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Najafi et al.

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(54) **MINIMALLY-INVASIVE PROCEDURE FOR MONITORING A PHYSIOLOGICAL PARAMETER WITHIN AN INTERNAL ORGAN**

(2013.01); **A61B 5/6867** (2013.01); **A61B 5/0031** (2013.01); **A61B 5/076** (2013.01)

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See application file for complete search history.

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(60) Provisional application No. 60/937,321, filed on Jun. 28, 2007, provisional application No. 60/937,457, filed on Jun. 28, 2007.

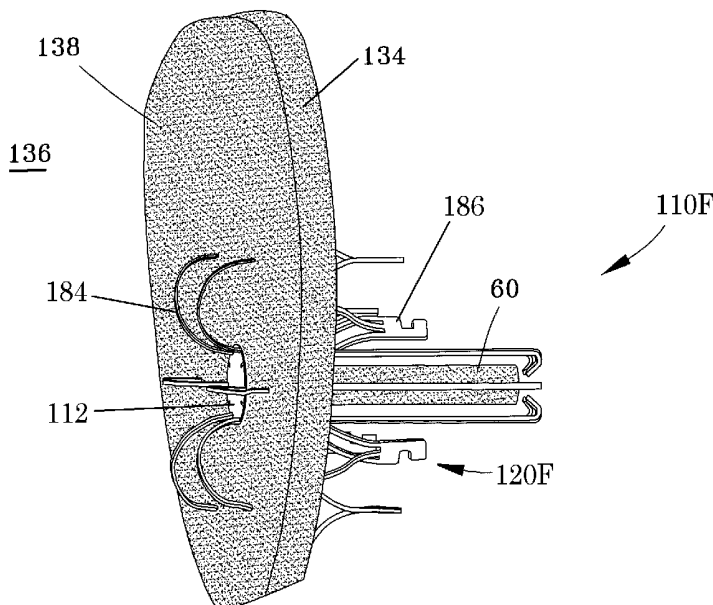
(51) **Int. Cl.**
A61B 5/00 (2006.01)
A61B 5/07 (2006.01)

(52) **U.S. Cl.**
CPC **A61B 5/6882** (2013.01); **A61B 5/686**

(57) **ABSTRACT**

A minimally-invasive surgical procedure for monitoring a physiological parameter within an internal organ of a living body. The procedure entails making a first incision in the body to enable access to the organ. An endoscopic instrument is then inserted through the first incision and a second incision is made therewith through an external wall of the organ and into the internal cavity thereof. A sensing unit is placed in the second incision such that the second incision is occluded by the unit and a proximal end of the unit is outside the organ. The unit includes a sensing device having a sensing element adapted to sense the physiological parameter within the organ, and an anchor to which the sensing device is secured. The first incision is closed, after which a readout device outside the body telemetrically communicates with the sensing device to obtain a reading of the physiological parameter.

20 Claims, 8 Drawing Sheets



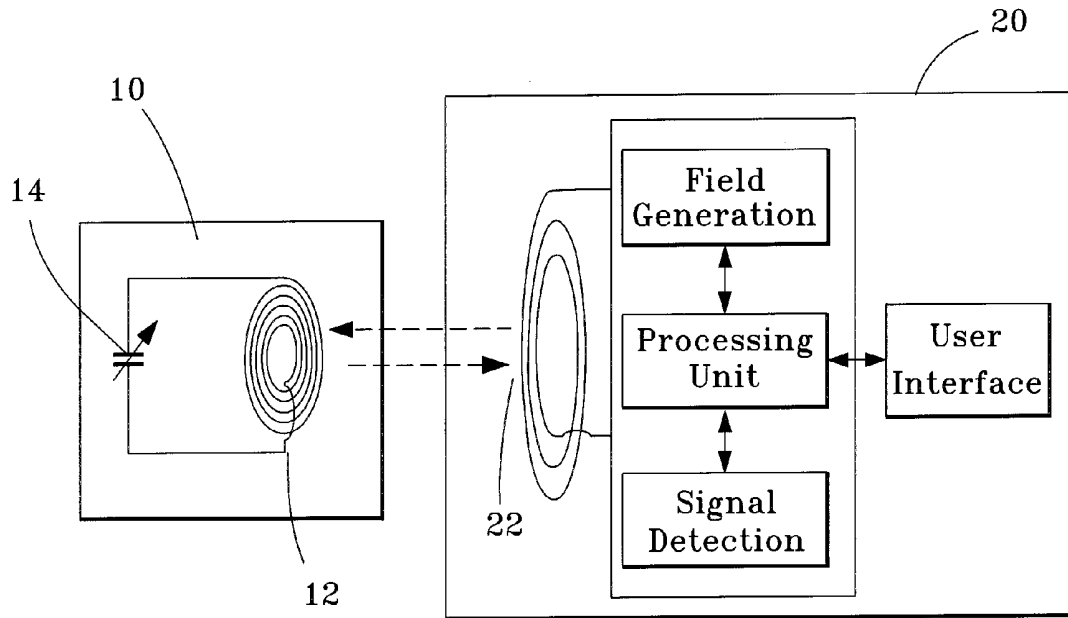


FIG. 1a
Prior Art

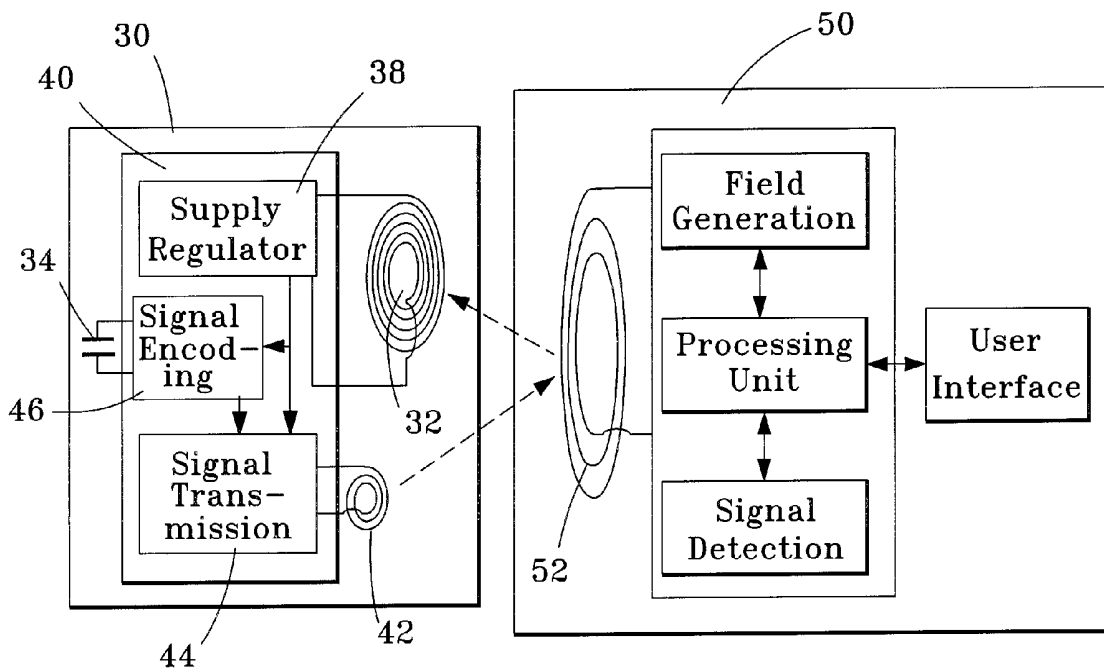


FIG. 1b
Prior Art

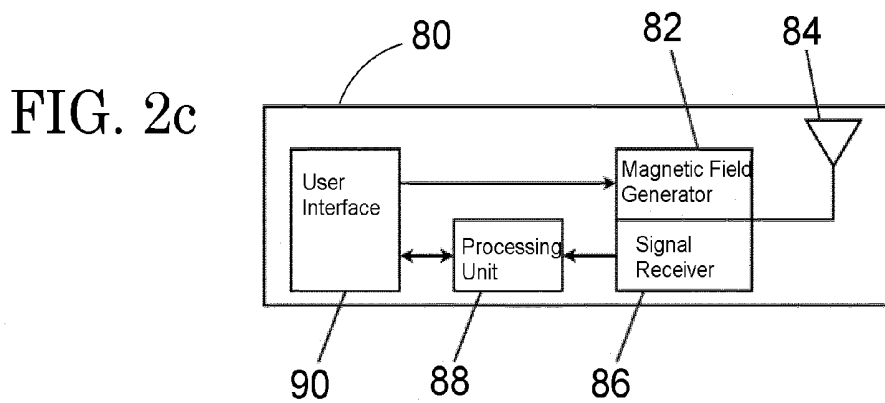
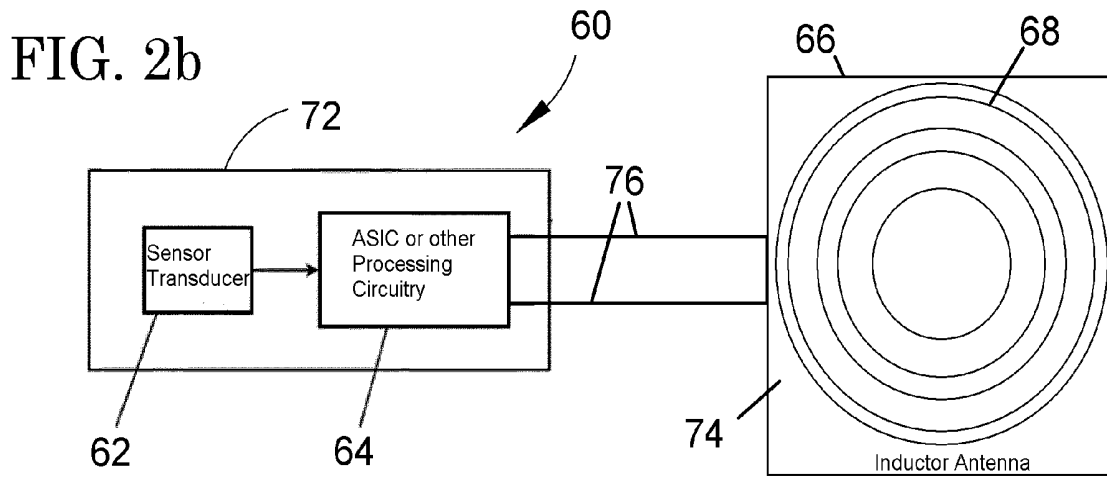
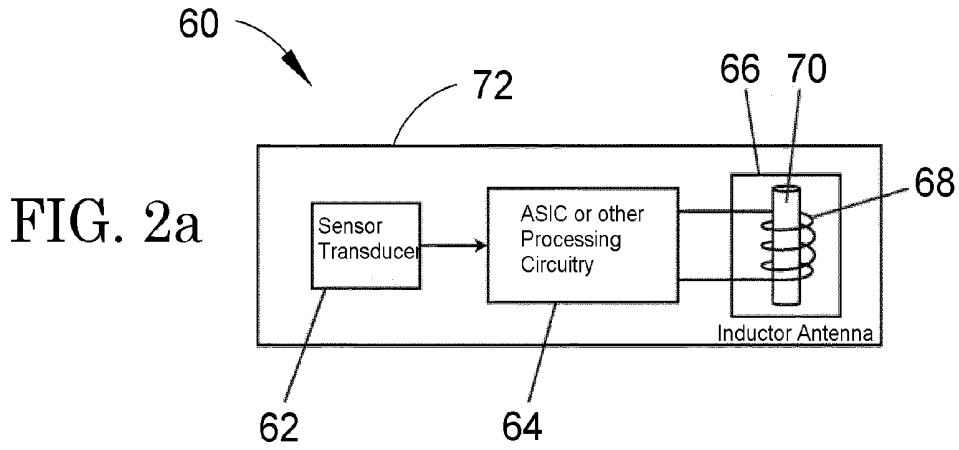


FIG. 3

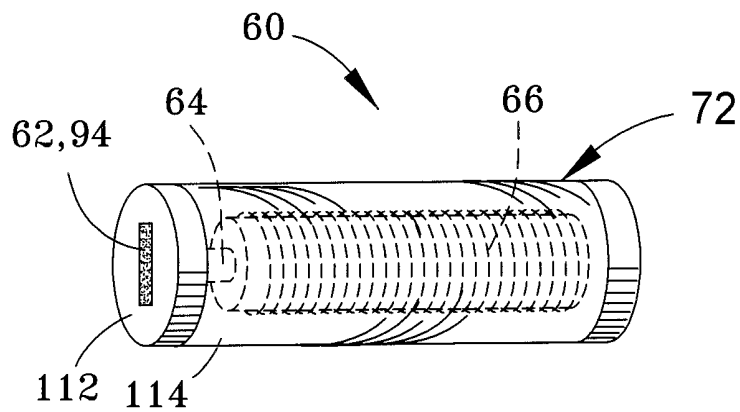
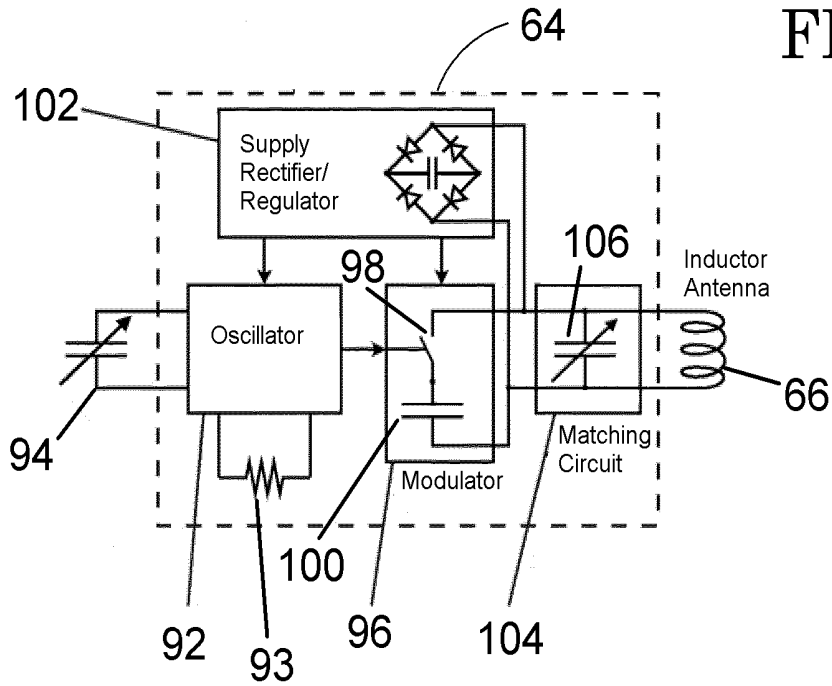


FIG. 4

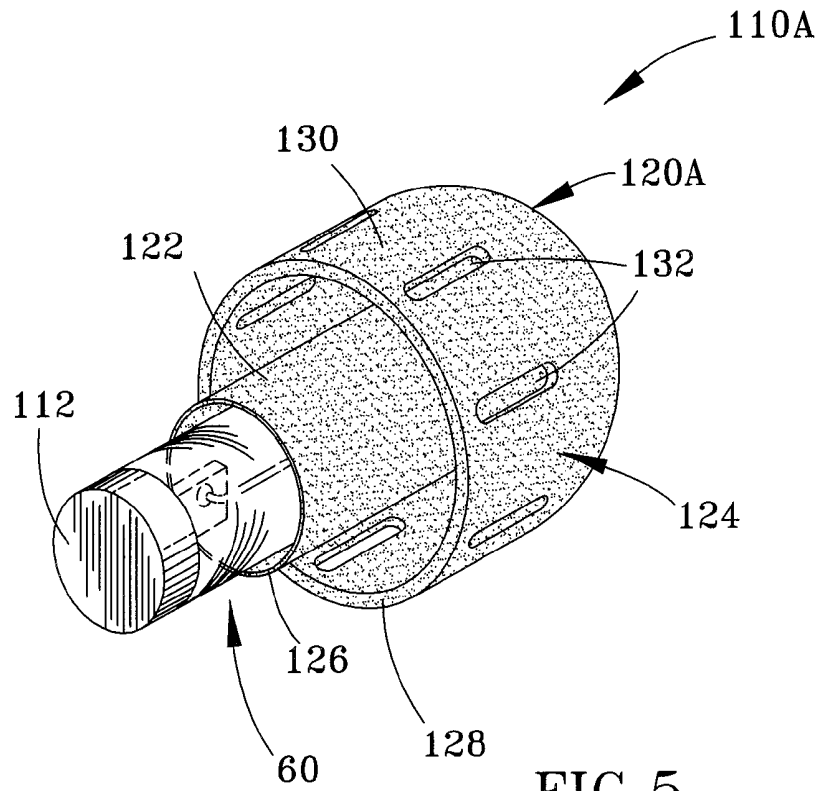


FIG. 5

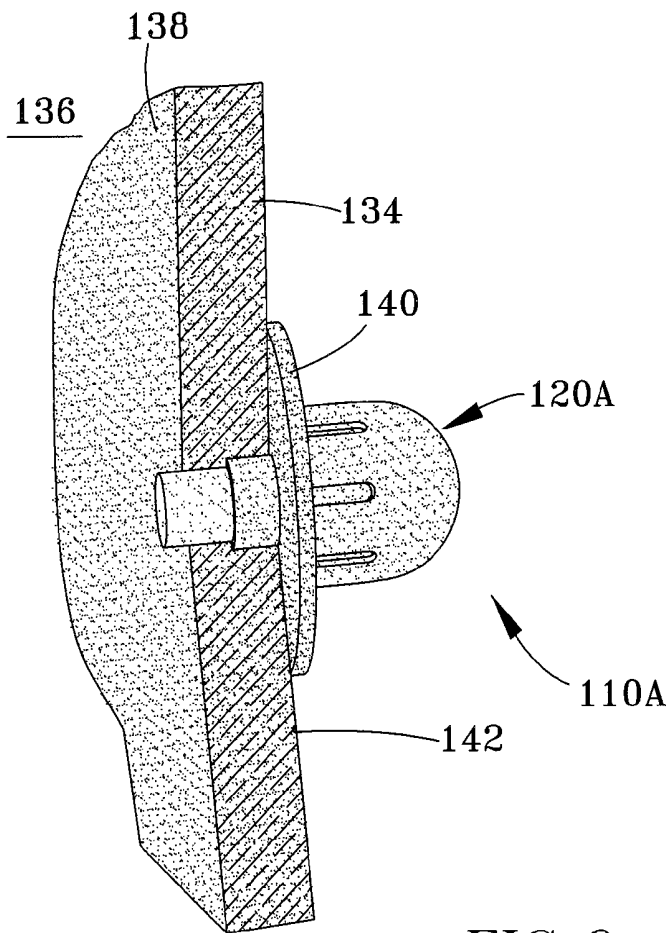


FIG. 6

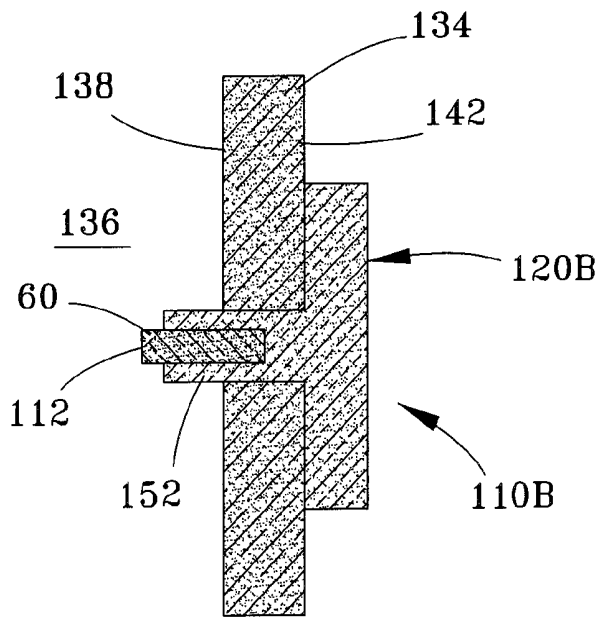
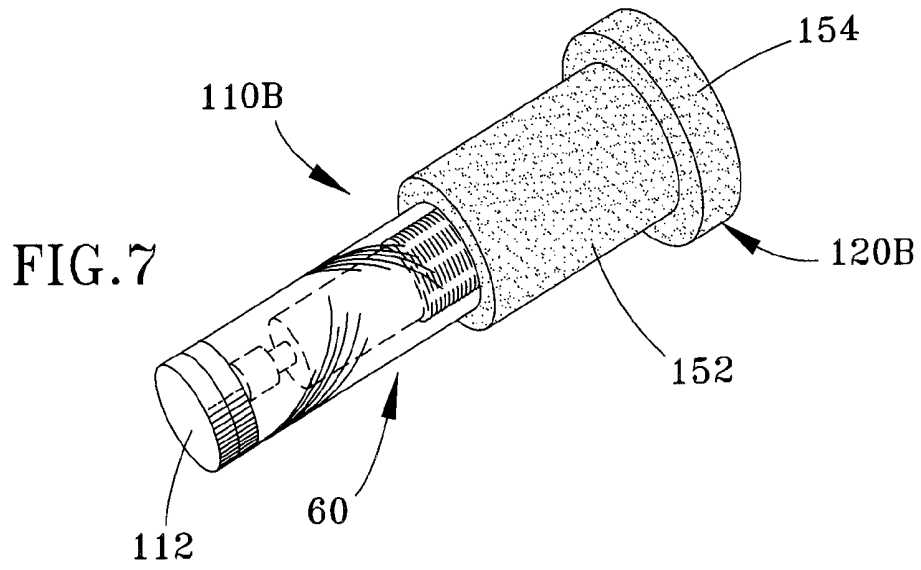


FIG. 8

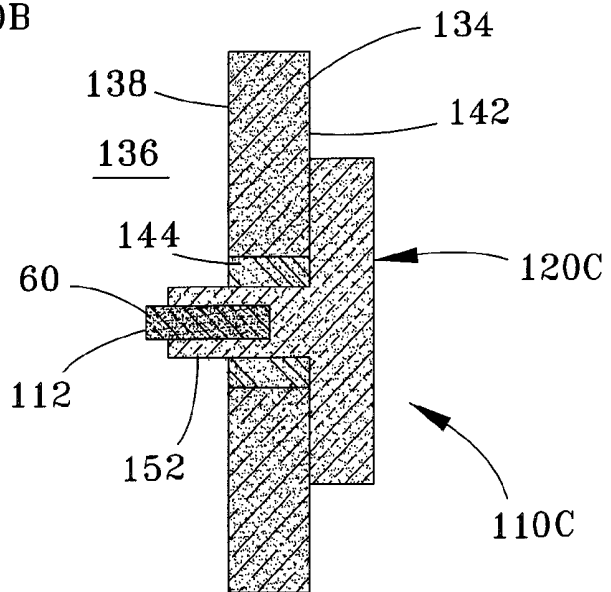


FIG. 9

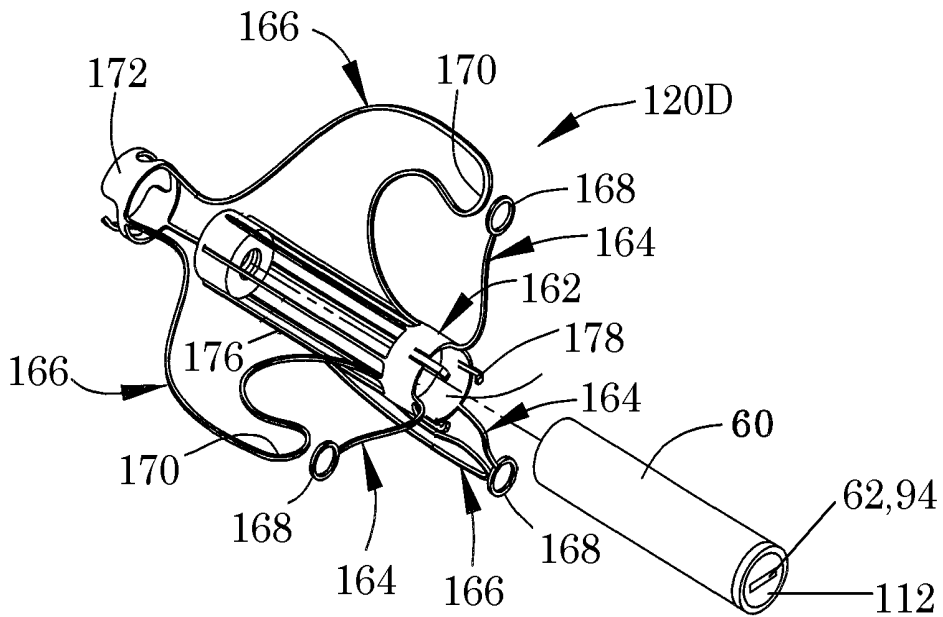


FIG. 10

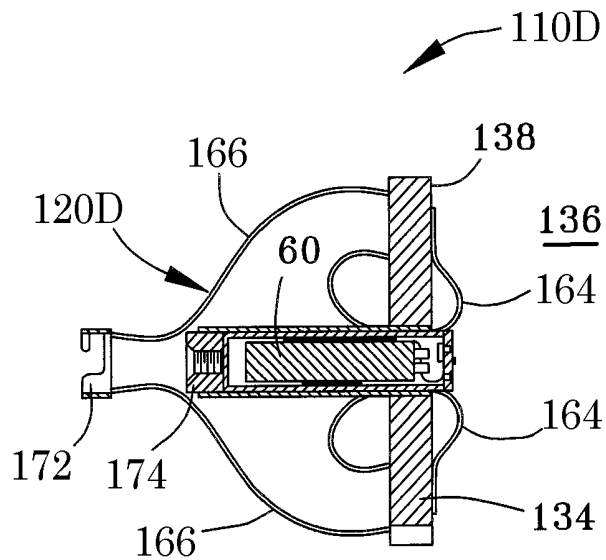


FIG. 11

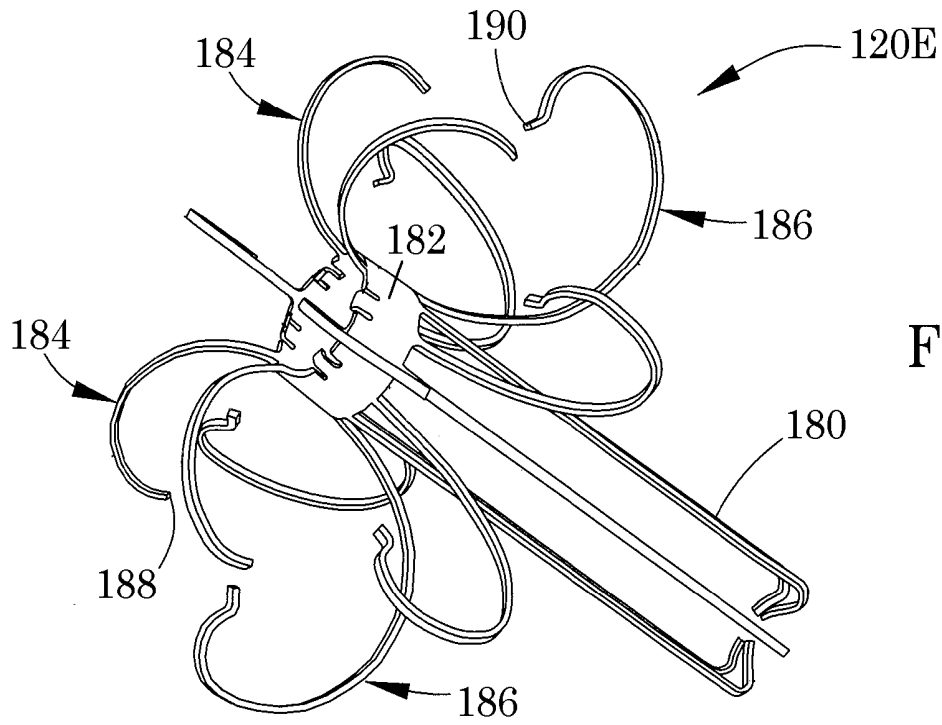


FIG. 12

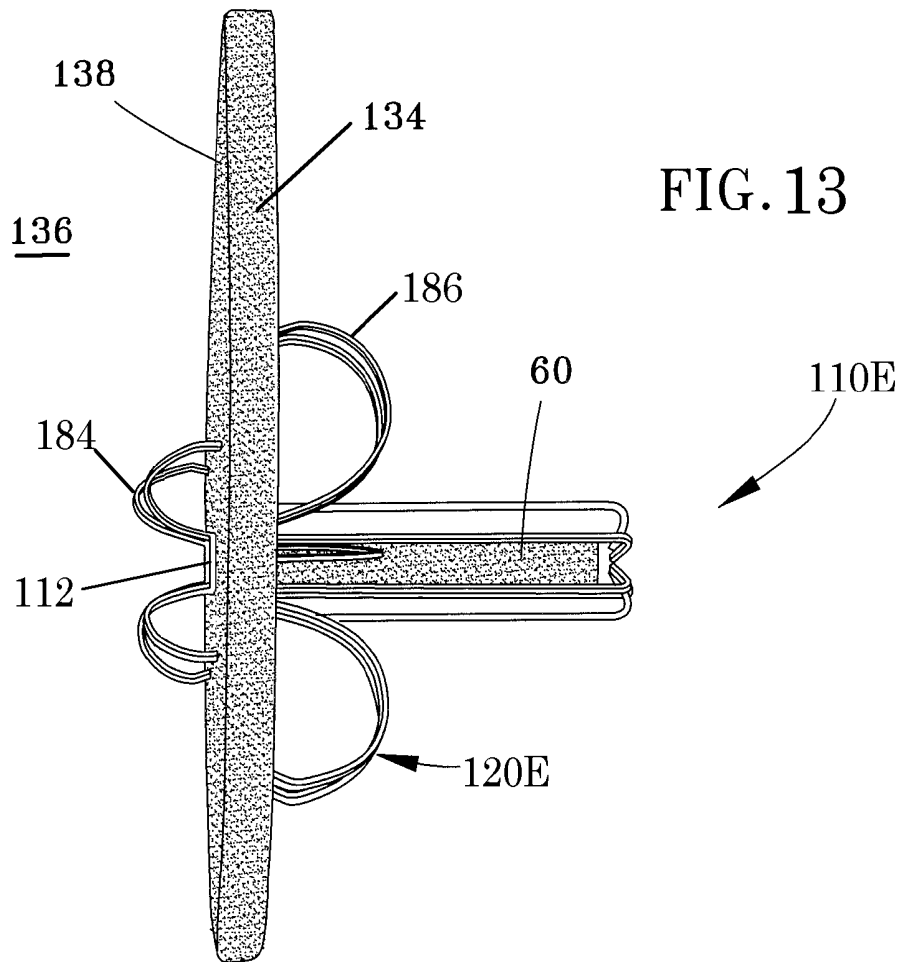
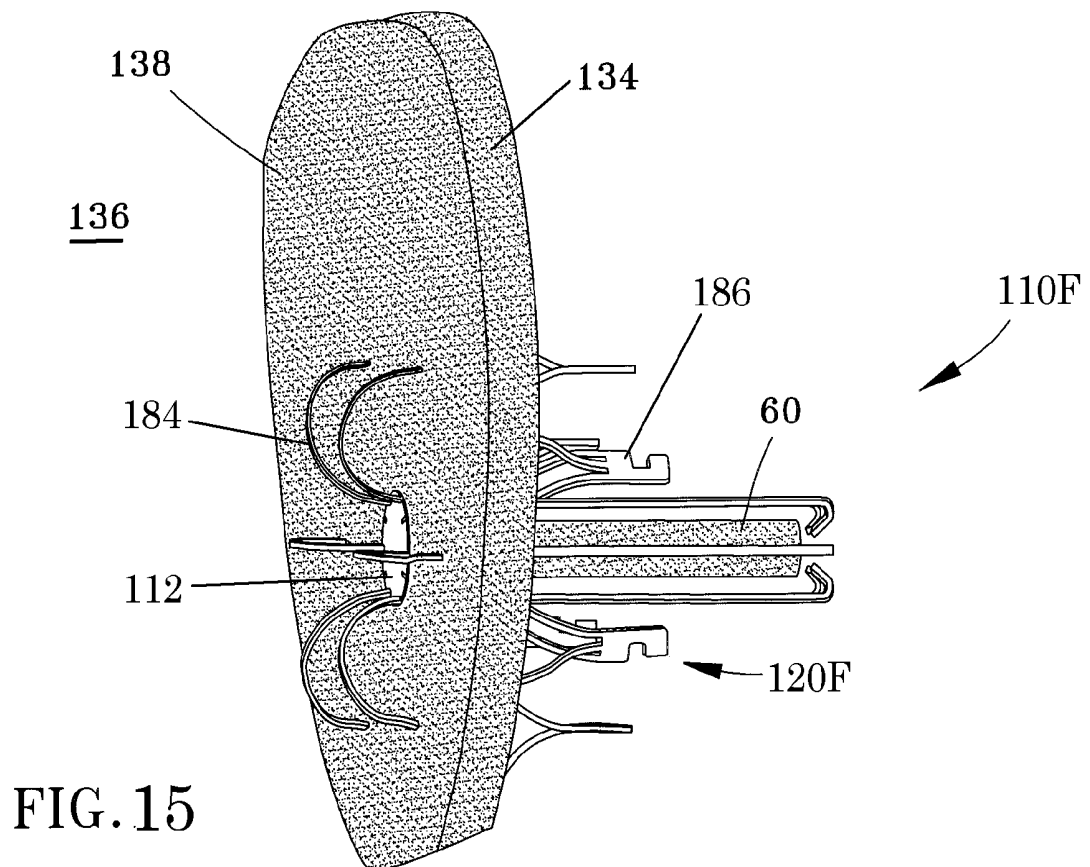
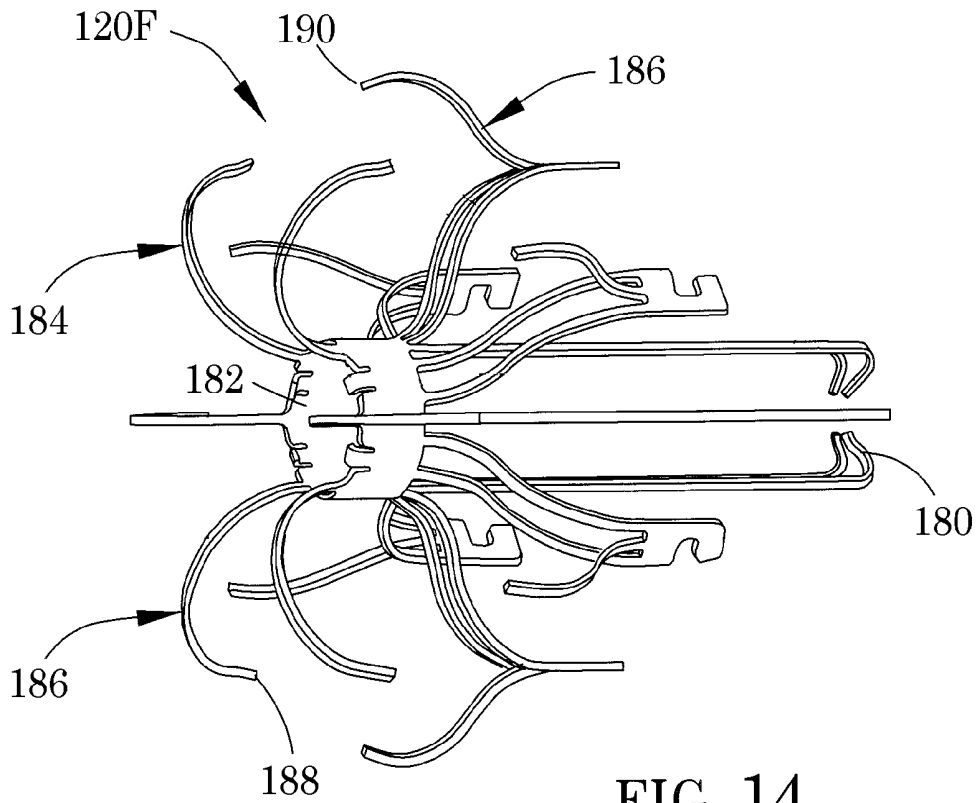


FIG. 13



MINIMALLY-INVASIVE PROCEDURE FOR MONITORING A PHYSIOLOGICAL PARAMETER WITHIN AN INTERNAL ORGAN

CROSS REFERENCE TO RELATED APPLICATIONS

This is a division patent application of U.S. patent application Ser. No. 12/145,546, filed Jun. 25, 2008 and now U.S. Pat. No. 8,322,346, which claims the benefit of U.S. Provisional Application Nos. 60/937,321 filed Jun. 28, 2007 and 60/937,457 filed Jun. 28, 2007. The contents of these prior patent applications are incorporated herein by reference. In addition, this application is related to U.S. patent application Ser. No. 12/111,954 filed Apr. 29, 2008 and now U.S. Pat. No. 8,267,863, whose contents are also incorporated herein by reference.

BACKGROUND OF THE INVENTION

The present invention generally relates to implantable medical devices, monitoring systems and implantation procedures. More particularly, this invention relates to a minimally-invasive surgical procedure for implanting a sensing device adapted to monitor one or more physiological properties of a living body, such as pressure, temperature, flow, acceleration, vibration, composition, and other properties of biological fluids within an internal organ.

Various implantable devices have been developed to monitor and wirelessly communicate physiological parameters of the heart, as well as physiological parameters of other internal organs, including the brain, bladder and eyes. Such predicate wireless devices can generally be divided into two functional categories: large-sized (pacemaker-type) and smaller-sized telemetric devices. An example of a pacemaker-type wireless pressure sensor is the LVP-1000 Left Ventricular Pressure Monitoring System under development by Transoma Medical, Inc. The LVP-1000 comprises a sensor adapted to be implanted into an external wall of the heart, a wireless transmitting unit adapted to be located elsewhere within the patient, and wiring that physically and electrically connects the sensor and transmitting unit. The sensor of the LVP-1000 is adapted to be secured with sutures to the left side of the heart during an open-chest surgical procedure.

Smaller telemetric sensors include batteryless pressure sensors developed by CardioMEMS, Inc., Remon Medical, and the assignee of the present invention, Integrated Sensing Systems, Inc. (ISSYS). For example, see commonly-assigned U.S. Pat. Nos. 6,926,670 and 6,968,734 to Rich et al., and N. Najafi and A. Ludomirsky, "Initial Animal Studies of a Wireless, Batteryless, MEMS Implant for Cardiovascular Applications," *Biomedical Microdevices*, 6:1, p. 61-65 (2004). With such technologies, pressure changes are can be sensed with an implant equipped with a mechanical capacitor (tuning capacitor) having a fixed electrode and a moving electrode, for example, on a diaphragm that deflects in response to pressure changes. The implant is further equipped with an inductor in the form of a fixed coil that serves as an antenna for the implant, such that the implant is able to receive radio frequency (RF) signals from outside the patient and transmit the frequency output of the circuit. The implant can be placed directly within the heart chamber whose pressure is to be monitored, or in an intermediary structure such as the atrial or ventricular septum. Implantation involves a transluminal implantation technique using a placement catheter to deliver

the implant to a chamber of the heart or another cardiovascular chamber, after which the implant is secured to an interior wall surface of the chamber.

FIGS. 1a and 1b represent two types of wireless pressure sensing schemes disclosed in the Rich et al. patents. In FIG. 1a, an implant 10 is shown as operating in combination with a non-implanted external reader unit 20, between which a wireless telemetry link is established using a resonant scheme. The implant 10 contains a packaged inductor coil 12 and a pressure sensor in the form of a mechanical capacitor 14. Together, the inductor coil 12 and capacitor 14 form an LC (inductor-capacitor) tank resonator circuit that has a specific resonant frequency, expressed as $1/(LC)^{1/2}$, which can be detected from the impedance of the circuit. At the resonant frequency, the circuit presents a measurable change in magnetically-coupled impedance load to an external coil 22 associated with the reader unit 20. Because the resonant frequency is a function of the capacitance of the capacitor 14, the resonant frequency of the LC circuit changes in response to pressure changes that alter the capacitance of the capacitor 14. Based on the coil 12 being fixed and therefore having a fixed inductance value, the reader unit 20 is able to determine the pressure sensed by the implant 10 by monitoring the resonant frequency of the circuit.

FIG. 1b shows another wireless pressure sensor implant 30 operating in combination with a non-implanted external reader unit 50. A wireless telemetry link is established between the implant 30 and reader unit 50 using a passive, magnetically-coupled scheme, in which on-board circuitry of the implant 30 receives power from the reader unit 50. In the absence of the reader unit 50, the implant 30 lays passive and without any internal means to power itself. When a pressure reading is desired, the reader unit 50 must be brought within range of the implant 30.

In FIG. 1b, the implant 30 contains a packaged inductor coil 32 and a pressure sensor in the form of a mechanical capacitor 34. The reader unit 50 has a coil 52 by which an alternating electromagnetic field is transmitted to the coil 32 of the implant 30 to induce a voltage in the implant 30. When sufficient voltage has been induced in the implant 30, a rectification circuit 38 converts the alternating voltage on the coil 32 into a direct voltage that can be used by electronics 40 as a power supply for signal conversion and communication. At this point the implant 30 can be considered alert and ready for commands from the reader unit 50. The implant 30 may employ the coil 32 as an antenna for both reception and transmission, or it may utilize the coil 32 solely for receiving power from the reader unit 50 and employ a second coil 42 for transmitting signals to the reader unit 50. Signal transmission circuitry 44 receives an encoded signal generated by signal conditioning circuitry 46 based on the output of the capacitor 34, and then generates an alternating electromagnetic field that is propagated to the reader unit 50 with the coil 42.

The implant 30 is shown in FIG. 1b without a battery, and therefore its operation does not require occasional replacement or charging of a battery. Instead, the energy required to perform the sensing operation is entirely derived from the reader unit 50. However, the implant 30 of FIG. 1b could be modified to use a battery or other power storage device to power the implant 30 when the reader unit 50 is not sufficiently close to induce a voltage in the implant 30, in which case the wireless telemetry link between the implant 30 and reader unit 50 uses an active magnetically-coupled scheme.

BRIEF SUMMARY OF THE INVENTION

The present invention provides a minimally-invasive surgical procedure for monitoring one or more physiological

parameters within an internal organ of a living body, such as the human heart, brain, kidneys, lungs, bladder, etc. The procedure entails endoscopically placing a miniature implantable sensing device through an external wall of the organ, such as a wall of the heart, blood vessel, kidneys, lungs, bladder, etc., or a wall surrounding the organ, such as the abdominal wall or the meninges surrounding the brain.

The minimally-invasive surgical procedure makes use of at least one sensing unit adapted to be implanted in the living body and attached to an organ therein, and a readout device that is not adapted to be implanted in the living body. The sensing unit includes a sensing device having a sensing element adapted to sense the physiological parameter within the organ, and an anchor to which the sensing device is secured. The sensing unit is adapted for placement in an incision in an external wall of the organ so that when a distal end of the sensing unit is within the wall or extends into the internal cavity, an oppositely-disposed proximal end of the sensing unit is outside the organ and the sensing unit occludes the incision. The readout device telemetrically communicates with the sensing device to obtain a reading of the physiological parameter.

The minimally-invasive surgical procedure generally entails making a first incision in a living body to enable access to the internal organ. An endoscopic instrument is then inserted through the first incision and a second incision is made therewith through an external wall of the organ and into the internal cavity thereof. The sensing unit is then placed in the second incision such that a distal end of the sensing unit is within the wall or extends into the internal cavity. The sensing unit includes a sensing device having a sensing element adapted to sense the physiological parameter within the organ, and an anchor to which the sensing device is secured. The sensing unit is placed in the second incision so that a proximal end of the sensing unit is outside the organ and the sensing unit occludes the incision. The anchor is then secured to the external wall of the organ such that the sensing device is secured within the second incision by only the anchor. The first incision can then be closed, after which the readout device is used outside the living body to telemetrically communicate with the sensing device and obtain a reading of the physiological parameter.

The minimally-invasive surgical procedure is intended to be particularly well-suited for providing safe, fast, detailed, real-time, and continuous measurements for both short-term and long-term applications, such as over a period of hours, days, weeks or longer in an emergency room or hospital. In cases where the patient is moved to a rehabilitation facility, the sensing device can be utilized for much longer periods and data relating to the physiological parameter(s) being monitored can be wirelessly sent to a physician or nurse in order to provide diagnostic tailored treatment of the patient. For patients that need even longer term monitoring, at-home monitoring can be easily accomplished by tying the readout device to the Internet, telephone, or other long-distance communication system. The wireless sensing device can be configured for batteryless operation, allowing the device to potentially function for a patient's lifetime with no maintenance or need for replacement after initial implantation.

Miniaturization of the sensing unit can be effectively achieved by fabricating the sensing element as a miniature MEMS (micro-electromechanical system) sensor, combined with custom electronics and a telemetry antenna. A preferred aspect of the invention is to limit the volume protrusion of the sensing unit into the cavity being monitored. In the case of the heart, the risk of thrombogenesis can be significantly reduced by limiting protrusion of the sensor unit into the blood stream

within a heart chamber, in terms of distance into the cavity as well as shape and size of the protruding portion of the sensing unit. For this purpose, the sensing device is preferably configured so that the sensing element is located on a distal surface (relative to insertion direction) of the device, such that only the distal surface of the sensing device need contact the biological fluid being monitored.

The implantation procedure and sensing system of this invention can be used to measure a variety of physiological parameters, a particularly notable example of which is physiological pressures such as cardiovascular pressures, intracranial pressures, intra-sac pressures, radial artery pressure, pulmonary artery pressure, etc. A key advantage of the invention is that only a small portion of the sensing system—namely, the sensing device and its anchor—need be implanted inside the body, with only a portion thereof actually being within the organ, while the remaining members of the system—including the readout unit—are located outside the organ and, in the case of the readout unit, outside the body. As a result, the procedure for implanting the sensing device as well as the device itself are minimally invasive, which allows greater flexibility in the implant location and allows the sensing device to be used in many areas and organs of the body, including the heart. When used in the heart, the sensing device greatly reduces the risk of complications, in particular thrombosis and thrombogenicity.

Other objects and advantages of this invention will be better appreciated from the following detailed description.

BRIEF DESCRIPTION OF THE DRAWINGS

FIGS. 1a and 1b are block diagrams of wireless pressure monitoring systems that utilize resonant and passive sensing schemes, respectively, which can be utilized by monitoring systems of this invention.

FIGS. 2a and 2b are schematic representations of wireless sensing devices suitable for use in wireless monitoring systems of this invention.

FIG. 2c is a schematic representation of a readout device suitable for use in wireless monitoring systems of this invention.

FIG. 3 schematically represents internal components of processing circuitry suitable for use in the sensing devices of FIGS. 2a and 2b.

FIG. 4 represents a perspective view of a cylindrical self-contained sensing device of the type represented in FIGS. 2a and 2b.

FIG. 5 schematically represents the sensing device of FIG. 4 assembled with a dome-type anchor to form a sensing unit ready for implantation in accordance with a first embodiment of the invention.

FIG. 6 schematically represents the sensing unit of FIG. 5 implanted in a wall of an internal organ in accordance with the first embodiment of the invention.

FIG. 7 schematically represents the sensing device of FIG. 4 assembled with a bolt-type anchor in accordance with a second embodiment of the invention.

FIGS. 8 and 9 schematically represent sensing units equipped with bolt-type anchors implanted in a wall of an internal organ in accordance with the second embodiment of the invention.

FIGS. 10, 12 and 14 schematically represent alternative anchors suitable for use with the sensing device of FIG. 4 to form sensing units in accordance with additional embodiments of the invention.

FIGS. 11, 13 and 15 schematically represent the sensing units of FIGS. 10, 12 and 14, respectively, implanted in a wall

of an internal organ in accordance with the additional embodiments of the invention.

DETAILED DESCRIPTION OF THE INVENTION

Illustrated in FIGS. 2a through 13 are monitoring systems and components thereof that implement one or more implantable sensors configured to be placed through an external wall of an internal organ for monitoring one or more physiological parameters within an internal cavity of the organ. Organs of particular interest include but are not limited to the heart, brain, kidneys, lungs, and bladder. The physical footprint of the implanted portion of each monitoring system is limited to the sensing device, its anchor and optionally a separate antenna, such that the sensing unit can be far smaller than, for example, the Transoma Medical, Inc., LVP-1000 Left Ventricle Pressure Monitoring System, which must be physically connected to a relatively large remote transmitting device.

While the resonant, passive and active schemes described in reference to FIGS. 1a and 1b are also within the scope of the invention, sensing devices of this invention are preferably passive and preferably translate a physiologic parameter into a frequency tone and modulate the impedance of an antenna with the frequency tone to communicate the physiologic parameter to an external readout unit. FIG. 2a represents a wireless implantable sensing device 60 as comprising a transducer 62, electronic circuitry 64 (e.g., an application specific integrated circuit, or ASIC), and an antenna 66. These and any additional or optional components (e.g., additional transducers) of the sensing device 60 are preferably contained in a single sealed housing 72. The antenna 66 is shown as comprising a coil 68 (e.g., copper windings) wrapped around a core 70 (e.g., ferrite), though other antenna configurations and materials are foreseeable. The transducer 62 is preferably a MEMS device, more particularly a micromachine fabricated by additive and subtractive processes performed on a substrate. The substrate can be rigid, flexible, or a combination of rigid and flexible materials. Notable examples of rigid substrate materials include glass, semiconductors, silicon, ceramics, carbides, metals, hard polymers, and TEFLON. Notable flexible substrate materials include various polymers such as parylene and silicone, or other biocompatible flexible materials. A particular but nonlimiting example of the transducer 62 is a MEMS capacitive pressure sensor for sensing pressure, such as various blood pressures within the heart, intracranial pressure, intraocular pressure, etc., though other materials and any variety of sensing elements, e.g., capacitive, inductive, resistive, piezoelectric, etc., could be used. For example, the transducer 62 could be configured to sense temperature, flow, acceleration, vibration, pH, conductivity, dielectric constant, and chemical composition, including the composition and/or contents of a biological fluid, for example, oxygen, carbon dioxide, glucose, gene, hormone, or gas content of the fluid. The sensing device 60 may be powered with a battery or other power storage device, but in preferred embodiments is powered entirely by a remote device that is not configured for implantation, such as a readout unit 80 represented in FIG. 2c.

Because the sensing device 60 is equipped with a built-in antenna 66, the device 60 requires only an anchor for implantation, and does not require a wire, cable, tether, or other physical component that conducts the output of the sensing device 60 to a separate location where another component utilizes the output of the sensing device and/or transmits the output of the sensing device to a location outside the body of the patient. In FIG. 2b, consistent reference numbers are used to identify functionally equivalent structures of a second

wireless implantable sensing device 60 that differs from the device 60 of FIG. 2a by the placement of the antenna 66 outside the housing 72. The antenna 66 is shown as comprising a conductive coil 68 patterned on a substrate 74, and connected to the device 60 with wires 76. The substrate 74 can be rigid, flexible, or a combination of rigid and flexible materials such as those described above in reference to the transducer 62, and may carry additional electronics. The antenna 66 can be placed remotely from the sensing device 60, such as immediately under the skin, to provide better wireless transmission between the device 60 and the readout device 80 of FIG. 2c. A remotely-placed antenna for use with the invention can also be configured in accordance with the antenna 66 as shown in FIG. 2a, with a coil 68 wrapped around a core 70 and connected to the device 60 with wires 76.

In addition to powering the sensing device 60, the readout unit 80 is represented as being configured to receive an output signal from the sensing device 60, process the signal, and relay the processed signal as data in a useful form to a user. The readout unit 80 is shown equipped with circuitry 82 that generates a high-frequency (e.g., 13.56 MHz), high-power signal for an antenna 84 to create the magnetic field needed in communicate with the sensing device 60. The readout unit 80 contains additional circuitry 86 to receive and demodulate a backscattered signal from the sensing device 60, which is demodulated and then processed with a processing unit 88 using calibration coefficients to quantify the physiological parameter of interest. The readout unit 80 is further shown as being equipped with a user interface 90, by which the operation of the readout unit 80 can be controlled to allow data logging or other user control and data examination.

FIG. 3 represents a block diagram showing particularly suitable components for the electronic circuitry 64 of FIGS. 2a and 2b. The circuitry 64 includes an oscillator 92, for example a relaxation oscillator, connected to a resistor 93 and a MEMS mechanical capacitor 94. A preferred MEMS capacitor 94 comprises a fixed electrode and a moving electrode on a diaphragm that deflects relative to the fixed electrode in response to pressure, such that the capacitor 94 is able to serve as a pressure sensing element for the transducer 62. A nonlimiting example of a preferred MEMS capacitor 94 has a pressure range of about -100 to about +300 mmHg, with an accuracy of about 1 mmHg. Alternatively, a variable resistor transducer could be used with a fixed capacitance, or an inductor could be substituted for the transducer or fixed circuit element. Based on the RC or other time constant ($1/(LC)^{1/2}$), the oscillator 92 produces a frequency tone that directly relates to the capacitive value of the capacitor 94 and, therefore, the physiologic parameter of interest.

The circuitry 64 is further shown as including a modulator 96, with which the frequency tone of the oscillator 92 is encoded on a carrier frequency, placed on the antenna 66, and then transmitted to the readout unit 80. This is accomplished simply by opening and closing a switch 98 and adding a capacitance 100 to the antenna matching circuit, resulting in an AM (amplitude modulation) LSK (load shift keying) type modulation. This transmission approach is similar to that used in RFID (radio frequency identification) communications, except RFID does not typically encode analog information but instead encodes a few digital bits either on an AM LSK or FSK (frequency shift keying) modulation.

Because the preferred embodiment of the sensing device 60 does not utilize wires to transmit data or power to the readout unit 80, nor contains an internal power source, the circuitry 64 further includes a regulator/rectifier 102 to extract its operating power from an electromagnetic (EM) waves generated by the readout unit 80 or another EM power

source. The regulator/rectifier **102** rectifies incoming power from the inductive antenna **66** and conditions it for the other circuit components within the circuitry **64**. Finally, a matching circuit **104** is shown as comprising a trimmable capacitor bank **106** to resonate the inductor antenna **66**, which is energized by the magnetic field and backscatters data as previously described.

As an alternative to the embodiment of FIG. **3**, the modulator **96** could use a 13.56 MHz (or other frequency) magnetic field as a clock reference to create a second carrier frequency, such as one that is one-quarter or another sub-multiple or multiple of the original frequency. The second carrier frequency can then be amplitude modulated (AM) using the oscillator frequency tone and transmitted to the readout unit **80** via the same antenna **66**. In this embodiment, the readout unit **80** may or may not have a second antenna to receive the second carrier frequency-based AM signal.

The communication scheme described above differs from resonate tank communication systems that use capacitive pressure transducer elements in conjunction with an inductor/antenna. In particular, the circuitry **64** allows the use of any frequency for the high power readout unit **80**, which in preferred embodiments utilizes an industrial, scientific, medical (ISM) band frequency. In contrast, the frequencies and potentially large bandwidths required of resonate tank communication systems are subject to FCC emission limitations, likely requiring the use of extra shielding or potentially other measures taken in the facilities where the sensing device **60** and readout unit **80** are to be used. Another feature of the circuitry **64** is the allowance of more combinations of oscillator elements to be used. Because resonator tank systems require an inductive element and a capacitive element in which at least one of the elements serves as a transducer, resonator tank systems do not lend themselves well to resistive-based or other based sensors. Finally, the circuitry **64** also allows for signal conditioning, such as transducer compensation, which allows for such items as removing temperature dependence or other non-idealities that may be inherent to the transducer **62**. In the preferred embodiment, a negative temperature coefficient of the MEMS capacitor **94** can be compensated with simple circuitry relying on the positive temperature coefficient of resistor elements arranged in a trimmable bank of two resistor units with largely different temperature coefficients that can be selectively added in a trimming procedure in production to select the precise level to compensate the transducer variation.

In the past, the restrictive levels of energy available to small implantable medical sensing devices and the desire to maximize data rates to capture more detailed physiological parameter response have been met with a robust type of analog communication that places information on the frequency rather than amplitude of the carrier. In U.S. Pat. No. 6,929,970 to Rich et al., a secondary carrier frequency is used for communication with an interrogator unit, resulting in a technique that consumes substantially more power in the implant and requires a second external antenna to receive the signal. The greater power consumption of the implant necessitates a tradeoff between smaller size and longer communication range. In contrast, the communication scheme described above for this invention draws upon the RFID-type communications, such as those described in U.S. Pat. Nos. 7,015,826 and 6,622,567, whose contents are incorporated herein by reference. However instead of communicating digital data using a fixed rate clock, the present invention transmits analog information as the frequency of the clock to lower power consumption and enhance powering and communication range. In this way, much of the readout unit **80** can utilize

hardware that is commercially available for RFID, except that a different demodulator is required. An early example of RFID can be found in U.S. Pat. No. 4,333,072.

FIG. **4** depicts a preferred example of the housing **72** as having a cylindrical shape with a flat distal face **112**. (The terms “distal” and “proximal” are used herein in reference to orientation during the implantation procedure described below.) Other shapes are also possible, for example, a torpedo-shape in which the peripheral face **114** of the housing **72** immediately adjacent the distal face **112** is tapered or conical (not shown). The housing **72** can be formed of glass, for example, a borosilicate glass such as Pyrex Glass Brand No 7740 or another suitably biocompatible material. A biocompatible coating, such as a layer of a hydrogel, titanium, nitride, oxide, carbide, silicide, silicone, parylene and/or other polymers, can be deposited on the housing **72** to provide a non-thrombogenic exterior for the biologic environment in which the sensing device **60** will be placed. As can be seen in FIG. **4**, the inductive antenna **66** (comprising the copper coil **68** surrounding the core **70** of FIG. **2a**) occupies most of the internal volume of the housing **72**. The size of the antenna **66** is governed by the need to couple to a magnetic field to enable telepowering with the readout unit **80** from outside the body, for example, a transmission distance of about 10 cm or more. The cylindrical shape of the housing **72** is convenient for the sensing device **60** to be endoscopically placed with anchors discussed in reference to FIGS. **5** through **15**. The circuitry **64** is disposed between the antenna **66** and an end of the housing **72** that preferably carries the transducer **62**. A nonlimiting example of an overall size for the housing **72** is about 3.7 mm in diameter and about 16.5 mm in length.

A preferred aspect of the invention is to locate the transducer **62** on a distal surface of the sensing device **60**, for example, the flat distal face **112** of the cylindrical housing **72**, or on the peripheral face **114** of the housing **72** immediately adjacent the distal face **112**. In a preferred embodiment, the flat distal face **112** is defined by a biocompatible semiconductor material, such as a heavily boron-doped single-crystalline silicon, in whose outer surface the pressure-sensitive diaphragm (or other sensing element **94**) is formed. In this manner, only the distal face **112** of the housing **72** need be in contact with a biological fluid whose physiological parameter is to be monitored. In the case of monitoring pressure within the heart, this aspect of the invention can be utilized to minimize protrusion of the sensing device **60** into the heart chamber, thereby reducing the risk of thrombogenesis.

FIGS. **5** through **15** represent embodiments for anchors with which the sensing device **60** of FIG. **4** can be anchored to a wall of an internal organ, for example, by making an incision in the wall from the exterior of the organ, inserting the sensing device **60** in the incision from the exterior side of the wall, and then securing the sensing device **60** to the wall. According to a preferred aspect of the invention, access to the organ and implantation of the sensing device **60** is achieved using an endoscope, for example, via laparoscopic surgery, thoracoscopic surgery, or another similar minimally-invasive procedure, as opposed to transluminal implantation techniques using a placement catheter that places a sensing device within an organ and then secures the device to an interior wall surface of the organ. As an endoscopic procedure, an endoscope or other suitable instrument comprising a rigid or flexible tube is utilized to enable the procedure to be visual observed, as well as the use of instruments for making the incision and securing the anchor as required by the invention. The procedure can be performed through small incisions (on the order of a few centimeters, for example, about three centimeters or less) as compared to much larger incisions needed

in traditional surgical procedures. The procedure may entail insufflation of the body cavity surrounding the organ to create a working and viewing space for implantation and securement of the sensing device 60.

Together, the sensing device 60 and the anchors of FIGS. 5 through 15 form sensing units that have minimal protrusion into the organ when implanted through the organ wall from the exterior of the organ. Maximum protrusion of the sensing units is preferably not more than one centimeter, more preferably not more than eight millimeters, for example between about 0.5 to about 2 millimeters, with a preferred volumetric protrusion of not more than about 0.02 cm³. The distal end of the sensing units (for example, as defined by the distal face 112 of the housing 72 and/or the distal end of the anchor) may also be slightly recessed below the internal surface of the wall, for example, up to about two millimeters from the internal surface of the wall. Particularly suitable materials for the anchors include but are not limited to NITINOL, TEFLON, polymers such as parylene, silicone and PEEK, metals, glass, and ceramics.

In FIGS. 5 and 6, an anchor 120A is shown configured to have a distal tubular portion 122 partially surrounded by a proximal dome-shaped portion 124. The anchor 120A is preferably in accordance with the teachings of commonly-assigned U.S. patent application Ser. No. 12/111,954 to Najafi et al., whose contents regarding anchor construction and use are incorporated herein by reference. The sensing device 60 is axially disposed within the tubular portion 122 to yield a sensing unit 110A in which the distal face 112 carrying the transducer 62 protrudes from the tubular portion 122. The sensing device 60 can be secured in the tubular portion 122 by any suitable means, such as an interference fit, a biocompatible epoxy, glue or cement, or any other type of attachment method or combinations of attachment methods known to those skilled in the art. The dome-shaped portion 124 generally joins the tubular portion 122 at an end 125 opposite the open end 126 of the tubular portion 122 through which the sensing device 60 is received. The dome-shaped portion 124 defines a substantially tubular section 130 that circumscribes the tubular portion 122 and terminates at an edge 128 short of the open end 126 of the tubular portion 122. Multiple oblong openings 132 are defined in the tubular section to enable the anchor 120A to be secured to a wall of an internal organ, such as with standard surgical sutures or another suitable attachment technique that can be performed during the endoscopic procedure, such as nails, screws, springs, and biocompatible adhesives such as cements, glues, epoxies, etc.

FIG. 6 depicts the sensing unit 110A of FIG. 5 implanted in an incision in a wall 134 of an internal organ for the purpose of sensing a physiological parameter of a biological fluid within an internal cavity 136 of the organ. The wall 134 may be an exterior wall of the heart, a blood vessel, kidneys, lungs, bladder, etc., or a wall surrounding an organ, such as the abdominal wall or the meninges surrounding the brain. As evident from FIG. 6, only the tubular portion 122 of the anchor 120A is inserted into the incision, and the dome-shaped portion 124 remains entirely outside the incision; as such, the tubular and dome-shaped portions 122 and 124 are not configured to clamp the wall 134 therebetween. Furthermore, the anchor 120A does not protrude through the wall 134, but instead is recessed in the wall 134, whereas the distal end 112 of the sensing device 60 protrudes into the internal cavity 136 of the organ. As noted above, the distance the distal end 112 protrudes from the internal surface 138 of the wall 134 (for example, the endocardium lining a chamber of the heart) is preferably not more than one centimeter, and more preferably not more than eight millimeters. As also noted

above, the sensing device 60 and anchor 120A could be configured so that the anchor 120A, and not the sensing device 60, protrudes beyond the wall 134, in which case the distal end 112 of the sensing device 60 may be recessed up to about two millimeters from the internal surface 138 of the wall 134. Again, the anchor 120A preferably does not protrude more than one centimeter, and more preferably not more than eight millimeters, beyond the internal surface 138 of the wall 134. Finally, it is within the scope of the invention that both the anchor 120A and the sensing device 60 could protrude into the internal cavity 136, or that neither the anchor 120A nor the sensing device 60 protrudes into the internal cavity 136, but instead are recessed in the wall 134.

FIG. 6 further shows the inclusion of a felt pad 140 between the peripheral edge 128 of the anchor 120A and the external surface 142 of the wall 134. A suitable material for the felt pad 140 is standard surgical grade felt. The anchor 120A and the felt pad 140 can be simultaneously attached (e.g., sutured) to the wall 134. Depending on the material from which it is formed, the felt pad 140 may be used to promote cell (tissue) growth and encapsulation of the incision, leading to further stabilization of the sensing unit 110A.

FIGS. 7 and 8 show an anchor 120B that is again configured to have a distal tubular portion 152, but with a proximal disk-shaped portion 154. Such an anchor is also disclosed in commonly-assigned U.S. patent application Ser. No. 12/111,954 to Najafi et al. As before, the sensing device 60 is shown axially disposed within the tubular portion 152, yielding a sensing unit 110B in which the distal face 112 of the device 60 carrying the transducer 62 protrudes from the tubular portion 152. Though not shown, the disk-shaped portion 154 may be formed to have multiple oblong openings to enable the anchor 120B to be secured to the wall 134 of an internal organ, such as with sutures or another suitable attachment technique that can be performed during the surgical procedure. In FIG. 9, a sensing unit 110C essentially identical to the unit 110B of FIGS. 7 and 8 is shown as further including a tubular insert 144 secured in the incision prior to placement of the remainder of the unit 110C. The insert 144 can be attached to the wall 134 with an interference fit, or with the use of a biocompatible cement, glue or epoxy, screws, springs, nails, etc. The tubular portion 152 of the anchor 120C can then be secured within the bore of the insert 144. A preferred aspect of this embodiment is that the anchor 120C is not permanently joined to the insert 144 to permit the exchange of the sensing unit 110C and/or its sensing device 60, and/or the use of a different anchor with additional features.

As evident from FIGS. 8 and 9, both anchors 120B and 120C and the sensing device 60 protrude into the internal cavity 136, with the sensing devices 60 protruding farther, though any of the configurations discussed in reference to FIGS. 5 and 6 could also be present in the embodiments of FIGS. 7 through 9.

FIGS. 10 through 15 show anchors that are adapted to clamp a wall of an organ, in contrast to the attachment techniques associated with the anchors 120A-C of FIGS. 5-9. As represented in FIGS. 11, 13, and 15, the sensing device 60 is recessed within anchors 120D, 120E, or 120F, and elements of the anchors 120D-F providing the clamping action extend farther into the internal cavity 136 of the organ than the distal face 112 of the device 60 carrying the transducer 62.

The anchor 120D shown in FIGS. 10 and 11 is preferably in accordance with the teachings of commonly-assigned U.S. Pat. No. 7,317,951 to Schneider et al., whose contents regarding the anchor construction and use are incorporated herein by reference. The anchor 120D is represented as having an annular-shaped central body 162 that defines a bore in which

the sensing device 60 is received. The central body 162 has arcuate arms 164 that extend substantially radially from a distal end of the central body 162, and arcuate members 166 that extend substantially radially and in the opposite direction from the proximal end of the central body 162. As can be seen from FIG. 10, each arm 164 is axially aligned with one of the arcuate members 166 so as to lie in the same plane as the arcuate member 166. Each arm 164 terminates with a pad 168 and each arcuate member 166 defines a leg 170 that oppose each other, such that the pads 168 and legs 170 cooperate to clamp the wall 134 as seen in FIG. 11.

The arcuate members 166 connect a ring 172 to the central body 162. A second ring 174 is axially spaced by struts 176 between the central body 162 and the ring 172, forming a cage for containing the sensing device 60. The sensing device 60 is secured within the central body 162 by crimping fingers 178 over the opening in which the sensing device 60 is received. The rings 172 and 174 can be configured to allow delivery and placement of the anchor 120D and its sensing device 60 using an appropriately-configured endoscopic instrument (not shown). As with the previous embodiments of the invention, the anchor 120D of FIGS. 10 and 11 is configured to place the distal face 112 of the device 60 carrying the transducer 62 in contact with fluid within the internal cavity 136 with minimal protrusion into the cavity 136 by either the device 60 or anchor 120D. In the configuration shown in FIGS. 10 and 11, the distal face 112 of the sensing device 60 is recessed beneath the internal surface 138 of the wall 134, and the arms 164 preferably do not protrude more than five millimeters into the cavity 136.

The anchors 120E and 120F of FIGS. 12 through 15 are preferably in accordance with the teachings of commonly-assigned U.S. patent application Ser. No. 11/684,910 to Goetzing et al., whose contents regarding these anchor constructions and their use are incorporated herein by reference. The anchor 120E of FIGS. 12 and 13 is shown as having an annular-shaped base 182 and retention legs 180 that cooperate to retain the sensing device 60 within the anchor 120E. Distal arms 184 and proximal legs 186 extend from distal and proximal ends, respectively, of the base 182. When deployed as shown, the arms 184 and legs 186 have arcuate shapes, each terminating with an extremity or tip 188 and 190, respectively. Each arm 184 and leg 186 lies in a different radial plane, with the result that the tips 188 and 190 of the arms 184 and legs 186 do not directly oppose each other when deployed, such that the wall 134 into which the anchor 120E is inserted is not locally compressed by directly opposing arms 184 and legs 186. Furthermore, the tips 188 and 190 of the arms 184 and legs 186 are preferably capable of piercing the wall 134, so that the tips 188 and 190 can become embedded in the wall 134 without puncturing the wall 134. The minimized compressive forces applied by the anchor 120E to the wall 134 is believed to reduce tissue killed after implantation, and the configurations of the arms 184 and legs 186 and their opposing actions also accommodate walls of differing thicknesses. The anchor 120E and its sensing device 60 can be delivered and placed using an appropriately-configured endoscopic instrument (not shown). As with the previous embodiments of the invention, the anchor 120E of FIGS. 12 and 13 is configured to place the distal face 112 of the device 60 carrying the transducer 62 in contact with fluid within the internal cavity 136 with minimal protrusion into the cavity 136 by either the device 60 or anchor 120E. In the configuration shown in FIGS. 12 and 13, the distal face 112 of the sensing device 60 protrudes not more than two millimeters into the cavity 136, and the arms 184 preferably do not protrude more than five millimeters into the cavity 136.

FIGS. 14 and 15 identify elements of the anchor 120F with the same reference numbers used in FIGS. 12 and 13 to identify functionally similar structures. The primary differences evident in the anchor 120F are the different configuration of its legs 186. The legs 186 have a compound deployment action, during which they initially spread radially and then travel axially in a distal direction until the tips 190 of the legs 186 engage and become embedded in the wall 134. As with the previous embodiments of the invention, the anchor 120F of FIGS. 14 and 15 is configured to place the distal face 112 of the device 60 in contact with fluid within the internal cavity 136 with minimal protrusion into the cavity 136 by either the device 60 or anchor 120F. In the configuration shown in FIGS. 14 and 15, the distal face 112 of the sensing device 60 is substantially flush with the internal surface 138 of the cavity 136, and the arms 184 preferably do not protrude more than five millimeters into the cavity 136.

To accurately locate the distal face 112 and its transducer 62 relative to the internal surface 138 of the wall 134, the thickness of the wall 134 can be measured using one or more of the following procedures: an echocardiogram; a pressure-sensitive needle inserted through the desired location for the implant, wherein the pressure signal displays atrial waveforms when the needle reaches the inside of the heart; or estimation of the wall thickness by observation of the patient's size and weight. Based on the wall thickness, an appropriate combination of sensing device 60 and anchor 120A-F can be selected to achieve a desired placement of the transducer 62 relative to the internal surface 138 of the cavity 136. Thereafter, the incision is made at the desired location for the sensing device 60. For example, using standard devices and procedures, a tool can be inserted into the incision and a small circular portion (for example, about 3.5 mm diameter) of the wall 134 is excised. The previously assembled sensing unit 110A-F (with the selected sensing device 60 and anchor 120A-F) is then inserted in the resulting circular hole, after which the anchor 120A-F is secured to the wall 134, for example, sutured to the myocardium and pericardial layer of the heart (FIGS. 5-9) or by deployment of the arms 164/184 and legs 166/186 (FIGS. 10-15).

In accordance with a preferred aspect of the invention, the sensing device 60 can be implanted to monitor a variety of physiological parameters. For example, the device 60 can be used to monitor radial artery pressure. In this embodiment, the sensing device 60 can be implanted with an anchor under the skin of the wrist above the radial artery, while the readout unit 80 is located outside the body. The device 60 may contain the antenna 66 (FIG. 2a) or the antenna 66 may be located elsewhere in the arm or body (FIG. 2b). The readout unit 80 or portions thereof can be located on the outside of the body in close proximity to the device 60, for example, worn on the wrist of the patient similar to a wrist watch.

The sensing device 60 can also be used to monitor intrasac pressures in an aneurysm sac of a patient who has had surgery to repair an abdominal aortic aneurysm or a thoracic aortic aneurysm. In this embodiment, the sensing device 60 can be implanted within the aneurysm sac, while the readout unit 80 is located outside the body. The device 60 may contain the antenna 66 (FIG. 2a) or the antenna 66 may be located elsewhere in the arm or body (FIG. 2b). The readout unit 80 or portions thereof can be located on the outside of the body in close proximity to the device 60, for example, worn on a belt.

Another example is to use the sensing device 60 to monitor intracranial pressures in patients with traumatic brain injuries (blunt trauma or penetrating trauma), including but not limited to patients with intracranial hemorrhage, closed head injuries, epidural hematoma, subdural hematoma, subarach-

noid hemorrhage, diffuse axonal injury, and intracranial hypertension. Depending on the type of injury, the sensing device 60 can be implanted with one of its anchors 120A-F, preferably one of the anchors 120A, 120B or 120C, using a minimally-invasive surgery technique into any area of the brain to place the distal face 112 of the device 60 (carrying the transducer 62) in contact with either brain tissue or fluid. Portions of the readout unit 80 and optionally the antenna 66 of the sensing device 60 can be implanted between the skull and scalp of the patient.

Still another example is to use the sensing device 60 to monitor pulmonary artery pressures and other cardiovascular pressures near or within the heart. For example, the sensing device 60 can be implanted with one of its anchors 120A-F, preferably one of the anchors 120A, 120B or 120C, through the outer wall of the right ventricle, left ventricle, right atrium, left atrium, left ventricular apex, right ventricular apex, left atrial appendage, right atrial appendage, pulmonary artery, etc. As particular examples, the sensing device 60 can be implanted in the ventricular apex (right or left) or the atrial appendage (left or right), with only the distal face 112 of the device 60 (carrying the transducer 62) being inside the ventricular apex or atrial appendage while the remainder of the sensing device 60 and its anchor 120A-F are either within the heart wall, outside the heart, in a different location within the body, and/or outside the body. In each case, the risk of complications inside the heart, in particular thrombosis and thrombogenicity, are greatly reduced.

In each of the above-noted embodiments and applications, the anchors 120A-F can be modified to provide other features beyond those described, for example, a device similar to an RFID tag can be added to the anchor such that it wirelessly transmits ID information concerning the sensing device 60. The ID information may include an ID number, ID name, patient name/ID, calibration coefficients/information, range of operation, date of implantation, valid life of the device (operation life), etc. The anchors 120A-F may further include additional capabilities such as features for connection to a catheter, shunt, or other device (not shown).

In addition to the sensing units 110A-F and reader unit 80 described above, the monitoring systems of this invention can be combined with other technologies to achieve additional functionalities. For example, the reader unit 80 can be implemented to have a remote transmission capability, such as home monitoring that may employ telephone, wireless communication, or web-based delivery of information received from the sensing units 110A-F by the reader unit 80 to a physician or caregiver. In this manner, the reader unit 80 can be adapted for remote monitoring of the organ and patient, closed-loop drug delivery of medications to treat the organ, closed-loop pacemaker parameter tuning to treat congestive heart failure or congestive heart failure related conditions, warning of critical worsening of congestive heart failure or congestive heart failure related conditions, portable or ambulatory monitoring or diagnosis, monitoring of battery operation, data storage, reporting global positioning coordinates for emergency applications, and communication with other medical devices chosen from the group consisting of pacemakers, left ventricular assist devices (LVAD), defibrillators, cardioverter defibrillators, drug delivery systems, non-drug delivery systems, and wireless medical management systems. Furthermore, the placement of the sensing units 110A-F can be utilized as part of a variety of different medical procedures, including early diagnosis of a heart failing due to congestive heart failure related conditions, early diagnosis of failure of the organ, early intervention in treatment of congestive heart failure related conditions, tailoring of medications, disease

management, identification of complications from congestive heart failure related conditions, identification of complications from cardiovascular disease related conditions, treatment of complications from congestive heart failure related conditions, treatment of complications from cardiovascular disease related conditions, pacing adjustments to the heart, reduction in frequency and severity of hospitalizations due to cardiovascular diseases, reduction in frequency and severity of hospitalizations due to congestive heart failure, tuning of defibrillator or pacemaker parameters to improve congestive heart failure related conditions, identification of mitral valve stenosis, treatment of mitral valve stenosis, feedback regarding the impact of medication on the organ, and chronic disease management of the organ.

While the invention has been described in terms of specific embodiments, it is apparent that other forms could be adopted by one skilled in the art. Therefore, the scope of the invention is to be limited only by the following claims.

The invention claimed is:

1. A minimally-invasive surgical procedure for placing a sensing device through a wall of an internal organ of a living body to sense a physiological parameter in an internal cavity of the organ, the procedure comprising:

making a first incision in the living body to enable access to the internal organ;

inserting an instrument through the first incision and making a second incision therewith through an external wall of the organ from an outer surface of the external wall and into the internal cavity thereof;

placing a sensing unit in the second incision such that a distal end of the sensing unit is within the external wall or extends into the internal cavity and a proximal end of the sensing unit is outside the organ and exterior of the external wall thereof, the sensing unit consisting essentially of a sensing device and an anchor to which the sensing device is secured, the sensing device having a distal end disposed at the distal end of the sensing unit and a sensing element that is disposed at the distal end of the sensing device and adapted to sense the physiological parameter within the internal cavity, the anchor comprising a distal portion that has arms and a proximal portion that has legs and defines the proximal end of the sensing unit, the distal portion of the sensing device and the distal portion of the anchor and the arms thereof being inserted through the second incision during the placing step, the proximal portion of the anchor and the legs thereof not being inserted into the second incision during the placing step but instead being external to the organ following the placing step;

securing the anchor to the external wall of the organ such that the sensing device is secured within the second incision by only the anchor, the sensing element is exposed to the internal cavity, the second incision is occluded by only the sensing unit, the arms of the distal portion radially expand outward to engage tips of the arms with an inner surface of the external wall of the organ, and the legs of the proximal portion of the anchor radially expand outward to engage tips of the legs with the outer surface of the external wall of the organ so that the tips of the arms and the tips of the legs clamp the external wall therebetween as a result of the securing step;

closing the first incision; and then

telemetrically communicating with the sensing device to obtain a reading of the physiological parameter using a readout device located outside the living body.

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2. The minimally-invasive surgical procedure according to claim 1, wherein the organ is chosen from the group consisting of a heart, blood vessel, meninges, kidney, lung, bladder, and abdominal wall.

3. The minimally-invasive surgical procedure according to claim 1, wherein the distal end of the sensing device is recessed within the anchor such that the anchor defines the distal end of the sensing unit.

4. The minimally-invasive surgical procedure according to claim 1, wherein the distal end of the sensing unit is recessed beneath an interior lining of the internal cavity, or is substantially flush with the interior lining, or extends into the internal cavity not more than one centimeter beyond the interior lining.

5. The minimally-invasive surgical procedure according to claim 1, wherein the distal end of the sensing unit does not extend more than one centimeter into the internal cavity following the securing step.

6. The minimally-invasive surgical procedure according to claim 1, wherein the organ is a heart, the internal cavity is a chamber of the heart, and the distal end of the sensing device is recessed up to about two millimeters beneath the endocardium of the chamber, or is substantially flush with the endocardium, or extends into the chamber up to eight millimeters beyond the endocardium.

7. The minimally-invasive surgical procedure according to claim 1, wherein the distal end of the sensing device has a distal face at which the sensing element is disposed, the physiological parameter is of a biological fluid within the internal cavity, and contact between the biological fluid and the sensing device is only at the distal face of the sensing device.

8. The minimally-invasive surgical procedure according to claim 1, wherein the distal face of the sensing element is flat and defined by a biocompatible semiconductor material.

9. The minimally-invasive surgical procedure according to claim 1, wherein the arms do not protrude more than five millimeters into the internal cavity following the securing step.

10. The minimally-invasive surgical procedure according to claim 1, wherein the legs have a compound deployment action by which the legs initially spread radially and then travel axially in a distal direction until the tips of the legs engage and become embedded in the external wall of the organ.

11. The minimally-invasive surgical procedure according to claim 1, wherein the sensing device has a cylindrical shape with the distal end thereof and an oppositely-disposed proximal end disposed within the anchor following the placing step, and the sensing element is at a distal surface defined by the distal end of the sensing device.

12. The minimally-invasive surgical procedure according to claim 1, wherein the physiological parameter is at least one chosen from the group consisting of pressure, temperature, flow, acceleration, vibration, composition of a biological fluid, oxygen content of a biological fluid, carbon dioxide content of a biological fluid, glucose content of a biological fluid, gene content of a biological fluid, hormone content of a biological fluid, and gas content of a biological fluid.

13. The minimally-invasive surgical procedure according to claim 1, wherein the sensing unit further comprises a telemetry antenna and the readout device comprises means for telemetrically communicating with the telemetry antenna of the sensing device and optionally means for electromagnetic powering of the sensing device.

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14. The minimally-invasive surgical procedure according to claim 13, wherein the telemetry antenna of the sensing unit is within the sensing device.

15. The minimally-invasive surgical procedure according to claim 13, wherein the telemetry antenna of the sensing unit is outside the sensing device and implanted at a location within the living body apart from the sensing device.

16. The minimally-invasive surgical procedure according to claim 13, wherein the telemetric communication between the sensing device and the readout device is established using a resonant or passive scheme in which the sensing device telemetrically receives power from the readout device.

17. The minimally-invasive surgical procedure according to claim 13, wherein the telemetric communication between the sensing device and the readout device is established using an active scheme in which the sensing device receives power from a battery within the sensing unit.

18. The minimally-invasive surgical procedure according to claim 1, wherein the sensing element comprises a micro-machined structure.

19. The minimally-invasive surgical procedure according to claim 1, wherein the minimally-invasive surgical procedure is part of at least one of the following medical procedures: diagnosis of chronic diseases; diagnosis of a heart failing due to congestive heart failure related conditions; diagnosis of failure of the organ; intervention in treatment of congestive heart failure related conditions; tailoring of medications; disease management; identification of complications from congestive heart failure related conditions; identification of complications from cardiovascular disease related conditions; treatment of complications from congestive heart failure related conditions; treatment of complications from cardiovascular disease related conditions; pacing adjustments to the heart; reduction in frequency and severity of hospitalizations due to cardiovascular diseases; reduction in frequency and severity of hospitalizations due to congestive heart failure; tuning of defibrillator or pacemaker parameters to improve congestive heart failure related conditions; identification of mitral valve stenosis; treatment of mitral valve stenosis, feedback regarding the impact of medication on the organ; and chronic disease management of the organ.

20. The minimally-invasive surgical procedure according to claim 1, wherein the readout device is used to perform at least one of the following: remote monitoring of the organ and the living body, remote monitoring of the organ and the living body with a telephone-based data and information delivery system; remote monitoring of the organ and the living body with a wireless telephone-based data and information delivery system; remote monitoring of the organ and the living body with an Internet-based data and information delivery system; closed-loop drug delivery of medications to treat the organ; closed-loop pacemaker parameter tuning to treat congestive heart failure or congestive heart failure related conditions; warning of critical worsening of congestive heart failure or congestive heart failure related conditions; portable or ambulatory monitoring or diagnosis; monitoring of battery operation; data storage; reporting global positioning coordinates for emergency applications; and communication with other medical devices chosen from the group consisting of pacemakers, left ventricular assist devices, defibrillators, cardioverter defibrillators, drug delivery systems, non-drug delivery systems, and wireless medical management systems.

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专利名称(译)	用于监测内部器官内的生理参数的微创手术		
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[标]发明人	NAJAFI NADER MORGAN LEONARD CATHERINE HOOK		
发明人	NAJAFI, NADER MORGAN-LEONARD, CATHERINE HOOK		
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摘要(译)

一种用于监测活体内部器官内的生理参数的微创外科手术。该过程需要在体内进行第一次切口以便能够进入器官。然后将内窥镜器械插入第一切口,并通过器官的外壁进入第二切口并进入其内腔。传感单元放置在第二切口中,使得第二切口被单元闭塞,并且单元的近端在器官外部。该单元包括感测装置,该感测装置具有适于感测器官内的生理参数的感测元件,以及固定感测装置的锚。关闭第一切口,之后身体外部的读出装置与传感装置遥测通信以获得生理参数的读数。

