



US007384395B2

(12) **United States Patent**
Hatlestsad et al.

(10) **Patent No.:** **US 7,384,395 B2**
(45) **Date of Patent:** **Jun. 10, 2008**

(54) **DETECTION OF CONGESTION FROM MONITORING PATIENT RESPONSE TO A RECUMBENT POSITION**

4,308,872 A 1/1982 Watson et al.
4,470,987 A 9/1984 Wurtman et al.
4,559,946 A 12/1985 Mower
4,562,843 A 1/1986 Djordjevich et al.
4,567,892 A 2/1986 Plicchi et al.
4,576,183 A 3/1986 Plicchi et al.

(75) Inventors: **John Hatlestsad**, Maplewood, MN (US); **Qingsheng Zhu**, Little Canada, MN (US); **Jeffrey E. Stahmann**, Ramsey, MN (US)

(Continued)

(73) Assignee: **Cardiac Pacemakers, Inc.**, St. Paul, MN (US)

FOREIGN PATENT DOCUMENTS

(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 68 days.

EP 348271 12/1989

(Continued)

(21) Appl. No.: **11/619,821**

OTHER PUBLICATIONS

(22) Filed: **Jan. 4, 2007**

"Heart Sounds", <http://www.chfpatients.com/faq/s3s4.htm>.

(Continued)

(65) **Prior Publication Data**

US 2007/0106130 A1 May 10, 2007

Primary Examiner—Robert L. Nasser

(74) *Attorney, Agent, or Firm*—Schwegman, Lundberg & Woessner, P.A.

Related U.S. Application Data

(62) Division of application No. 10/267,982, filed on Oct. 9, 2002, now Pat. No. 7,226,422.

(57) **ABSTRACT**

(51) **Int. Cl.**

A61B 5/00 (2006.01)
A61B 5/02 (2006.01)
A61B 5/08 (2006.01)
A61B 5/103 (2006.01)
A61B 5/117 (2006.01)

Systems and methods obtain information that allows detection of whether a patient suffers from congestion by monitoring a response of the patient to a recumbent position of the patient's body. The patient may be monitored to determine a respiration pattern for a non-recumbent position such as standing and a respiration pattern for a recumbent position such as lying down. The two patterns may be compared, either by a processing device or a physician, to determine a difference in the two respiration patterns. Furthermore, the congestion may be inferred from detecting an amount of time that the patient spends in a recumbent position or from detecting the recumbent angle that the patient obtains, either of which is presumed to indicate whether a recumbent position presents discomfort to the patient due to the presence of congestion.

(52) **U.S. Cl.** **600/300**; 600/481; 600/529; 600/587

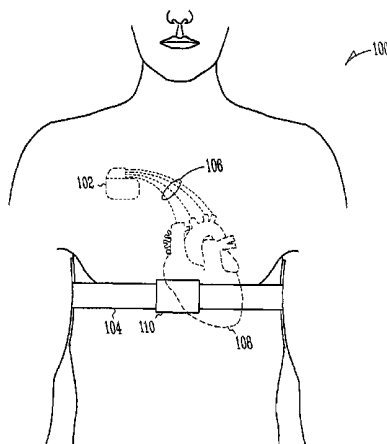
(58) **Field of Classification Search** None
See application file for complete search history.

(56) **References Cited**

U.S. PATENT DOCUMENTS

4,003,379 A 1/1977 Ellinwood, Jr.
4,059,169 A 11/1977 Hagen
4,271,192 A 6/1981 Wurtman et al.

27 Claims, 7 Drawing Sheets



U.S. PATENT DOCUMENTS			FOREIGN PATENT DOCUMENTS		
4,651,716 A	3/1987	Forester et al.	5,974,340 A	10/1999	Kadhiresan
4,693,253 A	9/1987	Adams	5,978,705 A	11/1999	KenKnight et al.
4,880,005 A	11/1989	Pless et al.	6,002,963 A	12/1999	Mouchawar et al.
4,884,576 A	12/1989	Alt	6,015,388 A	1/2000	Sackner et al.
4,904,472 A	2/1990	Belardinelli et al.	6,035,233 A	3/2000	Schroepfel et al.
4,980,379 A	12/1990	Belardinelli et al.	6,044,297 A	3/2000	Sheldon et al.
4,987,897 A	1/1991	Funke	6,047,203 A	4/2000	Sackner et al.
5,002,052 A	3/1991	Haluska	6,049,730 A	4/2000	Kristbjarnarson
5,003,976 A	4/1991	Alt	6,049,735 A	4/2000	Hartley et al.
5,025,786 A	6/1991	Siegel	6,076,015 A	6/2000	Hartley et al.
5,040,536 A	8/1991	Riff	6,078,834 A	6/2000	Lurie et al.
5,113,869 A	5/1992	Nappholz et al.	6,104,949 A	8/2000	Pitts Crick et al.
5,117,825 A	6/1992	Grevious	6,154,672 A	11/2000	Pendekanti et al.
5,199,428 A	4/1993	Obel et al.	6,298,267 B1	10/2001	Rosborough et al.
5,213,098 A	5/1993	Bennett et al.	6,317,631 B1	11/2001	Ben-Haim et al.
5,215,083 A	6/1993	Drane et al.	6,336,903 B1	1/2002	Bardy
5,233,984 A	8/1993	Thompson	6,409,675 B1	6/2002	Turcott
5,233,985 A	8/1993	Hudrlik	6,411,844 B1	6/2002	Kroll et al.
5,246,008 A	9/1993	Mueller	6,473,640 B1	10/2002	Erlebacher
5,271,395 A	12/1993	Wahlstrand et al.	6,512,949 B1	1/2003	Combs et al.
5,273,034 A	12/1993	Nilsson	6,574,506 B2	6/2003	Kramer et al.
5,282,836 A	2/1994	Kreyenhagen et al.	6,595,927 B2	7/2003	Pitts-Crick et al.
5,282,840 A	2/1994	Hudrlik	6,616,607 B2	9/2003	Hashimoto et al.
5,284,136 A	2/1994	Hauck et al.	6,625,492 B2	9/2003	Florio et al.
5,292,343 A	3/1994	Blanchette et al.	6,665,564 B2	12/2003	Lincoln et al.
5,300,093 A	4/1994	Koestner et al.	6,678,547 B2	1/2004	Carlson et al.
5,313,953 A	5/1994	Yomtov et al.	6,719,701 B2	4/2004	Lade
5,324,309 A	6/1994	Kallok	6,738,666 B1	5/2004	Park et al.
5,324,315 A	6/1994	Grevious	6,748,271 B2	6/2004	Spinelli et al.
5,342,404 A	8/1994	Alt et al.	6,752,765 B1	6/2004	Jensen et al.
5,344,429 A	9/1994	Smits	6,811,537 B2	11/2004	Bardy
5,354,317 A	10/1994	Alt	6,829,503 B2	12/2004	Alt
5,354,319 A	10/1994	Wyborny et al.	6,829,507 B1	12/2004	Lidman et al.
5,355,894 A	10/1994	Sivard	6,912,420 B2	6/2005	Scheiner et al.
5,366,485 A	11/1994	Kroll et al.	6,937,900 B1	8/2005	Pianca et al.
5,370,665 A	12/1994	Hudrlik	6,949,075 B2	9/2005	Hatlestad et al.
5,404,877 A	4/1995	Nolan et al.	7,149,573 B2	12/2006	Wang
5,405,362 A	4/1995	Kramer et al.	7,177,681 B2	2/2007	Zhu et al.
5,411,031 A	5/1995	Yomtov	7,191,000 B2	3/2007	Zhu et al.
5,431,682 A	7/1995	Hedberg	7,226,422 B2	6/2007	Hatlestad et al.
5,441,525 A	8/1995	Shelton et al.	2002/0123674 A1	9/2002	Plicchi et al.
5,454,377 A	10/1995	Dzwonczyk et al.	2002/0147475 A1	10/2002	Scheiner et al.
5,464,434 A	11/1995	Alt	2002/0170193 A1	11/2002	Townsend et al.
5,479,369 A	12/1995	Matsumura et al.	2003/0055461 A1	3/2003	Girouard et al.
5,501,701 A	3/1996	Markowitz et al.	2003/0105496 A1	6/2003	Yu et al.
5,507,785 A	4/1996	Deno	2003/0144595 A1	7/2003	Lade
5,522,860 A	6/1996	Molin et al.	2003/0176896 A1	9/2003	Lincoln et al.
5,534,018 A	7/1996	Wahlstrand et al.	2003/0220580 A1	11/2003	Alt
5,540,728 A	7/1996	Shelton et al.	2004/0073128 A1	4/2004	Hatlestad et al.
5,562,711 A	10/1996	Yerich et al.	2004/0102712 A1	5/2004	Belalcazar et al.
5,562,712 A	10/1996	Steinhaus et al.	2004/0106962 A1	6/2004	Mai et al.
5,593,431 A	1/1997	Sheldon	2004/0116819 A1	6/2004	Alt
5,626,623 A	5/1997	Kieval et al.	2004/0133079 A1	7/2004	Mazar et al.
5,676,686 A	10/1997	Jensen et al.	2004/0147982 A1	7/2004	Bardy
5,706,829 A	1/1998	Kadri	2004/0172080 A1	9/2004	Stadler et al.
5,722,999 A	3/1998	Snell	2004/0215097 A1	10/2004	Wang
5,725,561 A	3/1998	Stroebel et al.	2004/0215270 A1	10/2004	Ritscher et al.
5,725,562 A	3/1998	Sheldon	2005/0004609 A1	1/2005	Stahmann et al.
5,732,710 A	3/1998	Rabinovich et al.	2005/0038327 A1	2/2005	Tanaka et al.
5,749,369 A	5/1998	Rabinovich et al.	2005/0080460 A1	4/2005	Wang et al.
5,749,900 A	5/1998	Schroepfel et al.	2005/0119586 A1	6/2005	Coyle et al.
5,782,879 A	7/1998	Rosborough et al.	2005/0283197 A1	12/2005	Daum et al.
5,788,643 A	8/1998	Feldman	2006/0020295 A1	1/2006	Brockway et al.
5,800,464 A	9/1998	Kieval	2006/0025699 A1	2/2006	Maile et al.
5,874,420 A	2/1999	Pelleg	2006/0241512 A1	10/2006	Kwok et al.
5,876,353 A	3/1999	Riff	2006/0293609 A1	12/2006	Stahmann et al.
5,882,352 A	3/1999	Duncan et al.			
5,913,879 A	6/1999	Ferek-Petric et al.	EP	0584388 A1	3/1994
5,919,210 A	7/1999	Lurie et al.	EP	0620420	10/1994
5,957,861 A	9/1999	Combs et al.	EP	0663219 A1	7/1995
5,957,957 A	9/1999	Sheldon	EP	0985374 A2	3/2000

EP	0985429 A2	3/2000
EP	1151719	11/2001
EP	1238630 A2	9/2002
EP	1115350 B1	8/2003
EP	1011803 B1	9/2004
EP	0985374 B1	12/2004
EP	0985429 B1	12/2004
WO	WO-8400227	1/1984
WO	WO-9800197 A1	1/1998
WO	WO-9833554 A1	8/1998
WO	WO-0018317 A2	4/2000
WO	WO-0119426 A2	3/2001
WO	WO-2004012815 A1	2/2004
WO	WO-2004047638 A1	6/2004
WO	WO-2004050178 A1	6/2004
WO	WO-2004060166 A2	7/2004
WO	WO-2004095306 A1	11/2004
WO	WO-2005046472 A1	5/2005
WO	WO-2005046472 A2	5/2005

OTHER PUBLICATIONS

"Medtronic Announces European Release Of Innovative InSync Sentry Cardiac Resynchronization Therapy Defibrillator", http://www.medtronic.com/newsroom/news_20040614a.html, (2004).

"Medtronic: InSync Sentry 7298: Dual Chamber Implantable Cardioverter Defibrillator with Cardiac Resynchronization Therapy (VVE-DDR) and Opti-Vol Fluid Monitoring: Reference Manual", www.medtronic.com.

Aaron, S. D., et al., "How accurate is spirometry at predicting restrictive pulmonary impairment?", *Chest*, 115(3), (Mar. 1999),869-873.

Adamicza, A. , et al., "Changes in transthoracic electrical impedance during endotoxemia in dogs", *Acta Physiol Hung.*, 85(4), (1997-98),291-302.

Adamicza, A. , et al., "Investigation of the thoracic electrical impedance during endotoxemia in dogs", *Acta Chir Hung.*, 36(1-4), (1997),1-3.

Alt, Eckhard , et al., "Control of Pacemaker Rate by Impedance-based Respiratory Minute Ventilation", *Chest*, 92(2), (Aug. 1987),247-252.

Baarends, E. M., et al., "Body-water compartments measured by bio-electrical impedance spectroscopy in patients with chronic obstructive pulmonary disease", *Clinical Nutrition*, 17(1), (Feb. 1998),15-22.

Belalcazar, Andres , et al., "Improved lung edema monitoring with coronary vein pacing leads", *Pacing and Clinical Electrophysiology*, 26(4 pt. II), Abstract 18,(Apr. 2003),933.

Belalcazar, Andres , et al., "Improved lung edema monitoring with coronary vein pacing leads: a simulation study", *Physiological Measurement*, vol. 25, (2004),475-487.

Berman, Irwin R., et al., "Transthoracic electrical impedance s a guide to intravascular overload", *Archives of Surgery*, 102(1), (Jan. 1971),61-64.

Bradbury, M. G., et al., "Assessment of the sensitivity of bioimpedance to volume changes in body water", *Pediatr Nephrol.*, 9(3), (Jun. 1995),337-40.

Campbell, J. H., et al., "Clinical applications of electrical impedance tomography in the monitoring of changes in intrathoracic fluid volumes", *Physiol. Meas.*, vol. 15, (1994),A217-A222.

Campbell, J. H., et al., "Detection of changes in intrathoracic fluid in man using electrical impedance tomography", *Clinical Science*, vol. 87, (1994),97-101.

Charach, Gideon , et al., "Transthoracic monitoring of the impedance of the right lung in patients with cardiogenic pulmonary edema", *Critical Care Medicine*, 29(6), (Jun. 2001),1137-44.

Chiolero, R. L., et al., "Assessment of changes in body water by bioimpedance in acutely ill surgical patients.", *Intensive Care Medicine*, 18(6), (1992),322-6.

Cooke, W. H., et al., "Human responses to upright tilt: a window on central autonomic integration", *J Physiol.*, 517(Pt 2), (Jun. 1, 1999),617-28.

Daum, Douglas R., "Systems and Methods for Hypotension", U.S. Appl. No. 11/141,260, filed May 31, 2005, 51 pages.

Defaye, P. , et al., "Automatic Recognition of Abnormal Respiratory Events During Sleep by a Pacemaker Transthoracic Impedance Sensor", *Journal of Cardiovascular Electrophysiology*, 15(9), (Sep. 2004),1034-40.

Denniston, J. C., et al., "Factors Influencing the measurement of stroke volume by electrical impedance", *Physiology* (1372-1377), Abstract No. 1373,463.

Denniston, J. C., et al., "Measurement of pleural effusion by electrical impedance.", *Journal of Applied Physiology*, 38(5), (May 1975),851-7.

Ellenbogen, Kenneth A., et al., "Rate-adaptive pacing based on impedance-derived minute ventilation", *Clinical Cardiac Pacing*, Philadelphia : Saunders,(1995),219-233.

Ellenbogen, Kenneth A., et al., "The Electrode-Tissue Interface and the Foreign Body Response", *Clinical Cardiac Pacing*, Philadelphia : Saunders,(1995),22-23.

Fein, Alan , et al., "Evaluation of Transthoracic Electrical Impedance in the Diagnosis of Pulmonary Edema", *Circulation*, 60(5), (Nov. 1979),1156-1160.

Foreman, B , et al., "Intra-thoracic impedance: a surrogate measure of thoracic fluid—fluid accumulation status trial (FAST)", *Journal of Cardiac Failure*, 10(4 Suppl), Abstract 251,(2004),S86.

Forro, M. , et al., "Total body water and ECFV measured using bioelectrical impedance analysis and indicator dilution in horses", *Journal of Applied Physiology*, 89(2), (Aug. 2000),663-71.

Frerichs, I. , et al., "Electrical impedance tomography in monitoring experimental lung injury", *Intensive Care Med.*, 24(8), (Aug. 1998),829-36.

Garland, J. S., et al., "Measurement of extravascular lung water in hemodialysis patients using blood ultrasound velocity and optical density dilution.", *ASAIO Journal* 2002 48(4), (Jul.-Aug. 2002),398-403.

Goovaerts, H. G., et al., "Microprocessor-based system for measurement of electrical impedances during haemodialysis and in postoperative care", *Medical & Biological Engineering & Computing*, vol. 26, (Jan. 1998),75-80.

Gotshall, R W., et al., "Bioelectric impedance as an index of thoracic fluid.", *Aviation Space and Environmental Medicine*, 70(1), (Jan. 1999),58-61.

Grimbert, F. , et al., "Pulmonary water and thoracic impedance. Evaluation of a measurement technic]", *Annales de L'anesthésiologie Française*, 16 Spec No. 2-3, French,(1975), 157-63.

Harris, N. D., et al., "Applications of applied potential tomography (APT) in respiratory medicine". *Clinical Physics and Physiological Measurement*, 8 Suppl A, (1987),155-65.

Hatlestad, John D., et al., "Physiological Response to Posture Change", U.S. Appl. No. 11/466,925, filed Aug. 24, 2006, 21 Pages.

Hoon, Raghunath S., et al., "Changes in Transthoracic electrical impedance at high altitude", *British Heart Journal*, vol. 39, (1977),61-66.

Hull, E. T., et al., "The Transthoracic Impedance Method for the Determination of the Degree and Change in Extravascular Water", *Acta Tuberc. Pneumol. Belg.*, 68(4), (1977),369-377.

Hull, E. T., et al., "Transthoracic electrical impedance: artifacts associated with electrode movement", *Resuscitation*, 6(2), (1978),115-124.

Ishibe, Y. , et al., "Transthoracic electrical impedance method for measurement of pulmonary edema in vivo", *Masui*,27(13), Japanese,(Dec. 1978),1559-67.

Joekes, A. M., et al., "Impedance Cardiography—Its value in an intensive care unit", *D) Materiels et techniques/Cardiocirculatory Equipment and Technics*, Abstract No. 141, 1 Page.

Keller, Guido , et al., "Monitoring of Pulmonary Fluid Volume and Stroke Volume by Impedance Cardiography in Patients on Hemodialysis", *Chest*, 72(1), (Jul. 1977),56-62.

Khan, Mahfooz R., et al., "Quantitative electrical-impedance plethysmography for pulmonary oedema", *Medical & Biological Engineering & Computing*, vol. 15, (Nov. 1977),627-633.

- Kiesler, T. W., et al., "Impedance cardiography by use of a spot-electrode array to track changes in cardiac output in anesthetized dogs.", *Journal of the American Veterinary Medical Association*, 196(11), (Jun. 1, 1990),1804-10.
- Koizumi, T., "Changes of transthoracic impedance (zinf 0 and deltax) in newborn infants", *Acta Neonatol. Jpn.*, 14(3), (1978),335-340.
- Kubo, S. H., et al., "Circulatory autoregulation in chronic congestive heart failure: responses to head-up tilt in 41 patients.", *Am J Cardiol.*, 52(5), (Sep. 1, 1983),512-8.
- Kunst, P. W., et al., "Electrical impedance tomography in the assessment of extravascular lung water in noncardiogenic acute respiratory failure", *Chest*, 116(6), (Dec. 1999),1695-702.
- Kusumoto, Fred M., et al., "Medical Progress: Cardiac Pacing", *New England Journal of Medicine*, 334(2), (Jan. 11, 1996),89-98.
- Larsen, F., et al., "Influence of furosemide and body posture on transthoracic electrical impedance in AMI", *Chest*, 90(5), (733-7), Nov. 1986.
- Laszlo, Z., et al., "Cardiovascular and Hormonal Changes with Different Angles of Head-up Tilt in Men", *Physiol. Res.*, vol. 50, (2001),71-82.
- Lau, C. P., et al., "Rate-responsive pacing with a pacemaker that detects respiratory rate (Biorate): clinical advantages and complications", *Clinical Cardiology*, 11(5), (May 1988),318-24.
- Lau, C. P., "The range of sensors and algorithms used in rate adaptive cardiac pacing", *Pacing and clinical electrophysiology; Pace*, 15(8), (Aug. 1992),1177-211.
- Leung, Zoe K., et al., "Feasibility of an automatic atrial and ventricular threshold determination using transthoracic using impedance", *Pacing and Clinical Electrophysiology*, vol. 19, Part II, Abstract 263, (Apr. 1996),631.
- Levine, T. B., et al., "The neurohumoral and hemodynamic response to orthostatic tilt in patients with congestive heart failure.", *Circulation*, 67(5), (May 1983),1070-5.
- Lucas, C., "Congestive Heart Failure, Freedom from Congestion Predicts Good Survival Despite Previous Class IV Symptoms of Heart Failure", *American Heart Journal*, 140(6), (Dec. 2000),840-847.
- Luepker, R. V., et al., "Transthoracic Electrical Impedance: Quantitative Evaluation of a Non-Invasive Measure of Thoracic Fluid Volume", *American Heart Journal*, 85(1), (Jan. 1973),83-93.
- Mai, J., et al., "Enhanced Rate Response Algorithm for Orthostatic Compensation Pacing", *Pacing Clin Electrophysiol*, 23, Naspe Abstracts, Abstract No. 678, (Apr. 2000),722.
- McCarty, Richard N., et al., "Assessment of pulmonary edema in acute congestive heart failure with impedance cardiography", *J Am Osteopath Assoc.*, 74(9), (May 1975),879.
- McNamee, James E., et al., "Peribronchial electrical admittance measures lung edema and congestion in the dog", *Special Communications, Electrical Admittance and Pulmonary Edema*, 337-341.
- Miyamoto, S., "Effects of posture on cardiac autonomic nervous activity in patients with congestive heart failure.", *J Am Coll Cardiol.*, 37(7), (Jun. 1, 2001),1788-93.
- Newell, J. C., et al., "Assessment of acute pulmonary edema in dogs by electrical impedance imaging", *IEEE Transactions on Biomedical Engineering*, 43(2), (Feb. 1996),133-138.
- Nierman, D. M., et al., "Evaluation of transthoracic bioelectrical impedance analysis in monitoring lung water during diuresis", *Applied Cardiopulmonary Pathophysiology*, 7(1), (1997),57-62.
- Nierman, David M., "Transthoracic Bioimpedance Can Measure Extravascular Lung Water in Acute Lung Injury", *Journal of Surgical Research* 65, Article No. 0350, (1996),101-108.
- Noble, T. J., et al., "Diuretic induced change in lung water assessed by electrical impedance tomography", *Physiol Meas.*, 21(1), (Feb. 2000),155-63.
- Nukiwa, Toshihiro, et al., "Responses of Serum and Lung Angiotensin-Converting Enzyme Activities in the Early Phase of Pulmonary Damage Induced by Oleic Acid in Dogs", *Am Rev Respir Dis.*, 126(6), (Dec. 1982),1080-1086.
- Petersen, J. R., et al., "Electrical impedance measured changes in thoracic fluid content during thoracentesis", *Clin Physiol.*, 14(4), (Jul. 1994),459-86.
- Platia, Edward V., et al., "Time Course of Transvenous Pacemaker Stimulation Impedance, Capture Threshold, and Electrogram Amplitude", *Pacing Clin Electrophysiol.*, 9(5), (Sep./Oct. 19),620-625.
- Pomerantz, M., et al., "Transthoracic electrical impedance for the early detection of pulmonary edema", *Surgery*, 66(1), (Jul. 1969),260-8.
- Raaijmakers, E., et al., "Estimation of non-cardiogenic pulmonary oedema using dual-frequency electrical impedance.", *Medical & Biological Engineering & Computing*, 36(4), (Jul. 1998),461-6.
- Ragueneau, J. L., et al., "Monitoring of intracellular and extracellular hydric compartments by body impedance", *Anesth Anal. Rean*, vol. 36, (1979),439-443.
- Ramos, Marcos U., et al., "Transthoracic electric impedance. A clinical guide of pulmonary fluid accumulation in congestive heart failure", *Minnesota Medicine*, 58(9), (Sep. 1975),671-676.
- Rosborough, John P., et al., "Electrical Therapy for Pulseless Electrical Activity", *NASPE*, 23(4), Part II, Abstract, (Apr. 2000),591.
- Saunders, Charles E., "The Use of Transthoracic Electrical Bioimpedance in Assessing Thoracic Fluid Status in Emergency Department Patients", *American Journal of Emergency Medicine*, 6(4), (Jul. 1988),337-340.
- Schuster, C. J., et al., "Application of Impedance Cardiography in Critical Care Medicine", *Resuscitation*, vol. 11, (1984),255-274.
- Schwartzman, David, et al., "Serial Defibrillation Lead Impedance in Patients with Epicardial and Nonthoracotomy Lead Systems", *Journal of Cardiovascular Electrophysiology*, 7(8), (Aug. 1996),697-703.
- Segev, Gil, et al., "B-Type Natriuretic Peptide: A Novel Clinical Tool for Diagnosis and Management of Heart Failure", www.turner-white.com, Article in Sep. 2003 "Hospital Physician" magazine, (Sep. 2003),19-24.
- Shochat, M., et al., "Internal thoracic impedance monitoring: a new prospect in acute heart failure", *European Heart Journal*, 25(Suppl), (Aug.-Sep. 2004),P72-72.
- Shoemaker, William C., et al., "Multicenter trial of a new thoracic electrical bioimpedance device for cardiac output estimation", *Critical Care Medicine*, 22(12), (Dec. 1994),1907-1912.
- Smith, R. M., et al., "Canine thoracic electrical impedance with changes in pulmonary gas and blood volumes.", *Journal of Applied Physiology*, 53(6), (Dec. 1982),1608-13.
- Spinale, F. G., et al., "Noninvasive estimation of extravascular lung water using bioimpedance.", *The Journal of Surgical Research*, 47(6), (Dec. 1989),535-40.
- Spinelli, J. C., "Method and System for Treatment of Neurocardiogenic Syncope", U.S. Appl. No. 10/862,831, filed Jun. 7, 2004, 15 pages.
- Stadler, R., et al., "Automated detection of decreases in intrathoracic impedance to predict CHF hospitalization", Abstract 263, 26(4 pt II), Abstract 16, (Apr. 2003),932.
- Staub, N. C., "The measurement of lung water content.", *The Journal of Microwave Power*, 18(3), (Sep. 1983),259-63.
- Stevenson, L. W., et al., "The limited reliability of physical signs for estimating hemodynamics in chronic heart failure", *JAMA*, 261(6), (Feb. 19, 1989),884-8.
- Tang, W., "Assessment of total body water using bioelectrical impedance analysis in neonates receiving intensive care", *Arch Dis Child Fetal Neonatal Ed.*, 77(2), (Sep. 1997),F123-6.
- Tempel, G., et al., "Transthoracic electrical impedance in anaesthesia and intensive care.", *Resuscitation*, 6(2), (1978),97-105.
- Thakur, Ranjan K., et al., "Pericardial Effusion Increases Defibrillation Energy Requirement", *Pacing Clin Electrophysiol.*, 16(6), (Jun. 1993),1227-1230.
- Vainshtein, G. B., et al., "The Functioning of the Cerebral Circulation System in Hyperthermia in Rabbits", *Fiziol Zh SSSR Im I M Sechenova*, 75(11), (Nov. 1989), 1608-1614.
- Van De Water, Joseph M., et al., "Monitoring the Chest with Impedance", *Chest*, 64(5), (Nov. 1973),597-603.
- Viirola, H., "Controlled growth of antimony-doped tin dioxide thin films by atomic layer epitaxy", *Thin Solid Films*, 251, (Nov. 1994),127-135.

- Virola, H., et al., "Controlled growth of tin dioxide thin films by atomic layer epitaxy", *Thin Solid Films*, 249(2), (Sep. 1994),144-149.
- Visokay, M R., "Application of HfSiON as a gate dielectric material", *Applied Physics Letters*, 80(17), (Apr. 2002),3183-3185.
- Wang, L., et al., "Impedance based prediction of CHF admission precedes symptoms in heart failure patients", *Heart rhythm : the official journal of the Heart Rhythm Society*, 1 (Suppl 1), Abstract 679,(2004),S213.
- Wang, Li., et al., "Multiple Sources of the Impedance Cardiogram Based on 3-D Finite Difference Human Thorax Models", *IEEE Transactions on Biomedical Engineering*, 42(2), (Feb. 1995),141-148.
- Wang, L., et al., "Prediction of CHF hospitalization by ambulatory intrathoracic impedance measurement in CHF patients is feasible using pacemaker or ICD lead systems", *Pacing and Clinical Electrophysiology*, 26(4 pt. II), Abstract 123,(Apr. 2003),959.
- Wuerz, Richard C., et al., "Effects of prehospital medications on mortality and length of stay in congestive heart failure", *Annals of Emergency Medicine*, 21(6), (Jun. 1992),669-74.
- Yu, C., et al., "Changes in device based thoracic impedance in decompensating congestive heart failure", *Circulation*, 104(17 supplement), Abstract 1994,(2001),II-419.
- Yu, C. M., et al., "Correlation of device-based intra-thoracic impedance and patient fluid status during intravenous diuretic therapy in acute CHF", *European Heart Journal*, 23(Abtract Supplement), (2002),158.
- Yu, C., et al., "Device-based intra-thoracic impedance correlates with fluid status and provides automated prediction of CHF hospitalization", *Journal of Cardiac Failure*, 10(4 Suppl), Abstract 354,(2004),S113.
- Yu, Cheuk-Man, et al., "Early warning of CHF hospitalization by intra-thoracic impedance measurement in CHF patients with pacemakers", *Pacing and Clinical Electrophysiology*, 24, (Apr. 2001),19.
- Yu, C., et al., "Early warning of CHF hospitalization by intra-thoracic impedance measurement in CHF patients with pacemakers", *Pacing and Clinical Electrophysiology: Pace*, 24(4 pt II), Abstract 19,(2002),527.
- Yu, C. M., et al., "Impedance measurements from implanted devices provide automated prediction of CHF hospitalization", *European Heart Journal*, 25(Supp), (Aug.-Sep. 2004),p. 27-27.
- Yu, C. M., et al., "Intrathoracic impedance: A surrogate measure of fluid retention and predictor of hospitalization in patients with heart failure", *Journal of the American College of Cardiology*, 41(6 Supplement A), Abstract 1206-70,(2003),210A.
- Zellner, J. L., et al., "Bioimpedance: a novel method for the determination of extravascular lung water.", *The Journal of Surgical Research*, 48(5), (May 1990),454-9.
- Zima, E., "Intracardiac impedance in biventricular electrode configuration for left ventricular volume monitoring", *European Heart Journal*, 25(Supp), (Aug.-Sep. 2004),p. 165-165.
- Non-Final Office Action mailed 5-2-5 in U.S. Appl. No. 10/267,982, 10 pages.
- Notice of Allowance and Fees Due mailed Oct. 3, 2006 in U.S. Appl. No. 10/267,982, 9 pages.
- Notice of Allowance and Fees Due mailed Dec. 29, 2005 in U.S. Appl. No. 10/267,982, 6 pages.
- Notice of Allowance and Fees Due mailed Jun. 2, 2006 in U.S. Appl. No. 10/267,982, 17 pages.
- Sanderson, John E., et al., "Impact of changes in respiratory frequency and posture on power spectral analysis of heart rate and systolic blood pressure variability in normal subjects and patients with heart failure", *Clinical Science*, vol. 91, (1996),35-43.

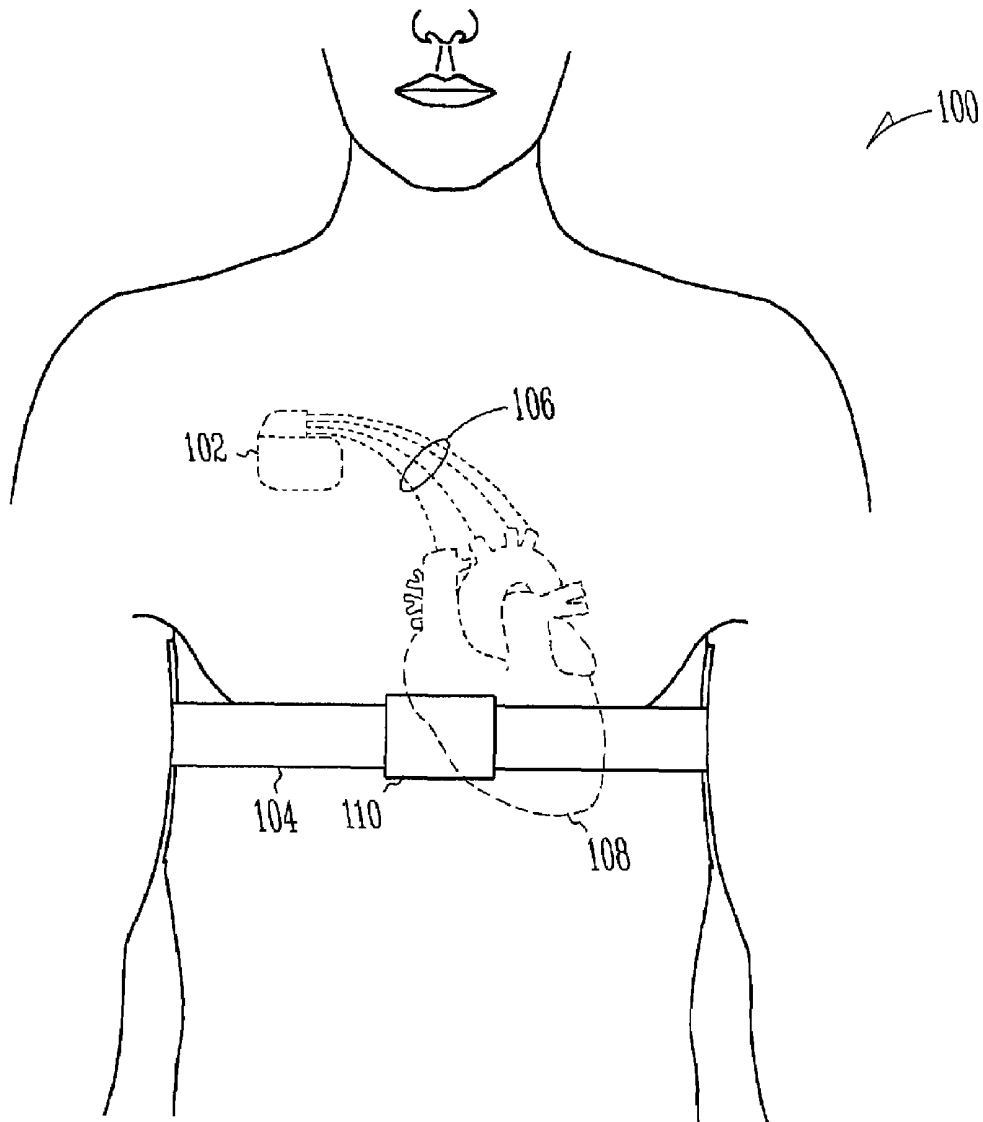


Fig. 1

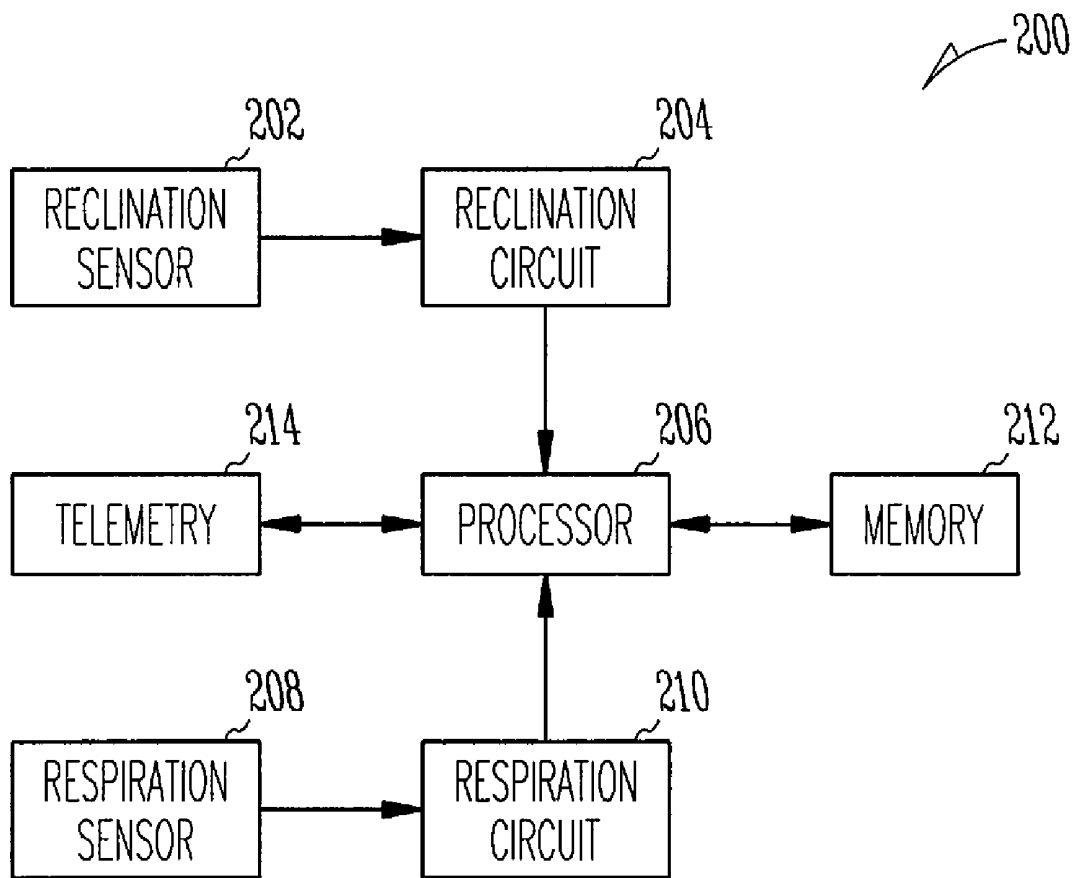


Fig. 2

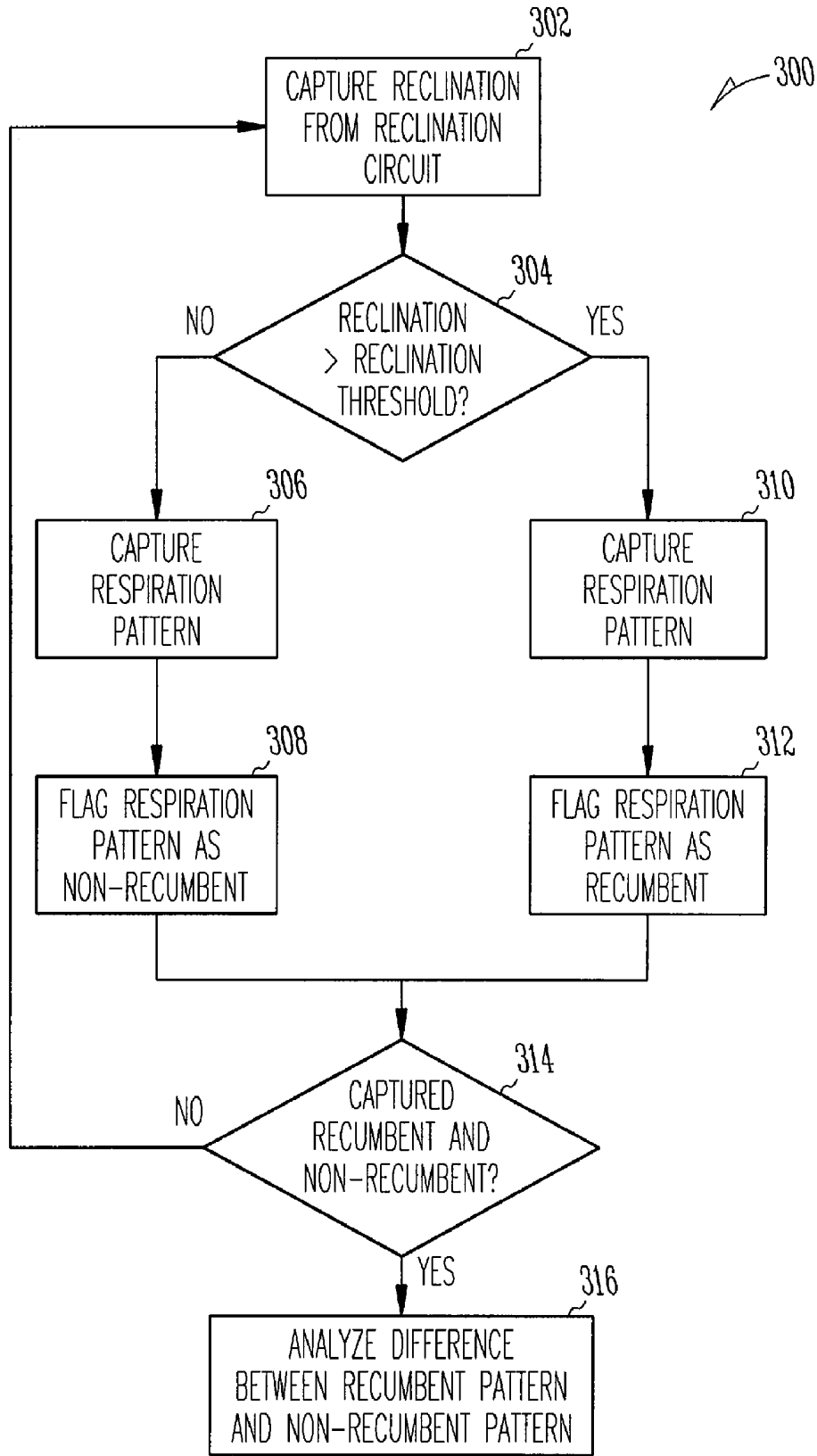


Fig. 3

400

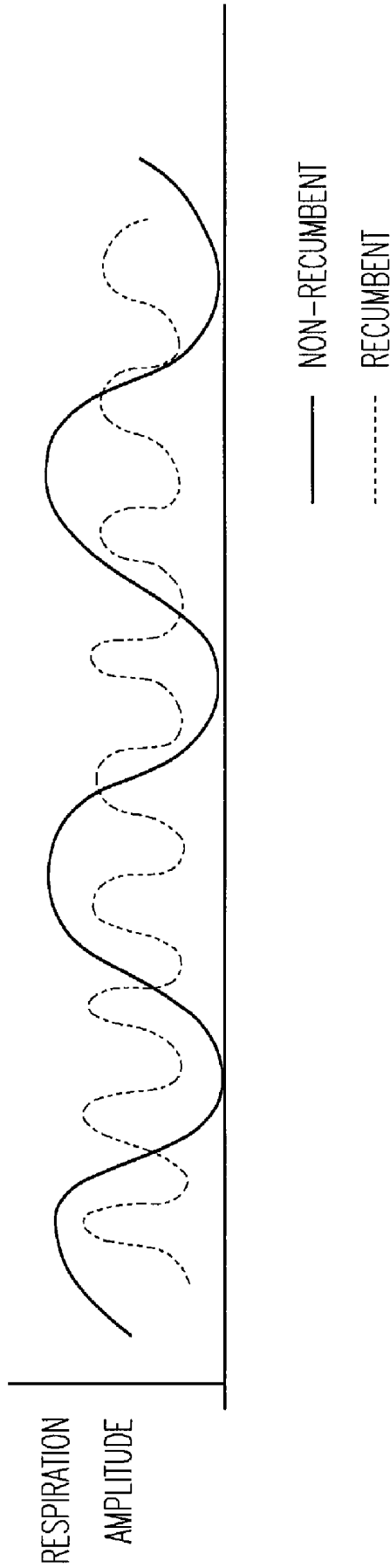


Fig. 4

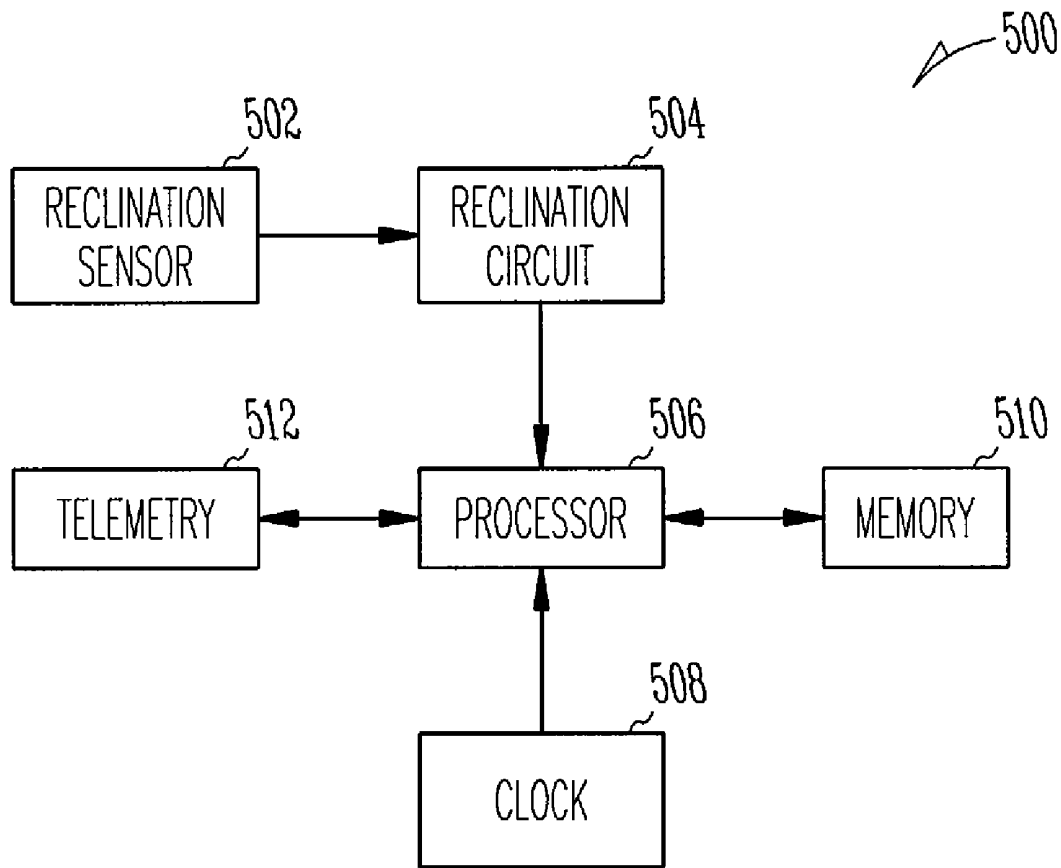


Fig. 5

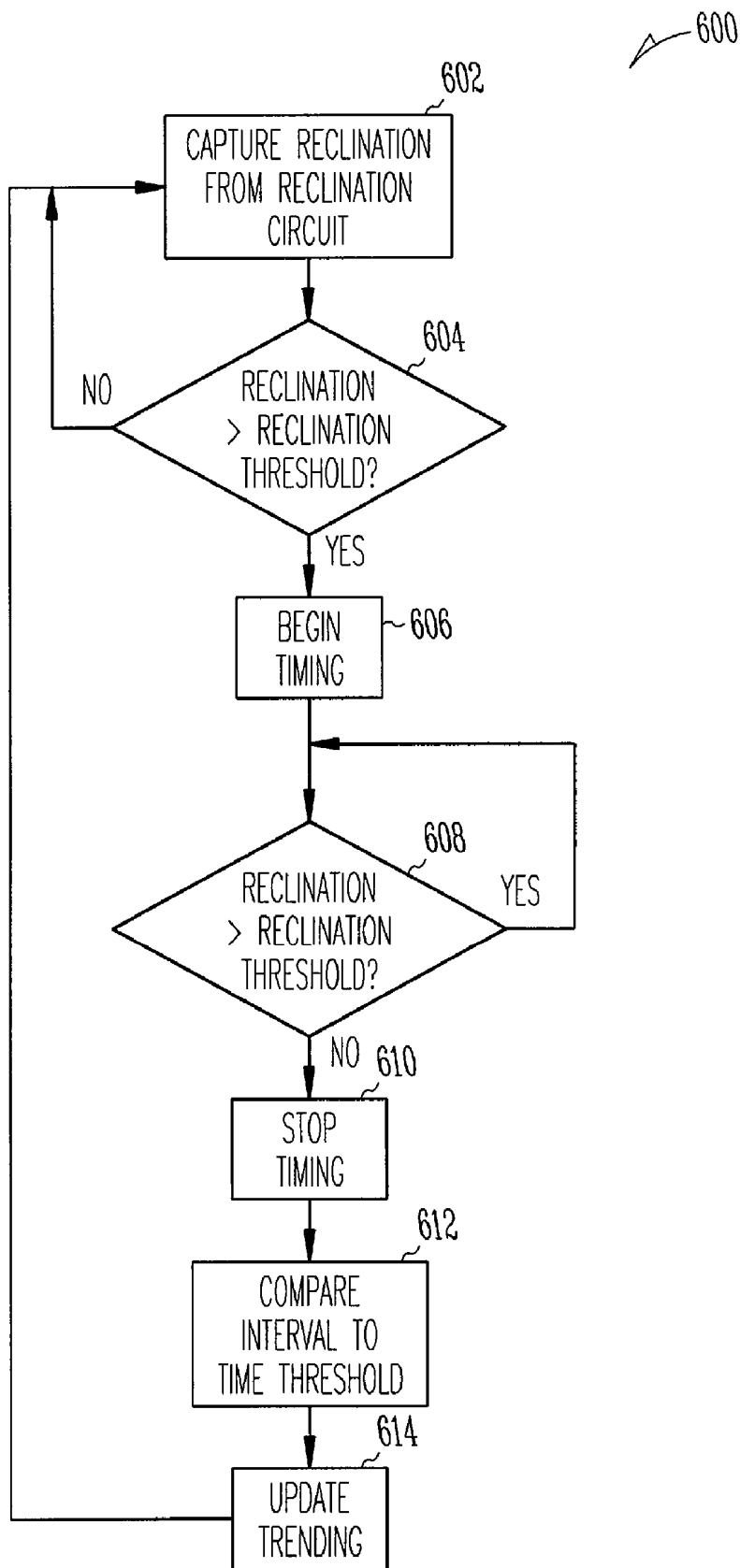


Fig. 6

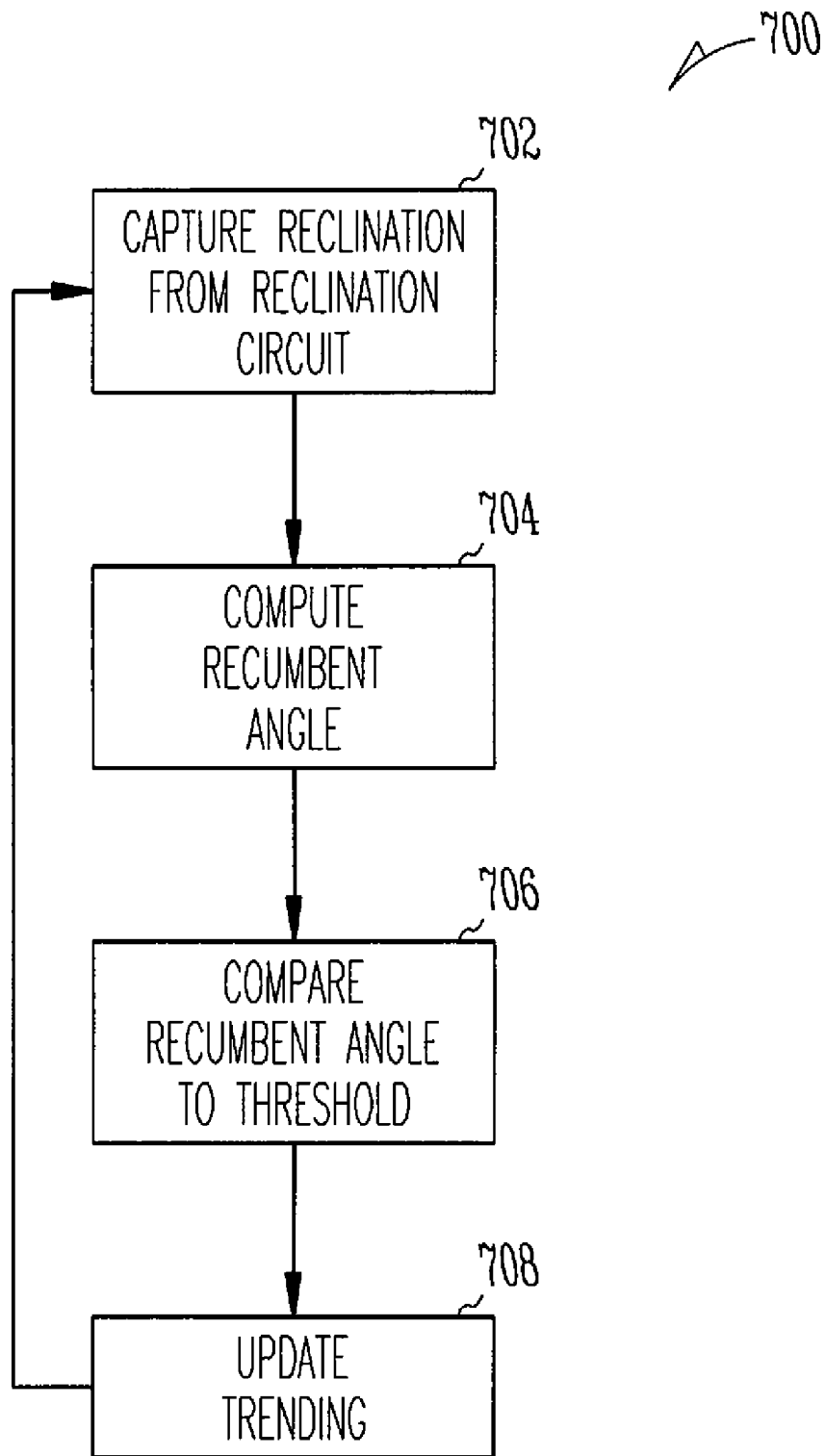


Fig. 7

DETECTION OF CONGESTION FROM MONITORING PATIENT RESPONSE TO A RECUMBENT POSITION

CROSS REFERENCE TO RELATED APPLICATION(S)

This application is a divisional of U.S. Pat. application Ser. No. 10/267,982, filed on Oct. 9, 2002 now U.S. Pat. No. 7,226,422, the specification of which is incorporated herein by reference.

TECHNICAL FIELD

The present invention is related to the detection of congestion of a patient. More particularly, the present invention is related to the detection of congestion through monitoring a patient's response to a recumbent position of the patient's body.

BACKGROUND

A patient suffers from congestion when filling pressure of the heart, which results from the return of blood from the body to the heart, is relatively high due to the heart's inability to effectively pump blood back out to the body. Thus, congestion is indicative of heart failure and is one factor that should be closely monitored for a heart failure patient. Congestion may be manifested in several ways in the heart failure patient's body.

One condition highly correlated with congestion is respiratory distress upon lying down. Congestion often results in the lungs becoming partially filled with fluid once the patient lies down, and the lungs maintain the partially filled state until the patient becomes upright. This filling causes the patient to have difficulty breathing while in the recumbent position, and the respiratory distress that may result from the lungs remaining filled with fluid is a good indicator of congestion.

Attempts have been made to assess congestion from observation of a patient's posture relative to his average trans-thoracic impedance, which decreases as the lungs fill with fluid. However, the average trans-thoracic impedance masks any change that might occur in the patient's respiratory patterns. Thus, average trans-thoracic impedance measurements fail to indicate the patient's level of respiratory distress that results from the recumbent position.

SUMMARY

Embodiments of the present invention address the issues discussed above and others by providing systems and methods that obtain information that allows detection of congestion by assessing the patient's respiratory distress. The respiratory distress may be assessed based on a comparison of respiration pattern before and after the patient becomes recumbent. Alternatively, the respiratory distress may be assessed by inferring distress from the amount of time the patient is able to remain in a recumbent position or the recumbent angle the patient is able to obtain.

The information related to congestion may be obtained by first detecting whether the patient is in a recumbent position. When the patient is not in the recumbent position, the respiration of the patient is monitored to detect a first respiration pattern. When the patient is in the recumbent position, the respiration of the patient is monitored to detect a second respiration pattern. Differences in the two breathing

patterns may indicate respiratory distress due to the recumbent position, which is a sign of congestion.

The information related to congestion may be obtained by continuously monitoring the patient over a period of time to determine an amount of time during the period that the patient is in a recumbent position. The amount of time that the patient is in a recumbent position may indicate patient discomfort due to respiratory distress arising from the recumbent position, which is a sign of congestion.

The information related to congestion may be obtained by continuously monitoring the patient over a period of time to determine a recumbent angle that the patient is able to obtain during the period. The recumbent angle may indicate patient discomfort at greater angles approaching horizontal due to respiratory distress arising from the recumbent position, which is a sign of congestion.

DESCRIPTION OF THE DRAWINGS

FIG. 1 illustrates one or more devices coupled to a patient to obtain information allowing the detection of congestion by monitoring the patient's response to a recumbent position.

FIG. 2 shows a diagram of major components of one embodiment of a system for obtaining information allowing the detection of congestion by comparing an upright respiration pattern of the patient to a recumbent respiration pattern.

FIG. 3 shows an example of operational flow for the system of FIG. 2 for obtaining information related to congestion and for detecting congestion from the information.

FIG. 4 depicts first and second respiration patterns whose difference indicates congestion.

FIG. 5 shows a diagram of major components of one embodiment of a system for obtaining information allowing the detection of congestion by determining the amount of time a patient remains in a recumbent position relative to a threshold indicative of congestion and/or by determining the recumbent angle that the patient obtains relative to a threshold indicative of a normal recumbent angle.

FIG. 6 shows an example of operational flow for the system of FIG. 5 to determine the amount of time that the patient remains in the recumbent position.

FIG. 7 shows an example of operational flow for the system of FIG. 5 to determine a recumbent angle that the patient obtains.

DETAILED DESCRIPTION

Embodiments of the present invention attempt to obtain information related to a congestive condition and/or to diagnose a congestive condition of a patient from the information by monitoring the patient's response to a recumbent position of the patient's body. For patients suffering from congestion, respiratory distress will likely occur at some point after the patient's body achieves a recumbent state. The respiratory distress may be measured by comparison of respiratory patterns detected during the recumbent state and during a non-recumbent state. Alternatively, the respiratory distress may be detected by measuring the amount of time the patient remains recumbent and by presuming the patient is experiencing respiratory distress if the amount of time is shorter than a predetermined threshold related to a congestive condition. As another alternative, the respiratory distress may be detected by measuring an angle from vertical of the patient's position and by presuming the

patient is experiencing respiratory distress for greater angles of reclination if the recumbent angle is less than a normal recumbent angle.

FIG. 1 shows a patient's body **100** having one or more devices coupled to the body **100** to detect and/or infer respiratory distress occurring once the body **100** becomes recumbent. For example, an implantable medical device (IMD) **102** such as a pacemaker or device dedicated to congestion detection may be implanted in the body **100** and may be configured to monitor the patient's behavior in relation to a recumbent state, such as by detecting a change in respiratory patterns, finding the amount of time the patient remains in the recumbent state, or finding the recumbent angle the patient is able to obtain. Alternatively, an external device such as a respiratory effort band **104** may be coupled to the torso of the body **100** to monitor the patient's respiration in relation to the recumbent state by measuring the chest movement caused by the respiratory patterns.

In situations where an IMD **102** is utilized, the IMD **102** may make respiratory measurements as part of its routine for providing therapy to the patient, such as a pacemaker measuring respiratory rate to control pulse rate of the patient's heart **108**. These respiratory measurements can also be utilized, either by the IMD **102** or another device to detect respiratory patterns of the patient. One manner of detecting the respiratory patterns is through monitoring trans-thoracic impedance variation through one or more leads **106** during each individual inhale and exhale cycle. The IMD **102** or other device coupled to the body **100** is provided with a reclination sensor, such as a tilt switch, to allow a distinction between the body **100** being in a recumbent or non-recumbent state. Furthermore, the reclination sensor may be an accelerometer to allow the recumbent angle of the patient to be measured.

In situations where an external device **104** is utilized, the external device **104** can similarly make respiratory measurements and sense the recumbent state of the body **100**. For example, a respiratory effort band measures the expansion and contraction of the torso of the body **100** resulting from respiratory cycles to produce signals that represent the respiratory patterns of the patient. The external device **104** or other device also detects the reclination using a tilt switch or accelerometer to distinguish between the recumbent and non-recumbent states. The external device **104** includes a module **110** that contains electrical circuitry discussed below for obtaining information related to congestion and may also detect congestion from the obtained information.

Alternatively, the IMD **102** or external device **104** may measure the reclination of the patient and then employ a clock to track the amount of time that the body **100** is in a recumbent state. The amount of time may then be compared to a predetermined threshold to infer whether the patient has respiratory distress while in a recumbent state. The inference may be made because it may be presumed that the patient becomes non-recumbent once respiratory distress begins to occur to relieve the discomfort.

As another alternative, the IMD **102** or external device **104** may measure the recumbent angle obtained by the patient for a period of time, such as the maximum recumbent angle or an average recumbent angle that the patient achieves while sleeping. The recumbent angle may then be compared to a predetermined threshold, such as a typical recumbent angle for a healthy patient, to infer whether the patient suffers respiratory distress at recumbent angles greater than the recumbent angle actually measured for the patient. The inference may be made because it may be presumed that the patient achieves the greatest recumbent

angle possible while resting that does not result in discomfort due to respiratory distress.

FIG. 2 shows the major components of an illustrative system **200** that detects respiratory distress caused by a recumbent position of the body **100**. As discussed above, any or all of the components of system **200** may be internal or external to the body **100**. For example, any or all of the components may be contained within the IMD **102** and/or module **110** of external device **104**.

The system **200** includes a reclination sensor **202** that produces an electrical signal that is representative of the orientation of the reclination sensor **202** relative to gravity. One example of a reclination sensor **202** is a tilt switch. Another example is a DC accelerometer. In either case, a signal is produced by the reclination sensor **202** in response to the reclination sensor **202** having a particular orientation relative to gravity. Therefore, the reclination sensor **202** is coupled to the body **100** with a known orientation so that the reclination sensor **202** produces a detectable signal in response to the body **100** having a recumbent or non-recumbent state. The reclination sensor **202** may be multi-axis responsive so that regardless of the orientation of the body **100** while in a recumbent position (i.e., lying on back versus lying on side), a detectable signal is produced.

A reclination circuit **204** is electrically connected to the reclination sensor **202** to convert the reclination sensor signal into digital data that may be processed. For a tilt switch, the conversion may be simply recognizing the switch as open or closed, where one state indicates a recumbent patient and the other state indicates a non-recumbent patient. For an accelerometer, the reclination circuit **204** may amplify and/or filter the accelerometer signal prior to conversion to digital data to maintain a sufficient granularity for more precisely determining the degree of reclination of the body **100**. The reclination circuit **204** then provides the reclination data to a processing device **206** where the degree of reclination of the body **100** can be factored into the determination of congestion.

A respiration sensor **208** detects the respiration patterns of the body **100** and produces a signal representative of the respiration patterns. The respiration sensor **208** may be of various forms such as a trans-thoracic impedance sensor of an IMD **202**. Other forms are possible as well, including the respiratory effort band **104** whose impedance varies as the strap **104** expands and contracts in relation to the chest of the body **100** expanding and contracting.

The signal representative of respiration is provided to a respiration circuit **210** that produces digital data from the respiration signal that can be further processed and factored into the detection of congestion. The respiration circuit **210** may amplify and/or filter the respiration signal received from the respiration sensor **208**. The respiration circuit **210** then provides the respiration data that identifies the respiration pattern to the processing device **206**.

The processing device **206** may be a general-purpose programmable processor, hardwired digital logic, or other suitable processing device for applying logical operations to the reclination and respiration data. One example of the logical operations of the processing device **206** are described below with reference to FIG. 3. The processor **206** utilizes memory **212** for programming and/or storage of received and processed data while implementing the logical operations of FIG. 3.

In the embodiment shown in FIG. 2, the system **200** includes telemetry **214** that allows the processor **206** to communicate information to an external device (not shown) used by the physician monitoring the patient. For example,

the IMD 102 employs telemetry 214 to communicate bi-directionally and wirelessly with a device programmer. An external device 104 may also employ telemetry 214 to communicate either wirelessly or through a wired connection to a device such as a programmer. The programmer may also communicate back to the device 200, such as to update instructions stored in memory 212 that are employed by the processor 206 to bring about the logical operations of FIG. 3.

The illustrative logical operations 300 of FIG. 3 are performed by the processor 206 to detect whether the patient is suffering from congestion by finding whether the respiratory distress is experienced when lying down. The logical operations begin at data operation 302 where the processor 206 receives reclination data from the reclination circuit 204. At query operation 304, the processor 206 detects whether the reclination of the torso of body 100 is greater than a reclination threshold stored in memory 212. The reclination threshold may be chosen based on the desired amount of reclination necessary to be considered recumbent. This value may be patient specific as some patients may choose to sleep or recline to different degrees. For example, reclination of at least 65 degrees away from vertical may be considered a recumbent position for one patient while reclination of at least 85 degrees away from vertical is considered a recumbent position for another.

If the reclination is not greater than the reclination threshold as determined by query operation 304, then the processor 206 accepts data from the respiration circuit 210 at data operation 306 and flags the received data as non-recumbent data at flag operation 308. If the reclination is greater than the reclination threshold as determined at query operation 304, then the processor 206 accepts data from the respiration circuit 210 at data operation 310 and flags that data as recumbent data at flag operation 312.

Query operation 314 detects whether the processor 206 has received and flagged a sufficient quantity of both recumbent data and non-recumbent data. If not, then operational flow returns to data operation 302 where the processor 206 continues to receive reclination data. If query operation 314 finds that a sufficient quantity of both recumbent and non-recumbent data have been received and flagged, then operational flow proceeds to analysis operation 316.

At analysis operation 316, the processor 206 compares the two respiration patterns represented by the respiration data flagged as recumbent data and non-recumbent data. FIG. 4 shows two illustrative hypothetical respiration patterns. The non-recumbent respiration pattern shows that the patient is taking relatively slow and deep breaths as can be seen by the relatively low frequency and high amplitude of the pattern. However, the recumbent respiration pattern shows that the patient is taking relatively rapid and shallow breaths as indicated by the relatively high frequency and low amplitude of the pattern. The rapid and shallow breathing of the recumbent respiration pattern indicates a patient suffering from orthopnea, or paroxysmal nocturnal dyspnea ("PND") that eventually occurs upon lying down.

The presence of orthopnea or PND such as shown in FIG. 4 is known to be a sign of congestion. However, other recumbent respiration pattern changes resulting from lying down may also be indicative of congestion. Therefore, at analysis operation 316 the processor 206 may perform various comparisons in addition to or as an alternative to looking for both rapid and shallow breaths. For example, the processor 206 may search for only rapid recumbent respiration relative to upright respiration. Similarly, the processor 206 may search for only shallow, or low tidal volume,

recumbent respiration relative to upright respiration. As another example, the processor 206 may search for a difference in the combination of respiratory rate to tidal volume between the recumbent and non-recumbent respiration patterns. Such a combination may be a ratio of respiratory rate to tidal volume. Additionally, the processor 206 may search for a difference in inspiratory times and expiratory times, inspiratory time of a recumbent pattern versus inspiratory time for a non-recumbent pattern, and/or expiratory time of a recumbent pattern versus expiratory time of a non-recumbent pattern.

The results of the analysis may then be telemetered to a programmer, either in real-time or at a subsequent time, for viewing by a physician. Alternatively, for an external device an indicator such as a light emitting diode or a display screen may be included to provide direct feedback to the patient or to a physician examining the patient.

Although not shown in the logical operations 300 of FIG. 3, a trending operation may also be provided for the logical operations 300 so that the result of the analysis between recumbent and non-recumbent breathing patterns may be trended over time to also allow the physician to track to the progression of the patient's congestion. Furthermore, the detection of differences in breathing patterns that are indicative of congestion may be based upon difference thresholds in rate, volume, or some combination thereof. The difference thresholds may also be based upon breathing pattern differences that are known to be normal for a population so that differences beyond this threshold are considered to be an indicator of congestion. Also, the breathing pattern information, including the patterns themselves and/or any detected differences may be communicated from the medical device for review by a physician who may make the determination of whether congestion is present.

FIG. 5 shows the major components of another illustrative embodiment of a system 500 that detects congestion by determining the amount of time a patient can remain in a recumbent position and by comparing the amount of time to a threshold related to a congestive condition. As was discussed for the system 200 of FIG. 2, any or all of the components of system 500 may be located internally or externally of the body 100. The system 500 includes a reclination sensor 502 and reclination circuit 504 as previously discussed for the system 200.

A processing device 506 such as the processing device 206 of system 200 is also included in the system 500 and receives the reclination data from the reclination circuit 504. The processor 506 utilizes the memory 510 to access programming for performing logical operations such as those discussed below with reference to FIG. 6. Additionally, the processor 506 may utilize the memory 510 to store data describing the results of the determination of the amount of time a recumbent position can be maintained and whether a congestive condition is presumed to be present. Thus, the memory 510 can be used to maintain trending information for detecting whether the patient is experiencing congestion and whether the condition is worsening over time.

Telemetry 512 may also be included as discussed above for system 200. Telemetry 512 may be used to provide an indication to a programmer as to whether the patient is presumed to be suffering from congestion. Alternatively, the telemetry may be used to provide the amount of time the patient remains in a recumbent state to the programmer for observation by a physician. Additionally, the telemetry 512 may be used to provide an update to programming for the processor 506 that is stored in memory 510.

A clock **508** is provided to allow the processor **506** to determine how long the patient remains in the recumbent position. The clock **508** may be a simple timer circuit such as a clock used to drive the operations of the processor **506** or a more elaborate time keeping device such as a clock that maintains the actual time of day. The clock **508** provides timing data or pulses to the processor **506** that the processor **506** uses to determine time intervals.

Illustrative logical operations **600** that are implemented by the processor **506** are shown in FIG. 6. The logical operations **600** allow the processor **506** to determine the amount of time the patient remains in the recumbent state. This determination then allows an inference to be drawn as to whether the patient is suffering from congestion brought on by respiratory distress upon lying down. The logical operations **600** begin at data operation **602** where the processor **506** receives reclinaton data from the reclinaton circuit **504**.

Query operation **604** then detects whether the reclinaton is greater than a reclinaton threshold specified in memory **510**. As discussed above, the reclinaton threshold may be patient specific as one patient may choose to lie down or sleep while reclined at an angle greater than another patient. If the reclinaton is not greater than the reclinaton threshold as determined at query operation **604**, then the processor **506** receives the next set of reclinaton data at data operation **602**. If the reclinaton is greater than the reclinaton threshold, then the processor **506** begins keeping track of time at timing operation **606** so that the interval from the time the patient became recumbent until the time the patient is upright can be found.

Query operation **608** detects whether the reclinaton is greater than the reclinaton threshold. If it is, then the patient is still recumbent, and query operation **608** repeats. If the reclinaton is no longer greater than the reclinaton threshold, then the processor **506** stops keeping track of time at timing operation **610**. From the timing by the processor **506**, an interval of time is known for the period when the patient was in the recumbent state.

In this embodiment, the processor **506** then compares the interval of time to a time threshold that is related to a congestive condition at comparison operation **612**. This threshold may be known from a study of patients suffering from congestion who experience respiratory distress after a particular amount of time in a recumbent position. Furthermore, this threshold may vary depending upon the degree of congestion that the patient is being tested for through application of the logical operations **600**. Additionally, the threshold may be based upon a particular percentage of an average normal sleep time that corresponds to a particular degree of congestion, such as a patient who remains recumbent for 50% of an average normal sleep time for a population may be diagnosed as severely congested. Alternatively, the raw numbers or percentages could be trended and/or reported from the medical device to a physician who then may interpret the information to determine whether congestion is present.

For the embodiment shown in FIG. 6, the patient's congestion level may be trended as part of an overall wellness program. Thus, upon completion of comparison operation **612**, trending information stored in memory **510** or in memory of another external device may be continuously updated based on the results of the comparison operation **612** at trend operation **614**. Through these trending updates, the physician can see the progression of the

patient's congestion as well as additional conditions of the patient that may be simultaneously monitored with congestion.

Illustrative logical operations **700** that may alternatively be implemented by the processor **506** are shown in FIG. 7 where the reclinaton sensor such as an accelerometer provides a signal that is representative of the recumbent angle rather than a signal that is merely indicative of a recumbent versus non-recumbent state. The logical operations **700** allow the processor **506** to obtain the recumbent angle that the patient is able to obtain for further processing and/or for transmission to a physician. The determined recumbent angle allows an inference to be drawn as to whether the patient is suffering from congestion brought on by respiratory distress upon reaching a degree of reclinaton.

The logical operations **700** begin at data operation **702** where the processor **506** receives reclinaton data from the reclinaton circuit **504** over a period of time. The reclinaton data is representative of the recumbent angles the patient obtains during the period. At process operation **704**, the processor **506** computes a recumbent angle from the reclinaton data for the period, such as by finding the maximum recumbent angle specified by the reclinaton data or by averaging the recumbent angle values for the period. The period may be limited to times of day when the patient is expected or known to be resting so that there is little or no reclinaton data obtained while the patient is upright that would skew the average. Alternatively, a query operation may be employed by the processor **506** to throw out reclinaton data taken during the period that indicates an upright recumbent angle.

Comparison operation **706** then determines whether the recumbent angle is greater than a recumbent angle threshold specified in memory **510**. This recumbent threshold, whose value may differ from the reclinaton threshold of FIG. 6, may also be patient specific as one patient may choose to lie down or sleep while reclined at a recumbent angle that is greater than another patient. If the recumbent angle is not greater than the recumbent angle threshold, then the processor **506** of this embodiment determines that the patient is suffering from congestion since it is presumed that the patient does not recline beyond the recumbent threshold due to congestion related discomfort. If the reclinaton is greater than the reclinaton threshold, then the processor **506** of this embodiment determines the patient is not suffering from congestion since it is presumed that the patient would not recline beyond the recumbent threshold due to discomfort if congestion was present.

In the embodiment of FIG. 7, the recumbent angle threshold may be known from a study of patients suffering from congestion who experience congestion once the recumbent angle is beyond a certain amount from vertical. Furthermore, this recumbent angle threshold may vary depending upon the degree of congestion that the patient is being tested for through application of the logical operations **700**. Additionally, the recumbent angle threshold may be based upon a particular percentage of an average normal recumbent angle that corresponds to a particular degree of congestion, such as a patient who may only rest at a recumbent angle that is 50% of an average normal recumbent angle for a population may be diagnosed as severely congested.

For the embodiment shown in FIG. 7, the patient's congestion level may be trended as part of an overall wellness program. Thus, upon completion of comparison operation **706**, trending information stored in memory **510** or in memory of another external device may be continuously updated based on the results of the computation

operation 704 and/or comparison operation 706 at trend operation 708. Through these trending updates, the physician can see the progression of the patient's congestion as well as additional conditions of the patient that may be simultaneously monitored with congestion.

In another embodiment, the processor 506 may not determine whether congestion is present. Instead, the medical device may transmit the recumbent angle information to the physician who can then interpret the information to make the determination. As discussed above, the raw recumbent angle data could be trended and/or reported from the medical device to a physician who then may interpret the information to determine whether congestion is present.

While the invention has been particularly shown and described with reference to preferred embodiments thereof, it will be understood by those skilled in the art that various other changes in the form and details may be made therein without departing from the spirit and scope of the invention.

What is claimed is:

1. A method of obtaining information related to congestion of a patient, the method comprising:

monitoring a recumbent angle of the patient over a period of time; and

comparing the recumbent angle of the patient to a recumbent angle threshold, wherein the recumbent angle threshold is related to a congestive condition.

2. The method of claim 1, wherein monitoring a recumbent angle of the patient comprises obtaining the recumbent angle by using an acceleration.

3. The method of claim 1, comprising:

monitoring the recumbent angle of the patient over multiple periods of time to determine recumbent angle values for each period; and

analyzing the recumbent angle values for each period to determine a trend.

4. The method of claim 1, wherein monitoring the recumbent angle comprises obtaining recumbent angle values during the period and obtaining a maximum recumbent angle value for the period.

5. The method of claim 1, wherein monitoring the recumbent angle comprises obtaining recumbent angle values during the period and obtaining an average of the recumbent angle values for the period.

6. The method of claim 1, comprising limiting the period to when the patient is expected or known to be resting.

7. The method of claim 6, comprising limiting the period to when the patient is expected to be resting.

8. The method of claim 6, comprising limiting the period to when the patient is known to be resting.

9. The method of claim 1, comprising discarding reclination data taken during a period that indicates an upright recumbent angle.

10. The method of claim 1, wherein comparing the recumbent angle of the patient to a recumbent angle threshold comprises comparing the recumbent angle of the patient to a patient-specific recumbent angle threshold.

11. The method of claim 1, wherein comparing the recumbent angle of the patient to a recumbent angle threshold comprises comparing the recumbent angle of the patient to a recumbent angle threshold that is a specified percentage or fraction of a recumbent angle threshold that corresponds to a congestive condition.

12. A system for obtaining information related to congestion of a patient, the system comprising:

a reclination sensor that is configured to produce a signal indicative of a reclination of the patient;

reclination circuitry that is configured to produce reclination data from the reclination signal; and

a processing device that is configured to communicate with the reclination circuitry to determine a recumbent angle of the patient from the reclination data, and that is configured to compare the recumbent angle to a recumbent angle threshold that is related to a congestive condition.

13. The system of claim 12, wherein the reclination sensor includes an accelerometer.

14. The system of claim 12, comprising a communication device adapted for transmitting the recumbent angle to another location.

15. The system of claim 12, wherein the processing device is configured to limit the reclination data to a period to when the patient is expected or known to be resting.

16. The system of claim 15, wherein the processing device is configured to limit the reclination data to a period to when the patient is expected to be resting.

17. The system of claim 15, wherein the processing device is configured to limit the reclination data to a period to when the patient is known to be resting.

18. The system of claim 12, wherein the processing device is configured to discard reclination data taken during a period that indicates an upright recumbent angle.

19. The system of claim 12, wherein the processing device is configured to compare the recumbent angle of the patient to a patient-specific recumbent angle threshold.

20. The system of claim 12, wherein the processing device is configured to compare the recumbent angle of the patient to a recumbent angle threshold that is a specified percentage or fraction of a recumbent angle threshold that corresponds to a congestive condition.

21. A system for obtaining information related to congestion of a patient, the system comprising:

means for determining a recumbent angle of the patient; and

means for comparing the recumbent angle to a recumbent angle threshold that is related to a congestive condition.

22. The system of claim 21, wherein the means for determining a recumbent angle includes an accelerometer.

23. The system of claim 21, further comprising means for transmitting information about the recumbent angle.

24. The system of claim 21, comprising means for limiting the reclination data to a period to when the patient is expected or known to be resting.

25. The system of claim 21, comprising means for discarding reclination data taken during a period that indicates an upright recumbent angle.

26. The system of claim 21, comprising means for comparing the recumbent angle of the patient to a patient-specific recumbent angle threshold.

27. The system of claim 21, comprising means for comparing the recumbent angle of the patient to a recumbent angle threshold that is a specified percentage or fraction of a recumbent angle threshold that corresponds to a congestive condition.

UNITED STATES PATENT AND TRADEMARK OFFICE
CERTIFICATE OF CORRECTION

PATENT NO. : 7,384,395 B2
APPLICATION NO. : 11/619821
DATED : June 10, 2008
INVENTOR(S) : Hatlestad et al.

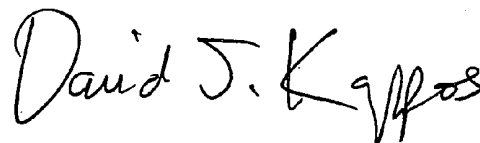
Page 1 of 1

It is certified that error appears in the above-identified patent and that said Letters Patent is hereby corrected as shown below:

In column 10, line 38, in Claim 20, after "threshold" delete "tat" and insert -- that --, therefor.

Signed and Sealed this

Sixth Day of October, 2009

A handwritten signature in black ink that reads "David J. Kappos". The signature is written in a cursive style with a large initial 'D' and a stylized 'K'.

David J. Kappos
Director of the United States Patent and Trademark Office

专利名称(译)	通过监测患者对卧位的反应来检测充血		
公开(公告)号	US7384395	公开(公告)日	2008-06-10
申请号	US11/619821	申请日	2007-01-04
[标]申请(专利权)人(译)	心脏起搏器股份公司		
申请(专利权)人(译)	心脏起搏器, INC.		
当前申请(专利权)人(译)	心脏起搏器, INC.		
[标]发明人	HATLESTSAD JOHN ZHU QINGSHENG STAHMANN JEFFREY E		
发明人	HATLESTSAD, JOHN ZHU, QINGSHENG STAHMANN, JEFFREY E		
IPC分类号	A61B5/00 A61B5/02 A61B5/08 A61B5/103 A61B5/11 A61B5/113 A61B5/117 A61N1/365		
CPC分类号	A61B5/0809 A61B5/0816 A61B5/1116 A61B5/1135 A61B5/6831 A61B5/6846 A61B5/1071 A61B5/4806 A61N1/36542 A61B5/686 G16H40/63 G16H50/20		
其他公开文献	US20070106130A1		
外部链接	Espacenet USPTO		

摘要(译)

系统和方法通过监测患者对患者身体的躺卧位置的响应来获得允许检测患者是否患有充血的信息。可以监测患者以确定非躺卧位置的呼吸模式，例如站立和呼吸模式，例如躺卧。可以通过处理设备或医生来比较这两种模式，以确定两种呼吸模式的差异。此外，可以通过检测患者在躺着位置花费的时间量或者通过检测患者获得的躺着角度来推断拥挤，其中任一个被假定为指示躺着的位置是否由于患者而给患者带来不适。拥挤的存在。

