

(19)



(11)

EP 3 569 166 B1

(12)

EUROPEAN PATENT SPECIFICATION

(45) Date of publication and mention
of the grant of the patent:

04.03.2020 Bulletin 2020/10

(51) Int Cl.:

A61B 17/34 ^(2006.01) **A61M 5/32** ^(2006.01)
A61M 5/42 ^(2006.01) **A61B 5/00** ^(2006.01)
A61B 17/12 ^(2006.01) **A61M 1/10** ^(2006.01)
A61M 1/12 ^(2006.01) **A61B 34/30** ^(2016.01)

(21) Application number: **19171346.0**

(22) Date of filing: **02.12.2016**

(54) **A DEVICE FOR EMERGENCY TREATMENT OF CARDIAC ARREST**

VORRICHTUNG ZUR NOTFALLBEHANDLUNG EINES HERZSTILLSTANDS

DISPOSITIF POUR LE TRAITEMENT D'URGENCE D'UN ARRÊT CARDIAQUE

(84) Designated Contracting States:

**AL AT BE BG CH CY CZ DE DK EE ES FI FR GB
GR HR HU IE IS IT LI LT LU LV MC MK MT NL NO
PL PT RO RS SE SI SK SM TR**

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(30) Priority: **02.12.2015 EP 15197607**

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(43) Date of publication of application:

20.11.2019 Bulletin 2019/47

(62) Document number(s) of the earlier application(s) in
accordance with Art. 76 EPC:

16805427.8 / 3 324 867

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US-A1- 2015 065 916

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Description

FIELD OF THE INVENTION

[0001] The invention relates to automation of insertion of vascular catheters and in particular the invention relates to an automated device for deployment of such catheters.

BACKGROUND OF THE INVENTION

[0002] Cardiovascular disease contributes 30.9% of global mortality. Currently only 1 out of 10 survive a cardiac arrest to hospital discharge. It is responsible for higher mortality rates than any other disease in industrialized countries, and three-quarters of non-infectious mortality in developing countries. In the US there are around 350.000 cardiac arrests outside of hospitals; and at least as many inside hospitals. The potential for improvement is massive. In 2010, the cost of medical care for heart disease in the US was \$273 billion and the loss in productivity was \$172 billion.

[0003] By the early 1970s, CPR (Cardiopulmonary Resuscitation), defibrillation, and prehospital care were all in place. The introduction of automated defibrillation units (AED) expanded the possibility for prehospital treatment of cardiac arrest, and the first AED was successfully put to use by paramedics in Brighton in 1980. In spite of this, our current best practice only has the ability to achieve resuscitation, return of spontaneous circulation (ROSC), for around 25-30% of patients both in pre-hospital and in-hospital settings.

[0004] There is a change in the characteristics of the population suffering cardiac arrest. Ten years ago, broad population studies showed that around 70% of people suffering cardiac arrest had initial shockable rhythms (ventricular fibrillation or ventricular tachycardia) as the first documented electrocardiographic rhythm. Today, multiple large population studies note that only 20% to 30% of those suffering a cardiac arrest have a shockable rhythm as their initial rhythm.

[0005] The defibrillator is far from effective for everyone, even when stratifying for presenting rhythm. Roughly stated electricity cannot open an occluded coronary artery. There is rarely enough time to diagnose and treat the underlying cause of the cardiac arrest, and even defibrillation depends on optimizing hemodynamic variables beforehand. From other patient settings we know of and perform time-consuming treatments that could save the patients life but cannot currently be performed within the time constraints of a cardiac arrest.

[0006] This change in initial arrhythmia also has wide implications. We can try to defibrillate a shockable rhythm, but we have no truly effective treatments otherwise.

[0007] CPR and Defibrillation have been basically unchanged since their implementation. CPR cannot generate sufficient cerebral blood flow to preserve normal cer-

bral viability until cardiac function is restored. This explains why cardiac arrest has such high neurological morbidity and mortality. Therefore, we need new methods to improve cerebral blood flow and subsequent neurological outcome from cardiac arrest, especially if we want to do more efforts than defibrillation. Even if only defibrillation is performed, new methods to improve coronary blood flow can improve the likelihood of success from defibrillation.

[0008] As an example, coronary artery disease represents the most common cause of out-of-hospital cardiac arrest, but the treatment, percutaneous coronary intervention (PCI), cannot to be performed within the time limits of current CPR. Alternatively, even treatments of fibrinolytics and CABG (coronary artery bypass graft surgery), takes too long time to perform in a cardiac arrest.

[0009] Cooling (therapeutic hypothermia) has only proved useful in the patients that achieve a return of heartbeat, so-called ROSC (return of spontaneous circulation), and do not alter the proportion of those who achieve ROSC or not. Cooling slows down the cellular requirement, lowering the need to match the lowered supply - e.g. cerebral metabolic demands lower by about 8% per degree Celsius drop in temperature - but it usually takes hours to reach the desired temperature and is therefore not an effective way to bridge the patient in cardiac arrest to definitive treatment. By then, the patient is already irreversibly and totally neurologically damaged.

[0010] Late therapy like cardiopulmonary bypass or ECMO (extra corporal membrane oxygenation) devices, no matter how good, is never effective once the ischemic capability of the heart and brain is exceeded. Nevertheless, recovery may be improved by these devices, which unfortunately cannot be initiated fast enough in cardiac arrest to replace the need for an intermediate suspended state device.

[0011] Continued cardiac arrest will result in metabolic acidosis. Here e.g. sodium bicarbonate can maintain blood pH and plasmapheresis can clear the build-up of toxins.

[0012] US 2015/0065916 A1 discloses devices for automated vascular access.

OBJECTS OF THE INVENTION

[0013] It is an object of embodiments of the invention to provide means for automated deployment of a vascular catheter.

[0014] Particularly, it is an object of embodiments of the invention to enable the delivery of diagnostics and treatments that cannot currently be delivered to the patient in cardiac arrest, where almost universally only defibrillation and drug administration can be achieved within the current window of intervention of around 10-30 minutes.

SUMMARY OF THE INVENTION

[0015] It has been found by the present inventor that a main problem during cardiopulmonary resuscitation (CPR) of cardiac arrest patients is the fact that non-vital organs and tissues are perfused and supplied with oxygen at an - under these circumstances - unnecessary high level and that this happens at the expense of the CNS, in particular the brain, and the heart, which in contrast to these non-vital organs and tissues are highly sensitive to low oxygenation. Further it has been found by the inventor that if this imbalance during CPR could be changed to favour the perfusion of the CNS and the heart, then the chances of survival of these patients would be greatly enhanced.

[0016] However, it is normally necessary to perform a surgical intervention in order to establish preferential perfusion of the brain and heart in a patient and this surgical intervention requires the skills of a surgeon. On the other hand, staff of rescue teams is normally not surgeons so it is hence advantageous to be able to provide a device or system, which via a very simple intervention - which does not require surgical skills - can bring about the advantageous preferential perfusion of brain and heart.

[0017] The present inventor has hence realized a novel technological appliance and new methods. Unlike cooling (also referred to as 'suspended animation'), where the metabolism in the cells is slowed down considerably, which cannot be initiated fast enough if the cardiac arrest has already occurred, we wish to introduce a new term of 'suspended state', where the neurological damage process itself is put to a halt, by controlled redistribution of the cardiac output from chest compressions to the brain and heart - to create an increasing metabolic debt to the tissues that can tolerate this state, thus still keeping every single cell in the body viable. The use of a supraceliac aortic occlusion can increase the coronary and cerebral perfusion pressure with about a 100%, thus reaching viable levels again. We can extrapolate this from the use of cross clamps in surgical correction of aortic aneurysms, from the use of simple surgical balloon catheters in e.g. aortic aneurysm graft expansion and in the care of pelvic and truncal traumas, and that the remaining organs can tolerate this intervention for some time.

[0018] The use of vasodilator drugs can have a substantial impact on lowering the restriction on perfusion delivered to the brain and heart. For the first time we want to propose the use of a cardiac arrest aortic occlusion balloon therapy being used together with the addition of high-potency vasodilators, hereunder sodium nitropruside or high-dose nitro-glycerine, to create a high-flow state to the brain and heart with low microcirculatory resistance, while at the same mitigating the systemic vascular collapse caused by the vasodilator through the use of the aortic occlusion balloon.

[0019] Using this one or several abovementioned in a new bridge therapy could carry patients in cardiac arrest directly to definitive treatment methods, or to an interme-

diat intervention such as hypothermia or ECMO and subsequently to definitive treatment methods. However, these devices and methods will remain theoretical curiosities, if we do not also invent ways of putting them in the hands of the doctors, paramedics and nurses, that deliver the first-aid for patients in cardiac arrest, and not only in the hands of our specialist physicians in the receiving hospital departments. Alternatively the proposed methods can be used to increase the immediate resuscitation chances from e.g. defibrillation.

[0020] The population who suffers from cardiac arrest very often suffers from comorbid aortic atherosclerosis making the aorta fragile, brittle and porcelain-like. This makes it necessary to invent intelligent safe ways in which the redistribution can be carried out while protecting the anatomy of the patient to the maximum possible extent. The use of external abdominal aortic binding or compression as an alternative to an endovascular technique is therefore not without substantial risk and can lead to e.g. plaque rupture, dissection, wall rupture, or thromboembolic incidences.

[0021] On the other hand, leading a balloon catheter blindly without careful control of where and when the balloon exercises its pressure can lead to damage on the patient's anatomy, especially in the stressful situation of a cardiac arrest. If only verified by human estimation, the balloon catheter could inadvertently, how rare these incidences might occur, end in e.g. an arterial branch of the aorta, in a venous vessel side of the vascular system, in a dissection between layers of the aortic wall or in a tissue compartment outside of the vascular system.

[0022] Accordingly, the present invention provides an automated vascular catheter deployment device, which comprises means for detection of blood vessels and means for introduction of a catheter into a blood vessel, such as an artery or vein, wherein the means for introduction of the catheter comprises

- 1) means for motorized sideways movement of a percutaneous cannula or needle,
- 2) means for motorized introduction of the percutaneous cannula or needle into an artery or a vein via longitudinal axial movement of said cannula or needle, and
- 3) means for motorized introduction of the catheter into an artery or a vein through or across said cannula or needle;

wherein the device is comprised in a housing or frame that is configured to be applied to a position of a human limb selected from a group consisting of: frontal part of the thigh, frontal part of the pelvis, frontal part of the groin, the wrist, frontal part of the arm and/or frontal part frontal part of the neck.

[0023] To improve the existing methods for redistribution, and to enable safe redistribution for non-medical practitioners or semi-skilled practitioners, e.g. for rescue teams etc. the present disclosure also provides a device

or system for providing resuscitation or suspended state through redistribution of cardiac output to increase supply to the brain and heart for a patient, the device comprising

- an electrically or manually controllable redistribution component in the form of a catheter attachable to the patient and being configured to interact with the patient to provide redistribution of the cardiac output to increase supply to the brain and heart, the redistribution component following a predefined reaction pattern based on an electrical signal,
- computer means configured to 1) receive a patient data which identifies physiological and/or anatomical characteristics of the patient; and 2) provide the electrical signal for controlling the redistribution component and/or for presenting the physiological and/or anatomical characteristics for a user based on the patient data or a standard response, and.
- means for detection of blood vessels and motorized means for introduction of the catheter into an artery.

[0024] This device is useful not only in patients that have suffered a heart attack but also in patients where the supply of oxygenated blood to the brain and heart is inadequate for other reasons. An example is a patient having an asthma attack; in such a patient, the device disclosed herein can provide for rational distribution of the reduced amount of oxygen, which is available while the patient's respiratory system is compromised during the asthma attack.

[0025] When automatically operated, the redistribution operates in a predefined value, e.g. based on universal threshold values not directly connected to a specific patient, but the same may be attained if using manual operation - in that case the redistribution is controlled manually (e.g. by manually controlling an occlusion device, e.g. a balloon) in response to the measured values. Due to the electrically or manually controllable redistribution component and the ability of the computer means to receive patient data, the device can enable a redistribution taking the individual's actual aortic specifications into account. In this process, the ability of the computer means to provide electrical signals for the redistribution component (or for a device presenting data to the operator thereof) enables control of the redistribution component directly based on the received patient data and the predefined reaction pattern. Accordingly, the device facilitates a safe procedure in which a computer interacts with the patient based on knowledge on not only the patient but also knowledge regarding the redistribution component. According, the intervention can be predictable and repeatable compared to the procedure carried out manually based on an intuitive understanding of the patient.

[0026] For instance, the device can take the actual placement of a catheter head into account, whether the catheter is in an intended position or has ended in an

unintended position, withholding occlusion.

[0027] The term "redistribution" is in the present context intended to mean an intervention (preferably mechanical) that ensures that the cardiac output is preferentially directed to the brain and the heart in order to supply these two organs with sufficient perfusion of (oxygenated) blood at the expense of perfusion of other organs that are not highly supply sensitive over a limited time span.

[0028] The term "suspended state" is meant to denote a state in a cardiac arrest patient or other patient who is undergoing or to undergo treatment, where neurological damage processes are put to a halt by controlled redistribution.

[0029] The term "to bridge" is in the present context intended to mean an allowance to expand the time window of intervention for the patient to allow time for diagnostics and treatments and/or as an allowance to transport the patient from one physical location to another and/or an allowance to transfer the patient between the care of different professional groups of people.

[0030] The term "attachable" is in the present context intended to mean a tissue-device connection that allows for an interface of one the following: Outside a patient, onto a patient, through a puncture or surgical site and an interface that is implanted inside the patient.

[0031] The term "inflation" is in the present description and claims used in a broad sense and also includes a process where an object is expanded without literally being filled with a liquid or a gas. It will be understood that preferred implementations utilise an inflatable aortic expansion member (such as a fillable balloon), but expansion members that accomplish occlusion of a blood vessel via other reversible mechanisms are also understood to be "inflated" in the sense used herein. If, for instance, an aortic expansion member occludes an artery by being extended into a configuration that extends the expansion member's periphery by purely mechanical means, this is still understood as an inflation herein. Alternatives to inflation in its traditional sense are discussed *infra* in connection with the description of implantable versions of the device disclosed herein.

[0032] Due to the combination between an electrically or manually controllable redistribution component and the computer means configured to provide the electrical signal based on the patient data, the device disclosed herein becomes capable of facilitating a risk-mitigating factor.

[0033] The electrically or manually controllable redistribution component is attachable to the patient such that its interaction becomes independent of user error. Examples of redistribution components include aortic balloons, patient tilting devices and any other device, which is capable of providing blood redistribution in the patient.

[0034] An alternative to the use of such component is a redistribution component, which comprises or consists of an aortic retrograde perfusion pump. Relatively large volumes of aerated blood may be present in the periph-

eral vessels and making this blood volume accessible to the heart and brain can significantly increase the chances of survival.

[0035] The redistribution component can interact with the patient to provide redistribution of the cardiac output by following a predefined reaction pattern that means that a specific control signal provides a well-known and expected result. In that way, the electrical signal provided by a computer based on patient data enables a safer and more predictable treatment.

[0036] The computer means may include memory means, e.g. in the form of a so-called flash memory or similar computer memory containing re-definable data or fixed data. The memory means may include a predefined definition of the electrical signal as a response to the patient data.

[0037] In one example, the predefined definition is a function determining the electrical signal or a representation of the electrical signal as a function of the patient data, and in another example, the predefined definition is in the form of a table containing a representation of the electrical signal for corresponding patient data.

[0038] The patient data may e.g. include parameters selected from the group consisting of: aortic blood pressure, aortic blood flow, duration of cardiac arrest, expiratory CO₂, ECG, blood pressure, compression rate and depth, pulse, respiratory frequency, cardiac output redistribution degree, aortic O₂ saturation or concentration, cerebral or peripheral saturation, temperature, fluid administered, pharmaceuticals administered, biochemical data and ultrasound imaging.

[0039] The electrical signal may control function of the redistribution which in a controlled manner influence the patient and which is reflected in the patient data.

[0040] The device may further comprise patient data generation means configured to generate patient data during external cardiac compression carried out on the patient, the patient data generation means configured to generate the patient data by sensing biosignals from the patient. Examples of such biosignals are aortic pressure e.g. generated during cardiac compression (heart massage) or aortic blood flow e.g. generated during cardiac compression.

[0041] Accordingly, the patient data generation means may be configured to sense biosignals from a blood vessel or a tissue compartment. The patient data generation means may include one or more pressure and/or flow sensors including e.g. traditional pressure sensors and flow measuring devices of the kind known in the art.

[0042] In one embodiment, the redistribution component comprises an aortic expansion member, e.g. an aortic balloon with electrically or manually controlled inflation and/guiding means for positioning of the balloon in the aorta and being capable of expanding e.g. upon introduction of an expansion fluid medium. In other words the inflation means can be adapted to be capable of being operated manually by a user; this will normally require that the user is informed by the device about the values

that the automated version of the device receives. However, in the most user-friendly versions of the device/system of the inflation means is adapted to be capable of being operated automatically.

[0043] Particularly, the redistribution component may comprise an elongated body extending between a proximal end and a distal end. Herein, the distal end is that end which is insertable into the patient, and the proximal end is that end which is left outside the patient. The redistribution component may further comprise inflation means connected to the aortic expansion member for expanding the aortic expansion member, e.g. a traditional pump such as a roller or piston pump for pumping a fluid medium into the expansion member.

[0044] The expansion fluid medium could be a liquid or gaseous substance, e.g. a saline solution or helium.

[0045] The device may further comprise an adaptable tissue protection mechanism configured to:

- determine a blood pressure or blood flow present in a blood vessel of the patient during cardiac compression;
- determine an aortic expansion member characteristics defining a degree of expansion of the aortic expansion member based on the determined blood pressure or blood flow; and
- to provide an electrical signal for controlling the inflation means in accordance with the determined aortic expansion member characteristics.

[0046] The expansion member characteristics may e.g. be the pressure inside the expansion member, it may be a volume of the expansion fluid medium, which is introduced into the expansion member, or it could be represented by a degree of deformation of the expansion member etc.

[0047] The adaptable tissue protection mechanism could be configured to determine the aortic expansion member characteristics based on the determined blood pressure or blood flow multiplied by a predetermined factor, e.g. a factor being in the range of 1.0-1.2 times the pressure of the blood in the aorta during cardiac compression.

[0048] If the redistribution component is an aortic expansion member, the electrical signal may e.g. specify a degree of expansion, a timing of expansion, i.e. when the expansion member should be expanded, duration of expansion of the aortic expansion member, and/or a timing of contraction of the aortic expansion member - i.e. when the expansion member should be contracted to allow blood flow across the expansion member to thereby reduce the degree of redistribution of the cardiac output.

[0049] The device may therefore comprise means for specifying a degree of expansion of the expanding member, means for timing of the expansion, means for determining duration of expansion, and/or means for timing of

contraction of the expanding member. In one implementation, any of these means are controlled based on the patient data in combination with the above-mentioned pre-defined definition of the electrical signal.

[0050] The device may further comprise a location safety mechanism comprising at least one first sensor capable of determining a biosignal that is characteristic for the aorta of the patient and an electronic circuit configured to verify a position of the expansion member in the aorta based on the biosignal. The at least one first sensor may e.g. comprise a pressure sensor or a flow sensor or a force sensor or any other sensor of the biosignals discussed herein.

[0051] The first sensor could be located on the redistribution component to determine the biosignal in a position distal to the aortic expansion member. Typically, this means located either in a position distal to the aortic expansion member or in connection to a member positioned distal the aortic expansion member.

[0052] The device may be configured to use data from the first sensor in combination with data from sensors located at other locations, e.g. at least one other sensor located to determine the biosignal in a position proximal to the aortic expansion member, e.g. a sensor attached to the redistribution component. Typically, this other sensor would be placed caudal to the first sensor.

[0053] The data from the first and other sensors could be diastolic or systolic blood pressure or it can be pressure, force, distance, width, volume and/or flow.

[0054] The location safety mechanism may be configured to determine whether the aortic expansion member is located in a position selected from a group consisting of: a pulsating vessel in accordance with being the aorta of the patient, a pulsating vessel not in accordance with being the aorta, a pulsating vessel being indeterminate as the aorta of the patient, a venous vessel, a tissue compartment not being a blood vessel, a tissue compartment indeterminate in location. As an example, the location safety mechanism may thereby determine if the aortic expansion member is located in a renal artery, in tissue outside a blood vessel, in a blood vessel not being the aorta, and to determine when it is positioned, as desired, in the aorta.

[0055] The device may further comprise a second sensor inside the aortic expansion member or proximal to the expansion member.

[0056] The device may be configured with a feedback loop receiving data from at least one of the first and second sensor, to control the filling of the aortic expansion member. The feedback loop may e.g. be capable of controlling flow, volume, distance, width, force and/or pressure of the aortic expansion member, hereunder the filling of the member to reach a pressure that is the result of a standard the multiplication of the pressure sensed above the member and a predefined factor or interval.

[0057] The device may further comprise a first failsafe mechanism, configured to determine a pressure in the aortic expansion member and to determine a volume of

the aortic expansion member, to determine a ratio between the pressure and the volume, and to compare the ratio with an upper and lower threshold value, and to execute a control sequence including stopping of further inflation of the aortic expansion member or deflation of the aortic expansion member.

[0058] The control sequence could be carried out during a period of e.g. 10-20 seconds or longer. Alternatively, the filling is immediately stopped, or alternatively immediately reverted, due to a concern that the member might not be in the right vessel or tissue compartment.

[0059] In addition, the device/system may comprise a transponder and transceiver system for location verification of the redistribution component (e.g. a catheter) and/or the aortic expansion member (e.g. a balloon). Also a transponder and receiver system may be included to determine the position of the outer wall of the aortic expansion member to verify the degree of redistribution. Transponders may be based on any convenient and available technology and could be based on RFID (radio frequency identification) technology, Magnet, NFC (near field communication) technology; even optical communication is a feasible possibility. The relative locations of transponders and transceivers may vary - the transponder may be integrated into the parts of the system that are intended for introduction into the patient and the transceivers are in that case located externally, but the opposite arrangement is also feasible.

[0060] Another means for verification of position is to ensure that the redistribution device exhibits enhanced detectability for ultrasound detection devices - for instance, the redistribution component may be - at least partially - coated with a polymer that provides enhanced ultrasound detection, cf. Tavakoli, SM et al, 2001. ("Paper 401 presented at Society of Plastics Engineers Annual Technology Meeting SPE Antec 2001"). In this type of implementation, the ultrasound detection apparatus may be considered a "transceiver" while the polymeric coating can be regarded as a transponder because upon excitation (with ultrasound) emits a signal that can be detected as a result of a predefined reaction pattern of the polymer.

[0061] The term "transceiver" is used in the present application in its broadest sense to denote a system comprising a signal transmitter and a signal receiver, which may exist as one integrated unit or as separate units. Likewise, a transponder is used in a broad sense and denotes a device or composition of matter, which, when exposed to a defined signal, emits a detectable response signal.

[0062] In these additional systems for position verification, either the transponder or the transceiver is conveniently located on the external surface of the patient in a non-invasive manner.

[0063] The device may further comprise a user interface for use of selectable operation of the inflation means, e.g. a control button which controls operation of the inflation means directly such that the medical practitioner can initiate inflation or deflation of the expansion means

at will.

[0064] The device may comprise a halt interface allowing manually selectable deflation of the aortic inflation member, and the halt interface may be configured to execute the deflation over a period of time, such as a pre-defined number of seconds, e.g. over 1-10 or more seconds. This may cause a smoother and less stressing deflation and thus protect the heart function of the patient.

[0065] The device may comprise a patient state monitor configured to determine a biosignal representing Return of Spontaneous Circulation (ROSC), and to control deflation of the aortic expansion member based on the determined signal.

[0066] The device may further comprise an electronic human interface with a graphical or audio user interface configured to provide instructions or information related to the location and degree of filling of the aortic expansion member in the aorta of the patient. The user interface may e.g. be a graphical and/or audible user interface configured to provide instructions related to placement of the aortic expansion member in aorta of the patient and device and patient status feedback. E.g. "Filling underway"; "Balloon occlusion successful" or "Catheter head is outside of the aorta. Retract and try again". If the redistribution component and/or occlusion means is manually operated the instructions provided may be more detailed and can e.g. provide details about the status of the redistribution efforts to the user.

[0067] The device disclosed herein may provide the anatomical verification of placement of the expansive member in an arterial vessel by the use of at least one sensor for determining pressure, flow and/or volume data significant for pressure, flow and/or volume of a fluid inside the expansive member or inside a blood vessel or tissue of the patient.

[0068] The user interface may communicate with the sensor, and based on signals from the sensor, the device may determine a plausible position of the expanding member in the body of the patient and provide user instructions via the electronic human interface based on the plausible position.

[0069] The computer means may e.g. be configured to compare the pressure; flow and/or volume data with reference input data and based on the comparison to verify a position of the aortic expansion member in the body. I.e. when the expansion member is in an intended position in the aorta, the corresponding pressure, flow and/or volume data should be within a certain expected upper and lower limit. If it is outside of this expected limit, the user may be notified that the expansion member is possibly not in correct position or approximated damaging the patient and was therefore stopped. Should the device find another position which corresponds to the determined pressure, flow and/or volume data, the user may be notified, e.g. by a graphical representation of the aorta and the expansion member, which position appears to be the actual position. Thus the device disclosed herein may comprise an interactive human user guide config-

ured to provide information related to a position of the aortic expansion member in the patient, the information being determined based on the pressure, flow and/or volume data.

[0070] The computer mean can then determine the size and type of blood vessel by analysing the pressure, flow and/or volume data continuously, and activate a fail-safe for some verified positions in the body, thereby stopping the redistribution component interaction with the patient.

[0071] The computer means can use the input data to determine and deliver the lowest needed impact from the aortic expansion member to accomplish the redistribution and carry out said redistribution.

[0072] A device is thus disclosed herein with a built-in safety mechanisms for verification of the intervention, to withhold the potentially damaging effort, the expansion of an occlusion balloon within a patient, when and where it ought not to happen - To put the technology of 'suspended state' in the hands of trained first-responders, not only physicians. This will enable a new intervention that spearheads new opportunities for treatment that is not possible within the current time window of 10-30 minutes. The time-expanding intervention would be initiated in a cardiac arrest once initial defibrillation and drug treatment prove useless.

[0073] Particularly, the device may be used in e.g. the following protocol, which specifies:

- 1) Initiate and continue either manual or automatic chest compressions, possibly preceded by administration of tissue protectant e.g. recombinant human erythropoietin.
- 2) Attempt defibrillation of the patient. 3) Cardiac arrest won't revert. Decision to use safe device for aortic occlusion. 4) Turn on device. Administer safe aortic occlusion through device mechanisms. 5) Attempt to defibrillate the patient again with the improved hemodynamics after the occlusion. 6) If unsuccessful, potential administration of a vasopressor, e.g. vasopressin. This is a clinical decision based on presumed cause of arrest e.g. anaphylaxis. Repeat administration periodically. Potential administration of a vasodilator, e.g. sodium nitroprusside. This is a clinical decision based on presumed cause e.g. refractory coronary artery disease. Potential periodic repetition of either drug and/or administration before use of Device. 7) Cardiac arrest won't revert => Decision to put patient in suspended state. 9) Potential application of 30-90 degree head down or head up tilt. 10) Potential application of intravascular 2 degree Celsius saline solution, surface cooling pads on body, hypothermic total liquid ventilation and/or administration of muscle relaxant. 12) Potential administration of a vasodilator, e.g. sodium nitroprusside, to improve suspended state microcirculation. Potential periodic repetition of vasodilator administration. 13) Transport to Specialist Center. 14) Initiate in-hospital cardiopulmonary bypass, ECMO or deliver e.g. PCI-treatment directly. 15) Potential plasmapheresis or dialysis. 16) Achieve return of patient heartbeat with other means possible. 17) Continuation

of cooling for additional 24 hours after return of heartbeat. 18) Prognosticate the patient after at least 72 hours of sustained therapy. 19) Continuous monitoring of treatment with e.g. end-tidal CO₂, aortic pressure or trend-NIRS measurement, attached from the very beginning to evaluate efforts.

[0074] To further increase the safety and to provide improved information e.g. related to the position of the aortic expansion member in the body, the device may comprise means for ultrasound imaging. Data from such means may be used for guidance of the user.

[0075] If the aortic expansion member is an aortic occluding balloon, the device may comprise means for filling the aortic occluding balloon with a liquid, e.g. with saline, or a gas, including e.g. helium or CO₂, and measuring the aortic pressure and balloon pressure. In an interesting implementation, the device further comprises a handheld unit comprising the computer means and the filling means and being attachable to the aortic occluding balloon. In another interesting implementation, the device further comprises a human interface unit comprising the filling means and being attachable to the aortic occluding balloon, said human interface optionally being attachable in a fixed position on a patient and wherein said human interface is optionally integrated with the human interface described above or with the handheld unit. In both cases, the aortic occluding balloon can be pre-attached to the handheld unit.

[0076] When the human interface is being attachable in a fixed position, it is convenient that the interface can accommodate the shape of the underlying surface of the patient or a physical surface in the vicinity of the patient. It also convenient that the interface can accommodate to external pressure exerted on the outer surface of the patients (e.g. when the interface is introduced the patient's surface and other equipment attached - such as a pelvic splinter or pelvic sling - to the patient). This capability of accommodation can e.g. be achieved in preferred implementations where selected parts of the interface are comprised of a flexible material, such as a soft plastic material, where an adhesive is present on the patient engaging part of at least parts of the flexible material.

[0077] The computer means could be configured not only to communicate the electrical control signals to the redistribution component but also to receive input data from the redistribution component. The redistribution component may include a sensor function e.g. specifying faults, or providing data relevant for controlling the redistribution component. Such data may include data indicating a lack of expansion, use of the redistribution component, e.g. the number of expansions and contractions, which have been attained.

[0078] The device may further comprise a component attachable to the patient and being configured to administer fluids and drugs to the patient. The administering of such fluids and drugs may be controlled by the computer means of the device, and feedback regarding the administration of the fluids or drugs may be provided via the

aforementioned electronic user interface.

[0079] The component for administering fluids and drugs to the patient may e.g. be configured for administering timed and controlled amount of fluids and/or drugs.

[0080] The device may further comprise additional components, e.g. components from the group consisting of: a patient monitor, a vitals signs monitor, a watch, an external chest compression device, a respirator, an ECG monitor, a defibrillator, a pacemaker, a pH measurement device, an ultrasound device, an ECMO/ECLS device, a body cooling device, an infusion pump, a capnograph, a ventricular assist device, a dialysis device, touchscreen and a telecommunications device. An interesting implementation, when the device integrates a defibrillator is to include in the catheter carrying the occlusion device at least one electrode that allows the establishment of a voltage difference between the catheter (i.e. the interior of a vessel such as the aorta) and an external electrode, e.g. place on the anterior chest wall.

[0081] The redistribution component may comprise means for tilting the patient in a head down tilt orientation or for tilting the patient in a head up position. The first may provide a sometimes advantageous increase in blood pressure in the redistribution compartment, whereas the latter may alleviate the resistance against the venous blood leaving the brain and heart. Both of these may be advantageous for a patient in a redistributed state depending on how the patient's physiology presents itself in this new type of treatment.

[0082] The device may further comprise means for a self-test system, double circuitry, and usage event data recording.

[0083] In interesting implementations the device disclosed herein is able to receive a signal of, or being able itself sense that the patient is in a state of cardiac arrest or reduced cardiac output, the device being able to respond to that state with an increase in blood flow and/or pressure towards the cranial side of the patient, through a separate member, or through a part of the device being intravascular. In other words, in this implementation the device is adapted to be permanently present (implanted) in a patient (typically a patient likely to suffer from cardiac arrest). In this implementation, the device can respond to a decrease in blood pressure and/or blood flow and/or heart rate and/or any other relevant indication of cardiac arrest and automatically effect redistribution of cardiac output so as to preferentially supply the heart and brain. It is especially preferred in this implementation that the device acts in coordination with e.g. a cardiac pacemaker or other implanted devices in order to further enhance chances of survival. Conveniently, the device is capable of signalling to an external source that the patient is said state, e.g. to alert EMS to locate and attend the patient.

[0084] So, a device is disclosed herein, where the device is adapted to be delivered to and implanted within a human body. Typically, such a device will be present in the patient in a "resting state" and will only become active to effect redistribution when the patient's physio-

logical state so demands, for example when the systolic blood pressure drops below a predetermined value over a period of time considered to be relevant for intervention. Relevant positions of the redistribution component and the occlusion component will be the descending aorta (preferably in suprarenal segment of the descending aorta).

[0085] Such an implantable version will have to be anchored in a position so as to be permanently attached in the position where it can become active. For instance, the device can be anchored using struts or have an expandable frame as the ones known from implantable stents and valves or similar systems known by the skilled person.

[0086] Also, such an implantable version will have to be able - on demand - to occlude the vessel where it is positioned and hence need to include a power source - e.g. a battery or a capacitor; also the necessary sensors of the device need to be powered to provide correct measurements of relevant physiological parameters. The power sources may be rechargeable, e.g. via induction or other wireless energy transmission, but the device may also include a minor turbine (e.g. with or without a rotatable impeller) driven by the blood-flow. Also, the patient may have an implanted electrical wire that can supply the necessary recharging power.

[0087] The occlusion exerted by the implantable version can be attained in several ways: the occlusion component may be a motor-driven mechanical iris or other mechanical device such as a motor-driven shutter corresponding to those found in a camera. Alternatively, controllable valves that are released upon an adequate signal can provide this effect. Finally a balloon which is expanded by the patient's blood is a possibility as is use of reversible gas generation process (classical electrolysis). It will be understood that occlusion attained in this way may also be useful in the non-implantable versions of the device disclosed herein and that the methods for attaining the occlusion are considered "inflation" of an expansion member as discussed above.

[0088] As with other devices disclosed herein, the implantable version can be configured to be catheter-deployable by methods generally known in the art, cf. e.g. the methods described by Procyron, cf. US 2014/0128659.

[0089] An implantable device is schematically set forth in Fig. 14.

[0090] During insertion, there may exist a safety risk if each procedure step is not carried out correctly and finalized before the next procedure begins. Particularly during insertion of the aforementioned elongated body constituting in one implementation the redistribution component, it is of particular importance to ensure a systematic insertion approach.

[0091] Accordingly, the device may comprise an aortic detection and puncture means configured for attachment to the patient and being configured to operate in at least five distinct operation phases including a vessel detection

phase, a vessel puncture phase, a vessel insertion phase, a catheter dilatation phase, and a confirmation phase. Data related to one phase may be stored and used subsequently when carrying out the next phase.

[0092] As is apparent from the above, the inventive device is configured with means for detecting the location of blood vessels and (motorized) introduction of a cannula into an artery. For instance, the device can comprise 1) means for motorized movement of a percutaneous cannula (in a direction parallel to a patient's surface, i.e. the movement is sideways and will not move the cannula along its own axis or along an axis that brings it in contact with the patient), which is either in a fixed or motorized adjustable angle relative to the patient's surface, 2) means for the motorized movement of a redistribution component through said cannula or needle into a patient. Part of the means for motorized movement of the redistribution component can be a means for motorized movement of the cannula/needle along an axis that introduces it into the patient.

[0093] It is believed that a separate, independent invention is related thereto. Therefore, this independent invention relates to an automated vascular catheter deployment device; this device is configured with means for detecting the location of blood vessels, means for the motorized movement of a percutaneous cannula, which is in in a fixed or motorized adjustable angle relative to the surface of a patient, and means for the motorized movement of a catheter through or across said cannula or motorized movement of a catheter already located inside said cannula or located on the outside of said cannula.

[0094] Hence, the invention relates to an automated vascular catheter deployment device, which comprises means for detection of blood vessels and means for introduction of a catheter into an artery wherein the means for introduction of the redistribution component comprises 1) means for motorized sideways movement of a percutaneous cannula or needle, 2) means for motorized introduction of the percutaneous cannula or needle into an artery via longitudinal axial movement of said cannula or needle, and 3) means for motorized introduction of the catheter into an artery through or across said cannula or needle, and wherein the automated vascular catheter deployment device is situated in a housing or frame configured to be a position on a human limb selected from one or more members of the group consisting of the frontal part of the thigh, the frontal part of the pelvis, the frontal part of the groin, the wrist, the frontal part of the arm, and the frontal part of the neck

[0095] The means for detection of blood vessels may comprise an ultrasound detection component, an infrared or near-infrared imaging component. Also, the cannula or needle may be able to move sideways in a fixed or adjustable angle, preferably along a rail or cable. In both the specific device described above as well as in the automated vascular catheter deployment device of the invention, the detection means will conveniently in-

clude at least one means for detecting an artery, in particular the femoral artery. For example, the detection means may include an ultrasound transmission and/or sensor element, or an element for near infrared or infrared imaging. The motorized movement system will typically be configured to allow the component for the motorized movement of the cannula to move attached to a motor that travels on a rail in housing or a frame that is attached to the patient. Hence, the cannula will move in the manner of the print head nozzles of an inkjet printer, e.g. through a step motor, pneumatic motor or hydraulic motor.

[0096] In one specific embodiment, the automated vascular catheter deployment device is situated in a housing or frame that can be attached to the upper part of the frontal part of a patient's thigh (the part that covers A. femoralis). In the housing or frame, the vessel detection means will - when activated - scan an area between the medial and lateral side of the frontal face of the upper part of the covered region to identify the location of the most likely candidate for the femoral artery. Based on this location determination, the cannula is moved by a motor on its rail to point directly towards the identified artery. Subsequently, the cannula is introduced by motorized action into the artery and finally the catheter is automatically inserted. The cannula insertion system of US 2009/0275823 or US 2011/0301500 both are useful implementation of the part of the system for introduction of the Cannula.

[0097] Also, the automated vascular catheter deployment device may be situated in a housing or frame configured to be applied to other positions on human limbs, e.g. selected from one or more members of the group consisting of the frontal part of the thigh, the frontal part of the pelvis, the frontal part of the groin, the wrist, the frontal part of the arm, the frontal part of the arm, and the frontal part frontal part of the neck. In the cases where the automated catheter deployment device is used to introduce the device disclosed herein for providing resuscitation or suspended state, the housing or frame is configured to be applied one or more members of the group consisting of the frontal part of the thigh, the frontal part of the pelvis, and the frontal part of the groin, i.e. those locations where it is possible to get access to A. femoralis.

[0098] A detailed figure showing embodiments of the automated vascular catheter deployment device of the invention is set forth in Fig. 15.

[0099] The computer means of the device/system disclosed herein may be adapted to communicate with at least one other therapeutic and/or monitoring device so as to allow coordination of the operation of said therapeutic devices (or simply coordination with other therapeutic measures) and the device according to any one of the preceding claims. This at least one other therapeutic and/or monitoring device is preferably selected from a cardiac resynchronization therapy device, a cardioverter-defibrillator, and a cardiac pacemaker; another possibility is a capnograph, i.e. a device for measuring

CO₂ pressure or saturation in exhaled breath.

[0100] Examples of coordination between therapeutic devices could e.g. be the coordination between timing of defibrillation and the control of the degree of occlusion exerted by the aortic expansion member - it could e.g. be relevant to relax the aortic expansion member immediately prior to defibrillation in order to avoid exposure of the heart to an excessive afterload. Also it is possible for certain patients to relax the occlusion immediately after defibrillation - again to avoid an excessive afterload.

[0101] In situation where chest compression are administered automatically it is also of relevance to control the cessation of automatic compressions in coordination with the degree of redistribution, e.g. the occlusion exerted by the occlusion device - the aortic expansion member may e.g. be relaxed following cessation of automatic chest compression and prior to defibrillation in order to optimize the chances that the heart will return to spontaneous rhythm, because this order of events decreases the mechanical irritability of the heart.

[0102] The computer means may also receive and process signals from a device/means (either separate or integrated into the device and systems disclosed herein) that gauges a central venous pressure, thereby enabling calculation of the coronary perfusion pressure (CPP) in a patient and presenting the CPP as part of the output in the device/system disclosed herein - the CPP is calculated from the received signal of a measured central venous pressure and a measured aortic pressure.

[0103] A convenient way of achieving coordination with a defibrillator is to integrate defibrillating capability into the device disclosed herein. From a practical viewpoint, it is by this implementation ensured that the electric shock provided during defibrillation will be present in the relevant anatomical region and thereby it is enabled to use substantially lower electric power than in the situation where external electrodes are applied. In practice, the device disclosed herein can include one or both of the defibrillation electrodes - the latter implementation will typically include use of a second, external, electrode positioned on the patient's body so as to ensure that defibrillation establishes a short-lived electric circuit through the hearts. The skilled artisan will know where to optimally place the second electrode.

[0104] One device or system disclosed herein is a device or system for providing resuscitation or suspended state through redistribution of cardiac output to increase supply to the brain and heart for a patient, the device comprising

- an electrically or manually controllable redistribution component in the form of a catheter attachable to the patient and being configured to interact with the patient to provide redistribution of the cardiac output to increase supply to the brain and heart, the redistribution component following a predefined reaction pattern based on an electrical signal,

- computer means configured to 1) receive a patient data which identifies physiological and/or anatomical characteristics of the patient; and 2) provide the electrical signal for controlling the redistribution component and/or for presenting the physiological and/or anatomical characteristics for a user based on the patient data or a standard response, and.
- means for detection of blood vessels and motorized means for introduction of the catheter into an artery wherein
- the redistribution component comprises 1) an elongated body extending between a proximal end and a distal end, the distal end being insertable into the patient, and 2) an aortic expansion member and inflation means connected to the aortic expansion member for expanding the aortic expansion member,
- said device comprises a location safety mechanism comprising at least one first sensor capable of determining pressure distal to the aortic expansion member, where the pressure is characteristic for aorta of the patient, and an electronic circuit configured to verify a position of said expansion member in aorta based on said pressure,
- said device optionally comprises at least one second sensor of pressure inside the aortic expansion member or proximal to the expansion member, and
- said device is configured with a feedback loop receiving pressure data from at least one of said first sensor and optional second sensor to control the filling of the aortic expansion member so as to control the pressure of the aortic expansion member.

[0105] This particular implementation takes advantage of the dual use of measurements from the first sensor. As detailed herein, the first sensor is in implementations capable of determining the (blood) pressure in a position distal to the aortic expansion member. When the redistribution component, e.g. the catheter, is correctly inserted, this measurement will when the expansion member has occluded the aorta provide for the aortic pressure, which will vary synchronously with the heart rate or manual chest compressions. If incorrectly inserted (e.g. into a renal artery), the measurement from the first sensor will be constant (typically around zero) after the expansion member has occluded the blood vessel - thus, the measurement immediately indicates that the catheter has been incorrectly positioned and the occlusion by the expansion member can be terminated. In other words, the measurement from the first sensor provides a direct indication of correct or incorrect insertion of the redistribution component and aortic expansion member. At the same time, the measurements from the first sensor indicates the pressure that at least has to be exceeded by the aortic expansion member when engaging with the aortic wall in order to occlude the aorta. But this provides

the advantage that this occluding pressure can be attained but not exceeded to too high a degree; thereby it can be prevented that the aortic occlusion is made with such a high pressure or force on the aortic wall that the tissue would be damaged.

METHODS DISCLOSED HEREIN

[0106] As will be apparent, the presently described device is useful in methods for providing resuscitation or suspended state in a human cardiac arrest patient, said method comprising subjecting the patient to heart massage (chest compression which may be manual or accomplished by use of a mechanical chest compression device) while at the same time ensuring redistribution of the cardiac output to preferentially supply blood to the brain and the heart; these methods need not necessarily utilize the device disclosed herein as will also be apparent. In other patients, where the heart action is not compromised, but where the heart and/or brain receives insufficient amounts of oxygenated blood such as in patients suffering from acute asthma attacks, the chest compressions are dispensed with, since it is only necessary to ensure proper redistribution of the blood.

[0107] It is nevertheless preferred that methods for resuscitation or suspended state provision in a human entails deploying the device disclosed herein by introducing the redistribution component of said device into the aorta of said human (preferably via the femoral artery) and expanding the aortic expansion member so as to occlude the descending aorta, thereby redistributing the cardiac output to preferentially supply blood to the brain and the heart

[0108] In said methods, the redistribution is typically accomplished by at least one of the following:

- occlusion of the aorta caudal to the left subclavian artery;
- head-down or head up tilting of the patient so as to reach an angle of between 30 and 90 degrees relative to the horizontal plane;
- applying an external compression force onto the abdomen and/or thigh(s) and/or arm(s) so as to reduce the perfusion distal to the external compression force;
- passively raising the legs to reach an angle between 30 and 90 degrees relative to the horizontal plane.

[0109] The method may be combined with at least one of the following treatments of the patient:

- administration of fluids, including saline and buffers such as bicarbonate,
- administration of vasopressive drugs, including vasopressin and analogues,
- administration of a tissue-protecting agent, such as erythropoietin;
- administration of anti-arrhythmic drug, such as ami-

odarone;

- reduction of body temperature, such as by use of cold IV-fluid infusion, cooling catheters, transnasal evaporative cooling, extracorporeal cooling or total liquid ventilation with temperature controlled perfluorocarbons. This may be done repeatedly, optionally according to a fixed sequence.

[0110] The method according preferably comprises that redistribution is accomplished by occlusion of the aorta caudal to the left subclavian artery and even more preferred by use of a device disclosed herein for this purpose. For instance, occlusion can be accomplished by introducing a device disclosed herein into the aorta, preferably via the femoral artery, and subsequently decreasing or interrupting the blood flow distal to the redistribution component by expanding the redistribution component of said device. In this implementation it is preferred that the redistribution component is expanded in a controlled manner in response to measurement(s) that indicate the degree of occlusion and correct placement of said device in the patient's aorta. As indicated above in the discussion of the device disclosed herein, this occlusion and placement may be fully automated or manually operated. The measurements are typically selected from the group consisting of:

- duration of expansion redistribution component usage;
- blood flow passing by the redistribution component;
- blood pressure distal of the redistribution component, optionally combined with blood pressure proximal to the redistribution component;
- aortic O₂ saturation distal of, and preferably in close proximity to, the redistribution component, optionally combined with arterial O₂ saturation proximal of the redistribution component.

[0111] It is preferred that expansion of the redistribution component is controlled manually or by the computer means of the device to avoid incorrect positioning or expansion degree of said device and by activating the fail-safe of claim 9 in case said device is verified to be incorrectly positioned thereby interrupting the expansion of the redistribution component to allow subsequent correct positioning. In broad terms, the method preferably includes means and measures that avoid incorrect redistribution of blood flow.

[0112] In certain implementations redistribution is temporarily interrupted at regular or irregular intervals so as to ensure sufficient perfusion of all parts of the body of the patient. However, some caution must be exercised due to spontaneous dilation of blood vessels in the non-perfused part of the body during the redistribution, meaning that reestablishment of the redistribution state can be difficult.

[0113] The method disclosed herein may act during or as a bridge to one or more of

therapeutic hypothermia; angioplasty, including PCI and angiography; dialysis; administration of drugs such as vasopressors, thrombolytic drugs such as fibrinolytics, fluids, bicarbonate, antidotes, and antiarrhythmic drugs; the use of ultrasound, X-ray, CT, or MR; intubation; mechanical ventilation; ventricular assist devices; heart transplantation, including artificial heart transplantation; surgery, including CABG surgery and valve surgery; blood transfusion; placement of external or internal pacemaker or ICD; catheter ablation; thromboendarterectomy; defibrillation; transportation; ECMO; ECLS and cardiopulmonary bypass. In other words, the method may be combined with any one of a number of other methods that are commonly used in resuscitation.

[0114] The method may further comprise that the restriction on perfusion delivered to the brain and heart is lowered through the use of a vasodilator, hereunder specifically sodium nitroprusside or nitroglycerin and repeated administration of sodium nitroprusside or nitroglycerin, hereunder repetition in intervals of 2-10 minutes. This may be combined with the use of an aortic expansion member to prevent the systemic vascular collapse caused by the vasodilator.

[0115] The method disclosed herein can also be combined with the use of any one of the following: active compression-decompression CPR, an impedance threshold device, adenosine administration, controlled pauses in the CPR (e.g. compressions for 20 seconds, then a pause in compressions for 20 seconds.)

[0116] A related method disclosed herein for providing resuscitation or suspended state through redistribution of cardiac output to increase supply to the brain and heart for a human in cardiac arrest or imminent cardiac arrest comprises subjecting the patient to external chest compression while at the same time ensuring redistribution of the cardiac output accomplished by occlusion of the aorta caudal to the left subclavian artery, and comprising lowering the restriction on perfusion delivered to the brain and heart through the use of a vasodilator, hereunder specifically sodium nitroprusside or nitroglycerin, hereunder repetition in intervals of 2-10 minutes. Also this method may act as a bridge to one or more of the following:

ECMO; ECLS; cardiopulmonary bypass; angioplasty, including PCI and angiography; dialysis; therapeutic hypothermia, hereunder cold IV-fluid infusion, cooling catheters, transnasal evaporative cooling, extracorporeal cooling or total liquid ventilation; administration of drugs, hereunder vasopressors or vasodilators, hereunder sodium nitroprusside or nitroglycerin, thrombolytic drugs such as fibrinolytics, fluids, bicarbonate, antidotes, tissue-protecting agents and antiarrhythmic drugs, such as amiodarone; the use of ultrasound, X-ray, CT, or MR; intubation; mechanical ventilation; ventricular assist devices; surgery, including CABG surgery and valve surgery; blood transfusion; placement of external or internal pacemaker or ICD; catheter ablation; thromboendarterectomy; heart transplantation; defibrillation; transporta-

tion.

[0117] A second related method for providing resuscitation or suspended state through redistribution of cardiac output to increase supply to the brain and heart for a human in cardiac arrest or imminent cardiac arrest, comprises subjecting the patient to external chest compression while at the same time ensuring redistribution of the cardiac output accomplished by sustained abdominal compression or abdominal binding, and comprising lowering the restriction on perfusion delivered to the brain and heart through the use of a vasodilator, hereunder specifically sodium nitroprusside or nitroglycerin, hereunder repetition in intervals of 2-10 minutes, and comprising acting as a bridge to one or more of the following: ECMO; ECLS; cardiopulmonary bypass; angioplasty, including PCI and angiography; dialysis; therapeutic hypothermia, hereunder cold IV-fluid infusion, cooling catheters, transnasal evaporative cooling, extracorporeal cooling or total liquid ventilation; administration of drugs, hereunder vasopressors or vasodilators, hereunder sodium nitroprusside or nitroglycerin, thrombolytic drugs such as fibrinolytics, fluids, bicarbonate, antidotes, tissue-protecting agents and antiarrhythmic drugs, such as amiodarone; the use of ultrasound, X-ray, CT, or MR; intubation; mechanical ventilation; ventricular assist devices; surgery, including CABG surgery and valve surgery; blood transfusion; placement of external or internal pacemaker or ICD; catheter ablation; thromboendarterectomy; heart transplantation; defibrillation; transportation.

[0118] During development work of the present invention, the inventor has realized that the controlled occlusion of blood vessels that is obtained by the device disclosed herein has a wider range of applications.

[0119] For instance, when performing surgery of a patient where excessive bleeding occurs, it may be inexpedient to interrupt the bleeding by traditional means (such as compression or suture of influent blood vessels), since some patients' vasculature may be too fragile and/or to sclerotic to allow such approaches. In such patients the introduction of an occlusion device, which in principle functions and is operated like the above-discussed aortic expansion member, but is dimensioned so as to be able to expand and safely occlude smaller vessels, is believed to provide a much less traumatic way of preventing blood from reaching the traumatized area where bleeding occurs.

[0120] So also disclosed is a method for stopping or reducing bleeding from tissue(s) or organ(s) during surgery of said tissue(s) or organ(s), the method comprising inserting an occlusion device into a blood vessel, which supplies said tissue(s) or organ(s) with blood, wherein said occlusion device is reversibly expanded to occlude said blood vessel and wherein the pressure exerted by the expanded occlusion device on the wall of the blood vessel is adapted to be between 1 and 2 times the vascular pressure difference across the occlusion device.

[0121] Typically, the pressure exerted by the expand-

ed occlusion device on the wall of the blood vessel is adapted to be at most 1.5 times the vascular pressure difference across the occlusion device, such as at most 1.3, at most 1.2, and at most 1.1 times; the important goal to reach is to not traumatize the vascular wall, and in certain implementations, the occlusion device is expanded up to exactly or just above the point where the pressure is sufficient to prevent blood from passing the device in the blood vessel.

[0122] The occlusion device will typically include or be attached to at least one vascular pressure sensor, which can determine the vascular pressure in said blood vessel. Such a pressure sensor can be positioned in said vessel between the occlusion in said vessel and said tissue(s) or organ(s) and/or positioned in the part of said vessel which is separated from said tissue(s) or organ(s) by the occlusion. In the first case, the occlusion device is sufficiently expanded when the pressure sensor can no longer measure fluctuations in vascular pressure, in the second case, the occlusion device is sufficiently expanded when the pressure exerted on the vessel's walls by the device is equal to or slightly higher than the measured vascular pressure.

[0123] Further disclosed is a method for stopping or reducing bleeding from tissue(s) or organ(s), hereunder during e.g. surgery or other situations where bleeding occur of said tissue(s) or organ(s), the method comprising inserting an occlusion device (such as a device disclosed herein) into a blood vessel, which supplies said tissue(s) or organ(s) with blood, wherein said occlusion device is reversibly expanded to occlude said blood vessel and wherein the pressure exerted by the expanded occlusion device on the wall of the blood vessel is adapted to be between 1 and 2 times the vascular pressure difference across the occlusion device. In this implementation, use is made of the same pressure measurements and controls that define the device disclosed herein but the pressure measurements are interpreted to provide for a different use, namely to induce arrest of bleeding of an organ. The advantage is that the vessels which are occluded are not subjected to excess stress, thus preventing damage to the vessels under such operation.

DETAILED DESCRIPTION OF IMPLEMENTATIONS

[0124] In the following, embodiments of the invention will be described in further details with reference to the drawing in which:

- | | | |
|----|--------|---|
| 50 | Fig. 1 | illustrates a device according to the invention; |
| | Fig. 2 | illustrates functions of a device according to the invention; |
| 55 | Fig. 3 | illustrates a user interface; |
| | Fig. 4 | illustrates a digital sensing component; |

- Fig. 5 illustrates software functions;
- Figs. 6-7 illustrate an aortic expansion member;
- Fig. 8 illustrates a user interface screen on a PC;
- Fig. 9 illustrates placement in a human being;
- Fig. 10 illustrates attachment of the device to a limb of a patient;
- Fig. 11 illustrates a retrograde pump; and
- Figs. 12a-12e illustrate an implanted device.
- Fig. 13 illustrates an arrangement of a catheter in a state ready for insertion.
- Fig. 14 illustrates implementations of implanted devices.
- Fig. 15 illustrates an automated vascular catheter deployment device of the invention.

[0125] Further scope of applicability of the present invention will become apparent from the following detailed description and specific examples. However, it should be understood that the detailed description and specific examples, while indicating preferred embodiments of the invention, are given by way of illustration only, since various changes and modifications within the scope of the invention will become apparent to those skilled in the art from this detailed description.

[0126] Redistributing the cardiac output during cardiac arrest may be carried out with the device illustrated in Fig. 1, performing e.g. according to the algorithm structure illustrated in Fig. 2, and working in conjunction with a human user interface as illustrated in Fig. 3.

[0127] Fig. 1 illustrates a device 1 which contains a piston pump, a fluid container, power supply with batteries, a CPU, RAM, Memory with computer program code for the CPU, and power driven motor means for operating the piston pump.

[0128] The device is capable of providing resuscitation or suspended state through redistribution of cardiac output to increase supply to the brain and heart for a patient. The illustrated device comprises an electrically or manually controllable redistribution component in the form of an occlusion catheter sub-part 2 suitable for insertion through a femoral arterial line

[0129] The occlusion catheter facilitates redistribution of the cardiac output by reducing blood flow across a balloon which is inflated in the aorta and thereby increases supply to the brain and heart.

[0130] The device is adapted for automatic operation. The CPU is configured to receive a patient data which

identifies physiological and/or anatomical characteristics of the patient and to provide the electrical signal for controlling the redistribution component and/or for presenting the physiological and/or anatomical characteristics for a user based on the patient data or a standard response. In the illustrated implementation, the occlusion catheter comprises two sensors, one being above the balloon and one being inside the balloon, or alternatively below the balloon. The sensor may particularly be pressure sensors which can provide blood pressure which herein is considered as patient data. These patient data may be generated e.g. during external cardiac compression carried out on the patient.

[0131] The signals from the sensors are transmitted to the CPU which, based on the computer program code, controls checks the location of the catheter in the aorta and the patent safety during use of the device and which controls the filing of the balloon. The CPU thereby follows a predefined reaction pattern based on the electrical signal from the sensor.

[0132] The device has a screen 3 which forms part of a user interface. The user further comprises control buttons and visual feedback through LED lights and/or text display. As illustrated in Fig. 1, the user interface may inform the user when filling is underway, and it may further inform the user about a successful balloon occlusion and thus cardiac output redistribution or alternatively that the catheter is not at the desired location in aorta.

[0133] The digitally sensing catheter sub component may be designed as illustrated in Figs. 4a and 4b. Fig. 4a is a transverse view and Fig. 4b is a longitudinal view. The structure and location of the sensors relative to the catheter may be as illustrated in Fig. 4.

[0134] The catheter body comprises an elongate tube 4 with a lumen 5 wherein saline can flow in both directions, i.e. both to and from the balloon and wherein the sensor units 6, 7 and sensor wires 8 can pass through the extent of the catheter body, as illustrated in Fig. 4. The catheter body may be constructed from PEBAX with a working length of 75 cm. The sensors are separated by a sealing, e.g. glue, 9.

[0135] The balloon (not shown) can be made from low durometer urethane, with a wall thickness of 0.05 mm, an overall length of 30 mm, and a diameter from 20-40 mm depending on filling degree, having a burst pressure of at least 500 mmHg.

[0136] The balloon may be configured in size to occlude the aorta of the patient.

[0137] The sensors may pressure sensors of the type MEMS, e.g. MEMS pressure sensor, MEM2000, Metalux Switzerland.

[0138] The sensors can be interfaced with a print circuit board via USB. The USB connection allows for the signal to be processed digitally and used as input for the software algorithms as illustrated in Fig. 2 and Fig. 5.

[0139] The device further comprises a controller component. The controller component may contain a membrane keyboard with LEDs for user interface, integrated

circuit, a pump, hereunder e.g. a piston pump or roller pump, battery, and any other additional component for controlling, powering, or operating the device.

[0140] In the implementations where a roller pump (i.e. a peristaltic pump) is included, it is of particular importance to avoid deformation and/or loss of function (due to e.g. "shape memory" of the polymer of the tubes) during storage of the flexible tubes with which the rollers are in contact during operation of the device. It is envisaged that the device may be stored for prolonged periods of time (e.g. in a rescue vehicle) before it comes into use, and in the event the flexible tubes were constantly compressed by the rollers in the roller pump during storage, the operation of the device could be seriously compromised due to changes in shape of the tubes. One solution to this problem is to ensure that the tubes are not compressed by the rollers during storage by including a mechanism that prevents the rollers from being in contact with the tubes during storage but which can render the rollers operational and bring them in contact with the tube(s) at the time of operation. One simple solution is to secure the roller heads in fixed positions during manufacture by e.g. a spring load mechanism, which can be easily removed (e.g. by removal of a pin from a socket) and thereby allow the roller head(s) to attain functional position(s): Typically, rollers in a roller pump are pushed towards the tube wall by a spring mechanism, and when packaging the device, the springs of this mechanism can be compressed so that the rollers are kept in a locked position.

[0141] Another issue related to the potential prolonged storage times is the fact that tubing, in particular catheters, may attain an undesired shape (again due to shape memory of soft plastic polymers) due to the physical shape of the storage package. Solutions to this have been devised in the prior art - for instance, US patent no. 7,670,331 describes systems for ensuring correct shape of catheters upon insertion after prolonged storage. Catheter tubes are typically stored by folding the catheter tube in a "J" or "U" shape to ensure that only the parts of the tubing where shape memory is an insignificant problem will be folded during storage.

[0142] Another implementation is illustrated in Fig. 11. In this implementation, the catheter component 15 of the device further comprises a retrograde pump 16 controlled by communication with the CPU contained in the external part 17 of the device. The pump could be a brushless type pump such as brushless EC6 motor from Maxon, Maxon precision motors Inc. The pump is located in the aorta 18.

[0143] The catheter subpart may be inserted into the aorta of the patient by locating and puncturing the femoral artery and by inserting the device through the defined opening. The device could be used for the puncturing and placement procedures and these procedures may be integrated into the device. The device can aid the user from unintended harmful events occurring to the patient through the active security mechanism modes illustrated in Fig. 5.

[0144] The controller component of the device can be attached or fixed to the leg 10 of a patient through e.g. a wraparound leg belt or an adhesive fixation pad. Fig. 10 illustrates an implementation where the device 11 is strapped to the patient with a strap 12 or fixed to the patient by an adhesive 13. In both implementations, the catheter 14 extends into the aorta through a sealed port.

[0145] In another implementation, the device can be implanted into a patient. This device may function through wireless coordination and electricity transfer between the device and a pacemaker, ICD or similar implantable cardiovascular diagnostic or therapeutic medical device, as illustrated in Figs. 12a-12e.

[0146] Fig. 12a illustrates a heart 19 with a pacemaker/ICD 20 communicating signals with a redistribution component 21. In Fig. 12b and 12c, the redistribution component is a pump, and in Fig. 12d and 12e, the redistribution component is an occlusion balloon 22.

[0147] In another implementation which is detailed elsewhere herein, the device functions as part of a robotic puncture and insertion system, further decreasing the room for user error. In other words, the device is integrated with automated means for vessel recognition. Expectedly, the system includes a variation of the above configurations and modes.

[0148] In certain implementations, the device is stored prior to use as a sealed outer compartment comprising a protection cover for the outside of the display and parts of the device that come into direct contact with the patient and an inner compartment which comprises the majority of the functional components (e.g. battery, CPU, pump, circuitry, memory, tubing, actuator etc.). These two compartments can be stored separately from the parts introduced into the patient, or the parts introduced into the patient may be part of the outer compartment. This arrangement of components allows that the outer compartment and its components can be readily removed for later destruction/disinfection after use and that the inner compartment and its components can be partially recycled or refurbished. One convenient arrangement is in the form of an "oyster" package, where the two compartments are disengaged immediately after use.

[0149] Typically, connectors between the insertable parts (cannulas, catheter tubes) are those state of the art connector systems that ensure sterile connection in order to avoid contamination of both patient and personnel operating the device.

[0150] A preferred implementation entails that the redistribution component is in the form of a catheter, which is introduced into the femoral artery and advanced to the correct position in the aorta. To ensure sterility the catheter is conveniently covered by a sheath that can be handled by the end user. The catheter is allowed to move freely relative to the inner surface of this sheath, meaning that the catheter can be advanced stepwise through the entrance cannula by simply grasping the catheter via the external sheath which is then gradually peeled off towards the proximal end of the catheter until the catheter

is completely introduced. To further assist in maintaining sterility, the tip of catheter is embedded in a hollow "grip" (a handling means) that allows the user to introduce the tip into the entry cannula without directly touching any part of the catheter.

[0151] A specific implementation of a catheter with sheath and handling means is shown in Fig. 13, where the packaged product is shown after the sheath has been opened for use. Prior to being opened, the catheter is entirely comprised inside the sheath to maintain sterility. The sheath is in this implementation comprised of two sheets that are welded together at the edges and which can be separated at least at the end of the package comprising the handling means in a manner known per se (by tearing the sheets apart, e.g. by handling parts of the separate sheets that are not welded together and are positioned in the circumference of the welded area) - similar systems are known from e.g. packages containing urinary catheters. After having separated the two sheets, the user may handle the "grip" with one hand and the external part of the sheath with the other hand, thus avoiding direct contact with the catheter. The grip may be used to introduce the catheter tip into a cannula, and the user can slide and push the catheter forward through the cannula by handling the sheath.

EXAMPLE 1

Operation of a device disclosed herein

[0152] The device is started by pressing the button **ON** or it is started by unpacking the device e.g. by releasing an attachment to the electrical circuit between device and battery. The user uncovers the catheter and inserts the catheter into the patient. Once the user has completed the procedure, the user presses **INFLATE**, and the system enters the **Position verification** mode.

Position verification mode

[0153] When the criteria for the correct position is met, the indicator "**Position correct** ✓" starts blinking green and the indicator "**Pumping** ☉" starts blinking yellow, then the system enters **Actuator (inflation)** mode.

[0154] If the correct position is not achieved or if the correct position is lost, then indicator "**Pumping** ☉" stops blinking, an alarm sounds and "**Retry placement** ✕" starts blinking, until **INFLATE** is pressed again.

Actuator (inflation) mode

[0155] The actuator is activated and the balloon is inflated. When the criteria for a filled balloon is reached the actuator is stopped, the indicator "**Pumping** ☉" stops blinking yellow and **Self-adjustment** mode is entered.

[0156] If the criteria are not met after one minute, or the user presses the **DEFLATE** button, the **Deflation** mode is entered followed by "**Retry placement** ✕" start-

ing to blink and staying lit until **INFLATE** is pressed again.

Self-adjustment mode

5 [0157] The indicator "**Balloon filled** -*" starts blinking green. The self-adjustment mode regulates the pressure in the balloon to a correct pressure according to the criteria.

10 [0158] If the criteria can't be held, an alarm sounds, the deflation mode is entered followed by "**Retry placement** ✕" starting to blink until **INFLATE** is pressed again, or if the user presses the **DEFLATE** button, the **Deflation** mode is entered.

15 **Deflation mode**

[0159] The indicator "**Pumping** ☉" starts blinking yellow. The actuator is activated and the balloon is deflated.

20 [0160] When the balloon is deflated "**Balloon deflated** - ♦" starts blinking blue until the user presses **INFLATE** again.

Glossary

25 [0161] P1 is Pressure sensor 1, as illustrated in Fig. 1, and P2, is pressure sensor 2.

Positioning criteria

30 [0162] The maximum pressure measured by P1 is above 15 mmHg and has a delta between the max and min pressure measured higher than 5 mmHg. 50 Hz.

Filling criteria

35 [0163] P2 reach the pressure measured by P1 x 1.20. 50 Hz

Self-adjustment criteria

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[0164] P2 is still within the following range: (P1 x 1.10) - (P1 x 1.30). 0.1 Hz.

[0165] The device may signal the user with the following visual and/or auditory signals:

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Message A: " Filling. Continue CPR."

Message B: " Retry placement. Balloon is now empty."

Message C: " Aorta Occlusion success."

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Message D: " Deflation done."

EXAMPLE 2

Simulation experiment

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[0166] A model of the human ascending aorta, aortic arch, and common femoral arteries was produced in silicone rubber. The model was submerged in water and

internal pressure (100 mmHg) in the model was applied via a connected water column. Chest compressions were simulated by manually applying pressure to an attached balloon.

[0167] The test device was inserted from an opening in the part of the model corresponding to the left common femoral artery so as to allow the tip to reach a position corresponding to just proximal of the renal arteries. The occlusion balloon was inflated while recording MEMS pressure sensor data from the tip of the catheter and from the interior of the balloon compartment.

[0168] It was demonstrated that the positioning and occlusion of the redistribution catheter can be controlled and verified through the use of software-hardware integration mechanisms. For example, measuring the correct pressures during filling corresponding to the catheter tip being in the aorta (and e.g. not misplaced in the renal artery) allows pressure control of the filling of the balloon as a function of the pressures intended to be countered. In other words, if the catheter is not placed in the correct position, filling of the balloon counter the aortic pressure and has the consequence that the pressure measured at the tip drops to zero instead of remaining at the level of the aortic pressure.

EXAMPLE 3

In vivo experiment

[0169] A prototype device was tested in two pilot animal trials. The animals were healthy Danish farm pigs of 30-38 kg, which were sedated using pentobarbital (Mebumal) 50mg/ml, 6 mg/kg/h and ketamine (Ketaminol vet) 100 mg/ml, 15mg/kg/h. The animals further were administered 2000 unites of unfractionated heparin.

[0170] The animals were mechanically ventilated and oxygen levels were set to 23% oxygen prior to cardiac arrest. During the experiment the animals were continuously supplied with saline (0.9% NaCl) at an infusion speed of 2 l/h.

[0171] Cardiac arrest was induced by applying 9 V DC directly to the heart by electrodes introduced via the right jugular vein. Cardiac arrest was defined as a systolic blood pressure <25 mmHg for more than 5 seconds.

[0172] ROSC was defined as a pulsatile rhythm with a systolic aortic blood pressure >60 mm Hg maintained for at least 5 min.

[0173] Arterial blood pressure, venous blood pressure and heart rate were measured with intravascular gauges in the aortic arch through the right carotid artery at the junction with the aorta, and the right jugular vein entering the central vena cava.

[0174] Pig no. 1 had the following baseline values prior to induction of cardiac arrest: heart rate 85 bpm, arterial blood pressure 98/63 mmHg, venous blood pressure 15 mmHg. After the induction of cardiac arrest, the pig was left in no-flow state for 1 min. Hereafter mechanical chest compressions were delivered with the LUCAS 2 device

(Physiocontrol) continued for an additional 5 min. After the pig had sustained a cardiac arrest for a total of 6 min, the prototype device was introduced to the aorta through the right femoral artery. The parameters after the 6 min. of cardiac arrest were measured as the following: Heart rate 0 bpm, with a mechanical setting at 100 compressions/min, blood pressure was 34/23 mmHg, and central venous pressure was 20 mmHg. Hereafter the prototype device was turned on and the effect were left to take hold for 1 min. The values were measured to the following regarding 1 min of sustained use of the prototype device: Heart rate 0, with a mechanical setting at 100/compressions/min, central arterial blood pressure was 59/28 mmHg, central venous pressure was 22 mmHg.

[0175] The use of the prototype device demonstrated an increase of the central arterial pressure, and thus also of the coronary perfusion pressure and cerebral perfusion pressure, from systolic 34 mmHg to 59 mmHg, and a sustained venous pressure going from 20 to 22 mmHg. The coronary perfusion pressure, the central parameter in cardiac resuscitation, is calculated as the difference between the systolic central arterial pressure and the central venous pressure. We are thus able to demonstrate an increase of the coronary perfusion pressure with 164%.

[0176] Pig no. 2 was subjected to the same conditions as Pig no. 1, but cardiac arrest was effected by inducing blood loss (700 ml) by bleeding from the right femoral artery prior to instigation of the treatment.

[0177] Pig no. 2 had the following baseline values prior to induction of cardiac arrest: heart rate 105 bpm, arterial blood pressure 96/42 mmHg, venous blood pressure 12 mmHg. After blood loss the values were: heart rate: 93 bpm, arterial blood pressure: 35/20 mmHg, central venous pressure: 10 mmHg. Treatment was commenced. After 1 minute of treatment the values had changed to: heart rate: 95 bpm, arterial blood pressure: 55/30 mmHg, central venous blood pressure: 10 mmHg.

[0178] Hence, by using the prototype, it was achieved to obtain a 57% increase the arterial blood pressure, whereas an 80% increase in coronary perfusion pressure was obtained.

Claims

1. An automated vascular catheter deployment device, which comprises means for detection of blood vessels and means for introduction of a catheter into a blood vessel, such as an artery or vein, wherein the means for introduction of the catheter comprises

- 1) means for motorized sideways movement of a percutaneous cannula or needle,
- 2) means for motorized introduction of the percutaneous cannula or needle into an artery or a vein via longitudinal axial movement of said cannula or needle, and

3) means for motorized introduction of the catheter into an artery or a vein through or across said cannula or needle;

wherein the device is comprised in a housing or frame that is configured to be applied to a position of a human limb selected from a group consisting of: frontal part of the thigh, frontal part of the pelvis, frontal part of the groin, the wrist, frontal part of the arm and/or frontal part of the neck.

2. The device according to claim 1, wherein the means for detection of blood vessels comprises an ultrasound detection component or an infrared or near-infrared imaging component.
3. The device according to claim 1 or 2, wherein the cannula or needle can move sideways in a fixed or adjustable angle, preferably along a rail or cable.

Patentansprüche

1. Automatische Gefäßkatheter-Anlegevorrichtung, die ein Instrument zur Detektion von Blutgefäßen und ein Instrument zur Einführung eines Katheters in ein Blutgefäß, wie eine Arterie oder Vene, umfasst, wobei das Instrument zur Einführung des Katheters umfasst:

- 1) ein Instrument zur motorisierten Seitwärtsbewegung einer perkutanen Kanüle oder Nadel,
- 2) ein Instrument zur motorisierten Einführung der perkutanen Kanüle oder Nadel in eine Arterie oder eine Vene über eine längsaxiale Bewegung der Kanüle oder Nadel und
- 3) ein Instrument zur motorisierten Einführung des Katheters in eine Arterie oder eine Vene mittels oder quer durch die Kanüle oder Nadel;

wobei die Vorrichtung in einem Gehäuse oder Rahmen enthalten ist, das/der so ausgeführt ist, dass es/er an einer Position einer menschlichen Gliedmaße, ausgewählt aus einer Gruppe bestehend aus: vorderem Teil des Oberschenkels, vorderem Teil des Beckens, vorderem Teil der Leiste, dem Handgelenk, vorderem Teil des Arms und/oder vorderem Teil des Halses, angebracht werden kann.

2. Vorrichtung gemäß Anspruch 1, wobei das Instrument zur Detektion von Blutgefäßen eine Ultraschall-Detektionskomponente oder eine Infrarot- oder Nah-Infrarot-Bildgebungskomponente umfasst.
3. Vorrichtung gemäß Anspruch 1 oder 2, wobei sich die Kanüle oder Nadel in einem fixierten oder einstellbaren Winkel seitwärts bewegen kann, vorzugs-

weise entlang einer Schiene oder eines Kabels.

Revendications

1. Dispositif de déploiement de cathéter vasculaire automatique, qui comprend un moyen de détection de vaisseaux sanguins et un moyen d'introduction d'un cathéter dans un vaisseau sanguin, tel qu'une artère ou une veine, dans lequel le moyen d'introduction du cathéter comprend

- 1) un moyen de déplacement latéral motorisé d'une canule ou d'une aiguille percutanée,
- 2) un moyen d'introduction motorisée de la canule ou de l'aiguille percutanée dans une artère ou une veine via un mouvement axial longitudinal de ladite canule ou aiguille, et
- 3) un moyen d'introduction motorisée du cathéter dans une artère ou une veine par ou à travers ladite canule ou aiguille ;

dans lequel le dispositif est compris dans un boîtier ou un châssis qui est conçu pour être appliqué à une position d'un membre humain sélectionné dans un groupe consistant en : la partie frontale de la cuisse, la partie frontale du pelvis, la partie frontale de l'aîne, le poignet, la partie frontale du bras et/ou la partie frontale du cou.

2. Dispositif selon la revendication 1, dans lequel le moyen de détection des vaisseaux sanguins comprend un composant de détection échographique ou un composant d'imagerie infrarouge ou proche-infrarouge.
3. Dispositif selon l'une quelconque la revendication 1 ou 2, dans lequel la canule ou l'aiguille peut se déplacer latéralement suivant un angle fixe ou réglable, de préférence le long d'un rail ou d'un câble.

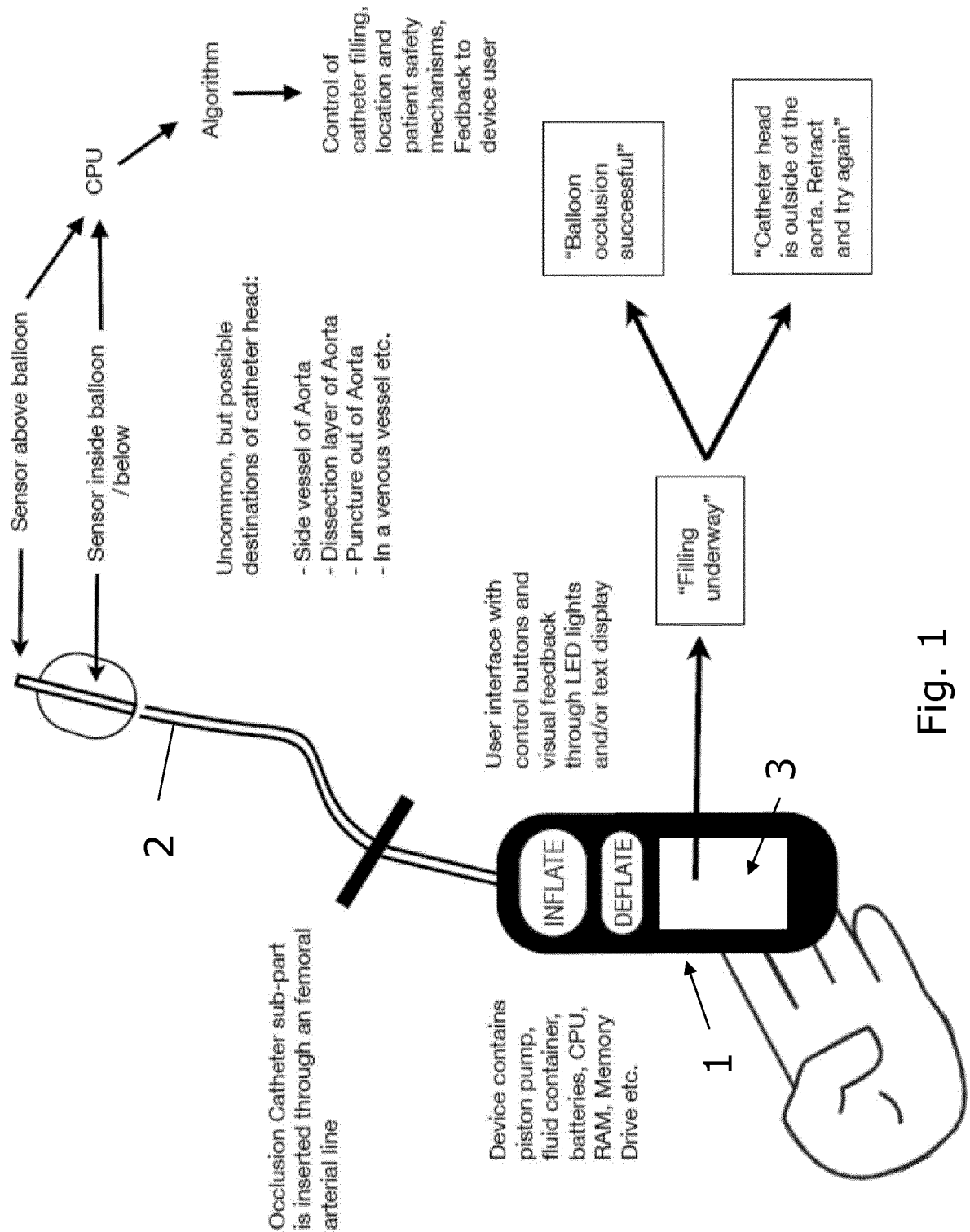


Fig. 1

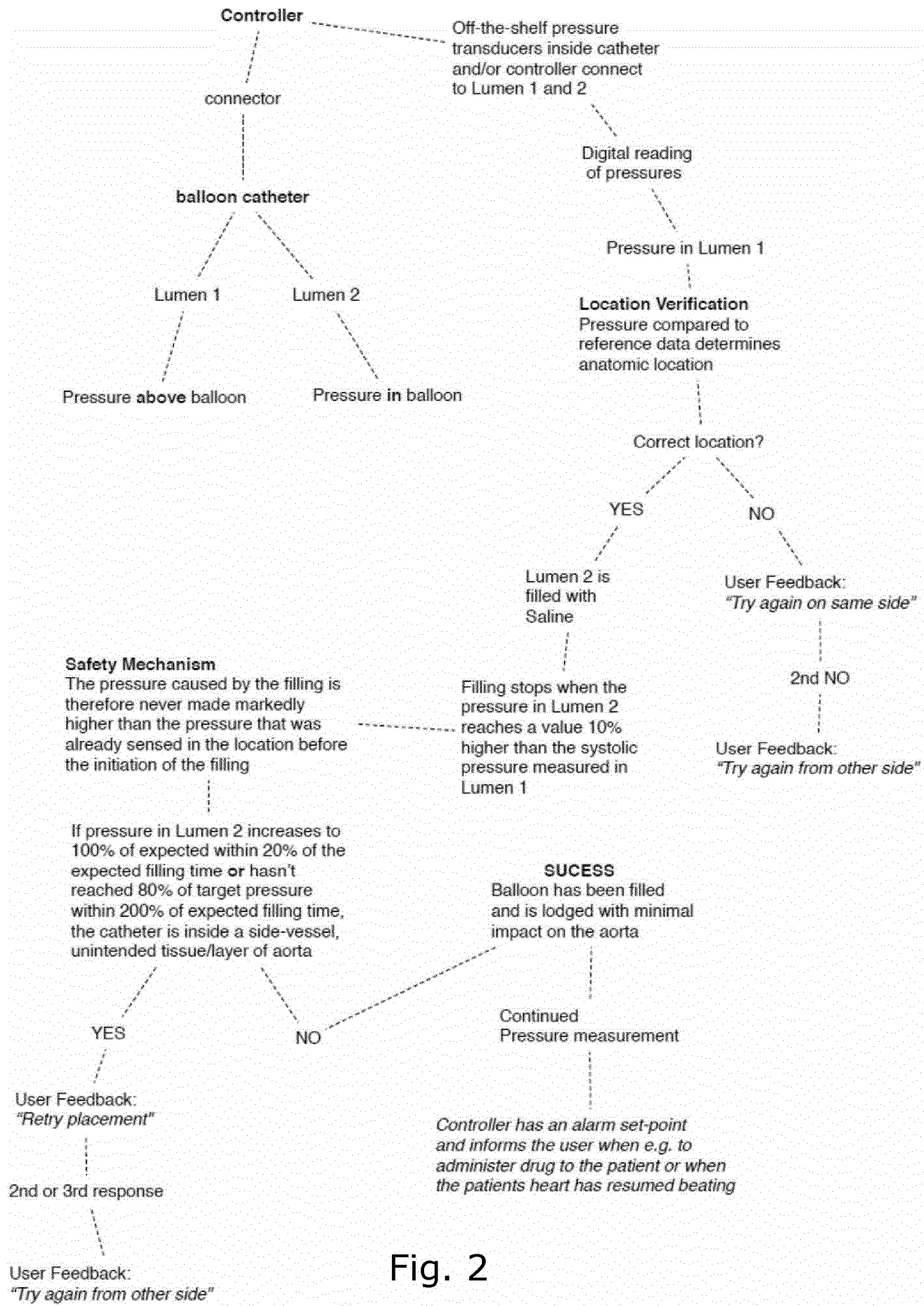


Fig. 2

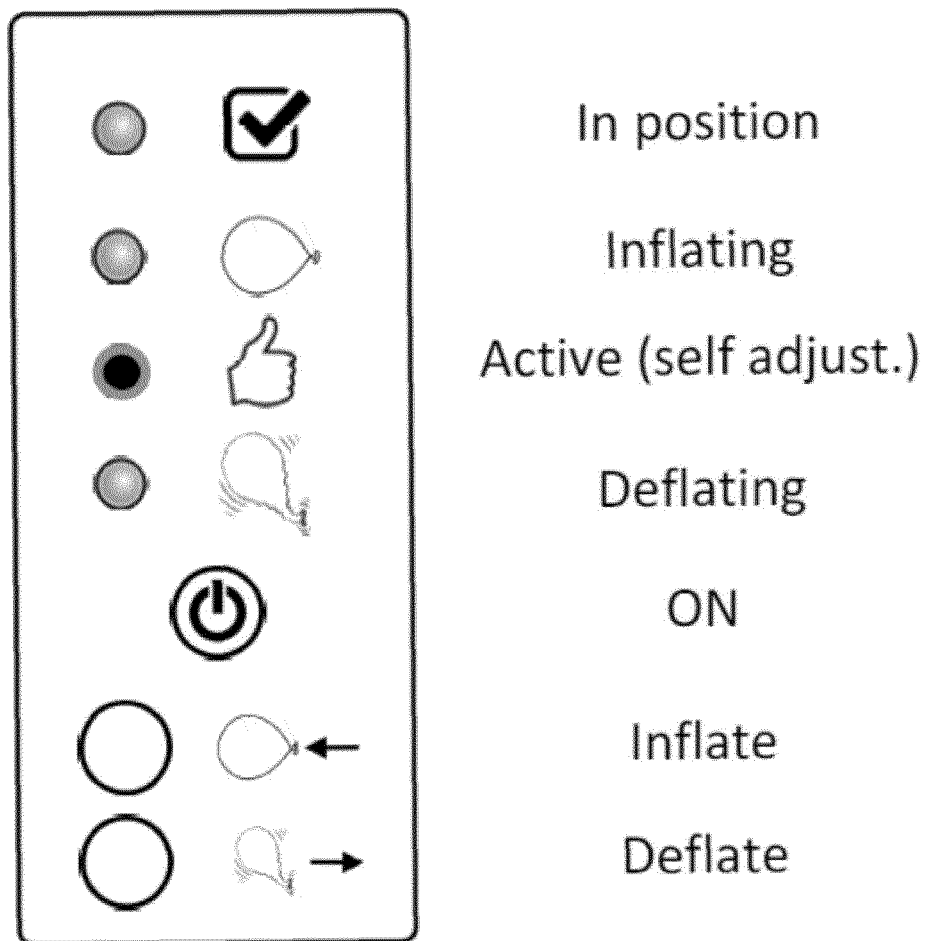
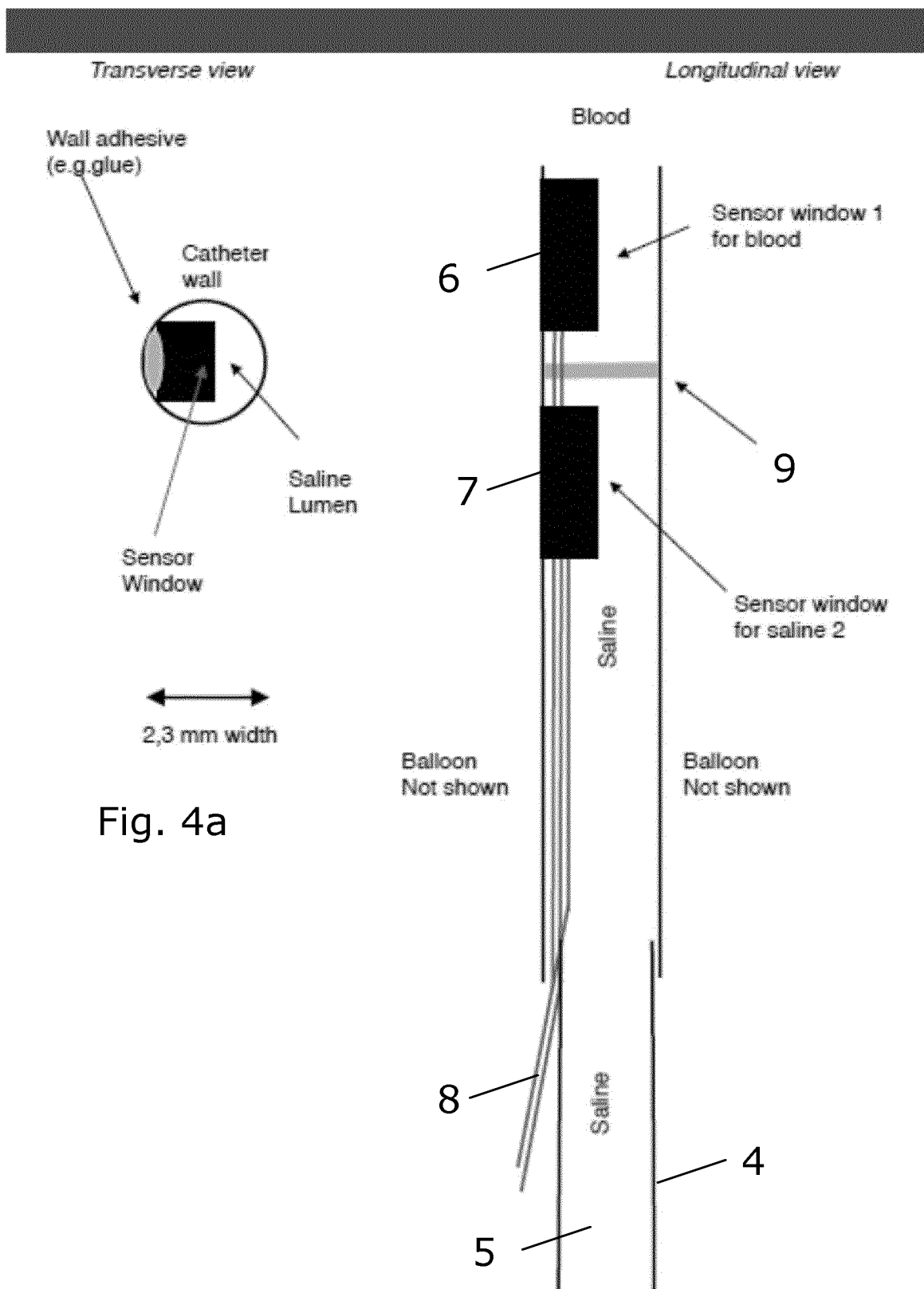


Fig. 3



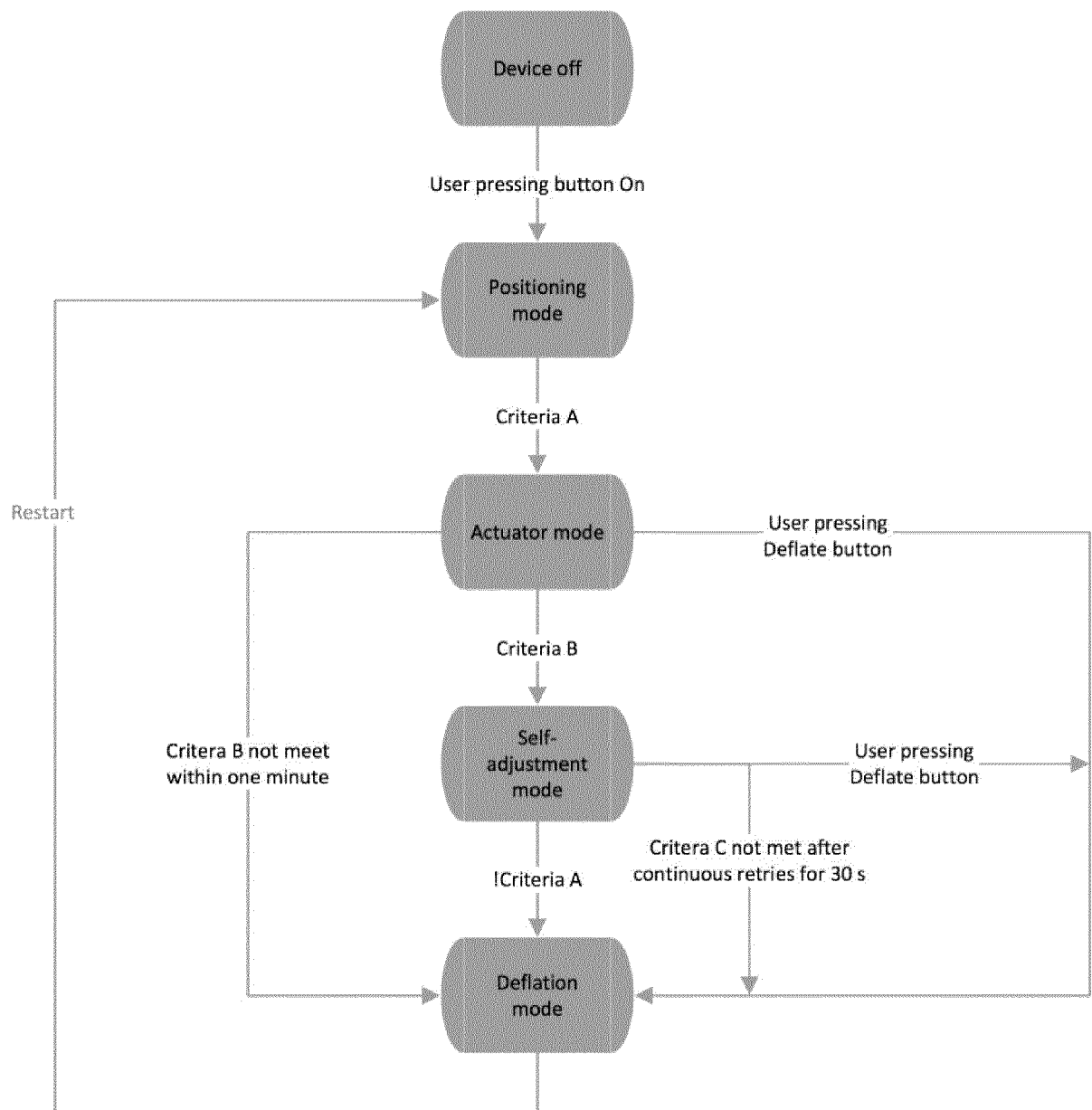


Fig. 5

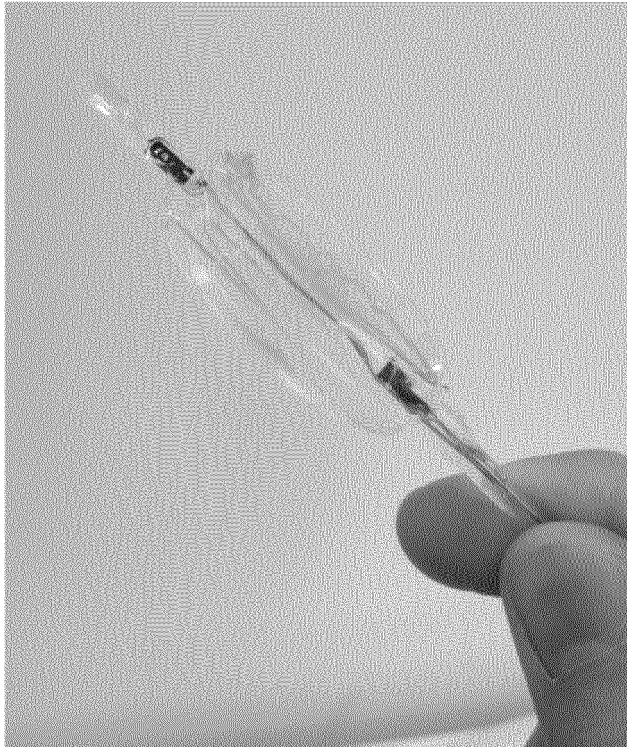


Fig. 6

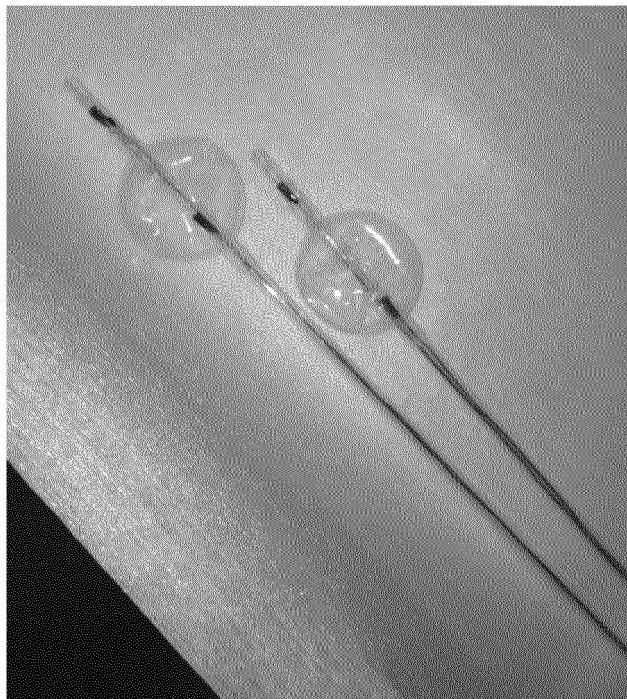


Fig. 7

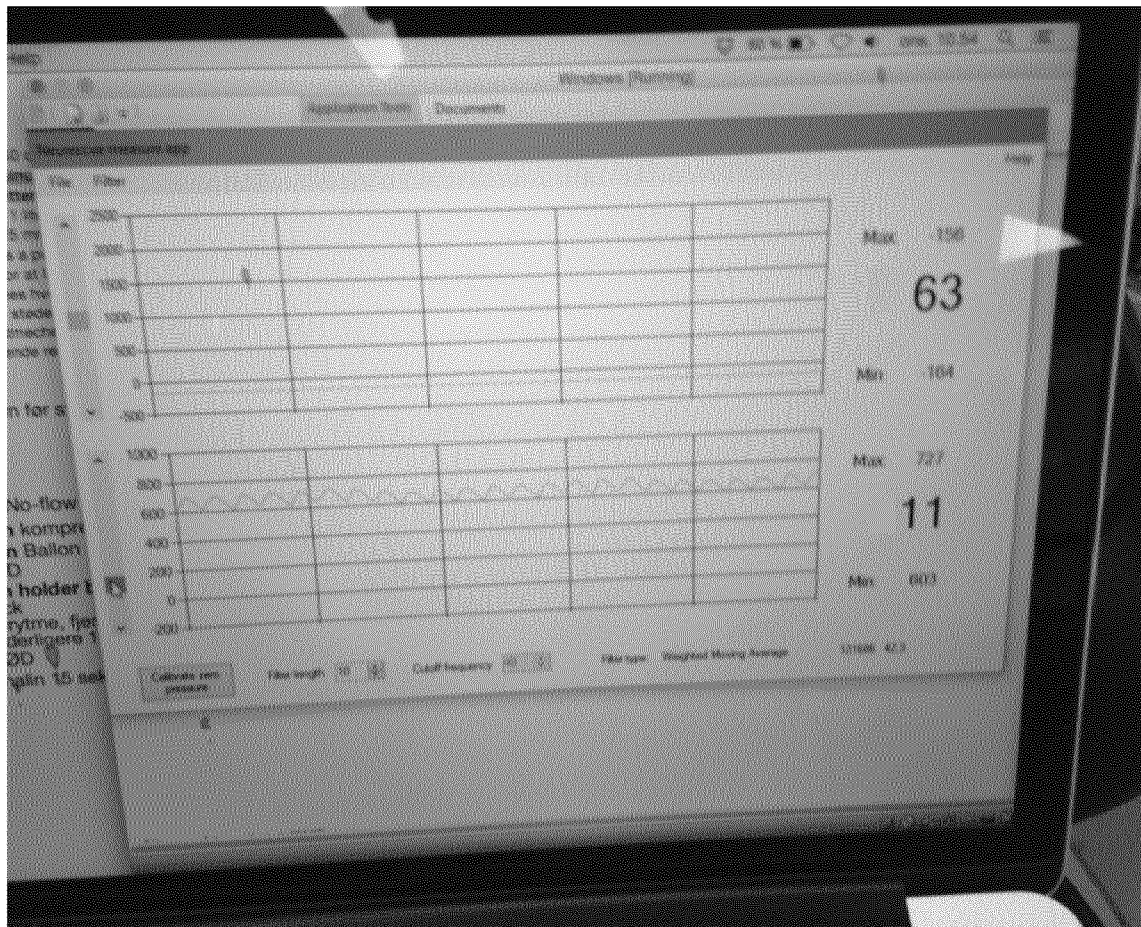


Fig. 8

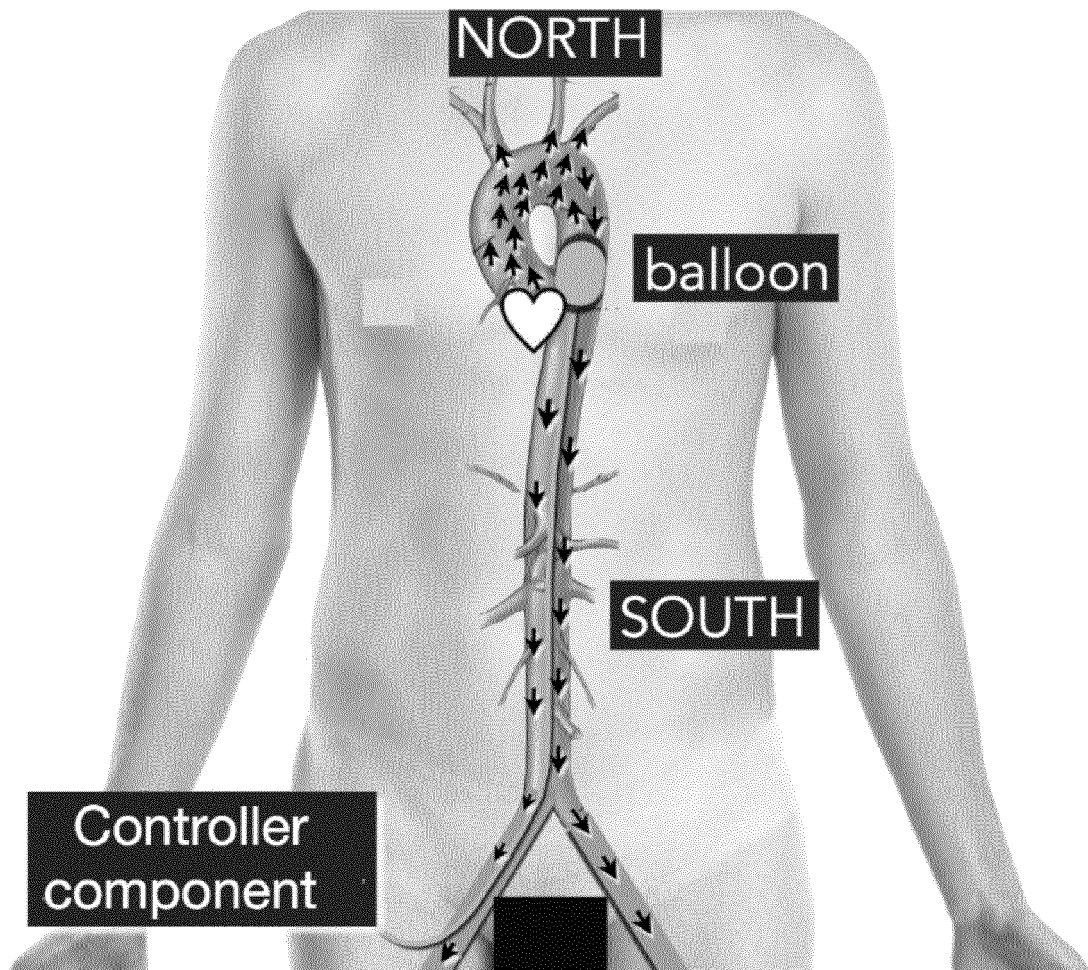


Fig. 9

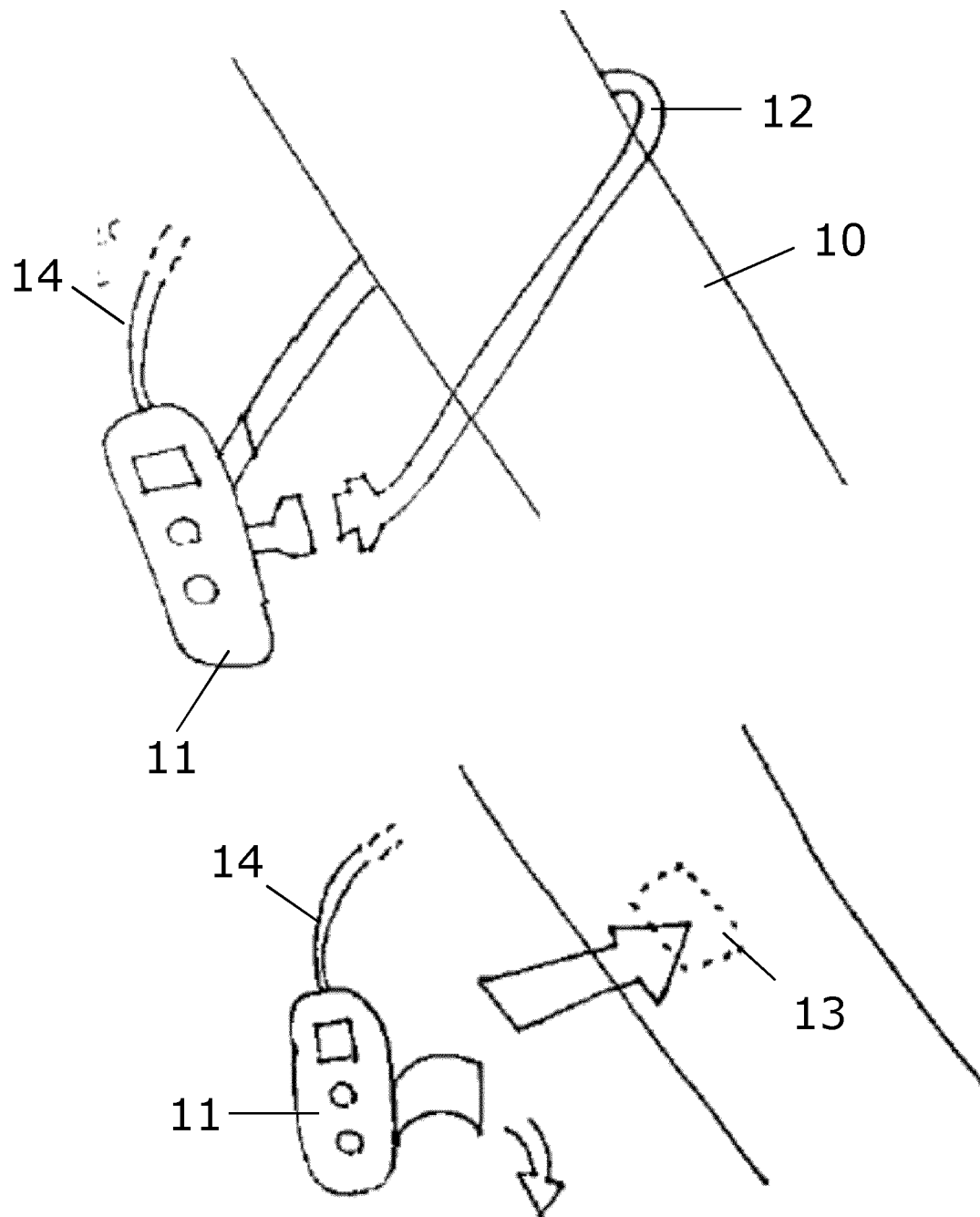


Fig. 10

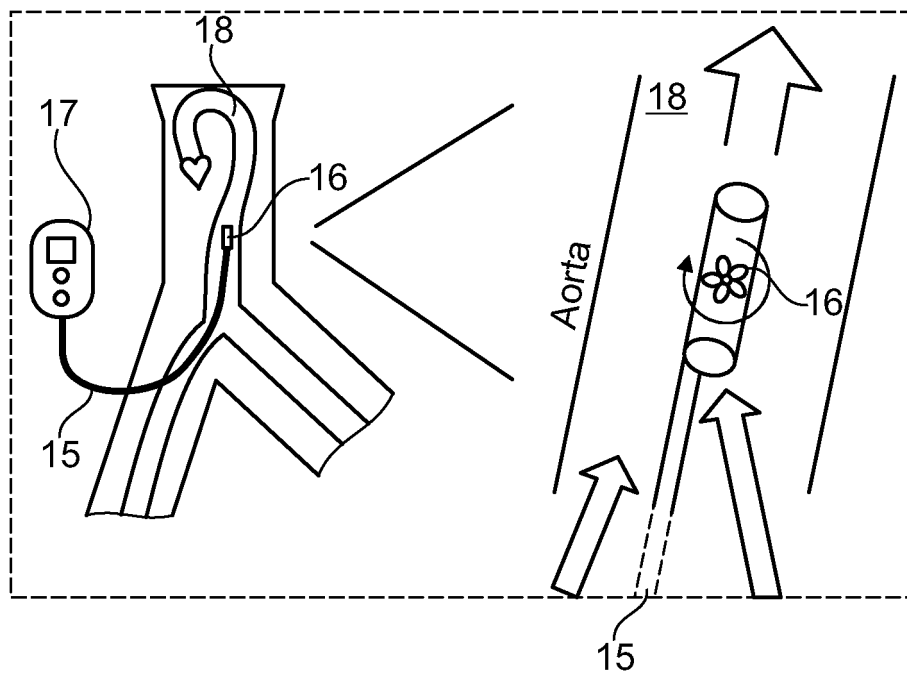


Fig. 11

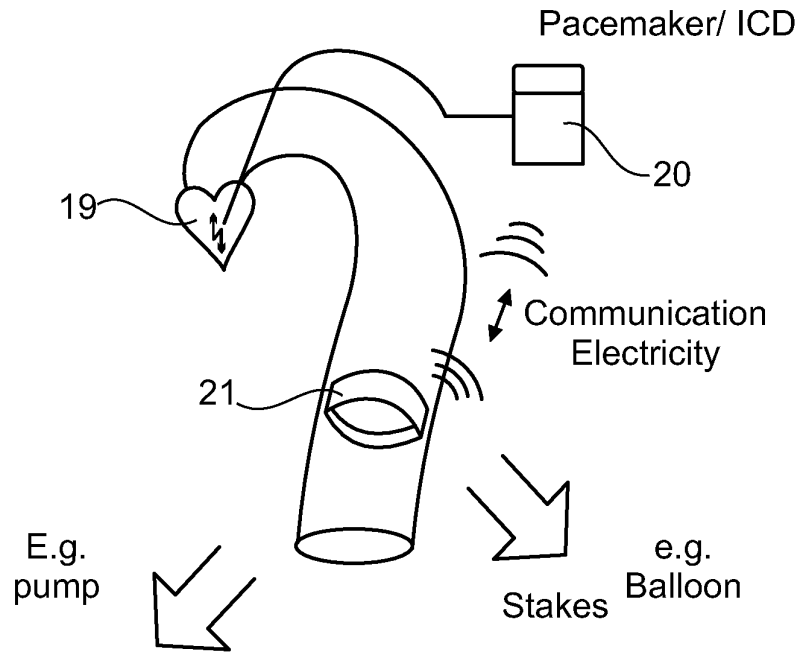


Fig. 12a

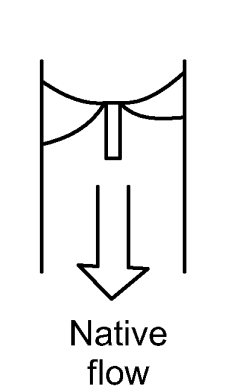


Fig. 12b

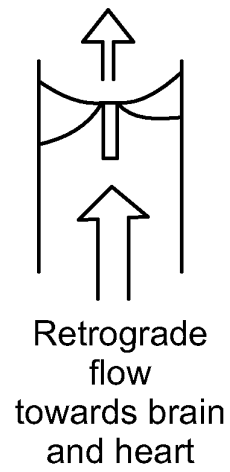


Fig. 12c

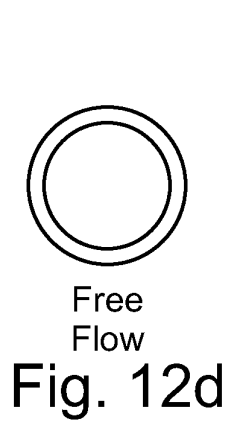


Fig. 12d

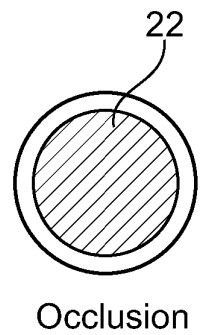


Fig. 12e

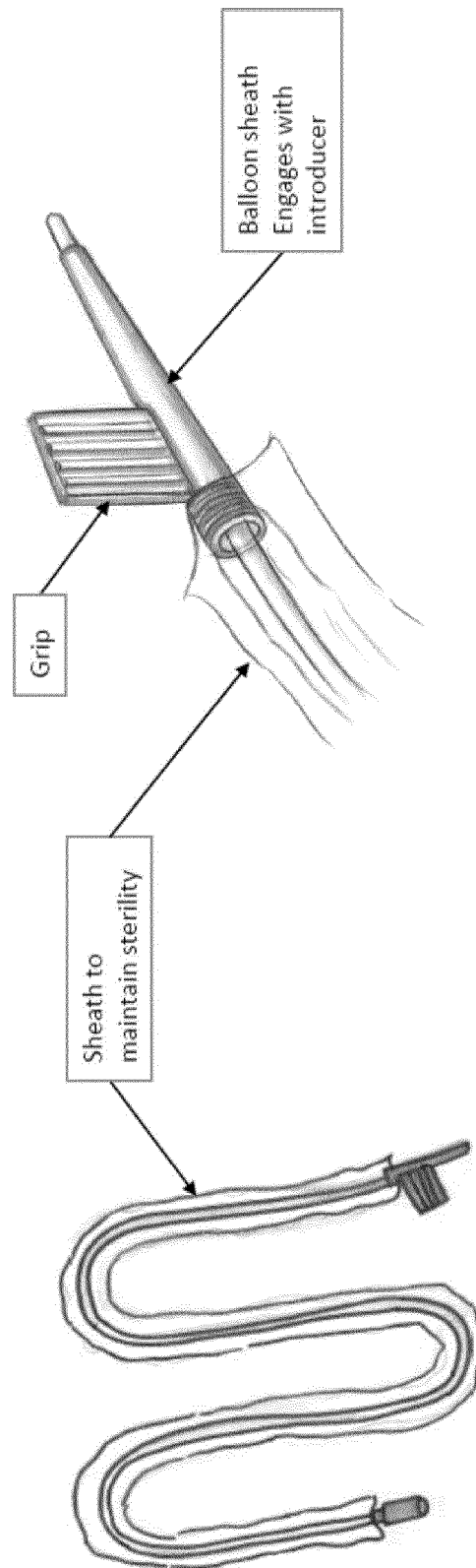


Fig. 13

Implantable preventive device for high-risk patients

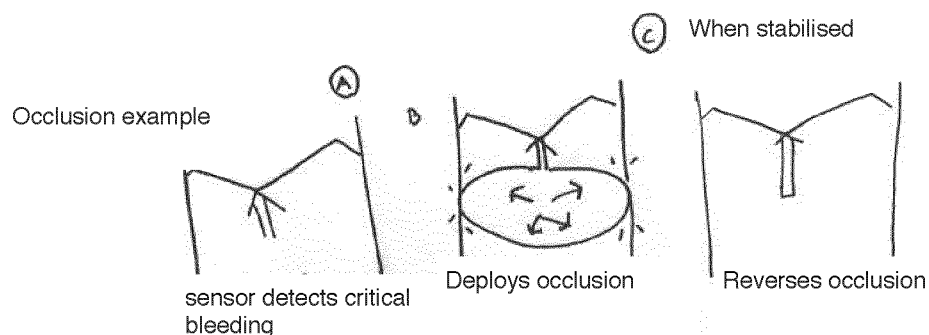
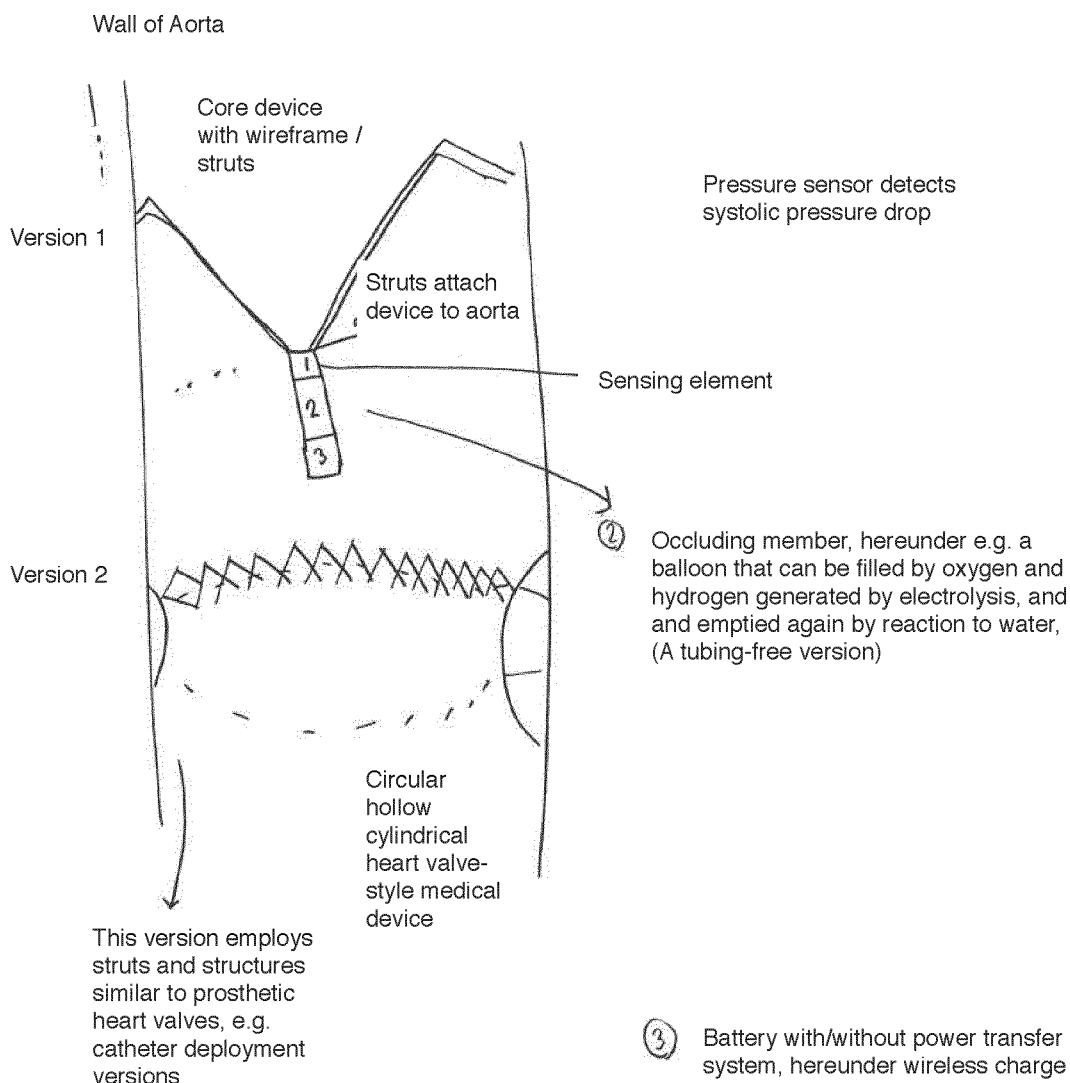


Fig. 14

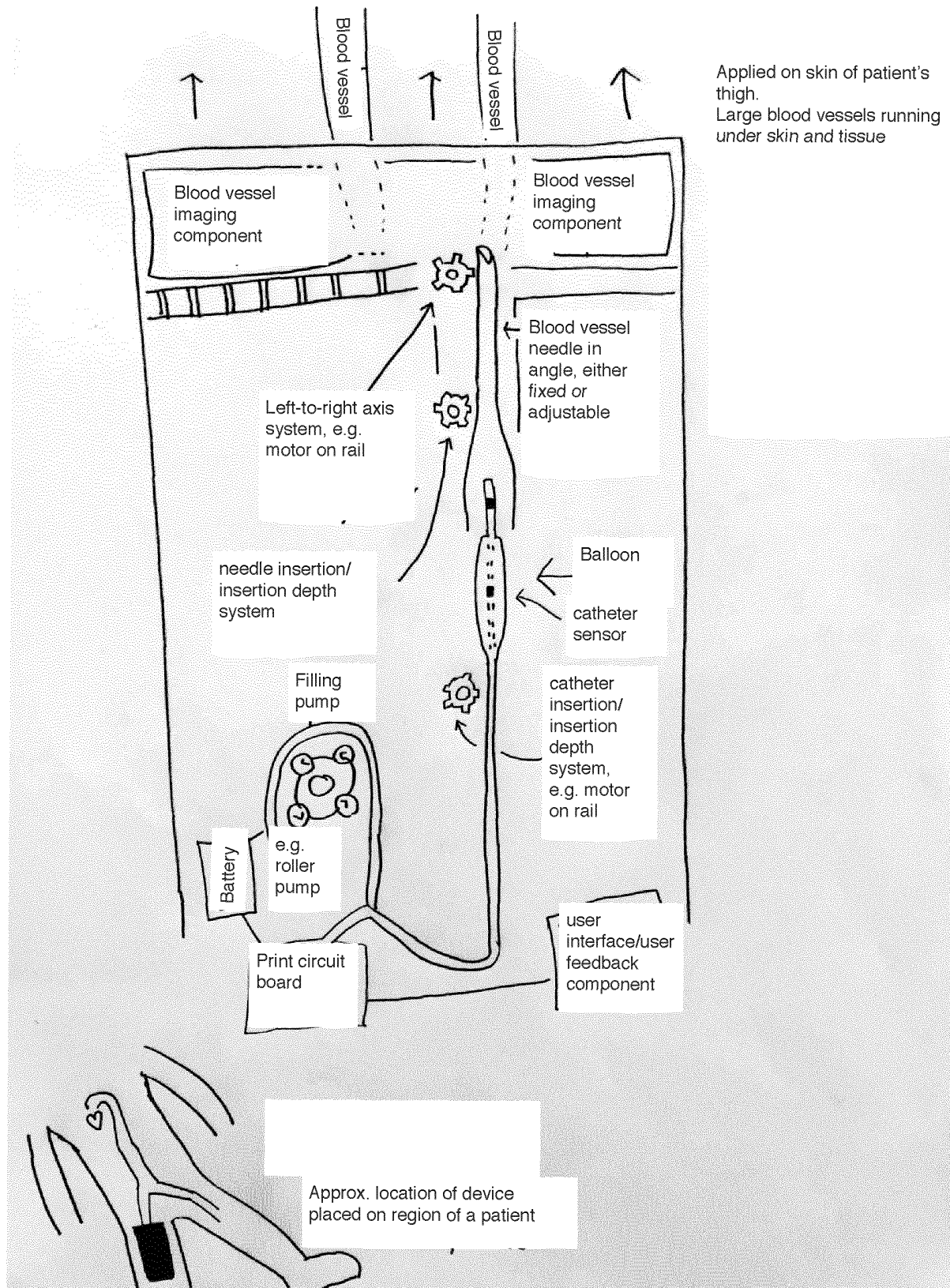


Fig 15

REFERENCES CITED IN THE DESCRIPTION

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专利名称(译)	紧急停止装置		
公开(公告)号	EP3569166B1	公开(公告)日	2020-03-04
申请号	EP2019171346	申请日	2016-12-02
[标]申请(专利权)人(译)	纽莱斯科公司		
申请(专利权)人(译)	neurescue APS		
当前申请(专利权)人(译)	neurescue APS		
[标]发明人	FROST HABIB		
发明人	FROST, HABIB		
IPC分类号	A61B17/34 A61M5/32 A61M5/42 A61B5/00 A61B17/12 A61M1/10 A61M1/12 A61B34/30		
CPC分类号	A61B5/02042 A61B5/02055 A61B5/065 A61B5/6853 A61B17/1204 A61B17/12122 A61B17/12136 A61B2017/00017 A61B2017/00057 A61B2017/00106 A61B2505/01 A61M1/101 A61M1/1072 A61M1/1086 A61M1/125 A61B2034/301 A61M5/3287 A61M5/427 A61B5/4842		
优先权	2015197607 2015-12-02 EP PCT/EP2016/079586 2016-12-02 WO		
其他公开文献	EP3569166A1 EP3569166B8		
外部链接	Espacenet		

摘要(译)

公开了一种用于通过心输出量的重新分配以提供复苏或暂停状态以增加对患者的脑和心脏的供应的设备，该设备包括呈导管形式的电可控的重新分配组件，该组件可附接到患者并且正在配置为与患者互动以提供心输出量的重新分配以增加对大脑和心脏的供应，重新分配组件遵循基于电信号的预定义反应模式，以及计算机装置，其配置为：接收标识生理和生理指标的患者数据 /或患者的解剖特征；并根据患者数据或标准响应为重新分配组件提供电信号。该装置还包括用于检测血管的装置和用于将导管引入到动脉中的电动装置。该装置可以提供机构，以保护患者的主动脉和其余的解剖结构不受在任何使用情况下由所公开的装置造成的无意损害。正确的预期用途或意外用途。

