricles (208).

3. The method (200) of claim 1, wherein said obtaining acquisition data is implemented with protocols directed for imaging the coronary arteries and ventricles.

4. The method (200) of claim 3, further comprising utilizing post processing software to process said acquisition data so as to generate interior views of the coronary arteries and ventricles.

5. The method (200) of claim 4, wherein said 3D model (130) and said interior views are visualized through a display screen (120, 132) associated with said interventional system.

6. The method (200) of claim 1, further comprising registering MIDCAB instruments on said interventional system (220).

7. The method (200) of claim 1, further comprising measuring size, extent and number of lesions in the coronary arteries needing MIDCAB.

8. The method (200) of claim 1, wherein said obtaining acquisition data is EKG gated (202).

9. A method (200) for planning minimally invasive direct coronary artery bypass (MIDCAB) for a patient, the method (200) comprising:

obtaining acquisition data from a medical imaging system using a protocol directed toward the coronary arteries and left ventricle (202);

segmenting said acquisition data using a 3D protocol so as to visualize the coronary arteries and the left ventricle (204);

generating a 3D model (130) of the coronary arteries and the left ventricle of the patient (206);

identifying one or more anatomical landmarks on said 3D model (130) (208);

registering saved views of said 3D model (130) on an interventional system (220);

visualizing one or more of said registered saved views with said interventional system; and

identifying, from said 3D model (130), orientation and any anomalies associated with the coronary arteries and the left ventricle.

10. The method (200) of claim 9, further comprising utilizing post processing software to process said acquisition data so as to generate interior views of the coronary arteries and ventricles (206).

11. The method (200) of claim 10, wherein said 3D model (130) and said interior views are visualized through a display screen (120, 132) associated with said interventional system.

12. The method (200) of claim 9, wherein said obtaining acquisition data is EKG gated.

13. The method (200) of claim 9, further comprising registering MIDCAB instruments on said interventional system.

14. The method (200) of claim 9, further comprising measuring size, extent and number of lesions in the coronary arteries needing MIDCAB.

15. The method (200) of claim 9, wherein said medical imaging system is one of a computed tomography system (100), a magnetic resonance imaging system and an ultrasound system.

16. A method (200) for planning minimally invasive direct coronary artery bypass (MIDCAB) for a patient, the method (200) comprising:

obtaining acquisition data from a cardiac computed tomography (CT) imaging system (100) using a protocol directed toward the coronary arteries and left ventricle (202);

segmenting said acquisition data using a 3D protocol so as to visualize the coronary arteries and left ventricle, including interior views of the coronary arteries (204);

generating a 3D model (130) of the coronary arteries and left ventricle of the patient (206);

identifying one or more anatomical landmarks on said 3D model (130) (208);

registering saved views of said 3D model (130) on a fluoroscopy system (220); and

visualizing one or more of said registered saved views with said fluoroscopy system; and

identifying, from said 3D model (130), orientation and any anomalies associated with the coronary arteries and the left ventricle.

17. The method (200) of claim 16, further comprising utilizing post processing software to process said acquisition data so as to interior views of the coronary arteries and ventricles.

18. The method (200) of claim 17, wherein said 3D model (130) and said immersible views are visualized through a display screen (120, 132) associated with said fluoroscopy system.

19. The method (200) of claim 16, wherein said obtaining acquisition data is EKG gated.

20. The method (200) of claim 16, further comprising registering MIDCAB instruments on said interventional system.

21. The method (200) of claim 20, further comprising measuring size, extent and number of lesions in the coronary arteries needing MIDCAB.

22. A system for planning minimally invasive direct coronary artery bypass (MIDCAB) for a patient, comprising:

a medical imaging system for generating acquisition data;

an image generation subsystem (110) for receiving said acquisition data and generating one or more images of the coronary arteries and the left ventricle of the patient;

an operator console (116) for identifying one or more anatomical landmarks on said one or more images;

a workstation (124) including post processing software for registering saved views of said 3D model (130) on an interventional system; and

wherein said interventional system is configured for visualizing one or more of said registered saved views therewith, quantifying distance and location information for a cardiac point of interest, and identifying an incision location and path for MIDCAB based on said quantified distance and location information for said cardiac point of interest.

23. The system of claim 22, wherein said image generation subsystem (110) is configured with protocols directed for imaging the coronary arteries and ventricles.

24. The system of claim 23, wherein said post processing software is further configured to process said acquisition data so as to generate interior views of the coronary arteries and ventricles.

25. The system of claim 24, further comprising a display screen (120, 132) associated with said interventional system, said display screen (120, 132) for visualizing said 3D model (130) and said interior views.

26. The system of claim 22, wherein said interventional system is configured for registering MIDCAB instruments therewith.

27. The system of claim 22, wherein said image generating subsystem (110) is EKG gated.

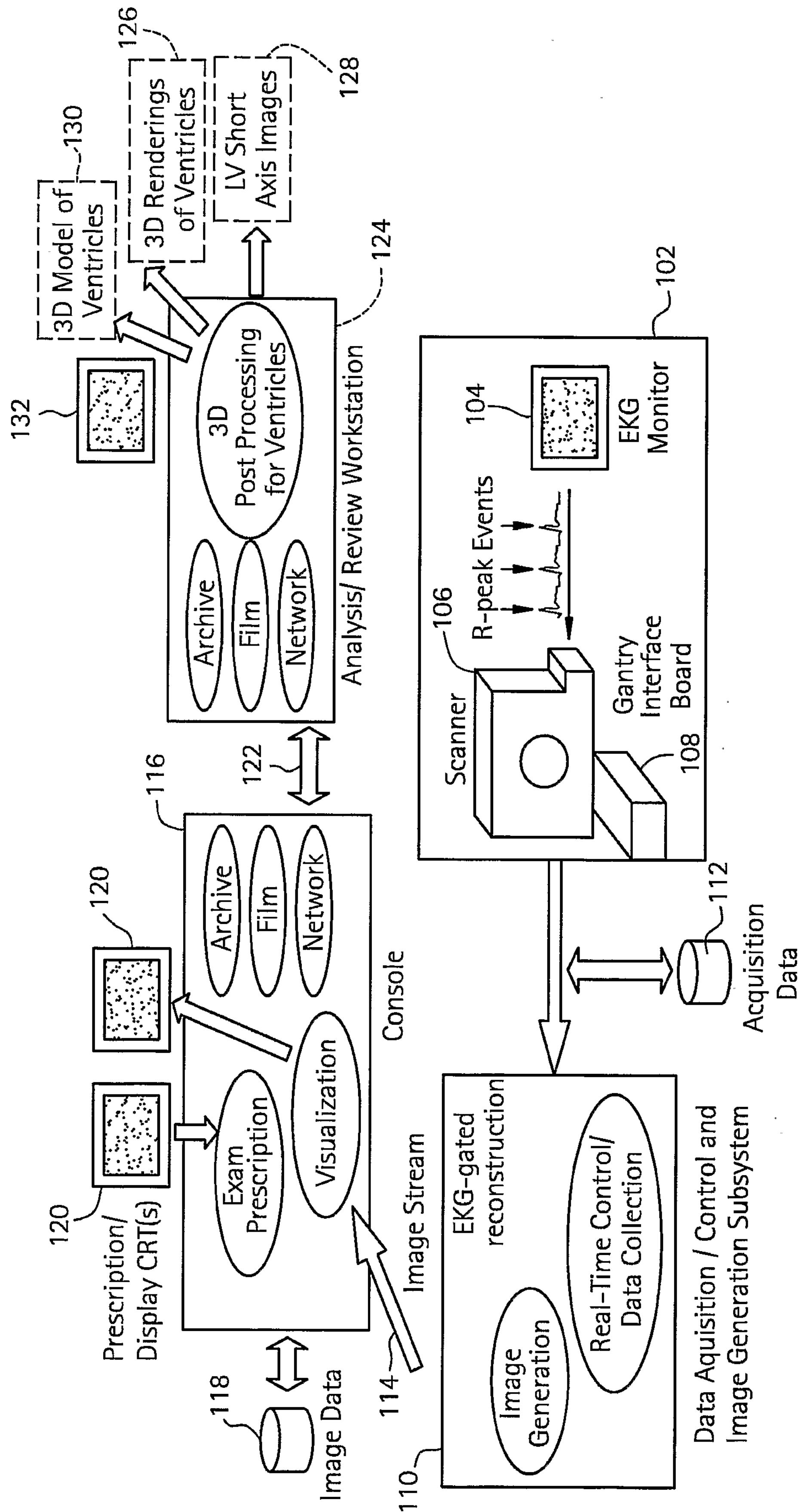
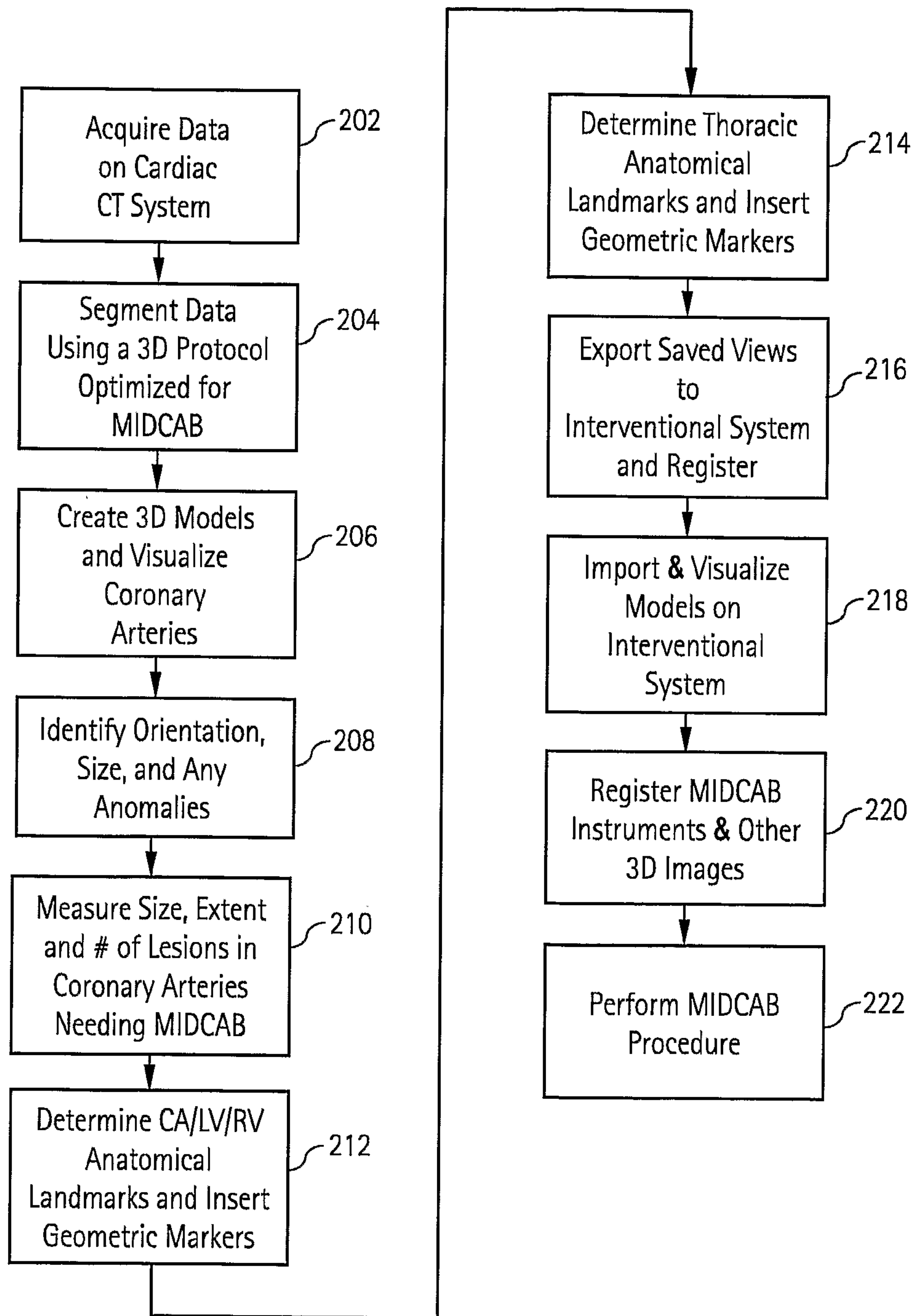


FIG. 1
100
3D Model of Ventricles
130
3D Renderings of Ventricles
126
LV Short Axis Images
128
132
124
3D Post Processing for Ventricles
Archive
Film
Network
Analysis/ Review Workstation
122
116
120
120
Prescription/ Display CRT(s)
Exam Prescription
Visualization
Archive
Film
Network
Console
118
Image Data
114
Image Stream
110
EKG-gated reconstruction
Image Generation
Real-Time Control/ Data Collection
Data Aquisition / Control and Image Generation Subsystem
112
Acquisition Data
102
104
EKG Monitor
R-peak Events
106
Scanner
Gantry Interface Board
108

FIG. 2



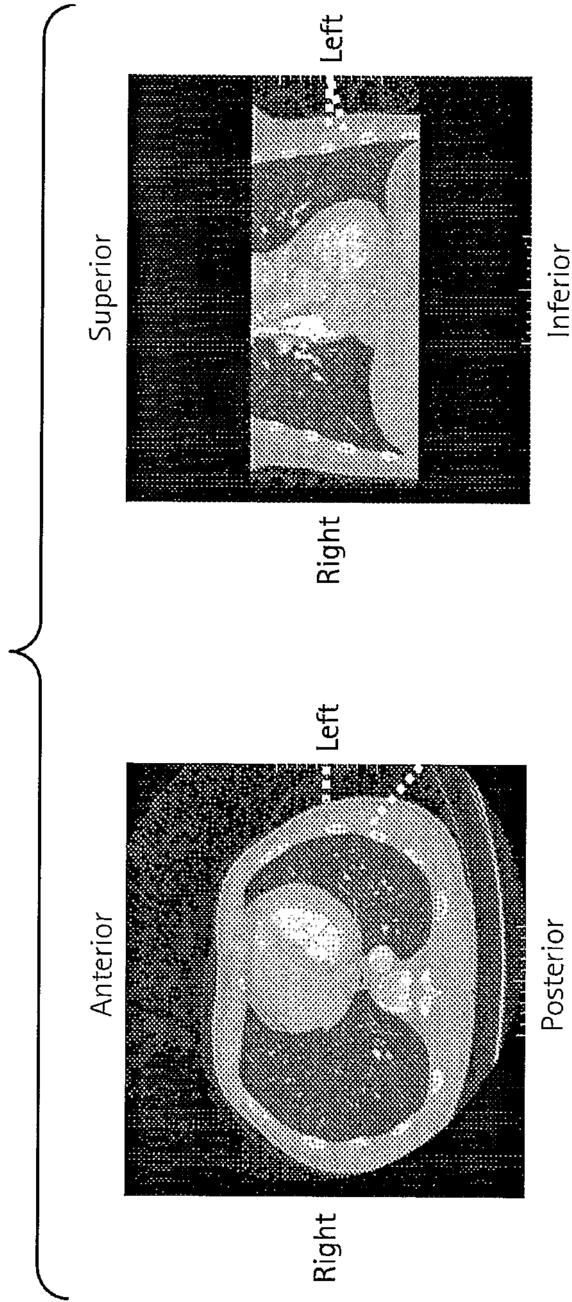
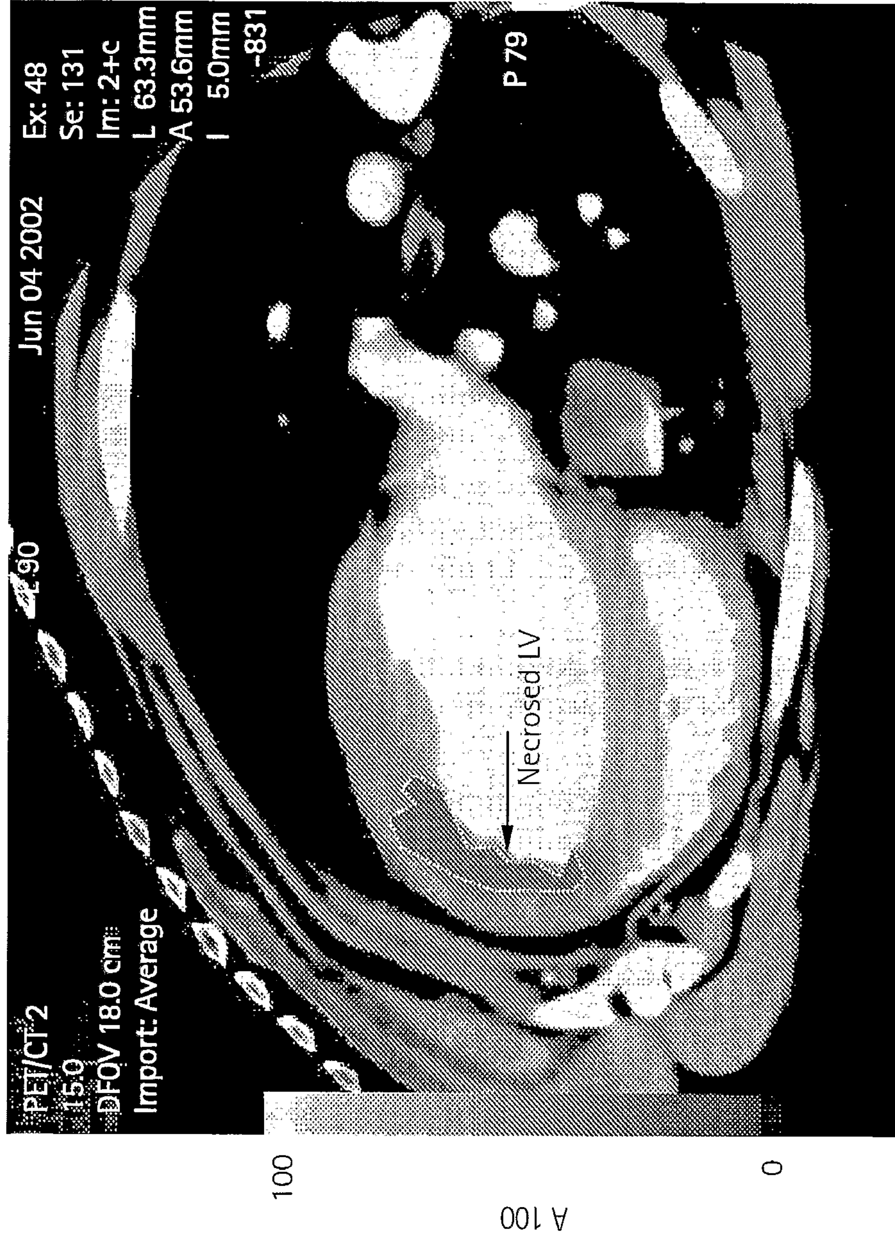


FIG. 3

FIG. 4



INTERNATIONAL SEARCH REPORT

International Application No
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A. CLASSIFICATION OF SUBJECT MATTER
IPC 7 A61B6/00 A61B19/00 G06F19/00

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)
IPC 7 A61B G06F

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)

EPO-Internal

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category °	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	EP 1 182 619 A (BIOSENSE INC) 27 February 2002 (2002-02-27) paragraph '0019! - paragraph '0036!; figures 1-3	1-6,8, 22-27
P,X	US 2003/187358 A1 (KNOPLIOCH JEROME ET AL) 2 October 2003 (2003-10-02) the whole document	1,3-6,8, 22-27
A	EP 1 321 101 A (PHILIPS INTELLECTUAL PROPERTY ; KONINKL PHILIPS ELECTRONICS NV (NL)) 25 June 2003 (2003-06-25) paragraph '0016! - paragraph '0024!	1,22
A	WO 91/07726 A (I S G TECHNOLOGIES INC) 30 May 1991 (1991-05-30) page 5, line 8 - page 11, line 10; figures 1,4,5	1,22

-/--

[X] Further documents are listed in the continuation of box C.

[X] Patent family members are listed in annex.

° Special categories of cited documents :

"A" document defining the general state of the art which is not considered to be of particular relevance

"E" earlier document but published on or after the international filing date

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"O" document referring to an oral disclosure, use, exhibition or other means

"P" document published prior to the international filing date but later than the priority date claimed

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"X" document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone

"Y" document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art.

"&" document member of the same patent family

Date of the actual completion of the international search	Date of mailing of the international search report
21 October 2004	28/10/2004

Name and mailing address of the ISA	Authorized officer
European Patent Office, P.B. 5818 Patentlaan 2 NL – 2280 HV Rijswijk Tel. (+31–70) 340–2040, Tx. 31 651 epo nl, Fax: (+31–70) 340–3016	Artikis, T

INTERNATIONAL SEARCH REPORT

International Application No
PCT/US2004/020909

C.(Continuation) DOCUMENTS CONSIDERED TO BE RELEVANT

Category °	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
A	US 2003/097219 A1 (LUO HUI ET AL) 22 May 2003 (2003-05-22) paragraph '0030! - paragraph '0039!; figure 6	1

INTERNATIONAL SEARCH REPORT

International application No.
PCT/US2004/020909

Box II Observations where certain claims were found unsearchable (Continuation of item 2 of first sheet)

This International Search Report has not been established in respect of certain claims under Article 17(2)(a) for the following reasons:

1. [X] Claims Nos.: 7,9-21
because they relate to subject matter not required to be searched by this Authority, namely:
Rule 39.1(iv) PCT - Diagnostic method practised on the human or animal body

2. [ ] Claims Nos.:
because they relate to parts of the International Application that do not comply with the prescribed requirements to such an extent that no meaningful International Search can be carried out, specifically:

3. [ ] Claims Nos.:
because they are dependent claims and are not drafted in accordance with the second and third sentences of Rule 6.4(a).

Box III Observations where unity of invention is lacking (Continuation of item 3 of first sheet)

This International Searching Authority found multiple inventions in this international application, as follows:

1. [ ] As all required additional search fees were timely paid by the applicant, this International Search Report covers all searchable claims.

2. [ ] As all searchable claims could be searched without effort justifying an additional fee, this Authority did not invite payment of any additional fee.

3. [ ] As only some of the required additional search fees were timely paid by the applicant, this International Search Report covers only those claims for which fees were paid, specifically claims Nos.:

4. [ ] No required additional search fees were timely paid by the applicant. Consequently, this International Search Report is restricted to the invention first mentioned in the claims; it is covered by claims Nos.:

Remark on Protest

[ ] The additional search fees were accompanied by the applicant's protest.

[ ] No protest accompanied the payment of additional search fees.

INTERNATIONAL SEARCH REPORT

Information on patent family members

International Application No
PCT/US2004/020909

Patent document cited in search report	Publication date	Patent family member(s)	Publication date
EP 1182619 A	27-02-2002	US 6650927 B1	18-11-2003
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patsnap

专利名称(译)	心脏成像系统和用于规划手术的方法		
公开(公告)号	EP1643911A1	公开(公告)日	2006-04-12
申请号	EP2004756376	申请日	2004-06-30
[标]申请(专利权)人(译)	通用电气公司		
申请(专利权)人(译)	通用电气公司		
当前申请(专利权)人(译)	通用电气公司		
[标]发明人	OKERLUND DARIN ROBERT SRA JASBIR LAUNAY LAURENT VASS MELISSA		
发明人	OKERLUND, DARIN, ROBERT SRA, JASBIR LAUNAY, LAURENT VASS, MELISSA		
IPC分类号	A61B6/00 A61B19/00 G06F19/00 A61B5/00 A61B8/00 A61B17/00 A61B90/00		
CPC分类号	A61B6/563 A61B5/7285 A61B6/504 A61B6/541 A61B8/543 A61B8/565 A61B34/10 A61B90/36 A61B2017/00243 G16H50/50		
优先权	10/708564 2004-03-11 US 60/484012 2003-07-01 US		
其他公开文献	EP1643911B1		
外部链接	Espacenet		

摘要(译)

用于为患者规划微创直接冠状动脉旁路（MIDCAB）的方法（200）包括从医学成像系统获得采集数据，以及生成冠状动脉和一个或多个感兴趣的心腔的3D模型（130）。在3D模型上识别一个或多个解剖标志（130），并且在介入系统上登记3D模型（130）的保存视图。使用介入系统可视化一个或多个已注册的已保存视图。