



- (51) **International Patent Classification:**  
*A61F 2/00* (2006.01) *A61F 2/06* (2013.01)
- (21) **International Application Number:**  
PCT/US2016/052005
- (22) **International Filing Date:**  
15 September 2016 (15.09.2016)
- (25) **Filing Language:** English
- (26) **Publication Language:** English
- (30) **Priority Data:**  
62/219,118 15 September 2015 (15.09.2015) US  
62/363,716 18 July 2016 (18.07.2016) US
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(81) **Designated States** (*unless otherwise indicated, for every kind of national protection available*): AE, AG, AL, AM, AO, AT, AU, AZ, BA, BB, BG, BH, BN, BR, BW, BY, BZ, CA, CH, CL, CN, CO, CR, CU, CZ, DE, DK, DM, DO, DZ, EC, EE, EG, ES, FI, GB, GD, GE, GH, GM, GT, HN, HR, HU, ID, IL, IN, IR, IS, JP, KE, KG, KN, KP, KR, KW, KZ, LA, LC, LK, LR, LS, LU, LY, MA, MD, ME, MG, MK, MN, MW, MX, MY, MZ, NA, NG, NI, NO, NZ, OM, PA, PE, PG, PH, PL, PT, QA, RO, RS, RU, RW, SA, SC, SD, SE, SG, SK, SL, SM, ST, SV, SY, TH, TJ, TM, TN, TR, TT, TZ, UA, UG, US, UZ, VC, VN, ZA, ZM, ZW.

(84) **Designated States** (*unless otherwise indicated, for every kind of regional protection available*): ARIPO (BW, GH, GM, KE, LR, LS, MW, MZ, NA, RW, SD, SL, ST, SZ, TZ, UG, ZM, ZW), Eurasian (AM, AZ, BY, KG, KZ, RU, TJ, TM), European (AL, AT, BE, BG, CH, CY, CZ, DE, DK, EE, ES, FI, FR, GB, GR, HR, HU, IE, IS, IT, LT, LU, LV, MC, MK, MT, NL, NO, PL, PT, RO, RS, SE, SI, SK, SM, TR), OAPI (BF, BJ, CF, CG, CI, CM, GA, GN, GQ, GW, KM, ML, MR, NE, SN, TD, TG).

**Published:**

— with international search report (Art. 21(3))

(54) **Title:** DEVICES AND METHODS FOR EFFECTUATING PERCUTANEOUS GLENN AND FONTAN PROCEDURES

(57) **Abstract:** In some implementations, a radially self-expanding endograft prosthesis is provided that includes (i) distal flange that is self-expanding and configured to flip generally perpendicularly with respect to a body of the prosthesis to help seat the prosthesis against a tissue wall, (ii) a distal segment extending proximally from the distal flange that has sufficient stiffness to maintain a puncture open that is formed through a vessel wall (iii) a compliant middle segment extending proximally from the distal segment, the middle segment being more compliant than the distal segment, and having independently movable undulating strut rings attached to a tubular fabric, the combined structure providing flexibility and compliance to allow for full patency while flexed, the segment being configured to accommodate up to a 90 degree bend, (iv) a proximal segment having a plurality of adjacent undulating strut rings that are connected to each other.



## DEVICES AND METHODS FOR EFFECTUATING PERCUTANEOUS GLENN AND FONTAN PROCEDURES

### CROSS-REFERENCE TO RELATED APPLICATIONS

The present patent application claims the benefit of priority to U.S. Provisional Patent Application Serial No. 62/219,118, filed September 15, 2015, and U.S. Provisional Patent Application Serial No. 62/363,716, filed July 18, 2016. Each of the foregoing patent applications is incorporated by reference herein for any purpose whatsoever.

### FIELD OF THE DISCLOSURE

The present disclosure relates to devices and methods for transcatheter (i.e., performed through the lumen of a catheter) Glenn shunt and Fontan systems (transcatheter cavopulmonary bypass endograft prosthesis and delivery) for nonsurgical, percutaneous extra-anatomic bypass between two adjacent vessels.

### BACKGROUND

Children born with single ventricle physiology (SVP), a form of cyanotic congenital heart disease (CCHD), represent 7.7% of all congenital heart disease patients and have a birth incidence of approximately 4–8 per 10,000. In the United States, this represents approximately 2,000 children born each year. Currently, SVP infants undergo a series of staged surgical procedures. The first palliative procedure establishes a balance between systemic and pulmonary output while minimizing the overload on the single ventricle. The following palliative procedure is often cavopulmonary anastomosis through a bidirectional Glenn shunt or hemi-Fontan procedure to allow for passive pulmonary bloodflow. These are surgical procedures that are invasive and traumatic, requiring significant recuperation time and excessive burden on such a young patient.

### SUMMARY OF THE DISCLOSURE

The purpose and advantages of the present disclosure will be set forth in and become apparent from the description that follows. Additional advantages of the disclosed embodiments will be realized and attained by the methods and systems particularly pointed out in the written description hereof, as well as from the appended drawings.

A transcatheter approach for obtaining the results of the surgical procedures described above can revolutionize the management of these children with congenital heart disease. As an alternative to the Norwood Procedure, Bi-directional Glenn operation and Fontan procedure, a nonsurgical transcatheter intervention can limit the burden of surgery for infants while also reducing cost. There is a considerable unmet need for a purpose-built cavopulmonary anastomosis device. To Applicant's knowledge no commercial alternatives exist for off-label medical use.

To achieve these and other advantages and in accordance with the purpose of the disclosure, as embodied herein, in one aspect, the disclosure includes embodiments of a cavopulmonary self-expanding implant to permit an interventional cardiologist to create a shunt between the Superior Vena Cava (SVC) and the main pulmonary artery (MPA). The implant can provide an urgently needed option for children with congenital heart failure to avoid the burden of a three-stage surgery (so called palliative surgery), the burden of an additional heart transplantation after failure of the palliative surgeries, or of the lifelong medication intake after direct heart transplantation.

In some implementations, a radially self-expanding endograft prosthesis is provided that includes (i) distal flange that is self-expanding and configured to flip generally perpendicularly with respect to a body of the prosthesis to help seat the prosthesis against a tissue wall, (ii) a distal segment extending proximally from the distal flange that has sufficient stiffness to maintain a puncture open that is formed through a vessel wall (iii) a compliant middle segment extending proximally from the distal segment, the middle segment being more compliant than the distal segment, and having independently movable undulating strut rings attached to a tubular fabric, the combined structure providing flexibility and compliance to allow for full patency while flexed, the segment being configured to accommodate up to a 90 degree bend, (iv) a proximal segment having a plurality of adjacent undulating strut rings that are

connected to each other, the proximal segment being sufficiently stiff to seat within and urge against a vessel wall, and (v) a proximal end including a plurality of openings around the proximal end for accommodating a tether that is threaded through the openings to cause the prosthesis to collapse radially inwardly when tension is applied to the tether.

In some implementations, a delivery system is provided including the prosthesis as set forth above, wherein the prosthesis is mounted on a longitudinal inner member and inside of a retractable sheath. Both ends of the tether that is routed through the prosthesis can extend proximally through and out of a proximal region of the delivery system. The delivery system can further include a first set of radiopaque markers near the distal end of the delivery system, and a second set of markers that are visible outside the patient during a procedure that indicates the relative position of the delivery system and prosthesis, wherein the first and second set of markers are maintained in registration with each other during the procedure. The first set of markers can be located on a distal atraumatic tip of the delivery system made of iron oxide to facilitate navigation under MRI or other imaging modality to position the delivery system accurately, and the second set of markers can indicate the relative longitudinal position of the portions of the delivery system. The markers can be configured to indicate when the distal flange of the prosthesis is suitably configured to pull against an inner face of the wall of an artery, such as main pulmonary artery.

The prosthesis can further include a flared or bell-shaped proximal region to enhance apposition against the interior wall of a lumen. The prosthesis can further define at least one fenestration through a sidewall thereof to permit leakage of bodily fluid through the fenestration.

In some implementations, a tubular prosthesis is provided having a first flanged end and a second flanged end, each flanged end being configured to urge against an inner surface of a first body lumen and a second body lumen when the prosthesis is mounted through openings formed into the walls of the first body lumen and second body lumen. The prosthesis can be adjusted in length. The prosthesis can include proximal and distal portions connected by a central elastic region such that the prosthesis can be stretched to cause the flanged ends of the prosthesis to pull against the lumens that the flanged ends are mounted into.

It is to be understood that both the foregoing general description and the following detailed description are exemplary and are intended to provide further explanation of the embodiments disclosed herein.

The accompanying drawings, which are incorporated in and constitute part of this specification, are included to illustrate and provide a further understanding of the method and system of the disclosure. Together with the description, the drawings serve to explain the principles of the disclosed embodiments.

### BRIEF DESCRIPTION OF THE DRAWINGS

The foregoing and other objects, aspects, features, and advantages of exemplary embodiments will become more apparent and may be better understood by referring to the following description taken in conjunction with the accompanying drawings, in which:

FIG. 1A depicts a view of a self-expanding prosthesis for performing a Glenn procedure disposed about a distal region of a delivery system for the prosthesis.

FIG. 1B depicts a close-up view of a portion of the prosthesis depicted in FIG. 1A.

FIG. 2A-FIG. 2C illustrate use of the loading tool of FIG. 12 to load a prosthesis such as that of FIG. 1A onto a delivery system.

FIGS. 3A-FIG. 3B illustrate a prosthesis delivery system in its initial deployment position.

FIG. 3C illustrates the prosthesis fully deployed but threaded with a retraction tether.

FIG. 3D illustrates the prosthesis fully deployed with the retraction tether removed.

FIG. 4A illustrates an exemplary prosthesis for a Glenn procedure, for example, in a deployed condition.

FIG. 4B illustrates the same prosthesis being articulated to the right at its distal end.

FIG. 4C illustrates the articulated prosthesis of FIG. 4B to show the flared distal end.

FIG. 4D shows a model of a Glenn shunt prosthesis in accordance with the disclosure being deployed in the main pulmonary artery (MPA) and the superior vena cava (SVC).

FIG. 4E shows a scan of a fully deployed percutaneous cavopulmonary bypass endograft self-expanding prosthesis in a large porcine model used in a Glenn procedure.

FIG. 5A is an isometric schematic view of an illustrative prosthesis for use in a Fontan procedure, and FIG. 5B is a plan view of such a prosthesis.

FIG. 6A is a first illustrative embodiment of a prosthesis for use in a Fontan procedure, and FIG. 6B is a second illustrative embodiment of a prosthesis for use in a Fontan procedure.

FIG. 7 is an image of prostheses deployed in Glenn and Fontan procedures in a test animal in accordance with the disclosure.

FIG. 8A – FIG. 8E are illustrations of various aspects of a method of deploying a prosthesis in accordance with the disclosure.

FIG. 9A – FIG. 9E are illustrations of further aspects of the illustrative prostheses and delivery systems in accordance with the disclosure.

FIG. 10A, B – FIG. 10C, D are illustrations of two further embodiments of prostheses in accordance with the disclosure.

FIGS. 11A-11B are illustrations of a further embodiment of a prosthesis in accordance with the disclosure.

FIGS. 12A-12H are illustrations of a prosthesis loading tool in accordance with the disclosure.

### DETAILED DESCRIPTION

Reference will now be made in detail to the present preferred embodiments of the disclosure, examples of which are illustrated in the accompanying drawings. The method and corresponding steps of the disclosed embodiments will be described in conjunction with the detailed description of the system. The exemplary embodiments illustrated herein can be used to perform Glenn and Fontan procedures, but percutaneously. It will be appreciated, however, that the disclosed embodiments, or variations thereof, can be used for a multitude of procedures involving the connection of blood vessels or other biological lumens to native or artificial structures.

Embodiments of a disclosed TCBE (Transcatheter Cavopulmonary Bypass Endograft) represent a potential breakthrough for physicians and young patients who require a safe, less-burdensome, and effective alternative to open heart surgery: a percutaneous approach to heal congenital heart failure.

In particular implementations, the underlying design of the TCBE is based on four components: (i) a distal segment, which is divided into a flange (consisting of a multi-pointed (e.g., six-pointed) star) and two to four rows of connected (e.g., by stitching) undulating wire segments; (ii) a middle segment, which includes longer non-connected undulating wire segments, (iii) and the largest, proximal, segment, which is useful for bridging and stabilization of the implant in the vessel. Depending on the size of the implant, it can be built as a “Glenn Shunt” (about 5 cm in length) or a “Fontan Shunt” (about 8 cm in length). These can be, for example, super elastic Nitinol-supported tubular polyester fabric implants that are delivered through a specially designed delivery system. Preferably, the prosthesis and delivery system are both MRI compatible. The illustrated TCBE embodiments can incorporate several useful features specifically developed for transcatheter cavopulmonary bypass.

For purposes of illustration, and not limitation, as embodied herein and as illustrated in FIG. 1, a prosthesis is provided for transcatheter cavopulmonary bypass situated on a distal region of a delivery system. As can be seen, the device has a tubular stent-like structure formed from ring shaped segments that have an undulating “zig-zag” pattern. A first, proximal end of the prosthesis has an undulating end defined by the proximal-most ring of the prosthesis. The distal end has a similar undulating end formed from a ring of undulating material, but the material is heat treated such that it “flips” from a first direction that is generally parallel to a central longitudinal axis of the prosthesis, and relaxes into a bent over flange having a tip that is generally perpendicular to the longitudinal axis of the prosthesis when permitted to expand. The flange can be oriented at any suitable angle with respect to the longitudinal axis, and is preferably perpendicular thereto, or forms a slightly acute angle with respect to the wall of the prosthesis (e.g., between 70 and 90 degrees). The flange is useful for pulling against the inside of a vessel or other tissue wall when the remaining prosthesis is advanced through an opening in such vessel or other tissue wall, preventing pull

through, and permitting a facilitated anastomosis procedure generally, as well as for Glenn and Fontan procedures.

As can be seen, the proximal end of the prosthesis receives a tether therethrough that is routed through the windings of the undulating ring. The tethers are withdrawn proximally through a tubular member (e.g., a sheath) that also passes a core member therethrough that forms the core, or push rod of the delivery system. The core is slidably disposable with respect to the sheath. By advancing the core member with the prosthesis mounted thereto distally outwardly of the sheath, the prosthesis self-expands. However, if the tether is tensioned, it causes the proximal end of the prosthesis to collapse radially inwardly such that the prosthesis can be withdrawn into the sheath. While adjacent undulating rings of the prosthesis particularly near the distal end of the prosthesis can be connected to each other (e.g., by sewing), they can also be kept independent of one another, and be attached to an inner and/or outer tubular fabric layer. The rigidity of the prosthesis is selected and/or configured to provide a desired performance. Thus, the distal end is relatively rigid to maintain an opening in the wall of a vessel or other organ in an open state that the prosthesis traverses through by resisting the force of the vessel wall to want to “close” the hole in itself. The proximal region is less rigid and can accommodate increasing vessel curvature of the vessel that it is mounted in.

The delivery system typically includes an atraumatic distal tip that can pass a guidewire therethrough, and may be provided with one or more radiopaque markers to facilitate visualization under fluoroscopy, for example. The distal end or end region of the sheath of the delivery system (that surrounds the prosthesis when loaded onto the delivery system) can also include a radiopaque marker.

FIGS. 2A-2D illustrate loading of the prosthesis on the core member of the delivery system using a clam shell like loading tool described in further detail below with respect to FIG. 12. FIG. 2C illustrates the delivery system in a collapsed condition. The delivery system includes the aforementioned core member defining a guide wire lumen therethrough. The sheath is fitted over the core, and the tethers run between the components in the annular space between the core and sheath. As shown in FIG. 3A, the flared distal end of the prosthesis flips over from zero to 90 degrees as the sheath is advanced proximally. The proximal end of the prosthesis is held radially inwardly by



the tether until tension of the tether is released. Tension can be reapplied to the tether to permit the prosthesis to be fully removable unless the tether is removed.

FIG. 4a shows the disclosed prosthesis for a Glenn procedure. The distal region on the prosthesis is flexible to permit passage of the prosthesis through a curved vessel. FIG. 4D shows the distal flanged end of the prosthesis pulling against the inner wall of the main pulmonary artery (MPA), with the proximal end of the prosthesis extending into the superior vena cava in a Glenn procedure.

FIG. 5A shows a schematic perspective view of a Fontan-type prosthesis, and FIG. 5B shows a side view schematic of such a prosthesis. Adjoining rings of the framework of the prosthesis are attached (e.g., by stitching) to a tubular fabric that preferably passes through the rings of the framework, wherein the framework is made, for example, of .014 inch diameter NiTi. The longitudinal dimension of each structural ring can be different. For example, region "A" of the prosthesis can be comparatively stiff, wherein the rings can be attached to each other directly or via the fabric, wherein regions B, C, D, and E can have different, lower stiffnesses.

Figure 6A illustrates a first embodiment of a prosthesis for a Fontan procedure. The body is similar to that of the prosthesis in FIG. 5, but is made, for example, from .013 inch diameter Ni Ti wire. FIG. 6B illustrates a second embodiment that is also formed from the same wire, but the flange is formed at a steeper angle to create an increased flip, or displacement, of the distal flange when the prosthesis is deployed. The prosthesis can include one or more (e.g., 2) fenestrations through the fabric in a central region thereof to permit leakage into the right atrium when the prosthesis spans from its distal end situated within the main pulmonary artery to the superior vena cava. The below chart illustrates suitable dimensions for the prosthesis illustrated in FIG. 5B.

**Fontan Structural Component Chart**

	Section "A"	Section "B"	Section "C"	Section "D"	Section "E"	Section "F"
ID Diameter	12mm	12mm	12mm	20mm	20mm	12mm
Zig Length	5mm	5mm	8mm	8mm	8mm	5mm
Wire Size	.014"	.012"	.012"	1-.014"	.014"	.013"
Zig Connection	connected	unconnected	connected	connected	connected	connected

The star shaped flange on the end of each prosthesis helps the prosthesis seat well within the vasculature. In some embodiments the tethers can be routed through parallel lumens along the length of the delivery system to prevent them from tangling with each other. The prosthesis for the Fontan procedure preferably includes a proximal region that flares out, as illustrated in FIG. 6B to provide enhanced wall apposition.

FIG. 7 illustrates an animal model wherein two prostheses are installed as disclosed herein using the disclosed delivery system; one in a Glenn procedure (connecting the SVC to the MPA to supply blood from the superior vena cava (SVC) to the main pulmonary artery (MPA)), and one in a Fontan procedure (connecting the inferior vena cava (IVC) through the ventricle to the main pulmonary artery (MPA)), wherein the prosthesis includes fenestrations to permit leakage through the prosthesis into the ventricle.

FIG. 8A shows the delivery system with the prosthesis (for the Glenn or Fontan procedure) mounted thereon. FIG. 8B shows the core and distal tip advanced distally, and the distal flared end of the prosthesis deployed. FIG. 8C shows a close up of the flared distal end of the prosthesis. FIG. 8D shows the prosthesis mostly deployed, but the tether tensioned so as to keep the proximal end of the prosthesis held radially inwardly. FIGS. 9A and 9B show two different embodiments of a prosthesis as described above, FIG. 9C shows the prosthesis collapsed and within a sheath of the delivery system, whereas FIG. 9D shows the proximal ends of the delivery systems for each prosthesis. FIG. 9E shows differing sizes of distal tips that can be used, depending on the application. The distal tip acts as a strain relief from a guidewire extending distally outwardly of a central guidewire lumen of the device. As such, while it is preferable to have the tip be relatively long, it is also useful to have it not be too long so as to prevent the delivery system from navigating a relatively narrow lumen when entering it obliquely.

FIGS. 10A-10B show side and isometric views of a prosthesis having a flanged distal end. FIGS. 10CA-10D show side and isometric views of a prosthesis having a flanged distal end as well as a flanged proximal end (upon prosthesis deployment). The illustrated prostheses also include a first section of relatively large diameter, such as near the flanged end, that transitions to a region of lower diameter by way of a transition region. The prosthesis can also be of adjustable telescoping length. The

inside diameter preferably remains substantially unchanged when the prosthesis is adjusted in length.

FIGS. 11A-11B show a flanged prosthesis of adjustable length having two flanged ends attached to tubular structural regions, that are in turn structurally joined in a central region by an elastic member, such as a spring. A tubular fabric member preferably traverses the inside or the outside of the length of the prosthesis. The prosthesis is shown without such a tubular fabric member for illustrative purposes, and each end can be of a different diameter from the other. Such a prosthesis can be useful, for example, for forming a shunt from the descending aorta to the main pulmonary artery to decompress the aorta. The length can be adjusted of the prosthesis, and tension can be maintained on the prosthesis by way of the spring, helping the flanged ends to seat against the inner walls of the aorta and the MPA.

FIGS. 12A-12H illustrate aspects of a prosthesis loading tool in accordance with the disclosure. As illustrated, the loading tool includes two halves, the inner faces of which are illustrated in FIGS. 12A and 12B. An interior channel including a first funnel portion necking down from a relatively large diameter to a relatively small diameter transitions into a second region of constant diameter, but wherein a step, or shoulder is present on the region of smaller diameter that effectively results in the funnel portion having a slightly smaller diameter than the region of constant diameter. As illustrated in FIGS. 12C-12E, the two halves align and mate with each other by way of a pair of protrusions on one half of the tool being received by a pair of indentations, or holes, on the other half of the tool. In use, the distal end of the sheath that will cover the prosthesis is inserted into the end of the prosthesis having the portion of constant diameter until it abuts the shoulder. In use, the central shaft of the delivery system passes through the sheath and the funnel section. The prosthesis, loaded with the tether on its proximal end, is then advanced into the funnel and is necked down to fit inside the sheath, but surrounding the central shaft, or tubular core member, of the delivery system. Advancing the prosthesis into the funnel section helps effectuate the compression. After the prosthesis is loaded, the loading tool is simply removed.

Generally, during deployment, the delivery system is advanced to a position where the prosthesis should be deployed. The distal tip and core of the guidewire are then advanced distally as well as the prosthesis, and the prosthesis flange is deployed

thorough an opening in a wall of a vessel or other tissue wall. The flanged end then urges against the inner wall of the vessel. A corresponding marker can be used on the proximal end of the delivery system to show at what point of relative advancement the flange has been deployed. The delivery system is then pulled proximally slightly to seat the flange. When satisfied with seating, the user holds the inner shaft of the delivery system and pulls back on outer sheath to release the entire implant. The tether can then be de-tensioned to open the proximal end of implant. Finally, the user can pull on one end of the tether to remove it from the implant, and the delivery system can be removed. However, if desired, prior to removal of the tether, the tether can be re-tensioned, causing the proximal end of the prosthesis to collapse radially inwardly, and the prosthesis can be withdrawn into the sheath of the delivery system, and removed.

The devices and methods disclosed herein can be used for other procedures in an as-is condition, or can be modified as needed to suit the particular procedure. In view of the many possible embodiments to which the principles of this disclosure may be applied, it should be recognized that the illustrated embodiments are only preferred examples of the disclosure and should not be taken as limiting the scope of the disclosure.

## CLAIMS

What is claim is:

1. A radially self-expanding endograft prosthesis comprising:
  - a distal flange that is self-expanding and configured to flip generally perpendicularly with respect to a body of the prosthesis to help seat the prosthesis against a tissue wall;
  - a distal segment extending proximally from the distal flange that has sufficient stiffness to maintain a puncture open that is formed through a vessel wall;
  - a compliant middle segment extending proximally from the distal segment, the middle segment being more compliant than the distal segment, and having independently movable undulating strut rings attached to a tubular fabric, the combined structure providing flexibility and compliance to allow for full patency while flexed, the segment being configured to accommodate up to a 90 degree bend;
  - a proximal segment having a plurality of adjacent undulating strut rings that are connected to each other, the proximal segment being sufficiently stiff to seat within and urge against a vessel wall; and
  - a proximal end including a plurality of openings around the proximal end for accommodating a tether that is threaded through the openings to cause the prosthesis to collapse radially inwardly when tension is applied to the tether.
2. A delivery system including the prosthesis of Claim 1, wherein the prosthesis is mounted on a longitudinal inner member and inside of a retractable sheath.
3. The delivery system of Claim 2, wherein both ends of the tether that is routed through the prosthesis extend proximally through and out of a proximal region of the delivery system.
4. The delivery system of Claim 3, further comprising a first set of radiopaque markers near the distal end of the delivery system, and a second set of markers that are visible outside the patient during a procedure that indicates the relative position of the

delivery system and prosthesis, wherein the first and second set of markers are maintained in registration with each other during the procedure.

5. The delivery system of claim 4, wherein the first set of markers is located on a distal atraumatic tip of the delivery system made of iron oxide to facilitate navigation under MRI or other imaging modality to position the delivery system accurately, and wherein the second set of markers indicates the relative longitudinal position of the portions of the delivery system.

6. The delivery system of claim 4, wherein the markers are configured to indicate when the distal flange of the prosthesis is suitably configured to pull against an inner face of the wall of a lumen.

7. The prosthesis of Claim 1, further including a flared or bell-shaped proximal region to enhance apposition against the interior wall of a lumen.

8. The prosthesis of Claim 1, further defining at least one fenestration through a sidewall thereof to permit leakage of bodily fluid through the fenestration.

9. A tubular prosthesis having a first flanged end and a second flanged end, each flanged end being configured to urge against an inner surface of a first body lumen and a second body lumen when the prosthesis is mounted through openings formed into the walls of the first body lumen and second body lumen.

10. The prosthesis of Claim 9, wherein the prosthesis can be adjusted in length.

11. The prosthesis of Claim 10, wherein the prosthesis includes proximal and distal portions connected by a central elastic region such that the prosthesis can be stretched to cause the flanged ends of the prosthesis to pull against the lumens that the flanged ends are mounted into.

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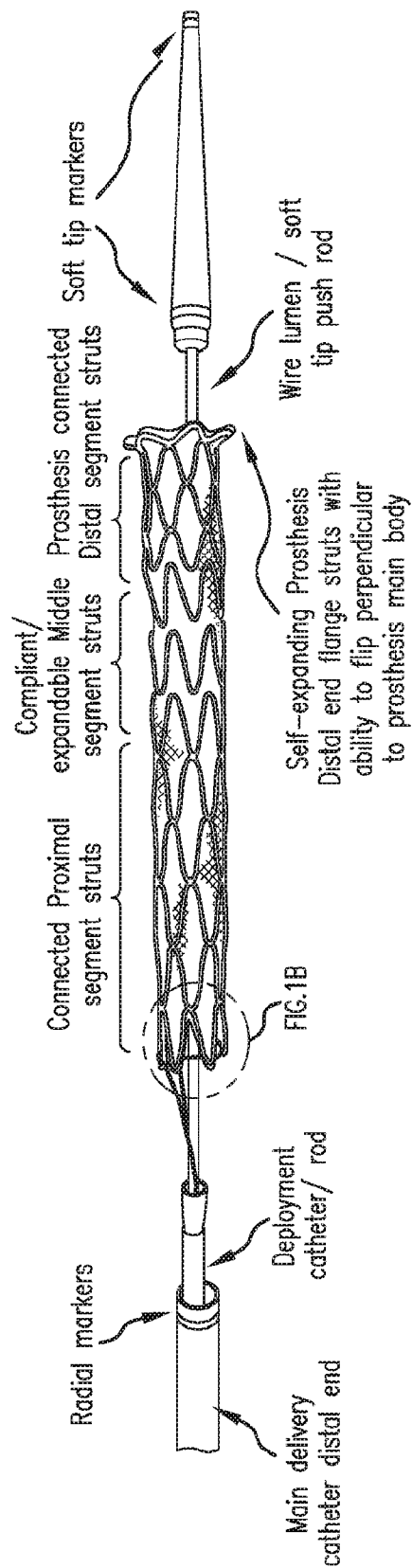


FIG. 1A

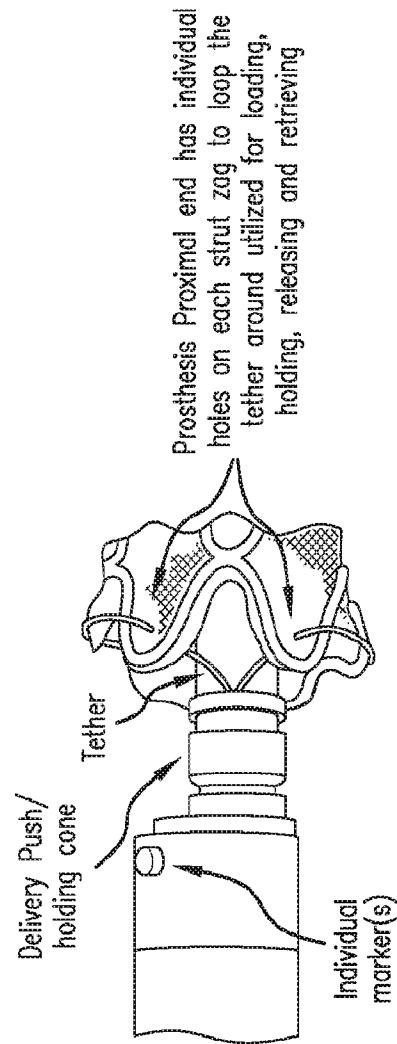


FIG. 1B

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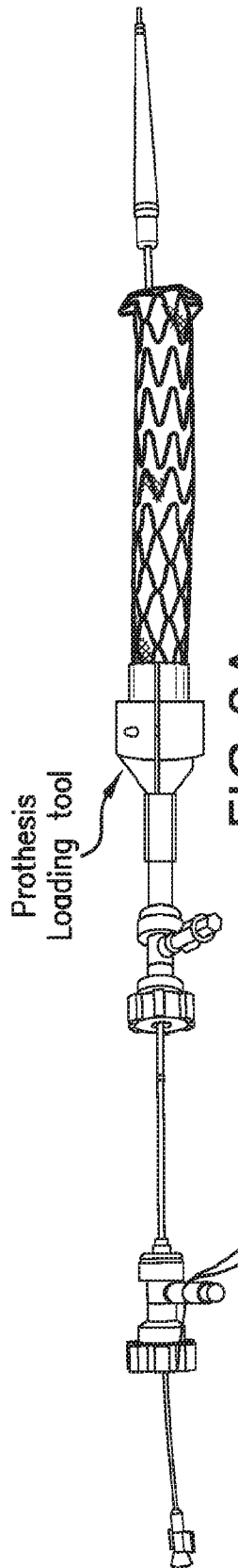


FIG. 2A

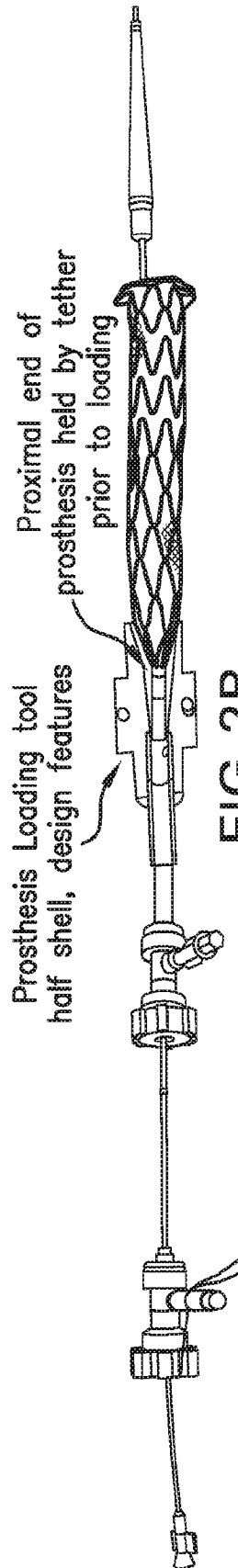


FIG. 2B

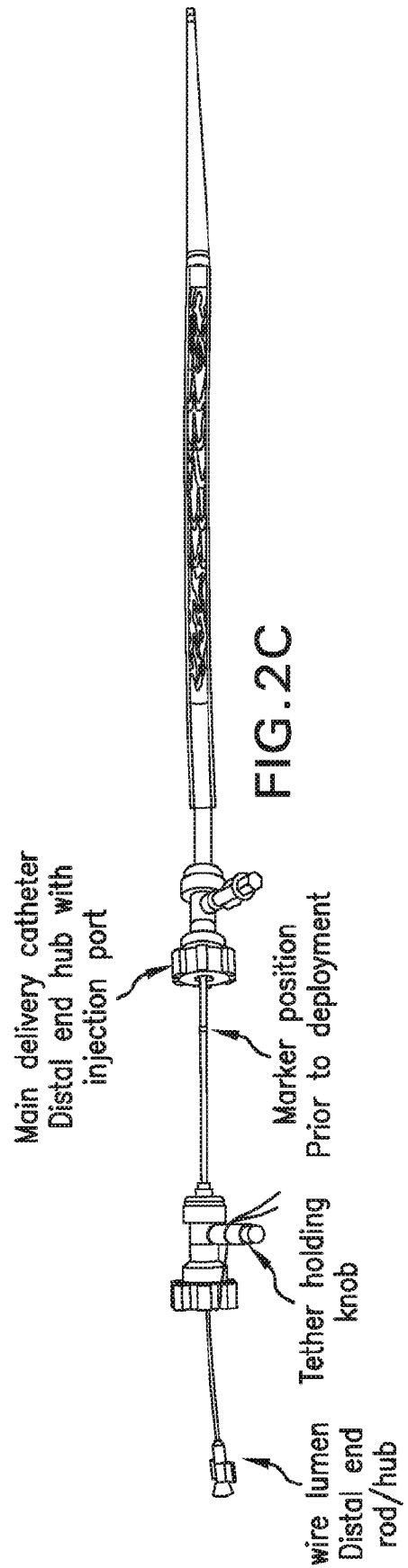
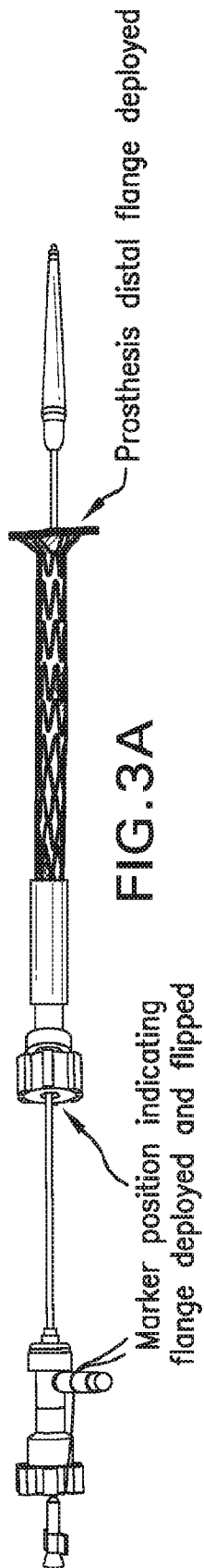


FIG. 2C



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Prosthesis distal flange deployed



FIG. 3B

Proximal end of prosthesis held by tether prior to full release

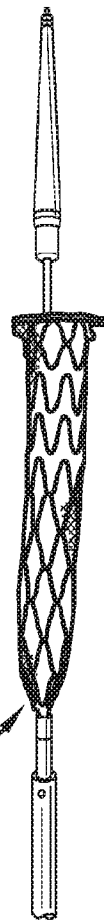


FIG. 3C

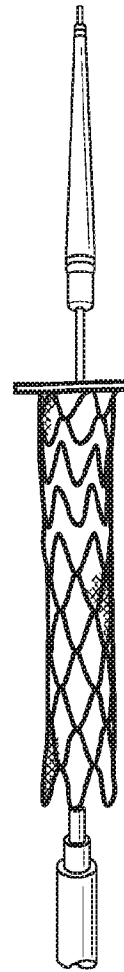


FIG. 3D

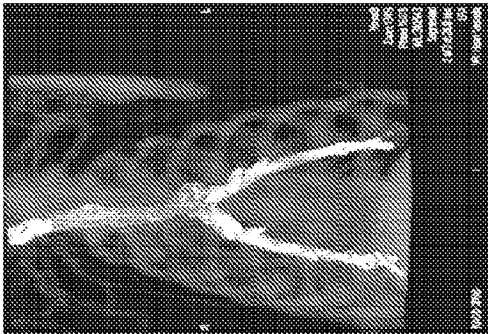


FIG. 4E

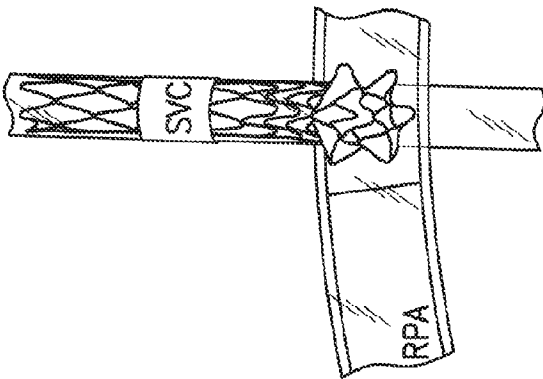


FIG. 4D

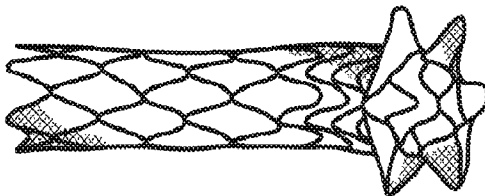


FIG. 4C

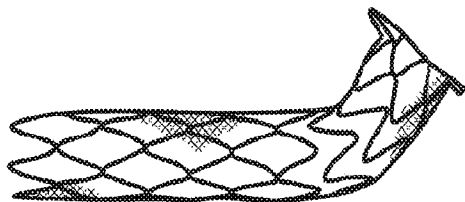


FIG. 4B

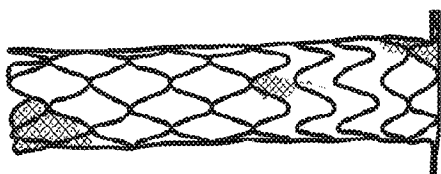


FIG. 4A

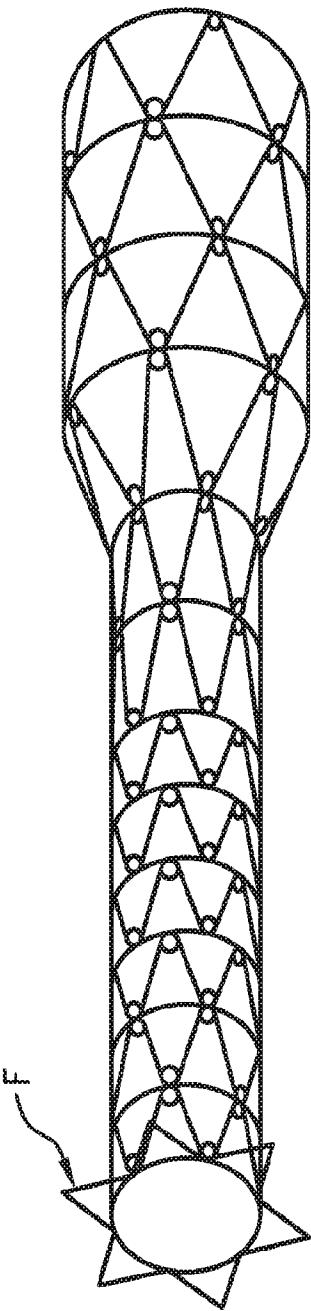


FIG. 5A

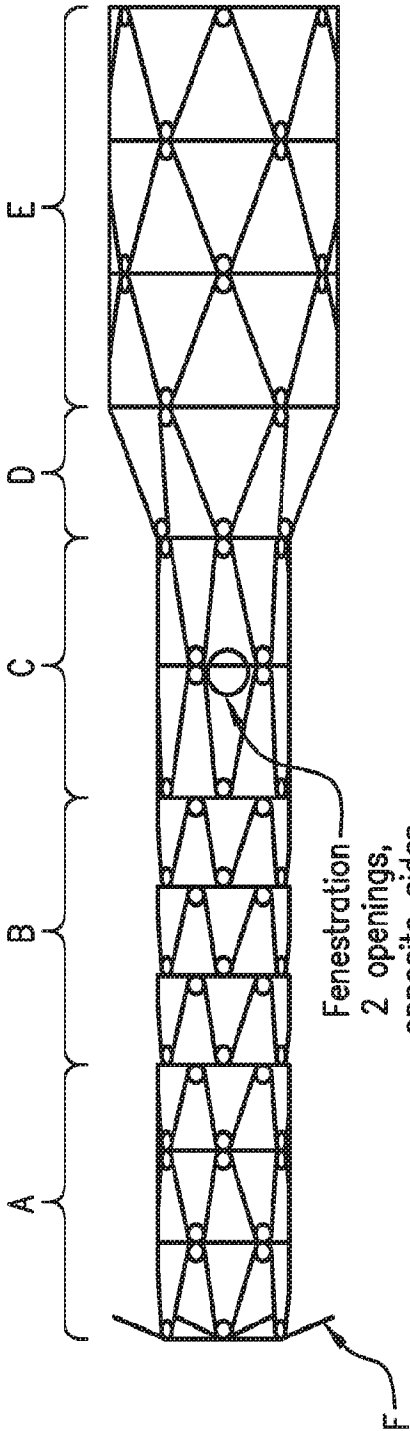
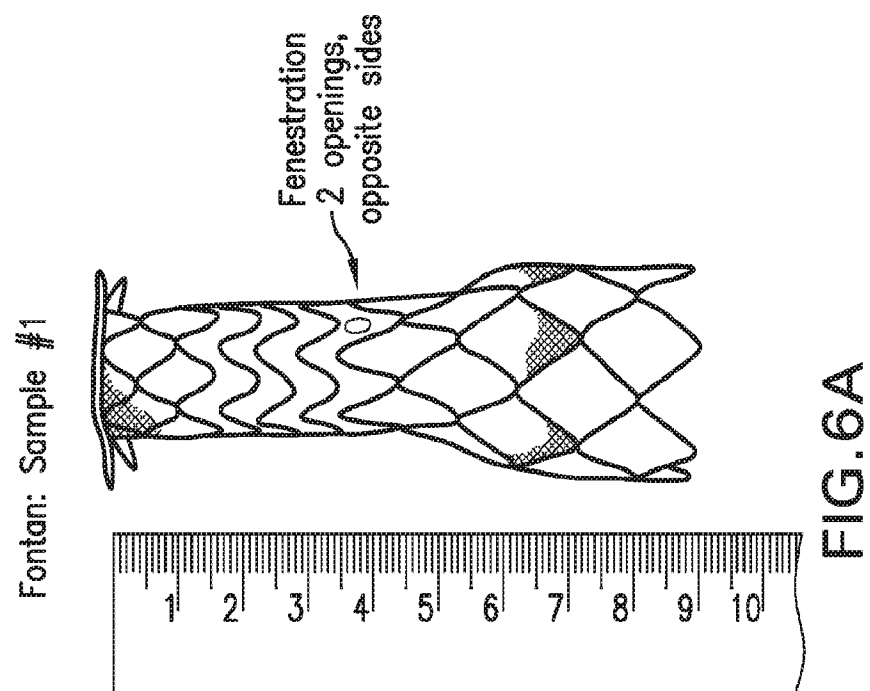
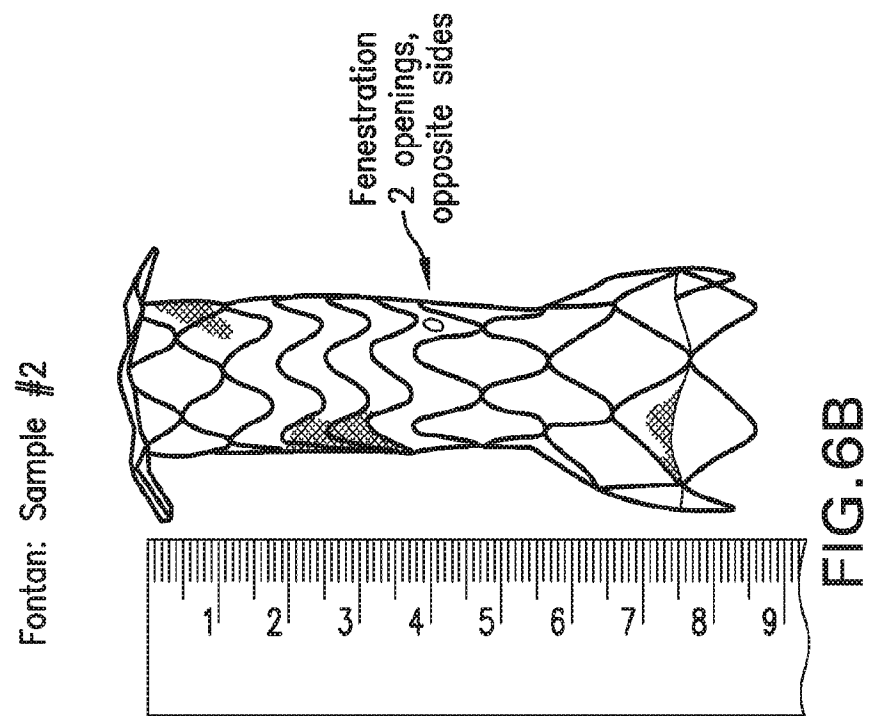


FIG. 5B

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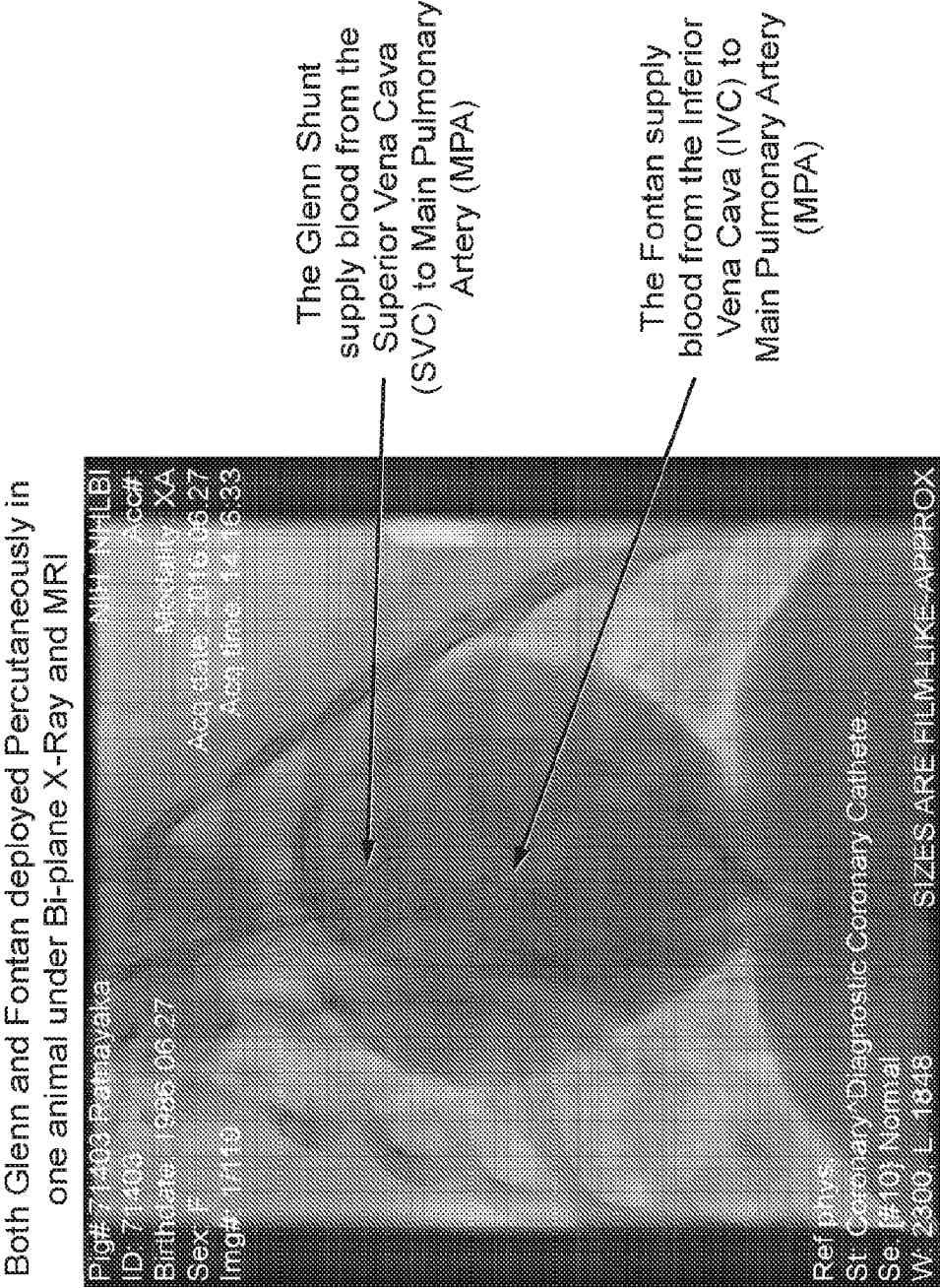


FIG.7



FIG. 8A

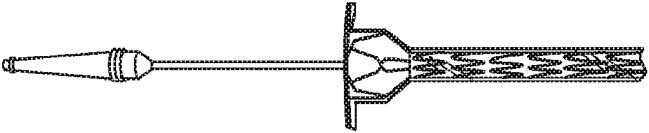


FIG. 8B



FIG. 8C



FIG. 8D

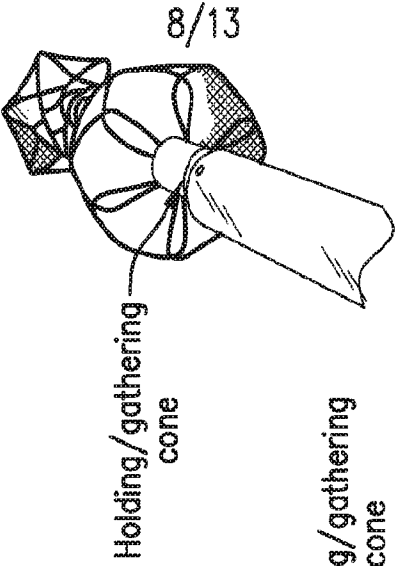
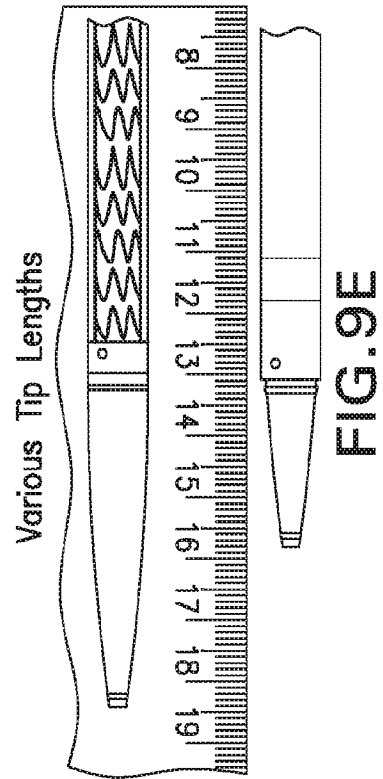
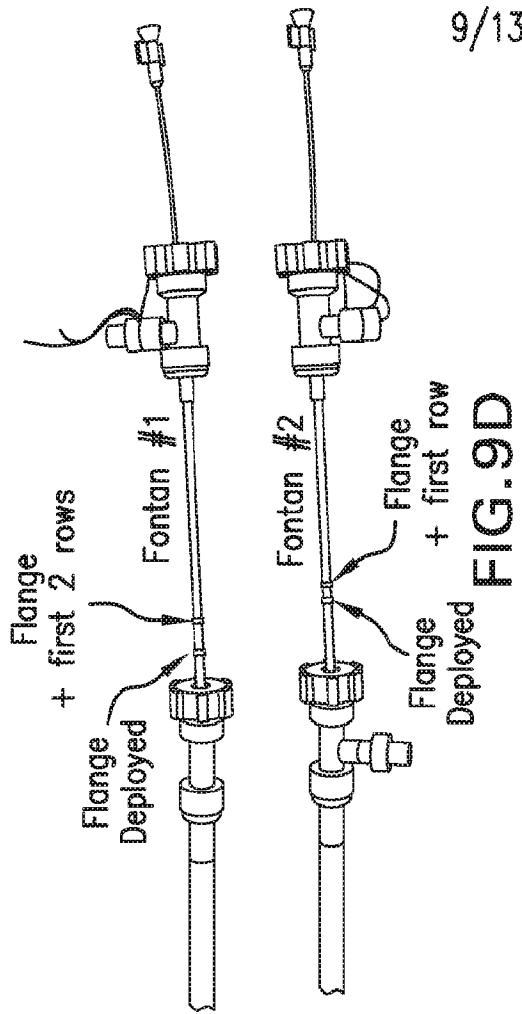
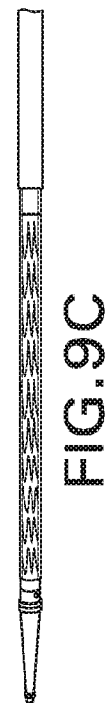
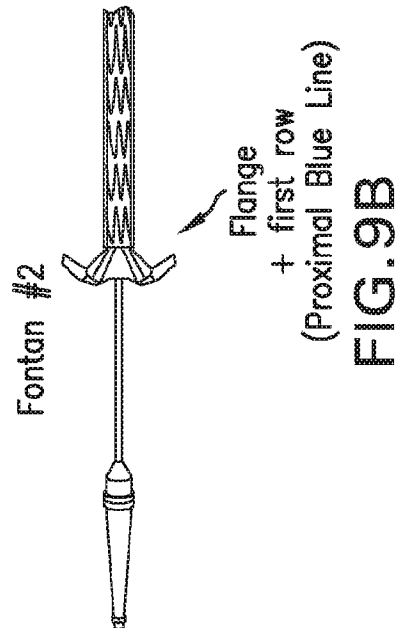
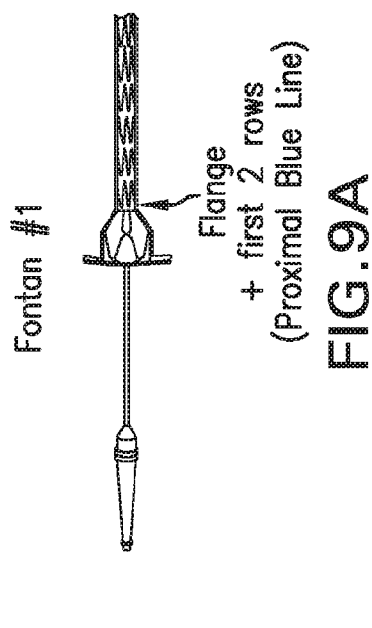


FIG. 8E

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Holding/gathering  
cone

Holding/gathering  
cone



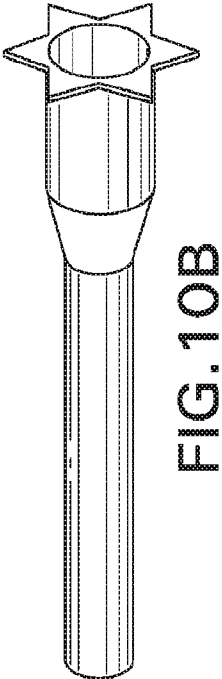


FIG. 10B

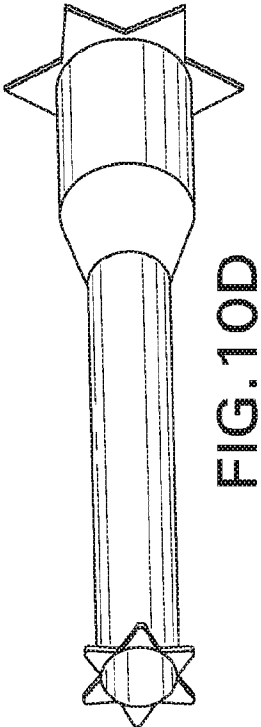


FIG. 10D

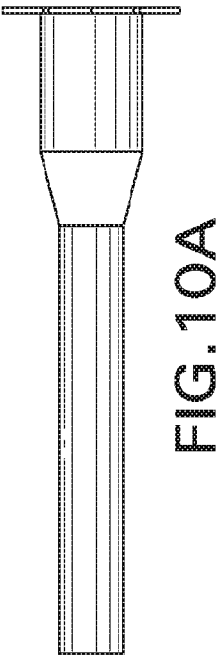


FIG. 10A

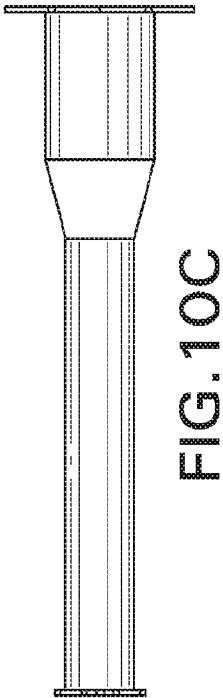


FIG. 10C



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Elongation element, ordinarily covered with tubular graft material; shown without material to illustrate elastic member

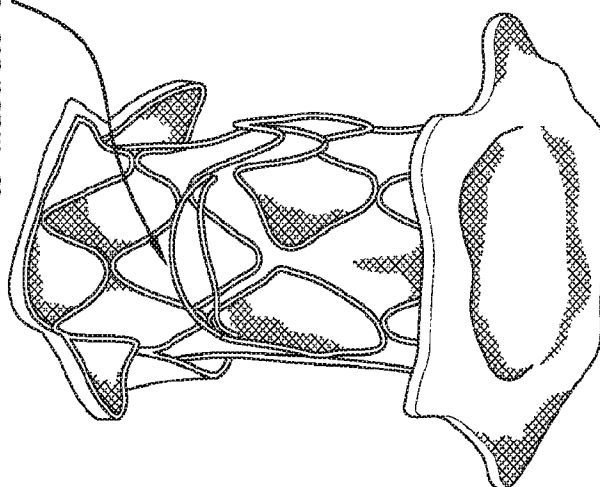


FIG. 11A

Elongation element, ordinarily covered with tubular graft material; shown without material to illustrate elastic member

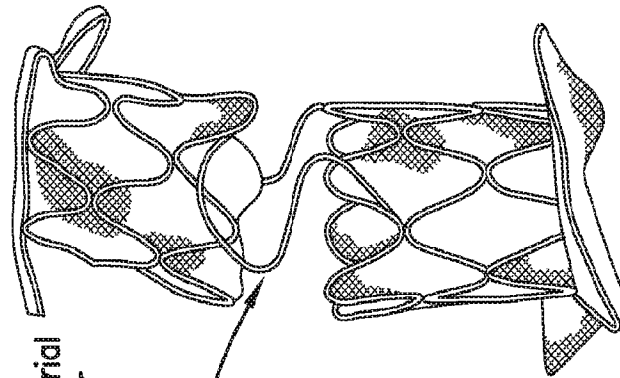


FIG. 11B

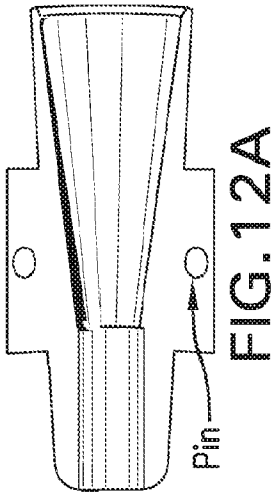


FIG. 12A

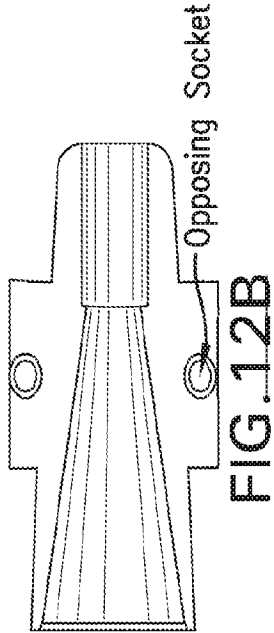


FIG. 12B

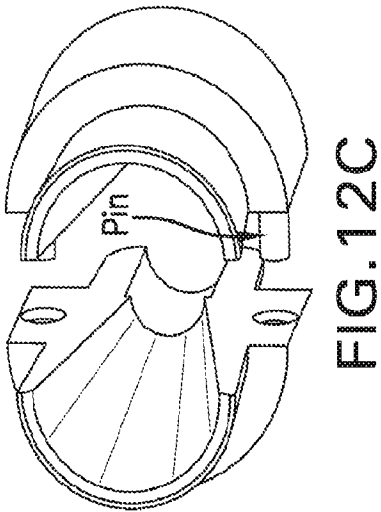


FIG. 12C

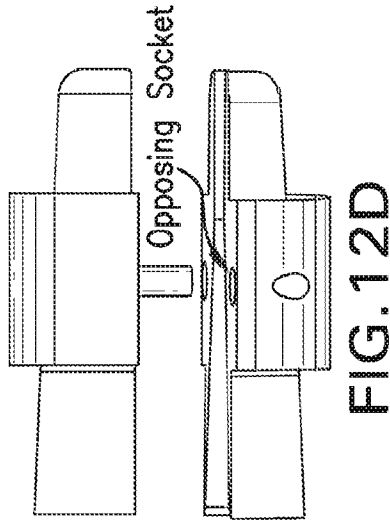


FIG. 12D

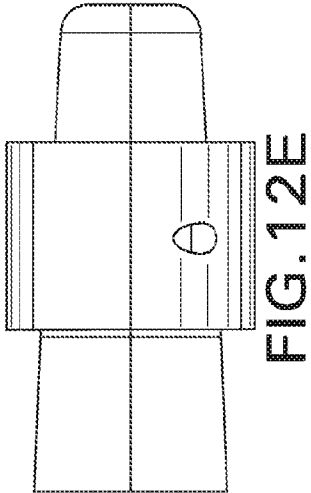


FIG. 12E

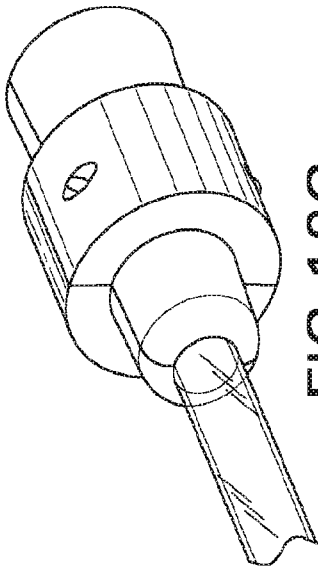


FIG. 12G

Lumen of Delivery Shaft  
Aligned with Bottom of Taper

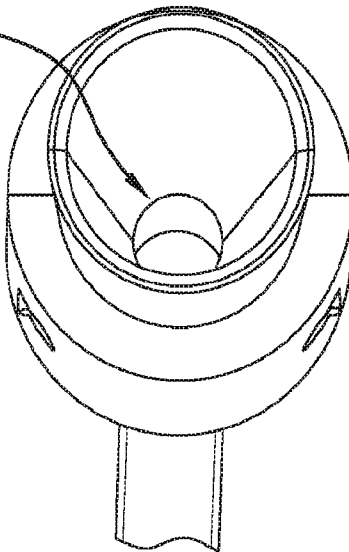
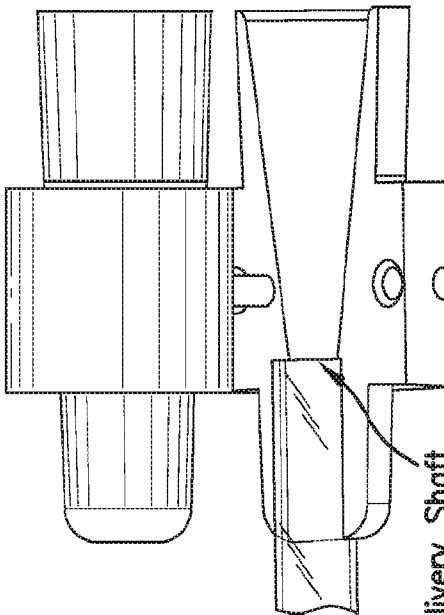


FIG. 12H



Delivery Shaft  
Inserted up to Step FIG. 12F

**INTERNATIONAL SEARCH REPORT**

International application No.

PCT/US 2016/052005

<b>A. CLASSIFICATION OF SUBJECT MATTER</b> <div style="text-align: right; margin-right: 100px;"> <i>A61F 2/00 (2006.01)</i>  <i>A61F 2/06 (2013.01)</i> </div> <p>According to International Patent Classification (IPC) or to both national classification and IPC</p>		
<b>B. FIELDS SEARCHED</b> <p>Minimum documentation searched (classification system followed by classification symbols)</p> <p style="text-align: center;">A61B 17/00, A61F 2/00, 2/02, 2/06, 2/82, 2/844, A61M 1/12</p> <p>Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched</p> <p>Electronic data base consulted during the international search (name of data base and, where practicable, search terms used)</p> <p style="text-align: center;">PatSearch (RUPTO internal), DWPI, Espacenet, Google, Yandex, Patentscope</p>		
<b>C. DOCUMENTS CONSIDERED TO BE RELEVANT</b>		
Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
Y	US 8518096 B2 (LIFESHIELD SCIENCES LLC) 27.08.2013, abstract, claims 1-3, 10, 12, col. 3, lines 17-43, col. 6, lines 43-67, col. 7, lines 30-67, col. 8, lines 1-6, fig. 3, 6	1-8
X	US 5639278 A (CORVITA CORPORATION) 17.06.1997, abstract, claims 1, 26, 27, col. 4, lines 57-65, col. 5, lines 15-23, 44-67, col. 6, lines 1-21, 61-67, col. 7, lines 13-28, 47-56, col. 10, lines 54-67, col. 11, lines 1-39, fig. 1-6, 20, 21, 24, 25	9-11
Y		1-8
Y	US 6238430 B1 (VASCULAR ARCHITECTS, INC.) 29.05.2001, abstract, claims 11, 12, 24, 27, 43, col. 5, lines 57-67, col. 6, lines 1-16, 46-59, col. 13, lines 18-58, fig. 1, 1a, 16A-F, 18-20	1-8
<div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Further documents are listed in the continuation of Box C.</span> <span><input type="checkbox"/> See patent family annex.</span> </div>		
*	<div style="display: flex;"> <div style="width: 45%;"> <p>Special categories of cited documents:</p> <p>“A” document defining the general state of the art which is not considered to be of particular relevance</p> <p>“E” earlier document but published on or after the international filing date</p> <p>“L” document which may throw doubts on priority claim(s) or which is cited to establish the publication date of another citation or other special reason (as specified)</p> <p>“O” document referring to an oral disclosure, use, exhibition or other means</p> <p>“P” document published prior to the international filing date but later than the priority date claimed</p> </div> <div style="width: 55%;"> <p>“T” later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention</p> <p>“X” document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone</p> <p>“Y” document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art</p> <p>“&amp;” document member of the same patent family</p> </div> </div>	
Date of the actual completion of the international search <p style="text-align: center;">19 December 2016 (19.12.2016)</p>		Date of mailing of the international search report <p style="text-align: center;">29 December 2016 (29.12.2016)</p>
Name and mailing address of the ISA/RU: Federal Institute of Industrial Property, Berezhkovskaya nab., 30-1, Moscow, G-59, GSP-3, Russia, 125993 Facsimile No: (8-495) 531-63-18, (8-499) 243-33-37		Authorized officer <p style="text-align: center;">E. Nosova</p> Telephone No. (495)531-64-81