



US009776009B2

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

(10) **Patent No.:** **US 9,776,009 B2**
(45) **Date of Patent:** **Oct. 3, 2017**

(54) **NON-INVASIVE DETECTION OF PHRENIC NERVE STIMULATION**

(58) **Field of Classification Search**
CPC A61N 1/3706
USPC 607/27, 28
See application file for complete search history.

(71) Applicant: **Medtronic, Inc.**, Minneapolis, MN (US)

(56) **References Cited**

(72) Inventors: **Subham Ghosh**, Blaine, MN (US);
Vincent Splett, Apple Valley, MN (US)

U.S. PATENT DOCUMENTS

(73) Assignee: **Medtronic, Inc.**, Minneapolis, MN (US)

- 4,233,987 A 11/1980 Feingold
- 4,402,323 A 9/1983 White
- 4,428,378 A 1/1984 Anderson et al.
- 4,497,326 A 2/1985 Curry
- 4,566,456 A 1/1986 Koning et al.
- 4,593,702 A 6/1986 Kepski
- 4,674,511 A 6/1987 Cartmell
- 4,763,660 A 8/1988 Kroll et al.
- 4,777,955 A 10/1988 Brayton et al.
- 4,787,389 A 11/1988 Tarjan
- 4,979,507 A 12/1990 Heinz et al.
- 5,052,388 A 10/1991 Sivula et al.

(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 0 days.

(Continued)

(21) Appl. No.: **14/220,733**

FOREIGN PATENT DOCUMENTS

(22) Filed: **Mar. 20, 2014**

- CN 1043621 A 11/1990
- CN 1253761 A 5/2000

(Continued)

(65) **Prior Publication Data**

US 2015/0265840 A1 Sep. 24, 2015

OTHER PUBLICATIONS

U.S. Appl. No. 13/916,353, filed Jun. 12, 2013, Ghosh.

(Continued)

(51) **Int. Cl.**

- A61N 1/00** (2006.01)
- A61N 1/37** (2006.01)
- A61B 5/04** (2006.01)
- A61B 5/11** (2006.01)
- A61N 1/372** (2006.01)
- A61B 5/00** (2006.01)
- A61B 5/0408** (2006.01)

Primary Examiner — Nadia A Mahmood

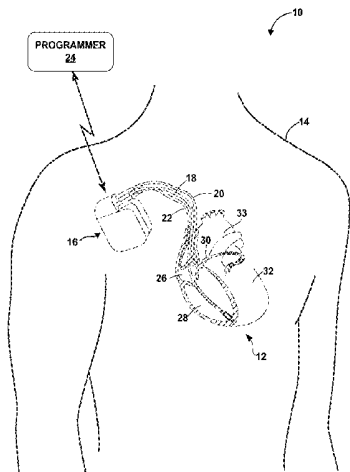
(52) **U.S. Cl.**

- CPC **A61N 1/3702** (2013.01); **A61B 5/04001** (2013.01); **A61B 5/1107** (2013.01); **A61N 1/37247** (2013.01); **A61B 5/04012** (2013.01); **A61B 5/04085** (2013.01); **A61B 5/6823** (2013.01); **A61B 5/7235** (2013.01); **A61B 5/7267** (2013.01); **A61B 5/743** (2013.01)

(57) **ABSTRACT**

Systems, methods, and graphical user interfaces are described herein for non-invasively detecting phrenic nerve stimulation during cardiac pacing therapy. Phrenic nerve stimulation information may be generated for one or more electrical pacing vectors at one or more power configurations. The phrenic nerve stimulation information may be displayed to a user for use in configuring and/or evaluating cardiac pacing therapy.

25 Claims, 22 Drawing Sheets



(56)

References Cited

U.S. PATENT DOCUMENTS

5,054,496	A	10/1991	Wen et al.	7,499,743	B2	3/2009	Vass et al.
5,311,873	A	5/1994	Savard et al.	7,509,170	B2	3/2009	Zhang et al.
5,331,960	A	7/1994	Krenzke	7,565,190	B2	7/2009	Okerlund et al.
5,334,220	A	8/1994	Sholder	7,587,074	B2	9/2009	Zarkh et al.
5,443,492	A	8/1995	Stokes et al.	7,599,730	B2	10/2009	Hunter et al.
5,485,849	A	1/1996	Panescu et al.	7,610,088	B2	10/2009	Chinchoy
5,514,163	A	5/1996	Markowitz et al.	7,613,500	B2	11/2009	Vass et al.
5,552,645	A	9/1996	Weng	7,616,993	B2	11/2009	Müssig et al.
5,628,778	A	5/1997	Kruse et al.	7,664,550	B2	2/2010	Eick et al.
5,671,752	A	9/1997	Sinderby et al.	7,684,863	B2	3/2010	Parikh et al.
5,683,429	A	11/1997	Mehra	7,742,629	B2	6/2010	Zarkh et al.
5,683,432	A	11/1997	Goedeke et al.	7,747,047	B2	6/2010	Okerlund et al.
5,687,737	A	11/1997	Branham et al.	7,751,882	B1	7/2010	Helland et al.
5,810,740	A	9/1998	Paisner	7,769,451	B2	8/2010	Yang et al.
5,876,336	A	3/1999	Swanson et al.	7,778,685	B2	8/2010	Evron et al.
5,891,045	A	4/1999	Albrecht et al.	7,778,686	B2	8/2010	Vass et al.
5,922,014	A	7/1999	Warman et al.	7,787,951	B1	8/2010	Min
6,055,448	A	4/2000	Anderson et al.	7,813,785	B2	10/2010	Okerlund et al.
6,128,535	A	10/2000	Maarse	7,818,040	B2	10/2010	Spear et al.
6,141,588	A	10/2000	Cox et al.	7,848,807	B2	12/2010	Wang
6,187,032	B1	2/2001	Ohyu et al.	7,860,580	B2	12/2010	Falk et al.
6,205,357	B1	3/2001	Ideker et al.	7,894,889	B2	2/2011	Zhang
6,226,542	B1	5/2001	Reisfeld	7,912,544	B1	3/2011	Min et al.
6,236,883	B1	5/2001	Ciaccio et al.	7,917,214	B1	3/2011	Gill et al.
6,243,603	B1	6/2001	Ideker et al.	7,941,213	B2	5/2011	Markowitz et al.
6,246,898	B1	6/2001	Vesely et al.	7,953,475	B2	5/2011	Harlev et al.
6,301,496	B1	10/2001	Reisfeld	7,953,482	B2	5/2011	Hess
6,311,089	B1	10/2001	Mann et al.	7,983,743	B2	7/2011	Rudy et al.
6,330,476	B1	12/2001	Ben-Haim et al.	7,996,063	B2	8/2011	Vass et al.
6,358,214	B1	3/2002	Tereschouk	7,996,070	B2	8/2011	Van Dam et al.
6,377,856	B1	4/2002	Carson	8,010,194	B2	8/2011	Muller
6,381,493	B1	4/2002	Stadler et al.	8,019,402	B1	9/2011	Kryzpow et al.
6,393,316	B1	5/2002	Gillberg et al.	8,019,409	B2	9/2011	Rosenberg et al.
6,418,346	B1	7/2002	Nelson et al.	8,032,229	B2	10/2011	Gerber et al.
6,442,433	B1	8/2002	Linberg	8,036,743	B2	10/2011	Savage et al.
6,456,867	B2	9/2002	Reisfeld	8,060,185	B2	11/2011	Hunter et al.
6,473,638	B2	10/2002	Ferek-Petric	8,150,513	B2	4/2012	Chinchoy
6,480,745	B2	11/2002	Nelson et al.	8,160,700	B1	4/2012	Ryu et al.
6,484,118	B1	11/2002	Govari	8,175,703	B2	5/2012	Dong et al.
6,507,756	B1	1/2003	Heynen et al.	8,180,428	B2	5/2012	Kaiser et al.
6,532,379	B2	3/2003	Stratbucker	8,195,292	B2	6/2012	Rosenberg et al.
6,584,343	B1	6/2003	Ransbury et al.	8,213,693	B1	7/2012	Li
6,599,250	B2	7/2003	Webb et al.	8,214,041	B2	7/2012	Van Gelder et al.
6,625,482	B1	9/2003	Panescu et al.	8,265,738	B1	9/2012	Min et al.
6,640,136	B1	10/2003	Helland et al.	8,285,377	B2	10/2012	Rosenberg et al.
6,650,927	B1	11/2003	Keidar	8,295,943	B2	10/2012	Eggen et al.
6,766,189	B2	7/2004	Yu et al.	8,326,419	B2	12/2012	Rosenberg et al.
6,772,004	B2	8/2004	Rudy	8,332,030	B2	12/2012	Hess et al.
6,804,555	B2	10/2004	Warkentin	8,380,308	B2	2/2013	Rosenberg et al.
6,847,836	B1	1/2005	Sujdak	8,401,616	B2	3/2013	Verard et al.
6,856,830	B2	2/2005	He	8,478,388	B2	7/2013	Nguyen et al.
6,882,882	B2	4/2005	Struble et al.	8,527,051	B1	9/2013	Hedberg et al.
6,885,889	B2	4/2005	Chinchoy	8,583,230	B2	11/2013	Ryu et al.
6,915,149	B2	7/2005	Ben-Haim	8,615,298	B2	12/2013	Ghosh et al.
6,968,237	B2	11/2005	Doan et al.	8,617,082	B2	12/2013	Zhang et al.
6,975,900	B2	12/2005	Rudy et al.	8,620,433	B2	12/2013	Ghosh et al.
6,978,184	B1	12/2005	Marcus et al.	8,639,333	B2	1/2014	Stadler et al.
6,980,675	B2	12/2005	Evron et al.	8,694,099	B2	4/2014	Ghosh et al.
7,016,719	B2	3/2006	Rudy et al.	8,738,132	B1	5/2014	Ghosh et al.
7,031,777	B2	4/2006	Hine et al.	8,744,576	B2	6/2014	Munsterman et al.
7,058,443	B2	6/2006	Struble	8,768,465	B2	7/2014	Ghosh et al.
7,062,315	B2	6/2006	Koyrakh et al.	8,805,504	B2	8/2014	Sweeney
7,092,759	B2	8/2006	Nehls et al.	8,972,228	B2	3/2015	Ghosh et al.
7,142,922	B2	11/2006	Spinelli et al.	9,037,238	B2	5/2015	Stadler et al.
7,184,835	B2	2/2007	Kramer et al.	9,155,897	B2	10/2015	Ghosh et al.
7,215,998	B2	5/2007	Wesselink et al.	9,199,087	B2	12/2015	Stadler et al.
7,286,866	B2	10/2007	Okerlund et al.	9,265,951	B2	2/2016	Sweeney
7,308,297	B2	12/2007	Reddy et al.	9,265,954	B2	2/2016	Ghosh
7,308,299	B2	12/2007	Burrell et al.	9,265,955	B2	2/2016	Ghosh
7,313,444	B2	12/2007	Pianca et al.	9,278,219	B2	3/2016	Ghosh
7,321,677	B2	1/2008	Evron et al.	9,278,220	B2	3/2016	Ghosh
7,346,381	B2	3/2008	Okerlund et al.	9,282,907	B2	3/2016	Ghosh
7,398,116	B2	7/2008	Edwards	9,320,446	B2	4/2016	Gillberg et al.
7,426,412	B1	9/2008	Schecter	2002/0087089	A1	7/2002	Ben-Haim
7,454,248	B2	11/2008	Burrell et al.	2002/0143264	A1	10/2002	Ding et al.
				2002/0161307	A1	10/2002	Yu et al.
				2002/0169484	A1	11/2002	Mathis et al.
				2003/0018277	A1	1/2003	He
				2003/0050670	A1	3/2003	Spinelli et al.

(56)

References Cited

U.S. PATENT DOCUMENTS

2003/0105495 A1	6/2003	Yu et al.	2010/0174137 A1	7/2010	Shim
2003/0236466 A1	12/2003	Tarjan et al.	2010/0198292 A1	8/2010	Honeck et al.
2004/0015081 A1	1/2004	Kramer et al.	2010/0228138 A1	9/2010	Chen
2004/0059237 A1	3/2004	Narayan et al.	2010/0234916 A1	9/2010	Turcott et al.
2004/0097806 A1	5/2004	Hunter et al.	2010/0254583 A1	10/2010	Chan et al.
2004/0102812 A1	5/2004	Yonce et al.	2010/0268059 A1	10/2010	Ryu et al.
2004/0122479 A1	6/2004	Spinelli et al.	2011/0004111 A1	1/2011	Gill et al.
2004/0162496 A1	8/2004	Yu et al.	2011/0004264 A1	1/2011	Siejko et al.
2004/0172078 A1	9/2004	Chinchoy	2011/0022112 A1	1/2011	Min
2004/0172079 A1	9/2004	Chinchoy	2011/0054286 A1	3/2011	Crosby
2004/0193223 A1	9/2004	Kramer et al.	2011/0054559 A1	3/2011	Rosenberg et al.
2004/0215245 A1	10/2004	Stahmann et al.	2011/0054560 A1*	3/2011	Rosenberg A61N 1/3627 607/28
2004/0215252 A1	10/2004	Verbeek et al.	2011/0075896 A1	3/2011	Matsumoto
2004/0220635 A1	11/2004	Burnes	2011/0092809 A1	4/2011	Nguyen et al.
2004/0267321 A1	12/2004	Boileau et al.	2011/0112398 A1	5/2011	Zarkh et al.
2005/0008210 A1	1/2005	Evron et al.	2011/0118803 A1	5/2011	Hou et al.
2005/0027320 A1	2/2005	Nehls et al.	2011/0137369 A1	6/2011	Ryu et al.
2005/0090870 A1	4/2005	Hine et al.	2011/0144510 A1	6/2011	Ryu et al.
2005/0096522 A1	5/2005	Reddy et al.	2011/0172728 A1	7/2011	Wang
2005/0149138 A1	7/2005	Min et al.	2011/0190615 A1	8/2011	Phillips et al.
2006/0074285 A1	4/2006	Zarkh et al.	2011/0201915 A1	8/2011	Gogin et al.
2006/0224198 A1	10/2006	Dong et al.	2011/0213260 A1	9/2011	Keel et al.
2006/0235478 A1	10/2006	Van Gelder et al.	2011/0319954 A1	12/2011	Niazi et al.
2006/0253162 A1	11/2006	Zhang et al.	2012/0004567 A1	1/2012	Eberle et al.
2007/0142871 A1	6/2007	Libbus et al.	2012/0101543 A1	4/2012	Demmer et al.
2007/0232943 A1	10/2007	Harel et al.	2012/0101546 A1	4/2012	Stadler et al.
2007/0250129 A1	10/2007	Van Oort	2012/0203090 A1	8/2012	Min
2007/0265508 A1	11/2007	Sheikhzadeh-Nadjar et al.	2012/0253419 A1	10/2012	Rosenberg et al.
2008/0021336 A1	1/2008	Dobak et al.	2012/0283587 A1	11/2012	Gosh et al.
2008/0058656 A1	3/2008	Costello et al.	2012/0284003 A1*	11/2012	Gosh A61B 5/0402 703/2
2008/0119903 A1	5/2008	Arcot-Krishnamurthy et al.	2012/0296387 A1	11/2012	Zhang et al.
2008/0140143 A1	6/2008	Ettori et al.	2012/0296388 A1	11/2012	Zhang et al.
2008/0146954 A1	6/2008	Bojovic et al.	2012/0302904 A1	11/2012	Lian et al.
2008/0242976 A1	10/2008	Robertson et al.	2012/0303084 A1	11/2012	Kleckner et al.
2008/0269818 A1	10/2008	Sullivan et al.	2012/0310297 A1	12/2012	Sweeney
2008/0269823 A1	10/2008	Burnes et al.	2012/0330179 A1	12/2012	Yuk et al.
2008/0281195 A1	11/2008	Heimdal	2013/0006332 A1	1/2013	Sommer et al.
2008/0306567 A1	12/2008	Park et al.	2013/0018250 A1	1/2013	Caprio et al.
2008/0306568 A1	12/2008	Ding et al.	2013/0018251 A1	1/2013	Caprio et al.
2009/0005832 A1	1/2009	Zhu et al.	2013/0030491 A1	1/2013	Stadler et al.
2009/0036947 A1	2/2009	Westlund et al.	2013/0060298 A1	3/2013	Splett et al.
2009/0043352 A1	2/2009	Brooke et al.	2013/0072790 A1	3/2013	Ludwig et al.
2009/0048528 A1	2/2009	Hopenfeld et al.	2013/0096446 A1	4/2013	Michael et al.
2009/0053102 A2	2/2009	Rudy et al.	2013/0116739 A1	5/2013	Brada et al.
2009/0054941 A1	2/2009	Eggen et al.	2013/0131529 A1	5/2013	Jia et al.
2009/0054946 A1	2/2009	Sommer et al.	2013/0131749 A1	5/2013	Sheldon et al.
2009/0084382 A1	4/2009	Jalde et al.	2013/0131751 A1	5/2013	Stadler et al.
2009/0093857 A1	4/2009	Markowitz et al.	2013/0136035 A1	5/2013	Bange et al.
2009/0099468 A1	4/2009	Thiagalingam et al.	2013/0150913 A1	6/2013	Bornzin et al.
2009/0099469 A1	4/2009	Flores	2013/0165983 A1	6/2013	Ghosh et al.
2009/0099619 A1	4/2009	Lessmeier et al.	2013/0165988 A1	6/2013	Ghosh
2009/0112109 A1	4/2009	Kuklik et al.	2013/0261471 A1	10/2013	Saha et al.
2009/0143838 A1	6/2009	Libbus et al.	2013/0261688 A1	10/2013	Dong et al.
2009/0157134 A1	6/2009	Ziglio et al.	2013/0289640 A1	10/2013	Zhang et al.
2009/0157136 A1	6/2009	Yang et al.	2013/0296726 A1	11/2013	Niebauer et al.
2009/0198298 A1	8/2009	Kaiser et al.	2013/0304407 A1	11/2013	George et al.
2009/0216112 A1	8/2009	Assis et al.	2013/0324828 A1	12/2013	Nishiwaki et al.
2009/0232448 A1	9/2009	Barmash et al.	2014/0005563 A1	1/2014	Ramanathan et al.
2009/0234414 A1	9/2009	Sambelashvili et al.	2014/0018872 A1	1/2014	Siejko et al.
2009/0254140 A1	10/2009	Rosenberg et al.	2014/0135866 A1	5/2014	Ramanathan et al.
2009/0270729 A1	10/2009	Corbucci et al.	2014/0135867 A1	5/2014	Demmer et al.
2009/0270937 A1	10/2009	Yonce et al.	2014/0163633 A1	6/2014	Ghosh et al.
2009/0299201 A1	12/2009	Gunderson	2014/0222099 A1	8/2014	Sweeney
2009/0299423 A1	12/2009	Min	2014/0236252 A1	8/2014	Ghosh et al.
2009/0306732 A1	12/2009	Rosenberg et al.	2014/0276125 A1	9/2014	Hou et al.
2009/0318995 A1	12/2009	Keel et al.	2014/0277233 A1	9/2014	Ghosh
2010/0022873 A1	1/2010	Hunter et al.	2014/0323893 A1	10/2014	Ghosh et al.
2010/0049063 A1	2/2010	Dobak, III	2014/0371807 A1	12/2014	Ghosh et al.
2010/0069987 A1	3/2010	Min et al.	2014/0371808 A1	12/2014	Ghosh et al.
2010/0087888 A1	4/2010	Maskara	2014/0371832 A1	12/2014	Ghosh et al.
2010/0094149 A1	4/2010	Kohut et al.	2014/0371833 A1	12/2014	Ghosh et al.
2010/0113954 A1	5/2010	Zhou	2015/0032016 A1	1/2015	Ghosh
2010/0114229 A1	5/2010	Chinchoy	2015/0032171 A1	1/2015	Ghosh
2010/0121403 A1	5/2010	Schecter et al.	2015/0032172 A1	1/2015	Ghosh
2010/0145405 A1	6/2010	Min et al.	2015/0032173 A1	1/2015	Ghosh
			2015/0045849 A1	2/2015	Ghosh et al.
			2015/0142069 A1	5/2015	Sambelashvili

(56)

References Cited

OTHER PUBLICATIONS

U.S. PATENT DOCUMENTS

2015/0157225 A1 6/2015 Gillberg et al.
 2015/0157231 A1 6/2015 Gillberg et al.
 2015/0157232 A1 6/2015 Gillberg et al.
 2015/0157865 A1 6/2015 Gillberg et al.
 2015/0216434 A1 8/2015 Ghosh et al.
 2016/0030747 A1 2/2016 Thakur et al.
 2016/0030751 A1 2/2016 Ghosh et al.
 2016/0045737 A1 2/2016 Ghosh et al.
 2016/0045738 A1 2/2016 Ghosh et al.
 2016/0045744 A1 2/2016 Ghosh et al.
 2016/0184590 A1 6/2016 Ghosh

FOREIGN PATENT DOCUMENTS

CN 1878595 A 12/2006
 CN 101073502 A 11/2007
 EP 1 072 284 A2 1/2001
 EP 1 504 713 A1 2/2005
 EP 2 016 976 A1 1/2009
 EP 2 391 270 A1 7/2011
 EP 1 925 337 B1 3/2012
 EP 2 436 309 A2 4/2012
 EP 2 435 132 B1 8/2013
 WO WO 98/26712 A1 6/1998
 WO WO 99/06112 A1 2/1999
 WO WO 00/45700 8/2000
 WO WO 01/67950 A1 9/2001
 WO WO 03/070323 A1 8/2003
 WO WO 2005/056108 A2 6/2005
 WO WO 2006/069215 A2 6/2006
 WO WO 2006/105474 A2 10/2006
 WO WO 2006/115777 A1 11/2006
 WO WO 2006/117773 A1 11/2006
 WO WO 2007/013994 A2 2/2007
 WO WO 2007/027940 A2 3/2007
 WO WO 2007/013994 A3 4/2007
 WO WO 2007/027940 A3 6/2007
 WO WO 2007/139456 A1 12/2007
 WO WO 2008/151077 A2 12/2008
 WO WO 2006/069215 A3 6/2009
 WO WO 2009/079344 A1 6/2009
 WO WO 2009/139911 A2 11/2009
 WO WO 2009/148429 A1 12/2009
 WO WO 2010/019494 A1 2/2010
 WO WO 2010/071520 A1 6/2010
 WO WO 2010/088040 A1 8/2010
 WO WO 2010/088485 A1 8/2010
 WO WO 2011/070166 A1 6/2011
 WO WO 2011/090622 A1 7/2011
 WO WO 2011/099992 A1 8/2011
 WO WO 2012/037471 A2 3/2012
 WO WO 2012/037471 A3 6/2012
 WO WO 2012/106297 A2 8/2012
 WO WO 2012/106297 A3 8/2012
 WO WO 2012/109618 A2 8/2012
 WO WO 2012/110940 A1 8/2012
 WO WO 2012/109618 A3 11/2012
 WO WO 2012/151364 A1 11/2012
 WO WO 2012/151389 A1 11/2012
 WO WO 2013/006724 A2 1/2013
 WO WO 2013/010165 A1 1/2013
 WO WO 2013/010184 A1 1/2013
 WO WO 2013/006724 A3 4/2013
 WO PCT/US2014/036153 4/2014
 WO PCT/US2014/036163 4/2014
 WO WO 2014/179454 A1 11/2014
 WO WO 2014/179459 A2 11/2014
 WO WO 2014/179459 A3 1/2015
 WO WO 2015/013271 A1 1/2015
 WO WO 2015/013493 A1 1/2015
 WO WO 2015/013574 A1 1/2015

U.S. Appl. No. 13/916,377, filed Jun. 12, 2013, Ghosh.
 U.S. Appl. No. 13/952,043, filed Jul. 26, 2013, Ghosh.
 U.S. Appl. No. 13/952,061, filed Jul. 26, 2013, Ghosh.
 U.S. Appl. No. 14/190,508, filed Feb. 26, 2014.
 U.S. Appl. No. 14/190,578, filed Feb. 26, 2014.
 U.S. Appl. No. 14/220,733, filed Mar. 20, 2014, Ghosh et al.
 U.S. Appl. No. 14/227,719, filed Mar. 27, 2014, Gillberg et al.
 U.S. Appl. No. 14/227,919, filed Mar. 27, 2014, Ghosh et al.
 U.S. Appl. No. 14/227,955, filed Mar. 27, 2014, Ghosh et al.
 U.S. Appl. No. 14/227,962, filed Mar. 27, 2014, Ghosh et al.
 U.S. Appl. No. 14/228,009, filed Mar. 27, 2014, Gillberg et al.
 U.S. Appl. No. 14/228,024, filed Mar. 27, 2014, Ghosh et al.
 U.S. Appl. No. 14/228,038, filed Mar. 27, 2014, Ghosh et al.
 International Search Report and Written Opinion for PCT/US2014/036262, dated May 3, 2012; 9 pg.
 International Search Report and Written Opinion for PCT/US2014/036302, dated May 3, 2012; 9 pg.
 "CardioGuide System Enables Real-Time Navigation of Left Ventricular Leads During Medtronic CRT Implants," Press Release, Apr. 9, 2013, Medtronic, Inc., 2 pgs.
 Czerwinska et al., "Method of Segmentation of Thorax Organs Images Applied to Modeling the Cardiac Electrical Field," *Engineering in Medicine and Biology Society, Proceedings of the 22nd Annual International Conference of the IEEE*, vol. 1, 23, Jul. 23, 2000.; pp. 402-405.
 Ghosh et al. "Accuracy of Quadratic Versus Linear Interpolation in Noninvasive Electrocardiographic Imaging (ECGI)," *Annals of Biomedical Engineering*, vol. 33, No. 9, Sep. 2005; pp. 1187-1201.
 Ghosh et al., "Cardiac Memory in Patients with Wolff-Parkinson-White Syndrome: Noninvasive Imaging of Activation and Repolarization Before and After Catheter Ablation" *Circulation*, 2008; 118:907-915. Published online Aug. 12, 2008.
 Ghosh et al. "Application of L1-Norm Regularization to Epicardial Potential Solution of the Inverse Electrocardiography Problem," *Annals of Biomedical Engineering*, vol. 37, No. 5, May 2009; pp. 902-912.
 Gold et al., "Comparison of Stimulation Sites within Left Ventricular Veins on the Acute Hemodynamic Effects of Cardiac Resynchronization Therapy" *Heart Rhythm*, Apr. 2005; 2(4):376-381.
 Gulrajani, "The Forward and Inverse Problems of Electrocardiography," *IEEE Engineering in Medicine and Biology*, IEEE Service Center, vol. 17, No. 5, Sep. 1, 1988; pp. 84-101, 122.
 Hansen, "Regularization Tools: A Matlab Package for Analysis and Solution of Discrete Ill-Posed Problems," Version 4.1 for Matlab 7.3; Mar. 2008; 128 pages. Retrieved from the Internet: Jun. 19, 2014 <http://www.mathworks.com/matlabcentral/fileexchange/52-regtools>.
 "Heart Failure Management" datasheet [online]. Medtronic, Minneapolis, Minnesota, [Last updated on Jun. 3, 2013]. Retrieved from the Internet: www.medtronic.com; 9 pages.
 Jia et al., "Electrocardiographic Imaging of Cardiac Resynchronization Therapy in Heart Failure: Observation of Variable Electrophysiologic Responses," *Heart Rhythm*, vol. 3, No. 3; Mar. 1, 2006, pp. 296-310.
 Kornreich, "Body Surface Potential Mapping of ST Segment Changes in Acute Myocardial Infarction," *Circulation*, 1993; 87: 773-782.
 Modre et al., "Noninvasive Myocardial Activation Time Imaging: A Novel Inverse Algorithm Applied to Clinical ECG Mapping Data" *IEEE Transactions on Biomedical Engineering*, vol. 49; No. 10, Oct. 2002; pp. 1153-1161.
 Ryu et al., "Simultaneous Electrical and Mechanical Mapping Using 3D Cardiac Mapping System: Novel Approach for Optimal Cardiac Resynchronization Therapy," *Journal of Cardiovascular Electrophysiology*, Feb. 2010; 21(2):219-22.
 Silva et al., "Cardiac Resynchronization Therapy in Pediatric Congenital Heart Disease: Insights from Noninvasive Electrocardiographic Imaging" *Heart Rhythm*, vol. 6, No. 8, Aug. 1, 2009; pp. 1178-1185.
 Sperzel et al., "Intraoperative Characterization of Interventricular Mechanical Dyssynchrony Using Electroanatomic Mapping System—A Feasibility Study," *Journal of Interventional Cardiac*

(56)

References Cited

OTHER PUBLICATIONS

Electrophysiology, Nov. 2012; 35(2):189-96.

Steinhaus BM., "Estimating cardiac transmembrane activation and recovery times from unipolar and bipolar extracellular electrograms : a simulation study," *Circulation Research*, 1989, 64:449-462.

Sweeney et al., "Analysis of Ventricular Activation Using Surface Electrocardiography to Predict Left Ventricular Reverse Volumetric Remodeling During Cardiac Resynchronization Therapy," *Circulation*, Feb. 9, 2010; 121(5):626-34. Available online Jan. 25, 2010.

Turner et al., "Electrical and Mechanical Components of Dyssynchrony in Heart Failure Patients with Normal QRS Duration and Left Bundle-Branch Block," *Circulation* 2004; 109: 2544-2549.

Van Deursen et al., "Vectorcardiography as a Tool for Wasy Optimization of Cardiac Resynchronization Therapy in Canine LBBB Hearts," *Circulation Arrhythmia and Electrophysiology*, Jun. 1, 2012; 5(3):544-52. Available online Apr. 24, 2012.

Varma et al., "Placebo CRT," *Journal of Cardiovascular Electrophysiology*, vol. 19, Aug. 2008; p. 878.

Williams et al., "Short-Term Hemodynamic Effects of Cardiac Resynchronization Therapy in Patients With Heart Failure, a Narrow QRS Duration, and No Dyssynchrony," *Circulation*, Oct. 27, 2009; 120: 1687-1694.

International Search Report and Written Opinion issued on Mar. 9, 2015, for International Application No. PCT/US2014/069214.

International Search Report and Written Opinion issued on Mar. 17, 2015, for International Application No. PCT/US2014/069192.

International Search Report and Written Opinion issued on Mar. 16, 2015, for International Application No. PCT/US2014/069182.

U.S. Appl. No. 14/173,288, filed Feb. 5, 2014, Sambelashvili.

Bilfi et al., "Occurrence of Phrenic Nerve Stimulation in Cardiac Resynchronization Therapy Patients: the Role of Left Ventricular Lead Type and Placement Site," *Europace*, 2013; 15:77-82.

Hayes et al., "Cardiac Resynchronization Therapy and the Relationship of Percent Biventricular Pacing to Symptoms and Survival," *Heart Rhythm*, Sep. 2011; 8(9):1469-1475.

Singh et al., "Left Ventricular Lead Position and Clinical Outcome in the Multicenter Automatic Defibrillator Implantation Trial-Cardiac Resynchronization Therapy (MADIT-CRT) Trial," *Circulation*, 2011; 123:1159-1166.

Vardas et al., The Task Force for Cardiac Pacing and Cardiac Resynchronization Therapy of the European Society of Cardiology. Developed in Collaboration with the European Heart Rhythm Association, *European Heart Journal*, 2007; 28:2256-2295.

International Search Report and Written Opinion issued May 3, 2012 for International Application No. PCT/US2012/036262; 9 pages.

International Search Report and Written Opinion issued May 3, 2012 for International Application No. PCT/US2012/036302; 9 pages.

International Search Report and Written Opinion issued Aug. 6, 2014 for International Application No. PCT/US2014/036153; 14 pages.

International Search Report and Written Opinion issued Nov. 7, 2014 for International Application No. PCT/US2014/036163; 12 pages.

International Search Report and Written Opinion issued Oct. 28, 2014 for International Application No. PCT/US2014/041928; 15 pages.

International Search Report and Written Opinion issued Oct. 24, 2014 for International Application No. PCT/US2014/041929; 14 pages.

International Search Report and Written Opinion issued on Apr. 8, 2015, for International Application No. PCT/US2014/069070; 11 pages.

International Search Report and Written Opinion issued on Nov. 4, 2014 for International Application No. PCT/US2014/0247583; 7 pages.

International Search Report and Written Opinion issued on Nov. 12, 2014 for International Application No. PCT/US2014/047971; 7 pages.

International Search Report and Written Opinion issued on Nov. 12, 2014 for International Application No. PCT/US2014/048120; 7 pages.

Cuculich et al., "The Electrophysiological Cardiac Ventricular Substrate in Patients After Myocardial Infarction," *J. Am. Coll. Cardiol.*, 2011; 58:1893-1902.

Dawoud et al., "Inverse Electrocardiographic Imaging to Assess Electrical Dyssynchrony in Cardiac Resynchronization Therapy Patients," *Computing in Cardiology*, 2012; 39:993-996.

Medtronic Vitatron Carelink Encore® Programmer Model 29901 Reference Manual, 2013, Medtronic, Inc., Minneapolis, MN.

Ghosh et al., "Electrophysiological Substrate and Intraventricular LV Dyssynchrony in Non-ischemic Heart Failure Patients Undergoing Cardiac Resynchronization Therapy," *Heart rhythm : the official journal of the Heart Rhythm Society*, 2011; 8(5):692-699.

Potse et al., "Mathematical Modeling and Simulation of Ventricular Activation Sequences: Implications for Cardiac Resynchronization Therapy," *J. of Cardiovasc. Trans. Res.*, 2012; 5:146-158.

Prinzen et al., "Cardiac Resynchronization Therapy State-of-the-Art of Current Applications, Guidelines, Ongoing Trials, and Areas of Controversy" *Circulation*, 2013; 128: 2407-2418.

Strik et al., "Electrical and Mechanical Ventricular Activation During Left Bundle Branch Block and Resynchronization," *J. of Cardiovasc. Trans. Res.*, 2012; 5:11-126.

International Search Report and Written Opinion issued on Jun. 11, 2015 for International Application No. PCT/US2015/021442; 13 pages.

Miri et al., "Applicability of body surface potential map in computerized optimization of biventricular pacing," *Annals of Biomedical Engineering*, vol. 38, No. 3, Mar. 2010, pp. 865-875.

Miri et al., "Comparison of the electrophysiologically based optimization methods with different pacing parameters in patient undergoing resynchronization treatment," *30th Annual International IEEE EMBS Conference*, Aug. 2008, pp. 1741-1744.

Miri et al., "Computerized Optimization of Biventricular Pacing Using Body Surface Potential Map," *31st Annual International Conference of the IEEE EMBS*, Sep. 2009, pp. 2815-2818.

Miri et al., "Efficiency of Timing Delays and Electrode Positions in Optimization of Biventricular Pacing: A Simulation Study," *IEEE Transactions on Biomedical Engineering*, Nov. 2009, pp. 2573-2582.

Svensden et al., "Computational Models of Cardiac Electrical Activation," Chapter 5, *Computational Nov. 2010*, pp. 73-88.

Wang et al., "Application of the Method of Fundamental Solutions to Potential-based Inverse Electrocardiography," *Annals of Biomedical Engineering*, Aug. 2006, pp. 1272-1288.

Botker MD, PhD., et al., "Electromechanical Mapping for Detection of Myocardial Viability in Patients with ischemia Cardiomyopathy," *Circulation*, Mar. 2001; vol. 103, No. 12, pp. 1631-1637.

Fung et al., Chapter 20, *Optimization of Cardiac Resynchronization Therapy, Cardiac Resynchronization Therapy, Second Edition*, Copyright 2008, Blackwell Publishing Ltd., pp. 356-373.

Hopenfeld et al., "The Effect of Conductivity on ST-Segment Epicardial Potentials Arising from Subendocardial Ischemia," *Annals of Biomedical Eng.*, Jun. 2005; vol. 33, No. 6, pp. 751-763.

Nash et al., "An Experimental-Computational Framework for Validating in-vivo ECG Inverse Algorithms," *International Journal of Bioelectromagnetism*, vol. 2, No. 2, Dec. 31, 2000, 9 pp.

Sweeney et al., QRS Fusion Complex Analysis Using Wave Interference to Predict Reverse Remodeling During Cardiac Resynchronization Therapy, *Heart Rhythm*, 2014, 11:806-813.

Wellens, MD et al., "The Electrocardiogram 102 Years After Einthoven," *Circulation*, Feb. 2004; vol. 109, No. 5, pp. 562-564.

* cited by examiner

FIG. 1

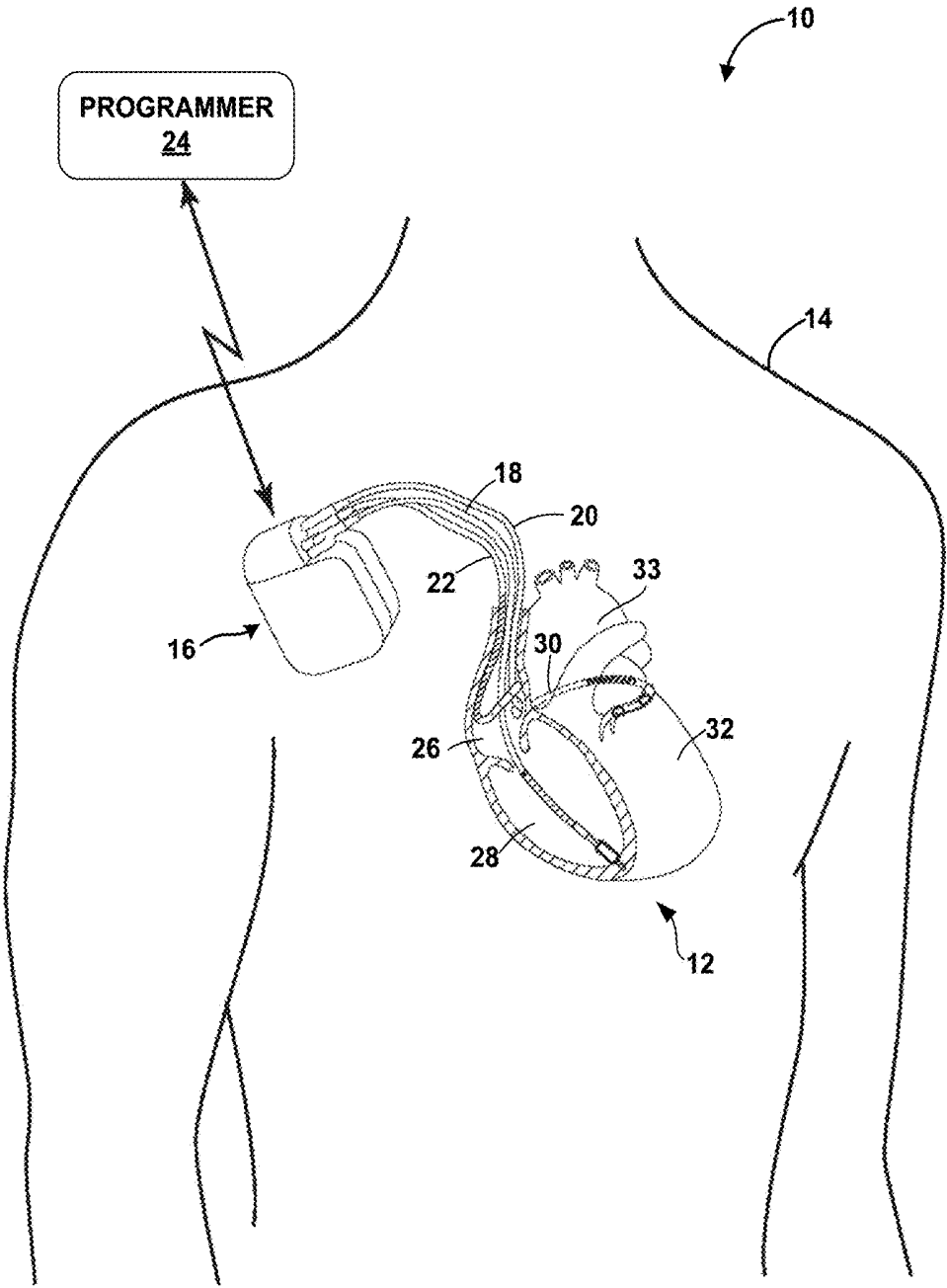


FIG. 2A

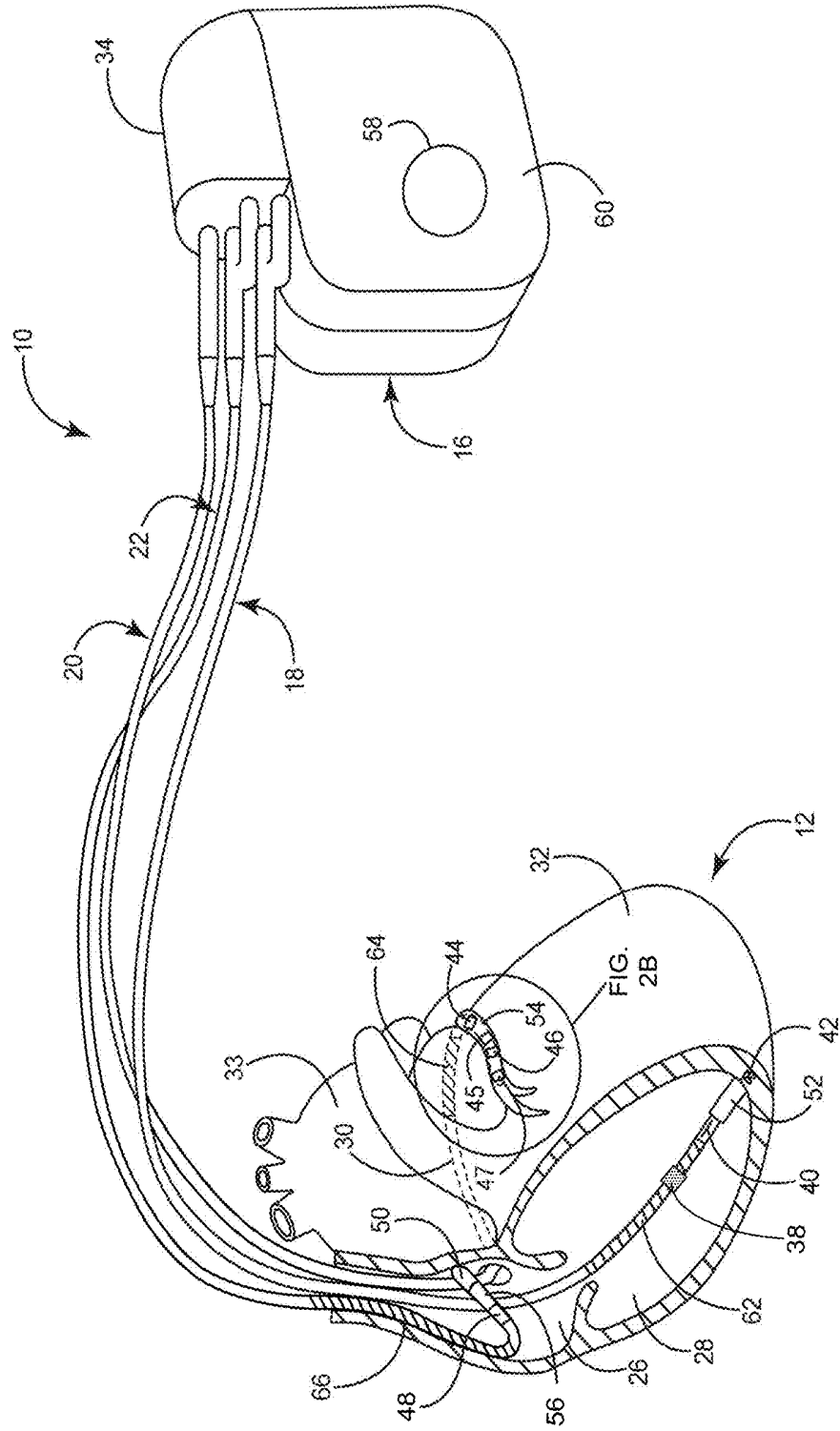


FIG. 2B

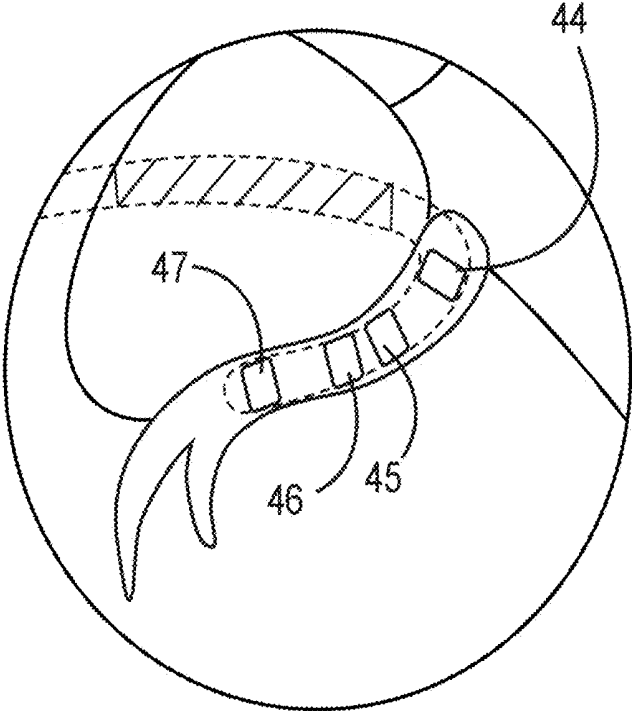


FIG. 3A

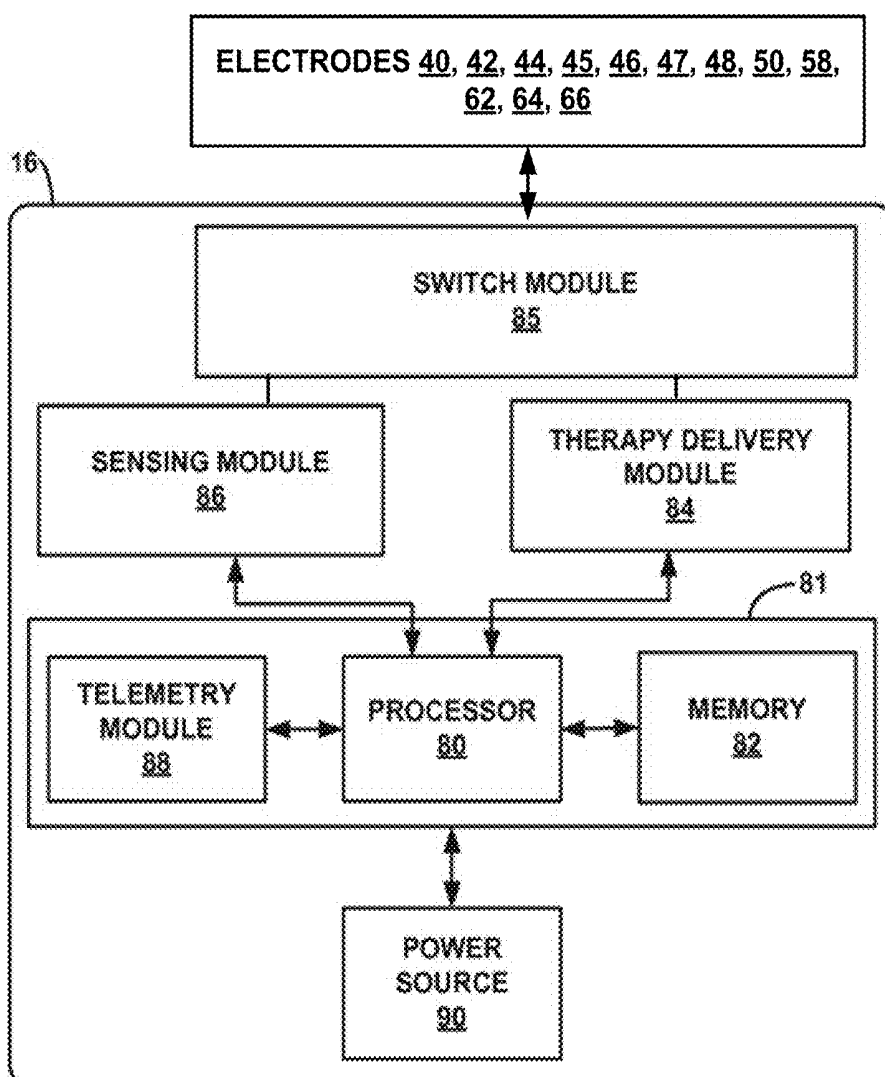


FIG. 3B

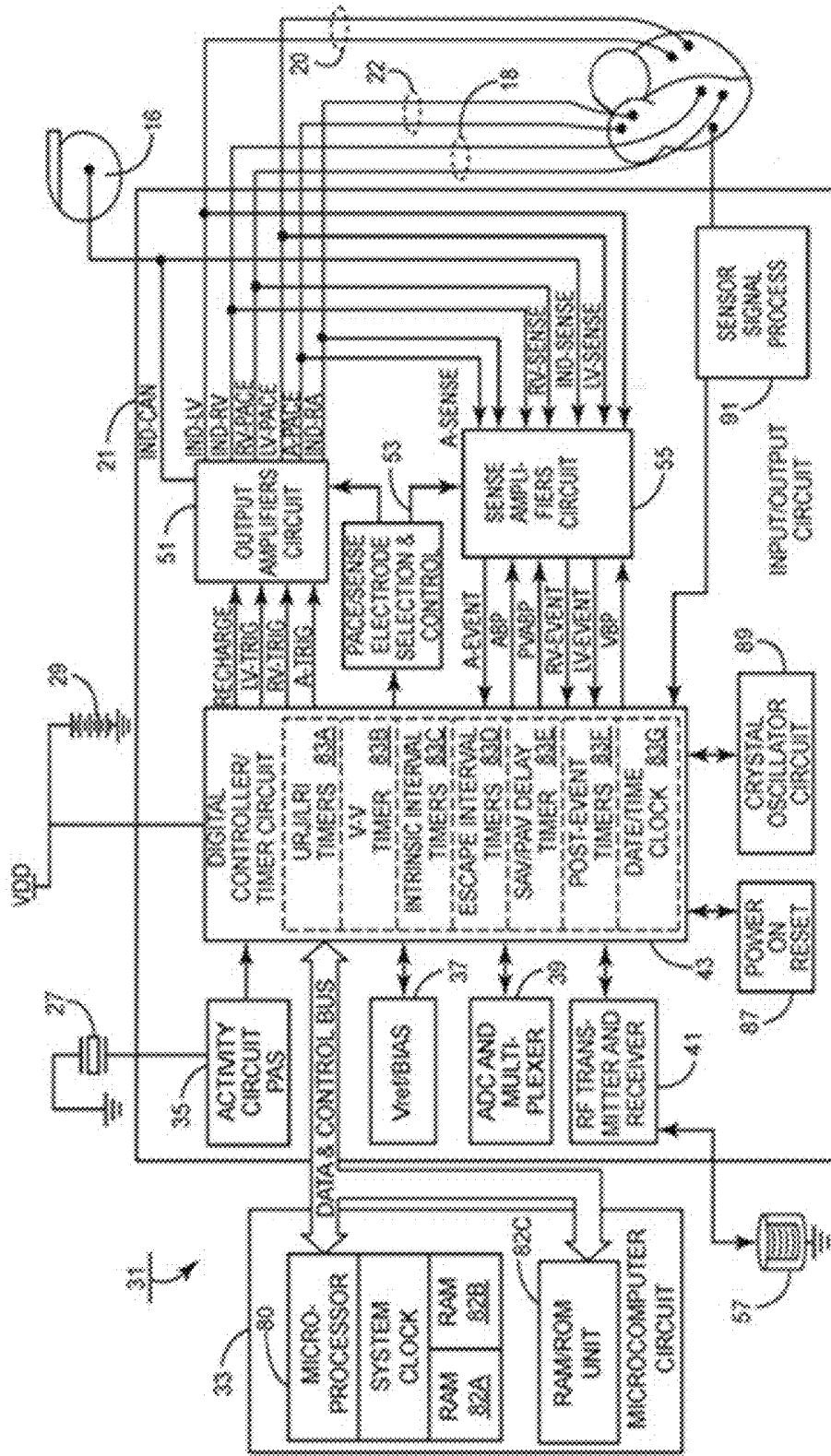


FIG. 4

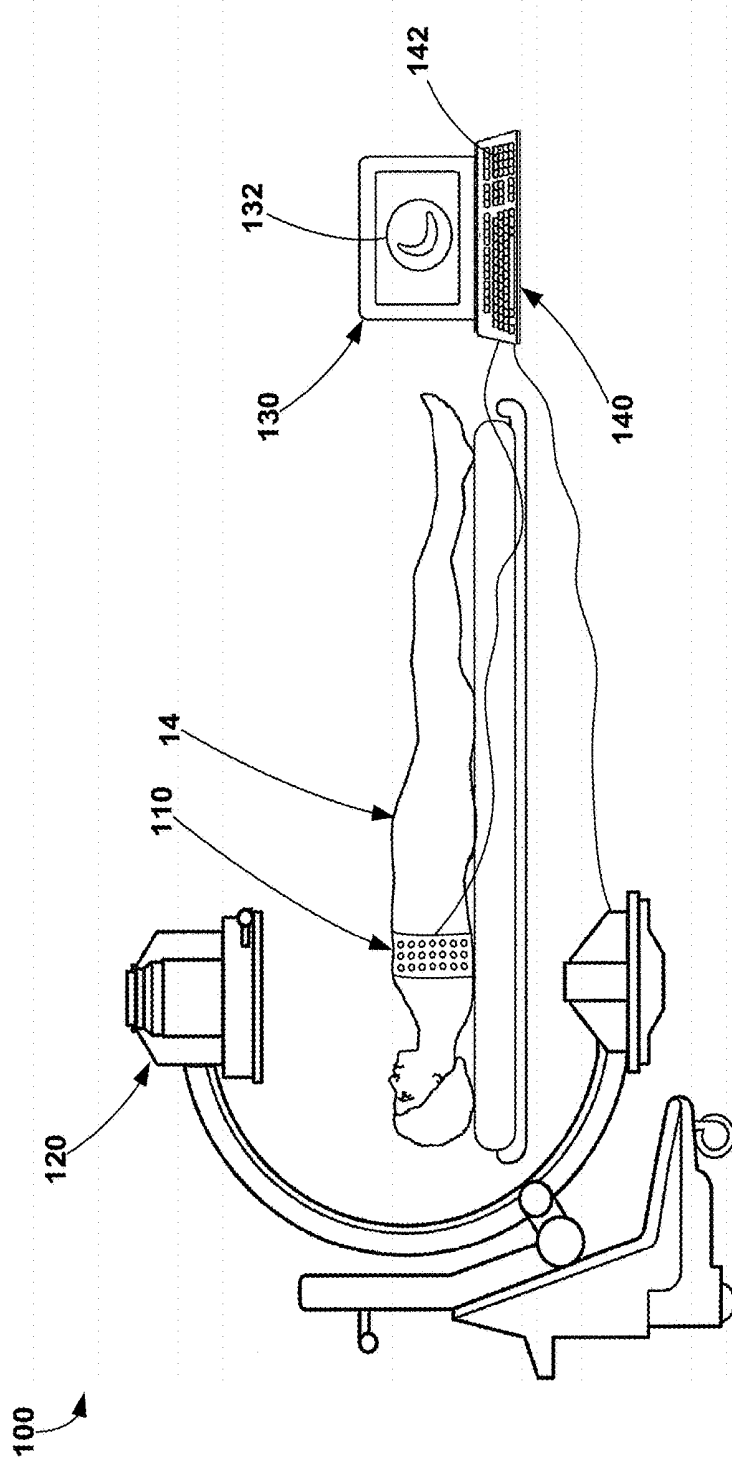


FIG. 5A

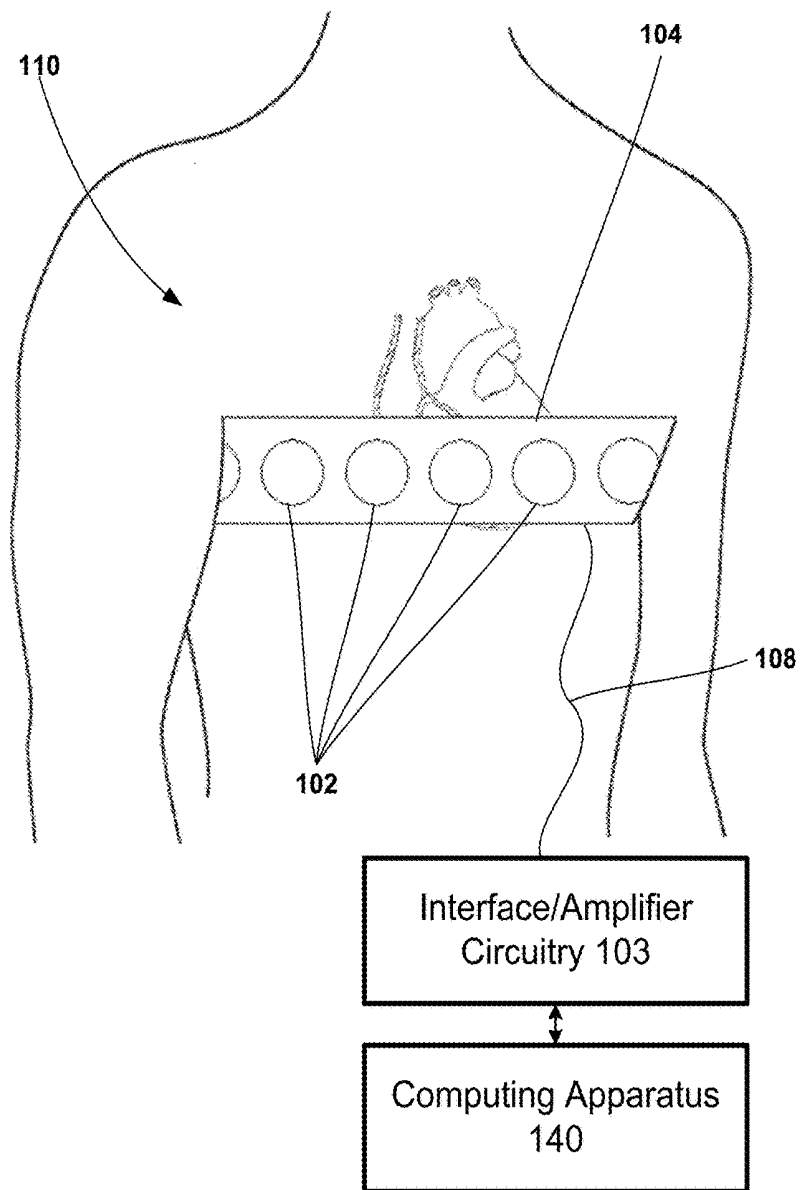


FIG. 5B

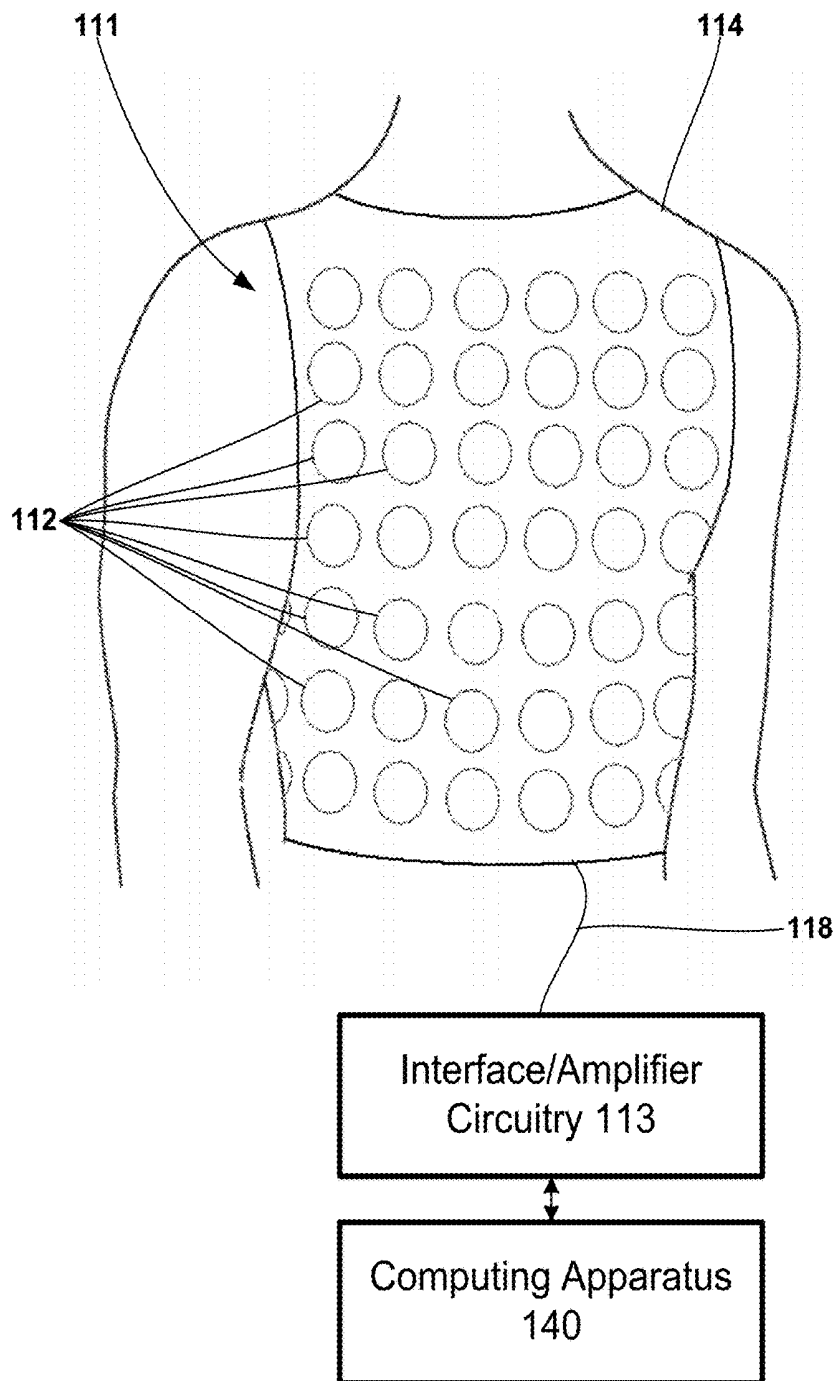


FIG. 6

150

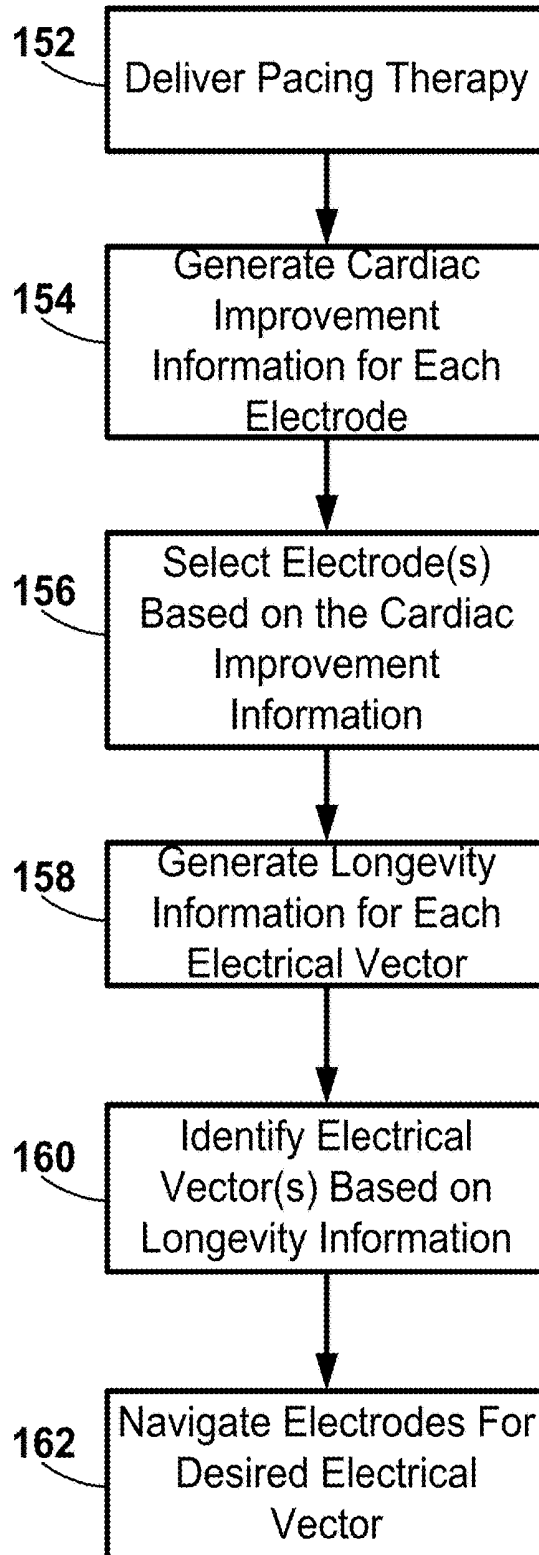
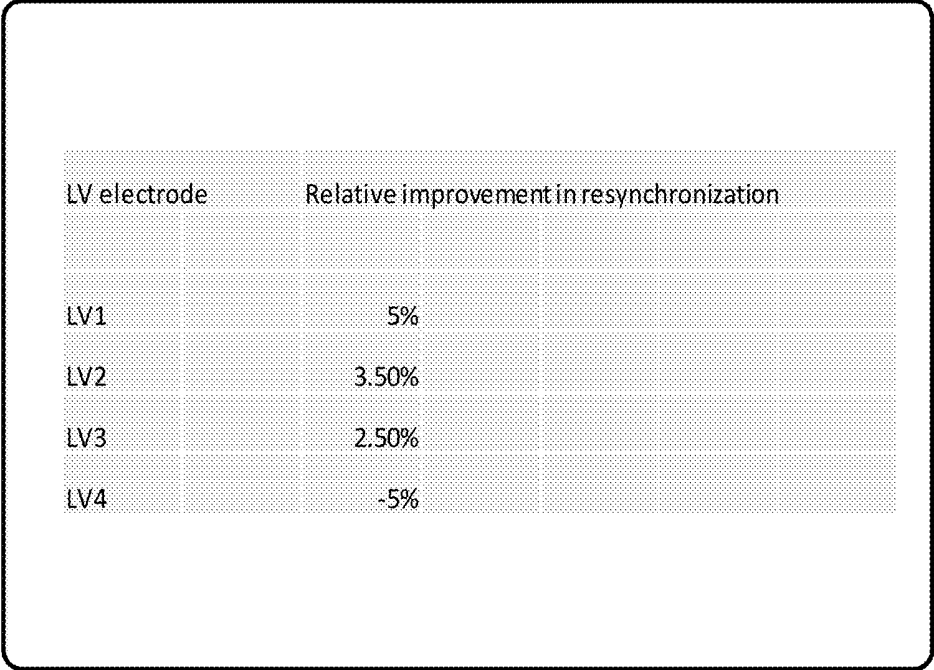


FIG. 7

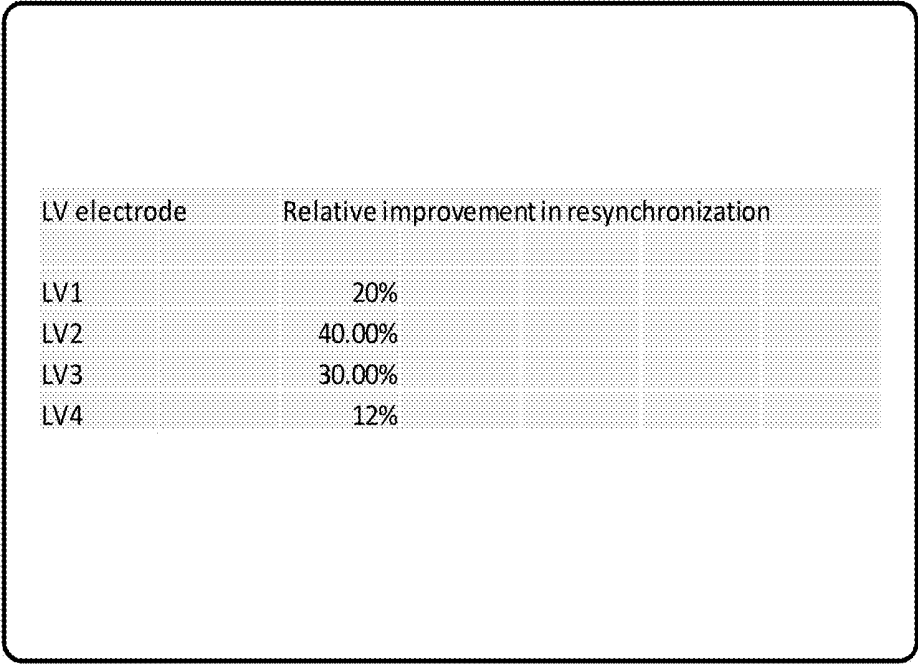
132



LV electrode	Relative improvement in resynchronization
LV1	5%
LV2	3.50%
LV3	2.50%
LV4	-5%

FIG. 8

132



LV electrode	Relative improvement in resynchronization
LV1	20%
LV2	40.00%
LV3	30.00%
LV4	12%

FIG. 9

132

172

Pacing Vector	Relative Longevity	Phrenic Nerve Stim present
LV2-RV Coil	3 months less	Absent
LV2-LV1	6 months less	Absent
LV2-LV3	Maximum	Absent
LV2-LV4	Maximum	Present
LV3-RVCoil	5 months less	Absent
LV3-LV1	4 months less	Absent
LV3-LV2	3 months less	Absent
LV3-LV4	1 year less	Present

FIG. 10

132

LV Pace Polarity	Relative Longevity	Capture Threshold	Last Impedance	Phrenic Nerve Stimulation	Change in Dyssynchrony Index
LV1 to Rvcoil	2 months less	0.75 V @ 0.40 ms	589 ohms	Not Tested	+5%
LV1 to LV2	5 months less	1.25 V @ 0.40 ms	874 ohms	Not Tested	+1%
LV1 to LV3	Maximum	1.00 V @ 0.40 ms	855 ohms	No	
LV1 to LV4	Maximum	1.00 V @ 0.40 ms	836 ohms	Not Tested	
LV2 to Rvcoil	7 months less	1.00 V @ 0.40 ms	399 ohms	Not Tested	+1%
LV2 to LV1	7 months less	1.75 V @ 0.40 ms	874 ohms	Not Tested	
LV2 to LV3	1.1 years less	1.25 V @ 0.40 ms	437 ohms	Yes	
LV2 to LV4	9 months less	1.25 V @ 0.40 ms	589 ohms	Not Tested	
LV3 to Rvcoil	6 months less	0.75 V @ 0.40 ms	361 ohms	Yes	
LV3 to LV1	7 months less	1.75 V @ 0.40 ms	855 ohms	Not Tested	+1%
LV3 to LV2	1.1 years less	1.25 V @ 0.40 ms	437 ohms	Not Tested	
LV3 to LV4	9 months less	1.25 V @ 0.40 ms	570 ohms	Not Tested	-10%
LV4 to Rvcoil	1.5 years less	1.25 V @ 0.40 ms	304 ohms	Not Tested	-15%
LV4 to LV1	1.4 years less	3.00 V @ 0.40 ms	836 ohms	Not Tested	
LV4 to LV2	***	***	589 ohms	Not Tested	
LV4 to LV3	***	***	570 ohms	Not Tested	

FIG. 11

132

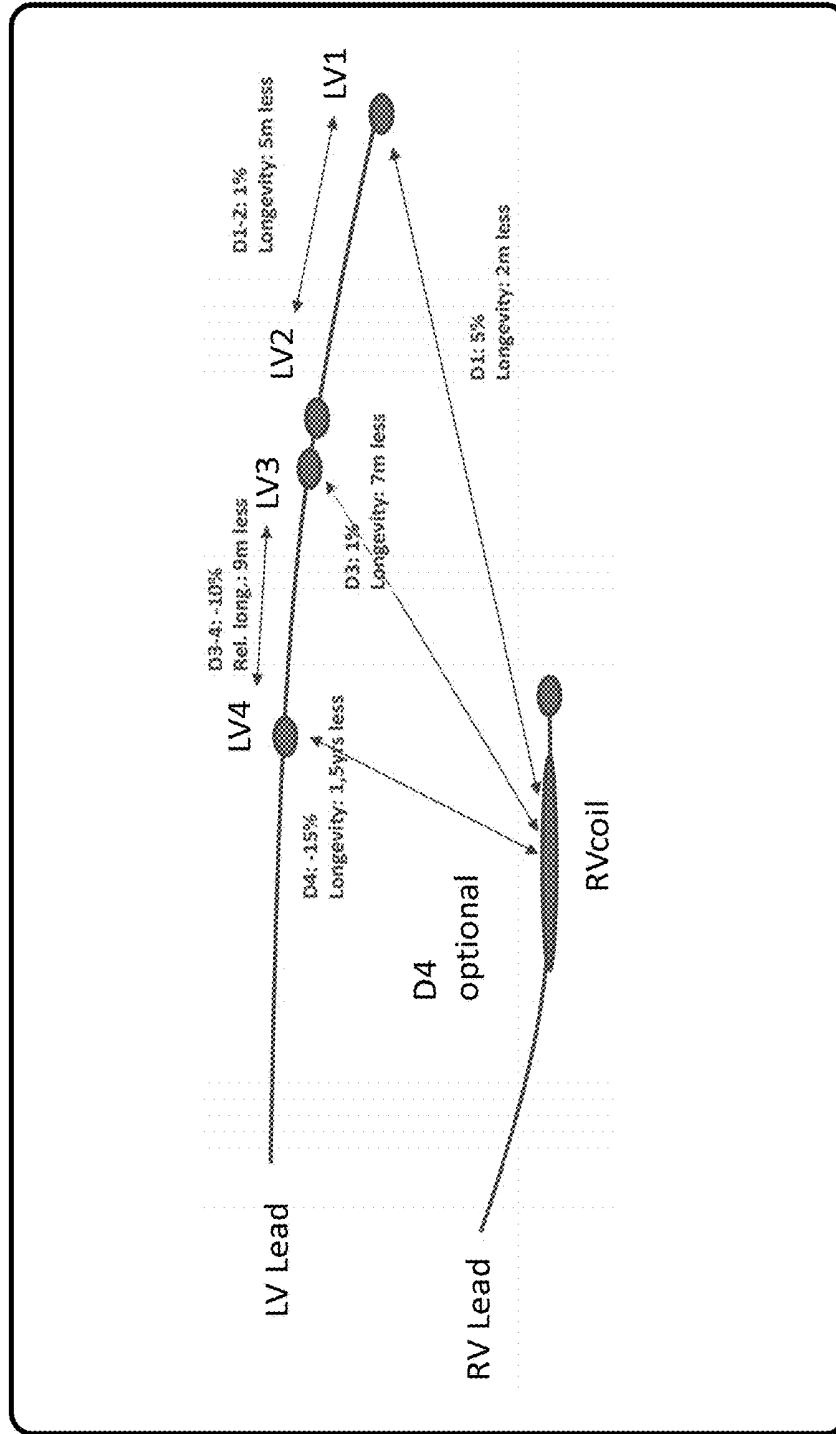


FIG. 12

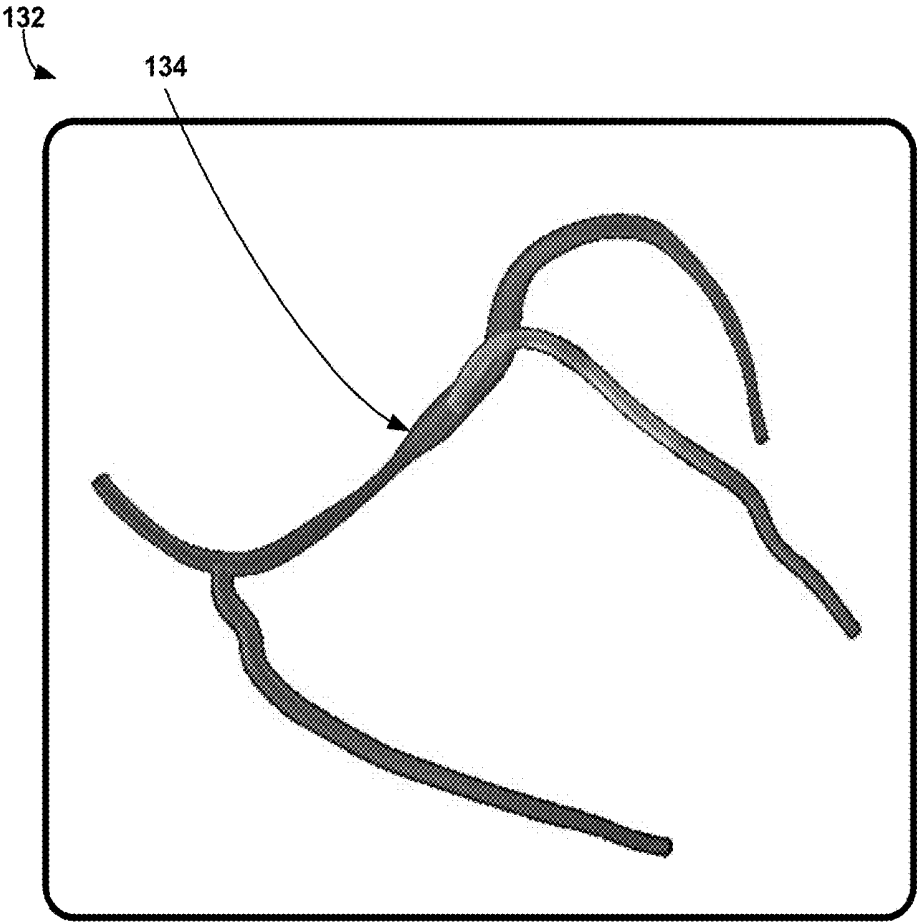


FIG. 13

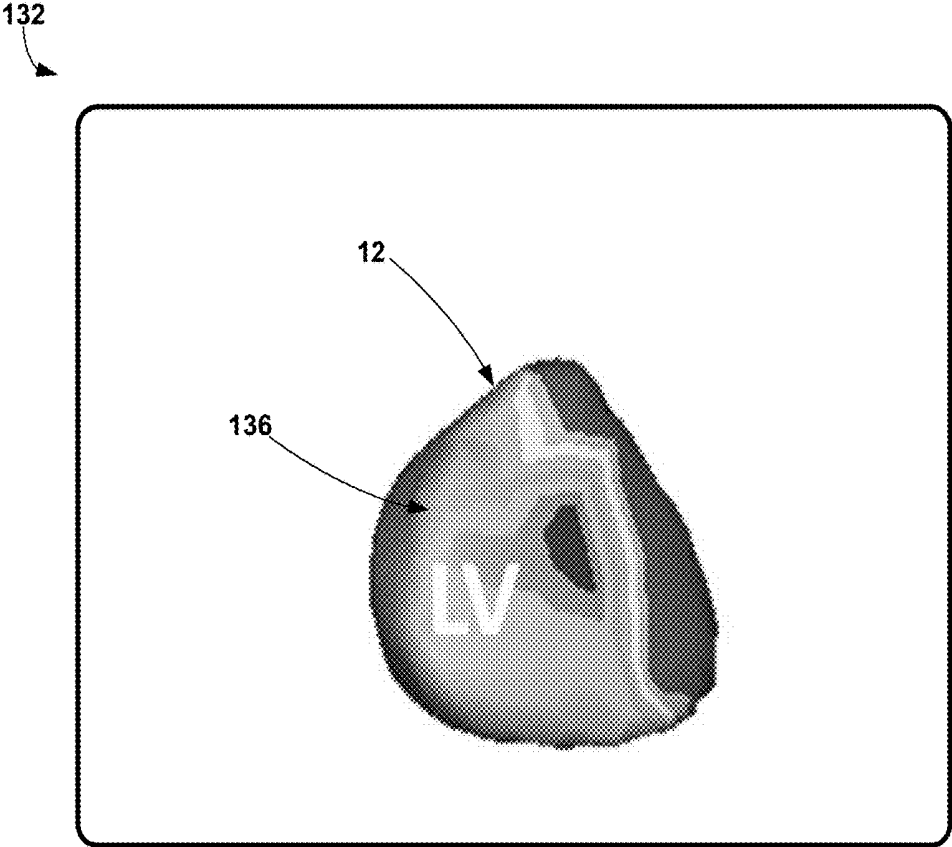


FIG. 14

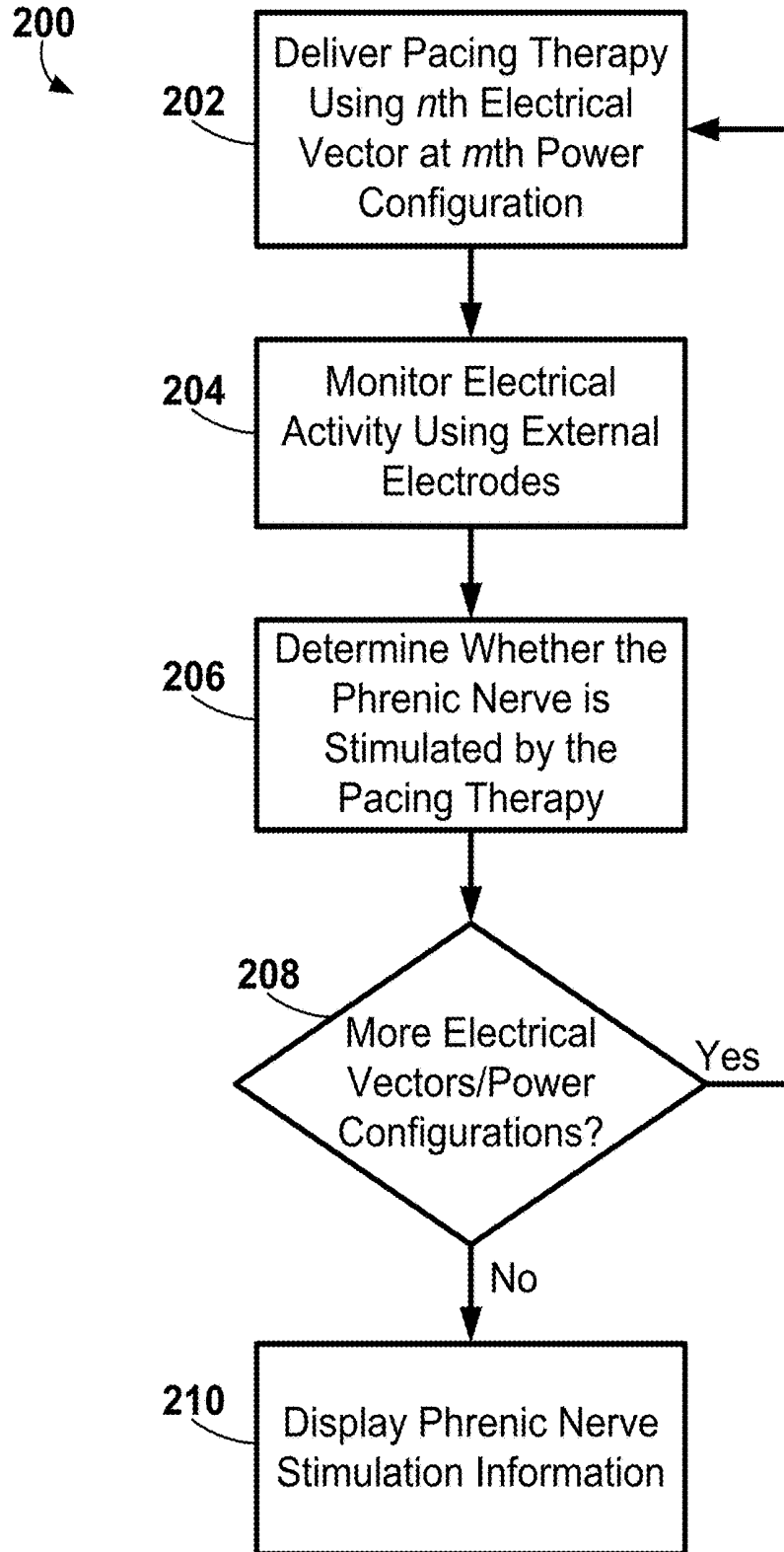


FIG. 15

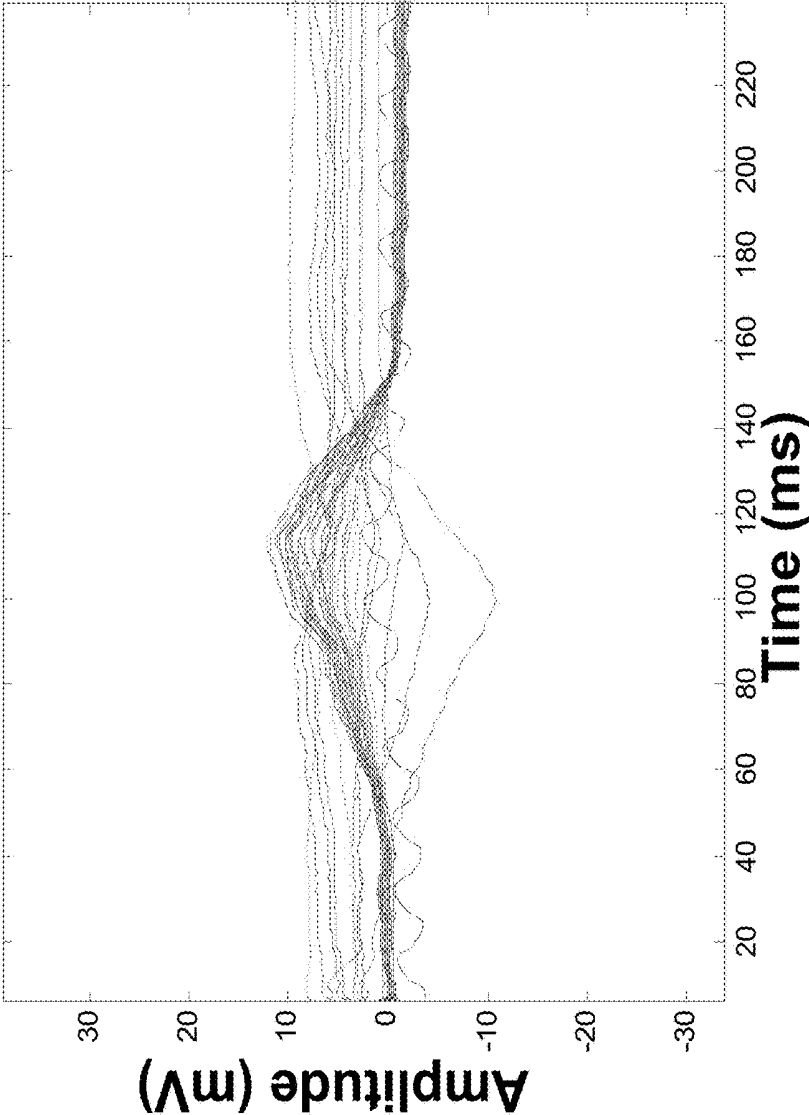


FIG. 16

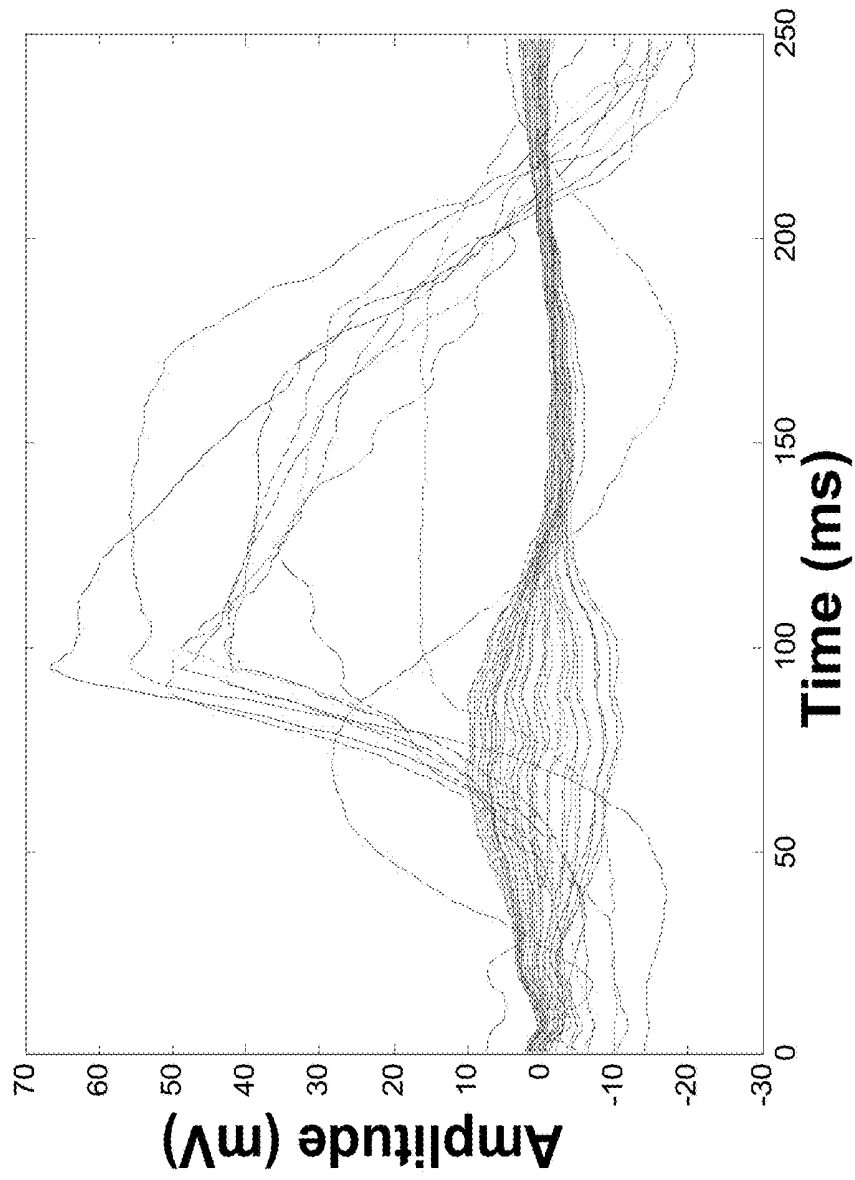


FIG. 17

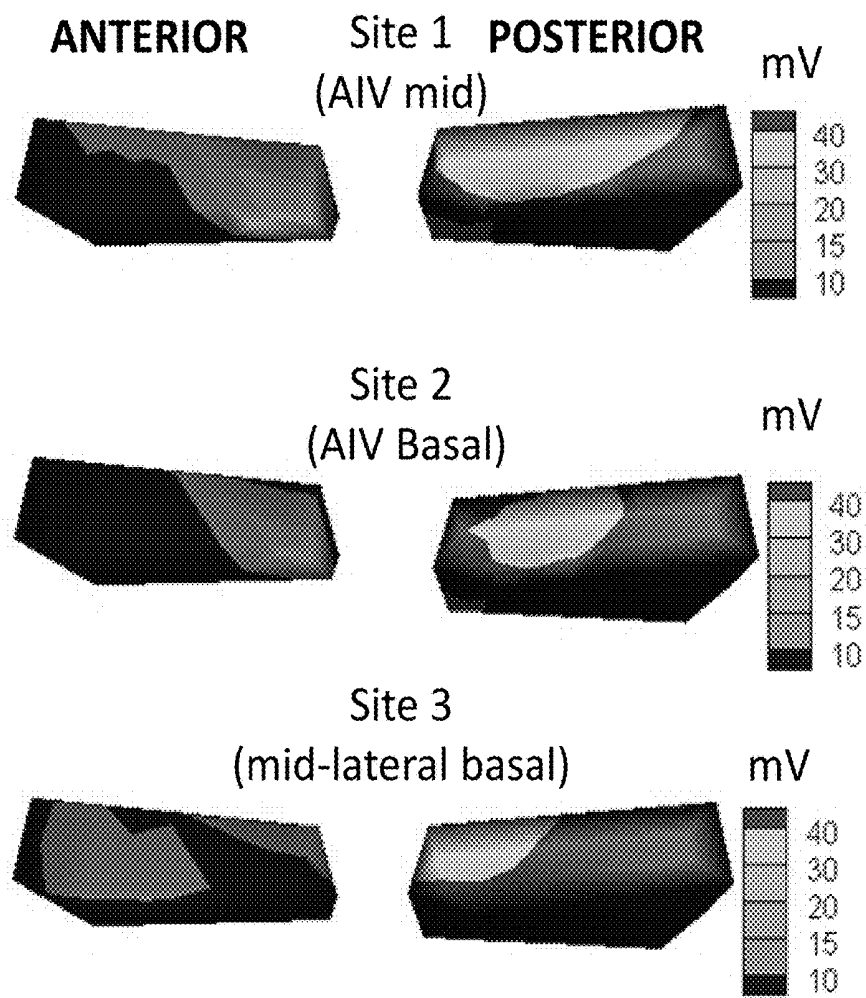


FIG. 18

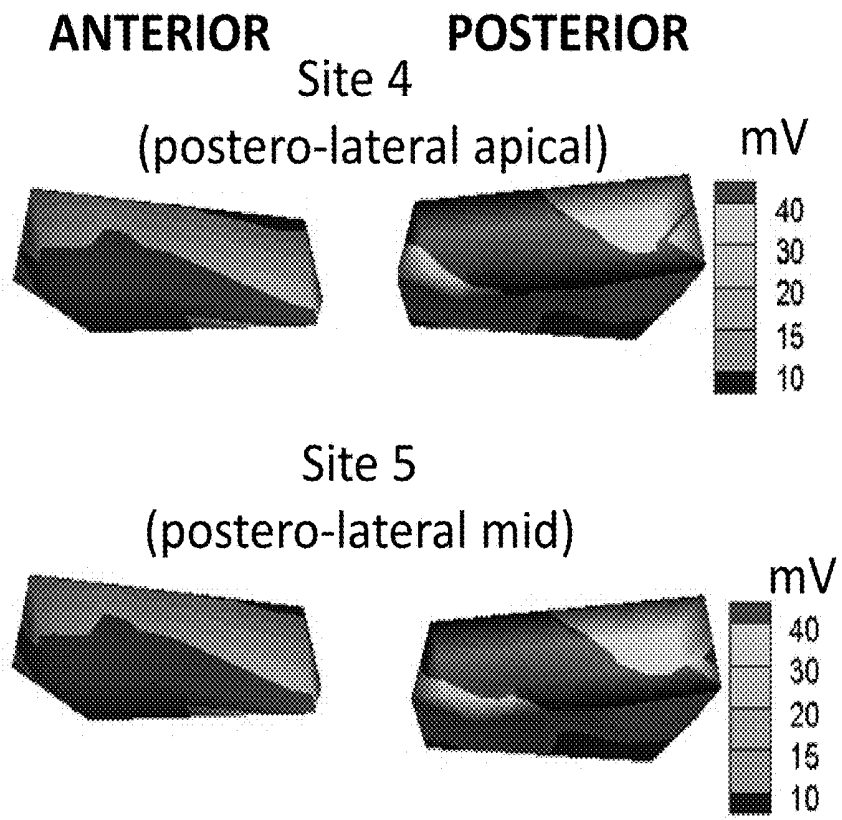
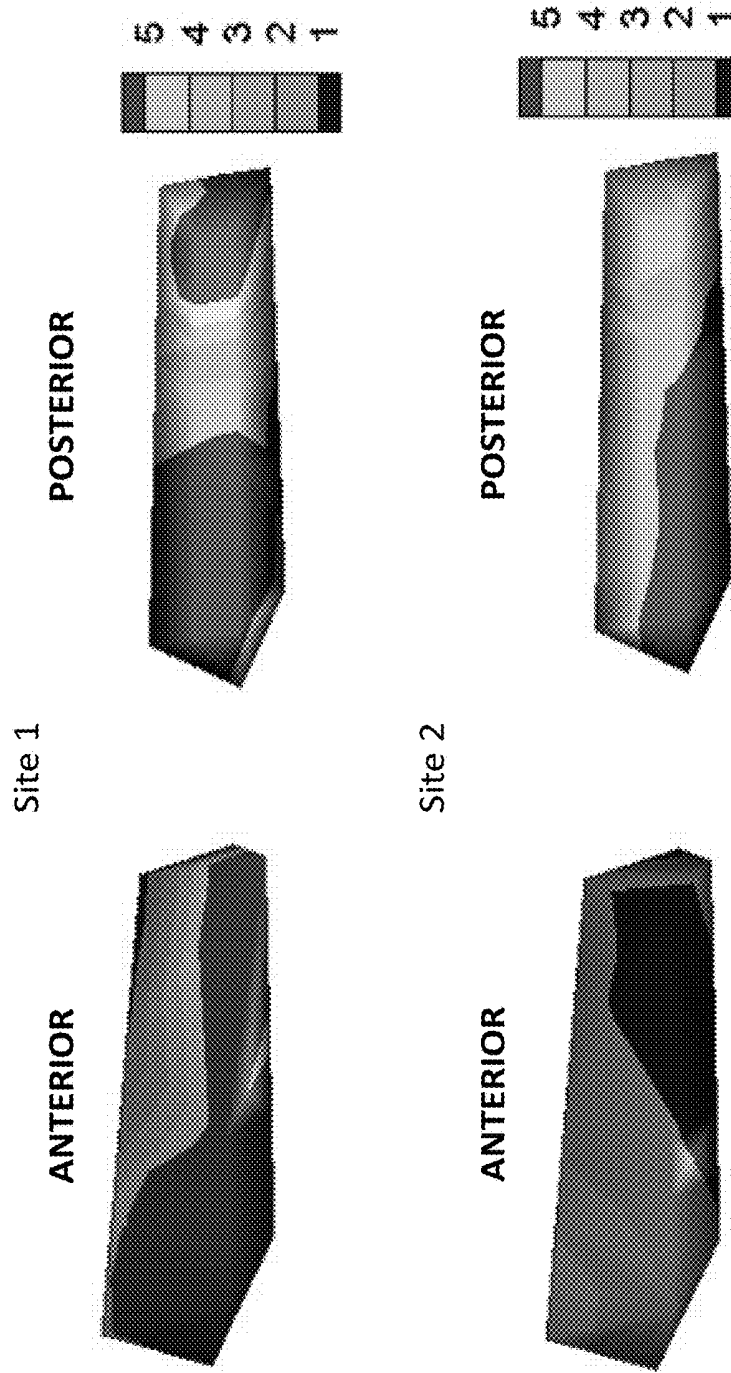


FIG. 19



NON-INVASIVE DETECTION OF PHRENIC NERVE STIMULATION

The disclosure herein relates to systems and methods for non-invasive detection of phrenic nerve stimulation during delivering of cardiac pacing therapy. The system and methods may use a plurality of external electrodes proximate tissue of a patient to monitor electrical activity of the patient during cardiac pacing therapy and may use the monitored electrical activity to determine whether the cardiac pacing therapy is stimulating the phrenic nerve.

Cardiac pacing electrodes may be used in various systems, apparatus, and methods for medical treatment of a patient. More specifically, cardiac pacing electrodes may be located adjacent, or in contact, with tissue (e.g., cardiac tissue, skin, etc.) of a patient to deliver cardiac pacing therapy to the patient using various different electrical pacing vectors. Some electrodes and/or electrical pacing vectors used for cardiac pacing therapy may inadvertently or unintentionally stimulate the patient's phrenic nerve, e.g., causing undesired diaphragm movement, patient discomfort, etc.

Phrenic nerve stimulation detection has been disclosed in U.S. Pat. App. Pub. No. 2012/0296388 A1 filed on May 17, 2012 and entitled "PHRENIC NERVE STIMULATION DETECTION USING HEART SOUNDS" and U.S. Pat. App. Pub. No. 2012/0296387 A1 filed on Nov. 22, 2012 and entitled "PHRENIC NERVE STIMULATION DETECTION USING HEART SOUNDS," each of which is incorporated herein by reference in their entirety.

SUMMARY

The exemplary systems and methods described herein may be configured to determine whether a patient's phrenic nerve is being stimulated (e.g., unintentionally or inadvertently stimulated) by pacing therapy. More specifically, the exemplary systems and methods may monitor electrical activity using two or more external electrodes (e.g., proximate the torso of a patient, in contact with the skin of the patient, etc.) during cardiac pacing therapy and may determine that the patient's phrenic nerve is being stimulated based on the monitored electrical activity.

The exemplary systems and methods may be used to test each of a plurality of different electrical pacing vectors (e.g., each different electrical pacing vector may use a different set of pacing electrodes) and may indicate to a user (e.g., a physician) which of the electrical pacing vectors stimulate the patient's phrenic nerve. Further, the exemplary systems and methods may be used to test each of a plurality of different power configurations for each different electrical pacing vector (e.g., each different power configuration may use a different pulse width, voltage, number of pulses, etc.) and may indicate to a user (e.g., a physician) which of the power configurations for each electrical pacing vector stimulate the patient's phrenic nerve.

In one or more embodiments, a graphical user interface may be used to display phrenic nerve stimulation information such as, e.g., an indication of whether each of the electrical pacing vectors stimulate the patient's phrenic nerve, the power configuration for each electrical pacing vector that stimulates the phrenic nerve, etc. The exemplary systems and methods may be used during implant of pacing apparatus such as an implantable medical device including one or more leads having, or carrying, pacing electrodes. The exemplary systems and methods may be also used

during follow-up examinations after pacing apparatus has already been implanted or applied to a patient.

One exemplary non-invasive system may be configured for detecting phrenic nerve stimulation during pacing therapy using one or more pacing electrodes of a plurality of pacing electrodes defining one or more of electrical pacing vectors. The exemplary system may include external electrode apparatus and computing apparatus coupled to the external electrode apparatus. The external electrode apparatus may include a plurality of external electrodes configured to be located proximate tissue of a patient (e.g., configured to be located on the anterior torso of the patient). The computing apparatus may be configured to monitor electrical activity using two or more external electrodes of the plurality of external electrodes during delivery of pacing therapy (e.g., monitoring for a selected time period after delivery of a pacing pulse such as, e.g., less than or equal to 250 milliseconds) using each electrical pacing vector of one or more electrical pacing vectors and determine whether the patient's phrenic nerve is stimulated by the pacing therapy delivered using each electrical pacing vector of the one or more electrical pacing vectors based on the monitored electrical activity.

In one or more embodiments, the external electrode apparatus may include one of a band and a vest configured to be worn about the torso of the patient and the plurality of external electrodes may be coupled to the band or vest.

In one or more embodiments, determining whether the patient's phrenic nerve is stimulated by the pacing therapy may include comparing a maximum peak-to-peak amplitude of the monitored electrical activity to a threshold value (e.g., greater than or equal to 30 millivolts, based on baseline measurements, etc.).

In one or more embodiments, determining whether the patient's phrenic nerve is stimulated by the pacing therapy may include determining that the patient's phrenic nerve is stimulated if the monitored electrical activity from a selected percentage of the two or more external electrodes used to monitor electrical activity during delivery of pacing therapy is indicative of phrenic nerve stimulation.

In one or more embodiments, the system may include display apparatus. The display apparatus may include a graphical user interface configured to present information for use in assisting a user in at least one of evaluating pacing therapy and configuring pacing therapy. The computing apparatus may be coupled display apparatus and further configured to display, on the graphical user interface, phrenic nerve stimulation information for the one or more electrical pacing vectors for use in assisting a user in at least one of evaluating pacing therapy and configuring pacing therapy. In at least one embodiment, the phrenic nerve stimulation information is displayed proximate a graphical depiction of at least a portion of anatomy of the patient's heart (e.g., blood vessel anatomy of the patient's heart).

In one or more embodiments, the delivery of pacing therapy using each electrical pacing vector of one or more electrical pacing vectors may include delivery of pacing therapy using each electrical pacing vector configured in each power configuration of a plurality of different power configurations. In at least one embodiment, the computing apparatus may be further configured to display, on a graphical user interface, power configuration information for at least each electrical pacing vector of the one or more electrical pacing vectors that is determined to stimulate the patient's phrenic nerve.

One exemplary non-invasive method may be configured for detecting phrenic nerve stimulation during pacing

therapy using one or more pacing electrodes of a plurality of pacing electrodes defining one or more of electrical pacing vectors. The exemplary method may include monitoring electrical activity of a patient using two or more external electrodes of a plurality of external electrodes during delivery of pacing therapy using each electrical pacing vector of one or more electrical pacing vectors (e.g., where the plurality of external electrodes are located proximate tissue of the patient) and determining whether the patient's phrenic nerve is stimulated by the pacing therapy delivered using each electrical pacing vector of the one or more electrical pacing vectors based on the monitored electrical activity. In at least one embodiment, the method may further include displaying, on a graphical user interface, phrenic nerve stimulation information for the one or more electrical pacing vectors for use in assisting a user in at least one of evaluating pacing therapy and configuring pacing therapy.

One exemplary non-invasive system may be configured for detecting phrenic nerve stimulation during pacing therapy using one or more pacing electrodes of a plurality of pacing electrodes defining one or more of electrical pacing vectors. The exemplary system may include electrode means for monitoring electrical activity of a patient during delivery of pacing therapy using each electrical pacing vector of one or more electrical pacing vectors and computing means for determining whether the patient's phrenic nerve is stimulated by the pacing therapy delivered using each electrical pacing vector of the one or more electrical pacing vectors based on monitored electrical activity. In at least one embodiment, the system may further include display means for displaying, on a graphical user interface, phrenic nerve stimulation information for the one or more electrical pacing vectors for use in assisting a user in at least one of evaluating pacing therapy and configuring pacing therapy.

One exemplary electrode belt or vest for use in phrenic nerve stimulation detection may include electrodes configured to be located on the anterior torso surface as well as posterior torso surface of a patient. The exemplary electrode belt or vest may be used to automatically detect phrenic nerve stimulation (PNS) during left ventricular (LV) and/or biventricular (BV) stimulation corresponding to a given pacing vector and pacing output. If PNS is present, then the depolarization complexes monitored by electrodes on the anterior surface (e.g., electrodes closer to the diaphragm) may have augmented amplitudes due to artifacts due to, or resulting from, the diaphragm movement compared to the depolarization complexes monitored by electrodes on the posterior surface or compared to the same electrodes during LV and/or BV stimulation without PNS.

The exemplary methods and systems to detect phrenic nerve stimulation may be automatic or automated. For example, an automated routine can be used that initiates LV/BV pacing at a short atrio-ventricular delay for a given LV pacing vector and given pacing outputs, segments depolarization complexes from each ECG electrode during one or more cardiac cycle at rest with the patient in a given posture, extracts the peak-to-peak amplitudes of the depolarization complex, and then evaluates how many of the anterior electrodes have peak-to-peak amplitudes greater than a certain millivolt (mV) threshold. For example, an exemplary mV threshold may be about 30 mV, which may indicate highly exaggerated amplitudes (e.g., typical amplitudes may be in the order of about 10 mV or less) that are attributable to artifacts from PNS. In at least one embodiment, if more than a certain proportion (e.g., 80%) of the anterior electrodes exhibit exaggerated amplitudes (e.g., the amplitudes exceed a threshold, etc.), then PNS may be detected for that

particular pacing vector and pacing output. In one or more embodiments, the information on presence/absence of PNS at a given pacing vector at a given output may be stored and/or displayed.

Further, automated detection of PNS may be performed at varying pacing outputs corresponding to a given LV pacing vector and the minimum outputs at which PNS occurs corresponding to a given LV pacing vector may also be stored/displayed. This PNS information may be used in conjunction with other information (e.g., impedance, thresholds, dyssynchrony information, battery longevity information, cardiac improvement information, etc.) to assist a user in selecting, or deciding on, an optimal LV pacing vector for use in pacing therapy. Further, the detection of PNS for a given LV pacing vector may be repeated for different resting postures of the patient (e.g., supine, lying on right side, lying on left side, etc.). Additionally, exemplary automated routines to detect PNS during implant and/or follow-up may be integrated with automated routines for LV capture management to assist a user in identifying, or finding, an optimal pacing vector for affecting better patient response.

In at least one embodiment, instead of looking at absolute values of peak-to-peak amplitudes, a ratio of peak-to-peak depolarization amplitudes during LV/BV stimulation may be compared to peak-to-peak depolarization amplitudes during baseline rhythm (e.g., that does not involve left ventricular pacing). If more than a certain proportion (e.g., 80%) of anterior electrodes exhibit a high ratio (e.g., greater than 5) when compared to the baseline values, PNS may be detected for LV/BV stimulation.

The above summary is not intended to describe each embodiment or every implementation of the present disclosure. A more complete understanding will become apparent and appreciated by referring to the following detailed description and claims taken in conjunction with the accompanying drawings.

BRIEF DESCRIPTION OF THE DRAWINGS

FIG. 1 is a diagram of an exemplary system including an exemplary implantable medical device (IMD).

FIG. 2A is a diagram of the exemplary IMD of FIG. 1.

FIG. 2B is a diagram of an enlarged view of a distal end of the electrical lead disposed in the left ventricle of FIG. 2A.

FIG. 3A is a block diagram of an exemplary IMD, e.g., the IMD of FIGS. 1-2.

FIG. 3B is another block diagram of an exemplary IMD (e.g., an implantable pulse generator) circuitry and associated leads employed in the system of FIGS. 1-2 for providing three sensing channels and corresponding pacing channels.

FIG. 4 is a diagram of an exemplary system including electrode apparatus, imaging apparatus, display apparatus, and computing apparatus.

FIGS. 5A-5B are conceptual diagrams illustrating exemplary systems for measuring torso-surface potentials.

FIG. 6 is a block diagram of an exemplary method of identifying an optimal electrical vector.

FIG. 7 is an exemplary graphical user interface depicting a table of cardiac improvement information for a plurality of electrodes.

FIG. 8 is another exemplary graphical user interface depicting a table of cardiac improvement information for a plurality of electrodes.

FIG. 9 is an exemplary graphical user interface depicting a table of longevity information for a plurality of electrode vectors.

FIG. 10 is an exemplary graphical user interface depicting a table of longevity information, phrenic nerve stimulation, and cardiac improvement information for a plurality of electrical vectors.

FIG. 11 is an exemplary graphical user interface depicting a graphical representation of a pair of leads and cardiac improvement information and longevity information depicted proximate the electrodes of the leads.

FIG. 12 is an exemplary graphical user interface depicting blood vessel anatomy configured to assist a user in navigating an implantable electrode to a region of a patient's heart for cardiac therapy.

FIG. 13 is an exemplary graphical user interface depicting a human heart including activation times mapped thereon configured to assist a user in navigating an implantable electrode to a region of a patient's heart for cardiac therapy.

FIG. 14 is a block diagram of an exemplary method of detecting phrenic nerve stimulation.

FIG. 15 is a graph of electrical signals monitored over time using multiple external electrodes coupled to a patient that is not undergoing phrenic nerve stimulation.

FIG. 16 is a graph of electrical signals monitored over time using multiple external electrodes coupled to a patient that is undergoing phrenic nerve stimulation.

FIG. 17 depicts graphical representations of electrical activity of a patient that is not undergoing phrenic nerve stimulation.

FIG. 18 depicts graphical representations of electrical activity of a patient that is undergoing phrenic nerve stimulation.

FIG. 19 depicts graphical representations of electrical activity of a patient that is undergoing phrenic nerve stimulation and is not undergoing phrenic nerve stimulation.

DETAILED DESCRIPTION OF EXEMPLARY EMBODIMENTS

In the following detailed description of illustrative embodiments, reference is made to the accompanying figures of the drawing which form a part hereof, and in which are shown, by way of illustration, specific embodiments which may be practiced. It is to be understood that other embodiments may be utilized and structural changes may be made without departing from (e.g., still falling within) the scope of the disclosure presented hereby.

Exemplary systems, methods, and interfaces shall be described with reference to FIGS. 1-19. It will be apparent to one skilled in the art that elements or processes from one embodiment may be used in combination with elements or processes of the other embodiments, and that the possible embodiments of such systems, methods, and interfaces using combinations of features set forth herein is not limited to the specific embodiments shown in the Figures and/or described herein. Further, it will be recognized that the embodiments described herein may include many elements that are not necessarily shown to scale. Still further, it will be recognized that timing of the processes and the size and shape of various elements herein may be modified but still fall within the scope of the present disclosure, although certain timings, one or more shapes and/or sizes, or types of elements, may be advantageous over others.

As described herein, various exemplary systems, methods, and interfaces may utilize electrodes configured to sense one or more electrical signals (e.g., depolarization

complexes, etc.) from the tissue of a patient (e.g., the skin about the torso of the patient) and/or deliver therapy to tissue of the patient (e.g., cardiac tissue of the patient). For example, external electrodes configured for sensing may be located on the skin of the patient's torso. Further, for example, electrodes configured for delivering pacing therapy may be included as part of an implantable medical device (IMD) and located on one or more leads configured to be located proximate one or more portions of a patient's heart.

The exemplary methods and processes described herein may be utilized and implemented by one or more (e.g., two or more, a plurality, etc.) systems, apparatus, interfaces, and devices that include and/or are coupled to one or more sensing electrodes. Additionally, the exemplary methods and processes may be used in conjunction with an exemplary therapy system 10 described herein with reference to FIGS. 1-3. Further, the exemplary methods and processes may use the exemplary system 100 including a spatial electrode-array as described herein with reference to FIGS. 5A-5B to sense one or more electrical signals of a patient. Although only therapy system 10 and sensing system 100 are described and depicted herein, it is to be understood that the exemplary methods and processes may be used by any system including computing apparatus capable of analyzing signals from one or more electrodes. The computing apparatus, for example, may be located in an external computer or programmer, may be located in an IMD, or may be located in a server attached to a network.

FIG. 1 is a conceptual diagram illustrating an exemplary therapy system 10 that may be used to deliver pacing therapy to a patient 14. Patient 14 may, but not necessarily, be a human. The therapy system 10 may include an implantable medical device 16 (IMD), which may be coupled to leads 18, 20, 22 and/or a programmer 24. The IMD 16 may be, e.g., an implantable pacemaker, cardioverter, and/or defibrillator, that provides electrical signals to the heart 12 of the patient 14 via electrodes coupled to one or more of the leads 18, 20, 22.

The leads 18, 20, 22 extend into the heart 12 of the patient 14 to sense electrical activity of the heart 12 and/or to deliver electrical stimulation to the heart 12. In the example shown in FIG. 1, the right ventricular (RV) lead 18 extends through one or more veins (not shown), the superior vena cava (not shown), and the right atrium 26, and into the right ventricle 28. The left ventricular (LV) coronary sinus lead 20 extends through one or more veins, the vena cava, the right atrium 26, and into the coronary sinus 30 to a region adjacent to the free wall of the left ventricle 32 of the heart 12 (in other embodiments, the LV lead 20 may be placed in the LV endocardium). The right atrial (RA) lead 22 extends through one or more veins and the vena cava, and into the right atrium 26 of the heart 12.

The IMD 16 may sense, among other things, electrical signals attendant to the depolarization and repolarization of the heart 12 via electrodes coupled to at least one of the leads 18, 20, 22. The IMD 16 may be configured to provide pacing therapy (e.g., pacing pulses) to the heart 12 based on the electrical signals sensed within the heart 12. Further, the IMD 16 may be operable to adjust one or more parameters associated with the pacing therapy such as, e.g., AV delay and other various timings, pulse width, amplitude, voltage, burst length, etc. Further, the IMD 16 may be operable to use various electrode configurations to deliver pacing therapy, which may be unipolar, bipolar, quadripolar, or further multipolar. For example, a multipolar lead may include several electrodes which can be used for delivering pacing

therapy. Hence, a multipolar lead system may provide, or offer, multiple electrical vectors to pace from. A pacing vector may include at least one cathode, which may be at least one electrode located on at least one lead, and at least one anode, which may be at least one electrode located on at least one lead (e.g., the same lead, or a different lead) and/or on the casing, or can, of the IMD. While improvement in cardiac function as a result of the pacing therapy may primarily depend on the cathode, the electrical parameters like impedance, pacing threshold voltage, current drain, longevity, etc. may be more dependent on the pacing vector, which includes both the cathode and the anode. The IMD 16 may also provide defibrillation therapy and/or cardioversion therapy via electrodes located on at least one of the leads 18, 20, 22. Further, the IMD 16 may detect arrhythmia of the heart 12, such as fibrillation of the ventricles 28, 32, and deliver defibrillation therapy to the heart 12 in the form of electrical pulses. In some examples, IMD 16 may be programmed to deliver a progression of therapies, e.g., pulses with increasing energy levels, until a fibrillation of the heart 12 is stopped.

In some examples, a programmer 24, which may be a handheld computing device or a computer workstation, may be used by a user, such as a physician, technician, another clinician, and/or patient, to communicate with the IMD 16 (e.g., to program the IMD 16). For example, the user may interact with the programmer 24 to retrieve information concerning phrenic nerve stimulation information for one or more electrical pacing vectors (e.g., whether one or more electrical pacing vectors stimulate the phrenic nerve, the power configuration at which one or more electrical pacing vectors stimulate the phrenic nerve, etc.), cardiac improvement information (e.g., dyssynchrony information, etc.) for one or more electrodes, and longevity information (e.g., capture threshold information, impedance values, etc.). Additionally, the user may interact with the programmer 24 to select one or more electrical vectors, e.g., for use in delivering therapy. Further, the user may interact with the programmer 24 to retrieve information concerning one or more detected or indicated faults associated within the IMD 16 and/or the pacing therapy delivered therewith. For instance, computing apparatus located in one or both of the IMD 16 and the programmer 24 may be configured to analyze or evaluate signals from one or more electrodes to select one or more electrodes and identify one or more optimal electrical vectors. The IMD 16 and the programmer 24 may communicate via wireless communication using any techniques known in the art. Examples of communication techniques may include, e.g., low frequency or radiofrequency (RF) telemetry, but other techniques are also contemplated.

FIG. 2A is a conceptual diagram illustrating the IMD 16 and the leads 18, 20, 22 of therapy system 10 of FIG. 1 in more detail. The leads 18, 20, 22 may be electrically coupled to a therapy delivery module (e.g., for delivery of pacing therapy using one or more electrodes), a sensing module (e.g., for sensing one or more signals from one or more electrodes), and/or any other modules of the IMD 16 via a connector block 34. In some examples, the proximal ends of the leads 18, 20, 22 may include electrical contacts that are electrically coupled to respective electrical contacts within the connector block 34 of the IMD 16. In addition, in some examples, the leads 18, 20, 22 may be mechanically coupled to the connector block 34 with the aid of set screws, connection pins, or another suitable mechanical coupling mechanism.

Each of the leads 18, 20, 22 includes an elongated insulative lead body, which may carry a number of conductors (e.g., concentric coiled conductors, straight conductors, etc.) separated from one another by insulation (e.g., tubular insulative sheaths). In the illustrated example, bipolar electrodes 40, 42 are located proximate to a distal end of the lead 18. In addition, the bipolar electrodes 44, 45, 46, 47 are located proximate to a distal end of the lead 20 and the bipolar electrodes 48, 50 are located proximate to a distal end of the lead 22.

The electrodes 40, 44, 45, 46, 47, 48 may take the form of ring electrodes, and the electrodes 42, 50 may take the form of extendable helix tip electrodes mounted retractably within the insulative electrode heads 52, 54, 56, respectively. Each of the electrodes 40, 42, 44, 45, 46, 47, 48, 50 may be electrically coupled to a respective one of the conductors (e.g., coiled and/or straight) within the lead body of its associated lead 18, 20, 22, and thereby coupled to respective ones of the electrical contacts on the proximal end of the leads 18, 20, 22.

In at least one embodiment, electrodes 44, 45, 46, 47 may have an electrode surface area of about 5.3 mm² to about 5.8 mm². Electrodes 44, 45, 46, and 47 may also be referred to as LV1, LV2, LV3, and LV4, respectively. The LV electrodes (i.e., left ventricle electrode 1 (LV1) 44, left ventricle electrode 2 (LV2) 45, left ventricle electrode 3 (LV3) 46, left ventricle 4 (LV4) 47, etc.) on the lead 20 can be spaced apart at variable distances. For example, electrode 44 may be a distance of, e.g., about 21 millimeters (mm) away from electrode 45, electrodes 45, 46 may be spaced a distance of, e.g., about 1.3 mm to about 1.5 mm away from each other, and electrodes 46, 47 may be spaced a distance of, e.g., about 20 mm to about 21 mm away from each other.

The electrodes 40, 42, 44, 45, 46, 47, 48, 50 may further be used to sense electrical signals (e.g., morphological waveforms within electrograms (EGM)) attendant to the depolarization and repolarization of the heart 12. The sensed electrical signals may be used to determine which of the electrodes 40, 42, 44, 45, 46, 47, 48, 50 are the most effective in improving cardiac function. The electrical signals are conducted to the IMD 16 via the respective leads 18, 20, 22. In some examples, the IMD 16 may also deliver pacing pulses via the electrodes 40, 42, 44, 45, 46, 47, 48, 50 to cause depolarization of cardiac tissue of the patient's heart 12. In some examples, as illustrated in FIG. 2A, the IMD 16 includes one or more housing electrodes, such as housing electrode 58, which may be formed integrally with an outer surface of a housing 60 (e.g., hermetically-sealed housing) of the IMD 16 or otherwise coupled to the housing 60. Any of the electrodes 40, 42, 44, 45, 46, 47, 48 and 50 may be used for unipolar pacing or sensing in combination with housing electrode 58. In other words, any of electrodes 40, 42, 44, 45, 46, 47, 48, 50, 58 may be used in combination to form an electrical pacing vector, e.g., a pacing vector that may be used to deliver pacing therapy to a patient's heart. It is generally understood by those skilled in the art that other electrodes can also be selected to define, or be used for, pacing and sensing vectors. Further, any of electrodes 40, 42, 44, 45, 46, 47, 48, 50, 58, which are not being used to deliver pacing therapy, may be used to sense electrical activity during pacing therapy.

As described in further detail with reference to FIGS. 3A-3B, the housing 60 may enclose a therapy delivery module that may include a stimulation generator for generating cardiac pacing pulses and defibrillation or cardioversion shocks as well as a sensing module for monitoring the patient's heart rhythm. The leads 18, 20, 22 may also include

elongated electrodes **62**, **64**, **66**, respectively, which may take the form of a coil. The IMD **16** may deliver defibrillation shocks to the heart **12** via any combination of the elongated electrodes **62**, **64**, **66** and the housing electrode **58**. The electrodes **58**, **62**, **64**, **66** may also be used to deliver cardioversion pulses to the heart **12**. Further, the electrodes **62**, **64**, **66** may be fabricated from any suitable electrically conductive material, such as, but not limited to, platinum, platinum alloy, and/or other materials known to be usable in implantable defibrillation electrodes. Since electrodes **62**, **64**, **66** are not generally configured to deliver pacing therapy, any of electrodes **62**, **64**, **66** may be used to sense electrical activity (e.g., for use in determining electrode effectiveness, for use in analyzing pacing therapy effectiveness, etc.) and may be used in combination with any of electrodes **40**, **42**, **44**, **45**, **46**, **47**, **48**, **50**, **58**. In at least one embodiment, the RV elongated electrode **62** may be used to sense electrical activity of a patient's heart during the delivery of pacing therapy (e.g., in combination with the housing electrode **58** forming a RV elongated coil, or defibrillation electrode, to housing electrode vector).

The configuration of the exemplary therapy system **10** illustrated in FIGS. 1-2 is merely one example. In other examples, the therapy system may include epicardial leads and/or patch electrodes instead of, or in addition to, the transvenous leads **18**, **20**, **22** illustrated in FIG. 1. Further, in one or more embodiments, the IMD **16** need not be implanted within the patient **14**. For example, the IMD **16** may deliver various cardiac therapies to the heart **12** via percutaneous leads that extend through the skin of the patient **14** to a variety of positions within, or outside of, the heart **12**. In one or more embodiments, the system **10** may utilize wireless pacing (e.g., using energy transmission to the intracardiac pacing component(s) via ultrasound, inductive coupling, RF, etc.) and sensing cardiac activation using electrodes on the can/housing and/or on subcutaneous leads.

In other examples of therapy systems that provide electrical stimulation therapy to the heart **12**, such therapy systems may include any suitable number of leads coupled to the IMD **16**, and each of the leads may extend to any location within or proximate to the heart **12**. For example, other examples of therapy systems may include three transvenous leads located as illustrated in FIGS. 1-2. Still further, other therapy systems may include a single lead that extends from the IMD **16** into the right atrium **26** or the right ventricle **28**, or two leads that extend into a respective one of the right atrium **26** and the right ventricle **28**.

FIG. 3A is a functional block diagram of one exemplary configuration of the IMD **16**. As shown, the IMD **16** may include a control module **81**, a therapy delivery module **84** (e.g., which may include a stimulation generator), a sensing module **86**, and a power source **90**.

The control module **81** may include a processor **80**, memory **82**, and a telemetry module **88**. The memory **82** may include computer-readable instructions that, when executed, e.g., by the processor **80**, cause the IMD **16** and/or the control module **81** to perform various functions attributed to the IMD **16** and/or the control module **81** described herein. Further, the memory **82** may include any volatile, non-volatile, magnetic, optical, and/or electrical media, such as a random access memory (RAM), read-only memory (ROM), non-volatile RAM (NVRAM), electrically-erasable programmable ROM (EEPROM), flash memory, and/or any other digital media. An exemplary capture management module may be the left ventricular capture management (LVCM) module described in U.S. Pat. No. 7,684,863 entitled "LV THRESHOLD MEASUREMENT AND CAP-

TURE MANAGEMENT" and issued Mar. 23, 2010, which is incorporated herein by reference in its entirety.

The processor **80** of the control module **81** may include any one or more of a microprocessor, a controller, a digital signal processor (DSP), an application specific integrated circuit (ASIC), a field-programmable gate array (FPGA), and/or equivalent discrete or integrated logic circuitry. In some examples, the processor **80** may include multiple components, such as any combination of one or more microprocessors, one or more controllers, one or more DSPs, one or more ASICs, and/or one or more FPGAs, as well as other discrete or integrated logic circuitry. The functions attributed to the processor **80** herein may be embodied as software, firmware, hardware, or any combination thereof.

The control module **81** may be used to determine the effectiveness of the electrodes **40**, **42**, **44**, **45**, **46**, **47**, **48**, **50**, **58**, **62**, **64**, **66** using the exemplary methods and/or processes described herein according to a selected one or more programs, which may be stored in the memory **82**. Further, the control module **81** may control the therapy delivery module **84** to deliver therapy (e.g., electrical stimulation therapy such as pacing) to the heart **12** according to a selected one or more therapy programs, which may be stored in the memory **82**. More specifically, the control module **81** (e.g., the processor **80**) may control various parameters of the electrical stimulus delivered by the therapy delivery module **84** such as, e.g., AV delays, pacing pulses with the amplitudes, pulse widths, frequency, or electrode polarities, etc., which may be specified by one or more selected therapy programs (e.g., phrenic nerve stimulation detection programs, AV delay adjustment programs, pacing therapy programs, pacing recovery programs, capture management programs, etc.). As shown, the therapy delivery module **84** is electrically coupled to electrodes **40**, **42**, **44**, **45**, **46**, **47**, **48**, **50**, **58**, **62**, **64**, **66**, e.g., via conductors of the respective lead **18**, **20**, **22**, or, in the case of housing electrode **58**, via an electrical conductor disposed within housing **60** of IMD **16**. Therapy delivery module **84** may be configured to generate and deliver electrical stimulation therapy such as pacing therapy to the heart **12** using one or more of the electrodes **40**, **42**, **44**, **45**, **46**, **47**, **48**, **50**, **58**, **62**, **64**, **66**.

For example, therapy delivery module **84** may deliver pacing stimulus (e.g., pacing pulses) via ring electrodes **40**, **44**, **45**, **46**, **47**, **48** coupled to leads **18**, **20**, **22**, respectively, and/or helical tip electrodes **42**, **50** of leads **18**, **22**. Further, for example, therapy delivery module **84** may deliver defibrillation shocks to heart **12** via at least two of electrodes **58**, **62**, **64**, **66**. In some examples, therapy delivery module **84** may be configured to deliver pacing, cardioversion, or defibrillation stimulation in the form of electrical pulses. In other examples, therapy delivery module **84** may be configured deliver one or more of these types of stimulation in the form of other signals, such as sine waves, square waves, and/or other substantially continuous time signals.

The IMD **16** may further include a switch module **85** and the control module **81** (e.g., the processor **80**) may use the switch module **85** to select, e.g., via a data/address bus, which of the available electrodes are used to deliver therapy such as pacing pulses for pacing therapy, or which of the available electrodes are used for sensing. The switch module **85** may include a switch array, switch matrix, multiplexer, or any other type of switching device suitable to selectively couple the sensing module **86** and/or the therapy delivery module **84** to one or more selected electrodes. More specifically, the therapy delivery module **84** may include a plurality of pacing output circuits. Each pacing output

circuit of the plurality of pacing output circuits may be selectively coupled, e.g., using the switch module **85**, to one or more of the electrodes **40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66** (e.g., a pair of electrodes for delivery of therapy to a pacing vector). In other words, each electrode can be

selectively coupled to one of the pacing output circuits of the therapy delivery module using the switching module **85**. The sensing module **86** is coupled (e.g., electrically coupled) to sensing apparatus, which may include, among additional sensing apparatus, the electrodes **40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66** to monitor electrical activity of the heart **12**, e.g., electrocardiogram (ECG)/electrogram (EGM) signals, etc. The ECG/EGM signals may be used to identify the effectiveness of each of the electrodes **40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66** (e.g., by monitoring or measuring the signals for analysis by the control module **81**, the programmer **24**, etc.). Further, the ECG/EGM signals may be used to measure or monitor activation times (e.g., ventricular activations times, etc.), heart rate (HR), heart rate variability (HRV), heart rate turbulence (HRT), deceleration/acceleration capacity, deceleration sequence incidence, T-wave alternans (TWA), P-wave to P-wave intervals (also referred to as the P-P intervals or A-A intervals), R-wave to R-wave intervals (also referred to as the R-R intervals or V-V intervals), P-wave to QRS complex intervals (also referred to as the P-R intervals, A-V intervals, or P-Q intervals), QRS-complex morphology, ST segment (i.e., the segment that connects the QRS complex and the T-wave), T-wave changes, QT intervals, electrical vectors, etc.

The switch module **85** may be also be used with the sensing module **86** to select which of the available electrodes are used, or enabled, to, e.g., sense electrical activity of the patient's heart (e.g., one or more sensing electrical vectors of the patient's heart may use any combination of the electrodes **40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66**). Likewise, the switch module **85** may be also be used with the sensing module **86** to select which of the available electrodes are not to be used (e.g., disabled) to, e.g., sense electrical activity of the patient's heart. In some examples, the control module **81** may select the electrodes that function as sensing electrodes via the switch module within the sensing module **86**, e.g., by providing signals via a data/address bus.

In some examples, sensing module **86** includes a channel that includes an amplifier with a relatively wider pass band than the R-wave or P-wave amplifiers. Signals from the selected sensing electrodes may be provided to a multiplexer, and thereafter converted to multi-bit digital signals by an analog-to-digital converter for storage in memory **82**, e.g., as an electrogram (EGM). In some examples, the storage of such EGMs in memory **82** may be under the control of a direct memory access circuit. The control module **81** (e.g., using the processor **80**) may employ digital signal analysis techniques to characterize the digitized signals stored in memory **82** and to analyze one or more morphological waveforms of the EGM signals to determine pacing therapy effectiveness, etc. For example, the processor **80** may be configured to determine, or obtain, one more features of one or more sensed morphological waveforms within one of more electrical vectors of the patient's heart and store the one or more features within the memory **82** for use in comparing features, values, etc. of the waveforms to determine effectiveness of the electrodes.

In some examples, the control module **81** may operate as an interrupt driven device, and may be responsive to interrupts from a pacer timing and control module, where the interrupts may correspond to the occurrences of sensed

P-waves and R-waves and the generation of cardiac pacing pulses. Any necessary mathematical calculations may be performed by the processor **80** and any updating of the values or intervals controlled by the pacer timing and control module may take place following such interrupts. A portion of memory **82** may be configured as a plurality of recirculating buffers, capable of holding one or more series of measured intervals, which may be analyzed by, e.g., the processor **80** in response to the occurrence of a pace or sense interrupt to determine whether the patient's heart **12** is presently exhibiting any arrhythmia (e.g., atrial or ventricular tachyarrhythmia).

The telemetry module **88** of the control module **81** may include any suitable hardware, firmware, software, or any combination thereof for communicating with another device, such as the programmer **24** as described herein with respect to FIG. 1. For example, under the control of the processor **80**, the telemetry module **88** may receive downlink telemetry from and send uplink telemetry to the programmer **24** with the aid of an antenna, which may be internal and/or external. The processor **80** may provide data to be uplinked to the programmer **24** and the control signals for the telemetry circuit within the telemetry module **88**, e.g., via an address/data bus. In some examples, the telemetry module **88** may provide received data to the processor **80** via a multiplexer.

The various components of the IMD **16** are further coupled to a power source **90**, which may include a rechargeable or non-rechargeable battery. A non-rechargeable battery may be selected to last for several years, while a rechargeable battery may be charged (e.g., inductively charged) from an external device, e.g., on a daily or weekly basis.

FIG. 3B is another embodiment of a functional block diagram for IMD **16**. FIG. 3B depicts bipolar RA lead **22**, bipolar RV lead **18**, and bipolar LV CS lead **20** without the LA CS pace/sense electrodes and coupled with an implantable pulse generator (IPG) circuit **31** having programmable modes and parameters of a bi-ventricular DDD/R type. In turn, the sensor signal processing circuit **91** may be indirectly coupled to the timing circuit **83** and via data and control bus to microcomputer circuitry **33**. The IPG circuit **31** is illustrated in a functional block diagram divided generally into a microcomputer circuit **33** and a pacing circuit **21**. The pacing circuit **21** includes the digital controller/timer circuit **83**, the output amplifiers circuit **51**, the sense amplifiers circuit **55**, the RF telemetry transceiver **41**, the activity sensor circuit **35** as well as a number of other circuits and components described below.

Crystal oscillator circuit **89** provides the basic timing clock for the pacing circuit **21** while a battery **29** provides power. Power-on-reset circuit **87** may respond to an initial connection of the circuit to the battery for defining an initial operating condition, and similarly, may reset the operative state of the device in response to detection of a low battery condition. Reference mode circuit **37** may generate stable voltage reference and currents for the analog circuits within the pacing circuit **21** while analog to digital converter ADC and multiplexer circuit **39** may digitize analog signals and voltages to provide real time telemetry of cardiac signals from sense amplifiers **55** for uplink transmission via RF transmitter and receiver circuit **41**.

If the IPG circuit **31** is programmed to a rate responsive mode, the signals output by one or more physiologic sensor may be employed as a rate control parameter (RCP) to derive a physiologic escape interval. For example, the escape interval may be adjusted proportionally to the

patient's activity level developed in the patient activity sensor (PAS) circuit 35 in the depicted, exemplary IPG circuit 31. The patient activity sensor 27 may be coupled to the IPG housing and may take the form of a piezoelectric crystal transducer and its output signal may be processed and used as the RCP. Sensor 27 may generate electrical signals in response to sensed physical activity that are processed by activity circuit 35 and provided to digital controller/timer circuit 83. Activity circuit 35 and associated sensor 27 may correspond to the circuitry disclosed in U.S. Pat. No. 5,052,388 entitled "METHOD AND APPARATUS FOR IMPLEMENTING ACTIVITY SENSING IN A PULSE GENERATOR" and issued on Oct. 1, 1991 and U.S. Pat. No. 4,428,378 entitled "RATE ADAPTIVE PACER" and issued on Jan. 31, 1984, each of which is incorporated herein by reference in its entirety. Similarly, the exemplary systems, apparatus, and methods described herein may be practiced in conjunction with alternate types of sensors such as oxygenation sensors, pressure sensors, pH sensors and respiration sensors, etc. Alternately, QT time may be used as the rate indicating parameter. Similarly, the exemplary embodiments described herein may also be practiced in non-rate responsive pacemakers.

Data transmission to and from the external programmer may be accomplished by way of a telemetry antenna 57 and an associated RF transceiver 41, which may serve both to demodulate received downlink telemetry and to transmit uplink telemetry. Uplink telemetry capabilities may typically include the ability to transmit stored digital information such as, e.g., operating modes and parameters, EGM histograms, and other events, as well as real time EGMs of atrial and/or ventricular electrical activity and marker channel pulses indicating the occurrence of sensed and paced depolarizations in the atrium and ventricle.

Microcomputer circuit 33 may contain, or include, a microprocessor 80 and associated system clock and on-processor RAM chip 82A and ROM chip 82B, respectively. In addition, microcomputer circuit 33 includes a separate RAM/ROM chip 82C to provide additional memory capacity. Microprocessor 80 may normally operate in a reduced power consumption mode and may be interrupt driven. For example, the microprocessor 80 may be awakened in response to defined interrupt events, which may include A-TRIG, RV-TRIG, and LV-TRIG signals generated by timers in digital timer/controller circuit 83 and A-EVENT, RV-EVENT, and LV-EVENT signals generated by sense amplifiers circuit 55, etc. The specific values of the intervals and delays timed out by digital controller/timer circuit 83 may be controlled by the microcomputer circuit 33 by way of data and control bus from programmed-in parameter values and operating modes. In addition, if programmed to operate as a rate responsive pacemaker, a timed interrupt, e.g., every cycle or every two seconds, may be provided in order to allow the microprocessor to analyze the activity sensor data and update the basic A-A, V-A, or V-V escape interval, as applicable. In addition, the microprocessor 80 may also serve to define variable, operative AV delay intervals and the energy delivered to each ventricle.

In one embodiment, microprocessor 80 is a custom microprocessor adapted to fetch and execute instructions stored in RAM/ROM unit 82 in a conventional manner. It is contemplated, however, that other implementations may be suitable to practice the present disclosure. For example, an off-the-shelf, commercially available microprocessor or microcontroller, or custom application-specific, hardwired logic, or state-machine type circuit may perform the functions of microprocessor 80.

Digital controller/timer circuit 83 may operate under the general control of the microcomputer 33 to control timing and other functions within the pacing circuit 21 and may include a set of timing and associated logic circuits. The depicted timing circuits include URI/LRI timers 83A, V-V delay timer 83B, intrinsic interval timers 83C for timing elapsed V-EVENT to V-EVENT intervals or V-EVENT to A-EVENT intervals or the V-V conduction interval, escape interval timers 83D for timing A-A, V-A, and/or V-V pacing escape intervals, an AV delay interval timer 83E for timing the A-LVp delay (or A-RVp delay) from a preceding A-EVENT or A-TRIG, a post-ventricular timer 83F for timing post-ventricular time periods, and a date/time clock 83G.

The AV delay interval timer 83E may be loaded with an appropriate delay interval for one ventricular chamber (e.g., either an A-RVp delay or an A-LVp delay) to time-out starting from a preceding A-PACE or A-EVENT. The interval timer 83E may trigger pacing stimulus delivery and can be based on one or more prior cardiac cycles (or from a data set empirically derived for a given patient).

The post-event timer 83F may be configured to time out the post-ventricular time period following an RV-EVENT, LV-EVENT, RV-TRIG, or LV-TRIG and post-atrial time periods following an A-EVENT or A-TRIG. The durations of the post-event time periods may also be selected as programmable parameters stored in the microcomputer 33. The post-ventricular time periods include the PVARP, a post-atrial ventricular blanking period (PAVBP), a ventricular blanking period (VBP), a post-ventricular atrial blanking period (PVARP) and a ventricular refractory period (VRP) although other periods can be suitably defined depending, at least in part, on the operative circuitry employed in the pacing engine. The post-atrial time periods include an atrial refractory period (ARP) during which an A-EVENT is ignored for the purpose of resetting any AV delay, and an atrial blanking period (ABP) during which atrial sensing is disabled. It should be noted that the starting of the post-atrial time periods and the AV delays can be commenced substantially simultaneously with the start or end of each A-EVENT or A-TRIG or, in the latter case, upon the end of the A-PACE which may follow the A-TRIG. Similarly, the starting of the post-ventricular time periods and the V-A escape interval can be commenced substantially simultaneously with the start or end of the V-EVENT or V-TRIG or, in the latter case, upon the end of the V-PACE which may follow the V-TRIG. The microprocessor 80 may also optionally calculate AV delays, post-ventricular time periods, and post-atrial time periods that vary with the sensor based escape interval established in response to the RCP(s) and/or with the intrinsic atrial rate.

The output amplifiers circuit 51 may include a RA pace pulse generator (and a LA pace pulse generator if LA pacing is provided), a RV pace pulse generator, and a LV pace pulse generator. In order to trigger generation of an RV-PACE or LV-PACE pulse, digital controller/timer circuit 83 generates the RV-TRIG signal at the time-out of the A-RVp delay (in the case of RV pre-excitation) or the LV-TRIG at the time-out of the A-LVp delay (in the case of LV pre-excitation) provided by AV delay interval timer 83E (or the V-V delay timer 83B). Similarly, digital controller/timer circuit 83 generates a RA-TRIG signal that triggers output of a RA-PACE pulse (or an LA-TRIG signal that triggers output of an LA-PACE pulse, if provided) at the end of the V-A escape interval timed by escape interval timers 83D.

The output amplifier circuit 51 may include switching circuits for coupling selected pace electrode pairs from

among the lead conductors and the IND_CAN electrode **20** to the RA pace pulse generator (and LA pace pulse generator if provided), RV pace pulse generator and LV pace pulse generator. Pace/sense electrode pair selection and control circuit **53** may select lead conductors and associated pace output amplifiers within output amplifiers circuit **51** for accomplishing RA, LA, RV, and LV pacing.

The sense amplifier circuit **55** may include sense amplifiers such as, e.g., high impedance P-wave and R-wave sense amplifiers that may be used to amplify a voltage difference signal that is generated across the sense electrode pairs by the passage of cardiac depolarization wavefronts. High impedance sense amplifiers may further use high gain to amplify low amplitude signals and may rely on pass band filters, time domain filtering, and amplitude threshold comparison to discriminate a P-wave or R-wave from background electrical noise. Digital controller/timer circuit **83** may further control sensitivity settings of the atrial and ventricular sense amplifiers **55**.

The sense amplifiers may be typically uncoupled from the sense electrodes during blanking periods before, during, and after delivery of a pace pulse to any of the pace electrodes of the pacing system to avoid saturation of the sense amplifiers. The sense amplifier circuit **55** may include blanking circuits for uncoupling the selected pairs of the lead conductors and the IND-CAN electrode **20** from the inputs of the RA sense amplifier (and LA sense amplifier if provided), RV sense amplifier and LV sense amplifier during the ABP, PVABP and VBP. The sense amplifiers circuit **55** may also include switching circuits for coupling selected sense electrode lead conductors and the IND-CAN electrode **20** to the RA sense amplifier (and LA sense amplifier if provided), RV sense amplifier and LV sense amplifier. Again, sense electrode selection and control circuit **53** may select conductors and associated sense electrode pairs to be coupled with the atrial and ventricular sense amplifiers within the output amplifiers circuit **51** and sense amplifiers circuit **55** for accomplishing RA, LA, RV, and LV sensing along desired unipolar and bipolar sensing vectors.

Right atrial depolarizations or P-waves in the A-SENSE signal that are sensed by the A sense amplifier result in a RA-EVENT signal that is communicated to the digital controller/timer circuit **83**. Similarly, left atrial depolarizations or P-waves in a LA-SENSE signal may be sensed by a LA sense amplifier, if provided, and may result in a LA-EVENT signal that is communicated to the digital controller/timer circuit **83**. Ventricular depolarizations or R-waves in the RV-SENSE signal are sensed by a ventricular sense amplifier result in an RV-EVENT signal that is communicated to the digital controller/timer circuit **83**. Similarly, ventricular depolarizations or R-waves in the LV-SENSE signal are sensed by a ventricular sense amplifier result in an LV-EVENT signal that is communicated to the digital controller/timer circuit **83**. The RV-EVENT, LV-EVENT, RA-EVENT, and/or LA-EVENT signals may be refractory or non-refractory, and can inadvertently be triggered by electrical noise signals or aberrantly conducted depolarization waves rather than true R-waves or P-waves.

As described herein, various exemplary systems, methods, and interfaces may be configured to use electrode apparatus including external electrodes, imaging apparatus, display apparatus, and/or computing apparatus to noninvasively assist a user (e.g., a physician) in evaluating pacing therapy, in configuring pacing therapy, in selecting one or more locations (e.g., implantation site regions) proximate a patient's heart for one or more implantable electrodes,

and/or navigating one or more implantable electrodes to one or more selected location(s). An exemplary system **100** including electrode apparatus **110**, imaging apparatus **120**, display apparatus **130**, and computing apparatus **140** is depicted in FIG. **4**.

The electrode apparatus **110** as shown includes a plurality of electrodes incorporated, or included, within a band wrapped around the chest, or torso, of a patient **14**. The electrode apparatus **110** is operatively coupled to the computing apparatus **140** (e.g., through one or more wired electrical connections, wirelessly, etc.) to provide electrical signals from each of the electrodes to the computing apparatus **140** for analysis. Exemplary electrode apparatus may be described in U.S. Provisional Patent Application No. 61/913,759 entitled "Bioelectric Sensor Device and Methods" and filed on Dec. 9, 2013, which is incorporated herein by reference in its entirety. Further, exemplary electrode apparatus **110** will be described in more detail in reference to FIGS. **5A-5B**.

The imaging apparatus **120** may be any type of imaging apparatus configured to image, or provide images of, at least a portion of the patient in a non-invasive manner. For example, the imaging apparatus **120** may not use any components or parts that may be located within the patient to provide images of at least a portion of the patient except non-invasive tools such as contrast solution. It is to be understood that the exemplary systems, methods, and interfaces described herein may noninvasively assist a user (e.g., a physician) in testing whether pacing therapy stimulates the patient's phrenic nerve, evaluating pacing therapy, configuring pacing therapy, selecting a location proximate a patient's heart for an implantable electrode, and implanting, or navigating, an implantable electrode into the patient, e.g., proximate the patient's heart.

Additionally, the exemplary systems, methods, and interfaces may provide image guided navigation that may be used to navigate leads including electrodes, leadless electrodes, wireless electrodes, catheters, etc., within the patient's body. Further, although the exemplary systems, methods, and interfaces are described herein with reference to a patient's heart, it is to be understood that the exemplary systems, methods, and interfaces may be applicable to any other portion of the patient's body.

The imaging apparatus **120** may be configured to capture, or take, x-ray images (e.g., two dimensional x-ray images, three dimensional x-ray images, etc.) of the patient **14**. The imaging apparatus **120** may be operatively coupled (e.g., through one or more wired electrical connections, wirelessly, etc.) to the computing apparatus **140** such that the images captured by the imaging apparatus **120** may be transmitted to the computing apparatus **140**. Further, the computing apparatus **140** may be configured to control the imaging apparatus **120** to, e.g., configure the imaging apparatus **120** to capture images, change one or more settings of the imaging apparatus **120**, etc.

It will be recognized that while the imaging apparatus **120** as shown in FIG. **4** may be configured to capture x-ray images, any other alternative imaging modality may also be used by the exemplary systems, methods, and interfaces described herein. For example, the imaging apparatus **120** may be configured to capture images, or image data, using isocentric fluoroscopy, bi-plane fluoroscopy, ultrasound, computed tomography (CT), multi-slice computed tomography (MSCT), magnetic resonance imaging (MRI), high frequency ultrasound (HIFU), optical coherence tomography (OCT), intra-vascular ultrasound (IVUS), two dimensional (2D) ultrasound, three dimensional (3D) ultrasound,

four dimensional (4D) ultrasound, intraoperative CT, intraoperative MRI, etc. Further, it is to be understood that the imaging apparatus **120** may be configured to capture a plurality of consecutive images (e.g., continuously) to provide video frame data. In other words, a plurality of images taken over time using the imaging apparatus **120** may provide video, or motion picture, data. Additionally, the images may also be obtained and displayed in two, three, or four dimensions. In more advanced forms, four-dimensional surface rendering of the heart or other regions of the body may also be achieved by incorporating heart data or other soft tissue data from an atlas map or from pre-operative image data captured by MRI, CT, or echocardiography modalities. Image datasets from hybrid modalities, such as positron emission tomography (PET) combined with CT, or single photon emission computer tomography (SPECT) combined with CT, could also provide functional image data superimposed onto anatomical data to be used to reach target locations within the heart or other areas of interest.

The display apparatus **130** and the computing apparatus **140** may be configured to display and analyze data such as, e.g., phrenic nerve stimulation information (e.g., whether each electrical pacing vector stimulates the patient's phrenic nerve, what power configuration of each electrical pacing vector stimulates the patient's phrenic nerve, electrical activity data with respect to the patient's surface potentials after and/or during pacing therapy, etc.), surrogate electrical activation data, image data, mechanical motion data, etc. gathered, or collected, using the electrode apparatus **110** and the imaging apparatus **120** to noninvasively assist a user in evaluating/configuring pacing therapy and selecting a location for implantation of an implantable electrode. In at least one embodiment, the computing apparatus **140** may be a server, a personal computer, or a tablet computer. The computing apparatus **140** may be configured to receive input from input apparatus **142** and transmit output to the display apparatus **130**. Further, the computing apparatus **140** may include data storage that may allow for access to processing programs or routines and/or one or more other types of data, e.g., for driving a graphical user interface configured to noninvasively assist a user.

The computing apparatus **140** may be operatively coupled to the input apparatus **142** and the display apparatus **130** to, e.g., transmit data to and from each of the input apparatus **142** and the display apparatus **130**. For example, the computing apparatus **140** may be electrically coupled to each of the input apparatus **142** and the display apparatus **130** using, e.g., analog electrical connections, digital electrical connections, wireless connections, bus-based connections, network-based connections, internet-based connections, etc. As described further herein, a user may provide input to the input apparatus **142** to manipulate, or modify, information including phrenic nerve stimulation information, one or more graphical depictions displayed on the display apparatus **130** to view and/or select one or more target or candidate locations of a portion of a patient's heart as further described herein.

Although as depicted the input apparatus **142** is a keyboard, it is to be understood that the input apparatus **142** may include any apparatus capable of providing input to the computing apparatus **140** to perform the functionality, methods, and/or logic described herein. For example, the input apparatus **142** may include a mouse, a trackball, a touchscreen (e.g., capacitive touchscreen, a resistive touchscreen, a multi-touch touchscreen, etc.), etc. Likewise, the display apparatus **130** may include any apparatus capable of displaying information to a user, such as a graphical user

interface **132** including graphical depictions of anatomy of a patient's heart, images of a patient's heart, graphical depictions of locations of one or more electrodes, graphical depictions of one or more target or candidate locations, alphanumeric representations of one or more values, graphical depictions or actual images of implanted electrodes and/or leads, etc. For example, the display apparatus **130** may include a liquid crystal display, an organic light-emitting diode screen, a touchscreen, a cathode ray tube display, etc.

The graphical user interfaces **132** displayed by the display apparatus **130** may include, or display, one or more regions used to display graphical depictions, to display images, to allow selection of one or more regions or areas of such graphical depictions and images, etc. As used herein, a "region" of a graphical user interface **132** may be defined as a portion of the graphical user interface **132** within which information may be displayed or functionality may be performed. Regions may exist within other regions, which may be displayed separately or simultaneously. For example, smaller regions may be located within larger regions, regions may be located side-by-side, etc. Additionally, as used herein, an "area" of a graphical user interface **132** may be defined as a portion of the graphical user interface **132** located with a region that is smaller than the region it is located within.

The processing programs or routines stored and/or executed by the computing apparatus **140** may include programs or routines for computational mathematics, matrix mathematics, decomposition algorithms, compression algorithms (e.g., data compression algorithms), calibration algorithms, image construction algorithms, signal processing algorithms (e.g., Fourier transforms, fast Fourier transforms, etc.), standardization algorithms, comparison algorithms, vector mathematics, or any other processing required to implement one or more exemplary methods and/or processes described herein. Data stored and/or used by the computing apparatus **140** may include, for example, image data from the imaging apparatus **120**, electrical signal data from the electrode apparatus **110**, graphics (e.g., graphical elements, icons, buttons, windows, dialogs, pull-down menus, graphic areas, graphic regions, 3D graphics, etc.), graphical user interfaces, results from one or more processing programs or routines employed according to the disclosure herein, or any other data that may be necessary for carrying out the one and/or more processes or methods described herein.

In one or more embodiments, the exemplary systems, methods, and interfaces may be implemented using one or more computer programs executed on programmable computers, such as computers that include, for example, processing capabilities, data storage (e.g., volatile or non-volatile memory and/or storage elements), input devices, and output devices. Program code and/or logic described herein may be applied to input data to perform functionality described herein and generate desired output information. The output information may be applied as input to one or more other devices and/or methods as described herein or as would be applied in a known fashion.

The one or more programs used to implement the systems, methods, and/or interfaces described herein may be provided using any programmable language, e.g., a high level procedural and/or object orientated programming language that is suitable for communicating with a computer system. Any such programs may, for example, be stored on any suitable device, e.g., a storage media, that is readable by a general or special purpose program running on a computer system (e.g., including processing apparatus) for configuring

and operating the computer system when the suitable device is read for performing the procedures described herein. In other words, at least in one embodiment, the exemplary systems, methods, and/or interfaces may be implemented using a computer readable storage medium, configured with a computer program, where the storage medium so configured causes the computer to operate in a specific and predefined manner to perform functions described herein. Further, in at least one embodiment, the exemplary systems, methods, and/or interfaces may be described as being implemented by logic (e.g., object code) encoded in one or more non-transitory media that includes code for execution and, when executed by a processor, is operable to perform operations such as the methods, processes, and/or functionality described herein.

The computing apparatus **140** may be, for example, any fixed or mobile computer system (e.g., a controller, a micro-controller, a personal computer, mini computer, tablet computer, etc.). The exact configuration of the computing apparatus **130** is not limiting, and essentially any device capable of providing suitable computing capabilities and control capabilities (e.g., graphics processing, etc.) may be used. As described herein, a digital file may be any medium (e.g., volatile or non-volatile memory, a CD-ROM, a punch card, magnetic recordable tape, etc.) containing digital bits (e.g., encoded in binary, trinary, etc.) that may be readable and/or writeable by computing apparatus **140** described herein. Also, as described herein, a file in user-readable format may be any representation of data (e.g., ASCII text, binary numbers, hexadecimal numbers, decimal numbers, graphically, etc.) presentable on any medium (e.g., paper, a display, etc.) readable and/or understandable by a user.

In view of the above, it will be readily apparent that the functionality as described in one or more embodiments according to the present disclosure may be implemented in any manner as would be known to one skilled in the art. As such, the computer language, the computer system, or any other software/hardware which is to be used to implement the processes described herein shall not be limiting on the scope of the systems, processes or programs (e.g., the functionality provided by such systems, processes or programs) described herein.

FIGS. **5A-5B** are conceptual diagrams illustrating exemplary electrode systems for measuring electrical signals (e.g., body-surface potentials and, more particularly, torso-surface potentials) from the patient. The exemplary electrode systems in FIGS. **5A-5B** may be configured to measure electrical signals used to determine whether cardiac pacing is stimulating the patient's phrenic nerve, to measure cardiac improvement information during pacing therapy (e.g., pacing therapy that utilizes one or more pacing electrodes to form one or more electrical pacing vectors), etc. As shown in FIG. **5A**, the exemplary system **110** includes a set, or array, of electrodes **102**, a strap **104**, interface/amplifier circuitry **103**, and computing apparatus **140**. The electrodes **102** are attached, or coupled, to the strap **104**, and the strap **104** may be configured to be wrapped around the torso of patient such that the electrodes **102** surround the patient's torso and/or heart. As further illustrated, the electrodes **102** may be positioned around the circumference of patient, including the posterior, lateral, and anterior surfaces of the torso of patient. In other examples, electrodes **102** may be positioned on any one or more of the posterior, lateral, and anterior surfaces of the torso. Further, the electrodes **102** may be electrically connected to interface/amplifier circuitry **103** via wired connection **108**. The interface/amplifier circuitry **103** may be configured to amplify the signals from the

electrodes **102** and provide the signals to the computing apparatus **140** such as described herein with reference to FIG. **4**. Other exemplary systems may use a wireless connection to transmit the signals sensed by electrodes **102** to the interface/amplifier circuitry **103** and, in turn, the computing apparatus **140**, e.g., as channels of data.

Although in the example of FIG. **5A** the electrode system **110** includes a strap **104**, any of a variety of mechanisms, e.g., tape or adhesives, may be employed to aid in the spacing and placement of electrodes **102**. In some examples, the strap **104** may include an elastic band, strip of tape, or cloth. In other examples, the electrodes **102** may be placed individually on the torso of a patient. Further, in other examples, electrodes **102** (e.g., arranged in an array) may be part of, or located within, patches, vests, and/or other means of securing the electrodes **102** to the torso of the patient.

The electrodes **102** may be configured to record, or monitor, the electrical signals (e.g., depolarizations, repolarizations, etc.) associated with phrenic nerve activity and/or the heart after the signals have propagated through and/or about the torso of patient. For example, the electrodes **102** may be configured to record, or monitor, any electrical signals associated non-cardiac tissue such as, e.g., the patient's diaphragm (e.g., tissues that interact with phrenic nerve stimulation), that have propagated through and/or about the torso of patient. Each of the electrodes **102** may be used in a unipolar configuration to sense the torso-surface potentials. The interface/amplifier circuitry **103** may also be coupled to a return or indifferent electrode (not shown) which may be used in combination with each of electrodes **102** for unipolar sensing. In some examples, about 12 electrodes to about 50 electrodes **102** may be spatially distributed around the torso of patient. Other configurations may have more or fewer electrodes **102**.

The computing apparatus **140** may record and analyze the torso-surface potential signals sensed by electrodes **102** and amplified/conditioned by the interface/amplifier circuitry **103**. The computing apparatus **140** may be configured to analyze the signals from the electrodes **102** to determine whether pacing therapy is stimulating the patient's phrenic nerve and/or to generate cardiac improvement information (e.g., provide dyssynchrony information, dyssynchrony index, etc.) usable to determine whether pacing electrodes improve cardiac functionality. Additionally, the computing apparatus **140** may be configured to provide output to a user indicative of phrenic nerve stimulation information and/or cardiac improvement information. Exemplary systems and/or methods may use the phrenic nerve stimulation information and/or cardiac functionality improvement information (e.g., dyssynchrony information) to determine whether one or more electrodes and/or one or more electrical pacing vectors are desirable, optimal, and/or effective for use in pacing therapy.

In some examples, analysis of electrical signals sensed by the external electrodes **102** by the computing apparatus **140** may take into consideration the location of electrodes implanted proximate cardiac tissue (e.g., electrodes located on leads implanted in the patient's heart) and/or additional tracking points based on anatomic fiducial elements or intracardiac catheters placed proximate cardiac tissue. In such examples, the computing apparatus **140** may be communicatively coupled to an imaging device **120** as shown in FIG. **4**, which may provide an image that allows the computing apparatus **140** to determine coordinate locations of each of the electrodes and/or other anatomic fiducial elements or intracardiac catheters. The imaging device **120** may be configured to monitor movement of the one or more

visible electrodes to provide phrenic nerve stimulation information and/or cardiac improvement information (e.g., dyssynchrony information).

FIG. 5B illustrates another exemplary electrode system 111 that includes a plurality of electrodes 112 configured to be located about the torso of the patient and record, or monitor, the electrical signals associated with phrenic nerve stimulation and/or the depolarization and repolarization of the heart after the signals have propagated through the torso of patient. The electrode system 110 may include a vest 114 upon which the plurality of electrodes is attached, or to which they are coupled. In at least one embodiment, the plurality, or array, of electrodes 112 may be used to provide phrenic nerve stimulation information and/or cardiac improvement information (e.g., dyssynchrony information). Similar to the electrode system 110, the electrode system 111 may include interface/amplifier circuitry 113 electrically coupled to each of the electrodes 112 through a wired connection 118 and configured to transmit signals from the electrodes 112 to a computing apparatus 140. As illustrated, the electrodes 112 may be distributed over the torso of patient, including, for example, the anterior, lateral, and posterior surfaces of the torso of patient.

The vest 114 may be formed of fabric, or any other material, with the electrodes 112 attached thereto. The vest 114 may be configured to maintain the position and spacing of electrodes 112 on the torso of the patient. Further, the vest 114 may be marked to assist in determining the location of the electrodes 112 on the surface of the torso of the patient. In some examples, there may be about 25 to about 256 electrodes 112 distributed around the torso of the patient, though other configurations may have more or fewer electrodes 112.

The exemplary systems, apparatus, methods, and/or interfaces described herein are configured to detect phrenic nerve stimulation during pacing therapy for one or more electrical pacing vectors at one or more power configurations and/or identify one or more optimal electrical pacing vectors for delivering cardiac therapy, and the systems including electrodes and computing apparatus described herein with reference to FIGS. 1-5 may utilize the exemplary systems, apparatus, methods, and/or interfaces. More specifically, the exemplary systems, apparatus, methods, and/or interfaces may be used, for example, to determine which electrical vectors (e.g., electrical pacing vectors) defined by one or more electrodes in the systems of FIGS. 1-5 stimulate the patient's phrenic nerve, what power configurations used by the electrical vectors defined by one or more electrodes in the systems of FIGS. 1-5 stimulate the patient's phrenic nerve, and/or which electrical vectors defined by one or more electrodes in the systems of FIGS. 1-5 are optimal for delivering pacing therapy to tissue of the patient.

For example, when the leads 18, 20, 22 of the system 10 of FIGS. 1-3 are located, or implanted, in a patient's heart, a plurality of different electrical vectors for delivering cardiac therapy may be defined by the electrodes 40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66. As such, the exemplary systems, apparatus, methods, and/or interfaces may be used with the system 10 of FIGS. 1-3 to determine which electrodes 40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66 and which electrical vectors defined by the electrodes 40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66 may stimulate the patient's phrenic nerve (e.g., a potentially undesirable effect) and/or may be optimal for delivering electrical therapy to the cardiac tissue of the patient.

An exemplary method 150 for identifying one or more optimal electrical pacing vectors is depicted in FIG. 6. The

method 150 includes delivering pacing therapy 152 using a plurality of electrodes in a plurality of different pacing configurations. The pacing therapy 152 may utilize one or more electrodes such as the electrodes 40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66 of the system 10. For example, each electrode (e.g., as a cathode) may be used individually to deliver pacing therapy (e.g., using the same or a different anode). In other words, one electrode at a time may be used to deliver pacing therapy. Further, for example, more than one electrode (e.g., two electrodes, three electrodes, etc.) may be used simultaneously to deliver pacing therapy (e.g., if none of the electrodes used individually achieves capture, if none of the electrodes used individually provides cardiac improvement (e.g., significant cardiac improvement, sufficient cardiac improvement, etc.), etc.). In other words, more than one electrode at a time may be used to deliver pacing therapy. Additionally, one or more pacing electrodes may deliver electrical pacing therapy at one or more different power configurations. For example, the one or more pacing electrodes may be configured to deliver more than one pacing pulse (e.g., each pacing pulse having a selected pacing width, each pacing pulse separated by a selected separation time period, etc.), deliver pacing pulses at greater voltages, deliver longer pacing pulses (e.g., pacing pulses have a longer time duration or pulse width, etc.), etc. Further, the power configurations of a pacing vector may be re-configured (e.g., the power of the electrical stimulation may be increased by increasing the number of pulses, the width of the pulses, and/or the voltage of the pulses until the pacing vector achieves capture (e.g., trigger depolarization of cardiac tissue)).

In essence, the exemplary method 150 may deliver pacing therapy using a plurality of different pacing configurations (e.g., a plurality of different pacing vectors at a plurality of different power configurations) using the plurality of electrodes. In some embodiments, a common anode may be used for each different pacing configuration. In other embodiments, each different pacing configuration may use a different anode.

For each different pacing configuration, the method 150 may generate cardiac improvement information 154. The cardiac improvement information may be defined as information that is representative of a change in mechanical and/or electrical cardiac functionality resulting from pacing. In other words, the cardiac improvement information may be indicative of improvement of cardiac functionality from baseline cardiac functionality. The baseline cardiac functionality may be cardiac functionality without any pacing therapy being delivered to the patient.

In one or more embodiments, the cardiac improvement information may include dyssynchrony information. Dyssynchrony information may be defined as information indicative of the mechanical and/or electrical dyssynchrony of the heart. In at least one embodiment, the dyssynchrony information may include a standard deviation of ventricular activation times corresponding to electrodes on the surface array. Further, regional dyssynchrony may be also computed from the standard deviation of activation times corresponding to electrodes located in certain anatomic areas of the torso, for e.g. electrodes on the left side of the torso would be used to compute regional LV dyssynchrony. The dyssynchrony information may be generated using one or more various systems and/or methods. Dyssynchrony information may be generated using an array, or a plurality, of surface electrodes and/or imaging systems as described in U.S. Pat. App. Pub. No. 2012/0283587 A1 published Nov. 8, 2012 and entitled "ASSESSING INTRA-CARDIAC ACTIVATION

PATTERNS AND ELECTRICAL DYSSYNCHRONY,” U.S. Pat. App. Pub. No. 2012/0284003 A1 published Nov. 8, 2012 and entitled “ASSESSING INTRA-CARDIAC ACTIVATION PATTERNS”, and U.S. Pat. No. 8,180,428 B2 issued May 15, 2012 and entitled “METHODS AND SYSTEMS FOR USE IN SELECTING CARDIAC PACING SITES,” each of which is incorporated herein by reference in its entirety.

Dyssynchrony information may include one or more dyssynchrony indices. For example, one of the indices of electrical dyssynchrony may be a standard deviation index computed as the standard deviation of the activations-times (SDAT) of some or all of the electrodes on the surface of the torso of patient. In some examples, the SDAT may be calculated using the estimated cardiac activation times over the surface of a model heart.

A second example index of dyssynchrony may be a range of activation times (RAT) which may be computed as the difference between the maximum and the minimum torso-surface or cardiac activation times, e.g., overall, or for a region. The RAT reflects the span of activation times while the SDAT gives an estimate of the dispersion of the activation times from a mean. The SDAT also provides an estimate of the heterogeneity of the activation times, because if activation times are spatially heterogeneous, the individual activation times will be further away from the mean activation time, indicating that one or more regions of heart have been delayed in activation. In some examples, the RAT may be calculated using the estimated cardiac activation times over the surface of a model heart.

A third example index of electrical dyssynchrony estimates the percentage of surface electrodes located within a particular region of interest for the torso or heart, whose associated activation times are greater than a certain percentile, for example the 70th percentile, of measured QRS complex duration or the determined activation times for surface electrodes. The region of interest may be a posterior, left anterior, and/or left-ventricular region, as examples. This index, the percentage of late activation (PLAT), provides an estimate of percentage of the region of interest, e.g., posterior and left-anterior area associated with the left ventricular area of heart, which activates late. A large value for PLAT may imply delayed activation of a substantial portion of the region, e.g., the left ventricle, and the potential benefit of electrical resynchronization through CRT by pre-exciting the late region, e.g., of left ventricle. In other examples, the PLAT may be determined for other subsets of electrodes in other regions, such as a right anterior region to evaluate delayed activation in the right ventricle. Furthermore, in some examples, the PLAT may be calculated using the estimated cardiac activation times over the surface of a model heart for either the whole heart or for a particular region, e.g., left or right ventricle, of the heart.

In one or more embodiments, the cardiac improvement information may include indicators of favorable changes in global cardiac electrical activation such as, e.g., described in Sweeney et al., “Analysis of Ventricular Activation Using Surface Electrocardiography to Predict Left Ventricular Reverse Volumetric Remodeling During Cardiac Resynchronization Therapy,” *Circulation*, 2010 Feb. 9, 121(5): 626-34 and/or Van Deursen, et al., “Vectorcardiography as a Tool for Easy Optimization of Cardiac Resynchronization Therapy in Canine LBBB Hearts,” *Circulation Arrhythmia and Electrophysiology*, 2012 Jun. 1, 5(3): 544-52, each of which is incorporated herein by reference in its entirety. Cardiac improvement information may also include measurements of improved cardiac mechanical function mea-

sured by imaging or other systems to track motion from implanted leads within the heart as, e.g., described in Ryu et al., “Simultaneous Electrical and Mechanical Mapping Using 3D Cardiac Mapping System: Novel Approach for Optimal Cardiac Resynchronization Therapy,” *Journal of Cardiovascular Electrophysiology*, 2010 February, 21(2): 219-22, Sperzel et al., “Intraoperative Characterization of Interventricular Mechanical Dyssynchrony Using Electro-anatomic Mapping System—A Feasibility Study,” *Journal of Interventional Cardiac Electrophysiology*, 2012 November, 35(2): 189-96, and/or U.S. Pat. App. Pub. No. 2009/0099619 A1 entitled “METHOD FOR OPTIMIZING CRT THERAPY” and published on Apr. 16, 2009, each of which is incorporated herein by reference in its entirety.

In one or more embodiments, the cardiac improvement information may be generated by tracking lead motion and inter-electrode distances with fluoroscopy to generate at least one metric (e.g., value(s), functions, comparisons, differences, averages, slopes, etc.) that correlates with cardiac contractility. For example, a contractility curve may be generated based on the variation in distance between the RV and LV electrode-tips during the course of one or more cardiac cycles and one or more metrics relating to fractional shortening may be derived from this curve. In another embodiment, multiple points on intracardiac leads and/or catheter systems may be tracked during course of one or more cardiac cycles to generate metrics relating to contractility or global cardiac mechanical dyssynchrony.

In at least one embodiment, a computing apparatus such as the computing apparatus 140 described herein with reference to FIG. 4 may be used to measure a dyssynchrony index during intrinsic rhythm and during pacing with each electrode to generate cardiac functionality information used to select one or more electrodes to be possibly used in one or more optimal pacing vectors. For example, a physician may place a LV lead in a target location and a user may initiate CRT pacing from the programmer/analyzer. For each of a plurality of CRT pacing configurations, the system may be configured to detect the pacing parameters displayed on the programmer/analyzer screen (e.g., using character recognition from VGA output), and then, the system may measure a dyssynchrony index. The CRT pacing configurations may be automatically, or manually, changed on a programmer/analyzer. Then, the system may classify each of the electrodes, or electrode configurations, as one of “improved,” “neutral,” or “worsened” using the dyssynchrony measurements.

In at least one embodiment, changes in dyssynchrony during CRT pacing may be measured from each LV electrode as the cathode at a common A-V delay (e.g., less than 60 milliseconds from the intrinsic AV time) to, e.g., avoid fusion of the pacing depolarization with the intrinsic depolarization. Further, a common anode may be selected for these preliminary evaluations such as, e.g., a RV coil. Cathode capture can be verified by morphology of a LV cathode to RV coil electrocardiogram.

In at least one embodiment, if poor dyssynchrony is measured, the exemplary method may switch to higher amplitudes to encourage some anodal capture and/or switch to multi-site pacing (e.g., pacing using more than one electrode) to, e.g., see if dyssynchrony improves.

Based on the cardiac improvement information, the method 150 may select one or more electrodes 156. To select the one or more electrodes, the cardiac improvement information may provide one or more numerical metrics or values (e.g., value(s), functions, differences, comparisons, averages, slopes, etc.) that may be compared against each

other and/or one or more threshold values. The electrodes having the best cardiac improvement information and/or metrics or values exceeding selected thresholds may be selected to be used in, or defining, one or more (e.g., one, two or more, a plurality, etc.) different pacing vectors.

For example, dyssynchrony information may include a dyssynchrony improvement value for each electrode. The dyssynchrony improvement value may be generated by monitoring the dyssynchrony of the patient's heart without resynchronization pacing therapy to establish a baseline, monitoring the dyssynchrony of the patient's heart during pacing using each electrode (or electrode configuration), and comparing the baseline dyssynchrony to the dyssynchrony during resynchronization pacing to provide a dyssynchrony improvement value for each electrode (or electrode configuration). In at least one embodiment, the dyssynchrony improvement value for each electrode (or electrode configuration) may be compared to a threshold value and each electrode (or electrode configuration) exceeding the threshold value may be selected.

The dyssynchrony improvement values themselves may assist in defining, or selecting the threshold value. Generally, the threshold may be defined as a decreasing function of the maximal dyssynchrony improvement value (e.g., maximal relative improvement in resynchronization). More specifically, the threshold value may be calculated by multiplying a factor by the maximal, or maximum, dyssynchrony improvement value.

Further, the factor used to calculate the threshold value may be selected based on the maximum generated dyssynchrony improvement value. In at least one embodiment, if a maximal dyssynchrony improvement value, or maximal relative improvement in resynchronization value, is between 0% and 5%, then the factor may be set of 0.9. If the maximal dyssynchrony improvement value is between 5% and 10%, then the factor may be set to 0.8. If the maximal dyssynchrony improvement value is between 10% and 25%, then the factor may be set to 0.75. If the maximal dyssynchrony improvement value is above 25%, then the factor may be set to 0.7. A threshold for a maximal dyssynchrony improvement value means that all electrodes with a resynchronization efficacy greater than the threshold multiplied by the maximal dyssynchrony improvement value should be selected (e.g., selected to be possibly used in one or more optimal pacing vectors).

The one or more electrodes selected based on the cardiac improvement information **156** may define, or be used to form, one or more electrical vectors configured to deliver therapy to the patient's heart. For example, if a first left ventricular electrode and a second left ventricular electrode are selected based on the cardiac improvement information, one or more electrical vectors may be defined between the first left ventricular electrode and one or all of the remaining electrodes and one or more electrical vectors may be defined between the second left ventricular electrode and one or all of the remaining electrodes.

In other words, the selection of one or more electrodes based on the cardiac improvement information **156** may provide one or more electrical vectors that may be used to deliver therapy. To determine whether the one or more electrical vectors are optimal, the method **150** may take into consideration information such as longevity information for each electrical vector **158**, phrenic nerve stimulation information such as described herein with respect to FIGS. **14-19**, etc.

For example, generated longevity information **158** may include an energy expenditure value for each electrical

vector, which can be determined based on a capture threshold for each electrical vector, an impedance value for each electrical vector, a pulse width for each electrical vector (e.g., required for capture), information regarding each pacing pulse for multi-site pacing configurations, etc. Energy expenditure may be expressed in actual or relative estimated energy usage or actual or relative predicted battery longevity when an IMD operates using a particular parameter selection.

One or more processes and/or methods disclosed in U.S. Pat. App. Pub. No. 2012/0101543 A1 filed on Oct. 21, 2010 and entitled "CAPTURE THRESHOLD MEASUREMENT FOR SELECTION OF PACING VECTOR," U.S. Pat. App. Pub. No. 2012/0101546 A1 filed on Jul. 29, 2011 and entitled "METHOD AND APPARATUS TO DETERMINE THE RELATIVE ENERGY EXPENDITURE FOR A PLURALITY OF PACING VECTORS," U.S. Pat. App. Pub. No. 2013/0030491 A1 filed on Jul. 28, 2011 and entitled "METHOD FOR DISCRIMINATING ANODAL AND CATHODAL CAPTURE," and U.S. patent application Ser. No. 13/790,683 filed on Mar. 8, 2013 and entitled "CAPTURE THRESHOLD MEASUREMENT FOR SELECTION OF PACING VECTOR" (issued as U.S. Pat. No. 8,781,584), each of which is incorporated herein by reference in their entirety, may be implemented to provide cardiac improvement information such as longevity information, capture thresholds, impedance, etc. for one or more selected electrical vectors.

After longevity information has been generated for each electrical vector **158**, the method **150** may identify one or more optimal electrical vectors based on the longevity information **160**. For example, the method **150** may identify the optimal electrical vectors and automatically configure the pacing system to use the optimal electrical vectors for pacing. Further, for example, the method **150** may generate a graphical user interface **132** depicting each of the selected electrical vectors and their associated longevity information, e.g., as shown in FIG. **11**. Further, the method **150** may identify the selected electrical vectors having optimal longevity information on the graphical user interface **132**, e.g., by highlighting, circles, arrows, etc. (e.g., as shown in FIG. **9**).

In one or more embodiments, the method **150** may identify the most optimal electrical vector, e.g., by identifying the electrical vector having one or more of the greatest longevity, lowest capture threshold, smallest impedance, etc.

Additionally, whether the one or more selected electrical vectors stimulate the phrenic nerve may be used to identify the one or more optimal electrical vectors. For example, the method **150** may include determining whether each electrical vector stimulates the phrenic nerve and identifying the optimal electrical vector of the plurality of electrical vectors based on an absence of phrenic nerve stimulation.

After the method **150** has identified one or more optimal electrical vectors based on the longevity information **160**, the method **150** may further **162** allow a user (e.g., physician) to navigate, or locate, one or more electrodes **162** (e.g., implantable electrodes on one or more leads, wireless/leadless electrodes, etc.) to one or more regions proximate a patient's heart to provide pacing therapy, e.g., using the one or more identified optimal electrical vectors **160**. For example, a graphical user interface **132**, such as shown in FIG. **11** described further herein, may include a graphical depiction and/or actual imaging (e.g., using imaging apparatus **120** of FIG. **4**) of a patient's heart in conjunction with the identified one or more optimal pacing vectors. Using the graphical user interface **132**, a user may navigate, or locate,

the one or more electrodes in the desired locations based on the identified optimal electrical vectors **160**.

Exemplary systems, methods, apparatus, and interfaces for electrode location selection and implantation may be described in U.S. patent application Ser. No. 13/916,353 filed on Jun. 12, 2013 and entitled “Implantable Electrode Location Selection,” (published as U.S. Pat. App. Pub. No. 2014/0371832 A1 on Dec. 18, 2014); U.S. patent application Ser. No. 13/916,377 filed on Jun. 12, 2013 and entitled “Implantable Electrode Location Selection,” (published as U.S. Pat. App. Pub. No. 2014/0371833 A1 on Dec. 18, 2014); U.S. Provisional Patent Application No. 61/817,483 filed on Apr. 30, 2013 and entitled “Identifying Effective Electrodes,” and U.S. Provisional Patent Application No. 61/913,795 filed on Dec. 9, 2013 and entitled “Systems, Methods, and Interfaces for Identifying Effective Electrodes,” each of which is incorporated herein by reference in its entirety.

Exemplary graphical user interfaces **132** including displays and tables used and/or generated by the exemplary methods and/or systems described herein for identifying one or more optimal electrical vectors are shown in FIGS. 7-11. As shown in FIG. 7, cardiac improvement information has been generated for four different left ventricular electrodes (LV1, LV2, LV3, LV4). Since the maximal improvement is 5% in this example, the factor for generating the threshold value may be set to 0.9 so all electrodes with relative improvement greater than or equal to 0.9 multiplied by 5% (i.e., the maximal improvement) may be considered equivalent/effective, and thus, may be considered as the cathode for optimal vector selection. In this example, only LV1 has a relative improvement greater than or equal to 4.5. For lower relative improvements (e.g., 0% to 5%) as depicted in FIG. 6, the factor for generating the threshold for equivalence should be high (e.g., 0.9).

As shown in the exemplary graphical user interface **132** of FIG. 8, cardiac improvement information has been again generated for four different left ventricular electrodes (LV1, LV2, LV3, LV4). Since maximal improvement is 40%, the factor for generating the threshold may be set to 0.7 so all electrodes with relative improvement greater than or equal to 0.7 multiplied by 40% (i.e., the maximal improvement) may be considered equivalent/effective, and thus, may be considered as the cathode for optimal vector selection. In this exemplary, two electrodes, LV2 and LV3, have a relative improvement greater than or equal to 28%. For larger improvements (e.g., greater than 28%) as depicted in FIG. 7, the factor for generating the threshold for equivalence can be more relaxed (e.g., 0.7).

Longevity information may be generated for all possible vectors with the selected electrodes, LV2 and LV3, of FIG. 7 as cathodes, and may be presented in the exemplary graphical interface **132** depicting a table as shown in FIG. 9. As shown, vectors LV2-LV3 and LV2-LV4 are indicated as having maximum relative longevity. Additionally, phrenic nerve stimulation information is depicted in the table of FIG. 9.

Vector LV2-LV3 may be determined as being the most optimal vector based on the longevity information and the phrenic nerve stimulation information (e.g., such as phrenic nerve stimulation being absent). As shown in FIG. 9, an indication **172** (i.e., an oval) may be depicted on a graphical user interface used to select electrical vectors to indicate the most optimal electrical vector.

Although not shown, all vectors corresponding to the chosen LV cathodes and which do not have associated phrenic nerve stimulation may be sorted in descending order

of longevity (e.g., max longevity at the top) to make the selection convenient. In this example, the system may automatically select or the implanter or physician may select LV2-LV3 as the pacing vector to be used for pacing therapy.

An exemplary graphical user interface **132** depicting a table of longevity information, phrenic nerve stimulation information, and cardiac improvement information for a plurality of electrical vectors is shown in FIG. 10. In this example, the cardiac improvement information is displayed simultaneously with the longevity information and phrenic nerve stimulation information. As shown, the LV3-LV4 vector may be identified as being the most optimal electrical vector because, e.g., electrode LV3 provided a change in dyssynchrony index of -10% (e.g., an improvement of 10%) and the relative longevity has been determined to be 9 months less than a maximum longevity. Although the dyssynchrony index is indicated as a negative value (i.e., -10%) when indicating an improvement and a positive value when indicating a worsened condition, it to be understood that the dyssynchrony index may be indicated as positive value when indicating an improvement and a negative value when indicating a worsened condition.

An exemplary graphical user interface **132** including a graphical representation of a pair of leads, a LV lead and a RV lead, is depicted in FIG. 11, which define the electrode vectors shown and described with respect to FIG. 10. Although not shown, the graphical user interface of FIG. 11 may further include the table of FIG. 10, e.g., to display information to a physician, to allow a physician to select one or more optimal vectors, to identify the one or more optimal vectors graphically, etc. As shown, cardiac improvement information and longevity information are depicted proximate the electrical vectors defined by the electrodes of the leads.

Generally, any factor (e.g., cardiac improvement information, longevity information, phrenic nerve stimulation information, etc.) alone or in combination may be used to identify one or more optimal electrical vectors. For example, dyssynchrony information may be used in combination with phrenic nerve stimulation information, dyssynchrony information may be used in combination with longevity information, longevity information may be used alone, dyssynchrony information may be used alone, phrenic nerve stimulation may be used alone, etc.

The graphical user interfaces **132** described herein with reference to FIGS. 7-11 may be provided to users such as physicians to assist them in determining which of the electrical vectors to use for pacing therapy (e.g., such as before implantation of pacing electrodes, during implantation of pacing electrodes, or in follow-up visits after implantation of pacing electrodes) and/or navigating one or more electrodes (e.g., implantable electrodes on one or more leads) to one or more regions of a patient's heart to perform pacing at one or more electrical vectors.

An exemplary graphical user interface **132** including blood vessel anatomy **134** of a patient's heart is shown in FIG. 12 that may be used by a user to navigate an implantable electrode to a region of the patient's heart. The blood vessel anatomy as well as other data such as mechanical motion information, etc. of the heart may be captured using the imaging apparatus **120** described herein, which may be configured to image at least a portion of blood vessel anatomy of the patient's heart and provide image data used by the computing apparatus **140** to provide mechanical motion information or data. The data or information depicted on the blood vessel anatomy of the patient's heart

in FIG. 12 may be further monitored, or gathered, using the electrode apparatus 110 described herein.

A user may view and/or use the graphical user interface 132 of FIG. 12 to determine, or identify, one or more candidate site regions of the displayed portion or region of the patient's heart for implantation of implantable electrodes. For example, a user may view mechanical motion information, e.g., grey-scaling or color-coding applied to the blood vessel anatomy in FIG. 12, and identify a candidate site region of the patient's heart based on the mechanical motion information. For example, a user may identify one or more regions having, e.g., mechanical motion times greater than a threshold, having the longest mechanical motion time, etc.

Another exemplary graphical user interface 132 including a graphical depiction of a patient's heart 12 is shown in FIG. 13 that may be used by a user to navigate an implantable electrode to a region of the patient's heart. More specifically, a posterior side of a human heart 12 is depicted in the graphical user interface 132 of FIG. 13 with surrogate electrical activation times 136 color-coded, or gray-scaled, across the surface of the heart 12. As used herein, surrogate electrical activation data (e.g., surrogate electrical activation times, surrogate electrical activation time maps, etc.) may be defined as data representative of actual, or local, electrical activation data of one or more regions of the patient's heart. For example, electrical signals measured at the left anterior surface location of a patient's torso may be representative, or surrogates, of electrical signals of the left anterior left ventricle region of the patient's heart, electrical signals measured at the left lateral surface location of a patient's torso may be representative, or surrogates, of electrical signals of the left lateral left ventricle region of the patient's heart, electrical signals measured at the left posterolateral surface location of a patient's torso may be representative, or surrogates, of electrical signals of the posterolateral left ventricle region of the patient's heart, and electrical signals measured at the posterior surface location of a patient's torso may be representative, or surrogates, of electrical signals of the posterior left ventricle region of the patient's heart.

As shown, the posterolateral left ventricle region shows late activation (e.g., about 150 milliseconds). In other embodiments, both a posterior and anterior side of a human heart may be graphically depicted and overlaid with electrical activation information. The data or information depicted on the patient's heart 12 in FIG. 13 may be further monitored, or gathered, using the electrode apparatus 110 described herein.

As described herein, the exemplary systems, methods, and interfaces may provide phrenic nerve stimulation information for one or more electrical pacing vectors at one or more power configurations. An exemplary method 200 for detecting phrenic nerve stimulation during pacing therapy is depicted in FIG. 14. The method 200 includes delivering pacing therapy using one or more electrical pacing vectors at one or more power configurations 202. As shown in FIG. 14, process 202 is written as delivering pacing therapy using nth electrical vector at mth power configuration, where n and m may each represent one or more or a plurality. For example, each of n electrical pacing vectors at m different power configurations may be used in process 202 to deliver pacing therapy. In one or more embodiments, the pacing therapy may be delivered at a short atrioventricular delay such as, e.g., less than or equal to about 50 milliseconds, to avoid interference of pacing with intrinsic electrical conduction (e.g., if the patient has intrinsic atrio-ventricular electrical conduction).

Each electrical pacing vector may utilize one or more electrodes such as the electrodes 40, 42, 44, 45, 46, 47, 48, 50, 58, 62, 64, 66 of the system 10. For example, each electrode may be used individually to deliver pacing therapy. In other words, one electrode at a time may be used to deliver pacing therapy. Further, for example, more than one electrode (e.g., two electrodes, three electrodes, etc.) may be used simultaneously to deliver pacing therapy if, e.g., none of the electrodes used individually achieves capture, if none of the electrodes used individually provides cardiac improvement (e.g., significant cardiac improvement, sufficient cardiac improvement, etc.), etc. In other words, more than one electrode at a time may be used to deliver pacing therapy. Additionally, one or more pacing electrodes may deliver electrical pacing therapy at one or more different power configurations. For example, the one or more pacing electrodes may be configured to deliver more than one pacing pulse (e.g., each pacing pulse having a selected pacing width, each pacing pulse separated by a selected separation time period, etc.), deliver pacing pulses at greater voltages, deliver longer pacing pulses (e.g., pacing pulses have a longer time duration or pulse width, etc.), etc. Further, the power configurations of a pacing vector may be re-configured (e.g., the power of the electrical stimulation may be increased by increasing the number of pulses, the width of the pulses, and/or the voltage of the pulses) until the pacing vector achieves capture (e.g., trigger depolarization of cardiac tissue).

For each different electrical pacing vector and power configuration, the method 200 may monitor electrical activity of the patient (e.g., surface potentials, depolarizations, repolarizations, etc.) using external electrodes 204 such as the external electrodes of electrode apparatus 110, 112. The method 200 may include monitoring electrical activity of the patient 204 using one or more external electrodes, a set of external electrodes proximate a selected location of the torso of the patient, and/or all of the external electrodes. In at least one embodiment, the method 200 may monitor the electrical activity of the patient 204 using a set of electrodes located proximate the lower, anterior side of the torso of the patient.

The method 200 may further monitor a selected, or predetermined, portion, or time window, of the electrical activity of the patient using external electrodes 204. For example, the method 200 may monitor electrical signals using the external electrodes 204 for a time period after the delivery of pacing therapy (e.g., one or more pacing pulses used to depolarize cardiac tissue) that is greater than or equal to about 5 milliseconds (ms), greater than or equal to about 7 ms, greater than or equal to about 10 ms, greater than or equal to about 12 ms, greater than or equal to about 15 ms, greater than or equal to about 20 ms, greater than or equal to about 30 ms, greater than or equal to about 50 ms, greater than or equal to about 75 ms, etc. Further, for example, the method 200 may monitor electrical signals using the external electrodes 204 for a time period after the delivery of pacing therapy (e.g., one or more pacing pulses to depolarize cardiac tissue) that is less than or equal to about 500 ms, less than or equal to about 300 ms, less than or equal to about 250 ms, less than or equal to about 200 ms, less than or equal to about 150 ms, less than or equal to about 100 ms, less than or equal to about 80 ms, less than or equal to about 60 ms, less than or equal to about 50 ms, less than or equal to about 40 ms, less than or equal to about 35 ms, less than or equal to about 30 ms, etc. The electrical activity monitored for a time period after the delivery of pacing therapy may be described as a "window" of the electrical activity of the patient.

Additionally, the exemplary method **200** may monitor electrical signals using the external electrodes **204** for multiple time windows over a plurality of cardiac cycles. One or more statistical operations (e.g., averaging, etc.) may be performed on the plurality of time-windowed signals to provide a composite signal.

The delivering of pacing therapy **202** and the monitoring of electrical signals **204** for use in phrenic nerve stimulation detection may be performed while the patient is in a resting position or posture such as, e.g., supine, lying on right side, lying on left side, sitting, standing up, etc.

The method **200** may then determine whether the patient's phrenic nerve has been stimulated **206** by the pacing therapy based on the monitored electrical activity. For example, the amplitude of the monitored electrical activity may be greater when the patient's phrenic nerve is stimulated by pacing therapy than when the patient's phrenic nerve is not stimulated by pacing therapy.

A graph of electrical signals monitored over time by multiple external electrodes coupled to a patient that is not undergoing phrenic nerve stimulation is shown in FIG. **15**. Each line represents the electrical activity for a different external electrode after the delivery of pacing therapy. As shown, most of the electrical activity does not exceed 10 millivolts (mV), which may indicate that patient's phrenic nerve is not stimulated.

A graph of electrical signals monitored over time by multiple external electrodes coupled to a patient that is undergoing phrenic nerve stimulation is shown in FIG. **16**. Each line represents the electrical activity for a different external electrode after the delivery of pacing therapy. As shown, a portion of the electrical activity does exceed 10 millivolts (mV), which may indicate that patient's phrenic nerve is stimulated. More specifically, 10 lines representing electrical activity monitored by different electrodes exceed 10 mV.

To determine whether the patient's phrenic nerve has been stimulated **206** by the pacing therapy based on the monitored electrical activity, the method **200** may use one or more mathematical and/or statistical techniques and processes such as, e.g., comparisons, averages, thresholds, baseline values, proportions, ratios, normalization processes, etc. For example, in one embodiment, the method **200** may determine whether the patient's phrenic nerve is stimulated by the pacing therapy by comparing a maximum peak-to-peak amplitude of the monitored electrical activity to a threshold value. If the maximum peak-to-peak amplitude of the electrical activity monitored by an external electrode is greater than the threshold value, then the electrical activity monitored by that external electrode may indicate that the patient's phrenic nerve has been stimulated by the pacing therapy.

The threshold value may be greater than or equal to about 5 mV, greater than or equal to about 7 mV, greater than or equal to about 10 mV, greater than or equal to about 15 mV, greater than or equal to about 20 mV, greater than or equal to about 25 mV, greater than or equal to about 30 mV, greater than or equal to about 35 mV, greater than or equal to about 40 mV, greater than or equal to about 50 mV, etc. Further, the threshold value may be less than or equal to about 100 mV, less than or equal to about 80 mV, less than or equal to about 60 mV, less than or equal to about 50 mV, less than or equal to about 40 mV, less than or equal to about 30 mV, less than or equal to about 25 mV, less than or equal to about 15 mV, etc.

Further, the threshold value may be normalized to the monitored electrical activity. For example, the threshold

value may be a multiple of a baseline value (e.g., twice the baseline value, three times the baseline value, four times the baseline value, five times the baseline value, etc.). The baseline value may be established using one or more processes or techniques. For example, baseline electrical value may be established by monitoring electrical activity during atrial-only pacing (e.g., so as to avoid inadvertently stimulating the phrenic nerve) or during intrinsic rhythm. Further, for example, a baseline electrical value may be established by monitoring electrical activity using external electrodes located on the posterior side of the patient's torso.

The determination of whether the patient's phrenic nerve has been stimulated **206** by the pacing therapy may utilize each of a plurality of electrical signals monitored by a plurality of external electrodes to, e.g., avoid outliers, artifacts, errors, electrode contact issues, etc. For example, a plurality of electrical signals may be monitored by a plurality of external electrodes, and the method **200** may determine that the patient's phrenic nerve has been stimulated **206** by the pacing therapy if a selected percentage, or proportion, of the plurality of electrical signals exceeds a threshold value. The selected percentage may be greater than or equal to about 20%, greater than or equal to about 25%, greater than or equal to about 30%, greater than or equal to about 35%, greater than or equal to about 40%, greater than or equal to about 50%, greater than or equal to about 60%, greater than or equal to about 70%, greater than or equal to about 75%, greater than or equal to about 80%, greater than or equal to about 85%, etc., and/or less than or equal to about 90%, less than or equal to about 80%, less than or equal to about 70%, less than or equal to about 60%, less than or equal to about 55%, less than or equal to about 50%, less than or equal to about 45%, less than or equal to about 40%, less than or equal to about 35%, etc.

Additionally, as described herein, only a portion of external electrodes of a plurality of external electrodes (e.g., on a vest as shown in FIG. **5B**) may be used to monitor electrical activity for use in determining whether the patient's phrenic nerve has been stimulated. For example, only the external electrodes located on the anterior side of the torso of the patient may be used to determine whether the patient's phrenic nerve has been stimulated. Further, for example, only a selected set of the external electrodes located on the anterior side of the torso of the patient may be used to determine whether the patient's phrenic nerve has been stimulated. Further, for example, only a set of the external electrodes located on the lower, anterior side of the torso of the patient may be used to determine whether the patient's phrenic nerve has been stimulated.

After the method **200** has determined whether the patient's phrenic nerve has been stimulated **206** for a particular electrical pacing vector and power configuration, the method **200** may loop back to the beginning to deliver pacing therapy **202** if more power configurations of m power configurations have not been tested for the electrical pacing vector or if more electrical pacing vectors of n electrical pacing vectors have not been tested **208**. The method **200** may continue until each electrical pacing vector n and power configuration m has been tested for phrenic nerve stimulation.

The method **200** may further include displaying phrenic nerve stimulation information **210** with respect to the electrical pacing vectors and power configurations tested for phrenic nerve stimulation. For example, as shown in the graphical user interface **132** of FIG. **9**, an indication of either "Absent" or "Present" for phrenic nerve stimulation is displayed for each electrical pacing vector, which may assist

a user in configuring, evaluating, and/or selecting an electrical pacing vector for delivery of pacing therapy to the patient. In one or more embodiments, an indication 172 may also be displayed indicating the optimal electrical pacing vector. As shown, the indicated optical pacing vector is indicated as not stimulating the patient's phrenic nerve. Further, further example, as shown in the graphical user interface 132 of FIG. 10, an indication of either "Yes," "No," or "Not Tested" for phrenic nerve stimulation is displayed for each electrical pacing vector. In at least one embodiment, an additional category may be displayed on the graphical user interface 13 that indicates that while PNS may exist for a particular electrical pacing vector, the PNS exists at a power configuration/level that is considerably higher than would be used clinically.

Additionally, the phrenic nerve stimulation information may include each power configuration for each electrical pacing vector such that, e.g., a user may be able to see, or read, phrenic nerve stimulation information for each of the power configurations. In another example, only the lowest power configuration for each electrical vector that exhibits phrenic nerve stimulation may be included in the phrenic nerve stimulation information.

Graphical representations of electrical activity monitored on a patient using three different electrical pacing vectors, or pacing sites (e.g., AIV mid, AIV basal, mid-lateral basal), are shown in FIG. 17. Specifically, the maximum peak-to-peak amplitudes of the electrical activity monitored by the electrodes on the anterior and posterior sides of the patient's torso are color coded spatially about graphical representations of the patient's anterior and posterior torso. As depicted, none, or not a significant portion, of the electrical activity monitored on the anterior side of the patient's torso during pacing therapy for each of these three electrical pacing vectors exceeds a threshold value of 20 mV. Thus, the electrical activity depicted in FIG. 17 does not indicate phrenic nerve stimulation for any of the three different electrical pacing vectors.

Graphical representations of electrical activity monitored on a patient using two different electrical pacing vectors, or pacing sites (e.g., postero-lateral apical, postero-lateral mid), are shown in FIG. 18. Specifically, the maximum peak-to-peak amplitudes of the electrical activity monitored by the electrodes on the anterior and posterior sides of the patient's torso are color coded spatially about graphical representations of the patient's anterior and posterior torso. As depicted, a significant portion of the electrical activity monitored on the anterior side of the patient's torso during pacing therapy for each of these two electrical pacing vectors exceeds a threshold value of 20 mV. Thus, the electrical activity depicted in FIG. 18 does indicate phrenic nerve stimulation for each of the two different electrical pacing vectors.

As described herein, the electrical activity monitored by external electrodes for use in determining whether the patient's phrenic nerve is stimulated by pacing therapy may be normalized. Graphical representations of electrical activity monitored on a patient using two different biventricular electrical pacing vectors, or pacing sites (e.g., Site 1, Site 2), are shown in FIG. 19. The electrical activity has been normalized to a scale of 1-5. In this case, the normalization is performed by dividing the peak-to-peak amplitude of the windowed depolarization complex at each electrode with the minimum peak-to-peak amplitude among all electrodes. As depicted, a significant portion of the electrical activity monitored on the anterior side of the patient's torso during pacing therapy for Site 1 meets or exceeds a normalized

threshold value of 5, and thus, the electrical activity monitored for Site 1 indicates phrenic nerve stimulation. As depicted, none, or not a significant portion, of the electrical activity monitored on the anterior side of the patient's torso during pacing therapy for Site 2 exceeds a normalized threshold value of 5, and thus, the electrical activity monitored for Site 2 does not indicate phrenic nerve stimulation.

The techniques described in this disclosure, including those attributed to the IMD 16, the programmer 24, the computing apparatus 140, and/or various constituent components, may be implemented, at least in part, in hardware, software, firmware, or any combination thereof. For example, various aspects of the techniques may be implemented within one or more processors, including one or more microprocessors, DSPs, ASICs, FPGAs, or any other equivalent integrated or discrete logic circuitry, as well as any combinations of such components, embodied in programmers, such as physician or patient programmers, stimulators, image processing devices, or other devices. The term "module," "processor," or "processing circuitry" may generally refer to any of the foregoing logic circuitry, alone or in combination with other logic circuitry, or any other equivalent circuitry.

Such hardware, software, and/or firmware may be implemented within the same device or within separate devices to support the various operations and functions described in this disclosure. In addition, any of the described units, modules, or components may be implemented together or separately as discrete but interoperable logic devices. Depiction of different features as modules or units is intended to highlight different functional aspects and does not necessarily imply that such modules or units must be realized by separate hardware or software components. Rather, functionality associated with one or more modules or units may be performed by separate hardware or software components, or integrated within common or separate hardware or software components.

When implemented in software, the functionality ascribed to the systems, devices and techniques described in this disclosure may be embodied as instructions on a computer-readable medium such as RAM, ROM, NVRAM, EEPROM, FLASH memory, magnetic data storage media, optical data storage media, or the like. The instructions may be executed by one or more processors to support one or more aspects of the functionality described in this disclosure.

This disclosure has been provided with reference to illustrative embodiments and is not meant to be construed in a limiting sense. As described previously, one skilled in the art will recognize that other various illustrative applications may use the techniques as described herein to take advantage of the beneficial characteristics of the apparatus and methods described herein. Various modifications of the illustrative embodiments, as well as additional embodiments of the disclosure, will be apparent upon reference to this description.

What is claimed:

1. A non-invasive system for detecting phrenic nerve stimulation during pacing therapy comprising:
 - external electrode apparatus comprising a plurality of external electrodes configured to be located proximate tissue of a patient; and
 - computing apparatus coupled to the external electrode apparatus and configured to:
 - monitor electrical activity using two or more external electrodes of the plurality of external electrodes during delivery of pacing therapy, wherein such

monitoring results in two or more electrical signals measured using the two or more external electrodes indicative of whether or not phrenic nerve stimulation occurred as a result of the pacing therapy delivered, and

determine whether the patient's phrenic nerve is stimulated by the pacing therapy based on the monitored electrical activity, wherein determination of whether the patient's phrenic nerve is stimulated comprises comparison of each of the electrical signals measured using the two or more external electrodes or a value determined from the electrical signals measured using the two or more external electrodes to a phrenic nerve stimulation threshold.

2. The system of claim 1, wherein the two or more external electrodes of the plurality of external electrodes are configured to be located on the anterior torso of the patient.

3. The system of claim 1, wherein the external electrode apparatus comprises one of a band and a vest configured to be worn about the torso of the patient, wherein the plurality of external electrodes are coupled to the band or vest.

4. The system of claim 1, wherein monitoring electrical activity using two or more external electrodes of the plurality of external electrodes during delivery of pacing therapy comprises monitoring electrical activity using two or more external electrodes of the plurality of external electrodes for a selected time period after delivery of a pacing pulse.

5. The system of claim 1, wherein determining whether the patient's phrenic nerve is stimulated by the pacing therapy comprises comparing a maximum peak-to-peak amplitude of the monitored electrical activity to a threshold value.

6. The system of claim 5, wherein the threshold value is based on baseline measurements monitored using one or more external electrodes of the plurality of external electrodes during one of intrinsic rhythm and atrial pacing, wherein the threshold value is greater than or equal to 3 times a baseline value based on the baseline measurements.

7. The system of claim 1, wherein determining whether the patient's phrenic nerve is stimulated by the pacing therapy comprises determining that the patient's phrenic nerve is stimulated if the monitored electrical activity from a selected percentage of the two or more external electrodes used to monitor electrical activity during delivery of pacing therapy is indicative of phrenic nerve stimulation.

8. A non-invasive method for detecting phrenic nerve stimulation during pacing therapy comprising:

monitoring electrical activity using two or more external electrodes of a plurality of external electrodes during delivery of pacing therapy, wherein the plurality of external electrodes located proximate tissue of the patient, and further wherein such monitoring results in two or more electrical signals measured using the two or more external electrodes indicative of whether or not phrenic nerve stimulation occurred as a result of the pacing therapy delivered; and

determining whether the patient's phrenic nerve is stimulated by the pacing therapy based on the monitored electrical activity, wherein determining whether the patient's phrenic nerve is stimulated by the pacing therapy based on the monitored electrical activity comprises comparing each of the electrical signals measured using the two or more external electrodes or a value determined from the electrical signals measured using the two or more external electrodes to a phrenic nerve stimulation threshold.

9. The method of claim 8, wherein the two or more external electrodes of the plurality of external electrodes are configured to be located on the anterior torso of the patient.

10. The method of claim 8, wherein monitoring electrical activity using two or more external electrodes of the plurality of external electrodes during delivery of pacing therapy comprises monitoring electrical activity using two or more external electrodes of the plurality of external electrodes for a selected time period after delivery of a pacing pulse.

11. The method of claim 8, wherein determining whether the patient's phrenic nerve is stimulated by the pacing therapy comprises comparing a maximum peak-to-peak amplitude of the monitored electrical activity to a threshold value.

12. The method of claim 11, wherein the threshold value is based on baseline measurements monitored using one or more external electrodes of the plurality of external electrodes during one of intrinsic rhythm and atrial pacing, wherein the threshold value is greater than or equal to 3 times a baseline value based on the baseline measurements.

13. The method of claim 8, wherein determining whether the patient's phrenic nerve is stimulated by the pacing therapy comprises determining that the patient's phrenic nerve is stimulated if the monitored electrical activity from a selected percentage of the two or more external electrodes used to monitor electrical activity during delivery of pacing therapy is indicative of phrenic nerve stimulation.

14. A non-invasive system for detecting phrenic nerve stimulation during pacing therapy comprising:

electrode means for monitoring electrical activity of a patient during delivery of pacing therapy, wherein the electrode means comprises two or more external electrodes configured to be located on the anterior torso of the patient; and

computing means for determining whether the patient's phrenic nerve is stimulated by the pacing therapy based on monitored electrical activity, wherein the electrode means for monitoring electrical activity using the two or more external electrodes results in two or more electrical signals measured using the two or more external electrodes indicative of whether or not phrenic nerve stimulation occurred as a result of the pacing therapy delivered, and wherein the computing means comprises means for determining whether the patient's phrenic nerve is stimulated by the pacing therapy based on the monitored electrical activity, wherein the means for determining whether the patient's phrenic nerve is stimulated comprises means for comparing each of the electrical signals measured using the two or more external electrodes or a value determined from the electrical signals measured using the two or more external electrodes to a phrenic nerve stimulation threshold.

15. A non-invasive system for use in detecting phrenic nerve stimulation during pacing therapy using one or more pacing electrodes of a plurality of pacing electrodes defining one or more of electrical pacing vectors, the system comprising:

external electrode apparatus comprising a plurality of external electrodes configured to be located proximate tissue of a patient;

display apparatus comprising a graphical user interface, wherein the graphical user interface is configured to present information for use in assisting a user in at least one of evaluating pacing therapy and configuring pacing therapy; and

computing apparatus coupled to the external electrode apparatus and display apparatus and configured to: monitor electrical activity using two or more external electrodes of the plurality of external electrodes during delivery of pacing therapy using each electrical pacing vector of one or more electrical pacing vectors, wherein such monitoring results in two or more electrical signals measured using the two or more external electrodes indicative of whether or not phrenic nerve stimulation occurred as a result of the pacing therapy delivered,

determine whether the patient's phrenic nerve is stimulated by the pacing therapy delivered using each electrical pacing vector of the one or more electrical pacing vectors based on the monitored electrical activity, wherein determination of whether the patient's phrenic nerve is stimulated comprises comparison of each of the electrical signals measured using the two or more external electrodes or a value determined from the electrical signals measured using the two or more external electrodes to a phrenic nerve stimulation threshold, and

display, on the graphical user interface, phrenic nerve stimulation information for the one or more electrical pacing vectors for use in assisting a user in at least one of evaluating pacing therapy and configuring pacing therapy.

16. The system of claim 15, wherein the two or more electrodes of the plurality of external electrodes are configured to be located on the anterior torso of the patient.

17. The system of claim 15, wherein the external electrode apparatus comprises one of a band and a vest configured to be worn about the torso of the patient, wherein the plurality of external electrodes are coupled to the band or vest.

18. The system of claim 15, wherein monitoring electrical activity using two or more external electrodes of the plurality of external electrodes during delivery of pacing therapy comprises monitoring electrical activity using two or more external electrodes of the plurality of external electrodes for a selected time period after delivery of a pacing pulse.

19. The system of claim 15, wherein determining whether the patient's phrenic nerve is stimulated by the pacing therapy comprises comparing a maximum peak-to-peak amplitude of the monitored electrical activity to a threshold value.

20. The system of claim 15, wherein determining whether the patient's phrenic nerve is stimulated by the pacing therapy comprises determining that the patient's phrenic nerve is stimulated if the monitored electrical activity from a selected percentage of the two or more external electrodes used to monitor electrical activity during delivery of pacing therapy is indicative of phrenic nerve stimulation.

21. The system of claim 15, wherein the computing apparatus is further configured to display, on the graphical user interface, phrenic nerve stimulation information for the

one or more electrical pacing vectors proximate a graphical depiction of at least a portion of anatomy of the patient's heart.

22. The system of claim 15, wherein the delivery of pacing therapy using each electrical pacing vector of one or more electrical pacing vectors comprises delivery of pacing therapy using each electrical pacing vector configured in each power configuration of a plurality of different power configurations, wherein the computing apparatus is further configured to display, on the graphical user interface, power configuration information for at least each electrical pacing vector of the one or more electrical pacing vectors that is determined to stimulate the patient's phrenic nerve.

23. A non-invasive system for detecting phrenic nerve stimulation during pacing therapy comprising:

at least one implantable electrode;

external electrode apparatus comprising a plurality of external electrodes configured to be located proximate tissue of a patient; and

computing apparatus coupled to the external electrode apparatus and configured to:

control delivery of pacing therapy using the at least one implantable electrode,

monitor electrical activity using two or more external electrodes of the plurality of external electrodes during delivery of pacing therapy using the at least one implantable electrode, wherein such monitoring results in two or more electrical signals measured using the two or more external electrodes indicative of whether or not phrenic nerve stimulation occurred as a result of the pacing therapy delivered, and

determine whether the patient's phrenic nerve is stimulated by the delivered pacing therapy based on the two or more electrical signals measured using the two or more external electrodes, wherein the determination of whether the patient's phrenic nerve is stimulated comprises comparing the two or more electrical signals measured using the two or more external electrodes or a value determined from the two or more electrical signals measured using the two or more external electrodes to a phrenic nerve stimulation threshold.

24. The system of claim 23, wherein determining whether the patient's phrenic nerve is stimulated by the delivered pacing therapy comprises comparing a maximum peak-to-peak amplitude of the monitored electrical activity to a threshold value.

25. The system of claim 24, wherein determining whether the patient's phrenic nerve is stimulated by the delivered pacing therapy comprises determining that the patient's phrenic nerve is stimulated if the monitored electrical activity from a selected percentage of the two or more external electrodes used to monitor electrical activity during delivery of pacing therapy is indicative of phrenic nerve stimulation.

* * * * *

专利名称(译)	无创检测膈神经刺激		
公开(公告)号	US9776009	公开(公告)日	2017-10-03
申请号	US14/220733	申请日	2014-03-20
[标]申请(专利权)人(译)	美敦力公司		
申请(专利权)人(译)	美敦力公司, INC.		
当前申请(专利权)人(译)	美敦力公司, INC.		
[标]发明人	GHOSH SUBHAM SPLETT VINCENT		
发明人	GHOSH, SUBHAM SPLETT, VINCENT		
IPC分类号	A61N1/00 A61N1/37 A61B5/04 A61N1/372 A61B5/11 A61B5/00 A61B5/0408		
CPC分类号	A61N1/3702 A61B5/04001 A61B5/1107 A61N1/37247 A61B5/04012 A61B5/04085 A61B5/6823 A61B5/7235 A61B5/7267 A61B5/743		
其他公开文献	US20150265840A1		
外部链接	Espacenet USPTO		

摘要(译)

本文描述了用于在心脏起搏治疗期间非侵入性地检测膈神经刺激的系统，方法和图形用户界面。可以在一个或多个功率配置下为一个或多个电起搏矢量生成膈神经刺激信息。可以向用户显示膈神经刺激信息以用于配置和/或评估心脏起搏治疗。

