



(72) SWARTZ, JOHN F., US

(72) BEDNAREK, MICHAEL C., US

(72) STEHR, RICHARD E., US

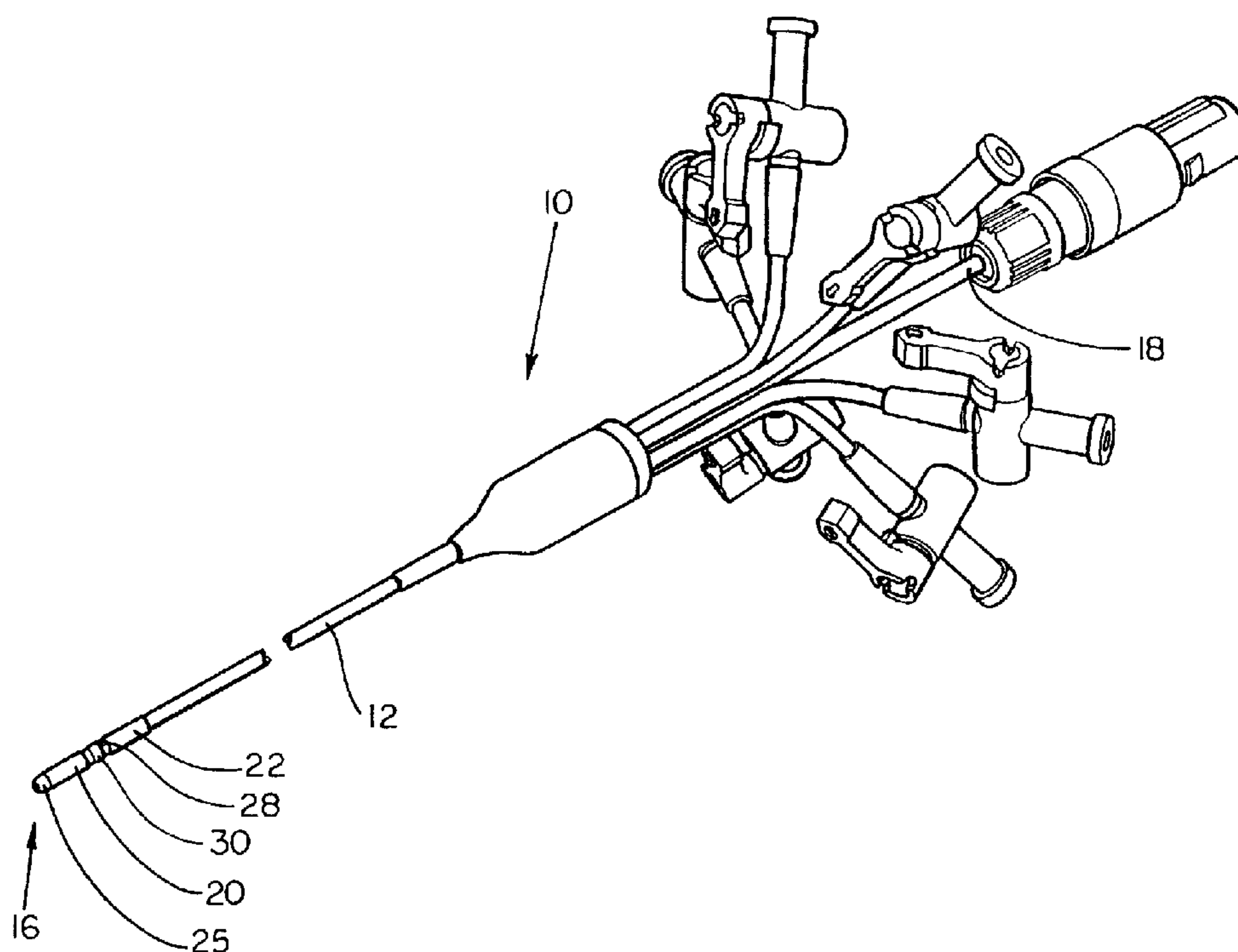
(72) COYLE, MICHAEL J., US

(71) DAIG CORPORATION, US

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(54) **DISPOSITIF MEDICAL SERVANT A EFFECTUER DES
ABLATIONS A L'INTERIEUR DE VAISSEAUX SANGUINS**
(54) **MEDICAL DEVICE FOR ABLATION PROCEDURES WITHIN
VESSELS**



(57) Dispositifs médicaux (10) qu'on met en application afin de créer des lésions par ablation circonférentielle dans des vaisseaux associés au coeur. Un dispositif préféré comprend un cathéter (16), une paire de joints (20, 22) fixés au cathéter (16) et un système permettant d'introduire des moyens conducteurs dans un espace situé entre les joints et un système d'ablation (30).

(57) Medical devices (10) used for formation of circumferential ablation lesions in vessels associated with the heart are disclosed. The components of one preferred system includes a catheter (16), a pair of seals (20, 22) secured to the catheter (16), a system to introduce conductive media into a space between the seals and an ablating system (30).

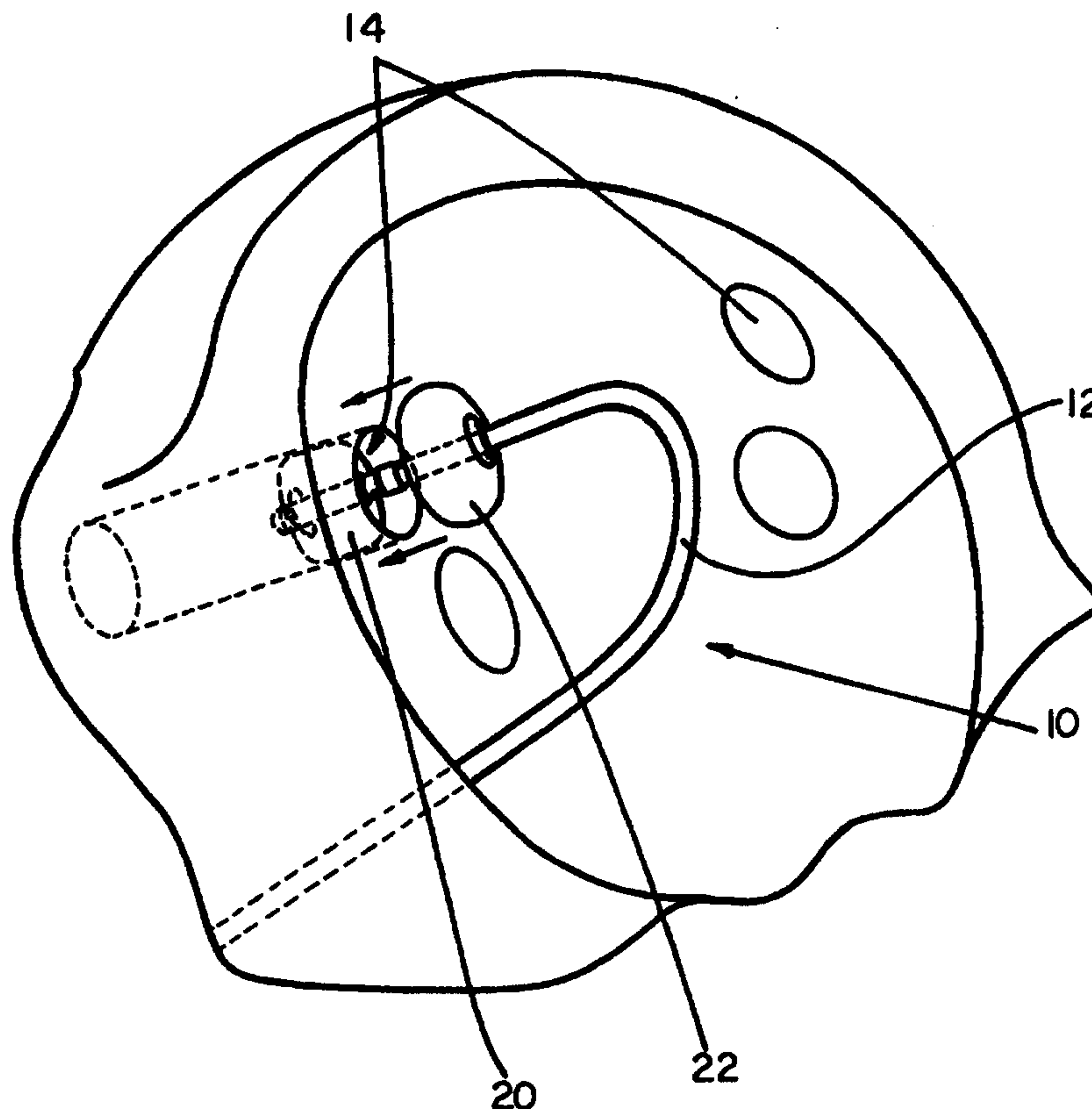
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(21) International Application Number: PCT/US98/12544 (22) International Filing Date: 16 June 1998 (16.06.98) (30) Priority Data: 08/883,668 27 June 1997 (27.06.97) US (71) Applicant: DAIG CORPORATION [US/US]; 14901 DeVeau Place, Minnetonka, MN 55345 (US). (74) Agent: COX, Scott, R.; Lynch, Cox, Gilman & Mahan, P.S.C., 500 Meidinger Tower, 462 So. 4th Avenue, Louisville, KY 40202 (US).		(81) Designated States: CA, GB, JP, European patent (AT, BE, CH, CY, DE, DK, ES, FI, FR, GB, GR, IE, IT, LU, MC, NL, PT, SE). Published <i>With international search report.</i>

(54) Title: MEDICAL DEVICE FOR ABLATION PROCEDURES WITHIN VESSELS**(57) Abstract**

Medical devices (10) used for formation of circumferential ablation lesions in vessels associated with the heart are disclosed. The components of one preferred system includes a catheter (16), a pair of seals (20, 22) secured to the catheter (16), a system to introduce conductive media into a space between the seals and an ablating system (30).



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Title of Invention

MEDICAL DEVICE FOR ABLATION PROCEDURES WITHIN VESSELS

This invention relates to medical devices and processes useful for the treatment of atrial arrhythmia. In particular, it relates to a preferred process and medical device used for ablation procedures in vessels of the human body.

Background of Invention

Introducers and catheters have been in use for medical procedures for many years. For example, one procedure utilizes a catheter to convey an electrical stimulus to a selected location within the human body. Another procedure utilizes a catheter to monitor locations in the body for diagnostic tests. Catheters may examine, diagnose and treat while positioned at a specific location within the body which is otherwise inaccessible without more invasive procedures. In use, catheters may be inserted into a major vein or artery which is near the body surface. These catheters are then guided to a specific location for examination, diagnosis and treatment by manipulating the catheter through the artery or vein of the human body, frequently with the assistance of other medical devices, such as introducers or guidewires.

One common medical procedure utilizing specialized catheters is the treatment of vessels located within the human body, frequently vessels associated with the human heart. Those procedures, most notably angioplasty procedures, utilize a

catheter which often contains an inflatable balloon secured to the catheter. In some of these medical procedures, the catheter contains a pair of inflatable balloons used to limit the portion of the vessel that is treated and/or to assure that the catheter remains at a fixed location within the vessel throughout the medical procedure.

Multiple balloon catheters are utilized throughout the body. For example, U.S. Patent No. 5,468,239 discloses a device for circumferential laser burning of tissue in a urethral canal. This device utilizes a pair of cuffs or balloons (60) with a laser probe (12) located between those balloons. U.S. Patent No. 5,588,961 discloses an infusion catheter for delivery of medication to a vessel and contains a pair of balloons (16, 17) and an electrode (35) secured to the catheter. Ports are provided in the catheter to introduce the medication into the space between the two balloons within the vessel. EMF energy may also be introduced into the electrode to encourage the movement of the medication away from the catheter toward the walls of the vessel. DE 4,001,086 discloses a two balloon (14, 15) device to remove and widen constrictions in vessels conveying body fluid. Once the two separated balloons constrict the flow of fluid through these vessels, the space between these vessels is then contacted with a chemical angiotropic solution or other treatment to remove a stenosis or calcification. A heat conductive piece (22) is mounted in the catheter (1) between the balloons (14,

15). An optical fiber (23) transmits external laser light to radiate the conductive piece (22). At least the outer surface (25) of the heating body (22) is resistant to the treatment medium for at least the period of treatment. The device is specifically designed for clearing fatty and calcified stenosis within arteries and is not designed for utilization within a pulmonary vein. In addition, neither balloon (14, 15) is structured to allow the flow of a conductive medium around one of the balloons and, in fact, each balloon is designed to constrict the flow of any fluids around the balloons within the artery. The U.S. Patent No. 5,256,141 discloses a pair of balloons (14, 18) with an electrode secured to a catheter to apply a controlled electric charge to material introduced into the space in the vessel between the two balloons. Biological material is introduced into this space for medical treatment of the vessel. This device is designed for utilization within a vascular segment and is not designed for use within a pulmonary vein. In addition, each balloon is inflated to such an extent as to restrict completely the flow of blood around each of the balloons. In fact, this restriction is so complete that a bypass system must be established to permit the flow of blood through a lumen of the device before and after the balloons. U.S. Patent No. 5,366,490 discloses a pair of balloons (30, 32) secured to a catheter and a stylette (36) through which radio frequency energy is supplied to destroy tissue. U.S. Patent No.

5,599,307 discloses a pair of balloons (41, 42) secured to a catheter designed to occlude a vessel. This device is similar to many of the other two balloon devices which are used for the treatment of stenosis within a vein or artery. The chamber (50) located between the pair of balloons (41 and 42) is blocked off so that fluids cannot pass around either of the balloons (41 and 42). This chamber (50) is then provided with a means for providing fluid to and removing fluid from the chamber (50). Thus, this device does not allow the flow of fluid from within the chamber (50) around either of the balloons (41, 42). Finally, U.S. Patent No. 5,002,532 discloses a pair of balloons (21, 22) secured to a catheter (12) for use in a dilation procedure within a vessel, whereby the two balloons may be inflated to different levels.

15 In addition to the use of multiple balloons on a single catheter for medical procedures, U.S. Patent No. 5,462,529 discloses a medical device containing a pair of catheters (12, 28), each containing a balloon (20, 48) secured at or near its distal end, which device is utilized to perform a medical procedure within a vessel. This device is designed for the treatment of saphenous vein grafts. The expandable sealing members (20, 48) are inflated "so that they form a fluid seal with the walls of the vessel and create the treatment chamber around the site." (Column 6, lines 48-49) Thus, as with the other two balloon devices, this device is designed to close off

a section of a vein to permit a medical procedure to occur at the location between these two balloons. No fluid can pass around either of the balloons. U.S. Patent No. 5,484,412 also discloses a pair of catheters (18, 22) utilized to perform a medical procedure within a vessel, each containing an inflatable balloon (36, 38). U.S. Patent No. 4,911,163 discloses a pair of balloons (2, 8) secured to a pair of catheters (1, 7) for introduction of medicine or diagnostic fluids into the space between the two balloons.

Atrial fibrillation is the most common sustained heart arrhythmia. It is estimated to occur in upwards of 0.4 percent of the adult population and perhaps as many as 10 percent of the population who are 60 years or older. Cox, J.L., et al., Electrophysiology, Pacing and Arrhythmia, "Operations for Atrial Fibrillation," Clin. Cardiol. 14, 827-834 (1991). Atrial arrhythmia may be transient or persistent. While most atrial arrhythmia occurs in individuals having other forms of underlying heart disease, some atrial arrhythmias occur independently. While atrial arrhythmias do not directly cause death as frequently as ventricular arrhythmias, they increase the risk factors for a number of other diseases such as systemic and cerebral embolism and may cause a number of additional medical problems.

Certain patients with symptomatic or life threatening atrial arrhythmias, however, cannot be adequately treated by drugs or

these medical devices. Other forms of aggressive treatment are mandated, which have in the past often included surgery. For example, a surgical procedure for the treatment of atrial arrhythmia known as the "Maze" procedure is discussed in Cox, J.L. et al., Electrophysiology, Pacing and Arrhythmia, "Operations for Atrial Fibrillation," Clin. Cardiol. Vol. 14, pgs. 827-834 (1991).

Another procedure increasingly used within the last 10 to 15 years for the treatment of certain types of cardiac arrhythmia involves ablation of cardiac tissue. For example, this procedure has been used to interrupt or modify existing conduction pathways associated with arrhythmias within the heart. The particular area for ablation depends on the type of underlying arrhythmia. The use of radio frequency catheter ablation for the treatment of paroxysmal atrial fibrillation is disclosed in Haissaguerre, M., et al., "Right and Left Atrial Radiofrequency Catheter Therapy of Paroxysmal Atrial Fibrillation" J. Cardiovascular Electrophysiology, V.7, pgs. 1132-1144 (Dec. 1996). Ablation procedures are also used for the treatment of atrioventricular (AV) nodal reentrant tachycardia. With this condition, ablation of the fast or slow AV nodal pathways has become an accepted treatment. Singer, I., et al., "Catheter Ablation for Arrhythmias" Clinical Manual of Electrophysiology, pgs. 421-431 (1993); Falk, R.H., et al., Atrial Fibrillation Mechanisms in Management, pgs. 359-374 (1992); Horowitz, L.N., Current

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Management of Arrhythmias, pgs. 373-378 (1991); and Martin, D., et al., Atrial Fibrillation, pgs. 42-59 (1994). In addition, the use of ablation catheters for ablating locations within the heart has been disclosed, for example in U.S. Patent Nos. 4,641,649, 5,263,493, 5,231,995, 5,228,442 and 5,281,217.

The sources of energy used for catheter ablation vary. Initially, high voltage, direct current (DC) ablation techniques were commonly used. However, because of problems associated with the use of DC current, radio frequency (Rf) energy has become the preferred source of energy for ablation procedures. The use of Rf energy for ablation has been disclosed, for example, in U.S. Patent Nos. 4,945,912, 5,209,229, 5,281,218, 5,242,441, 5,246,438, 5,281,213 and 5,293,868. Other energy sources which are being used currently or are being considered for ablation of heart tissue include laser, ultrasound, microwave and fulgutronization.

Ablation of a precise location within the heart requires the precise placement of the ablation catheter within the heart. Precise positioning of the ablation catheter is especially difficult because of the physiology of the heart, particularly as the ablation procedures generally occur while the heart is beating. Commonly, the placement of the catheter is determined by a combination of electrophysiological guidance and fluoroscopy (placement of the catheter in relation to known features of the heart which are marked by radiopaque diagnostic catheters which

are placed in or at known anatomical structures such as the coronary sinus, high right atrium and the right ventricle).

A process for the mapping and treatment of atrial arrhythmia using ablation catheters guided to a specific location by shaped, guiding introducers is disclosed in U.S. Patent Nos. 5,427,119, 5,497,774, 5,575,766, 5,564,440, 5,628,316 and 5,640,955. In particular, a process for the ablation of defined tracks within the left and/or right atrium as an element of the treatment of atrial fibrillation is disclosed in U.S. Patent No. 5,575,766.

The mechanism for initiation of some forms of atrial arrhythmia, such as atrial premature contractions, is not well understood. As a result, ablation procedures up to the present have focused on the formation of lesions within the chambers of the heart at selected locations which will either prevent the passage of electrical signals associated with atrial premature contractions or prevent the formation of improper electrical pathways within the heart which can result in atrial arrhythmia.

It has been surprisingly discovered that one source for these atrial premature contractions originates deep within vessels associated with the heart, in particular the pulmonary veins. Once these atrial premature contractions form in the pulmonary veins, they are periodically conducted into the left atrium. When the atrial premature contractions enter the left atrium, they can initiate or continue an episode of atrial fibrillation.

Invasive treatment of atrial fibrillation in the past has been limited to the formation of lesions around the pulmonary veins in the left atrium created by an invasive surgical procedure, such as is disclosed by Cox, J.L., et al.,
5 Electrophysiology, Pacing and Arrhythmia, "Operations for Atrial Fibrillation" Clin. Cardiol. Vol. 14, pgs. 827-834 (1991). In addition, the use of precurved guiding introducers to guide ablation catheters to appropriate locations in the left atrium for use in the formation of lesions around the pulmonary veins
10 has been disclosed in U.S. Patent No. 5,575,766.

While these procedures have been successful in some patients, other patients require additional treatment or the
treatments previously proposed have not been completely
successful in the elimination of the atrial fibrillation. In
15 addition, these ablation procedures are very time consuming, requiring as long as 10-15 hours.

It is therefore an aspect of this invention to disclose a
medical device useful in the treatment of atrial arrhythmia,
particularly atrial fibrillation.

20 It is an additional aspect of this invention to disclose a medical device useful for the formation of circumferential ablation lesions in vessels in the body.

It is a still further aspect of this invention to disclose a medical device containing a pair of inflatable balloons and an
25 Rf energy ablation electrode, which device is utilized to form

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a circumferential ablation lesion for the treatment of atrial arrhythmia, particularly atrial premature contractions.

It is a still further aspect of this invention to disclose a medical device for the chemical ablation of tissue within a vessel.

These and other aspects can be obtained by the design of the medical products for use with those processes which are disclosed by the instant invention.

Summary of Invention

The present invention is a medical device for ablation within a vessel of a human and includes a catheter. A first seal is secured to the catheter to seal the vessel and prevent substantially the flow of blood through the vessel. A second seal is secured to the catheter located proximal from the first seal, to limit the backflow of blood into the vessel. An introducing system is also secured to the catheter to introduce a conductive media into the vessel at a location in communication with the first and second seals. An ablating system is secured to the catheter for ablating tissue within the vessel. The ablating system is located between the first and second seals.

The seals preferably are either inflatable balloons or flexible disks attached to the catheter. The ablating system preferably is an Rf energy ablation electrode.

Alternatively, the present invention is a medical system for ablation within a vessel of a human and includes an introducer

with a proximal and distal end and a lumen passing from its proximal to its distal end. A catheter is inserted within the lumen of the introducer. A first seal is secured to the catheter to seal the vessel and prevent substantially the flow of blood through the vessel. A second seal is secured to the introducer at or near its distal end to substantially limit the backflow of blood into the vessel. An introducing system to introduce conductive media into the vessel at a location is in communication with the first and second seal members. An ablating system for ablating tissue within the vessel is located between the first and second seals.

The instant invention also includes specific components for each of the medical devices which are used in the processes for ablation of tissue within the vessel.

15 Brief Description of the Drawings

Figure 1 is a cut away view of the heart showing the left atrium and the four pulmonary veins.

Figure 2 is a cut away side view of the left atrium showing the first embodiment of the ablation catheter of the present invention partially introduced within one of the pulmonary veins.

Figure 3 is a perspective view of the first embodiment of the ablation catheter of the present invention with two balloons which are secured to the catheter not inflated.

Figure 4 is a perspective view of a distal portion of the ablation catheter of Figure 3 with balloons not inflated.

Figure 5 is a perspective view of the first embodiment of the ablation catheter of Figure 3 with balloons inflated.

Figure 6 is a perspective view of a distal portion of the ablation catheter of Figure 3 with balloons inflated.

Figure 7 is a side view of the distal portion of the ablation catheter of Figure 3 with balloons inflated.

Figure 8 is a perspective view of a second embodiment of the ablation catheter of the present invention utilizing a disk and a single, not inflated balloon.

Figure 9 is a perspective view of a distal portion of the ablation catheter of Figure 8 with the single balloon not inflated.

Figure 10 is a perspective view of the distal portion of the ablation catheter of Figure 8 with single balloon inflated.

Figure 11 is a perspective view of an alternative embodiment of the present invention comprising a medical system with an introducer and a catheter utilized in combination, with one balloon secured to the introducer and one balloon secured to the catheter, neither inflated.

Figure 12 is a perspective view of a distal portion of the medical system of Figure 11 with two balloons not inflated.

Figure 13 is a perspective view of the distal portion of the medical system of Figure 11 with two balloons inflated.

Detailed Description of the Preferred Embodiment

A typical human heart includes a right ventricle, a right atrium, a left ventricle and a left atrium. The right atrium is in fluid communication with the superior vena cava and the inferior vena cava. The atrioventricular septum separates the right atrium from the right ventricle. The tricuspid valve contained within the atrioventricular septum provides communication between right atrium and the right ventricle. On the inner wall of the right atrium where it is connected with the left atrium is a thin walled, recessed portion, the fossa ovalis. A drawing of the left atrium (11) and the openings (os) into the pulmonary veins (14) is shown in Figure 1.

In the normal heart, contraction and relaxation of the heart muscle (myocardium) takes place in an organized fashion as electro-chemical signals pass sequentially through the myocardium from the sinoatrial (SA) node to the atrioventricular (AV) node and then along a well defined route which includes the His-Purkinje system into the left and right ventricles. Initial electric impulses are generated at the SA node and conducted to the AV node. The AV node lies near the ostium of the coronary sinus in the interatrial septum in the right atrium. The His-Purkinje system begins at the AV node and follows along the membranous interatrial septum toward the tricuspid valve through

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the atrioventricular septum and into the membranous interventricular septum. At about the middle of the interventricular septum, the His-Purkinje system splits into right and left branches which straddle the summit of the muscular part of the interventricular septum.

Sometimes abnormal rhythms occur in the atrium which are referred to as atrial arrhythmia. Three of the most common arrhythmia are ectopic atrial tachycardia, atrial fibrillation and atrial flutter. Atrial fibrillation can result in significant patient discomfort and even death because of a number of associated problems, including: (1) an irregular heart rate which causes the patient discomfort and anxiety, (2) loss of synchronous atrioventricular contractions which compromises cardiac hemodynamics resulting in varying levels of congestive heart failure, and (3) stasis of blood flow, which increases the vulnerability of the patient to thromboembolism.

Efforts to alleviate these problems in the past have included significant usage of pharmacological treatments. Occasionally surgical procedures have also been utilized in the treatment of atrial arrhythmia. Another procedure for treatment of atrial arrhythmia involves ablating the His bundle. It has been discovered that similar success can be achieved without invasive surgery by ablation procedures performed within the atria as disclosed in U.S. Patent No. 5,575,766. To accomplish this non-invasive procedure successfully, the ablation catheter

must be positioned at pre-determined locations within the right and left atria to ablate predetermined tracks, thus forming a natural barrier to the formation of the reentry circuits.

The specific pathological cause for atrial fibrillation is not well understood. It has been surprisingly discovered that one source for atrial premature contractions which may cause atrial fibrillation, particularly paroxysmal atrial fibrillation, originates in the pulmonary veins associated with the left atrium of the heart.

In order to understand the structure of the medical devices of the invention, the medical procedure for their use within the heart must first be understood. In use, the medical device of the present invention is advanced into the left atrium and is then introduced into the appropriate pulmonary vein as shown in Figure 2. (It is understood that ablation procedures may be necessary in more than one of the pulmonary veins. However, for purposes of discussion, the process will be limited to a single medical procedure performed in a single pulmonary vein.) Once in place, the ablation catheter creates a lesion which electrically isolates the source of an atrial premature contraction in the pulmonary vein from connection with the left atrium.

The pulmonary veins are generally tubular in structure, increasing in size as they open into the left atrium. It has

been discovered that the conduction of atrial premature contraction through the pulmonary vein into the left atrium can be completely halted by formation of a circumferential ablation lesion around the pulmonary vein at a location proximal from the
5 source of the atrial premature contraction. Merely ablating a single point in the pulmonary vein, which is perceived to be the source of the premature atrial contraction, may not be sufficient to isolate the source of the atrial premature contraction from the left atrium.

10 Because the pulmonary vein returns blood into the left atrium and because heating of blood during an ablation procedure may result in the formation of blood clots, it is critical to a successful procedure that substantially all of the blood in the
pulmonary vein be removed from that area of the pulmonary vein
15 where the ablation lesion is being formed.

It is also important that the medical practitioner be able to monitor the electrical activity of the pulmonary vein both before and after the ablation procedure to assure that the source of atrial premature contraction has been successfully isolated
20 from the left atrium.

Conventional procedures for ablation within the heart

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generally utilize either a conventional tip electrode or one or more ring electrodes on an ablation catheter. To effectively ablate tissue, these electrodes are relatively small in diameter, usually in the range of about 5 French to about 8 French (1 French equals one-third millimeter (0.039 in.)). Because the diameter of a pulmonary vein may be as large as about 20 millimeters (0.79 in.), it is impractical to use a conventional ablation electrode on a conventional ablation catheter to form the circumferential lesion around the inside of a pulmonary vein.

The steps of the process in one embodiment for the formation of a circumferential ablation lesion within a pulmonary vein include introducing into a pulmonary vein a catheter or other medical device containing a seal to prevent the flow of blood through the pulmonary vein, introducing a second seal into the pulmonary vein to a location proximal from the first seal, substantially preventing the backflow of blood into the pulmonary vein from the left atrium utilizing the second seal, substantially removing blood located in a space in the pulmonary vein between the first and second seal by introducing a conductive media, introducing an ablating system for ablating tissue into that space, and while substantially preventing blood from entering that space, ablating tissue within the pulmonary vein at a location proximal to the source of the atrial premature contraction to

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form a circumferential lesion.

The first seal prevents blood from flowing into the area where the ablation procedure will occur. The conductive media introduced into the space between the first and second seals replaces this blood and also conducts the ablating energy, preferably radiofrequency energy, to the tissue to be ablated. The second seal, which is located proximal from the first seal, prevents blood from backflowing from the left atrium into the space between the two seals. While the first seal must form a tight seal about the wall of the vessel to prevent the flow of any blood from the vessel into the space between the first and second seals, the second seal preferably is not tightly secured against the walls of the vessel, thus permitting the conductive media introduced into the space between the first and second seals to replace the blood normally present in that space. In addition, the conductive media cleans that space of any blood that may seep into the space between the two seals, conducts the energy from the ablating source to the tissue to be ablated and also flows out of the space around sides of the second seal. By evacuating blood from the space between the first and second seals and replacing it with conductive media, clots of blood are prevented from forming.

In a first preferred embodiment the medical device (10) contains first and second seals (20, 22) as shown in Figures

3-10. The seals are secured to a single medical instrument, preferably a catheter (12). The catheter (12) is inserted into a pulmonary vein (14) as shown in Figure 2. In an alternate preferred embodiment as shown in Figures 11-13, the first seal (36) is secured to a catheter (32) which is introduced within the lumen of an introducer (34) onto which the second seal (38) is secured. The specific structure of the mechanism of the various inventions will now be discussed in detail.

10 The catheter (12) of the first embodiment of the present invention contains distal and proximal ends (16, 18). The composition of the catheter (12) is conventional and should be sufficiently pliable to permit the catheter to be advanced through the vasculature into the heart and ultimately into a pulmonary vein. While the distal portion (16) of the catheter (12) may be more pliable than the remaining portions of the catheter (12), the pliability of the catheter (12) may also be consistent throughout the length of the catheter (12). An increase in pliability can be achieved through conventional procedures well known in the industry. To assist in the advancement of the catheter through the vasculature, the main portion of the catheter may be stiffer and less pliable than the distal portion. In one embodiment, this main portion can be formed of any conventional catheter material having shape memory or permitting distortion from and subsequent

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substantial return to its desired shape. This main portion
may also be reinforced, for example, by use of a reinforcing
braid or other such suitable strand material having high
temporal strength. The enhanced pliability of the distal
5 portion of the catheter can be achieved by a number of methods
well known in the industry, including the use of a fused
flexible tip catheter or soft tipped catheters comprised of
the same or similar materials with similar performance
characteristics as are present in the reinforced portion of
10 the catheter. In addition, a more pliable distal portion of
the catheter can be created through modifications made in the
catheter such as by additional drawing of the catheter body
to reduce the thickness of the walls thus achieving the
enhanced pliability.

15 The overall length of the catheter should be about 50 to
about 150 cm. (20 to about 60 in.)

The components of the invention for use in the formation
of circumferential lesions are generally secured to the
catheter near or at its distal end (16). These elements
20 include at least the following: a pair of seals (20, 22),
secured at different locations on the distal portion of the
catheter (12) forming a space between them, a system to
introduce conductive media into the space between the first
and second seals (20, 22), and an ablating system located
25 between the first and second seals (20, 22) for ablating

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tissue. In addition, other elements may be secured to the catheter to assist in for the formation of circumferential ablation lesions, including, for example: sensors to sense the presence of premature atrial contractions, temperature sensing for sensing the temperature of the tissue being ablated, markers for marking the location of the catheter and its components within the vessel and other conventional components normally associated with an ablation catheter.

The two seals secured to the catheter are preferably inflatable balloons (20, 22) secured to the surface of the catheter (12) as shown in Figures 3, 4, 5, 6 and 7. The balloons typically measure approximately 15 mm (0.59 in) in length and when inflated, generally conform to an ellipsoid shape. The maximum diameter of the balloons when fully inflated may vary from about 15 mm to about 20 mm (0.59 in. to about 0.78 in.). They are manufactured according to conventional technology from materials such as a flexible or thermoplastic rubber, urethane, latex, cellulose or other conventional materials.

Associated with the balloons is one or more conventional lumens (not shown) located within the catheter for inflation of the balloons and one or more openings (24) in the catheter as shown in Figures 5, 6 and 7. Those openings (24) are located in the surface of the catheter (12) inside the balloon in communication with lumen to receive the media used to

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inflate and vent the balloons. Inflation of the balloon is accomplished using conventional methods, preferably a radiopaque contrast solution, and more preferably a marked saline solution. In addition, if desired, radiopaque marker bands may be secured to the balloons to mark their relative position. Preferably, a tip electrode (25) is secured to the catheter (12) at a position distal to the distal balloon (20). This tip electrode (25) is utilized to monitor the electrical activity within the pulmonary vein distal to the balloons (20, 22) and to discover or map the location within the pulmonary vein for the atrial premature contraction. Once that location is determined, the catheter (12) may be withdrawn slightly within the pulmonary vein from this location so that the subsequently formed circumferential ablation lesion will be located proximal from the source of the premature atrial contraction.

When the distal balloon (20) is inflated, it should completely prevent the flow of blood through the pulmonary vein (14) around the balloon. In order to assure that this distal balloon (20) forms a tight seal, a system to introduce a contrast media may be provided at a location distal to the distal balloon, such as a lumen in the catheter with an opening in the surface of the catheter (not shown). Contrast media may then be introduced into the vessel distal to the distal balloon (20) to identify if any leaks exist around the

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distal balloon (20). If such leaks do exist, additional pressure may be supplied to the balloon until distal balloon (20) completely stops the flow of blood into the space between the two seals.

5 Proximal from the first seal is the second seal. In one preferred embodiment, this second seal is a proximal balloon (22) of similar construction to the distal balloon (20). The purpose of proximal balloon (22) is to seal off any backflow of blood from the left atrium back into the pulmonary vein.

10 While the structure of this proximal balloon (22) is similar to that of the distal balloon, it preferably has the capability to inflate to a greater diameter than that of the first balloon because it must be inflated at a location in the pulmonary vein closer to the os of the pulmonary vein than is

15 the distal balloon (20) and, in fact, may be at the os itself. As pulmonary veins approach the left atrium, their diameters increase. While this proximal balloon (22) preferably must substantially occlude this larger diameter, it need not, and preferably will not, seal tightly against the walls of the

20 pulmonary vein, as is necessary for the distal balloon (20). In a preferred embodiment, the seal created by the proximal balloon (22) need only prevent the backflow of blood into the space between the proximal and distal balloons. In fact, in a preferred embodiment, the seal created by the proximal

25 balloon (22) must not be so tightly sealed against the walls

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of the pulmonary vein to prevent conductive media, which is introduced into the space between the proximal and distal balloons (20, 22), to escape around the edges of the proximal balloon (22). Because of the pressure created against the outside edges of the proximal balloon (22) by continuous introduction of conductive media into the space between the proximal and distal balloons (20, 22), the seal created by the proximal balloon (22) must be loose enough to permit excess conductive media to escape around the proximal balloon (22). This constant flow of conductive media away from the seal formed by the proximal balloon (22) guarantees that blood does not backflow into the space or area between the two balloons from the left atrium and also washes out any blood that may enter the space from around the seal formed by the distal balloon (20). Conventional inlet openings (24) are also located in the catheter (12) inside proximal balloon (22) to inflate proximal balloon (22).

In an alternative preferred embodiment, the second seal is a flexible disk (26) as shown in Figures 8, 9, and 10. This flexible disk (26) functions in a manner similar to that of the proximal balloon (22), i.e., it substantially seals the pulmonary vein to prevent the backflow of blood into the space between the distal balloon (20) and the disk (26).

The term "flexible" refers to the disk (26) folding on itself in a manner similar to that of an umbrella being closed

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when the device to which the disk (26) is secured is located within an introducer. Once the medical device to which the flexible disk is secured is extended from the tip of the introducer, the disk returns to its conventional disk-shape.

5 By constructing the diameter of the disk (26) of sufficient size, it will be effective in substantially sealing the pulmonary vein (14). As the flexible disk (26) is preferably only used as the second seal, it is not necessary that it completely seal off the pulmonary vein (14) as this
10 would interrupt the flow of conductive media. In fact, as discussed above, it is important that there be sufficient space between the disk (26) and the wall of the pulmonary vein to permit blood and conductive media that is introduced between the distal balloon (20) and the disk (26) to escape
15 around the outside surface of the disk (26) and to continually flush the space between the distal balloon (20) and the disk (26). Thus, the overall diameter of the disk when extended should be at least about 5 mm (0.2 in.) and preferably at least about 20 mm (0.8 in.). The thickness of the disk is not
20 particularly critical as long as it is of sufficient strength to maintain the disk in its extended position and thus should have a thickness of at least about 1 millimeter (0.004 inch). The flexible disk (26) is preferably made of biocompatible material such as silicone.

25 Conductive media is introduced between the first and

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second seals through one or more conductive media openings
(28) in the catheter located between the first and second
seals, for example, as shown in Figures 4 and 9. Preferably
two openings are provided between the two seals so that the
5 flow of the conductive media will be uninterrupted during the
ablation procedure. This media is introduced through a lumen
(not shown) passing through the catheter then through the
media openings (28) into the space between the seals with the
flow of this conductive media monitored by conventional
10 methods. By locating the media openings (28) between the two
seals and by filling the space between the two seals with
media, any blood present in the area between the two seals is
flushed away.

In one embodiment, the conductive media is a saline
15 solution marked with markers so that it can be monitored by
fluoroscopy, although any appropriate conductive media may be
used. The preferred source for the ablation energy is
radiofrequency energy. During an ablation process, the
radiofrequency energy from the ablation catheter is carried
20 through the conductive media to the tissue. In a preferred
embodiment, the impedance of the conductive media should be
less than the impedance of the human tissue so that the tissue
will heat up to an ablation temperature at a faster rate than
does the media.

25 As stated above, in a preferred embodiment the second

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seal is not secured as tightly against the walls of the pulmonary vein as is the first seal. By this arrangement, as the conductive media is continually introduced into the space between the two seals, it will continually flush out any blood which seeps into the space between the two seals and replace that blood with conductive media.

In an alternative embodiment, a chemical ablating material is injected through the media openings (28) into the space between the first and second seals. The chemical ablating material ablates the tissue of the vessel located between the first and second seals. In this embodiment, in contrast with the earlier embodiments, the second seal must be a balloon. This proximal balloon must also be secured tightly against the surface of the vessel to seal the vessel. In contrast to the first preferred embodiment where the conductive media escapes around the edges of the second seal, when the chemical ablating material is used, this material should not escape from the space between the two seals around the edges of the second seal. Thus, in this embodiment the proximal balloon should fit tightly against the vessel to prevent not only the backflow of blood from the left atrium, but also the escape of the chemical ablating material from between the two balloons.

The chemical ablating material is introduced into the space between the two balloons (such as 20 and 22 as shown on

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Figure 7) through a lumen and the media opening or openings_ (28) in the surface of the catheter (12) located between the two balloons. The types of chemical ablating materials that can be utilized for this ablation procedure include any liquid material which will ablate cardiac tissue and preferably includes any anhydrous alcohol. Once the chemical ablating material has successfully ablated the tissue, it should be flushed out by introducing a flushing media into the space between the two balloons. The flushed chemical ablating material and the flushing media are removed through one of the media openings (28) in the catheter into a lumen to be discarded.

In all embodiments it is important that the space between the first and second seals not be too large. If there is too much space between the two seals, it will be difficult to form an adequate circumferential lesion as the energy, preferably radio frequency energy, will be dispersed over too large a space. Thus, in a preferred embodiment, the distance between the distal balloon (20) and the proximal balloon (22) when inflated or disk (26) should be no more than about 10 mm (0.39 in.) and preferably from about 2 mm to about 4 mm (0.08 in. to about 0.16 in.). Notwithstanding, the distance between the two balloons or balloon and disk can be increased or decreased depending upon a number of conditions including but not limited to the thickness of the pulmonary vein, the

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diameter of the opening in the pulmonary vein at the point of ablation, the amount of energy being supplied by the ablating system, and the quantity of media needed to fill the space between the two seals.

5 Also secured to the catheter between the two seals is the ablating member or system. In a preferred embodiment as shown in Figures 3-7, the ablation system is a radiofrequency ring electrode (30) secured to the catheter (12) operating in conjunction with the conductive media that has been introduced
10 between the two seals. By choice of an appropriate conductive media, upon the introduction of energy to the space between the two seals, the energy will be transferred through the media to the surface of the tissue of the pulmonary vein located between the two seals. By continuing to introduce
15 energy for a sufficient period of time as is determined by the physician, a circumferential lesion will be formed in the tissue. Other forms of energy can also be used for the ablation.

 In order to monitor the formation of this lesion, a
20 temperature sensor, such as thermistors or thermocouples (not shown) may be secured to the catheter. Sensing electrodes (not shown) can also be secured to the catheter between the two seals to monitor electrical activity in the pulmonary vein.

25 In an alternate preferred embodiment, as shown in Figures

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11-13, each of the first and second seals are secured separately to one of two medical devices, such as a catheter (32) and an introducer (34). The two medical devices form a medical device system (110). In this alternative preferred embodiment, the first seal or distal balloon (36) is secured to the catheter (32) in the manner discussed above, while the second seal is secured at or near the distal tip of the introducer (34) into which the catheter (32) is introduced. This second seal, which is secured to the introducer (34), is the same as the second seal above discussed and thus may be a proximal balloon (38) as shown in Figures 11-13. When using this embodiment, the first and second seals are utilized to form the space between them. However, because each of the seals is secured to separate medical instruments, the space between the two seals can be adjusted, as needed. By controlling the size of the space between the two seals, the physician can also control the size of the lesion formed during the ablation procedure. Because the diameter of the pulmonary veins may vary, resulting in greater or lesser volume of media being introduced between the seals, it may be appropriate to adjust the distance between the two seals. In a preferred embodiment, the distance between these two seals is at least about 0.5 mm (0.02 in.) and more preferably from about 2 mm (0.08 in.) to about 4 mm (0.16 in.).

In this embodiment, the other components of the system for production of a circumferential ablation lesion within a pulmonary vein can be secured to either the catheter (32) or introducer (34), as appropriate. For example, the conductive media may be introduced through a lumen and an injection port located either in the catheter or in the introducer or the media may pass through a lumen in the introducer exiting at the introducer's distal tip (42) as is shown, for example, in Figure 12, to flush out the blood located between the two seals.

In this embodiment, the tip electrode (46) is secured at or near the distal tip of the catheter (32) so that it can sense the presence of premature atrial contractions within the pulmonary vein.

The ablating system for this embodiment, preferably a ring electrode (44), may be secured to either the catheter (32) or the introducer (34). However, it is preferably secured to the catheter (32) at a location proximal from the distal balloon (36) as shown in Figure 11. Openings (48) leading to lumens (not shown) are also provided in the catheter (32) and the introducer (34) for introduction of media to inflate the balloons (36, 38). A temperature sensing mechanism (not shown) may also be secured to either the catheter (32) or the introducer (34) at an appropriate location.

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This two-part system (110) utilizing an introducer (34) with a proximal balloon (38) and a catheter (32) with a distal balloon (36) may also be used with the chemical ablation system as long as both the proximal and distal balloons are securely sealed against the wall of the vessel. In all other ways this embodiment is similar to those previously discussed.

In operation, a modified Seldinger technique is normally used for the insertion of the medical device (10) into the body. Using this procedure, a small skin incision is made at the appropriate location to facilitate catheter or dilator passage. Subcutaneous tissue is then dissected, followed by a puncture of the vessel with an appropriate needle with a stylet positioned at a relatively shallow angle. The needle is then partially withdrawn and reinserted at a slightly different angle into the vessel making sure that the needle remains within the vessel. The soft flexible tip of an appropriate size guidewire is then inserted through, and a short distance beyond, the needle into the vessel. Firmly holding the guidewire in place, the needle is removed. The guidewire is then advanced into the right femoral vein and through the inferior vena cava into the right atrium. (The preferred procedure uses the inferior approach to the right and left atria. Procedures for the retrograde and superior approach to the left atrium can also be used.) With the guidewire in place, a dilator is then placed over the wire

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with the introducer to be used placed over the dilator. The dilator and introducer generally form an assembly to be advanced together along the guidewire into the inferior vena cava.

5 A Brockenbrough needle or trocar is then inserted through the lumen of the dilator to the right atrium to be used to create an opening through the interatrial septum, preferably at the fossa ovalis. The entire assembly (dilator and Brockenbrough needle) passes through the vena cava into the
10 right atrium so that the tip rests against the interatrial septum at the level of the fossa ovalis. The Brockenbrough needle is then advanced within the dilator to reach the fossa ovalis. After an opening is made through the interatrial septum, the needle, dilator and first guiding introducer for
15 the left atrium are advanced into the left atrium. After the introducer is advanced through the interatrial septum into the left atrium, the Brockenbrough needle and dilator are removed leaving the introducer in the left atrium. The ablation catheter (12) is then advanced through the lumen of the
20 introducer and is placed within the left atrium. After the catheter (12) is advanced through the lumen of the introducer into the left atria, a precurved guiding introducer is advanced over the catheter to assist in the placement of the ablation catheter within the appropriate pulmonary vein as
25 shown in Figure 2.

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Once the distal end (16) of the ablation catheter (12) has been advanced into the pulmonary vein (14), it is positioned within that pulmonary vein by use of a sensing tip electrode (25) secured at or near the distal end (16) of the catheter (12) as shown in Figures 3-7. This sensing tip electrode (25) senses electrical activity within the pulmonary vein, including atrial premature contractions. Once the source of the atrial premature contractions has been confirmed to be distal to the sensing tip electrode (25), the distal balloon (20) is inflated using conventional procedures. This distal balloon (20) must be sufficiently inflated to prevent completely the flow of blood through the pulmonary vein (14) around this balloon (20). To assure that no blood flows around this balloon, marked media may be injected into the pulmonary vein (14) at a point distal from the distal balloon (20) through a lumen in the catheter. Any leakage around the distal balloon (20) can then be determined by fluoroscopy and eliminated by additional pressure on the distal balloon (20). Once the distal balloon (20) is properly inflated in the pulmonary vein, a proximal balloon (22) is inflated. The second, proximal balloon (22) need only substantially prevent the backflow of blood into the pulmonary vein (14) from the left atrium. In order to assure that the proximal balloon (22) is properly but not overly inflated, conductive media is introduced into the space between the distal (20) and proximal

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(22) balloons through conventional conductive media openings (28) located in the catheter (12) between the two balloons (20, 22). This conductive media flushes out any blood located between the two balloons around the edge of the proximal balloon (22). A continual flow of conductive media into this space between the balloons throughout the procedure prevents any backflow of blood from the left atrium and provides a source of constant cooling while ablation energy is being applied. The ablating system, preferably an Rf ring electrode (30), is secured to the catheter (12) between the two balloons (20, 22). The Rf electrode (30) emits energy which is conducted by the conductive media to the tissue in the vein between the balloons. Sufficient energy is emitted to create a circumferential lesion of sufficient width and breadth to block the passage of atrial premature contractions. The temperature of the tissue may be monitored by temperature sensors, such as thermistors or thermocouples (not shown), located on the surface of the catheter (12) between the two balloons (20, 22). In addition, sensing electrodes (not shown) may be located between the two balloons or proximal from the balloon to sense electrical activity through the vessel after the ablation procedure has been completed to assure complete blockage of the pulmonary vein.

In an alternate preferred embodiment, as shown in Figures 8, 9 and 10, the proximal balloon (22) can be replaced by a

flexible disk (26) which will perform in generally the same manner as the proximal balloon (22) described above.

In an alternate preferred embodiment, the catheter (12) with two balloons (20, 22) is replaced by a catheter (32) containing the distal balloon (36) and an introducer (34) containing the proximal balloon (38). All other components of the system are similar to those of the first preferred embodiment. In all other aspects, this alternative preferred embodiment performs the ablation procedure in the same way as above discussed for the first preferred embodiment.

After the ablation procedure has been completed and tested by use of sensing electrodes, each of the elements of the system are removed from the pulmonary vein and left atrium. If desired, additional sensing devices can be introduced into the left atrium to determine whether there are any other sources for the atrial premature contractions in other pulmonary veins.

It will be apparent from the foregoing that while particular forms of the invention have been illustrated and described, various modifications can be made. For example, the present invention could also be used for ablation procedures

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in other vessels such as the coronary sinus and other veins. _

We Claim:

1. A medical device (10) for ablation within a vessel (14) associated with a human heart comprising

a. a catheter (12),

5 b. a first seal (20) secured to the catheter (11), to seal the vessel (14) and substantially prevent the flow of blood through the vessel (14),

c. a second seal (22) secured to the catheter (11), located proximal to the first seal,

10 d. an introduction member secured to the catheter (11), to introduce a conductive media into a space within the vessel (14) at a location between the first (20) or second (22) seals, and

15 e. an ablating member (30) secured to the catheter (12), for ablating tissue within the vessel (14) between the first (20) and second (22) seals,

20 wherein the second seal (22) is characterized by a structure that encourages a flow of conductive media around the second seal (22) away from the space between the first (20) and second (22) seals yet substantially limits backflow of blood into that space.

2. The medical device of Claim 1 wherein the ablating member is located between said first and second seals.

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3. The medical device of Claim 1 or 2 wherein the first seal is an inflatable balloon.

4. The medical device of any of Claims 1-3 wherein the second seal is an inflatable balloon.

5. The medical device of any of Claims 1-4 wherein the ablating member is a radiofrequency electrode (30).

6. The medical device of any of Claims 1-5 wherein said introduction member comprises a lumen passing through said catheter into an opening in the catheter between the first and second seals for introduction of a conductive media into the vessel between the first and second seals.

7. The medical device of any of Claims 1 or 2 wherein the second seal is a flexible disc.

8. The medical device of any of Claims 1-7 wherein a sensor for sensing cardiac activity is secured to the catheter.

9. The medical device of Claim 8 wherein the sensor is located distal from the first seal.

10. The medical device of any of Claims 1-9 further

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comprising an introducer (34) with a proximal and a distal end and a lumen passing through the introducer from the proximal to the distal end.

11. The medical device of any of Claims 1-10 wherein the ablating member is secured to the catheter and located distal to the second seal.

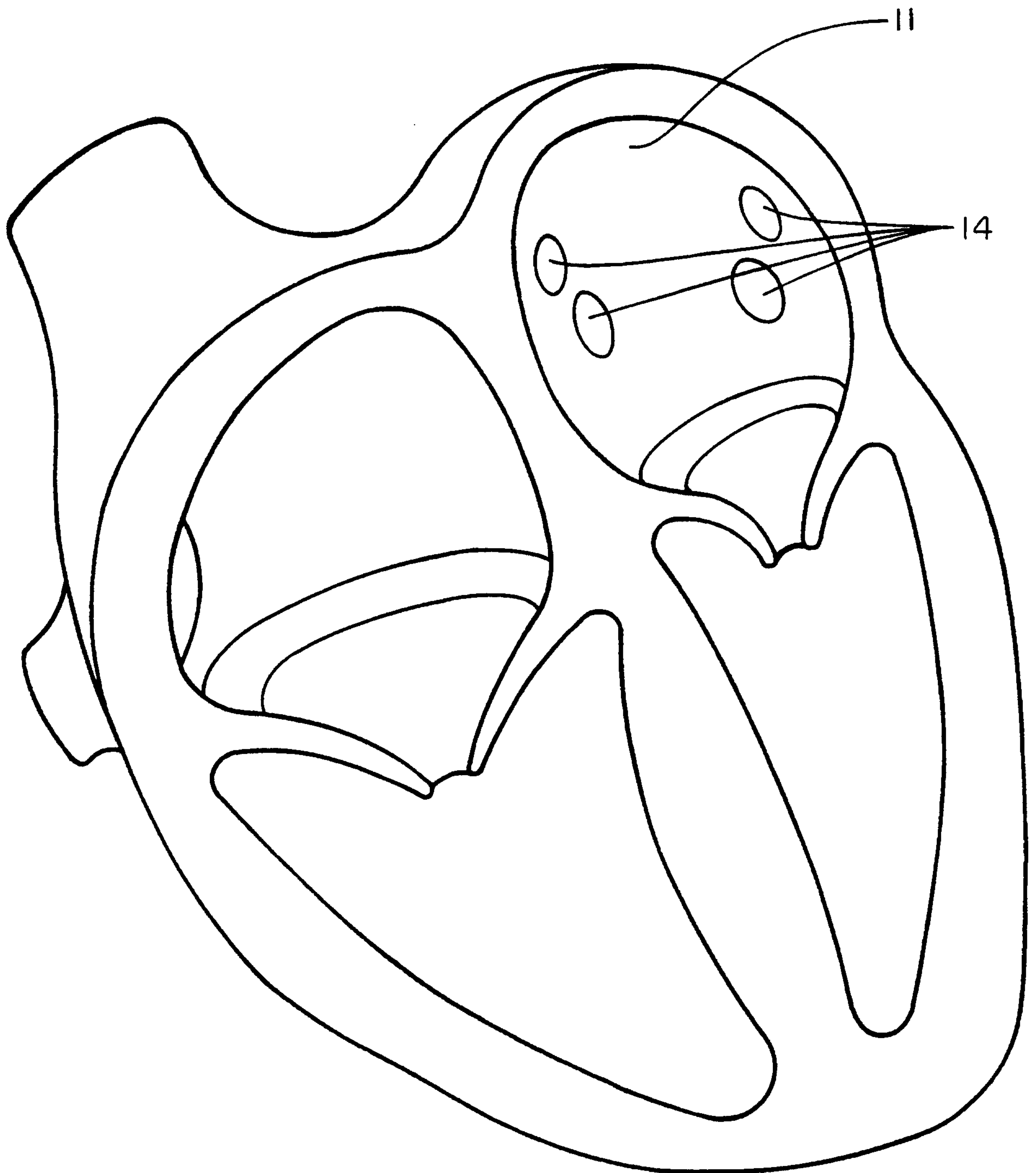


FIG. 1

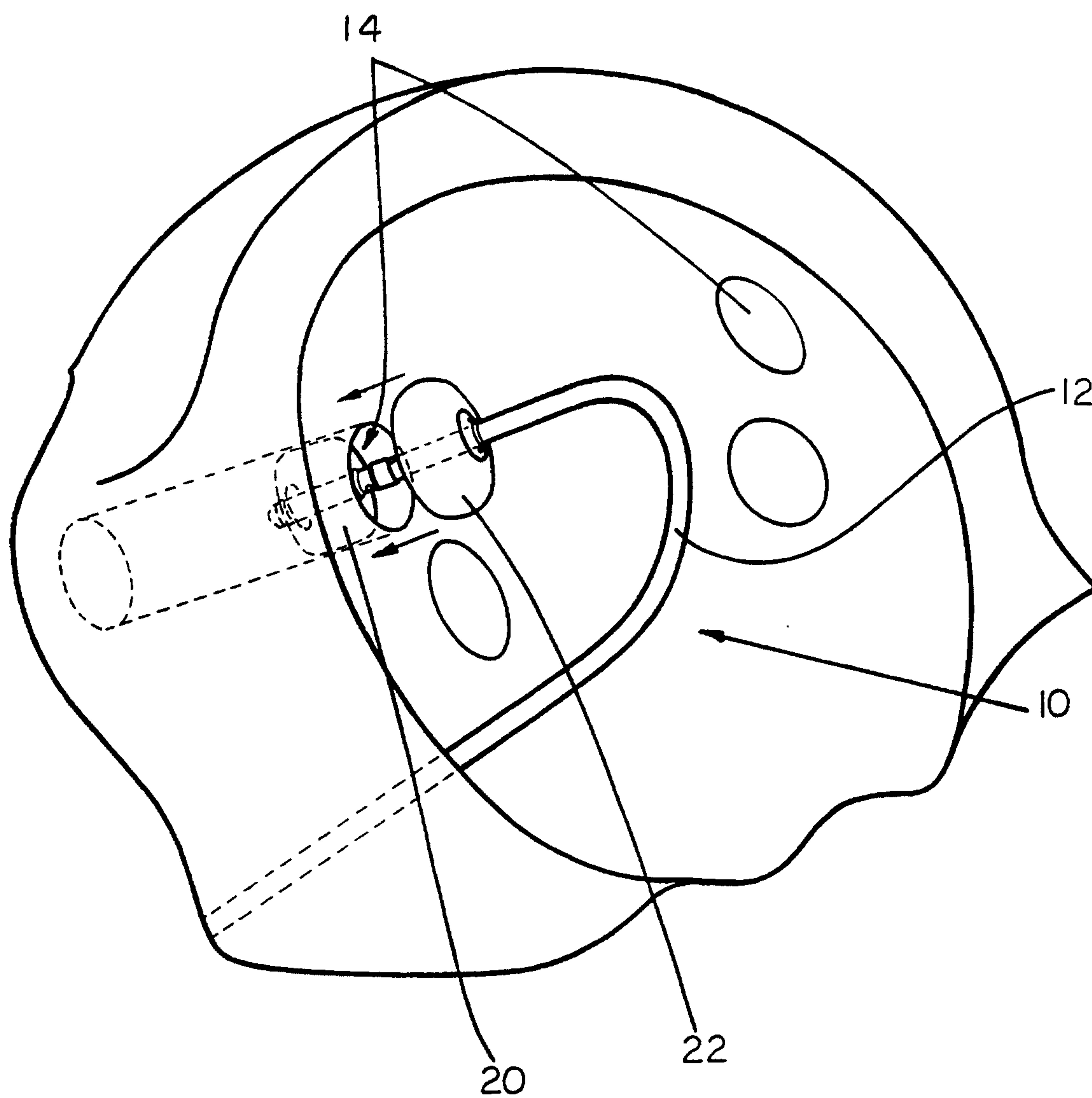
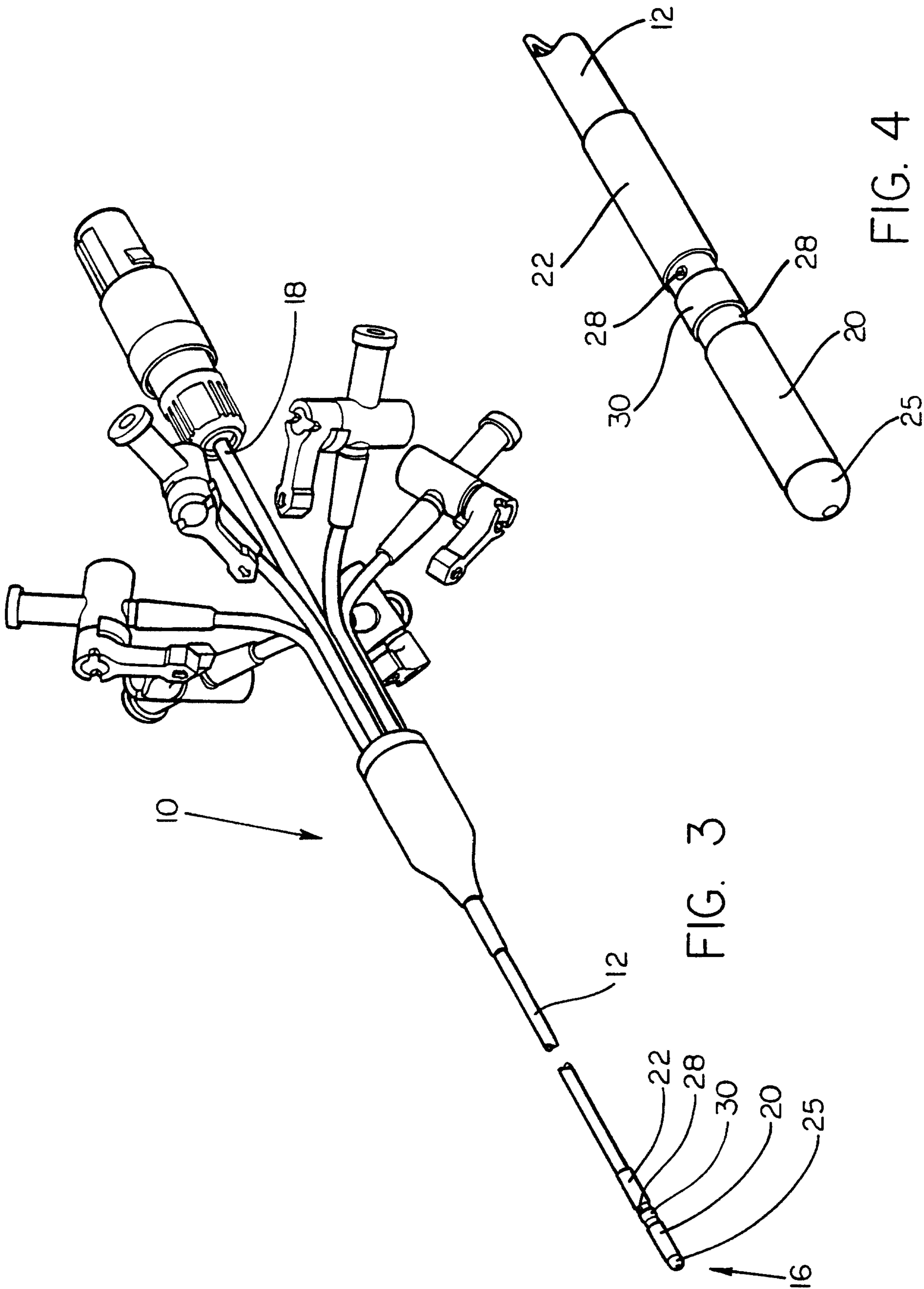


FIG. 2



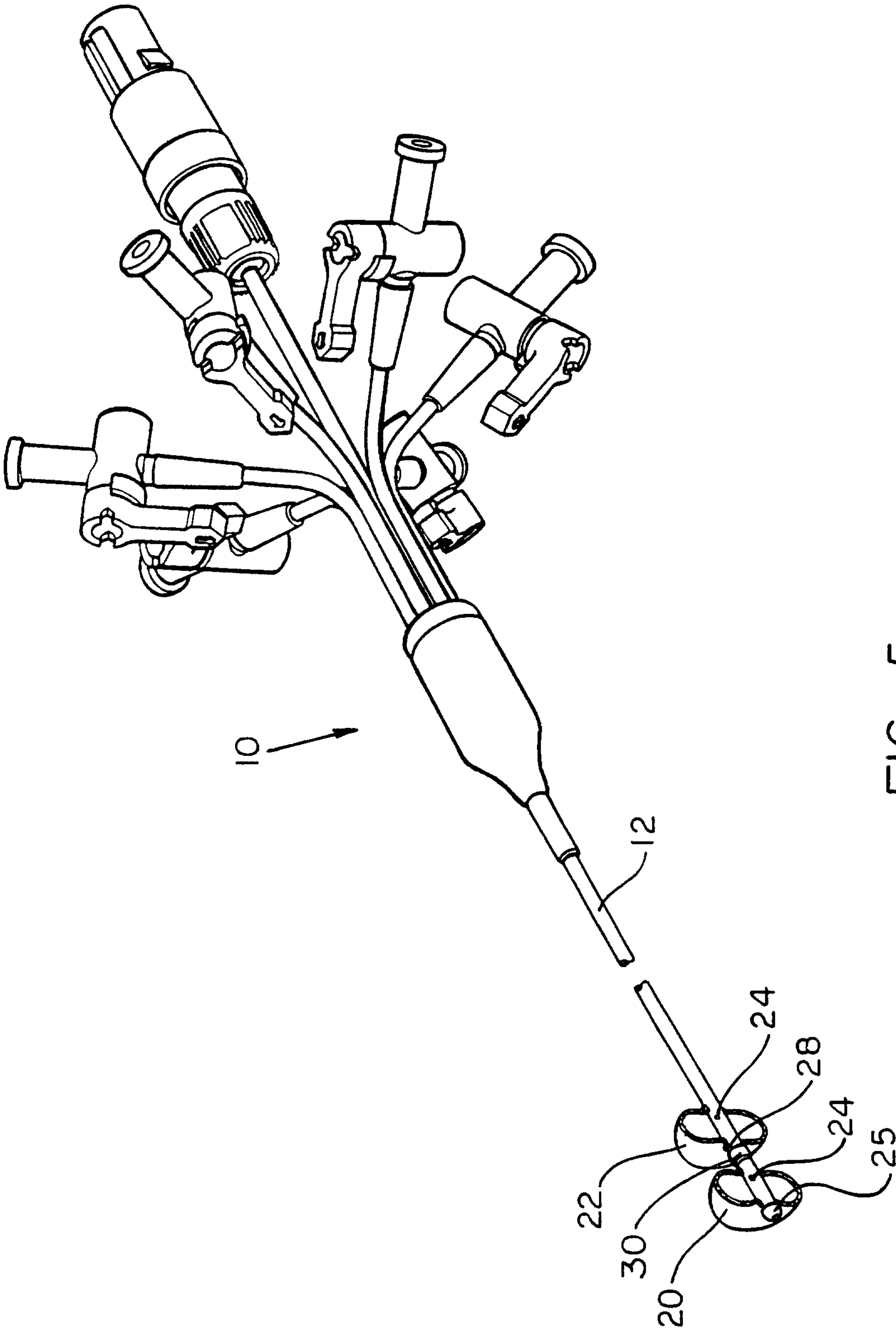


FIG. 5

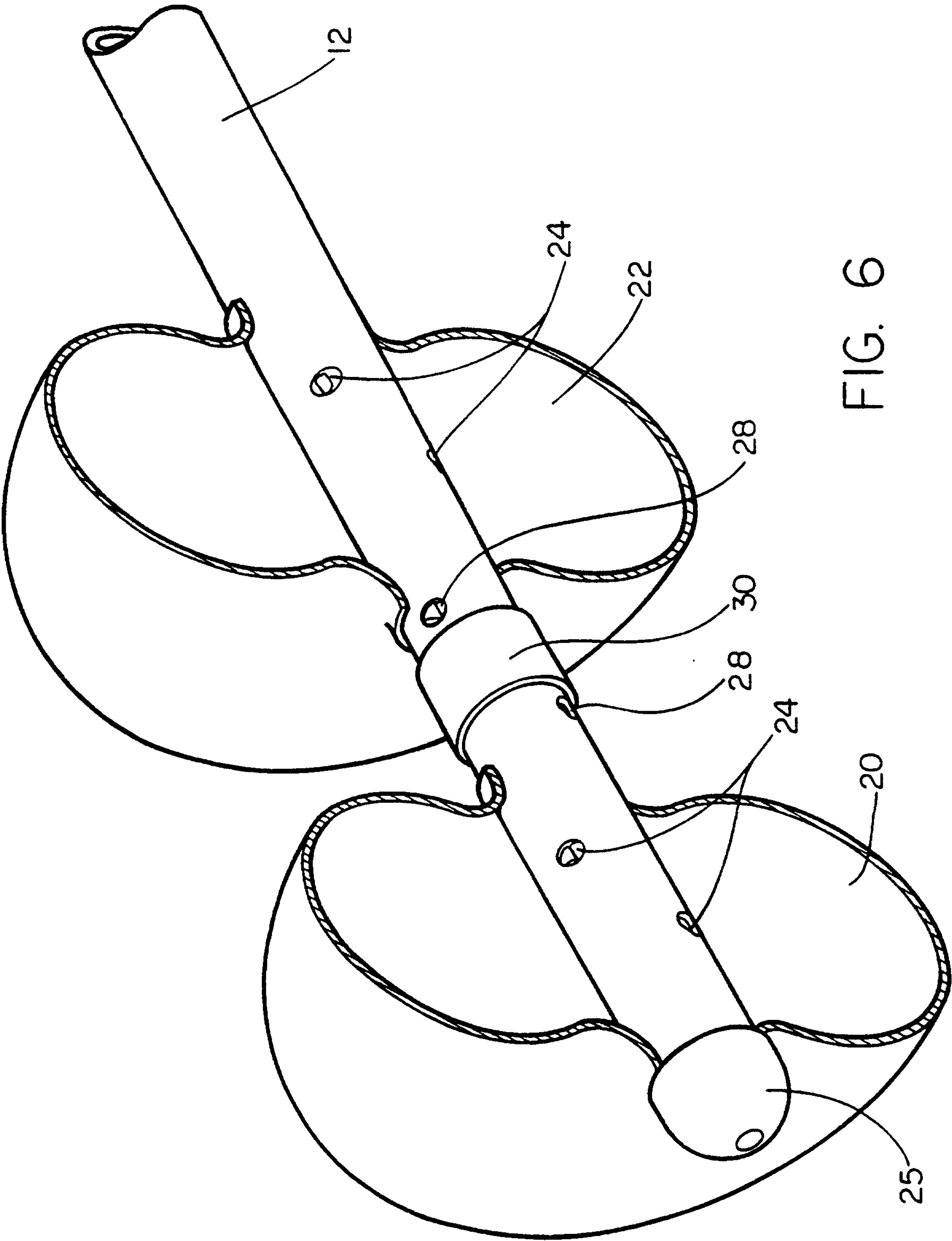


FIG. 6

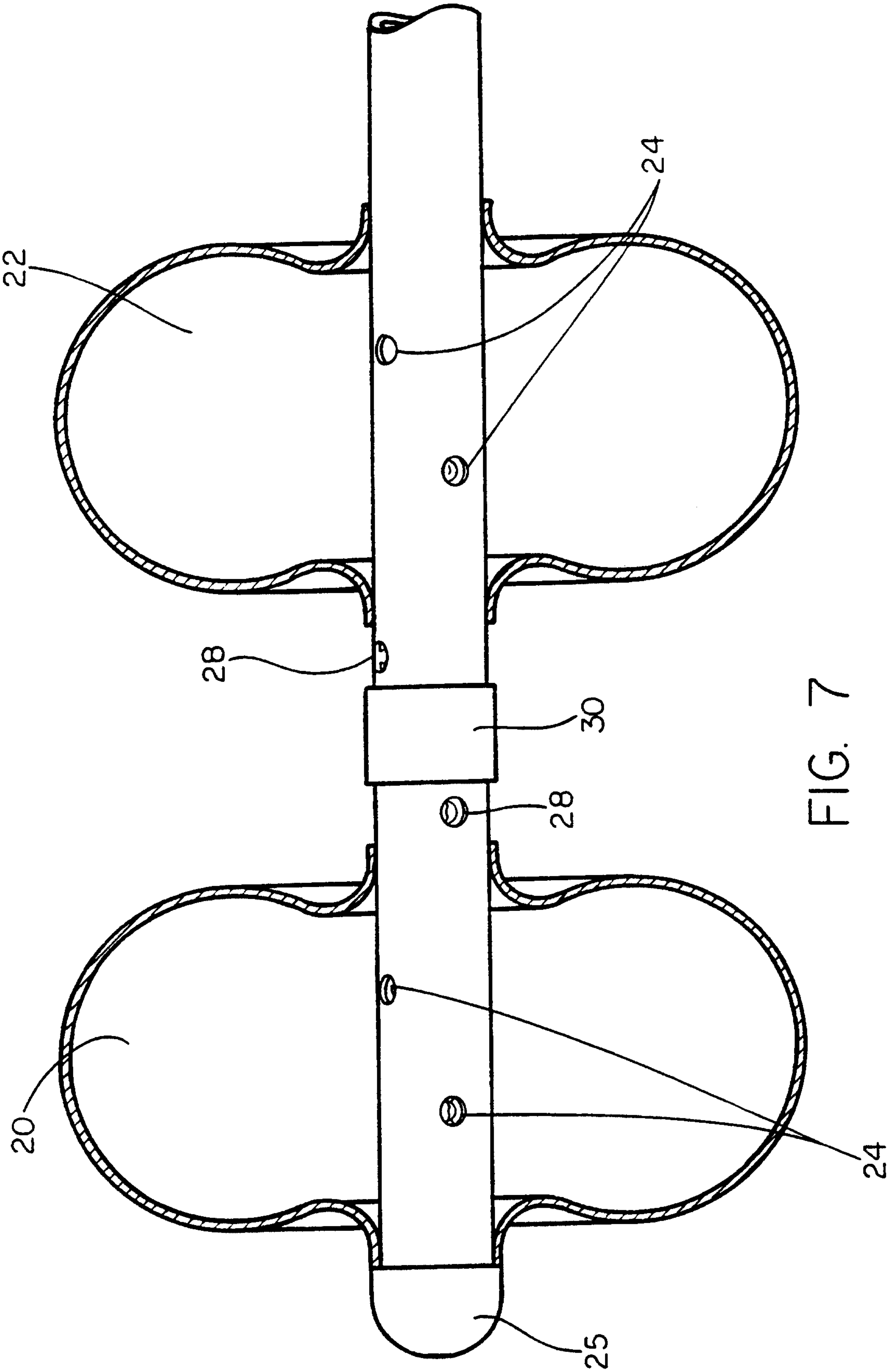
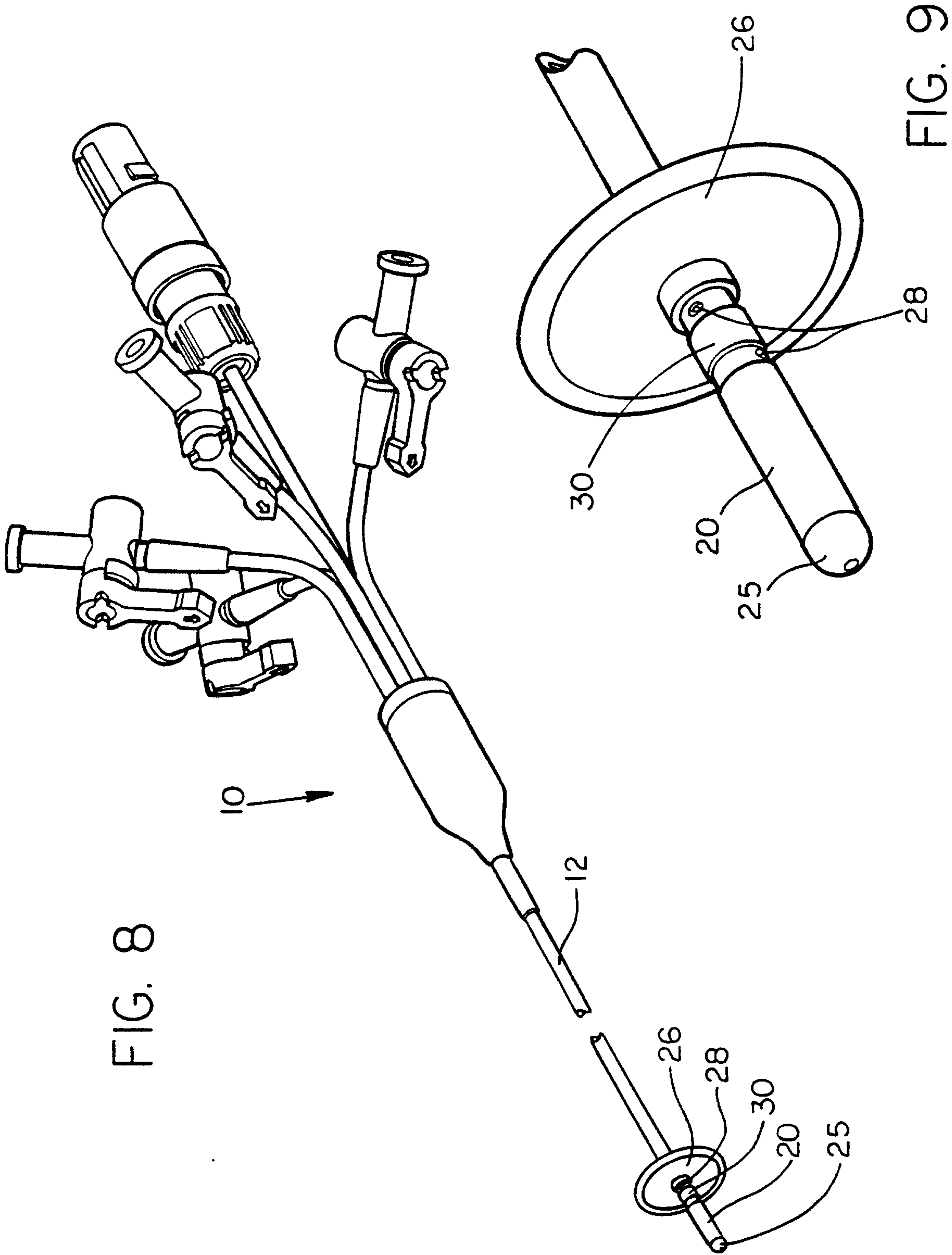


FIG. 7



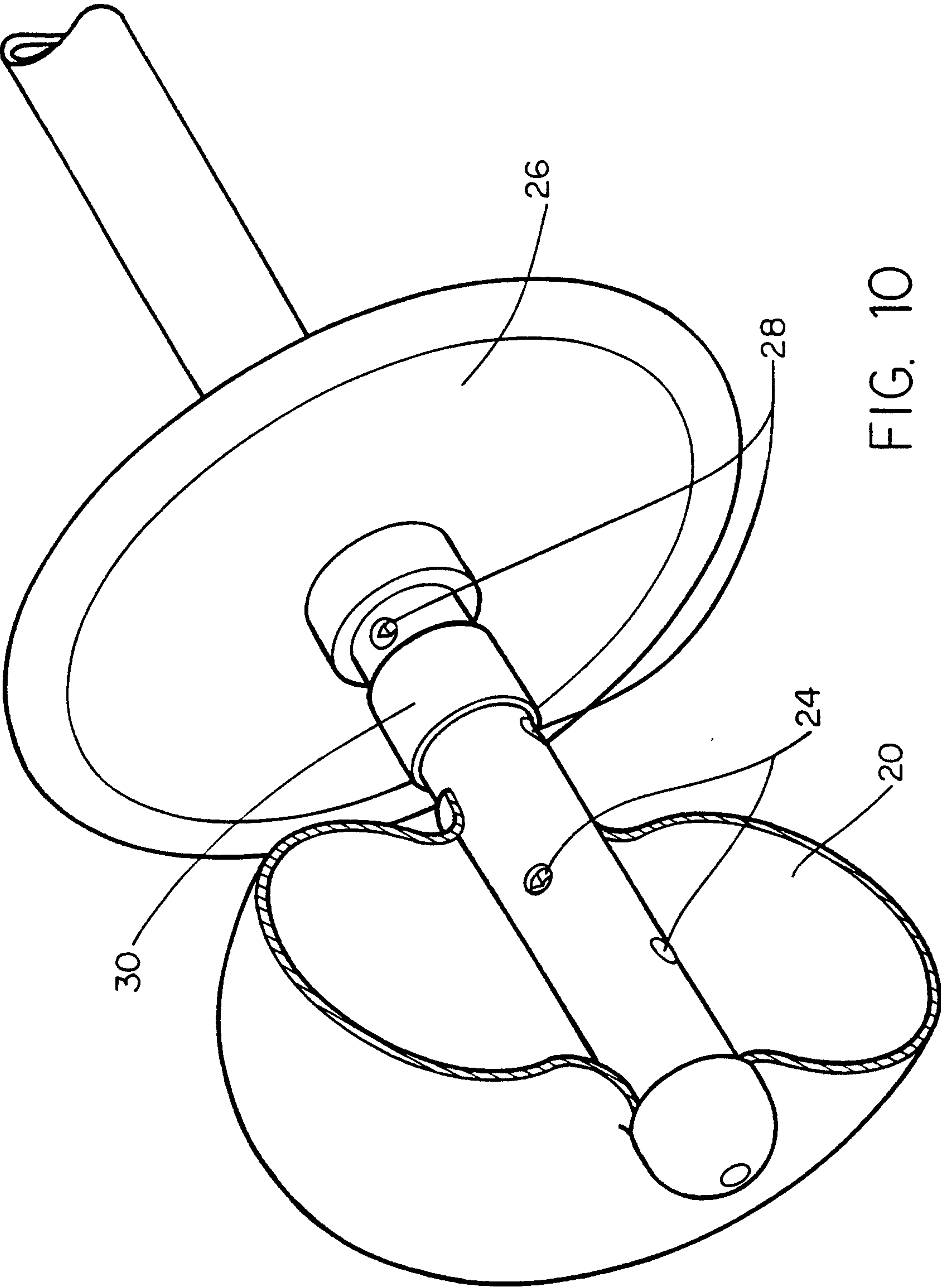
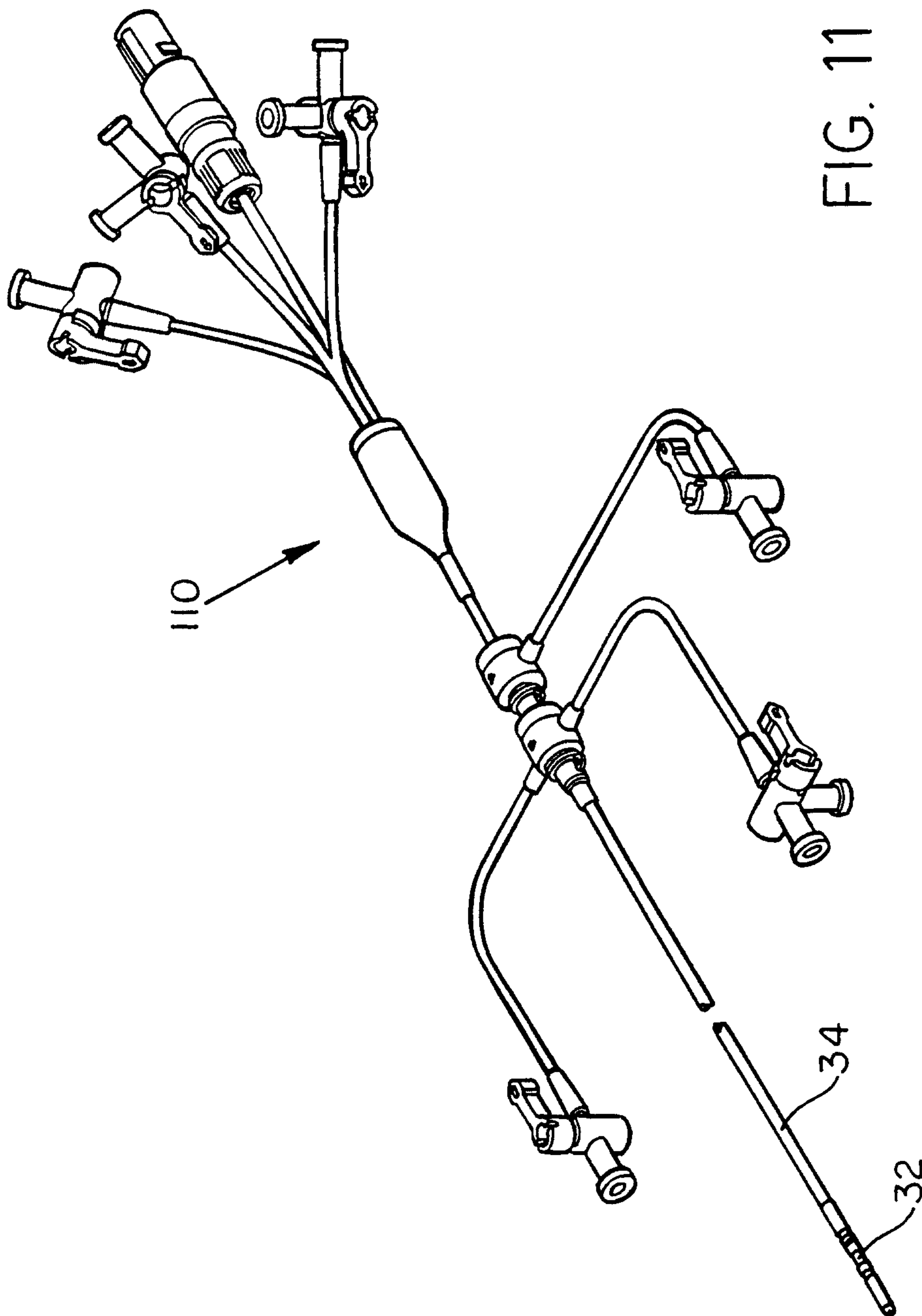


FIG. 10



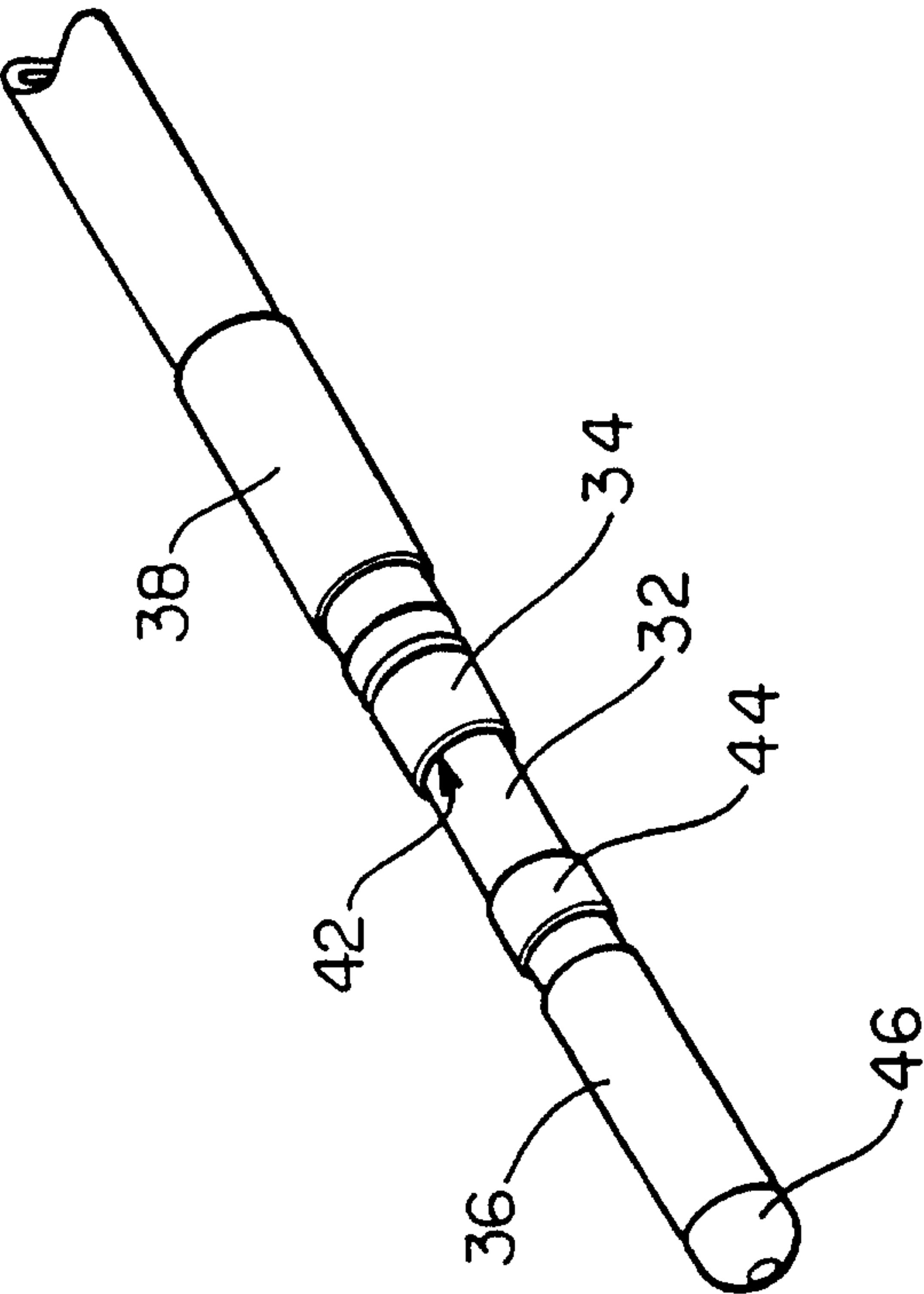


FIG. 12

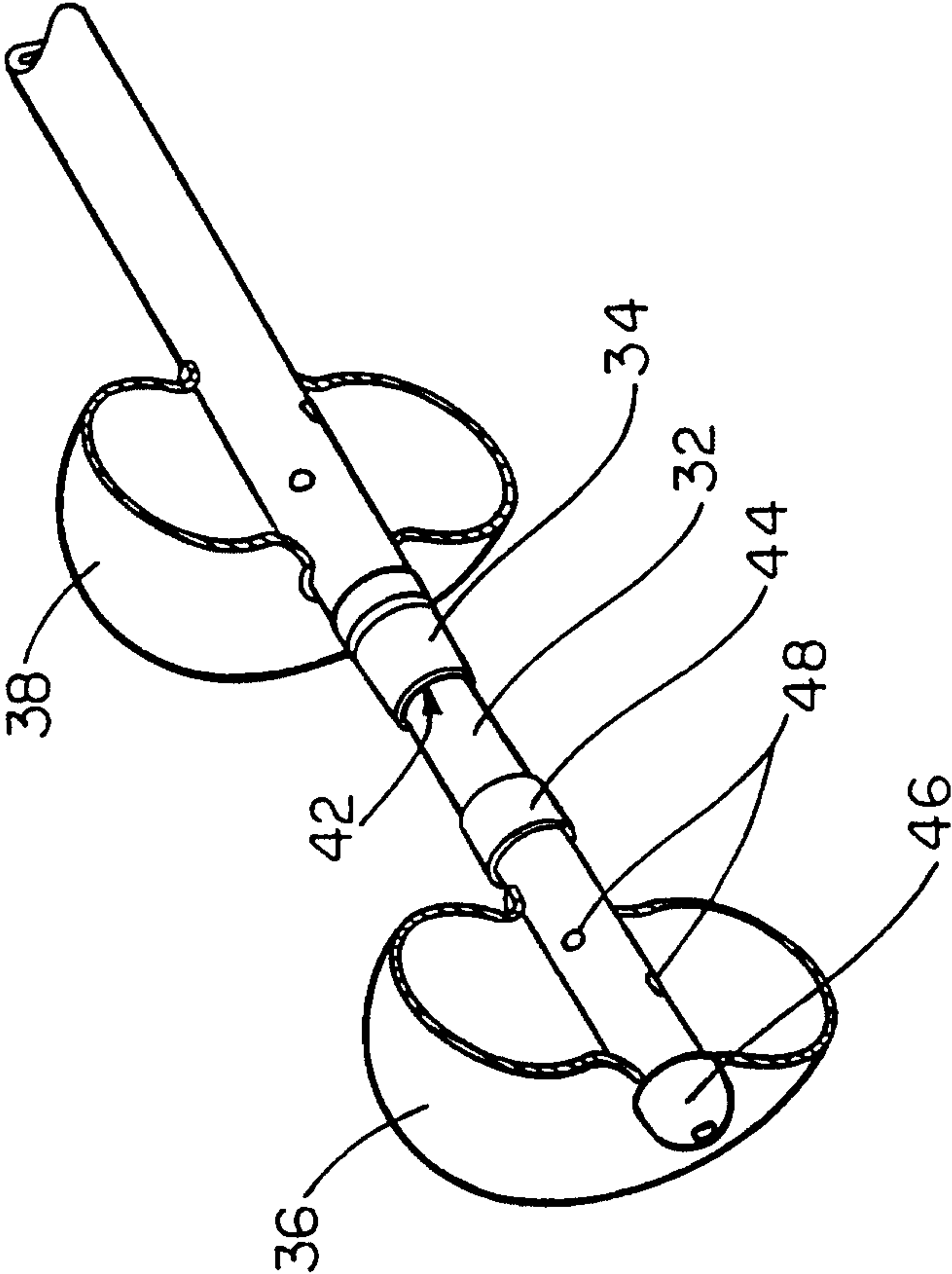


FIG. 13