(12) INTERNATIONAL APPLICATION PUBLISHED UNDER THE PATENT COOPERATION TREATY (PCT)

(19) World Intellectual Property Organization
International Bureau

(43) International Publication Date
15 December 2005 (15.12.2005)

PCT

(10) International Publication Number
WO 2005/117733 A2

(51) International Patent Classification[7]: A61B 18/02, 5/04

(21) International Application Number:
PCT/US2005/010316

(22) International Filing Date: 28 March 2005 (28.03.2005)

(25) Filing Language: English

(26) Publication Language: English

(30) Priority Data:

10/847,057	17 May 2004 (17.05.2004)	US
10/877,639	25 June 2004 (25.06.2004)	US

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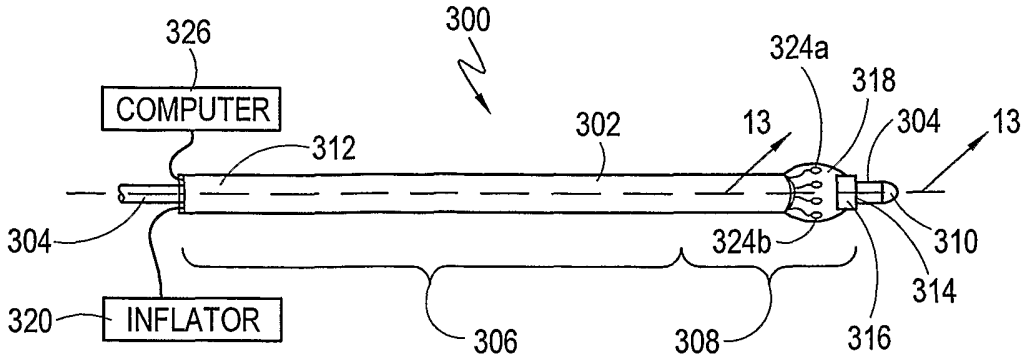
(81) Designated States *(unless otherwise indicated, for every kind of national protection available)*: AE, AG, AL, AM, AT, AU, AZ, BA, BB, BG, BR, BW, BY, BZ, CA, CH, CN, CO, CR, CU, CZ, DE, DK, DM, DZ, EC, EE, EG, ES, FI, GB, GD, GE, GH, GM, HR, HU, ID, IL, IN, IS, JP, KE, KG, KP, KR, KZ, LC, LK, LR, LS, LT, LU, LV, MA, MD, MG, MK, MN, MW, MX, MZ, NA, NI, NO, NZ, OM, PG, PH, PL, PT, RO, RU, SC, SD, SE, SG, SK, SL, SM, SY, TJ, TM, TN, TR, TT, TZ, UA, UG, US, UZ, VC, VN, YU, ZA, ZM, ZW.

(84) Designated States *(unless otherwise indicated, for every kind of regional protection available)*: ARIPO (BW, GH, GM, KE, LS, MW, MZ, NA, SD, SL, SZ, TZ, UG, ZM, ZW), Eurasian (AM, AZ, BY, KG, KZ, MD, RU, TJ, TM), European (AT, BE, BG, CH, CY, CZ, DE, DK, EE, ES, FI, FR, GB, GR, HU, IE, IS, IT, LT, LU, MC, NL, PL, PT, RO, SE, SI, SK, TR), OAPI (BF, BJ, CF, CG, CI, CM, GA, GN, GQ, GW, ML, MR, NE, SN, TD, TG).

Published:
— *without international search report and to be republished upon receipt of that report*

For two-letter codes and other abbreviations, refer to the "Guidance Notes on Codes and Abbreviations" appearing at the beginning of each regular issue of the PCT Gazette.

(54) Title: DEVICE AND METHOD FOR POSITIONING A CATHETER TIP FOR CREATING A CRYOGENIC LESION



(57) Abstract: A device and method for ablating tissue includes a sheath system with an occlusion structure. In certain embodiments, arrhythmias originating in pulmonary veins are treated cryogenically.

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DEVICE AND METHOD FOR POSITIONING A CATHETER TIP FOR CREATING A CRYOGENIC LESION

This application is a continuation-in-part of Application Serial No. 10/847,057, filed May 17, 2004, which is a continuation application of Application Serial No. 09/872,117, filed June 1, 2001, which is currently pending. The contents of Application Serial No. 09/872,117 and 10/847,057 are incorporated herein by reference.

The entire disclosures of each of U.S. Pat. No. 6,035,657, issued Mar. 14, 2000 for a FLEXIBLE CATHETER CRYOSURGICAL SYSTEM ("the '657 patent"), U.S. Pat. No. 5,910,104 issued Jun. 8, 1999 for a CRYOSURGICAL PROBE WITH DISPOSABLE SHEATH ("the '104 patent") and U.S. Pat. No. 5,275,595 issued Jan. 4, 1994 for a CRYOSURGICAL INSTRUMENT ("the 595 patent"), all assigned to CryoGen, Inc. of San Diego, Calif. are hereby expressly incorporated by reference in their entireties.

FIELD OF THE INVENTION

The present invention relates generally to devices and methods for the treatment of cardiac arrhythmia and more specifically relates to devices and methods for the treatment of focal atrial arrhythmia.

BACKGROUND OF THE INVENTION

Cardiac rhythm is maintained by precisely timed nerve signals electrically exciting and being conducted through cardiac tissue to stimulate synchronous contractions of the four heart chambers (2 ventricles and 2 atria). In a normal sinus rhythm, the nerve signals are typically conducted along paths initiating at the sino-atrial (SA) node and passing from there through the atrioventricular (AV) node and the bundle of His to the ventricular myocardial tissue.

Potentially dangerous abnormal cardiac rhythms, or arrhythmias, including atrial fibrillation, are common medical conditions which may result from disturbances in the site of origin and/or the pathways of conduction of the nerve signals exciting contraction of the four chambers of the heart. The

site of origin and pathways of conduction of these signals are currently mapped, for example using an electrocardiograph (ECG) in conjunction with mapping methods such as those described in U.S. Pat. No. 4,641,649 to Walinsky et al.

One common type of atrial fibrillation occurs when the contraction initiating signals originate within one or more of the pulmonary veins rather than at the SA node. These atrial arrhythmias have been treated by a variety of methods including pharmocologic treatments, highly invasive surgical procedures and linear and circumferential RF ablations of the myocardial wall. However, each of these methods has drawbacks, e.g., the pain and extended recovery time for invasive surgery, relative ineffectiveness of pharmacologic treatments and restenosis at the ablation site due to the application of RF energy or other heat based therapies thereto.

SUMMARY OF THE INVENTION

The present invention is directed to a method and apparatus for ablating tissue within a patient comprising inserting into a patient's venous system a substantially rigid sheath, piercing a desired point of penetration in the patient's interatrial septum to pass the rigid sheath through the interatrial septum into the patient's left atrium, maneuvering a flexible section mounted on the rigid sheath into a position in which a distal end of the flexible section is located adjacent to a portion of tissue to be ablated, the flexible section including an occluding structure which has a retracted position and extended position, and passing an ablation catheter through the flexible section so that an ablation tip of the ablation catheter is adjacent to the portion of tissue to be ablated.

In another aspect of the present invention, a plurality of electrodes are affixed to the occluding structure (i.e. a balloon), and the occluding structure is mounted at the distal end of the sheath. In operation, the sheath with the electrodes are prepositioned at a predetermined site in the vasculature, and the occluding structure (balloon) is then activated to assume its extended

position (i.e. inflated balloon). In this configuration, the electrodes are urged into contact with tissue at the site in the vasculature. Specifically, with this contact, the electrodes sense signals from the tissue that are indicative of contraction origination activity. These signals, in turn, are used to map the activity. In accordance with indications from the resultant map, cryoablation procedures are then conducted in the vicinity of the vasculature site. As intended for the present invention, these procedures can be conducted either proximal or distal to the occluding structure (balloon).

BRIEF DESCRIPTION OF THE DRAWINGS

The novel features of this invention, as well as the invention itself, both as to its structure and its operation, will be best understood from the accompanying drawings, taken in conjunction with the accompanying description, in which similar reference characters refer to similar parts, and in which:

FIG. 1 shows a partially cross-sectional side view of a device according to the present invention;

FIG. 2 shows a cross-sectional view of the device of FIG. 1, taken along line 2-2;

FIG. 3 shows a view of the device in position within the right atrium of a patient with a distal tip of a dilator adjacent to the foramen ovale;

FIG. 4 shows a side view of the device of FIG. 1 in position with a needle penetrating the foramen ovale of a patient;

FIG. 5 shows a side view of the device of FIG. 1 in position with a dilator penetrating the opening in the foramen ovale made by the needle of FIG. 4;

FIG. 6 shows a side view of the device of FIG. 1 in position within a pulmonary vein;

FIG. 7 shows a side view of the device of FIG. 1 in position within the pulmonary vein with an occluding balloon inflated;

FIG. 8 shows the depth markers of the catheter according to certain embodiments of the invention;

FIG. 9 shows a cross section of the left atrium and pulmonary vein illustrating the extended atrial tissue;

FIG. 10 shows a side view of a device according to an alternate embodiment of the invention;

FIG. 11 shows a side view of a collection of pre-shaped rigid sheaths for use with an embodiment of the invention;

FIG. 12 is a schematic view of a system of the present invention;

FIG. 13A is a view of the distal portion of an embodiment of the system of the present invention as would be seen along the line 13-13 in FIG. 12 when the system is operationally deployed; and

FIG. 13B is a view of an alternate embodiment of the system of the present invention, with portions shown in cross section for clarity and with the alternate embodiment shown as would be seen along the line 13-13 in FIG. 12 when the system is operationally deployed.

DESCRIPTION OF THE PREFERRED EMBODIMENTS

The present invention may be further understood with reference to the following description and the appended drawings, wherein like elements are provided with the same reference numerals.

When arrhythmia resulting from the origination of contraction initiating signals within one or more of the pulmonary veins rather than at the SA node is detected, known techniques may be used to locate the point of origination and the path of conduction. After this data has been obtained, the device and method according to the present invention allows a user to ablate a portion of the identified pulmonary vein near the orifice or collar of the pulmonary vein to create a circumferential conduction block preventing these improper contraction origination signals from propagating into the left atrium and restoring a normal sequence of contractions.

As shown in FIG. 1, the device 10 may include a flexible section 12 which is flexible laterally but is axially stiff so that it may be pushed distally to seal the orifice as will be described below. The flexible section 12 according to this embodiment of the invention may be formed as a sheath extending from a proximal end (not shown) which remains outside a patient's body to a distal end 14 which, when the device 10 is in an operative position is located within the patient's body. As shown in FIG. 2, the flexible section 12 includes a central lumen 16 extending therethrough from the proximal end to the distal end 14. As shown in FIGS. 1 and 2, an annular balloon 18 is mounted to the flexible section 12 adjacent to the distal end 14 and is coupled to an inflation lumen 20 extending along the outside of the flexible section 12 from the proximal end to the distal end 14 at which the inflation lumen 20 is fluidly coupled to the balloon 18. Alternatively, inflation lumen 20 may extend internally along the device. A rigid sheath 22 is slidably received within the flexible section 12. Alternatively, the flexible section 12 may simply consist of a flexible sheath 12' extending from a distal end of the rigid sheath 22 as described below in regard to FIG. 10.

The rigid sheath 22 may have a predetermined shape selected to aid in the insertion of the device 10 into the left atrium (LA) via a transeptal puncture and an approach from the inferior vena cava into the right atrium (RA) as will be described in more detail below. Specifically, the rigid sheath 22 may preferably have an outer diameter of between 9 and 14 French, more preferably approximately 11 French. Those skilled in the art will understand that an outer diameter of the flexible section 12 will be slightly larger than that of the rigid sheath 22, while the ablation catheter 24 will have an outer diameter slightly smaller than that of the rigid sheath 22. For example, an ablation catheter 24 with an outer diameter of 10 French may be slidably received within a rigid sheath 22 having an outer diameter of 11 French with an flexible section 12 having an 11.5 French outer diameter.

An ablation catheter 24 is slidably received within a central lumen of the rigid sheath 22 so that the ablation catheter 24 may be advanced distally beyond a distal end of the rigid sheath 22 to an extended position in which a

cryogenic tip 26 mounted at a distal end of the ablation catheter 24 extends distally beyond a distal end of the flexible section 12. The ablation catheter 24 and the cryogenic tip 26 may, for example, be constructed in accord with the teaching of any of the '657, 104 and '595 patents. Specifically, the ablation catheter 24 may include a high pressure refrigerant lumen 25 extending through the ablation catheter 24 to a Joule-Thomson expansion element, e.g., a capillary tube, which opens into an expansion chamber formed within the cryogenic tip 26. Furthermore, the ablation catheter 26 may include one or more electrodes as described in the '657 patent which may be used to locate and map the site of the origin of the improper contraction origination signals.

In one embodiment, the catheter 24 may be a cryosurgical catheter that uses a two stage Joule-Thompson cooling system. A first loop, which may be closed or open, may extend into the tip of catheter 24. This first open loop may be pre-cooled by a second loop, which may be closed or open, whereby at least the high pressure portion of the first loop and the low pressure portion of the second loop are placed in a heat exchange relationship. In certain embodiments, the fluid circulating in the first loop may be a mixed gas refrigerant. The mixed gas refrigerant may include a hydrocarbon. As another example, the refrigerant in the first loop may be nitrous oxide.

Furthermore, in certain embodiments of the invention, the catheter 24 may be deflectable. That is, the catheter tip may be deflectable via a deflection mechanism associated with the catheter handle. In use, the deflectable section of the catheter will be generally within or extending from the flexible section 12. This combination of the deflectable catheter and flexible section may allow the device 10 to more easily be positioned in the desired pulmonary vein, as explained below.

When a user (e.g., an electro-physiologist or EP) has previously determined that contraction origination signals are improperly originating from a site within one of the pulmonary veins (PV), using, for example, electro-physiology (EP study) the device 10 is inserted into the LA of the patient using

the Seldinger technique as is known to those skilled in the art as follows. Of course, those skilled in the art will understand that, where an EP study has not previously been performed, an EP mapping catheter may be inserted into the LA via the rigid sheath 22 of the device 10.

Specifically, a guide wire (not shown) is inserted into the RA through the inferior vena cava. The rigid sheath 22 is inserted into the flexible section 12 and is then advanced along the guide wire until a distal end of the rigid sheath enters the RA via the inferior vena cava, as shown in FIG. 3. Further advancing the rigid sheath 22 and the flexible section 12 distally along the guide wire will advance the bent section of the rigid sheath 22 toward the point at which the inferior vena cava enters the RA. The bend in the rigid sheath 22 is selected so that, at this point, a distal end of the rigid sheath 22 is pointed substantially toward a position on the interatrial septum at which the foramen ovale (FO) is located. The dimensions of the rigid sheath 22 are also selected so that, at this point, the distal end of the rigid sheath 22 is positioned adjacent to the FO. The curvature of the rigid sheath 22 may preferably be between 30 and 90 degrees depending on the anatomy of the patient, and in one embodiment a 60 degree curvature is used.

As shown in FIGS. 3 and 4, a dilator 28 with a Brouchenborogh needle 30 received therein is then inserted through a central lumen 23 of the rigid sheath 22 until a distal end of the dilator 28 extends beyond a distal end of the rigid sheath 22. The user may then probe the interartial septum noting the relative strength of various locations on the interatrial septum until the precise location of the FO is determined (i.e., the FO forms a soft apical spot on the septum). Those skilled in the art will understand that intracardiac ultrasound may also be used to assist in locating the FO. Then the Brouchenborogh needle 30 is extended from the distal end of the dilator 28 to pierce the FO forming a transeptal puncture (TP) extending into the LA as shown in FIG. 4. The dilator 28 is then advanced through the TP in the interatrial septum to expand a diameter of the TP as shown in FIG. 5.

Thereafter, the Brouchenborogh needle 30 is retracted into the dilator 28 and removed from the body. The rigid sheath 22 is then advanced along

the dilator 28 to pass through the TP into the LA. The flexible section 12 is then pushed along the rigid sheath 22 (utilizing the longitudinal rigidity of the flexible section 12) until a distal end of the flexible section 12 extends through the opening in the interatrial septum into the LA as shown in FIG. 6.

The ablation catheter 24 is then advanced distally through the rigid sheath 22 until the cryogenic tip 26 extends distally beyond the distal end of the rigid sheath 22 and the distal end of the flexible section 12. At this point there are several known techniques for maneuvering a catheter to a desired position within the opening of the one of the PV's from which the contraction origination signals are improperly originating. In certain embodiments, the catheter 24 is deflectable via a deflection mechanism associated with the catheter handle, which may ease the positioning of the catheter. Furthermore, by advancing the rigid sheath 22 further into the LA, the bend in the rigid sheath may be employed to assist in aiming the cryogenic tip 26 toward the desired PV opening. After the cryogenic tip 26 has been properly positioned well within the PV, the flexible section 12 is advanced distally along the ablation catheter 24 until the distal end of the flexible section is near the orifice at which the PV opens into the LA. To aid in ensuring proper positioning of the cryogenic tip 26 and the flexible section 12 in the orifice of the PV, the flexible section 12 and the rigid sheath 22 include radiopaque markers at the respective distal ends thereof or other desired locations.

Once the flexible section 12 has been positioned near the opening to the PV, the user may inject radiopaque dye into the PV via the flexible section 12 with the radiopaque fluid exiting the flexible section 12 via openings 36 located distally of the balloon 18. This may be done so as to aid in locating, under imaging, the orifice of the PV. The user may then inflate the balloon 18 by coupling a source of inflation fluid (not shown) to a proximal end of the inflation lumen 20. In one embodiment, the inflation fluid may be a diluted radiopaque or contrast fluid such that the balloon may more easily be seen under imaging. The flexible section 12 is then advanced until the balloon 18 is seated on the orifice of the PV, thereby occluding the flow of blood from the PV into the LA as shown in FIG. 7. The description herein of a balloon does

not imply that blood flow must be occluded by an inflatable cuff. Rather, any structure which is radially extendible from the sheath 12 to occlude blood flow therepast will serve the purposes of this invention. There are many alternative constructions for this structure, which will be known to those skilled in the art.

The ablation catheter 24 is then retracted from the PV so that the distal end of the ablation catheter is positioned slightly beyond the distal end of the flexible section 12 at the orifice of the PV. As shown in FIG. 8, depth markings 31 may be provided on the shaft of catheter 24 adjacent catheter handle 27. The depth markings 31 may be used to determine the relative positions of the distal ends of the flexible section 12 and ablation catheter 24. This allows the user to more precisely determine the distance that the catheter tip 26 extends in the PV.

In certain embodiments of the invention, the user may wish to preferably ablate tissue in the extended atrial tissue zone of the PV. As shown in FIG. 9, in the transition region between the left atrium and PV, atrial tissue extends into the PV for about 1-2 cm.

At least two advantages may be obtained by making the ablation in the extended atrial tissue. First, if the ablation is made deeper in the PV and not in the extended atrial tissue, it is believed that in some cases the contraction initiating signal, which originates in the PV, will find a new path, which bypasses the ablated tissue, and resumes the arrhythmia. It is believed that this bypass problem will not occur or will be less frequent when the ablation has been performed in the extended atrial tissue. Second, it is believed that restenosis is more common if the ablation is made more deep in the PV (i.e., in the venous tissue) than if the ablation is made in the extended atrial tissue.

Accordingly, in certain embodiments, once desired catheter tip location has been confirmed, the ablation of tissue may be initiated.

The user supplies a cryogenic fluid to an expansion chamber formed in the cryogenic tip 26 via the cooling fluid lumen 25 to lower the temperature of the cryogenic tip 26 so that an ice ball forms around the tip. Because blood flow from the PV into the LA is substantially impeded by the balloon 18,

warming of the cryogenic tip 26 by the flow of blood past the cryogenic tip 26 is minimized and the formation of a large frozen tissue mass or ice ball is facilitated. The ice ball formed may be large enough that it contacts the entire circumference of the inner wall of the PV ablating the tissue and forming a circumferential conduction block between the LA and the site of origination of the improper contraction originating signals.

It may not be desirable to move the cryogenic tip while an ice ball is formed therearound as this ice ball may adhere to tissue and cause damage when moved. If the ice ball formed is not large enough to immediately form a completely circumferential conduction block, the user may ablate a first portion of tissue with a first ice ball and then thaw this first ice ball. The user may reposition the cryogenic tip adjacent to a second portion of tissue to be ablated and form a second ice ball, repeating this process until the entire desired portion of tissue has been ablated thereby forming the circumferential conduction block.

In addition, a user may stun tissue by applying the cryogenic tip 26 thereto at a temperature warmer or for a duration shorter than that required to ablate the tissue. Changes in the path of conduction of the contraction origination signals may then be electrically monitored to further locate the site of origin. A user may also utilize the electrodes at the distal end of the ablation catheter 24 to apply an electric charge to one side of the circumferential conduction block while monitoring the state of the opposite side thereof to determine whether the tissue has been ablated sufficiently to create the desired conduction block.

FIG. 10 shows a device according to an alternate embodiment of the invention wherein a device 10' includes a flexible section 12' formed as a tube extending distally from the distal end of the rigid sheath 22'. The flexible section 12' is coupled to the distal end of the rigid sheath 22' and is preferably not slidable relative thereto. Sections 12' and 22' may be heat fused together. Accordingly, a single sheath may be formed with a flexible section 12' and a rigid section 22.' The inflation lumen 20', which is formed on an outer surface of the sheath extends from an inflation port 52' to balloon 18'. Alternatively,

inflation lumen 20' may extend along the interior of the sheath. An ablation catheter 24 as described above in regard to the device 10 is then slidably received through the sheath. In other respects, the device 10' may be constructed in accord with the description of the device 10 above. Ablation catheter 24 may be inserted into the sheath via hemostasis valve 50, which may have a side port 54 and 3-way stopper 56 associated therewith.

Once the device 10' has been inserted into the LA of the patient using the Seldinger technique, the ablation catheter 24 is advanced distally through the rigid section 22' and the flexible section 12' until the cryogenic tip 26 extends distally beyond the distal end of the flexible section 12' and is maneuvered so that the cryogenic tip 26 is within the opening of the one of the PV's from which the contraction origination signals are improperly originating. The balloon 18' is then inflated and the rigid section 22' and the flexible section 12' are then advanced distally along the ablation catheter 24 until the balloon 18' is seated in the orifice at which the PV opens into the LA. As with the device 10, to ensure proper positioning of the cryogenic tip 26, a radiopaque marker 34' is provided adjacent balloon 18'. In addition, radiopaque fluid may be injected into the PV via the opening 36'.

Once the desired position of the ablation catheter 26 has been confirmed, the ablation of tissue may be initiated as described above in regard to the device 10.

Another embodiment of the invention is shown in FIG. 11. In this embodiment, instead of providing a flexible section 12, a plurality of generally rigid sheaths 200, 210, 220 and 230 are provided with various degrees of curvature. While only four sheaths are shown more or less may be provided so as to accommodate various degrees of curvature, e.g., from straight to 180 degrees of curvature. Depending on the patient's anatomy and the particular PV to be treated, the user would select the desired sheath to aid in placement of the catheter and balloon.

Referring now to FIG. 12, an operational system as envisioned for the present invention is shown and is generally designated 300. In FIG. 12 it will be seen that the system 300 essentially includes a guide sheath 302, and a

cryoablation catheter 304. As intended for the system 300, and as shown, the cryoablation catheter 304 can be inserted completely through the guide sheath 302. Structurally, the guide sheath 302 includes an elongated tubular body 306, and it has a tubular member 308 that extends distally from the tubular body 306. In this combination, it is intended that the tubular body 306 be generally rigid, or stiff, in order to provide for an axial, or longitudinal, advancement of the guide sheath 302 through a vein or artery of a patient. On the other hand, the tubular member 308 is preferably flexible or deformable, in order to facilitate such an advancement of the guide sheath 302.

FIG. 12 also shows that the cryoablation catheter 304 includes a cryo-tip 310 that is located at the extreme distal end of the cryoablation catheter 304. Thus, when the catheter 304 has been inserted into the sheath 302 and passed therethrough from its entry point at the proximal end 312 of the tubular body 306, the cryo-tip 310 of the catheter 304 will project from an orifice 314 at the extreme distal end 316 of the tubular member 308 (see FIG. 13A).

Still referring to FIG. 12, it will also be seen that the guide sheath 302 includes an inflatable balloon 318 (i.e. occluding structure) that is located near the distal end 316 of the tubular member 308. Functionally, the balloon 318 is connected in fluid communication with an inflator 320 via an inflation lumen 322 that is formed into the guide sheath 302 (see FIG. 13B). Further, FIG. 12 shows that a plurality of electrodes 324 are mounted, or affixed, to the outer surface of the balloon 318. More specifically, these electrodes 324 are individually connected in electronic communication with a computer 326, via respective electrical leads 328 (see FIG. 13A). For purposes of disclosure, the electrodes 324a and 324b, and their respective electrical leads 328a and 328b are only exemplary.

For an alternate embodiment of the system 300, the guide sheath 302 can be formed with a deflector 330, as shown in FIG. 13B. Specifically, the purpose of the deflector 330 is to direct the cryo-tip 310 of the cryoablation catheter 304 through an orifice 332 that is formed into the sidewall 334 of the guide sheath 302. Importantly, the orifice 332 is located proximal to the

balloon 318. This is in contrast with the location of orifice 314 which, as indicated above, is located distal to the balloon 318. As will be appreciated by the skilled artisan, for one embodiment of the system 300, the deflector 330 may be a device (e.g. a rotatable flap) that can be selectively activated by extracorporeal controls (not shown). For such an embodiment, depending on the orientation of the deflector 330, the cryo-tip 310 can be selectively projected from either the orifice 314 (distal to balloon 318), or from the orifice 332 (proximal to the balloon 318). Alternatively, the deflector 330 may be structurally rigid (e.g. see FIG. 13B), or the system 300 need not have either the deflector 330 or the orifice 332.

In the operation of the system 300, the guide sheath 302 is first prepositioned in the vasculature 336 of a patient. During an advancement of the guide sheath 302 to a predetermined site in the vasculature 336, the balloon 318 is maintained in a deflated configuration (see FIG. 12). The purpose here is to facilitate movement of the guide sheath 302. Once the guide sheath 302 is in position, however, and the balloon 318 is positioned at the predetermined site in the vasculature 336, the inflator 320 can be activated. With its activation, the inflator 320 inflates the balloon 318 into its inflated configuration (see FIG. 13A and 13B). For the present invention, this inflation of the balloon 318 accomplishes, at least, two different functions. For one, inflation of the balloon 318 anchors the guide sheath 302 at a predetermined site in the vasculature 336. For another, inflation of the balloon 318 also urges the electrodes 324 into contact with tissue 338 at the site in the vasculature 336.

While the electrodes 324 are in contact with tissue 338, the computer 326 can be used to obtain signals that are indicative of contraction origination activity in the tissue 338. More specifically, as intended for the system 300, these signals are used to create a map which identifies locations in the vasculature 336 where contractions in the tissue 338 may, or may not, originate. Importantly, indications from the map can be used to precisely employ the cryoablation catheter 304. It will be appreciated by the skilled artisan that, during a mapping process, the balloon 318 may be selectively

deflated and moved to different locations in the vasculature 336 to obtain additional signals.

As intended for the system 300 of the present invention, and in accordance with the map that is created by signals from the vasculature 336, the cryo-tip 310 is advanced through the guide sheath 302 and into contact with vasculature tissue 338. As shown in FIG. 13A and FIG. 13B, this can be accomplished in either of two ways. In FIG. 13A, the cryo-tip 310 is shown projecting through the orifice 314 at the extreme distal end 316 of the tubular member 308. In FIG. 13B, the cryo-tip 310 is shown projecting through an orifice 332 in the sidewall 334 of the tubular member 308. In either case, the purpose is to employ the cryo-tip 310 for the cryoablation of tissue 338.

In the preceding specification, the present invention has been described with reference to specific exemplary embodiments thereof. It will, however, be evident that various modifications and changes may be made thereto without departing from the broadest spirit and scope of the present invention as set forth in the claims that follow. The specification and drawings are accordingly to be regarded in an illustrative rather than restrictive sense. For example, while the invention has been described for use with PV ablation, the device may be used in other parts of the vasculature.

What is claimed is:

1. A guide sheath for use with a cryoablation catheter in the vasculature of a patient which comprises:

an elongated tubular body for receiving the catheter therethrough, said tubular body defining an axis and having a proximal end and a distal end;

a tubular member extending axially from the distal end of said tubular body for steering said guide sheath to a predetermined site in the vasculature, said tubular member being formed with an orifice for projecting the cryoablation catheter from said guide sheath for contact with vasculature tissue in a vicinity of the site;

a device mounted on said tubular member, said device being moveable between a first configuration wherein said device establishes a low profile against said tubular member during movement of said sheath in the vasculature, and a second configuration wherein said device extends radially from the axis to anchor said sheath in the vasculature; and

a plurality of electrodes mounted on said device, said electrodes being urged against vasculature tissue when said device is in its second configuration to obtain electrical signals from the tissue to create a map for use during cryoablation of vasculature tissue in the vicinity of the predetermined site.

2. A guide sheath as recited in claim 1 wherein the orifice is located on said tubular member proximal to said device.

3. A guide sheath as recited in claim 1 wherein the orifice is located on said tubular member distal to said device.

4. A guide sheath as recited in claim 1 wherein said device is an inflatable balloon, with the balloon being deflated when said device is in its first configuration and being inflated when said device is in its second configuration.

5. A guide sheath as recited in claim 4 wherein the balloon has an external surface and further wherein said electrodes are mounted on the external surface of the balloon.

6. A guide sheath as recited in claim 5 wherein said electrodes substantially form an annulus when said device is in its second configuration.

7. A guide sheath as recited in claim 1 wherein the signals are indicative of contraction origination activity in the tissue.

8. A guide sheath as recited in claim 7 further comprising a computer, wherein said computer is electronically connected with said plurality of electrodes for obtaining the signals and creating the map therewith as a visual display of contraction origination activity in the tissue.

9. A guide sheath as recited in claim 1 wherein said tubular member is preformed.

10. A guide sheath as recited in claim 1 wherein said tubular member is steerable.

11. A system for cryoablating tissue in the vasculature of a patient which comprises:

a cryoablation catheter;

a sheath means for guiding said catheter to a predetermined site in the vasculature;

an electronic means attached to said sheath means for creating a map of contraction origination activity in a vicinity at the predetermined site; and

a directing means for projecting said catheter from said sheath means for cryoablating vasculature tissue in the vicinity at the site, in accordance with indications from the map.

12. A system as recited in claim 11 wherein said sheath means comprises an elongated tubular body for receiving the catheter therethrough, said tubular body defining an axis and having a proximal end and a distal end.

13. A system as recited in claim 12 wherein said directing means comprises a tubular member extending axially from the distal end of said tubular body for steering said sheath means to the predetermined site in the vasculature, said tubular member being formed with an orifice for extending the cryoablation catheter therefrom for contact with vasculature tissue in the vicinity of the site.

14. A system as recited in claim 13 wherein said electronic means comprises:

a device mounted on the tubular member, said device being moveable between a first configuration wherein said device establishes a low profile against the tubular member during movement of said sheath means in the vasculature, and a second configuration wherein said device extends radially from the axis to anchor said sheath means in the vasculature; and

a plurality of electrodes mounted on said device, said electrodes being urged against vasculature tissue when said device is in its second configuration to obtain electrical signals from the tissue to create a map for use during cryoablation of vasculature tissue in the vicinity of the predetermined site.

15. A system as recited in claim 14 wherein the orifice is located on said tubular member proximal to said device.

16. A system as recited in claim 15 wherein said device is an inflatable balloon, with the balloon being deflated in its first configuration and inflated in its second configuration, and further wherein the balloon has an external surface and said plurality of electrodes are mounted on the external surface of the balloon.

17. A system as recited in claim 14 further comprising a computer, wherein said computer is electronically connected with said plurality of electrodes for obtaining the signals and creating the map therewith as a visual display of contraction origination activity in the tissue.

18. A method for cryoablating tissue in the vasculature of a patient which comprises the steps of:

prepositioning a guide sheath at a predetermined site in the vasculature;

urging a plurality of electrodes against vasculature tissue in a vicinity of the site to obtain electrical signals, wherein the signals are indicative of contraction origination activity in the vasculature tissue, and wherein the signals are used to create a map for use during cryoablation of the vasculature tissue in the vicinity of the predetermined site;

advancing a cryoablation catheter through the guide sheath; and

projecting the catheter from the guide sheath, through an orifice in the guide sheath, for cryoablating tissue in the vicinity at the site, in accordance with indications from the map.

19. A method as recited in claim 18 wherein the guide sheath has a proximal end and a distal end and defines an axis, and wherein said urging step is accomplished by the steps of:

providing a device, the device being mounted on the guide sheath and moveable between a first configuration wherein the device establishes a low profile during movement of the guide sheath in the vasculature, and a second configuration wherein the device extends radially from the axis to anchor said guide sheath in the vasculature; and

mounting a plurality of electrodes on the device, the electrodes being urged against vasculature tissue when the device is in its second configuration.

20. A method as recited in claim 18 wherein the orifice of the guide sheath is located proximally to the device.

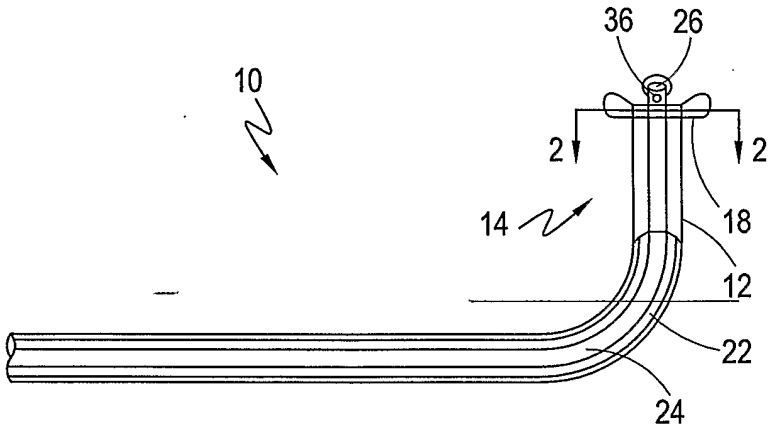


Fig. 1

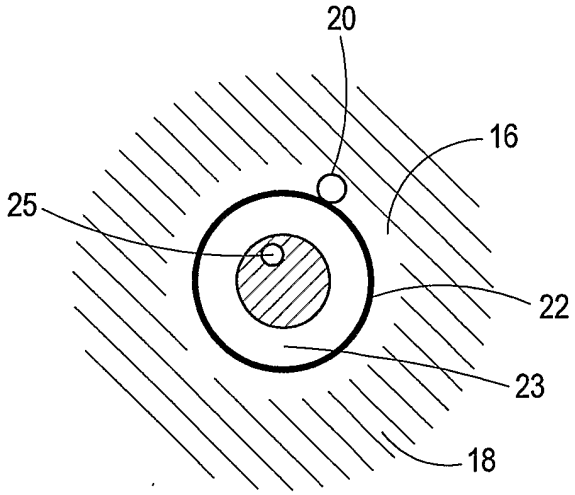


Fig. 2

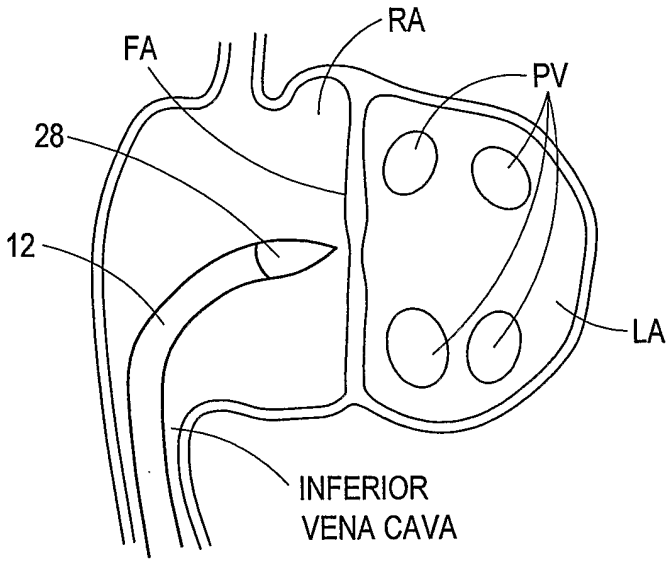

RA
FA
PV
28
12
LA
INFERIOR
VENA CAVA

Fig. 3

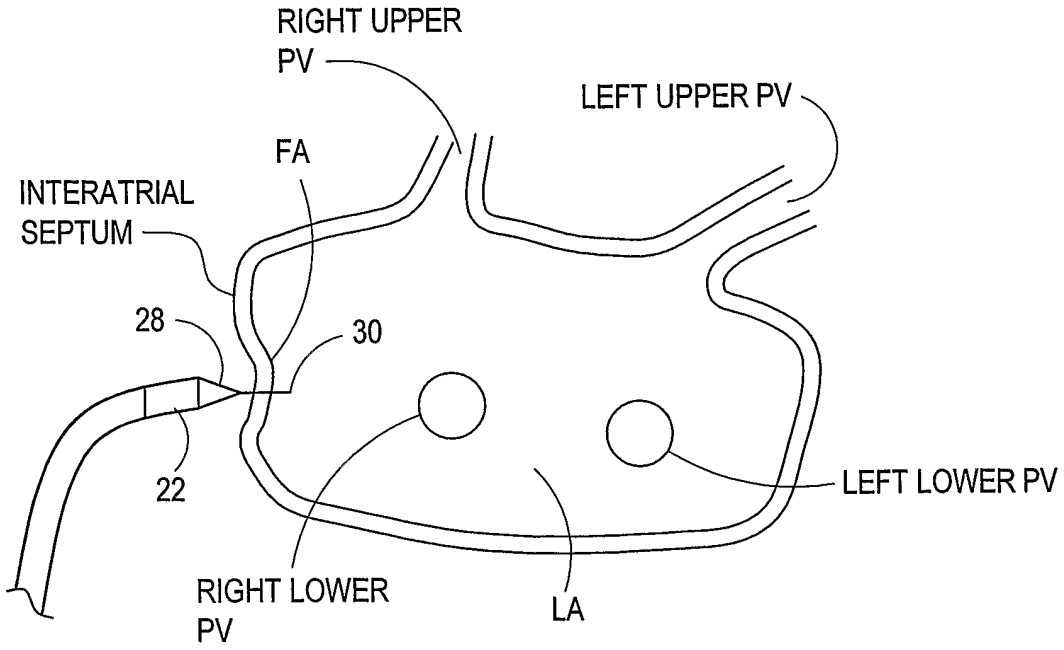

RIGHT UPPER
PV
LEFT UPPER PV
FA
INTERATRIAL
SEPTUM
28
30
22
LEFT LOWER PV
RIGHT LOWER
PV
LA

Fig. 4

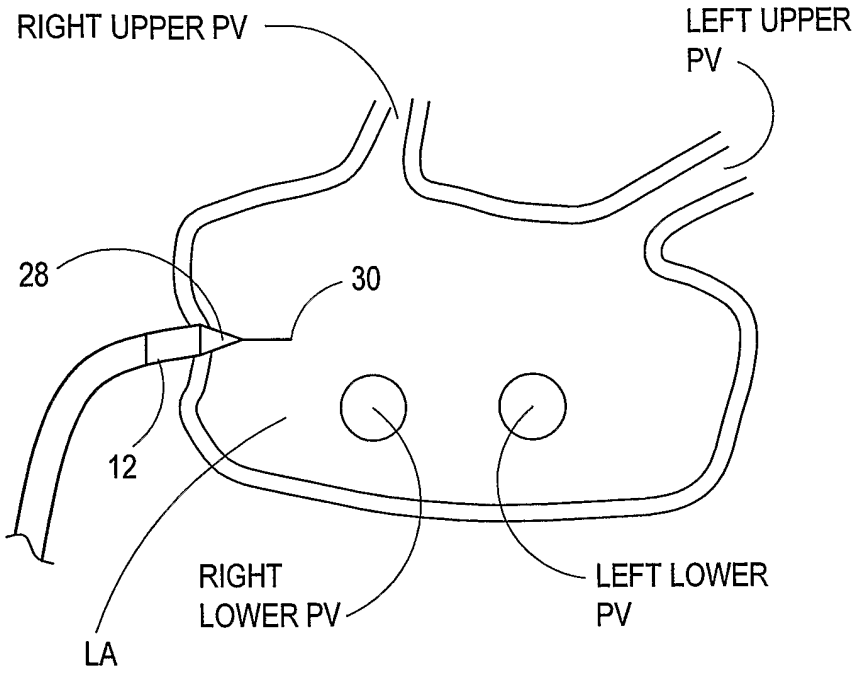

RIGHT UPPER PV
LEFT UPPER PV
28
30
12
RIGHT LOWER PV
LEFT LOWER PV
LA

Fig. 5

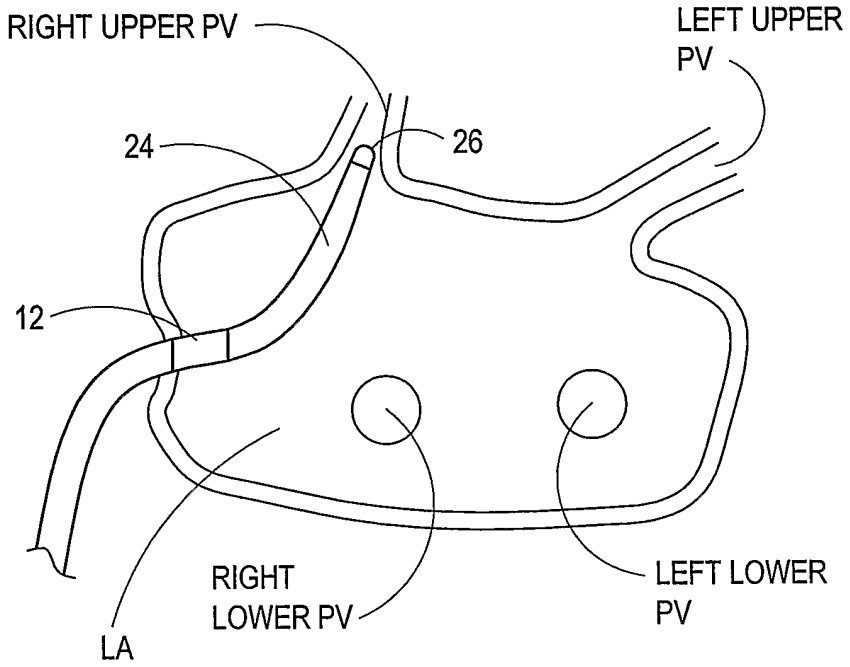

RIGHT UPPER PV
LEFT UPPER PV
24
26
12
RIGHT LOWER PV
LEFT LOWER PV
LA

Fig. 6

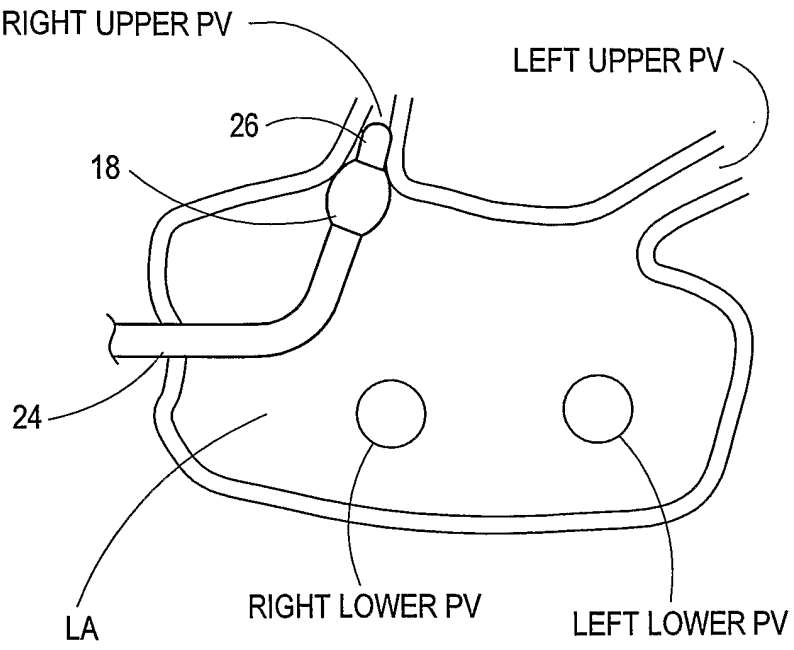

RIGHT UPPER PV
LEFT UPPER PV
26
18
24
LA
RIGHT LOWER PV
LEFT LOWER PV

Fig. 7

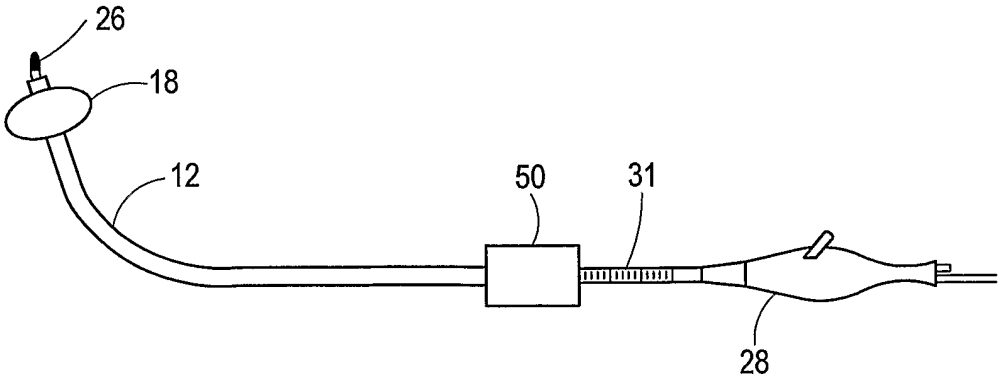

26
18
12
50
31
28

Fig. 8

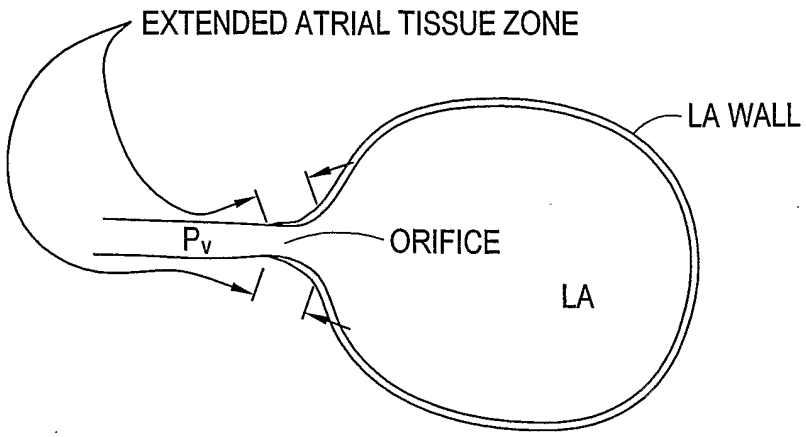

EXTENDED ATRIAL TISSUE ZONE
LA WALL
P_V
ORIFICE
LA

Fig. 9

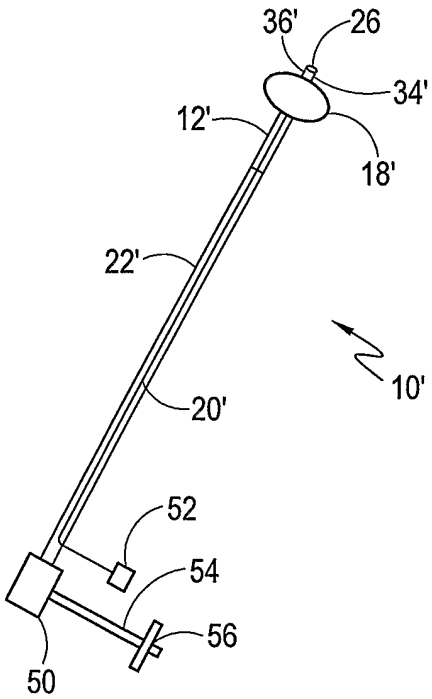

36'
26
34'
12'
18'
22'
10'
20'
52
54
56
50

Fig. 10

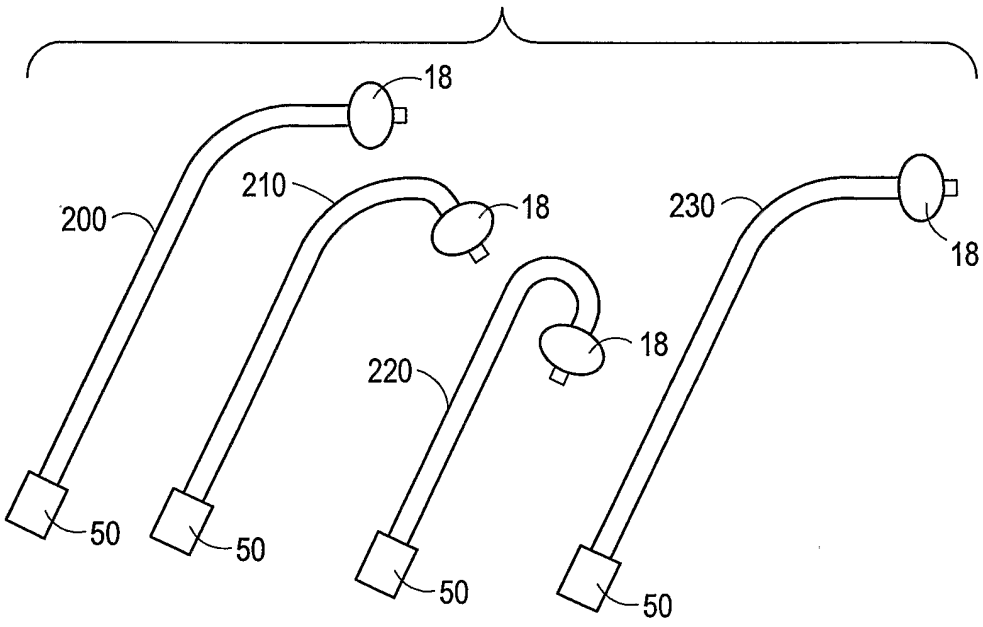


Fig. 11

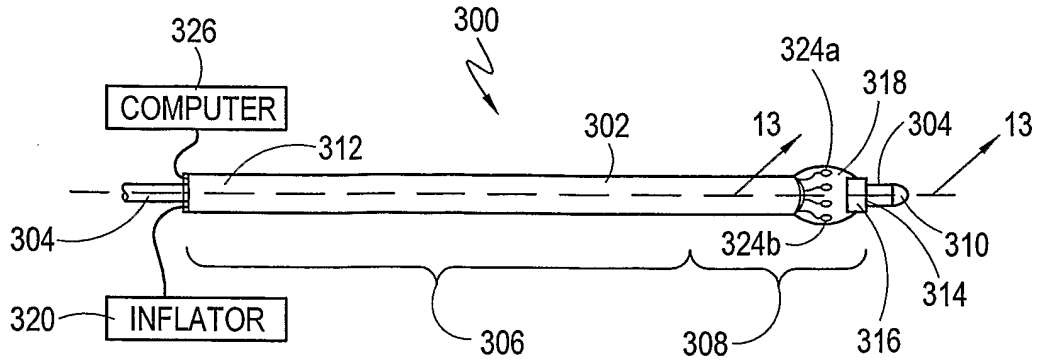


Fig. 12

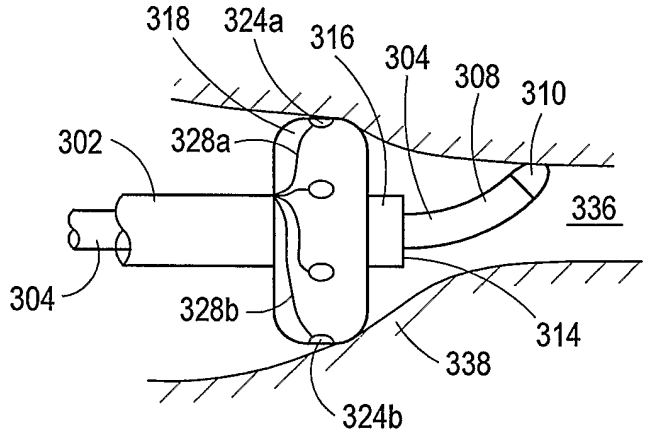


Fig. 13A

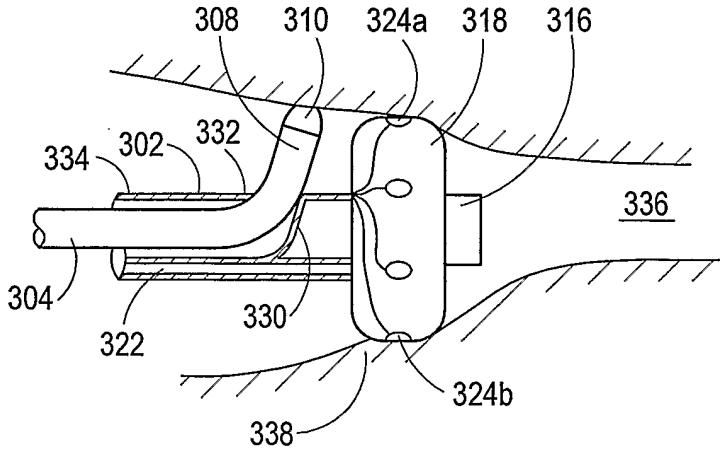


Fig. 13B