



US00RE50347E

(19) **United States**
(12) **Reissued Patent**
Kaczorowski

(10) **Patent Number:** **US RE50,347 E**
(45) **Date of Reissued Patent:** **Mar. 25, 2025**

(54) **DEVICES FOR ENDOVASCULAR ACCESS THROUGH EXTRACORPOREAL LIFE SUPPORT CIRCUITS**

(71) Applicant: **ECMOtek, LLC**, Venetia, PA (US)

(72) Inventor: **David Kaczorowski**, Venetia, PA (US)

(73) Assignee: **ECMOtek, LLC**, Venetia, PA (US)

(21) Appl. No.: **18/374,032**

(22) Filed: **Sep. 28, 2023**

Related U.S. Patent Documents

Reissue of:

(64) Patent No.: **10,576,260**
Issued: **Mar. 3, 2020**
Appl. No.: **15/338,139**
Filed: **Oct. 28, 2016**

U.S. Applications:

(62) Division of application No. 17/684,028, filed on Mar. 1, 2022, which is an application for the reissue of Pat. No. 10,576,260.

(Continued)

(51) **Int. Cl.**
A61M 39/10 (2006.01)
A61B 17/34 (2006.01)
(Continued)

(52) **U.S. Cl.**
CPC **A61M 39/1055** (2013.01); **A61B 17/3423** (2013.01); **A61M 1/1698** (2013.01);
(Continued)

(58) **Field of Classification Search**
CPC **A61M 39/1055**; **A61M 1/1698**; **A61M 1/3653**; **A61M 1/3655**; **A61M 1/3659**;
(Continued)

(56) **References Cited**

U.S. PATENT DOCUMENTS

3,565,074 A 2/1971 Philip
4,000,739 A 1/1977 Stevens
(Continued)

FOREIGN PATENT DOCUMENTS

EP 0411605 A1 2/1991
WO WO2015089047 A1 6/2015

OTHER PUBLICATIONS

Endemann, Dierk H. et al. "A simple method of vascular access to perform emergency coronary angiography in patients with veno-arterial extracorporeal membrane oxygenation," *Intensive Care Med* (2011), 37:2046-2049.

(Continued)

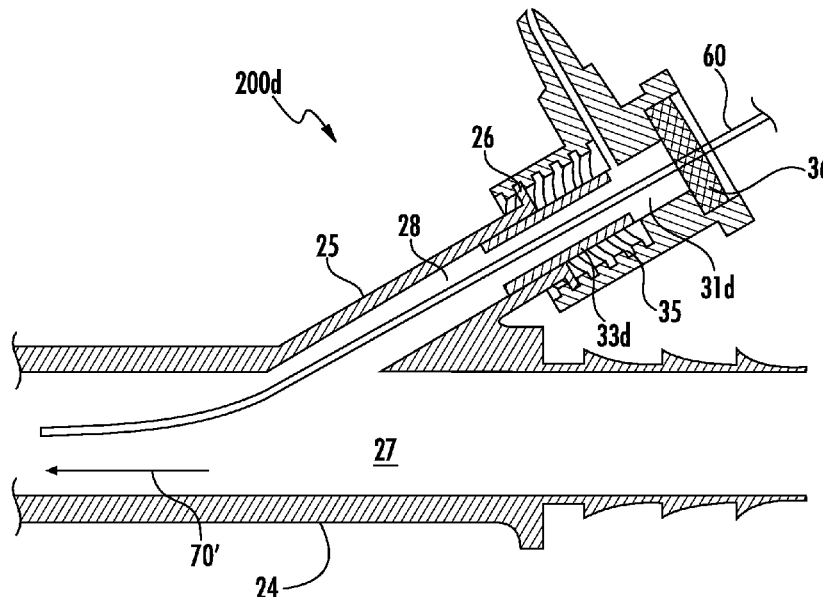
Primary Examiner — Ling X Xu

(74) *Attorney, Agent, or Firm* — Gregory Smock

(57) **ABSTRACT**

Adaptors, cannulas, caps, tube couplers, and systems thereof provide endovascular access through an established ECLS system. Adaptors having curved or angled shafts navigate right angle side ports of standard bypass cannulas and permit hemostatic introduction and direction of an intervention device to the axial flow path of the cannula lumen and bypass system. A modified cannula having an angled side port is also provided for use as an arterial cannula. A cap having an occluding surface may be inserted into the angled side port to prevent blood from stagnating in the angled side port. A tube coupler is also provided having an access port, such as an angled access port, and may be spliced into an established bypass system for vascular access point. Multiple couplers can be used to provide multiple access points. The adaptors and occlusive cap are interchangeable with each other and with secondary circuits.

25 Claims, 13 Drawing Sheets



Related U.S. Application Data

		5,584,803 A	12/1996	Stevens et al.
		5,613,956 A	3/1997	Patterson
(60)	Provisional application No. 62/248,525, filed on Oct. 30, 2015.	5,669,881 A	9/1997	Dunshee
		5,702,368 A	12/1997	Stevens
		5,702,370 A	12/1997	Sylvanowicz et al.
(51)	Int. Cl.	5,769,816 A	6/1998	Barbut
	<i>A61M 1/16</i> (2006.01)	5,779,681 A	7/1998	Bonn
	<i>A61M 1/36</i> (2006.01)	5,785,693 A	7/1998	Haining
	<i>A61M 39/20</i> (2006.01)	5,788,676 A	8/1998	Yoon
		5,797,888 A	8/1998	Yoon
(52)	U.S. Cl.	5,839,443 A *	11/1998	Rose G01N 33/86
	CPC <i>A61M 1/3653</i> (2013.01); <i>A61M 1/3655</i> (2013.01); <i>A61M 1/3659</i> (2014.02); <i>A61M 39/10</i> (2013.01); <i>A61M 39/105</i> (2013.01); <i>A61M 39/20</i> (2013.01); <i>A61M 1/3666</i> (2013.01); <i>A61M 2039/1077</i> (2013.01)	5,863,366 A *	1/1999	Snow A61B 17/12022
				435/13
				156/143
		5,868,703 A	2/1999	Bertolero
		5,935,110 A	8/1999	Brimhall
		5,944,019 A	8/1999	Knudson
(58)	Field of Classification Search	6,029,671 A	2/2000	Stevens et al.
	CPC A61M 39/10; A61M 39/105; A61M 39/20; A61M 1/3666; A61M 2039/1077; A61B 17/3423	6,083,215 A	7/2000	Milavetz
	See application file for complete search history.	6,095,997 A	8/2000	French et al.
		6,099,506 A	8/2000	Macoviak et al.
		6,120,480 A	9/2000	Zhang et al.
		6,142,446 A	11/2000	Leinsing
		6,228,071 B1	5/2001	Moshe et al.
		6,238,404 B1	5/2001	Hidalgo et al.
		6,458,103 B1	10/2002	Albert et al.
		6,482,171 B1	11/2002	Corvi et al.
		6,514,236 B1	2/2003	Stratienko
		6,569,117 B1	5/2003	Ziv et al.
		6,620,124 B1	9/2003	Peavey
		6,673,040 B1	1/2004	Samson et al.
		6,716,189 B1	4/2004	Jarvik
		6,802,836 B2	10/2004	Bouphavichith et al.
		6,808,508 B1	10/2004	Zafirelis et al.
		6,821,287 B1	11/2004	Jang
		6,905,481 B2	6/2005	Sirimanne
		6,913,021 B2	7/2005	Knudson et al.
		7,093,859 B2	8/2006	Warburton-Pitt et al.
		7,473,239 B2	1/2009	Wang et al.
		7,651,481 B2	1/2010	Raybuck
		7,766,853 B2	8/2010	Lane
		7,854,731 B2	12/2010	Rome et al.
		7,914,519 B2	3/2011	Moran et al.
		8,177,770 B2	5/2012	Rasmussen et al.
		8,177,771 B2	5/2012	Butts et al.
		8,267,897 B2	9/2012	Wells
		8,286,657 B2	10/2012	Belley et al.
		8,308,692 B2	11/2012	McQueen
		8,308,713 B2	11/2012	Li et al.
		8,357,122 B2	1/2013	Kraus et al.
		8,372,072 B2	2/2013	Lindenbaum et al.
		8,398,612 B2	3/2013	Frey et al.
		8,412,300 B2	4/2013	Sonderegger
		8,444,602 B2	5/2013	Valaie
		8,562,519 B2	10/2013	Smith et al.
		8,585,660 B2	11/2013	Murphy
		8,617,138 B2	12/2013	Barron et al.
		8,720,065 B2	5/2014	Christensen et al.
		8,747,387 B2	6/2014	Belley et al.
		8,753,317 B2	6/2014	Osborne et al.
		9,205,244 B2	12/2015	Valaie
		9,278,188 B2	3/2016	King
		2002/0087127 A1	7/2002	Finch et al.
		2003/0032969 A1	2/2003	Gannoe et al.
		2005/0171479 A1	8/2005	Hruska et al.
		2005/0209584 A1	9/2005	Rome
		2005/0245868 A1	11/2005	Olsen et al.
		2006/0089604 A1	4/2006	Guerrero
		2008/0147012 A1	6/2008	Rome
		2008/0179882 A1	7/2008	Hanlon et al.
		2009/0005725 A1	1/2009	Shorey
		2009/0241963 A1	10/2009	Macmillan
		2010/0241068 A1	9/2010	Chen
		2011/0040241 A1	2/2011	Wang et al.
		2012/0123392 A1	5/2012	McKinnon et al.
		2013/0237925 A1	9/2013	Trainer et al.
		2013/0310767 A1	11/2013	Solar et al.
		2014/0221968 A1	8/2014	Ransbury et al.
		2014/0236088 A1	8/2014	Rashdan et al.

(56) **References Cited**

U.S. PATENT DOCUMENTS

4,054,136 A	10/1977	Zeppelin	
4,099,528 A	7/1978	Sorenson et al.	
4,143,853 A	3/1979	Abramson	
4,149,535 A *	4/1979	Volder	A61M 5/1582
			604/164.01
4,177,814 A	12/1979	Knepshield et al.	
4,235,232 A	11/1980	Spaven et al.	
4,287,892 A	9/1981	Schiff	
4,318,401 A	3/1982	Zimmerman	
4,334,551 A	6/1982	Pfister	
4,424,833 A	1/1984	Spector et al.	
4,430,081 A	2/1984	Timmermans	
4,468,224 A	8/1984	Enzmann et al.	
4,535,969 A *	8/1985	Riley	F16K 5/04
			251/215
4,578,057 A	3/1986	Sussman	
4,580,573 A	4/1986	Quinn	
4,610,665 A	9/1986	Matsumoto et al.	
4,634,432 A	1/1987	Kocak	
4,655,752 A	4/1987	Honkanen et al.	
4,730,616 A	3/1988	Frisbie et al.	
4,803,999 A *	2/1989	Liegner	A61M 25/065
			600/576
4,804,365 A	2/1989	Litzie et al.	
4,826,477 A	5/1989	Adams	
4,886,507 A	12/1989	Patton et al.	
4,944,729 A	7/1990	Buckberg et al.	
4,960,412 A	10/1990	Fink	
4,994,027 A	2/1991	Farrell	
5,009,636 A	4/1991	Wortley et al.	
5,011,469 A	4/1991	Buckberg et al.	
5,066,285 A	11/1991	Hillstead	
5,125,902 A	6/1992	Berry et al.	
5,171,218 A	12/1992	Fonger et al.	
5,186,713 A	2/1993	Raible	
5,209,741 A	5/1993	Spaeth	
5,254,097 A	10/1993	Schock et al.	
5,256,150 A	10/1993	Quiachon et al.	
5,290,249 A	3/1994	Foster et al.	
5,300,023 A	4/1994	Lowery et al.	
5,312,344 A	5/1994	Grinfield	
5,330,433 A	7/1994	Fonger	
5,330,451 A	7/1994	Gabbay	
5,352,215 A	10/1994	Thome et al.	
5,395,341 A	3/1995	Slater	
5,395,352 A	3/1995	Penny	
5,417,665 A	5/1995	De La Mata et al.	
5,451,207 A	9/1995	Yock	
5,478,309 A	12/1995	Sweezer et al.	
5,520,655 A	5/1996	Davila et al.	

(56)

References Cited

U.S. PATENT DOCUMENTS

2014/0275724 A1 9/2014 Wang et al.
 2015/0133720 A1 5/2015 Farnan et al.
 2016/0015955 A1 1/2016 Joseph et al.

OTHER PUBLICATIONS

Thuus, Clarke et al. "Vascular Access for Pediatric Coronary Angiography on Extracorporeal Membrane Oxygenation," *World Journal for Pediatric and Congenital Heart Surgery* (2015), 6(1): 126-129.

Squiers JJ, Lima B, DiMaio JM. Contemporary extracorporeal membrane oxygenation therapy in adults: Fundamental principles and systematic review of the evidence. *J Thorac Cardiovasc Surg.* Jul. 2016;152(1):20-32.

Hill JD, O'Brien TG, Murray JJ, Dontigny L, Bramson ML, Osborn JJ, Gerbode F. Prolonged extracorporeal oxygenation for acute post-traumatic respiratory failure (shock-lung syndrome). Use of the Bramson membrane lung. *N Engl J Med.* Mar. 23, 1972;286(12):629-34.

Australia and New Zealand Extracorporeal Membrane Oxygenation (ANZ ECMO) Influenza Investigators, Davies A, Jones D, Bailey M, Beca J, Bellomo R, Blackwell N, Forrest P, Gattas D, Granger E, Herkes R, Jackson A, McGuinness S, Nair P, Pellegrino V, Pettilä

V, Plunkett B, Pye R, Torzillo P, Webb S, Wilson M, Ziegenfuss M. Extracorporeal Membrane Oxygenation for 2009 Influenza A(H1N1) Acute Respiratory Distress Syndrome. *JAMA.* Nov. 4, 2009;302(17):1888-95.

Lawler PR, Silver DA, Scirica BM, Couper GS, Weinhouse MD, Camp PC Jr. Extracorporeal Membrane Oxygenation in Adults With Cardiogenic Shock. *Circulation.* 2015; 131:676-680.

International Searching Authority; International Search Report and Written Opinion of the International Searching Authority; International Application No. PCT/US2016/059546; Patent Cooperation Treaty; pp. 1-8; publisher United States International Searching Authority; Published Alexandria, Virginia, US; copyright and dated Jan. 3, 2017; copy enclosed (8 pages).

International Searching Authority; International Search Report and Written Opinion of the International Searching Authority; International Application No. PCT/US2016/059562; Patent Cooperation Treaty; pp. 1-9; publisher United States International Searching Authority; Published Alexandria, Virginia, US; copyright and dated Jan. 3, 2017; copy enclosed (9 pages).

International Searching Authority; International Search Report and Written Opinion of the International Searching Authority; International Application No. PCT/US2016/059570; Patent Cooperation Treaty; pp. 1-9; publisher United States International Searching Authority; Published Alexandria, Virginia, US; copyright and dated Jan. 3, 2017; copy enclosed (9 pages).

* cited by examiner

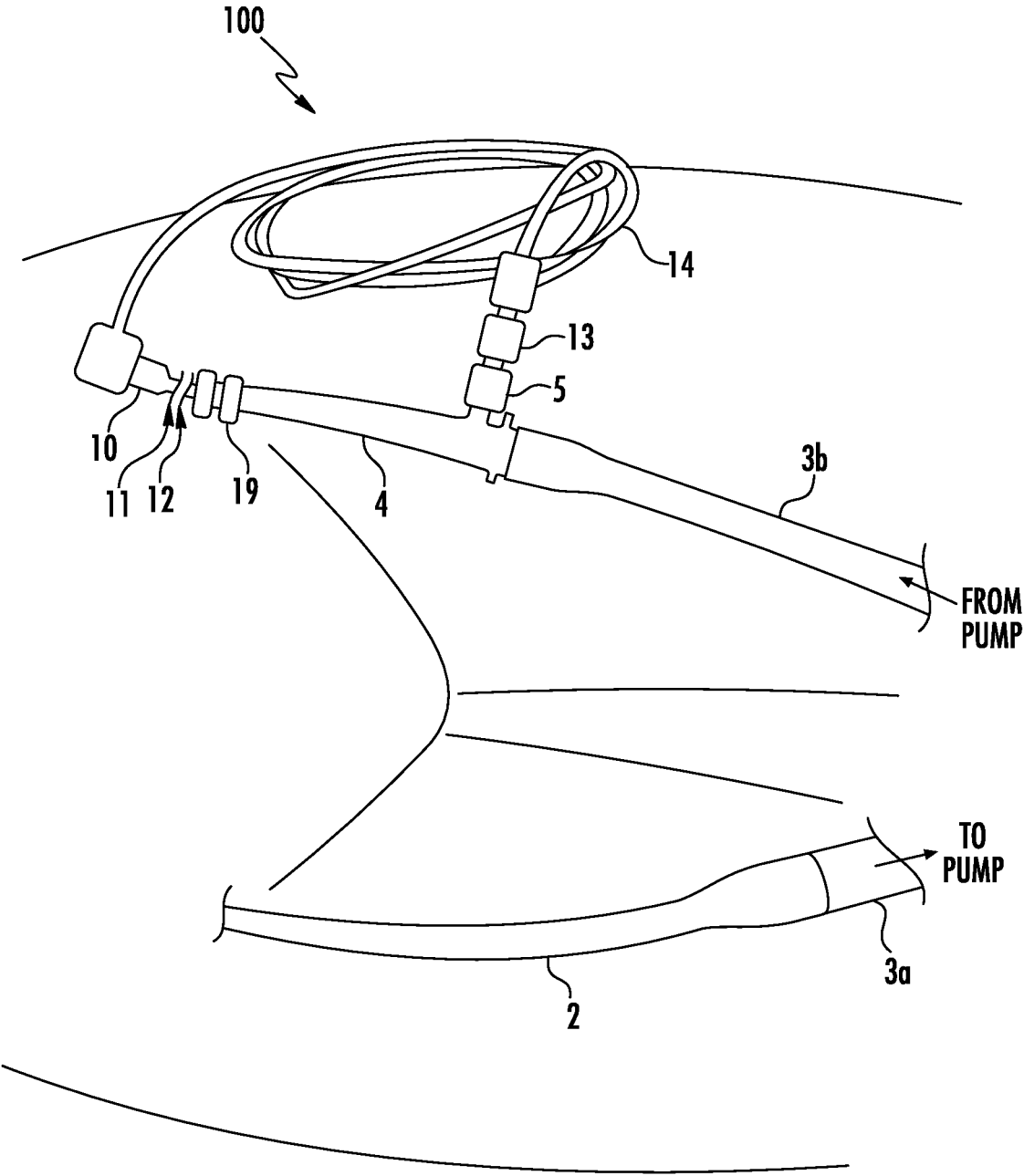


FIG. 1
(PRIOR ART)

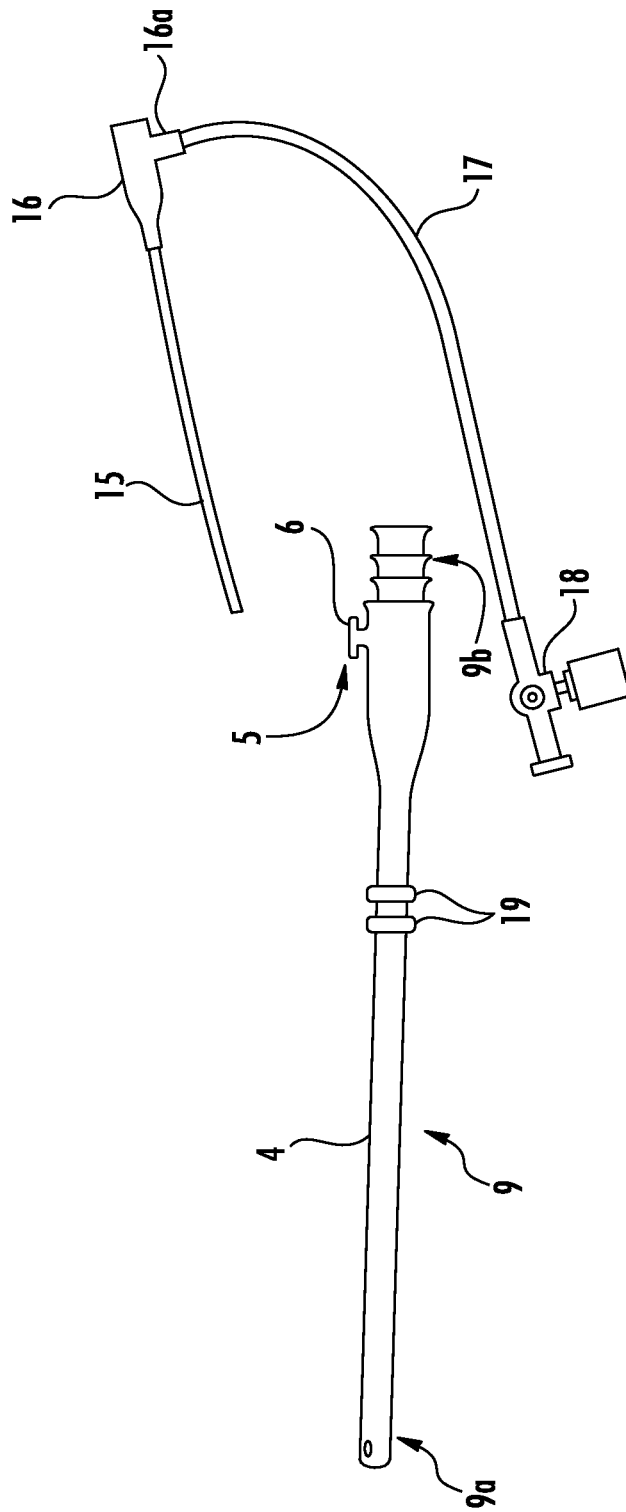
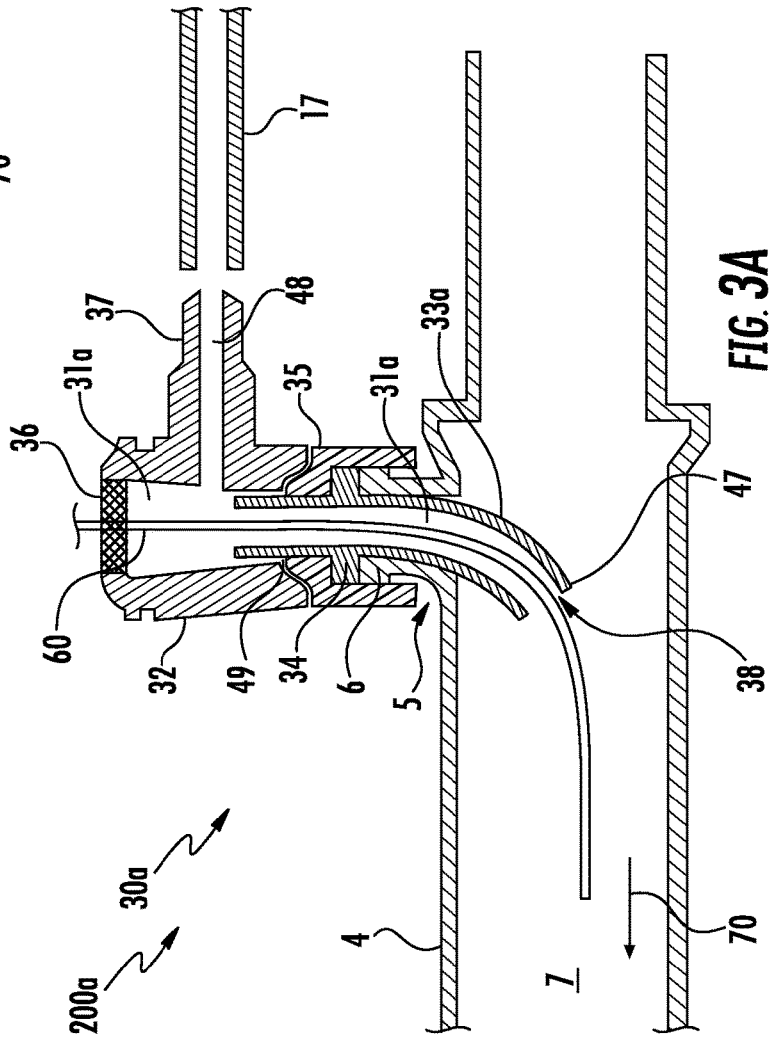
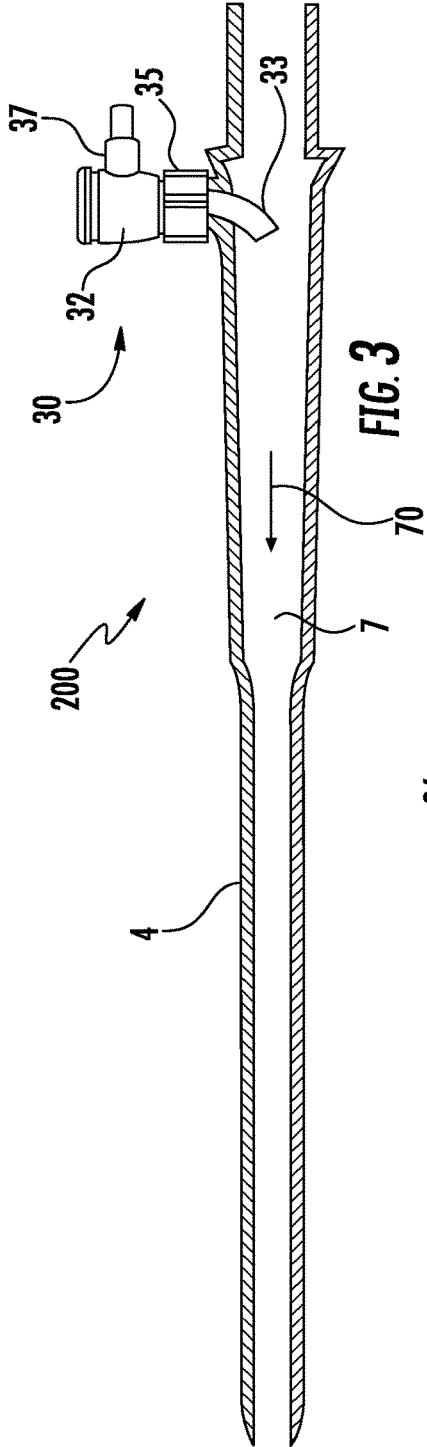
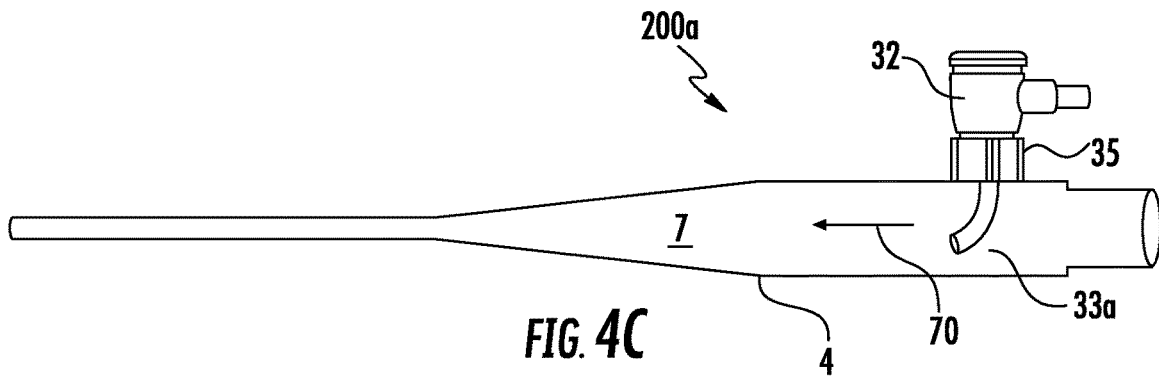
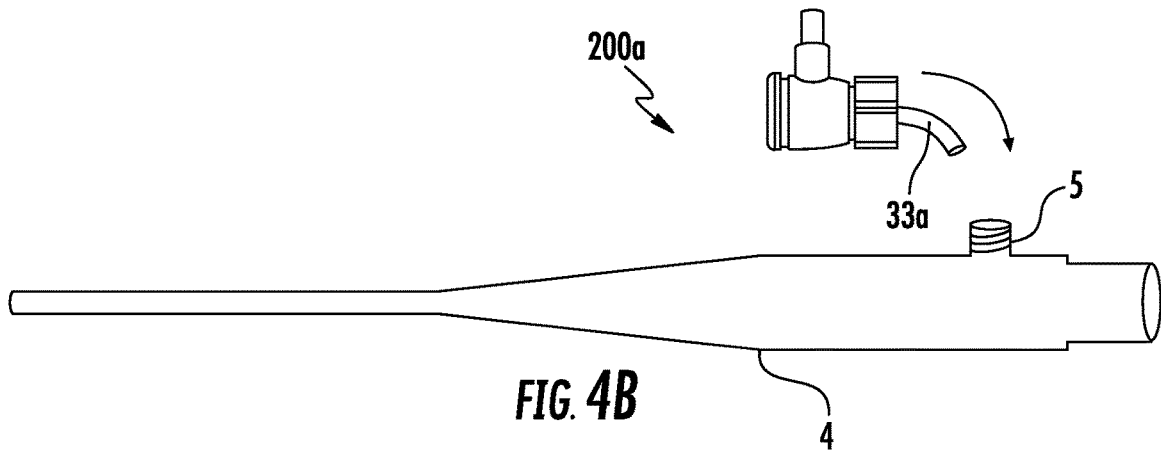
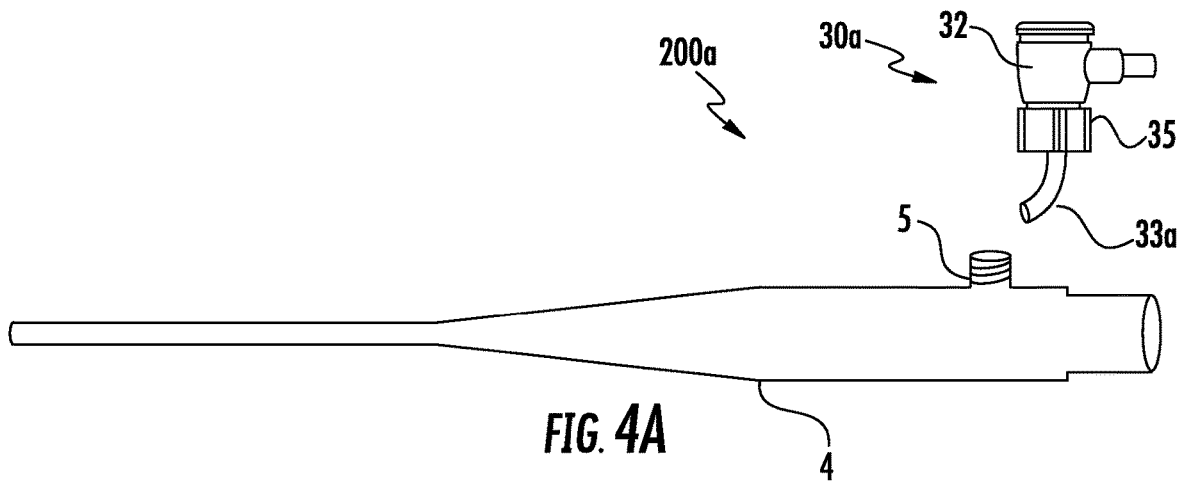
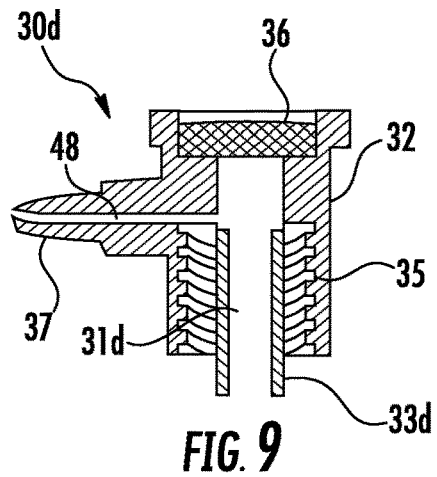
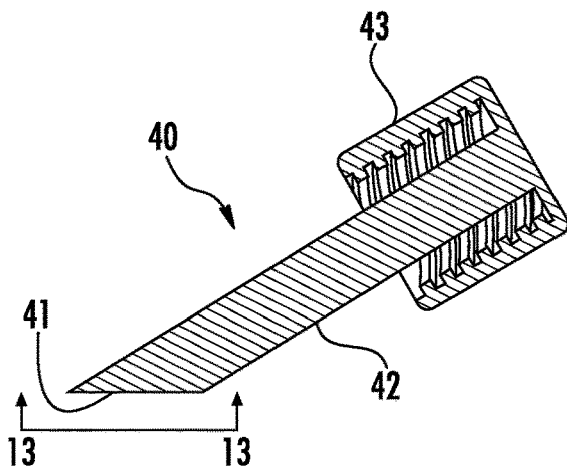
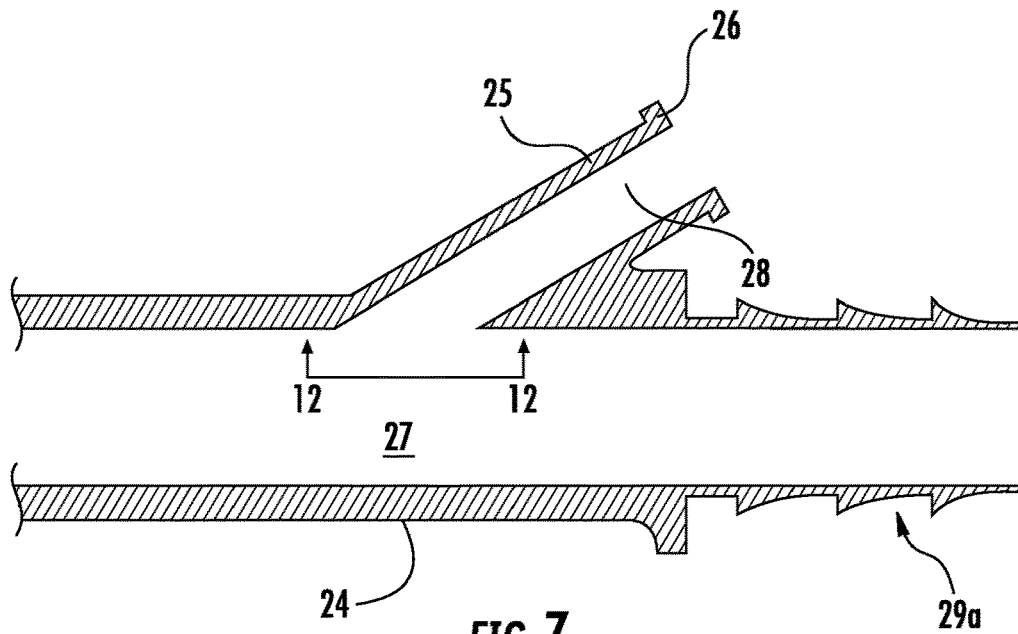


FIG. 2
(PRIOR ART)







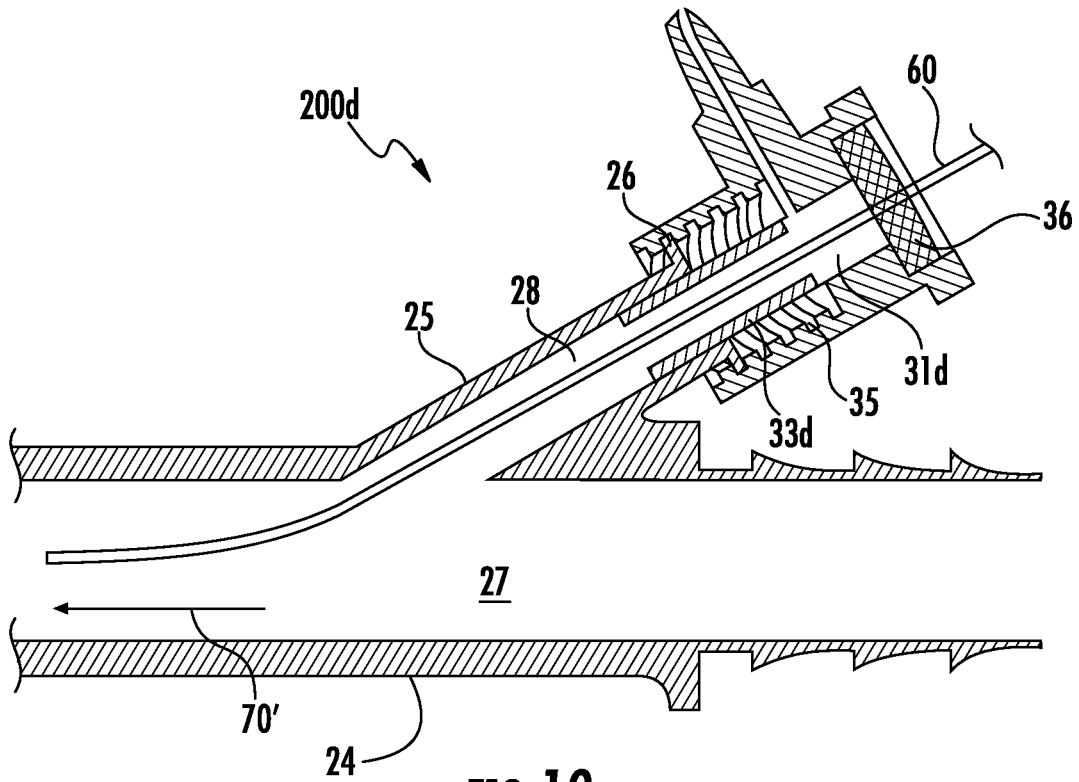


FIG. 10

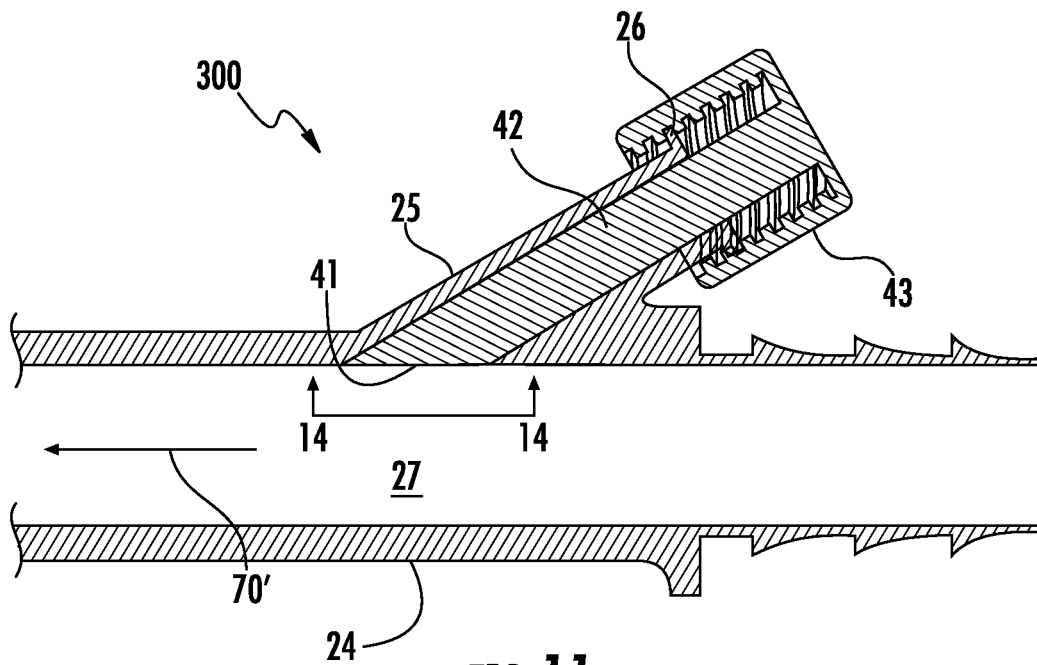


FIG. 11

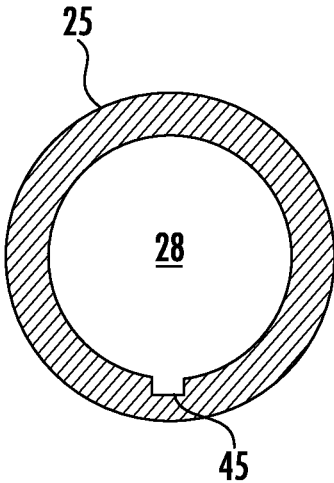


FIG. 12

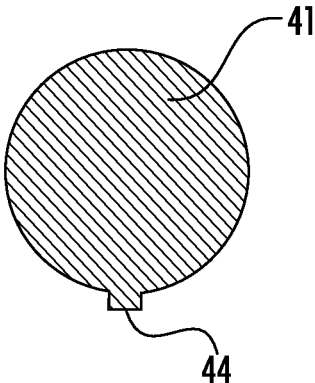


FIG. 13

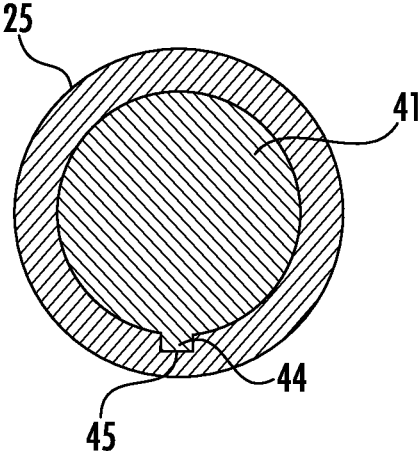
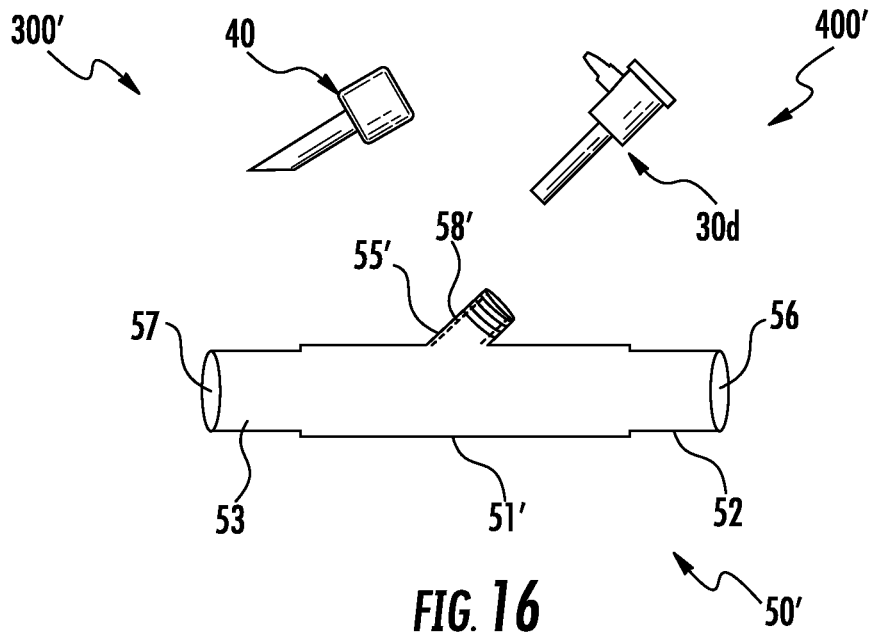
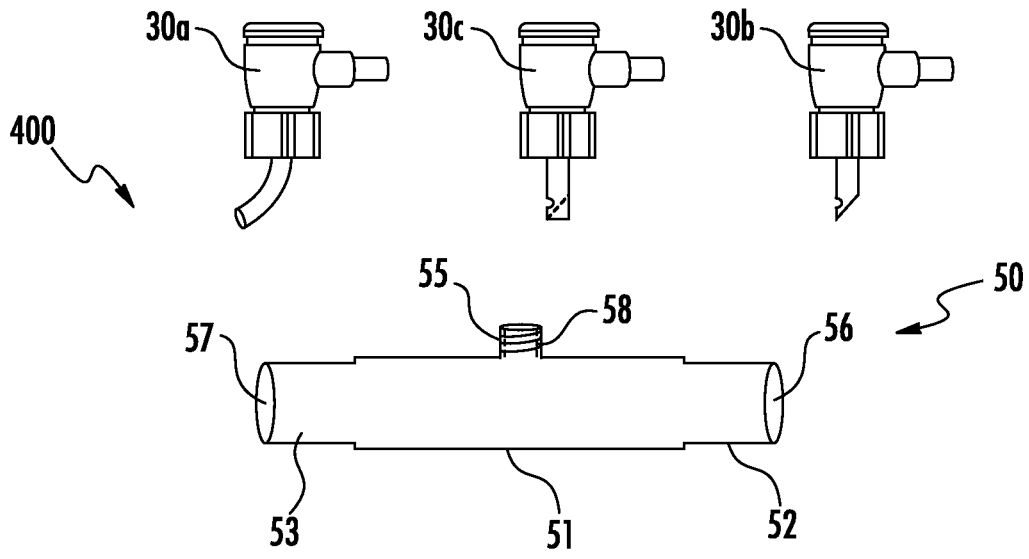
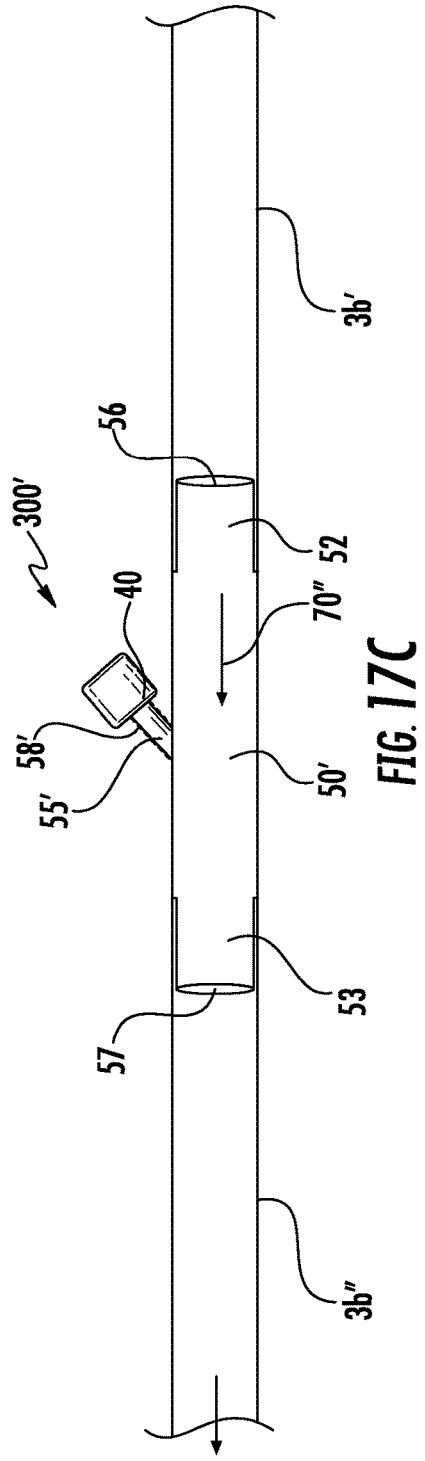
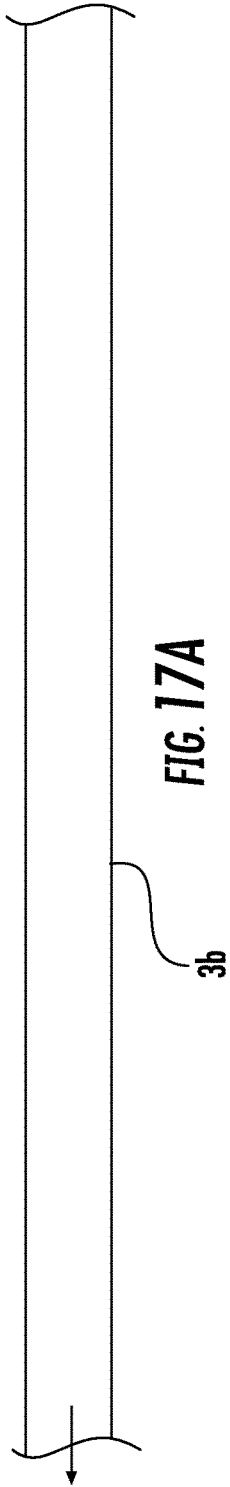
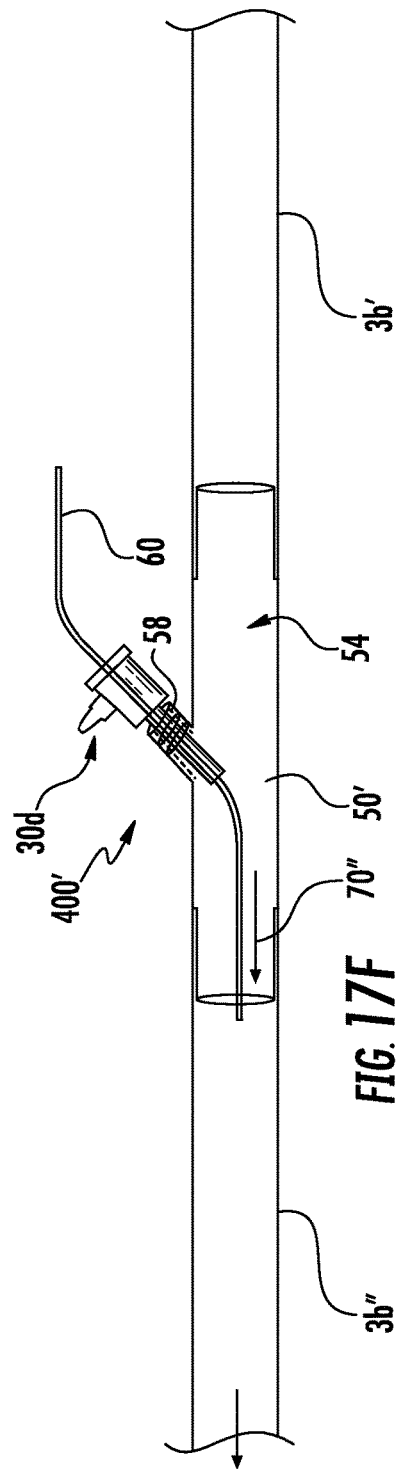
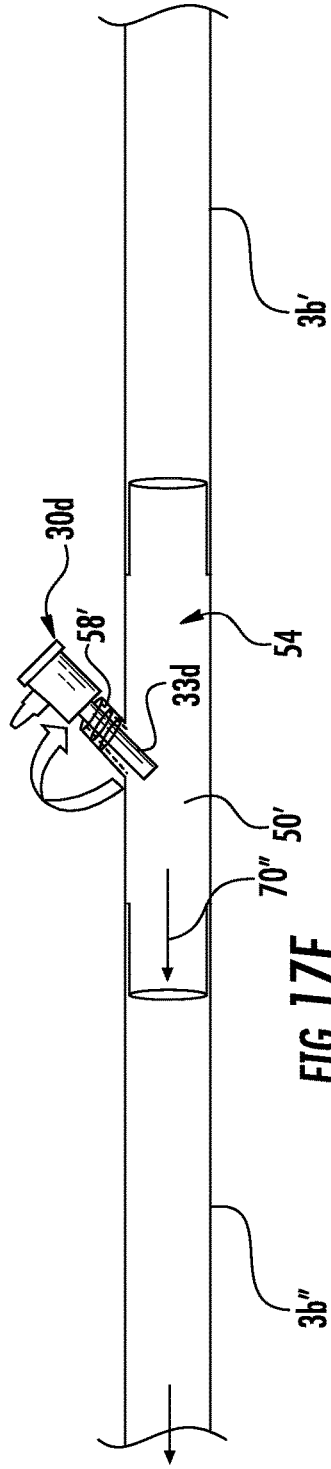
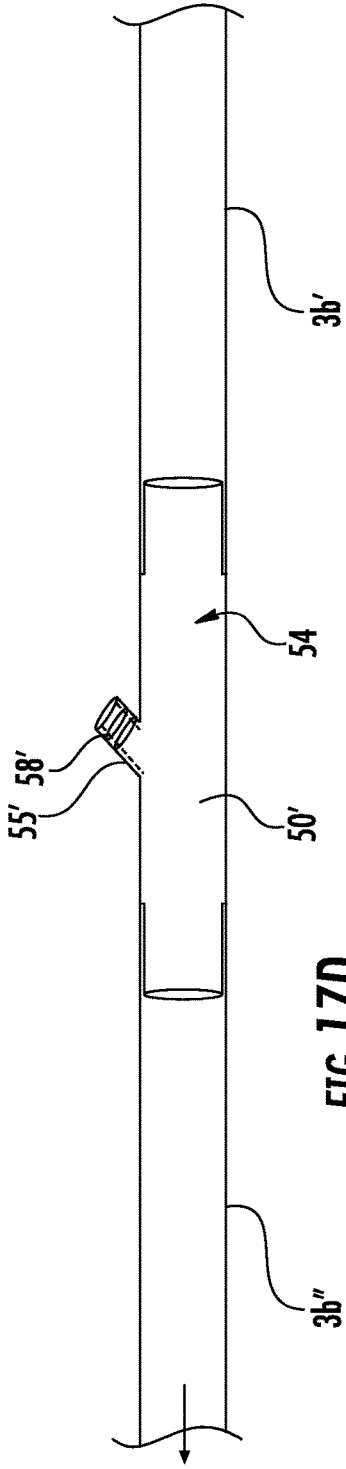


FIG. 14







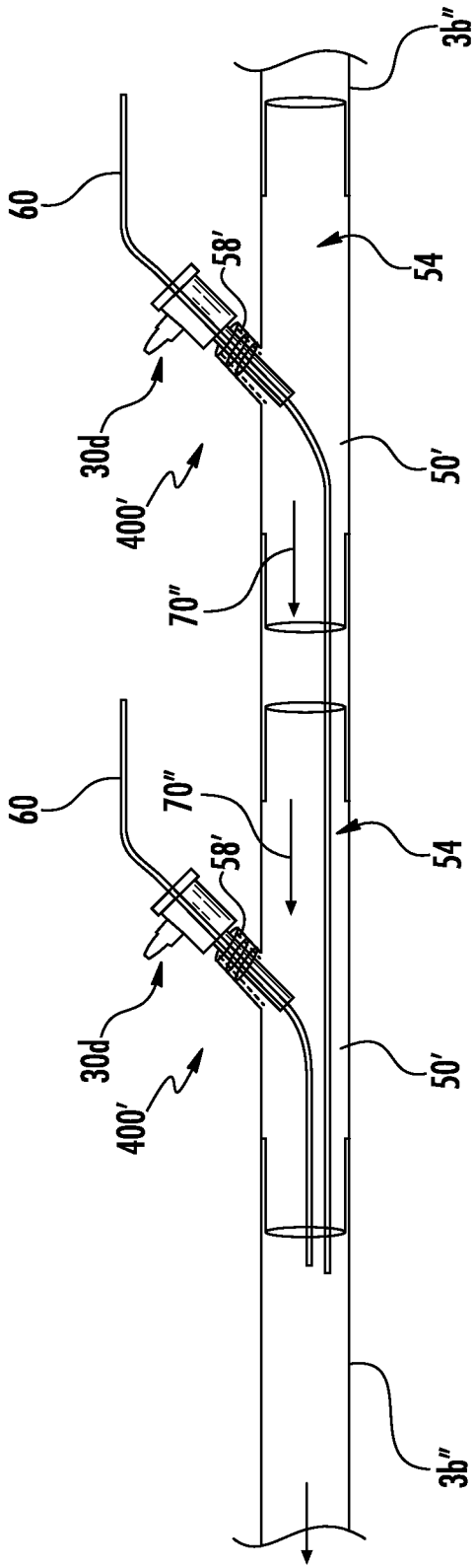


FIG. 18

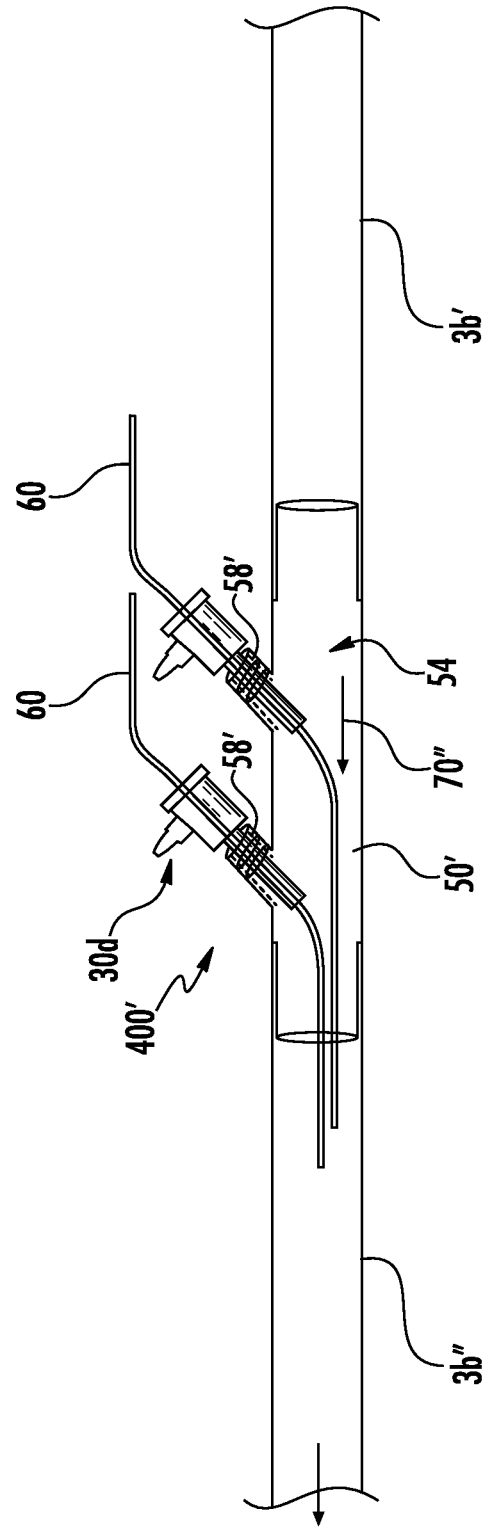


FIG. 19

**DEVICES FOR ENDOVASCULAR ACCESS
THROUGH EXTRACORPOREAL LIFE
SUPPORT CIRCUITS**

Matter enclosed in heavy brackets [] appears in the original patent but forms no part of this reissue specification; matter printed in italics indicates the additions made by reissue; a claim printed with strikethrough indicates that the claim was canceled, disclaimed, or held invalid by a prior post-patent action or proceeding.

CROSS-REFERENCE TO RELATED
APPLICATIONS

The present application is *divisional reissue of U.S. Reissue application Ser. No. 17/684,028, entitled "DEVICES FOR ENDOVASCULAR ACCESS THROUGH EXTRACORPOREAL LIFE SUPPORT CIRCUITS" and filed Mar. 1, 2022, which is an application for reissue of U.S. Pat. No. 10,576,260, entitled "DEVICES FOR ENDOVASCULAR ACCESS THROUGH EXTRACORPOREAL LIFE SUPPORT CIRCUITS" and filed on Oct. 28, 2016, which claims the benefit of U.S. Provisional Application Ser. No. 62/248,525, entitled "CATHETER SHEATHS" and filed on Oct. 30, 2015, the contents of each of which are incorporated by reference herein in [its] entirety.*

The present application is also an application for reissue of U.S. Pat. No. 10,576,260, entitled "DEVICES FOR ENDOVASCULAR ACCESS THROUGH EXTRACORPOREAL LIFE SUPPORT CIRCUITS" and filed on Oct. 28, 2016, which claims the benefit of U.S. Provisional Application Serial No. 62/248,525, entitled "CATHETER SHEATHS" and filed on Oct. 30, 2015, the contents of each of which are incorporated by reference herein in their entirety.

FIELD OF THE INVENTION

This invention relates to devices for accessing the interior of a subject, such as the vascular system, through extracorporeal life support (ECLS) system components, such as extracorporeal membrane oxygenation ("ECMO") circuits. More in particular, it relates to cannulas, adaptors, sheaths, tubing, connectors and other medical devices for use as or in connection with bypass system components to gain entry to the vascular system through the bypass system, such as an ECMO circuit.

BACKGROUND

Extracorporeal membrane oxygenation ("ECMO") is a form of cardio-pulmonary bypass that is employed to support critically ill patients with acute cardiac failure, respiratory failure, or combined cardiopulmonary failure. A typical ECMO circuit **100** as shown in FIG. **1** consists of multiple components including cannulas, tubing, an oxygenator, and pump with a controller. A heater-cooler element may be added for temperature management as well. Generally, a venous cannula **2** is inserted either into a large vein, such as a femoral vein, or the right atrium of the heart for drainage of blood from the patient. The blood is carried via bypass tubing **3a** to a pump (not shown), which provides forward flow through the circuit, and to an oxygenator (not shown), which both oxygenates the blood and allows removal of carbon dioxide. The blood is then returned to the patient via bypass tubing **3b** connected to a return or arterial

cannula **4**, which is generally placed in either the aorta or a large peripheral vessel, such as the femoral artery. Depending on the configuration, an ECMO circuit can provide gas exchange for patients with acute pulmonary failure, or both gas exchange and hemodynamic support for patients with acute cardiac or combined cardiopulmonary failure. In the setting of acute cardiac and pulmonary failure, ECMO can provide immediate restoration of perfusion and oxygen delivery to tissues, thereby preventing worsening acidosis, shock, multisystem organ failure and ultimately death and allowing for time for either organ recovery or diagnosis and intervention.

Use of this form of temporary mechanical circulatory support was initially reported in 1972. Since its introduction, technological advances in all components of the ECMO circuit have occurred. For example, improved cannula design has allowed more facile insertion with less trauma to blood vessels. Advances in pump and oxygenator design have allowed for greater efficiency and less trauma to blood elements. In the context of these advances, it was discovered that ECMO could serve as a valuable tool in supporting critically ill patients afflicted with H1N1 influenza. In its most severe manifestations, H1N1 was associated with a high mortality rate and it was found that ECMO could reduce mortality in these critically ill patients. Improvements in ECMO technology, along with its demonstrated success with critically ill H1N1 patients, have led to a dramatic growth in the use of ECMO for patients with acute cardiopulmonary failure.

ECMO is generally considered to be a supportive technology intended to provide oxygen and hemodynamic support to patients with acute cardio-pulmonary failure through a closed system. Many patients that require ECMO also require invasive procedures for diagnosis and potentially intervention. Many of these procedures, such as left and right heart catheterization, percutaneous coronary intervention, or insertion of catheters for instillation of thrombolytics, require access to the cardiovascular system, which is usually established by inserting an introducer sheath into a peripheral vessel after obtaining access with a needle. However, institution of ECMO generally requires thorough systemic anticoagulation to increase blood flow and prevent clotting. Anticoagulation, however, complicates obtaining access to the vascular system for other subsequent diagnostic and therapeutic procedures, as the anticoagulants cause an increased risk of bleeding when attempting to access a vessel. Furthermore, vascular access is often obtained in the clinical setting by palpating a patient's pulse as a landmark for locating the blood vessel. ECMO provides laminar flow and a patient on ECMO may have very little or no difference in systolic or diastolic blood pressure, resulting in a very low pulse pressure. While a patient may have adequate blood pressure, there may be very little pulsatility and it may be difficult or impossible to palpate a pulse while on ECMO. Thus, despite the potential necessity for vascular access for subsequent diagnostic and therapeutic procedures while on ECMO, obtaining vascular access in patients on ECMO may be challenging and result in complications including vascular injury and bleeding.

Since establishment of an ECMO circuit requires insertion of cannulas into the vascular system, the ECMO circuit itself has the potential to serve as an access point to the cardiovascular system and allow the performance of diagnostic and therapeutic procedures to promote the recovery of the patient. Utilizing the ECMO circuit itself for access to the cardiovascular system would circumvent the challenges and risks associated with attempting to access another blood

vessel. However, an ECMO circuit is generally not used as a vascular access point in clinical practice as a safe and facile means of doing so does not exist with currently available technology.

For example, the arterial or in-flow cannula **4** generally represents the most proximate component of the ECMO circuit to the patient's cardiovascular system. This arterial cannula **4** is typically inserted into a large peripheral vessel, such as the femoral or axillary artery, or directly into the aorta. Most commercially produced cannulas have a small, perpendicular side port **5** with a Luer connector, as shown in FIG. 1. This side port **5** allows air to be eliminated from the circuit and also allows for establishment of a secondary circuit, such as for perfusion of blood to the ipsilateral limb. Such secondary circuits are established by a secondary circuit connector **13** attaching to the side port **5** of the arterial cannula. Secondary circuit tubing **14** directs blood from the side port **5** to a superficial cannula **10**, such as a superficial femoral arterial cannula. Both the main arterial cannula **4** and the superficial cannula **10** may be introduced into the artery at the same insertion point **12**, with the cannula **4** being directed toward the heart, and the superficial cannula **10** being directed toward the ipsilateral limb, such as the leg in a femoral arterial setting. The secondary circuit therefore allows perfusion into the ipsilateral leg and prevents ischemia and tissue damage in the leg.

Many patients on ECMO systems will typically require diagnostics and therapeutic interventions, which are commonly facilitated by the placement of an introducer sheath **15**, shown in FIG. 2, in the patient's artery. The introducer sheath **15** may also include a hub **16** with side arm **16a** for venting air out of the system through venting tubing **17** by operation of a valve **18**. The side port **5** of an ECMO arterial cannula **4** represents a potential access point to the ECMO circuit for vascular access. However, current vascular introducer sheaths **15** have no mechanism of interfacing with the side port **5**. As is evident from FIG. 2, arterial sheaths **15** are too long and incompatible with the short right angle side port **5** provided in a cannula **4**. They therefore offer no mechanism to negotiate the right angle presented by the side port **5**, and no mechanism to direct a diagnostic or interventional wire or catheter in the appropriate direction (toward the patient rather than toward the ECMO pump) once inserted. Because insertion is not possible, introducer sheaths **15** provide no mechanism for establishing a hemostatic seal to the cannula **4**, which would be needed for safe insertion of a wire or catheter. Attempts to insert a standard arterial sheath **15** into the side port **5** of a cannula **4** would result in uncontrolled bleeding around the sheath **15**, inability to maintain the sheath **15** in appropriate position, kinking of the sheath **15**, misdirection of intervention devices such as wires or catheters, and inability to pass wires or catheters altogether. For these reasons, currently available arterial sheaths are not amenable for insertion directly into a cannula.

SUMMARY OF THE INVENTION

The present invention is directed to adaptors, caps, cannulas, tube couplers, and systems including combinations thereof to permit the cannulas of an ECLS system, such as an ECMO circuit, to be used as an access point to gain endovascular entry. The various components provide the ability to interchangeably utilize the side port of a cannula not only for introduction of intervention devices, such as wires or catheters, into the cardiovascular system, but also for other purposes as well, such as establishing a secondary circuit for distal perfusion. Full occlusion of the side port is

also made possible when the side port is not in use, to prevent blood stagnation and thrombus formation.

Specifically, the present invention is directed to a variety of adaptors that enable the use of an ECMO circuit as a vascular access point, and systems for vascular access that include such adaptors. These adaptors can interface with a standard cannulas currently used in ECLS systems, such as ECMO circuits, and provide an access point for intervention devices such as wires or catheters into the system. The adaptors of the present invention include curved or straight shafts having an angle that can negotiate the right angle of a standard cannula side port and provide directionality to a wire or catheter inserted therein. A hemostatic membrane allows for insertion of the intervention device without back bleeding.

The present invention is also directed to a modified cannula with an angled side port. Such modified cannulas can be used with an adaptor as described herein. An occlusive cap is also provided that fully blocks the angled side port when vascular access or secondary perfusion is not needed. This occlusive cap prevents blood from stagnating in the angled side port, which could lead to thrombosis. Systems including the modified cannula, adaptor and occlusive cap are also described.

The present invention is further directed to a tube coupler that can be spliced into the tubing of an established or pre-existing ECLS system, including ECMO circuits. The coupler may have a standard right angle side port, or may have an angled side port with interchangeable adaptor and occlusive cap. A series of couplers may be inserted into the tubing of the bypass system, such as when a series of instruments or intervention devices must be inserted simultaneously for vascular access. Systems including the coupler with adaptors and/or occlusive caps, as previously described, are also included.

The adaptors, modified cannula, cap, coupler, and systems including the same, together with their particular features and advantages, will become more apparent from the following detailed description and with reference to the appended drawings.

DESCRIPTION OF THE DRAWINGS

FIG. 1 is a diagram of a typical ECMO system of the prior art.

FIG. 2 is a diagram demonstrating the difficulties of direct access to an ECMO cannula.

FIG. 3 is a partial cross-section of one embodiment of an adaptor of the present invention shown inserted in an ECMO cannula.

FIG. 3A is a cross-section of the adaptor of FIG. 3.

FIG. 4A shows the adaptor of FIG. 3 prior to insertion into an ECMO cannula.

FIG. 4B shows the adaptor of FIG. 4A being inserted into the ECMO cannula.

FIG. 4C shows the adaptor of FIG. 4A fully inserted into the ECMO cannula.

FIG. 5A is a cross-section of a second embodiment of an adaptor of the present invention.

FIG. 5B is a cross-section of a third embodiment of an adaptor of the present invention.

FIG. 6 shows a modified ECMO cannula, cap and adaptor of the present invention.

FIG. 7 is a cross-section of the modified ECMO cannula of FIG. 6.

FIG. 8 is a cross-section of a modified cap of FIG. 6.

FIG. 9 is a cross-section of the adaptor of FIG. 6.

5

FIG. 10 is a cross-section showing the adaptor and modified ECMO cannula of FIG. 6.

FIG. 11 is a cross-section showing the cap and modified ECMO cannula of FIG. 6.

FIG. 12 is a cross-section of the sideport opening of one embodiment of the modified ECMO cannula of the present invention.

FIG. 13 is a cross-section of the occluding surface of one embodiment of the cap of the present invention.

FIG. 14 is a cross-section of the occluding surface of the cap of FIG. 13 when inserted in the sideport of the modified ECMO cannula of FIG. 12.

FIG. 15 is one embodiment of a system using one version of a tubing connector with various adaptors of the present invention.

FIG. 16 is another embodiment of a tubing connector of the present invention.

FIG. 17A depicts standard bypass tubing before insertion of a tube coupler.

FIG. 17B depicts the tubing of FIG. 17A cut in preparation of receiving a coupler.

FIG. 17C shows a coupler placed between sections of bypass tubing, where a cap is in place.

FIG. 17D shows the coupler of FIG. 17C where the cap is removed, in preparation for direct access.

FIG. 17E shows the coupler of FIG. 17D where an adaptor is placed in the side port of the modified cannula for direct access.

FIG. 17F shows the coupler and adaptor of FIG. 17E in which direct access of an insertion device to the ECMO system is achieved through the adaptor and tubing connector.

FIG. 18 shows another embodiment of the tube coupler system where multiple couplers are serially spliced into the same bypass tubing and each provides endovascular access for a different insertion device.

FIG. 19 shows still another embodiment of the tube coupler system in which a single coupler includes a plurality of access ports, where each access port permits entry of a different insertion device for endovascular access.

Like reference numerals refer to like parts throughout the several views of the drawings.

DETAILED DESCRIPTION

As shown in the accompanying drawings, the present invention is directed to devices, such as adaptors, cannulas, tubing, and connectors that enable the use of an ECLS circuit, such as ECMO, as a vascular access point. The devices and systems enable not only vascular access for an intervention device, such as a wire, catheter or the like, but also provide full occlusion of the side port of the ECMO cannula when not in use. They are interchangeable with each other depending on whether vascular access is desired or not, and are further interchangeable with tubing connectors for secondary circuits, such as to establish secondary perfusion to an ipsilateral limb. This level of accessibility and interchangeability of components with a side port of a long-term use cannula has not been seen before. Further, the need to fully occlude the side port when not in use is of extreme importance in long-term systems, such as ECLS circuits, because of the increased potential for thrombus formation. The present invention addresses all of these needs not seen heretofore.

Although described here in the context of an ECMO system, it should be understood that the adaptors, cannulas, cap, tubing, couplers and systems of the present invention

6

may be used with any appropriate cannulation or ECLS system, and is not limited to vascular applications. In addition, the devices and systems described herein can be used with bypass systems, such as a cardiopulmonary bypass circuit, for temporary support such as during an open heart operation. The inventions described herein may be more preferably used with longer term support circuits, such as those in use over 6 hours or more. In addition, the terms "subject" and "patient" may be used interchangeably and refer to the individual who is on bypass in which intracorporeal access is desired.

Adaptors for Standard Cannulas

As seen in FIGS. 3-5B, one aspect of the invention includes a variety of adaptors 30 designed for use with standard ECMO arterial cannulas 4 having a right angle side port 5 as an access point. These adaptors 30 can successfully navigate or circumvent the 90° turn of the side port 5 of an arterial or in-flow cannula 4 without kinking or damage. They therefore permit access to the cannula lumen 7, without obstructing the lumen, for access to the vascular system through the cannula 4. Accordingly, the adaptor 30 may be used instead of an introducer sheath 15 to access the vascular system, and enables access to the vascular system through the ECMO circuit without further percutaneous action.

As depicted in FIG. 3, the adaptor 30 includes a body 32 that acts as a hub for the remaining components of the adaptor 30, and may be manipulated by an operator or user during insertion. The body 32 is preferably made of a medical-grade plastic or other suitable material for medical use, and may be rigid. In some embodiments, the body 32 may include a side arm 37 that can be used for venting and otherwise removing air from the system, described in greater detail below.

The adaptor 30 also includes a shaft 33 that extends from one end of the body 32. In at least one embodiment, the shaft 33 may extend at least partially into the body 32 on one end, and extends away from the body 32 on the opposite end. The shaft 33 may include an elongate structure dimensioned to be inserted and pass through the side port 5 of a cannula 4, as shown in FIG. 3A. For instance, the shaft 33 may have a circular or tubular configuration, and a diameter that corresponds to, or is smaller than, the inner diameter of the side port 5. Accordingly, the shaft 33 may fit inside the side port 5, and may provide a snug fit in some embodiments. The shaft 33 is at least as long as the side port 5 of a cannula 4, and may extend into the cannula lumen 7. In some embodiments, the shaft 33 may extend to the wall of the cannula 4, but in at least one preferred embodiment the shaft 33 does not extend to the wall of the cannula 4. Regardless of the embodiment, however, the shaft 33 of the present adaptor 30 is shorter in length than that of a standard introducer sheath 15. The shorter length of the sheath 33 facilitates the navigation of the right angle side port 5 (discussed below) and prevents kinking of the shaft 33 when inserted into the side port 5.

The shaft 33 may be made of a semi-flexible plastic material, such as fluorinated ethylene polypropylene or polyether block amide plastics used in endovascular and other intervention systems, or other suitable medical-grade plastics and materials. Such a semi-flexible material provides sufficient rigidity to maintain its shape for directional guiding of a wire or catheter, but is flexible enough to bend or flex slightly as needed during the insertion process and to prevent damage to the shaft 33 upon the introduction of a medical device therein. The body 32 of the adaptor 30 may be made of a similar semi-flexible material as the shaft 33, or may be made of more rigid material than the shaft 33.

The shaft 33 may have a variety of configurations that enables modifying an angle of insertion of an intervention device, such as a wire or catheter, inserted into the adaptor 30 and directs the intervention device into the cannula lumen 7. For example, in at least one embodiment as depicted in FIGS. 3-4C, the shaft 33a is curved. The curved shape of the shaft 33a provides directionality to a medical device introduced therein, such as a wire or catheter. When positioned correctly, the curved shaft 33a reliably directs the wire or catheter introduced therein toward the patient's heart, rather than back in the direction of the ECMO system. The curved shaft 33a is long enough to extend into the cannula lumen 7 when inserted, but is also short enough in length to easily navigate the right angle of the side port 5 during insertion, as depicted through FIGS. 4A-4C. In FIG. 4A, an adaptor 30a having a curved shaft 33a is provided. To gain access to the cannula lumen 7, the distal opening of the curved shaft 33a is aligned with the opening of the side port 5, as shown in FIG. 4B. The distal end of the curved shaft 33a is inserted into the side port 5 of the cannula 4, and the adaptor 30a is rotated along the directional arrow shown in FIG. 4B until the curved shaft 33a is passed through the side port 5 and extends into the cannula lumen 7, as in FIG. 4C. Alignment of the curved shaft 33a and rotation of the adaptor 30a for insertion of the curved shaft 33a are performed so as to direct the opening of the curved shaft 33a toward the heart of the patient once fully inserted in the cannula 4, as depicted throughout FIGS. 4A-4C. The relatively short length of the curved shaft 33a, being slightly longer than the length of the side port 5, combined with the curvature of the shaft 33a, allows it to be rotated around the right angle of the side port 5 during insertion. It also prevents the shaft 33a from kinking at the inner wall of the cannula lumen 7, since in at least one embodiment the curved shaft 33a is not long enough to reach the opposite wall of the cannula lumen 7 during insertion. In some embodiments, the curved shaft 33a may be long enough to reach the opposite wall of the cannula lumen 7 during insertion, but in these embodiments the semi-flexible material of the curved shaft 33a allows it to flex and deflect off of the cannula wall, and resiliently keep its curved shape. Once the adaptor 30a is in place, as in FIG. 4C, a connector 35 can be tightened to selectively and releasably secure the adaptor 30a to the cannula 4, thereby securing the adaptor in place and preventing bleeding around it.

In other embodiments, as in FIG. 5A, the shaft 33b has a straight configuration and extends substantially linearly from the body 32 of the adaptor 30b. In such embodiments, the distal end of the shaft 33b opposite of the body 32 includes a deflector 39 that protrudes or extends from an interior wall of the shaft 33b at an angle, thereby creating an angled surface for upon which a wire, catheter or other medical device inserted through the adaptor 30b may be deflected in a gentle curve to direct it into the cannula lumen 7. Accordingly, the deflector 39 changes the angle of the intervention device 60 from the initial angle of insertion to a different angle that directs the intervention device 60 into the cannula lumen 7. The deflector 39 may be made of the same semi-flexible material as the rest of the shaft 33b, as discussed previously, or may be made of a slightly more rigid material that resists flexing when pressure is applied, so as to direct an intervention device 60, such as a wire or catheter, appropriately and not lose its shape. As used herein, an intervention device 60 may be any diagnostic and therapeutic device used in medical procedures, and is not limited to wires or catheters. In some embodiments, the deflector 39 is made of a hard medical-grade plastic, such as polycar-

bonate or nylon, although other suitably rigid materials are also contemplated. In further embodiments, the entire shaft 33b,c and deflector 39 may be made of a hard plastic, polycarbonate or nylon, or other rigid material. In some embodiments, as in FIG. 5A, the deflector 39 may be at the terminal end 47 of a straight shaft 33b, such that the shaft 33b has an angled end.

In other embodiments, as in FIG. 5B, the straight shaft 33c may include a deflector 39 as before, but has a flat or straight terminal end 47 outer end. In these embodiments having a straight shaft 33b,c and a deflector 39, the shaft 33b,c may have an opening 38 at the side at the terminal end 47. Accordingly, the opening 38 is facing or pointed in the direction of the patient's heart, so as to appropriately direct a wire or catheter exiting from the shaft 33b,c. Additionally, the straight shaft 33b,c is longer in length than the side port 5, but is shorter than the distance to the opposite wall of the cannula 4. Accordingly, the right angle side port 5 does not pose a navigational risk in these straight shaft 33b,c embodiments, since the straight shaft 33b,c easily conforms to the straight channel 8 of the side port 5, and the internal deflector 39 creates the required angular change to direct an inserted wire or catheter toward the patient's heart.

Regardless of the particular configuration, the shaft 33 provides access for an intervention device 60 to the cannula lumen 7, and modifies the angle of insertion of the intervention device 60 and directs the intervention device 60 into the cannula lumen 7. Specifically, as seen in FIGS. 3A, 5A and 5B, the cannula lumen 7 has an axial flow path 70 of fluid (such as blood from an ECMO system) being directed through it. The shaft 33 of the adaptor 30 changes the direction of the intervention device 60 upon insertion and directs it not only into the cannula lumen 7, but specifically in the direction of, or consistent with, the axial flow path 70 of the cannula lumen 7. In at least one embodiment, this is toward the patient's heart, for cardiopulmonary intervention.

The shaft 33, and with reference to FIGS. 3A, 5A and 5B, may include a flange 34 that has a wider diameter than the remainder of the shaft 33. For example, the flange 34 may be circumferentially disposed around the shaft 33 and extend radially away from the shaft 33. The flange 34 is dimensioned to correspond with and abut a terminal lip 6 at the outermost edge of the side port 5 when the adaptor 30 is fitted on the side port 5. In this manner, the flange 34 may limit how far the shaft 33 may enter the side port 5 and cannula lumen 7.

The adaptor 30 may further include a connector 35, as shown in FIGS. 3A, 5A and 5B. The connector 35 is a fitting that removably secures the adaptor 30 to the side port 5 of the cannula 4. The connector 35 may be any suitable fitting for selectively releasable connection, such as a snap fitting, or a Luer connector that connects by screw action through a series of threads on the inside of the connector 35. These threads may interact with the lip 6 of the side port 5, such that as the connector 35 is turned or rotated about the side port 5, the lip 6 engages and is moved through the threads of the connector 35. In at least one embodiment, the connector 35 is a floating Luer connector that rotates independently of the remainder of the adaptor 30, such as the shaft 33. Such floating connector 35 may be preferable in embodiments where maintaining the direction or alignment of the opening 38 of the shaft 33 within the cannula lumen 7 is important, as in FIGS. 3-5B. In other embodiments, as when the orientation or direction of the shaft 33 is not critical after insertion, as in FIGS. 6 and 9-10, the connector 35 may be secured to and/or rotate with the adaptor 30 or shaft 33. In

such embodiments, the connector 35 may be integrated into the adaptor 30, such as in the body 32 of the adaptor 30.

In at least one embodiment, the flange 34 of the shaft 33 may act as a washer between the connector 35 and the lip 6 of the side port 5, forming a seal when the connector 35 is tightened down onto the side port 5. Further, in some embodiments, the body 32 may include a cavity 49 on the underside which is correspondingly shaped to the connector 35, such that at least a portion of the connector 35 may be inserted into the cavity 49 of the body 32, as seen in FIG. 3A for example.

The adaptor 30 also includes an adaptor lumen 31 extending through and connecting the interior of the body 32 and shaft 33, shown in FIGS. 3A, 5A and 5B. The adaptor lumen 31 provides a hollow interior through which an intervention device 60 such as a wire or catheter may be introduced. The adaptor lumen 31 may be a single lumen, or may be separate lumens of the body 32 and the shaft 33 that are continuous with one another. Accordingly, in some embodiments, the adaptor lumen 31a is curved through a curved shaft 33a, as in FIG. 3A. In other embodiments, the adaptor lumen 31b,c is straight through a majority of its length, and is angled at the distal end of the shaft 33b,c.

The adaptor lumen 31 is in fluidic communication with the cannula lumen 7 when the adaptor 30 is in place. Specifically, the adaptor lumen 31 extends through the body 32 and shaft 33 of the adaptor 30, and ends at the opening 38 of the distal end of the shaft 33. Therefore, the adaptor lumen 31 provides exterior access to the cannula lumen 7 of the ECMO system, including the axial flow path 70 thereof. The adaptor lumen 31 may also be in fluidic communication with a passage 48 extending through a side arm 37 of the adaptor 30. In such embodiments, any air that may be present in the cannula lumen 7 and the adaptor lumen 31 may be removed by selective venting through the passage 48 of the side arm 37, such as by operation of a valve connected to the side arm 37 through vent tubing 17, as in FIG. 3A.

The adaptor lumen 31 is dimensioned to receive an intervention device 60 such as wires and catheters, which may be up to about 7 French in diameter, or greater in some embodiments. The flange 34 of the shaft 33 and the connector 35 form a hemostatic seal with the side port 5, as mentioned previously, so that blood flowing through the ECMO system will not be lost during vascular access.

Further, the adaptor 30 may include a membrane 36 opposite of the shaft 33 through which a wire, catheter or other suitable diagnostic, therapeutic or other medical intervention device 60 may be passed to enter the adaptor 30 and gain access to the ECMO system and vascular system. In at least one embodiment, the membrane 36 is a hemostatic diaphragm, such as a silicone or other soft biocompatible plastic disc with a perforating slit(s) for access, as is used in insertion sheaths 15. As shown in FIGS. 3A, 5A and 5B, the membrane 36 is disposed in the body 32 of the adaptor 30 and spans the distance between the edge of the adaptor lumen 31 and the outer edge or exterior of the body 32. In other embodiments, the membrane 36 is coextensive with a top surface of the adaptor 30, as in FIGS. 3A, 5A and 5B. In other embodiments, the top surface of the adaptor 30 may not be uniformly flat, but may recess in, as in FIG. 9. Here, the membrane 36 spans from the adaptor lumen 31 to the outer edge of the body 32, which is the recessed portion. Regardless of configuration, the membrane 36 allows access to the adaptor lumen 31 while maintaining hemostatic conditions and preventing back bleeding upon insertion of an intervention device 60 therein.

The invention also includes various systems for vascular access 200. Each system 200 includes a cannula 4 and an adaptor 30 as described herein. For instance, at least one embodiment of a vascular access system 200a includes a cannula 4 and an adaptor 30a having a curved shaft 33a, as in FIG. 3A. In at least one other embodiment, the vascular access system 200b includes a cannula 4 and an adaptor 30b having a straight shaft 33d terminating in an angled deflector 39, as in FIG. 5A. In at least one other embodiment, the vascular access system 200c includes a cannula 4 and an adaptor 30c having a straight shaft 33c and a flat terminal end, with an internal deflector 39, as in FIG. 5B. These are just a few illustrative examples, and are not intended to be limiting.

15 Modified Cannula, Adaptor and Occlusive Cap

Turning now to FIGS. 6-14, the present invention is also directed to a modified cannula 24 that can be used in an ECLS system in place of a standard arterial cannula 4, such as an ECMO vascular cannula. The modified cannula 24 is made of a flexible medical-grade plastic, silicon, or polymer material, or other material suitable for insertion and residence in a patient. As depicted in FIGS. 6 and 7, the modified cannula 24 includes an elongate portion 29 extending between a proximal end 29a and an opposite distal end 29b. The proximal end 29a is positioned closest to the pump of the bypass system, and has an opening at its terminal end and a diameter sized to receive and form a tight seal with the bypass tubing 3b around its perimeter. For example, such bypass tubing 3b may be $\frac{3}{8}$ inch to $\frac{1}{2}$ inch in diameter, and the proximal end 29a may have a diameter ranging from 6 to 51 French depending on the particular application and whether it is used on an adult, child or infant. In some embodiments, the proximal end 29a includes ribs, barbs, serrations, or other frictional elements that engage the interior of the bypass tubing 3b upon insertion and maintains or facilitates a tight seal with the tubing 3b. Accordingly, when attached to the bypass tubing 3b, the proximal end 29a of the modified cannula 24 receives blood from the ECLS system, such as an ECMO system.

The opposite distal end 29b of the modified cannula 24 is dimensioned to be inserted into a subject or patient, such as a blood vessel for vascular access, and more in particular an artery, such as the femoral artery or aorta, or a vein, such as the femoral vein or internal jugular vein. For instance, the distal end 29b may have a diameter ranging from 14 to 22 French, although smaller or larger sizes are also contemplated. The distal end 29b is preferably narrower than the proximal end 29a, as in FIGS. 6 and 7. In other embodiments, however, the distal end 29b and proximal end 29a may have the same diameter, or the distal end 29b may have a larger diameter than the proximal end 29a. The distal end 29b is also made of a flexible medical-grade plastic, silicon, or polymer material, or other suitable material, so as to avoid damaging or puncturing the blood vessel. The distal end 29b may also include an opening(s) at or near the distal tip to allow reinfusion of blood into the surrounding blood vessel from the modified cannula 24.

Between the proximal end 29a and distal end 29b, the modified cannula 24 may include a depth guide(s) 22 located along the length of the elongate portion 29. The depth guide(s) 22 provide a visual indicator for a user, such as a medical practitioner, of how far to insert the distal end 29b of the modified cannula 24 into the subject. For instance, in at least one embodiment, the distal end 29b of the modified cannula 24 is inserted into the patient at an incision point until the depth guide(s) 22 reaches the incision. The depth guide(s) 22 therefore provides a maximum limit for inser-

tion. In at least one embodiment, the depth guide **22** may be a collar or series of collars disposed circumferentially around the exterior of the elongate portion **29** of the modified cannula **24**. In other embodiments, the depth guide **22** may be a marking or series of markings on or integrally formed in the wall of the modified cannula **24**, such as printed on or engraved in the exterior surface of the modified cannula **24**.

The modified cannula **24** also includes a modified cannula lumen **27** extending through the length of the modified cannula **24** from the opening at the proximal end **29a** to the opening at the distal end **29b**. Accordingly, the modified cannula lumen **27** provides an axial flow path **70'** through which fluid, such as blood, may pass during ECMO circulation. The modified cannula lumen **27** has a diameter similar to that of the modified cannula **24**, and in at least one embodiment takes up a majority of the inner volume of the modified cannula **24**.

As shown in FIGS. 6 and 7, the modified cannula **24** further includes an angled side port **25** that extends from the surface of the modified cannula **24**. Notably, the angled side port **25** extends away from the surface at an angle, which may be any angle other than 90°. For instance, the angled side port **25** extends from the surface of the modified cannula **24** at an acute angle less than 90°, such as in the range of 10° to 40° from the modified cannula **24** wall in at least one embodiment. In another embodiment, the angle of the angled side port **25** is in the range of 25° to 35°. These are illustrative examples, and are non-limiting. For instance, depending on the perspective, the angled side port **25** could be considered to extend at an obtuse angle from the modified cannula **24**.

The angled side port **25** terminates at a lip **26** having a wider diameter than the rest of the angled side port **25**, so as to form an overhanging portion. The angled side port **25** may also have a thread to allow interaction with Luer connections or other counterthreads on the connector **35** of adaptors **30**. The angled side port **25** also has an opening at the terminal end, and an angled side port channel **28** extending through the angled side port **25** in fluid communication with the opening on one end and the modified cannula lumen **27** on the opposite end. Accordingly, the angled side port **25** provides exterior access to the modified cannula lumen **27**, and therefore to the vascular system for endovascular diagnostic and therapeutic procedures.

The angled side port **25** of the modified cannula **24** provides a number of benefits over the standard right angle side ports **5** of current vascular arterial cannulas **4**. For instance, the angle of the angled side port **25** directs an incoming wire, catheter or other inserted medical device to more closely align with the modified cannula lumen **27** in a direction toward the heart of the patient. This facilitates the insertion of such a device without having to navigate around a right angle, as with standard cannulas **4**, thereby preventing kinking and obstruction of the wire or catheter.

Cardiopulmonary bypass cannulas with an angled side arm or a Y-shape have been described in the prior art. However, these cannulas have several disadvantages that limit their utility in an ECMO system. For instance, when a typical bypass cannula is inserted into a vessel, it may occlude blood flow to distally located tissues. As shown in FIG. 1, when a cannula is inserted into the femoral artery, blood flow to the entire ipsilateral leg may be jeopardized. In order to prevent ischemia of distal tissue beds, the right angle side port **5** of a cannula **4** can be used to establish a secondary circuit **14** to direct a portion of the blood flow in the opposite direction to the cannula **4**. Blood flow may be

directed out of the right angle side port **5** of the cannula **4** and down the ipsilateral leg to separately perfuse the leg. Secondary circuits for distal perfusion are not always necessary, and may not be needed the entire time the patient is supported on the ECMO system, but they are frequently used. Thus, the ability to establish of a downstream flow circuit is an important option when using long-term bypass systems such as ECMO. However, cardiopulmonary bypass cannulas with angled side arm previously described in the prior art lacks the requisite structure to establish a connection for a secondary circuit **14** for distal perfusion.

In contrast, the modified cannula **24** with angled side port **25** of the present invention includes a lip **26** at the terminal end, as seen in FIG. 7. This lip **26** provides a surface on which a connector, such as a Luer connector, can be used to engage for secure yet selectively removable connection. Accordingly, a Luer connector commonly used as a secondary tubing connector **13**, shown in FIG. 1, can engage the lip **26** of the angled side port **25** of the modified cannula **24**, shown in FIG. 7, to establish a secondary circuit as previously described for distal perfusion. For example, the lip **26** of the angled side port **25** is dimensioned to fit within the grooves, threads, or tracks of a connector, such as a Luer connector having internal threading for connection by screwing action. Common cardiopulmonary bypass cannulas, even those with angled side arms, lack this structure. Although Luer connectors are described here as removably engaging the lip **26** of the angled side port **25**, it should be appreciated that other types of connectors could also be used to removably engage the lip **26** for a secure connection, such as snap on connectors.

In addition, in an ECMO circuit, blood flow along the main lumen **7** of the cannula **4** is laminar. A typical angled side arm represents an arm with a blind end, since laminar flow does not penetrate the side arm. The lack of flow in the side arm creates a potential for stagnant blood to pool in the side arm, which may result in thrombus formation, particularly during periods of prolonged support on ECMO. If a thrombus forms and is later dislodged, it may result in devastating complications including stroke, myocardial infarction, ischemic bowel, or ischemia of other tissues. Therefore, known cardiopulmonary bypass cannulas with an angled side arm or a Y-shape cannot be used in ECMO systems. Further, many cardiopulmonary bypass cannulas with an angled side arm or a Y-shape have permanent valves located within the side arm. Such permanent valves may increase the risk of stagnant blood flow and thrombus formation. The angled side port **25** of the modified cannula **24** of the present invention lacks such permanent valves that would lead to stagnant blood flow and thrombus formation.

In addition, the angled side port **25** of the modified cannula **24** of the present invention is designed to coordinate with a specialized occlusive cap **40** for use when access to a secondary circuit **14** or endovascular access is not needed. Specifically, the occlusive cap **40** of the present invention is designed to fit inside the angled side port channel **28** of the angled side port **25** and occlude substantially all of the angled side port **25**, such that blood does not flow into the angled side port **25** from the ECMO system when access is not needed. This prevents blood stagnation and potential thrombus formation, and is not available with known ECMO or cardiovascular bypass cannulas.

As seen in FIGS. 7, 8 and 11, at least a portion of the occlusive cap **40** is correspondingly dimensioned in size and shape to fit inside the angled side port channel **28** and provide a tight fit therein. Specifically, the occlusive cap **40** includes an occluding member **42** terminating in an occlud-

13

ing surface 41, as seen in FIGS. 8, 11, 13 and 14. The occluding surface 41 blocks the angled side port channel 28 and prevents blood from entering. It therefore prevents blood stagnation and potential thrombus formation. As depicted in the cross-section of FIG. 11 and the view along line 14-14 shown in FIG. 14, the edges of the occluding surface 41 are adjacent to and abut the interior surface of the angled side port channel 28, so as to form a tight fit therewith. In a preferred embodiment, as in FIG. 11, the occluding surface 41 is flush or coextensive with the wall of the modified cannula lumen 27, such that the occluding member 42 of the occlusive cap 40 does not extend into the modified cannula lumen 27 and laminar blood flow through the modified cannula lumen 27 is not disrupted. However, in some embodiments the occluding member 42 may extend into the modified cannula lumen 27, such as to ensure the angled side port channel 28 is entirely blocked.

In some embodiments, the occluding surface 41 may have a locking member 44, as shown in FIGS. 13 and 14. This locking member 44 is located along the perimeter of the occluding surface 41 and is correspondingly dimensioned with a receiver 45 located in the inner perimeter or edge of the angled side port 25, such as in the angled side port channel 28. As illustrated through FIGS. 12-14, the locking member 44 and receiver 45 correspondingly fit together to form a tight fit, but may also provide locking engagement for securely retaining the occluding surface 41 in the angled side port 25 in a particular orientation. This engagement may also be used to ensure the occlusive cap 40 is fully inserted and/or properly aligned within the angled side port channel 28 so that the occluding surface 41 is flush or fully coextensive with the wall of the modified cannula lumen 27, as the locking member 44 and corresponding receiver 45 may only interact and engage in a particular configuration. In at least the embodiment shown in FIGS. 12-14, the locking member 44 is an extension that extends from the perimeter of the occluding surface 41, and the receiver 45 is a recess formed in the angled side port 25 having a corresponding shape, contour and dimension to the locking member 44. However, it should be understood that in other embodiments, the locking member 44 may be located in the angled side port 25 and the receiver 45 may be located in the perimeter of the occluding surface 41. Similarly, the locking member 44 and receiver 45 may have any shape, dimension or contour permitted by the occluding surface 41 and angled side port 25, so long as they coordinate together. For example, the locking member 44 may be a keyed extension, the receiver 45 may be a rail or track, and either or both the locking member 44 and receiver 45 may include threading for coordinated interaction. These are just a few illustrative examples, and are not meant to be limiting.

In at least one embodiment, the occluding member 42 may have an elongate shape, such as a cylinder or shaft that extends at least a portion of the length of the occlusive cap 40. In some embodiments, the occluding member 42 extends the entire length of the occlusive cap 40. At least a portion of the occluding member 42 has a diameter that is substantially the same as or slightly smaller than the diameter of the angled side port channel 28. In one embodiment, the entire length of the occluding member 42 has a diameter corresponding to the diameter of the angled side port channel 28 of the modified cannula 24. In other embodiments, however, only a portion of the occluding member 42 has a diameter corresponding to the diameter of the angled side port channel 28. This portion may be located anywhere along the occluding member 42, such as at an end or anywhere along the length of the occluding member 42.

14

Regardless of the length and diameter of the occluding member 42, it terminates at the occluding surface 41 on one end, as depicted in FIG. 8. Therefore, the occluding member 42 may be at least as long as the angled side port channel 28 and the angled side port 25 in some embodiments. In a preferred embodiment, the occluding member 42 is the same length as the angled side port channel 28. In some embodiments, the width or diameter of the occluding member 42 is the same as that of the occluding surface 41. In other embodiments, the width or diameter of the occluding member 42 is less than that of the occluding surface 41, or may vary in its diameter over its length.

At the opposite end of the occluding member 42 from the occluding surface 41, the occlusive cap 40 may also include a cap connector 43, as shown in FIG. 8. The cap connector 43 selectively retains the occlusive cap 40 on the modified cannula side port 25 for selectively reversible securing. For instance, the cap connector 43 is dimensioned to removably engage the lip 26 of the angled side port 25 to secure the occlusive cap 40 in place upon insertion into the angled side port 25. The cap connector 43 may be shaped as a Luer connector, such as a floating or fixed Luer connector, and may include threads disposed along an inner surface for receiving the lip 26 of the angled side port 25. Of course, other forms of selectively reversible attachment are also contemplated, and are not limited to threaded engagement. The cap connector 43 may be integrally formed with the occlusive cap 40, as in FIG. 8, although in other embodiments it may be formed separately and attached to the occlusive cap 40, such as at the occluding member 42. The cap connector 43 allows the occlusive cap 40 to be secured to the angled side port 25 when the modified cannula 24 does not need to be accessed. However, it is selectively reversible to permit removal of the occlusive cap 40 for access to the modified cannula 24 through the angled side port 25, such as to establish a secondary circuit as previously discussed or to insert a wire, cannula or other medical device.

Accordingly, the occlusive cap 40 and modified cannula 24 described herein together form an occlusion system 300, as seen in FIG. 11. When the occlusive cap 40 is fully inserted in the angled side port 25 of the modified cannula 24, the laminar blood flow through the bypass system is substantially entirely occluded from the angled side port 25. This is important to prevent thrombus formation in long-term use systems such as ECLS.

When access to the modified cannula lumen 27 is desired, such as for the insertion of a wire or catheter or to establish a secondary circuit for distal perfusion, the occlusive cap 40 may be removed from the angled side port 25. The bypass tubing 3b may be clamped upstream of the modified cannula 24 prior to removal of the occlusive cap 40, such that blood flow through the system is temporarily interrupted. This prevents blood from seeping into the angled side port channel 28 upon removal of the occluding surface 41 and the occlusive cap 40. Once the occlusive cap 40 is removed, secondary circuit tubing may be connected to the angled side port 25 in a similar fashion as it would connect to a right angle side port 5. The clamp on the bypass tubing 3b may then be released, reestablishing the blood flow through the system, which now includes a secondary circuit for distal perfusion. On the other hand, if endovascular access is desired, such as through the insertion of a wire or catheter, an adaptor 30d may be attached to the angled side port 25 during temporary interruption of the ECMO system, as described below. After either is attached, the clamp may be removed and ECMO flows reinstated.

15

The present invention also includes an adaptor **30d**, as seen in FIGS. **9** and **10**. Because the adaptor **30d** and occlusive occlusive cap **40** are interchangeable, the adaptor **30d** may also be considered an insertion cap, and the terms are used interchangeably herein. The adaptor/insertion cap **30d** includes a body **32**, a membrane **36** for hemostatic access, and an adaptor or insertion lumen **31d** extending from the membrane **36** and through the body **32**, similar to those of the previously described adaptors **30a,b,c**. However, the adaptor/insertion cap **30d** is used with the angled side port **25** of the modified cannula **24** to permit exterior access to the modified cannula lumen **27**, and thus the ECMO system for endovascular entry. The adaptor **30d** need not provide directionality for the insertion of a wire or catheter since that function is already provided by the angle of the angled side port **25**. Therefore, in at least one embodiment the adaptor/insertion cap **30d** may not include a shaft **33** or other structure that extends into the angled side port channel **28** of the angled side port **25**. In such embodiments, the adaptor or insertion lumen **31d** is in fluid communication with the angled side port channel **28** when the adaptor/insertion cap **30d** is connected to the angled side port **25**. In other embodiments, as in FIGS. **9** and **10**, the adaptor/insertion cap **30d** includes a shaft **33d**. The adaptor lumen **31d** is sized to coordinate with the angled side port channel **28**, and may be the same or similar diameter as the angle side port channel **28**. The adaptor lumen **31d** is sized to allow the passage of wires, catheters and other medical devices that may be used for cardiovascular interventions, such as 7 French or greater. Accordingly, an intervention device **60** can be passed through the hemostatic membrane **36** and enter the adaptor lumen **31d**, pass through the adaptor lumen **31d** directly into the angled side port channel **28**, and on into the modified cannula lumen **27**.

In other embodiments, the adaptor/insertion cap **30d** may include a shaft **33d** that is straight and may be shorter than the shafts **33a,b,c** of the previously discussed adaptors **30a,b,c**. When present, the shaft **33d** may extend into at least a portion of the angled side port channel **28**, or even into the modified cannula lumen **27**. Accordingly, in some embodiments, the shaft **33d** may be 7 French in diameter or greater, such as to permit the passage of intervention devices such as medical devices for cardiovascular intervention, but still fits within the angled side port channel **28**. The shaft **33d** may be integrally formed in the body **32** of the adaptor/insertion cap **30d**, or may attach to the body **32** such as by secure attachment as with adhesive or molding.

The adaptor/insertion cap **30d** may attach to the exterior of the angled side port **25**, such as by engaging the lip **26** of the angled side port **25** with a connector **35** as previously described. Because directionality is not a function of the adaptor **30d** with an angled side port **25**, the connector **35** of the adaptor **30d** may be fixed, formed in or integral with the body **32** of the adaptor **30d**, as shown in FIG. **9**. Thus, when the adaptor **30d** is attached to the angled side port **25**, the entire body **32** may be rotated around the angled side port **25**, to provide a secure, selectively reversible connection such as by screw-type action of threading of the connector **35** with the lip **26** of the angled side port **25**. Of course, in other embodiments, the connector **35** may be a floating Luer connector as previously described, or a retaining structure that permits the adaptor **30d** to slide or snap onto the lip **26** of the angled side port **25**, whereby the lip **26** retains the adaptor/insertion cap **30d** in place.

Accordingly, the present invention also include another embodiment of a vascular access system **200d** including a modified cannula **24** having an angled side port **25** and an

16

adaptor/insertion cap **30d** having a shorter shaft **33d** as described above, such as depicted in FIG. **10**. The adaptor/insertion cap **30d**, and specifically the shaft **33d**, provides exterior access of an intervention device **60** to the modified cannula lumen **27** so as to change the angle of insertion of the insertion device **60** to be inline with or consistent with the axial flow path **70'**. In addition, the cannula may not be limited to one side port. For example the cannula may have one or more angled side ports, right angle side ports, or some combination thereof.

Tube Coupler

In addition, the present invention also includes a tube coupler **50** that may be inserted or spliced into ECMO or any bypass tubing to provide additional side ports **5**, **25** for endovascular access. For instance, some patients arrive at a medical facility with an ECMO or other ECLS system already in place, in which the arterial cannula **4** may not have a side port **5** for endovascular access, and yet endovascular access may become necessary at some point while the patient is on support. In other instances, the arterial cannula **4** of the ECLS system may only have a single side port **5**, but multiple devices (such as wires, catheters, etc.) may be needed to be inserted at the same time for simultaneous endovascular access, such as for coordinated actions to perform a medical procedure. The side port **5** and its hemostatic membrane **36** may allow only one device through at a time, in order to maintain the hemostatic seal and prevent back bleeding. Since multiple couplers could be inserted into an ECLS circuit, the tube coupler **50** of the present invention therefore provides a way to introduce additional side ports **5**, **25** for additional points of access to the ECMO or other ECLS system.

As seen in FIG. **15**, the tube coupler **50** includes a first end **52** having a first end opening **56**, and an opposite second end **53** with a second end opening **57**, and a coupler body **51** disposed there between. The first and second ends **52**, **53** are sized and shaped to accommodate and selectively matingly fit independent or separate sections of bypass tubing **3b**, such as ECMO tubing, on an arterial side of the bypass system. The first and second ends **52**, **53** may be slightly narrower in diameter than the coupler body **51** of the tube coupler **50**, and in some embodiments may taper slightly, to allow a tight hemostatic seal when the tubing **3b** is attached. In some embodiments, the first and second ends **52**, **53** may have ribs, barbs, serrations, beveling, or other frictional structure to promote a tight seal and retention of the ECMO or bypass tubing **3b**. Accordingly, the first and second ends **52**, **53** may have a similar structure to the proximal end **9a** of a standard arterial cannula **4**, as discussed previously, although it is not required. In some embodiments, the first and second ends **52**, **53** have the same diameters and structural features. In other embodiments, the first and second ends **52**, **53** may have different diameters and structural features from one another.

The coupler body **51** extends between the first and second ends **52**, **53** and may have an elongate length. In a preferred embodiment, the coupler body **51** may be a cylinder, although other shapes and configurations are contemplated. A coupler lumen **54** extends through at least a portion of the tube coupler **50** at the coupler body **51**. In at least one embodiment, the coupler lumen **54** extends from the first end opening **56** to the second end opening **57** and through the coupler body **51** such that the coupler lumen **54** provides an axial flow path **70'** for fluid such as blood to flow entirely through the tube coupler **50** when inserted in a bypass system. The coupler lumen **54** thus allows the tube coupler

50 to be inserted into, and become part of, an established bypass system and permit the continued functioning of the bypass system.

The tube coupler 50 further includes a access port 55 located along the coupler body 51. The access port 55 may be a right angle side port 5, as shown in FIG. 15, such as is provided on commercially available arterial cannulas 4 as described above. Specifically, the access port 55 includes a length that extends away from the coupler body 51 of the tube coupler 50. The access port 55 defines a access port channel 58 extending through at least a portion of the interior of the access port 55, which is in fluid communication with the coupler lumen 54 at one end, and has an opening at the other end for receiving the shaft 33 of an adaptor 30 as previously described, such as adaptors 30a,b,c. Accordingly, the access port channel 58 provides exterior access to the coupler lumen 54 such that a wire, catheter or other intervention device 60 may be inserted through a hemostatic membrane 36 within such adaptor 30, as previously described, and be inserted into the access port channel 58 of the tube coupler 50, and on into the coupler lumen 54 consistent with the axial flow path 70' and bypass tubing 3b.

In other embodiments, as seen in FIG. 16, the tube coupler 50' includes an angled access port 55', such as the angled side port 25 previously described in connection with the modified cannula 24. Accordingly, it should be appreciated that the tube coupler 50, 50' may include a traditional access port 55 or angled access port 55' providing an access point to the interior of the tube coupler 50, 50', and therefore, the endovascular system. The angled access port 55' is located along the coupler body 51 of the tube coupler 50', and may have any angle relative to the coupler body 51 as may promote ease of insertion of intervention devices 60. For instance, as previously discussed, the angle of the angled access port 55' may be any angle between 0° up to 90°. The angled access port 55' extends from the coupler body 51 and defines an angled access port channel 58' extending through at least a portion of the interior of the angled access port 55', which is in fluid communication with the coupler lumen 54 at one end, and has an opening at the other end for receiving an adaptor/insertion cap 30d and/or shaft 33d as previously described. Accordingly, the angled access port channel 58' provides exterior access to the coupler lumen 54 and axial flow path 70" therein such that a wire, catheter or other intervention device 60 may be inserted through a hemostatic membrane 36 within such adaptor 30d, as previously described, and be inserted into the access port channel 58' and axial flow path 70" of the tube coupler 50', and on into the coupler lumen 54 and bypass tubing 3b, as shown in FIG. 17F.

The tube coupler 50' may also coordinate with the adaptor/insertion cap 30d and occlusive cap 40 as previously described, either to provide endovascular access through the tube coupler 50' or to seal off and occlude the angled access port 55' when access is not desired. Accordingly, the tube coupler 50, 50' may comprise a part of a vascular access system 400, 400', respectively, in conjunction with an adaptor 30 as described herein, such as in FIG. 17F. The tube coupler 50, 50' may also be part of an occlusion system 300' in conjunction with a occlusive cap 40, as in FIG. 17C. The angled access port 55' of the tube coupler 50' can also be used to establish a secondary circuit for distal perfusion, as previously described.

FIGS. 17A-17F demonstrate the steps of inserting a tube coupler 50, 50' into an already established ECLS system. A tube coupler 50' with angled access port 55' is shown, but it should be appreciated that a tube coupler 50 with a right

angle access port 55 would be inserted in a similar manner. To begin, as in FIG. 17A, a location along the bypass tubing 3b where the tube coupler 50' is to be inserted is identified. This location may be anywhere in the bypass system, but is preferably on the arterial side of the bypass system. In at least one embodiment, the location is proximate to, and upstream or proximal to, the location for intervention device use.

Once an insertion location is identified, the bypass system is temporarily interrupted, such as by clamping, crimping or otherwise restricting the bypass tubing 3b on either side, or at least upstream of, the insertion location. This prevents the flow of blood through the ECMO system, and allows the tubing to be cut without loss of blood. The bypass tubing 3b is then cut downstream of the restriction point, resulting in two pieces of bypass tubing, as seen in FIG. 17B. The proximal piece 3b' of bypass tubing is located with the restriction point, and is closer to the pump of the ECMO system. The distal piece 3b" of bypass tubing is located downstream of the cut in the tubing, and is closer to the arterial incision 12 where the bypass system is reintroduced back into the subject or patient.

Once the tubing 3b is cut, the tube coupler 50' is then inserted between the proximal piece 3b' and distal piece 3b" of bypass tubing, as shown in FIG. 17C. For instance, the first end 52 of the tube coupler 50' is joined to the proximal piece 3b' of the bypass tubing, and the opposite second end 53 of the tube coupler 50' is joined to the distal piece 3b" of bypass tubing. The first and second ends 52, 53 of the tube coupler 50' will be oriented such that the angled access port 55' opens toward the proximal piece 3b' of bypass tubing, such that an intervention device 60 inserted therein is directed toward the distal piece 3b" and toward the heart of the subject. When the tube coupler 50' is first inserted and joined to the proximal and distal pieces 3b', 3b" of the bypass tubing, a occlusive cap 40 may already be inserted in the angled side port 25 in a fully occluding position.

Once the bypass tubing is joined and a hemostatic seal is established at the first and second ends 52, 53, the clamp or other restriction device temporarily interrupting the flow through the bypass system is removed, and flow through the system is re-established. The coupler lumen 54 is in fluid communication with both the proximal piece 3b' and distal piece 3b" of bypass tubing, defining a flow path with the tubing such that as blood flows through the bypass tubing it enters the proximal piece 3b', then the coupler lumen 54, then the distal piece 3b" of bypass tubing on its path from the oxygenator to the patient's heart. When the occlusive cap 40 is included in the angled access port 55' of a tube coupler 50', or when a standard cap is inserted in the right angle access port 55 of a tube coupler 50, the access port channel 58, 58' is occluded and blood is prevented from pooling and stagnating in the access port 55, 55'.

When access to the bypass system is desired, such as to establish a secondary circuit as previously described or to gain endovascular access for medical intervention, the occlusive cap 40 may be removed from the access port 55, 55', as depicted in FIG. 17D. An adaptor 30d, as previously described, is then inserted and attached to the access port 55, 55', as shown in FIG. 17E. Once the adaptor 30d is in place, an intervention device 60 such as a wire or catheter or other suitable device may be inserted into the tube coupler 50', as in FIG. 17F. Specifically, the intervention device 60 enters through the membrane 36 of the adaptor 30d and continues to advance through the shaft 33d, into the coupler lumen 54, and on into the distal piece 3b" of bypass tubing until the particular site for intervention is reached.

In at least one embodiment, as described above with reference to FIGS. 17A-17F, the tube coupler 50, 50' may be inserted, such as spliced, into an already established ECLS system, such as an ECMO system. In other embodiments, the tube coupler 50, 50' may be included in an ECLS system when it is being assembled for use. It may take the place of an arterial cannula 4, and it may be used in conjunction with an arterial cannula 4 or a modified cannula 24 as described above. In at least one embodiment, as shown in FIG. 18, the bypass system may include one or more couplers 50, 50' in series in the bypass tubing 3b, so that multiple intervention devices 60 can gain access to the endovascular system at the same time, such as when multiple devices are needed to perform an endovascular procedure. Each tube coupler 50, 50' provides one access point to the system, and as many couplers 50, 50' can be include in the system as may be needed for a particular procedure. In other embodiments, each tube coupler 50, 50' may also have more than one access port 55, 55', as shown in FIG. 19, where each access port 50, 50' provides entry for one insertion device 60, such as a wire or catheter, or an occlusive occlusive cap 40, or establishing a secondary circuit for distal perfusion.

Since many modifications, variations and changes in detail can be made to the described preferred embodiments, it is intended that all matters in the foregoing description and shown in the accompanying drawings be interpreted as illustrative and not in a limiting sense. Thus, the scope of the invention should be determined by the appended claims and their legal equivalents. Now that the invention has been described,

What is claimed is:

[1. An occlusive cap for a cannula side port having an angled cannula side port channel with a terminal opening in a wall of a cannula lumen, said side port channel disposed at an acute angle relative to said cannula lumen, said occlusive cap comprising:

a cap connector threadably received on the exterior of said side port for selectively retaining said occlusive cap on said cannula side port; and

an occluding member extending from said cap into said cannula side port channel and extending to and filling said terminal opening when said occlusive cap connector is fully retained on said cannula side port for thereby preventing inflow of fluid into said terminal opening and said cannula side port channel;

said occluding member terminating in an occluding surface at said terminal opening that is disposed at an acute angle relative to the direction of extension of said occluding member and flush with said cannula lumen wall whereby laminar flow through said cannula lumen is not disrupted, edges of said occluding surface being adjacent to and abutting interior surfaces of said side port channel to thereby form a tight fit therewith;

said occluding member further including a locking member disposed between said occluding member and said side port channel for retaining the orientation of said occluding surface flush with said terminal opening when said occlusive cap connector is fully retained on said cannula side port, and

said cap connector including a floating Luer connection securing said occlusive member to said cannula side port.]

[2. The occlusive cap according to claim 1, wherein said occluding member has a diameter corresponding to said cannula side port channel.]

3. A method, comprising:

providing endovascular access through an extracorporeal life support system, which includes providing an access port having a port opening at its terminal end and a port channel extending through it for the introduction of an intervention device to a flow path of the extracorporeal life support system; and

when endovascular access through the extracorporeal life support system is not in use, inserting and securing an occlusive cap having an occluding surface into the access port, thereby sealing off the port channel by way of the occluding surface,

wherein a perimeter of the occluding surface is positioned adjacent to a wall defining the port channel and a wall defining the flow path.

4. The method of claim 3, further comprising removing the occlusive cap from the access port when endovascular access through the extracorporeal life support system is in use.

5. The method of claim 3, wherein the extracorporeal life support system is an extracorporeal membrane oxygenation circuit.

6. The method of claim 3, wherein providing endovascular access through the extracorporeal life support system includes providing access into a patient's cardiovascular system.

7. The method of claim 6, further comprising introducing one or more intervention devices into the patient's cardiovascular system.

8. The method of claim 3, wherein providing endovascular access through the extracorporeal life support system includes establishing secondary perfusion for distal perfusion.

9. The method of claim 3, wherein providing the access port includes splicing a tube coupler into the extracorporeal life support system.

10. The method of claim 9, further comprising restricting the flow path of the extracorporeal life support system at a location upstream of the splice location prior to splicing the tube coupler into the extracorporeal life support system.

11. The method of claim 9, wherein splicing the tube coupler into the extracorporeal life support system includes coupling a first end of the tube coupler adjacent a proximal end of a cannula and coupling a second end of the tube coupler to tubing of the extracorporeal life support system.

12. The method of claim 11, wherein the first and second ends of the tube coupler include one or more ribs, barbs, serrations, or bevels.

13. The method of claim 3, wherein providing the access port includes providing multiple access ports by splicing two or more tube couplers, each having an access port, into the extracorporeal life support system.

14. The method of claim 3, wherein providing the access port includes providing multiple access ports by splicing a single tube coupler having a plurality of access ports into the extracorporeal life support system.

15. The method of claim 3, wherein providing the access port includes providing a cannula having an angled side port.

16. The method of claim 3, wherein inserting and securing the occlusive cap in the access port includes locking an orientation of the occluding surface.

17. The method of claim 16, wherein, in the locked orientation, the occluding surface is flush or coextensive with the wall defining the flow path of the extracorporeal life support system.

21

18. The method of claim 16, wherein locking the orientation of the occluding surface includes engaging a locking projection located at the perimeter of the occlusive surface with a locking recess located in the port channel.

19. The method of claim 3, wherein securing the occlusive cap in the access port includes engaging a luer lock connection between the occlusive cap and the access port.

20. The method of claim 19, wherein a connector of the occlusive cap is threadably received by an exterior rim of the port opening.

21. The method of claim 3, wherein inserting and securing the occlusive cap in the access port includes simultaneously forming an occlusion arrangement configured to prevent blood stagnation or thrombus formation in the port channel.

22. The method of claim 3, wherein inserting and securing the occlusive cap in the access port includes simultaneously forming an occlusion arrangement configured to maintain laminar blood flow in the flow path of the extracorporeal life support system.

23. The method of claim 3, wherein the flow path of the extracorporeal life support system is maintained open for 6 hours or more, regardless of whether the endovascular access is in use or not.

24. A method, comprising:

providing endovascular access through an extracorporeal life support system, which includes providing an access port having a port opening at its terminal end and a port channel extending through it for the introduction of an intervention device to a flow path of the extracorporeal life support system; and

when endovascular access through the extracorporeal life support system is not in use, inserting and securing an occlusive cap having an occluding surface into the access port, thereby sealing off the port channel by way of the occluding surface,

wherein inserting and securing the occlusive cap includes locking an orientation of the occluding surface in the access port, and wherein, in the locked orientation, the occluding surface is flush or coextensive with a wall defining the flow path of the extracorporeal life support system.

22

25. The method of claim 24, wherein locking the orientation of the occluding surface includes engaging a locking projection of the occlusive cap with a locking recess in the port channel.

26. An occlusive cap for a cannula side port having an angled cannula side port channel with a terminal opening in a wall of a cannula lumen, said side port channel disposed at an acute angle relative to said cannula lumen, said occlusive cap comprising:

a cap connector threadably received on the exterior of said side port for selectively retaining said occlusive cap on said cannula side port; and

an occluding member extending from said cap into said cannula side port channel and extending to and filling said terminal opening when said occlusive cap connector is fully retained on said cannula side port for thereby preventing inflow of fluid into said terminal opening and said cannula side port channel;

said occluding member terminating in an occluding surface at said terminal opening that is disposed at an acute angle relative to the direction of extension of said occluding member and flush with said cannula lumen wall whereby laminar flow through said cannula lumen is not disrupted, edges of said occluding surface being adjacent to and abutting interior surfaces of said side port channel to thereby form a tight fit therewith;

said occluding member further including a locking member disposed between said occluding member and said side port channel for retaining the orientation of said occluding surface flush with said terminal opening when said occlusive cap connector is fully retained on said cannula side port; and

said cap connector including a floating Luer connection securing said occlusive member to said cannula side port.

27. The occlusive cap according to claim 26, wherein said occluding member has a diameter corresponding to said cannula side port channel.

* * * * *