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(71) Applicant (for all designated States except US):

MEDTRONIC, INC. [US/US]; 710 Medtronic Parkway
Ne, Minneapolis, Minnesota 55432 (US).

(72) Inventors; and

(75) Inventors/Applicants (for US only): **KALPIN, Scott L.**
[US/US]; 4225 430th Street, Harris, Minnesota 55032
(US). **MIESEL, Keith A.** [US/US]; 896 Ashland Avenue,
St. Paul, mn 55104 (US). **SOLEFACK, Lucien Bell**
[US/US]; 1623 Willis Avenue, St. Paul, MN 55075 (US).

(74) Agents: **MARKS, Scott A.** et al.; **MEDTRONIC, INC.**,
710 Medtronic Parkway NE, Minneapolis, Minnesota
55432 (US).

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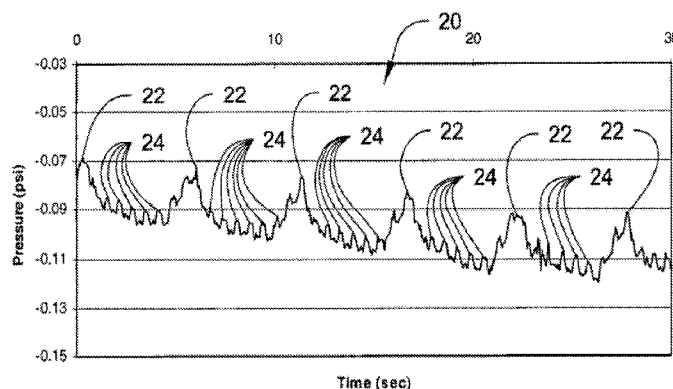


FIG. 10

(57) Abstract: A method for determining status of an implanted catheter includes acquiring raw pressure data (20) from a pressure sensor of in an implantable infusion device. The pressure sensor is in communication with a lumen of the catheter operably coupled to the infusion device. The catheter has a delivery region, in communication with the lumen, intended to be positioned in a fluid-filled target location of a patient. The method further includes filtering the raw pressure data to remove the DC component, leaving the AC component within a relevant physiological frequency range; rectifying the AC component to produce a rectified pressure signal; calculating a mean magnitude of the rectified signal; and determining whether the mean magnitude is below a predetermined threshold. If the mean magnitude is below the threshold, the catheter is determined to be in a state other than a normal state.

DEVICES AND METHODS FOR DETECTING CATHETER COMPLICATIONS

FIELD

5 The present disclosure relates generally to devices, systems and methods for detecting catheter complications in implantable infusion systems.

BACKGROUND

10 Implantable infusions systems have been used to treat a variety of diseases, such as spasticity, pain and cancer by targeting drug delivery to a selected area of a patient. Therapies employing such systems have proven to be very helpful for patients for whom systemic therapy is not effective, possible, or practicable. The implantable systems typically include an implantable infusion device containing a reservoir for housing the drug and a catheter coupled to the reservoir to direct the drug to the target area. The
15 devices typically include a pump or mechanism for driving fluid from the reservoir, or withdrawing fluid from the reservoir, and through the catheter to the selected area of the patient.

20 While perhaps the least complex component of an infusion system, catheters can have or can develop operational problems. For example, catheters may be placed in the wrong location when originally deployed, or the catheters may migrate over time such that drug-containing fluids delivered through the catheters are not delivered to the desired internal delivery site. Catheters can also become obstructed or clogged during use. A partial or complete blockage can prevent the drug-containing fluid from reaching the selected delivery site in an amount to be therapeutically effective. Catheters can also
25 contain leaks, cuts, tears or the like, or can become dislodged from the infusion device, causing some or all of the drug-containing fluid to reach a site other than the intended delivery site.

30 Some infusion devices have been proposed that are capable of monitoring catheter complications, such as a leak, a dislodgement, a migration, or an occlusion. Many of these proposed infusion systems employ pressure sensors capable of monitoring pressure within the catheter to determine whether a complication or

malfunction exists. Upon detection of a catheter malfunction or the likelihood of such a malfunction, the device may alert the patient to seek medical attention.

Methods and devices that use changes in physiological pressure to determine whether a catheter complication exists have recently been proposed. These methods and
5 devices are based on the finding that physiological pressure changes can cause pressure modulations within an implanted catheter, provided that at least a portion of the catheter is placed in a fluid-filled space of the body that experiences the physiological pressures. For example, physiological pressure changes due to beating of the heart or patient
10 breathing may be transduced through normally functioning catheters having at least a portion residing in cerebrospinal fluid (CSF). If the catheter migrates from the CSF, becomes dislodged, or develops a leak or tear at a location outside the CSF, a characteristic pressure profile associated with the physiological activity (e.g., heart beat or respiration) is not detected by a pressure sensor in communication with the catheter (and associated circuitry), and a catheter complication is determined to exist.

15 However, implementation of such methods in implantable infusion devices presents a number of challenges. First, development and detection of a full physiological pressure profile can require a good deal of sensing and processing power, which is not desired for an implantable infusion device with a limited power supply. However, limiting the acquisition or processing of data associated with the
20 physiological pressure profiles may compromise the ability to detect catheter complications. Second, such physiological pressure profiles can be difficult to detect in the presence of background noise. For example, the amplitude of physiological pressure signals associated with heart beat or respiration within the CSF, and thus transmittable via a catheter positioned in the CSF, are quite small relative to pressure changes
25 associated with patient activity. One or more of these and other challenges are addressed in one or more embodiments described herein.

SUMMARY

This disclosure, among other things, describes devices, systems and methods for
30 detecting catheter complications via monitoring of pressure modulations within the catheter that are associated with physiological pressure changes, such as pressure

changes due to heart beats. The methods, devices and systems may be configured to employ low power by limiting complexity of pressure data processed and limiting the sampling frequencies and sampling windows to those suitable for obtaining meaningful data.

5 The complexity of the data for processing may be reduced by preconditioning raw pressure data with a band-pass filter configured to pass through the AC component of an acquired pressure data stream that is within a relevant physiological frequency range, a rectifier and an integrator.

10 In some embodiments, the frequency of the pressure sampling and duration of the sampling window are determined based on population data regarding patient activity. Because patient activity may produce too much noise for meaningful pressure data to be collected, frequencies and durations of sampling may be selected based on acceptable missed detection rates, false positive rates, and latencies of detection, taking into account patient activity data as described herein. Alternatively or in addition, in
15 some embodiments, a patient activity sensor is employed for determining whether patient activity is sufficiently low for meaningful pressure data to be collected.

 In various embodiments, described herein, a method for determining status of an implanted catheter includes acquiring raw pressure data from a pressure sensor of in an implantable infusion device. The pressure sensor is in communication with a lumen of
20 the catheter operably coupled to the infusion device. The catheter has a delivery region intended to be positioned in a fluid-filled target location of a patient. The delivery region is in communication with the lumen. The method further includes filtering the raw pressure data to remove the DC component, leaving the AC component within a relevant physiological frequency range; rectifying the AC component to produce a
25 rectified pressure signal; obtaining a mean-magnitude of the rectified pressure signal; and determining whether the mean-magnitude is below a predetermined threshold. If the mean-magnitude is below the threshold, the catheter is determined to be in a state other than a normal state; i.e. a catheter complication exists or may exist.

 Computer readable media and implantable infusion devices configured to carry
30 out the method described above are discussed and contemplated herein.

One or more embodiments of the systems, devices and methods described herein may provide one or more advantages over prior systems, devices and methods for detecting catheter complications by sensing pressure within the catheter. Such advantages will be apparent to those of skilled in the art upon reading the following
5 detailed description.

BRIEF DESCRIPTION OF THE DRAWINGS

The accompanying drawings, which are incorporated into and form a part of the specification, illustrate several embodiments of the present disclosure and, together with
10 the description, serve to explain the principles of the disclosure. The drawings are only for the purpose of illustrating embodiments of the disclosure and are not to be construed as limiting the disclosure.

FIG. 1 is a schematic top view of an implantable infusion system that includes an implantable infusion device and a catheter.

15 **FIG. 2** is a schematic view showing an implantable infusion system implanted in a patient.

FIG. 3 is a schematic block diagram showing some selected components of an implantable infusion device, where dashed lines represent electrical connections and solid lines represent fluid connections.

20 **FIG. 4** is a partial sectional view of a portion of a catheter.

FIG. 5 is a graph of pressure versus time within a catheter located in the CSF in the intrathecal space of a subject.

FIG. 6 is a graph of pressure versus time within a catheter located outside of the CSF a subject.

25 **FIG. 7** is a schematic drawing of an over view of data processing and components in accordance with various embodiments described herein.

FIG. 8 is a simulated graph of pressure versus time of a catheter located outside of the CSF a subject.

FIG. 9 is a schematic block diagram showing selected preconditioning components and processing according to various embodiments described herein.

FIG. 10 is a schematic block diagram of an embodiment of a band-pass filter.

FIG. 11 is a simulated graph of pressure versus time of the pressure data depicted in **FIG. 8** following band-pass filtering.

FIG. 12 is a simulated graph of pressure versus time of the pressure data depicted in **FIG. 8** following band-pass filtering and rectifying.

FIG. 13 is a simulated plot of pressure versus time showing a CSF pressure cardiac effect artifact.

FIG. 14 is a schematic depiction of a Markov state machine model in accordance with various embodiments described herein.

FIG. 15 is a flow diagram of an overview of a method described herein.

FIG. 16 is simulated plot of voltage versus pressure relationship for a sensor at various temperatures.

FIG. 17 is a plot of simulated pressure sensor sensitivity as a function of pressure.

FIG. 18 is a schematic drawing of an overview of data processing and components in accordance with various embodiments described herein.

FIG. 19 is a simulated plot of energy levels during periods of patient activity.

FIG. 20 is a plot of activity duration per hour versus hour of day.

FIG. 21 is a zoomed in view of a simulation record of activity and sampling windows.

FIG. 22 is a full 24 hour view of a simulation record of activity and sampling windows.

FIG. 23 is a plot of activity simulation with latency calculation included.

FIG. 24 is a bar graph of maximum and mean latency for varying sizes of sampling window durations (based on 1 sampling per hour).

FIG. 25 is a bar graph of maximum and mean expected latency for varying sampling frequencies (samples per day) assuming a 15 second window duration.

FIG. 26 is a flow diagram of an overview of a method in accordance with various embodiments described herein.

5 **FIG. 27** is a schematic drawing of an overview of data processing and components in accordance with various embodiments described herein.

FIG. 28 is a flow diagram of an overview of a method in accordance with various embodiments described herein.

10 **FIG. 29** is a schematic block diagram showing selected components of an implantable infusion device.

The schematic drawings presented herein are not necessarily to scale. Like numbers used in the figures refer to like components, steps and the like. However, it will be understood that the use of a number to refer to a component in a given figure is not intended to limit the component in another figure labeled with the same number. In
15 addition, the use of different numbers to refer to components is not intended to indicate that the different numbered components cannot be the same or similar.

DETAILED DESCRIPTION

20 In the following detailed description, reference is made to the accompanying drawings that form a part hereof, and in which are shown by way of illustration several embodiments of devices, systems and methods. It is to be understood that other embodiments are contemplated and may be made without departing from the scope or spirit of the present disclosure. The following detailed description, therefore, is not to be taken in a limiting sense.

25 All scientific and technical terms used herein have meanings commonly used in the art unless otherwise specified. The definitions provided herein are to facilitate understanding of certain terms used frequently herein and are not meant to limit the scope of the present disclosure.

As used in this specification and the appended claims, the singular forms “a”, “an”, and “the” encompass embodiments having plural referents, unless the content clearly dictates otherwise.

As used in this specification and the appended claims, the term “or” is generally
5 employed in its sense including “and/or” unless the content clearly dictates otherwise.

As used herein, “have”, “having”, “include”, “including”, “comprise”, “comprising” or the like are used in their open ended sense, and generally mean “including, but not limited to.”

As used herein, a “physiological pressure modulation profile,” or the like, is a
10 pressure profile that is modulated by a physiological event. For example, beating of a heart may result in pressure oscillations having a frequency and amplitude within characteristic ranges, which pressure oscillations are detectable in fluid-filled compartments of the patient, such in the vascular system or cerebrospinal fluid, and which may be transferred to a catheter having a delivery region or opening within the
15 fluid-filled compartment. Such pressure oscillations have profiles that result from the physiological event (e.g., heart beat) and are examples of physiological pressure modulation profiles.

As used herein, “mean-magnitude” of a rectified (absolute value) pressure signal is the sum of the rectified values of an AC component of samples of pressure data
20 acquired over time divided by the number of samples obtained in the period of time. The mean-magnitude may be obtained in any suitable manner. For example, the mean magnitude may be obtained by integrating the rectified pressure signal and then dividing by the number of pressure signals; the mean-magnitude may be obtained by integrating and right-shifting the rectified pressure signal, provided that the number of samples
25 acquired is equal to $2n$ (2 to n th power), where n is an integer; or the like. Throughout the specification and drawings “mean magnitude” is referred to as “E” or “EU”, which reflects that the mean magnitude value is related to pressure energy or energy units.

As used herein, the “AC” component of a pressure signal means the changes in pressure that reverse direction (i.e., increasing pressure then decreasing pressure) in
30 predictable intervals and that result from physiological events, such as heart beats and

breathing. The magnitude of pressure changes associated with AC component is typically small in relation to the magnitude of the baseline pressure.

As used herein, the “DC” component of a pressure signal means the magnitude of the pressure signal that is substantially constant and which is primarily determined by atmospheric pressure.

This disclosure, among other things, describes devices, systems and methods for detecting catheter complications via monitoring of pressure modulations within the catheter that are associated with physiological pressure changes, such as pressure changes due to heart beats. The methods, devices and systems may be configured to employ low power by limiting complexity of pressure data processed, limiting the sampling frequencies, or limiting the duration of sampling windows to those suitable for obtaining meaningful data.

1. Overview of Infusion Systems

The methods and systems described herein may be employed with any suitable implantable infusion system. **FIGS. 1-2** show examples of infusion systems **100** with which pressure monitoring systems and methods described herein may be used. The infusion system depicted in **FIG. 1** includes an infusion device **110**, a catheter **120**, and a catheter access port **119** in fluid communication with the catheter **120**. The infusion device **110** also includes a refill port **118** in communication with a reservoir (not shown in **FIG. 1**) for containing therapeutic agent disposed within the housing of the device **110**. The infusion device **110** may include any suitable mechanism or structure capable of delivering one or more fluids to a patient. The structures used to drive fluids in the infusion devices may be powered (e.g., piston pumps, diaphragm pumps, peristaltic pumps, etc.), may be activated based on pressure to drive fluid out of a reservoir (e.g., using collapsing diaphragms, expanding bladders, etc.), or the like. Examples of some potentially suitable pump assemblies may include, e.g., commercially available implantable infusion pumps such as, for example, the SYNCHROMED II and EL pumps, manufactured by Medtronic, Inc., Minneapolis, Minn.

The infusion system **100** depicted in **FIG. 2** is shown implanted in a patient. The infusion system **100** includes an infusion device **110** and catheter **120** having a

proximal end **122** attached to the infusion device **110**. The infusion device **110** may be surgically implanted in any suitable location, such as subcutaneously in the pectoral, abdominal or other region of the subject's body. The distal end **124** of the catheter **120** is implanted in a patient such that the distal end **124** is located at the selected internal
5 delivery site in the patient (in the intrathecal space of the patient as depicted in **FIG. 2**, the cerebroventricles, or elsewhere as desired). While not shown in **FIG. 2**, it will be understood that the depicted infusion device **100** may include a catheter access port in fluid communication with the catheter **120** as described above with regard to **FIG. 1**. The pump assembly **110** may also include a reservoir that contains a fluid (e.g., a
10 therapeutic substance) to be infused using the system. The fluid contained within the reservoir may preferably be replenished periodically using known techniques and structures.

An overview of selected components of an example of an implantable infusion device **110** is depicted in **FIG. 3**. The depicted infusion device **110** includes a pump
15 mechanism **112** operably coupled to a catheter **120** such that fluid within a reservoir **114** can be delivered to the catheter **120** via the pump mechanism **112**. The depicted infusion device **110** includes a power supply **116** and control electronics **117** operably coupled to the power supply **116** and the pump mechanism **112** such that the infusion of fluids using the system can be controlled. Although not specifically depicted, the
20 infusion device **110** may also include other components such as, e.g., communication devices (e.g., telemetry modules, etc.) to provide for control and/or communication between the infusion system and external devices.

The implantable infusion device **110** depicted in **FIG. 3** also includes a pressure sensor **130** that is operably coupled to the control electronics **117**. The pressure sensor
25 **130** is operably coupled to the catheter **120** in a manner that allows the pressure sensor **130** to measure the pressure of fluid located within the catheter **120** and to provide a pressure signal (to, e.g., the control electronics **117**) that is representative of the fluid pressure of the fluid in the catheter **120**.

FIG. 4 depicts a portion of a catheter **120** in an enlarged cross-sectional view.
30 The catheter **120** includes an elongated tubular portion **123** that preferably extends from the proximal end (not shown) to the distal end **124**. The catheter **120** depicted in **FIG. 4**

includes a lumen **126** that terminates at opening **128** (or delivery region) at the distal end **124**. Therapeutic substances (or other fluids) delivered from the infusion device **110** to the catheter **120** pass through lumen **126** and preferably exit the catheter **120** through opening **128** (also referred to herein as “delivery region” or “infusion section”).

5 The body of catheter **120** may be constructed of any suitable material, e.g., an elastomeric tube. Examples of some suitable materials include, but are not limited to, silicone rubber (e.g., polydimethyl siloxane) or polyurethane, both of which can provide good mechanical properties and are very flexible. Suitable materials for the catheter **120** are also preferably chemically inert such that they will not interact with therapeutic
10 substances, body tissues, or body fluids while implanted in the patient.

Where the catheter is to be used for intrathecal fluid delivery, it may be preferred that at least a portion of the catheter **120** be sized to fit in the gap between the spinal cord and the dura within the intrathecal space. Catheters intended for delivering fluids to other internal delivery sites will be sized appropriately for those locations. As
15 another consideration in sizing the catheter, the diameter of the lumen **126** is preferably large enough to accommodate expected infusion rates with acceptable flow resistance. The wall **121** of the catheter **120** is preferably thick enough to withstand normal handling during the implant procedure and forces from body tissues during normal motion. As an example, a catheter intended for use in intrathecal fluid delivery may
20 have an outside diameter of 1.25 millimeters (mm), an inside diameter of 0.5 mm, and a wall thickness of 0.375 mm. Such a catheter may have a length of, e.g., 50 centimeters (cm) long to reach from, e.g., a drug infusion pump implanted in the patient's abdomen to the spine.

Although the opening **128** through which the fluid exits the catheter **120** is
25 depicted as a single opening in the distal end **124** of catheter **120**, such an opening **128** is only one embodiment of an infusion section that may be used in connection with the teachings presented herein. Other embodiments of infusion sections may include, e.g., multiple openings, permeable membranes, or the like. Although the infusion section (opening **128**) of the depicted catheter **120** is located at the distal end **124** of the catheter
30 **120**, the infusion section(s) may be positioned at any location along the length of the catheter **120** that can be used to deliver the fluid to the selected internal delivery site.

2. Physiological Pressure Modulations

Because physiological pressure modulations at the selected internal delivery site are preferably transmitted into the fluid located within the lumens of catheters in various embodiments, the construction of the infusion sections is preferably selected to provide
5 for that pressure transmission. In other words, the infusion sections are preferably capable of transmitting physiological pressure modulations (e.g., from the CSF where the infusion sections may be located) into the fluid located within the catheter lumen.

As mentioned above, one way to determine the status of a catheter of an implantable infusion device is to monitor pressure within a lumen of a catheter for
10 characteristic physiologic pressure changes of cerebral spinal fluid (CSF) in which the catheter is implanted. Examples of such methods are described in U.S. Patent Application Publication No. 2008/0243074A1, entitled CATHETER MALFUNCTION DETERMINATIONS USING PHYSIOLOGIC PRESSURE, published on October 2, 2008.

15 An example of a representative pressure profile of CSF in an animal, such as a sheep or dog, on mechanical ventilation is shown in **FIG. 5**. Pressure in the CSF has characteristic patterns that can be transmitted to a catheter in communication with the CSF. The representative data plotted in **FIG. 5** demonstrates these patterns, where the plot **20** represents pressure of fluid within a lumen of a catheter located in fluid
20 communication with the CSF. The pressure profile includes repeating major peaks **22** representative of patient respiration activity and repeating minor peaks **24** representative of cardiac activity (i.e., heartbeats). The major peaks **22** and minor peaks **24** are transmitted into the fluid in the lumen from the CSF (into which the lumen opens). The major peaks **22** repeat about every 2 to 10 seconds, which corresponds to about 30 to 6
25 breaths per minute. Typically, major peaks **22** repeat about every 3 to 5 seconds, which corresponds to about 20 to 12 breaths per minute. The amplitude of the major peaks **22** can vary (e.g., depending on the nature of the catheter), but are often less than 4 mmHg in amplitude, typically between about 1 mmHg and about 4 mmHg or between about 1 mmHg and 3 mmHg within a catheter such as Medtronic, Inc.'s Model 8709SC or
30 8731SC silicone catheters with an inner diameter of about 0.53 mm.

The minor peaks **24** repeat about every half second to about every second and a half, which corresponds to about 40 to 120 heart beats per minute. Typically, the minor peaks **24** repeat about every 0.6 seconds to about every 1 second, corresponding to a heart rate of about 100 beats per minute to about 60 beats per minute. The amplitude of the minor peaks **24** can vary (e.g., depending on the nature of the catheter), but are often between about 0.5 mmHg and about 1 mmHg in amplitude within a catheter such as Medtronic, Inc.'s Model 8709SC or 8731SC silicone catheters with an inner diameter of about 0.53 mm.

It should be noted that the pressure associated with respiration (major peaks **22**) is exaggerated in cases where an animal is on mechanical ventilation (e.g., as shown in **FIG. 5**) relative to a free-breathing animal. Accordingly, the differences in amplitude of the peaks corresponding to respiration (major peaks) and heart rate (minor peaks) may not be as discernable in a free-breathing animal or human. It will be understood pressure changes that generally repeat in coordination with the animal's or patient's breathing or heart rate may be detected, regardless of the amplitude. In some instances, it may be difficult to detect pressure changes associated with both breathing and heart rate. However, pressure changes in the CSF or other fluid filled compartment associated with one or the other of heart rate and respiration are typically detectable and are transmittable via a catheter having an infusion section opening into the compartment. In some embodiments, characteristic pressure changes associated with one or both of heart rate and respiration are detected to determine catheter status.

Referring now to **FIG. 6**, a representative physiological pressure profile of a catheter having a delivery region located outside the CSF in a non-fluid compartment of an animal is shown. As depicted in **FIG. 6**, representative physiological pressures are not detected within catheters located in non-fluid filled compartments as the physiological signal is attenuated. Similar attenuation is expected with a variety of other catheter states, as indicated below in **Table 1**.

Table 1. Expected attenuation values for a variety of catheter states

Catheter State	Expected Attenuation (at 1 Hz)
Normal	0 dB
Partial occlusion (10X increased restriction)	-12 dB
Migration from intrathecal to epidural	-12 dB
Full occlusion (100X increased restriction)	-30 dB
Disconnect	-40 dB
Air bubble (1/4 length of catheter)	-14 dB

It should be understood that the values presented above may vary with the nature of the catheter and infusion device employed. However, regardless of the catheter and infusion device employed, the attenuation associated with a catheter complication should result in sufficient loss of signal for a determination that a catheter complication exists when employing embodiments of the methods described herein.

It should also be understood that the ability to detect a catheter complication via the ability (or lack of ability) to detect a characteristic physiological pressure modulation profile can be affected by noise. For purposes of example, noise will be described with regard to the AC signal related to a patient's cardiac and respiratory pressure as measured via a catheter in communication with a patient's CSF. In this context, noise has two types: patient CSF noise and sensor sampling system noise. The CSF noise arises from pressure signals within the relevant frequency range (e.g., 0.5 to 3 Hz) due to patient movement or posture change (collectively referred to herein as "patient activity"). Sensor and sampling system noise provides a minimal signal amplitude that needs to be obtained for purposes of meaningful data collection. Through filtering or other pre-processing of raw pressure data, sensor and sampling system noise can readily be reduced to manageable levels. However, CSF noise can render it nearly impossible to detect a catheter complication during periods of patient activity.

For example, assuming that relevant physiological pressure (e.g. cardiac or respiratory) amplitudes range from 1 to 5 mmHg from peak to peak, patient activity (due

to , e.g., walking) that falls within the relevant frequency range can result in signals of greater than 10 mmHg, such as around 20 mmHg. Accordingly in various embodiments (described in more detail below), pressure data is sampled at a high enough frequency to increase the chances that, during at least some sampling windows, meaningful pressure data is obtained. However, a balance should be reached between sampling frequency (and sampling window duration) and the power requirements of such sampling and data processing, as higher frequency sampling typically requires more power.

3. Data Processing and Complication Detection

Various embodiments are described herein that provide a practical approach for detecting physiological pressure modulations for purposes of determining whether a catheter complication exists in an implanted infusion system. One or more of these embodiments balance the power concerns of an implantable infusion system, which have a limited power supply (e.g., battery) or require recharging or replenishing (e.g., rechargeable battery) of the power supply, with the need to obtain and process sufficient data to make reliable determinations as to catheter status.

In general, the methods, devices and systems described herein process pressure data as indicated in **FIG. 7**. Where raw pressure data (input pressure data or “ P_{in} ”) obtained from pressure sensor **130** is pre-conditioned by components **200** before algorithm processing by components **300** for determining whether a catheter complication exists. Components **300** may include a processor, memory (such as RAM, ROM, or the like), or the like. The memory may store computer-readable instructions that enable the processor to carry out an algorithm as described herein. An appropriate output, such as alerting a patient or physician or storing results in memory, may be made by components **400**.

For purposes of illustration, graphical depictions of results of various steps of processing of data, according to some embodiments, will be shown. The raw pressure data that is used as the input for purposes of illustration is shown in the simulated plot in **FIG. 8**, which includes the DC pressure level, cardiac and respiratory physiological AC pressure signals (**Ph**) and occasional pulse due to a pump stroke (**S**) (of a piston pump). For purposes of illustration, catheter complications (**C**) between about 30 and 55 seconds and between about 70 and 95 seconds, and a change in pressure (**Po**) due to a

posture change from a patient standing up from a supine position (assuming catheter location in lumbar intrathecal space) is shown. The simulated plot depicted in **FIG. 8**, is based on previous studies showing, with the particular system employed, the amplitude of CSF artifacts that track with the patient's cardiac and respiratory rhythms are roughly
5 between 1 mmHg and 5 mmHg peak to peak with frequencies between 2 Hz down to 1/10 Hz depending on patient activity levels. For example, at-rest cardiac base frequency can be between 30 bps for an extreme athlete to 120 bps for a patient exhibiting tachycardia.

A. Pre-Conditioning

10 In various embodiments described herein, raw pressure data is preconditioned to reduce the complexity of the data for processing, thereby reducing the power requirements for processing the data. As discussed above (e.g., with regard to **Table 1**) catheter complications result in a diminishing of the characteristic physiological cardiac and respiratory artifacts ordinarily present in the CSF as read by a pressure sensor in
15 communication with the lumen of a catheter having an infusion section placed in a patient's CSF. Therefore, a technical approach for a complication detection algorithm described in accordance with various embodiments presented herein is to merely measure an "energy" level in a particular band of physiologic interest.

This unitless energy level may be derived from a root mean square average of a
20 sampled data stream in any suitable manner. By way of example and with reference to **FIG. 9**, raw analog pressure data obtained from pressure sensor **130** may be preprocessed by components **200**, which include an analog-to-digital converter **210**, a band pass filter **220**, a rectifier **230**, and an integrator **240**. Preferably the band pass filter **220** is configured to remove the average DC pressure component and to pass only
25 the time-varying portion of the pressure signal through. In addition, the band pass filter **220** is preferably configured to filter out noise that is above the frequency band of interest. In various embodiments, the band pass filter with a lower frequency cutoff of between 0.1 and 1 Hz and with an upper frequency cutoff of between 2 Hz and 5Hz. In some embodiments, the band pass filter has a lower frequency cutoff between 0.1 Hz
30 and 0.5 , such as between 0.2 and 0.5 Hz, and has an upper frequency cutoff of between 2 and 4 Hz, such as between 2 and 3 Hz.

It will be understood that the low frequency component of the band pass filter will typically determine the filter settling time (i.e., the amount of time to achieve a reliable baseline measurement). For example, a 0.1 Hz band-pass filter may require approximately 10 to 20 seconds to settle out. For implantable medical devices that have limited battery life, such long settling times may be unacceptable. For example, the amount of time of a sampling window can be considered to be the sum of (i) data acquisition on time, (ii) filter settling time, and (iii) algorithm dwell time (time needed to gather enough data for meaningful processing). The data acquisition turn on time is relatively short – typically less than a second. If cardiac or respiratory CSF physiological pressure signals are used for determining catheter complications, a minimum dwell time of about 5 to 15 seconds may be need to include a reasonable number of heart beats or respiratory cycles. Accordingly, if the filter settling time is between 10 and 20 seconds, it can account for more than 50% of the total data acquisition energy consumed. However, a 0.5 Hz band-pass filter typically requires 5X less time to settle out than a 0.1 Hz filter. The use of a 0.5 Hz filter will thus result in much more efficient data acquisition, but may result in the loss of the frequencies needed to detect patient respirations.

In some embodiments, the band-pass filter **220** includes a chain of two or more stages of 2nd order bi-quad filters as shown in **FIG. 10**. In the depicted filter **220**, a band-pass is implemented by cascading two biquad stages. The first stage is configured as a High Pass biquad and the following stage is configured as a Low Pass biquad.

The band-pass filter requirements are preferably selected to optimize the signal-to-noise-ratio (SNR) between cardiac physiological pressure and sensor noise over the range of possible frequencies of use. The pressure signal from CSF is a superimposition of the cardiac base frequency and a third harmonic of the base frequency. It is assumed that the detection system will support at-rest heart rates between 30 and 120 bps. The corresponding frequency range for this is .5 Hz to 2 Hz. The computed physiological energy (discussed below in more detail) will include components of base frequency and the 3rd harmonic. As the high-frequency cutoff of the band pass filter moves down, the contribution from the 3rd harmonic decreases. However, the total sensor noise component will likewise decrease as described below in **Equation 1**.

$$SNR = \frac{CardiacEnergy}{SensorNoiseEnergy}$$

Equation 1: Sensor to noise ratio

5 A simulated plot of the resulting pressure data after passing the band pass filter (0.1-3 Hz) **220** is shown in **FIG. 11**.

The pressure signal resulting from band pass filter **220** is then rectified by rectifier **230** and integrated by integrator **240** (see, e.g., **FIG. 9**). The rectifier **230** may take the absolute values of data samples of the pressure signal resulting from the band
 10 pass filter or may square the values of the data samples. The integrator **240** also serves a low-pass filter. In various embodiments, the block **240** integrates, dumps, and right shifts the pressure data received from the rectifier block **230** to compute the average for a set of samples collected over the sampling window. It will be understood that data obtained during the settling time of the band-pass filter **220** may not be meaningful and
 15 should be accounted for by the integrator **240**. For example, in some embodiments, only data acquired later in the sampling period is integrated.

A simulated plot of the data received from block **220** after passing through blocks **230** and **240** is shown in **FIG. 12**, where the dashed line shows the computed average for the sampling window.

20 The output of the preconditioning sub-blocks **210**, **220**, **230**, **240** is a value corresponding to the amount of CSF signal magnitude in the cardiac and respiratory frequencies measured by a pressure sensor in communication with a lumen of a catheter in communication with the CSF. The effect of applying the preconditioning sub-blocks of band pass-filter **220**, rectifier **230**, integrate, divide and dump **240** is to create mean-
 25 magnitude average (MM) of the sampled data stream. A mathematical conversion is:

$$P_{MM} = \frac{1}{N} \sum_{i=1}^N |P_i|$$

Equation 2: MM conversion from sampled data stream

It will be understood that the mean-magnitude is similar to a root-mean square (RMS) average. That is, if the rectifier squared the sampled values (e.g., if rectifier were a diode), then the square root could be taken of the sum of the squared sampled values divided by the number of sampled values to obtain the RMS average. For purposes of the present disclosure, RMS is subsumed under the definition of “mean-magnitude.”

If the sampled data is a well-behaved sinusoid, the conversion from a peak-to-peak magnitude will be:

$$P_{MM} = \frac{\sqrt{2}}{4} P_{PP}$$

Equation 3: Peak-Peak to MM conversion (ideal sign wave)

In various embodiments, a measure of mean magnitude (EU) is calculated from P_{MM} for signals having peak-to-peak spectral signal amplitudes (A_f) as follows:

$$EU = \frac{\sqrt{2} \cdot A_f}{4} \sum_{f=1}^N A_f$$

Equation 4: Mean magnitude (EU) calculation

A mean magnitude calculation of a CSF cardiac signal having a fundamental frequency and a third harmonic component may be made as follows:

$$EU = \frac{\sqrt{2} \cdot T_{duration}}{4} \cdot (A_1 \cdot H(f_1) + A_3 \cdot H(3 \cdot f_1))$$

Equation 5: Mean magnitude (EU) calculation of signal having 3rd harmonic component

Based on typical CSF signal waveforms captured using direct pressure measurement, the relative amplitude of the first and third harmonic are approximately 1/3 as shown in **FIG. 13**.

A respiratory frequency component (about 1/6 the heart rate) also contributes to the CSF signal that will pass through the digital band-pass filter, $H(f)$, if the low frequency component of the band-pass filter is at a sufficiently low frequency (e.g. 0.1

Hz). The resultant energy value can be predicted to be a function of cardiac signal frequency and amplitude and will be affected by the filter transfer function, $H(f)$.

$$EU(f_c, A_c, A_r) = \frac{\sqrt{2} \cdot T_{duration}}{4} \cdot (A_c \cdot H(f_c) + \frac{A_c}{3} \cdot H(3 \cdot f_c) + A_r \cdot H(\frac{f_c}{6}))$$

- 5 **Equation 6:** Mean magnitude (EU) calculation accounting for filter transfer function and cardiac and respiratory components

The transfer function, for CSF inputs to the sensor, is actually a composite of the band-pass filter and the effective filtering action provided by the catheter itself. The
10 catheter behaves as a simple 1st order low pass filter with attenuation equal to:

$$H_{cath}(f, f_c) = \frac{f_c}{f + f_c}$$

Equation 7: Catheter attenuation

B. Catheter Complication Algorithm

15 Any suitable algorithm for determining whether the mean magnitude derived from pre-conditioning components **200**, as described above, may be used to determine whether a catheter complication exists. As discussed above, a variety of catheter complications will result in attenuation and diminished mean magnitude associated with CSF pressure modulation profiles. Thus, if the mean magnitude is below a
20 predetermined minimum, a determination may be made that a catheter complication exists or may exist.

In various embodiments, the algorithm (block **300** see, e.g., **FIG. 7**) includes a Markov model state machine that translates mean magnitude (E) to discrete catheter states. As depicted in **FIG. 14**, the Markov state machine includes at least two discrete
25 catheter states “Normal” and “Complication Detected.” The state machine may include additional discrete catheter states, such as “Lack of Energy Detected” and “Possible Complication Detected” to reduce false detection rates, if necessary or desired.

An overview of the process employed with regard to the Markov state machine depicted in **FIG. 14** is shown in the flow diagram of **FIG. 15**. As shown in **FIG. 15**, raw pressure data is preconditioned (**500**), e.g. as described above. An mean magnitude (EU) is derived from the preconditioned pressure data (**510**), e.g. as described above. A determination is then made as to whether the EU is below a predetermined minimum (**520**). The predetermined minimum may be determined by balancing the desire to minimize “missed detection” of known occurrences and “false detection” of complications for properly functioning catheters (e.g. as described in more detail below under the heading “Detection Threshold Analysis”). If the EU is not below the minimum, the catheter is in the “Normal” state and catheter complication is determined not to exist (**530**). If the EU is below the predetermined minimum, a determination as to whether the EU is below the minimum for a time greater than a minimum dwell time may then be made (**550**). If the EU is not below the energy minimum for a time greater than a minimum dwell time, a “lack of energy” state is observed (**540**). If the EU is below the minimum for a time greater than a minimum dwell time, a determination as to whether the EU is below the energy minimum for a time greater than a minimum dwell time and for greater than a predetermined minimum number or retries may then be made (**570**). If the EU is not below the energy minimum for a time greater than a minimum dwell time and for greater than a predetermined minimum number or retries, a “possible catheter complication” state is observed (**560**). If the EU is below the energy minimum for a time greater than a minimum dwell time and for greater than a predetermined minimum number or retries, a “catheter complication” state is observed (**580**).

i. Accounting for Gain/Sensor Variation/Sensitivity

As discussed below with regard to **FIGS. 16-18**, it may be desirable to apply an appropriate correction factor to integrated pressure data or mean magnitude to account for sensor gain or variation because sensor output and conversion is not necessarily linear.

In various embodiments, pressure sensor data is converted into digital numeric format in a set of two transforms. In the first transform, the sensor converts pressure into voltage via a functional relationship as shown in **FIG. 16**, which shows that the pressure to voltage transformation provided by the sensor is not necessarily a linear one.

Over the expected operating range of pressures (400 mmHg to 800 mmHg), the sensitivity (or, gain) of the filter can change (e.g., from a value of 0.4 mV/mmHg to 0.8 mV/mmHg as shown in the embodiment depicted in **FIG. 17**). (Sensor Sensitivity is defined by $S = \frac{\Delta V}{\Delta P}$ such that the sensor output, in volts, is given by $V_s = S \cdot P + Offset$).

- 5 In **FIG. 17**, the target sensitivity of 0.0008 V/mmHg is depicted by closed circles, the upper sensitivity limit is depicted by vertical dash marks, and the lower sensitivity limit is depicted by asterisks.

As shown in the embodiment depicted in **FIG. 17**, absent correction, computed mean magnitude (EU) could be over (or under) by an amount proportional to the deviation from the presumed sensor sensitivity. For example, a sensor with a presumed
 10 sensitivity of 0.8 that is operating at 400 mmHg, which has an actual sensitivity of 0.4, could lead to an under-calculation of EU by 50%. On the other hand, operation at low temperature at 800 mmHg could lead to an over-calculation of EU by 15%.

Accordingly, it may be desirable to correct for such sensor gain. This can be
 15 done by calibrating the sensor prior to use by collecting a number of values within the relevant pressure ranges (e.g., 400 mmHg to 800 mmHg) and identifying a correction factor curve or compensation coefficient for application to detected raw pressures during actual use. The calibration curve or correction factors can stored in a lookup table.

By way of example and with reference to **FIG. 18**, raw pressure data (e.g.,
 20 following ADC, but before band pass filtering) not subjected to preconditioning **200** may obtained for purposes of identifying a pressure point for applying the appropriate compensation factor to account for sensor gain.

C. Sampling Frequency and Window Duration

25 Any suitable sampling frequency and sampling window duration may be employed in accordance with the teachings presented herein. Preferably, the sampling frequency and window duration take into account desired performance characteristics in light of power consumption issues. Three key performance measures of the catheter complication algorithm described herein are (i) missed detection rate, (ii) false detection
 30 rate, and (iii) latency of detection.

Missed detection rate is the probability that the algorithm will not detect a catheter complication within the specified worst case latency period when an actual catheter complication does exist. Any suitable missed detection rate may be employed. However, as the missed detection rate approaches zero, increased sampling (and power consumption) is needed. Missed detection rate is a unitless quantity. In various embodiments, the missed detection rate is set between about 3% and about 10%, such as about 5% or about 6%.

False detection rate is the probability that algorithm and device will detect a catheter complication when no problem actual exists. This is a unit-less quantity. Any suitable missed detection rate may be employed. However, as the set missed detection rate approaches zero, increased sampling (and power consumption) is needed. False detection rate is a unitless quantity. In various embodiments, the false detection rate is set between about 0% and about 5%.

Latency of detection is the amount of time from onset before the algorithm will detect a catheter complication condition. Both average and worst case measures of latency can be important. Units of detection latency are used herein are hours. Any suitable average and worst case latency of detection may be employed. However, the shorter the set latency, the more sampling (and power consumption) required.

Testing to identify suitable missed detection rates, false detection rates, and latencies of detection was performed in two parts. The first part provided an understanding of the mean magnitude pressure values and ranges for expected and worst case conditions of CSF pressure signals and catheter states which were used to support prediction of missed and false detection rates. The second part provided an understanding of latency. This testing incorporated a stochastic model of patient activity which was then monitored relative to varying sampling frequencies and durations.

i. Detection Threshold Analysis

For the system employed herein, raw intrathecal CSF pressure signals have a range of 1.2 – 3.9 mmHg peak-to-peak due to patient variations. Each catheter state also presents a range of attenuation values based on the frequency of the cardiac rate.

The greatest attenuation (-1.7 dB) will occur at the highest cardiac rate (2 Hz) and the least attenuation (-.14 dB) will occur at the lowest cardiac rate (0.5 Hz). The superposition of the range of CSF pressure signal magnitudes and the attenuations at the lower and upper end of the heart rate resulted in the calculation of a set of four values (quadruple). The quadruple was calculated for each of 7 catheter complication states, and the results are presented below in **Table 2**.

Table 2: Simulated Physiological Mean Magnitude (MM) Pressure Values for a variety of patient and catheter states

Condition	MM value for 1.20 pp min at 2 Hz in mmHg	MM value for 1.20 pp min at .5 Hz in mmHg	MM value for 3.9 pp max at 2 Hz in mmHg	MM value for 3.9 pp max at .5 Hz in mmHg
Normal 8709SC, normal patient (-1.7 dB to -.14 dB)	0.288	0.413	1.122	1.342
10X Increased Restriction (-9 to -12 dB)	0.072	0.104	0.398	0.476
Migration – epi (-9 to -12 dB)	0.072	0.104	0.398	0.476
100X Occlusion (-20 to -30 dB)	0.009	0.013	0.112	0.134
Migration – full (-20 to -30 dB)	0.009	0.013	0.112	0.134
Disconnect (-35 to -40 dB)	0.003	0.004	0.020	0.069
Air bubble – 50 uL bubble (-5 to -14 dB)	0.057	0.082	0.631	0.755

10

These computed mean magnitude values are shown graphically in **FIG. 19**. For reference, the infusion device's pressure measurement, post-filtered, noise floor (-40 dB) as well as the selected complication threshold, are overlaid in **FIG. 19**. For the 0dB reference, a 2.86 mmHg pk-pk (or, 1 mmHg MM) signal is assumed.

15

In the tested system, an occlusion does not present any measurable degradation in flow accuracy until it reaches approximately 100X (100 times the occlusion or resistance to flow of a normal length patent catheter). The “10X Occlusion” state may not be considered a must-detect complication, as a sufficient amount of fluid will likely

be able to be delivered through such a catheter. For similar reasons, a “Partial Migration” may not be considered a must-detect complication since the infusion section of the catheter remains in communication with CSF, and hence, drug delivery to the CSF continues.

5 Selection of the proper detection threshold is a tradeoff between minimizing “Missed Detection” of known complications occurrences and “False Detection” of complications for properly functioning catheters.

 For the example presented in **FIG. 19**, a threshold of -20dB may be a suitable reference level or 1 mmHg RMS. This corresponds to a value of 0.1 mmHg MM in the
10 tested system. This selection provides 9 dB of margin between the minimal signal level for a normal and patent catheter. This margin is important to minimize False Detection of complications. Gain shift or gain uncertainty of the pressure sensor also adds to the range of each of the expected MM values for each catheter state, which can be compensated for as described above.

15 With regard to “Missed Detections,” a -20 dB threshold slightly overlaps the expected distribution of “100X Occlusion” signal levels. However, with this threshold, it is expected that about 84% of catheter occlusions will be detected. Further, as catheter occlusions account for about 30% of the overall catheter complications that are typically detected, an overall catheter complication detection rate with this threshold in
20 this system is expected to be about 95% . Thus, the missed detection rate should be about 5%.

ii. Latency Analysis

 Results of the present simulation testing indicate that patient activities will tend to mask the ability to detect catheter complications. For example, simple walking
25 results in 0.67 g’s of peak-to-peak acceleration. This translates into 20 mmHg peak-to-peak which is four times the magnitude of a large cardiac pressure signal.

 During periods of patient activity, even with catheter complication states, large MM values of pressure, that are above any practical detection threshold, are predicted. Complications will rarely be detectable during periods of patient activity. Hence, in
30 various embodiments described herein, the algorithm relies on the assumption that

patients do not always exhibit high levels of activity (at least as it relates to measured catheter pressure). In various embodiments, the algorithm (or device executing the algorithm) will sample data for a window of time at regularly spaced intervals. The duration and periodicity of these sampling windows may be determined by analysis of human motion activity profiles, as described below.

In the simulation discussed below, actual patient activity data from a population of patients was used to augment the CSF pressure model with realistic activity patterns. The data was used to generate a stochastic profile of daily activity characterized total duration of activity episodes per hour versus hour of the day as shown in **FIG. 20**.

Algorithm simulation was used to determine the number of sampling windows that occurred during periods of non-activity (good or quiet periods) relative to the total number of sampling windows. **FIG. 21** and **FIG. 22** show a two hour and the full 24-hours of simulation trace. In **FIGS. 21-22**, the top panel reflects activity, the middle panel represents sampling, and the bottom panel represents samples obtained during a time of patient inactivity.

The sampling window durations and the sampling frequency were varied each yielding different simulation output traces. In addition, instantaneous and average latency calculations were added to the simulation as shown in **FIG. 23**. Sampling window durations were varied from 5 seconds to 240 seconds. In addition, the frequency of sampling was varied from 3 per day (once every 8 hours) to 96 per day (4 per hour).

FIG. 24 presents the maximum and mean expected latency for varying sizes of sampling window durations (based on one sampling per hour). **FIG. 25** presents the maximum and mean expected latency for varying sizes of sampling frequencies (based on a 15 second window duration).

As shown in **FIG. 24**, a sample duration of as little of 5 seconds should provide suitable latencies of detection. However, the sample duration should be sufficiently long to obtain meaningful data from a reasonable number of cardiac or respiratory physiological cycles. Accordingly, a 10 to 20 second window may be desirable. Of course, filter settling time may also need to be accounted for, e.g. as discussed above. In

some embodiments, a 30 second window is used to account for filter settling time, yet still obtain data from a reasonable number of physiological cycles. As depicted in **FIG. 24**, a 30 second sampling window duration should provide reasonable mean and maximum latencies.

5 As shown in **FIG. 25**, sampling at about once an hour (or 24 times in a day) should provide similar mean and maximum latencies to those obtainable with 15-30 second window durations.

 Of course, any suitable or desired sampling window duration or frequency of sampling may be selected by using the results presented herein or obtainable using
10 methods described herein.

 Referring now to **FIG. 26**, an example of an embodiment of a method carried out by an implantable infusion device for determining the state of a catheter in accordance with the teachings presented herein is shown. As a particular detection cycle starts (**600**) a determination is made as to whether the time period since the last
15 detection cycle has elapsed (**605**). If the time period has not elapsed, detection is delayed. If the period has elapsed, raw unfiltered processing data is read (**610**) and an energy unit correction factor for the raw data is identified from a lookup table (**615**) based on sensor calibration. The preconditioning chain is configured (**620**) and a buffer command is started (**625**). The duration (sampling window duration) timer is started
20 (**630**) and the period (sampling frequency period) timer is restarted (**635**). Until the sample window duration has been determined to have elapsed (**640**), pressure data is collected and preconditioned (**637**). Once the sample window duration has been determined to have elapsed (**640**), pressure data is no longer collected. The latest integrator output is read (**645**) and the algorithm for determining catheter status is
25 executed based on the latest buffered data and threshold (**650**).

 Of course, this is only one suitable way for a process described herein to be carried out. It will be understood that additional processes may be used for carrying out the methods described herein.

D. Activity Sensor

As an alternative or in addition to selecting suitable sampling frequencies and sample window durations to ensure that meaningful data can be captured during a period of patient activity, one or more activity sensors may be employed in accordance with the methods and systems described herein. The activity sensors may be used to determine that a patient is sufficiently inactive for meaningful pressure data to be collected.

Any suitable activity sensor may be employed. For example, activity sensors and configurations described in US 2005/0234518, entitled “Collecting Activity and Sleep Quality Information via a Medical Device”, published on October 20, 2005, filed on March 16, 2005, naming Kenneth T. Heruth and Keith A. Miesel as inventors, may be used or modified for use with the methods and systems described herein. Examples of sensors that may be used to detect patient activity are accelerometers, heart rate detectors or ECGs, muscle tone monitors, and the like. The activity sensors may be implanted or may be external and in communication with the implanted device.

Referring now to **FIG. 27**, an overview of a method for determining catheter status via pressure sensing in conjunction with activity sensing is described. The method depicted in **FIG. 27** is similar to that depicted in, and described above with regard to, **FIG. 18** with like reference numbers referring to like or similar steps and components. As shown in **FIG. 27**, the systems and methods described herein may include one or more activity sensors or incorporate information from the activity sensors in determining whether a catheter complication exists. When data received from the activity sensor (and associated electronics, such as an analog-to-digital converter or the like) is indicative of sufficiently low activity such that meaningful physiological pressure modulation profiles may be obtained, the pressure readings may be acquired and processed as described above.

Referring now to **FIG. 28**, a flow diagram of a method employing activity sensing is depicted. In the depicted method, a determination is made as to whether the patient is sufficiently inactive to obtain meaningful pressure data based on data from the activity sensor (710). If the patient is determined to be sufficiently inactive, pressure data is acquired and processed (715), e.g. as described above, and a catheter complication algorithm is executed (720), e.g. as described above. While not shown, it

may be desirable to include period and duration timers with the method shown in **FIG. 28**.

4. Output

If a catheter complication or a catheter state other than “Normal” is detected, the implantable infusion device may have one or more output components to alert the patient or a healthcare provider of the potential catheter complication, to record the event, or the like. For example and with reference to **FIG. 29**, an implantable infusion device **110** having an output component **400** is shown. The device depicted in **FIG. 29** is similar to the device depicted in, and described with regard to, **FIG. 3** above with like numbered components referring to the same or similar components.

Any suitable output components **400** may be employed. For example, the output components **400** may include an audible alarm, a vibration component, or the like to provide the patient sensory feedback that a problem exists or may exist with the infusion system. The output components **400** may include a telemetry component for wirelessly communicating with a device external to the patient to provide a similar warning or to remotely inform a healthcare provider that a problem exists or may exist with the infusion system. Preferably, the nature of the problem (e.g., “catheter complication” is communicated). Alternatively or in addition, a catheter complication event or potential catheter complication event may be stored in memory of the device **110** for later recall by a physician or other clinician when the patient visits the clinic.

Overview of Various Aspects

The present disclosure describes various embodiments of methods, systems, devices and the like for use in detecting catheter status of an implantable infusion system.

In a first aspect, a method for determining status of an implanted catheter includes acquiring raw pressure data from a pressure sensor of an implantable infusion device. The pressure sensor is in communication with a lumen of the catheter operably coupled to the infusion device. The catheter has a delivery region configured to be positioned in a fluid-filled target location of a patient. The delivery region is in communication with the lumen. The method further includes filtering the raw pressure

data to remove the DC component, leaving the AC component within a relevant physiological frequency range; rectifying the AC component to produce a rectified pressure signal; calculating a mean magnitude from the integrated rectified signal; and determining whether the mean magnitude is below a predetermined threshold. If the mean magnitude is below the threshold, the catheter is determined to be in a state other than a normal state; i.e. a catheter complication exists or may exist.

A second aspect is a method of the first aspect, wherein calculating the mean magnitude comprises integrating the rectified pressure signal and dividing by the number of samples within the integrated time period.

10 A third aspect is a method of the first or second aspect, wherein filtering the raw pressure data comprises filtering the data with a band pass filter that has a lower frequency cutoff of between 0.1 Hz and 1 Hz and has an upper frequency cutoff of between 2 Hz and 5 Hz.

15 A fourth aspect is a method the first or second aspect, wherein filtering the raw pressure data comprises filtering the data with a band pass filter that has a lower frequency cutoff of between 0.2 Hz and 0.5 Hz and has an upper frequency cutoff of between 2 Hz and 3 Hz.

20 A fifth aspect is a method of the first or second aspect, wherein filtering the raw pressure data comprises filtering the data with a band pass filter that leaves AC data within the frequency range of between 0.5 Hz and 2 Hz.

A sixth aspect is a method of any of the first five aspects, further comprising sampling the raw pressure data prior to the filtering to obtain a pressure reading and obtaining a compensation factor related to sensor gain for the pressure reading, wherein calculating the mean magnitude comprises applying the compensation factor.

25 A seventh aspect is a method of any of the first six aspects, further comprising determining whether the mean magnitude remains below the predetermined threshold for a predetermined amount of time.

An eighth aspect is a method of the seventh aspect, further comprising determining whether the mean magnitude remains below the predetermined threshold for a predetermined amount of time for a predetermined number of testing cycles.

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A ninth aspect is a method of the eighth aspect, further comprising providing an alarm if the mean magnitude is determined to remain below the predetermined threshold for a predetermined amount of time for a predetermined number of testing cycles.

5 A tenth aspect is a method of any of the first seven aspects, further comprising providing an alarm if the mean magnitude is determined to be below the predetermined threshold.

10 An eleventh aspect is a method of any of the first ten aspects, further comprising determining whether a sampling frequency period of time has elapsed, wherein the acquiring, filtering, rectifying and calculating steps are commenced if the sampling frequency period of time has elapsed, and wherein the acquiring, filtering, rectifying and calculating steps are not commenced until the sampling frequency period of time has elapsed.

A twelfth aspect is a method of the eleventh aspect, wherein the sampling frequency is between 3 and 96 times per day.

15 A thirteenth aspect is a method of the eleventh aspect, wherein the sampling frequency is between 6 and 24 times per day.

20 A fourteenth aspect is a method of the eleventh aspect, further comprising determining whether a sampling window duration has elapsed, wherein if the sample period window has elapsed, the acquiring, filtering, rectifying and calculating steps are stopped.

A fifteenth aspect is a method of the fourteenth aspect, wherein the sampling window duration is between 10 and 60 seconds.

A sixteenth aspect is a method of the fourteenth aspect, wherein the sampling window duration is between 15 and 30 seconds.

25 A seventeenth aspect is a method of any of the first sixteen aspects, further comprising acquiring patient activity data via an activity sensor and determining whether the patient activity data is indicative of patient activity below a predetermined threshold prior to performing the acquiring, filtering, rectifying and calculating steps.

An eighteenth aspect is a computer readable medium comprising instructions that, when executed by an implantable infusion device, cause the device to carry out a process according to any of the first seventeen aspects.

5 A nineteenth aspect is an implantable infusion device comprising a pressure sensor configured and positioned to be in communication with a lumen of a catheter configured to be coupled to the infusion device; an analog-to-digital converter for converting raw analog data from the pressure sensor to raw digital data; a band-pass filter for filtering the raw digital data; a rectifier for rectifying the filtered pressure data; an integrator for integrating the filtered pressure data over time; the computer readable
10 medium of the eighteenth aspect; and a processor operably coupled to the pressure sensor, the analog-to-digital converter, the band-pass filter, the rectifier, and the integrator, wherein the processor is configured to execute the instructions of the computer readable medium.

A twentieth aspect is an implantable infusion device comprising a pressure
15 sensor configured and positioned to be in communication with a lumen of a catheter operably couplable to the infusion device; an analog-to-digital converter for converting raw analog data from the pressure sensor to raw digital data; a band-pass filter for filtering the raw digital data; a rectifier for rectifying the filtered pressure data; an integrator for integrating the filtered pressure data over time; electronics configured to
20 calculate an mean magnitude of the integrated pressure data and configured to determine whether the mean magnitude is below a predetermined threshold for identifying a catheter complication or potential catheter complication.

Those skilled in the art will recognize that the preferred embodiments may be altered or amended without departing from the true spirit and scope of the disclosure, as
25 defined in the accompanying claims.

What is claimed is:

1. A method for determining status of an implanted catheter, the method comprising:

acquiring raw pressure data from a pressure sensor of an implantable infusion

5 device, wherein the pressure sensor is in communication with a lumen of the catheter configured to be coupled to the infusion device, wherein the catheter has a delivery region intended to be positioned in a fluid-filled target location of a patient, the delivery region being in communication with the lumen;

10 filtering the raw pressure data to remove the DC component, leaving the AC component within a relevant physiological frequency range;

rectifying the AC component to produce a rectified pressure signal;

calculating a mean magnitude of the integrated rectified signal;

determining whether the mean magnitude is below a predetermined threshold,

15 wherein if the mean magnitude is below the threshold, the catheter is determined to be in a state other than a normal state.

2. The method of claim 1, wherein calculating the mean magnitude comprises integrating the rectified pressure signal and dividing by the number of samples
20 within the integrated time period.

3. The method of claim 1, wherein filtering the raw pressure data comprises filtering the data with a band pass filter that has a lower frequency cutoff between 0.1 Hz and 1 Hz and has an upper frequency cutoff of between 2 Hz
25 and 5 Hz.

4. The method of claim 1, wherein filtering the raw pressure data comprises filtering the data with a band pass filter that has a lower frequency cutoff of

between 0.2 Hz and 0.5 Hz and has an upper frequency cutoff of between 2 Hz and 3 Hz.

5. The method of claim 1, wherein filtering the raw pressure data comprises
5 filtering the data with a band pass filter that leaves AC data within the frequency range of between 0.5 Hz and 2 Hz.
6. The method of claim 1, further comprising sampling the raw pressure data prior
to the filtering to obtain a pressure reading and obtaining a compensation factor
10 related to sensor gain for the pressure reading, wherein calculating the mean magnitude comprises applying the compensation factor.
7. The method of claim 1, further comprising determining whether the mean
magnitude remains below the predetermined threshold for a predetermined
15 amount of time.
8. The method of claim 7, further comprising determining whether the mean
magnitude remains below the predetermined threshold for a predetermined
amount of time for a predetermined number of testing cycles.
20
9. The method of claim 8, further comprising providing an alarm if the mean
magnitude is determined to remain below the predetermined threshold for a
predetermined amount of time for a predetermined number of testing cycles.
- 25 10. The method of claim 1, further comprising providing an alarm if the mean
magnitude is determined to be below the predetermined threshold.

11. The method of claim 1, further comprising determining whether a sampling frequency period of time has elapsed, wherein the acquiring, filtering, rectifying and calculating steps are commenced if the sampling frequency period of time has elapsed, and wherein the acquiring, filtering, rectifying and calculating steps are not commenced until the sampling frequency period of time has elapsed.
12. The method of claim 11, wherein the sampling frequency is between 3 and 96 times per day.
13. The method of claim 11, wherein the sampling frequency is between 6 and 24 times per day.
14. The method of claim 11, further comprising determining whether a sampling window duration has elapsed, wherein if the sample period window has elapsed, the acquiring, filtering, rectifying and calculating steps are stopped.
15. The method of claim 14, wherein the sampling window duration is between 10 and 60 seconds.
16. The method of claim 14, wherein the sampling window duration is between 15 and 30 seconds.
17. The method of claim 1, further comprising acquiring patient activity data via an activity sensor and determining whether the patient activity data is indicative of patient activity below a predetermined threshold prior to performing the acquiring, filtering, rectifying and calculating steps.

18. A computer readable medium comprising instructions that, when executed by an implantable infusion device, cause the device to carry out a process according to claim 1.
- 5 19. An implantable infusion device comprising:
- a pressure sensor configured and positioned to be in communication with a lumen of a catheter configured to be coupled to the infusion device;
- an analog-to-digital converter for converting raw analog data from the pressure sensor to raw digital data;
- 10 a band-pass filter for filtering the raw digital data;
- a rectifier for rectifying the filtered pressure data;
- an integrator for integrating the filtered pressure data over time;
- the computer readable medium of claim 18; and
- a processor operably coupled to the pressure sensor, the analog-to-digital
- 15 converter, the band-pass filter, the rectifier, and the integrator, wherein the processor is configured to execute the instructions of the computer readable medium.
20. An implantable infusion device comprising:
- 20 a pressure sensor configured and positioned to be in communication with a lumen of a catheter operably couplable to the infusion device;
- an analog-to-digital converter for converting raw analog data from the pressure sensor to raw digital data;
- a band-pass filter for filtering the raw digital data;
- 25 a rectifier for rectifying the filtered pressure data;
- an integrator for integrating the filtered pressure data over time;

electronics configured to calculate a mean magnitude of the integrated pressure data and configured to determine whether the mean magnitude is below a predetermined threshold for identifying a catheter complication or potential catheter complication.

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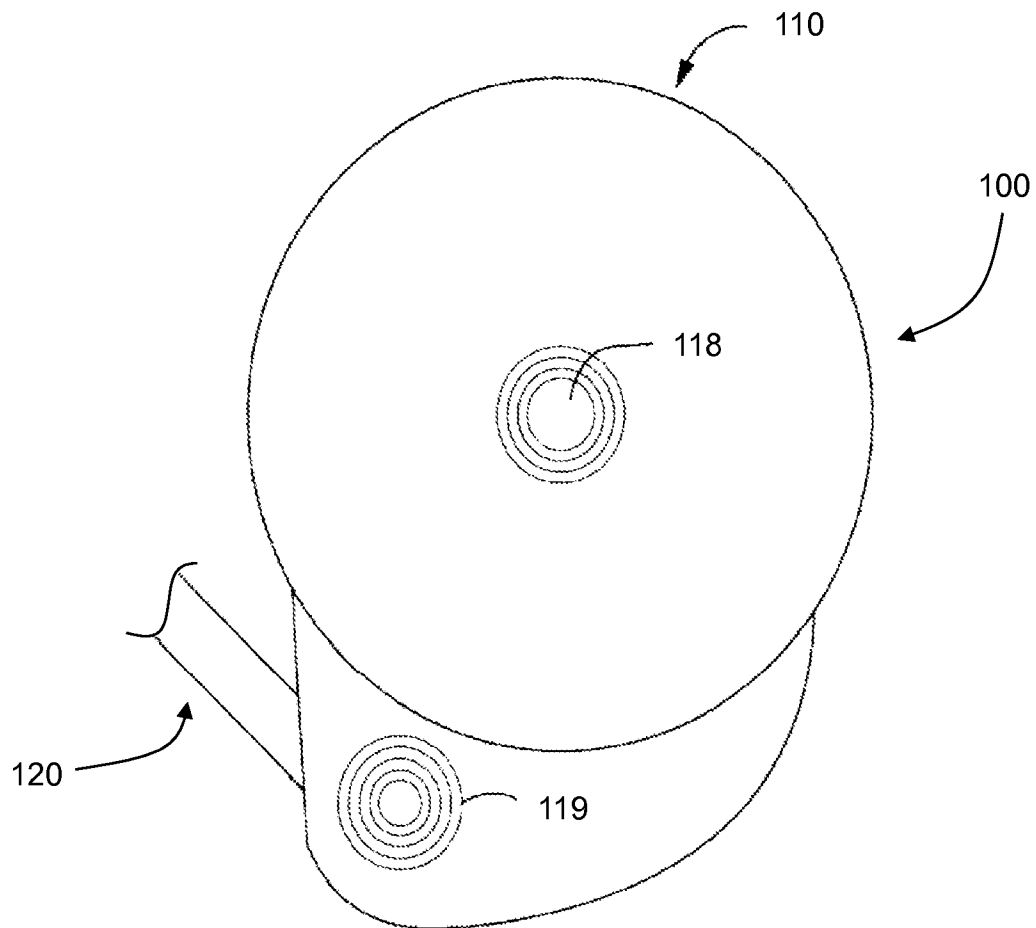


FIG. 1

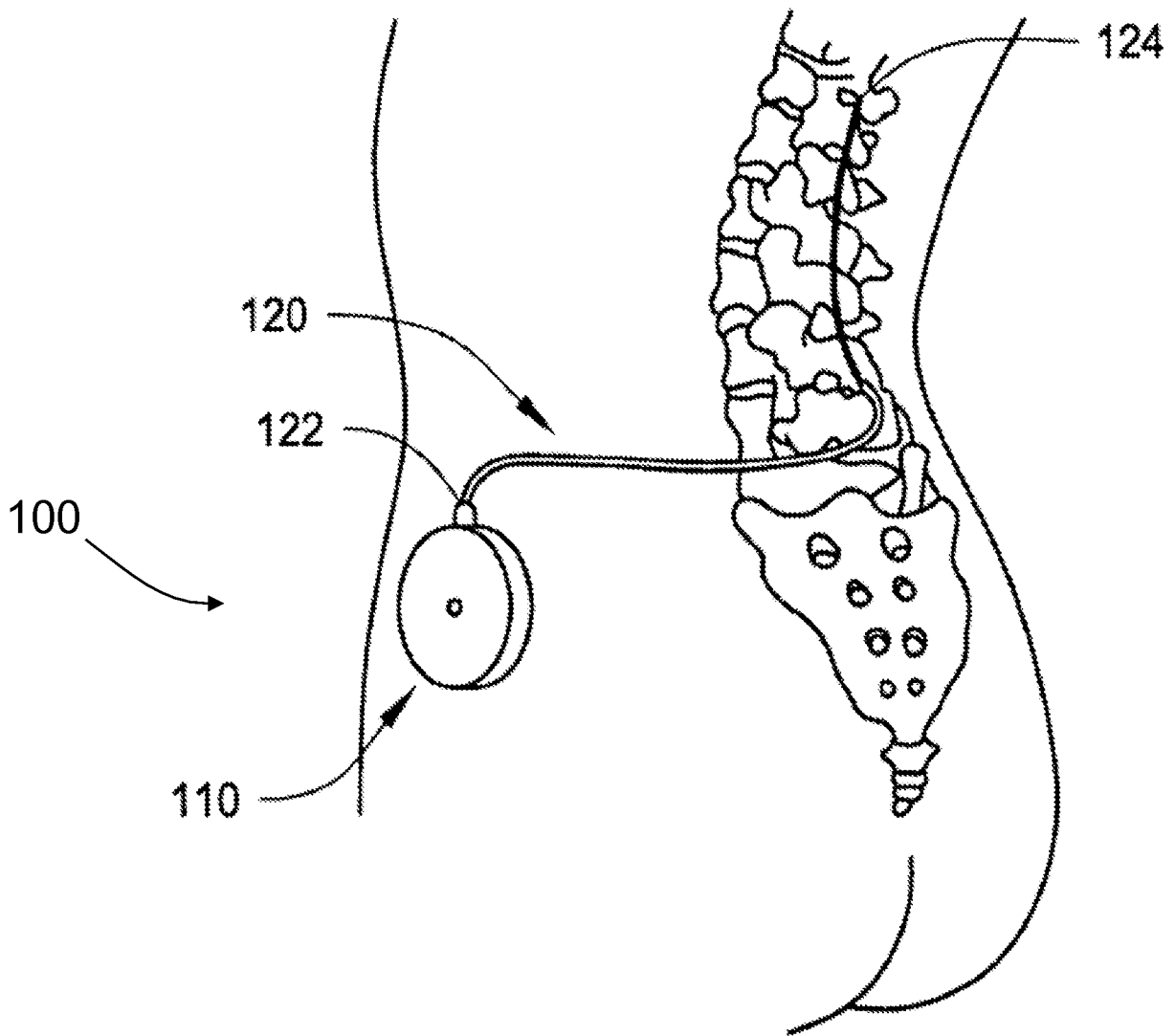


FIG. 2

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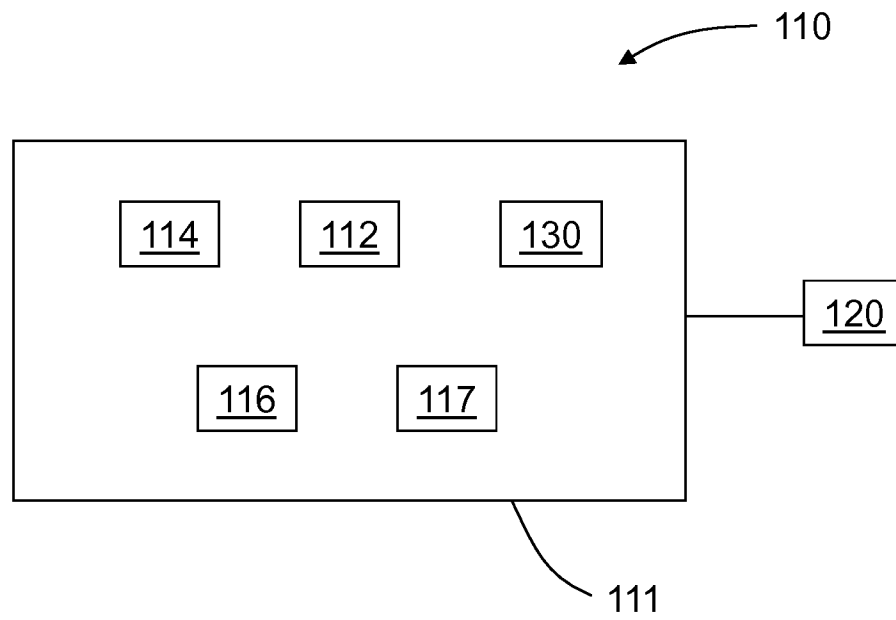


FIG. 3

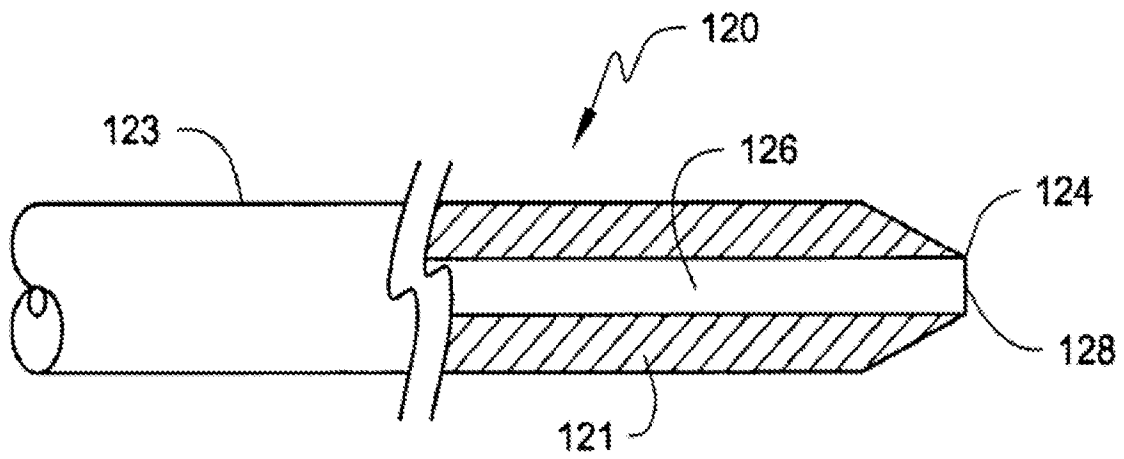


FIG. 4

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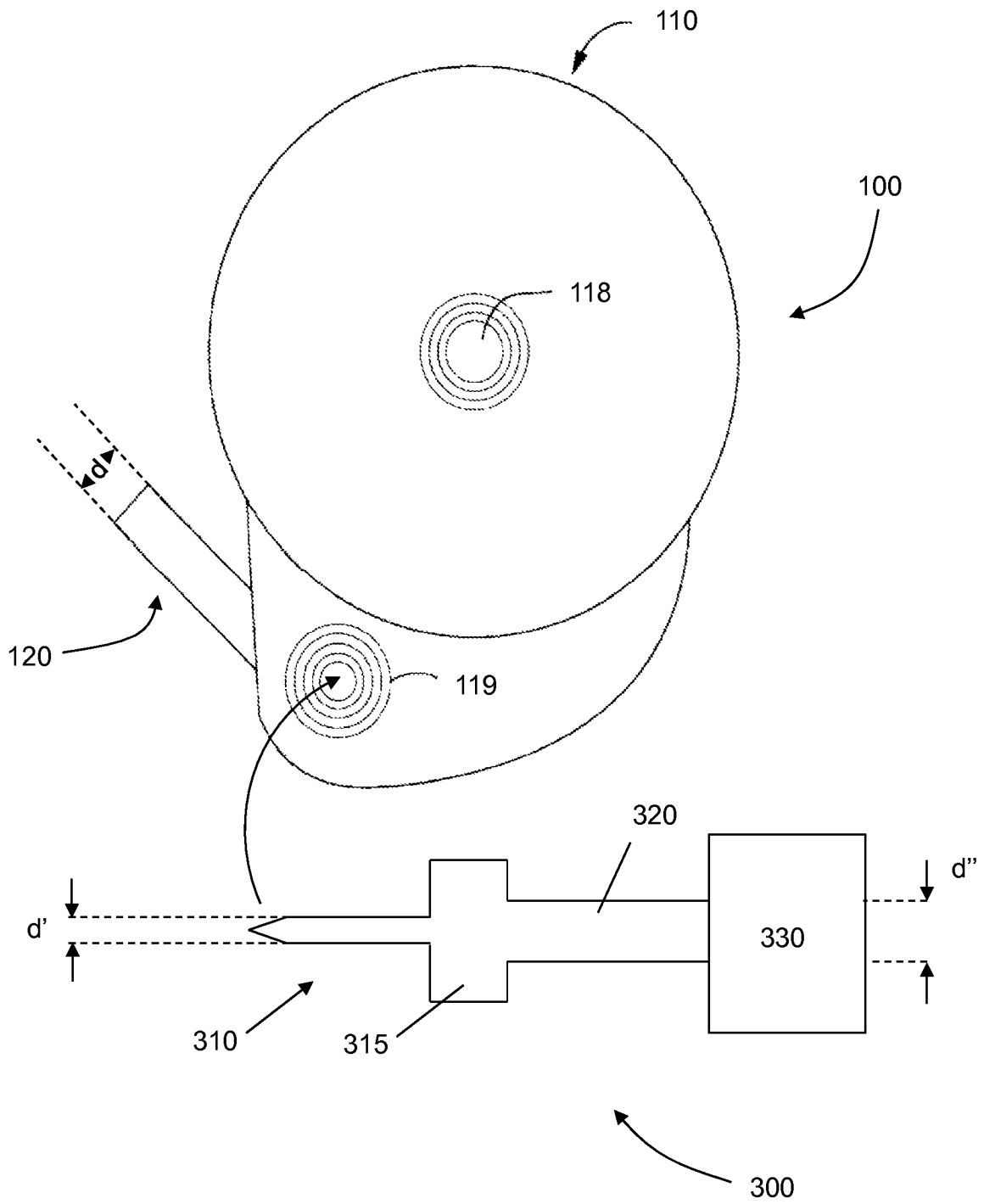


FIG. 5

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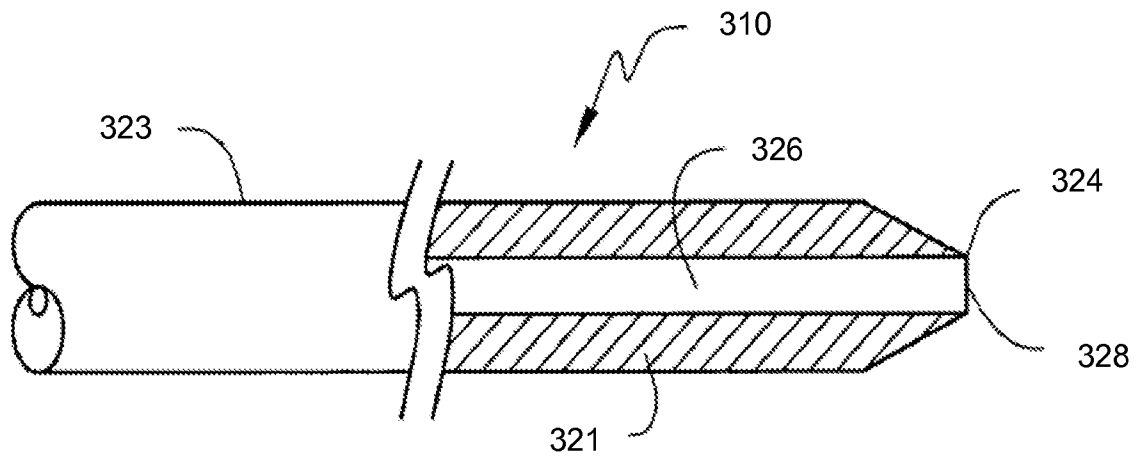


FIG. 6

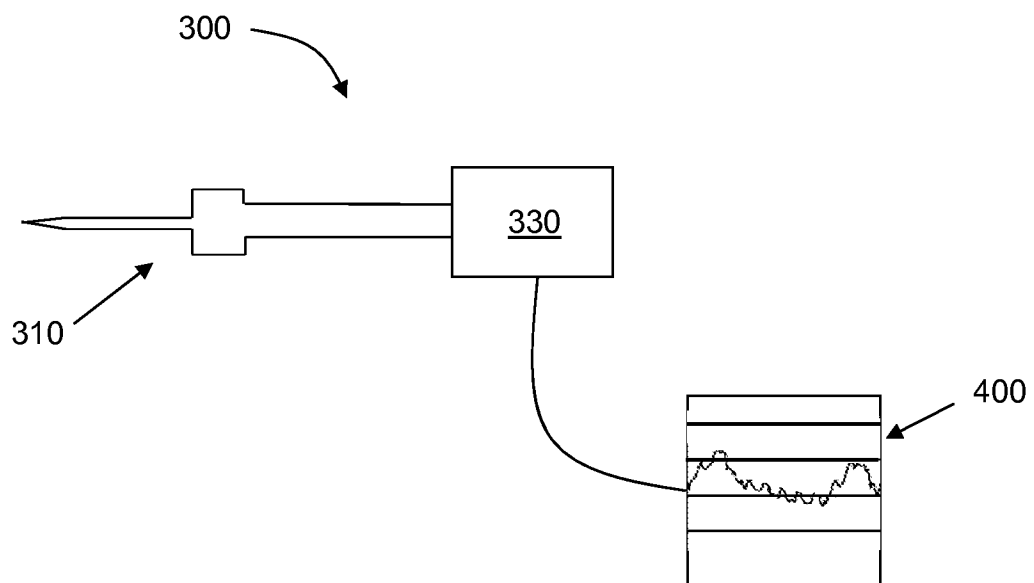
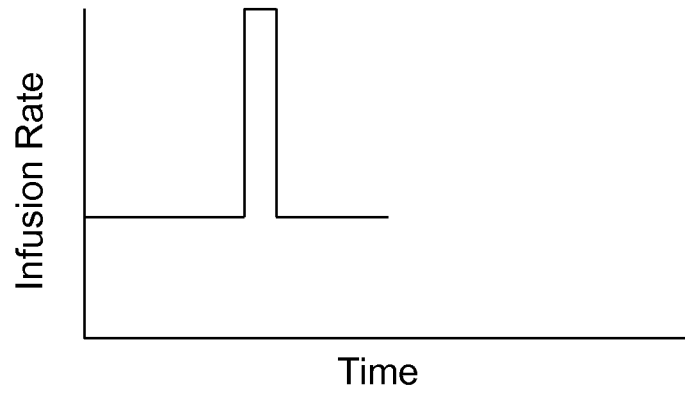


FIG. 7

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A)



B)

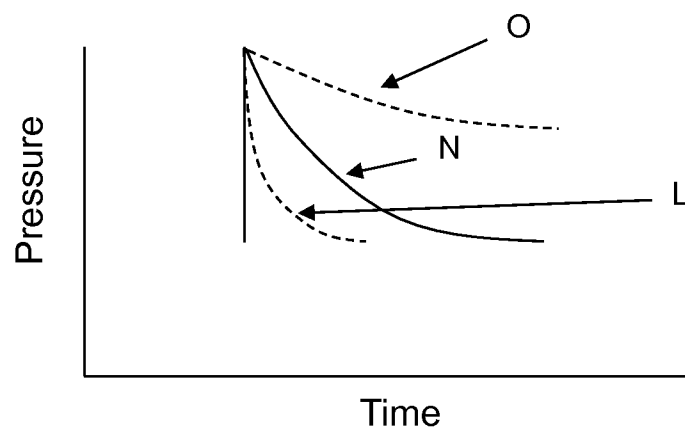


FIG. 8

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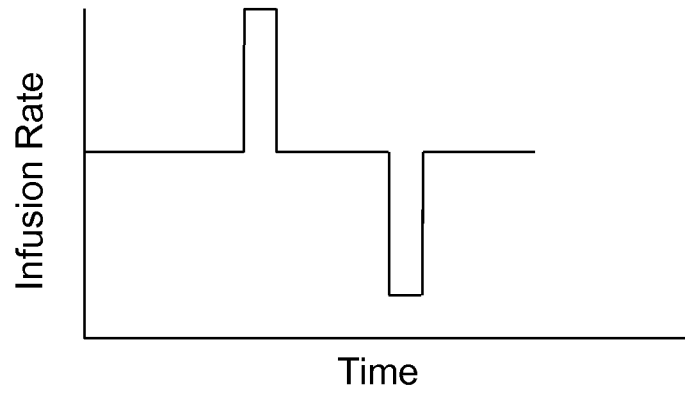


FIG. 9A

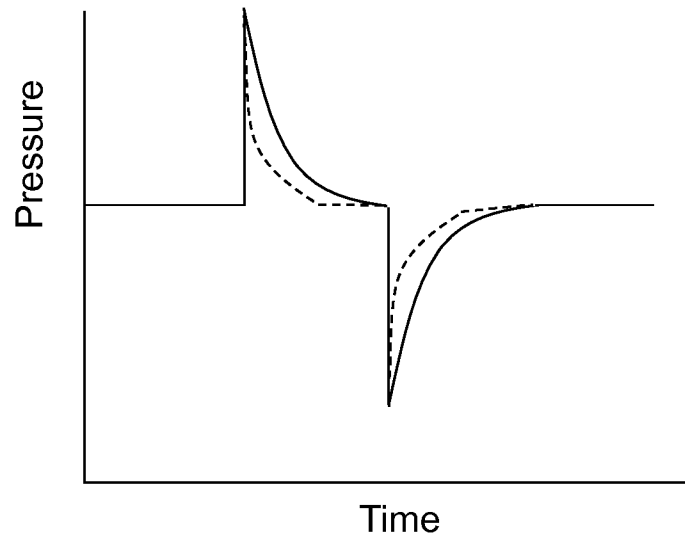


FIG. 9B

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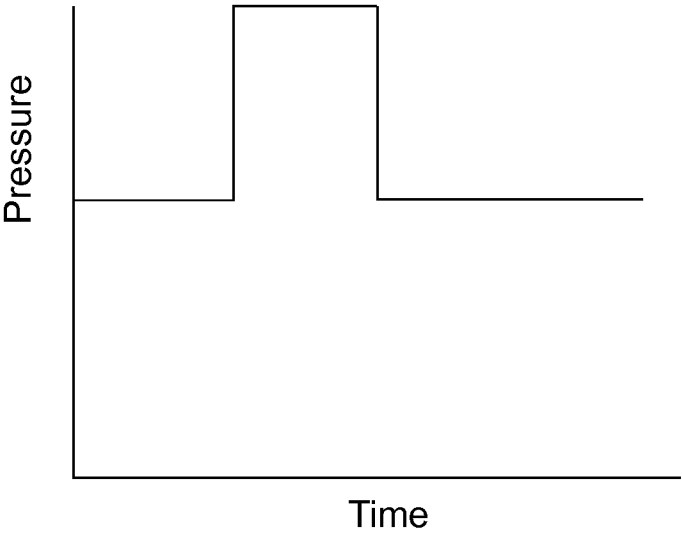


FIG. 9C

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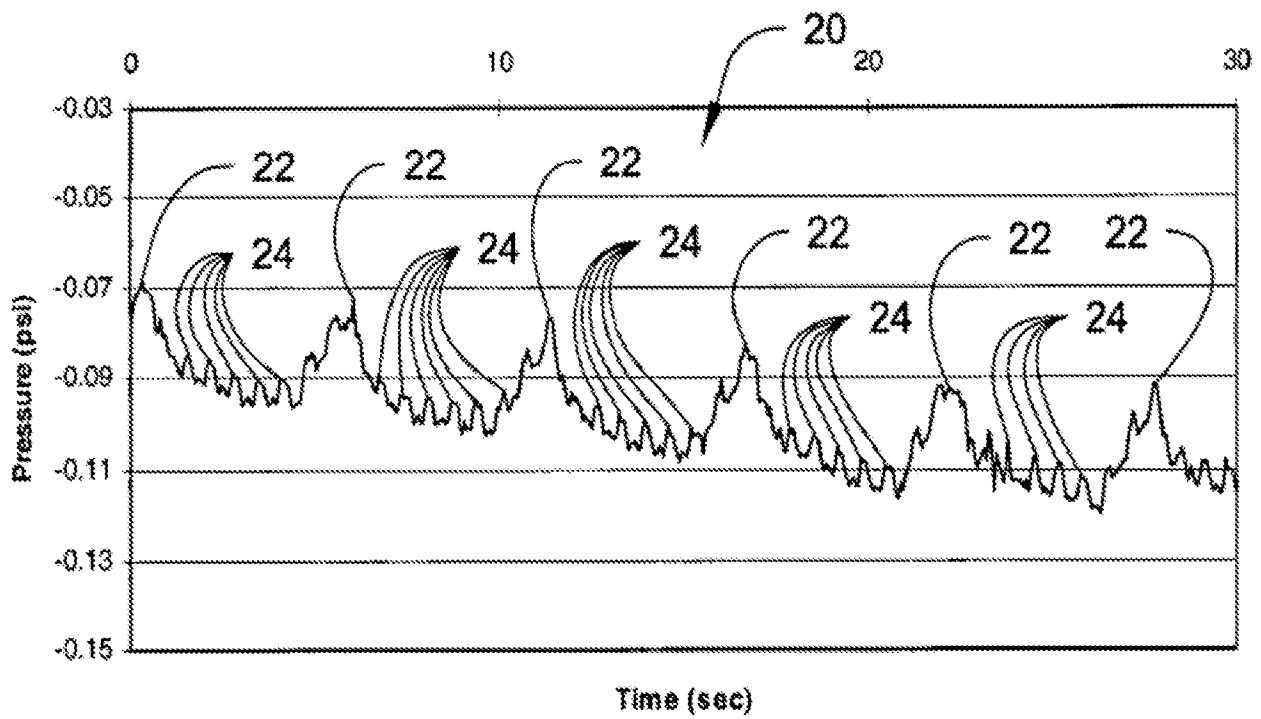


FIG. 10

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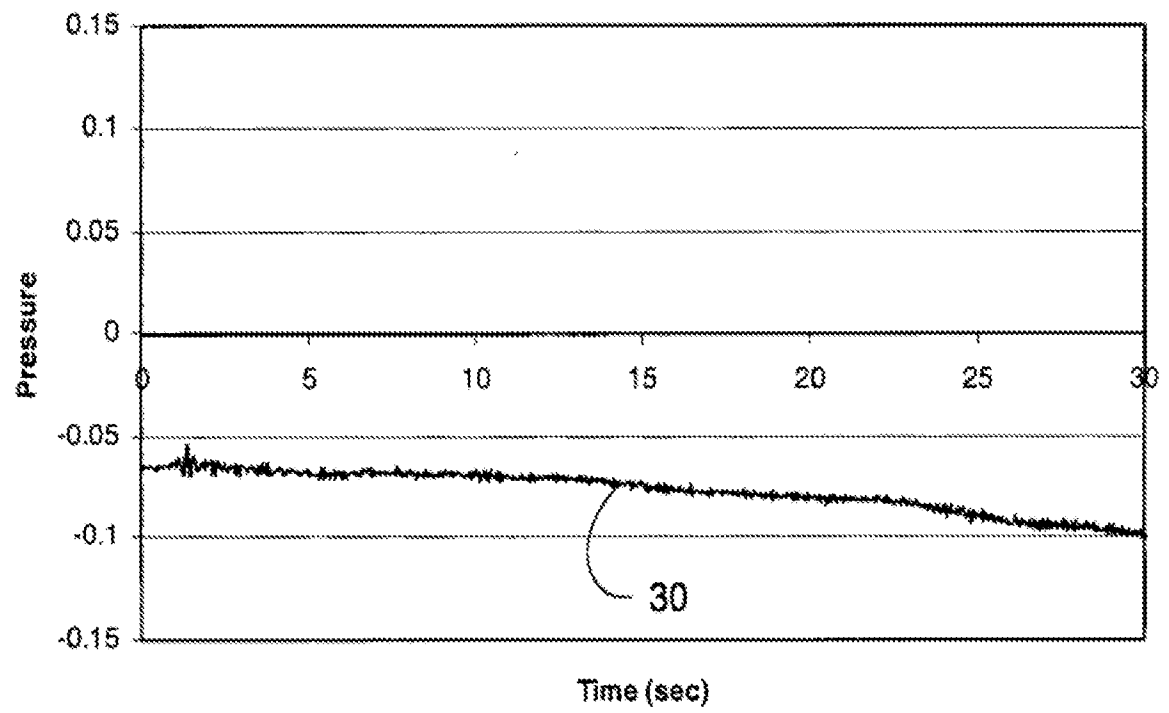


FIG. 11

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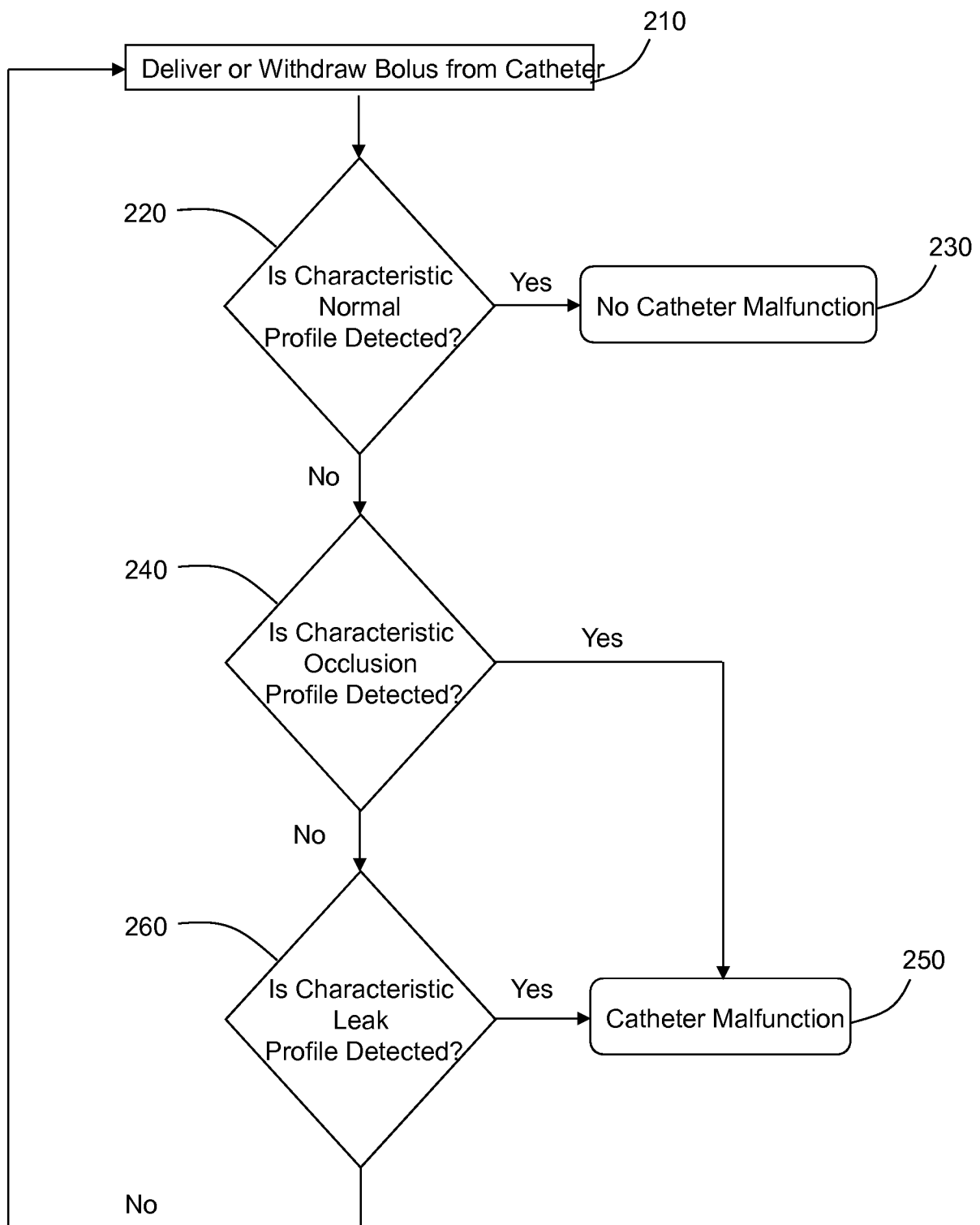


FIG. 12

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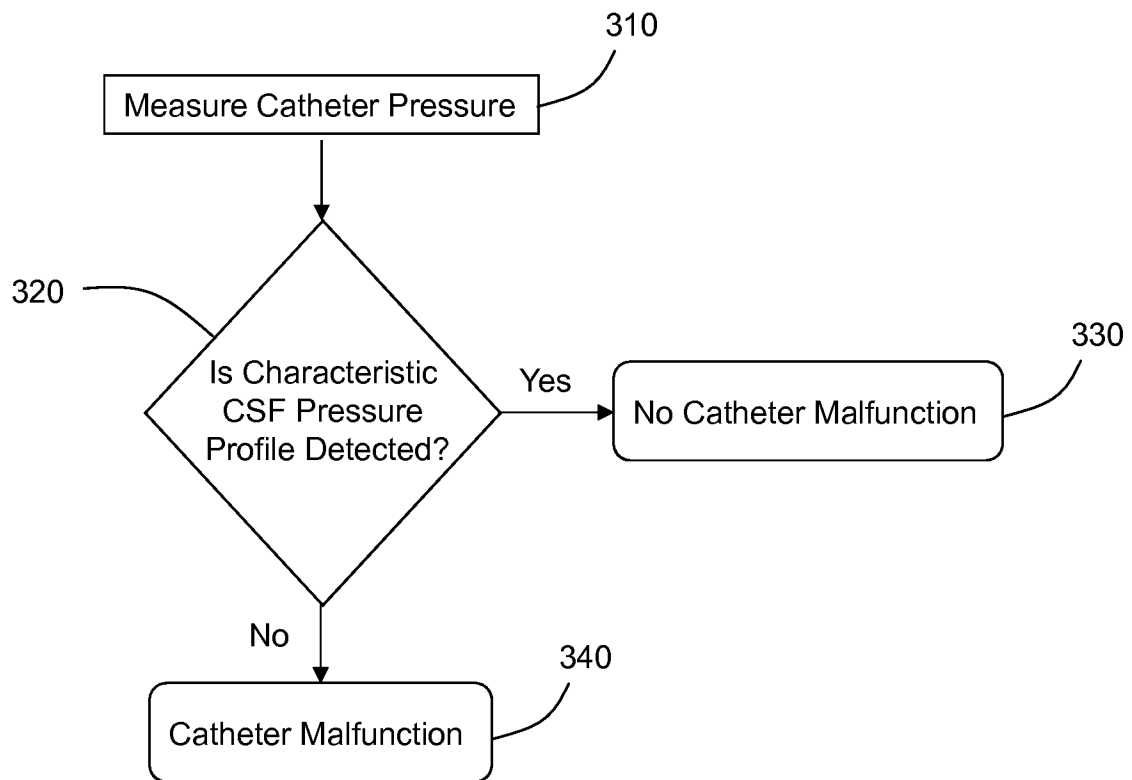


FIG. 13

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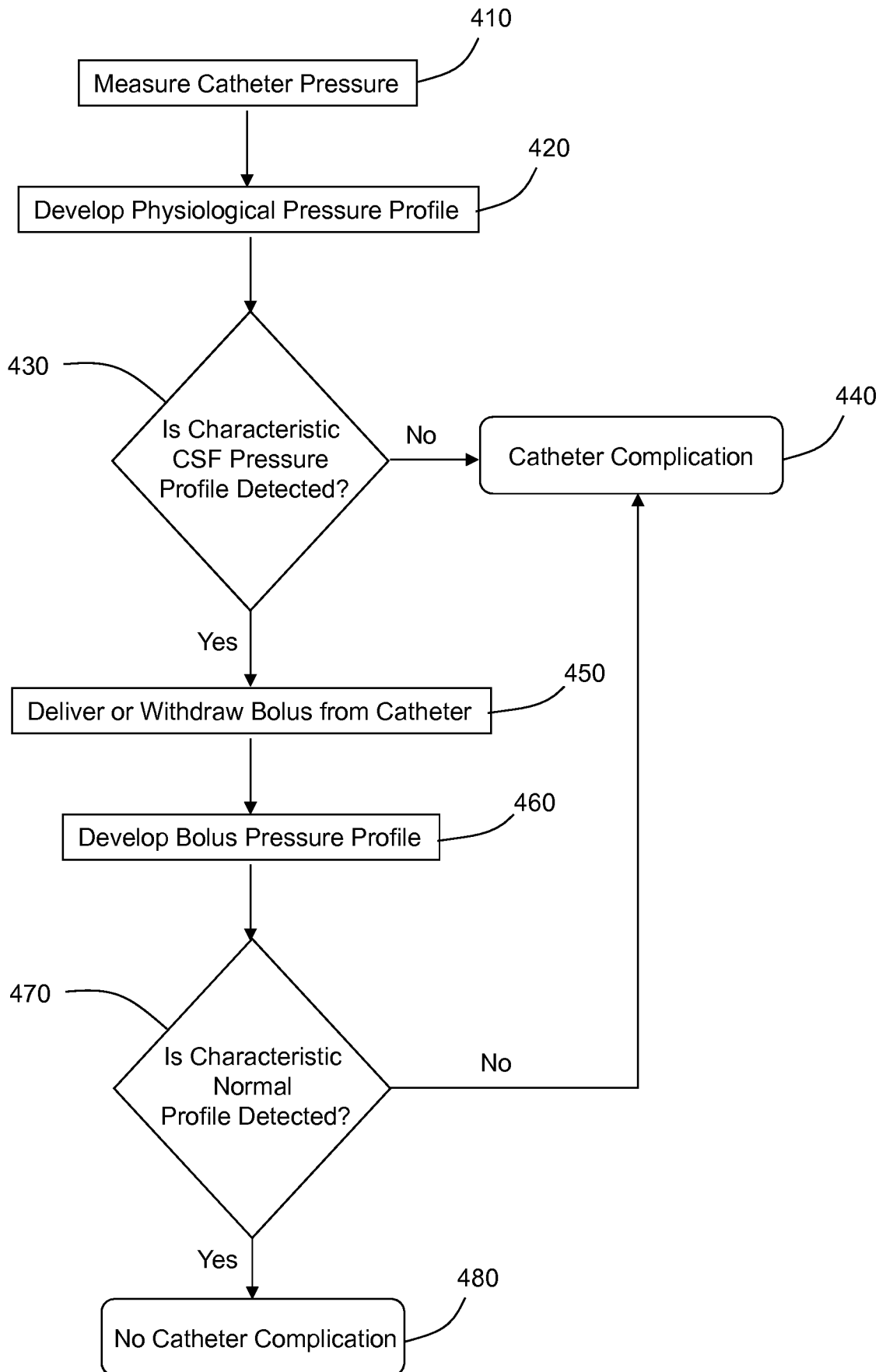


FIG. 14

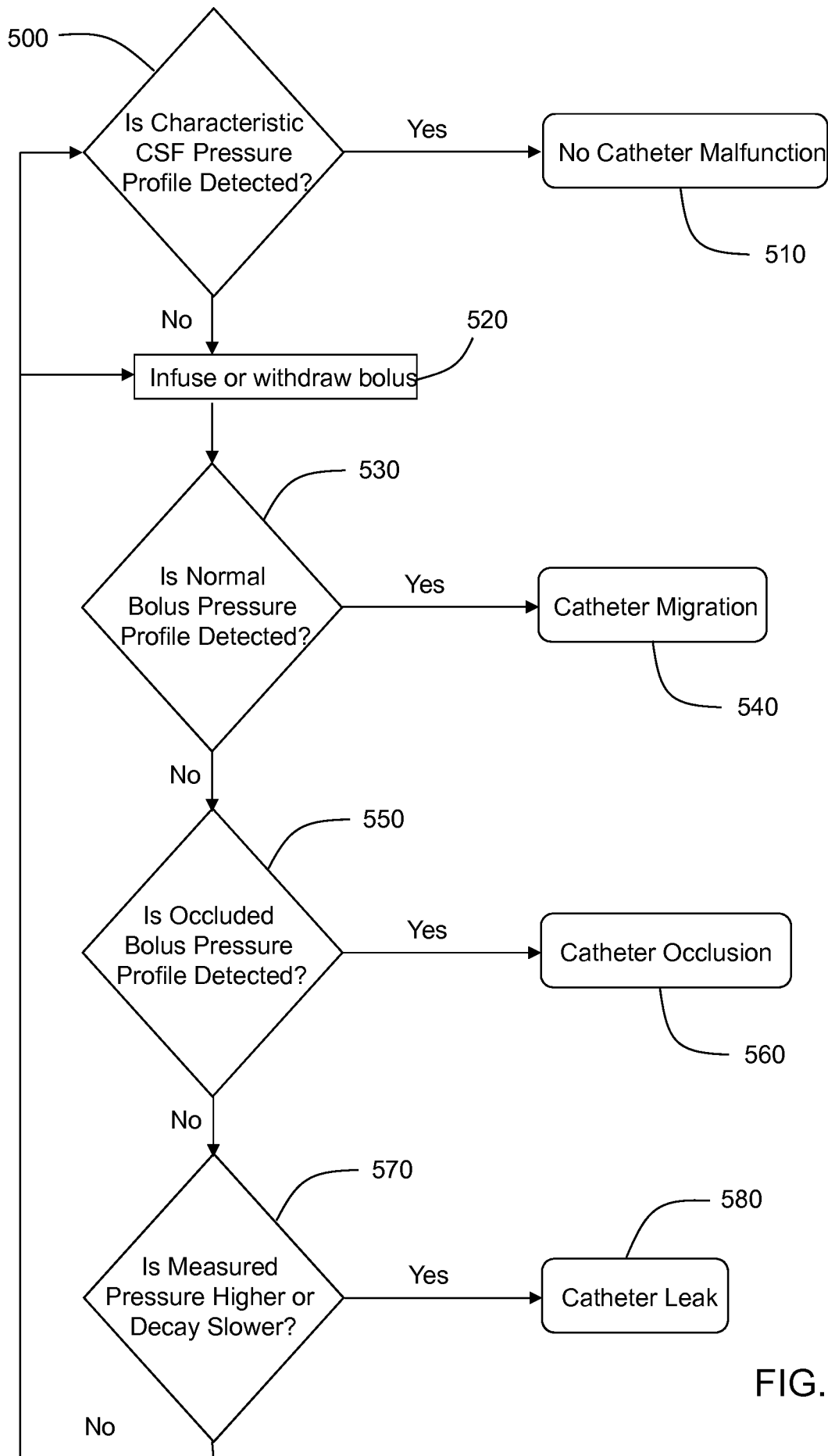


FIG. 15

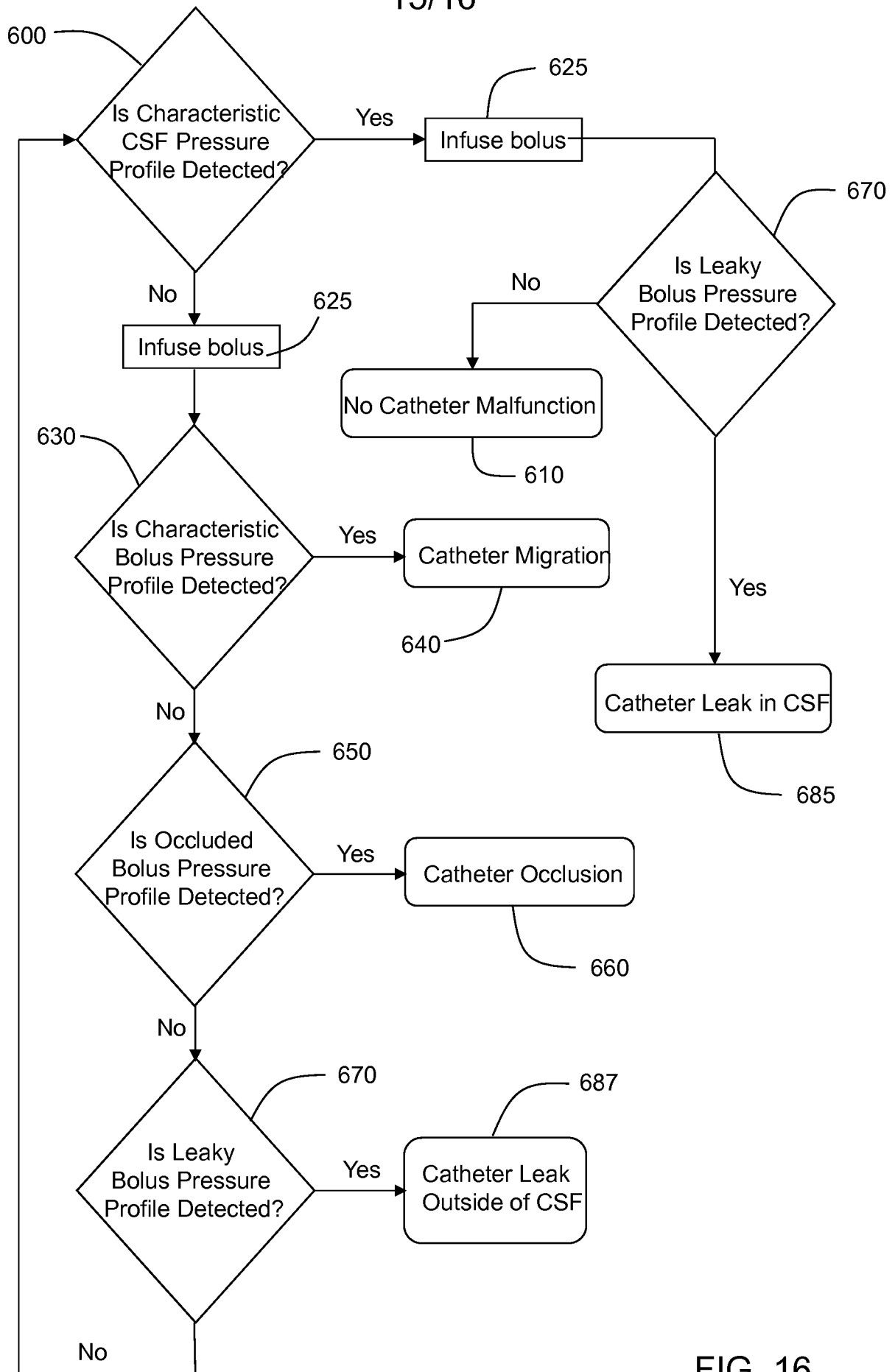


FIG. 16

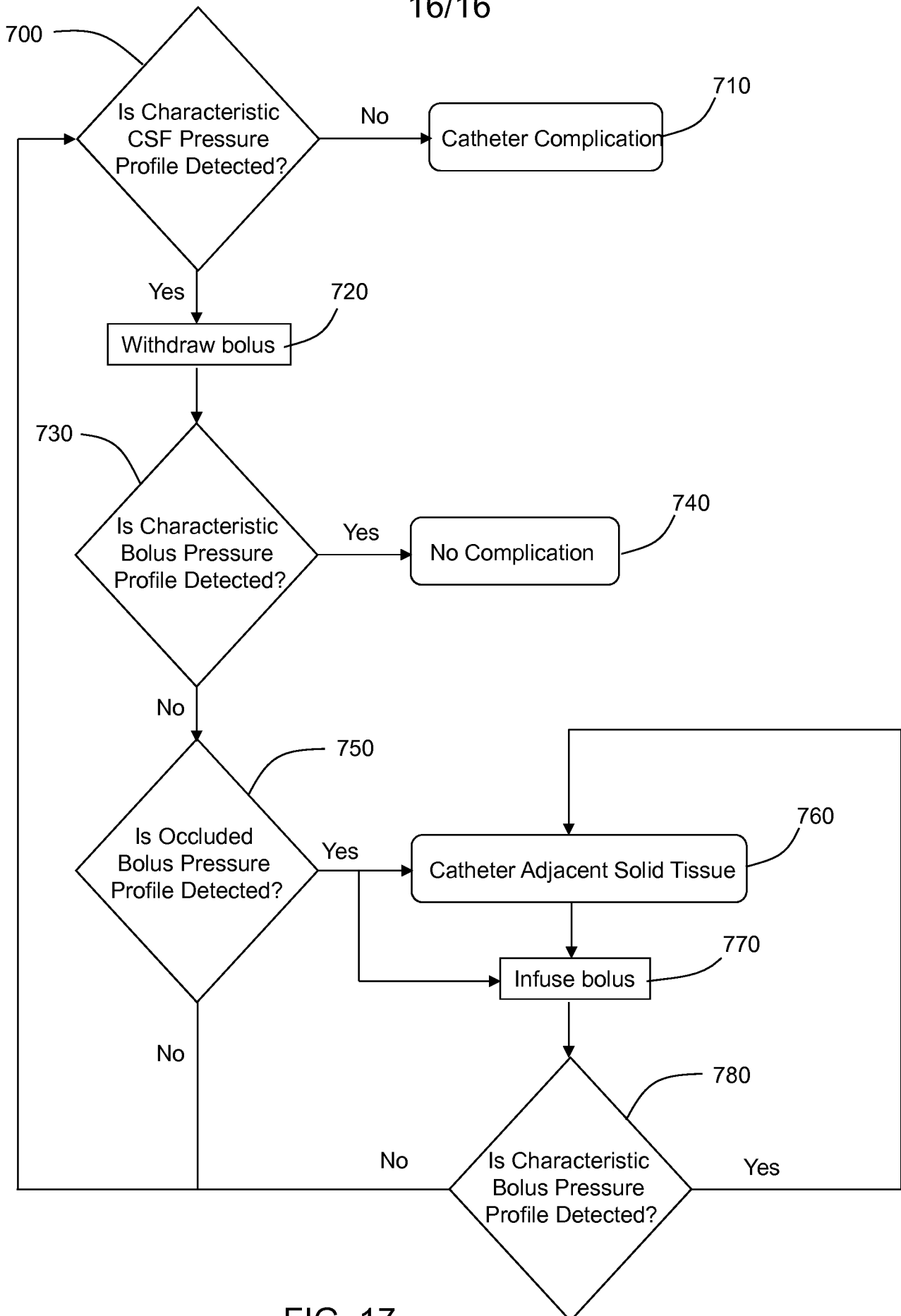


FIG. 17

INTERNATIONAL SEARCH REPORT

International application No
PCT/US2012/023277

A. CLASSIFICATION OF SUBJECT MATTER

INV. A61M5/168 A61M5/172 A61M5/142
ADD. A61M27/00

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)

A61M

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)

EP0-Internal, WPI Data

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	US 2010/069841 A1 (MIESEL KEITH A [US]) 18 March 2010 (2010-03-18) abstract; figures 1-21 paragraphs [0002], [0008], [0009], [0049] - [0051], [0056] - [0057], [0069] - [0079], [0086]	1-20
X	US 2008/243074 A1 (MIESEL KEITH A [US] ET AL) 2 October 2008 (2008-10-02) the whole document	1-20
X	US 4 551 133 A (ZEGERS DE BEYL RENE H [US] ET AL) 5 November 1985 (1985-11-05) the whole document	1-20
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Further documents are listed in the continuation of Box C.



See patent family annex.

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"O" document referring to an oral disclosure, use, exhibition or other means

"P" document published prior to the international filing date but later than the priority date claimed

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Date of the actual completion of the international search

25 April 2012

Date of mailing of the international search report

04/05/2012

Name and mailing address of the ISA/

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NL - 2280 HV Rijswijk
Tel. (+31-70) 340-2040,
Fax: (+31-70) 340-3016

Authorized officer

Petersch, Bernhard

INTERNATIONAL SEARCH REPORT

International application No

PCT/US2012/023277

C(Continuation). DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	EP 0 328 162 A2 (IVAC CORP [US]) 16 August 1989 (1989-08-16) abstract; figures 1,6 column 3, lines 40-54 column 5, lines 27-45 column 11, line 18 - column 12, line 15 -----	1-20
A	US 4 979 940 A (BOBO JR DONALD E [US] ET AL) 25 December 1990 (1990-12-25) the whole document -----	17

INTERNATIONAL SEARCH REPORT

International application No

PCT/US2012/023277

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EP 0328162	A2	16-08-1989	NONE
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