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(54) **METHOD AND DEVICES FOR PERFORMING CARDIAC WAVEFORM APPRAISAL**

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(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 260 days.

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(51) **Int. Cl.**
A61N 1/00 (2006.01)

(52) **U.S. Cl.** 607/5; 607/17

(58) **Field of Classification Search** 607/5, 607/17

See application file for complete search history.

(57) **ABSTRACT**

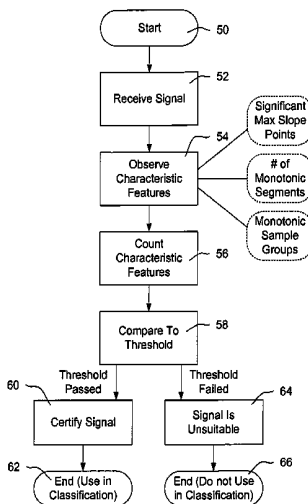
The present invention is directed toward a sensing architecture for use in cardiac rhythm management devices. The sensing architecture of the present invention provides a method and means for certifying detected events by the cardiac rhythm management device. Moreover, by exploiting the enhanced capability to accurately identifying only those sensed events that are desirable, and preventing the use of events marked as suspect, the sensing architecture of the present invention can better discriminate between rhythms appropriate for device therapy and those that are not.

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4 Claims, 12 Drawing Sheets



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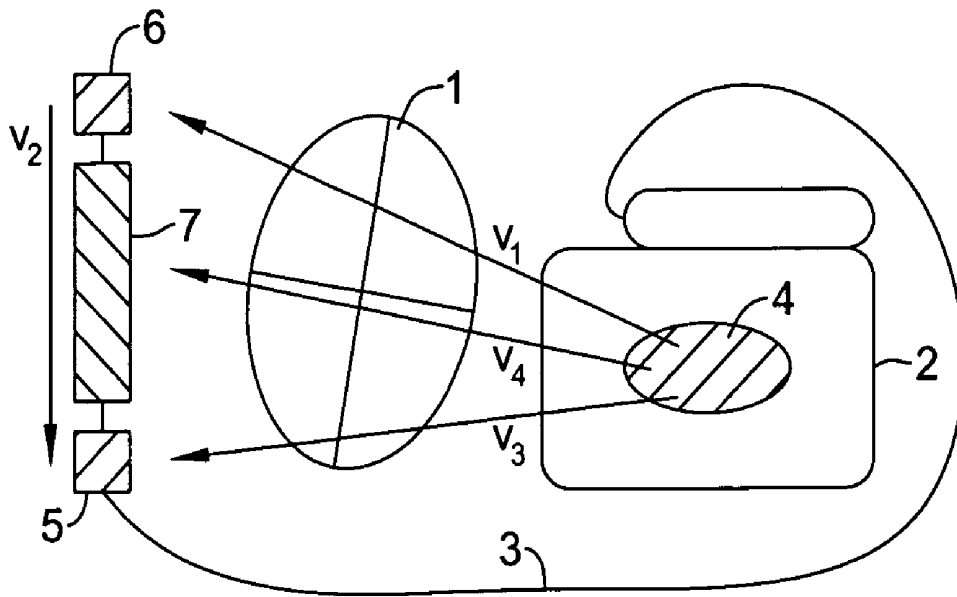


Fig. 1A

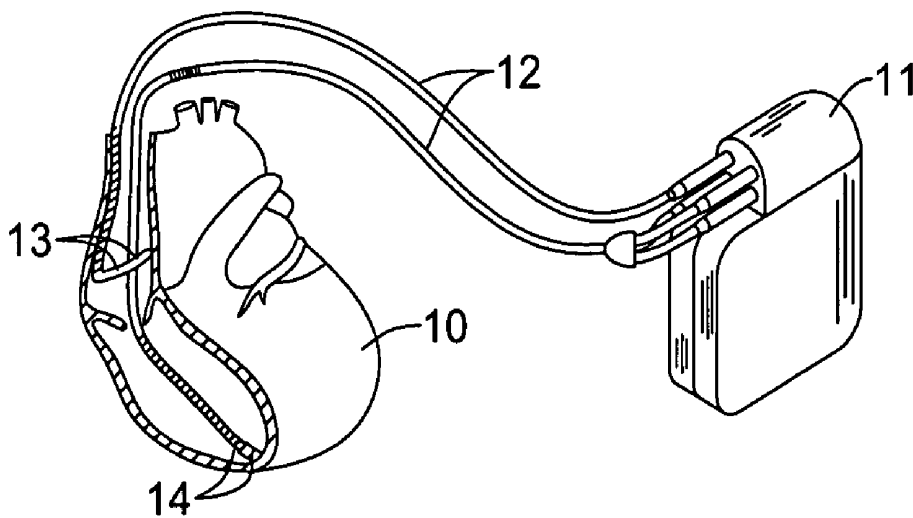


Fig. 1B

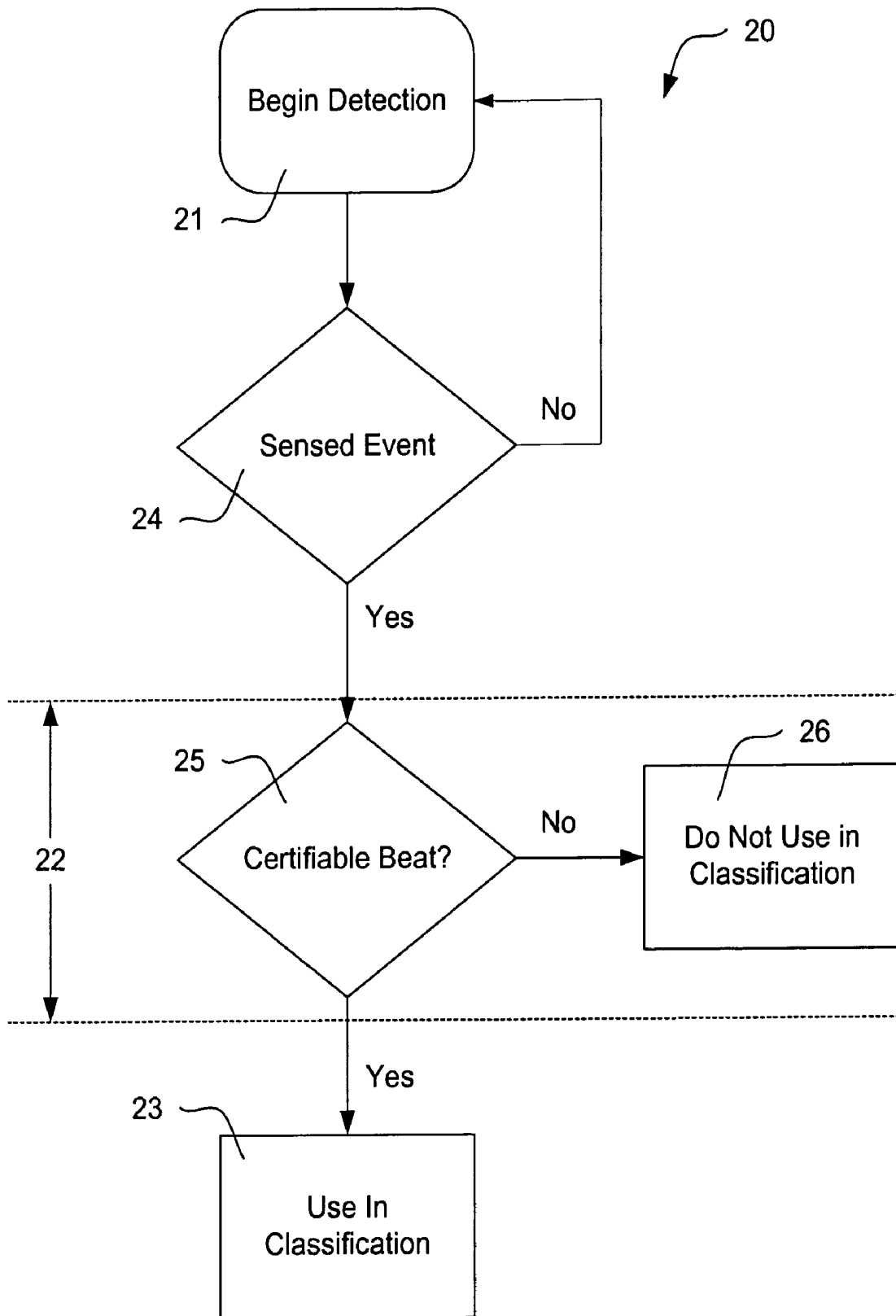


Fig. 2

Fig. 3

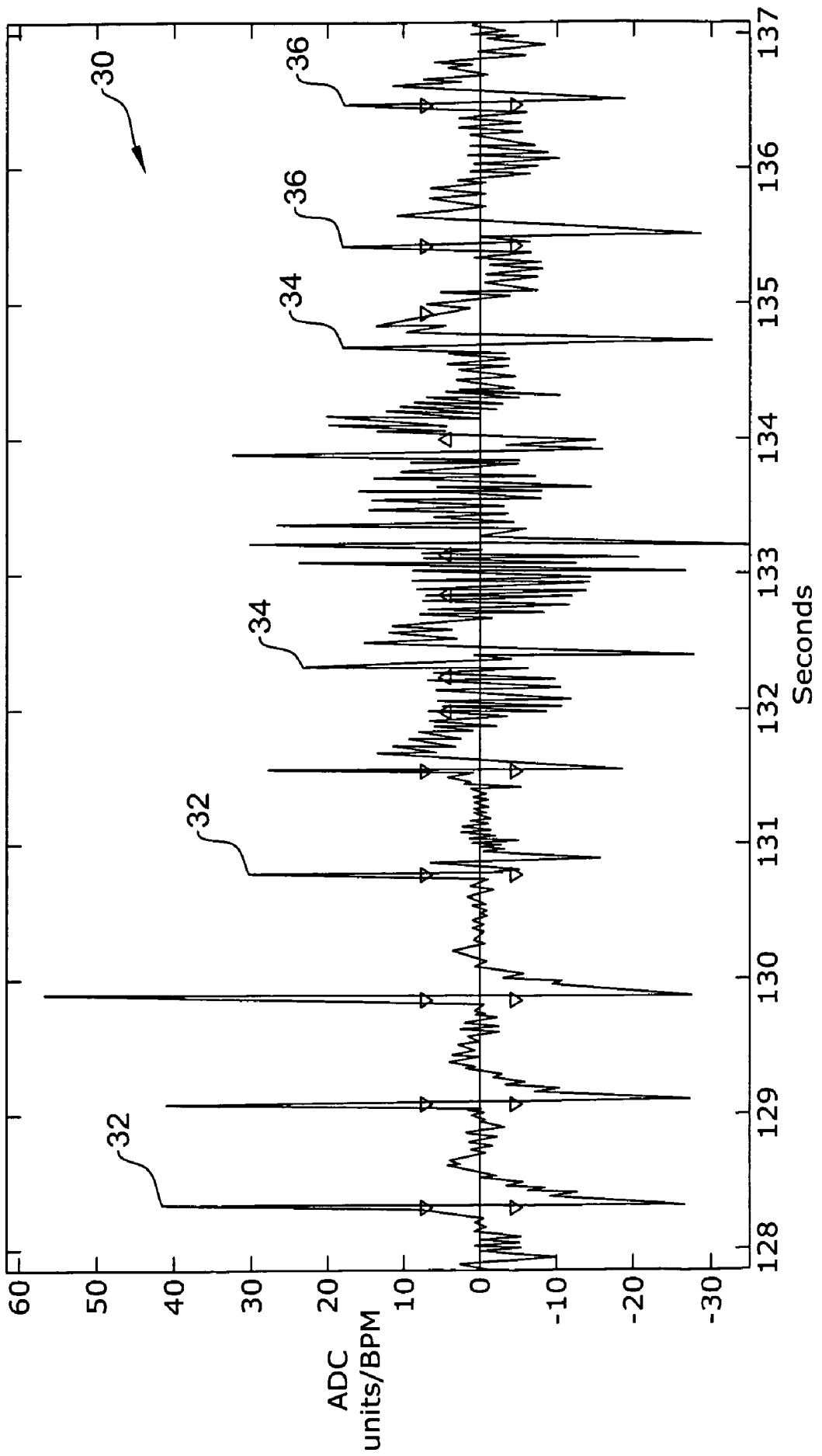


Fig. 4

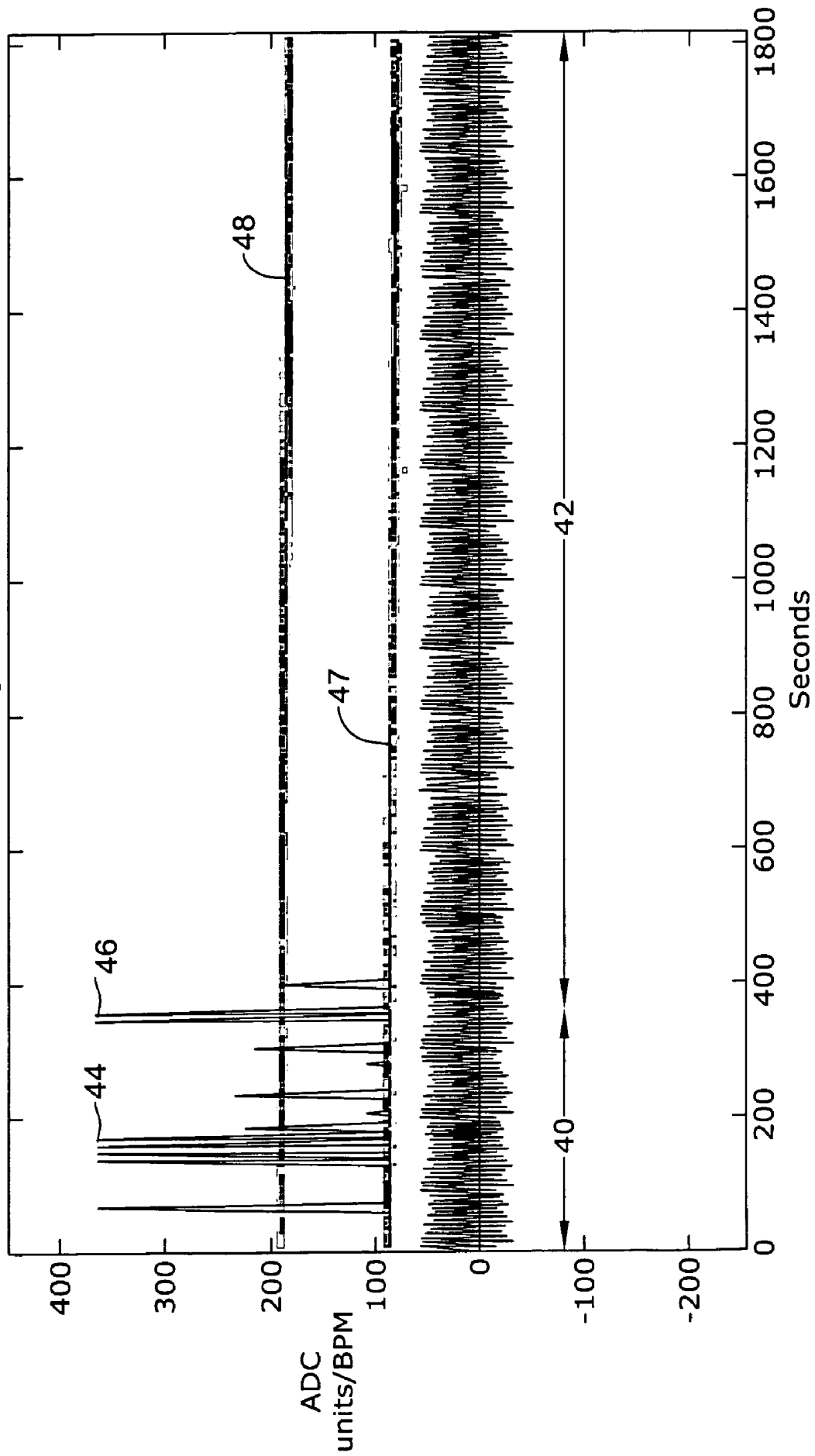
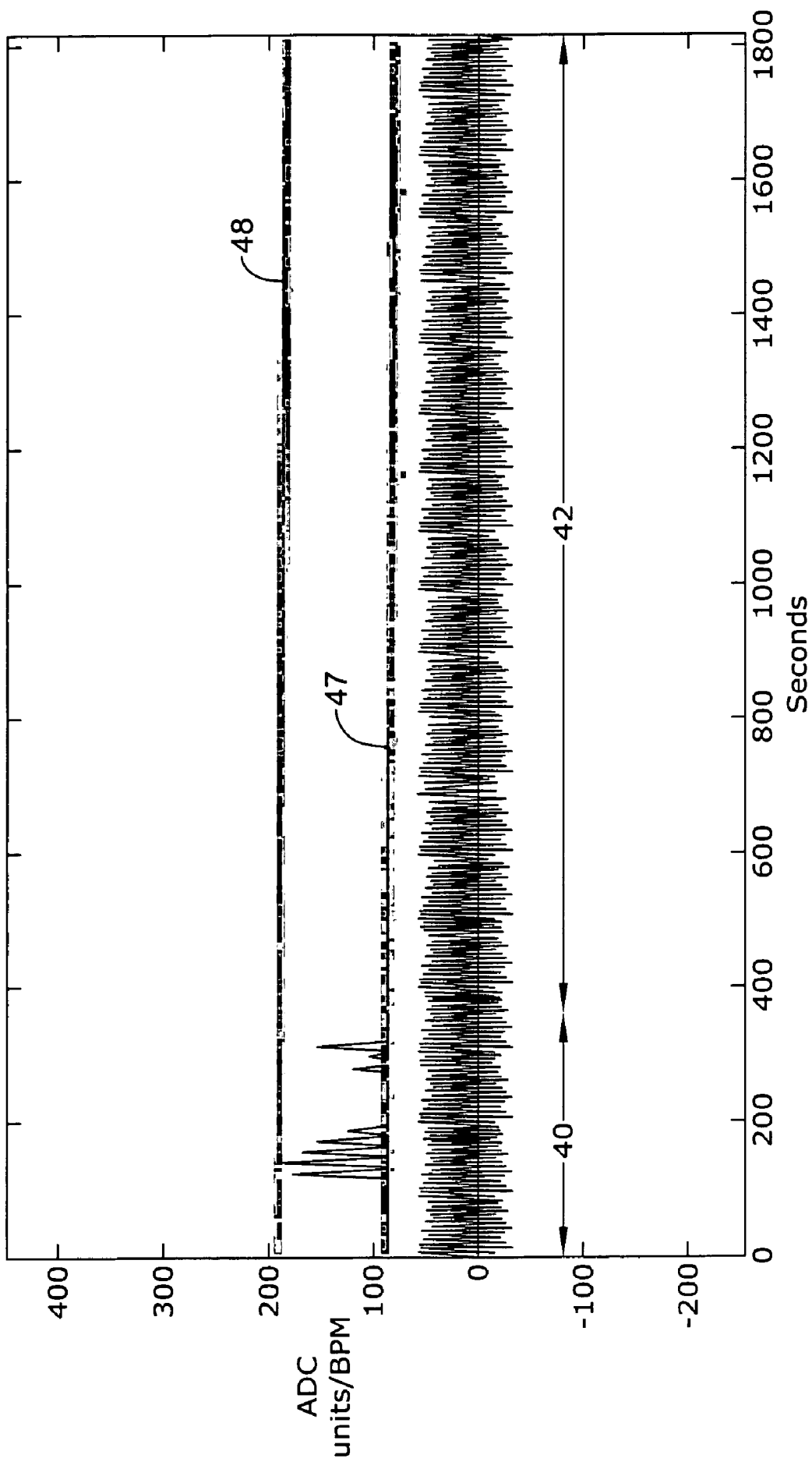


Fig. 5



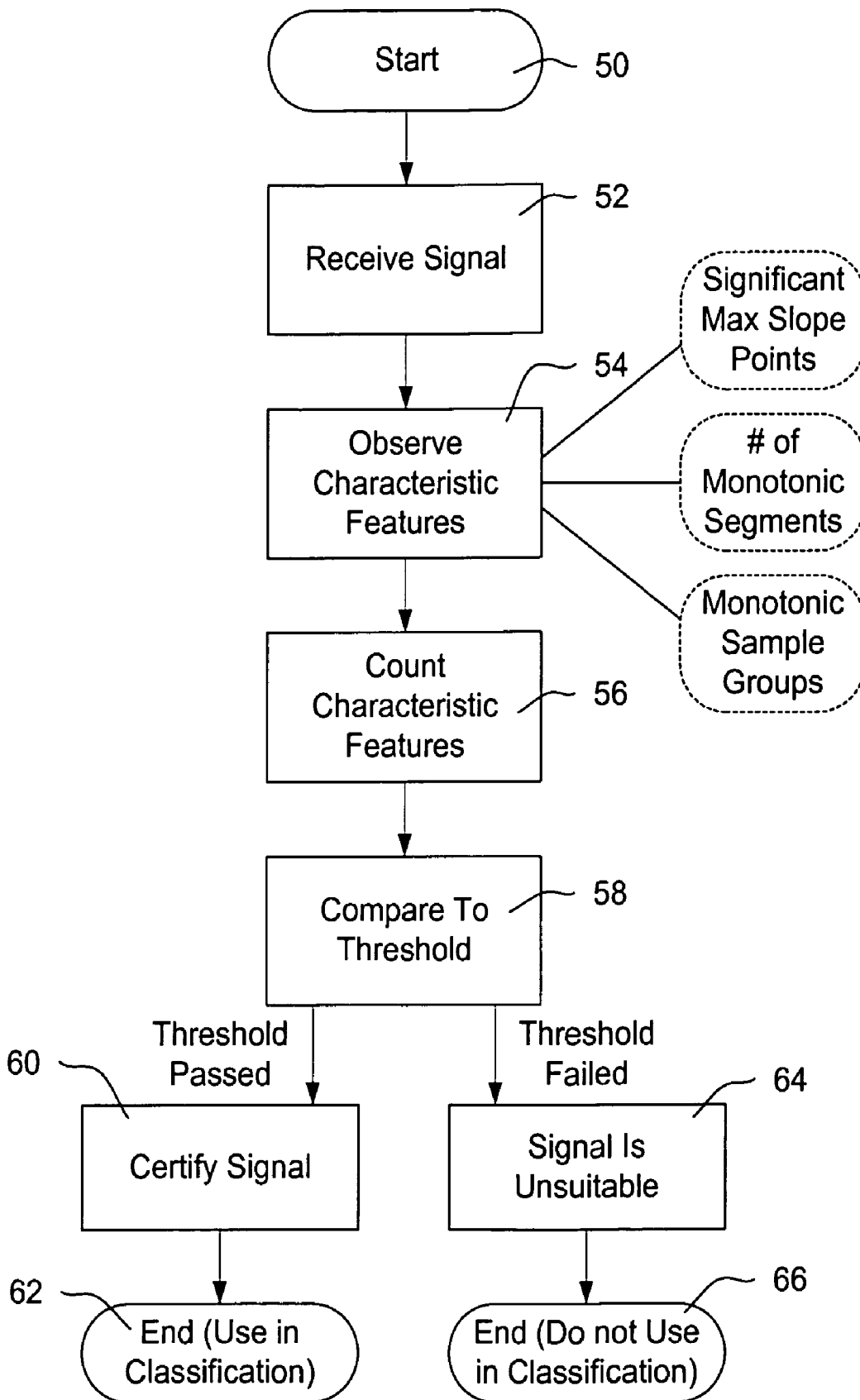


Fig. 6

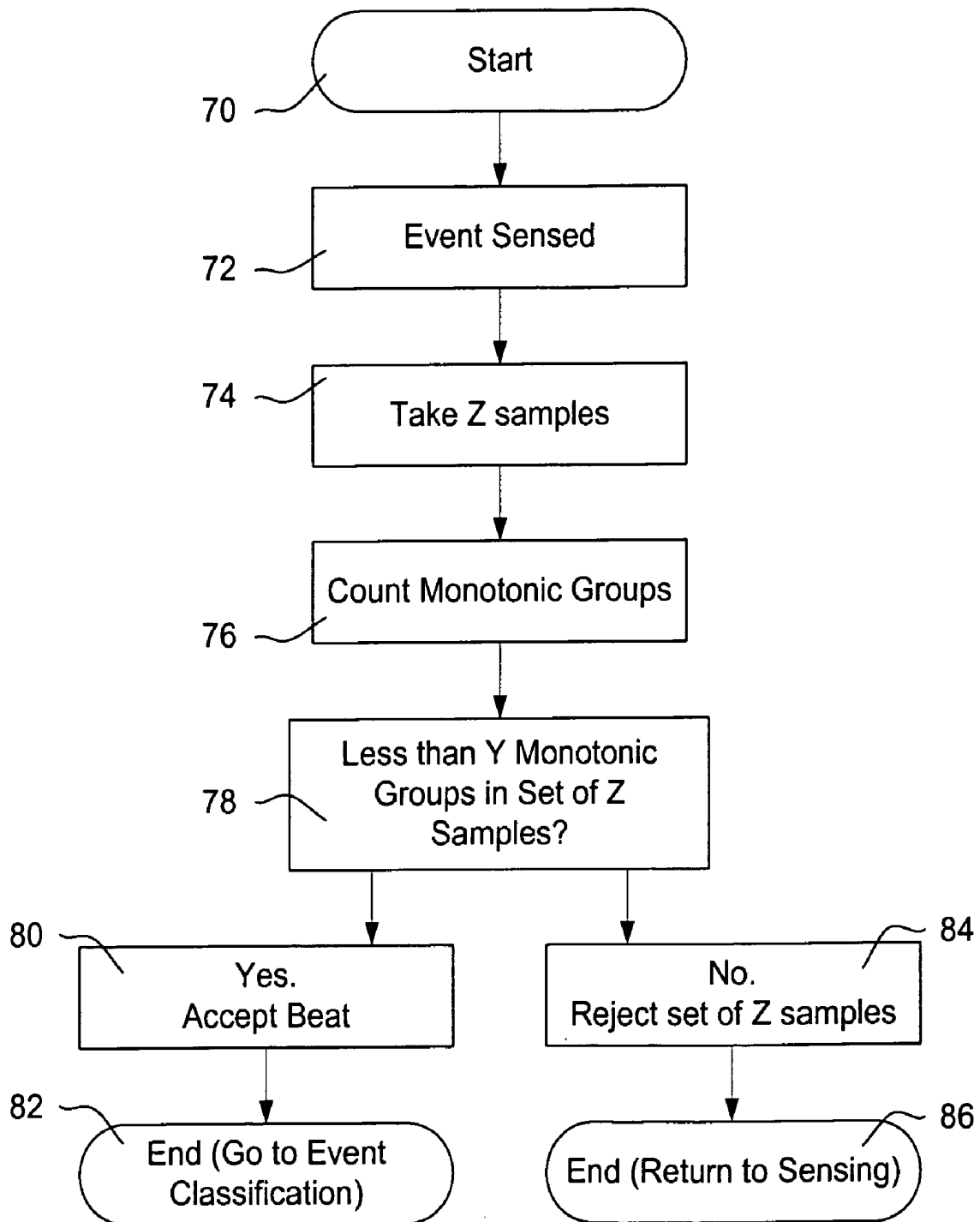


Fig. 7

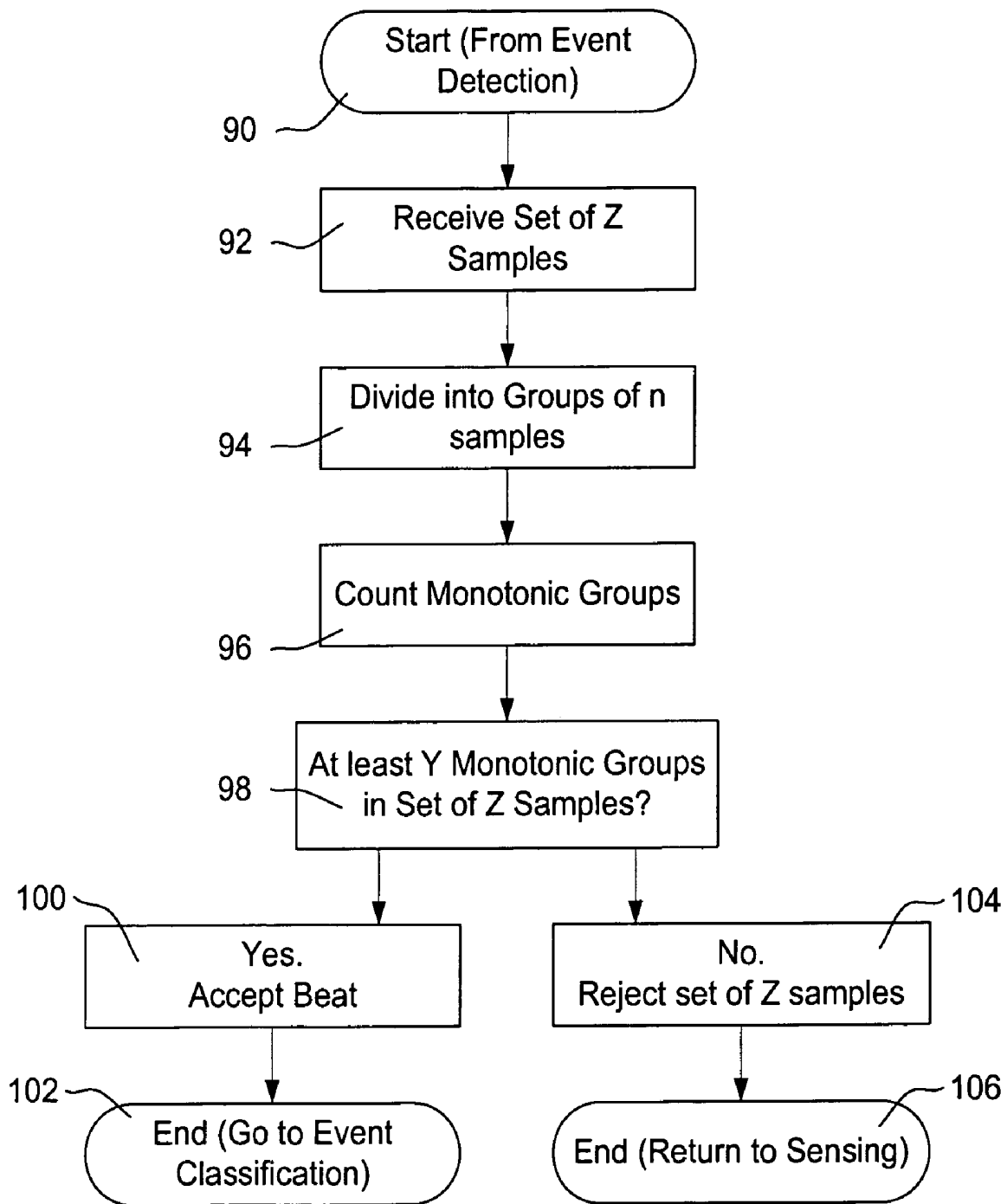


Fig. 8

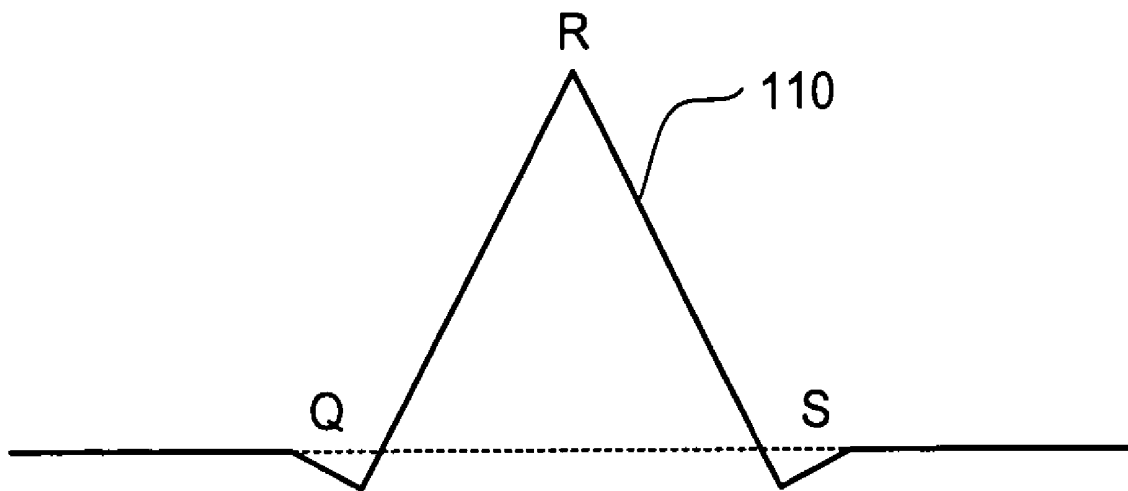


Fig. 9A

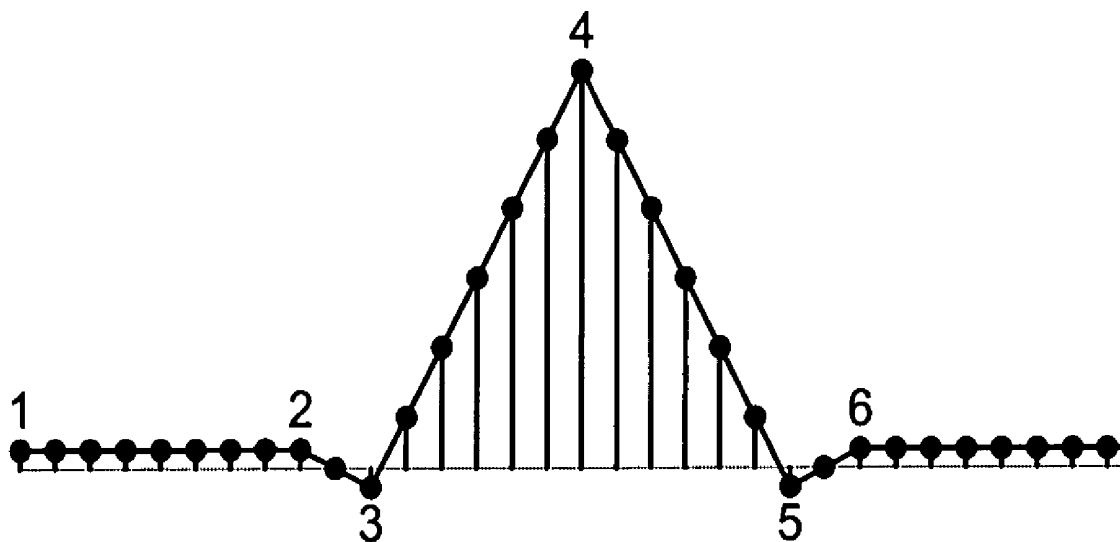


Fig. 9B

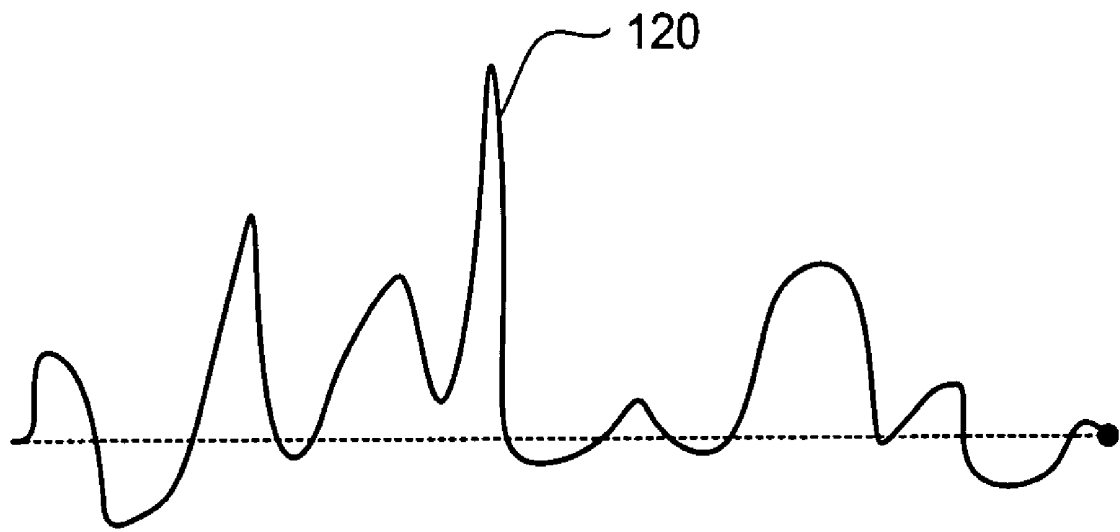


Fig. 10A

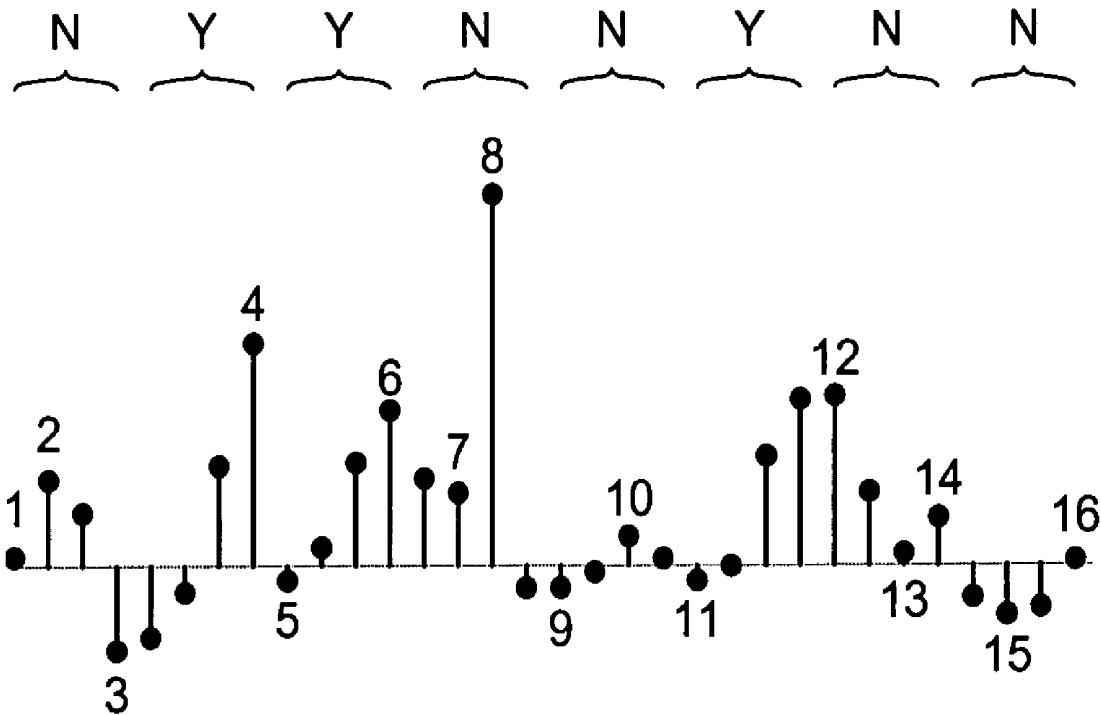


Fig. 10B

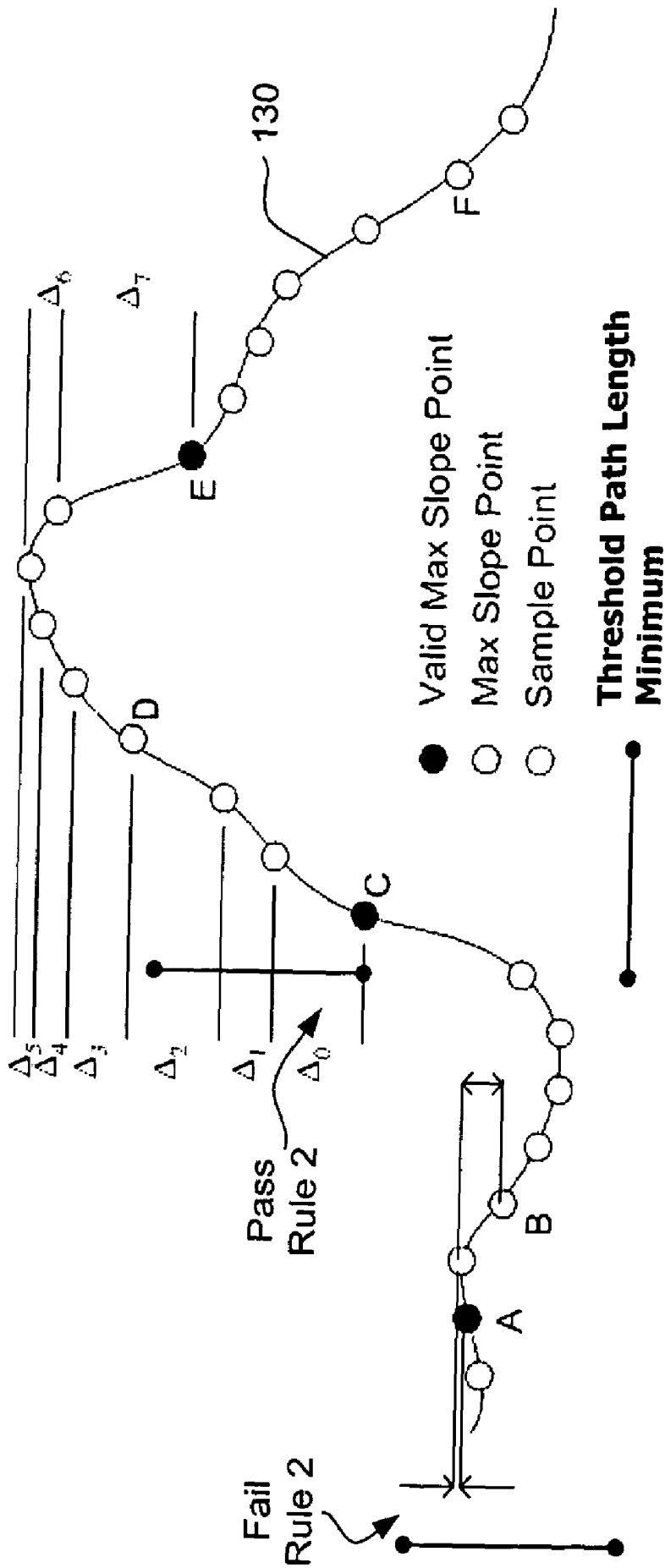


Fig. 11

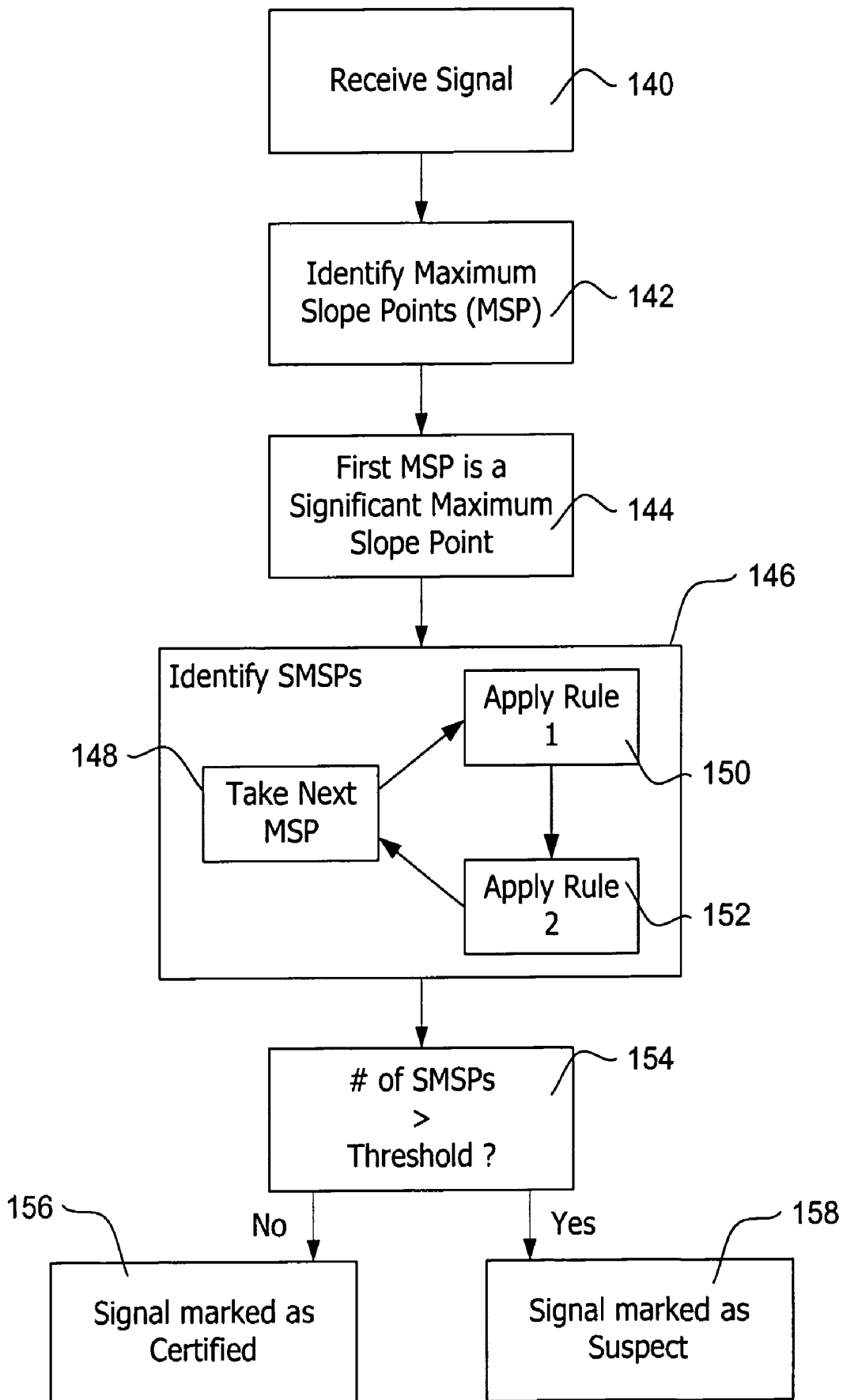


Fig. 12

METHOD AND DEVICES FOR PERFORMING CARDIAC WAVEFORM APPRAISAL

CROSS-REFERENCE OF CO-PENDING APPLICATIONS

This application claims the benefit of U.S. Provisional Application Ser. No. 60/475,279, filed Jun. 2, 2003, the disclosure of which is incorporated herein by reference.

FIELD

The present invention is related to the field of implantable cardiac treatment devices. More particularly, the present invention is related to methods of electrically sensing cardiac events and confirming the accuracy in detecting a cardiac event prior to determining whether treatment is needed.

BACKGROUND

Implantable cardiac rhythm management devices are an effective treatment in managing irregular cardiac rhythms in particular patients. Implantable cardiac rhythm management devices are capable of recognizing and treating arrhythmias with a variety of therapies. These therapies range from providing anti-bradycardia pacing for treating bradycardia, anti-tachycardia pacing or cardioversion energy for treating ventricular tachycardia, to high energy shock for treating ventricular fibrillation. Frequently, the cardiac rhythm management device delivers these therapies for the treatment of tachyarrhythmias in sequence; starting with anti-tachycardia pacing and then proceeding to low energy shocks, and then, finally, to high energy shocks. Sometimes, however, only one of these therapies is selected depending upon the tachyarrhythmia detected.

To effectively deliver these treatments, cardiac rhythm management devices must first accurately detect and classify an episode. Through accurate determination and quantification of sensed cardiac events, these cardiac rhythm management devices are able to classify the type of arrhythmia that is occurring and assess the appropriate therapy to provide to the heart, if any. A problem arises, however, when the cardiac rhythm management device senses noise, and mistakenly declares an episode. As a result, in particular instances, the cardiac rhythm management device may inappropriately deliver therapy.

Extra-cardiac noise may cause a cardiac rhythm management device to misclassify noise events as a tachyarrhythmia. In illustration, by incorporating skeletal muscle noise artifact, or other noise, into a cardiac rate calculation, the cardiac rhythm management device might inaccurately calculate the ventricular rate as one that is elevated. If the ventricular rate is mistakenly calculated to be elevated over a threshold rate boundary, a frequent determiner of tachyarrhythmias, the cardiac rhythm management device may inappropriately deliver therapy to a patient.

Additionally, problems arise when the cardiac therapy device withholds therapy after mischaracterizing a sensed event. For example, anti-bradycardia devices deliver a pacing pulse based on whether a cardiac event is sensed within a particular time frame. If the sensing architecture fails to sense a cardiac event within a preset time period, the cardiac rhythm management device will deliver a pacing pulse to the heart. This pacing pulse is timed in a preset sequence to induce the patient's heart to contract in a proper rhythm.

This therapy, however, may be compromised by having the cardiac rhythm management device sense and characterize an extraneous event as a "true" cardiac event. If the sensing architecture erroneously classifies noise (such as skeletal muscle artifact or other noise) as a "true" cardiac event, then a pacing pulse may be incorrectly withheld. This is particularly problematic when a pacing pulse is required to maintain a physiologically necessary rate of the patient's heart.

Besides being noticeable and sometimes physically painful to the patient, when a cardiac rhythm management device delivers inappropriate treatment, it can be extremely disconcerting to the patient. Moreover, delivery of an inappropriate therapy can intensify the malignancy of the cardiac arrhythmia. Therefore, the accuracy of a sensing architecture is an important factor in ensuring that appropriate therapy is delivered to a patient.

Current implantable cardiac rhythm management devices incorporate a sensing architecture that detects likely cardiac events and renders a decision regardless of the accuracy of those originally detected events. As such, current implantable cardiac rhythm management devices must include painstakingly designed sensing architectures to try and avoid erroneous detections. Prior art devices have been developed with rudimentary systems and methods in an attempt to determine whether noise is present on a sampled cardiac signal. If noise is detected in these devices, the manner in which the cardiac signal is acquired, or the manner in which the device operates in response to the acquired signal, is altered. This reduces the impact of erroneously detecting noise and, therefore, inappropriately triggering or withholding therapy. This methodology, however, leaves the cardiac rhythm management device open to significant sensing drawbacks, one of which is that it continually perturbs the sensing architecture.

Certain prior art implantable cardiac rhythm management devices continuously adjust parameters such as amplifier gain in response to extra-cardiac noise, which allows for the possibility that the sensing architecture may miss cardiac events. When adjusting the gain control to lessen sensitivity by raising the sensing floor to avoid noise, it is possible to miss actual cardiac events especially during polymorphic rhythms including ventricular fibrillation. In particular, the sensing architecture may miss discrete cardiac beats, or otherwise stated, miss true positives. By missing a cardiac event, rhythm and beat sensitivity is diminished.

Other implantable cardiac rhythm management devices in the prior art repeatedly extend a noise window during continuous noise. When these window extensions either reach a specific number, or more commonly reach the end of a predetermined interval, the device reverts to a non-sensing or asynchronous behavior for a limited period of time. This type of reversion behavior can miss a cardiac event, therefore reducing rhythm and beat sensitivity. Additionally, these reversion approaches to noise are generally only useful for continuous noise. Noise is most frequently burst in nature, for which most reversion schemes are not effective. This often results in overdetection and a potential for inappropriate therapy. Prior art cardiac rhythm management devices frequently utilize these methodologies contiguously.

SUMMARY

The present invention, in an illustrative embodiment, is directed toward a sensing architecture for use in cardiac rhythm management devices. The sensing architecture of the present invention provides a method and means for certifying detected events by the cardiac rhythm management

device. Moreover, by exploiting the enhanced capability for accurately identifying and using information from only those sensed events that are certified, the sensing architecture of the present invention can better discriminate between rhythms appropriate for device therapy and those that are not.

In an illustrative method embodiment, the present invention includes a method of signal detection enhancement for a cardiac rhythm device comprising receiving a signal from electrodes implanted for cardiac observation, observing characteristic features of the signal, counting the characteristic features, and comparing the number of characteristic features to a threshold either to certify the signal for use in characterizing a cardiac complex, or to determine the signal is unsuitable for use in characterizing a cardiac complex. In some embodiments, the characteristic features may include a number of significant maximum slope points in the sensed signal. In some embodiments, the characteristic features may include a number of monotonic segments in the sensed signal, or may include a number of sample groups within the sensed signal that are monotonic. Additional embodiments include systems and devices suited for performing such methods.

BRIEF DESCRIPTION

FIGS. 1A-1B illustrate, respectively, representative subcutaneous and intravenous ICD systems;

FIG. 2 illustrates a block diagram of a sensing architecture in accordance with an illustrative embodiment of the present invention;

FIG. 3 shows an electrocardiogram having a plurality of certified cardiac complexes used in classification and a plurality of cardiac complexes being marked suspect by the sensing architecture and not used in classification;

FIG. 4 shows an electrocardiogram sample having no waveform appraisal phase implemented by the sensing architecture;

FIG. 5 shows the same electrocardiogram sample as that depicted in FIG. 3, but with the waveform appraisal phase implemented;

FIG. 6 shows a block diagram illustrating the steps employed in some embodiments of the present invention for waveform appraisal;

FIG. 7 shows a block diagram illustrating the steps employed in another embodiment of the present invention for waveform appraisal;

FIG. 8 shows a block diagram illustrating the steps employed in another embodiment of the present invention for waveform appraisal;

FIGS. 9A-9B illustrate, graphically, operation of the waveform appraisal methods of FIGS. 7 and 8 on a clean QRS signal;

FIGS. 10A-10B illustrate, graphically, operation of the waveform appraisal methods of FIGS. 7 and 8 on a noisy signal that is not suitable for beat classification;

FIG. 11 illustrates, graphically, operation of another waveform appraisal method further illustrated in FIG. 12; and

FIG. 12 shows a block diagram illustrating the steps employed in a maximum slope point method of waveform appraisal.

DETAILED DESCRIPTION

The following detailed description should be read with reference to the drawings, in which like elements in different

drawings are numbered identically. The drawings, which are not necessarily to scale, depict selected embodiments and are not intended to limit the scope of the invention. Those skilled in the art will recognize that many of the examples provided have suitable alternatives that may be utilized.

The present invention is generally related to cardiac rhythm management devices (e.g., an Implantable Cardioverter/Defibrillator (ICD) system) that provide therapy for patients experiencing particular arrhythmias. The present invention is directed toward sensing architectures for use in cardiac rhythm management devices. In particular, the present invention is suited for ICD systems capable of detecting and defibrillating harmful arrhythmias. Although the sensing architecture is intended primarily for use in an implantable medical device that provides defibrillation therapy, the invention is also applicable to cardiac rhythm management devices directed toward anti-tachyarrhythmia pacing (ATP) therapy, pacing, and other cardiac rhythm devices capable of performing a combination of therapies to treat rhythm disorders, including external devices.

To date, ICD systems have been epicardial systems or transvenous systems implanted generally as shown in FIG. 1B, however, as further explained herein, the present invention is also adapted to function with a subcutaneous ICD system as shown in FIG. 1A.

FIG. 1A illustrates a subcutaneously placed ICD system. In this illustrative embodiment, the heart 1 is monitored using a canister 2 coupled to a lead system 3. The canister 2 may include an electrode 4 thereon, while the lead system 3 connects to sensing electrodes 5, 6, and a coil electrode 7 that may serve as a shock or stimulus delivery electrode as well as a sensing electrode. The various electrodes define a number of sensing vectors V1, V2, V3, V4. It can be seen that each vector provides a different vector "view" of the heart's 1 electrical activity. The system may be implanted subcutaneously as illustrated, for example, in U.S. Pat. Nos. 6,647,292 and 6,721,597, the disclosures of which are both incorporated herein by reference. By subcutaneous placement, it is meant that electrode placement does not require insertion of an electrode into a heart chamber, the heart muscle, or the patient's vasculature.

FIG. 1B illustrates a transvenous ICD system. The heart 10 is monitored and treated by a system including a canister 11 coupled to a lead system 12 including atrial electrodes 13 and ventricular electrodes 14. A number of configurations for the electrodes may be used, including placement within the heart, adherence to the heart, or disposition within the patient's vasculature. For example, Olson et al., in U.S. Pat. No. 6,731,978, illustrate electrodes disposed in each chamber of the heart for sensing, as well as shocking electrodes in addition to the sensing electrodes.

The present invention, in some embodiments, is also embodied by operational circuitry including select electrical components provided within the canister 2 (FIG. 1A) or canister 11 (FIG. 1B). In such embodiments, the operational circuitry may be configured to enable the methods to be performed. In some similar embodiments, the present invention may be embodied in readable instruction sets such as a program encoded in machine or controller readable media, wherein the readable instruction sets are provided to enable the operational circuitry to perform the analysis discussed in the above embodiments. Further embodiments may include a controller or microcontroller adapted to read and execute the above methods.

FIG. 2 illustrates a sensing architecture embodiment 20 of the present invention. The sensing architecture 20 is separated into three distinct and autonomous phases. The three

phases are (1) the detection phase **21**, (2) the waveform appraisal phase **22** and (3) the classification phase **23**. Decisions are made in each of the three phases. Moreover, decisions made in each phase may affect the decision-making process in subsequent phases. However, it is not necessarily the case that decisions made in an individual phase will affect the decision-making process in preceding phases. In illustration, a decision made in the waveform appraisal phase **22** may affect the decision-making process in the classification phase **23**, but it may have no effect on the detection phase **21**, or in any future decisions made in the detection phase **21**.

The first phase of the sensing architecture **20** is the detection phase **21**. Within the detection phase **21** of the sensing architecture **20**, data is collected by a cardiac rhythm management device. The manner in which the data is collected and the type of data collected is dependent on the cardiac rhythm management device being used. Moreover, the cardiac rhythm management device can be programmed to, or may automatically adapt to, optimally detect a particular form of data which is sought by the cardiac rhythm management device. In a subcutaneous ICD system, subcutaneous electrodes are used to detect cardiac signals emitted from the patient's heart.

Once the raw detected signal data is received by the cardiac rhythm management device, the detected data is then preprocessed, if required or desired. Preprocessing steps may include smoothing of the detected data, differentiation, filtering and other preprocessing methodologies known in the art. Finally, the detected data, whether preprocessed or raw, is initially classified as being either an event or not an event—indicated in the block diagram at **24**. More specifically, a determination is made that an event was detected by the sensing architecture **20**. An illustrative determination that an event was detected may include, for example, a determination that a signal has been received having at least a certain amplitude likely indicating an R-wave from a cardiac complex or noise. The result is that the detection phase **21** provides a sensed event to the waveform appraisal phase **22**.

Following the detection phase **21** of the sensing architecture **20**, sensed events are appraised in the second phase, the waveform appraisal phase **22**. In the illustrative embodiment, the waveform appraisal phase **22** is a separate and independent phase in the sensing architecture **20**. It is within the waveform appraisal phase **22** where an analysis is performed on the sensed event **24** recognized in the detection phase **21** of the sensing architecture **20**. In the waveform appraisal phase **22**, an operation is performed on the sensed event. More specifically, the appraisal operator **25** evaluates and certifies that what is sensed during the detection phase **21** is a high quality sensed event. A high quality sensed event is a sensed event that can be used in classifying a cardiac rhythm, such as a sensed event that closely represents a cardiac “beat” without excessive noise. In contrast, a low quality event may be a noise signal that does not represent the desired cardiac signal, or may represent a sensed cardiac beat but the beat is superimposed with a noise artifact sufficient to render the sensed event unsuitable for classification.

In particular embodiments of the present invention, the sensed event being certified in the waveform appraisal phase **22** is the detection of a cardiac ventricular depolarization. In the art, a cardiac ventricular depolarization is often referred to as a QRS complex or R-wave. In this embodiment, the waveform appraisal phase **22** evaluates and certifies that the sensed event is a high quality R-wave that can be used for

further decision making. In alternative embodiments of the present invention, the events being certified may be the detection of a P-wave (cardiac atrial depolarization), T-wave (cardiac ventricular repolarization), a pacing artifact, or any other sensed signal that may be utilized within a rhythm classification architecture. The present invention may also evaluate whether the sensed event was not an R-wave, P-wave, T-wave, pacing artifact, or any other sensed signal that could be misidentified as the sensed event of particular interest.

In particularly noisy conditions, certain noise may appear as a cardiac event, and thus be mistakenly sensed as such. Examples of noise that may create a low quality electrocardiogram signal include extra-cardiac (skeletal) muscle artifact, 50/60 Hertz interference, electromagnetic interference, electrocautery, or any other passing or intermittent electrical occurrence.

Assuming that the detection phase **21** does sense noise as an event, this sensed event is then processed through the waveform appraisal phase **22** so that the sensed event may be certified. For the illustrative embodiment, at least some, but preferably all sensed events are processed through the waveform appraisal phase **22**. In the waveform appraisal phase **22**, the appraisal operator **25** examines the sensed event through various methods and procedures (described below). In this example, noise may diminish the quality of the sensed event. Thus, the sensed event would be determined by the appraisal operator **25** to be something other than a certifiable event. A non-certifiable event is one that is “suspect”. Once the appraisal operator **25** has determined that the sensed event cannot be a certifiable event, the appraisal operator **25** further makes the determination to refrain from presenting the suspect event to the third phase of the sensing architecture **20**, the classification phase **23**. Specifically, the appraisal operator **25** prevents information from suspect event **26** from proceeding any further in the decision making process of the sensing architecture **20**. As such, the waveform appraisal phase **25** greatly reduces the likelihood that suspect events will inappropriately direct treatment.

In further illustration, the appraisal operator **25** also confirms accurately sensed events. When an accurately sensed event is presented to the appraisal operator **25** of the sensing architecture **20**, it will be certified. After the appraisal operator **25** has confirmed that the sensed event is certifiable, the appraisal operator **25** then presents the sensed event to the classification phase **23** for its consideration. Thus, again, only sensed events that have been processed through the waveform appraisal phase **22** will be presented to the classification phase **23** of the sensing architecture **20**. All suspect events are prevented **26** by the appraisal operator **25** from being available to the classification phase **23**.

The third and final phase of the sensing architecture **20** is the classification phase **23**. The classification phase **23** receives data corresponding to events certified by the appraisal operator **25** and performs certain mathematical operations to this certified data. Through these mathematical operations, the classification phase **23** examines attributes such as rare, template comparisons and morphological characteristics, among others. Some illustrative classification phase **23** operations are further discussed in co-pending U.S. patent application Ser. No. 10/856,084 entitled METHOD FOR DISCRIMINATING BETWEEN VENTRICULAR AND SUPRAVENTRICULAR ARRHYTHMIAS, filed May 27, 2004, the disclosure of which is incorporated herein by reference. Any other suitable classification or analytical methods may also be used, as desired. These analyses aid the

sensing architecture 20 in determining whether the certified events are associated with a particular class of rhythms. The classification phase 23 preferably accumulates a sufficient amount of data to render a determination which directs the cardiac rhythm management device to either withhold or deliver therapy to a patient.

The incorporation of a waveform appraisal phase 22 into a sensing architecture 20 enables the present invention to possess enhanced positive predictivity values. The mathematical formula for positive predictivity is as follows:

$$\text{Positive Predictivity} = (\text{True Positives}) / (\text{True Positives} + \text{False Positives})$$

In several illustrative embodiments, only certified events, and therefore only the highest quality, accurate and representative data, are designed to be sent to the classification phase 23 for evaluation. As such, even legitimate cardiac signals possessing poor quality may not be sent to the classification phase 23 for evaluation. The waveform appraisal phase 22, therefore, is designed to eliminate the preponderance of false positives from consideration by the classification phase. By reducing the number of false positives observed in a classification scheme, the positive predictivity increases and the system benefits from the reduction in inappropriate therapies delivered to a patient.

This heightened positive predictivity is directly observable in counting schemes used within the classification phase 23 employed by cardiac rhythm management devices. For example, the sensing architecture 20 of an embodiment of the present invention may utilize an X out of Y parameter requiring the classification of eighteen malignant cardiac events out of twenty-four total detected and certified events to declare an episode. The present invention can utilize this classic X out of Y filter; however, the Y input in the present invention will only comprise those events that have been certified. Suspect events, which will include the preponderance of false positives, will have been rejected by the appraisal operator 25 and would not be included in the Y input. Similarly, the X input comprises only those events that are appraised as being certified events through the waveform appraisal phase 22 and classified as dysrhythmic events through the classification phase 23. Thus, a preponderance of false positives are removed by the present invention, dramatically improving the system's positive predictivity.

In contrast, the inclusion of false positive events in the X out of Y filter will result in the reduction of positive predictivity. Therefore, in systems without a waveform appraisal phase 22, the positive predictivity of the counting scheme may be compromised during low quality electrocardiograms. If the positive predictivity is compromised, this may decrease the system's ability to accurately and reliably direct therapy to a patient.

FIG. 3 shows an approximately nine second segment of a patient's electrocardiogram 30 that is of low quality. Referring both to FIGS. 2 and 3, the electrocardiogram in FIG. 3 was processed through the sensing architecture 20; including the waveform appraisal phase 22 of the illustrative embodiment. The electrocardiogram 30 shows seven certified events (depicted by the symbol of an inverted triangle) and ten suspect events that were attributed as possessing low quality (depicted by the symbol of a dotted upright triangle). In this particular example, the low quality of the electrocardiogram is attributable to muscle artifact noise.

The first five sensed events 32 in the electrocardiogram were sensed by the detection phase 21, certified through the waveform appraisal phase 22, and presented to the classi-

fication phase 23 of the sensing architecture 20 as true cardiac complexes. In contrast, the ten subsequently following sensed events 34 in time were sensed by the detection phase 21, and evaluated and rejected through the waveform appraisal phase 22 as being suspect. Thus, these ten suspect events were not presented to the classification phase 23—as noted illustratively by the placement of a solid dot in an upright triangle. The last two sensed events 36 in time in the electrocardiogram, however, are depicted as being sensed and certified, and were presented to the classification phase 23.

If the overall system makes use of a counter or register to determine when to provide therapy to a patient, the occurrence of suspect events 34-34 need not necessarily reset or undermine the counting scheme to any great extent. In the illustrative example, counting during a low-quality signal is suspended during the occurrence of one, or a series of suspect events—such as those sensed events 34 graphically illustrated in FIG. 3. Embodiments of the classification phase 23 of the present invention could suspend the count through the low quality signal detection, and again continue the count where it left off following the passage of the low quality signal detection. Thus, in the above described example, the classification phase 23 of the present invention would detect the non-continuity of the stream of sensed data, but could still attribute the first certified event following the interruption, the count of eleven and not one. This feature permits the sensing architecture 20 of the present embodiment to greatly reduce any delay in detection. More specifically, the counting requirement could be fulfilled more quickly by the present invention's ability to hold a count as non-certifiable (suspect) events are rejected by the waveform appraisal phase 22, and therefore, would be quicker to declare an episode than a prior art device that must restart the count following the detection of noise. Thus, the present invention is capable of swift and accurate episode detection, which significantly increases the success of therapy delivered to a patient.

Certain embodiments of the present invention and counting operations may also limit the ability to suspend a count. For example, it would be less desirable to have a counting operation, requiring a preset number of events before declaring an episode, be one event shy of the required number, experience a considerable low-quality signal detection period, and then declare an episode on the first certified event following the low-quality signal detection. In this last example, the present invention may hold the count out longer to assure that the most recently sensed events are part of the trend observed prior to the low-quality signal detection. Similarly, if a lengthy low-quality signal is observed by the present invention (one that far outnumbers the previously certified events) or the continuity of the sensed signal is extremely poor, the present invention could also restart a count to assure that the declaration is accurate.

FIGS. 4 and 5 show how the application of an illustrative embodiment can enhance ICD operation in directing therapy to a patient. The rate threshold for arrhythmia declaration in both FIGS. 4 and 5 is approximately 180 BPM, and is depicted as a solid line 48. The running average cardiac rate is depicted generally as line 47.

The electrocardiogram in FIG. 4 illustrates a scenario where the calculated rate is the only determinative factor in deciding whether to apply or withhold therapy. Therefore, the analytical method applied to the electrocardiogram in FIG. 4 does not include a waveform appraisal phase. In the electrocardiogram of FIG. 4, a normal sinus rhythm interspersed with low quality cardiac events is depicted as

segment 40, and a high quality segment of normal sinus rhythm is shown as segment 42.

The upward excursions of the running cardiac rate 47 during segment 40 are caused by the inappropriate counting of low-quality events. As a result of this inappropriate rate counting, the patient would have been delivered at least one inappropriate shock, because the only determinative factor for therapy is rate. The points in the electrocardiogram where an event is declared using a prior art algorithm is shown as lines 44 and 46.

The electrocardiogram in FIG. 5 illustrates a scenario where a sensing architecture such as sensing architecture 20 in FIG. 2 is used, including a waveform appraisal phase 22, as discussed above with reference to FIG. 2. The inclusion of the waveform appraisal phase 22 greatly reduces the instances of inappropriate rate counting, and, therefore, inappropriate shocks, such as the ones declared in FIG. 4. When the illustrative sensing architecture 20 evaluates the same electrocardiogram signal as FIG. 4, it rejects the non-certifiable events as suspect. After the waveform appraisal phase 22 rejects the suspect events, it is observed that the illustrative embodiment does not include those suspect events in calculating the running average cardiac rate, and therefore does not deliver therapy. Specifically, when the appraisal operator 20 is presented with the low-quality segment 40, the waveform appraisal phase 22 evaluates the low-quality segment 40, and finds it to be of insufficient quality to use for declaring an event. Thus, in striking comparison to an industry standard sensing architecture as used for the evaluation shown in FIG. 4, the illustrative embodiment does not deliver therapy based on the low-quality signals observed in segment 40.

In preferred embodiments of the present invention, whether a cardiac event is accurately detected by the detection phase 21 of the sensing architecture 20, the detection phase 21 is not adjusted by the waveform appraisal phase's determinations. The detection phase 21 continues to operate independently of the remaining portions of the sensing architecture 20. Thus, although the waveform appraisal phase 22 may be evaluating detected events as suspect beats, the detection phase 21 of the sensing architecture 20 continues to sense such events in its customary manner. In alternative embodiments of the present invention, the detection phase 21 may adjust its sensing parameters to compensate for the frequency and number of mischaracterized, and therefore, suspect events.

Although the present invention has been described with relation to an ICD, a pacing device such as a pacemaker may utilize the present invention when in an ATP state. Thus, when a pacemaker is pacing a heart out of a tachyarrhythmia, the pacemaker may utilize the multi-phase sensing architecture of the present invention to certify whether sensed events have high quality or whether they are of low quality such that they may cause a mischaracterized detection. Additionally, there are other cardiac rhythm management devices that may have applicable states where the sensing architecture of the present invention is particularly suited and beneficial.

Referring again to FIG. 2, the sensing architecture 20 of the illustrative embodiment is capable of implementing several appraisal operators 25, and mechanisms necessary for the performance of the waveform appraisal phase 22. As described above, the events sensed are highly dependent on the type of cardiac rhythm management device used. Likewise, the appraisal operator 25, and the mechanics behind its operation, is highly dependent on both the cardiac rhythm management device used and the type of events sensed and

requiring certification. The present invention, therefore, is not limited in terms of the particular mechanics used during the waveform appraisal phase of the sensing architecture 20. The following descriptions are to illustrate an exemplary mode or configuration chosen from numerous plausible examples.

FIG. 6 shows a block diagram illustrating the steps employed in some embodiments of the present invention for waveform appraisal. From a start block 50, the waveform appraisal is triggered when an event is sensed, as noted at 52. Next, characteristic features of the sensed event are observed, as shown at 54. As noted, the "characteristic features" may take many forms. In illustrative embodiments, the characteristic features concern the shape of the sensed event. Some characteristic features that relate to the event's shape include the inclusion of monotonic segments, monotonic sample groups, or significant maximum slope points (example methods incorporating each are shown, respectively, in FIGS. 7, 8, and 12). Those skilled in the art will recognize that many of the characteristic features provided have suitable alternatives that may be utilized.

The waveform appraisal method in FIG. 6 continues with the step of counting the characteristic features, as shown at 56. The number of characteristic features is then compared to a threshold, as noted at 58. If the threshold is met, the event is certified as shown at 60, and the waveform appraisal is complete 62. The system then submits the certified event to the classification phase for further analysis. If the threshold is not met, the event is found to be a suspect event that is unsuitable for further analysis, as shown at 64. Then, the system is directed to return to the event sensing module or step until a next event is sensed, as shown at 66.

FIG. 7 shows a block diagram illustrating the steps employed in another embodiment of the present invention for waveform appraisal. From a start block 70, the system senses an event 72. Once the event is sensed 72, the system then implements the waveform appraisal phase, including at least some of steps 74-86. First, a collection of Z samples is taken from the sensed event, as shown at 74. This collection of Z samples is analyzed to count the monotonic groups therein, as noted at 76.

The step of counting monotonic groups 76 may be performed, for example, by comparing each successive sample to its predecessor. First a value for a group counter (typically stored in a counter, register or other memory location) is set to zero. Starting with a first sample, the next sample is compared. If the second sample has a value that is greater than the first sample, a direction register can be set to indicate that the samples are increasing in amplitude with time; alternatively, if the second sample has a value that is less than the first sample, the direction register may be set to indicate that the samples are decreasing. If the second sample has the same amplitude as the first sample, then the direction register may be left at its previous value (which is irrelevant until set). If desired, there may be a minimum change in amplitude required to cause a change in the direction register. Each successive sample is then compared in turn. Whenever the direction register is set to a new value, indicating a change in direction of sensed amplitude change over time, the group counter is incremented to indicate that a new monotonic segment has started.

After the step of counting monotonic groups shown at 76, the number of monotonic groups is compared to a threshold Y, as noted at 78. If there are less than Y monotonic groups in the Z samples, this indicates a high quality sensed event. A YES result 80 calls for certifying the event, and the system goes to an end 82 that directs the certified event to the

classification phase. If a NO result **84** occurs, the system rejects the set of Z samples as a suspect event, discarding the samples from memory, and returns to the sensing step as shown at **86**.

FIG. **8** is a block diagram of another illustrative embodiment of an appraisal system **80** including a waveform appraisal phase. The system begins at start block **90** by the system detecting an event. This illustrative embodiment is adapted to work with a sensing architecture that operates in terms of blocks of samples that are received and then sent forward in the analysis structure. As shown at step **92**, a set of Z samples are received by the system. The Z samples are then divided into groups of n samples as shown at **94**. Each group of samples is evaluated to determine whether it is monotonic or not, and these groups are counted as shown at **96**. The system next checks whether at least a threshold value, Y, of the groups are monotonic, as shown at **98**. For example, given thirty-two samples, the system may divide the set into eight groups of four samples and determine how many of the groups are monotonic. For such an example, a value of Y=5 could be used, such that five or more of the groups of samples would have to be monotonic to indicate a certified event.

If there are at least Y monotonic groups, the event is certified as a high-quality sensed event, as shown at **100**. The waveform appraisal phase then ends and the system directs the certified event to the classification phase, as shown at **102**. Otherwise, if there are less than Y monotonic groups in the set of Z samples, the method rejects the set of samples as a suspect event, as shown at **104**, and returns to the sensing block as shown at **106**.

FIGS. **9A-9B** show operation of an illustrative waveform appraisal system on a sensed event. The sensed event **110**, as shown in its continuous time analog representation in FIG. **9A**, is rather idealized and includes only that portion of the cardiac signal including the QRS complex. The T wave, in particular, has been excluded by keeping the time window of sensing narrow. For example, the time window of sensing may be less than one second, less than six-hundred milliseconds, or in the range of about fifty to two-hundred-fifty milliseconds. FIG. **9B** illustrates a sampled, discrete time representation of the sensed event **110**, with the signal including thirty-two samples. The representation of FIG. **9B**, as can be appreciated by looking at FIG. **9A**, is a temporally ordered set of samples. The numbers illustrate the number of monotonic segments and when they start by a method similar to the method of FIG. **7**. The brackets with Y and N letters placed above illustrate whether grouped samples are monotonic by the method of FIG. **8**, with the thirty-two samples placed in groups of four.

As can be seen, the event in FIG. **9B** includes six monotonic segments as counted in the manner illustrated in FIG. **7**. If a further refinement is included where a segment illustrating no change is not considered a separate monotonic segment, segments **1-2** and **5-6** would each count as a single monotonic segment such that the beat would have only four monotonic segments. If a maximum number of segments is set at six, then the sensed event **110** of FIGS. **9A-9B** would be certified.

For the method of FIG. **8**, the results of the group checks yields six monotonic groups and two groups that are not monotonic. If a threshold of $\frac{5}{8}$ groups being monotonic is used, then the sensed event **110** of FIGS. **9A-9B** would be certified.

FIGS. **10A-10B** show operation of an illustrative appraisal operation on a sensed event **120**, however, in this example, the sensed event **120** is a low quality event that

does not resemble a typical cardiac event. Again, FIG. **10A** illustrates the sensed event **120** in continuous, analog form. FIG. **10B** is a sampled (and, if desired, digitized), temporally ordered form of the event, and again indicates analytical results with numbers, brackets, and letters. Using the method of FIG. **7**, the sensed event **120** includes sixteen monotonic segments. Again using the threshold of six, this sensed event **120** fails to meet the threshold and would be considered suspect. As a result, the method of FIG. **7** would not certify the sensed event **120**.

Applying the method of FIG. **8**, the sensed event **120** has four groups that are monotonic segments. Again, using a threshold of five monotonic segments to be certifiable, the sensed event **120** would be found suspect. Application of the method of FIG. **7** would, again, not certify the sensed event **120**.

In another illustrative embodiment, the present invention includes a method of waveform appraisal that includes counting certain maximum slope points in a cardiac signal. The purpose of the maximum slope counter is to capture slope variation in the signal during the generated set of data. Low quality signals tend to have much more first derivative variation than a clean high quality cardiac signal. To capture the variation of the first derivative, the second derivative of the generated set is computed and checked for zero crossings. For an illustrative embodiment, a zero crossing of the second derivative is defined as one where the second derivative crosses from a non-zero negative to a non-zero positive value and vice versa. Preferably, simply reaching zero is not considered a zero crossing point. Zero crossings of the second derivative of a single generally correspond to the points of local maximum slope (either positive or negative) of the original signal.

For the illustrative embodiment, the first second derivative zero crossing is accepted as a significant maximum slope point. After that, as each maximum slope point is encountered, it is checked to see if it is significant by applying two rules based on path length. The path length is defined as an accumulation of the magnitude of amplitude changes in the original signal. The rules for the illustrative embodiment are as follows:

1. The path length of the signal between the last significant maximum slope point and the current maximum slope point must be greater than the amplitude difference between the two points.
2. The path length of the signal between the last significant maximum slope point and the current maximum slope point must be greater than a programmed threshold value, derived as a percentage (50%) of the average peak amplitudes of the beats recorded prior to the current detection. If desired, a maximum or minimum for the threshold value may be set. In an illustrative example, using an 8 bit ADC, if the derived threshold value is less than 7 ADC units, the threshold is set at 7 ADC units. If the derived threshold value is greater than 20 ADC units, the threshold is set at 20 ADC units.

FIG. **11** illustrates a method of signal analysis for counting significant maximum slope points. In the illustrative example, a number of signal sample points are shown along with a corresponding analog signal **130**. The method includes determining where the second derivative of the sampled signal crosses zero, indicating a maximum magnitude for the slope of the signal at each point. Points A, B, C, D, E and F indicate these points.

Next, the method includes the step of determining which of points A-F are significant for the purpose of appraising the signal. The magnitude of amplitude change from point to

point is determined, including the magnitude of such changes for the intermediate points between points A-F. These amplitude changes are indicated as segments Δ_0 - Δ_7 in FIG. 11. A path length value is then determined. The path length value, as noted above, is the accumulation of the magnitude of amplitude changes in the sampled signal occurring between two points. Thus, the sum of the magnitudes of segments Δ_0 to Δ_2 is the path length from C to D, the sum of the magnitudes of segments Δ_0 to Δ_7 is the path length from C to E, and the sum of the magnitudes of segments Δ_3 to Δ_7 is the path length from D to E.

Next, the actual change in signal amplitude between the points is measured. With these values, the two rules noted above are applied to determine which maximum slope points are significant for appraising the signal. For illustrative purposes, point C is assumed to be certified (C would in fact be certified in the Figure). Using point C as a reference point, from point C to point D, the path length is the same as the amplitude change, therefore, point D is not a significant maximum slope point under Rule 1. Therefore, point D is rejected.

The next step is to go to the next identified maximum slope point, point E, to determine if it is significant for the appraisal method. In this case, the path length from point C to point E exceeds the amplitude change between these two points. Rule 2 is passed because the path length exceeds the illustrated threshold path length minimum. Because the requirements of both rules are met, point E is a significant maximum slope point for the appraisal method.

In further illustration, it can be seen that point B is not a significant maximum slope point because the path length from point A to point B does not exceed the threshold path length minimum. This fails Rule 1, above, and point B would be rejected.

The above analysis yields three significant maximum slope points in the signal shown in FIG. 11. If, for example, the threshold maximum number of significant maximum slope points is set at six, then the illustrated signal is considered a certified signal.

FIG. 12 shows in block form steps of an illustrative maximum slope point counting method for appraising a received signal. The method begins by receiving a signal, as shown at 140. Next, the maximum slope points are identified, as noted at 142. The first maximum slope point is identified as a significant maximum slope point, as noted at 144. As illustrated in block 146, the rest of the significant maximum slope points are identified by taking a next maximum slope point as shown at 148, and applying the first rule as shown at 150 and the second rule as shown at 152. After the significant maximum slope points are identified in block 148, the number of significant maximum slope points is compared to a threshold, as shown at 154. If the threshold is not exceeded, the signal is certified, as noted at 156. If the threshold is exceeded, then the signal is marked as suspect, as noted at 158. In some embodiments, after the signal is marked as suspect, it may be subjected to further analysis, for example, to determine if changes in the event detection architecture are needed. In other embodiments, suspect signals are discarded.

The following illustrative embodiments are explained in terms of operational circuitry. The operational circuitry may be configured to include such controllers, microcontrollers, logic devices, memory, and the like, as selected, needed, or desired, for performing the steps for which each is configured.

An illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly

including a number of electrodes, and a canister housing operational circuitry. For the illustrative embodiment, the lead electrode assembly is coupled to the canister; and the operational circuitry is configured to receive a cardiac signal from implanted electrodes, observe characteristic features of the shape of the signal, count the characteristic features, and compare the number of characteristic features to a threshold. With the comparison to the threshold, the operational circuitry is further configured to certify the signal for use in characterizing a cardiac complex, or determine the signal is unsuitable for use in characterizing a cardiac complex. In another embodiment, the operational circuitry is configured such that the step of receiving a signal includes sensing electrical activity and using an event detector to determine the parameters of the signal. In yet a further embodiment, the operational circuitry is configured such that the step of observing characteristic features includes identifying a number of points in the signal where the signal slope reaches a local maximum magnitude.

For a related illustrative embodiment, the implantable cardioverter/defibrillator includes operational circuitry configured such that the step of identifying a number of points in the signal includes identifying zero crossings of the second derivative of the signal. In another embodiment, the operational circuitry is configured such that the step of observing characteristic features includes selecting a first zero crossing as a significant maximum slope point, and characterizing subsequent zero crossings as either significant maximum slope points or not significant maximum slope points, wherein the significant maximum slope points are observed to be the characteristic features. In a related embodiment, the operational circuitry is configured such that the step of characterizing subsequent zero crossings includes application of a rule related to a threshold for consideration of separate points in the signal. In yet another embodiment, the operational circuitry is configured such that the rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds a path length threshold. A further related embodiment includes operational circuitry configured such that the path length threshold is related to a selected percentage of the maximum signal amplitude for a chosen cardiac complex.

In another embodiment, the operational circuitry is configured such that the step of characterizing subsequent zero crossings includes application of a rule related to the signal shape between two points in the signal. In a further, related embodiment, the operational circuitry is configured such that the rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds the magnitude of the difference in amplitude between the signal at the time of the most recent significant maximum slope point, and the signal at the time of the zero crossing under consideration.

In another embodiment, the operational circuitry is configured such that a step of characterizing subsequent zero crossings includes analysis using a first rule and a second rule, the first rule being related to a threshold for consideration of separate points in the signal, the second rule being related to the signal shape between two points in the signal. In a further embodiment, the operational circuitry is configured such that the first rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds a path length threshold, and the second rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under

consideration exceeds the magnitude of the difference in amplitude between, the signal at the time of the most recent significant maximum slope point, and the signal at the time of the zero crossing under consideration. In another related embodiment, the operational circuitry is configured such that the step of observing characteristic features of the signal includes assessment of the degree of monotonicity of the signal.

In another embodiment, the operational circuitry is configured such that the step of observing characteristic features of the signal includes counting a number of monotonic segments of the signal. Yet another embodiment includes operational circuitry configured such that the signal has a duration of less than one second. In several embodiments, the implantable cardioverter/defibrillator includes operational circuitry comprising a controller and a controller readable memory.

An illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to: sample a signal from an implanted electrode; identify maximum slope points in the sample signal corresponding to local signal slope maximums; analyze the sample signal to determine which of the maximum slope points are significant; and compare the number of significant maximum slope points to a threshold.

Another illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to: receive a signal from a pair of implanted electrodes; sense whether a likely cardiac event has occurred; observe the monotonic characteristics of the signal during a time period corresponding to the likely cardiac event; and determine whether the signal during the time period is sufficiently monotonic to indicate the cardiac signal can be certified for classifying a cardiac rhythm. In a further embodiment, the operational circuitry is configured such that the step of observing the monotonic characteristics includes grouping together samples of the cardiac signal from the time period into sample groups, and observing whether each sample group is monotonic. In yet another embodiment, the operational circuitry is configured such that the step of observing the monotonic characteristics includes counting the number of times that an ordered set of samples of the cardiac signal corresponding to the time period changes its direction of amplitude change. Another illustrative embodiment includes operational circuitry is configured such that the step of observing the monotonic characteristics includes counting a number of monotonic segments found in a sampling of the cardiac signal corresponding to the time period. An illustrative embodiment further includes operational circuitry configured to classify the event to determine whether the event indicates treatment. In another embodiment, the operational circuitry is further configured to determine whether a cardiac signal appears to indicate a patient's heart is beating at a rate above a rate threshold before performing the receive, sense, observe, and determine steps. In yet another embodiment, the operational circuitry comprises a controller and a controller readable memory.

An illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing

operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to: sample a cardiac signal from a pair of implanted electrodes; define a number of groups of samples from a portion of the signal; determine how many of the groups of samples are monotonic; and, if the number of monotonic groups does not exceed a threshold, discard the portion of the signal.

Another illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to determine whether a heart is pumping at a rate exceeding a threshold, and, if so, perform the following steps: sample a cardiac signal from a pair of implanted electrodes; define a number of groups of samples from a portion of the signal; determine how many of the groups of samples are monotonic; and if the number of monotonic groups does not exceed a threshold, discard the portion of the signal. In another embodiment, the operational circuitry is further configured to classify the signal by analyzing non-discarded portions of the signal, wherein the step of classifying the signal includes classifying portions of the signal as either indicating treatment or not indicating treatment. In yet another illustrative embodiment, the operational circuitry is further configured such that the step of classifying the signal includes keeping a count of classified portions until a threshold number of portions are classified; wherein, when the threshold number of portions are classified, the method further includes determining whether to provide treatment based upon whether a predetermined number of classified portions indicate treatment.

Another illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to: sample a signal from first and second implanted electrodes; set a threshold for the monotonicity of a sensed signal; determine whether the sampled signal meets the threshold; and if the sampled signal does not meet the threshold, discard the signal.

Yet another illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to: receive a signal from first and second implanted electrodes; observe a point in the signal; observe a number of samples of the signal following the point; group the samples into a number of groups; observe which of the groups are monotonic; count the monotonic groups; determine whether the number of monotonic groups exceeds a threshold; and, if the number of monotonic groups does not exceed the threshold, discard the portion of the signal from which the number of signals following the point were taken.

An illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to: receive a signal from first and second implanted electrodes; observe a monotonic segment of the signal; measure the length of the monotonic segment; compare the length to a threshold; and, if the length is less than

the threshold, determine that the monotonic segment does not correspond to a certifiable cardiac event. In a related embodiment, the operational circuitry is further configured to observe a portion of the signal around the monotonic segment, determine whether the monotonic segment ends in a highest signal strength for the portion, and, if the monotonic segment does not end in a highest signal strength for the portion, determining that the monotonic segment does not correspond to a certifiable cardiac event. In another embodiment, the operational circuitry is further configured such that the portion corresponds to time window around the monotonic segment, at least a portion of the time window occurring before the monotonic segment begins, and at least a portion of the time window occurring after the monotonic segment ends, the window having a duration in the range of 50-250 milliseconds.

Another embodiment includes an implantable cardiac treatment system comprising first and second electrodes, and circuitry contained in a housing, the circuitry electrically coupled to the first and second electrodes, wherein the circuitry is adapted to perform the following steps: sampling a signal from first and second implanted electrodes; setting a threshold for the monotonicity of a sensed signal; determining whether the sampled signal meets the threshold; and, if the sampled signal does not meet the threshold, discarding the signal. In a further embodiment, the circuitry includes a controller and a controller readable medium, the controller readable medium containing instructions thereon for performing the steps of sampling, setting, determining and discarding.

Yet another embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to monitor a signal produced between implanted electrodes to observe an event, observe an event and gathering a signal corresponding to the event, observe characteristic features of the shape of the signal, count the characteristic features, and compare the number of characteristic features to a threshold to certify the signal for use in characterizing a cardiac complex, or determine the signal is unsuitable for use in characterizing a cardiac complex. In the illustrative embodiment, if the signal is certified, the operational circuitry is also configured to use the signal to determine whether a malignant cardiac rhythm is likely occurring.

An illustrative embodiment includes an implantable cardioverter/defibrillator comprising a lead electrode assembly including a number of electrodes, and a canister housing operational circuitry, wherein the lead electrode assembly is coupled to the canister, and the operational circuitry is configured to capture a signal using implanted electrodes placed for observing electrical cardiac activity, analyze the signal to determine whether the signal is suitable for characterizing a cardiac rhythm, and, if the signal is suitable, use the signal to determine whether a malignant cardiac rhythm is likely occurring, or, if the signal is not suitable, reject the signal.

Numerous characteristics and advantages of the invention covered by this document have been set forth in the foregoing description. It will be understood, however, that this disclosure is, in many aspects, only illustrative. Changes may be made in details, particularly in matters of shape, size and arrangement of parts without exceeding the scope of the invention. The invention's scope is defined, of course, in the language in which the claims are expressed.

What is claimed is:

1. A method of signal detection enhancement for a cardiac rhythm device comprising:

receiving a signal from electrodes implanted for cardiac observation;
observing characteristic features of the signal;
counting the characteristic features;
comparing the number of characteristic features to a threshold to:
certify the signal for use in characterizing a cardiac complex; or
determine the signal is unsuitable for use in characterizing a cardiac complex;

wherein:

the step of observing characteristic features includes identifying a number of points in the signal where the signal slope reaches a local maximum magnitude;
the step of identifying a number of points in the signal includes identifying zero crossings of the second derivative of the signal;

the step of observing characteristic features includes:

- (a) selecting a first zero crossing as a significant maximum slope point;
- (b) characterizing subsequent zero crossings as either significant maximum slope points or not significant maximum slope points; and
- (c) the significant maximum slope points are observed to be the characteristic features;

the step of characterizing subsequent zero crossings includes application of a rule related to the signal shape between two points in the signal; and

the rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds the magnitude of the difference in amplitude between:
the signal at the time of the most recent significant maximum slope point; and
the signal at the time of the zero crossing under consideration.

2. A method of signal detection enhancement for a cardiac rhythm device comprising:

receiving a signal from electrodes implanted for cardiac observation;
observing characteristic features of the signal;
counting the characteristic features;
comparing the number of characteristic features to a threshold to:
certify the signal for use in characterizing a cardiac complex; or
determine the signal is unsuitable for use in characterizing a cardiac complex;

wherein:

the step of observing characteristic features includes identifying a number of points in the signal where the signal slope reaches a local maximum magnitude;
the step of identifying a number of points in the signal includes identifying zero crossings of the second derivative of the signal;

the step of observing characteristic features includes:

- (a) selecting a first zero crossing as a significant maximum slope point; and
- (b) characterizing subsequent zero crossings as either significant maximum slope points or not significant maximum slope points;

the step of characterizing subsequent zero crossings includes analysis using a first rule and a second rule, the first rule being related to a threshold for consideration

of separate points in the signal, the second rule being related to the signal shape between two points in the signal;

wherein the first rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds a path length threshold;

and the second rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds the magnitude of the difference in amplitude between: the signal at the time of the most recent significant maximum slope point; and the signal at the time of the zero crossing under consideration.

3. An implantable cardioverter/defibrillator comprising: a lead electrode assembly including a number of electrodes; and a canister housing operational circuitry; wherein: the lead electrode assembly is coupled to the canister; and the operational circuitry is configured to:

- receive a cardiac signal from implanted electrodes;
- observe characteristic features of the shape of the signal;
- count the characteristic features; and
- compare the number of characteristic features to a threshold to:
 - certify the signal for use in characterizing a cardiac complex; or
 - determine the signal is unsuitable for use in characterizing a cardiac complex;

wherein:

the operational circuitry is configured such that the step of observing characteristic features includes identifying a number of points in the signal where the signal slope reaches a local maximum magnitude;

the operational circuitry is configured such that the step of identifying a number of points in the signal includes identifying zero crossings of the second derivative of the signal;

the operational circuitry is configured such that the step of observing characteristic features includes:

- selecting a first zero crossing as a significant maximum slope point; and
- characterizing subsequent zero crossings as either significant maximum slope points or not significant maximum slope points; wherein the significant maximum slope points are observed to be the characteristic features;

the operational circuitry is configured such that the step of characterizing subsequent zero crossings includes application of a rule related to the signal shape between two points in the signal; and

the operational circuitry is configured such that the rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds the magnitude of the difference in amplitude between: the signal at the time of the most recent significant maximum slope point; and

the signal at the time of the zero crossing under consideration.

4. An implantable cardioverter/defibrillator comprising: a lead electrode assembly including a number of electrodes; and a canister housing operational circuitry; wherein: the lead electrode assembly is coupled to the canister; and the operational circuitry is configured to:

- receive a cardiac signal from implanted electrodes;
- observe characteristic features of the shape of the signal;
- count the characteristic features; and
- compare the number of characteristic features to a threshold to:
 - certify the signal for use in characterizing a cardiac complex; or
 - determine the signal is unsuitable for use in characterizing a cardiac complex;

wherein:

the operational circuitry is configured such that the step of observing characteristic features includes identifying a number of points in the signal where the signal slope reaches a local maximum magnitude;

the operational circuitry is configured such that the step of identifying a number of points in the signal includes identifying zero crossings of the second derivative of the signal;

the operational circuitry is configured such that the step of observing characteristic features includes:

- selecting a first zero crossing as a significant maximum slope point; and
- characterizing subsequent zero crossings as either significant maximum slope points or not significant maximum slope points; wherein the significant maximum slope points are observed to be the characteristic features;

the operational circuitry is configured such that the step of characterizing subsequent zero crossings includes analysis using a first rule and a second rule, the first rule being related to a threshold for consideration of separate points in the signal, the second rule being related to the signal shape between two points in the signal; and

the operational circuitry is configured such that:

- the first rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds a path length threshold; and
- the second rule calls for determining whether the path length from a most recent significant maximum slope point to the zero crossing under consideration exceeds the magnitude of the difference in amplitude between: the signal at the time of the most recent significant maximum slope point; and the signal at the time of the zero crossing under consideration.

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专利名称(译)	用于执行心脏波形评估的方法和设备		
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[标]申请(专利权)人(译)	卡梅伦保健公司		
申请(专利权)人(译)	CAMERON HEALTH, INC.		
当前申请(专利权)人(译)	CAMERON HEALTH, INC.		
[标]发明人	PALREDDY SUREKHA WARREN JAY A PHILLIPS JAMES WILLIAM		
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IPC分类号	A61N1/00 A61B5/00 A61B5/042 A61B5/0452 A61N1/362 A61N1/368		
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摘要(译)

本发明涉及一种用于心律管理装置的传感结构。本发明的感测架构提供了用于通过心律管理设备认证检测到的事件的方法和装置。此外，通过利用增强的能力来仅精确地识别所需的那些感测事件，并防止使用标记为可疑的事件，本发明的感测架构可以更好地区分适合于设备治疗的节奏和不适合于设备治疗的节奏。

